

Unfinished Business: Designing Appeals Procedures In The Dual-Eligible Demonstrations

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Introduction

The core concept in the dual eligible financial alignment demonstration is integration – integration of payment streams, integration of services and, importantly, integration of appeals processes so that beneficiaries will have a system that protects both Medicare and Medicaid rights, ensures due process, and is easy to understand and navigate.

As planning and implementation progress on the demonstrations, designing an appeals system that achieves these goals is proving to be a challenge. Even though demonstrations already are operational in five states, many details of the appeals system remain to be worked out. Key notices have not yet been written. Nailing down the details of how this core consumer protection will function in each demonstration state is becoming an

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increasingly urgent priority.

In September 2013, NSCLC prepared an analysis of how the appeal processes in the demonstrations had developed up to that date and what still needed to be accomplished.¹ It looked at the six states that, at that time, had signed Memorandums of Understanding (MOUs) with the federal Centers for Medicare and Medicaid Services (CMS). Now, a year later, ten states are participating in the demonstration and in five of them, demonstration programs are operational. Several appeals policy decisions that were unclear in 2013 have been addressed. However, even in states with active demonstration programs, many details remain to be worked out. In all states, the absence of a complete set of appeals notices is a concern.

NSCLC created this tool, *Unfinished Business*, to update consumer representatives on developments over the last year and to highlight appeals issues that continue to be outstanding. The goal is to help stakeholders focus their advocacy about appeals on areas where a consumer voice can have the most potential to affect program design. In states that have not yet finalized three-way contracts, advocates may still have an opportunity to influence contract terms. Even in states where MOUs or three-way contracts appear to have settled an issue, opportunities for advocacy remain. CMS has indicated an openness to modifying procedures in the second and third years of a demonstration, particularly if change will propel integration forward or enhance consumer protections.

1 NSCLC, Appeals Processes in the Dual Eligible Demonstrations (Sept, 2013), available at www.nsclc.org/wp-content/uploads/2013/09/Appeals-in-MOUs-A-Tool-for-Advocates-092013.pdf.

Background

The dual eligible financial alignment demonstrations have moved from conceptual planning into concrete programs, some of which already are enrolling and serving beneficiaries. In the demonstrations, managed care plans provide Medicare and Medicaid services through one entity and receive a combined capitation payment to pay for all covered services. Ten states are participating in the financial alignment demonstration and all have signed Memorandums of Understanding (MOUs) with the Centers for Medicare and Medicaid Services (CMS).² As of November, 2014, seven of those states also have entered into three-way contracts with managed care plans (MCOs) that will participate in the demonstrations and five of those have begun operations.³

The signed MOUs and three-way contracts outline the appeal process for each demonstration. In all demonstration states, the appeal process integrates Medicare Part A and Part B appeals with Medicaid appeals

2 They are California, Illinois, Massachusetts, Michigan, New York, Ohio, South Carolina, Texas, Virginia and Washington. An eleventh state, Minnesota, has signed an MOU for an alternative model that shares many characteristics of the financial alignment demonstration. All MOUs and three-way contracts are available on the CMS financial alignment website, www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsInCareCoordination.html.

3 Beneficiaries have been enrolled in plans and are receiving services in California, Illinois, Massachusetts, Ohio and Virginia. New York and Michigan have entered into three-way contracts with plans but the plans have not yet enrolled beneficiaries.

at the managed care plan level.

New York is the only state that has included significant integration at higher appeal levels. In New York, all Part A and Part B appeals of plan denials, along with all Medicaid appeals, proceed automatically to a special FIDA⁴ Administrative Hearing Unit at the state's Office of Temporary and Disability Assistance with aid paid pending rights attaching to both the Medicare and Medicaid services.⁵ After the FIDA hearing, further appeals go to the federal Medicare Appeals Council (MAC).⁶ The MAC reviews a claim by applying both Medicare and Medicaid law. Aid paid pending can continue through the MAC decision.⁷ Appeals to the MAC are not automatic; the beneficiary must file a request. The final appeal level is Federal District Court.⁸ Aid paid pending is not available at this level. The New York system is slated to be operational when the state's demonstration begins, currently scheduled for January, 2015.⁹

For all other states, full integration is available only at the plan level. Details about time frames and procedures vary among the states and, in some important areas,

4 FIDA is an acronym for Fully Integrated Dual Advantage, the term adopted by New York State to identify its demonstration.

