NSCLC

National Senior Citizens Law Center

Protecting the Rights of Low-Income Older Adults

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Building an Integrated Appeals System for Dual Eligibles

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The National Senior Citizens Law Center is a non-profit organization whose principal mission is to protect the rights of low-income older adults. Through advocacy, litigation, and the education and counseling of local advocates, we seek to ensure the health and economic security of those with limited income and resources, and access to the courts for all.

Our Project

- Four technical issue briefs describing and providing recommendations on important issues facing dual eligibles:
  - Ensuring Consumer Protections in Integrated Models
  - Addressing “Bump-ups” in program rules and benefits
  - Building an integrated appeals system
  - Improving delivery of the QMB benefit

Our Support

- Supported by a grant from The SCAN Foundation, dedicated to creating a society in which seniors receive medical treatment and human services that are integrated in the setting most appropriate to their needs. For more information, please visit www.TheSCANFoundation.org.

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Vice President, Policy and Communications

Outline of Presentation

- Why Integrated Appeals?
- Appeals in existing integrated models
- Resolving Differences in Medicare and Medicaid
  - Notices
  - Levels
  - Timing
  - Aid Paid Pending
  - Amount in Controversy
  - Additional Protections
- Options for Integrating External Structures
- Special Considerations

Why Integrated Appeals?

- Integrated models need integrated appeals
- Lots of types/points of appeal
- Cart before the horse?
  - Decisions about how benefits, benefits, decision-making, funding and oversight will be structured will dictate options for integrating appeals

Current Processes

- Many processes to be thinking about:
  - Medicare FFS
  - Medicare Advantage
  - Medicare Part D
  - Medicaid FFS (state-by-state variation)
  - Medicaid Managed Care (state-by-state variation)

Examples of 'Integrated' Processes

- PACE
  - Broad requirement for an internal appeal process which must included an expedited process (72 hours, normal is 30 days).
  - Review is done by a credentialed, impartial third party not involved in the original action and without a stake in the outcome.
  - Enrollee retains access to external processes under Medicare or Medicaid managed care.
  - 42 CFR 460.122, 124; contracts and state regs provide detail

Examples of 'Integrated' Processes

- Wisconsin Partnership Program
- Minnesota Senior Health Options
  - Integrated dual eligible SNP programs
  - State contracts requires integrated internal review.
  - External options are to Medicaid state agency, fair hearing; also subject to Medicare Advantage external procedures for Medicare coverage.

Examples of 'Integrated' Processes

- CMS SNP Guidance:
  - Optional model that attempt to align processes, unclear if any states have adopted it
  - Integrates first/plan level of appeal
  - Automatically forwards to Medicare IRE and Medicaid FH for second level
  - No additional integration

https://www.cms.gov/IntegratedCareInt/Downloads/Integrated_Appeals_Process.pdf
http://www.cms.gov/IntegratedCareInt/Downloads/ExpeditedAppealFlowchart.pdf

Resolving Differences

- Notices-type, timing and content
- Levels of Appeal
- Timeframes for appeals
- Aid paid pending
- Amount in Controversy
- Other protections

Initial Notice

- Medicaid:
  - Notice of action is issued when coverage for a service is denied in whole or in part, terminated, or reduced.
  - Notice provided before the action.
  - Notice is issued by Medicaid agency or Medicaid managed care plan
  - Notice is appealable.

Initial Notice

- Medicare
  - Medicare Summary Notice (MSN). Quarterly report of claims submitted. Comes after delivery of services. Can be appealed. (substitute EOB in managed care).
  - An Important Message from Medicare About Your Rights. Hospital discharge. Can request expedited determination.
  - Notice of Medicare Provider Non-Coverage. From SNFs, home health, outpatient rehab, hospice. Prior to termination. Can request expedited determination.
  - Advance Beneficiary Notice of Non-Coverage (ABN). From provider or supplier, not appealable.

Initial Notice

- Medicare Advantage
  - EOB
  - Notice of Denial of Medical Coverage
  - Notice of Denial of Payment
- All are appealable.
- Medicare Part D
  - Denial at pharmacy
  - Must ask for coverage determination, which is appealable.

Notice Content

- Medicaid:
  - Appeal rights
  - Statement of intended action, reason and specific law that supports.
  - APP rights
- Medicare Advantage
  - Appeal rights
  - Reason for determination

Recommendation

- Follow Medicaid rules
- Advance notice is critical for duals
- Duals are unable to pay and appeal later
- Good process for expedited review is needed
- Detailed content providing legal basis for denial
- Accessible notices-plain language, LEP, disability accessible.

