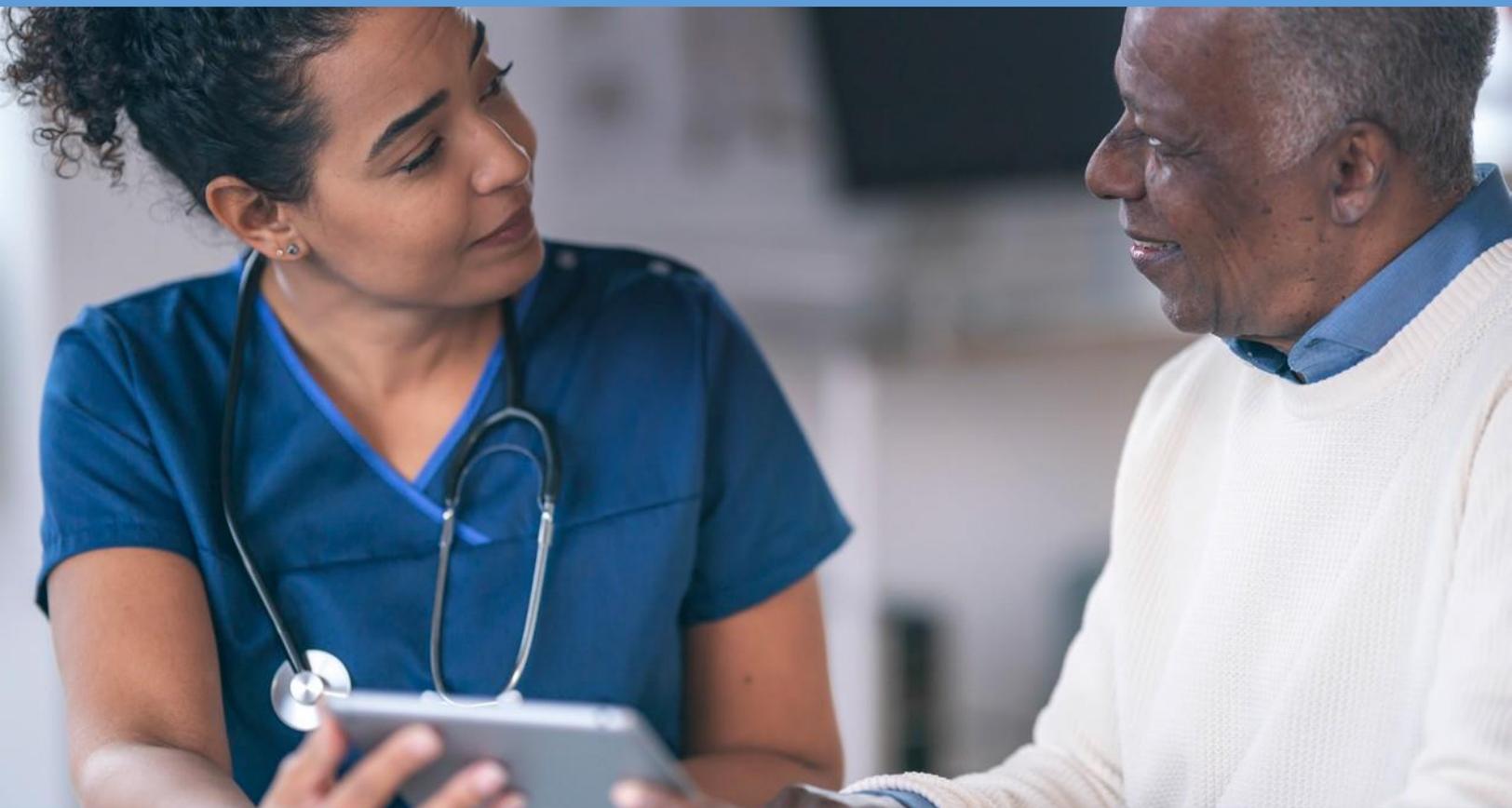


FINANCIAL ALIGNMENT INITIATIVE

New York Integrated Appeals and Grievances Demonstration: First Brief Report

March 2022



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NEW YORK INTEGRATED APPEALS AND GRIEVANCES DEMONSTRATION
FIRST BRIEF REPORT

