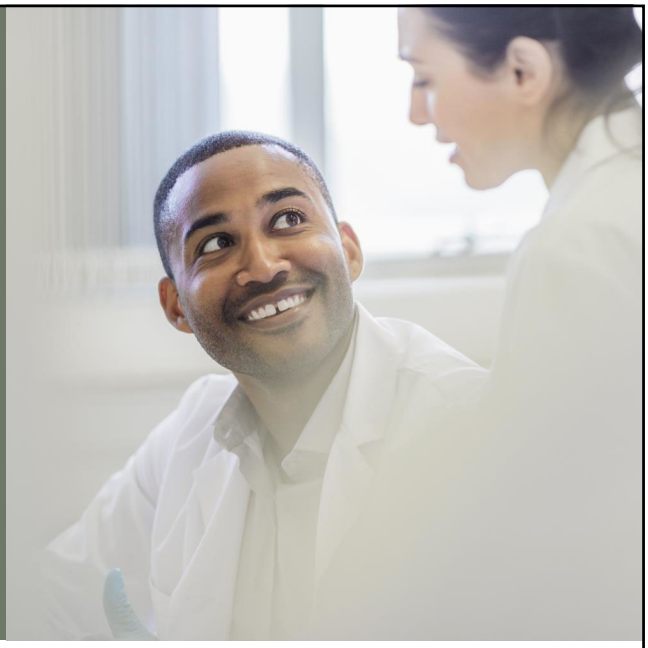
Integrated Appeals and Grievances: A Roadmap for D-SNPs



Presented by
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Integrated Appeals and Grievances

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2. DSNPs
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Integrated Appeals and Grievances
Today's Speakers

Justin Frazer

Director, Mazars

- Justin has over 15 years of experience working for diverse healthcare entities serving the underserved and uninsured. Justin has served in a leadership role with both large and small Medicaid, Medicare, MLTC and QHP (Obamacare) MCOs overseeing regulatory affairs, compliance, operations and business development. As an attorney admitted in NYS, he also has hands-on experience negotiating value-based agreements, applying for state and federal licenses, serving as an ad-hoc compliance officer for providers and vendors as well as assuring regulatory compliance for various healthcare entities including IPAs, Special need plans and tech start-ups.
- Specializing in Operational and Structural Assessment, Enterprise Risk Management, Health Plan/RBO Licensing, Privacy and Cybersecurity, Network Adequacy and Contracting, Survey, Audit, and Certification Readiness (DMHC, DHCS, CMS, NCQA, HITrust)

Sarah E. Swank

Counsel, Nixon Peabody

- As a former senior in-house counsel for two national health care systems, Sarah Swank provides strategic, regulatory and operational advice to health systems, hospitals and academic medical centers, as well as large national and regional physician organizations and telehealth and other startups.
- Specializing in Accountable Care Organizations, Clinical Integration, Managed Care, Digital Health, telehealth, Artificial Intelligence, HIPAA, Fraud and Abuse, Compliance, Clinical Research and IRBs

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Integrated Appeals and Grievances
Introduction

The right of an MCO enrollee to appeal decisions about his or her health care or even complain about the quality of care given is a critical consumer protection.

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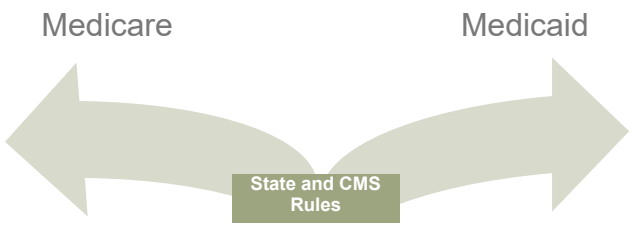
Integrated Appeals and Grievances

Medicare and Medicaid Have Separate Rules

For most consumers, the separate State and CMS rules for appeals and grievances did not pose so much a problem. A Medicaid enrollee would file an appeal and grievance through her MCO that would use state guidance regarding the notifications, turnaround times and appeal rights.

