Coalition to Protect the Rights of New York's Dually Eligible

Creating an Integrated Appeals Process for fully integrated dual advantage (FIDA)Health Plans

March 27, 2013

Overview

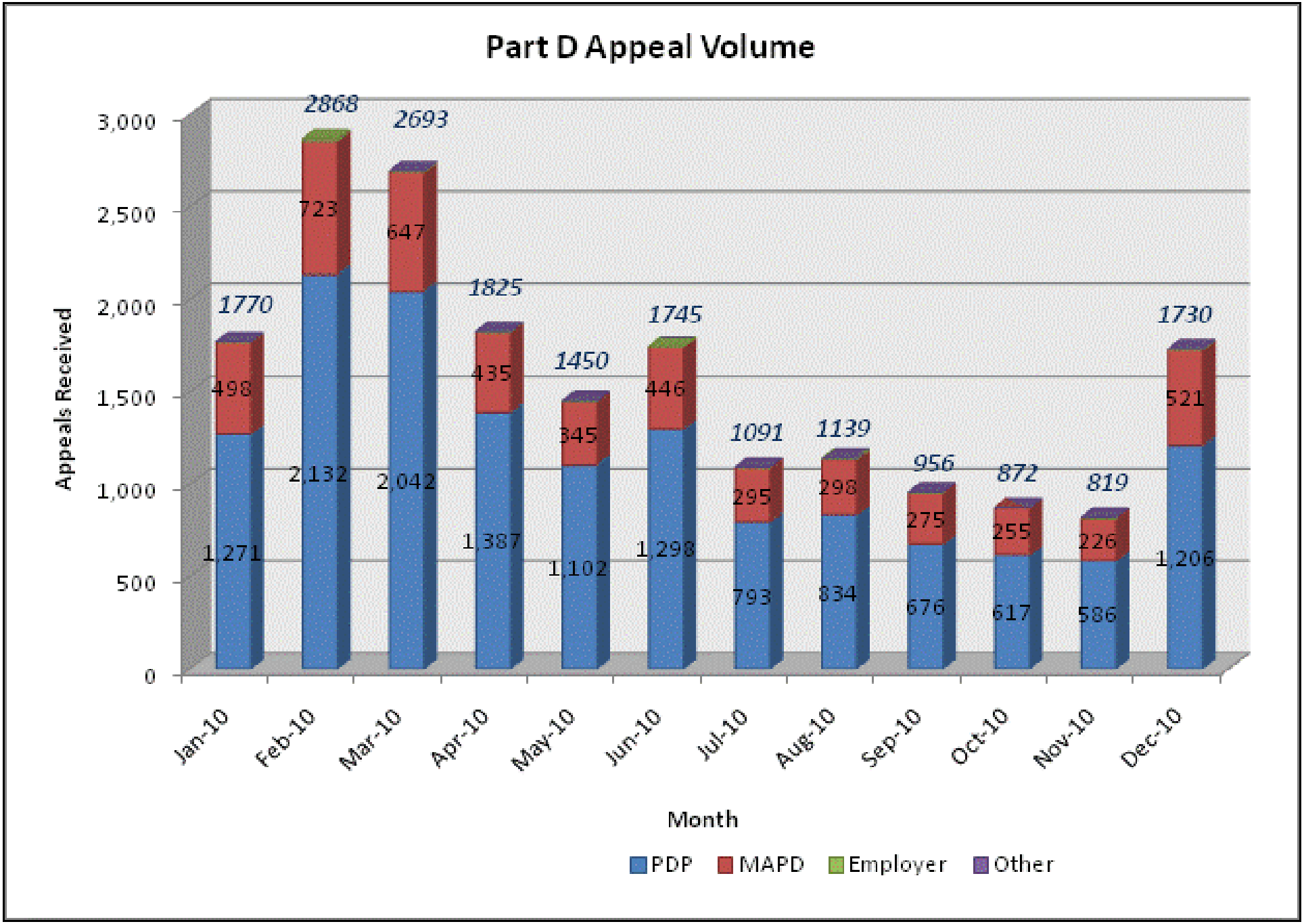
- What is meant by integrated appeals for Medicare and Medicaid benefits?
  - Medicare, Medicaid, and Medicare Part D appeals
  - The Massachusetts model
- Promising practices and concerns for New York State and FIDA
- Integration questions from the Medicare and Medicaid Coordination Office

