

...[Slide #1] Medicare – How It’s Changing to Help More People:
A Teleconference Series for Health Care Professionals
Appeals and Grievances

December 20, 2005
Noon EDT

BETH WITTEN: Hi, everyone. My name is Beth Witten. I am the Medicare Modernization Programs Manager for the National Kidney Foundation.

[Slide #2] The Kidney Medicare Drugs Awareness and Education Initiative was established to inform professionals and people with kidney disease about Medicare prescription drug coverage.

[Slide #3] Over 35 organizations, representing patients, professionals of all disciplines, government, and industry, have participated in it.

We’re glad you joined us today, and I’d like to welcome you to the fifth teleconference that is part of this initiative. The series is entitled *Medicare -- How It’s Changing to Help More People*.

[Slide #4] As you may remember, our August teleconference described changes to Medicare, showed how those with limited income and resources could take advantage of extra help, and how Medicare beneficiaries could potentially benefit from the changes in Medicare.

Our September teleconference addressed how Medicare’s new drug coverage will coordinate with other types of drug coverage that patients may already have.

Our October teleconference discussed tips to help you help your patients choose a plan.

Our November teleconference addressed formularies, exceptions, and coverage determinations.

And, today, we will cover the processes required to file appeals if services or payment for services are denied and grievances if there are complaints about how the Medicare health plan is giving care.

If you missed any of these teleconferences you can find the transcripts, audio, and slides on our website at www.kidneydrugcoverage.org. Click on *Teleconferences*. Look for the *Teleconference Archive*. You can download and print the slides and transcript. If you have speakers on your computer, look for the presentation that has sound and slides synched so you can hear the speakers and see the presentation at the same time.

[Slide #5] As you probably know, the first day for anyone with Medicare to join a Medicare drug plan was November 15. Those with Medicare and Medicaid have a few more days this month to choose a plan before coverage under the plan Medicare picked for them takes effect January 1. Even after that date, they can change plans as often as once a month, with their new plan starting the following month. Although everyone has until May 15, 2006 to choose a plan before possibly facing penalties or limited periods to join, they can start saving on January 1 if they join a plan by December 31.

Our goal is to help people with kidney disease and kidney failure make the best decision about whether they need a Medicare drug plan and, if so, which plan will help them afford to take the drugs they need to live long, healthy, and enriched lives. We know this is what you want, too. This teleconference series is one of many ways the Kidney Medicare Drugs Awareness and Education Initiative is working to meet that goal.

So let's get started. I'd like to introduce you to our moderator, Duane Dunn, who is the lead social worker for DaVita, Inc. Duane will introduce our other speakers. Duane?

DUANE DUNN: **[Slide #6]** Thank you for inviting me here today to moderate this teleconference on appeals and grievances. With us today we have Vicki Gottlich, Senior Policy Attorney at the Center for Medicare Advocacy, Inc., where she provides legal assistance, research, consultation, and litigation support regarding Medicare and employer-sponsored health benefits, and John Scott from the Center of [sic] Beneficiary Choices at the Center of [sic] Medicare and Medicaid Services. John drafted CMS's regulation on Part D grievances, coverage determinations, and appeals based on statutory provisions contained in Section 1860D-4 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

DUANE DUNN: First, Vicki, can you remind us what coverages [sic] determination is?

VICKI GOTTLICH: **[Slide #7]** Yes. Thanks for inviting me here today to talk with your listeners about their right to appeal and to file a grievance against a Medicare drug plan. I've listened to your November teleconference. Speakers described formularies, which are lists of covered drugs, tiers which set co-payments or coinsurance, and coverage limits, such as prior authorization, quantity limits, and step therapy.

[Slide #8] They talked about the exceptions process. A plan member may request a formulary exception if a prescribed drug isn't on the formulary and the member cannot take a drug on the plan-sponsored formulary for reasons of medical necessity. A plan member may request a tiering exception if the member cannot take a preferred drug with lower cost sharing for reasons of medical necessity.

To request an exception, the plan member can ask the prescribing physician to certify that the prescribed drug is medically necessary for treating his or her condition, and the preferred or other formulary drug for treating that condition would not be as effective or would have an adverse effect for the member.

[Slide #9] In general, plan sponsors must notify enrollees of their decisions as quickly as the enrollee's health condition requires, but no later than 72 hours for a standard request or 24 hours for an expedited request. If a member requests an exception, the plan sponsor must notify the enrollee no later than 72 or 24 hours after receiving the prescribing physician's supporting statement.

