

# Building an Integrated Appeals System for Dual Eligibles

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## Foreword

This paper provides recommendations for building an integrated appeals process for individuals that qualify for Medicare and Medicaid (dual eligibles). It is the third in a series of four papers that highlight pressing issues facing dual eligibles and provide recommendations to the Medicare-Medicaid Coordination Office (MMCO), state Medicaid agencies and other interested policymakers and stakeholders on how to address them. The first paper addressed consumer protections needed in delivery system models that integrate Medicare and Medicaid.<sup>1</sup> The second paper discussed differences in Medicare and Medicaid program rules and coverage standards.<sup>2</sup> The final paper will focus on opportunities for improving the delivery of the Qualified Medicare Beneficiary (QMB) benefit.

<sup>1</sup> Available at [www.nsclc.org](http://www.nsclc.org) under Health Care/Dual Eligibles.

<sup>2</sup> Available at [www.nsclc.org](http://www.nsclc.org) under Health Care/Dual Eligibles.

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## Executive Summary

The Medicare-Medicaid Coordination Office (MMCO) at the Centers for Medicare and Medicaid Services has contracted with state Medicaid agencies to develop new models for integrating care for people that qualify for Medicare and Medicaid, also known as dual eligibles. MMCO has made clear in various forums that consumer protection will be an essential component of any new model. Perhaps no consumer protection is more important than the right an individual has to appeal decisions made about their health care.

Medicare and Medicaid each have their own appeals process with distinct rules and protections related to notice, levels of appeal, review entities, timelines for filing appeals and making decisions and more. If new models will integrate benefits and financing, they should also integrate the appeals processes provided by each program. However, any attempt to build an integrated appeals system will have to resolve conflicts that exist between the two programs. In doing so, it is important to retain the elements from each program that provide the greatest protection to dual eligibles.

In most cases Medicaid provides stronger protections to beneficiaries pursuing appeals and, therefore, provides the starting point for an integrated process. Where Medicare does provide stronger protections, those should be followed.

This brief recommends the following:

- **Follow Medicaid's rules regarding notice timing and content.** Notice must be provided prior to the termination, suspension or denial of services. Dual eligibles are unable to afford the risk of receiving services and then waiting to see whether Medicare or Medicaid will cover the service. They need to know whether a service will or will not be covered before it is provided.
- **No more than five levels of appeal are needed; beneficiaries should have direct access to an external appeal.** There should be only one level of internal appeal that the dual eligible has to pursue before getting to an external review entity. The process should also include the option, currently available only in Medicaid to pursue an external hearing instead of or in addition to the plan level review. Dual eligibles need a quick route to an independent reviewer outside a plan.
- **Provide fairer timelines and faster decision deadlines.** Dual eligibles need sufficient time to understand a denial, discuss options with their providers and secure assistance with an appeal. They cannot afford, however, to pay out-of-pocket for services or prescription drugs while waiting for an appeal decision.
- **Benefits should continue pending an appeal.** Dual eligibles are not in a financial position to pay for their own care while an appeal is being processed. This is true whether the service is covered by Medicare or Medicaid.
- **Medicare's amount in controversy should not apply.** Dual eligibles do not have sufficient income or resources to pay for services or supplies below the amount in controversy limits.
- **Include additional protections.** The protections include the right to notice of services; the right to file an appeal orally or in writing; the right to review records; the right to decision makers at the internal review level who were not involved in the initial coverage decision; the right to participate in an in-person, video conference or teleconference meeting at the plan level review and in external hearings; the right to submit new information and present an argument at each level of review; and the right to receive materials and participate in reviews and hearings in a language the beneficiary understands.

Defining the structure of the integrated appeals process that will operate with the protections described above is a difficult task. Which organizations and agencies will actually perform the function of reviewing appeals will be guided by how the benefits, authorization rules, financing and oversight are structured. If one entity, such as a managed care organization, is responsible for providing both Medicare and Medicaid benefits, that entity must create a process that is integrated in the internal appeal level. Integrating the external levels of appeal is much more difficult.

This brief evaluates four options for an integrated appeals structure:

1. **Allow the dual eligible to retain the right to pursue an appeal under both the Medicare and Medicaid external processes.** This option preserves current protections in each program, but requires the beneficiary to understand and evaluate the differences between each. It is also cumbersome to pursue two separate appeals for the same service.
2. **Channel all appeals of services denied by the integrated model through existing Medicaid external review entities.** This option utilizes the expertise the Medicaid review entities have with Medicaid's standards for coverage, especially long-term services and supports and behavioral health, but these entities lack expertise in Medicare coverage rules.
3. **Channel all appeals of services denied by the integrated model through the existing Medicare external review entities.** Using the Medicare appeals structures would create a single structure used by models across the country and would draw on the experience those structures have with Medicare coverage rules. But these entities are not familiar with Medicaid's more generous coverage rules or with the complexities of long-term services and supports in each state.
4. **Create a new set of entities with particular expertise in evaluating both Medicare and Medicaid coverage.** The new entities would be trained in the coverage rules of each program and the conflicts that can arise. This option poses significant challenges including the complexity of the Medicare program and the wide variation in Medicaid program and coverage rules by state.

An integrated appeal process which provides the strongest protections afforded by each program will be key to ensuring that new models are held accountable to provide beneficiaries access to the services they need. There is not yet a model which effectively integrates the Medicare and Medicaid appeals processes from start to finish. Designing a completely integrated model may not be possible. Creating a more integrated system, however, is achievable and, if done in a way that preserves existing protections, offers an improvement to dual eligibles who enroll in integrated models.

