



# SNP Alliance

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## Integrated Grievance and Appeals Processes for Medicare-Medicaid Beneficiaries Enrolled in Integrated Medicare-Medicaid D-SNPs

### Background

Nearly two million people dually eligible for both Medicare and Medicaid (Medicare Medicaid beneficiaries or enrollees) are enrolled in Medicare Advantage Dually Eligible Special Needs Plans (D-SNPs) or Medicare Medicaid Plans (MMPs) engaged in integration of Medicare and Medicaid services under agreements with CMS and states. Different provisions of the Social Security Act govern the Medicare and Medicaid health plans' appeals processes leading to different procedures, amounts in question, and levels of appeals.<sup>1</sup> However, conflicts between the appeals and grievance processes for remaining Medicare benefits under Parts A and B, and for Medicaid benefits continue to complicate the system for enrollees, resulting in barriers to seamless care delivery for plans working to integrate benefits.

In addition to federal requirements, state Medicaid programs are also subject to state statutes and regulatory provisions that may differ from Medicare's appeals process, and may vary across the country in definitions, timeframes, notice requirements and other processes.

For the past two years, the Medicare Medicaid Coordination Office (MMCO) has submitted legislative recommendations for an integrated appeals process for Medicare-Medicaid enrollees who are enrolled in managed care plans providing both Medicare and Medicaid benefits. Under demonstration authority, the MMCO has aligned the Grievance & Appeals (G&A) process to some extent through the Financial Alignment Initiative and Minnesota D-SNP demonstration but additional authority is needed for similar improvements for the broader dually eligible populations enrolled in Medicare-Medicaid D-SNPs outside the federal demonstration authority.

Recent changes in Medicaid regulations being implemented over the next 18-months provide opportunities to states and plans to further align grievance and appeals processes.

### Medicaid Managed Care Rule Changes

Under its final Medicaid managed care rule issued April 25, 2016, CMS has taken significant steps to align the Medicaid

G&A process further with Medicare. In the rule commentary, CMS states that their goal is to align with Medicare and/or the private market wherever possible.

The new Medicaid rules will require changes to state level requirements and provide a much more standardized national Medicaid G&A process including:

- Requires that enrollees must first exhaust the plan level appeal process (providing one level of appeal) prior to accessing the Medicaid state fair hearings (SFH) process while preserving the enrollee right to a direct SFH if the plan does not adhere to plan level notice and response requirements.
- Standardizes time frames for enrollees filing appeals to within 60 days of the adverse determination, with an additional 120 days for submittal of SFH. Plans must respond/resolve in 30 days or 72 hours for expedited appeals.
- Standardizes use of "calendar day" for time frames.
- Providers must obtain enrollee permission prior to provider submission of appeals on the enrollee's behalf.
- Clarifies that benefits continue throughout the appeal until a final determination is made even though authorizations may have expired in the meantime.
- Clarifies that each plan must have a G&A system that meets federal standards.
- Requires states to monitor and report on plan performance related to G&A.
- Gives states the option to allow an external independent medical review at the enrollee's request provided it does not extend the timeframes for appeal and SFH.
- Clarifies that state grievance systems also incorporate appeals.

For some states (such as Minnesota) these changes could alleviate the need for demonstration waivers related to differences in appeals processes timelines, allowing further alignment of Medicare and Medicaid benefit determinations and G&A timelines at the plan level.

CMS and states will likely need time, guidance and technical assistance for work with stakeholders to determine

<sup>1</sup> Medicare Part D covers nearly all prescription drugs for Medicare-Medicaid beneficiaries, so already has a single appeals and grievance process. This document does not address Part D.)

how best to take advantage of the new Medicaid alignments to ensure meaningful simplification for beneficiaries.