Levels of Appeal-Medicaid

- Level 1: Local evidentiary hearing (rare)
- Level 2: State Fair Hearing
- Level 3: State Medicaid agency review
- Level 4: Civil action

Levels of Appeal-Medicaid

- Medicaid managed care:
  - One or more plan level appeals
  - State may allow direct access to Fair Hearing

Levels of Appeal-Medicare

- Level 1: Redetermination
- Level 2: Reconsideration
- Level 3: ALJ hearing
- Level 4: Medicare Appeals Council
- Level 5: Civil Action- federal district court
- Six levels for Part D if counting request for coverage decision.

Recommendation

- Recommended Levels of Appeal:
  - No more than one plan level
  - Option to shortcut to external review
  - ALJ/Fair Hearing (option to go straight here)
  - Agency review (only at beni option)
  - Court

Timelines

- Filing deadlines
  - Medicaid: varies, 20-90 days
  - Medicare FFS: L1, 120 (expedited: next day); L2, 180 (expedited: next day); L3-5, 60
  - Medicare Advantage & Part D: 60 days
- Review deadlines
  - Medicaid FFS: 90 days; Managed Care: L1, 45
  - Medicare FFS: L1-L2, 60 days; L3-L4, 90
  - Medicare Advantage: L1-L2, 30 days pre-service, 60 days payment
  - Part D: L1-L2, 7 days

Timelines

- Standards for expedited
  - Medicaid: up to 3 business days; “seriously jeopardize the enrollee’s life or health or ability to *attain, maintain* or regain maximum function “
  - Medicare: 72 hours; “seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function”
    - For Part D, Level 1: expedited is 24 hours

Recommendation

- Use faster Medicare decision deadlines, particularly for expedited consideration
- Allow Medicaid procedure to bypass internal review
- Use most generous filing deadlines-usually Medicare

Aid Paid Pending

- Medicaid:
  - Benefits can continue if requested within certain timeframes (generally, within 10 days of notice)
  - Benefits can also be reinstated if appeal filed within timelines
  - State can recover if appeal not successful
- Medicare: generally no APP

Recommendation

- Permit aid paid pending for all services, whether Medicare or Medicaid

Amount in Controversy

- Medicaid:
  - No amount in controversy requirements
- Medicare:
  - Amount in controversy requirements at ALJ and in federal court
    - $130 for ALJ
    - $1350 for federal court

Recommendation

- Eliminate amount in controversy requirements for integrated systems.

Additional Protections

- Right to notice of services that may have been available or considered, but were ultimately not recommended by a provider or care coordination team.
- Right to file an appeal orally in addition to in writing.
- Right to review records.

Additional Protections

- Right to a review by a decision maker who was not involved in the initial coverage decision
- Right to participate in an in-person, video conference or teleconference meeting at the plan level review and in an external hearing with the format being the choice of the individual.
- Right to submit new information and present an argument at each level of review
- Right to receive materials and participate in reviews and hearings in a language the beneficiary understands.

Integration Options

- Guided by how benefits, decision-making, funding and oversight are structured.
- Internal is easier.
- External is more difficult

Integration Options

- Review entities once outside of plan do not match
  - IRE v. State review entity and/or SFH
  - ALJ v. SFH
  - MAC v. State agency review
  - State court v. Federal Court

Integration Options

- Big picture options:
  - Maintain access to both processes
  - Send everything through Medicaid side
  - Send everything through Medicare side
  - New process just for duals

Integration Options

- Maintain access to both
  - Pros: All protections and expertise of each system retained
  - Cons: Not integrated
- Medicaid side
  - Pros: More experience with full range of benefits (LTSS, etc.). Medicaid lens re: coverage may be better fit.
  - Cons: Variation, state-based managed care laws could be restrictive/add complexity; lack of experience with Medicare

Integration Options

- Medicare side
  - Pros: Standardization, experience with complex Medicare coverage rules
  - Cons: Lack of experience with Medicaid rules, especially LTSS; more medially oriented
- New process
  - Contract with external decision-makers uniquely tasked with evaluating coverage under both programs together

Special Considerations

- "Supplemental" benefits
- Impact of design of integration model on appeals process
- Oversight of process by state, CMS, courts

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