## Introduction

The Medicare-Medicaid Coordination Office (MMCO) at the Centers for Medicare and Medicaid Services (CMS) is actively working with states to develop new models for providing person-centered, integrated care to individuals who qualify for Medicare and Medicaid, also known as dual eligibles.<sup>3</sup> Strong consumer protections are key to ensuring that these new models achieve the promise of improved care coordination and increased access to the right services in the right place at the right time.<sup>4</sup>

Among the essential protections is an individual's right to appeal decisions made by the integrated model and to file complaints about problems encountered in dealing with the program. Appeal rights encompass many issues including the right to: appeal the denial, limitation, or termination of services, appeal eligibility for enrollment in the model, choose to participate in the model, appeal an assignment to a provider or a care team, appeal elements or non-elements of a care plan, request a second opinion or evaluation of eligibility for a service, and file a grievance or complaint about the integrated model and/or its providers.

Perhaps most important among these is the right to appeal the denial, limitation, or termination of services. Since these models will be responsible for coordinating the delivery of both Medicare and Medicaid appeals processes, it is important that the appeals process also be integrated. Currently, dual eligibles seeking to appeal the denial of a service have to navigate two different appeals systems. It is often unclear which service should be appealed to which program and in which order. Integrated models offer the opportunity to create an integrated appeals process that can work for both the individual

needing service and the organization seeking to resolve any complaints.

Before an integrated appeals process can be designed, however, basic questions about how benefits and financing will be integrated need to be answered. Who ultimately is responsible for authorizing which services will dictate the path enrollees in new models will take in their appeals. States are working with local stakeholders and CMS now to answer these questions. To provide guidance to states, CMS released in July 2011 a State Medicaid Director letter describing two models for financing, administering and overseeing integrated models.<sup>5</sup>

The first model would allow states and CMS to enter into three-way contracts with managed care organizations to provide all Medicaid and Medicare benefits under a single, risk-based capitation. Under the second model, a state would be eligible to receive a portion of savings resulting from efforts undertaken by the state to improve quality and reduce costs for both Medicare and Medicaid in a managed fee-for-service environment.

The first model, which puts responsibility for providing benefits into one entity, provides a clearer path to an integrated appeals process. Several steps can be taken, however, to improve the appeals process for dual eligibles who ultimately enroll in shared savings models or remain in the current fee-for-service system.

The discussion in this paper will be relevant to both of the integrated financing models CMS has put forward and others that may be pursued. The paper summarizes the current Medicaid and Medicare appeals processes, outlines important differences, and provides recommendations for resolving each difference in a way to provide the maximum protection for the beneficiary. The paper also evaluates several options for creating an integrated appeals structure.

<sup>3</sup> See MMCO website at [www.cms.gov/medicare-medicaid-coordination/](http://www.cms.gov/medicare-medicaid-coordination/).

<sup>4</sup> See [www.nsclc.org](http://www.nsclc.org) under Health Care/Dual Eligibles.

<sup>5</sup> Available at [www.cms.gov/smdl/downloads/Financial\\_Models\\_Supporting\\_Integrated\\_Care\\_SMD.pdf](http://www.cms.gov/smdl/downloads/Financial_Models_Supporting_Integrated_Care_SMD.pdf).

## Current Examples of ‘Integrated’ Processes

Current models for integrating Medicare and Medicaid benefits provide minimal integration of appeals processes. PACE programs, which are responsible for providing all Medicare and Medicaid services to their enrollees through capitated payments from Medicare and Medicaid, offer an integrated internal process.<sup>6</sup> In the initial coverage determination and the internal, plan level appeal, the PACE plan makes a single evaluation of whether a service can be covered by either Medicare or Medicaid. The individual gets just one notice and only needs to file one appeal. Once the appeal moves to an external level, however, integration stops. The PACE enrollee is provided the choice of pursuing an external appeal under either the Medicare or Medicaid managed care process.<sup>7</sup>

The Wisconsin Partnership Program and Minnesota Senior Health Options offer other examples of programs that provide both Medicare and Medicaid benefits to enrollees. In these two programs, the internal coverage determination and first level of appeal processes are integrated.<sup>8</sup> As with PACE, however, once an enrollee decides to appeal to an external entity, the process is not integrated at all. Enrollees are given a choice of pursuing a Medicare and/or a Medicaid appeal.

For Special Needs Plans that have contracts to provide both Medicare and Medicaid

benefits, CMS created an optional model of an integrated appeals process.<sup>9</sup> Under the optional model, the plan would make a single finding of whether a service is covered by either program at the initial determination and in the first level of appeal, or reconsideration. If the plan’s reconsideration decision is fully or partially unfavorable, the plan then would simultaneously forward its decision to the Medicare Independent Review Entity and the Medicaid state fair hearing agency for review. Subsequent appeals would continue down the separate Medicaid and Medicare paths. Similar to the PACE, Wisconsin, and Minnesota models, this process integrates the internal appeals process but not the external. It is unclear whether any states or Special Needs Plans have adopted this option.

While these models provide some level of integration, they still fall far short of providing the type of integration that will ease the experience of dual eligibles. Since none of these models integrate the external review process, the beneficiary is still left to either pursue both a Medicare and Medicaid appeal or just one or the other. Someone choosing just one path poses the risk of not eventually securing coverage for an item or service that may have been covered if they chose the other path. Pursuing both paths simultaneously is arduous and complicated.

<sup>6</sup> 42 C.F.R. § 460.122.

