FINANCIAL ALIGNMENT INITIATIVE

New York Integrated Appeals and Grievances Demonstration: Third Brief Report

December 2023

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RTI Project Number 0214448.001.007.000.000.006

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

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CMS Contract No. HHSM-500-2014-00037i TO#7

December 2023

This project was funded by the Centers for Medicare & Medicaid Services under contract no. HHSM-500-2014-00037i TO #7. The statements contained in this report are solely those of the authors and do not necessarily reflect the views or policies of the Centers for Medicare & Medicaid Services. RTI assumes responsibility for the accuracy and completeness of the information contained in this report.

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Acknowledgments

We would like to thank the State officials who contributed information reflected in this evaluation report through interviews during site visits and quarterly telephone calls. We also thank the other stakeholders who also answered our questions about their experience and perspectives on the demonstrations. We gratefully acknowledge the many contributions of CMS staff, especially our project officer, Susannah Woodman. Emily Callot, Christopher Klotschkow and Catherine Boykin provided excellent editing and document preparation.

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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 demonstration under the Medicare-Medicaid Financial Alignment Initiative, the NY Integrated A&G demonstration began on January 1, 2020, and tests continuing implementation of the integrated process in other plans covering both Medicare and Medicaid.

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 or savings for plans, the State, and Federal agencies. The integrated appeals and grievances process is available to beneficiaries in 13 Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs) and applies to all Medicare Part C and Medicaid services covered by the plans.[1,2]

Under the NY Integrated A&G demonstration, beneficiaries use one process for appealing Medicare and Medicaid coverage decisions made by the plan. There are four levels of appeal, starting with a beneficiary 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) within the Office of Temporary and Disability Assistance. Beneficiaries 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.

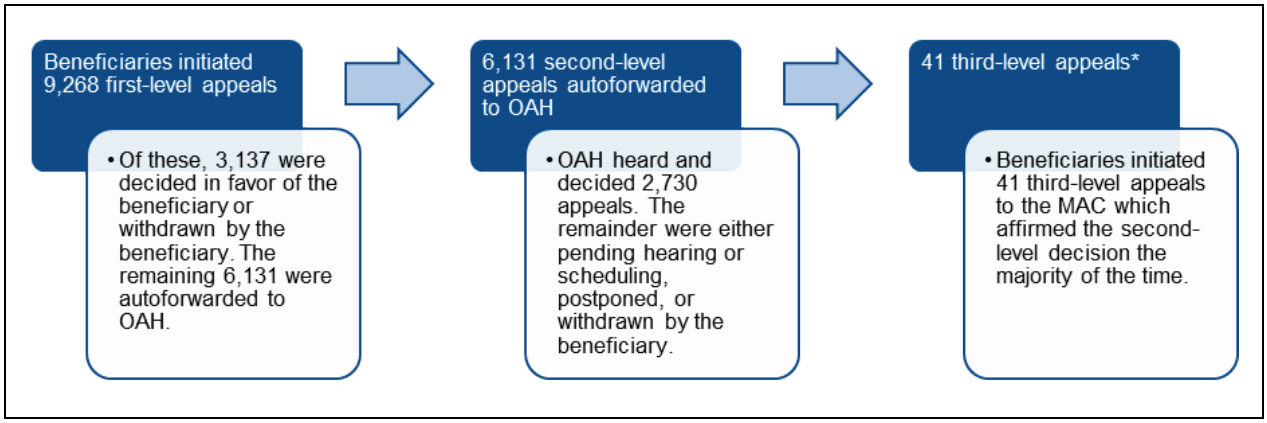
CMS contracted with RTI International to conduct an independent evaluation of the NY Integrated A&G demonstration to determine its impact on beneficiary and plan experience. This third brief report covers the third demonstration year, January 1, 2022, through December 31, 2022, and includes reflections on the demonstration overall. It includes qualitative findings from interviews conducted in Spring 2023 with beneficiary advocates, plans, CMS, and New York State officials. Data on the number of appeals at the first- and second-levels reflect calendar year data, and the number of appeals at the third- and fourth-levels reflect fiscal year data. 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 for fiscal years 2020 through 2022.[3]

[1] The State and CMS call the plans participating in the demonstration Medicaid Advantage Plus plans. They are FIDE SNPs—a combination of a managed long-term services and supports (known as managed long-term care in New York) and a Dual Eligible Special Needs Plan under the same parent organization.
[2] Medicare Part D Pharmacy appeals are excluded from the NY Integrated A&G demonstration.
[3] Because the demonstration started on January 1, 2020, fiscal year 2020 costs include data from January 1, 2020 through September 30, 2020.

Highlights

The NY Integrated A&G demonstration provided a pathway for dually-eligible beneficiaries to use a single appeals process for over 9,000 plan coverage decisions in 2022 (see ***Figure ES-1***). Plans upheld their coverage decisions in over 6,000 of these first-level appeals, which were then automatically forwarded to the second level at OAH. The OAH Administrative Law Judges (ALJs) issued decisions on over 2,700 appeals. The remainder of appeals were pending scheduling or hearing, postponed, or withdrawn by the beneficiary. In more than 700 of the appeals heard by ALJs, the ALJs overturned the plan's decision, resulting in the beneficiary receiving coverage for services. Of the second-level decisions that upheld the plan's decision, a relatively small number (41) were sent, at the beneficiary's request, to the third level at the MAC for further review. The fourth level, the Federal District Court, received no appeals.

Figure ES-1
The number of 2022 appeals at each level of the NY Integrated A&G demonstration



* The third-level appeals data are from fiscal year 2022.