Consequently, a Medicare Advantage Part C consumer who is not satisfied with their MCO's decision, would file an appeal or grievance with their plan and being a Part C Medicare Advantage Plan, the MCO would handle the consumer's appeal or grievance utilizing CMS notification and timeframe requirements.



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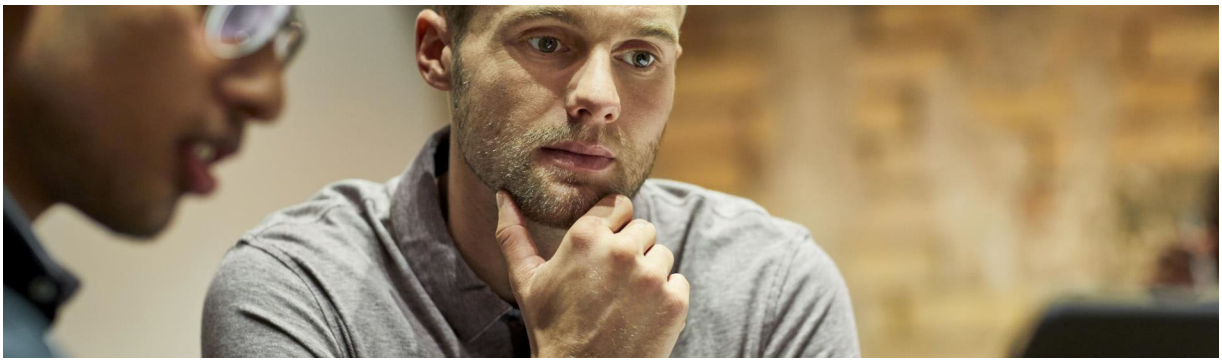
Integrated Appeals and Grievances

One MCO Offering Medicaid and Medicare Benefits (D-SNPs)

However, the appeal process became murky when the MCO manages both a consumer's state Medicaid and Part C Medicare benefit because the consumer is enrolled in a Highly Integrated Dual Eligible Plan (HIDE SNP) or a Fully Integrated Dual Eligible Plan (FIDE SNP).



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Integrated Appeals and Grievances
What is a HIDE and FIDE DSNP?

DSNP Non-Integrated

- A Dual Eligible Special Needs Plan that may or may not have membership aligned with another MCO.
- An enrollee may have Medicaid benefits with one MCO and Medicare Part C and Part D with another MCO
- Enrollee also may not enroll in an MCO for Medicare benefits (FFS Medicare)
- States have flexibility in the determining timeframes

FIDE SNP A Fully Integrated Dual Eligible (FIDE)

- Special Needs Plan has a single parent organization that offers both DSNP and Medicaid MCO with MLTSS or behavioral health services.

HIDE SNP A Highly Integrated Dual Eligible (HIDE)

- Special Needs Plan fully integrates care for dually eligible beneficiaries. FIDE operates as a single managed care organization (entity) that is responsible for all Medicare and Medicaid covered benefits

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Medicaid and Medicare Benefits as One Product

Typically, a FIDE SNP and HIDE SNP cover the following benefit with one MCO line of business:

Medicare Covers

Part A

Hospital Care
Skilled Nursing Care
Nursing Home Care (not custodial care)
Hospice
Home Health Services

Part B

Physicians visits
Preventive Care
Outpatient Care
Emergency Room (ER)
Clinical Research
Ambulance Service/Emergency Ground Transportation
Durable Medical Equipment (DME)
Mental Health services (inpatient, outpatient, partial hospitalization)
Getting a second opinion prior to surgery
Limited Outpatient Pharmacy Prescription Drugs