<sup>7</sup> 42 C.F.R. § 460.124.

<sup>8</sup> See Wisconsin Model Contract, p. 135 et seq. available at [www.dhs.wisconsin.gov/LTCare/StateFedReqs/cy2011mcocontract.pdf](http://www.dhs.wisconsin.gov/LTCare/StateFedReqs/cy2011mcocontract.pdf) and Minnesota; Minnesota Model Contract, pp. 183-84, available at [www.dhs.state.mn.us/main/groups/business\\_partners/documents/pub/dhs16\\_156513.pdf](http://www.dhs.state.mn.us/main/groups/business_partners/documents/pub/dhs16_156513.pdf).

<sup>9</sup> See [www.cms.gov/IntegratedCareInt/2\\_Integrated\\_Care\\_Roadmap.asp](http://www.cms.gov/IntegratedCareInt/2_Integrated_Care_Roadmap.asp).

# Identifying and Resolving Differences: Recommendations for Preserving Key Protections

**B**oth Medicare and Medicaid provide comprehensive appeal rights to beneficiaries, implementing the protections guaranteed by the due process clause of the United States Constitution. The Medicare appeals rules apply to the program nationally; federal Medicaid statutes, regulations and case law provide a floor of basic protections and appeal rights which states have the authority to strengthen in their own statutes and regulations.

The process of building an integrated model must begin with an understanding of the ways the two programs' appeals processes differ. Once these differences are identified, a new process can be designed which retains the elements from each program that provide the greatest protection to dual eligibles. Below is an attempt to highlight key differences between the programs and provide recommendations for resolving differences in a person-centered way.

As described in more detail below, Medicaid provides stronger protections in most cases to beneficiaries pursuing appeals and, therefore, provides the starting point for an integrated process. Where Medicare does provide stronger protections, those should be followed.

## Notice Type, Timing, and Content Differ

Medicare and Medicaid appeals processes are different right from the beginning, with each

program applying different rules for the type of notice that triggers appeals rights. In the Medicaid program a notice of action is issued when coverage for a service is denied (in whole or in part), terminated, or reduced. The notice is provided before the action is taken. Issuance of the notice triggers the right of the beneficiary to appeal the Medicaid action.

For Medicare Part A and B services, there are four different types of notices that can be issued when a service is denied, reduced or terminated.<sup>10</sup> Not all of these notices are appealable and not all of them are notices of an official Medicare decision. As explained below, some of these notices are from providers, not Medicare. In Medicare, there generally must be a Medicare decision or initial coverage determination before an appeal can be filed. Action by the beneficiary is often required to get an official determination from Medicare that can then be appealed. There are exceptions for individuals challenging discharge from a hospital or termination of services by skilled nursing facilities, home health agencies, outpatient rehabilitation facilities and hospices. In these cases, a beneficiary has a right to request an expedited determination on the basis of the notice from the provider.

The four notices are:

### 1. A Medicare Summary Notice (MSN).

This is a quarterly report of claims submitted and paid during the previous quarter. The notice comes after the service has been provided, informs the beneficiary if Medicare denied payment for the claim, and provides information about how to appeal the decision by requesting a redetermination. In Medicare Advantage and Part D, the Explanation of Benefits (EOB) takes the place of the MSN. This notice functions as an initial coverage determination and can be appealed.

<sup>10</sup> Copies of beneficiary notices in Medicare related to financial liability and appeal rights are available at [www.cms.gov/BNI/01\\_overview.asp#TopOfPage](http://www.cms.gov/BNI/01_overview.asp#TopOfPage).

**2. An Important Message from Medicare About Your Rights.** This is a notice that a hospital provides when a beneficiary is admitted or discharged from an inpatient hospital stay. If the beneficiary disagrees with the discharge decision, she can request an expedited determination by a contracted Medicare review organization, called a Quality Improvement Organization. Once this request is made, the hospital is required to provide an additional notice called a Detailed Notice of Discharge.

**3. A Notice of Medicare Provider Non-Coverage.** This type of notice is issued by skilled nursing facilities, home health agencies, outpatient rehabilitation facilities and hospices before they terminate Medicare covered services. The notice reflects the provider's opinion that Medicare will no longer cover the service because the beneficiary no longer qualifies under Medicare's coverage rules; it is not a Medicare initial coverage determination. The notice must be provided at least two days before the date the provider plans to terminate the service. If the beneficiary disagrees with the provider's opinion, she can request an expedited determination by the Quality Improvement Organization. Once that request is made, a more detailed notice must be generated by the provider.

**4. An Advance Beneficiary Notice of Non-Coverage (ABN).** This notice is given when a provider or supplier believes that a service will not be covered by Medicare. In contrast to the Notice of Medicare Provider Non-Coverage which is provided when services are being terminated, the ABN is given before any service has been provided. The ABN is

an opinion of the provider or supplier, not a Medicare coverage determination, so it cannot be appealed. Instead, if a beneficiary wants to receive the service, the beneficiary must request that the provider or supplier deliver the service and bill Medicare. If Medicare denies the claim, it will send a MSN which serves as the initial coverage determination and can be appealed. If the appeal is not successful, the beneficiary is liable for paying the provider since the service has already been received and the ABN had given notice to the beneficiary that the service may not be covered.