Consistent with findings in prior Brief Reports,[4] the State, CMS, and beneficiary advocates continued to speak highly of the demonstration because it automatically forwards first-level appeals denied by the plan to the second level at OAH, a key beneficiary protection. Plans would prefer having second-level appeals be member-initiated instead of automatically forwarded to OAH. Plans believed that, if members initiated the appeals, members would be more engaged in the process. Advocates thought requiring member-initiated appeals at the second level would present a barrier to dually eligible beneficiaries who can be intimidated by the appeals process and who would then go without needed services. Because many first-level appeals were overturned at the second level in favor of the beneficiary, advocates believed the automatic process provided an essential protection and due process.

Beneficiary understanding of the integrated process continued to vary. Plans and advocates said that some beneficiaries understood how their appeals went to the second level at OAH, some were surprised that a hearing had been scheduled for them, and some tried to initiate

[4] See the First Brief Evaluation Report and the Second Brief Evaluation Report.

a second-level appeal on their own. Advocates suggested communication about the process could be improved.

As described in earlier reports, OAH initially had difficulty scheduling and hearing appeals forwarded from the first level, leading to a backlog of cases and lengthy delays in issuing decisions. In 2022, by hiring more ALJs, developing trainings for ALJs, and redesigning the hearing scheduling process, OAH reported it was able to schedule and hear more appeals, apply decisions more quickly and consistently, and markedly reduce the backlog of cases awaiting hearing. The State and CMS viewed this outcome as a success. Although scheduling hearings improved, plans reported it could still take several months for OAH to issue a decision on second-level appeals.

The demonstration had a challenging first 2 years coinciding with the COVID-19 public health emergency (PHE), but its third year was more successful. Because it was running more smoothly, the State and advocates were supportive of continuing the demonstration. Plans supported the demonstration as well but would prefer changes to the automatic forwarding process. At the time of this report, CMS was exploring the possibility of a 2-year extension to allow CMS and the State additional time to determine whether improved staffing and distance from the PHE has had an impact on beneficiary experience.

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 fiscal years 2020 through 2022.

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 a demonstration under the Medicare-Medicaid Financial Alignment Initiative (FAI)—the Fully Integrated Duals Advantage (FIDA) demonstration). Statewide, 13 Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs) participated in the NY Integrated A&G demonstration in 2022.[5]

Medicare-Medicaid beneficiaries who are not enrolled in the demonstration and who appeal their health plan's reduction, termination, or denial of services must navigate two systems—one for Medicare and one for Medicaid—with different procedures and policies. The NY Integrated A&G demonstration eliminates this division and provides a streamlined appeals process for beneficiaries 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 not included in a participating FIDE SNP's benefit package.

As of January 2022, there were 31,516 beneficiaries enrolled in participating FIDE SNPs (NYSDOH, 2022a). Demonstration enrollment increased to 35,061 as of December 2022 (NYSDOH, 2022b). Throughout 2022, over 95 percent of beneficiaries in the demonstration lived in New York City.

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 brief report, covering the third demonstration year, January 1, 2022, through December 31, 2022,[6,7] 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

[5] 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.
[6] The First Brief Report covers the first demonstration year, January 1, 2020, through December 31, 2020. The Second Brief Report covers the second demonstration year, January 1, 2021, through December 31, 2021.
[7] The number of appeals at the first- and second-levels in this report reflect calendar year 2022 data, and the number of appeals at the third- and fourth-levels reflect fiscal year 2022 data.

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

We include findings from interviews conducted in April and May of 2023 with staff and representatives from the following agencies and types of organizations: CMS, NYSDOH, New York Office of Administrative Hearings (OAH), U.S. Department of Health and Human Services (HHS) Departmental Appeals Board Medicare Appeals Council (MAC), three participating FIDE SNPs, and beneficiary advocates.[8] CMS also provided RTI with results of a monitoring analysis of HHS cost data. We summarize those data as well.

[8] We spoke with three of the 13 plans that participated during the report period. Unless otherwise noted, findings on the plans' perspective or experience are from those three plans.

SECTION 2

Integrated Appeals and Grievances Process

2.1 Integrated Appeals Process Overview

The key objectives of the NY Integrated A&G demonstration are to improve beneficiary experience with the grievances and appeals processes and to generate administrative streamlining or savings for plans, the State, and Federal agencies.[9] To accomplish these goals, the demonstration uses one appeals process for both Medicare- and Medicaid-covered services provided by the participating plans. A beneficiary who disagrees with a coverage decision first appeals to the participating plan for a reconsideration. If the plan upholds its coverage decision,[10] the appeal is automatically forwarded to the second level of appeal for a fair hearing with OAH at the Office of Temporary and Disability Assistance (OTDA). A beneficiary who disagrees with the OAH decision can appeal to the MAC. If the beneficiary continues to disagree with the decision, they can appeal to the Federal district court.

At all levels of the integrated appeals process, Medicare and Medicaid policy guidance are applied, allowing the beneficiary to navigate one appeals process for all covered services. Outside of the demonstration, dually eligible beneficiaries in managed care products 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.

Beneficiaries in the demonstration may appeal coverage decisions for new services or previously authorized stoppages, reductions, or restrictions of services (e.g., reductions of personal care services). Beneficiaries may continue to receive previously authorized services during the appeals process through the third level of appeals at the MAC.

In-network providers can also file an appeal through the integrated process on behalf of beneficiaries, but if the provider has a dispute with a plan not involving a beneficiary (i.e., a payment dispute), it must follow the dispute resolution process outlined in its contract with the plan. The State allows out-of-network providers to use the integrated process to file appeals for payment disputes because they otherwise do not have contracts with plans that describe a dispute resolution process.

