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Denials and Appeals in Medicaid Managed Care

Background and state scan findings

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Overview

- Project work plan
- Background
- Federal Medicaid requirements
- Key findings from state scan
- Next steps

Work Plan: Denials and Appeals

To what extent are Medicaid beneficiaries in managed care experiencing denials and filing appeals?

How do states and CMS monitor and oversee denials and appeals in managed care?

Do beneficiaries find the appeals process to be accessible?

2023

JANUARY

- Literature review
- Federal policy review
- State scan

APRIL

- State and stakeholder interviews

SEPTEMBER

- Beneficiary focus groups

Background: Definitions

- Adverse benefit determinations (denials): This includes when a managed care organization (MCO):
  - Denies or limits the authorization of a beneficiary's requested service
  - Reduces, suspends, or terminates a beneficiary's previously authorized service
  - Denies payment for services already received
- Appeal:
  - A review of an adverse benefit determination by the MCO
- Grievance:
  - An expression of dissatisfaction about any matter other than an adverse benefit determination

Background

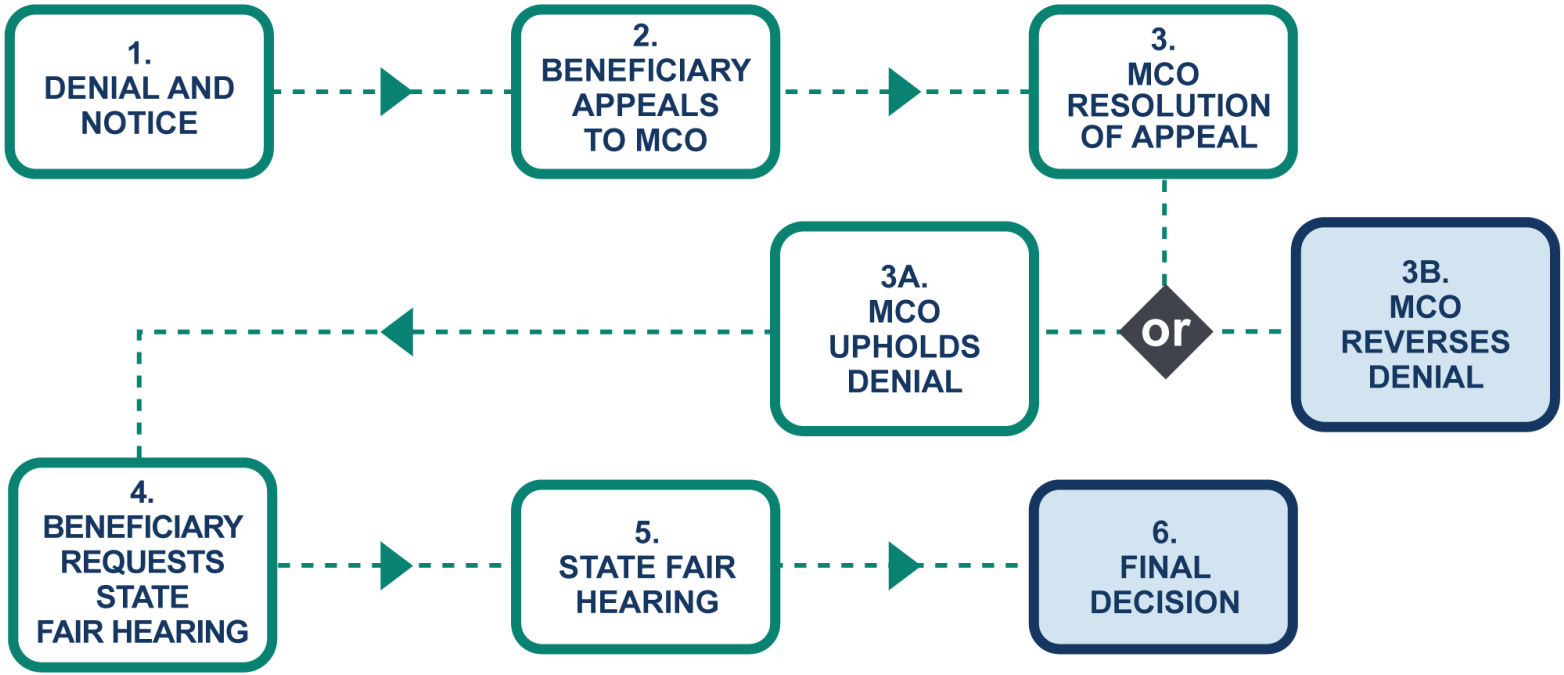
- Little is known about the extent to which Medicaid MCOs deny care
  - Research suggests Medicaid MCOs deny care at higher rates than Medicare Advantage (MA) plans
- Very few denials are appealed
  - Federal exchanges: One-tenth of one percent of denials were appealed, and 27 percent of denials were overturned by the plan
  - MA: the appeal rate is 1.1 percent, and 75 percent of denials are overturned by the plan
- Media reports have highlighted several instances of Medicaid MCOs inappropriately delaying or denying medically necessary services

