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Improving the Managed Care Appeals Process

Lesley Baseman and Amy Zettle

MACPAC

Medicaid and CHIP Payment and Access Commission

@macpacgov

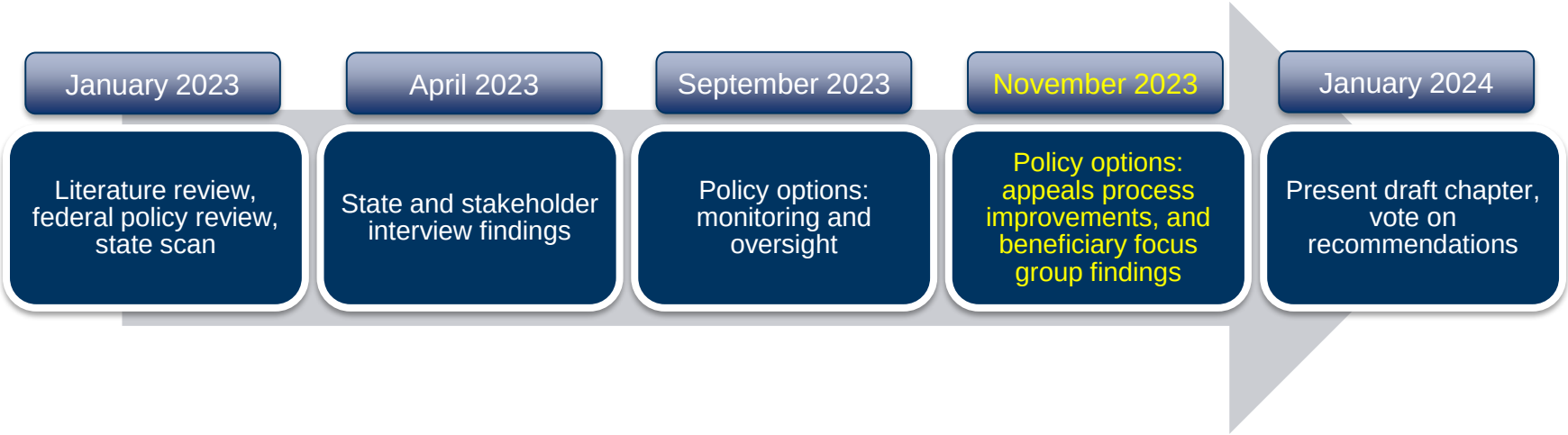
www.macpac.gov

Overview

- Project overview
- Focus group methodology
- Appeals process challenges
- Policy options
- Next steps

Project Overview

- Study objective:
  - Examine how state and federal officials monitor Medicaid managed care denial and appeal processes
  - Examine whether denial and appeal processes ensure access to covered, medically necessary care
  - Explore whether beneficiaries find the appeals process to be accessible



Focus Group Methodology

Methodology

- MACPAC contracted with Mathematica to conduct focus groups with beneficiaries and caregivers to learn about their experiences navigating the appeals process
  - Four focus groups with four to six participants per group
  - Two individual interviews with beneficiaries

- Participants were eligible for focus groups if they had appealed a managed care denial in the last three years
  - Recruitment largely occurred through community-based organizations, primarily legal assistance agencies and state ombudsman's offices

Participant Characteristics

Characteristics	Count (N = 22)
State	
New York	9
Ohio	6
Delaware	2
Other*	5
Type of participant	
Caregiver	17
Enrollee	5
Service or item that was denied or reduced	
Home health aide/nursing hours	15
Medication or medical device	5
Unknown**	2
Gender	
Female	16
Male	6
Race	
White	13
Black	6
Asian	1
Unknown**	2

Notes:

* States for which there was only one participant: Louisiana, Massachusetts, Michigan, New Jersey, and Washington.

** Information was not collected or participant did not want to provide this information.

Appeals Process Challenges

Lack of Trust and Frustration with the Appeals Process

- Many focus groups participants did not have a positive experience with their MCO
  - Several focus group participants indicated that the member services representatives were unknowledgeable and unhelpful
- Several focus group participants felt powerless against the MCO
- Participants who had filed appeals previously had lower expectations to win their appeal than those who were filing for the first time

“The level of the customer service agent’s ability to help needs to match the seriousness of the situation that’s being dealt with. And I find that there’s a large gap in that knowledge and ability to be helpful.”

