



---

## **Due Process Protections in Duals Demonstrations: A Closer Look at New York Managed Care and Older Adults Series Issue No. 4**

**Prepared By: Janelle McClure<sup>1</sup>**

---

### **Introduction**

Medicaid is an entitlement program that offers a dependable source of health insurance for the vulnerable populations that need it, including low-income older adults and those that are dually eligible for Medicare. Medicaid enrollees are entitled to certain critical protections; one of the most important of which is due process. The essential elements of due process in Medicaid are adequate written notice and the opportunity to challenge an adverse state action before an impartial decision maker. These protections must be preserved as states and the U.S. Department of Health and Human Services (HHS) explore different delivery system reforms, like duals demonstrations. This issue brief provides background on Medicaid due process rights and the typical appeals processes available to individuals dually enrolled in Medicaid and Medicare. The brief then takes a closer look at a new demonstration in New York that integrates the Medicare and Medicaid appeals processes. In looking at the New York demonstration, the issue brief analyzes the effects of integration on enrollees' due process rights, considers the strengths of New York's integrated appeals process, identifies an area of concern, and makes recommendations on ways to improve the appeals process.

### **1. The Right to an Appeal in Medicaid**

All Medicaid enrollees are entitled to due process before their Medicaid eligibility or services are denied, reduced, suspended, or terminated. This includes those participating in duals demonstrations. For example, these rights entitle Medicaid enrollees to notice and a fair hearing before an adverse action can be taken against them. Enrollees who appeal a notification of a termination, suspension, or reduction of service can continue to receive coverage and services during the appeal, if they request the appeal before the date of the adverse action.<sup>2</sup> This right to "aid paid pending" can be a lifeline for low-income individuals who cannot afford to pay out-of-pocket for health care services while they exercise their due process rights.

The right to due process is rooted in the Medicaid statute and regulations and in the U.S. Constitution.<sup>3</sup> Because of the constitutional underpinning, Medicaid due process rights cannot be subjected to administratively created exceptions nor may they be waived by federal and state governments.

## 2. Due Process for Individuals Dually Eligible for Medicare and Medicaid

Most individuals who are dually eligible for Medicare and Medicaid must navigate two different care systems *and* two different appeals systems.

Several states are working with HHS to develop duals demonstrations designed to address this fragmentation and better integrate Medicare and Medicaid care and services for individuals who are dually eligible for Medicare and Medicaid. Each participating state has worked with HHS to develop and tailor its specific demonstration

***A single, integrated appeals system should not leave an enrollee with fewer rights than the enrollee would have faced under either the Medicare or Medicaid appeals system.***

project. Most state duals demonstrations create a partially integrated Medicare and Medicaid appeals process, but New York is striving to create a single, fully integrated appeals process. On August 23, 2013, HHS and the State of New York signed a Memorandum of Understanding (MOU) outlining how they anticipate the New York duals demonstration will operate.<sup>4</sup> For example, in New York, the duals demonstration will be available to dually eligible individuals who are over 21 years old, require long-term care, and live in one of eight participating counties.

A single, integrated appeals system should not leave an enrollee with fewer rights than the enrollee would have faced under either the Medicare or Medicaid appeals system, as the enrollee is entitled to all the Medicaid and Medicare due process protections. Any attempt to integrate the appeals processes, through a duals demonstration or otherwise, should make sure that these rights are preserved. For example, a Medicaid enrollee should not end up with *fewer* due process protections after becoming eligible for Medicare. Rather, an integrated appeals process should preserve the strongest protections of each program.

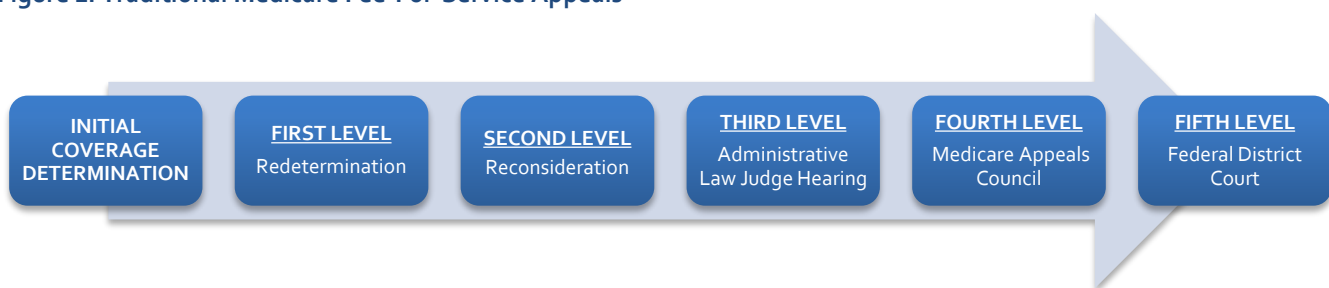
## 3. Background on Appeals Processes for Medicaid Beneficiaries who are also Eligible for Medicare

Individuals who are dually eligible for Medicaid and Medicare can receive covered services through a combination of different programs, each with a unique appeals process. The appeals processes in four different coverage options commonly available to dual eligibles are described below.

