



Coordinated Appeals for Dually Eligible Individuals Enrolled in PACE, D-SNPs, and Capitated Duals Demonstrations

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Introduction

In recent years improving coordination for individuals eligible for both Medicare and Medicaid has gained popularity as a policy objective. Integrating the appeals process is often a component of integration efforts, and both President Obama's budget proposal and the Medicare and Medicaid Coordination Office's Report to Congress have advocated for integrating Medicare and Medicaid appeals.¹

There are existing programs and demonstrations that attempt to better integrate care delivery and the appeals process for dually eligible individuals. Before expanding these existing programs or designing new programs, it is important to learn from the existing programs. Three such programs will be examined in this paper: the Program of All-Inclusive Care for the Elderly (PACE), Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs), and the capitated duals demonstrations.² A key principle for any integration effort must be the protection of existing enrollee rights; the pursuit of integration should not compromise or reduce the right of enrollees. This paper will examine how well these three programs incorporate this principle. This paper will also help advocates better understand how these three existing programs operate, how they approach appeals integration, and identify best practices of integration when it is pursued.

¹ See Medicare-Medicaid Coordination Office, *Fiscal Year 2014 Report to Congress 7*, https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMCO_2014_RTC.pdf. See also Office of Management & Budget, *Fiscal Year 2016 Budget of the U.S. Government 62*, <https://www.whitehouse.gov/sites/default/files/omb/budget/fy2016/assets/budget.pdf>.

² This is not a comprehensive list of programs that attempt to improve coordination between Medicare and Medicaid.

PACE

Background

PACE is a model of care for individuals who need nursing home level care, but who, with supports or otherwise, are able to live in the community at the time of enrollment.³ PACE enrollees may be eligible for Medicare, Medicaid, both programs, or neither program.⁴ However, roughly 90 percent of PACE enrollees are dually eligible for Medicare and Medicaid.⁵ In 2015, there were 35,000 PACE enrollees who were served by 115 PACE organizations operating in 32 states.⁶ PACE organizations are capitated programs, where PACE providers are paid a monthly capitated rate from CMS for each Medicare participant and states negotiate capitated payment rates for each Medicaid participant. PACE enrollees are entitled to comprehensive benefits including the full scope of Medicare benefits, all Medicaid state plan benefits, and other services determined necessary by an enrollee's interdisciplinary team.⁷

Appeals

PACE is a unique program and, as such, the rules governing PACE appeals are at times different from the rules for appeals under Medicare Advantage or Medicaid managed care. The federal regulations require a PACE organization to:

- Have a written, formal appeals process;
- Have an impartial decision maker who was not involved in making the original decision make internal appeals decisions;
- Decide internal appeals within 30 calendar days of the date the PACE organization received the appeal;
- Ensure that enrollees have the right to present evidence in writing and in-person;
- Ensure that enrollees have the right for an expedited decision in certain situations; and

³ NATIONAL PACE ASSOCIATION

<http://www.npaonline.org/website/article.asp?id=12&title=Who, What and Where Is PACE>.

Traditionally, PACE enrollment has also been limited to individuals age 55 and older. On November 5, 2015 President Obama signed into law legislation expanding the PACE program by allowing demonstration projects to waive some PACE requirements, such as the age requirement.

⁴ 42 C.F.R. § 460.150(d).

⁵ NATIONAL PACE ASSOCIATION, *PACE in Your Community* 5 (March 2013),

<http://www.npaonline.org/sites/default/files/PDFs/PACE%20Critical%20Success%20Factors%20White%20Paper.pdf>.

⁶ Jade Gong, *PACE: Now is the time to scale* (Oct. 19, 2015), <http://www.mcknights.com/guest-columns/pace-now-is-the-time-to-scale/article/447856/>.

⁷ 42 C.F.R. § 460.92. See also 42 C.F.R. § 438.402(a).

- Continue to provide disputed services to Medicaid enrollees (including those enrolled in both Medicare and Medicaid) if requested, until a final determination is made.⁸

These requirements are minimums that must be met – a PACE organization can offer more generous protections. For instance, a PACE organization may decide to furnish disputed services for a Medicare-only recipient during an appeal, even though this is only required for participants who are Medicaid enrollees (either Medicaid only or dually eligible for both programs).⁹

According to the PACE requirements, after an adverse internal determination dually eligible PACE enrollees can then choose to pursue an external appeal under either Medicare or Medicaid, but they cannot pursue an external appeal with both programs.¹⁰ The PACE organization must help enrollees determine whether it is most appropriate to pursue a Medicare or Medicaid appeal.¹¹ This is important because the Medicaid process may be more favorable in many situations. For instance, Medicaid requires benefits to continue during an appeal until there is a resolution at the State Fair Hearing level, whereas there is no such requirement in Medicare. Additionally, unlike in Medicare, there is not a minimum amount in controversy requirement for a Medicaid appeal to appear before an Administrative Law Judge. Once an enrollee has determined which path to pursue, the PACE organization must forward the appeal to the next step in the appeals process.¹²