### Issues That Still Need Resolution

**Notice requirements:** Section 1852(g) of the Social Security Act currently requires a plan to issue a Medicare denial notice whenever a service is denied under Medicare, even if the service is covered under Medicaid. This requirement is incompatible with an integrated appeals process and can lead to millions of unnecessary and confusing notices sent to Medicare Medicaid beneficiaries. For example, this provision could be interpreted to mean that a denial notice must be sent for certain home care services or durable medical equipment items that are clearly outside of the scope of Medicare but are normally part of the Medicaid benefit. Even though the plan is going to cover the service under Medicaid, a Medicare denial may be required, confusing and alarming the beneficiary. This problem has been mitigated somewhat (but not eliminated) by new CMS Integrated Denial Notice (IDN) instructions. However, this is only one of several notices required for different parts of the Medicare benefit. Much more could be done to address this IDN issue and to consolidate other duplicative or confusing notices and make them more understandable.

**Auto-forwarding:** Medicare law provides that a plan's denial for services under Parts A and B is automatically forwarded to an external entity for a review (Social Security Act §1852(g)(4)). (Part D has a separate, more streamlined process.) This is an important beneficiary protection that does not exist in Medicaid. However, Medicaid requires that beneficiaries have the opportunity to request an SFH before a Medicaid ALJ (§1902(a)(3)), rather than going first through a paper review. Both the auto-forward process under Medicare and the Medicaid right to request a hearing after a plan denial are important beneficiary protections, and preserving both in an integrated system is challenging. However, the new Medicaid rules requiring enrollees to exhaust the plan level appeal process prior to moving to the SFH can facilitate integrated benefit determinations at the plan level allowing the appeals and grievances to be sorted into appropriate buckets for auto forwarding to either Medicare or Medicaid as appropriate. Such plan level integrated benefit determinations can significantly reduce the number of items forwarded to second level appeals while preserving rights to second level reviews and hearings under both authorities. While some parties believe a single third party reviewer should be established for both Medicare and Medicaid grievance and appeals, this would require additional resources and regulatory change and may not be necessary if the volume of second level reviews is significantly reduced through integrated benefit determinations.

**Selecting a forum:** Section 1902(a)(3) of the SSA requires that beneficiaries always retain the right to have a Medicaid appeal before their state Medicaid agency, even if the state chooses to delegate appeals to another agency. If unchanged, this provision would make it difficult to ensure that all

integrated appeals went to the designated agency (either at the state or federal level) so this provision could be a barrier

to using a single third party reviewer. However, as discussed above, the new Medicaid requirement that members first exhaust plan level appeals prior to moving to SFH may mitigate some current confusion around this issue.

**Amount-in-controversy:** There are no amount-in-controversy limits to appeals in Medicaid, reflecting the program's low-income population. Applying Medicare's amount-in-controversy rules in Section 1852(f) to Medicaid would be incompatible with Medicaid appeal rights. However, this Medicare provision is only applicable at the second level of review so would only apply to those Medicare appeals that move to the Medicare external review process and would not interfere with the Medicaid SFH process.

**Aid pending appeal:** Under Medicaid, beneficiaries have a constitutional right to continue to receive services while their appeal is pending as long as they request the appeal in a timely manner. This is mandated by Supreme Court rulings (see, e.g., *Goldberg v. Kelly* 397 U.S. 254 (1970)), and implemented through federal regulations. Currently there is no statutory authority or additional funding provided in Medicare to require plans to continue services during a beneficiary's appeal.

**Timeframes:** Medicare and Medicaid have generally had different timeframes for rendering a decision, however as noted earlier, the new rules include significant steps in aligning Medicaid timeframes with Medicare's. This issue should be monitored to see whether state specific problems remain after the new rule is implemented.

**Provider appeals:** Under Medicare, non-network providers are allowed to submit appeals without beneficiary permission, while under the new Medicaid rule, providers continue to be required to have beneficiary permission. Ideally this would be aligned in an integrated appeals system. However, this provision affects a very small number of providers so may not be a large barrier to further integration.

### Summary

The new Medicaid rule appears to provide significant new opportunities for states and plans to re-examine how best to coordinate or integrate the grievance and appeals processes. Further obstacles (such as the IDN) appear to require additional policy changes. These issues are highly technical and any changes must be informed by expert advice. As a result, the MMCO should be provided with authority to waive federal Coverage Determinations, and Appeals requirements whenever an individual is a dual eligible and is entitled to service pursuant to a contract between Medicare Advantage and the State Medicaid agency, with guidance provided from stakeholders, including consumer advocates, state Medicaid agencies, MMPs, SNPs and others.