### ***Traditional Medicare Fee-for-Service (FFS) for Parts A and B<sup>5</sup>***

In traditional Medicare, the right to an appeal is triggered by a Medicare initial coverage determination. Sometimes an enrollee will receive a notice from Medicare that serves as an initial coverage determination. Other times the enrollee must take additional, potentially burdensome steps to receive an initial coverage determination.<sup>6</sup> Once an enrollee receives an initial coverage determination, the enrollee can request a redetermination by individuals who were not involved in the initial coverage determination.

**Figure 1: Traditional Medicare Fee-For-Service Appeals**



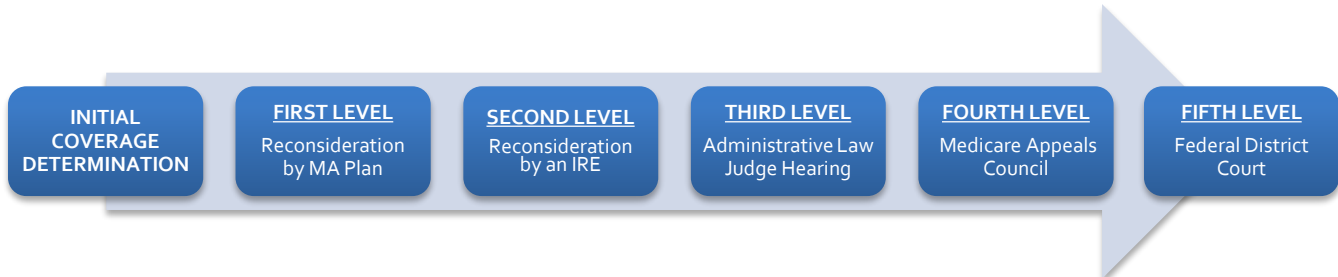
Following redetermination, the next step in the Medicare appeals system is reconsideration by a qualified independent contractor (QIC). That step is followed by a hearing before an Administrative Law Judge; but, for a Medicare claim to be heard by an Administrative Law Judge the claim must meet minimum amount in controversy requirements.<sup>7</sup> If the Administrative Law Judge makes an unfavorable decision, the next step in the process is an appeal to the Medicare Appeals Council. The final step in the Medicare fee-for-service appeals process is to file a complaint appealing the Medicare Appeals Council's decision in district court.<sup>8</sup>

### ***Medicare Advantage***

In Medicare Advantage (MA), a private health insurance company contracts with Medicare to provide health care coverage to plan enrollees. The appeals process for MA enrollees begins after an enrollee receives an initial coverage determination from the MA plan. The first step is for the enrollee to request reconsideration from the plan. If the plan reconsideration is not decided in the enrollee's favor, the decision is automatically forwarded to the second step in the appeals process, which is reconsideration by an Independent Review Entity (IRE). An enrollee who receives an unfavorable IRE decision can appeal to an Administrative Law Judge. As in Medicare fee-for-service, the disputed claim must meet minimum amount in controversy requirements.<sup>9</sup> The next step is to request review

by the Medicare Appeals Council. The final step in the MA appeals process is to file a complaint in district court.<sup>10</sup>

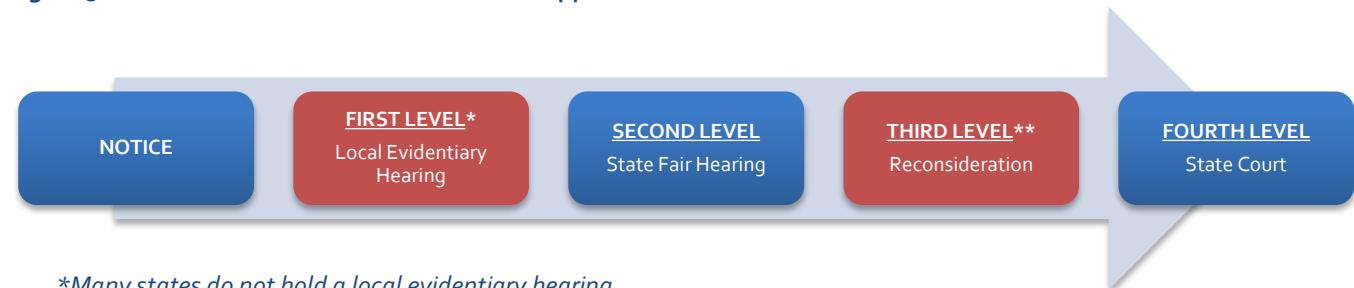
Figure 2: Medicare Advantage Appeals



### Traditional Medicaid Fee-for-Service

State Medicaid agencies must send enrollees a notice of action. In most cases where Medicaid eligibility or services are being terminated, reduced or suspended, the notice must be sent at least 10 days before the agency plans to take the action. For the first step in the appeal, State Medicaid agencies have the flexibility to require a local hearing, although many states (including New York) choose not to hold local hearings. In addition states can choose to hold local hearings in some political subdivisions and not others.<sup>11</sup> If a local hearing is held, the next step in the process is a state fair hearing. This is the first step if there is no local hearing. The fair hearing may be held before an Administrative Law Judge or a hearing officer who makes either a recommendation or a final decision. In the vast majority of states (including New York), the final determination is made by the director of the state Medicaid agency or the director’s designee. In addition, every state has a process that allows individuals to appeal an unfavorable final administrative decision in state court.<sup>12</sup>

Figure 3: Traditional Medicaid Fee-For-Service Appeals



\*Many states do not hold a local evidentiary hearing.

