FINANCIAL ALIGNMENT INITIATIVE

New York Integrated Appeals and Grievances Demonstration: Second Brief Report

April 2023

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FINANCIAL ALIGNMENT INITIATIVE
NEW YORK INTEGRATED APPEALS AND GRIEVANCES DEMONSTRATION
SECOND BRIEF REPORT

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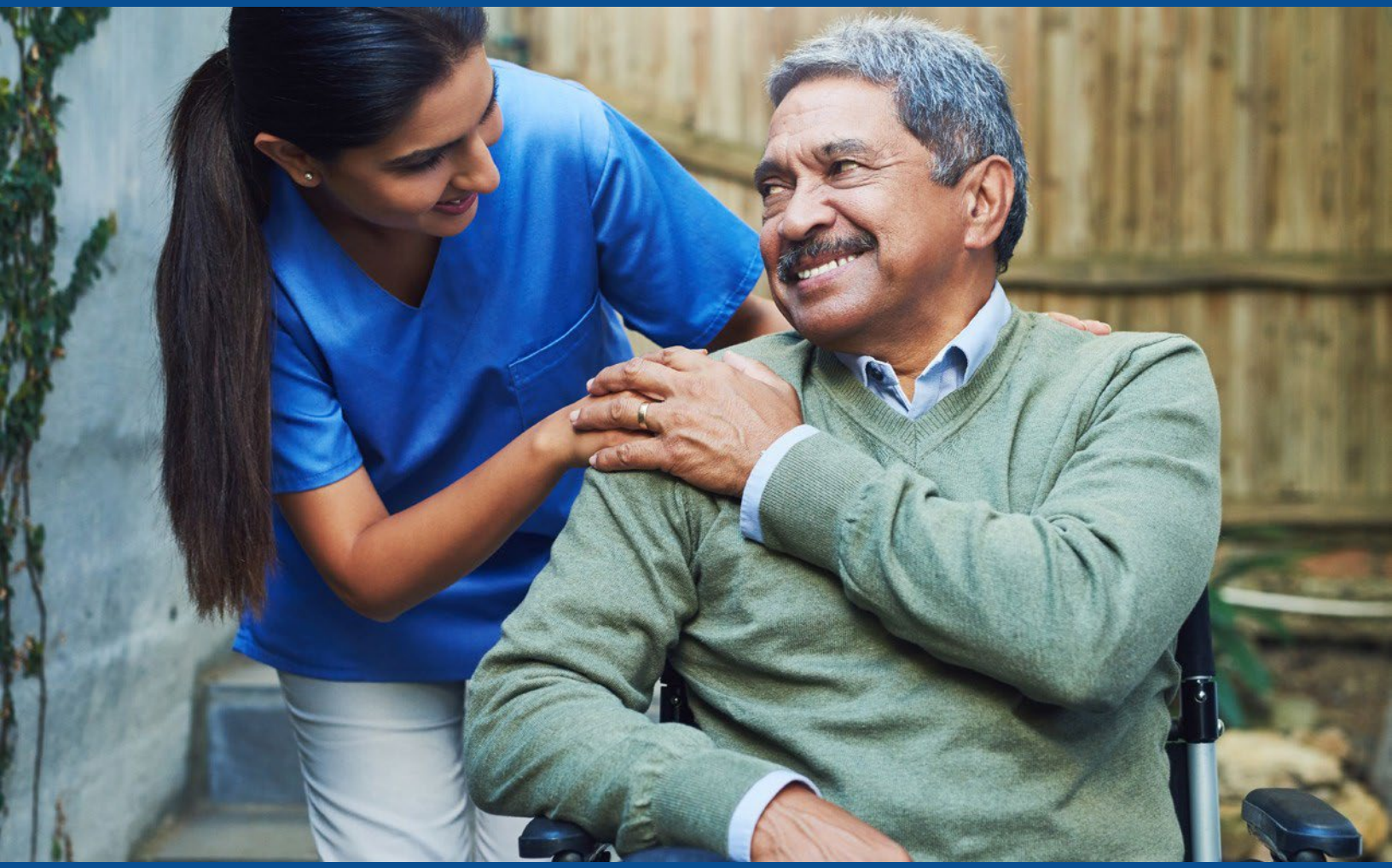
Glossary of Acronyms

A&G	Appeals and Grievances
ADL	Activity of Daily Living
ALJ	Administrative Law Judge
CMS	Centers for Medicare & Medicaid Services
D-SNP	Dual Eligible Special Needs Plan
FIDA	Fully Integrated Duals Advantage
FIDA-IDD	Fully Integrated Duals Advantage for Individuals with Intellectual and/or Developmental Disabilities
FIDE SNP	Fully Integrated Dual Eligible Special Needs Plan
HHS	U.S. Department of Health and Human Services
IADL	Instrumental Activity of Daily Living
MA	Medicare Advantage
MAC	Medicare Appeals Council
MLTC	Managed long-term care
MLTSS	Managed long-term services and supports
MMCO	Medicare-Medicaid Coordination Office
MOU	Memorandum of Understanding
NYSDOH	New York State Department of Health
OAH	Office of Administrative Hearings
OTDA	New York Office of Temporary and Disability Assistance
PHE	Public health emergency