Beneficiaries in Medicare Advantage generally receive the same notices as individuals in the fee-for-service system. As mentioned above, Medicare Advantage plans provide an EOB that replaces the MSN. In addition to the EOB, plans may provide information about payment and coverage denials in two standardized notices referred to as the Notice of Denial of Medical Coverage and the Notice of Denial of Payment. These notices are coverage determinations that can be appealed.<sup>11</sup>

The notice process in Medicare Part D is unique. A beneficiary usually first learns that a prescription will not be covered at the pharmacy counter. The denial at the pharmacy does not constitute an initial coverage determination and the beneficiary does not receive an individualized notice that would trigger appeal rights. Instead the beneficiary is told by the pharmacist that the plan denied coverage and may be directed to a generic notice posted somewhere in the pharmacy.<sup>12</sup> To pursue an appeal, the beneficiary must contact the drug plan and request an initial coverage determination. A negative coverage determination will generate an individualized notice which can then be appealed.

<sup>11</sup> Medicare Managed Care Manual (MMCM), Ch. 13 at 40.2.2.

<sup>12</sup> Beginning in January 2012, the generic notice that is currently required to be posted somewhere in the pharmacy will be replaced by a generic notice that will be handed to the beneficiary.



Medicaid and Medicare requirements for the content of a notice also vary in important ways. In both programs, a notice denying coverage for a service or claim must include information about the beneficiary’s appeal rights. In Medicare, the notice must include the reason for the determination that the service or claim is not covered.<sup>13</sup> Medicaid goes further. In addition to requiring the notice to include a statement of the intended action and the reason for it, the Medicaid notice must identify the specific law or regulation that supports the action.<sup>14</sup> The Medicaid notice must also include information about the beneficiary’s right to continue receiving benefits pending the outcome of the appeal. This benefit, commonly referred to as “aid paid pending,” is not available in the Medicare program as described below.

**Recommendation: Follow Medicaid’s rules regarding notice timing and content.**

The Medicaid process of providing a notice prior to the provision or termination of a service is of critical importance for this population. Dual eligibles are unable to afford the risk of receiving services and then waiting to see whether Medicare or Medicaid will cover the service. Advance notice must be provided whenever a service is being denied, approved at a lesser amount than requested, terminated, suspended or reduced. Notice should come before any change in current services or treatment regimes. In order to ensure that the notice and appeal process does not delay the delivery of urgent services, an expedited review system is essential.

The content of notices should also mirror the requirements of the Medicaid program. Notices

should clearly explain the individual’s appeal and aid paid pending rights and include a statement of the intended action, the reason for the action and the specific law, rule or contract provision supporting the decision. It is essential that notices be delivered in a format that the beneficiary can understand. Notices should be written using clear and simple terms and should be accessible to beneficiaries who are limited English proficient or visually impaired.<sup>15</sup> If coverage for a service is denied, dual eligibles need clear, timely information about the denial and their rights to pursue an appeal. They do not have other options for getting the services they need.

**Different Levels of Appeal Are Available**

Medicare and Medicaid each provide a different number of appeal levels. For services provided under Medicare, there are five levels of appeal once an individual is in the appeals process. It is important to remember, however, that the appeals process cannot begin until an initial coverage determination has been provided and that, in many cases, the beneficiary must take action to obtain that determination, creating a de facto sixth level of appeal at the start of the process. Below is a description of the five levels of appeal.

- **Level 1: Redetermination.** The redetermination process provides a review of the initial decision by a qualified individual who was not involved in the initial decision. In the Medicare fee-for-service (FFS) system, the redetermination is conducted by the Medicare contractors that make coverage determinations. In Medicare Advantage and Part D, the redetermination is handled internally at the plan.

<sup>13</sup> MMCM, Ch. 13 at 40.2.2.

<sup>14</sup> 42 C.F.R. § 431.210.

<sup>15</sup> Notices that are accessible and that can be understood by affected beneficiaries are an essential beneficiary protection that is needed for all communications with beneficiaries, not just appeals. See NSCLC’s papers, “Ensuring Protections for Dual Eligibles in Integrated Models” and “Medicare and Medicaid Alignment: Challenges and Opportunities for Serving Dual Eligibles,” both at [www.nsclc.org](http://www.nsclc.org).

- **Level 2: Reconsideration.** In Medicare fee-for-service, the reconsideration is conducted by a Qualified Independent Contractor (QIC).<sup>16</sup> CMS contracts with four regional QICs for Part A and B appeals and a single, national QIC for appeals related to Durable Medical Equipment, Prosthetics, Orthotics and Supply. In Medicare Advantage and Part D programs, the reconsideration is conducted by an Independent Review Entity.
  - **Level 3: Hearing with an Administrative Law Judge (ALJ).** This is the first level in which the beneficiary has an opportunity to meet face-to-face with a decision maker, typically via video-teleconference with the beneficiary provided the opportunity to submit evidence and present witnesses. The hearings are held by ALJs working for the Office of Medicare Hearings and Appeals, an agency within the U.S. Department of Health and Human Services.
  - **Level 4: Elevated appeal to the Medicare Appeals Council (MAC).** The MAC can accept or decline the request. If the request is accepted, the MAC can initiate its own decision or dismissal, or send the case back to the ALJ with instructions for how to proceed. The MAC provides the final administrative review of the coverage decision.
  - **Level 5: Civil action.** The final level of appeal in the Medicare process is to file a civil action with the federal district court.
- Federal Medicaid regulations provide for up to four levels of appeal in the Medicaid fee-for-service program.
- **Level 1: Local evidentiary hearing.** States have the option to require Medicaid beneficiaries who have filed an appeal to participate in a local hearing before having a state fair hearing as described below. This option is rarely exercised.
  - **Level 2: State Fair Hearing.** This is the most common starting point for Medicaid fee-for-service appeals. At a fair hearing, the beneficiary has the opportunity to present an argument to a hearing officer. Beneficiaries have the right to present evidence and witnesses and to question or refute opposing testimony or evidence, including the opportunity to confront and cross-examine opposing witnesses. They also have the right to examine before the hearing the content of their case file and all documents and records used at the hearing. Hearing officers are state officials who may be part of an independent hearing office within the state or part of the state’s Medicaid agency.
  - **Level 3: State Medicaid agency review.** States have the authority to create procedures for reviewing fair hearing decisions. Where these processes exist, beneficiaries can appeal to the agency to reconsider the hearing decision.
  - **Level 4: Civil action.** The final stage of the Medicaid process is an appeal to state court.<sup>17</sup> Beneficiaries also have the right to go directly to federal court to enforce provisions of the Medicaid statute, though their ability to do so has been limited in recent years by court decisions restricting those Medicaid provisions that are privately enforceable.<sup>18</sup>