5 New York MOU at 77.

6 New York Contract at 130.

7 Id. at 138-139.

8 Id. at 139.

9 Start dates for state demonstrations are subject to change. Current information for the implementation timetable for each participating state is available at www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsinCareCoordination.html.

questions and gaps remain. Beyond the plan level, integration has been very limited, at least for the start of the demonstration. Beneficiaries may follow the standard Medicare appeal route, the Medicaid route, or both routes, depending on the service and the preference of the individual. In all states, including New York, Medicare Part D appeals remain separate with no change from existing Medicare practice.

This advocate's tool discusses key elements in a combined appeals process and suggests approaches consumer representatives should consider taking when working with their states to design robust integrated appeals processes. It will:

- Look at appeals notices that have been developed to date;
- Review appeal provisions in federal-state Memorandums of Understanding (MOUs) and three-way contracts;
- Identify areas where gaps appear and areas where states have created processes that improve on prior models; and
- Suggest positions that consumer representatives can take when working with their states to finalize design of their appeals process and to improve its operation during the course of the demonstration.

Appeals Issues

Notices

Although states and stakeholders have been putting significant effort into drafting notices around enrollment, there has been much less progress to date in creating tailored notices around appeal rights in the demonstrations. Like enrollment, for appeal rights to be meaningful, beneficiaries need

clear, understandable notices. In most demonstration states, even those where plans are already operating, those notices have not yet been drafted. This is an area that deserves immediate and focused attention.

Much work remains to be done. Gaps in the development of demonstration notices include:

Initial Denial Notice: The only integrated notice that has been finalized to date is a model Integrated Denial Notice for Medicare Advantage plans, drafted by CMS.¹⁰ That model needs to be tailored to each state’s demonstration.¹¹ Further, it needs to be revised to add a prominently displayed statement directing the beneficiary to the demonstration ombudsman as the primary source of assistance. The current model notice mentions other sources of assistance but fails to make any reference to ombudsman assistance.

Denial of Internal Plan Appeal: No state has finalized a model integrated notice to be sent after a plan level appeal is denied.¹² It is not clear what notice plans are using in states

where the demonstrations are operational.

IRE Denial: CMS has not developed any demonstration-specific notices for use by the IRE. Instead, beneficiaries whose appeal is denied in whole or in part by the IRE will receive the standard Medicare notices. Those notices do not tell beneficiaries about the rights they may have to go to state fair hearing to appeal overlap services. They also do not mention the availability of ombudsman services.

Translating Notices: The current three-way contracts impose translation obligations on plans for their coverage determination and appeal notices. CMS, however, does not impose those same obligations on itself or its contractors, including the IRE. Thus, a beneficiary participating in a demonstration who speaks a “prevalent” or “threshold” language may receive a coverage determination notice and a notice about her plan appeal in the language she speaks but, once her appeal reaches the IRE or subsequent steps in the Medicare appeal process, that accommodation may end.¹³

Advocacy Points:

- **Modify model integrated denial notices.** Model integrated denial notices need to be modified to address the unique appeals system in each state. State should develop two versions: one that lays out both Medicare and Medicaid appeal routes and another, for Medicaid-only services, that only describes the Medicaid appeal route.
- **Develop integrated denial notices for each level of appeal.** Integrated denial notices need to be developed both for plan level

10 CMS Medicare Advantage Denial Notice, available at www.cms.gov/Medicare/Medicare-General-Information/BNI/MADenialNotices.html.