Executive Summary



Beneficiaries who are dually eligible for Medicare-Medicaid and who are enrolled in managed care plans must navigate two different systems if they appeal their plan's reduction, termination, or denial of services. Medicare and Medicaid have different policies and procedures and navigating these two systems is administratively complex and challenging for beneficiaries. The Centers for Medicare & Medicaid Services (CMS)-New York Integrated Appeals and Grievances (NY Integrated A&G) demonstration is designed to integrate and streamline these processes. First developed as part of New York's Fully Integrated Duals Advantage (FIDA) demonstration under the Medicare-Medicaid Financial Alignment Initiative, the NY Integrated A&G demonstration began on January 1, 2020, to test continuing implementation of the integrated process.

The goals of the NY Integrated A&G demonstration are to improve beneficiary experience in appealing health plan reduction, termination, or denial of Medicare and Medicaid services, and to generate administrative streamlining and/or savings for plans, the State, and Federal agencies. The integrated appeals and grievances process is available to enrollees in 13 Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs)[1] and applies to all Medicare Part C and Medicaid services covered by the plans.[2]

Under the NY Integrated A&G demonstration, enrollees use one process for appealing Medicare and Medicaid coverage decisions made by the plan. There are four levels of appeal, starting with an enrollee appealing a coverage decision directly to the plan. If the plan upholds its decision, the appeal is automatically forwarded to a second level through the New York Office of Administrative Hearings (OAH). Enrollees who disagree with the OAH decision can appeal to the Medicare Appeals Council (MAC) and finally, to Federal district court. Each level of appeal addresses both Medicare and Medicaid appeals.

CMS contracted with RTI International to conduct an independent evaluation of the NY Integrated A&G demonstration to determine its impact on beneficiary and plan experience. This second brief report covers the second demonstration year, January 1, 2021 through December 31, 2021. It includes qualitative findings from interviews conducted in Spring 2022 with beneficiary advocates, plans, CMS, and New York State officials. We also include high-level findings from beneficiary interviews and interviews with professionals from organizations that assist beneficiaries in navigating the integrated appeals process. Another CMS contractor conducted these interviews. Finally, we include an analysis of Medicare cost savings generated by the NY Integrated A&G demonstration that was conducted by the CMS Medicare-Medicaid Coordination Office (MMCO).

Highlights

CMS, the State, beneficiary advocates, and plans continued to speak highly of the demonstration because it streamlines the appeals and grievances process for beneficiaries and plans. CMS, the State, and beneficiary advocates viewed the process of requiring plans to

[1] The State and CMS call the plans participating in the demonstration Medicaid Advantage Plus (MAP) plans. They are FIDE SNPs—a combination of a managed long-term services and supports (MLTSS) (known as managed long-term care [MLTC] in New York) and a Dual Eligible Special Needs Plan (D-SNP) under the same parent organization.

[2] Medicare Part D Pharmacy appeals are excluded from the NY Integrated A&G demonstration.

automatically forward (known as autoforwarding) of first-level appeals denied by the plan to the second level at OAH as a key beneficiary protection. Feedback from plans interviewed by the evaluation team[3] was more mixed with some plans suggesting changes to the autoforwarding process to require more enrollee engagement to move the appeal to the second level.

One-third of beneficiary interviewees said they appreciated the autoforwarding of their appeals because they felt it prevented them from accidentally skipping a step in the appeals process. Beneficiaries who spoke Spanish or who did not have informal supports reported challenges in understanding the process. Spanish-speaking beneficiaries reported that not all appeals-related materials sent to them by the plans had been translated into their preferred language.

Hearings at the second level were often postponed, sometimes multiple times. This resulted in a lag time, often 6 months or longer, between when an appeal was autoforwarded and when it was heard. A major contributing factor to postponements was beneficiaries not having the evidence packet of documentation about the appeal from the plan. In beneficiary interviews, about one-half of interviewees recalled having received an evidence packet prior to their hearing date. Although plans used several methods to send and track receipt of the packets, plans and advocates reported that by the time the second-level hearing occurred, enrollees may have discarded or forgotten about the packet. The plan then had to resend the evidence packet, delaying the hearing further. To address this issue, plans suggested changes in the State-required timeframe for sending evidence packets so that they are sent closer to the hearing date, and advocates suggested including information on the importance of the evidence packet in the beneficiary appeal notices.

During the reporting period, OAH continued to experience staffing shortages that were exacerbated by the COVID-19 public health emergency (PHE). The shortages also contributed to the lag time between when OAH received autoforwarded appeals and when hearings were scheduled and occurred. The OAH staffing shortages also delayed trainings on New York Medicaid policy that were requested by the MAC.

A monitoring analysis of Health and Human Services cost data indicated that the NY Integrated A&G demonstration did not appear to increase or decrease Medicare costs of adjudicating appeals in 2020–2021.

