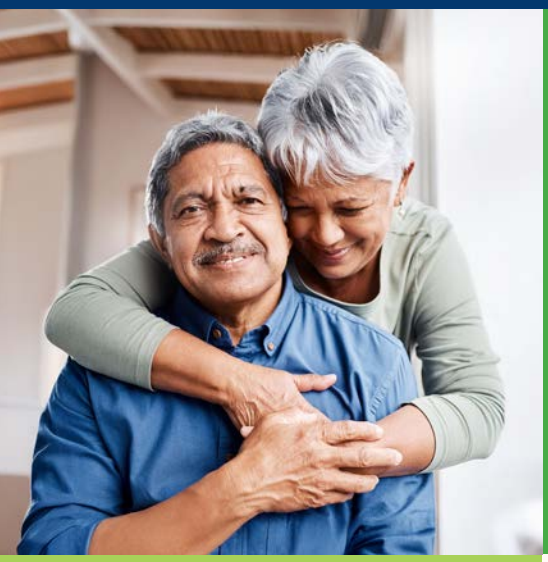
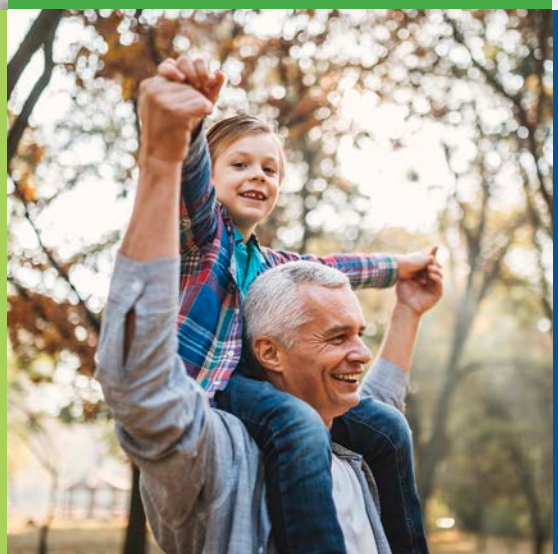
MAKING MEDICARE AND MEDICAID WORK BETTER TOGETHER

FIXING THE APPEALS PROCESS

MEDICARE RIGHTS CENTER
Getting Medicare right





This case study series aims to help policymakers, advocates, and beneficiaries better understand insurance navigation and access challenges faced by people with Medicare and Medicaid.

Each brief tells the story of a client who called the Medicare Rights Center's National Helpline for assistance. Briefs highlight common obstacles to coverage and care and provide possible solutions.

The two-part case study below explores common issues with unintegrated care for low-income individuals who are dually eligible for Medicare and Medicaid. In the context of this publication, integrated care refers to the coordination of Medicare and Medicaid benefits for dually eligible beneficiaries. Where integrated care exists, the task of coordination is most often assigned to private managed care plans and programs that pay for and deliver a person's Medicare and Medicaid services. But Medicare and Medicaid coverage is too often unintegrated or not successfully integrated, and the challenge of making two types of health insurance coverage work together falls to the beneficiary and their family/caregivers, providers, and community organizations. Thankfully, insurers can eliminate some of these challenges through program and plan designs that better coordinate and combine Medicare and Medicaid services and payments.

Integrated care is still a work in progress, results are varied, and there are significant lessons to be learned. For instance, major differences exist from plan to plan, with some plans offering integrated networks, benefit structures, and appeals, and others appearing to provide no substantially integrated benefits to their enrollees. At both the state and federal level, beneficiaries need tools and education to distinguish between integrated and nonintegrated plans and to understand why integrated plans are more likely to serve their needs. Protections must also be put in place to protect consumers from misleading marketing practices intended to entice duals into enrolling in minimally integrated plans, also known as "D-SNP lookalikes." These protections can include Special Enrollment Periods (SEPs) and heightened standards for integrated plans so there are fewer "less good" options. Strict limitations on marketing impropriety are especially important because disparities in benefit coordination and overall beneficiary experience in more integrated compared to less integrated products can be great even when the "perks" advertised are similar. States can require greater integration through plan contracts and should also work toward improving upon federal standards for integrated care so that all plans provide a meaningful minimum benefit.

UNINTEGRATED APPEALS:

Mr. H is Erroneously Denied a Power Wheelchair

Mr. H is a 62-year-old dually eligible beneficiary who called the Medicare Rights Center's National Helpline for assistance with a coverage denial. Mr. H is an active wheelchair user. He needs his power wheelchair about 13 hours a day; it is vital to his health and quality of life. His care manager referred him to Medicare Rights for help accessing a new power wheelchair.