\*\*Most states do not have this step.

### Medicaid Managed Care

Medicaid managed care may have a slightly different appeals process than Medicaid fee-for-service. As in Medicaid fee-for-service, a Medicaid managed care organization must send an enrollee notice 10

days before the plan reduces, suspends, or terminates services (eligibility changes are handled by the state and follow the Medicaid fee-for-service process). Medicaid managed care plans must have an internal grievance process that includes one or more reviews of their initial decision and allows for expedited review when the enrollee's condition calls for it. States can decide whether enrollees must exhaust this grievance process before requesting a state fair hearing or if an enrollee can directly request a state fair hearing.<sup>13</sup> In any event, the next (usually second) step in the appeals process is the state fair hearing. The final step in the process is to appeal the decision to state court.

**Figure 1: Medicaid Managed Care Appeals**



*\*States may choose to make the internal plan grievance optional or mandatory.*

*\*\*Most states do not have this step.*

#### 4. Appeals Process for the New York Duals Demonstration

New York is currently finalizing contracts for a demonstration that will transition some dual eligibles with long-term care needs into newly created Fully Integrated Duals Advantage (FIDA) plans. New York is preparing to create a single, integrated appeals process for enrollees in its demonstration. The integrated appeals process will be used for most claims and does not distinguish between services that are covered by Medicare, Medicaid, or both programs. However, enrollees will continue to use the current, separate appeals process for Medicare Part D prescription drug coverage appeals.<sup>14</sup>

Enrollees participating in New York's duals demonstration project will receive a single, integrated notice informing them of their appeal rights. The notice must include information on the availability of an ombudsperson that can offer assistance to enrollees.

New York proposes a four step appeals process within its duals demonstration. The first step is a mandatory internal plan appeal. Enrollees will have 60 days to file an appeal after a notice of denial is sent. Enrollees who file an appeal within 10 days of the notice's postmark date will continue to receive "aid paid pending" through the third level of the appeals process. Plans must acknowledge that they received the appeal and they must issue a decision within 30 calendar days for a standard appeal. In an expedited appeal, the plan must make a decision within 72 hours.

If the plan's decision is unfavorable for the enrollee, the claim automatically will be forwarded for a hearing before an Administrative Law Judge who will serve as the Integrated Administrative Hearing Officer. The Integrated Administrative Hearing Officer is housed within the state agency that handles Medicaid fair hearings. Since the officer will need to apply both Medicare and Medicaid rules, the officer will receive training from HHS and the state. The hearing officer must issue a decision within 90 days of the request during the first year of the demonstration. During years two and three, the decision must be made within 30 days. In the event of an expedited appeal, the decision must be made within 72 hours. All decisions must be issued in plain language and identify the next steps in the appeals process.

**Figure 2: New York Duals Demonstration Appeals**



After this step, enrollees have 60 days to file an appeal to the Medicare Appeals Council. The Medicare Appeals Council will review the record and may issue a decision within 90 days. The final step is to file a complaint in federal district court.

### ***Levels in the Appeals Process***

It is important to note that the New York duals demonstration proposes fewer levels of appeal than are currently used in Medicare Advantage; the demonstration eliminates reconsideration by the Independent Review Entity. However, the loss of reconsideration by the IRE may not present a significant lost opportunity for enrollees because the most important steps in a Medicare Advantage appeal generally do not occur until the third step in the MA appeals process – the hearing before an Administrative Law Judge.

Moreover, as mentioned in the previous section, in a Medicaid appeal, generally the Administrative Law Judge or hearing officer makes a recommendation/decision, and a final decision is made by the hearing authority – usually the director of the state Medicaid agency or the director's designee.<sup>15</sup> New York follows a similar process where the hearing officer creates an official report with a recommendation for the commissioner, who then issues a final binding fair hearing decision.<sup>16</sup> However, some states use a different system. For example, in Pennsylvania the hearing officer makes a decision that is affirmed, amended, reversed, or remanded by the Director of the Office of Hearings and Appeals, but in Pennsylvania enrollees can appeal the director's decision and request reconsideration by the Secretary. This is an extra level in the appeals process that gives enrollees in

Pennsylvania another opportunity to make their case.<sup>17</sup> This difference in the appeals processes in New York and Pennsylvania highlights the need for states pursuing integrated appeals to carefully consider their state's appeals process to ensure integration does not result in a lost opportunity for enrollees.