[3] We spoke with three of the eight plans that were participating during the report period (there are now 13 plans). Unless otherwise noted, findings on the plans' perspective or experience are from those three plans.

SECTION 1

Introduction

1.1 Background

The Centers for Medicare & Medicaid Services (CMS) and the New York State Department of Health (NYSDOH) designed the New York Integrated Appeals and Grievances (NY Integrated A&G) demonstration to reduce the beneficiary burden when appealing a health plan's coverage decision. CMS and NYSDOH entered into a Memorandum of Understanding (MOU) effective January 1, 2020, to conduct the demonstration. The demonstration is a continuation of the successful integrated appeals and grievances process developed for two demonstrations under the Medicare-Medicaid Financial Alignment Initiative (FAI)—the Fully Integrated Duals Advantage (FIDA) and the Fully Integrated Duals Advantage Demonstration for Individuals with Intellectual and Developmental Disabilities (FIDA-IDD). The NY Integrated A&G demonstration operates in New York City and some of the surrounding counties. The number of Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs) participating in the demonstration grew from eight plans in 2020 to 13 in 2021.[4]

Outside of the NY Integrated A&G demonstration, Medicare-Medicaid beneficiaries who appeal their health plan's reduction, termination, or denial of services must navigate two different systems—one for Medicare and one for Medicaid, each with different procedures and policies. The NY Integrated A&G demonstration eliminates this division and provides a streamlined appeals process for enrollees in participating plans. The integrated appeals and grievances process applies to the Medicare Part C and Medicaid services covered by the participating plans. It does not apply to Medicare Part D services or Medicaid non-Part D pharmacy and other Medicaid services outside a participating FIDE SNP's benefit package.

As of January 2021, approximately 24,700 beneficiaries were enrolled in participating FIDE SNPs (NYSDOH, 2021a). Demonstration enrollment increased to approximately 30,250 as of December 2021 (NYSDOH, 2021b).

1.2 Demonstration Evaluation

CMS contracted with RTI International to monitor the NY Integrated A&G demonstration implementation and to evaluate its continued impact on beneficiary and plan experience. Specifically, in this second brief report,[5] covering the second demonstration year, January 1, 2021, through December 31, 2021, we address the following:

1. the impact of the NY Integrated A&G demonstration on beneficiary experience and whether beneficiaries perceived the integrated appeals process to be fair, understandable, and easily navigable;
2. whether the NY Integrated A&G demonstration reduced administrative burdens for participating plans;

[4] FIDE SNPs are known as Medicaid Advantage Plus (MAP) plans in New York and are a combination of a Medicaid Managed Long-Term Care Plan and a D-SNP plan with exclusively aligned enrollment under the same sponsoring managed care organization.
[5] The First Brief Report covers the first demonstration year, January 1, 2020 through December 31, 2020.

3. Medicare cost savings associated with adjudicating appeals attributable to the demonstration.

We include findings from interviews conducted in April and May of 2022 with staff and representatives from the following agencies and types of organizations: CMS, NYSDOH, New York Office of Administrative Hearings (OAH), CMS Medicare Appeals Council (MAC), three participating FIDE SNPs, and beneficiary advocates. We also include high-level findings from beneficiary interviews and interviews with professionals from organizations that assist beneficiaries in navigating the integrated appeals process. The implementation contractor conducted these interviews.[6] CMS also provided RTI with results of a monitoring analysis of U.S. Department of Health and Human Services (HHS) cost data. We summarize those data as well.

[6] CMS contracted with Mathematica to evaluate beneficiary experience. Mathematica conducted semi-structured telephone interviews with 22 beneficiaries who were dually eligible for full Medicare and Medicaid benefits from March to May 2022. Beneficiaries were recruited from four MAPs that enrolled the largest number of beneficiaries and had the greatest number of appeals decided by the OAH between the first and third quarters of 2021 (the study planning period). Beneficiaries were eligible to take part in the study if they enrolled in one of these four MAP plans and had filed at least one appeal of their health plan's denial of coverage of a service or medical item between January 1 and December 31, 2021 (Rowan et al., 2022).

SECTION 2

Integrated Appeals and Grievances Process

The key objectives of the demonstration are to improve beneficiary experience with the appeals process and to generate administrative streamlining and savings for plans, the State, and Federal agencies (MOU, 2020, p.2). To accomplish these goals, the NY Integrated A&G demonstration uses one appeals process for both Medicare- and Medicaid-covered services provided by the participating plans. An enrollee who disagrees with a coverage decision first appeals to the participating plan for reconsideration. If the plan upholds its coverage decision,[7] the appeal is automatically forwarded to the second level of appeal for a review by OAH at the New York Office of Temporary and Disability Assistance (OTDA). An enrollee who disagrees with the OAH decision can initiate an appeal to the MAC. If the enrollee continues to disagree with the decision, they can initiate a final appeal to the Federal district court.