Throughout the demonstration, second-level appeals have taken place telephonically. Recent procedural changes in the demonstration included revisions to the MOU, finalized in August 2022, that clarified a beneficiary's right to request an in-person hearing rather than one by phone, although as of this report, OAH was not conducting in-person hearings due to the PHE. The revisions also allowed participating FIDE SNPs to provide a written statement instead of having a plan representative attend the OAH fair hearing (MOU, 2022, p.13).

[9] The primary focus of integration in the demonstration is the appeals process. The time frame for reviewing grievances was integrated for Medicare and Medicaid services, but there continue to be separate notices for each program, and beneficiaries have grievance appeal rights under Medicaid that they do not have under Medicare.
[10] Other terms for this include *adverse decision* and *adverse appeal* because these decisions are against the beneficiary.

2.1.1 Appeals in Demonstration Year 3

First-Level Appeals

All participating plans report quarterly data to CMS and the State on the number of appeals received, type of service, type of coverage, and plan decisions. As enrollment in participating plans increased over the reporting period, so did the number of first-level appeals. Plans reported 9,268 first-level appeals in 2022, compared with 7,010 in 2021. The three largest plans accounted for 87 percent (8,063) of appeals. CMS and the State conducted quarterly calls with plans to discuss issues and trends in appeals and to answer any questions about demonstration policy and implementation.

Most first-level appeals at the three largest participating plans in 2022 were for Medicaid-covered long-term services and supports (LTSS), such as personal care services and consumer-directed personal assistance services. Most of these appeals were requests for additional hours of care, and were not in response to service reductions. Although Medicaid services represented the majority of first-level appeals, the three plans reported variation in the percentage of appeals falling under Medicare, Medicaid, or both (see ***Table 2-1***). For example, 13 percent of Plan A appeals, 42 percent of Plan B appeals, and 39 percent of Plan C appeals were for Medicare-only coverage. All three plans reported an increase in the percentage of Medicare appeals compared to 2021 (increases of 3 percent for Plan A, 13 percent for Plan B, and 4 percent for Plan C).

Table 2-1
Percentage of appeals by type of coverage among the three largest FIDE SNPs in the NY Integrated A&G demonstration, January 1, 2022–December 31, 2022

Coverage type	FIDE SNP		
	Plan A	Plan B	Plan C
Medicare	13%	42%	39%
Medicaid	70%	42%	49%
Medicare and Medicaid	17%	16%	12%

Source: Plan-reported data to CMS and NYSDOH, 2022.

Second-Level Appeals

There were 6,131 appeals forwarded to OAH during the third demonstration year (2022). OAH heard and decided on 2,730 appeals, an increase from 1,546 appeals in 2021.[11] The remainder of appeals were waiting to be scheduled, awaiting a hearing, postponed, or withdrawn by the beneficiary. As in previous demonstration years, most second-level appeals were for Medicaid LTSS. Eighty-eight percent (2,390) of OAH's decisions related to coverage for personal care services or consumer-directed personal assistance. OAH upheld the plans' personal care decisions more often in 2022 compared to the prior year. Sixty-nine percent of personal care

[11] Some of the appeals OAH heard in 2022 could have been automatically forwarded in the previous year.

appeal decisions upheld the plan's denial of coverage, up from 52 percent in 2021. ***Table 2-2*** shows the number of appeals and their outcomes by service category.

Table 2-2
Total appeals decided by OAH, by outcome, January 1, 2022–December 31, 2022

Type of service	Plan decision upheld	Plan decision overturned	Decided by Stipulation[1]	Withdrawn	Pending	Total	Percent of total
Personal care/ CDPAS	1,654	655	52	0	29	2,390	88%
Inpatient Hospital Stay	5	2	0	0	1	8	0%
DME	57	8	2	0	2	69	3%
Dental	115	12	1	0	0	128	5%
Nutritional Shake	0	1	0	0	0	1	0%
Other	95	37	1	0	1	134	5%
Total	**1,926**	**715**	**56**	**0**	**33**	**2,730**	**100%**

CDPAS = consumer-directed personal assistance services; DME = durable medical equipment
[1] "Decided by Stipulation" mean that the plan and beneficiary came to an agreement about the service coverage
SOURCE: CMS, 2023.

Third-Level Appeals

The MAC reported receiving 41 appeals initiated by beneficiaries after OAH upheld a plan's decision during Federal fiscal year 2022 (October 1, 2021, through September 30, 2022). In fiscal year 2022, 61 percent of third-level appeals were for Medicaid personal care services. Only two of the 41 appeals received in fiscal year 2022 were for Medicare services. In Spring 2023, the MAC had already received 43 appeals since the end of fiscal year 2022 (i.e., since October 1, 2022). The MAC upheld OAH's decision in most of the appeals it reviewed.

SECTION 3

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

3.1 Beneficiary Experience

As in past demonstration years, the State, CMS, and beneficiary advocates continued to believe that the integrated process and automatic forwarding of plan-denied appeals to OAH provides an important protection for beneficiaries. Under the nonintegrated process outside of the demonstration, second-level appeals for Medicare Advantage (MA) service denials are automatically forwarded to an Independent Review Entity and second-level appeals for Medicaid service denials must be initiated by the beneficiary. Under the demonstration, all appeals are automatically forwarded to the second level. Most appeals forwarded to OAH were for Medicaid services; therefore, many beneficiaries experienced the benefit of having an automatic second-level review of these service denials, which was not otherwise available to them outside the demonstration.