### ***Medicaid Administrative Law Judges Serving as Integrated Hearing Officers***

Another important feature of the New York duals demonstration is that the integrated hearing decision is made by Medicaid Administrative Law Judges who receive training on Medicare rules. The State of New York and HHS had several options as to who would make the integrated hearing decision. For example, they could have decided that the Medicare Independent Review Entity or the Medicare Administrative Law Judge would instead receive Medicaid training and serve as the Integrated Hearing Officer. After weighing all their options, ultimately it was decided that the Medicaid Administrative Law Judge and state fair hearing process should be used. Many advocates expressed concern that the Medicare Independent Review Entity generally conducts a paper-based review and many Medicaid claims can heavily rely on specific facts and testimony. The experience of Medicaid Administrative Law Judges in making decisions regarding home care and other long-term care decisions was also taken into consideration. While New York decided that Medicaid Administrative Law Judges should make integrated hearing decisions, this was a state specific decision and other states must carefully consider how the different appeals processes are working in their state and the needs of the population served by the integrated process.

## **5. Analysis of the New York Duals Demonstration Appeals Process**

This section of the paper analyzes key components of the New York MOU, highlighting strengths of the proposal, a potential problem arising from the demonstration, and persistent problems within Medicaid managed care that will continue to be problematic for New York's FIDA enrollees if they are not corrected.

### **Strengths of the NY Proposal**

#### ***Appeals Integration***

New York strives to fully merge the Medicaid and Medicare appeals processes into one unified process (except for prescription drugs, as mentioned earlier). If an integrated appeals process maintains all the essential rights and protections currently available under Medicaid and Medicare, a coordinated appeals process with a single set of rules and deadlines would be simpler for enrollees to navigate than the current system.

New York's duals demonstration appeals process is more integrated than those of other participating states that have released an MOU. For example, Michigan's duals demonstration proposes an appeals process that differentiates between Medicare and Medicaid services. In Michigan's process, unfavorable plan-level decisions related to a Medicare service are automatically forwarded to the next step in the appeals process, but unfavorable plan decisions regarding a Medicaid service are not automatically forwarded.

***Ultimately, the laudable goal of integration should only be pursued – as a matter of law and policy – to the extent compatible with due process rights. No authority – whether through administrative exceptions (such as waivers) or legislative action – should be created to promote integration at the expense of appeals rights.***

Furthermore, to fully protect enrollees, a truly integrated appeals system requires decision makers to understand the rights afforded to enrollees under both Medicare and Medicaid. Ensuring that decision makers are competent and well-versed in both systems presents new challenges for HHS and states. New York's duals demonstration requires HHS and the State of New York to complete a readiness review of the staffing, training, and systems of the new Administrative Hearing Unit for the duals demonstration.<sup>18</sup> In addition, since the Integrated Administrative Hearing Officers will be Medicaid Administrative Law Judges who receive training in Medicare policy, their decisions on Medicare services will be reviewed by the Medicare Advantage qualified independent contractor (QIC) during the beginning of the demonstration. The QIC review will not affect the outcome of an appeal but is designed to provide feedback and quality assurance. Training will also be required for the Medicare Appeals Council Administrative Appeals Judges. While proper training, robust readiness review, and a strong audit process are important steps, these steps alone do not necessarily ensure that the decision makers fully understand and accurately apply Medicare and Medicaid policies. Advocates and officials involved in developing integrated appeals system need to be diligent in making sure decision makers are properly trained and equipped to make fair decisions, and decisions should be periodically reviewed to make sure that correct law is properly applied.

### ***Aid Paid Pending***

There are three notable aspects about aid paid pending in the New York duals demonstration that can serve as models for other states. First, as noted, New York will provide aid paid pending for *both* Medicaid and Medicare services throughout the appeals process. Aid paid pending is not required during appeals of Medicare services.



Notably, the ten states (including New York) that have released MOUs for a capitated duals demonstration all plan to allow enrollees to receive aid paid pending for non-Part D Medicare services during the initial internal grievance. However, the other states do not offer aid paid pending for Medicare services through the two subsequent appeals that follow an internal grievance as New York proposes. For example, Ohio allows aid paid pending for both Medicaid and Medicare services during the internal grievance, but in subsequent appeals aid paid pending is only available for Medicaid services.<sup>19</sup> NHeLP encourages HHS and other states working to integrate and improve care for individuals dually eligible for Medicare and Medicaid to allow aid paid pending for both services throughout the appeals process as was done in the New York demonstration.

Second, as mentioned earlier, according to New York's MOU, as long as an enrollee's first plan level appeal was filed within 10 days of the date the notice was postmarked, aid paid pending *automatically* will be available through the third step in the appeals process (the Medicare Appeals Council decision). In contrast, some state MOUs, such as South Carolina's, require enrollees to submit every appeal within 10 days of receiving notice of an unfavorable decision to continue to receive aid paid pending for Medicaid services through multiple appeal levels.<sup>20</sup> New York's automatic triggering of aid paid pending for subsequent appeals steps will simplify the process for enrollees, preserve access to much needed services for enrollees, and reduce the administrative burden for the state.

Note, however, that since there is no way for New York to distinguish between which individuals will file an appeal during the 60 day filing window following an unfavorable FIDA hearing decision and which will not, New York will need to automatically maintain aid paid pending for *all* applicants for 60 days after the Automatic Integrated Administrative Hearing decision (until the window for filing an appeal closes) to comply with the MOU. While neither New York nor HHS have explicitly confirmed this will be the policy, NHeLP has recommended it to HHS as the optimal policy for beneficiaries and the simplest policy administratively. NHeLP recommends that HHS and advocates working in other states also pursue this policy.

