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Denials and Appeals in Medicaid Managed Care

Review of recommendations and draft chapter for March report

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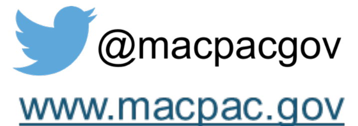
Medicaid and CHIP Payment and Access Commission



Chapter Outline

- Background
- Current federal requirements
- State role
- Current challenges
- Recommendations
- Additional considerations
- Looking ahead

Background

- Until recently, little was known about denials in Medicaid managed care
- The Department of Health and Human Services Office of the Inspector General (OIG) found that 12.5 percent of prior authorization requests were denied by Medicaid managed care organizations (MCOs), compared to 5.7 percent by Medicare Advantage (MA) organizations
- Few denials are appealed, and little is known about the beneficiary experience
- Media reports have highlighted several instances of Medicaid MCOs inappropriately delaying or denying medically necessary services

Current Federal Requirements

Appeals process

- MCOs may deny or limit services, and beneficiaries have a statutory right to appeal denials
- MCOs must have an internal system to review appeals
- Federal rules lay out requirements for service authorization and appeals processes

Monitoring, oversight, and transparency

- States are required to collect and monitor specific plan-reported data related to appeals
- States are required to work with external quality review organizations to conduct oversight of MCOs
- States must submit key metrics and data annually to the Centers for Medicare & Medicaid Services (CMS)

State Role

Appeals process

- States have some flexibility to modify the appeals process
  - Timelines, independent external medical review, and ombudsperson services

Monitoring, oversight, and transparency

- States have the responsibility to monitor and oversee MCOs and ensure beneficiary access
- Some states conduct more robust monitoring, beyond federal requirements (e.g., denial data collection)

Current Challenges

Appeals process

- Beneficiaries expressed both a lack of trust and general frustration with the MCO appeals process
- The appeals process is challenging and burdensome
- Denial notices can be late and the content is unclear
- Beneficiaries encounter multiple barriers in accessing continuation of benefits

Current Challenges

Monitoring, oversight, and transparency

- Federal rules do not require states to collect and monitor data needed to assess access to care
  - This includes data on: denials, use of continuation of benefits, appeals outcomes
- Federal rules do not require states to assess clinical appropriateness of denials
- Federal rules do not require that states publicly report information on plan denials and appeals outcomes

Recommendations, Rationale, and Implications

Recommendation 2.1 (as approved)

To bring independence and improve trust in the appeals process, Congress should amend Section 1932(b) of the Social Security Act to require that states establish an independent, external medical review process that can be accessed at the beneficiary's choice, with certain exceptions for automatic review at the state's discretion. The external medical review should not delay a beneficiary's access to a state fair hearing.

Recommendation 2.1: Rationale

- Findings suggest that many beneficiaries lack trust in the managed care appeals process
- An external medical review would ensure that the appeal review is:
  - Independent (i.e., not conducted by a provider associated with the MCO), and
  - Clinical (i.e., done by a clinician rather than an administrative law judge)
- 14 states offer external medical review as an option for Medicaid beneficiaries
  - Appeals to external medical reviewers were fully or partially overturned 46 percent of the time in favor of the beneficiary
- An independent external medical review can also be a tool for oversight and performance improvement

Recommendation 2.1: Implications

Federal spending. The Congressional Budget Office (CBO) estimates an increase in federal direct spending of less than $500 million over a ten-year period

States. States would see an increase in administrative burden to establish this program or align existing programs with federal rules

Enrollees. Beneficiaries may see an increase in access to care

Plans. Some plans may revisit authorization processes and see increased costs

Providers. Providers may see an increased administrative burden, as their documentation and expertise may be needed for the review, but providers may see more requested care approved

Recommendation 2.2 (as approved)

To improve the beneficiary experience with the appeals process, the Centers for Medicare & Medicaid Services (CMS) should issue guidance to improve the clarity and content of denial notices and share information on approaches managed care organizations can leverage to fulfill their requirements to provide beneficiary assistance in filing appeals. Additionally, CMS should clarify how Medicaid funding may be used to support external entities, such as ombudsperson services.

