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High Rates of Prior Authorization Denials by Some Plans and Limited State Oversight Raise Concerns About Access to Care in Medicaid Managed Care

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Why OIG Did This Review

As Medicaid managed care enrollment continues to grow, Medicaid managed care organizations (MCOs) play an increasingly important role in ensuring that people with Medicaid have access to medically necessary, covered services. In recent years, allegations have surfaced that some MCOs inappropriately delayed or denied care for thousands of people enrolled in Medicaid, including patients who needed treatment for cancer and cardiac conditions, elderly patients, and patients with disabilities who needed in-home care and medical devices. Ensuring access to appropriate care for people in Medicaid managed care is a priority for OIG. In addition, OIG received a congressional request to evaluate whether MCOs are providing medically necessary health care services to their enrollees.

How OIG Did This Review

We identified and selected the seven MCO parent companies with the largest number of people enrolled in comprehensive, risk-based MCOs across all States. These 7 parent companies operated 115 MCOs in 37 States, which enrolled a total of 29.8 million people in 2019. We collected data from the selected parent companies about prior authorization denials and related appeals for each MCO they operated. We also surveyed State Medicaid agency officials from the 37 States to examine selected aspects of State oversight of MCO prior authorization denials and appeals, along with State processes for external medical reviews and State fair hearings.

High Rates of Prior Authorization Denials by Some Plans and Limited State Oversight Raise Concerns About Access to Care in Medicaid Managed Care

Key Takeaway

Three factors raise concerns that some people enrolled in Medicaid managed care may not be receiving all medically necessary health care services intended to be covered: (1) the high number and rates of denied prior authorization requests by some MCOs, (2) the limited oversight of prior authorization denials in most States, and (3) the limited access to external medical reviews.

What OIG Found

Overall, the MCOs included in our review denied one out of every eight requests for the prior authorization of services in 2019. Among the 115 MCOs in our review, 12 had prior authorization denial rates greater than 25 percent—twice the overall rate. Despite the high number of denials, most State Medicaid agencies reported that they did not routinely review the appropriateness of a sample of MCO denials of prior authorization requests, and many did not collect and monitor data on these decisions. The absence of robust oversight of MCO decisions on prior authorization requests presents a limitation that can allow inappropriate denials to go undetected in Medicaid managed care.

Although the appeals process is intended to act as a potential remedy to correct inappropriate denials, several factors may inhibit its usefulness for this purpose in Medicaid managed care. Most State Medicaid agencies reported that they do not have a mechanism for patients and providers to submit a prior authorization denial to an external medical reviewer independent of the MCO. Although all State Medicaid agencies are required to offer State fair hearings as an appeal option, these administrative hearings may be difficult to navigate and burdensome on Medicaid patients. We found that Medicaid enrollees appealed only a small portion of prior authorization denials to either their MCOs or to State fair hearings.

In contrast to State oversight of prior authorization denials in Medicaid managed care, in Medicare managed care (called Medicare Advantage) CMS's oversight of denials by private health plans is more robust. For example, each year CMS reviews the appropriateness of a sample of prior authorization denials and requires health plans to report standardized

data on denials and appeals. Further, Medicare Advantage enrollees have access to automatic, external medical reviews of denials that plans uphold at the first level of appeal. These differences in oversight and access to external medical reviews between the two programs raise concerns about health equity and access to care for Medicaid managed care enrollees.

What OIG Recommends

More action is needed to improve enrollee protections and State oversight of prior authorization denials in Medicaid managed care to help ensure that enrollees have access to all medically necessary and covered services. Therefore, we recommend that CMS:

(1) require States to review the appropriateness of a sample of MCO prior authorization denials regularly, (2) require States to collect data on MCO prior authorization decisions, (3) issue guidance to States on the use of MCO prior authorization data for oversight, (4) require States to implement automatic external medical reviews of upheld MCO prior authorization denials, and (5) work with States on actions to identify and address MCOs that may be issuing inappropriate prior authorization denials.

In its response, CMS did not indicate whether it concurred with the first four recommendations; CMS concurred with the fifth recommendation.

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BACKGROUND

OBJECTIVES

1. To determine the extent to which selected Medicaid managed care organizations (MCOs) denied requests for the prior authorization of services, and the extent to which those denials were upheld or overturned on appeal.
2. To examine selected aspects of State oversight of MCOs' denial and appeals processes.
3. To examine appeal processes for Medicaid managed care, including the extent to which States offered external medical reviews as an option.

