

Chapter 2:

Denials and Appeals in Medicaid Managed Care

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Recommendations

- 2.1** 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.
- 2.2** 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.
- 2.3** 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.
- 2.4** 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.
- 2.5** 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.
- 2.6** 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.
- 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.

Denials and Appeals in Medicaid Managed Care

Key Points

- Medicaid managed care organizations (MCOs) manage and provide care to most Medicaid beneficiaries, and MCOs may deny or limit services to ensure that only appropriate and medically necessary care is provided.
- Beneficiaries have a statutory right to appeal MCO denial decisions. Yet few denials are appealed, and little is known about the beneficiary experience.
- Federal rules govern the denials and appeals process and require monitoring and oversight of MCOs.
- Our research indicated key challenges with the appeals process, including a lack of trust in the MCO appeals process, the burdensome nature of the appeals process, late and unclear denial notices, and barriers in accessing continuation of benefits.
- In addition, we identified gaps in federal monitoring, oversight, and transparency requirements, including that there are no federal requirements for states to collect data on denials, beneficiary use of continuation of benefits, and appeal outcomes; to evaluate denials for clinical appropriateness; or to publicly report this information.
- The Commission recommends improvements to the appeals process and federal monitoring, oversight, and transparency requirements:
 1. External medical reviews of denials should be required to bring greater independence to and improve trust in the appeals process.
 2. The Centers for Medicare & Medicaid Services (CMS) should issue guidance to improve denial notices and identify approaches for states and MCOs to assist beneficiaries in appealing denial decisions.
 3. Beneficiaries should have a choice to receive electronic denial notices to get these notices in a timely manner.
 4. Beneficiaries should have a longer timeline to file for continuation of benefits, and CMS guidance is needed to address existing barriers in accessing continuation of benefits.
 5. States should collect and monitor data on denials, beneficiary use of continuation of benefits, and appeals outcomes to better assess beneficiary access.
 6. States should conduct clinical audits of denials to assess clinical appropriateness of managed care denials and improve state oversight of managed care.
 7. CMS and states should make data on denials and appeals publicly available in accessible formats to improve transparency for beneficiaries, stakeholders, and researchers.

CHAPTER 2: Denials and Appeals in Medicaid Managed Care

Medicaid managed care organizations (MCOs) play a large role in providing health care services, with 74 percent of Medicaid beneficiaries enrolled in comprehensive managed care (MACPAC 2023). Under contracts with state Medicaid programs, MCOs manage and provide care to beneficiaries enrolled in their plan. MCOs may deny or limit services to ensure that only appropriate and medically necessary care is provided (42 CFR § 438.210).¹ To ensure access to medically necessary care, beneficiaries have a statutory right to appeal MCO denial decisions (Section 1932(b)(4) of the Social Security Act (the Act)). Federal monitoring and oversight requirements on states aim to ensure MCO compliance with authorization and appeals rules and promote access to appropriate care. However, recent federal reports and news coverage have highlighted instances of beneficiaries being denied medically necessary care, suggesting the need for improved managed care oversight (OIG 2023; Terhune 2019; McSwane and Chavez 2018).

The Commission sought to understand the extent to which federal and state agencies monitor MCOs to ensure that beneficiaries are not denied services inappropriately and can ultimately receive covered, medically necessary care through the appeals process. We also examined beneficiaries' experiences with the appeals process. To investigate these areas, we conducted a federal policy review, a state policy scan, state and stakeholder interviews, and beneficiary focus groups.

The federal policy review focused on current federal requirements for the Centers for Medicare & Medicaid Services (CMS) and state Medicaid agencies regarding the appeals process and associated monitoring and oversight. For the state scan, we reviewed publicly available data and documents from 40 states and the District of Columbia.² We conducted approximately 30 semi-structured interviews across a variety of organizations, including Medicaid officials

in five states, providers, MCOs, beneficiary groups, external quality review organizations (EQROs), national experts, and officials at CMS. Our interviews focused on denial and appeals processes as well as monitoring and oversight efforts. Last, we contracted with Mathematica to conduct focus groups with beneficiaries and caregivers who have filed appeals with their MCOs.³ The focus groups largely centered on the appeals process to better understand barriers throughout this process.

Findings from the state scan and stakeholder interviews identified gaps in the federal oversight requirements. Federal rules do not require that states collect and monitor certain key data, including denials, continuation of benefits, and appeals outcomes. There is also no federal requirement to assess denials for clinical appropriateness. In addition, transparency requirements are incomplete, with no federal requirements to publicly report information on MCO denials and appeals outcomes.

Findings from the stakeholder interviews and beneficiary focus groups identified several challenges with the appeals process. Beneficiaries and advocates indicated a lack of trust in and general frustration with the MCO appeals process, describing it as challenging and burdensome to navigate. MCOs are required to mail denial notices, but beneficiaries do not always receive these denial notices in time to pursue an appeal within regulatory time frames. Furthermore, stakeholders expressed that the content of notices can be unclear and difficult to understand, and MCOs acknowledged the challenges in conveying clinical and legal language to beneficiaries. Last, beneficiaries encounter barriers in accessing continuation of benefits, including a lack of awareness of this right, short timelines to file for receiving the benefit, and the risk of repayment for services delivered.

To address these challenges, improve the appeals process, and enhance monitoring and oversight of MCOs, the Commission makes seven recommendations:

- 2.1 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.

- 2.2 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.
- 2.3 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.
- 2.4 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.
- 2.5 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.

- 2.6 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.
- 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.

This chapter begins with a brief background on denials and appeals in managed care. It then outlines the current federal requirements for both the appeals process as well as for monitoring, oversight, and transparency of MCOs and the state's role in each domain. The chapter goes on to describe challenges with the appeals process and critical gaps in the federal monitoring, oversight, and transparency structure. Next, the chapter presents the Commission's recommendations and associated rationale as well as implications for federal spending, states, enrollees, plans, and providers. The chapter concludes with additional considerations and describes next steps.

Background

Until recently, little was known about the extent to which Medicaid beneficiaries experienced denials in managed care. The U.S. Department of Health and Human Services Office of the Inspector General (OIG) examined Medicaid managed care denials under prior authorization in 2019 and found a higher rate than in Medicare Advantage (MA). Specifically, the Medicaid MCOs included in the study denied 12.5 percent of prior authorization requests compared to 5.7 percent denied by MA plans. Furthermore, approximately 2.7 million Medicaid beneficiaries were enrolled in MCOs with prior authorization denial rates greater than 25 percent.⁴ The OIG found that 11.2 percent of prior authorization denials were appealed (OIG 2023).

Our findings also suggest that few denials are appealed. In conducting a state scan of publicly available data, we found a few examples demonstrating a low rate of appeals of denied services and items. However, we were unable to estimate an overall appeal rate in Medicaid managed care because few states publicly report these data, and they use a range of measures to monitor and report appeals. In Iowa, less than one-tenth of 1 percent of denials (0.05 percent) were appealed in fiscal year 2021 (IA HHS 2022). New Hampshire and Maryland publish data showing how many appeals are filed for every 1,000 beneficiaries. For plans in those states, there were 0.08 to 1.47 appeals for every 1,000 enrollees, respectively (NH HHS 2022, MD DOH 2021).⁵ New research suggests that lower income individuals are less likely to appeal and more likely to assume their denial will be upheld if appealed than those with higher incomes. One study found that every \$25,000 increase in annual income is associated with a 4 percent increased likelihood of appeal (Yaver 2024).

Media reports have highlighted instances of Medicaid MCOs inappropriately delaying or denying medically necessary services (Terhune 2019; McSwane and Chavez 2018). In California, one MCO failed to authorize health care services in a timely and adequate manner, including authorization delays for cancer patients, among others. This MCO also did not adhere to federal requirements regarding resolutions of grievances and appeals. As a result, the state fined this MCO \$55 million (CA DMHC 2022). In 2018, a

series of investigative news reports found that MCOs operating in Texas were inappropriately denying services, particularly for children in foster care, resulting in avoidable harm (McSwane and Chavez 2018). Subsequently, the Texas legislature passed a law to increase reporting requirements for Medicaid MCOs, including publicly reporting aggregated complaint and appeals data (Texas 2019). These news reports exposed weaknesses in managed care oversight processes and accountability mechanisms at the state and federal levels.