At all levels of the integrated appeals and grievances process, Medicare and Medicaid policy guidance are applied, allowing the enrollee to navigate one appeals process for all covered services. Outside of the demonstration, dually eligible beneficiaries in managed care products must follow the separate policies and procedures for appealing Medicare- or Medicaid-covered services. For services that have Medicare and Medicaid coverage components (e.g., durable medical equipment), the beneficiary may have to pursue both appeals processes. See ***Figure 1*** in the First Brief Report for more details on the process.

Recent procedural changes in the demonstration included revisions to the MOU, finalized in August 2022, that allow participating FIDE SNPs to decline to have a plan representative appear at fair hearings at OAH and, instead, provide a written statement at the hearing and to the enrollee. The revisions also clarify an enrollee's right to request an in-person hearing instead of a hearing by phone, although as of this report, OAH was not conducting in-person hearings due to the PHE.

[7] Other terms for this include "adverse decision" and "adverse appeal," because these decisions are against the beneficiary.

SECTION 3

Beneficiary, Plan, State, and CMS Experience with the Demonstration

3.1 Beneficiary Experience

Beneficiary advocates and State officials continued to believe that the integrated process and automatic forwarding of plan-denied appeals to OAH provide an important protection for beneficiaries. The simplicity of using one path reduces burden among beneficiaries who, in the non-integrated process, must navigate separate Medicare or Medicaid processes. Advocates noted that enrollees who are early in their appeal process have provided positive feedback about having an adverse determination automatically forwarded to the next level of appeal. In interviews, beneficiaries also indicated support for the automatic forwarding process, with one-third reporting they felt it protected them from unintentionally skipping a step in the appeal process.

Findings were mixed on the extent to which enrollee understanding of the process has improved since 2021. For example, one participating plan estimated that it had seen a definite improvement in beneficiary understanding, especially among those who had been through the process before. However, beneficiary advocates and other plans were less convinced that beneficiary understanding had improved. Advocates said that, outside of their conversations with enrollees about specific appeals and information provided in member handbooks, the integrated process was not marketed as a selling point for joining a participating FIDE SNP. One plan said that about one-half of its enrollees who received a notice that their appeal had been forwarded to OAH contacted their plan care managers or member services to ask why their appeal had moved forward. OAH reported receiving calls from FIDE SNP enrollees requesting a fair hearing, not realizing that their appeal had already been autoforwarded to OAH. One-third of beneficiary interviewees said they did not know their appeal had been forwarded.

More than one-half of beneficiaries interviewed said they received some help from their plan during the process, including answers to their questions, guidance through the second-level appeal process, and calls to inform them about when the hearing was scheduled. Plans also fulfilled requests for materials in languages other than English. However, Spanish-speaking interviewees reported barriers that likely impacted their understanding of the process. They reported that some elements of the evidence packet were not translated into their preferred language, and their evidence packets were printed in English on one side and Spanish on the other, making the packet longer and difficult to understand.

Beneficiary interviewees often received support from family caregivers during the appeals process, including assistance with navigating and understanding the process, filing appeal requests, and participating in the OAH hearing. Those who did not have informal or family caregiver support reported barriers to understanding the process including having low vision or inability to read.

Beneficiary advocates said that beneficiaries continued to be frustrated by the length of time between when an appeal was autoforwarded to OAH and when a hearing was scheduled and heard. Advocates gave an example of an appeal hearing that had been scheduled for August 2021 and was rescheduled to a new date of May 2022, 9 months later. For appeals to increase services, these delays resulted in enrollees going without services they may have needed. Some beneficiary interviewees said they waited a few weeks between a plan's initial denial and their OAH hearing, whereas others waited a few months. One-half of beneficiary interviewees said

they went without needed care and support during the appeal period. Advocates noted that during the PHE, the requirement of OAH to issue a decision within 90 days of when an appeal was denied by the plan was waived. When the PHE ends, the requirement will no longer be waived.

Beneficiaries not having the evidence packet[8] at the time of the second-level hearing continued to be a major source of postponements. About one-half of beneficiaries interviewed recalled that they had received an evidence packet prior to their OAH hearing. The State requires the evidence packet be sent to enrollees within two days after a plan decides against the enrollee at the first-level appeal. The plans questioned the necessity of sending the packet so far in advance of the hearing when doing so leads to postponements if the enrollee loses, discards, or forgets about it. Advocates, CMS, and the State noted that enrollees might not recognize or keep the packet until the hearing.

> *The bottom line is beneficiaries, they don't understand this big packet of mail. It's overwhelming [for beneficiaries], 'What is it?' 'I'll put it away,' or 'It's junk.' It's a stack of paper.*
>
> — Beneficiary Advocate (2022)

> *[The OAH] sent me a package that had 100 pages. I am not going to read all of that. I don't have the mental capacity for that. The information is in English and Spanish. I don't intend to read it. I don't know if I will need it for the hearing.*
>
> — Spanish-speaking Beneficiary (2022)

Advocates suggested changing the enrollee notice of autoforwarding to include information saying the enrollee should expect an evidence packet from the plan and it is important for their next level appeal. CMS reported it would try to have the plans send a mandatory coversheet with the evidence packet instructing the enrollee to keep it for the hearing.