Plans, advocates, the State and CMS agreed that, for services covered by both Medicare and Medicaid, the simplicity of using one path reduced burden among beneficiaries who, in the nonintegrated process, must navigate separate Medicare or Medicaid processes.

[Outside the demonstration] people are having to first go through a Medicare appeal to decide nope, that's not covered, now go to Medicaid. [In the demonstration] it's just, "Let's just do it." So, people are effectively getting the result, they're getting the final answer, they're getting due process.

—NYSDOH, 2023

3.1.1 Beneficiary Understanding of the Process

As in prior years, findings were mixed on beneficiaries' understanding of the autoforwarding process to the second level of appeal. Beneficiary advocates, the State, CMS, and plans said that some beneficiaries continued to be surprised that a second-level hearing had been scheduled with OAH, despite receiving information describing the process with the Appeal Denial Notice.[12] Advocates said that other beneficiaries would call their plan to start an appeal after receiving a denial notice, not realizing that an appeal was already underway. Plans said that some beneficiaries were not interested in pursuing an appeal after the first level and either asked to withdraw the forwarded appeal or simply did not answer the phone at the scheduled time of the hearing (see ***Section 3.2, Plan Experience***). Advocates suggested that, although one of the goals of the demonstration described in the MOU was to simplify the process for beneficiaries, going through an appeal could be confusing even to advocates who are versed in legal terms and procedures, and the demonstration population may need more outreach and assistance in navigating an appeal. The plans also noted the volume of notices and information sent to beneficiaries as a source of beneficiary confusion.

[12] Required beneficiary notices developed for the NY Integrated A&G demonstration can be found here: https://www.cms.gov/medicaid-chip/medicare-coordination/financial-alignment/ny.

As much as we have these processes in place to reach out to the member, to remind them, it still ends up in many cases with confused members. … We agree that the overall intent to integrate is the best approach, but the communication factor—we have so many notices, requirements in place, that really can add to member confusion.

— FIDE SNP, 2023

3.1.2 Evidence Packet

If an appeal is automatically forwarded to the second level at OAH, plans are required to send documents, called *evidence packets*, to OAH and the beneficiary, supporting how the plan made its coverage determination. The evidence packets include medical records, functional assessments, and plan policy documents.[13] If someone else acts as the beneficiary's representative at the hearing (such as a family member or legal advocate), they must provide documentation in advance of the second-level hearing that they have authority to appear on behalf of the member. Plans are required to send the evidence packets to beneficiary representatives as well.

Because the evidence packet provides documentation explaining and supporting how the plan made its coverage decision, ALJs at second-level hearings confirm that the beneficiary has received it and has it on hand for reference during the hearing. The State, CMS, and advocates said there had been improvement in 2022 in beneficiaries having received the evidence packet at the time of the second-level hearing. Advocates said that, although there had been improvement, they still had calls from beneficiaries or their representatives whose hearings were postponed because the beneficiary or representative denied having received the packet or because they could not find it or had thrown it away. The Appeal Denial Notice indicated the beneficiary would receive an evidence packet from the plan but did not say that the beneficiary needed to have the packet at the second-level hearing. Advocates made recommendations throughout the demonstration for improving communication with beneficiaries such as including a detailed cover letter with the evidence packet explaining the importance of keeping it, but as of this report, there were no additional requirements for an evidence packet cover letter.

3.2 Plan Experience

The RTI evaluation team interviewed a total of nine staff from the three participating plans with the largest enrollments about their experience with the NY Integrated A&G demonstration during 2022 and early 2023. These three plans accounted for approximately 85 percent of demonstration enrollees. One of these plans had the largest demonstration enrollment, over 21,000, and the two other plans had enrollments of approximately 3,000 each. In this section, we describe plans' experiences with improvements and continued challenges in how the integrated process was implemented in 2022.

[13] The volume of material included in the evidence packet can be very large (e.g., 600 to 1,000 pages). Plan policy documents can include the model contract, evidence of coverage, and member handbook. See ***Section 3.2, Plan Experience***.

3.2.1 Scheduling Hearings

All three plans described marked improvements over previous years in the time between when an appeal was automatically forwarded to OAH and when a hearing was scheduled. The State changed its scheduling process from scheduling telephonic hearings for a specific time to using a time window (e.g., 9:00AM to noon) when a hearing might take place. Previously, if a scheduled hearing was quickly adjourned because the beneficiary did not have the evidence packet or did not answer the phone, the plan representative would have blocked off an hour of their time for a hearing that did not take place. Under the new system, if a hearing was quickly adjourned, OAH could move onto another hearing scheduled within the same window of time. This change allowed the State to work through a significant backlog of appeals. Two of the plans said the new scheduling process decreased their administrative burden, with one also saying that it produced cost savings. The third plan noted that, although the change decreased the backlog of hearings, sometimes the plan waited for calls that never happened and that scheduling continued to be a "big headache."

3.2.2 Postponements

Although there were improvements in scheduling hearings in 2022, all three plans said that hearing postponements were still common and suggested that, if the second-level appeals were beneficiary-initiated instead of automatically forwarded to OAH, the postponement rate would decrease because beneficiaries would be more invested in the process, and would be more likely to keep the evidence packet and attend the hearings. Two plans said that postponements due to the beneficiary or their representative not having the evidence packet were common. One of these plans said that out-of-network provider appeals, which are also part of the demonstration, were also often postponed for this reason. These two plans thought the letter accompanying the evidence packet sufficiently explained its purpose, and they did not conduct additional outreach to beneficiaries. One of the plans (the largest interviewed) noted that it did not have the resources to call each beneficiary who had an upcoming hearing. The third plan (the smallest interviewed) said it had changed its communication strategy to include two phone calls prior to a hearing to ensure beneficiaries had the evidence packet and to urge them to attend the hearing. This plan said that repeated postponements due to the lack of the evidence packet decreased, and participation in the hearings improved.