Recommendation 2.2: Rationale

- Content of notices can be hard to parse and lack a clear reason for why medical necessity is not met
  - Guidance should help states and MCOs improve the denial notice
  - CMS can help identify strategies for improving the readability and understandability of notices
- The appeals process is challenging to navigate
  - CMS should also offer states and MCOs guidance on how they can better support beneficiaries in navigating the appeals process
  - Guidance should also detail how Medicaid can ensure that assistance from trusted external partners is available to beneficiaries

Recommendation 2.2: Implications

Federal spending. CBO estimates no changes in federal direct spending

States. States may choose to implement CMS guidance and improve how beneficiaries experience the appeals process

Enrollees. Beneficiaries may have improved access to the appeals process

Plans. States may require MCOs to make changes to their notices and they may implement CMS strategies to better support beneficiaries

Providers. Providers may need to supply documentation for a greater number of appeals, but burden may be lower if notices are clearer

Recommendation 2.3 (as approved)

To ensure beneficiaries receive denial notices in a timely manner, the Centers for Medicare & Medicaid Services should require managed care organizations to provide beneficiaries with the option of receiving an electronic denial notice, in addition to the mailed notice.

Recommendation 2.3: Rationale

- Written notices delivered by mail can be inadequate for some beneficiaries
  - Mail can be delayed or delivered to the wrong address
- Multiple modes of communication help to ensure that beneficiaries receive important information

Recommendation 2.3: Implications

Federal spending. CBO estimates no changes in federal direct spending

States. States may need to amend contracts and monitor MCO compliance

Enrollees. Electronic delivery could improve timely access to notices for beneficiaries

Plans. MCOs would need to update electronic systems to identify preferences of beneficiaries and generate the electronic notices

Providers. No direct effect on providers

Recommendation 2.4 (as approved)

To improve beneficiary access to continuation of benefits, the Centers for Medicare & Medicaid Services (CMS) should extend the timeline for requesting continuation of benefits. Additionally, CMS should issue guidance offering tools, including model notice language, to improve beneficiary awareness of their rights to continue receiving services while an appeal is pending. Guidance should also clarify the federal limitations on managed care organizations seeking repayment for continued benefits after a denial is upheld and provide model notice language to explain to beneficiaries that repayment could be required if the state allows for recoupment under fee for service.

Recommendation 2.4: Rationale

- Beneficiaries lack sufficient time to file for continuation of benefits
  - Extending the 10 day window to request would increase access
- There is limited awareness of this benefit
  - Model notices and other tools could improve notices to make this information more accessible and prominent
- Threat of repayment can be a barrier
  - CMS should clarify that MCOs are only allowed to pursue recoupment if the state allows repayment under fee for service
  - Denial notices should only describe recoupment if allowable in the state

Recommendation 2.4: Implications

Federal spending. CBO estimated that this recommendation would not have a significant effect on the federal budget

States. States will need to ensure MCOs offer the extended timeline for beneficiaries and states may choose to implement CMS guidance

Enrollees. Beneficiaries could become more aware of this benefit and choose to exercise this option, which would increase access to services during the appeals process

Plans. With guidance, MCOs will be encouraged to provide information on continuation of benefits in a more meaningful way to beneficiaries

Providers. If more beneficiaries request continuation of benefits, providers may provide more services to their patients

Recommendation 2.5 (as approved)

To improve monitoring and oversight of denials and appeals, the Centers for Medicare & Medicaid Services (CMS) should update regulations to require that states collect and report data on denials, beneficiary use of continuation of benefits, and appeal outcomes, using standardized definitions for reporting. The rules should require that states use these data to improve the performance of the managed care program. Additionally, CMS should update the Managed Care Program Annual Report template to require these data fields. CMS should also issue guidance to states regarding implementation of this data reporting requirement and incorporation of these data into monitoring and continuous improvement activities.