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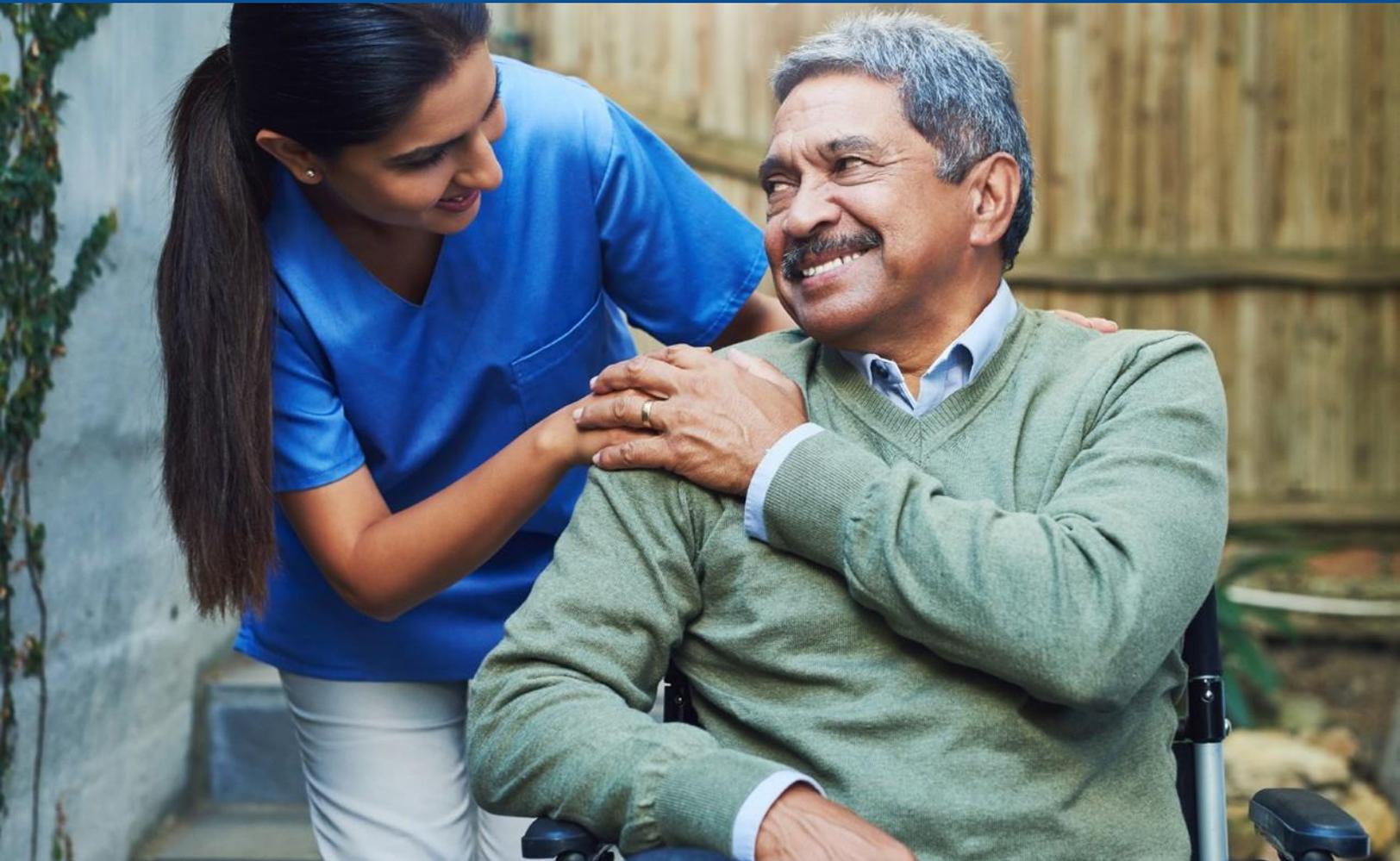
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Glossary of Acronyms

A&G	Appeals and Grievances
CMS	Centers for Medicare & Medicaid Services
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
IT	Information technology
LTSS	Long-term services and supports
MA	Medicare Advantage
MAC	Medicare Appeals Council
MLTC	Managed long-term care
MLTSS	Managed long-term services and supports
MOU	Memorandum of Understanding
NYSDOH	New York State Department of Health
OAH	Office of Administrative Hearings
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 service. 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 New York 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 eight Fully Integrated Dual Eligible Special Needs Plans¹ 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 the second level of appeal through the New York Office of Administrative Hearings (OAH). Enrollees who disagree with the OAH decision can appeal to the Medicare Appeals Council and finally to Federal District Court. Each level of appeal adjudicates 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 first brief report covers the first demonstration year, January 1, 2020 through December 31, 2020. It includes findings from interviews conducted in spring 2021 with beneficiary advocates, plans, CMS, and New York State officials. We also 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

Beneficiary advocates, plans, and the State favorably viewed the NY Integrated A&G demonstration because it unifies a divided process and fits within the CMS and State goals of better integrating Medicare and Medicaid services for dually eligible beneficiaries.

The State experienced some implementation challenges as it widened the scope of the integrated process to a group of enrollees that was significantly larger than under the original FIDA demonstration. In particular, OAH staffing shortages, exacerbated by the COVID-19

¹ The State and CMS refer to the plans participating in the demonstration as 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 D-SNP under the same parent organization.

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

public health emergency, caused communication problems with plans and beneficiaries and delayed scheduling and hearing second-level appeals. The delays frustrated plans, especially when the plans understood they needed to expedite appeals at the first level for personal care services but the State did not have to meet similar timeframes at the second level. There was a lack of uniformity in how and when beneficiaries were provided notice of auto-forwarding appeals and scheduled hearings, increasing confusion among beneficiaries and the level of hearing postponements and/or appeals ending in default.³

An MMCO 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.

³ If a beneficiary does not attend the hearing, OAH considers the appeal abandoned by the beneficiary. This is known as ending in default.

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. Eight Fully Integrated Special Needs Plans (FIDE-SNPs) operating in New York City and some of the surrounding counties participated in the demonstration in 2020.⁴ The demonstration is an outgrowth of the successful integrated appeals and grievances process developed for two demonstrations under the Medicare-Medicaid Financial Alignment Initiative, the Fully Integrated Duals-Advantage (FIDA) and the Fully Integrated Duals-Advantage Demonstration for Individuals with Intellectual and Developmental Disabilities (FIDA-IDD).

Outside of the NY Integrated A&G demonstration, Medicare-Medicaid beneficiaries who appeal their health plan's reduction, termination, or denial of service 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 the FIDE-SNP's benefit package.