Current Federal Requirements

Federal regulations allow Medicaid MCOs to limit services based on medical necessity criteria or utilization management tools (e.g., quantity limits, prior authorization). Such limitations of services can help to ensure that care provided is necessary, cost effective, and aligned with medical standards. While federal regulations allow plans to use these tools, plans must provide services that are no less than the amount, duration, and scope for the same services offered to beneficiaries under fee-for-service (FFS) Medicaid. MCOs are also prohibited from arbitrarily denying or reducing a required service solely based on the diagnosis, type of illness, or condition of the enrollee. (42 CFR § 438.210) Specific rules and protections apply to beneficiaries younger than age 21. Early and periodic screening, diagnostic, and treatment (EPSDT) requires states and MCOs to provide access to any Medicaid-coverable service in any amount that is medically necessary, regardless of whether the service is covered in the state plan (Section 1905(r) (5) of the Act).⁶ Federal regulations also specify the processes and timelines by which MCOs must make these decisions (42 CFR § 438.210). If the beneficiary disagrees with the MCO's decision, they have a statutory right to appeal the decision to the MCO (Section 1932(b)(4) of the Act).

For purposes of this chapter, denials include only an MCO's decision to deny or limit the authorization of a requested service or to reduce, suspend, or terminate a previously authorized service.⁷ Receiving a denial triggers a beneficiary's right to appeal.⁸ Appeals and

grievances are often discussed together; however, they are distinct actions—an appeal sets in motion a process that requires the health plan to review its denial, whereas a grievance is an expression of dissatisfaction about matters other than a denial (42 CFR § 438.400).⁹

Appeals process requirements

Section 1932(b)(4) of the Act requires MCOs to have an internal system for beneficiaries to challenge denials. Since 2002, federal rules have required that MCO contracts include specific language regarding MCO appeal systems. The 2016 and 2020 updates to managed care regulations added additional beneficiary protections and increased consistency in the appeals process (e.g., updated timelines and requiring only one level of internal MCO appeal) (CMS 2020, 2016).

Federal regulations specify the processes and timelines related to denials and appeals but allow states to modify certain aspects of the process (e.g., shorter time frames, external medical review) (Figure 2-1).

Denial and notice

Any MCO decision to deny or limit the authorization of a service must be made by an individual with the appropriate expertise in addressing the beneficiary's medical, behavioral health, or long-term services and support needs. MCOs must notify the requesting provider of the denial and give beneficiaries timely and adequate notice of a denial in writing (42 CFR § 438.210). This notice must explain the decision, the reason, the beneficiary's right to appeal, and the beneficiary's right to continue receiving services through the appeals process, as well as how to exercise this right.¹⁰ Federal rules require that this notice is written and mailed to beneficiaries; however, states may also require additional modes of communication (42 CFR § 438.404(c)). Federal rules require MCOs to provide this information in alternative formats, without cost and upon request. This may include auxiliary aids and written translation (42 CFR § 438.10).

Currently, standard authorization decisions that deny or limit services must be sent to beneficiaries and the requesting provider as expeditiously as the beneficiary's condition requires and within 14 days of the service request, or within 72 hours for expedited cases. States may impose shorter timelines for standard and expedited authorizations. In January 2024, CMS released a final rule on prior authorization and interoperability that will reduce the timeline for standard cases to seven days. These changes will take effect on January 1, 2026 (CMS 2024).¹¹ MCOs must provide 10 days' advance notice for decisions that terminate, suspend, or reduce previously authorized services (42 CFR § 438.404, 431.211).

Beneficiary appeals to MCOs

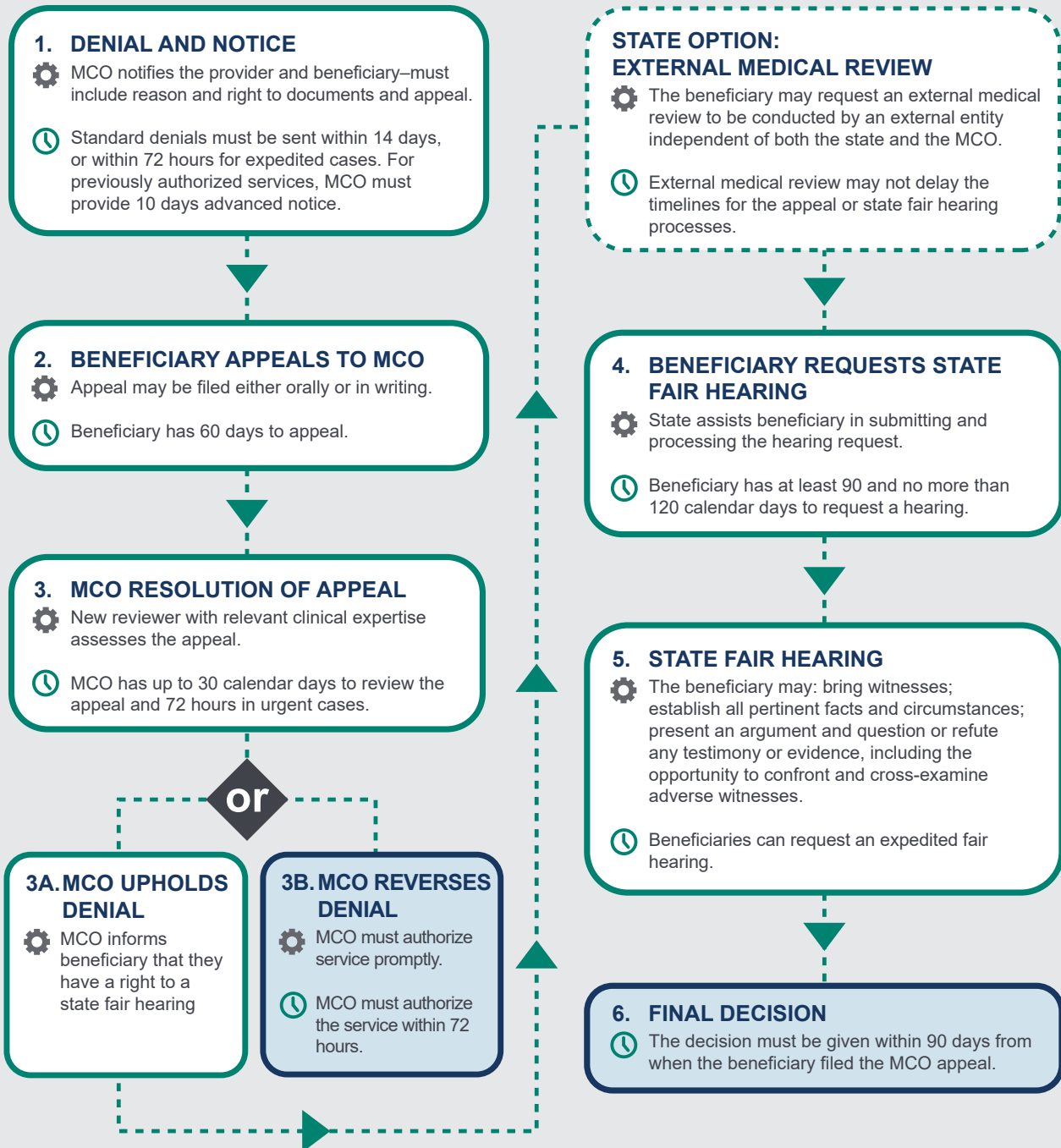
Beneficiaries have a statutory right to appeal denied services to their MCO. Beneficiaries have 60 calendar days to appeal the MCO's decision and may submit the appeal either in writing or orally (42 CFR § 438.402).¹² MCOs must provide beneficiaries with any reasonable assistance in completing the necessary steps to file an appeal (e.g., providing interpreter services). Additionally, when requested, MCOs must provide beneficiaries with case files, including medical records, and any other evidence considered by the MCO in connection with the appeal (42 CFR § 438.406).

Continuation of benefits

In cases in which the MCO terminates, reduces, or suspends a previously authorized service, beneficiaries have the right to continue receiving the services at the previously authorized level while either the appeal or state fair hearing is pending (42 CFR § 438.404, 42 CFR § 438.420(c)). The beneficiary, if eligible for continued benefits, must request them within 10 days of the date of the denial notice or before the denial goes into effect, whichever is longer (42 CFR § 438.420(a)).

If a beneficiary's denial is upheld by the MCO or in the state fair hearing process, federal rules allow the MCO to recover the costs of these services provided during the appeal in specific circumstances. Federal rules allow MCOs to recoup these costs only if the managed care policy is consistent with the state's usual policy on recoveries (42 CFR § 438.420(d)).

FIGURE 2-1. Timeline and Federal Process Requirements for Appeals



Note: MCO is managed care organization.

Source: MACPAC analysis of 42 CFR § 438.210, 402, 404, and 408.

Resolution of beneficiary appeals to MCOs

MCOs must ensure that the individuals reviewing the appeal were not involved in the initial decision and have the appropriate clinical expertise to evaluate the appeal (42 CFR § 438.408). MCOs must give beneficiaries timely and adequate notice of the resolution of appeals in writing. They also must explain the decision, the reason, the beneficiary's rights to a state fair hearing, and how to exercise those rights. MCOs must resolve the appeal as expeditiously as the beneficiary's health condition requires but within no more than 30 calendar days and within 72 hours for urgent cases. Extensions are allowed if requested by the beneficiary or if the MCO demonstrates a need for additional information and if the delay is in the beneficiary's interest (42 CFR § 438.408).