Third, enrollees in the duals demonstration technically may be able to receive aid paid pending for a longer period of time. Participants in the New York duals demonstration may continue to receive aid until a decision is made by the Medicare Appeals Council, which is the *third* level in the appeals process. Medicaid requires aid paid pending through a state fair hearing decision, which is the first or second level in the appeals process, depending on whether or not an enrollee must exhaust the internal grievance process before requesting a state fair hearing. Based on the filing deadlines and decision time frames, it is technically possible that participants in the demonstration may be able to receive aid paid pending for a longer duration than those outside of the demonstration. However, it remains to be seen in practice, whether participants in the demonstration will actually receive aid paid pending for a longer length of time. Furthermore, there may be incentives to file before the

filing deadline and for decision makers to make decisions before their deadline, making it so participants within the demonstration receive aid paid pending for similar lengths of time as those not participating in the demonstration.

The commitment to aid paid pending in the New York appeals process is an important virtue of the design. Hopefully, other states will build upon the aid paid pending provisions contained in the New York MOU. **In all cases, Medicaid aid paid pending is a critical protection for enrollees, and should not be reduced in any way through administrative waivers or legislative action to promote integration of care.**

### ***Automatic Forwarding***

Another important feature of the New York appeals process is that, in the event of an unfavorable plan level decision, the case is automatically forwarded to the Integrated Administrative Hearing Officer regardless of whether the service is for Medicare or Medicaid.<sup>21</sup> Currently, Medicare Advantage automatically forwards unfavorable plan level reconsiderations for reconsideration by the Independent Review Entity, but Medicaid does not automatically forward similar unfavorable decisions.

### ***Amount in Controversy***

Amount in controversy requirements limit an enrollee's ability to present an appeal. Although Medicare includes an amount in controversy requirement that must be met for a claim to be heard before an Administrative Law Judge, the New York MOU expressly prohibits amount in controversy requirements through the automatic administrative hearing.<sup>22</sup> Other states looking to integrate these appeals process should also work to eliminate the amount in controversy requirement.

### **New Problem: Delayed Access to Judicial Review**

Though it has many virtues, New York's integrated appeals process has the potential to create a new problem. Individuals enrolled in New York's duals demonstration may not be able to bring a claim in state or federal court as quickly as similarly situated individuals who are not participating in the demonstration. For example, in New York there is a state "Article 78" claim which allows individuals to access state court after any final agency decision.<sup>23</sup> For individuals, who are not participating in the duals demonstration this generally means that after they receive a state fair hearing, they may be able to commence an Article 78 proceeding in State Supreme Court to challenge the final agency decision on certain grounds. For individuals participating in the duals demonstration it is unclear when the final agency decision occurs and when they will be able to bring an Article 78 proceeding. It is possible that the final agency decision may occur after the Automatic Administrative Hearing. If that is the case then

access to court is not delayed. However, it is possible the final agency decision for enrollees participating in the duals demonstration will not occur until the Medicare Appeals Council decision, as they will be making decisions on Medicaid claims. If that is the case, then New York's integrated appeals system will force participants to go through more steps, delaying their ability to raise an Article 78 claim. As a practical matter, this may not be an area of great concern as advocates have reported that Article 78 proceedings are currently hard to win and therefore rare.

HHS should work to clarify where state and federal agency processes begin and end in the "integrated" process and ultimately implement a system where access to court is not delayed due to integration. If necessary, HHS and New York should structure the Medicare Appeals Council as an optional step for Medicaid services, making the state agency process technically complete after the administrative hearing if this is needed to ensure that enrollees are not worse off because of the integrated appeals system. Reducing the "integration" of the process is not the optimal result, but it is clearly preferable to interfering with enrollees' ability to seek judicial review.

### **Ongoing Medicaid Problems that May Continue in the Duals Demonstration**

***Enrollees in New York's demonstration may continue to experience several long-standing Medicaid problems that are not caused by integrating Medicare and Medicaid, but risk being repeated in the demonstrations. HHS should not approve demonstrations that continue these problems.***

#### ***Aid Paid Pending for Services that Are Due for Reauthorization***

Unfortunately, the rules that govern Medicaid managed care have been interpreted by some entities to only require plans to continue to cover services through the end of an authorization period. This causes Medicaid managed care enrollees to experience disruptions in medically necessary care as they may stop receiving services while an appeal is pending when the authorization period for such services expires. For example, if an enrollee needs ongoing therapy and the plan approves it in two month segments, some managed plans end aid paid pending when the two month window expires, even if no final decision has been reached on an individual's appeal. The next authorization is essentially treated as if it was an entirely new and distinct treatment, even though the treatment need is on-going and clearly prescribed for a life-long medical need. The constitutional due process requirement ensuring that enrollees are able to receive care during an appeal does not change because a managed care plan is using authorization periods. MOUs and subsequent three-way contracts are a prime opportunity to address this misapplication of law.<sup>24</sup> To help ensure this right is protected, advocates must work to

make sure states correct the reauthorization problem, and HHS should refuse to approve demonstration projects that do not properly address this issue. Advocates should also seek and HHS should mandate criteria requiring more sensible authorization periods (e.g., not every two months for a lifelong treatment) to reduce administrative burden and costs.