The original integrated appeals and grievances process was available to the few thousand enrollees in the FIDA and FIDA-IDD demonstrations. As of January 2020, the integrated process was available to approximately 20,000 members enrolled in FIDE-SNPs (NYSDOH, 2020). Enrollment in the participating FIDE-SNPs increased to 22,978 members as of December 2020 (NYSDOH, 2020).

1.2 Demonstration Evaluation

CMS contracted with RTI 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 first demonstration year (January 1, 2020, through December 31, 2020), we address the following:

1. The impact on beneficiary experience with the NY Integrated A&G demonstration and whether beneficiaries perceive the appeals process to be fair, understandable, and easily navigable
2. Participating plan experience regarding whether the NY Integrated A&G demonstration reduces their administrative burdens
3. Medicare cost savings of adjudicating appeals attributable to the demonstration

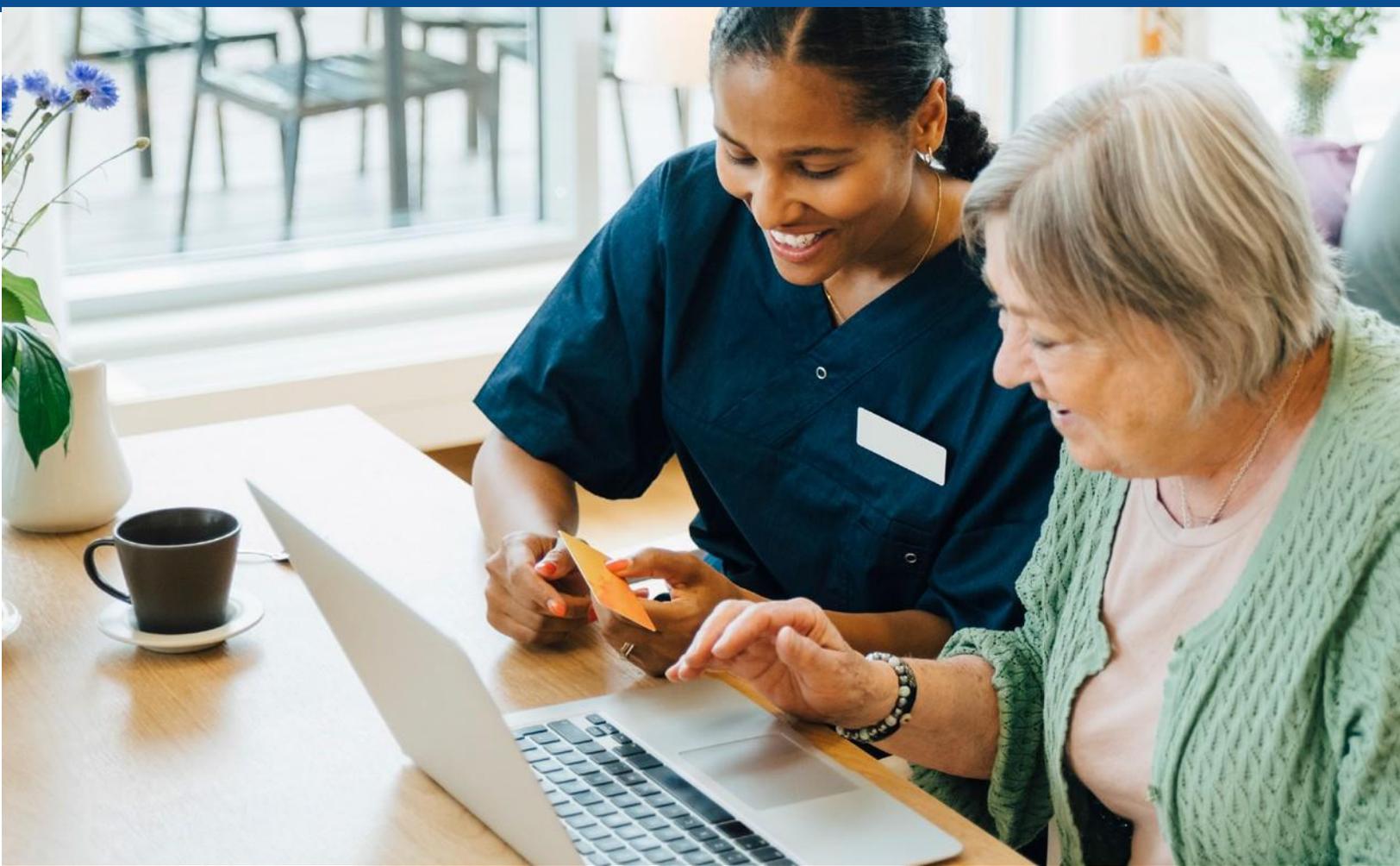
⁴ FIDE SNP plans are known as Medicaid Advantage Plus (MAP) plans in New York and are a combination of a Medicaid Managed Long-Term Care Plan and a D-SNP plan with exclusively aligned enrollment under the same sponsoring managed care organization.

We include findings from data gathered from May through June 2021 in interviews with the following types of key informants: NYSDOH staff, CMS Medicare Appeals Council representatives, ombudsman program officials, plan officials, and beneficiary advocates.⁵ The CMS Medicare-Medicaid Coordination Office (MMCO) compiled and provided RTI with results of an analysis of U.S. Department of Health and Human Services (HHS) cost data. CMS also provided RTI with information on demonstration policy and CMS demonstration activities during the first demonstration year.

For this report, the impact of the NY Integrated A&G demonstration on beneficiaries is based on information gathered from advocates, the State, and plans. Information on how providers experience the integrated process was unavailable for this report.

