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Integrated Appeals Processes for Medicare-Medicaid Enrollees: Lessons from States

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IN BRIEF

A user-friendly appeals process that gives people an easy way to request reconsideration of coverage or payment decisions is critical to the success of patient-centered, integrated care programs. Misalignments between Medicare and Medicaid appeals processes, however, pose barriers for states seeking to integrate these mechanisms in new models of care.

This brief explores opportunities for states to develop an integrated appeals process, either through a Dual Eligible Special Needs Plan (D-SNP) or a financial alignment demonstration. It presents lessons from Minnesota's D-SNP-based Senior Health Options program and the Health Plan of San Mateo's integrated health plan on aligning appeals processes, coverage determinations, and provider payments at the health plan level. It also highlights a significant opportunity for states implementing financial alignment demonstrations to develop fully integrated appeals processes using early insights from New York's Fully Integrated Duals Advantage program. The lessons outlined herein can inform state, health plan, and federal efforts to improve beneficiary experience in integrated programs.

Medicare and Medicaid appeals processes are significantly different, creating challenges for states in aligning them in new integrated models of care. This brief, developed with support from The Commonwealth Fund and The SCAN Foundation, presents lessons for achieving greater alignment in appeals processes for Medicare-Medicaid enrollees in capitated health plan arrangements, either through a Dual Eligible Special Needs Plan (D-SNP) or as part of a financial alignment demonstration.

Misalignments in Medicare and Medicaid Appeals Processes

The considerable differences between Medicare and Medicaid appeals processes create two distinct paths that Medicare-Medicaid enrollees must navigate when care is denied (Exhibit 1). While new, fully integrated models of care can be designed to offer an aligned appeals process, in most states appeals processes for Medicare-Medicaid enrollees remain fragmented and confusing. Having separate Medicare and Medicaid appeals processes requires beneficiaries to navigate through varying timelines for submissions of appeals, and potentially forego needed services during the process.

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EXHIBIT 1: Medicare and Medicaid Appeals Processes

Level	Medicare Appeals Process	Medicaid Appeals Process*
First	Reconsideration by the health plan	Reconsideration by the health plan**
Second	Reconsideration by the Independent Review Entity	State Fair Hearing
Third	Hearing with an Administrative Law Judge	Possible Medicaid agency review
Fourth	Review by the Medicare Appeals Council	Appeal to state or federal district court
Fifth	Judicial review in federal district court	Not applicable

*Varies by state.

**Some states allow direct access to a State Fair Hearing and some states require plans to send unfavorable decisions to a state Independent Review Entity.

Any attempt to integrate the Medicare and Medicaid appeals systems has to resolve conflicts between the two programs. Examples of misalignments in Medicare and Medicaid appeals processes include: (1) whether there can be a continuation of benefits pending appeals; (2) financial thresholds to access higher levels of appeals processes; and (3) access to in-person hearings (Exhibit 2). States interested in aligning Medicare and Medicaid appeals processes in these areas must work with federal partners to request waivers of Medicare requirements while preserving beneficiary protections. Additionally, although states have flexibility to change state-specific requirements related to appeals, they must adhere to federal Medicaid program rules.

EXHIBIT 2: Key Areas for Alignment in Integrating Medicare and Medicaid Appeals[1,2]

Area	Medicare Appeals	Medicaid Appeals
Requirement to appeal to health plan first	Yes	Varies; many states allow access to state fair hearing without exhausting plan appeal
Filing timeframe*	60 days	20 to 90 days (varies by state)
Amount in controversy	Financial threshold or amount in controversy must be met at Administrative Law Judge and federal district court levels	Varies by state; no financial threshold for most states
Continuation of benefits or aid paid pending	No continuing benefits pending appeal	Benefits can continue upon request
Automatic right to in-person fair hearing	Video conference or telephone, unless Administrative Law Judge approves good cause request for in-person hearing	Varies by state; often have automatic right to in-person hearing

*Additional Medicare and Medicaid timeframes at various levels of appeals are subject to alignment.