State option: Independent external medical review

External medical reviews are clinical reviews of an MCO's decision to uphold a denial by an independent, third-party entity not affiliated with the MCO or the state. Under federal rules, states may offer beneficiaries an external medical review after the completion of the internal MCO appeal. Specifically, the external medical review must not be a prerequisite for the state fair hearing and may be initiated only by the beneficiary's choice. In addition, the review must be independent of the MCO and the state, must be offered at no cost to the beneficiary, and may not disrupt a beneficiary's receipt of continuation of benefits or any timelines for the appeals process (42 CFR § 438.402(c)(1)(B)).

State fair hearing

If a beneficiary has completed the internal MCO appeals process and disagrees with the MCO's determination, they have a right to request a state fair hearing (Section 1902(a)(3) of the Act). A state fair hearing offers the beneficiary the opportunity to appear before an administrative law judge to request that the MCO's decision be overturned. The state should assist the beneficiary in submitting and processing the hearing request (42 CFR § 431.221). The beneficiary has at least 90 days but no more than 120 calendar days from the date of the MCO's notice of resolution to request a state fair hearing (42 CFR § 438.408). A fair

hearing decision must be granted within 90 days from when the beneficiary filed the appeal with the MCO (42 CFR § 431.244).

Monitoring, oversight, and transparency

Federal oversight of managed care denials and appeals includes three components: state monitoring, external quality review, and annual reporting. CMS requires that states establish internal monitoring programs to review health plan–reported data and use EQROs to conduct reviews of managed care programs and plan performance. The results of these activities must be reported to CMS annually.

Monitoring requirements

Federal rules require that states establish a managed care monitoring system and use the data collected to improve the performance of the program (42 CFR § 438.66). These rules require that states collect plan-reported data related to beneficiary appeals. At a minimum, states must collect: the reason for the appeal, relevant dates (e.g., received, reviewed, resolved), resolution at each level, and the name of the beneficiary (42 CFR § 438.416). CMS regulations do not require states to collect and monitor denials data.

External quality review

Section 1932 of the Act requires that states work with an EQRO to conduct an annual independent review to validate the performance of a state's contracted Medicaid MCOs. Among other things, the EQRO is required to conduct a review, at least every three years, of an MCO's compliance with standards in subpart D of 42 CFR § 438, which include the processes related to authorization of services and appeals.¹³ Under federal rules, EQROs are not required to collect and monitor trends related to denials and appeals, nor are they required to assess whether denial and appeal decisions are clinically appropriate. Although federal rules require that states use the findings from these reviews to improve the program, they do not obligate states to take specific actions upon these compliance findings from the EQRO (42 CFR § 438.66).

Managed Care Program Annual Report

In 2022, states began submitting data to CMS for the Managed Care Program Annual Report (MCPAR), which the agency introduced in the 2016 managed care rule. In finalizing this requirement, CMS explained that the report will provide valuable and timely information to assess managed care programs in each state, as well as improve transparency for beneficiaries, providers, and stakeholders (CMS 2016).

States must submit key metrics related to their Medicaid managed care program annually to CMS and make this report available to the public on the state website. Such key metrics include plan-level reporting on the number and type of appeals, the service types of appeals, the number of state fair hearings and their outcomes, and the outcomes of any external medical reviews. States are not required to collect or report on the outcome of MCO appeals unless the appeal goes to an external medical review or state fair hearing. This report also does not include data related to denials, as states are not required to collect this information (CMS 2023a).

State Role

The requirements described previously represent the minimum federal standards for the appeals process as well as for monitoring, oversight, and transparency of denials and appeals. States have flexibility in how they implement these requirements and may establish requirements that go beyond these minimums.

Appeals process

States have some flexibility to modify the appeals process. Although federal regulations require that states establish timelines for appeal resolution that are no longer than 30 days for non-urgent cases, some states have shorter time frames associated with the appeals process. For example, Ohio requires that MCOs resolve appeals within 15 calendar days (Ohio Admin. Code § 5160-26-08.4(D)(6)). Some states have elected to insert an additional step in the appeals process and offer independent external medical review to beneficiaries after the internal MCO denial is upheld.

Through the California Department of Managed Health Care, Medi-Cal enrollees can request an independent medical review if their MCO upholds a denial (CA DMHC 2023). Last, some states offer ombudsperson services beyond those federally required for individuals with long-term services and supports to assist with appeals. Minnesota offers ombudsperson services to any resident enrolled in MinnesotaCare or Medical Assistance (MN DHS 2023).

Monitoring, oversight, and transparency

States have the responsibility to monitor and oversee state managed care programs and ensure that beneficiaries have access to appropriate care. Through our state scan and interviews with state officials, we found that some states have developed more robust monitoring and external review programs, exceeding the federal minimum requirements discussed previously. These efforts include collecting data on denials and appeals outcomes and conducting clinical audits. For example, our review of state documents and contracts identified 23 states and the District of Columbia that require MCOs to report denial data to the state. Eleven states require that MCOs report denial reasons, and 14 states require that they report information related to the services that were denied.¹⁴

During our interviews, state Medicaid officials discussed how they use findings from routine monitoring of denials. In one case, monitoring of denials data led to uncovering an unclear state policy, which officials were able to correct. Another state shared how it uses these data in quarterly meetings with MCOs to examine any issues that arise. Last, another state has issued civil monetary penalties upon discovering improper denials by MCOs.

As part of this work, we also sought to understand the extent to which MCOs are complying with federal authorization and appeals regulations. In a review of state external quality review technical reports, we found that compliance issues with authorization of services and the appeals process are widespread. Twenty-two of the 46 states had MCO compliance issues with authorization of services, 25 states had

MCO compliance issues with the appeals process, and 18 had compliance issues with both areas.¹⁵ Again, states vary in how they use these findings. For example, some states issue corrective action plans or civil monetary penalties, and others use EQRO findings to alter auto-assignment algorithms for passive MCO enrollment.¹⁶

Currently, 14 states publicly report some data on denials or appeals in Medicaid managed care, but what is reported varies greatly. For example, New Hampshire reports the share of prior authorization requests denied across all plans, and Maryland reports the number of prior authorization denials per 1,000 enrollees for each MCO in the state (NH HHS 2022, MD DOH 2021). Among the states we interviewed, three states publicly posted denials or appeals information. Medicaid officials in one state believed the report to be largely unused by the public, though they found the denials and appeals data helpful for monitoring. The other two states viewed the public-facing data to be important for transparency of the program and helpful in holding MCOs accountable.

Current Challenges

Through interviews, focus groups, and the state scan, the Commission identified challenges with the appeals process as well as with monitoring, oversight, and transparency of MCOs. These challenges, detailed in the following sections, underscore accessibility issues with the appeals process and insufficient monitoring, oversight, and transparency of MCOs.

Appeals process

The Commission identified several challenges with the appeals process. Specifically, beneficiaries and caregivers who participated in our focus groups lack trust in the MCO appeals process and find navigating the process to be burdensome. In addition, those beneficiaries who have the right to continue receiving benefits face considerable barriers.

Beneficiaries expressed both a lack of trust and general frustration with the MCO appeals process

The appeals process can be a frustrating experience for beneficiaries, and they expressed a lack of trust

in the MCO appeals process. MCOs are responsible for notifying the beneficiary of their right to an appeal, providing the beneficiary support through the appeals process if requested, conducting the appeal, and notifying the beneficiary of the appeal outcome. Many focus group participants reached out to their MCO for information regarding an appeal upon learning of the denied service request, and most reported not having a positive experience. Many participants indicated that the member services representatives lacked knowledge about the appeals process, did not provide needed information to enrollees, or provided incorrect information regarding the appeal. Conversely, one focus group participant shared that they had a helpful experience with their health plan representative, and this representative helped them come up with an alternate treatment plan.

Additionally, several stakeholders provided examples of MCO member service representatives dissuading beneficiaries from filing an appeal. Some focus group participants did not reach out to their MCO for information about appealing a denied service because they did not think the MCO would provide helpful assistance on appeals. Conversely, interviewed MCOs discussed how they conduct regular trainings with member service representatives to assist beneficiaries. In addition, one interviewed MCO detailed internal monitoring efforts, which include routine training and testing for nurses and medical directors who evaluate appeals as well as monthly audits of performance.

The appeals process is challenging and burdensome

The appeals process can be burdensome and challenging for beneficiaries. Many focus group participants found the process to be time consuming and difficult to manage, specifically the effort to gather documentation. Assembling documentation can require working with multiple providers to gather letters and supporting clinical documents to demonstrate medical necessity. Beneficiaries who appeal multiple denials over the course of their coverage can experience substantial burden.