3.2.3 Contents of the Evidence Packet

Mailing the evidence packet to beneficiaries continued to challenge the plans administratively in 2022. The three plans we spoke with said the packet could be between 600 and 1,000 pages or more, depending on the case. The evidence packet is submitted electronically to OAH, but beneficiaries most often receive hardcopies. One plan said that, although it would be helpful if beneficiaries could receive the packets electronically, its membership typically required hardcopies.

Two plans said that, in addition to medical records, LTSS assessment results, and other material the plans used to make coverage decisions, ALJs required them to include the member handbook, model contract, and evidence of coverage in the evidence packet so these materials could be on hand for reference during the hearing. These policy documents can be hundreds of pages long. CMS and advocates were unsure why plans were sending all of the handbook and

contract documents to the beneficiaries instead of excerpts pertaining to the appeals. They noted that such large documents could be confusing and intimidating for beneficiaries.

OAH reported that, unlike the nonintegrated managed LTSS appeals process, the demonstration MOU requires the handbook and contract documents to be in the administrative record of the hearing,[14] and that, if an appeal went to the third level, the MAC would remand the appeal back to OAH if any of the documents were missing from the case file. The MOU states that the MAC will review third-level appeals based on the administrative record compiled by OAH and apply all Medicare and Medicaid coverage rules as specified in the plan's member handbook and model contract between the plan and the State and the evidence of coverage (MOU, 2022, p. 14-15). Although there is no language in the MOU, member handbook, or evidence of coverage specifying what documents must be in the evidence packet, the evidence of coverage requires the plan to send the same documents to the beneficiaries that it sends to the State. Because the MAC would remand cases back to OAH for missing documents, it appears that ALJs are requiring plans to submit the handbook and contract documents in their entirety so that they can be included in the administrative record sent to the MAC in the event of a third-level appeal. During interviews, advocates wondered whether OAH could have a library of annual model contracts and member handbooks for reference and inclusion in the administrative record for third-level appeals, rather than send them to beneficiaries.

3.2.4 Decisions

Two plans described continued improvement in the consistency of OAH ALJs' procedures and decisions in 2022. One of the plans said that it used to see cases with up to six postponements but that ALJs were now closing cases as defaulted after as few as three postponements.[15] The third plan we spoke with said that it still saw multiple postponements, and most appeals took between 6 and 10 months to resolve, with some taking more than a year. This plan also reported that, for out-of-network provider appeals, the ALJs assumed the role of mediator between the plan and provider to see whether the plan would agree to pay for a service or find a compromise with the provider, rather than make a decision based on Medicare or Medicaid coverage rules.

3.3 State Experience

In this section, we describe OAH's experience in implementing the demonstration, including scheduling and hearing of appeals, training for ALJs, use of interpreters during hearings, contents of the evidence packets, and postponements.

3.3.1 Backlog of Appeals

Over the reporting period, OAH made headway in scheduling and hearing the backlog of second-level appeals from previous demonstration years. Through hiring new staff, accessing ALJs available across the State instead of only New York City (the main demonstration coverage area), and streamlining processes like scheduling hearings in blocks of time instead of by the

[14] The administrative record documents OAH's decision-making process and the basis for its decision, including all materials that it had at the time its final decision was made.
[15] An appeal is defaulted when the beneficiary or representative does not attend the hearing but has not formally withdrawn the appeal.

hour, OAH reduced the backlog significantly, but had not yet completely eliminated it at the time of this report, according to CMS. As described in ***Section 2.1, Integrated Appeals Process Overview***, OAH received 6,131 new appeals in 2022 and heard and issued decisions on 2,730 appeals, some of which may have been automatically forwarded to the second level in 2021.

We really have finally, after a very slow and arduous ramp-up period, we're firing on all cylinders right now. We are getting people due process in timely and appropriate fashions and consistent decisions.

— OAH, 2023

3.3.2 Training and Operations

OAH instituted several strategies to improve the second-level appeals process in 2022:

- Developing and conducting staff training covering New York Medicaid and Medicare policy
- Scheduling ALJs to hear multiple similar types of appeals (e.g., for personal care services) during a scheduled block to build expertise in the relevant policy
- Designating some ALJs to have expertise in particular policy such as dental coverage or Medicare coverage of durable medical equipment
- Developing an archive of decisions for ALJs to review and draw from what was done in similar situations
- Working with staff from OTDA, NYSDOH, and the New York State Office of Information Technology Services to develop a tool to help ALJs write decisions more consistently and quickly[16]

3.3.3 Interpreters

As described in the Second Brief Report, the State noted that there were more non-English-speaking beneficiaries in the demonstration than in the non-integrated process. In 2022, OAH contracted with two full-time Spanish- and Russian-language interpreters who became familiar with the evidence packets, documentation, and legal terms. OAH said that the interpreters were able to explain the process and documents to non-English-speaking beneficiaries, allowing OAH to work through these cases more easily.

3.3.4 Evidence Packet

As previously noted, the State reported that hearings continued to be postponed when beneficiaries did not have the evidence packet. However, if beneficiaries said they did not have the packet, the ALJs were trained to describe the packet to the beneficiary, which sometimes led

[16] The tool automatically inserts into the written decision the relevant portions of the law, model contract, appellant name, date of appeal, and other elements pulled from other data systems.

to beneficiaries recalling that they actually did have it. OAH said it was working with NYSDOH and plans to have the packets sent to the beneficiary closer to the scheduled hearing time to increase the likelihood the beneficiary would have it on hand. OAH staff were particularly concerned about beneficiaries losing the packets or throwing them away.