An integrated appeals process, even at the health plan level, is easier to navigate and can reduce unnecessary denials of care, resulting in an improved beneficiary experience. Moreover, new integrated models of care have the potential to reduce the number of appeals filed when capitated health plans combine integrated coverage determinations and notices with an aligned appeals process. The section below describes approaches from Minnesota, California, and New York to integrate appeals processes for a streamlined and improved beneficiary experience.

Minnesota: Implementing Plan-Level Integration of Coverage Determinations and Appeals

Minnesota, similar to many states, contracts with D-SNPs to provide Medicaid benefits in addition to Medicare-covered services. Under the longstanding Minnesota Senior Health Options (MSHO) program, Medicare-Medicaid enrollees voluntarily enroll in the same health plan to receive all Medicare and Medicaid benefits.[3] From the beneficiary perspective, Minnesota makes MSHO health plan processes appear as seamless as possible, including maintaining unified Medicare and Medicaid coverage determinations and health plan-level appeals processes.

Early in the development of the 18-year-old MSHO program, the state identified integrated coverage determinations, denial notices, and alignment of Medicare and Medicaid appeals timeframes as key elements to reduce fragmentation for Medicare-Medicaid enrollees.[4] Minnesota also knew that it did not want MSHO plans to authorize services or pay claims in a non-integrated fashion. As a result, it required that provider payment by integrated MSHO plans be seamless to the beneficiary accessing care as well as to the provider requesting authorization or payment. The approach used in Minnesota leverages the health plan role to streamline the appeals processes.

Key Steps for Appeals in Minnesota's D-SNP Model[5]

1. Plan identifies whether a service is covered by either program at the initial determination and in the first level of appeal or reconsideration.
2. Plan does not notify the beneficiary of denial unless *neither* Medicare nor Medicaid covers – and an integrated denial notice is used.
3. Plan uses aligned Medicare and Medicaid filing timeframes for appeals and the enrollee has one streamlined timeframe within which to appeal the plan decision. (Applies only to services that could be covered by either Medicare or Medicaid.)
4. Plans follow the state's integrated coverage determination and appeals timeframes with integrated notices and payments to providers.

Lessons from Minnesota's D-SNP Platform

Other states with fully integrated D-SNP contracts can develop integrated coverage determination, appeals, and provider payment processes building on the Centers for Medicare & Medicaid Services (CMS) model for D-SNP appeals integration.[6] Following are lessons from Minnesota's integrated health plan-level appeals process on a D-SNP platform:

1. **Develop an integrated coverage determination process.** A basic premise during the implementation of the MSHO program was that the state did not want plans to deny a service under Medicare, only to end up approving the service under Medicaid. Although this process occurs under fee-for-service Medicare and Medicaid billing, under integrated program contracts states can require plans to review coverage under Medicare and Medicaid programs simultaneously. This ensures that MSHO enrollees do not receive unnecessary Medicare or Medicaid coverage denials that occur when integrated D-SNP/Medicaid contractors have systems configured to process Medicare and Medicaid

coverage determinations independently. Minnesota has found that this process reduces overall denials made by MSHO plans.

2. **Maintain beneficiary protections.** Another basic premise of Minnesota's integrated appeals process is maintaining beneficiary protections. Minnesota allows enrollee requests for a state fair hearing to be made without exhausting the internal health plan reconsideration process. This approach was driven by state interest to provide MSHO enrollees access to the same processes available to Medicaid beneficiaries in other Minnesota Medicaid managed care programs.

3. **Align Medicare and Medicaid filing timeframes.** Minnesota's integrated plan appeals process uses a uniform timeframe for beneficiaries to request an initial appeal or reconsideration of the health plan's coverage determination. Minnesota decided that applying the longer 90-day Medicaid state timeframe was more favorable to the beneficiary, so the state worked with CMS to obtain a waiver of the Medicare 60-day timeframe. When a uniform filing timeframe exists, beneficiaries who receive a notice of denial, suspension, or reduction of services do not need to keep track of whether the service is a Medicare or Medicaid service when a plan-level appeal is filed.

