

Inside Health Policy**MACPAC Recommends Changes To Denial Appeals Process, MCACs****Dorothy Mills-Gregg | October 30, 2024**

The Medicaid and CHIP Payment and Access Commission plans to continue its dive into Medicaid managed care organizations' external quality review practices and transparency during its meeting Friday (Nov. 1), furthering a conversation from its September meeting that included a discussion about PACE model transparency.

MACPAC began its latest season on Sept. 19 with a wish list of issues commissioners want to delve deeper into, including PACE model transparency and transparency into each state's Medicaid managed care organization practices.

The next meeting is set for Thursday (Oct. 31) and Friday (Nov. 1), and commissioners are scheduled to discuss access to medications for opioid use disorder, timely access to home- and community-based services, and the growing trend among states to offer multi-year continuous eligibility for children. The final session on Thursday will be reviewing federal and state findings of youth use of residential treatment services -- a [continuation of a discussion from September](#).

The Friday sessions are expected to focus on Medicaid managed care, specifically their external quality review (EQR) policy options and state directed payments.

Commissioners discussed MCO oversight during their last meeting, and several were on opposite sides on how to approach the EQRs. While several commissioners, including Vice Chair Robert Duncan, support standardizing the reports and making them easier for stakeholders and beneficiaries to understand and access, others were cautious not to compare state Medicaid programs to each other.

Commissioner Tricia Brooks emphasized EQRs help advocates understand the quality MCOs are providing beneficiaries, and she urged policymakers to find some way of standardizing EQRs so stakeholders, especially advocates, can see what care MCOs are or aren't providing.

"I've done a good bit of work trying to educate the advocacy community about quality and how it fits into their work, but it's just not very accessible," Brooks said in the September meeting. "I have done tons of scanning EQR reports when I can find them, looking for keywords that I'm interested in -- 'maternal,' 'pediatric,' 'children' -- and sometimes you don't even find any of those words in the EQR reports."

Commissioner Dennis Heaphy also wanted to see the EQRs more accessible, suggesting states be required to put those reports in full on their websites and written in plain language.

"Quality is really about access to services, like the number of denials, the number of appeals that are overturned, you know, waiting times for specialists, care plan quality, care coordination quality," Heaphy said. "Like, those are things I think are what matter, and yet that information really isn't there for folks to -- either to themselves to choose a plan or for other folks to actually provide external pressure on the state or plans to -- or CMS to do more to improve the quality of the services that are being provided."

But Commissioners John McCarthy, [Carolyn Ingram](#) and Michael Nardone were cautious about using the EQRs for something other than a state-focused evaluation tool.



If commissioners want to see the reports turn more stakeholder-friendly, McCarthy suggested they consider breaking EQRs into two separate reports.

For Ingram, the question of EQRs is whether they are being shared with Medicaid advisory committees, legislative bodies or stakeholders, not how one state is performing versus the others.

"I wouldn't want to compare EQR results in New Mexico, for example, where we have large, vast deserts with no providers and culturally diverse populations who don't access care the same way they do in other states, and then compare that to the work in New York by the same health plan," Ingram said. "It's apples and kumquats or something [and] basketballs."

While not on the October meeting agenda, commissioners had a detailed discussion during their September meeting about transparency issues with the PACE model.

The Programs for All-Inclusive Care for the Elderly model is a Medicare and Medicaid program meant to help older Americans living in the community receive preventive, primary, acute and long-term care services. Specifically, this type of home- and community-based care model is available for older beneficiaries who need a nursing facility level of care but can live safely at home. The model is unlike other integrated care options for dually eligible beneficiaries as it is provider-led.

Commissioners urged staff to prioritize PACE beneficiary experiences and the model's scalability as current research, while mixed on cost savings, shows the model has cut down participating beneficiaries' hospitalization rates. One commissioner wanted to know how the model's uptake and outcomes differ in rural versus urban areas.

But for Commissioner Patti Killingsworth, the biggest issues facing PACE are transparency and accountability.

"[W]e really have very little insight into what people are actually receiving through that contracted PACE entity," Killingsworth said. "So, there's a lack of understanding about the dollars and what people are actually getting for those dollars which, as your presentation highlighted, can be a lot."

She urged commissioners to consider a need for more financial accountability and consistency in the model's current rate-setting process, where capitation payments are based on a blend of nursing home and home- and community-based services

"[Y]et very few people in the PACE program receive nursing facility services," Killingsworth said. "So, there's probably a favorable rate setting process when you take the cost of institutional care into account."

She also asked staff to investigate why the PACE program is exempt from so many other home- and community-based program requirements.