A request for a coverage determination or exception can be expedited if the plan determines, or the enrollee's prescribing physician indicates, that applying the standard time frame may seriously jeopardize the Medicare plan member's life, health, or ability to regain function. If a plan sponsor does not notify the member of its decision within the applicable time frame, the plan sponsor must automatically forward the member's request to the independent review entity, or IRE, for review.

DUANE DUNN: John, what is an appeal and when might a Medicare drug plan member file one?

JOHN SCOTT: **[Slide #10]** I'm glad to be here today to help explain the Part D grievances, coverage determinations, and appeals processes. In general, a Medicare beneficiary may file an appeal if a Medicare contractor denies a request for health services or payment for services that are already provided. In the case of the Part D Medicare drug benefit, the appeals process is very similar to those processes applicable under Medicare Advantage—that is Medicare HMOs, PPOs, Private Fee-for-Service, and Special Needs Plans.

Under Part D, a Medicare drug plan member can appeal a plan sponsor's decision to deny drug coverage, which includes a plan sponsor's decision to deny payment for a drug obtained by an enrollee. A plan sponsor may deny coverage, for example, because the drug is not on the plan's formulary, is not considered medically necessary, or is furnished by an out-of-network pharmacy.

As Vicki stated, if a plan sponsor doesn't notify the enrollee of its coverage determination within the established time frame, the request is automatically forwarded to the IRE for review. A plan member can also appeal when a request for an exception is denied or if he or she is unhappy with a plan sponsor's decision regarding co-payment or coinsurance.

DUANE DUNN: How does a Medicare drug plan member learn about the appeals process?

JOHN SCOTT: **[Slide #11]** Each Medicare Prescription Drug Plan, or PDP, and Medicare

Advantage plan that offers benefits under Part D, or an MA-PD, must provide a written description of its appeals process in its membership materials sent to each Medicare drug plan member. Medicare drug plans should also provide information about appeal rights on request, and when the plan sponsor issues a coverage determination or—I would rather say issues an adverse coverage determination or redetermination.

DUANE DUNN: Is the appeal process the same for all Medicare drug plans?

VICKI GOTTLICH: [Slide #12] No, but each drug plan must give the plan member information and details of the plan's specific appeals process when he or she enrolls. Some members, of course, may not read the information or may not remember the information provided upon enrollment, so when a pharmacy determines that the plan will not pay for a drug, the drug plan member will be told to contact his or her plan for more information.

DUANE DUNN: John, what decisions can be appealed?

JOHN SCOTT: [Slide #13] I said earlier, only adverse coverage determinations are subject to appeal. These types of determinations include—the plan's decision not to pay for a prescribed drug because the drug is excluded by the Part D plan sponsor; is not on the plan's formulary; is not considered medically necessary; or was furnished by a non-network pharmacy. Also, other decisions include a plan sponsor's denial of the formulary or tiering exceptions request; a plan sponsor's failure to provide a timely determination when a delay would be harmful or adverse to the beneficiary; and that plan sponsor's decision about how much the member is required to pay for a Part D drug.

[Slide #14] Any time a plan sponsor issues an adverse decision, it must notify the enrollee of this adverse decision in writing. However, the plan sponsor may satisfy the applicable time frame requirement by providing notice orally, so long as the sponsor also sends a written follow-up notice to the enrollee within three calendar days after providing the oral notice.

[Slide #15] Note that the transaction that occurs at the pharmacy counter is not a coverage determination. Enrollees must formally request coverage determinations from their plan sponsors. However, plan sponsors are responsible for coordinating with their network pharmacies to either post or distribute a standard notice that explains the enrollee's right to request a coverage determination or exception if the member disagrees with the information provided by the pharmacist.

DUANE DUNN: Vicki, what are the steps in an appeal?

VICKI GOTTLICH: There are actually five levels of the appeals process. Each decision explains the procedures that enrollees must follow to request an appeal.

