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MACPAC: Prior Authorization, Denials, and Appeals

Overview of project work and recommendations

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Overview

- Prior Authorization
- Denials and appeals
  - Project overview
  - Federal Medicaid requirements
  - Challenges
  - Recommendations
- Other payment and finance work at MACPAC

Prior Authorization

General Background and Medicaid Policy

Background on Prior Authorization in Medicaid

Prior Authorization in Medicaid

- State Medicaid agencies and MCOs have flexibility to determine which items and services require prior authorization (§ 1902(a)(30) of the Act and 42 CFR § 438.210)
- States cannot use prior authorization for EPSDT screening services

Common Services Subject to Prior Authorization

Non-emergency medical transportation	Durable medical equipment	Behavioral health services	Inpatient hospital stays
Inpatient and outpatient surgeries and procedures	Rehabilitation services	Nursing facility services	Prescription drugs

Federal Requirements for Medicaid FFS

- States must establish a utilization control program and written criteria for evaluating the appropriateness of Medicaid services (42 CFR § 456)
- States must provide timely and adequate written notice of any decisions regarding a denial of benefits or services, or a change in the level of benefits or services covered (42 CFR § 435.917)
- Recent federal rulemaking will place new requirements on FFS programs, including decision timeframes

Federal Requirements for Medicaid MCOs

- Medical services must be comparable to services provided in FFS programs in amount, duration, and scope (42 CFR § 438.210)
- MCOs must:
  - Consult with the requesting provider when appropriate (42 CFR § 438.210)
  - Adopt practice guidelines that reflect clinical evidence and expert consensus, and use those guidelines for making utilization management decisions (42 CFR § 438.236)
  - Have tools in place to ensure that prior authorization review criteria are applied consistently; any MCO decisions to deny services must be made by individuals with appropriate clinical expertise to address the beneficiary's health care needs (42 CFR § 438.210)
  - Provide denial notifications to requesting providers and give beneficiaries a notice of denial in writing (42 CFR § 438.210)

Oversight of Prior Authorization

FFS

Current regulations do not specify any monitoring requirements for prior authorization practices (42 CFR § 447.203)

New oversight of prior authorization in both FFS and managed care is implemented by the 2024 Advancing Interoperability and Improving Prior Authorization Processes final rule

MCOs

MCOs are subject to oversight by state Medicaid agencies via external quality review organizations (EQROs).

EQRO reviews must include information on MCOs' compliance with standards Subpart D of 42 CFR Section 438.66, including the standards for authorization of services in 42 CFR Section 438.210

EQRO review guidance does not require collection of specific data elements related to utilization management, or that EQROs assess whether prior authorization denials are clinically appropriate

2024 Interoperability and Prior Authorization Final Rule

- The rule requires FFS programs and MCOs to:
  - Make prior authorization decisions in a standard time frame (7 days for standard requests and 72 hours for expedited requests)
  - Provide reasons for any prior authorization denials to the requesting provider
  - Publicly report aggregate prior authorization metrics on the payer's website
  - Implement and maintain four application programming interfaces (APIs) to promote electronic prior authorization

Note: This rule does not apply to drugs

State Efforts in Medicaid Prior Authorization

State Prior Authorization Laws and Regulations

Gold Carding
Temporarily exempts providers from prior authorization requirements when they achieve a set number of approvals for a particular medication or service

Reviewer Requirements
Requires that denial and appeal decisions are made by people with specific license requirements or clinical training and/or no financial incentive

Electronic Prior Authorization
Requires plans to implement automated electronic prior authorization systems or electronic portals as an alternative to traditional prior authorization mediums

Exceptions
Exempts certain medications or services from prior authorization requirements

Limits on Retrospective Denials
Limits denials of payment after the medication or service was provided