Part D

Medicare Covered Prescription Drugs

Medicaid Covers

Adult Day Health	Environmental Modifications
Adult Psychological Rehab Services	FQHCs
Anesthesia Services	Hearing Aids and Related Evaluations
Assisted Living	Home Health Services
Behavioral Health Professional Services: Outpatient and Substance Abuse Services	Hospice Services
Care Coordination	Hospital Inpatient and Outpatient
Community Health Workers	Indian Health Services
Dental Services	Vision Care Services
Dialysis Services	Podiatry Services
Durable medical equipment (DME)	Medical & Non-medical Transportation Services
Diagnostic Tests: X-rays, labs and radiology	Pharmacy Services
Emergency Services	Private Duty Nursing for Adults

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Integrated Appeals and Grievances

Integrated Care Delivery

DSNP Overview

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Integrated Appeals and Grievances

Integrated Care Delivery Does Not Mean Integrated Processes

For individuals enrolled in an integrated DSNP, separate processes to appeal a plan decision or to complain about a plan action or managed service, potentially resulted in confusion over which program is covering an item or service and how to file a grievance or appeal.

Scenario

The MCO utilizes a personal care plan for the DSNP enrollee that includes among other things weekly visits with visiting nurses, routine doctor appointments with the enrollee's PCP and specialists and six hours of Home Health Care to help with activities of daily living and administer medications.

The enrollee, the enrollee's family and PCP all feel that six (6) hours of personal care assistance is just not enough.

The enrollee, the PCP or the enrollee's family members appeal on behalf of the enrollee to increase the six hours of home health care.

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Integrated Appeals and Grievances

Filing a DNSP Appeal

The enrollee checks the member handbook and reads that she may contact Customer Service by phone or in writing to file a complaint about Medicare or Medicaid services. For Medicare services, the complaint must be made within 60 days after the enrollee had the problem. For Medicaid services, the enrollee has the right to make a complaint at any time.

In addition, what is not said in the handbook regarding the Medicare and Medicaid appeals processes is:

- Whether there can be a continuation of benefits pending appeals
- Financial thresholds to access higher levels of appeals processes
- Access to in-person hearings

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Integrated Benefit: Clarifying Whether the Benefit is Covered by Medicaid or Medicare

Home Health Care is a benefit covered by both Medicaid and Medicare.

How would the enrollee know whether to file an appeal through Medicare or Medicaid?

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Integrated Appeals and Grievances

How Medicare Appeal Rules and Medicaid Appeal Rules Differed before 2021

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

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How Medicare Appeal Rules and Medicaid Appeal Rules Differed before 2021 (Cont.)

Area	Medicare Appeal	Medicaid Appeal
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

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Confusing Denial Notices

Another significant challenge to having separate paths for DSNP appeals is Section 1852(g) of the Social Security Act that requires MCOs to provide Medicare beneficiaries with a written notice when a request for a service is denied--even when that service is covered under Medicaid for dual eligible beneficiaries.

For Example

If a DSNP enrollee is fitted for hearing aids and the provider bills for the hearing aides and the batteries, Medicare would deny the cost of the hearing aid batteries regardless that the DSNP coverers the batteries under the Medicaid benefit and regardless that the batteries are covered by the MCO, the enrollee would nonetheless receive a denial notice.

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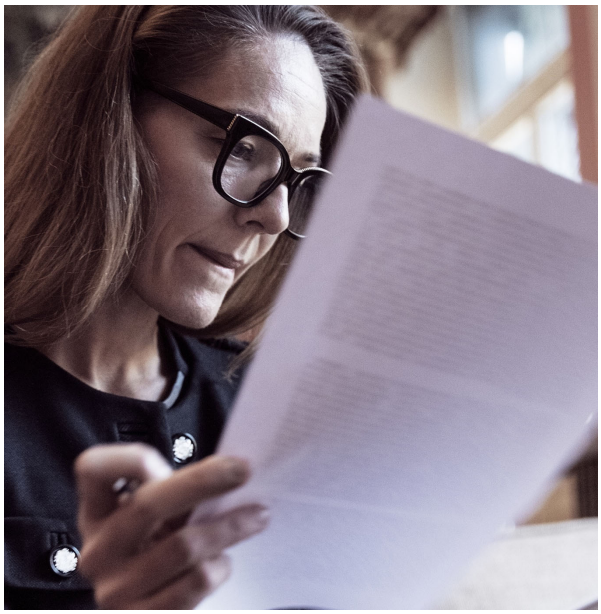
Integrated Denial Notice—A First Step