Under Medicaid managed care, States contract with insurance companies (referred to in this report as "parent companies") to deliver all or a portion of covered services to people enrolled in Medicaid through MCO health plans.[1] State Medicaid agencies (States) pay a set amount per person enrolled in the MCO, and MCOs are expected to provide coverage for efficient, high-quality care while also managing program costs. MCOs make decisions each year about whether to approve millions of requests for coverage of specific services for individual enrollees according to medical necessity and relevant coverage requirements (this process is referred to as "prior authorization"). Federal regulations stipulate that MCOs may not arbitrarily deny or reduce a required service because of a patient's diagnosis, type of illness, or condition.[2] In capitated payment models, such as the model used in Medicaid managed care, insurance companies receive a fixed amount of money per enrollee regardless of the number of services provided to the enrollee.[3]

Thus, a concern about capitated payment models is the potential incentive for insurers to inappropriately deny access to covered services and payments to increase profits. For example, media reports have detailed concerning allegations that MCOs in several States inappropriately delayed or denied care for thousands of people enrolled in Medicaid, including patients who needed treatment for cancer and cardiac difficulties, elderly patients, and patients with disabilities who needed in-home care and medical devices.[4] These allegations were particularly concerning because many Medicaid managed care enrollees are people of color (50 percent of enrollees)[5] and have low incomes.[6] People of color and people with lower incomes are at increased risk of receiving low-quality health care and experiencing poor health outcomes, which makes ensuring access to care particularly critical for the Medicaid population.[7]

In response to the allegations, the Office of Inspector General (OIG) received a congressional request to examine whether MCOs meet their obligations to serve people enrolled in Medicaid.

Similar program incentives exist in the capitated payment model used in Medicare Advantage (Medicare's managed care program), which makes the Centers for Medicare & Medicaid Services' (CMS's) oversight of Medicare Advantage a useful comparison to State oversight of Medicaid managed care.[8] As such, this evaluation includes an examination of the extent to which three key tools from the Medicare Advantage program were used in Medicaid managed care: (1) appropriateness reviews of health plan denials of care, (2) denials data collection and monitoring, and (3) external medical necessity reviews.

Background

As of May 2022, approximately 82 million people were enrolled in Medicaid—a 52-percent increase compared to enrollment in June 2012.[9] Approximately 72 percent of Medicaid enrollees received their health care coverage through comprehensive, risk-based MCOs in July 2020.[10, 11] Medicaid paid MCOs approximately $377 billion in fiscal year 2021—more than half of total Medicaid spending for the year.[12, 13]

MCO Prior Authorization Decisions and Appeals

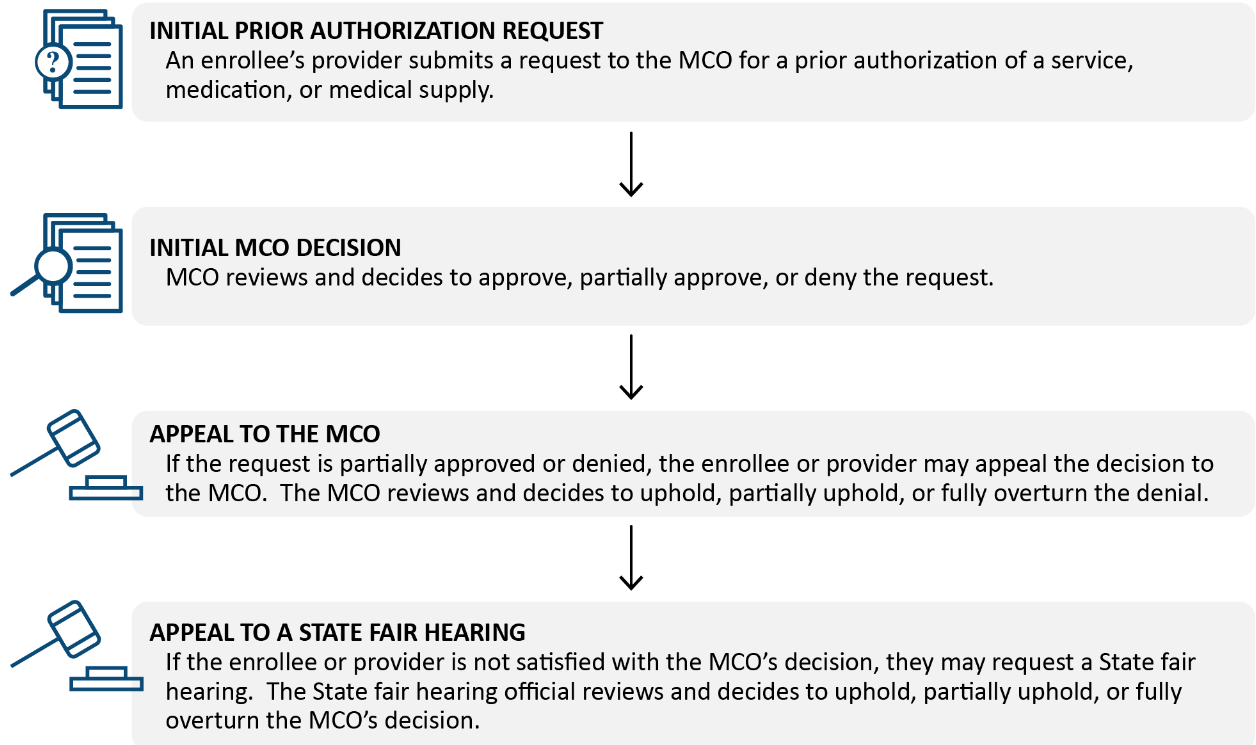
Under Federal regulations, States must allow MCOs to use prior authorization for certain items, services, and prescription drugs before a health care provider delivers the requested care.[14] Prior authorization can be used to manage costs by denying services that the MCO judges to be inappropriate or not medically necessary. However, Federal regulations stipulate that prior authorization may not be used to arbitrarily restrict access to medically necessary services covered by the MCO's contract. That is, States must ensure that MCOs cover services in at least the same "amount, duration, and scope" that would be covered under Medicaid Fee-for-Service.[15] In December 2022, CMS proposed a rule (which had not been finalized as of June 2023) that would implement an electronic prior authorization process, shorten the time frames for MCOs to process prior authorization requests, and establish policies to make the prior authorization process more efficient and transparent.[16]