11 Further, the current Integrated Denial Notice is confusing (and likely incorrect) in its optional language, which says “If you ask us for an appeal first, you may miss the deadline for requesting a State Fair Hearing.” It is our understanding that, in states that allow a beneficiary to go straight to Fair Hearing without first pursuing a plan appeal, the beneficiary who chooses an internal plan appeal does not lose the right to pursue a Fair Hearing after that internal appeal and will not lose any right to APP at the Fair Hearing level.

12 New York is working on draft notices but, as of November 1, they have not been finalized.

13 See, e.g., Massachusetts Contract at 93 and 110; New York Contract at 117 and 144.

appeals and for IRE appeals. Both plan appeal denial notices and IRE denial notices should spell out clearly for beneficiaries the next appeal steps available to them, including, where applicable, the right to state review and the right, if applicable, to APP. It is not enough to tell beneficiaries once, at the lowest plan level, that they have access to two appeals routes for overlap services. Omitting this information from subsequent notice eviscerates key protections in the demonstration.

- **Include ombudsman information.** All notices, including notices from CMS, should designate the demonstration ombudsman as the primary source of assistance with appeals.
- **Translate appeal notices.** Appeal notices are among the most critical documents that demonstration participants receive. All appeal notices, both at the plan level and at higher levels of appeal, should be available in threshold languages and should have multilingual inserts. State appeal entities, the IRE and the CMS Office of Medicare Hearings and Appeals should all be held to the same translation standards that are imposed on plans.
- **Develop and test notices now.** States that are operational need to focus attention on appeal notices now. States that are preparing for enrollment should allow adequate time and resources for development and testing of appeal notices. All notices specific to each state’s demonstration, including IRE notices, should be developed with stakeholder input, then tested with focus groups and translated.

Overlap Services

The MOUs use the term, “overlap services,” to describe services that both Medicare and Medicaid cover, though sometimes with different criteria for coverage. All of the MOUs say that, for appeals, overlap services will be further defined in the three-way contracts.¹⁴ Those contracts to date, however, have said little. The Massachusetts contract is typical, referencing overlap services as “including, but not limited to, Home Health, Durable Medical Equipment and skilled therapies, but excluding Part D.”¹⁵ Despite the open-ended “including but not limited to” language, advocates are concerned that states and plans are interpreting overlap services too narrowly and are including only the enumerated categories of home health, DME, and skilled therapies.

Advocacy Points:

- **Retain both routes of appeal for overlap services.** Most, if not all, Medicare-covered services are also covered by Medicaid. State medical necessity definitions and criteria may differ from Medicare. If the beneficiary believes that there may be a different outcome for any service that is covered by both Medicare and Medicaid, the beneficiary should have the right to appeal through both the Medicare and Medicaid routes. To decide otherwise takes away current due process rights from demonstration enrollees, an outcome not contemplated by the demonstrations. The three-way contracts should clarify and

¹⁴ See, e.g., Virginia MOU at 78.

¹⁵ Massachusetts Contract at 109. The Illinois Contract has a similar reference at 110: “including Home Health, Durable Medical Equipment and skilled therapies.”

communicate to plans that they may not arbitrarily narrow the definition of overlap services.

- **Review off-label determination requests under both criteria.** Coverage of off-label uses of prescription drugs presents a unique example of overlap. Medicare requires compendium support for the off-label use but Medicaid criteria can be broader, permitting reliance on support by peer reviewed journals. If a drug is denied by a plan because the off-label use is not for a “medically accepted indication,” the denial is a determination that the drug is not a “covered Part D drug,” and thus could be covered by Medicaid if Medicaid criteria were met. Plans should be required to review a coverage determination request under both Medicare and Medicaid criteria and the beneficiary should have recourse to both Medicare and Medicaid appeal routes when an off-label use is at issue.

Timing Issues

Timeframe For Appeal Resolution By Plans

All demonstrations provide paths for both standard and expedited appeals. Deadlines for plan resolution of standard appeals vary. Several states require that plans resolve appeals in 15 days,¹⁶ while others say 30 days.¹⁷ The Illinois MOU sets a deadline of 15 business days.¹⁸

¹⁶ See South Carolina MOU at 100, Washington MOU at 102 (note: Washington requires 14 days), Ohio MOU at 67.