All MA plans, including D-SNPs and FIDE SNPs, must send to beneficiaries to explain why Medicare coverage was denied and how beneficiaries can appeal that decision.

Despite this effort, state officials and health plans reported that beneficiaries continue to be confused and alarmed by receipt of the Integrated Denial Notice, because it may still appear that a service had been denied when it is covered under Medicaid.

Although CMS has tried to mitigate this issue by making additional clarifications to the Integrated Denial Notice, this has not completely resolved the problem.



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Integrated Appeals and Grievances
Bipartisan Budget Act and CMS Final Rule

Bipartisan Budget Act (BBA) of 2018

Strengthened D-SNP Medicare-Medicaid integration requirements unified Medicare and Medicaid grievance and appeals procedures for integrated D-SNPs beginning in 2021.

Final Rule

- CMS finalized rules implementing these new statutory provisions in April 2019
- Intended to provide DSNP enrollees a simpler, straightforward grievance and appeals process.
- Requires all D-SNPs to coordinate the delivery of Medicaid benefits.

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Integrated Appeals and Grievances
The Expectation of States and Plans

The new processes offer integrated plan-level appeal and grievance pathways for all Medicare and Medicaid benefits.

For appeals, the proposed rule establishes one process for applicable integrated plans to determine if they will cover a requested item or service, and if they do not, one unified process for a beneficiary to pursue an appeal. The unified process includes providing aid pending appeal for all Medicare and Medicaid services, instead of just for Medicaid services as exists under currently law. In addition, the unified process proposes a single set of rules to govern procedural matters such as timelines and rules for authorization.

In addition, states may implement requirements through their State Medicaid Agency Contracts (SMAC) that are more protective for enrollees than those described in regulation. The final rule does not modify post-plan level Medicare and Medicaid appeal processes.

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Integrated Appeals and Grievances

What is required for Integrated DSNPS

Starting in CY 2021, D-SNPs must meet the new Medicare-Medicaid integration criteria in at least one of the following ways:

Unified notices of both Medicare and Medicaid appeals, with notice timing and content following Medicaid guidelines;

Unified time frames for internal and external appeals following Medicaid guidelines;

No more than five levels of appeal with the option to pursue an external hearing instead of or in addition to plan level review;

Continuation of Medicare and Medicaid benefits pending a decision by the first level decision maker;

Training for hearing officers to ensure that they are prepared to adjudicate both Medicare and Medicaid claims applying the appropriate standards of review.

An integrated, easily navigable appeals process that combines appeals for both Medicare, including Medicare Part D, and Medicaid services could alleviate confusion, inefficiencies and administrative burden for beneficiaries as well as state and federal government.

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Integrated Appeals and Grievances

Key Dates for Implementation

All D-SNPs are required to submit a new contract with the state (or an evergreen contract with a contract addendum) to CMS for each state in which they seek to operate in for CY 2021 by July 6, 2020. This includes, as applicable, the new contract requirements identified in 42 CFR 422.107(c) and (d) and summarized in this bulletin. The table below provides key dates and activities for states and D-SNPs related to compliance with the new requirements.