⁵ The evaluation team anticipates interviewing staff from the State hearing office in subsequent site visits. This information will be included in future brief reports.

SECTION 2
Integrated Appeals and Grievances
Process

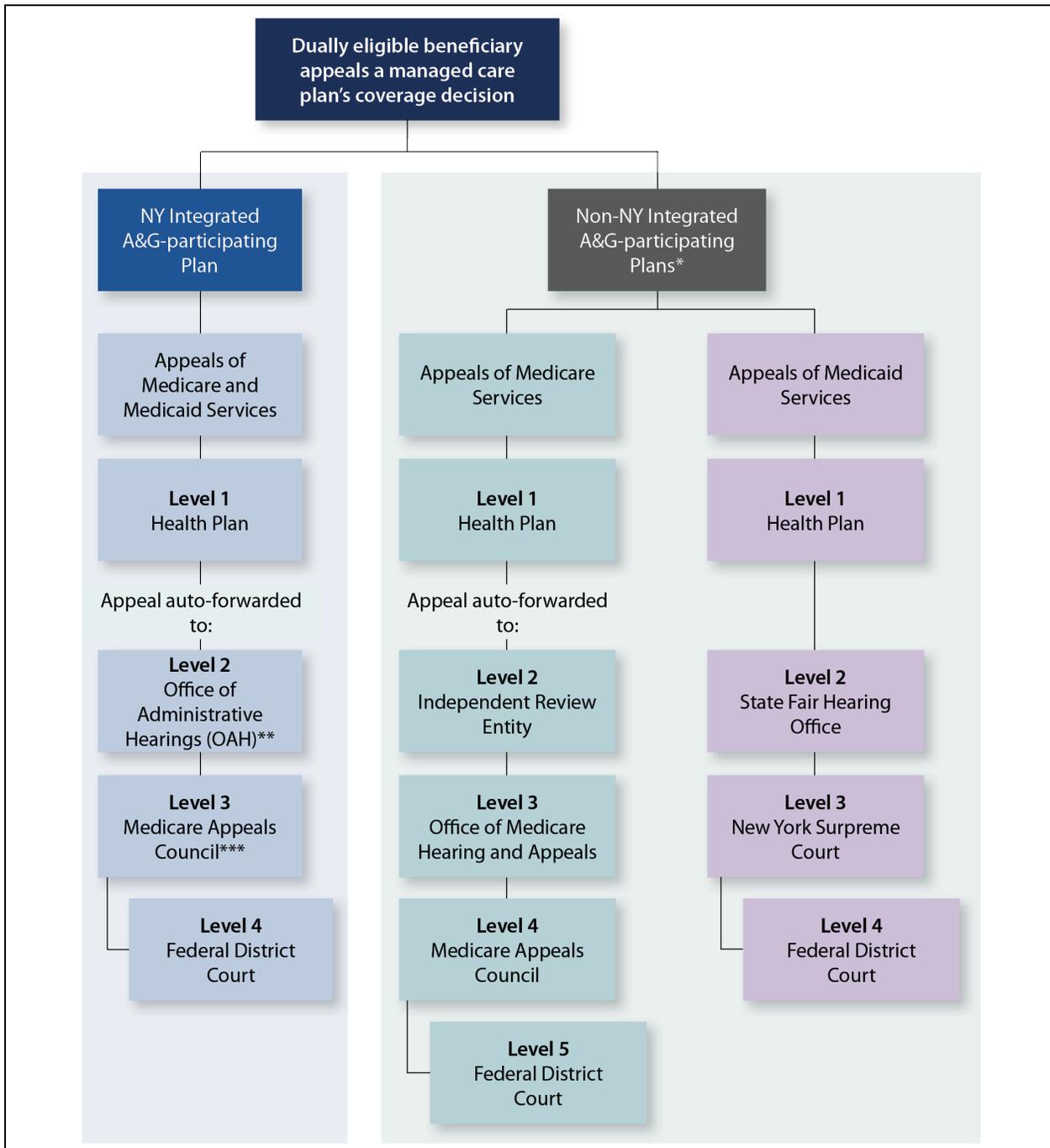


The key objectives of the demonstration are to improve beneficiary experience with the appeals process and to generate administrative streamlining and savings for plans, the State, and Federal agencies (MOU, 2020, p.2). To accomplish these goals, the NY Integrated A&G demonstration uses one appeals process for both Medicare and Medicaid covered services provided by the participating plans. A plan member who disagrees with a coverage decision first appeals to the participating plan for reconsideration. If the plan upholds its coverage decision,⁶ the appeal is automatically forwarded to the second level of appeal for a review by the Office of Administrative Hearings (OAH) at the New York Office of Temporary and Disability Assistance (OTDA). A member disagreeing with the OAH decision can initiate an appeal to the Medicare Appeals Council (MAC). If the member 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 member to navigate a single 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 (see *Figure 1*). For services that have Medicare and Medicaid coverage components (e.g., durable medical equipment), the beneficiary may have to pursue both appeals processes.

⁶ Other terms for this include “adverse decision” and “adverse appeal,” because these decisions are against the beneficiary.

Figure 1
Appeals process for dually eligible beneficiaries outside of the demonstration



Note: The enrollee initiates the appeal of decisions at every level except as noted.

* Could include Medicare Advantage, Medicaid mainstream managed care, and Medicaid managed long-term care plans.

**The Office of Administrative Hearings (OAH) at the New York Office of Temporary and Disability Assistance (OTDA) for the demonstration is located in New York City.