<sup>16</sup> Note that Qualified Independent Contractors (QIC) are different from Quality Improvement Organizations (QIO). See discussions by CMS at [www.cms.gov/QualityImprovementOrgs/](http://www.cms.gov/QualityImprovementOrgs/) and [www.medicare.gov/Basics/Finalqicfactsheet.pdf](http://www.medicare.gov/Basics/Finalqicfactsheet.pdf).

<sup>17</sup> State laws provide standards for state court review.

<sup>18</sup> For a discussion of federal court opinions that have severely limited beneficiary access to the courts, see R. Bobroff, “You Have a Right but Do You Have a Federal Remedy,” *Clearinghouse Review* (Jan.–Feb. 2011).

Beneficiaries enrolled in Medicaid managed care must also have access to an internal plan appeals process. In most states, this involves a single level of review by the plan of the initial coverage decision. The plan process must provide an opportunity for the beneficiary to present evidence and an argument in person as well as in writing. Beneficiaries must be provided access to their case file.

States may require managed care enrollees to use the plan's internal appeal process before pursuing a fair hearing. Negative decisions by the plan can be appealed to a state fair hearing. Some states have state laws that also allow managed care enrollees to appeal an internal appeal decision to an independent medical review by an external entity. Where this option is offered, rules vary on whether an external medical review can be requested after a fair hearing request has been made.

**Recommendation: No more than five levels of appeal are needed; Beneficiaries should have direct access to an external appeal.**

An integrated appeal process should never exceed five levels of appeal and beneficiaries should not be required to pursue every level of appeal. There should be no more than one internal, plan level appeal before an external review of the plan's determination.

Beneficiaries should not be required to exhaust internal review processes before pursuing an external review. The Medicaid option of allowing beneficiaries to go directly to an administrative hearing instead of or in addition to pursuing an internal plan appeal or an external medical review

should be adopted. Review of a hearing decision by a Medicaid or Medicare agency should only be at the request of the beneficiary and should not be available to plans and providers to challenge coverage decisions favorable to the beneficiary.

Dual eligibles need a quick route to an independent reviewer outside a plan. Statistics developed by CMS for the Part D program show that the reversal rate at the Independent Review Entity for plan decisions is 65 percent.<sup>19</sup> This significant reversal rate demonstrates the need for timely review outside plans. That need is only intensified if plans are determining both Medicare and Medicaid coverage.

**Timelines Vary**

Timelines for filing appeals vary greatly between Medicare and Medicaid. In the Medicare Part C and D programs, at all levels, the beneficiary must file an appeal within 60 days of receiving the most recent determination.<sup>20</sup> In the Medicare fee-for-service program some filing deadlines are longer.<sup>21</sup>

Filing deadlines for Medicaid appeals vary by state. In Medicaid managed care, states have the discretion to set the deadlines within a range of 20-90 days from the date on the denial notice.<sup>22</sup>

The timelines for reviewing decisions also vary between Medicaid and Medicare. In the Medicare managed care program, plans must make standard, non-expedited decisions within 30 days. Timeframes in Medicare fee-for-service and for external review entities vary between 60 and 90 days.<sup>23</sup> In the Part D program, the plan has 72 hours to make its initial coverage determination and then seven days to make the redetermination

<sup>19</sup> CMS Fact Sheet: Part D Reconsideration Appeals Data-2009, available at [www.cms.hhs.gov/MedPrescriptDrugApplGriev/07\\_Reconsiderations.asp#TopOfPage](http://www.cms.hhs.gov/MedPrescriptDrugApplGriev/07_Reconsiderations.asp#TopOfPage).

<sup>20</sup> 42 C.F.R. § 423.566-423.600(Part D).

<sup>21</sup> See, e.g., 42 C.F.R. § 405.807 (6 months for Part B).

<sup>22</sup> 42 C.F.R. § 438.402(b).