External support often plays a critical role in beneficiary appeals. Medical providers assist beneficiaries by providing supporting clinical documentation, requesting peer-to-peer consults with the MCO, and in some cases filing an appeal on behalf of the beneficiary. Community-based

organizations and ombudsperson offices help beneficiaries understand the process and get connected to legal assistance organizations. Many focus group participants noted the importance of legal representation in advocating for them throughout the process.

Denial notices can be late and content is unclear

Mail delivery of notices that is not timely can be a barrier for beneficiaries in filing an appeal. Denial notices often arrived late, leaving several focus group participants with insufficient time to request an appeal. Some focus group members serving as a caregiver to a beneficiary noted that letters were delivered to the beneficiary's address, which delayed the caregiver's ability to appeal on behalf of the beneficiary. In some cases, beneficiaries never received a denial letter. These concerns were echoed in interviews with state officials and stakeholders. Beneficiaries across all focus groups expressed support for adding more ways for beneficiaries to receive denial notices (e.g., text, e-mail, phone). Although federal rules allow MCOs to provide electronic denial notices, they are not required to do so (42 CFR § 438.10(c)(6)).

Denial notices can also lack clarity. Beneficiary advocates and providers shared that many beneficiaries receive only generic reasons for their denial, which can lead to confusion. For example, one beneficiary advocate shared that their client received a denial notice citing that the requested service was not medically necessary. However, they ultimately learned that the lack of medical necessity was the result of missing documentation from the provider. Most focus group participants shared that they did not understand the MCO's rationale for denying the service or upholding a denial after the appeal.

Denial notices can be lengthy and rely too heavily on clinical and legal jargon that can be challenging to understand.¹⁷ MCOs noted that it can be difficult to draft letters at the appropriate reading level (e.g., sixth-grade level) given the requirements to include the reasons for the denial, which are often clinical. In addition, some states require regulatory citations throughout the notice, which can add complexity.

Beneficiaries encounter multiple barriers in accessing continuation of benefits

Barriers to accessing continuation of benefits include lack of beneficiaries' awareness of their rights, tight timelines, and threat of repayment. Some stakeholders, including legal assistance organizations, described continuation of benefits as an important beneficiary protection but said awareness and use of the benefit are limited.

Awareness. Many focus group participants were not aware that they could continue receiving previously authorized services that are terminated, suspended, or reduced while pursuing an appeal. Additionally, several focus group participants indicated that they became aware of this beneficiary protection only once they had enlisted the help of a legal aid organization. Beneficiary advocates noted that knowledge of continuation of benefits is primarily spread by word of mouth rather than by the denial notice. These stakeholders raised concerns that the notices may lack or not prominently display required information regarding continuation of benefits.

Timelines. To continue receiving services at the previously authorized level throughout the appeals process, beneficiaries must file for this benefit within 10 days of the date of the notice to terminate, suspend, or reduce or before the termination, suspension, or reduction goes into effect, whichever is longer. This timeline is insufficient for many beneficiaries. Providers and beneficiary advocates indicated that beneficiaries often do not receive the notice until several days into the 10-day window. Many focus group participants corroborated these findings, emphasizing that the 10-day window to file for continuation of benefits is too short.

Repayment. The potential of having to repay for services if the appeal is upheld in favor of the MCO dissuades some beneficiaries from requesting a continuation of benefits. However, some interviewed stakeholders, including state officials, indicated that they have never heard of an MCO recouping costs associated with services provided while an appeal is pending.

Monitoring, oversight, and transparency

The Commission sought to better understand the extent to which federal and state agencies ensure that beneficiaries are not inappropriately denied services and can ultimately receive covered, medically necessary care through the authorization and appeals processes. The Commission found gaps in federal monitoring and oversight requirements for data monitoring, clinical audits, and transparency.

Federal rules do not require states to collect and monitor data needed to assess access to care

Federal data collection requirements provide only limited insight into MCO denials and the outcomes of beneficiary appeals (Figure 2-2). States are not required to monitor MCO denials. Although states are required to collect some beneficiary appeal data, they are not required to collect information on whether a beneficiary is exercising their right to continue benefits. Furthermore, states are not required to monitor the outcome of any appeal to the MCO.

Denials. Collecting and monitoring denial data allows states to assess the extent to which beneficiaries experience denials, and states can use these data to perform trend analysis to identify plan-wide issues with access to care. While not federally required, more than half of states with managed care collect or monitor these denial data from MCOs. Our state scan indicated that 23 states and the District of Columbia

require that MCOs report denials data to the state.¹⁸ Similarly, the OIG recently surveyed state Medicaid agencies on their monitoring efforts and found that 22 of the 37 surveyed states reported using prior authorization denials data for oversight (OIG 2023). In our interviews, there was broad consensus that reviewing denials is a critical component to identifying issues with beneficiary access to care. Some states noted that breaking down denial data by service type can help identify trends specific to certain services or populations. In addition, one interviewed MCO indicated that it routinely monitors denial data.

Continuation of benefits. Federal rules do not require states to collect data on the extent to which beneficiaries are continuing their benefits through the appeals process, and little is known about the beneficiary use of this benefit. The extent to which states monitor access to and use of continuation of benefits is unclear. Some state officials indicated that they have not heard from beneficiaries or advocates that accessing continuation of benefits is a problem. However, in our interviews with state Medicaid officials and MCOs, interviewees were not able to identify or describe any monitoring of this beneficiary protection (e.g., number of beneficiaries who exercise this option after a denial). Legal advocates have called for careful monitoring of this right (Perkins 2016). To ensure that beneficiaries have access to this protection, states would need to monitor beneficiary use of the benefit.

FIGURE 2-2. Federal Data Monitoring Requirements



Note: MCO is managed care organization.

Source: MACPAC analysis of 42 CFR § 438.66.

Appeals outcomes. Federal rules require that states collect only certain data on appeals (e.g., the reason for the appeal, relevant dates, resolution). However, it is unclear whether resolution includes the outcomes of the internal appeal to the MCO.¹⁹ Reviewing the outcomes of MCO appeals can provide a more complete picture of the appeals process and the extent to which denials are being upheld or overturned. In addition, examining appeals outcomes can help states understand underlying reasons for the denial (e.g., issues with documentation standards, clinical criteria, or any other part of the service authorization request that requires a change) and whether overturned denials are an indication of access issues resulting from denied or delayed care. Using these data allow state officials to identify and address underlying policies or practices that may be resulting in inappropriate denials. During interviews, one state official indicated that overturned appeals cause concern because often many other beneficiaries receive similar denials and yet do not appeal. Even fewer beneficiaries pursue a state fair hearing. Interviewed MCOs indicated that they also internally monitor the outcomes of appeals routinely.

Federal rules do not require states to assess clinical appropriateness of denials

Federal rules do not require that states audit or examine whether MCOs are making clinically appropriate denial decisions. Instead, regulations require an assessment of MCO compliance with the process requirements for service authorization and appeals through the external quality review process. These compliance checks are mandatory activities for EQROs and must be conducted at least every three years, but they do not assess whether MCOs are making appropriate clinical decisions.²⁰

Unlike compliance audits, clinical appropriateness audits can be used to determine whether an MCO has inappropriately denied services. In our interviews, one state official described how they perform spot checks and clinical reviews for the EPSDT benefit because of a history of improper denials for these services. This official pointed to these spot checks as a helpful oversight tool, allowing state officials to better understand the clinical rationale for denials and address access issues with the managed care plans.

The OIG found that 13 of 37 surveyed states reported regularly reviewing the clinical appropriateness of MCO prior authorization denials. These states found that some denials were inappropriate. Examples of inappropriately denied services include medically necessary health screening services for children, drug therapy, and inpatient hospital services. Among the states already conducting these audits, some use Medicaid agency staff, and others rely on their EQRO (OIG 2023).

CMS conducts audits of denials in the MA program and has found persistent problems, including inappropriate denials in more than half of the audited plans in 2015 (OIG 2018). Given that denial rates are higher in Medicaid managed care than in MA, audits of this nature would help identify whether those higher rates are appropriate. The OIG has recommended that CMS require states to review the appropriateness of a sample of MCO prior authorization denials regularly (OIG 2023).²¹

Federal requirements do not ensure that states publicly report information on plan denials and appeals outcomes

Federal rules currently do not require plans or states to publicly report information on denials. As a result, little is known about the extent to which beneficiaries are denied health care services by their MCOs. Similarly, limited information is available about the extent to which beneficiaries appeal service denials and whether these appeals are later reversed by the health plan or through the state fair hearing process. We found that 14 states publicly report data on denials or appeals in Medicaid managed care; however, what is reported varies widely.