3.2 Plan Experience

The evaluation team interviewed a total of 13 staff from three participating plans with the largest enrollments about their experience with the NY Integrated A&G demonstration during 2021 and early 2022. The three plans accounted for approximately 85 percent of enrollees in the demonstration. One of these plans had the largest enrollment, over 19,300, and the two other plans had enrollments of over 3,000 each.

[8] Evidence packets are often large and include medical records, assessment information, and other documentation about how the plan came to its decision.

3.2.1 Implementation

Two of the plans we spoke with noted that the integrated process removed the enrollee burden of deciding whether to file a grievance or appeal under Medicare or Medicaid for services, especially those covered by both programs, resulting in streamlining and efficiency for the plans.

Previously, we had to call [the member] to ask, 'What line of business would you want this grievance tracked under?' if it fell under both. And most of the time it was, 'I don't care, file my grievance.' So that piece has brought in some efficiencies.

— FIDE SNP Plan (2022)

The plans said that being able to send a single notice of denial instead of one for Medicaid and one for Medicare worked well for the plans and enrollees. However, they also noted that information about the autoforwarding of the appeal to OAH was not on the first page of the notice, and they were unsure if enrollees read the entire notice. One plan suggested that the State or Maximus, New York's Medicaid managed care enrollment broker, put more information about the integrated appeals process on their websites to boost enrollee awareness.

One plan reported having set up a Secure File Transfer Protocol to transmit the evidence packet and other files to OAH, allowing them to confirm with an electronic time stamp that OAH had received the files. Previously, the files had been emailed with encrypted links, and due to staffing shortages at OAH, the office was not always able to open the files before the links expired, requiring the files to be sent again. Another plan said it still used email to transmit files, but that the time between when the files were sent and when OAH sent notification of receipt to the plan was within 3 days, a substantial improvement from the year before.

Two of the plans we spoke with reported that the Administrative Law Judges (ALJs) who decide the second-level appeals at OAH had improved their knowledge of the demonstration—i.e., Medicare and Medicaid regulations and the benefits available in the participating plans. One plan said that ALJs had been mostly consistent with applying Medicare policy, but it had noticed a marked improvement in how ALJs were applying Medicaid policy, in particular, to coverage of supervision services. Under Medicaid policy, the need for supervision must be tied to a specific activity of daily living (ADL) or instrumental activity of daily living (IADL). Earlier in the demonstration, ALJs would often overturn the plan's denial of these services in cases where the request for supervision was not tied to an ADL or IADL need. In the last two quarters of 2021 and continuing into 2022, the plan said it had not seen these types of appeals being overturned.

All three plans said that it was administratively burdensome and costly to postpone hearings and resend evidence packets, sometimes several times. The plans used several different delivery services, some with tracking capacity and required signatures, to ensure that the documents were delivered. One plan said that even when there was proof the packet had been delivered, some ALJs would postpone the hearing if the enrollee said they did not have it. This plan had noticed a difference in how consistent ALJs were in allowing postponements in the NY Integrated A&G demonstration compared to those it encountered in the original FIDA

demonstration. As compared to the FIDA demonstration, the plan indicated ALJs supporting the Integrated A&G demonstration made more allowances for enrollees to postpone hearings when they said they did not have the evidence packet at hand.

> *The ALJs, or [from] our experience with the ALJs from the FIDA demonstration, [they] were more consistent with certain things. They kept to the schedule. If they heard a contradiction from a member or if, for example, a member said yes, 'I have received the case file but now I don't have it," the ALJs called this out to the members, and said, "Hey, no, you can't do that." With this set of ALJs under the [NY Integrated A&G] demonstration, we're not seeing the same thing. They don't push back when something doesn't make sense, which we can't quite understand why not.*
>
> — FIDE SNP (2022)

The plans reported that autoforwarding appeals to OAH led to unnecessary administrative costs when enrollees had no interest in pursuing an appeal after it was denied by the plan. In these cases, the enrollees did not show up to the scheduled hearings that the plan had prepared for. Two plans suggested that FIDE SNP enrollees should be required to initiate an appeal to OAH to help ensure that they want to move forward with the appeal. However, CMS, the State, and advocates see the autoforwarding process as an opportunity to provide beneficiary protections.

As described in the First Brief Report, enrollees' health often deteriorated over the course of postponed hearings. In these cases, the plans continued to be frustrated by OAH decisions—which were not based on the Uniform Assessment System for New York (UAS-NY)[9] that plans must use to determine level of care needs for Medicaid home and community-based long-term services and supports, but on other evidence presented during the hearing. In 2022, the plans again reported that some ALJs had awarded more or different services than were included as part of the originating appeal.

3.2.2 Types of appeals

All participating plans report quarterly data to CMS and the State on the number of appeals received, the type of services, type of coverage, and the plan decisions. The three largest plans accounted for 98 percent (6,822) of enrollee appeals in 2021. CMS, the State, and advocates reported that all of the participating FIDE SNPs have been able to administer the integrated process as it was designed. CMS and the State conducted quarterly calls with plans that had a certain number of appeals (relative to enrollment) to discuss issues and trends and to answer any questions.