***The Medicare Appeals Council is a component of the U.S. Department of Health & Human Services, Departmental Appeals Board.

SECTION 3
Site Visit Findings



3.1 Impact on Beneficiaries

Plans, advocates, and State officials described the demonstration's simplification of the fair hearings process as a key benefit for beneficiaries. They noted that having a single avenue of appeal streamlined the process and lessened beneficiary confusion from having to understand different appeal notices and navigate variations in timeframes and hearing forums for Medicare and Medicaid appeals.

The simplicity of the process in terms of one path, one letter, regardless of the type of service—whether it is Medicare or Medicaid—for the most part makes it more member-centric and easier to navigate...I think it is a positive [member] experience that we've seen here in New York.

— FIDE SNP official, 2021

Advocates also believed that the NY Integrated A&G demonstration design feature that requires auto-forwarding of appeals to OAH following an adverse decision at the plan level provides significant benefits to beneficiaries. One advocate believed that beneficiaries were discouraged by an adverse decision at the first level review conducted by the plan and that without auto-forwarding, they let their appeals drop before being heard by an independent reviewer. Getting to the second level of appeal is an important step for beneficiaries because significantly more adverse decisions are overturned at the second level of appeal than at the first level. One advocate also noted that the auto-forwarding triggered services continuing pending the second level appeal outcome, another important benefit not available under the non-integrated appeals process for Medicare services.

While most advocates and plans had not heard directly from beneficiaries about their satisfaction with the NY Integrated A&G demonstration, one advocate suggested that any dissatisfaction stemmed from staffing shortages at OAH and communication from plans, rather than the demonstration design itself. For example, advocates reported that beneficiaries sometimes had difficulty reaching someone at OAH who could answer their questions about their appeal. Although plans use standardized notices to describe the appeals process and beneficiary rights, some plans appeared to send additional information about beneficiary appeals while others do not. We discuss these implementation issues in the relevant sections below.

3.2 Plan Experience

We interviewed a total of 18 staff from four participating plans in May 2021 about their experience with the NY Integrated A&G demonstration during 2020 and early 2021. The four plans accounted for over 90 percent of enrollees eligible for the integrated process. CMS and the State conduct quarterly calls with any plans that have more than a few appeals.

3.2.1 *Types of Appealed Services and Resolutions*

All four plans said most member appeals were for Medicaid long-term services and supports (LTSS)—especially personal care worker services, which one plan said made up about 70 percent of appeals. The plans said appeals of Medicare services were not very common.

The plans said that appeals were often overturned by OAH at the second level. One plan reported that 14 percent of enrollee appeals for LTSS services were upheld by OAH (the uphold rate), compared to 60–65 percent for similar appeals in its sister MLTC plan under the same parent organization. The plan suggested that some of the administrative law judges at OAH who handle the MAP appeals did not understand the policy governing the appeals and were perhaps prioritizing member concerns. The plan said the administrative law judges would request information that the plan thought was irrelevant to the appeal. Another plan said it had not noticed a difference in the uphold rate between the organization’s FIDE-SNP and MLTC plans. One plan said that as the demonstration has progressed, more of its decisions were being upheld.

3.2.2 *Successes and Challenges*

In general, the plans implemented the NY Integrated A&G demonstration successfully, but they also encountered several challenges, especially regarding the timeliness of scheduled hearings.

Successes

Transition to larger membership eligible for the NY Integrated A&G demonstration. All four plans leveraged their previous experience with the FIDA demonstration for the NY Integrated A&G demonstration. One plan reported it did not have to retrain its appeals staff because they were already familiar with the integrated process and how to apply both Medicare and Medicaid policy to appeals decisions. The other three plans trained staff on the integrated process, either as a refresher for staff that had worked on FIDA or as training for new staff. CMS provided clarification and guidance to plans on the NY Integrated A&G demonstration’s policies and procedures that differ slightly from FIDA.

Total enrollment across the six plans remaining in the FIDA demonstration at the end of 2019 was 2,320 (NYSDOH, 2019). Nearly all these enrollees transitioned into their FIDA plan’s sister FIDE-SNP plan at the start of 2020. Total enrollment in the eight FIDE-SNP plans participating in the NY Integrated A&G demonstration in January 2020 was 20,203 (NYSDOH, 2020a). Enrollment increased to 22,949 at the end of 2020 and to over 28,000 in June 2021 (NYSDOH, 2020b, NYSDOH, 2021). The State and advocates reported that the plans appeared to be handling the increased volume of appeals generated by the larger number of enrollees eligible for the integrated process well. They also noted that, for the most part, the plans were auto-forwarding the appeals and sending out evidence packets, which include medical records and any other information the plans used to make their appeal decisions, appropriately. Advocates noted that the plans’ familiarity with the integrated process from the FIDA demonstration helped to smooth out the NY Integrated A&G demonstration’s rocky start during the PHE.

Challenges

Timeframe between appeal and hearing date. All four plans described frustration about the length of time between the auto-forwarding of an appeal and the scheduling of a hearing date. The NY Integrated A&G demonstration requires plans to comply with policies set forth in Federal regulation 42 CFR § 422.629 and §§ 422.631 through 422.634, including responding to an appeal request within standard or expedited timeframes, depending on the service or health of the member.