[Slide #16] First, an enrollee can file an appeal if the plan makes an adverse coverage determination, including an adverse decision about an exception request. This is called a *redetermination*. An enrollee has 60 calendar days from the date of the denial to file a request for redetermination with the plan. The enrollee or the enrollee's appointed representative must file standard requests in writing unless the plan accepts requests for redetermination by phone. Expedited requests may be filed orally or in writing. The enrollee and/or his or her physician can provide supporting evidence in writing or in person. Note that the in-person requirement does not require plan sponsors to provide actual in-person hearings for enrollees. If a member submits a request for a standard redetermination, the plan sponsor must notify the enrollee of its decision in writing no later than seven calendar days after receiving the request. If the member's life, health, or ability to regain maximum function may be seriously jeopardized by waiting seven days, the member or his or her appointed representative or doctor can request an expedited appeal. If the plan grants the request to expedite, or the enrollee's physician makes or supports the request to expedite, the plan sponsor must notify the enrollee of its decision within 72 hours after receiving the request.

[Slide #17] Second, if the Medicare drug plan makes an unfavorable redetermination, the enrollee or appointed representative may file a written request for a *reconsideration* with the independent review entity, or IRE. The IRE is an entity contracted by CMS to review such denials. The request for reconsideration must be filed within 60 days of the date of the redetermination denial. Again, the request can be filed as a standard or expedited reconsideration. A doctor with expertise in the medical field where that drug is used must review any denial that is based on lack of medical necessity. The IRE must solicit the prescribing doctor's opinion, and the doctor's oral or written opinion must be included in the record. For standard requests, the IRE must notify the member of its decision no later than seven calendar days after receiving the request. Again, if the member's life, health, or ability to remain...to regain maximum function may be seriously jeopardized by waiting seven days, the member or his or her appointed representative or doctor can request an expedited appeal. If the IRE grants the request to expedite, or the enrollee's physician makes or supports the request to expedite, the IRE must notify the enrollee of its decision within 72 hours after receiving the request.

[Slide #18] Third, if the IRE decides against the enrollee, the enrollee can request a *hearing with an administrative law judge*, or ALJ. The enrollee must submit his or her request in writing within 60 days from the date of the IRE decision. The IRE decision explains where the request must be filed and the minimal dollar amount that must be met to obtain an ALJ hearing. For 2006, the minimum dollar threshold for obtaining an ALJ hearing is \$110. This amount may change each year.

[Slide #19] Fourth, if the ALJ rules in favor of the plan, the enrollee or appointed

representative can request a *review by the Medicare Appeals Council*, or MAC. The MAC is an entity under the Department of Health and Human Services that reviews adverse decisions made by ALJs. The request must be filed in writing within 60 days of the ALJ's decision.

[Slide #20] The fifth and final level of appeal—if the Medicare Appeals Council does not reverse the plan sponsor's decision—is for the enrollee or appointed representative to *appeal the MAC's decision to a federal district court*. The request must be filed in writing within 60 days from the date of the MAC's decision. In addition, the amount remaining in controversy must meet a minimum dollar amount. For 2006, the minimum dollar threshold is \$1,090. Again, this amount may change each year.

DUANE DUNN: John, what is CMS's responsibility in the appeals process?

JOHN SCOTT: **[Slide #21]** CMS is responsible for monitoring plans to ensure that plans are complying with our regulatory requirements and other guidance. If CMS determines that a plan sponsor is not satisfying Medicare's requirements, CMS can take enforcement action against the plan.

DUANE DUNN: Vicki, does the expedited appeal process ensure that there are no gaps in coverage?

VICKI GOTTLICH: **[Slide #22]** No. Even with these protections, there may be some period of time during which a plan enrollee has a temporary gap in coverage while the exception or appeal is underway. However, CMS has required plan sponsors to provide continued coverage or temporary supplies of medications in certain circumstances. For example, plan sponsors must provide temporary supplies of medications to members residing in long-term care facilities while their exceptions are being adjudicated. It is important to emphasize the point that the supply is only temporary; plan sponsors are not required to continue providing a supply throughout the life of the appeal.

DUANE DUNN: The next teleconference on January 17 will address concerns about gaps in coverage and will provide suggestions for ways to help to fill these gaps. These processes sound like they could be complicated. Can Medicare beneficiaries obtain health following appeal?

VICKI GOTTLICH: **[Slide #23]** A Medicare beneficiary can appoint a representative to act on his or her behalf in the Part D appeals process. The appointed representative has all of the same rights and responsibilities of an enrollee in obtaining a coverage determination or with any level in the appeals process. The appointed representative may, for example, make requests, present or elicit evidence, or receive any notice in connection with the appeal that would have been sent to the enrollee. Appointed representatives who are not providers can and sometimes do charge a fee. They may need approval from the ALJ if the appeal reaches that

stage.