¹⁷ See Virginia MOU at 78, Massachusetts MOU at 88, New York MOU at 77; Texas MOU at 70, Michigan MOU at 88.

¹⁸ Illinois MOU at 76.

Advocacy Points:

- **Set a 15 day maximum for resolution.** Prompt resolution of appeals should be a goal in all demonstrations. Because plans should already be coordinating beneficiary paperwork and should have easy access to the information needed to make a decision, 15 days ought to be sufficient to resolve a plan-level appeal.
- **Use calendar day deadlines.** All decision deadlines should be expressed in terms of calendar days rather than business days. CMS has already moved away from the use of business days in its Part D guidance.

Timeframe For Appeal Resolution At State Fair Hearing

At the state fair hearing level, New York, Virginia, Ohio, South Carolina, and Texas allow 90 days for state hearing level appeals. Virginia requires resolution or a decision within 90 days during the first year of the demonstration, 75 days in the second year and 30 days in the third year.¹⁹

Advocacy Point:

- **Compress decision timelines.** The demonstrations offer an opportunity to streamline fair hearings. States should consider reducing fair hearing deadlines to provide beneficiaries with quicker resolution of their cases. Although 90 days is the current Medicaid standard in several states, the demonstrations offer an opportunity to follow Virginia’s approach of a staged compression of decision timelines.

¹⁹ Virginia MOU at 78.

Streamlining Part D Appeals

In all demonstrations, appeals of Medicare Part A and B services and appeals of overlap services are auto-forwarded to the Independent Review Entity (IRE) if the plan appeal decision is less than entirely favorable to the beneficiary.²⁰ For Part D, however, review by the IRE is not automatic; the beneficiary must affirmatively seek IRE review.

Advocacy point:

- **Auto forward Part D appeals.** A relatively simple step toward integration of Part D in the demonstrations would be automatic forwarding to the IRE of denied prescription drug claims. While it is highly unlikely that CMS would permit this change in the first year of the demonstrations, the idea is worth pursuing in subsequent years of the demonstration.

Aid Paid Pending

Aid Paid Pending At The Plan Level

Outside of the demonstrations, the right to continue to receive ongoing services (Aid Paid Pending or APP) while a denial or reduction is appealed is central to Medicaid but has been largely absent from Medicare. The demonstrations extend APP to Medicare services, creating an important new consumer protection.

The MOUs, however, leave open questions on how to obtain APP rights. New York²¹ and

²⁰ New York auto-forwards appeals to the FIDA Administrative Hearing Unit.

²¹ New York MOU at 76. The ten-day requirement is consistent with Medicaid regulations. 42 CFR 431.231(c).

Illinois²² set a 10 day filing deadline for plan level appeals in order to receive aid paid pending. The Ohio deadline is 15 days.²³ Other state MOUs are not explicit about the 10-day requirement.²⁴

Further, the MOUs are silent about whether the filing deadlines for APP apply to Medicare services or only to Medicaid services. The Ohio contract is an exception, stating specifically that APP and the 15 day deadline apply to all services other than Part D prescription drugs.²⁵ In all states, APP rights are not available in connection with Medicare Part D prescription drugs.

Some states require that the beneficiary explicitly request APP.²⁶ In other states, including Massachusetts and Illinois, it appears that APP is automatic at the plan level without a formal request but must be specifically requested if the beneficiary wants APP continued at the state fair hearing level.²⁷

Advocacy Points:

- **Clarify filing requirement.** The three-way contracts and beneficiary communications, including member handbooks and notices of action, should be clear about whether or not a 10 day filing is required and, if so, whether this requirement applies to Medicare as well as Medicaid services.

²² Illinois MOU at 77.

²³ Ohio Contract at 87.