As shown in exhibit 1 on page 3, the process for prior authorization requests, MCO decisions, and appeals involves several potential steps.[17]

Prior Authorization Requests. When a provider requests prior authorization for a service, the MCO decides whether to approve, partially approve, or deny the request.[18]

Appeals. Enrollees or providers who disagree with the MCO's decision have a right to appeal to the MCO for reconsideration.[19] Enrollees who exhaust the MCO appeals process have the right to request a State fair hearing.[20, 21] Beyond these required processes, States have the option to add a process for external medical review by an independent third party of prior authorization denials that are upheld by MCOs upon appeal.

Exhibit 1: Federally required steps for the Medicaid managed care prior authorization request, decision, and appeals process



Source: OIG analysis of the Medicaid managed care prior authorization denials and appeals process, 2023.

State Oversight of Denials and Appeals in Medicaid Managed Care

Each State must establish procedures for monitoring the operations and performance of its MCOs. For example, as part of this monitoring, States are required to collect and review data on appeals to MCOs and State fair hearings, and report it to CMS annually.[22, 23] States also contract with an independent organization (known as an external quality review organization) to conduct an annual review of each MCO.[24] These reviews include, among other things, an assessment of whether MCOs are meeting timeliness requirements for prior authorization decisions and an evaluation of notices to enrollees about MCO decisions.[25] States may also conduct additional

oversight activities at their discretion, such as routinely monitoring prior authorization denials data and reviewing individual denial cases for appropriateness.

Prior OIG Work

OIG issued three reports between 2018 and 2022 related to denials of care in managed care programs. Some of the Medicare Advantage and Medicaid managed care plans analyzed for prior reports were owned by the same parent companies examined in this report.

In a 2018 report on Medicare Advantage, OIG found that, when enrollees and providers appealed denied requests between 2014 and 2016, Medicare Advantage plans overturned about 75 percent of their own prior authorization and payment denials.[26] This suggests that at least some of these denials could have been avoided, given that ultimately the plans agreed to authorize the services and make the payments. OIG also found that CMS cited more than half of audited Medicare Advantage contracts in 2015 for inappropriately denying prior authorization and payment requests.

In a 2022 report on Medicare Advantage, OIG physician reviewers found that, among the prior authorization requests that Medicare Advantage plans denied, 13 percent met Medicare coverage rules.[27] In other words, these services likely would have been approved if the patients had been enrolled in Medicare Fee-for-Service rather than in Medicare Advantage. Denying requests that meet Medicare coverage rules may prevent or delay enrollees from receiving medically necessary care and can burden providers.

In a 2022 report on Medicaid managed care, OIG found that an MCO in Pennsylvania sometimes inappropriately denied overnight care for pediatric skilled nursing service requests.[28] In addition, OIG found that the denial notice template provided by Pennsylvania's Medicaid agency did not inform enrollees of their right to request a State fair hearing after exhausting the MCO's appeal process, which is a Federal requirement. Denying care that should be approved can put the health of enrollees at risk, and not informing them of their full appeal options means that they may not have the information needed to mount a successful appeal.

