# New Medicare Process: Limited Appeal for Elderly?

BY JOYCE FRIEDEN
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A new process for appealing Medicare coverage denials is raising concern among some advocates for senior citizens.

"We're concerned about the ability of beneficiaries to get a fair and favorable hearing," said Vicki Gottlich, senior policy attorney at the Center for Medicare Advocacy, a Mansfield, Conn.–based group that helps beneficiaries with the appeals process. Under the new process, which began on July 1, beneficiaries and providers whose claims are denied will be asked to appeal their claims to an administrative law judge (ALJ) via teleconference. Previously, these appeals were made in person.

"Older people and people with disabilities will have problems" with teleconferences, especially if their vision or hearing is impaired, Ms. Gottlich said. And if they ask for an in-person hearing instead, beneficiaries will waive their right to a timely decision if that request is granted. The new process also specifies that there will be three "regions" for hearing cases in person, rather than beneficiaries being allowed to have hearings in their home states.

Department of Health and Human Services spokesman Bill Hall said there are logistical reasons for waiving the right to speedy resolution in the case of an in-person hearing.

"We have to schedule everyone, allow time for them to travel, and set up a facility for the hearing," he said. "So logistics must come in play. That doesn't mean we'll take a year to do it."

Ms. Gottlich noted that the changes were made in the first place in part because members of Congress were dissatisfied with how long it was taking for beneficiaries to make their way through the appeals process.

"The changes are supposed to protect beneficiaries," but the system needs better funding to make sure everyone gets their chance to be heard in a timely way, she said. "There are some cases where teleconferencing could work, but for an individual beneficiary who's gone through the whole inhuman system and wants to see a real person, the system doesn't really work."

Another change in the process places administrative law judges under the jurisdiction of HHS, rather than the Social Security Administration. Further, judges are instructed to place more weight on Medicare regulations than they were before. "The [law] says the administrative law judge is supposed to be independent of [the Centers for Medicare and Medicaid Services], but now they are supposed to give deference to their rules," Ms. Gottlich said.

Mr. Hall said that his agency "has gone to great lengths to be sure this is a fair process." Questions about how well the new system will work "are virtually impossible to answer because we haven't even heard the first case yet. I think it's a lot more fair to ask these questions a year from now."

The Medical Group Management Association, which represents medical practice managers, is one group that is very interested in how the appeals process plays out. "We have concerns about how effective arbitration or review will be through a distance," said Jennifer Miller, external relations liaison at MGMA's Washington office. "How effective can someone be to advocate their position over teleconference? "

Ms. Miller added that MGMA supports having the judges hired by HHS rather than the Social Security Administration. and they are not concerned that being hired by HHS will bias the judges too much, she added.

Several senators expressed concern about the changes. A bill, the Justice for Medicare Beneficiaries Act, sponsored by Sens. Christopher Dodd (D-Conn.), Edward M. Kennedy (D-Mass.), John Kerry (D-Mass.), and Jeff Bingaman (D-N.M.) was introduced earlier this summer and would reverse many of the changes.

For instance, the bill says that judges "shall not be required to give substantial deference to local coverage determination, local medical review policies, or Centers for Medicare and Medicaid Services program guidance." The measure also calls for appeal hearings to be in-person "unless such individual requests that the hearing be conducted using tele- or video conference technologies." The bill was referred to the Senate Finance Committee. ■



# Onus on Physicians to Clarify Patients' Part D Drug Benefits

BY NELLIE BRISTOL
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WASHINGTON — Physician obligation to help patients negotiate the upcoming Medicare Part D outpatient drug benefit will result in "another unfunded mandate" for Medicare providers, Ronald Castellanos, M.D., chairman of the Practicing Physicians Advisory Council said at the group's recent meeting.

Noting that patients are most likely to rely on their physicians for aid in choosing among the new drug plans, Dr. Castellanos said, "Basically what you're doing is putting the burden on physicians in their offices to really educate the Medicare recipient."

PPAC members asked the Centers for Medicare and Medicaid Services to make educational materials as simple as possible, including information on whether beneficiaries are eligible for the low-income portion of the program.

"I really want a lot of information, very digestible," said PPAC member Geraldine O'Shea, D.O., an internist from Jackson, Calif. "Something very easy for them to understand, because I do not want to take time out of my time to do medicine with my patient to say, 'Well, let me see your tax return.' "

"We are trying to make the information available as simple as possible," said Jeffrey Kelman, M.D., medical officer for the CMS Center for Beneficiary Choices.

Council member Barbara McAneny, M.D., an oncologist from Albuquerque, requested that the agency develop a computer program that would allow physicians to type in the drugs a patient is using and come up with the plan that would cover all of them. She also proposed a draft recommendation that would require CMS to develop a reimbursement code for physician time spent on drug plan education, but it was voted down by the panel, with members saying it wasn't practical.

Walking through the benefit, Dr. Kelman said CMS is getting "much more robust formularies" from drug plans than officials had anticipated. "They're looking like commercial formularies," he said. He added that the formularies would be available on the Web site in October.

All drugs approved by the Food and Drug Administration must be on the formularies, Dr. Kelman said. If a drug is not included, a beneficiary can appeal, based on medical necessity, but "preferably with a physician's help," he said."All medically necessary drugs that are approved by the FDA with certain exceptions have to be available." However, off-label prescriptions will be covered, Dr. Kelman said.

In a move important to rare drug organizations, Dr. Kelman said if there is only one drug to treat a disease, it must be included in the formulary. Part D also will ensure drugs are available for chronic conditions by "favorably risk adjusting" those diseases, Dr. Kelman said. The plans also will "overadjust" for low-income individuals and nursing homes.

Council member Laura Powers, M.D., a neurologist from Knoxville, Tenn. said she was relieved by Dr. Kelman's comments. "We were so worried that our patients with very expensive drugs were going to be eliminated from all the formularies."

Dr. Kelman urged physicians to begin moving patients to the new formularies before the benefit is effective Jan. 1, 2006. Beneficiaries can enroll in the program from Nov. 15 through May 15.

In other issues, Dr. Kelman pointed out that by law, barbiturates and benzodiazepines will not be covered by the plans. Other drugs not covered include cosmetic agents and weight-loss and weight-gain products. ■