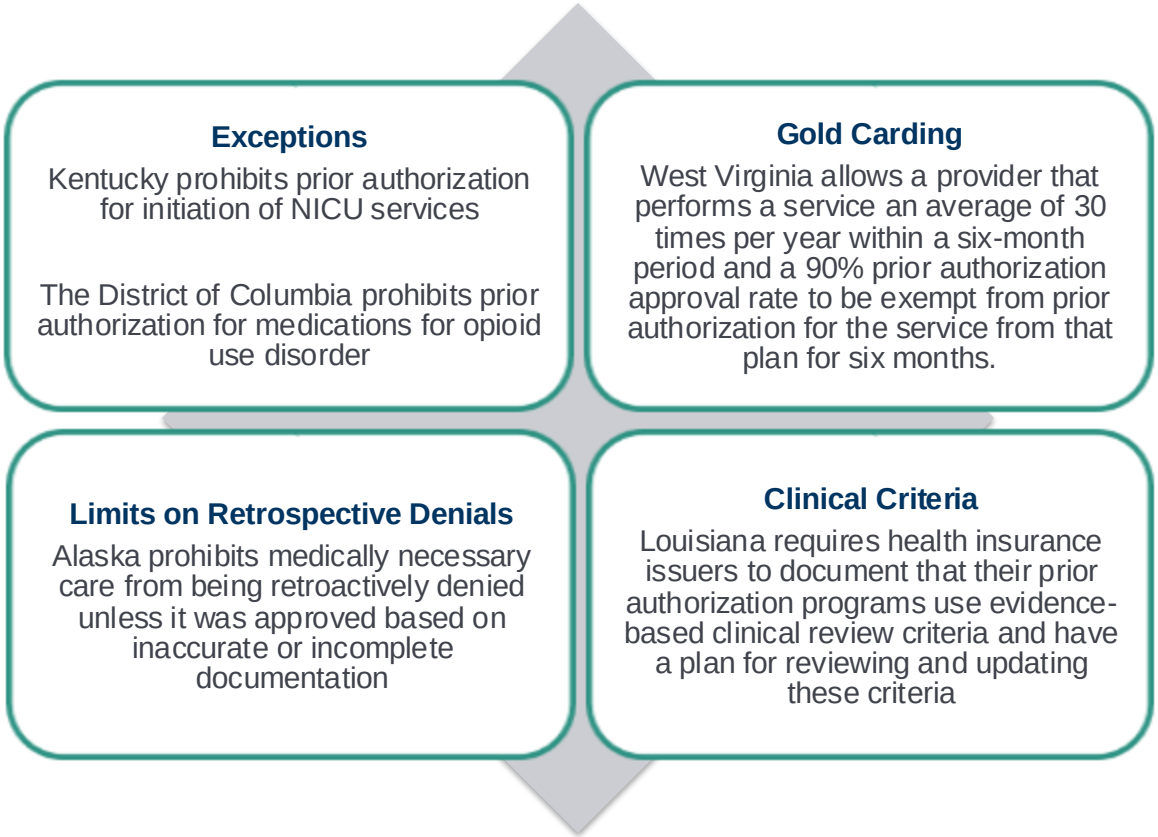
Transparency Requirements
Requires payers to publish their prior authorization requirements and provide the clinical basis for prior authorization decisions to the provider

Shortened Decision Timelines
Requires plans to issue prior authorization decisions sooner than under federally established timelines

Clinical Criteria
Sets standards for developing the clinical criteria informing prior authorization decisions

Data Reporting
Requires reporting of data on prior authorization to an authority such as the state

State Legislation Examples



Key Findings

Key Findings

- Prior authorization has been used successfully to reduce overutilization of some items, redirect care to less expensive treatments, and help ensure that care aligns with accepted clinical standards
- Prior authorization may cause delays or denials of needed care in some situations
- The prior authorization process can be burdensome and costly to providers and diverts clinical resources away from patient care
- The process may also be burdensome to patients and caregivers when they have to devote effort to get approval for care