> *Beneficiaries say they misplace, they don't remember, they discard [the evidence packet]. Eight hundred pages has a lot of personal information in it. What happens to that? … I [wouldn't] want 800 pages of my personal data laying in a trashcan somewhere. … This isn't just a fair hearing evidence packet, it's lots of things related to medical information. This is a large piece of information in one envelope.*
>
> — OAH, 2023

3.3.5 Postponements

In addition to missing evidence packets, the State noted that another cause of postponements was plans including outdated member handbooks in the packet—such as a 2021 handbook for an appeal of services in 2022. ALJs also postponed hearings if the packet did not include information such as letters from physicians or other supporting material requested by the beneficiary. When postponements occurred in 2022, ALJs began to personalize the process on the call—instead of simply telling the beneficiary that they would receive another scheduling notice and ending the call, the ALJ facilitated scheduling a new date with the plan and beneficiary on the call. The State said this process helped increase the likelihood of beneficiary attendance at the hearing on the new date, thereby decreasing further postponements.

3.4 MAC Experience

If a beneficiary disagrees with OAH's decision, they may initiate an appeal to the third level at the MAC, a division of the Departmental Appeals Board, within HHS. This section describes the MAC's experience with implementing the integrated process in 2022.

3.4.1 Decision Making

The MAC reported that 37 percent of the appeals it received in fiscal year 2022 had to be remanded back to OTDA before a decision could be made because the case files were missing the relevant evidence of coverage or member handbook. This finding supports OAH's interpretation of the MOU requiring these documents to be in the administrative record. The MAC upheld OAH's decisions in the remaining cases, although it occasionally used different reasoning.

MAC staff spent their time differently on appeals it receives through the demonstration compared to nonintegrated appeals (which are entirely for Medicare services). Because most demonstration appeals are for Medicaid services, staff spent more time looking for coverage rules or the applicable law in the evidence of coverage, member handbook, or New York State law. Because MAC staff are already knowledgeable about Medicare law, when they review nonintegrated appeals, they spent more time looking at chart records from physicians and nurses.

3.4.2 Translation Services

The MAC reported that approximately 35 percent of integrated appeals cases required translation of the MAC's decisions, which was much higher than its nonintegrated Medicare appeals. The MAC found that, in cases needing translation, the administrative steps it must take to contract for translation services were a contributing factor in delayed decisions. To procure translation services, the MAC must first send a request to a different division within the Departmental Appeals Board, which then needs budget approval from another agency within HHS. Once the budget for translation is approved, the MAC sends the decision to a contractor whose translation can take up to 15 days. Under the MOU, the MAC must issue a decision within 90 days. To meet this deadline for decisions requiring translation, the MAC found it had to ensure the ALJ made a decision within 60 days to account for the extra time for translating it, effectively reducing the time available to review the appeal and issue a decision by 30 days.

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 Federal costs to the appeals system in fiscal year 2022, MMCO compared fiscal year 2022 appeals cost estimates under the demonstration against what would have happened for the same time period without the demonstration. Both estimates were based on the same population: 35,061 total enrollment in FIDE SNPs in December 2022. This total includes 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 2022.

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 MA plan, or would have chosen to use 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 $139,504 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 2022. 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. Decisions appealed to the third and fourth levels are 100 percent federally funded through the demonstration. In fiscal year 2022, there were 41 appeals forwarded to the third level, and no appeals were forwarded to the fourth level.

Table 4-1 shows the estimated annual Medicare costs to the appeals system for fiscal years 2020 through 2022, and the net cost across the 3 demonstration years. The estimates include updated data for fiscal years 2020 and 2021 compared to previous evaluation reports which were based on projected budget amounts for third-level appeals in the demonstration. The current report uses the actual costs of third-level appeals, which were much lower than the projected costs for fiscal year 2021, although the reason for the disparity is unclear. A possible reason is that due to staffing issues related to the PHE, OAH heard and decided fewer second-level appeals than expected during fiscal year 2021. The budget amounts only include the costs from the Departmental Appeals Board and Federal District Court and do not include any administrative costs to CMS. For fiscal year 2022, there were no appeals to the Federal District Court, so there were no costs at that level. The State absorbs the cost for appeals that are at the second level heard by OAH.

Table 4-1
Net impact of the demonstration on the Federal costs of appeals in fiscal years 2020–2022