In site visit interviews, three of the four plans said they treated appeals for personal care hours (the majority of appeals) as expedited, based on their understanding of State guidance, which says all appeals of Medicaid services that an enrollee currently receives must be expedited at the plan level. The plans expressed frustration with having to process and complete level one appeals for personal care hours in a 72-hour expedited timeframe, but once adverse decisions for personal care hours were auto-forwarded to OAH, they were not considered expedited appeals by OAH because the enrollee’s health was not in jeopardy while waiting for the decision. As a result, the plans were burdened by having to rush to deliver the notification and documentation to the member and OAH only to have OAH schedule a hearing for months later.

New York State DOH is a stickler that anything concurrent [services that are already being received by the enrollee] should be expedited, and they consider home health aide [personal care worker] services as concurrent, which follows the expedited process. So that means that about 95 percent of our appeals are expedited.

— FIDE SNP official, 2021

In addition to scheduling delays by OAH, hearings, even for appeals that were expedited at the first level, were often postponed (or “adjourned”) at the request of the member or their family. The plans said that sometimes the member or their family wanted extra time to provide information to support their appeal, and other times they would say they had either not received the evidence packet from the plan or they had received it but had since discarded it. These adjournments, which sometimes happened multiple times, resulted in hearings that could be 6 months or more after the member first appealed a coverage decision. For the plans voicing frustration about having to expedite personal care services appeals, the lag time between the initial appeal and the final hearing made it difficult to reconcile the requirement that appeals for these services really needed to be expedited at the first level if they were not expedited at the second level.

Three of the plans and beneficiary advocates said that because of the lag time in scheduling a hearing, the member’s condition had often deteriorated by the hearing date. At that point, the member, their advocates, or family would present additional documentation explaining the member’s need for a particular number of personal care hours. The plans reported that OAH made decisions based on the new documents that the plan had not had access to review before the appeal. OAH sometimes increased the number of personal care hours beyond what were originally being appealed. The plans voiced frustration that these decisions were not based on the same information that the plans had used to make the service determinations that were being

appealed. For example, the plans must use the Uniform Assessment System for New York (UAS-NY)⁷ to determine the level of care need for Medicaid home and community-based long-term services and supports. The plans said that the OAH would essentially make care decisions based on the new information presented by the member or their family months after the plans had conducted the assessment that had informed the original service determination.

Given the lag time between the appeal and the hearing date, one plan suggested that appeals for personal care hours should not be auto-forwarded and should instead be initiated by the member.

Staffing. Two of the four plans interviewed had to increase their staffing to accommodate the larger number of appeals from the increased membership eligible for the process. One plan said it was actively trying to increase staffing to ease the workload of its nurses who review appeals of plan coverage decisions, since these nurses had been inundated by the number of appeals they understood needed to be expedited. The fourth plan did not have to make any staffing changes to accommodate the NY Integrated A&G demonstration.

Communication with members. Plans and advocates generally agreed that the written notice of appeal approved by CMS and the State for the demonstration was fairly well-crafted. However, they reported confusion about the process, particularly following the initiation of an appeal. The plans said second-level OAH hearings often ended in default when enrollees failed to show up for the hearings. Plans said that beneficiaries did not always understand that if the plan continued its original service determination, the appeal would automatically be forwarded to the second level of appeal at OAH. This was different from what most enrollees had previously experienced in other plans—only former FIDA enrollees had experienced the integrated appeals process before the NY Integrated A&G demonstration began. One plan noted that some enrollees contacted their care coordinators asking why they were getting notices of a hearing when they had not requested one. In some cases, beneficiaries would call the plan, rather than OAH, to withdraw the appeal.⁸ Advocates said that some enrollees would initiate a request for a fair hearing when they wanted to appeal a coverage decision because that is the process they followed in their previous plans.

Advocates noted an apparent lack of uniformity in how plans notified enrollees that an appeal had been auto-forwarded. The standardized appeal decision notice that the plans use describes the auto-forwarding process for decisions that are partially or wholly against the enrollee, but there is not a standardized notice of confirmation that an appeal has been auto-forwarded. Advocates said that some plans appeared to be sending such an additional notice.

Advocates suggested that it might be helpful to have an additional standardized notice confirming that an appeal had been auto-forwarded, as OAH typically notified beneficiaries of their hearing date by telephone rather than in writing. When OAH called the enrollee to tell them about a hearing date, the enrollee would not always understand why a hearing had been scheduled and would withdraw the appeal. One plan also noted that because some enrollees did

⁷ The UAS-NY is an evidence-based, standardized assessment tool that is intended to facilitate access to programs and services, eliminate duplicative assessments, and improve consistency in the assessment process for Medicaid services (NYSDOH, n.d.).

⁸ Plans are not allowed to directly assist beneficiaries in withdrawing an appeal, but they do provide the contact information for IAHO in those cases.

not recognize the telephone number from OAH, they would not answer the call. Then, when the hearing date arrived, the beneficiary would not attend. OAH would consider the appeal abandoned by the beneficiary, known as ending in “default.” One plan said that after repeated hearing adjournments, members might not remember what the appeal was about and would fail to attend. Two plans said that the rate of appeals ending in default had gone up under the demonstration. Although a default ends the appeals process, thereby favoring a plan’s care decision, advocates noted that OTDA has a process whereby a beneficiary can request a hearing be reopened within 1 year of the missed hearing date.

The plans, beneficiary advocates, and the State also described challenges in ensuring members received evidence packets prior to an administrative hearing. The State said OAH adjourned (postponed) hearings when members had not received the documents from their plans. Hearing delays impact beneficiaries because, although they can continue to receive previously approved services while their appeals of stopped, reduced, or restricted services are being reviewed, they must wait for OAH’s decision if they are appealing a plan’s decision about a new service. The State raised this issue with the plans. In response, some plans started using delivery services, such as FedEx, to track and get signatures to document when members received the evidence packets. Others continued using the US Postal Service and called the members to ask if they had received the documents.