– Beneficiary participant

“So, you’re really struggling with the whole [appeals] process, and it truly is a David versus Goliath thing where you’re up against the insurance company, and they know that and they make you feel like that.”

– Caregiver participant

“They want you to give up; that’s their goal. They want you to just like, throw your hands up in the air and just say, screw this. I’m going to pay for it myself because my mom or my dad or I can’t manage without the services.”

– Caregiver participant

Access Barriers to Continuation of Benefits

- **Awareness.** Focus group participants were generally unaware of their rights

- **Timelines.** Many interviewees thought the timeline of 10 days from the date of the denial notice to file was insufficient

- **Repayment.** Beneficiary advocates shared that the threat of potential repayment for services dissuades beneficiaries from continuing their services

“I would tell you from my perspective [on continuation of benefits], [the health plan] didn't allow, they didn't inform us, educate us, any of that.”

– Caregiver participant

Challenging and Burdensome Appeals Process

- Late and unclear denial notices
  - Some participants did not receive the notices with enough time to appeal or never received the notice
  - They did not understand the plan's rationale for denying the service or subsequently deciding the appeal
- Burdensome process
  - Many participants shared that the process is time-consuming and difficult to manage, especially the gathering of clinical documentation
- External support critical for appeals
  - Many focus group participants sought help from medical providers, community organizations, and the state ombudsman's office in navigating their appeal
  - Interviewees suggest that external support can influence a beneficiary's choice to appeal

“It's a lot of phone calls and a lot of time. We make jokes, people who are caring for a family member, it's a 20-phone call day…. You got to call, got to get the right person, or they have to call you back.”

– Caregiver participant

“The wheels turn very slowly and when people are dealing with elderly, dementia, children themselves, you just want to, you want to go in a corner and like, you know, and cry. It’s terrible. It’s like exasperating.”

– Caregiver participant

Policy Options

Policy Options

Challenge	Policy Option
Lack of trust and frustration with the MCO appeal process	1 CMS should require states to establish an independent, external medical review process for beneficiaries
Access barriers to continuation of benefits	2 CMS should issue guidance and rulemaking on continuation of benefits
Challenging and burdensome appeals process for beneficiaries	3 CMS should issue guidance to improve beneficiary access to and support throughout the appeals process
	4 CMS should require that MCOs provide individuals with a choice to receive notices in electronic format

Policy Option 1: External Medical Review

CMS should require states to establish an independent, external medical review

- CMS should:
  - Revise regulations to require states to establish an independent, external medical review (EMR) process for beneficiaries once they have exhausted the internal MCO appeal (42 CFR § 438.402(c)(i)(B), 438.408(f)(ii))
  - Offer states the option of setting up automatic, external medical review

- Rationale:
  - Requiring an independent clinical review would improve trust in the process and ensure appropriate access to medically necessary services
    - 46 percent of appeals to an EMR were overturned in favor of the beneficiary per the HHS Office of Inspector General
  - EMR can be helpful tool for monitoring and oversight of MCO denials and overturn rates

Policy Option 2: Continuation of Benefits

CMS should issue rulemaking and guidance on continuation of benefits

- CMS should:
  - Issue rulemaking to extend the timeline for beneficiaries to request continuation of benefits and require monitoring and oversight of continuation of benefits (42 CFR § 438.420, 438.66)
  - Issue clarifying guidance on ways to improve beneficiary notices to more prominently display information about continuation of benefits, and on instances in which beneficiaries may be subject to repayment for services

- Rationale:
  - Focus group beneficiaries were not aware of their right to continue benefits
  - Interviewed stakeholders shared that short timeframes for filing and potential repayment can be barriers
  - Federal rules do not require monitoring of the use of continuation of benefits

Policy Option 3: Beneficiary Access and Support

CMS should issue guidance to improve beneficiary access to and support throughout the appeals process

- CMS should:
  - Issue guidance to states detailing tools and approaches to support beneficiaries seeking to navigate the appeals process
  - Include tools for improving the denial notice, reiterate MCO requirements for beneficiary support, and detail Medicaid opportunities for external support