<sup>23</sup> See CMS flowcharts at [www.cms.gov/OrgMedFFSAppeals/downloads/AppealsProcessFlowchartAB2011.pdf](http://www.cms.gov/OrgMedFFSAppeals/downloads/AppealsProcessFlowchartAB2011.pdf) and [www.cms.gov/MMCAG/Downloads/Flow.pdf](http://www.cms.gov/MMCAG/Downloads/Flow.pdf).

decision. The Independent Review Entity has seven days to make the reconsideration decision in Part D.<sup>24</sup>

Medicaid state agencies are required to provide a final administrative decision within 90 days of the day the request for the hearing is filed.<sup>25</sup> Medicaid managed care plans must make the first level determination for a standard, non-expedited appeal within 45 days of the day the plan receives the appeal.<sup>26</sup>

Under both Medicare and Medicaid, beneficiaries can request an expedited appeal. The standards for when an appeal must be treated as expedited are different in the two programs. In the Medicare program, an appeal must be treated as expedited when failing to do so will “seriously jeopardize the life or health of the enrollee or the enrollee’s ability to regain maximum function.”<sup>27</sup> The Medicaid program’s standard is similar but adds the ability to attain or maintain maximum function as considerations.<sup>28</sup>

When Medicaid grants an expedited appeal, a decision must be made within three business days.<sup>29</sup> In the Medicare program, an expedited appeal must be decided within 72 hours.<sup>30</sup> In Medicare Part D, an expedited coverage determination must be made within 24 hours; the first two levels of appeal in Part D must be decided within 72 hours.<sup>31</sup>

**Recommendation: Provide Fairer Timelines and Faster Decision Deadlines**

Dual eligibles need speedy resolution of appeals. They cannot afford to pay for denied services and their medical needs are complex. Integrated models and government agencies should be held to strict timelines.

The faster decision *deadlines* that Medicare imposes on managed care plans, particularly the deadlines for expedited processing, are preferred over those that Medicaid imposes on plans. Also, the integrated model should follow Medicare’s approach by creating faster standard and expedited review times for prescription drugs.

Medicaid programs that do not require exhaustion of plan review processes before filing a Medicaid fair hearing provide the potential for the fastest decisions (90 days from the date of filing to a final administrative decision). Not requiring beneficiaries to pursue internal plan reviews before seeking a fair hearing or hearing with an Administrative Law Judge would preserve this favorable timeline.

Filing deadlines imposed on beneficiaries must give them sufficient time to understand a denial, discuss with a provider the necessity of pursuing an appeal and secure assistance with the appeal. Medicare’s timeframes for filing are usually more generous and are, therefore, preferred. Whatever filing deadlines are adopted, it is important that they can be extended for good cause.

<sup>24</sup> 42 C.F.R. § 423.568(b)(coverage determination); 42 C.F.R. § 423.590(a)(redetermination); 42 C.F.R. § 423.600(d) (reconsideration).

<sup>25</sup> 42 C.F.R. § 431.244(f).

<sup>26</sup> 42 C.F.R. § 438.408(b)(2).

<sup>27</sup> 42 C.F.R. 570(c)(2)(i)(Part C); 42 C.F.R. § 423.584(c)(2)(ii)(Part D).

<sup>28</sup> 42 C.F.R. § 438.410(a). Note also that the PACE regulations adopt the Medicaid standard. 42 C.F.R. § 460.122(f).

<sup>29</sup> 42 C.F.R. § 438.408(b)(3)(managed care); 42 C.F.R. § 431.244(f)(2)(fair hearing).

<sup>30</sup> MMCM, Ch. 13 at 80.1.

<sup>31</sup> 42 C.F.R. § 423.572(a)(coverage determination); 42 C.F.R. § 423.590(d)(redetermination ) 42 C.F.R. § 423.600(d) (reconsideration).

The *substantive standards* for expedited appeals should be taken from the Medicaid program. The Medicaid approach more closely matches the stated goals of the integration projects.

### Medicaid's Aid Paid Pending Appeal

Medicaid law includes a requirement that benefits continue to be provided if an appeal is filed within a certain timeframe, generally within 10 days of the notice informing the beneficiary of the suspension, reduction or termination of services.<sup>32</sup> If the relevant filing deadlines are met throughout various levels of appeal, benefits can continue to be provided. If the appeals are eventually unsuccessful, the state has the ability to seek recovery of costs incurred providing services during the appeal period.

This requirement is an important due process protection in the Medicaid program and is provided for by the due process clause of the United States Constitution.<sup>33</sup> It is designed to ensure that low-income Medicaid beneficiaries who would not be able to afford to continue a service or treatment regime by paying out-of-pocket while pursuing an appeal can retain access to needed services and treatments.

Medicare generally does not provide aid paid pending appeal though there are exceptions. For example, as described in the notice section above, a skilled nursing facility that believes that Medicare will no longer cover an individual's stay at the facility must issue a Notice of Medicare Provider Non-Coverage. An individual who files a timely appeal in response to that notice may remain in the facility while the appeal is pending. If the appeal is unsuccessful, the individual is

financially liable for the services provided beyond the original termination date.

### Recommendation: Benefits Should Continue Pending an Appeal

Integrated models should provide continued benefits while pursuing an appeal regardless of whether those benefits would be classified as Medicare or Medicaid benefits. The PACE program currently provides this protection to enrollees who are eligible for Medicaid.<sup>34</sup>

Dual eligibles are not in a financial position to pay for their own care while an appeal is being processed. This is true whether the service is covered by Medicare or Medicaid. If they do not receive continuing benefits they will experience a disruption in their treatment that can have serious, longer term repercussions on their health.

The development of a new appeals process for integrated models also presents the opportunity to address limits that some Medicaid managed care plans currently place on the right of individuals to continue receiving benefits pending the outcome of an appeal. Federal regulations provide Medicaid managed care plans with the authority to limit the duration of continuing benefits to the time period covered by the original authorization of services.<sup>35</sup> For example, Ms. Lee's managed care plan authorizes 40 hours of personal care services each month for period of three months. Near the end of the three months, the plan sends a notice to Ms. Lee informing her that the plan is reducing her hours to 25 per month. Ms. Lee files an appeal immediately and requests that her hours continue at the current level during the appeal. The plan refuses, citing

<sup>32</sup> 42 C.F.R. § 438.420.