While the regulations include important requirements for PACE appeals like those mentioned above, they are silent on other aspects of the appeals process. For example, Medicaid has specific requirements on the timing and content of the constitutionally required advanced notice that Medicaid enrollees must receive prior to an adverse action. Medicare does not have such robust notice requirements and the PACE regulations do not explicitly address notice requirements, although states may address notice in their state PACE regulations or manuals.¹³ The federal PACE requirements also do not give specific guidance on the timeframes enrollees have to file appeals and whether or not exhaustion of the internal appeal is required. These are areas where state Medicaid agencies have flexibility in setting the requirements for Medicaid

⁸ 42 C.F.R. § 460.122.

⁹ CMS, PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE) MANUAL Ch. 11 § 20.2.

¹⁰ CMS, PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE) MANUAL Ch. 11 § 20.4.

¹¹ 42 C.F.R. § 460.124.

¹² *Id.*

¹³ See OR. ADMIN. R. 411-045-0130(b) which requires the PACE organization to provide at least 10 days advanced notice before terminating or reducing a previously authorized treatment.

managed care enrollees.¹⁴ Filing deadlines and exhaustion requirements are also areas where some states have issued their own rules for PACE organizations in their states.

Key Advantages of PACE Appeals

- Medicaid participants enrolled in PACE can continue to receive disputed benefits during an appeal. Further PACE enrollees receive a comprehensive benefit and the regulations do not explicitly limit continued receipt of benefits to disputed *Medicaid* benefits.
- PACE organizations help enrollees determine whether to pursue an external appeal under Medicare or Medicaid, if both options are available.
- Following an adverse internal decision, the PACE organization forwards the appeal for external review.
- PACE organizations must resolve an internal appeal within 30 days. In Medicaid, states must require Medicaid managed care organizations to decide an internal appeal within 45 days.

Key Disadvantages of Integrated Appeals in PACE

- Following an adverse determination, PACE enrollees are limited to either pursuing an appeal with the Medicare Independent Review Entity or pursuing a state fair hearing, but not both.
- The federal rules and regulations on PACE do not address all of the specific details of the notice requirements (when notice must be received, the content of the notice, etc.) or the deadlines for filing an internal appeal.

Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs)

Background

A Medicare Advantage Dual-Eligible Special Needs Plan or D-SNP is a specific type of Medicare Advantage plan designed for individuals who are either fully or partially dually eligible for both Medicare and Medicaid. The first D-SNPs began operating in 2006.¹⁵ D-SNPs currently operate in 39 states.¹⁶

¹⁴ For example, states can set a timeframe for internal appeals that is anywhere between 20-90 days. 42 C.F.R. § 438.402(b)(2). States can also determine whether or not to require exhaustion. 42 C.F.R. § 438.402(b)(2)(ii).

¹⁵ Integrated Care Resource Center, *State Perspectives on Contracting with Dual Eligible Special Needs Plans (D-SNPs)* 6 (Feb.27, 2015), <http://www.integratedcareresourcecenter.com/PDFs/ICRC%20SHC%20State%20D-SNP%20Contracting%20Slides.pdf>.

¹⁶ Kaiser Family Foundation, *Medicare Advantage: Special Needs Plans (SNPs, by SNP Type)*, <http://kff.org/medicare/state-indicator/special-needs-plan-offerings/>.

D-SNPs are required to have a contract with the state Medicaid agency; however, there can be significant variance in the way D-SNPs and state Medicaid agencies approach coordination and integration.¹⁷ There are not strong standards that are specific to D-SNPs (as opposed to general MA standards) and without standards some D-SNPs have struggled to consistently improve care coordination for dually eligible individuals. For example, a Government Accountability Office report examined 2012 D-SNP contracts and found that only one-third of the contracts integrated benefits and only one-fifth had active care coordination between D-SNPs and the Medicaid agencies.¹⁸

Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP)

It is important to note that there is a specific type of D-SNP called a Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP) that is more integrated than the traditional D-SNP. There are roughly 37 FIDE SNPs.¹⁹ These plans have more requirements than a regular D-SNP. For example, they are required to have a coordinated or integrated appeals process.²⁰ However, there is not much specific guidance as to what a FIDE SNP's appeals process should look like.