Methodology

MCO Parent Company and State Selection

We selected seven parent companies with at least one million people enrolled in comprehensive, risk-based MCOs in 2019 across any States in which the parent company operated.[29] These 7 parent companies operated 115 MCOs with at least 10,000 enrollees (see Appendix A). The 115 MCOs were located in 37 States and covered 29.8 million people, representing approximately 57 percent of the total enrollment in comprehensive, risk-based MCOs in the States included in the review.

Determining the Numbers and Rates of MCO Denials, Appeals, and Appeal Outcomes

We collected MCO-level data on denials, appeals, and appeal outcomes for 2019 from the seven selected parent companies. Using the MCO-level data for the 115 MCOs, we calculated the number and rates at which: (1) MCOs denied prior authorization requests in 2019 (see Appendix B), (2) enrollees or their providers appealed those denials, and (3) MCOs upheld those denials upon appeal (see Appendix C). We also examined the extent to which MCOs reported that enrollees in their plans requested external medical reviews (where available) and State fair hearings, along with the outcomes of those reviews.

Examining State Oversight of Medicaid Managed Care Denials and Appeals

We surveyed State Medicaid officials from all 37 States in which at least 1 MCO from the selected parent companies operated. We analyzed the State survey and followup responses to determine the extent to which State Medicaid agencies regularly reviewed a sample of MCO denials for clinical appropriateness. We also determined how many State Medicaid agencies collected data on MCO denials of prior authorization requests and used it for oversight (see Appendix D). Additionally, we gathered information about the results of State oversight activities, including annual reviews by independent entities, and examined the extent to which States reported identifying instances of MCOs inappropriately denying prior authorization requests or found other administrative problems with MCO prior authorization and/or appeals processes from 2017 to 2019.

Finally, we determined the number of States that offered external medical reviews as an option for enrollees when MCOs upheld prior authorization denials that were appealed.

For added context, we compared requirements for State oversight of denials in Medicaid managed care to CMS's oversight of denials in the Medicare Advantage program, and we compared relevant denial and appeal outcome rates between the two programs.

See the Detailed Methodology on page 23 for further information.

Limitations

We did not independently verify the survey responses from State Medicaid agencies or the self-reported data from MCO parent companies. However, we did review the data for inconsistencies, discrepancies, or missing data and, where appropriate, followed up with parent companies and States to clarify their responses.

Standards

We conducted this study in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.[30]

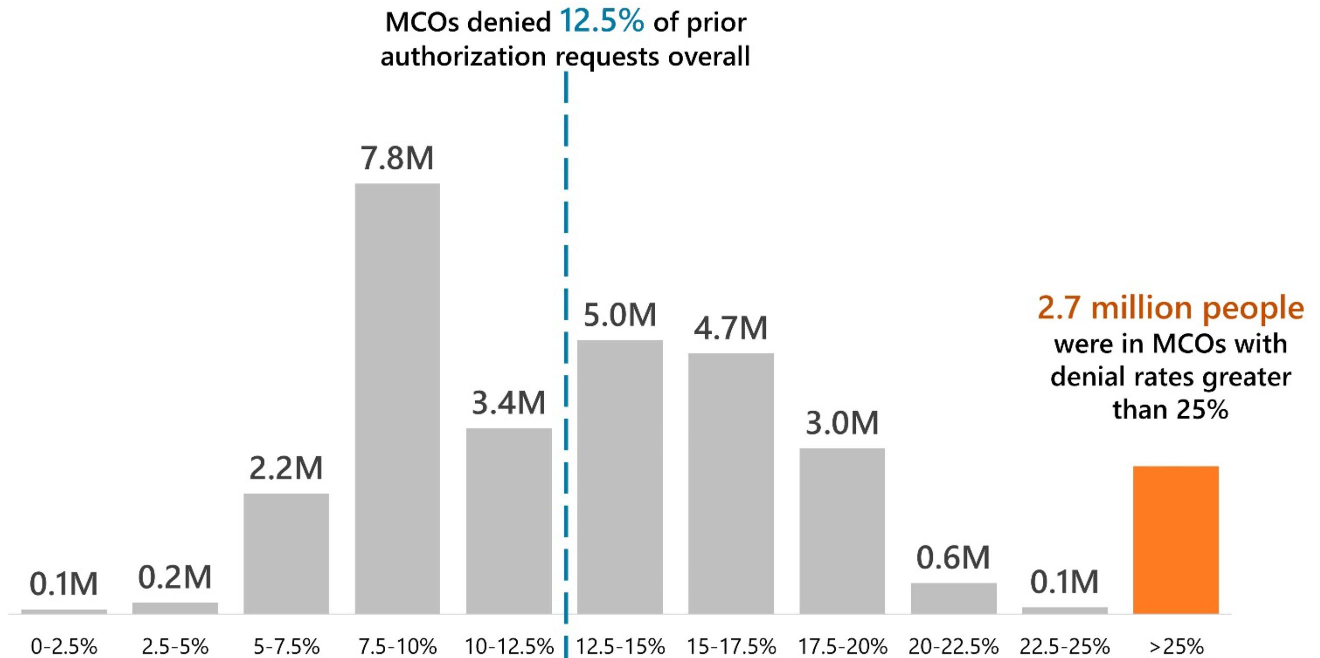
FINDINGS

Overall, MCOs denied one in eight requests for the prior authorization of services, and some MCOs had much higher denial rates