States are required to report some appeals data to CMS through the MCPAR. Specifically, states' MCPARs must include plan-level reporting on the number and type of appeals, the service types of appeals, the number of state fair hearings and their outcomes, and the outcomes of any external medical reviews (CMS 2023a). Although states are required to make this annual program report available to the public on state websites, current regulations do not specify a timeline for posting, and this information has yet to be made widely available. At the time of this

writing, MACPAC was able to find reports for six states on public websites.²² In the 2023 proposed managed care rule, CMS would require that states post these reports within 30 days of submitting them to CMS (CMS 2023b). Separately, CMS indicated that it would post the MCPARs on its website but had not done so at the time of this writing (CMS 2022a).²³

Additionally, the 2023 proposed rule on managed care included implementation requirements for the Medicaid managed care quality ratings system (QRS). The goal of the QRS is to increase accountability, empower beneficiaries with information about their MCO choices, and provide states with another tool to manage plan performance improvement (42 CFR § 438.334). Under the proposed rule, states will be required to set up websites, described as a “one-stop shop” for beneficiaries to access information about their health plan choices. The websites will include the quality ratings of MCOs and other key information, such as drug formularies, provider networks, and other CMS-identified metrics. CMS notes that since states are already required to report some information related to appeals, including such data would not impose substantial burden on states. In addition, individuals who participated in user testing indicated an interest in seeing appeals data on the QRS websites (CMS 2023b). The proposed rule did not address denials data, as states are not currently required to collect these data.

Through its final rule on prior authorization, CMS, beginning January 1, 2027, will require MCOs to publicly report aggregated prior authorization data, including the number of requests received, approved, and denied, on their websites. This transparency requirement is intended to encourage plans to measure their own performance on these metrics, allow beneficiaries to use this information when selecting a plan, and help inform provider decisions in selecting payer networks. Metrics would be available only at the aggregate level across all services and items (CMS 2024).²⁴ Although this requirement will improve transparency, it relies on MCOs to publicly post on their websites and does not incorporate the data in existing federally required Medicaid monitoring and oversight mechanisms (e.g., MCPARs and QRSs).

Recommendations

In the following sections, we present seven recommendations to improve the beneficiary experience with the appeals process as well as bolster monitoring, oversight, and transparency of managed care denials and appeals.

Recommendation 2.1

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.

Rationale

Findings from our stakeholder interviews and beneficiary focus groups suggest that many beneficiaries lack trust in the managed care appeals process. Beneficiary advocates and providers also expressed concern regarding potential conflicts of interest with MCOs adjudicating appeals of their own denial decisions. The current process does not require that an appeal be reviewed by a medical professional who is independent of the state or MCO. According to focus group participants and interviewed beneficiary advocates, requiring an external medical review conducted by an independent clinician could improve trust in the appeals process, reduce potential conflicts of interest, and ensure appropriate access to medically necessary care.

Under federal law, beneficiaries can request reconsideration of denial decisions through MCO appeals and state fair hearings, but those processes do not include an external medical review. An external medical review would ensure a review that is both 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). This type of review is not currently required in either the internal MCO appeal or the state fair hearing. Moreover, although beneficiaries have a right to a

state fair hearing, most beneficiaries do not ultimately request one.²⁵

In 2019, 14 of the 37 states that the OIG surveyed offered external medical review as an option for Medicaid managed care beneficiaries. The OIG found that appeals submitted to an external medical reviewer were fully or partially overturned 46 percent of the time in favor of the beneficiary (OIG 2023). Providing this intermediary step could help ensure greater access to medically necessary care and would better align with beneficiary protections in MA, which requires an automatic external medical review.²⁶ In promulgating rules and subregulatory guidance to codify this requirement, CMS can look to existing models to identify approaches that center this process around beneficiaries and reduce potential complexity. Commissioners discussed allowing states to incorporate external medical review into the state fair hearing process; however, this was not pursued, as it was outside the scope of this chapter.

This process should be oriented around the needs of beneficiaries to promote the use of external medical review. This process should be initiated by beneficiaries, but the Commission acknowledges there may be instances in which an automated process would be in the best interest of beneficiaries. For example, a state may choose to automate the external review for upheld denials of certain types of critical services, for particularly vulnerable populations, or for services for which access issues are documented. An independent, external medical review can also be a tool for oversight and performance improvement. For example, a high overturn rate on a specific service may indicate that improvements to the authorization process should be made to ensure appropriate access. Under current federal rules, if a state allows for external medical reviews, then it must collect and monitor the outcomes of these reviews and submit the data to CMS (CMS 2023a). It is the view of the Commission that this information should be used to improve the performance of the program.

Implications

Federal spending. The Congressional Budget Office (CBO) estimates that requiring external medical review would increase federal direct spending by less than \$500 million over a 10-year period.

States. States that currently do not have external medical review would have to implement this requirement, increasing their administrative burden. Conversely, states that already allow for an external medical review would likely see a reduced burden depending on the extent to which their program aligns with CMS rulemaking. Additionally, if states choose to make the external medical review process automatic, the burden would likely increase.

Enrollees. Implementing external medical review may bring increased accountability and improve beneficiary trust in the appeals process. As a result, more beneficiaries may choose to appeal denied services. Additionally, a clinical review, whether automatic or initiated by the beneficiary, may result in fewer MCO denials of medically necessary services, thus increasing access to care among beneficiaries. This option would be made available at no cost to the beneficiary.

Plans. The presence of a clinical review may encourage MCOs to revisit authorization protocols and deny fewer authorization requests for medically necessary services. Additionally, some states may require that MCOs pay for the cost of any requested external review.²⁷

Providers. Providers may see an increased administrative burden, as their documentation and expertise may be needed to support beneficiaries who choose to pursue external medical reviews. However, the clinical review may increase access to medically necessary services, meaning providers would be providing more care to their patients.

Recommendation 2.2

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 ombudsman services.

Rationale

Publicly available data indicate that few Medicaid beneficiaries appeal denied services. The OIG found 11 percent of prior authorization denials are appealed to the MCO, and 2.1 percent of denied prior authorization requests that MCOs upheld on appeal were appealed to a state fair hearing (OIG 2023). The low rates of appeal and the need for substantial external support speak to the challenging nature of the appeals process for Medicaid beneficiaries.

CMS guidance should help states and MCOs improve the denial notice, explain the requirements on MCOs to provide support, and elaborate on how Medicaid funding can be used to support third-party entities who provide beneficiary assistance. CMS should consider leveraging lessons learned from state beneficiary support systems that are required for beneficiaries who receive long-term services and supports. These support systems provide education and assistance on the appeals and state fair hearing processes (42 CFR § 438.71(d)(2,3)). Once implemented, the agency should monitor and assess the need for future guidance, technical assistance, or rulemaking to improve this process.

Focus group participants, beneficiary advocates, legal aid societies, and providers all expressed concern at the burdensome nature of the appeals process and indicated that external support is critical to navigate the process. The challenging nature of the process starts with the denial notice. Specifically, beneficiaries indicated that the content of notices can be hard to parse, and they can lack a clear reason for why medical necessity is not met. Unclear notices can be problematic if they do not describe what documentation MCOs need to approve the request. Beneficiaries described having to spend hours per day on the phone to seek further information from MCOs and then additional time with providers to obtain the documentation. In our interviews, nearly all stakeholders acknowledged that it is challenging to draft denial notices in a concise manner. It is the Commission's view that CMS has an important role in identifying strategies to improve the readability and understandability of notice content. For example, CMS could consider approaches to summarize the letter contents in plain language.

CMS should also offer states and MCOs guidance on how they can better support beneficiaries in navigating the appeals process. Federal rules require that MCOs provide support through the appeals process for any beneficiary who requests it. However, focus group participants indicated that this assistance is rarely meaningful. Some participants expressed distrust in MCOs and in the information they provide, and others hesitated to seek support from the entity that just denied their service request.

Focus group participants highlighted that external entities, including ombudsperson offices and legal aid societies, were trusted partners in helping navigate the appeals process. These entities can help with filing the appeal, gathering required documentation, and representing beneficiaries in meetings with the MCOs. It is the view of the Commission that CMS should provide states with guidance on how they may use Medicaid funding to ensure that these services from trusted external partners are available for beneficiaries.

Implications

Federal spending. CBO does not estimate any changes in federal direct spending as a result of implementing this recommendation. CBO estimates that the recommendation would increase federal discretionary spending to cover administrative activities related to issuing guidance.

States. States may choose to implement CMS guidance and improve how beneficiaries experience the appeals process. This guidance may help states revise their approaches to the appeals process—for example, by leveraging Medicaid dollars to support external entities that assist beneficiaries throughout the process. Additionally, states may choose to use model notices to standardize what is sent to beneficiaries regarding denials.

Enrollees. This recommendation is intended to improve the appeals process for beneficiaries, which may increase their access to the process. As a result of increased accessibility to the appeals process, beneficiaries may see increased access to medically necessary services.