Key Findings

- The CMS Interoperability and Prior Authorization final rule requires Medicaid and other payers to implement and maintain electronic prior authorization, shorten the time frames in which prior authorization decisions must be made, and increase transparency in the information that is made available to patients, providers, and the public
- Some states have passed legislation to streamline the prior authorization process, require standards for developing the clinical criteria to determine medical necessity, improve transparency of prior authorization requirements, and require reporting to state authorities

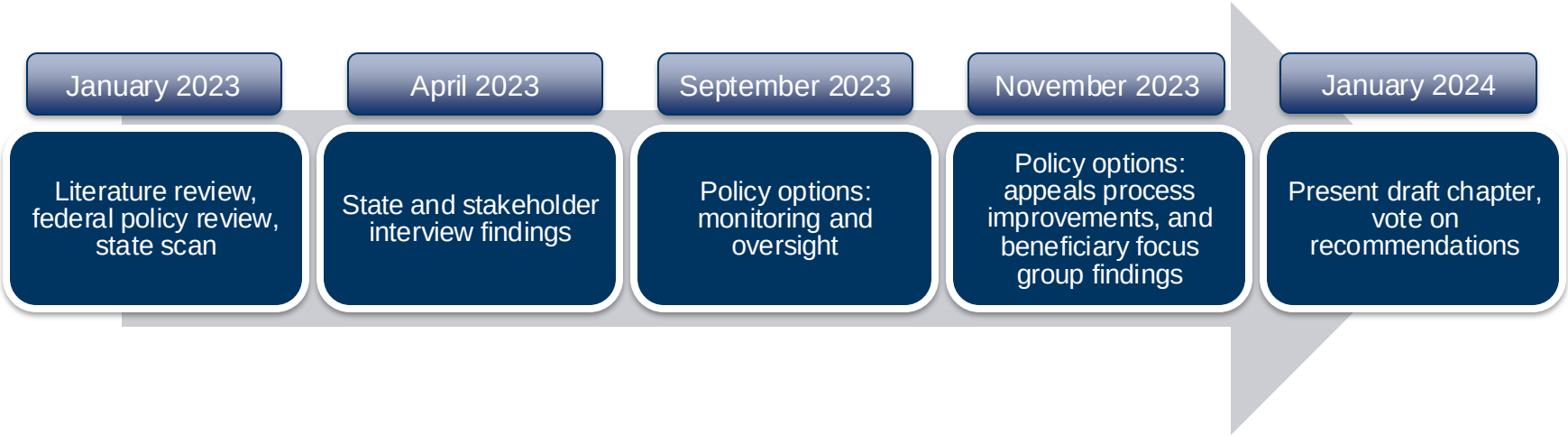
Denials and Appeals in Managed Care

MACPAC Work and Recommendations

Project Overview

Project Overview

- Study objectives:
  - Examine how state and federal officials monitor Medicaid MCOs' 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