Recommendation 2.5: Rationale

- Current federal monitoring requirements are insufficient and provide states with limited insight into MCO denials and appeal outcomes
- Requiring that states monitor data on denials allows them greater insight into the extent to which beneficiaries experience denials
  - States that already collect and monitor these data indicated they are important for assessing whether beneficiaries are experiencing any challenges with access
- Monitoring outcomes of MCO appeals can indicate the extent to which beneficiaries are receiving services, help states identify and correct inappropriate denials, and help states better understand the reasons for the initial denial

Recommendation 2.5: Implications

Federal spending. CBO estimates no changes in federal direct spending

States. States would see an increase in administrative burden to implement this requirement or align existing monitoring with federal rules

Enrollees. With improved monitoring, beneficiaries may see improved access to appropriate, medically necessary care

Plans. MCOs would face an increased burden to submit new data

Providers. No direct effect on providers

Recommendation 2.6 (as approved)

To improve oversight of denials, Congress should require that states conduct routine clinical appropriateness audits of managed care denials and use these findings to ensure access to medically necessary care. As part of rulemaking to implement this requirement, the Centers for Medicare & Medicaid Services (CMS) should allow states the flexibility to determine who conducts clinical audits and should add clinical audits as an optional activity for external quality review. CMS should release guidance on the process, methodology, and criteria for assessing whether a denial is clinically appropriate. CMS should update the Managed Care Program Annual Report template to include the results of the audit.

Recommendation 2.6: Rationale

- Clinical appropriateness audits can be effective at identifying inappropriate denials of care, yet these audits are not required in Medicaid managed care
  - Among the states voluntarily conducting these clinical audits, several have identified instances of MCOs inappropriately denying prior authorization requests
- The OIG has made a similar recommendation to CMS, which would require states to regularly review the appropriateness of a sample of MCO prior authorization denials
  - Similar types of audits are already conducted in the Medicare Advantage program and have identified inappropriate denials

Recommendation 2.6: Implications

Federal spending. CBO estimates that this recommendation would likely increase federal direct spending by less than $500 million over a 10-year period

States. States would see an increase in administrative burden to conduct these audits or align existing efforts with federal rules

Enrollees. Beneficiaries may see improved access to medically necessary care and a reduced administrative burden

Plans. MCOs would see an increase in their administrative burden

Providers. No direct effect on providers

Recommendation 2.7

To improve transparency, the Centers for Medicare & Medicaid Services (CMS) should publicly post all state Managed Care Program Annual Reports to the CMS website in a standard format that enables analysis. Reports should be posted in a timely manner following states' submissions to CMS. Additionally, CMS should require that states include denials and appeals data on their quality rating system websites to ensure beneficiaries can access this information when selecting a health plan.

Recommendation 2.7: Rationale

- Currently there is little transparency on MCO approvals and denials of services, limiting what is known about beneficiary access to medically necessary care
- This recommendation aims to improve transparency of denials and appeals information by leveraging the Managed Care Program Annual Reports (MCPARs) and quality rating system (QRS) websites
  - This would bring greater oversight and accountability to managed care programs and provide beneficiaries with key information on denials and appeals

Recommendation 2.7: Implications

Federal spending. CBO estimates no changes in federal direct spending

States. Including denials and appeals data on state QRS websites will add a modest administrative burden

Enrollees. Beneficiaries would have greater insight into the extent to which services may be denied and then overturned through appeals

Plans. No direct effect on plans. Transparency may encourage plans to improve authorization and appeals processes

Providers. No direct effect on providers

Additional Considerations and Looking Ahead

Additional Considerations

- States have the primary responsibility to oversee their MCOs and ensure beneficiary access to appropriate care
- Independent of federal action, current rules allow states flexibility to modify and improve the appeals process and implement more robust monitoring and oversight systems
- States should use tools available to them to respond to any MCO performance issues that arise

Looking Ahead

- Vote on recommendations tomorrow
- Finalize chapter for March report to Congress
- Review the recently-finalized rule on interoperability and prior authorization
- MACPAC staff have contracted work regarding prior authorization in Medicaid
- Continue to monitor state websites for MCPARs and investigate additional work with newly available data

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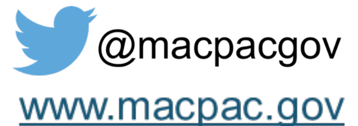

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