Plans. With guidance from CMS to improve denial notices, states may require that MCOs make changes to their notices. In addition, MCOs may implement strategies offered in the CMS guidance to provide more meaningful support to beneficiaries throughout the appeals process.

Providers. If CMS guidance results in a more accessible appeals process and beneficiary appeals increase, providers will need to supply clinical documentation for a greater number of appeals. However, if the notices are clearer and describe what documentation is needed, providers may experience a lower burden in supplying this information.

Recommendation 2.3

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.

Rationale

Written notices delivered by mail can be inadequate for some beneficiaries. Beneficiaries we spoke to noted that mail can be delayed or delivered to the wrong address. Some stakeholder interviewees indicated that these notices often arrive a week or more after the postmarked date, or not at all. This is consistent with findings from previous MACPAC work on eligibility notices, which indicated that beneficiaries who receive notices by mail have shorter windows of time to respond. Furthermore, delivery of mail can frequently be hampered by inaccurate addresses. Medicaid beneficiaries frequently change addresses, making it challenging to keep contact information up to date (MACPAC 2022).

Focus group participants agreed that states and managed care plans should add more ways for enrollees to receive information about denials and appeals decisions (e.g., text, e-mail, phone call). In addition, previous MACPAC work found that providing multiple modes of communication helps ensure that beneficiaries receive important information (MACPAC 2022). The Commission notes that the unwinding of the continuous coverage condition of the COVID-19 public health emergency further

supports this approach. This recommendation would provide beneficiaries with more options for receiving information about their care and would align notice delivery rules for denials and appeals with those applying to eligibility notices (42 CFR § 435.918(b)(4)).

CMS should continue to assess the best methods for delivering critical, time-sensitive information. In its 2022 proposed rulemaking, CMS proposed that states attempt to contact beneficiaries by two modalities, including mail and one other method (e.g., phone, electronic notice, text) when they receive returned mail (CMS 2022b). CMS should work with states to assess the effectiveness of other modes of communication and consider whether such methods would be appropriate for improving communication of adverse benefit determinations for beneficiaries in managed care.

Implications

Federal spending. CBO does not estimate any changes in federal direct spending as a result of implementing this recommendation. CBO estimates that the recommendation would increase federal discretionary spending to cover administrative activities related to conducting rulemaking.

States. States would be required to provide oversight to ensure that MCOs are offering this choice to beneficiaries. States may need to amend managed care contracts and add additional data elements to monitoring and oversight efforts to track adherence.

Enrollees. Allowing enrollees to select additional modes of delivery for notices may improve their access to timely and important information, which in turn could improve access to the appeals process.

Plans. MCOs would need to update systems to identify the communication preferences of enrollees and generate and send electronic notices. Some MCOs may experience an increased burden associated with collecting and maintaining electronic information for beneficiaries that are not already using these modes of communication.

Providers. This recommendation should have no direct impact on providers.

Recommendation 2.4

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.

Rationale

Our research identified three issues with accessing continuation of benefits: lack of beneficiary awareness of the right, threat of repayment, and tight beneficiary timelines. To address access barriers related to tight beneficiary timelines, CMS should promulgate regulations to extend the current 10-day timeline for beneficiaries to request continuation of benefits. Focus group participants and beneficiary advocates indicated that the 10-day window to file for continuation of benefits is too short. Beneficiaries often do not receive the denial notice in a timely manner, and since the clock starts on the postmarked date of the notice, many beneficiaries lack sufficient time to file for continuation of benefits. Commissioners discussed whether CMS should consider different timelines for continuation of benefits based on how the beneficiary receives the notice of denial; however, the Commission concluded that this may add an unnecessary level of operational complexity.

CMS should use clarifying guidance to address the two issues of lack of awareness and risk of repayment. This guidance should provide user-tested model language on continuation of benefits to improve denial notices and identify methods to make this information more prominent. Commissioners expressed the importance of ensuring that the notice is in plain language and easy to read.

Guidance should clarify that MCOs are allowed to pursue recoupment only if the state allows repayment under fee for service. Although our research did

not identify any instances in which an MCO sought repayment for services, advocates and beneficiaries clearly noted that the possibility of repayment is a barrier for beneficiaries to continue receiving services throughout an appeal. As such, CMS guidance could identify how states can evaluate and modify their recoupment policies to address this barrier. Relatedly, denial notices should not include language describing repayment unless it is allowable in the state.

Implications

Federal spending. Although this recommendation may result in an increase in the number of beneficiaries requesting continuation of benefits, CBO estimated that extending the timeline to request continuation of benefits would not have a substantial effect on the federal budget.

States. Following CMS rulemaking, states will need to ensure that MCOs implement the extended timeline for beneficiaries to request continuation of benefits. Additionally, with CMS guidance on how to make continuation of benefits more accessible, states may choose to implement these approaches to modify policies and procedures for their MCOs.

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. If beneficiaries elect to continue receiving services while an appeal is pending, MCOs may bear the cost of services provided.

Providers. If more beneficiaries request to continue receiving services while an appeal is pending, providers may provide more services to their patients.

Recommendation 2.5

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.

Rationale

Current federal monitoring requirements are insufficient and require only limited insight into MCO denials and appeals outcomes. By requiring that states monitor data on denials, states will have 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. Some states monitor data on denials and look at deviations from the trend in denial rates to identify potential problems with the authorization process.

The appeals data that are currently required to be collected are limited and do not provide states sufficient information to identify potential issues with inappropriate denials in both the authorization and appeals processes. 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 (e.g., unclear documentation requirements). In addition, given the lack of monitoring and oversight of continuation of benefits and how little is known about its accessibility and use, proposed rulemaking should establish requirements for states to monitor beneficiary access to and use of this benefit.

To reduce administrative burden, this recommendation builds on the existing MCPAR requirement. States are already required to submit plan-reported data annually, and under this recommendation, states would be required to also report the number and types of denials, the denial reason, the service types of the denied service or item, and the outcomes of MCO appeals. CMS will also have insight into these trends.

About half of states do not have experience collecting or monitoring these types of data, and federal guidance can help states establish a standardized

and effective monitoring program. For states already collecting these data, guidance can help improve existing processes and standardize data collection. The Commission supports CMS offering clear definitions for reporting. For example, in establishing denial data reporting standards, CMS may require separate reporting of partial denials (e.g., reduction in requested service) versus full denials (e.g., no service authorized). In addition, CMS may consider requiring both raw numbers (e.g., number of denials) as well as percentages (e.g., percentage of authorization requests that are denied). By offering standard categories and definitions, CMS can ensure adequate comparisons across plans and states. CMS should consider stratifying these data by types of service (e.g., behavioral health) and demographic characteristics (e.g., age, race, ethnicity, geography).

Implications

Federal spending. CBO does not estimate any changes in federal direct spending as a result of implementing this recommendation. CBO estimates that this recommendation would increase federal discretionary spending to cover CMS administrative activities related to conducting rulemaking, issuing guidance, and updating the MCPAR template.

States. States that do not collect these data already would have an increased administrative burden to implement this requirement. States that do collect these data already would likely face less of a burden, but these states may have to adjust current reporting depending on what CMS ultimately requires. This new information will provide state officials with greater insight into their managed care program and provide states an opportunity to improve monitoring and the ability to identify potential access issues. Once these issues are identified, states will be required to use this information to improve the performance of the program.

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

Plans. Managed care plans would face an increased burden, as they would be required to submit these new data. Although these fields may be a new federal requirement for Medicaid managed care, they are already federally required for MA plans and the plans

on the federally facilitated exchange. MCOs may be able to leverage practices and data collection techniques from other lines of business (e.g., exchange markets) and external accreditation reviews to comply with these new requirements.²⁸

Providers. We do not anticipate any direct effect on providers. To the extent that improved monitoring yields greater access to care and a corresponding reduced need for appeals, providers may see a reduction in their administrative burden.

Recommendation 2.6

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.

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, such as for drug therapies, health screening services for children, and inpatient hospital services (OIG 2023). In our interviews, one state official with experience conducting these reviews noted that they can be an effective tool for oversight and ensuring access to medically necessary care.

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 (OIG 2023). Similar types of audits are already conducted in the MA program

and have identified inappropriate denials (OIG 2022, 2018).

By establishing the clinical appropriateness audit as an optional activity under external quality review, this recommendation would allow states to leverage existing contracts with EQROs and receive enhanced match for this activity. Although all states operating Medicaid managed care programs are statutorily required to conduct an external, independent review of their program using an EQRO, the current protocol does not include a clinical appropriateness review. Furthermore, EQROs already collect some of the needed information to assess clinical appropriateness. Although this recommendation would require that CMS set federal standards for routine clinical appropriateness audits, it would not preclude states from conducting more frequent or ancillary audits as needed throughout the year.