Appeals Process

D-SNPs, including FIDE SNPs use the Medicare Advantage integrated denial notice. Individuals who are dually eligible for Medicare and Medicaid may receive a notice that contains both Medicare denial information and Medicaid appeal rights information.²¹ Plans are required to follow both the Medicare Advantage and Medicaid managed care appeals processes, but states have discretion in determining whether or not they will require D-SNPs to coordinate the Medicare and Medicaid appeals processes.²² States can take different approaches to do so. For example, New Jersey's contract calls for plans to treat appeals differently depending on which program covers the disputed service. The Medicare Advantage appeals process is followed for Medicare-only services and D-SNPs offer enrollees the right to pursue an appeal under either

¹⁷ See 42 C.F.R. § 422.107.

¹⁸ U.S. GOV'T ACCOUNTABILITY OFFICE, REPORT TO CONGRESSIONAL REQUESTERS, MEDICARE SPECIAL NEEDS PLANS (Sept. 2012), <http://www.gao.gov/assets/650/648291.pdf>. The lack of active care coordination between the D-SNP and the Medicaid agency suggests that the coordination efforts were done solely by the D-SNP.

¹⁹ James Verdier, et. al., *State Contracting with Medicare Advantage Dual Eligible Special Needs Plans: Issues and Options*, Integrated Care Resource Center 5 (Feb. 2015), <http://www.chcs.org/media/ICRC-Issues-and-Options-in-Contracting-with-D-SNPs-FINAL.pdf>.

²⁰ 42 C.F.R. § 422.2.

²¹ CENTERS FOR MEDICARE & MEDICAID SERVICES, *MA Denial Notices*, <http://www.cms.gov/Medicare/Medicare-General-Information/BNI/MADenialNotices.html>

²² See Verdier, *supra* note 21, at 15.

Medicare or Medicaid for overlap services that are covered by both programs.²³ In contrast, Massachusetts's contract makes less of a distinction between the types of service and instead generally follows a traditional Medicare Advantage process for appeals, but gives enrollees the right to additionally pursue a Medicaid appeal.²⁴

Most of the advantages and disadvantages of the appeals process for D-SNPs reflect the broader advantages and disadvantages of appeals within Medicare Advantage plans.

Key Advantages of Medicare Advantage D-SNP Appeals:

- Unfavorable internal reconsideration decisions are automatically forwarded to the first level of an external appeal.
- Plans are required to send an integrated notice.

Key Disadvantage of Medicare Advantage D-SNP Appeals:

- There is not a significant federal minimum for integration, coordination, or assistance beyond an integrated notice.

Capitated Dual Eligible Demonstrations

Background

Thirteen states have enacted demonstration projects to better align Medicare and Medicaid services. Ten of the 13 states are pursuing capitated duals demonstrations.²⁵ Under the capitated model a single Medicare-Medicaid plan (MMP) provides and coordinates all Medicare and Medicaid services. This paper will focus mainly on the appeals integration efforts taking place in the states with capitated models and will focus on the shared aspects of the different capitated demonstrations and not on the specific details of each demonstration.

²³ DUAL-ELIGIBLE SPECIAL NEEDS PLAN CONTRACT BETWEEN STATE OF NEW JERSEY DEP'T OF HUMAN SERVICES DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES AND CONTRACTOR 46 (2014), http://www.nj.gov/humanservices/dmahs/info/d-snp_contract.pdf.

²⁴ MASSHEALTH SENIOR CARE OPTIONS, CONTRACT FOR SENIOR CARE ORGANIZATIONS 49, http://www.chcs.org/media/2010_contract.pdf.

²⁵ The following states have duals demonstrations: California, Colorado, Illinois, Massachusetts, Michigan, Minnesota, New York, Ohio, South Carolina, Rhode Island, Texas, Virginia, and Washington. Washington and Colorado are pursuing managed fee for service demonstrations and Minnesota is pursuing an administrative alignment demonstration. The other states have capitated models. New York is pursuing two demonstrations its Fully Integrated Duals Advantage (FIDA) demo and its FIDA Intellectual and Developmental Disabilities demonstration.

Appeals

All of the capitated demonstrations require the MMPs to use an integrated notice and all enrollees must be given at least 10 days of advance notice before an adverse action takes effect. Additionally, all of the capitated models offer aid paid pending for all services, including Medicare services, at least through completion of the internal plan appeal.

There are important differences among the different state duals demonstrations. Some of the variances between Medicaid programs in different states that exist in traditional Medicaid managed care, like deadlines for filing appeals and exhaustion requirements, carry over into the state demonstrations. For example, Massachusetts requires exhaustion of the internal appeals process before a Medicaid claim can move forward to a State Fair Hearing both for enrollees in their duals demonstration and for the state's Medicaid managed care enrollees.²⁶ In contrast, Ohio does not require exhaustion either in its duals demonstration or in its general Medicaid managed care program.²⁷ Demonstrations also vary in how they treat overlap services that are covered by both Medicare and Medicaid. For example, some states allow enrollees disputing an overlap service at the external appeals level to simultaneously pursue an appeal under the Medicare and Medicaid processes making a favorable decision binding, while other states may require the completion of one external appeals process before enrollees can pursue the other process.