Medicare appeals

- Program Advantages
  - Auto-forwarding plan denials to an independent decision maker
  - Physician controls expedited appeals requests
  - 24 hour expedited plan review for Part D coverage determinations
  - Original Medicare circle and sign appeal
  - Independent reviewer, MAXIMUS, collects necessary medical data for the appeal
  - Expedited hospital discharge appeal

Medicare appeals

- Needed improvements
  - Three ladders: Original Medicare, Medicare Advantage, Medicare Part D
  - Medicare denials at the pharmacy counter are not true denials
  - No aid continuing for any benefits or services
  - Difficult to have an in-person Administrative Law Judge (ALJ) hearing
  - Plan overturn rates



Source: MAXIMUS Federal Services Data Available on www.cms.gov

Overturns by the Independent Review Entity in Medicare Part D

- Drug utilization management tool dispute 69%
- Out-of-network pharmacy coverage 56%
- Off-formulary exception request 59%
- Tiering exception request 40%
- Cost-sharing dispute 26%
- Non-Part D drug 24%

Source: MAXIMUS Federal Services data available at www.cms.gov

2010 -- Note by IRE 3 levels internal appeal so errors should have been correted. Include duals?

Medicaid managed care appeals

Denial

- Notice of action denying the appeal or reducing services

Plan

- Internal plan appeal
- The appeal must be decided within 30 days

ALJ

- A beneficiary may then proceed to an ALJ fair hearing
- In fee-for-service Medicaid a beneficiary may proceed immediately to a fair hearing following a notice of action

Medicaid appeals

- Program advantages
  - Aid continuing through the appeals
  - Review rarely extends beyond the ALJ level
  - In fee-for-service the first review is with an independent government decision maker
  - Greater due process protections

Medicaid appeals

- Needed improvements
  - The process can be lengthy
  - No physician control rule on an expedited review request
  - If the beneficiary accesses aid continuing and loses the appeal, the plan can recover the cost of aid continuing

Integrated appeal options

Choose one program structure

- Follow the **Medicare** appeals system for all health care services
- Follow the **Medicaid** appeals system for all health care services

Use both or neither program structure

- Follow the **Medicare** appeals for Medicare services and **Medicaid** appeals for Medicaid services
- Create **a new appeals system** borrowing from both programs

The Massachusetts model

- Massachusetts first dual demonstration MOU released
  - Limited integration
    - Part D stands alone
    - First level of appeal is to the plan for Medicare and Medicaid services
  - Can appeal multiple pathways of appeals
    - Most beneficiary friendly controls
    - Not clear what happens at the higher levels of appeal

A Pathway to integration

Denial

- Receive **denial** or reduction in coverage from the FIDA plan
- The beneficiary has 60 days to file an appeal

Plan

- The **FIDA plan** receives the appeal, 72 hours to process the appeal
- If the beneficiary loses the plan review 60 days to appeal

ALJ

- The **FIDA Administrative Law Judge (ALJ)** has 90 days to decide the appeal
- Medicaid Article 78 proceeding or Medicare Appeals Council

Cornerstones for integration

- Aid continuing to beneficiaries pending an appeal for all Medicaid services and some Medicare services
- Access to an ombudsman, which can provide assistance and counsel to beneficiaries pursing an appeal
- FIDA plan responsibility to collect materials and medical records necessary to make an appeals decision

Some questions for New York

1) Would hospital appeals mirror Medicare's expedited hospital appeal process?
2) Should the ALJ timeframe be less than 90 days?
3) Can this process include Part D appeals? Will a denial at the pharmacy count as a formal denial?
4) Does a denial from the plan automatically get forwarded to an ALJ?
5) How robust would the plan-level appeal be? What should the time frame be if the plan level appeal was more robust?

Questions from the Medicare Medicaid Coordination Office

- What medical necessity standards are used to determine appeals in an integrated process?
- Should the first level of appeal be to the health plan?
- Should the second level of appeal be an independent contractor, like MAXIMUS, or an administrative law judge?
- Who pays for the cost of aid continuing during the plan appeal?