- Rationale:
  - Few beneficiaries appeal services, and the complexity of the process highlights the need for significant external support
  - Improvements to denial notices would help beneficiaries better understand denials and the appeal process

Policy Option 4: Electronic Notices

CMS should require that MCOs provide beneficiaries with a choice to receive notices in an electronic format

- CMS should update federal rules to require that MCOs provide beneficiaries with a choice to receive electronic notices (e.g., phone, email, text message)
  - Current federal rules require that MCOs send written denial notices by mail (42 CFR § 438.404(c)).

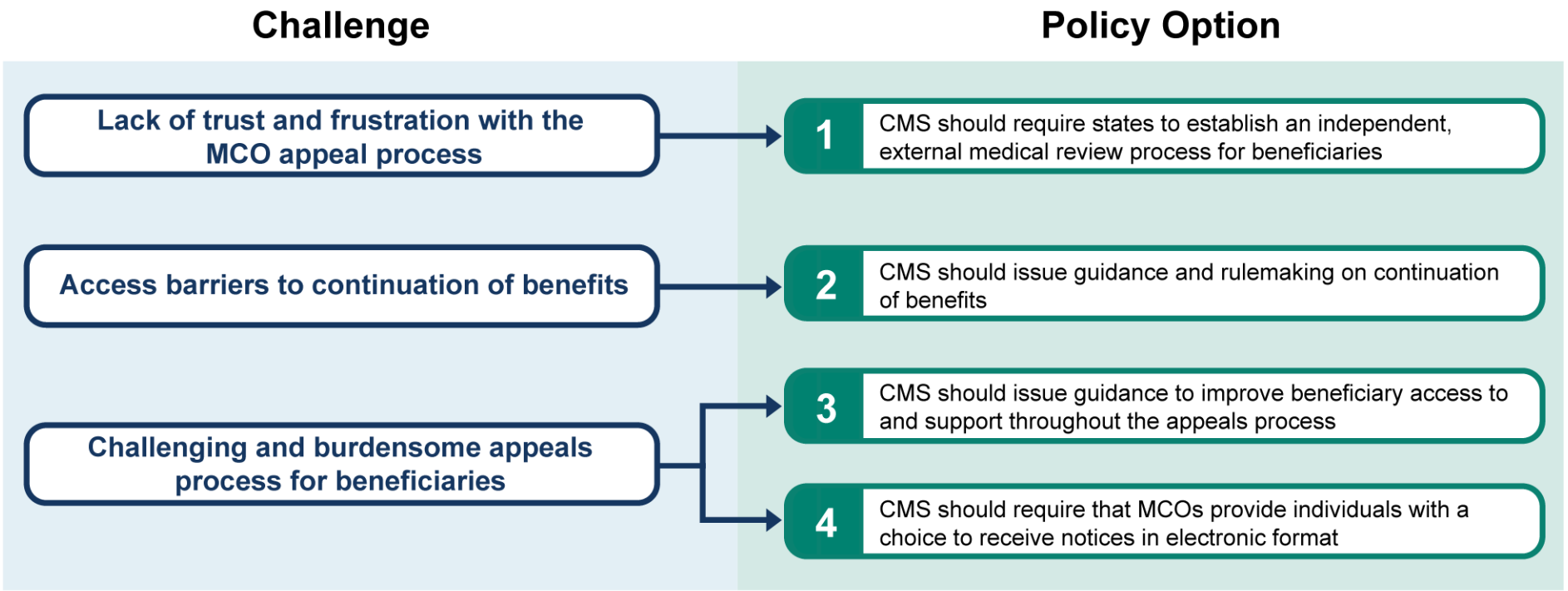
- Rationale:
  - Notices delivered by mail are often late or do not arrive at all
  - Beneficiary focus group participants supported additional modes of communication
  - This requirement would align with delivery requirements for eligibility notices (42 CFR § 435.918(b)(4))

Next Steps

- Commissioner discussion and feedback on policy options

- January meeting:
  - Vote on recommendations
  - Present draft chapter

Policy Options for Discussion



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