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Dorothy Mills-Gregg | January 26, 2024

A recommendation that Congress require states set up independent, external medical review processes for Medicaid denials wasn't unanimously endorsed by Congress' Medicaid payment advisers Friday (Jan. 26), but



they all supported six related recommendations to Congress and CMS, including one to require states report data on denials.

The Medicaid and CHIP Payment and Access Commission also approved recommendations last year that asked CMS to issue guidance clarifying how states can use monetary incentives to recruit beneficiaries, especially those from diverse backgrounds, to engage with federally mandated medical care advisory committees (MCACs). Overall, commissioners felt states can make better use of their MCACs.

On Friday (Jan. 26), Commissioners **Carolyn Ingram**, Angelo Giardino and John McCarthy voted against MACPAC's first recommendation that Congress require states set up review processes for appealing denials under Medicaid while Commissioner Adrienne McFadden abstained. McCarthy, Ingram and McFadden said they would instead rather see first implemented the sixth recommendation, which requires routine audits of managed care denials.

The finalized recommendation the three voted against, but which still passed, says, "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."

McCarthy voted against the first recommendation because he believes states can set up a better appeals process on their own and he wants to see how the audits work out. He also wants to tie incentives to the results of the state audits.

Specifically, the other suggestion, which passed unanimously, asks Congress to require states conduct routine clinical appropriateness audits of managed care denials and use the findings to ensure access to medically necessary care.

This sixth recommendation also would have CMS give states the flexibility to determine who conducts clinical audits and include clinical audits as an optional activity for external quality review, but commissioners also want to see the agency release guidance on the process, methodology and criteria necessary for determining if a denial was clinically appropriate.

MACPAC made several other denial process-related recommendations that passed unanimously.

CMS could improve the beneficiary experience with the appeals process if it issues guidance on the content and clarity of denials notices and shares best practices among managed care organizations when it comes to helping beneficiaries file an appeal, MACPAC recommends. CMS also could clarify how Medicaid can fund external entities like ombudsperson services.

CMS should require managed care organizations provide beneficiaries the option of receiving an electronic denial notice in addition to a mailed one, commissioners say.

MACPAC also recommends CMS extend the timeline for enrollees to request a continuation of benefits and the agency help states, via tools like providing model notice language, to ensure their enrollees know they have a right to continue receiving services while an appeal is pending.

CMS should also clarify the federal limits on repaying managed care organizations for continued benefits after a denial is upheld and supply states with model notice language that explains to beneficiaries they might have repay if their state allows for recoupment, commissioners say.



States should have standardized reporting requirements that make them collect and report data on denials, beneficiary use of continuation of benefits and appeal outcomes, MACPAC says. CMS would then require states to use these data to improve the performance of their managed care program.

Lastly, commissioners want to see CMS publicly post all state managed care program annual reports shortly after states submit them to CMS. States should also be required to include denials and appeals data on their quality rating system website so beneficiaries can use this information when selecting a health plan, MACPAC says.

MCACs

Meanwhile, MACPAC commissioners unanimously approved on Dec. 15 recommendations that CMS issue guidance focused on specific state concerns related to difficulties implementing MCACs. Commissioners also want state Medicaid agencies to develop plans to recruit beneficiary members from historically marginalized communities as well as develop and implement policies that reduce beneficiary participation barriers.

Though some commissioners were concerned their recommendations don't go far enough to increase beneficiary involvement in the local advisory committees that let stakeholders provide feedback on their state's Medicaid policies.

"It's not just about checking the box that we got this person and that person on the Commission or on the committee, but how did we incorporate their feedback into meaningful change into the program? And I think that's the piece we haven't nailed down yet, and I'd like to see us continue to work on it," Commissioner Tricia Brooks said after her colleague Heidi Allen made a similar plea that MACPAC keep MCACs on their radar.

Their MCAC recommendations come as CMS [plans to revamp the advisory committees](#) to let members comment on policy making and program administration, not just health services.

CMS also proposed in its rule last spring to require at least 25% of the newly named Medicaid Advisory Committee membership to include Medicaid beneficiaries, family members and caregivers. Others on the MAC would include consumer advocacy groups, clinical providers or administrators, Medicaid managed care plans and other state agencies that serve Medicaid beneficiaries, under proposed minimum representation requirements.

The White House Office of Management and Budget's website indicates the final rule will be released in April.

The National Law Review

Quick Hits

Stacey Weiner | May 8, 2023

The US Government Accountability Office announced the appointment of six new members to the Medicaid and CHIP Payment and Access Commission (MACPAC). The newly appointed members are Timothy Hill, [Carolyn Ingram](#), Patti Killingsworth, Adrienne McFadden and Jami Snyder, whose terms expire in April 2026, and John B. McCarthy, who was appointed to serve out Laura Herrera Scott's remaining term, which expires in April 2024. Current MACPAC member Robert Duncan was named the Commission's vice chair.