The New York MOU is silent on the issue of aid paid pending after an authorization period ends. However, recently enacted state law requires non-governmental entities, like managed care plans, that are authorized by the state to make prior authorization decisions to offer medical assistance and aid continuing to enrollees who appeal an action without regard to the expiration of the prior service authorization.<sup>25</sup> Clearly HHS should not approve any demonstration which does not effectuate a state's clear intent to address such grievous due process problems.

### ***Exhaustion of Plan-Level Appeals***

Managed care plans are required to have internal grievance processes to resolve disputes filed by enrollees. This raises the question of whether such plan-level internal grievance must be filed and completed by enrollees before they can take their appeal to a Medicaid Fair Hearing. Ideally, enrollees would always be able to skip this first step and directly request external review if they so choose. For example, some individuals might choose to do this because they have a more urgent need for the service in question and/or they do not trust the fairness of the internal plan reviewers.

Under Medicaid law states have the flexibility to *choose* whether or not they will require exhaustion of internal grievances for Medicaid managed care. Therefore, in some states, Medicaid enrollees are required to file and complete internal grievances with their health plan before they can proceed to an independent review. In other states, enrollees are free to appeal straight to a state fair hearing. Medicare Advantage, unlike Medicaid, *requires* enrollees to exhaust internal appeals before they can request external review. This raises a serious conflict for duals integration: the optimal policy for HHS to pursue would be to implement integrated demonstrations where plan-level exhaustion is always optional. HHS could waive the Medicare Advantage internal grievance requirement using their § 1115A waiver authority, which provides broad authority to waive Medicare requirements.<sup>26</sup> For example, in the Michigan duals demonstration HHS used its waiver authority to waive the requirement that Medicare Advantage appeals must be filed within 60 days. Instead, as a result of this authority enrollees in the Michigan duals demonstration will have 90 days to file their initial appeal for either Medicare or Medicaid services, thus effectively extending the deadline to file a Medicare appeal.<sup>27</sup> This was an intelligent use of waiver authority to promote integration and *improve* care for enrollees. Under this

***Under Medicaid law states have the flexibility to choose whether or not they will require exhaustion of internal grievances for Medicaid managed care.***

same authority HHS could choose to eliminate the Medicare Advantage exhaustion requirement. In contrast, HHS should never use such waiver authorities to advance integration at the *expense* of consumer protections.

New York proposes to require exhaustion in its duals demonstration (as it has done for Medicaid managed long-term care). For states like New York, advocates should work with HHS to use the duals demonstration as an opportunity to take the first step in reversing the existing internal exhaustion policy for their Medicaid program more broadly. In any case, advocates should be prepared to address the concerns of insurance companies, who will argue that the mandatory internal grievance process provides plans with a valuable mechanism to monitor and evaluate instances and patterns of care denial. However, confusion surrounding the exhaustion requirement in Medicaid managed long-term care has resulted in the loss of due process rights for some enrollees in New York. For example, some enrollees are unaware of the new exhaustion requirement and continue to file their first appeal as a request for a state fair hearing. Unfortunately, by the time they understand that they must first file a grievance with the plan; the window in which they can file an appeal has passed.<sup>28</sup> This jeopardizes due process rights in a way that substantially outweighs the concerns raised by managed care plans. New York partially compensates for some of the potential burdens caused by exhaustion by automatically forwarding unfavorable internal plan decisions, alleviating the burden of having to file an additional appeal for an integrated hearing.<sup>29</sup>

### ***Recoupment***

When Medicaid managed care enrollees receive aid paid pending, federal law permits states and managed care plans to recoup money spent on health care if the enrollee ultimately loses the appeal.<sup>30</sup> HHS has not required recoupment by any state operating a duals demonstration, though the agency has also not prohibited recoupment.

New York Medicaid managed care regulations allow a plan to recover benefits paid during the appeal if the final decision is unfavorable to the enrollee, though this does not mean recoupment is frequently used.<sup>31</sup> Nonetheless, the mere threat of having to pay for expensive medical care out-of-pocket may cause some low-income Medicaid recipients to forego an appeal, even when the services are desperately needed. The New York MOU does not address recoupment, which suggests that the state may intend to continue existing policy for participants in the duals demonstration. That said, New York advocates have worked tirelessly to eliminate this requirement within the duals demonstration project and there is hope the final contracts will not allow recoupment.

Given the serious health needs of many older adults making use of aid paid pending, HHS and states should prohibit recoupment in dual eligible demonstrations. This policy would minimize administrative hassles, protect seniors, and likely have little practical impact on costs. State advocates should pursue this policy in their demonstrations, and Medicaid programs more broadly. State

advocates should also be aware that if county or other local dollars are used in their state Medicaid financing, advocacy with these entities may be important, because they may have a financial interest in opposing measures that prohibit recoupment.