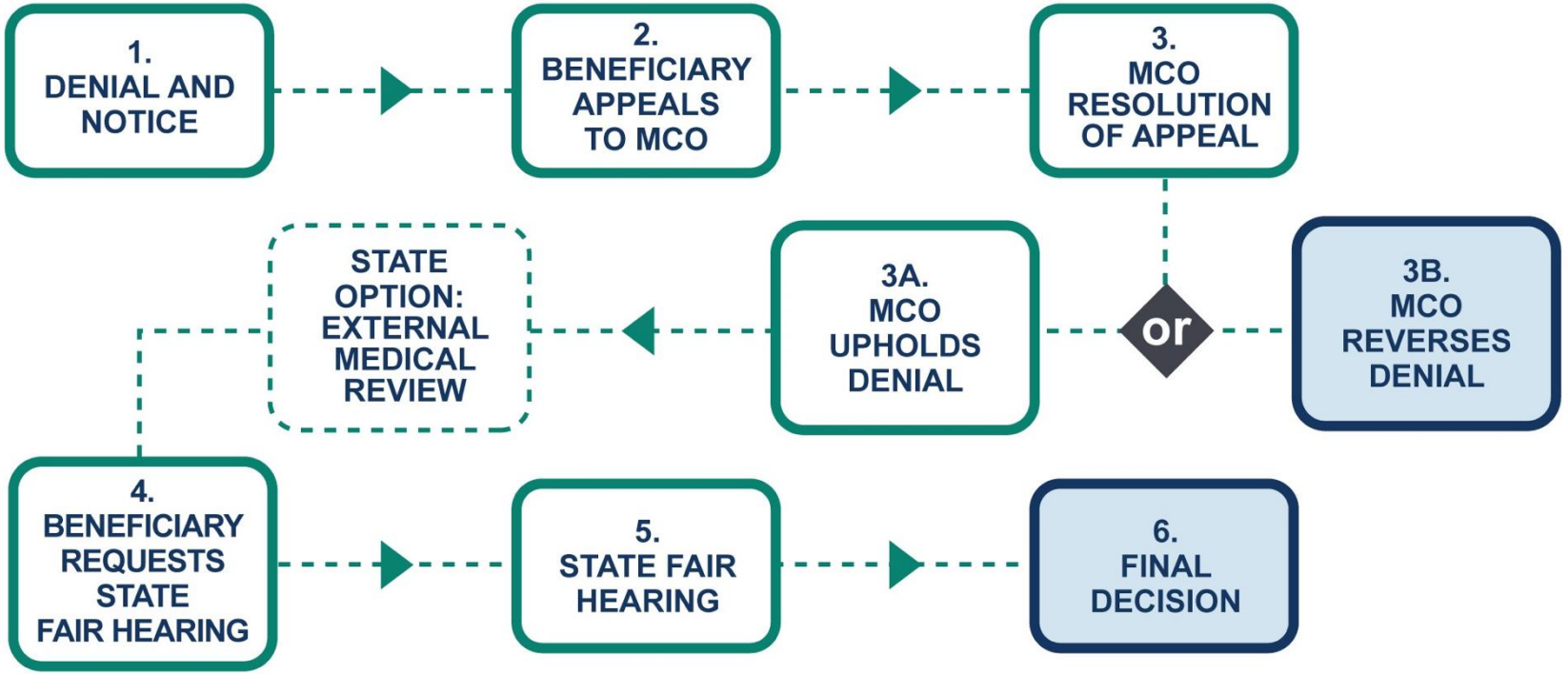


Federal Medicaid Requirements

Federal Medicaid Requirements: Overview

- MCOs may limit services based on medical necessity or utilization management tools (e.g., quantity limits, prior authorization)
  - MCO must provide notice of denial to beneficiary
- Beneficiaries have a statutory right to appeal denials
- MCOs must have an internal system to review appeals
- Federal rules lay out requirements for service authorization and appeals processes
  - 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

- **States** are required to collect and monitor specific plan-reported data related to appeals
  - Required to collect the reason for the appeal, relevant dates (e.g., received, reviewed, resolved), and the name of the beneficiary
  - Not required to collect data on denials or denial reasons
  - Not required to collect data on appeal outcomes
- In addition to state monitoring programs, states must contract with **EQROs** to conduct oversight of MCOs
  - Focus on compliance with federal requirements
- **Federal government** collects appeals data annually from states
  - Reporting includes the number and type of appeals, the service types of appeals, the number of state fair hearings and their outcomes, and the number of external medical reviews

