MEDICARE RIGHTS CENTER

Getting Medicare right

Medicare Snapshot:

Stories from the Helpline

Managing Medicare Advantage Denials of Coverage and Appeals

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The Medicare Rights Center is a national nonprofit, consumer service organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. We serve callers on our national helpline by providing comprehensive, timely, understandable information about their Medicare benefits, rights, and options. In 2013, we fielded over 15,000 questions from Medicare beneficiaries, family caregivers, and professionals. Many of our callers, like the one whose story is detailed in this brief, struggle to navigate the complexities of the Medicare Advantage system, secure coverage for needed services, and afford out-of-pocket health care costs.

Coverage Denials Come at a High Cost, Managing Appeals Remains a Struggle

Mr. W is a 77 year-old Chicago native who lives on less than $17,000 per year and has minimal savings. He called the Medicare Rights Center (Medicare Rights) seeking help with a $12,000 hospital bill. One year ago, Mr. W needed surgery to substantially lower his high risk of stroke. Mr. W used his Medicare Advantage (MA) plan's website to find an in-network doctor to perform the surgery. He did not receive a referral to see this doctor because he was informed by a plan representative that he could receive care from an in-network doctor without prior approval. Unfortunately, this information was not accurate, and Mr. W's pre-operational care and surgery were subsequently denied by his plan because the doctor did not obtain prior authorization from the plan.

A Medicare Rights helpline counselor spoke to Mr. W about the steps he took to resolve the issue, and it became clear that Mr. W pursued an appeal but did not fully understand what the process involved. Critically, he did not know what information he needed to provide at each step of the appeal to show that the surgery should be covered. Instead, perplexed by the complicated, multi-step appeals process, Mr. W simply returned the forms and followed the minimal steps outlined in the denial notices. Because of this, important information—including a formal letter of appeal and a letter of support from the physician who cared for him—was missing from Mr. W's appeal.

Ultimately, Mr. W lost his appeal, failing to make a case for coverage of his surgery owing to his own confusion about the appeals process. Mr. W's plan did him a disservice in multiple respects. Not only did the plan mislead Mr. W about what was needed to secure coverage for his surgery, the plan also failed to adequately support Mr. W through the appeals process. Not once during his appeal was Mr. W referred to outside resources that could have helped him make a stronger case for coverage.

This outcome could have been avoided. With appropriate information from his health plan, Mr. W may have secured a favorable decision at his hearing or in an earlier stage of the appeals process. Mr. W is frustrated and depressed by this situation. For the time being, he is afraid to go to the doctor because he does not want to incur additional medical bills and remains confused about his MA plan's coverage rules. Moving forward, the Medicare Rights counselor recommended that a local legal services provider represent Mr. W, should he choose to advance to the next level of appeal, and informed him about programs at his hospital that might reduce the amount he owes.

Information for Policymakers

Today, nearly 16 million seniors and people with disabilities are enrolled in an MA plan, representing 30 percent of the Medicare population.[i] Many people with MA plans have a positive experience and report a favorable experience with their plan. Yet, we find that managing denials of coverage and appeals remains a consistent concern for MA enrollees, such as in Mr. W's experience.

Over one-third of callers to the Medicare Rights Center's national helpline express difficulty managing coverage denials and appeals. While limited public data is available on how well MA plans address appeals and grievances, audit data made available by the Centers for Medicare & Medicaid Services (CMS) suggests significant room for improvement.

For instance, in 2012 CMS reported that MA plans "…were often noncompliant, predominantly in the areas of clinical decision making, timely processing and notification of decision…" In particular, MA plans were often inaccurate and noncompliant with respect to notification about plan denials and the timeliness of decision making.[ii] Findings from the 2013 audit do not demonstrate much improvement. For instance, in 2013, 89 percent of audited MA and Part D sponsors issued denial letters to beneficiaries that either failed to include an adequate rationale or contained incorrect information.[iii]

Even more worrisome, however, is that nearly 70 percent of cases where a beneficiary requests an independent review are dismissed or withdrawn, and no specific data is available on those cases.[iv] Medicare Rights often hears from people, like Mr. W, who misunderstood the appeals process and whose cases were dismissed based on narrow technicalities or delays outside of the beneficiary's control.

