MACPAC

Integrating Appeals Processes for Dually Eligible Beneficiaries

Medicaid and CHIP Payment and Access Commission

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Overview

- Introduction
- Appeals process in managed care
- Key differences between Medicare and Medicaid
- Examples of integrated appeals processes
- Next steps

Definition

- Appeal – an action a beneficiary can take if he or she disagrees with a coverage decision
- Right to appeal under Medicare and Medicaid is based on right to due process in the Constitution

Separate Processes

- Medicare and Medicaid each have their own appeals process
- Dually eligible beneficiaries have to navigate both
- Differences between Medicare and Medicaid appeals create opportunities for administrative alignment

Reasons for Integrating in Managed Care

- Efforts to streamline the two are focused on appeals in managed care
- Creating a seamless process may be easier in managed care because there is a single entity – the health plan – that can be the starting point for all appeals
- Simplified processes emphasize aspects most favorable to the beneficiary

Appeals Process in Managed Care

- Health plan denies coverage of a service; dually eligible beneficiary appeals
  - Decides which program to appeal to – provider helps with this but may not be easy to figure out, especially where coverage overlaps (e.g. DME, home health)
  - Files appeal within 60 days (10 days if appealing a Medicaid-covered service and want to continue Medicaid benefits during appeal)
  - Health plan typically has 30 days to resolve
  - If health plan decision is unfavorable to beneficiary, he or she can appeal to next levels

Federal Policy Changes

- Regulatory
  - CMS Medicaid managed care final rule aligned Medicaid with Medicare Advantage and the private sector by:
    - Aligning appeals timeframes
    - Requiring beneficiaries to exhaust the health plan level first before obtaining a state fair hearing
- Legislative (Proposed)
  - Chronic Care Act directs the Secretary of HHS to align appeals and grievances under D-SNPs to the extent feasible

Levels of Appeal in Managed Care

Level	Medicare	Medicaid
1	Reconsideration by the health plan	Same
2	Review by independent review entity (IRE)	State fair hearing
3	Hearing before an Administrative Law Judge (ALJ)	State court review
4	Review by the Medicare Appeals Council (MAC)	Federal district court review
5	Judicial review by federal district court	Not applicable

Notes: The first level is the same after changes in Medicaid managed care rules that require Medicaid beneficiaries to first appeal to the health plan before moving to a state fair hearing.
Source: Centers for Medicare & Medicaid Services (CMS 2017b) and Center for Health Care Strategies (Kruse and Philip 2015)

Key Differences between Medicare and Medicaid Appeals

- Amount in controversy
- Right to in-person fair hearing
- Continuation of benefits during appeal (aid paid pending)

State Efforts to Streamline – New York

- Financial Alignment Initiative demonstration uses a single, streamlined appeals process – NY is the only state to do this
- Applies provisions from each program most favorable to the beneficiary
- During a MedPAC-sponsored site visit, we heard that beneficiaries, providers, health plans, and other stakeholders support the single process.

Levels of Appeal in New York

Level	Action
1	Reconsideration by the health plan
2	Review by Integrated Administrative Hearing Officer (IAHO)
3	Review by the Medicare Appeals Council (MAC)
4	Judicial review by federal district court

Notes: Medicare Part D is not included in the fully integrated process. It has a separate appeals process.
Source: Center for Health Care Strategies (Kruse and Philip 2015)

Other State Efforts to Streamline

- States in Financial Alignment Initiative have integrated appeals to some extent
- Minnesota – Minnesota Senior Health Options (MSHO) contracts with dual-eligible special needs plans (D-SNPs) and streamlines appeals at health plan level
- California – Health Plan of San Mateo (HPSM) uses a single appeals process – plan identifies which program beneficiary must appeal to
  - if services overlap, plan applies the appeal rights most favorable to the beneficiary

Next Steps

- Identify questions of interest to the Commission, such as:
  - Is there evidence of improved beneficiary experience or reduced administrative burden?
  - Would alignment at the health plan level be a significant first step?
- Comments? Questions?

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