4. **Use integrated denial notices.** MSHO enrollees receive one integrated notification regarding Medicare and Medicaid coverage determinations, making the appeals process and next steps easier for the beneficiary to navigate. Minnesota has used an integrated denial notice since the MSHO program began. This notice is available for broad use in integrated D-SNP programs.[7,8]

5. **Review system capacity of integrated plans.** MSHO plans are required to have sophisticated authorization, claims, and reporting systems in place to manage integrated coverage determinations, notices, and plan appeals while also maintaining separate tracking mechanisms for Medicare and Medicaid reporting.[9] In Minnesota, what each MSHO plan does behind the scenes to make this happen varies. However, the state has found integration of coverage determinations and payments to be more challenging when a health plan delegates service authorizations or claims payment to a contracted entity.

Health Plan of San Mateo: Integrating Appeals within an Integrated Health Plan

Since 2006, the Health Plan of San Mateo (HPSM) has operated an integrated plan-level appeals process via a D-SNP model in San Mateo County, California. HPSM operates a county-based Medicaid health plan, an integrated D-SNP product, and a new Medicare-Medicaid Plan under California's financial alignment demonstration program. Since the creation of its D-SNP product, HPSM has sought to create seamless processes for approval/denial and coordination of Medicare and Medicaid services, including grievance and appeals. This includes: (1) integrated coverage determinations and beneficiary notification of approvals and denials of services; (2) an integrated plan-level grievance and appeal process; and (3) provider contracts with rates for services that incorporate both Medicare and Medicaid.

Lessons from HPSM's Plan-Level Perspective

HPSM has used its integrated coverage determination and provider payment processes to provide overlapping benefits in more coordinated and seamless ways. Following are lessons drawn from HPSM's integrated coverage determination and provider payment processes:

1. **Build plan expertise to support coverage determinations and reconsiderations.** HPSM developed staff expertise around both Medicare and applicable state Medicaid processes to ensure that beneficiary and provider rights are addressed. HPSM found it took time to build this expertise, but it was necessary to provide the best support to enrollees.

2. **Integrate provider payments and coverage determinations.** HPSM has established claims processes to allow streamlined payment processes for providers. If a service is a Medicare benefit, Medicare-allowable payment is made, and then the claim will loop to Medicaid for cost-sharing coverage. If a service is a Medicaid benefit, claims will "deny" under Medicare and then loop for payment under Medicaid. This sophistication of HPSM's claims system and integrated provider contracts is welcomed by providers since it prevents them from having to receive a denial of Medicare coverage before being able to submit for reimbursement under Medicaid.

3. **Streamline determinations and payments for overlapping benefits.** HPSM's integrated coverage determination and provider payment processes have helped to address conflicts that can arise with overlapping home health and durable medical equipment benefits. In addition to providing integrated coverage determination notices to beneficiaries, HPSM provides a consolidated remittance notice for providers to explain which program paid for each service. By streamlining coverage determinations and developing integrated provider payments and notices for overlapping Medicare and Medicaid benefits, HPSM has reduced administrative complexity for providers and improved access to care for beneficiaries.

New York: Aligning Appeals through the Financial Alignment Initiative

New York is notably the first state participating in the financial alignment demonstrations to develop an integrated appeals process above the health plan level.[10] In designing its Fully Integrated Duals Advantage (FIDA) financial alignment demonstration program, New York sought to align all aspects of Medicare and Medicaid – including the appeals process – in the way most favorable for beneficiaries. The state worked in partnership with CMS and stakeholders to design its appeals process and identify necessary authority and waivers.[11]

New York's FIDA program, launched on January 1, 2015, integrates five levels of Medicare appeals and four levels of Medicaid appeals into one four-level process (Exhibit 3). The first level is an integrated health plan reconsideration. In the second level, New York's process condenses the Medicare Independent Review Entity (IRE) and the Medicare Administrative Law Judge (ALJ) levels and combines them with the Medicaid ALJ level to create one integrated ALJ level. This new level is staffed by dedicated FIDA ALJs (known as Integrated Administrative Hearing Officers [IAHOs]) in the office that handles Medicaid fair hearings (the Office of Temporary and Disability Assistance