<sup>33</sup> *Goldberg v. Kelly*, 397 U.S. 254 (1970).

<sup>34</sup> 42 C.F.R. § 460.122(e).

<sup>35</sup> 42 C.F.R. § 438.420(b). This regulation addresses the responsibility and authority of Medicaid managed care plans. It does not address the independent obligation of the State Medicaid agency to provide the beneficiary's constitutional right to aid paid pending appeal.

the end of the three-month period for which the higher number of hours was originally approved.

This approach is particularly problematic and inappropriate for dual eligibles who have chronic conditions and permanent disabilities and whose needs are not likely to decrease over time. For this group, the continued payment of benefits while pursuing an appeal of a decision to reduce or terminate services can be life-saving.

### Medicare's Amount in Controversy

The Medicare program requires the value of the service, equipment or supply under review to exceed a minimum amount in order for the beneficiary to file for review by an ALJ or federal court. This minimum amount is referred to as the “amount in controversy.”<sup>36</sup> For 2012 the value of the service, equipment of supply under review must exceed \$130 to appeal to the ALJ and \$1,350 to appeal to federal court.<sup>37</sup> The amount in controversy increases annually by the percentage increase in the medical care component price index. Medicaid does not impose an amount in controversy requirement at any level.

### Recommendation: Medicare's Amount in Controversy Should Not Apply

This barrier to access to a hearing or to court review should not apply to dual eligibles pursuing appeals in integrated models. Costs below the Medicare thresholds are well above the ability of dual eligibles to absorb.

### Additional Important Protections

In addition to resolving the conflicts outlined above in a person-centered manner, an integrated appeals process should include additional protections including, but not limited to, the following:

- **The right to notice of services that may have been available or considered, but were ultimately not recommended by a provider or care coordination team.**

In models where there is a close financial relationship between the provider delivering and recommending services and the integration model responsible for making payments, it is possible that beneficiaries may never know that they were denied a service. Procedures must be in place to ensure that enrollees are informed of all options so that they can request that a particular service be considered by the care team or provider.<sup>38</sup> Opportunities must exist to appeal or seek second opinions based on the notice received.<sup>39</sup>

- **The right to file an appeal orally in addition to in writing.** Integrated models should make it as easy as possible for beneficiaries to file appeals. Where a written appeal is required, beneficiaries should be allowed to begin the appeal process with an oral request that can then be followed by the written request at a later time.

<sup>36</sup> 42 C.F.R. § 405.1006(b)(ALJ); 42 C.F.R. § 405.1006(c)(federal court).

<sup>37</sup> 76 Fed. Reg. 59138 (September 23, 2011).

<sup>38</sup> See PACE provision at 42 C.F.R. § 460.112(e)(1).

<sup>39</sup> See Wisconsin Model Contract, p. 80, available at [www.dhs.wisconsin.gov/LTCare/StateFedReqs/cy2011mcocontract.pdf](http://www.dhs.wisconsin.gov/LTCare/StateFedReqs/cy2011mcocontract.pdf).

- **The right to review records.** A beneficiary in an integrated model should have timely access to his records including his health risk assessment, any care plans that have been developed, records of services provided and any and all materials related to the decision not to approve the requested service. Medicare Advantage plans are currently required to make these files available to enrollees but are permitted to charge for duplicating and mailing the file.<sup>40</sup> Models serving dual eligibles should be prohibited from imposing any charges for access to these files.
- **The right to a review by a decision maker who was not involved in the initial coverage decision.** Both programs currently require this and it is a protection that should be part of the integrated models as well.<sup>41</sup> In addition, the physician who is the reviewer or a member of a review team should have expertise in a relevant field of medicine. This is a requirement in the Medicare Advantage program and particularly important given the specialized health care needs of the dually eligible population.<sup>42</sup> It would not be appropriate for pediatricians to be reviewing claims for personal care services for seniors with dementia.
- **The 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.** Medicare limits the ability for individuals to participate in lower level reviews,<sup>43</sup> whereas Medicaid offers more expedited access to an in-person review.<sup>44</sup>
- **The right to submit new information and present an argument at each level of review.** This would include the right to refute testimony or evidence presented by the integration model. Submission of information about the changed condition of the beneficiary should not require the beneficiary to start the appeals process from the beginning as is currently required in the Medicare Part D program.<sup>45</sup>
- **The right to receive materials and participate in reviews and hearings in a language the beneficiary understands.** Medicare does not have any rules providing language assistance services in the appeals context. Requirements that plans translate materials into languages spoken by a certain percentage of the population do not apply to appeals documents.<sup>46</sup> Medicaid programs generally do provide some protections for limited English proficient beneficiaries pursuing appeals.

<sup>40</sup> MMCM, Ch. 13, at 70.5 and 10.3.3; Prescription Drug Benefit Manual (PDBM), Ch. 18 at 70.5.

<sup>41</sup> MMCM, Ch. 13 at 70.6. PDBM, Ch. 18 at 70.6.

<sup>42</sup> MMCM, Ch. 13 at 70.6; see also PDBM, Ch. 18 at 70.6.1.

<sup>43</sup> PDBM, Ch. 18 at 70.5.

<sup>44</sup> 42 C.F.R. § 431.206.

<sup>45</sup> PDBM, Ch. 18 at 100.4.

<sup>46</sup> 42 C.F.R. § 422.2264(e) and 42 C.F.R. § 423.2264(e).