The form that the Medicare plan member would use to appoint a representative is CMS-1696. It can be found online on the Medicare website, www.Medicare.gov. Look under Medicare Appeals and find Appeal Forms.

In addition, an individual may be authorized under State or other applicable law to act on behalf of an enrollee in obtaining a coverage determination or in dealing with any of the levels of the appeals process, and an enrollee's prescribing physician may request a standard coverage determination, expedited coverage determination, and expedited redetermination on an enrollee's behalf without being the enrollee's appointed or authorized representative.

DUANE DUNN: I think we've covered the appeals process. Our patients and staff should understand that the [plan] enrollment materials must include information about appeals. John, what is a grievance?

JOHN SCOTT: [Slide #24] All organizations that sell Medicare drug plans must have a grievance process to help Medicare beneficiaries resolve complaints about issues that do not involve coverage determinations. A Medicare beneficiary can use the plan's grievance process when he or she is dissatisfied with any aspect of the Medicare drug plan's operations, activities, or behavior, including to express dissatisfaction about a pharmacy, pharmacist, a pharmacy benefit management program, or any of these entities' representatives.

DUANE DUNN: Vicki, who decides whether a Medicare drug plan member complaint is an appeal or a grievance?

VICKI GOTTLICH: [Slide #25] A plan reviews each complaint that it receives and decides whether the complaint is an appeal or grievance. There are then different processes for each.

DUANE DUNN: John, can you share with us the type of grievances and provide some examples?

JOHN SCOTT: [Slide #26] As stated previously, a grievance could involve any issue that does not involve a coverage determination. For example, complaints that fall into the grievance category include, but aren't limited to—difficulty getting through on the phone; the quality of care or benefits provided; interpersonal aspects of care, such as rudeness by a pharmacist or staff member; a complaint about a plan's benefit design structure; a plan sponsor's failure to issue a decision in a timely manner—I'd like to note here, though, that this type of grievance is not a substitute for the plan's responsibility of automatically forwarding the enrollee's request to the IRE if the plan fails to act timely, but this type of grievance is an additional right that may be exercised by the enrollee. Also, other types of grievances include—a plan sponsor's denial of an enrollee's request for an expedited coverage determination

or expedited redetermination; complaints about the appeals process; or complaints about a plan's written communications, including its written notices.

DUANE DUNN: When a Medicare plan member files a grievance, what can he or she expect the plan to do to resolve it?

JOHN SCOTT: [Slide #27] Medicare drug plans use dispute resolution techniques designed to ensure that disagreements over treatment or quality are considered in a structured manner. Unlike a coverage determination, a grievance does not go through a formal administrative appeals process.

DUANE DUNN: Vicki, how often must Medicare drug plans report grievances to CMS?

VICKI GOTTLICH: [Slide #28] Medicare drug plan sponsors must report all grievances that they have received quarterly.

DUANE DUNN: What are the procedures for [filing] a grievance, and what kind of response can a beneficiary expect when a grievance is filed?

VICKI GOTTLICH: [Slide #28] Each drug plan must provide meaningful procedures for timely hearing and resolving grievances. A drug plan member has 60 days to file a grievance after the event that precipitated the grievance. The enrollee may file the grievance by phone or in writing.

The drug plan must notify the member of its decision as quickly as the case requires, based on the member's health status, but no later than 30 days after receiving the grievance. The plan can extend the deadline by up to 14 more days if additional documentation is needed and the plan sponsor documents that the delay is in the best interests of the enrollee.

If an enrollee files a grievance because a plan sponsor refused to expedite a coverage determination or redetermination and the enrollee has not yet purchased or received the drug in dispute, the plan sponsor must respond to the enrollee's grievance within 24 hours.

DUANE DUNN: In the time we have left, let's take some questions people have sent to us about Medicare Part D appeals and grievances. These and other questions will be posted with the answers on www.kidneydrugcoverage.org.

John, what can [a] Medicare beneficiaries do if a salesman representing a company comes to his or her door asking to see the medication he or she is taking and asks for personal information in an [effort] to sign the person up for a plan?