[OTDA]). All non-favorable health plan reconsiderations are automatically forwarded to an IAHO. All appeals receive either a telephonic or in-person review. At both the IAHO and the Medicare Appeals Council (MAC) levels, coverage determinations are reviewed based on a uniform definition of medical necessity. IAHOs and MAC staff are cross-trained on both Medicare and Medicaid coverage guidelines.[12]

EXHIBIT 3: New York's Integrated Appeals Process[13]

Level of Appeal	Description of Activity
1. Plan	Beneficiaries go through the plan's internal appeals process prior to being able to access a state fair hearing. The same 60-day filing timeframe applies for filing an appeal after either a Medicare or Medicaid coverage determination. Any appeal filed within 10 days prompts continuing benefits pending the appeal decision.
2. State Integrated Administrative Hearing Officer (IAHO)	Any adverse decision by the plan is automatically forwarded to an integrated administrative hearing officer (IAHO) who decides whether the item or services should be covered under the integrated program. IAHOs are located in New York's State Office of Temporary and Disability Assistance, the state agency that handles state fair hearings in Medicaid. Benefits that were continuing pending the plan decision continue pending the IAHO decision.
3. Medicare Appeals Council (MAC)	Beneficiaries may choose to appeal an adverse decision by the IAHO to the MAC. Federal hearing officers apply both Medicare and New York Medicaid law, regulations, and guidance. Benefits may continue pending the appeal decision.
4. Federal District Court	An adverse decision by the MAC may be appealed to the Federal District Court.

Lessons from New York's Fully Integrated Duals Advantage Demonstration

As the first state participating in the financial alignment demonstrations to develop an integrated process above the health plan level, insights from New York's integrated appeals approach can inform other states. Following are key lessons:

1. **Develop a vision and maintain beneficiary protections.** New York began with a determined vision to fully align Medicare and Medicaid under the FIDA program in the most favorable way for the beneficiary. This philosophical approach guided New York's review and redesign of the Medicare and Medicaid appeals processes. States interested in aligning appeals processes may benefit from developing similar, clear goals for beneficiary protections.

2. **Have the right expertise at the table.** New York developed expertise on Medicare appeals processes by engaging an outside consultant to identify areas where federal or state rules presented barriers to alignment. Having this expertise positioned the state to work effectively with federal partners to waive statutory and regulatory requirements in negotiating the four-level appeals process.[14,15] New York also involved program staff with knowledge of Medicaid appeals process requirements. If a state's Medicaid program staff do not have the requisite knowledge, it can try to leverage partner agency and external expertise.

3. **Build consumer and advocate support.** Early in the design of New York's FIDA program, the state invited consumer advocates and other stakeholders to workgroup meetings to help

design an integrated appeals process and provide input on beneficiary protections. States can partner with consumer advocacy organizations, CMS, CMS technical assistance providers, and other stakeholders to achieve consensus on an integrated appeals process.

4. **Develop a culture of state-federal collaboration.** New York's fully integrated appeals approach involved state and federal collaboration from the design phase through to joint training of IAHOs in the state Medicaid appeals office and federal MAC hearing officers. A collaborative oversight process is also under development by state and federal partners. This collaboration, along with federal funding for FIDA implementation, has assisted New York in establishing the infrastructure necessary to implement and oversee the new appeals system. Similarly, other states must determine what resources and infrastructure modifications are needed to support all aspects of an integrated appeals process.

Conclusion

Misalignments between the Medicare and Medicaid appeals processes create confusion for individuals eligible for Medicare and Medicaid and could negatively affect access to the care they need. Pathways available through D-SNP contracting and the financial alignment demonstrations present an opportunity for state alignment of appeals processes in new integrated care programs. The integration of determinations, notifications, and provider payments has the potential to reduce the number of appeals filed in new integrated programs by streamlining coverage determinations and reducing unnecessary denials of services. To accomplish this, states can require health plans implementing integrated programs to develop system capacity and staff expertise to implement integrated coverage determinations and provider payments. For states eager to achieve the greatest level of plan-level integration, alignment of Medicare and Medicaid appeals timeframes may require demonstration authority.