Overall, the MCOs included in our review fully or partially denied approximately 2.2 million requests for the prior authorization of services in 2019, which is 1 out of every 8 requests (12.5 percent). By comparison, the overall denial rate for prior authorization requests was much lower in Medicare Advantage. Medicare Advantage health care plans denied only 5.7 percent of prior authorization requests in 2019.

Some MCOs had very high rates of prior authorization denials. Among the 115 MCOs in our review, 12 had prior authorization denial rates greater than 25 percent—twice the overall rate (see Appendix B for a list of MCOs and their prior authorization denial rates in 2019). Exhibit 2 shows the distribution of people enrolled in the 115 MCOs in our review by prior authorization denial rate, including the number of people enrolled in MCOs with denial rates greater than 25 percent. Although any individual prior authorization denial may be appropriate, it is unclear why some MCOs had rates of prior authorization denials that were so much higher than their peers.

Exhibit 2: In 2019, approximately 2.7 million people were enrolled in MCOs with prior authorization denial rates greater than 25 percent



Source: OIG analysis of 2019 MCO prior authorization denial data and enrollment data, 2023.

We examined MCO denial rates to determine whether there were differences associated with two factors: the State in which the MCO was operating and the MCO's parent company. We found that within States, MCOs often had very different denial rates, implying that State oversight and program characteristics alone did not drive the differences in rates. For example, California, Georgia, and Michigan each had at least one MCO with a prior authorization denial rate less than 10 percent and at least one MCO with a denial rate greater than 25 percent.[31]

However, we found that one of the seven parent companies we examined had a high concentration of MCOs with high prior authorization denial rates. Seven of Molina Healthcare Inc.'s 12 MCOs had prior authorization denial rates greater than 25 percent; these 7 MCOs had more than 1.2 million enrollees. Molina also denied a relatively high proportion of prior authorization requests in Medicare Advantage in 2019—the plans that it operated denied 19.5 percent of prior authorization requests, more than three times the overall denial rate of 5.7 percent in Medicare Advantage that year. As shown in Exhibit 3, Anthem Inc., Aetna Inc., and UnitedHealthcare also each operated at least one MCO with a prior authorization denial rate greater than 25 percent. Although data analysis alone is not sufficient to determine the reasons for denial rate variation among MCOs or parent companies, high denial rates may indicate differences in policies or performance. The wide variation in denial rates emphasizes the need for targeted State oversight of prior authorization denials to ensure that enrollees are not being inappropriately denied care.

Exhibit 3: In 2019, the seven parent companies operated MCOs with a wide range of denial rates, from as low as 2 percent to as high as 41 percent

Parent company	Lowest MCO denial rate	Highest MCO denial rate	Overall denial rate	Number of MCOs	Number of MCOs >25%
Aetna Inc.	5%	29%	12.1%	14	1
AmeriHealth Caritas	2%	20%	6.1%	11	
Anthem Inc.	6%	34%	12.9%	19	3
CareSource	8%	16%	15.4%	3	
Centene Corporation	3%	23%	12.2%	33	
Molina Healthcare Inc.	7%	41%	17.7%	12	7
UnitedHealthcare	7%	27%	13.6%	23	1

Source: OIG analysis of 2019 MCO parent company prior authorization denial data and operations data, 2023.

Most State Medicaid agencies' oversight of MCO prior authorization denials was limited

Most States did not use two key tools—appropriateness reviews for a sample of denials, and monitoring MCO denial data—for the monitoring and oversight of prior authorization denials. In contrast, in Medicare Advantage, CMS has implemented both tools in its oversight. CMS reviews the appropriateness of a sample of prior authorization denials in Medicare Advantage each year as part of its program audits and collects denials and appeals data for each Medicare Advantage plan every year. States that do not use these tools may not have the means to detect instances of inappropriate denials that can delay or deny needed health care to Medicaid enrollees.

Only one-third of States reported regularly reviewing the appropriateness of samples of MCO prior authorization denials

The audit found the [MCO] denied prior authorizations for medically necessary services. Unqualified individuals made a final denial determination without … Medical Director review.