While this paper will not discuss the specifics of the different demonstrations, it is important to note that New York has built a fully integrated appeals system for individuals participating in its duals demonstration. In the New York model, not only is the internal appeals process integrated, but all of the steps in the external appeals process are as well. Right now, New York is the only state where dual eligibles have a fully integrated appeals process, for all services except for Part D. NHeLP has

²⁶ See CONTRACT BETWEEN U.S. DEP'T OF HEALTH & HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES IN PARTNERSHIP WITH THE COMMONWEALTH OF MASSACHUSETTS 134 (DEC. 2015), <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MassachusettsContract.pdf>. See also 130 MASS. CODE REGS. 610.032(B).

²⁷ See CONTRACT BETWEEN U.S. DEP'T OF HEALTH & HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES IN PARTNERSHIP WITH STATE OF OHIO DEP'T OF MEDICAID 85 (FEB. 2014), <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/OhioContract.pdf>. See also OHIO ADMIN. CODE 5160-26-08.4(I)(2).

previously analyzed the New York appeals integration, identifying numerous virtues and a few concerns.²⁸

Key Advantages of Duals Demonstrations Appeals

- Aid paid pending is allowed during the internal appeals process for most Medicare and Medicaid services.
- The internal appeals process is integrated.

Key Disadvantages of Duals Demonstration Appeals

- With the exception of New York, the external appeals processes remain unintegrated.
- Medicare Part D appeals remain unintegrated.

Best Practices

Federal and state governments are clearly interested in increasing the coordination and integration of Medicare and Medicaid appeals. As new models of integration are pursued, it is critical that all of the underlying rights and benefits of each program are maintained. Integration should never leave an individual with fewer or weaker benefits than the individual had prior to integration. Some of the best practices for integrated appeals are discussed below:²⁹

- **Aid Paid Pending:** Medicaid enrollees have a constitutional right to aid paid pending. There is a positive trend within many integrated models to offer aid paid pending without distinguishing among the source of coverage. A key best practice for integrated appeals would be to expand the availability of aid paid pending to all covered services and to do so throughout the appeals process. An additional best practice would be to expressly forbid recoupment as was done in the New York duals demonstration.³⁰

²⁸ Janelle McClure, *Due Process in Duals Demonstrations: A Closer Look at New York* (Nov. 2014) <http://www.healthlaw.org/issues/medicaid/dual-eligible-beneficiaries/due-process-in-duals-demonstrations-a-closer-look-at-new-york#.VjDkRH6rRD8>.

²⁹ For more information on other features that should be incorporated into an integrated appeals process see Leo Cuello & David Machledt, *NHeLP Guide for Evaluating State Duals Integration Demonstration Proposals*, National Health Law Program 7 (April 2012), <http://www.healthlaw.org/about/staff/leo-cuello/all-publications/nhelp-guide-for-evaluating-state-duals-integration-demonstration-proposals#.VZ2VHfIVhBc>.

³⁰ CONTRACT BETWEEN U.S. DEP'T OF HEALTH & HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES IN PARTNERSHIP WITH STATE OF NEW YORK, DEP'T OF HEALTH AND PLAN 133 (2014), <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/NewYorkContract.pdf>.

- Explicit standards: As more and more demonstrations and programs are developed, there is the potential for real improvement. However, without explicit requirements for what integration looks like, it is possible for these models to fail to result in improvements for enrollees. More importantly, without strong minimum standards there is the possibility that enrollees may be worse off than they would be without the integration.
- Integrated Notices: Many integrated models require an integrated denial notice. A clear, informative integrated notice can simplify the appeals process and reduce the paperwork that dually eligible individuals receive. However, a confusing or incomplete notice may be worse than the current status quo, so sufficient care and detail should be put into developing a good notice.
- Advanced Notice: Medicaid enrollees have a constitutionally protected right to due process. Any integrated appeals system must maintain or enhance the notice protections to which Medicaid enrollees are entitled.
- Automatic Forwarding: Medicare Advantage plans are required to automatically forward an adverse decision at the internal plan reconsideration for external review. Many, integrated models retain some aspect of automatic forwarding. Automatic forwarding removes the burden of filing an additional appeal from enrollees.

Conclusion

With increased attention placed on integrated appeals for individuals who are dually eligible for Medicare and Medicaid, it is particularly important to study the existing integration efforts. If integration efforts continue to move forward then best practices and key lessons learned from the appeals processes in PACE, D-SNPs, and the duals demonstrations should be applied to future integration efforts or expansions of these existing programs.