Most first-level appeals at the three largest participating plans in 2021 were for Medicaid-covered long-term services and supports, such as personal care services and consumer-directed

[9] The UAS-NY is an evidence-based, standardized assessment tool intended to facilitate access to programs and services, eliminate duplicative assessments, and improve consistency in the assessment process for Medicaid services (NYSDOH, n.d.).

personal assistance services. Most were requests for additional hours of care, and not appeals of service reductions. Although Medicaid appeals represented the majority of appeals, the three plans reported variation in the percent of appeals falling under Medicare, Medicaid, or both programs (see ***Table 3-1***). For example, 10 percent of Plan A were for Medicare-only coverage compared to 29 percent and 35 percent for Plan B and Plan C, respectively.

Table 3-1
Percent of appeals by type of coverage among the three largest FIDE SNPs in the New York Integrated A&G demonstration, January 1, 2021–December 31, 2021

Coverage type	FIDE SNP		
	Plan A	Plan B	Plan C
Medicare	10%	29%	35%
Medicaid	72%	55%	54%
Medicare and Medicaid	18%	16%	12%

A&G = Appeals and Grievances; FIDE SNP = Fully Integrated Dual Eligible Special Needs Plan.
SOURCE: Plan-reported data to CMS and NYSDOH, 2022.

3.3 State Experience

3.3.1 Implementation

As described in the First Brief Report, the launch of the NY Integrated A&G demonstration coincided with the PHE in early 2020, presenting challenges for OAH in handling the volume of appeals it received. These challenges continued in 2021, and OAH said that although it had the support and resources from NYSDOH it needed, it was still not fully staffed. From January 1, 2020, through December 1, 2021, OAH received 7,420 appeals and made decisions in 2,080 of them. Fifty-five percent (4,056) appeals were postponed at some point, 22 percent (1,665) were withdrawn, and as December 1, 2021, there were 1,530 appeals awaiting initial scheduling (OAH, n.d.). The backlog of appeals awaiting a hearing was concerning to CMS and beneficiary advocates. CMS noted that they discussed strategies to address the backlog with NYSDOH and OTDA, and these discussions resulted in increased staffing and operational efficiencies at OAH. In addition to hiring more ALJs to hear cases, New York was also working on hiring administrative staff to schedule hearings.

OAH reported that it had been able to provide trainings to the ALJs on both Medicare and Medicaid policy, although it focused on Medicaid policy because most appeals are requests for increases in long-term services and supports. The State was looking forward to providing additional training in Spring of 2022 with the goal of increasing expediency and ensuring consistency in how ALJs apply the law, evaluate the evidence, and issue decisions after a fair hearing. New and experienced ALJs would participate in the training to make sure they share the same understanding of current law.

3.3.2 Types of Appeals

OAH heard and decided on 1,546 appeals during the second demonstration year. As in 2020, the majority were for Medicaid long-term services and supports. Eighty-four percent

(1,306) were appeals for personal care services or consumer-directed personal assistance. Fifty-two percent (689) of these appeals were upheld, and 35 percent (458) were overturned in favor of the enrollee. ***Table 3-2*** shows the number of appeals and their outcomes by service category.

Table 3-2
Total appeals decided by OAH, by outcome, January 1, 2021–December 31, 2021

Type of service	Plan decision upheld	Plan decision overturned	Plan withdrew	Plan decision correct but additional action needed	Other	Total	Percent of total
Personal care/CDPAS	689	458	69	70	19	1,306	84
Home health	30	13	0	1	2	46	3
Dental (preventive and comprehensive)	37	2	0	2	1	42	3
Durable medical equipment	33	6	0	0	1	40	3
Pre-utilization determinations	19	9	0	0	1	29	2
Other services	21	14	3	0	3	41	3
Total	847	522	73	75	28	1,546	

CDPAS = consumer-directed personal assistance services; OAH = Office of Administrative Hearings.
NOTES: There was one appeal in 2021 not shown on this table that was settled by the plan. "Other services" includes acute inpatient hospital care, including substance abuse and rehab services; specialist office visits/specialty care; inpatient services during a non-covered inpatient stay; diagnostic testing.
SOURCE: CMS, 2022.

Compared to the non-integrated appeals process, OAH said it was surprised it had not seen more appeals of reductions of benefits or services. Instead, as noted earlier, most integrated appeals are for requests for additional benefits or services.

OAH also noted that about 50 percent of the integrated appeals hearings are conducted in English and about 50 percent in Spanish. This contrasts with OAH's experience with hearing appeals in other State programs, where 90 percent are conducted in English. The plans said the racial and ethnic composition of enrollees with appeals were in line with the demographics of their membership.

3.4 CMS Experience

The MAC reported receiving 12 appeals during Federal fiscal year October 1, 2020 through September 30, 2021. In Spring 2022, the MAC had already received 23 appeals since October 1, 2021. To handle the increased volume, the MAC hired two judges and one attorney, bringing its current staff handling the integrated appeals cases up to three judges and six attorneys. The MAC requested updated training on New York Medicaid policy, but as of the writing of this report, that training had not yet occurred because of staffing shortages at OAH. All appeals that have gone to the MAC have been for personal care services.