Federal Medicaid Requirements: Appeals Process

Federal Medicaid Requirements

- MCOs may limit services based on medical necessity or utilization management tools (e.g., prior authorization)
- Services must be no less than the amount, duration, and scope for the same services offered under fee-for-service (FFS)
  - MCOs cannot arbitrarily deny based solely on illness or condition of the beneficiary
- Federal rules lay out requirements for service authorization and appeals processes
  - Timelines (e.g., MCOs must resolve appeals in 30 days)
  - Processes (e.g., staffing requirements for review of authorizations and appeals)
  - State flexibilities (e.g., external medical review, shorter review times for MCOs)

Federal Medicaid Requirements: Appeals Process



Federal Medicaid Requirements: Monitoring and Oversight

- Focus is largely on compliance reviews and monitoring trends related to appeals
  - No required monitoring of denial rates or reasons for denials
  - No required monitoring of outcomes of appeals
  - No required audit of denials or appeals to assess whether denials were clinically appropriate
- States must contract with External Quality Review Organization (EQRO) – focus is on compliance
- States may require plan accreditation, which includes compliance reviews

State Scan

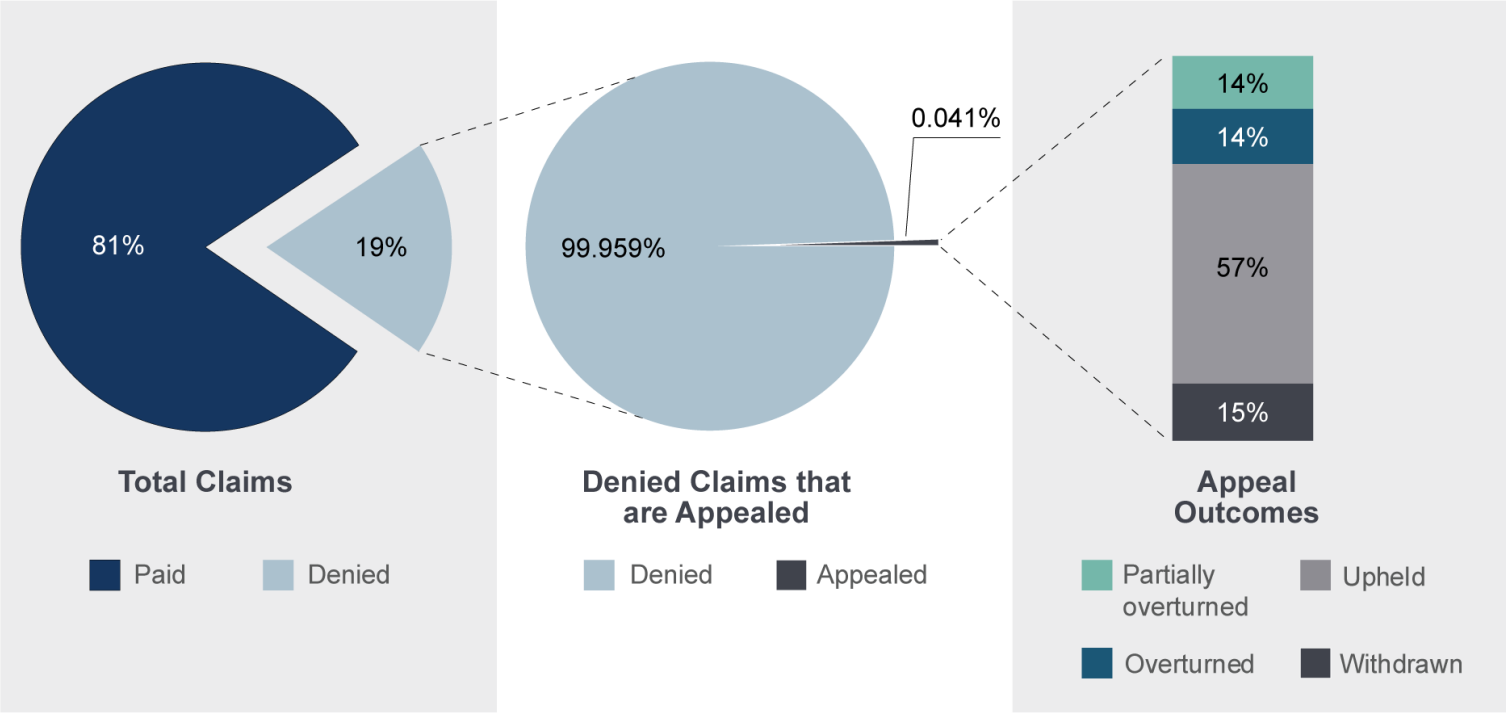
Key Questions

- What do we know about the extent to which Medicaid beneficiaries are denied services in managed care?
- What do we know about the extent to which Medicaid beneficiaries pursue appeals, and how frequently do MCOs or states reverse the original decision?
- What information are states collecting from MCOs on denials and appeals?
- Are MCOs complying with federal regulations for the appeals process?