Month/Year	Activity
Fall 2019	• States and D-SNPs begin drafting changes needed to ensure state contracts meet new requirements • States plan for any needed MCO contract changes
Winter 2020	• States and D-SNPs identify and create any new policies and procedures needed in response to contract changes
January 2020	• CMS releases Contract Year 2021 MA (SNP) applications
February 2020	• SNP applications (including SNP service area expansion applications) due to CMS
Spring 2020	• States and D-SNPs finalize state contracts
June 2020	• D-SNPs not renewing MA contracts notify CMS in writing
July 2020	• D-SNPs submit state contracts and related documents to CMS by July 6, 2020
July/August 2020	• D-SNPs work with CMS and states to address deficiencies in contracts
Summer 2020 - Fall 2020	• States and D-SNPs finalize policies and procedures for CY 2021
August/September 2020	• CMS sends D-SNP approval letter • D-SNPs provide Annual Notice of Change and Evidence of Coverage (including information about any changes to grievances and appeals procedures for applicable integrated plans) to current enrollees
January 1, 2021	• Effective date for most April 2019 final rule provisions

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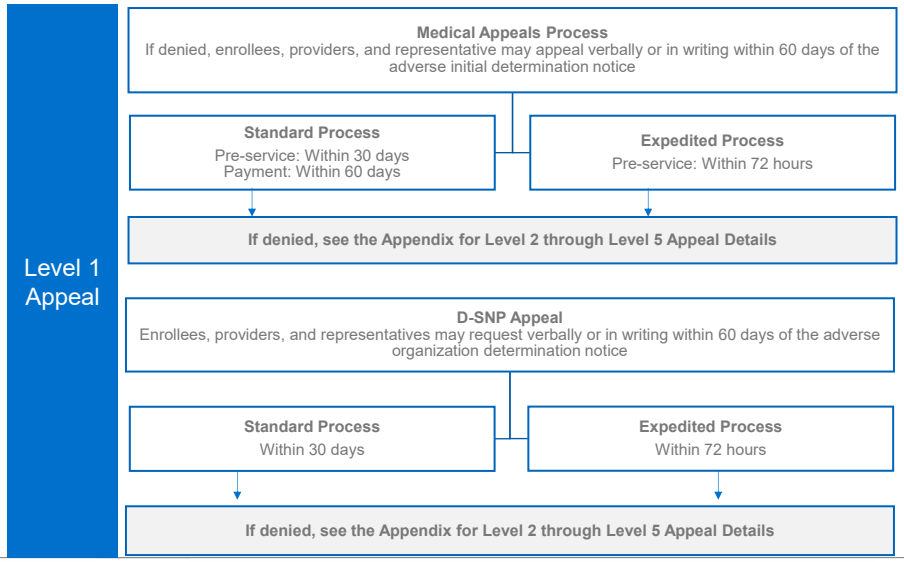
Before and After



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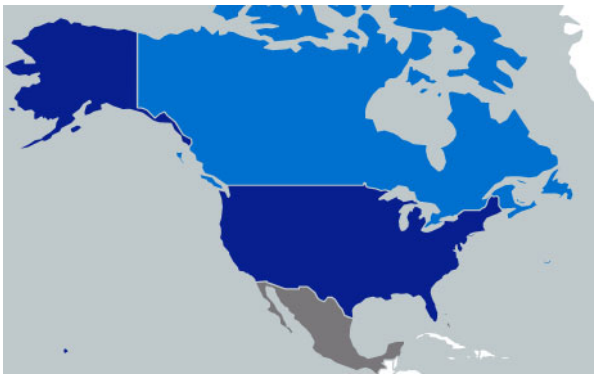
Integrated Appeals and Grievances



How it Works in NYS

In 2015, New York was the first state to develop an integrated appeals process above the health plan level. 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.