Since most states are not currently conducting these types of audits, guidance will help establish a standardized approach to this new monitoring tool. For states that do conduct these audits, guidance may help improve this process and allow for potential comparison across states and MCOs. As part of the guidance, CMS should allow states the flexibility to identify specific service areas, such as denials for services that may be under the EPSDT benefit, that must be included in the audit.

The Commission discussed, but did not agree on the timing of implementing the requirement for routine clinical audits in relation to the requirement for external medical review (in Recommendation 2.1). Some Commissioners stated that clinical audits should precede implementation of external medical review in order to gather additional evidence about the frequency of inappropriate denials. Other Commissioners stated that clinical audits and external medical review should be simultaneously implemented, citing the need for an independent and clinical review of beneficiary appeals and improved state oversight of denials. Ultimately, the Commission passed these recommendations independently without respect to timing.

The recommendation would also require that CMS update the MCPAR template to include findings from the clinical audit. These reports are provided

to CMS for its review and posted publicly on state websites. This would allow findings from clinical audits, along with other key reporting metrics that are already included in the MCPAR (e.g., appeals), to be accessible.

Implications

Federal spending. CBO estimates that this recommendation would likely increase federal direct spending by less than \$500 million over a 10-year period. This recommendation would also increase federal discretionary spending to cover CMS administrative activities related to conducting rulemaking, issuing guidance, and updating the annual managed care reports.

States. States not already conducting these audits would see an increase in administrative burden and spending as a result of conducting the audits. States already requiring such audits may experience less of a burden and cost, depending on how closely current audits mirror the requirements that CMS establishes. If states opt to have the EQRO conduct the audit, the activity would be eligible for enhanced match.

Enrollees. If states use this monitoring and oversight tool to correct any identified issues that result in inappropriate denials, beneficiaries may see improved access to medically necessary care and a reduced administrative burden. Specifically, this may reduce the need for beneficiaries to appeal inappropriate denials.

Plans. MCOs may see an increase in their administrative burden in supplying case files and documents. Some MCOs may currently be subject to these types of audits in the 13 states already implementing them. MCOs in states that already require such audits may experience less of a burden than MCOs in states that do not conduct these audits, depending on how closely aligned these audits are with new requirements from CMS.

Providers. We do not anticipate any direct effect on providers. To the extent that audits yield greater access to care and a corresponding reduced need for appeals, providers may see a reduction in their administrative burden.

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.

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 MCPARs and QRS websites. These changes would bring greater oversight and accountability to managed care programs and provide beneficiaries with key information on denials and appeals.

By requiring that CMS post all reports to its website, researchers and other stakeholders will be able to more easily access the reports, allowing for analysis of the managed care program as a whole. Although states are currently required to post these reports, at the time of this writing, we have found reports from only six states.²⁹

States will be required to set up QRS websites to assist beneficiaries in their selection of a plan. Given the importance of denials and appeals data in beneficiary access, these data should be available to beneficiaries on these websites. The Commission discussed how providing context around these data will be important. For example, websites may need to explain that data between plans are not necessarily comparable without additional information on prior authorization practices. Plans may differ in the extent to which they apply prior authorization, which in turn can affect the denial rate.

Together with Recommendations 2.5 and 2.6, the public would have access to data on managed care denials and appeals outcomes and the findings of

clinical appropriateness audits. This would make program-wide data publicly available for the first time.

This recommendation does not remove or change the requirement for transparency in the final prior authorization rule but instead complements it (CMS 2024). Recommendation 2.7 would apply to denials of outpatient prescription drugs, whereas this new regulatory requirement would not. Additionally, once implemented, MCOs will be required to report similar data (e.g., publicly posting prior authorization denial metrics), and this information can be made available for state oversight and transparency purposes. CMS and states should consider how these data could be incorporated into existing reporting requirements for MCPARs and QRSs.

Implications

Federal spending. CBO does not estimate any changes in federal direct spending as a result of implementing this recommendation. CBO estimates that this recommendation would increase federal discretionary spending to cover CMS administrative activities related to conducting rulemaking and issuing guidance.

States. Including denials and appeals data on state QRS websites will add a modest administrative burden, given that states will already collect this information under Recommendations 2.5 and 2.6. Officials will need to ensure that these data are posted in a usable format for beneficiaries.

Enrollees. Under this recommendation, beneficiaries would have greater insight into the extent to which services may be denied and then overturned through appeals. This information would be at the plan level, helping to inform their plan selection.

Plans. We do not anticipate any direct effect on plans. However, transparency efforts may encourage some plans to improve their authorization and appeals processes.

Providers. We do not anticipate any direct effect on providers. To the extent that transparency yields greater access to care and a corresponding reduced need for appeals, providers may see a reduction in their administrative burden.

Additional Considerations

Congress and CMS should implement the Commission's recommendations to ensure that these improvements apply uniformly to all state Medicaid programs and beneficiaries. However, the Commission acknowledges that states have the primary responsibility to oversee their managed care programs and ensure that beneficiaries have access to appropriate care. Independent of federal action, current rules allow states flexibility to modify and improve the appeals process. For example, states can elect to implement external medical review, even without a federal mandate, to improve trust in the appeals process, reduce potential conflicts of interest, and ensure appropriate access to medically necessary care. In addition, states can require that MCOs offer beneficiaries the option to also receive denial notices electronically. This would help ensure that beneficiaries receive these notices in a timely manner.

In addition, states have flexibility to implement more robust monitoring and oversight systems. Independent of actions by Congress or CMS on these recommendations, states could improve their monitoring and oversight programs by collecting data on denials and appeals outcomes, conducting clinical audits, and publicly reporting key data and findings.

States also can use denials and appeals data and clinical audits to enhance monitoring efforts and should use the tools available to them to respond to any managed care plan performance issues that arise. Specifically, states may need to revisit existing policies or contract requirements to ensure that MCOs are appropriately covering and authorizing services. Furthermore, states should enforce policies and contract requirements for MCOs that inappropriately deny care through the authorization and appeals processes.

Looking Ahead

MACPAC staff will continue to monitor state websites for the MCPARs and investigate further work with newly available data. MACPAC staff are also currently pursuing work on prior authorization policies in Medicaid.

Endnotes

¹ Federal rules governing the managed care authorization and appeals processes apply to MCOs, as referenced in this chapter, but also apply to other managed care entities, including primary care case management plans, prepaid inpatient health plans, and prepaid ambulatory health plans.

² We examined states with comprehensive managed care and excluded 10 states due to no or low rates of comprehensive managed care. We excluded states with comprehensive managed care rates of less than 5 percent but included North Carolina due to its recent transition to comprehensive managed care (MACPAC 2023). Excluded states are Alabama, Alaska, Arkansas, Connecticut, Idaho, Maine, Montana, Oklahoma, South Dakota, and Wyoming. Documents reviewed included state quality strategies, managed care contracts, Medicaid dashboards and websites, annual technical reports, and managed care manuals, among other documents.

³ Twenty-two beneficiaries and caregivers participated in focus groups between June and September 2023. Mathematica engaged community-based organizations, primarily legal assistance agencies and state ombudsperson offices, to recruit beneficiaries for this study. People were eligible to participate in focus groups if they had appealed a Medicaid denial or reduction in service within the last three years. Participants included residents across eight states: Delaware, Louisiana, Massachusetts, Michigan, New Jersey, New York, Ohio, and Washington. Most participants were caregivers to children, a person with a disability, or an elderly parent.

⁴ The OIG examined data across seven MCO parent companies with the largest number of people enrolled in comprehensive, risk-based MCOs across all states in 2019. These seven MCO parent companies include 115 MCOs in 37 states, which enrolled a total of 29.8 million people in 2019. The OIG calculated the denial rate as a share of total authorization requests, and as a result, there is no estimated denial rate as a share of total services provided. The OIG did not report on the extent to which services were subject to prior authorization or how this varied by MCO (OIG 2023).

⁵ Appeal rates are also low for other federal payers. However, publicly available data are not directly comparable across payers. Among exchange enrollees, the appeal rate was about 0.2 percent in 2021 for all in-network denied claims (Pollitz et al. 2023). In MA, the appeal rate was 1.1 percent between 2014 and 2016, which included appeals for

both payment denials and preservice denials (OIG 2018). The OIG calculated the MA appeal rate to include beneficiary appeals of denied services as well as provider appeals of denied payment after the service had been delivered.

⁶ Limits may be placed for purposes of utilization control. For example, states may not require prior authorization for EPSDT screening services but may apply prior authorization for certain treatment services. States must review these limits in light of a particular child's needs for determination of medical necessity (CMS 2014).

