Fully-Integrated Duals Advantage (FIDA) Stakeholder Workgroup

Navigation / Appeals / Grievances

Thursday, October 4, 2012, 1:00 p.m.

On Thursday, October 4, 2012, NYSDOH held its second of three FIDA Navigation/Appeals/ Grievances Workgroup meetings for stakeholders. Following is a summary of the meeting discussion.

I. Comments on Previous Call Summary

There were no comments or corrections to the previous call summary.

II. Medicare Appeals Process

Doug Goggin-Callahan provided the group with a walk through of the Medicare appeals process, as requested in the previous meeting. The group was provided a Medicare Appeals Process Chart as part of the meeting materials. Doug suggested the group focus on Medicare Advantage and Part D appeals, since they are most relevant to FIDA. Some of the best practices highlighted included: having a well-functioning standard and expedited process, ensuring that there are defined timeframes, ensure that there are adequate notices before and after appeal, and that the health plan or independent review board reaches out to provider directly if more medical information is needed. As suggested by NYSDOH, Doug will compile a wish list for the appeals process for the next FIDA call. Specific elements discussed include:

- **Medicare Part D.** Doug's opinion is that if possible the Part D appeals process should be improved for FIDA. Currently a patient usually encounters a pharmacy denial at the pharmacy counter, and Doug would like to make that a "true" denial that triggers appeals process. It would help mitigate the issue of the beneficiary trying to figure out multiple appeals process, which is why the integration of Part D would be important.

- **Fair hearing and internal appeals process**. David Silva proposed that a FIDA member should not be required to exhaust internal appeals process to get to fair hearing. Based on anecdotal evidence, David suspects that the reversal rate on internal appeals is low. Some workgroup members disagreed, saying that the internal appeals process is adequate and better for the member (reasons: less time consuming, shorter timeframes than judicial process, less expensive for the plan and State, objective as the internal appeal is not decided by the same provider). Doug Goggin-Callahan mentioned that data exists from Maximus reports the number of overturns it does and breaks them down into issues. There is also an OIG report from 2009 that has some overturn rates from Medicare side. David cited from the OIG report that regarding internal reviews: 54.1% favorable to member, 43% wholly adverse to member, 1% partially adverse. At the independent review entity, 1 in 5 are reversed. David specified that he does not object

to the idea of internal appeal, as long as member is fully informed about rights, process, etc.

- **PACE appeals process.** Bill Berry outlined the PACE appeals process, stating that when there is a denial or reduction in a fully capped PACE program the member has option of pursuing either the Medicare or Medicaid appeal process. There are no guidelines provided to help guide the individual's choice. Bill likes that in the MA proposal a member can pursue both appeals routes and take whichever decision is better to the member. Other workgroup members thought, while great for the member, this is a waste of limited resources. There is an internal appeals process in PACE before you go to fair hearing. Maria Oliveri stated that for MAP that you have to determine at the denial point if it is Medicare, Medicaid, or both. If both, a "dual denial" letter must be issued and the member can chose which track to pursue. If no choice is made it defaults to the more generous process, which is Medicaid.

- **IRE for all FIDA services.** NYSDOH asked the workgroup to consider if IRE should be used for all services in the package (ex. Meals on Wheels). Doug Goggin-Callahan stated that he doesn't want to replace fair hearing, however IRE as an option for all services is useful, and that the extent that there could be uniformity would be useful.

- **Expedited process and aid continuing.** Cathy Roberts mentioned that she did not like that there is no expedited process built in because a beneficiary could wait a long time for decisions. She stated that there is an expedited process in Medicare, and while there is no "functional" process in Medicaid a beneficiary has the right to aid continuing. It was noted that this process is not ideal, since it does not work if a person is requesting new or additional services. David Silva stated that he would want to make sure aid continuing can go beyond authorization period for both internal and external appeals. Participants liked the provision that the physician prevails regarding if an appeal should be expedited, which does not currently exist for Medicaid. Doug Goggin-Callahan raised the issue that backlog can result due to lack of judges. NYSDOH mentioned that reducing administrative backlog is on the State's radar, and Melissa Seeley from CMS will see if Federal dollars could be used to assist with this.

Overall the workgroup agreed that there should be focus on streamlining the grievances and appeals process so the workload (whatever the process) is not unduly burdensome. NYSDOH stated that they would welcome recommendations.

III. Review of CMS "Preferred Requirement Standard"

NYSDOH asked the workgroup if they had thoughts on the preferred requirement standard. As no comments were made, NYSDOH suggested members email or send in writing any comments they may have.

IV. Member Services, Access and Communication Requirements

NYSDOH stated that they would like to use the State model contract list—sections pertaining to member services, information for potential enrollees, quality (which includes access), information requirements, and member services—as a jumping off point for FIDA. NYSDOH would welcome recommendations from the workgroup regarding how to enhance that. Doug Goggin-Callahan reiterated that he would like to make sure that Part D is included so the process is fully integrated for beneficiaries.

V. Notices

Workgroup members discussed notices, particularly the Explanation of Benefits (EOB). Doug Goggin-Callahan stated that people don't understand what it's telling them—for example, on the notice is the statement "this is not a bill;" however, it is an appeal notice. Coding for denials are explained on reverse side of the notice, which is cumbersome. Some workgroup members would like to use FIDA as an opportunity to move EOBs into a more friendly and easier-to-understand direction. NYSDOH stated they will find out how much leeway CMS will give NYS to address this. David Silva added that he would like to have the appeals process (expedited or standard, fair hearing, aid continuing) right up front for the member, including phone/contact information.
Another participant suggested considering that a dedicated second party also receives these notices—Social Security has a similar process that could potentially be used. The workgroup and NYSDOH also discussed including as part of FIDA the creation of template notices, which all agreed were easier for everyone.

VI. Wrap up and next meeting: Thursday October 18 from 1-3pm

Please send any comments or materials to disseminate to the group to Laurie A. Arcuri (laa03@health.state.ny.us) at least two days prior to the next call.

Websites for the group to explore:

- State Demonstrations to Integrate Care for Dual Eligible Individuals: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateDemonstrationstoIntegrateCareforDualEligibleIndividuals.html

- Maximus webinar, "The Most Common Issues in Health Insurance Appeals:" https://www.maximus.com/sites/default/files/filemanager/MAXMUS_Webinar_1.15.10_Health_Appeals.pdf

- State Model Contract: http://www.health.ny.gov/health_care/managed_care/mltc/pdf/mltc_contract.pdf