JOHN SCOTT: [Slide #29] Plan sponsors are not supposed to sell Part D plans door-to-door. Plans can call a Medicare beneficiary so long as he or she is not on the "do not call" list. If someone tries to sell a plan door-to-door, the Medicare beneficiary

should file a complaint with 1-800-Medicare, and calling 1-800-Medicare, they could also ask that the Medicare Ombudsman review the complaint.

DUANE DUNN: Vicki, many people with Medicare have limited income and may not be able to hire an attorney to help with an appeal. Where can someone turn if he or she cannot afford to hire an attorney?

VICKI GOTTLICH: [Slide #30] First, an individual can file an appeal without the assistance of an attorney. If someone wants legal representation and cannot afford an attorney, he or she may be eligible for free legal assistance through the state's legal services program or state department on aging. They can call their state or county bar association for more information.

DUANE DUNN: John, how will appeals to an independent review entity be handled?

JOHN SCOTT: [Slide #31] CMS is required to contract with an independent review entity, IRE, to review adverse redeterminations that are made by the plan sponsor and coverage determinations. In addition to that, their plan sponsors are—excuse me, the IRE is required to review coverage determinations or redeterminations that aren't made within the applicable time frame by the plan sponsor. In September, CMS awarded the IRE contract to MAXIMUS, Inc., the same entity that's responsible for reviewing subsidy—or that was responsible for reviewing subsidy eligibility appeals under the Medicare prescription drug discount card program and performing the IRE function under the Medicare Advantage program. MAXIMUS has successfully demonstrated its ability to increase its staff in response to increasing workload.

DUANE DUNN: [Slide #32] Well Well, that's about all the time we have for questions. To review, in today's teleconference, we've learned -- all PDPs and MAPDs must provide written notification to enrollees of their appeals and grievance rights; there are deadlines for appeals and grievances; plans decide whether a complaint is an appeal or a grievance; the appeal process includes [an] review of the plan, an IRE review, a review by knowledgeable MD, and even courts, if necessary; grievances are handled by the plan using a structured approach; CMS receives quarterly notice of complaints; there could be a gap in coverage [if the disputed drugs] during an appeal.

I'd like to ask [Betty](sic) Witten to say a few words to conclude our teleconference.

BETH WITTEN: [Slide #33] I'd like to thank Duane Dunn, Vicki Gottlich, and John Scott for sharing their time and expertise with us today.

[Slide #34] As we've said before, although Medicare prescription drug coverage will help some people afford drugs they need, others may not need this coverage. Most of what you read is for the "average" person with Medicare. The Kidney

Medicare Drugs Awareness and Education Initiative and its participating organizations have kidney-specific information to help patients make informed decisions about whether to join a Medicare drug plan. Those who now have or choose plans that cover their drugs will fare better than those who don't.

One way social workers can help their patients is to ask them to bring in notices they get from government agencies, employers, health plans, or Medicare drug plans. Social workers can explain these notices, see if current coverage is creditable, help patients review options, and keep a copy of notices in case your patients need them later.

[Slide #35] We want to thank all our listeners for joining us and helping us inform patients who have Medicare about the new drug benefit. We hope this teleconference has helped you understand more about appeals and grievances. We are planning at least one more teleconference over the next few months. Be patient. Our motto is the right information at the right time.

[Slide #36] Our next teleconference will be on Tuesday, January 17, 2006, when we'll discuss helping to fill the coverage gap. You can participate live at noon Eastern Time or access our teleconferences later in the teleconference archive on www.kidneydrugcoverage.org.

Under today's teleconference date, there's a link to today's slides. We'll post the transcript and a presentation that synchs sound and slides in the same place on the website. Register at www.kidneydrugcoverage.org to get notice about our free teleconferences and website updates.

Now, you'll find four new booklets for patients and a *Compare Drug Plans* packet intended to guide patients and healthcare professionals through the process of comparing plans for key drugs, and those are available on the website. Soon you'll find 40 fact sheets for patients based on their treatment, finances, and current drug coverage.

If you'd like an attendance certificate for today's teleconference, go to www.kidneydrugcoverage.org. Look under the teleconferences for today's date and topic and complete the online evaluation. Check with your licensing agency to find out if you can get continuing education credit using this certificate. Also, feel free to submit your questions about this topic and future teleconference topics by emailing us at info@kidneydrugcoverage.org.

Thank you for listening. We look forward to your evaluations and hope you will listen in next month. Finally, I'd like to conclude today's teleconference by wishing everyone a safe and happy holiday season!