⁷ The focus of this chapter is on two types of denials, or adverse benefit determinations. This includes the denial or limitation of a requested service or item, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit (42 CFR § 438.400(b)(1)). It also includes any reduction, suspension, or termination of a previously authorized service (42 CFR § 438.400(b)(2)). Outpatient prescription drugs are included in this definition. When referring to denials, the Commission is not including denial of payment for services already received (42 CFR § 438.400(b)(3)).

⁸ CMS allows any adverse benefit determination to be appealed to the MCO; however, several of these adverse benefit determinations are outside the scope of this chapter. They include a denial of payment to a provider; the MCO's failure to provide services in a timely manner; the failure of an MCO to act within the time frames provided in 42 CFR § 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals; the denial of an beneficiary's request to obtain services outside the MCO network when the beneficiary is a resident of a rural area with one MCO; and the denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities (42 CFR § 438.400(b)(3–7)).

⁹ Grievances are outside the scope of this chapter.

¹⁰ MCO requirements for covered outpatient drugs are described in §1927(d)(5)(A) of the Act.

¹¹ This final rule will apply changes to interoperability and prior authorization requirements in Medicaid managed care and other programs, including Medicaid fee for service, the State Children's Health Insurance Program, MA, and exchange plan issuers on the federally facilitated exchange. Notably, these changes will not apply to outpatient drugs, including those administered by a physician. In addition

to shortening the time frame for MCOs to make prior authorization decisions, this final rule will make a number of other changes. First, MCOs will be required to implement and maintain an application programming interface (API) to facilitate the prior authorization process. The API is meant to reduce burdens on providers and payers and streamline the prior authorization process. Providers will be able to search individual MCOs' APIs to determine whether a requested service or item is subject to prior authorization and automate the process by compiling the required data for populating the prior authorization request. Through this final rule, CMS will also require that MCOs publicly report aggregated prior authorization data on their websites (CMS 2024).

¹² If state law permits and with the written consent of the enrollee, a provider or an authorized representative may request an appeal on behalf of the enrollee (42 CFR § 438.402(c)(1)(ii)).

¹³ CMS prescribes protocols that EQROs must use in their reviews. EQROs review samples of approved and denied items and services and examine who reviewed the coverage decision, the criteria used, and how and when the MCO communicated decisions with beneficiaries. EQROs assess compliance with timelines, qualifications of staff involved in coverage determinations, and content of notices regarding decisions and rights to appeals (CMS 2023c).

¹⁴ Specific reporting requirements varied by state. In some cases, the reporting template was publicly available, and we were able to identify the specific fields that MCOs must submit. In other cases, the contract, managed care manual, or quality strategy would include general information about reporting requirements or objectives, but specific requirements were not available.

¹⁵ This work was conducted under a contract with Bailit Health. It performed an environmental scan of EQRO reports in 46 states. It is difficult to assess the extent of non-compliance nationally because the EQROs' approach to scoring MCO compliance varies by state. Even within a single state, a finding of non-compliance may refer to one minor area of non-compliance that can be quickly remedied, or it may mean not compliant across various components.

¹⁶ When beneficiaries do not actively enroll in an MCO, states may automatically assign beneficiaries to one. States may use different criteria to assign beneficiaries. Federal rules detail requirements around this process (42 CFR §438.54).

¹⁷ Beneficiary advocates provided seven redacted notices across three plans to MACPAC staff. Among these notices, the length ranged from three to nine pages, and the readability scores ranged from grade 6.1 to 11.3. Additionally, some of the letters used headings and bold text to guide the reader, whereas others used unformatted text throughout the entire notice. We calculated grade-level readability scores using the Flesch-Kincaid grade level score tool available in Microsoft Word. The Flesch-Kincaid grade level is equivalent to the U.S. grade levels of education. A grade level of six indicates that a sixth-grade education is required to understand the given text.

¹⁸ States vary in their required reporting of denials. For example, Hawaii evaluates MCO performance by reviewing denial rates under prior authorization and the percentage of overturned prior authorization denials (HI DHS 2022). In Georgia, a quarterly prior authorization report includes denials by specific service categories (e.g., dental, pharmacy, and medical inpatient and outpatient) (GA DCH 2016). In Florida, MCOs must report monthly on authorizations and denials across more than 56 service types, which include 12 specifically related to behavioral health services (e.g., behavioral inpatient, outpatient, specialized therapeutic services) (FL AHCA 2019).

¹⁹ States are required to collect the resolution at each level of the appeal (42 CFR § 438.416(a)). The MCPAR defines an appeal as resolved when "the MCO has issued a decision, regardless of whether the decision was wholly or partially favorable or adverse to the beneficiary, and regardless of whether the beneficiary has filed a request for a state fair hearing or external medical review." States must report the total number of appeals resolved; however, the current MCPAR template does not require that states report the decision (e.g., the number of appeals favorable or adverse to the beneficiary) (CMS 2023a).

²⁰ Thirty-one states require National Committee for Quality Assurance (NCQA) health plan accreditation, which includes an assessment of the authorization and appeals systems in place. As a component of this accreditation, NCQA assesses MCO compliance with federal rules regarding coverage and authorization of services and appeals and grievances. NCQA does not currently evaluate for clinical appropriateness as a component of this accreditation process (NCQA 2022).

²¹ The OIG made four additional recommendations to CMS. They include that CMS should (1) require states to collect data on MCO prior authorization decisions, (2) issue

guidance to states on the use of MCO prior authorization data for oversight, (3) require states to implement automatic external medical reviews of upheld MCO prior authorization denials, and (4) work with states on actions to identify and address MCOs that may be issuing inappropriate prior authorization denials (OIG 2023).

²² States include Arkansas, Louisiana, Mississippi, Ohio, Pennsylvania, and Tennessee (AR DHS 2023, LA DOH 2023, MS DOM 2023, OH DOM 2023, PA DHS 2023, TennCare Medicaid 2023).

²³ CMS has indicated this delay is due to challenges in making MCPARs compliant with accessibility requirements.

²⁴ MCOs will be required to report a list of all items and services subject to prior authorization; the percentage of standard prior authorization requests that were approved, denied, and approved after appeal; the percentage of prior authorization requests for which the time frame of review was extended and the request was approved; the percentage of expedited prior authorization requests that were approved and denied; and the average and median time to process standard and urgent authorization requests (CMS 2024).

²⁵ According to the OIG study on prior authorization denials, only 2 percent of upheld denials were appealed to a state fair hearing in 2019. However, when state fair hearings occurred, they fully or partially overturned 38 percent of prior authorization denials in favor of the beneficiary (OIG 2023).

²⁶ In MA, the beneficiary may file an appeal with their health plan. If the denial is upheld, it is automatically forwarded to the independent review entity. If the denial is still upheld at this level, the beneficiary may file an appeal to the administrative law judge and then the Medicare appeals council (OIG 2023).

²⁷ For example, New Jersey requires that MCOs bear the cost of the review with the external medical reviewer, regardless of the outcome of the review (NJ DBI 2021).

²⁸ For example, when applying for accreditation with NCQA, MCOs must provide necessary data for NCQA to evaluate authorization and appeals policies and practices.

²⁹ States include Arkansas, Louisiana, Mississippi, Ohio, Pennsylvania, and Tennessee (AR DHS 2023, LA DOH 2023, MS DOM 2023, OH DOM 2023, PA DHS 2023, TennCare Medicaid 2023).

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Commission Vote on Recommendations

In its authorizing language in the Social Security Act (42 USC 1396), Congress requires MACPAC to review Medicaid and CHIP program policies and make recommendations related to those policies to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states in its reports to Congress, which are due by March 15 and June 15 of each year. Each Commissioner must vote on each recommendation, and the votes for each recommendation must be published in the reports. The recommendations included in this report, and the corresponding voting record below, fulfill this mandate.

Per the Commission’s policies regarding conflicts of interest, the Commission’s conflict of interest committee convened prior to the vote to review and discuss whether any conflicts existed relevant to the recommendations. It determined that, under the particularly, directly, predictably, and significantly standard that governs its deliberations, no Commissioner has an interest that presents a potential or actual conflict of interest.

The Commission voted on these recommendations on January 26, 2024.

Denials and Appeals in Medicaid Managed Care

2.1 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.

2.1 voting results	#	Commissioner
Yes	13	Allen, Bella, Bjork, Brooks, Duncan, Gerstorff, Heaphy, Hill, Johnson, Killingsworth, Medows, Snyder, Weno
No	3	Giardino, Ingram, McCarthy
Abstain	1	McFadden

2.2 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.

2.3 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.

2.4 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.

- 2.5 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.
- 2.6 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.
- 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.

2.2-2.7 voting results	#	Commissioner
Yes	17	Allen, Bella, Bjork, Brooks, Duncan, Gerstorff, Giardino, Heaphy, Hill, Ingram, Johnson, Killingsworth, McCarthy, McFadden, Medows, Snyder, Weno