- State Official

Although Federal rules do not require that States review a sample of MCO denials for clinical appropriateness, 13 of 37 States reported conducting such reviews regularly (see Appendix D). States conducted these reviews through a variety of oversight mechanisms, such as State audits and reviews by their external quality review organizations. Among States that did check a sample of denials for appropriateness, several found that MCOs sometimes inappropriately denied prior authorization requests between 2017 and 2019. For example, States found inappropriate denials for medically necessary drug therapy, health screening services for children, and inpatient hospital services. This demonstrates that regular reviews of denial appropriateness can give States opportunities to address MCOs that are denying medically necessary, covered services to patients.

Most States (22) reported that they did not conduct denial appropriateness reviews on a regular basis, although some conducted such reviews on an ad hoc basis. Among the 22 States, 13 did not conduct any appropriateness reviews, and 9 reported that, although they do not conduct such reviews on a regular basis, they sometimes review prior authorization denials in response to specific disputes, provider complaints, or identified problems that may necessitate such a review. Two States did not respond to requests about whether their oversight included the use of appropriateness reviews (see exhibit 4 on page 10).

Exhibit 4: Only 13 States regularly conducted appropriateness reviews of prior authorization denials

13 Conducted reviews **regularly**

9 Conducted **ad hoc** reviews

13 Conducted **no** such reviews

2 *Did not respond on this topic*

Source: OIG analysis of surveys of State Medicaid officials, 2023.

Across all 37 States that we surveyed, some identified systemic problems with certain MCO prior authorization processes that could lead to inappropriate denials. These problems included MCOs' allowing inappropriate staff or inadequately trained staff to make decisions about whether to approve prior authorization requests, using incorrect criteria to determine whether to approve requests, and failure to request additional information before issuing decisions. Problems with MCO prior authorization practices are especially concerning if State oversight does not review denials for appropriateness.

Fifty-nine percent of States reported collecting and monitoring data on MCO prior authorization denials

Although CMS does not require States to collect data on MCO denials, 22 of the 37 States (59 percent) that we surveyed reported collecting MCO denials data and using it as part of their oversight (see Appendix D). For example, some States reported monitoring:

- *Denials by service type*. Some States collected service-type data for all denials, while other States focused on selected service types of concern for monitoring, such as behavioral health, home health, and/or pharmacy services.
- *Denials by enrollee category*. Some States monitored denials for people who may be particularly at risk of adverse consequences if their care is disrupted by denied benefits, such as those receiving behavioral health care or long-term services and supports.
- *Broader trends and rates*. Some States reported using denials data for broader oversight activities, including analyzing trends, assessing the timeliness of MCO decisions, and monitoring rates of MCO denial overturns. States could then investigate any outliers and take appropriate action.

The data is compiled, analyzed, and trended monthly, which allows the Agency to track and compare plan denials and intervene as necessary.

- State Official

The 15 States that reported that they did not conduct any of these oversight efforts may not have been aware of MCOs that were outliers in their State. For example, 7 of these 15 States had at least 1 MCO with a prior authorization denial rate greater than

25 percent (see exhibit 5). Most of these seven States also did not regularly review the appropriateness of samples of MCO prior authorization denials.

Exhibit 5: Seven States that did not use denials data for oversight may have been unaware that some MCOs in their States had high denial rates

MCO parent company	Highest MCO denial rate	State used denials data for oversight	State regularly reviewed a sample of denials for appropriateness
Georgia	34%	✗	*No response*
Michigan	32%	✗	Ad hoc review
California	29%	✗	✓
Mississippi	27%	✗	✗
New Jersey	27%	✗	✗
Virginia	26%	✗	✗
Wisconsin	25%	✗	✗