Decisions at the second level appeal (OAH) that are adverse to enrollees are not autoforwarded to the MAC (the third level). Enrollees must request a review by the MAC. The MAC reported setting up a process with OTDA to assist in this process, consistent with Medicare appeals outside of the demonstration. If an enrollee reports orally to OTDA that they want a further review of the appeal, that request is recorded in the documentation OTDA sends to the MAC. This technical procedure allows the MAC to proceed with the reviewing the appeal.

The MAC reported that the few appeals it received in the first demonstration year had to be remanded back to OTDA because of incomplete documentation from the plans. As the demonstration progressed, the appeals it has received have had complete documentation, and the MAC was able to adjudicate them on substantive issues and often upheld OAH's decisions.

We have been doing less procedural remand, and they've been substantive decisions, and most of them have been upholding what was on the lower level.

— Medicare Appeals Council [2022]

SECTION 4

Impact on Medicare Costs

4.1 Medicare Cost Analysis

The CMS Medicare-Medicaid Coordination Office (MMCO) provided RTI with an analysis of the financial impact of the NY Integrated A&G demonstration on the cost of adjudicating Medicare appeals. In this section, we provide a summary of the MMCO analysis plan and findings.

To estimate annual Medicare costs to the appeals system, MMCO compared 2021 appeals cost estimates under the demonstration against what would have happened absent the demonstration for the same period. Both estimates were based on the same population: 30,256 enrollees in FIDE SNPs in December 2021. This included individuals who had previously been enrolled in the FIDA demonstration as of the end of 2019 in addition to other FIDE SNP enrollees covered by the integrated appeals and grievance system in 2021.

MMCO estimated costs of appeals absent the demonstration by first estimating the number of beneficiaries who, after the FIDA demonstration ended, would have chosen to enroll in a FIDE SNP or other Medicare Advantage plan or to go to fee-for-service Medicare. MMCO then multiplied the estimated number of beneficiaries in each of these subgroups with the estimated cost per appeal for each subgroup.

These calculations resulted in an estimated $83,048 total Federal costs of Medicare appeals absent the NY Integrated A&G demonstration. To compute costs under the demonstration, MMCO started with the total number of FIDE SNP appeals filed in 2021. Under the demonstration, New York absorbed the costs of adjudicating Medicare and Medicaid appeals through the integrated appeals system, so there was no Federal Medicare cost at that level. However, a small percentage of these decisions were appealed to the fourth level, and those costs are 100 percent federally funded through the demonstration. Twelve FIDE SNP appeals reached the fourth level during 2021 with an estimated total cost of $120,000. This $120,000 is the cost of the appeals that reached the fourth level during 2021 and does not reflect the additional costs of administering the demonstration (e.g., FTEs and the appeals-specific IT system).

Table 4-1 shows the estimated annual Federal Medicare costs to the appeals system for 2020[10], 2021, and the net cost across the 2 demonstration years.

Table 4-1
Net impact of the demonstration on Federal costs of appeals in 2020 and 2021

Year	Federal Costs in the Demonstration	Federal Costs Absent the Demonstration	Net Cost
2020	$90,000	$94,034	–$4,034
2021	$120,000	$83,048	$36,952
Total	$210,000	$177,082	$32,918