Challenges

Current Challenges

Appeals process

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

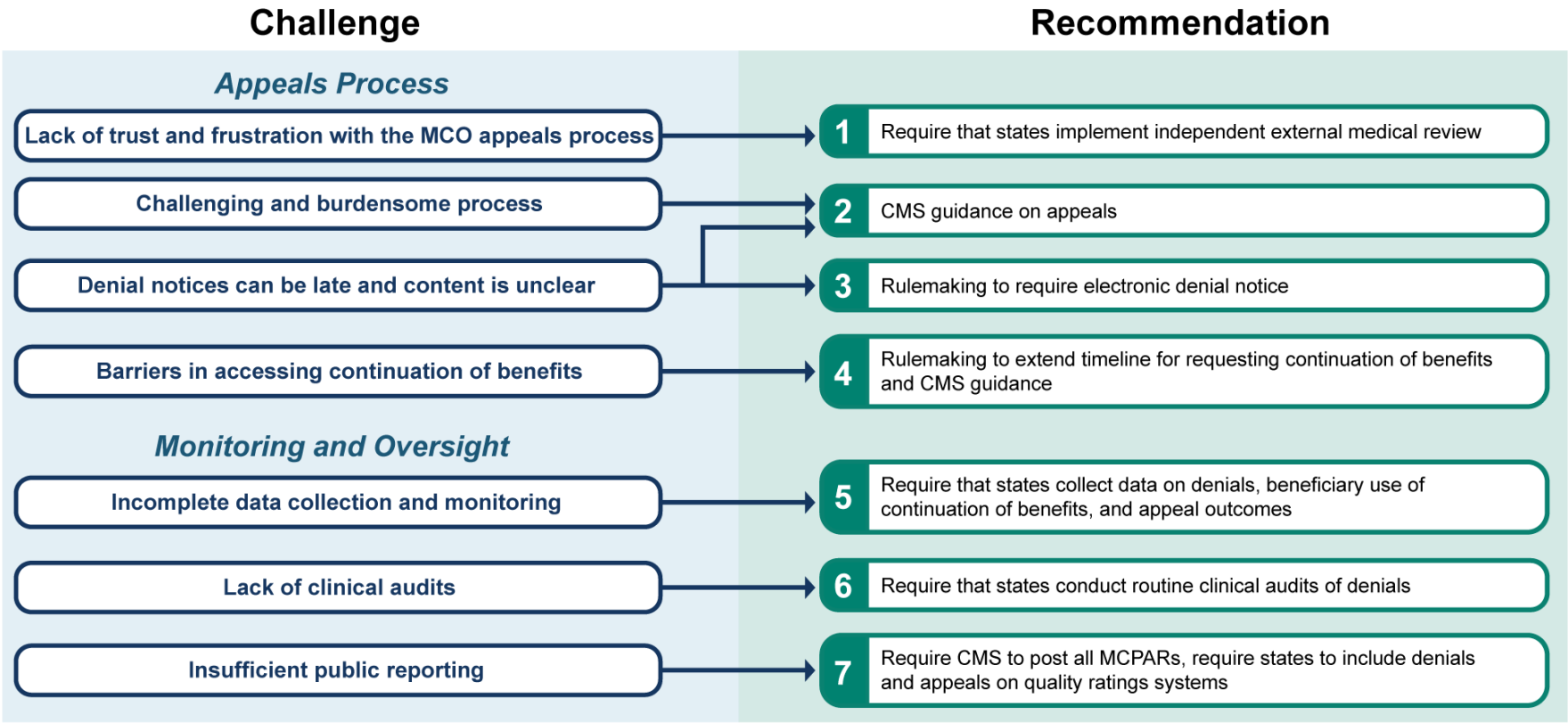
Current Challenges

Monitoring, oversight, and transparency

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

Recommendations

Policy Options



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.

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 ombudsperson services.

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.

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.

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.

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.

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.

Other MACPAC Work

Current projects and future work

Other MACPAC Work

- Hospital payment
  - Update 2017 MACPAC hospital payment index to include managed care and outpatient hospital services
  - Review new supplemental payment reports and state directed payment preprints to see how these payments are being targeted to different providers
- Use of automated tools in prior authorization processes
  - How are states and managed care plans using algorithms or artificial intelligence to assist in prior authorization decisions?
  - Are states currently monitoring or governing the use of automation in prior authorization processes in Medicaid?
  - What federal levers exist to govern the use of automation in the prior authorization process for MCOs and in FFS?

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