## **Interaction with Existing Statutory and Regulatory Framework**

There are many key Medicaid protections that the New York MOU does not directly address. The MOU does include language requiring FIDA plans to comply with the existing legislative and regulatory requirements of Medicare Advantage and Medicaid managed care unless the MOU otherwise specifies.<sup>32</sup> While language that specifically addresses all of the important Medicaid and Medicare protections is ideal, presumably the general requirement to comply with existing laws and regulations will address the gaps in the MOU. Advocates, along with HHS and states, should carefully monitor compliance with law and regulations that are generally, but not specifically, required by the demonstration MOUs and contracts.

However, the language in the MOU does not directly address which standards a plan must meet if the Medicare Advantage and Medicaid managed care requirements do not perfectly align. Language requiring plans to comply with the standard that is most beneficial to the enrollee would add clarity and additional enrollee protections. Such language is specifically applied to some issues; for example, the New York MOU requires the standard that is most beneficial to the enrollee to be used if there is a conflict between the standards that govern how plans communicate with enrollees.<sup>33</sup> This same standard should be specifically applied to all conflicts of law and regulation between Medicare and Medicaid.

To the extent that Medicaid regulations are properly applied, as the MOU requires, the following Medicaid (and in some cases, Medicare) protections should be in force, even though they are not directly addressed in the MOU:

- *Medicaid Notice Requirements:* Advance notice is an essential, constitutional due process protection in Medicaid. The advanced notice must include a statement of the intended action, the reason for the action, citations to supporting law or regulations, the effective date of the action, information on how to initiate an appeal, and the steps an enrollee should take to continue to receive benefits during an appeal.<sup>34</sup> The notice should inform individuals that they can be represented in their appeal and provide referrals to affordable representation.<sup>35</sup> Under state law, there may be further requirements for certain types of notices.<sup>36</sup>
- *Medicaid Fair Hearing Procedures:* Medicaid rules explicitly give enrollees the right to present evidence and examine the record. In addition, Medicaid managed care rules require that the case be decided by decision makers who did not participate in the prior decision.<sup>37</sup> During a

Medicaid state fair hearing, a claim must be presented to one or more impartial hearing officers.<sup>38</sup>

- *Oral Appeals Requirement:* Medicaid regulations require plans to treat oral inquiries seeking to appeal an action as appeals. This is right is particularly important in determining if a request was made within the timeframe allowed for an enrollee to receive aid paid pending.<sup>39</sup>
- *Medicare Good Cause Extension of Filing Deadlines:* Medicare Advantage regulations allow filing extensions for enrollees who can demonstrate that they had good cause for missing the filing deadline.<sup>40</sup> While the New York MOU includes general information about filing deadlines, it does not address good cause extensions of these deadlines.

## Conclusion

New York is taking important steps towards integrating the Medicare and Medicaid appeals systems. As this issue brief has explained, there are a number of protections that are needed to make sure that due process rights are not lost. Advocates in all states should work to implement these protections, and HHS should make them the norm for all states pursuing dual eligible demonstrations. Furthermore, these rights should never be abridged through administrative or legislative action in an attempt to promote integration.

## ENDNOTES

<sup>1</sup> Thanks to Valerie Bogart of the New York Legal Assistance Group, Krystal Knight of the Medicare Rights Center, and David Silva of the New York Legal Assistance Group for their consultation on earlier drafts of this brief. More information on the New York duals demonstration can be found at <http://www.nyduals.org>, a website developed by the Coalition to Protect the Rights of New York's Dually Eligible.

<sup>2</sup> 42 C.F.R. § 431.230(a).

<sup>3</sup> U.S. Const. amend. XIV, §1; 42 U.S.C. § 1396a(a)(3); 42 C.F.R. §§ 431.200-431.250; see *Goldberg v. Kelly*, 397 U.S. 254, 266 (1970) (holding that welfare recipients possess due process rights to notice and a hearing before benefits may be cancelled).

<sup>4</sup> See New York MOU, available at [http://www.health.ny.gov/health\\_care/medicaid/redesign/docs/2013-08-23\\_ny\\_mou\\_final](http://www.health.ny.gov/health_care/medicaid/redesign/docs/2013-08-23_ny_mou_final). It is important to note that the paper is based on provisions contained in the Memorandum of Understanding. These provisions are subject to change once the three-way contracts between the state, HHS, and participating plans are finalized.

<sup>5</sup> This describes a standard Medicare appeals process. Medicare has a different process for appealing hospital discharges and discharges from skilled nursing facilities, home health agencies, and comprehensive outpatient rehabilitation facilities. There is also a separate appeals process for Medicare Part D services.

<sup>6</sup> For more information on the Medicare appeals systems see Georgia Burke & Kevin Prindiville, *Building an Integrated Appeals System for Dual Eligibles* (October 2011), available at <http://www.nslc.org/wp-content/uploads/2011/10/Building-an-Integrated-Appeals-System-for-Duals.pdf>.

<sup>7</sup> For 2014, the Medicare ALJ threshold amount is \$140. See Medicare Program; Medicare Appeals: Adjustment to the Amount in Controversy Threshold Amounts for Calendar Year 2014, 78 Fed. Reg. 59702 (Sept. 27, 2013).