One plan instituted several changes to address this issue, including calling the member directly after the first level of appeal and providing information about the process and sending hearing documents with tracking information and a required signature upon delivery; 3 days before the hearing, an appeals and grievances coordinator from the plan, typically a nurse, then called the member again to remind them of the hearing and inquire again about the evidence packet. Another plan said that even when members had received the evidence packet, by the time of the hearing, they may have thrown it out, causing the hearing to be rescheduled and the packet re-sent. The State reported that adjournments due to the enrollee not receiving the evidence packets decreased as the demonstration progressed.

Communication with OAH. The email-based communication process between OAH and the plans presented challenges, especially when sharing large files with protected health information. Due to the increased volume of appeals it received compared to the volume received under the FIDA and FIDA-IDD demonstrations, OAH staff were unable to retrieve many of the emails and attached documents before the links to open the encrypted files expired. This required the plans to re-send the information and created further delays. Two plans suggested the State use a secure file transfer protocol or establish an online portal to upload the appeals documentation to facilitate this process.

3.3 State Experience

State officials and advocates reported OAH was short-staffed, especially at the start of the demonstration in early 2020. They said OAH received approval to hire additional staff at the end 2019 and was able to hire some new staff at the beginning of 2020. However, the State was challenged maintaining full staffing levels due to other staff retirements and turnover and the PHE. Recruiting and hiring replacement staff continued to be challenging throughout the year. Advocates and plans described instances when they called OAH and the phone went unanswered. Staffing shortages contributed to a significant backlog of cases in 2020.

Through monthly calls with NSYDOH, OTDA, and MAC Department of Appeals Board, CMS reported closely following OAH's inability to meet the timeframe requirements for adjudicating appeals and staffing the second level appeal hearings. CMS noted that, as a direct result of requesting NYSDOH to increase OAH staffing or risk termination of the demonstration, the State was able to secure funding for over 20 full-time positions to address the staffing shortage in Fall 2020. CMS also provided training on Medicare policy for OAH staff in summer and fall of 2020. The State reported that, to date, it was still actively trying to increase staff at OAH to meet the needs of the demonstration.

State staffing challenges also hindered Medicaid policy training for new MAC staff. MAC staff were trained on Medicaid policy by New York staff when the FIDA demonstration began in 2015, but MAC would like to repeat the training to expand the number of staff who can handle the integrated appeals, in anticipation of more cases as enrollment in the demonstration increases.

OAH heard and decided on 650 appeals during the first demonstration year. Ninety-four percent (614) were appeals for personal care services. Thirty-nine percent (237) of the personal care service appeals were upheld, and 45 percent (277) were overturned in favor of the enrollee. The number of appeals that were waiting to be heard was not made available. **Table 1** shows the number of appeals and their outcomes by service category.

Table 1
Total appeals decided by OAH, by outcome, January 1, 2020, through December 31, 2020

Service category	Upheld plan decision	Overturned plan decision	Decided by stipulation	Total	Percent of total
CDPAS/Personal Care Services	237	277	100	614	94%
Inpatient Hospital Stay	0	0	0	0	0%
DME	7	1	0	8	1%
Dental	3	2	0	5	1%
Nutritional Shake	4	1	5	10	2%
Other	8	4	1	13	2%
Total	259	285	106	650	

CDPAS = Consumer Directed Personal Assistance Services; DME = durable medical equipment.
SOURCE: CMS, 2021.

The State information technology (IT) system is not set up to allow OAH staff, plans, or enrollees to track appeals through the process. The State said it would be better to have an IT system that allowed for communication, document exchange via portal, and notifications for beneficiaries.

One plan discovered that, due to an internal issue that persisted over a 6-month period, several hundred appeals had not been auto-forwarded to OAH. The plan reported this issue, and the State and CMS put in place a remediation plan for those appeals. Although the auto-forwarding issue was a procedural error on the part of the plan, the State said the number of appeals reported by the plan through quarterly reports did not indicate an obvious drop in the

number of expected appeals. In addition to the remediation plan, the State required the plan to report on auto-forwarded appeals on a weekly basis.

The State supported the integrated appeals and grievances process and said that it is an important piece of integrated care. However, officials also noted that the NY Integrated A&G demonstration resulted in increased costs for the State in staffing, training, and IT. The State now must devote staff time and resources to hearing Medicare appeals that it normally does not deal with in the non-integrated appeals process. Advocates also recognized the State's burden of expanding the integrated process to an enrollment many times larger than under the original FIDA and FIDA-IDD demonstrations.

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SECTION 4

Impact on Medicare Costs



4.1 Medicare Cost Analysis

MMCO provided RTI with its own 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 2020 appeals cost estimates under the demonstration against what would have happened absent the demonstration for the same time period. Both estimates were based on the same population: 20,450 enrollees in FIDE-SNP plans in December 2020. This total included 2,308 individuals who had previously been enrolled in the FIDA demonstration as of the end of 2019, plus 18,142 other FIDE-SNP enrollees covered by the integrated appeals and grievance system in 2020.

MMCO estimated costs of appeals absent the demonstration by first estimating the number of beneficiaries who, after FIDA 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 \$94,034 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 2020. 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.