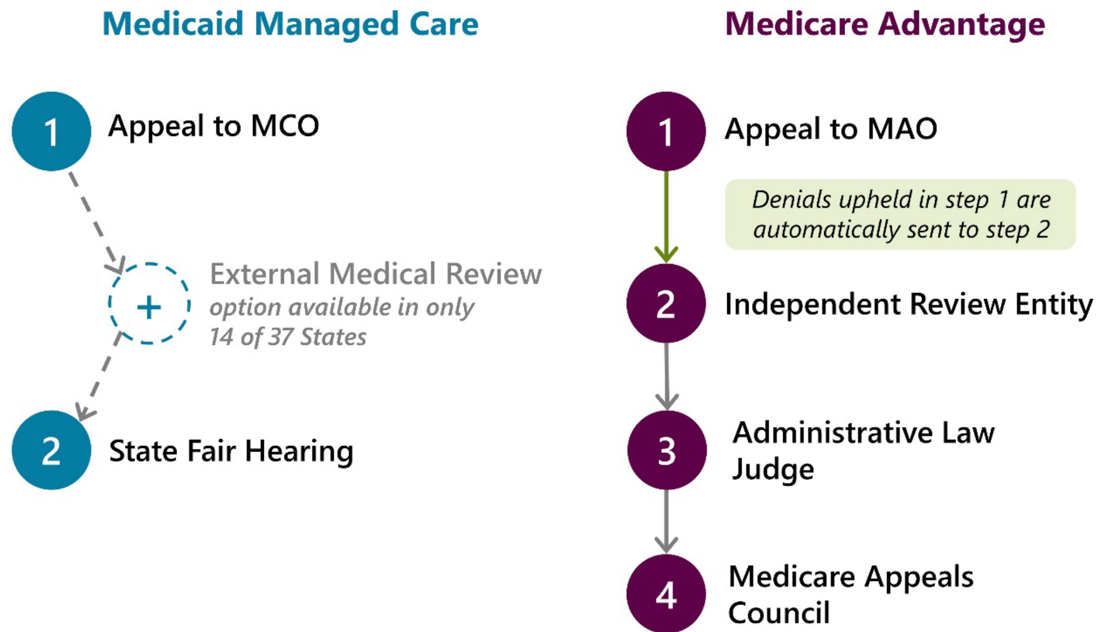
Source: OIG analysis of 2019 MCO prior authorization denial data data, 2023; OIG analysis of surveys of State Medicaid officials, 2023.

The absence of external medical reviews in many States, as well as other limitations, may inhibit the Medicaid managed care appeals process from remedying inappropriate prior authorization denials

Given the high number of prior authorization denials and limited State oversight in Medicaid managed care, a robust system for enrollees to appeal denials could act as an important safeguard to help ensure that patients receive needed services. However, as shown in exhibit 6 on page 12, Medicaid managed care has fewer appeal levels than Medicare Advantage. In both programs, the first step for enrollees who are not satisfied with a denial of a prior authorization request is to appeal to the managed care plan itself for reconsideration. In Medicare Advantage, if the health plan upholds its original denial, the case is automatically forwarded to the Independent Review Entity.[32] If the Independent Review Entity overturns the denial, the managed care plan must authorize the needed care for the patient. If the Independent Review Entity upholds the denial, two additional levels of appeal are available to the enrollee. In contrast, there is no *automatic* external medical review of

upheld denials in Medicaid managed care at any level, and patients are guaranteed access to only one level of appeal outside the MCO (a State fair hearing).

Exhibit 6: People enrolled in Medicaid managed care are guaranteed access to only two levels of appeal, compared to four levels of appeal guaranteed in Medicare Advantage



Note: "MAO" stands for Medicare Advantage Organization, which is an insurance company that offers health plans for Medicare enrollees. In Medicare Advantage, denials upheld by the Medicare Appeals Council can be challenged in Federal District Court. In Medicaid managed care, some States allow people to request a rehearing or judicial review of State fair hearing decisions.

Source: OIG analysis of the Medicaid managed care and Medicare Advantage appeals processes, 2023.

The automatic nature of the independent review step in Medicare Advantage may create a sentinel effect that ensures due diligence by health plans at the first level of appeal. Medicare Advantage organizations fully or partially overturned 82 percent of appealed denials in favor of enrollees in 2019.[33] By comparison, MCOs overturned only 36 percent of appealed denials (see Appendix C for a breakout of fully and partially overturned prior authorization denials). This suggests that the presence of automatic, independent review could be incentivizing Medicare Advantage organizations to closely scrutinize their denials at the first level of appeal. This extra scrutiny may be one reason that the Medicare Advantage Independent Review Entity only needed to overturn 9 percent of denials that were automatically forwarded to the second level of appeal.[34]

Only 14 of the 37 States in our review offered an external medical review option in Medicaid managed care

Although not required by Federal regulations, 14 of the States in our review offered external medical reviews as an option for Medicaid managed care enrollees in 2019.[35, 36] In these States, external medical reviews allowed enrollees to submit a prior authorization denial that their MCO upheld upon appeal to an entity independent of the State and MCO. According to States, external medical reviews are conducted by medical professionals who have expertise related to the denied service.

[External medical review] offers another level of review and determination on a case to ensure fairness and that ... program policies are being applied fairly and correctly.