²⁴ Although the Michigan MOU is unclear, the state's three-way contract, by referencing 42 CFR 438.420, is more explicit in setting a 10-day requirement. Michigan Contract at 119.

²⁵ Ohio Contract at 87.

²⁶ See, for example, Ohio Contract at 89.

²⁷ Massachusetts Contract at 109; Illinois Contract at 106.

- **Treat an appeal request as a request for continued service.** Requiring that a beneficiary make an explicit request for APP can be a barrier to continued receipt of needed services. Plans should be required to treat a timely-filed appeal as an automatic request for continued services or, at least, to specifically ask the beneficiary if she wants a continuation of services during the appeal.
- **Begin to integrate Part D.** If Part D cannot be totally integrated during the demonstration, at least some steps, such as an APP policy for prescription drugs that harmonizes with APP for all other services, could begin the integration process. This change may be more achievable during the second or third year of a state's demonstration.

Aid Paid Pending At The Ire Level

Once a beneficiary pursues an appeal beyond the plan level, integration breaks down (except in New York) and, for overlap services, beneficiaries face decisions about whether to pursue both state and federal appeal paths and, if so, in what order. When continuing services are at issue, keeping APP is an important consideration in evaluating those options. Some states have simplified choices for beneficiaries while others have not.

Innovations in the South Carolina, Illinois and New York MOUs make it easier for beneficiaries to efficiently pursue appeals of overlap services without losing APP. The South Carolina MOU provides that, for overlap services, APP will continue through the IRE level, allowing an individual to pursue an IRE appeal before going to a State Fair Hearing.²⁸ Illinois also provides for APP

²⁸ South Carolina MOU at 101.

through the IRE appeal and then through a State Fair Hearing if a hearing request is made within 10 days of notice of the IRE decision.²⁹ The more integrated New York model protects APP through both of its levels of external appeals for all services without a need to determine whether the services qualify as overlap services or not.³⁰

In other states, it appears that, to keep APP, a beneficiary would need to concurrently pursue appeals at the IRE and State Fair Hearing level. If the beneficiary waits until after the IRE decision to go to State Fair Hearing, APP rights would be forfeited.

Advocacy Points:

- **Provide APP at the IRE Level for overlap services.** Following the Illinois example of providing APP for overlap services until the IRE has rendered a decision would prevent waste of administrative resources from concurrent reviews and protect beneficiaries from the burden of pursuing a single claim simultaneously in two forums.
- **Provide APP at the IRE level for all Medicare services.** More integrated still would be to borrow from the New York approach and protect APP for all services, whether or not they overlap, through at least the first level of external appeal.³¹ This approach would be both more integrated and easier to communicate to beneficiaries.

²⁹ Illinois Contract at 113.

³⁰ New York Contract at 139-140.

³¹ As discussed above, most, if not all, Medicare-covered services should be treated as overlap services. Thus offering APP across the board is really no different than offering APP for overlap service. The New York formulation, however, is simple and easy to enforce, and avoids the issue of overlap services entirely.

Recoupment Of Aid Paid Pending

Most state Medicaid programs retain the right to recoup from beneficiaries the costs of services provided during an appeal if the appeal is ultimately unsuccessful. Even though states rarely try to collect, an individual's fear of repaying APP may deter her from exercising her appeal rights. In the demonstrations, the Ohio, Texas, and Michigan MOUs include a prohibition against recoupment of aid paid pending: "Payments will not be recouped based on the outcome of the appeal for service covered during pending appeals."³² The New York three-way contract also prohibits recoupment.³³ All other MOUs are silent on recoupment policy. The MOUs also do not address whether recoupment would apply to APP for Medicare services.

Advocacy Point:

- **Eliminate recoupment.** Including a no-recoupment provision in three-way contracts eliminates a disincentive for individuals to pursue their appeal rights. Given the poverty of the affected beneficiaries, few would be able to pay in any case. Explicitly directing demonstration plans not to try to collect will also ensure that beneficiaries receive uniform protection regardless of which demonstration plan they join.