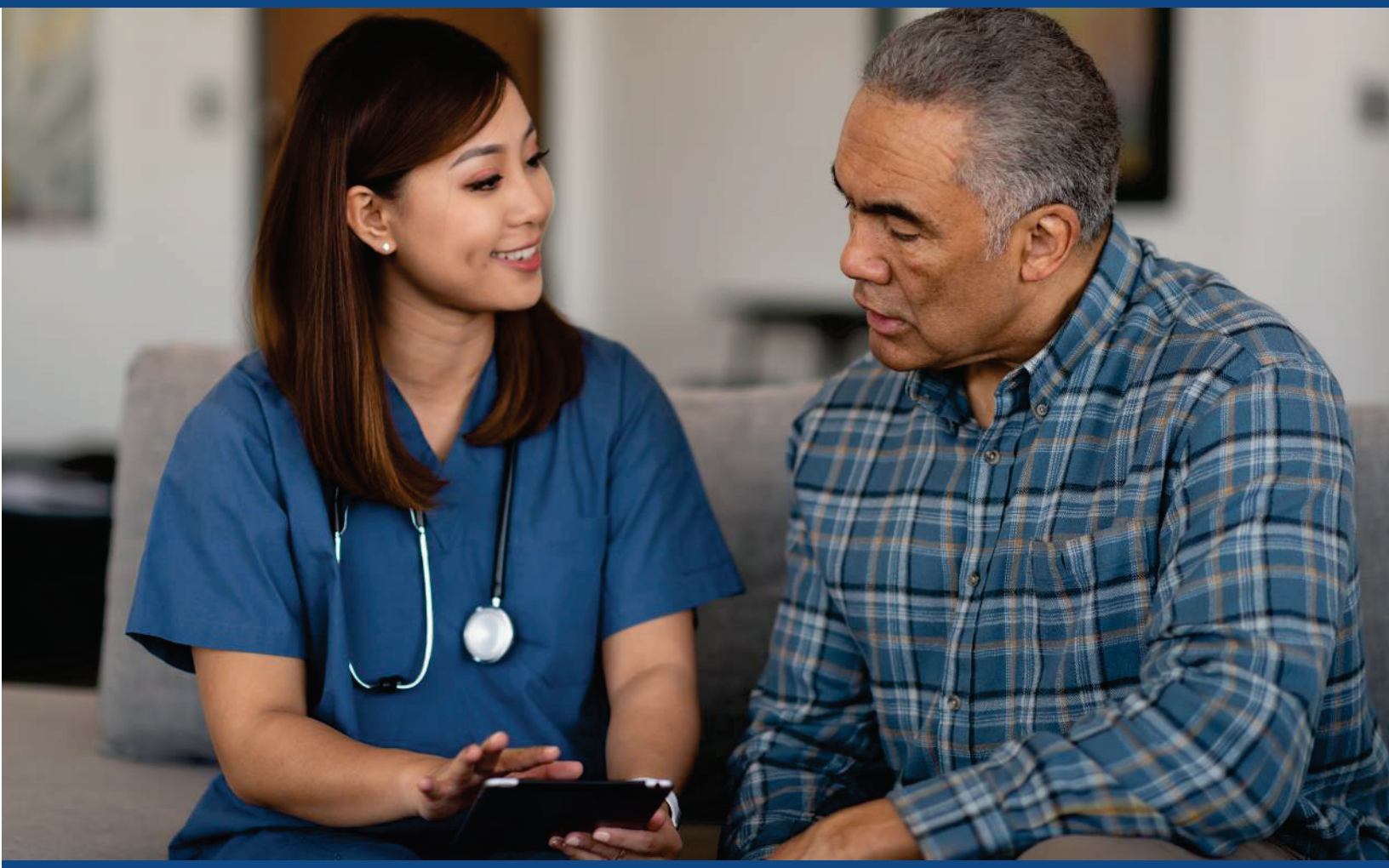
Fiscal year	Federal costs in the demonstration	Federal costs absent the demonstration	Net cost
2020	$107,965	$94,034	$13,931
2021	$14,106	$83,048	($68,942)
2022	$46,125	$139,504	($93,379)
TOTAL	**$168,196**	**$316,586**	**($148,390)**

NOTE: Because the demonstration began on January 1, 2020, fiscal year 2020 includes only the actual cost from January 1, 2020 through September 30, 2020.

For fiscal years 2020 through 2022, total Federal costs of appeals under the demonstration were $168,196 and were less than the estimated Federal costs, absent the demonstration, of $316,586. MMCO concluded that the NY Integrated A&G demonstration did not materially impact Medicare costs to the appeals process.

SECTION 5

Conclusions



5.1 Future Directions

The State was hopeful that CMS would continue the integrated appeals process because it has provided a streamlined, efficient use of resources. Because OAH had made many changes to ramp up its ability to schedule and hear appeals and issue decisions, and because the process was working well, disentangling it and returning to a nonintegrated approach at the end of 2023 was a daunting thought.

To even think that we'd have to unwind this, I can't even wrap my head around that option. I can't even wrap my head around unraveling this. I just can't.

— OAH, 2023

Advocates supported continuing the demonstration, particularly because the autoforwarding feature of the integrated process provides a safety net for beneficiaries, who would otherwise not pursue a fair hearing on their own. Now that the demonstration is running smoothly and OAH can hear appeals in a timelier way, more could be learned from the demonstration and how it compares with the nonintegrated process in terms of the number of appeals getting a fair hearing and whether they are decided in favor of the beneficiary.

[In Medicare Advantage] we have autoforwarding already set up. [A second level appeal] goes to the [Independent Review Entity]. And there's nothing like that on the Medicaid side. So, this demo is really unique, and I think there's so much that can be learned from it if someone would take the time and be able to access the data to compare this process versus those that aren't part of it, and does this autoforwarding make such a big difference, which I think it would find it does, because people get a chance at their appeal.

— Beneficiary Advocate, 2023

CMS was more ambivalent about continuing the demonstration and said that not enough definitive measures show that the integrated process has lowered costs or improved quality. CMS acknowledged that the demonstration gave beneficiaries the opportunity to have appeals for Medicaid services automatically continue to the second level, something unavailable outside of the demonstration. At the time of this report, CMS was exploring the possibility of a 2-year extension to allow CMS and the State additional time to determine whether improved staffing at OAH and distance from the PHE has an impact on beneficiary experience.