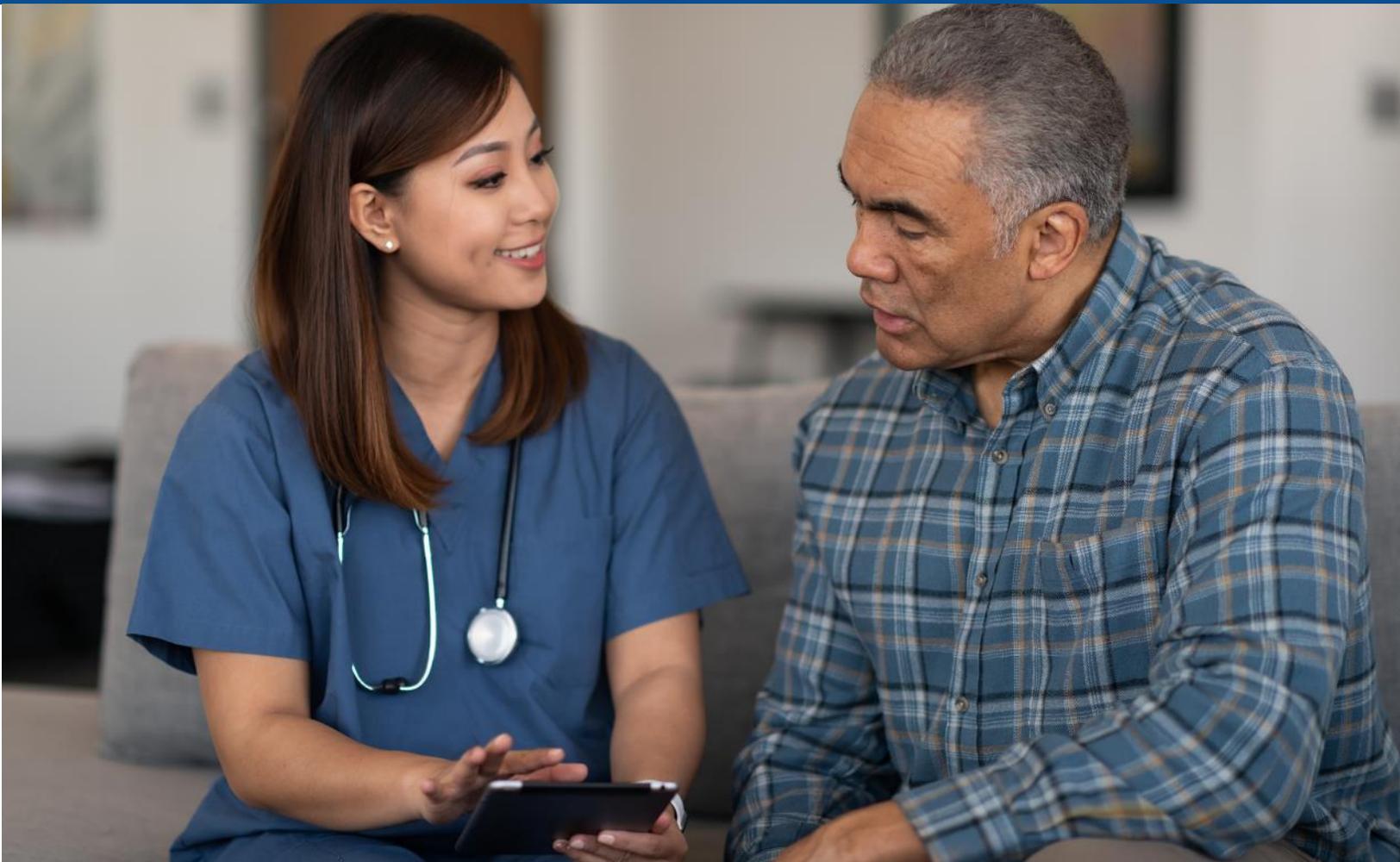
Only five FIDE-SNP appeals reached the fourth level during 2020. However, due to delays in submitting and processing appeals, many 2020 appeals were not heard until 2021. For the sake of annual cost estimates, MMCO assumed the same percentage of backlogged appeals would ultimately reach the fourth level as those that were heard during the calendar year, and MMCO treated those as 2020 costs despite the delays. That produced an estimate of nine fourth-level appeals for the year as a whole, which, under the terms of the demonstration, would result in \$90,000 billed to the demonstration for all 2020 appeals.

4.2 Impact on Medicare Costs

The estimated annual Federal Medicare costs to the appeals system under the demonstration (\$90,000) was comparable to estimated costs absent the demonstration (\$94,034). Therefore, the data from MMCO indicates that the demonstration did not materially change Medicare costs to the appeals system.

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SECTION 5
Conclusions and Next Steps



The State, CMS, plans, and stakeholders generally viewed the NY Integrated A&G demonstration as valuable for beneficiaries because of its unification of an otherwise divided appeals process and because it is consistent with the CMS and State larger goals of integrating Medicare and Medicaid for dually eligible beneficiaries. MMCO's cost analysis findings indicate that the integrated process did not appear to increase or decrease Medicare costs of adjudicating appeals during 2020.

The demonstration faced implementation challenges as it widened the scope of the integrated process to the larger FIDE-SNP enrollment, and these challenges were likely exacerbated by the PHE. In particular, delays in scheduling and hearing second level appeals due to OAH staffing shortages caused frustration for plans, especially when there was conflicting guidance about expedited appeals. Beneficiaries also found aspects of the process confusing. There was a lack of uniformity in how and when beneficiaries were provided notice of auto-forwarding and scheduled hearings, increasing the level of adjournments and defaults.

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

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