SOURCE: MMCO analysis, 2022

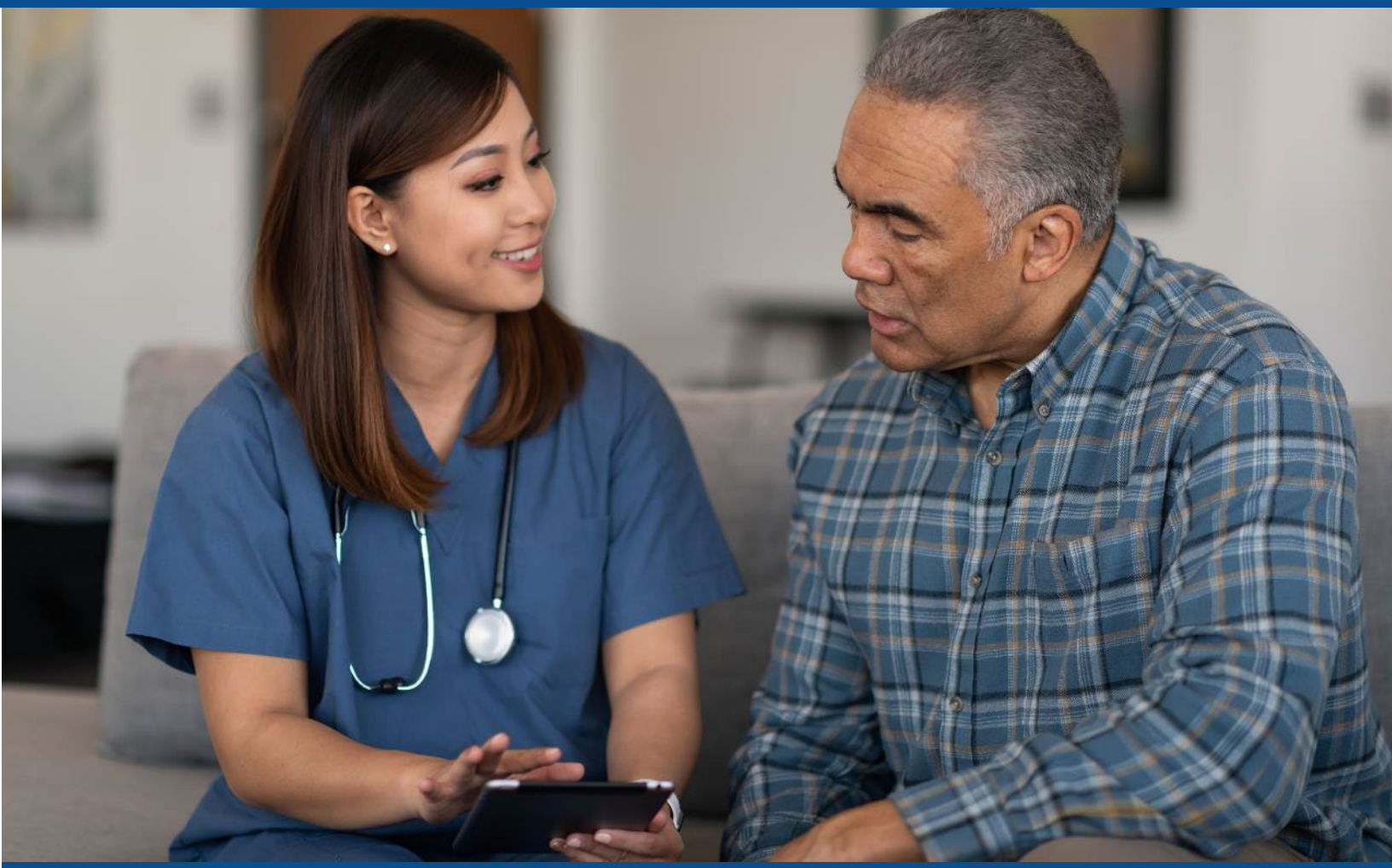
[10] See the First Brief Report for additional discussion.

4.2 Impact on Medicare Costs

For 2020–2021, total Federal costs of appeals under the demonstration were $210,000 and estimated Federal costs absent the demonstration were $177,082. MMCO concluded that the NY Integrated A&G demonstration did not materially impact Medicare costs to the appeals process.

SECTION 5

Conclusions



CMS, the State, beneficiary advocates, and the plans continued to view the design of the NY Integrated A&G demonstration favorably, because it streamlines the process for beneficiaries and plans. Feedback was mixed concerning the autoforwarding of adverse beneficiary decisions following the first level of appeal. Whereas CMS, the State, and advocates viewed this as a key beneficiary protection, plans reported that the autoforwarding of appeals likely increased their administrative burden, in part due to a high number of cancelled or postponed hearings. It also created confusion for some enrollees about the integrated appeals process.

In interviews, some beneficiaries said they appreciated the autoforwarding process, whereas others were not aware of it. Beneficiaries often reported getting help with the appeals process from informal supports as well as the plans. Some beneficiaries had trouble understanding the materials sent to them by the plans either because they were not translated into the beneficiary's preferred language, or because of vision or literacy issues.

Plans and advocates continued to report challenges around ensuring that enrollees receive the evidence packet following an adverse decision at the first-level appeal. In part, these challenges stem from the fact that the evidence package is often sent months before a scheduled hearing. Despite using different delivery methods including those with tracking capability, enrollees often arrived at a hearing without the packet, denied that they had received it, or had lost or forgotten about it, resulting in postponed hearings. One plan recommended the required timeframe for sending the evidence packet be adjusted to be closer to the actual hearing date. In addition, plans and advocates recommended increased communication with enrollees about the process through Maximus or beneficiary notices.

As in 2020, scheduling delays for hearings and resulting backlog of appeals in 2021 were attributed to staffing challenges at OAH, with OAH reporting a number of open positions. While these operational issues persisted, OAH and the MAC have acquired expertise in applying both Medicare and Medicaid policies, a key requirement of the demonstration's integrated approach. Although most enrollee appeals involved Medicaid services, neither OAH nor others reported challenges or concerns about the ability of OAH to apply Medicare regulations. Similarly, the MAC did not note any issues with applying Medicaid policies, although it has requested more training on New York Medicaid policy. OAH ALJs received training on Medicare and Medicaid regulations and anticipate more trainings in the future with the goal of becoming faster and more consistent in their decisions.

An MMCO cost analysis indicated the demonstration resulted in no material impact on Federal Medicare costs to the appeals process.

RTI will continue to gather information from plans, the State, and advocates about their experience with the NY Integrated A&G demonstration. MMCO will continue to provide information on the impact of the demonstration on Medicare costs. We will report findings in a subsequent report.

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