Mr. H was enrolled in a Medicare Advantage Plan and a separate plan offered by a different company provided his Medicaid managed long-term services and supports (MLTSS). His Medicare Advantage Plan was responsible for paying primary for all Medicare-covered services, and the MLTSS plan was responsible for specific Medicaid benefits. Certain services, like home health care and durable medical equipment (DME), are covered by both Medicare and Medicaid. For those services, Medicare is responsible for paying first but Medicaid may cover a beneficiary's cost-sharing amounts or even provide coverage beyond the limitations of the Medicare benefit.

The issue started after Mr. H went to his primary care doctor to get a new prescription for a power wheelchair, as his wheelchair had become worn with repeated use. He had received his wheelchair six years ago. Medicare covers power wheelchair replacements once every five years, so Mr. H was due for a wheelchair replacement. Due to changes in his health, Mr. H also now needed a wheelchair with a seat elevator.

Being able to raise, tilt, and recline his seat was medically necessary to alleviate lower back pain and prevent the edema in his legs from worsening. It would also make it easier for his caregiver to assist him with getting on and off the wheelchair.

Although Mr. H received prior authorization from his Medicare Advantage Plan for a new power wheelchair, they would not cover the seat elevator. He was told that Medicare did not cover it, but his Medicaid plan should. Unfortunately, Mr. H's Medicaid plan also denied coverage for the seat elevator. Their notice explained that Medicaid is the "payer of last resort" and that, because Mr. H is enrolled in Medicare, his Medicare Advantage Plan should cover the seat elevator.

Caught between his two separate plans, Mr. H was unsure what step to take next. He had the option of appealing. However, even after his doctor agreed to help, he did not know what he needed to do to be successful. Winning an appeal required gathering documentation, writing a letter explaining why he needs the wheelchair seat elevator, and possibly having to appeal again if he is denied. He also needed to obtain copies of the documents and mail or fax the materials—not simple tasks for a person with a worn-out wheelchair. The process was daunting in its own right. But Mr. H also wasn't sure who was right. Should he be appealing his Medicare Advantage Plan or his MLTSS plan? Both had significantly different appeal processes and timelines.

When Mr. H called Medicare Rights' helpline, he needed help deciding what to do. Fortunately, a counselor was able to explain that he should appeal his Medicaid plan's denial, as at the time of Mr. H's case, Medicare did not cover power seat elevation features.

His Medicare Advantage Plan's denial was correct, and because seat elevation was excluded from Medicare coverage, his MLTSS plan should have examined the claim to see if it met the criteria for Medicaid coverage. Medicare Rights suggested that Mr. H send his Medicaid plan the relevant pages from his Medicare Advantage Plan's evidence of coverage criteria.

Mr. H's appeal to his Medicaid plan was successful, and he received Medicaid coverage for his seat elevator. But without outside assistance, Mr. H may have spent months appealing to his Medicare plan for a benefit it would not cover. Many other dually eligible individuals in similar situations may give up before learning that their other plan should cover their needs and face adverse health consequences as a result.

INTEGRATED APPEALS:

Automation Eases the Appeals Process for Mrs. Z

Mrs. Z is an 88-year-old dually eligible beneficiary who called the Medicare Rights Center's National Helpline after receiving a denial from her Medicaid Advantage Plus (MAP) plan to increase her home care hours. Mrs. Z was receiving 84 hours per week of personal care services from her plan, including help with bathing, eating, dressing, getting around her home, and household chores. Her doctor felt that these hours were not enough to meet her needs and put in a request to the plan to have her home care hours increased.

At the same time, Mrs. Z also received a denial for a new electronic lift chair. Mrs. Z had received a Medicare-covered chair one year ago, and her doctor had requested a replacement chair after Mrs. Z's was damaged. With her doctor's help, Mrs. Z filed appeals for her home care hours increase and DME replacement, but her MAP plan denied coverage for both and she was unsure of her next steps.

A Medicare Rights helpline counselor was able to explain that Mrs. Z's MAP plan participated in the New York Integrated Appeals & Grievances demonstration. This demonstration integrates Medicare and Medicaid appeals, removing the need to use separate processes. Instead, Mrs. Z could receive Medicare and Medicaid determinations through the same appeal. Additionally, unfavorable or partially unfavorable appeals are auto-forwarded to the second level at the Integrated Administrative Hearings Office (IAHO).