<sup>8</sup> There is also an amount in controversy requirement to bring a Medicare appeal in district court. In 2014 the threshold amount is \$1430. See *id.*

<sup>9</sup> 42 C.F.R. § 422.602(d).

<sup>10</sup> The traditional Medicare amount in controversy requirements also apply here. See 42 C.F.R. § 422.612.

<sup>11</sup> 42 C.F.R. § 431.205(c).

<sup>12</sup> For more information on the Medicaid appeals process see National Health Law Program, *The Advocate's Guide to the Medicaid Program* 2.23 T (May 2011), available at [www.healthlaw.org](http://www.healthlaw.org).

<sup>13</sup> New York does not require exhaustion of internal plan appeals before requesting a fair hearing in typical Medicaid Managed Care plans. However, exhaustion of internal appeals was required for New York's Managed Long-Term Care plans.

<sup>14</sup> Currently, no state has released a proposal developing an integrated appeals system that incorporates Medicare Part D appeals. Excluding Part D appeals from integration efforts means that dually eligible individuals will continue to experience a complicated and fragmented appeals system for prescription drug claims.

<sup>15</sup> See CMS, STATE MEDICAID MANUAL § 2903 (regarding hearing decisions).

<sup>16</sup> See N.Y. SOC. SERV. §§ 358-5.6(b)(9); 358-6.1 (2014).

<sup>17</sup> 55 PA. CODE § 275.4 (2014).

<sup>18</sup> New York MOU, *supra* note 4, at 5-6.

<sup>19</sup> Ohio Three-way Contract at 84-87, available at <http://cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/OhioContract.pdf>.

<sup>20</sup> South Carolina MOU at 101, available at <http://cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/SCMOU.pdf>.

<sup>21</sup> Not all states automatically forward adverse Medicaid decisions. See, e.g., Virginia Three-way Contract at 108 available at <http://cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/VirginiaContract.pdf>. But see Washington MOU at 101, available at <http://cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/WACAPMOU.pdf> for another example of a state that automatically forwards unfavorable decisions on both Medicare and Medicaid services.

<sup>22</sup> See New York MOU, *supra* note 4, at 77.

<sup>23</sup> N.Y. C.P.L.R. 7801.

<sup>24</sup> See *Guidance to States using 1115 Demonstrations or 1915(b) Waivers for Managed Long term Services and Supports Programs* at 15 (May 20, 2013) for an example of HHS requiring states to ensure that fair hearing protections, including the right of continued services or "aid paid pending" during an appeal.

<sup>25</sup> N.Y. SOC. SERV. § 365-a(8) (2014).

<sup>26</sup> Section 1115A provides much more limited authority to waive Medicaid requirements.

<sup>27</sup> See Michigan MOU at 87 available at <http://cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MIMOU.pdf>.



<sup>28</sup> See New York City Bar, *Report on Budget Legislation by the Legal Problems of the Aging Committee* (March 2014) available at <http://www2.nycbar.org/pdf/report/uploads/20072678-SupportsLegislationtoAllowProvisionforMedicaidReviewsAppeals.pdf>.

<sup>29</sup> New York MOU, supra note 4, at 79.

<sup>30</sup> 42 C.F.R. § 438.420. For more information on recoupment see Jane Perkins, National Health Law Program, *Q & A Recoupment Following an Adverse Medicaid Appeal* (June 2011) available at [http://www.healthlaw.org/about/staff/jane-perkins/all-publications/recoupment-following-an-adverse-medicaid-appeal#.U\\_uikPldVZs](http://www.healthlaw.org/about/staff/jane-perkins/all-publications/recoupment-following-an-adverse-medicaid-appeal#.U_uikPldVZs).

<sup>31</sup> See N.Y. SOC. SERV. § 360-10.8(g)(2)(iv).

<sup>32</sup> New York MOU, supra note 4, at 3. The MOU later goes on to expressly waive Sections 1852(f) and (g) and 1860D-4 of the Social Security Act and implementing regulations at 42 C.F.R. Part 422, Subpart M and 42 C.F.R. Part 423 Subpart M insofar as the provisions are inconsistent with those contained in the MOU. See also New York MOU at 4.

<sup>33</sup> New York MOU, supra note 4, at 13-14.

<sup>34</sup> 42 C.F.R. §§ 438.404; 422.568.

<sup>35</sup> See CMS, STATE MEDICAID MANUAL § 2900.3 (regarding information on the right to legal representation).

<sup>36</sup> See *Mayer v. Wing*, 922 F.Supp. 902 (S.D.N.Y. 1996), codified at 18 N.Y.C.R.R. § 505.14(b)(5)(v)(c) (requiring notice of discontinuance or reduction of personal care services to state a reason relating to a change since the services were last authorized, such as medical improvement).

<sup>37</sup> 42 C.F.R. § 438.406.

<sup>38</sup> See 42 C.F.R. § 431.240(a)(3). To better protect enrollees, NHeLP recommends that these hearing officers receive training or certification from hearing officer entities to ensure that they fully understand impartiality.

<sup>39</sup> 42 C.F.R. § 438.406(b)(1).

<sup>40</sup> 42 C.F.R. § 422.582.