Based on our experience, Medicare Rights argues for critical improvements to and enhanced oversight of Medicare health plan appeals.

In particular, Mr. W's case and others like it underscore the need to:

- Make data on plan-level appeals and grievances publicly available. CMS recently released the first-ever public use file of plan-reported data on MA and Part D plan operations, including on appeals. CMS should continue to make this data available and strengthen the information available on MA and Part D pharmacy transactions, coverage determinations, and redeterminations.
- Require MA plans to send copies of all materials used to arrive at a denial decision to the beneficiary and to the independent review entity evaluating the appeal. These materials should include both plain language reasons for the denial and cited excerpts from internal plan or CMS rules relied upon in the determination. All relevant rules, including those that might weigh in favor of coverage, should be included in the appeals materials. For example, if a service is denied because the provider was out-of-network, the CMS rules describing under which circumstances out-of-network care must be covered, like for emergency services, should be included.
- Expand the ability of currently existing beneficiary resources, like State Health Insurance Assistance Programs (SHIPs), to represent people in appeals.
- Provide better consumer education, both through CMS and plans themselves, on how plans work, particularly with respect to coverage and access rules.
- Enhance monitoring and enforcement by CMS of how private health plans handle grievances and appeals to ensure accurate information and efficient assistance. In particular, CMS should enforce strict compliance with notice rules and requirements to effectuate timely decisions, holding beneficiaries harmless when a plan fails to meet the standards.
- Re-structure the appeals process to require more proactive outreach on the part of health plans to prove that coverage is not warranted and that the beneficiary can be billed—as opposed to expecting beneficiaries to be equipped to build a legal case for coverage.

Information for People with Medicare

Mr. W's experience is all too common. In fact, some people who call Medicare Rights do not even know that they have the right to appeal their plan's decision. The following is advice that Medicare Rights gives our clients who have been denied a health service or prescription medicine by their MA plan:

- Carefully read all materials that your plan sends you, and call your plan with any questions, or to confirm that you understand the rules that apply to your situation.
- Keep good records of all of your conversations with your plan, including the time you called, the person you spoke to, and what you were told.
- Appeal, appeal, appeal: if a service is denied or you disagree with your plan's coverage determination, you should appeal the plan's decision. Be sure to get the reason for the denial in writing from the plan.
- When putting together materials to support your appeal, try to:
  - Get help from your doctor—have your doctor write a letter in support of your appeal.
  - Respond as directly as possible to the reason listed in the plan's denial letter. If the reason is unclear, state that the denial letter is unclear, and provide as much information as possible.

For additional help, visit the Medicare Right's Center's informational website at www.medicareinteractive.org, or call us at 800-333-4114. Other resources include 800-MEDICARE and your State Health Insurance Assistance Program (SHIP).

[i] Kaiser Family Foundation, "Medicare Advantage," (May 2014), available at: http://kff.org/medicare/fact-sheet/medicare-advantage-fact-sheet/

[ii] CMS, "MA and Part D Sponsors: Best Practices and Common Findings from 2012 Program Audits," (September 2013), available at: http://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/Downloads/HPMS-Memo-Best-Practices-and-Common-Findings-from-2012-Program-Audits.pdf

[iii] Yochelson, M. "CMS Not Seeing Improvement in Plans' Audit Performance, Despite Memorandums," *Bloomberg BNA*, June 25, 2014, available at: http://www.bna.com/cms-not-seeing-n17179891546/

[iv] CMS "Fact Sheet: Part C Reconsideration Appeals Data" available at http://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/IRE.html