Therefore, Mrs. Z's two appeals were already being reconsidered at the IAHO without her having to take any action. For her DME, the IAHO would check if she was eligible based on Medicare or Medicaid criteria. And if she received another denial for either appeal, she could choose to move onto the next level.

Because of the unified process and the automatic escalation to an independent decision maker who could consider both Medicare and Medicaid policies, the IAHO overturned her plan's home care hours denial and approved the increase in hours without additional action from Mrs. Z or her provider. Critically, Mrs. Z did not have to determine which entity should be responsible for the care, research specific coverage rules, and marshal evidence about her needs. She did not risk filing an appeal with the "wrong" plan, wasting time, effort, and money. The integrated appeal office upheld the denial regarding the replacement wheelchair, but approved repairs to her current lift chair, efficiently ensuring her continued access to needed DME.

Key Policy Recommendations

Navigating two disparate appeals processes, as Mr. H was required to, can lead to delays or even complete barriers to accessing needed care, in addition to stress and frustration. Dually eligible beneficiaries without access to integrated appeals must work their way through multiple sets of notices, separate processes and timelines, and uncertainty as they follow the Medicare or Medicaid appeals track without knowing which has the highest likelihood of success.

Mistakes can have costly consequences. Plans themselves also misunderstand coverage rules, particularly with regard to programs they do not administer, which causes improper denials and can lead to negative health and financial impacts on vulnerable beneficiaries. Fully integrating appeals alleviates some of these issues. The following recommendations would help states and the federal government achieve the promise of truly integrated care for dually eligible individuals:

KEY RECOMMENDATION

Integrated Appeals

A single appeals process for both Medicare and Medicaid eliminates barriers and harmful delays in receiving coverage for those who are dually eligible. Integrating appeals simplifies the process for beneficiaries; they submit one appeal and learn whether their service will be approved under Medicare or Medicaid coverage criteria. Federally, only certain kinds of plans are required to integrate the first level of appeals. States may want to use New York's fully integrated appeals process as a model for integrating further.

KEY RECOMMENDATION

Expanded Integration

Certain products and services—including prescription drugs and long-term care—have been excluded from the integrated appeals process. To realize the promise of Medicare-Medicaid integration, program appeals processes must be improved and expanded.

KEY RECOMMENDATION

Ombudsman Programs

States should fund and implement ombudsman programs through which dually eligible beneficiaries can receive unbiased help and counseling. Problems with enrollment, coverage, and other issues for the dually eligible population are often complex, and even a well-informed person could easily make costly mistakes without professional guidance.

KEY RECOMMENDATION

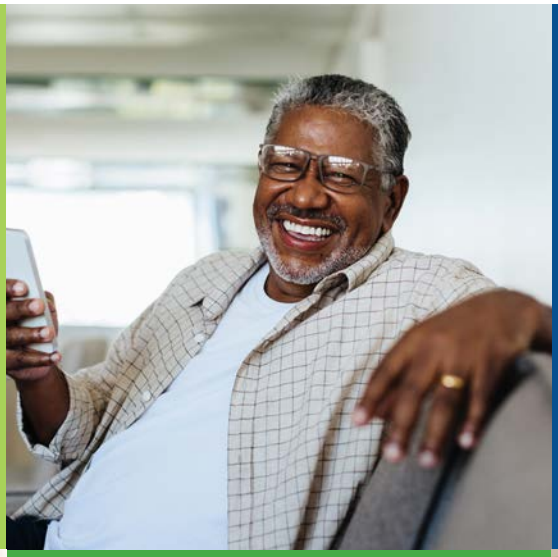
Direct Plan Assistance

CMS should require that the appeals departments of all Medicare D-SNPs—including coordination-only plans—have dedicated staff/messaging/notice requirements to help ensure that comprehensive information is provided to plan enrollees navigating denials and appeals where there is a question around whether Medicare or Medicaid should be the payer. Dually eligible enrollees should receive clear guidance through the appeals process. To that end, plan staff should work with CMS to create a script or education for handling cases when Medicaid may be the primary payer for certain benefits.

KEY RECOMMENDATION

Continuing Federal Support

As authority for running duals demonstrations ends in 2025, the Centers for Medicare & Medicaid Services (CMS) should find ways to allow states to continue their Medicare-Medicaid innovation efforts. For instance, New York's integrated appeals demonstration is set to end in December 2025. Without CMS support, dually eligible individuals will have no choice but to navigate multiple complicated and mentally taxing appeals processes. Some integration of initial appeals is captured as described above, but higher levels will be re-separated.



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