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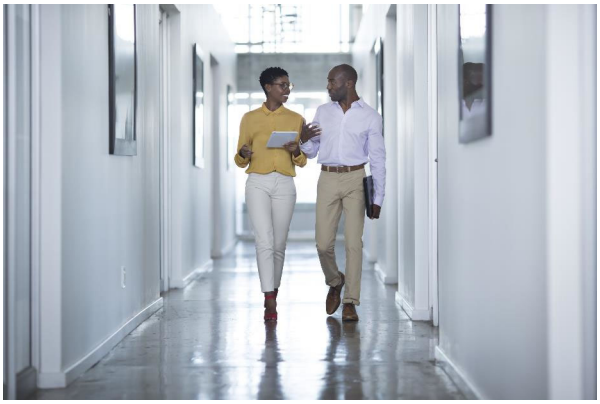
NYS FIDA Program

Appeals Integration

- New York's FIDA program integrated five levels of Medicare appeals and four levels of Medicaid appeals into one four-level process.
- The first level is an integrated health plan reconsideration.
- After the first level of health plan reconsideration, New York's process condenses and shifts the Medicaid administrative law judge (ALJ) and the Medicare Independent Review Entity levels into one integrated ALJ level that will be handled by dedicated FIDA ALJs 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 the dedicated FIDA ALJs at the new integrated administrative hearing officer (IAHO) within OTDA.
- All appeals will be received 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.
- IAHO and MAC staff are being cross trained on both Medicare and Medicaid coverage guidelines.

Integrated Appeals and Grievances



FIDA Sunset/Integrated Appeals Continues

On January 1, 2020, CMS and NYSDOH transitioned remaining FIDA enrollees to MAP plans and aligned D-SNPs. This transition also included extending the FIDA integrated appeals and grievances process to MAP and aligned D-SNP plans. Under the revamped NY Integrated Appeals and Grievances Demonstration, CMS and NYSDOH are testing the integrated appeals and grievances process begun under FIDA with a larger volume of full benefit dual eligible individuals. As of January 2020, approximately 18,000 individuals are enrolled in a MAP and aligned D-SNP plan.

Integrated Appeals and Grievances

Summary of the Integrated Grievance Process

The integrated grievance process offers individuals a single pathway to file a grievance with their plan, regardless of whether the grievance involves the delivery of a Medicare or a Medicaid benefit.

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Integrated Appeals and Grievances

Non-Integrated DSNPS

All other types of Medicare Advantage (MA) plans, without exclusively aligned enrollment, will continue to use existing Medicare appeal and grievance processes for Medicare benefits. The existing processes are required under 42 CFR Part 438 Subpart F and 42 CFR Part 422 Subparts M and N.

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Integrated Appeals and Grievances

Potential Benefits of the Integrated Appeal and Grievance Processes

The integrated processes may offer states, enrollees, and applicable integrated plans various benefits, including:

- State flexibilities
- Streamlined experiences for dually eligible individuals
- Administrative efficiencies for plans

Integrated Appeals and Grievances

State Roles in Implementing Integrated Appeal and Grievance Processes

- All D-SNPs must have contracts with state Medicaid agencies, referred to as the SMAC or "MIPPA contract."
- States needed to update their SMACs to require applicable integrated plans to use the integrated appeal and grievance processes starting January 1, 2021.

- Integrated appeal process includes use of a new integrated denial notice.
- Applicable integrated plans will use this letter beginning in 2021.
- CMS has also developed other model notices that plans may use in other parts of the integrated appeals process.
- States should ensure that D-SNPs and affiliated Medicaid MCOs use the notices with correct state-specific information.

- States may implement timeframe or notice standards that are more protective of enrollees than those specified for the integrated appeal and grievance processes as long as those state-specific standards are consistent with federal Medicaid rules.
- States using more protective standards must specify their requirements in their SMACs.
- This flexibility is useful for aligning integrated appeal and grievance standards with existing state Medicaid standards.

- Integrated appeal and grievance requirements went into effect **January 1, 2021**.
- D-SNPs that are applicable integrated plans will have until **November 2, 2020** to submit a SMAC amendment implementing the unified appeals and grievances procedures

Thank you!

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