In all cases, developing a fully integrated benefit package of Medicare and Medicaid services creates substantial opportunity to streamline coverage determinations and appeals processes for beneficiaries and providers. These insights from Minnesota, the Health Plan of San Mateo, and New York can inform other states, health plans, and stakeholders working to integrate appeals processes and improve access to care for Medicare-Medicaid enrollees.

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ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to advancing health care access, quality, and cost-effectiveness in publicly financed care. CHCS works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit www.chcs.org.

ENDNOTES

[1] The Medicare managed care appeals regulations are outlined in the Medicare Managed Care Manual (MMCM), Section 10.3.3 – Appeals.

[2] For more information on Medicaid managed care appeals regulations and state flexibility see 42 C.F.R. §438.400 – 438.424.

[3] MSHO plans are required to operate a D-SNP in order to participate in the program.

[4] The MSHO program was conceived in 1997 as a demonstration program and converted to a D-SNP based platform in 2006.

[5] The appeals process under the MSHO program is outlined in the 2014 MSHO/MSC+ Contract under Section 8.4 MCO Appeals Process Requirements at https://www.medica.com/~/media/Documents/Provider/2014%20MSHO%20MSC%20Contract.pdf

[6] CMS developed a proposed model for integrating the Medicare and Medicaid appeals processes for Dual Eligible Special Needs Plans (SNPs), see http://www.integratedcareresourcecenter.com/icmmedicarespecialneedsplans.aspx

[7] CMS approved an integrated denial notice (IDN) in June of 2013 for use in integrated D-SNP programs. An IDN provides individuals with a unified and understandable form consolidating Medicare Advantage coverage and payment denial notices and Medicaid appeal rights information. The IDN is used in D-SNP and capitated financial alignment demonstration programs. Medicare plans were required to begin issuing the IDN no later than November 1, 2013.

[8] For more information on how states can use an Integrated Denial Notice see the Integrated Care Resource Center Medicare-Medicaid integration study hall call on this topic at http://chcs.org/media/ICRC_Study_Hall_IDNfinal.pdf.

[9] On both D-SNP platforms and in capitated financial alignment demonstrations, integrated health plans may be asked to provide single notices and determinations to beneficiaries and single payments to providers, while maintaining separate reporting for Medicare and Medicaid payments and encounter data.

[10] The Financial Alignment Initiative is testing new integrated Medicare and Medicaid models to improve beneficiary experience, quality, and cost of care. The Financial Alignment Initiative gives states and CMS' Medicare-Medicaid Coordination Office the opportunity to integrate complicated Medicare and Medicaid appeals processes in capitated model financial alignment demonstrations. For states implementing the managed fee-for-service model demonstrations, grievance and appeal processes and timeframes will remain the same under the demonstration as currently existing under the Medicare and Medicaid programs.

[11] CMS' Medicare Medicaid Coordination Office has authority to waive Medicare appeals and related requirements with overarching guidance that focuses on maintaining beneficiary protections.

[12] New York's integrated medical necessity definition incorporates the most favorable elements of Medicaid and Medicare definitions: "Medically Necessary Items and Services (Also Medical Necessity) — Those items and services necessary to prevent, diagnose, correct, or cure conditions in the Participant that cause acute suffering, endanger life, result in illness or infirmity, interfere with such Participant's capacity for normal activity, or threaten some significant handicap. Notwithstanding this definition, the FIDA Plan will provide coverage in accordance with the more favorable of the current Medicare and NYSDOH coverage rules, as outlined in NYSDOH and Federal rules and coverage guidelines."

[13] New York's three-way contract describes the integrated appeals process under Section 2.13 Participant Appeals at http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/NewYorkContract.pdf

[14] In New York, the Medicare waived requirements include: Sections 1852 (f) and (g) and 1860D-4 and implementing regulations at 42 CFR Part 422, Subpart M and 42 CFR Part 423, Subpart M, only insofar as such provisions are inconsistent with the grievance and appeals processes provided for under the demonstration (NY MOU Appendix).

[15] 1115a Medicaid waivers; waiver of contract requirement rules at 42 CFR Part 438.6(a), insofar as its provisions are inconsistent with methods used for prior approval under this Demonstration (NY MOU Appendix).