## Four Options for Integrating External Appeals Structures

**D**efining the structure of the integrated appeals process that will operate with the protections described above is a difficult task. Which organizations and agencies will actually perform review functions will be guided by how the benefits, authorization rules, financing and oversight are structured.

If one entity, like a managed care organization, is responsible for providing both Medicare and Medicaid benefits, it should create a process that is integrated in the initial stages of an appeal. The entity would be required to make an initial coverage determination that evaluates whether a service is covered by either Medicare or Medicaid. Notice and timeline requirements could be consolidated retaining the protections of each program as described above. Internal reviews, if any, would again be based on whether the service could be covered under either program.

Integrating the external levels of appeal is much more difficult. Medicaid and Medicare each make use of external review entities during the appeal process, but each program has a distinct network of external reviewers it uses. This means that even where there are similarities in the levels of appeal used by each program, the decision-making entity is quite different. Where Medicare uses an Independent Review Entity, the state may use state-specific review entity or the state fair hearing process. Where Medicare uses a federal Administrative Law Judge for its review hearing, the state uses a state hearing officer for its fair hearing. Where Medicare uses a Medicare Appeals

Council to review ALJ decisions, a state Medicaid program may use the state Medicaid agency to review state fair hearing decisions. Finally, while a final Fair Hearing or state Medicaid agency decision may be appealed to state or federal court, a final MAC decision may only be appealed to federal court.<sup>47</sup>

There are four basic options that can be considered for integrating external levels of appeal.

- 1. Continue with the processes currently used by integrated models such as those in Minnesota, Wisconsin and PACE.** In this model, the beneficiary would retain the ability to pursue an appeal under both the Medicare and Medicaid external processes. As discussed above, this process protects the individual from losing the opportunity to pursue coverage under each program, but requires the beneficiary to understand and evaluate the differences between each. It is also cumbersome to pursue two separate appeals for the same service.
- 2. Send all appeals of services denied by the integrated model through the Medicaid external review process—the state’s external review entity, state fair hearing, potential Medicaid agency review and state and federal court.** This process offers the advantage of using Medicaid review entities that are more familiar with Medicaid’s standards of coverage, which are generally more generous than those for Medicare. Decision makers in the Medicaid appeals system are more familiar with the unique issues surrounding appeals of coverage for long term supports and services, an area ripe for appeals. The disadvantages of using

<sup>47</sup> If the MAC declines to review an ALJ decision, the ALJ decision becomes directly appealable to federal court. 42 C.F.R. § 423.1976.



this system include the fact that Medicaid review entities lack experience with Medicare coverage standards. The tremendous amount of variation in state Medicaid appeals systems would make this process difficult for CMS to monitor and evaluate. State managed care rules, which are often applied to Medicaid managed care plans, add additional complexity.

3. **Direct appeals of determinations made by the integrated model through the Medicare external review process—Medicare independent review entity, Administrative Law Judge, Medicare Appeals Council, federal court.** The advantages and disadvantages of this approach mirror those for the Medicaid process. Using the Medicare appeals structures would create a single structure used by models across the country and would draw on the experience those structures have with Medicare coverage rules. Medicare appeal entities are not, however, familiar with Medicaid's more generous coverage rules or with the complexities of long term supports and services. The practical difficulties for Medicare decision makers to develop expertise in the various state Medicaid programs would be significant.
4. **Create a set of entities with particular expertise in evaluating both Medicare and Medicaid coverage.** Current entities in either the Medicare or Medicaid appeals structure could be trained on the coverage rules of the other program. Alternatively, new entities

could be established. This option poses significant challenges including the complexity of the Medicare program and the wide variation in Medicaid program and coverage rules by state. Wherever they are housed, decision makers would need specialized training and likely would be limited to only handling integrated appeals. Mechanisms, including quality reviews by both Medicare and Medicaid agencies, would need to be in place to ensure that the rights of beneficiaries in integrated systems do not veer away from protections established separately in each program.

Whatever option is chosen, the task of integration is made more difficult by the fact that integrating entities may be providing benefits and services in addition to those traditionally covered by Medicare and Medicaid. One of the promising elements of these new integrated models will be the ability of these programs to use the new financing options to pay for services outside of the traditional scope of Medicare and Medicaid to help individuals remain in the community and avoid more costly settings like hospitals and nursing homes. Whoever is conducting the external levels of appeal will need to determine whether a service could be covered by either Medicare or Medicaid and whether, under the entity's contract terms, the service may be available as an alternative or enhanced benefit. Training will be necessary to prepare the medical reviewers, administrative law judges, and/or hearing officers that are ultimately tasked with making these determinations.

## Conclusion

As CMS and states work to create new integrated models to serve dual eligibles, strong, integrated appeal procedures that provide the strongest protections afforded by each program will be key to ensuring that entities are held accountable to provide beneficiaries access to the services they need. There is not yet a model that effectively integrates the Medicare and Medicaid appeals processes from start to finish. Designing a completely integrated model may not be possible and any design would need to take into account the underlying design of the integrated model adopted by a particular state. Creating a more integrated system, however, is

achievable and, if done in a way that preserves existing protections, offers an improvement to dual eligibles that enroll in integrated models.

Instead of asking each state to generate its own concept of an integrated appeal system, the Medicare-Medicaid Coordination Office in concert with other offices within CMS should take the lead in addressing the challenges that are common across the states. MMCO's leadership on this issue would preserve state-level resources and would be consistent with the clear signals the Office has sent that consumer protections, including appeals processes, must be part of these new, integrated models.

## Notes



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