Appealing Denials of Additional Services Set Out in the Three-way Contracts

The MOUs and three-way contracts give demonstration participants specific rights beyond those available generally for Medicare and Medicaid beneficiaries.

³² Ohio MOU at 68. See also Ohio Contract at 89; Texas MOU at 71; Michigan MOU at 88.

³³ New York Contract at 140.

They include, for example, the right to supplemental services (in some states), and continuity of care for new enrollees. Further, all MOUs have strong language requiring compliance with the Americans with Disabilities Act and Title VI of the Civil Rights Act of 1964, including language access. These rights appear in the Evidence of Coverage (Member Handbook) as well. The contractual rights to these services are important benefits for demonstration enrollees but ambiguity remains about what appeal paths are available to beneficiaries when these rights are denied. Additionally, there is ambiguity about what notices are triggered when a request for any of these services is denied.

For supplemental services, Massachusetts is the only state that directly addresses appeals. The Massachusetts three-way contract provides that the IRE handles appeals of the denial of supplemental services. In reviewing an appeal, the IRE must apply both Medicare and Massachusetts Medicaid medical necessity criteria and must "decide based on whichever definition, or combination of definitions, provides a more favorable decision for the Enrollee."³⁴

For ADA violations, Massachusetts and Illinois set out a specific process at the plan level. Both states require that plans establish an internal grievance procedure for complaints about ADA violations, but they do not establish any path for appeal to an external decision maker.³⁵ None of the MOUs or three-way contracts address appeals of care continuity denials or appeals involving language access rights. For example, none discuss the appeal route if a plan or a

³⁴ Massachusetts Contract at 113.

³⁵ Massachusetts Contract at 107; Illinois Contract at 102.

network provider denies a request for an interpreter during a medical visit.

Advocacy Points:

- **Use the appeal process for denial of any contractual right.** When a plan denies a beneficiary any contractually required benefit, that denial should be appealable and not merely treated as a grievance. Thus, for example, failure to grant care continuity or denying a requested supplemental service should trigger a notice of action specifying the basis for the denial and explaining appeal paths and deadlines.
- **Include an external decision maker.** The appeals path for contractual rights must include an external decision maker. The Massachusetts approach of making the IRE the external decision maker for supplemental services appears to be a reasonable choice that could be applied to care continuity and language and disability access claims as well. It is important, however, to ensure that the IRE has the requisite training to take on these additional areas.
- **Improve notices of action.** Notices of action about denial of disability accommodations or language access should, in addition to explaining appeal paths through the plan and the IRE, also explain to beneficiaries that they have the right to file a complaint with the HHS Office of Civil Rights. Appropriate notices should be developed.

Informing Beneficiaries Of The Right To Appeal The Care Plan

Written care plans, developed with the participation of the beneficiary, are a key element in the design of the demonstrations.

Beneficiaries or their representatives typically are asked to sign a care plan and plan updates. A beneficiary may fail to understand that signing a care plan does not waive appeal rights. The MOUs and three-way contracts do not address this issue.

Advocacy Point:

- **Inform beneficiaries.** The three-way contract, the Evidence of Coverage and the instructions around the signature line to the care plan should make clear that signing a care plan does not in any way waive a beneficiary’s appeal rights. The care plan should inform the beneficiary of the right to contest all or any portions of the document.

Conclusion

A fully functional appeal system should be up and running on the first day that any beneficiary is enrolled in a state’s financial alignment demonstration. It should ensure that beneficiaries have access to all the rights they would have had absent the demonstration and also that they have routes to appeal contractual rights specific to the demonstration. At every step, the appeals system should provide beneficiaries with clear information, which is understandable in their language, about all available appeal paths and about how to obtain assistance in the appeal process.

To date, these goals have not been accomplished. With five demonstrations already operational and another five preparing for enrollments in 2015, the need to get good appeal processes in place has taken on urgency. Ensuring both that systems are fair and accessible and that they are developed quickly should be a priority for consumer representatives.



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