5.2 Lessons Learned

The NY Integrated A&G demonstration ran more smoothly in 2022 than in its first 2 years because OAH instituted several changes that led to appeals at the second level to be heard

more quickly and to have more consistent decisions. Plans, advocates, the State, and CMS agreed that there was value in providing a simplified appeals process, especially for services covered by both Medicare and Medicaid.

NYSDOH and OAH recommended that, if other States pursue an integrated process like New York's in the future, the States should ensure they are properly staffed before the new process starts. Developing and implementing processes to handle increased numbers of appeals that are automatically forwarded to an administrative hearing office would be especially important for States pursuing this type of strategy. Although the NY Integrated A&G demonstration grew out of the FIDA demonstration and although ALJs were familiar with the process, the number of beneficiaries eligible for the integrated process jumped by over 15,000 at the start of the demonstration in 2020. That increase, combined with the impact of the PHE on OAH staffing, led to considerable delays in scheduling and hearing appeals.

There was disagreement about the utility of the automatic forwarding of appeals to OAH. Plans suggested that Medicaid services that are appealed to the second level should still be member-initiated; plans cited high rates of postponements as an indicator of beneficiaries' lack of desire to engage in the process. However, advocates and the State maintained that the automatic process provided a necessary beneficiary protection and facilitated due process. Given that over one-quarter of plan appeals were overturned in 2022 in favor of the beneficiary, the automatic forwarding process led to many beneficiaries getting services they were entitled to receive. In addition, many appeals that OAH had received in 2022 had not yet been heard at the time of this report, representing more beneficiaries who might eventually receive services when OAH issues a decision.

Non-English-speaking beneficiaries may especially benefit from the automatic forwarding process. Throughout the demonstration, plans said the number of non-English speakers with appeals mirrored the demographics of their demonstration membership, but the State and MAC noted they received more non-English speaking appeals than in their nonintegrated processes. This suggests that non-English speakers in the nonintegrated process do not pursue fair hearings as often as English speakers do, and that automatically forwarding appeals to the second level may be particularly valuable to these beneficiaries. Further investigation is warranted to learn why non-English speakers may pursue appeals at different rates than English speakers, and whether notices and other communications describing Medicare and Medicaid appeal rights and processes are effective and useful to non-English speakers.

Over the course of the demonstration, ensuring that the beneficiary had the evidence packet on hand at the time of the second-level hearing was challenging. The rationale for ALJs requiring plans to include the member handbook, evidence of coverage, and model contract in the beneficiary evidence packet appears to have come from their experience with third-level appeals being remanded back to OAH if the administrative record sent to the MAC does not include them. However, because the plans are required to send the same documents to beneficiaries that they send electronically to OAH, they sent voluminous packets with information extraneous to the service being appealed. This process was administratively burdensome to plans, and confusing and overwhelming to beneficiaries who did not understand the documents and discarded them. At the time of this report, CMS and the State planned to discuss the required contents of the evidence packet to see whether guidance for the plans should

be modified for the remainder of the demonstration. Increased communication on the importance of the evidence packet could also help beneficiary retention of the packet and participation in the hearings, as evidenced by one plan's experience with calling beneficiaries about upcoming appeals.

5.3 Conclusion

The NY Integrated A&G demonstration has streamlined the appeals process by allowing Medicare and Medicaid policy to be applied at the same time at all levels of appeal, including the first level at the plan. This aspect of the integrated process reduced burden for beneficiaries and for the plans because there was no longer a dual process for the same appeal. The demonstration also showed that State agency staff, who typically focus on State Medicaid policy, can effectively decide Medicare appeals at the second level. The demonstration also increased the number of appeals and led to more beneficiaries receiving needed services.

Plans, the State, and advocates had different suggestions for alleviating some of the challenges experienced by plans in sending large evidence packets and having beneficiaries keep them. These solutions included changing the documents required to be sent, sending the packet closer to the time of the hearing, and/or improving communication about what the packet was for. Increasing beneficiary understanding about their appeal rights, how the process works, and what to expect would likely improve beneficiary participation in hearings at the second level.

Increasing staff at the second level of appeal and streamlining the hearing schedule was essential to the State's ability to hear and decide appeals in a timelier way. Because appeals for Medicaid personal care services were by far the most common to be automatically forwarded to the second level of appeal and over one-quarter of these appeals were overturned in favor of the beneficiary, the demonstration provided dually eligible beneficiaries with the opportunity to receive needed Medicaid services they otherwise would not.

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

References

Centers for Medicare & Medicaid Services (CMS) and the State of New York: Memorandum of Understanding (MOU) Between the Centers for Medicare & Medicaid Services (CMS) and the New York State Department of Health to Operate Integrated Grievance and Appeals Processes for Certain Integrated Medicare and Medicaid Plans. August 2, 2022. https://www.cms.gov/files/document/nyiagmou.pdf. As obtained on May 17, 2023.

New York State Department of Health (NYSDOH): 2022 Monthly Medicaid Managed Care Enrollment Report for January 2022. 2022a. https://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/2022/docs/en01_22.pdf. As obtained on March 22, 2023.

New York State Department of Health (NYSDOH): 2022 Monthly Medicaid Managed Care Enrollment Report for December 2022. 2022b. https://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/2022/docs/en12_22.pdf/. As obtained on March 22, 2023.

New York State Department of Health (NYSDOH): Medicaid Redesign: Uniform Assessment System for Long-Term Care in New York State. n.d. https://www.health.ny.gov/facilities/long_term_care/uniform_assessment_system/. As obtained on June 27, 2022.

New York State Office of Administrative Hearings (OAH): Total Appeals Decided by OTDA by Outcome. January 31, 2023. As obtained on March 2, 2023, from Kristi Sugarman Coats at CMS.