State Scan: Key Findings on Denial Rates and Appeals

- Eleven states publicly report information on denials
  - Reporting across states is inconsistent
- Eleven states publicly report on appeals metrics
  - Very few beneficiaries appeal denials
  - Most states report the total appeal numbers, some report appeals per 1,000 members
- Nine of the 11 states report on appeal or state fair hearing outcomes
  - MCO denials overturned in favor of the beneficiary ranged from 19 percent (Iowa) to 74 percent (Ohio)

Selected Example: Iowa, 4th Quarter 2021

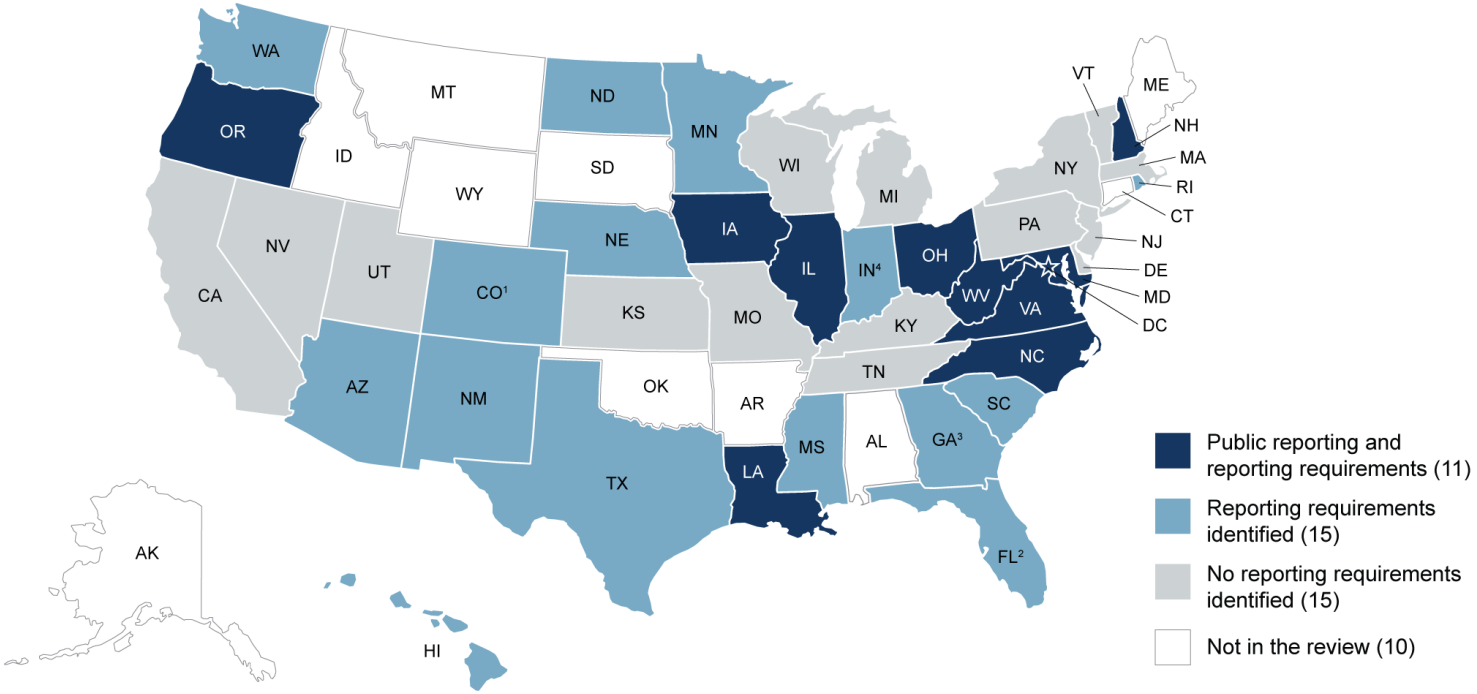


Source: Iowa Managed Care Organization Report, State Fiscal Year 2022

State Scan: Key Findings on Monitoring of Denials

- Over half of the study states require MCOs to report some data related to denials
- Reporting requirements varied
  - 11 states require MCOs to report reason for the denial
  - 14 states require MCOs to report denials by service type

State Scan: Voluntary Reporting of Denials



Sources: MACPAC analysis of state Medicaid websites and dashboards and EQRO annual reports, 2022.

Notes: Excluded states with comprehensive managed care rates lower than 5 percent, but included North Carolina due to their recent transition to comprehensive managed care (MACSTATS 20221). (1) Colorado collects data on denials for behavioral health only. (2) Florida collects data on denials for long term care only. (3) Georgia collects denial data by service type or category only. (4) Indiana collects data on the reasons for denials only.

State Scan: Key Findings from EQRO Study

- More than half of reviewed states had at least one plan out of compliance with federal regulations on appeals or authorization and coverage of services
- Challenging to compare EQRO findings
  - Scoring and methodology vary by states
- Examples of noncompliance:
  - Not meeting authorization or appeal timelines
  - Requiring follow up in writing, after filing an oral appeal
  - Reviewers without appropriate expertise

Next Steps

- Awaiting Office of the Inspector General (OIG) reports on denials in managed care (select states)
- April Meeting: findings from state and stakeholder interviews
- Commissioner feedback:
  - Specific areas of interest for interviews and focus groups
  - Direction of research and policy options

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