- State Official

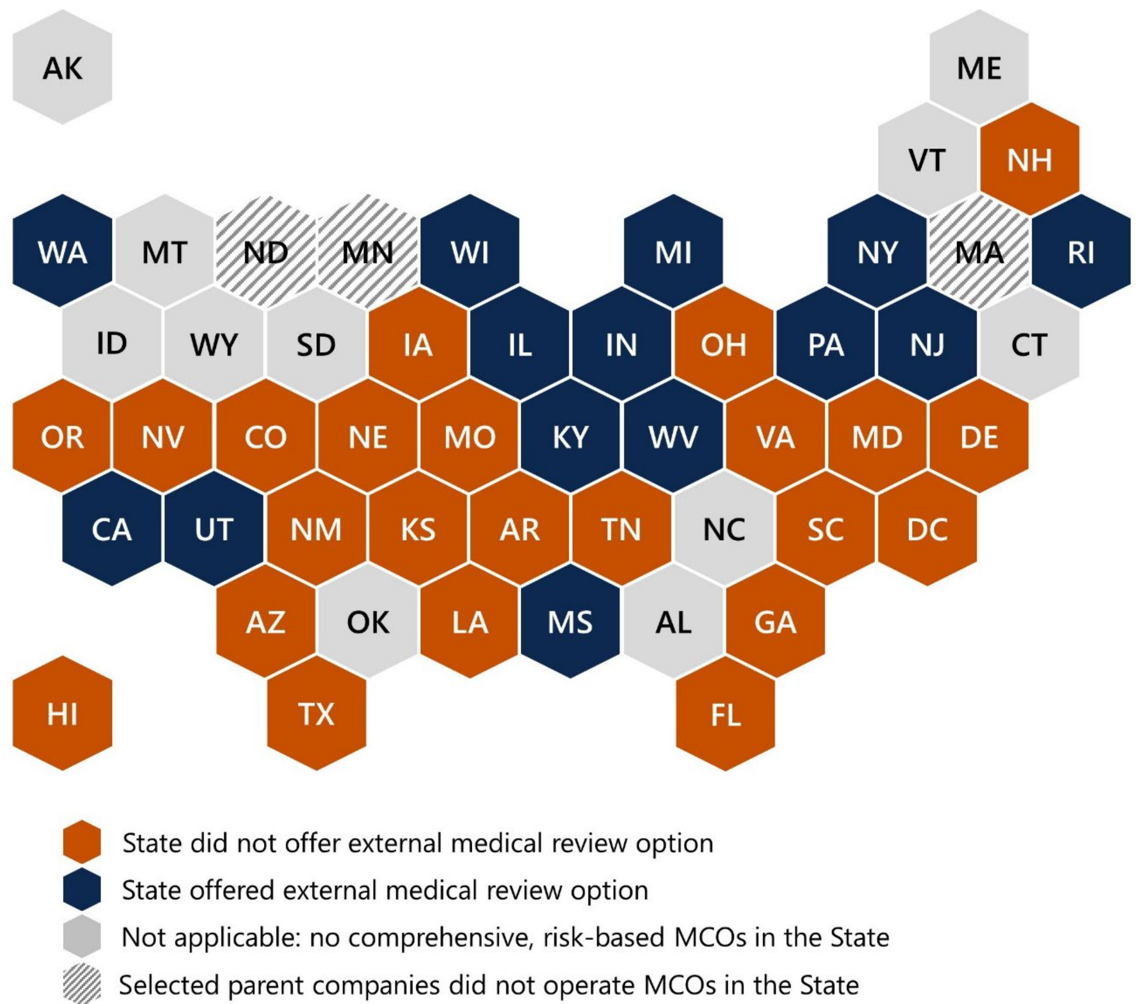
States that offered external medical reviews reported benefits from these reviews, including improving the prior authorization decision process and providing an independent check on MCO decisions. For example, one State reported that external medical reviews improved MCOs' decision-making processes by allowing the State to address MCO clinical criteria that often resulted in overturns. States also reported that, because State fair hearing officers are not medical professionals, external medical reviews aided the State fair hearing process by providing an independent clinical assessment. Further, States reported that external medical reviews provided an independent mechanism to check MCO denials for care that should have been approved.

Among prior authorization denials that were submitted to external medical reviews, independent reviewers fully or partially overturned 46 percent in favor of the enrollee (see Appendix C). In other words, in nearly half of cases submitted to external medical reviewers, these independent reviewers enabled enrollees to receive authorization for necessary medical care that initially had been denied by their MCOs.

Although external medical reviews have the potential to protect enrollees from inappropriate denials, the review process was not used often. Among the MCOs that operated in the 14 States that offered external medical reviews, only 5 percent of upheld denials were appealed to external medical review. The limited use of external medical reviews, even where available, raises concerns that either enrollees or their providers may have been unaware of this option or unsure of how to navigate the process.

As shown in exhibit 7 on page 14, 23 States (covering 22.9 million people) reported that they did not offer external medical reviews as an option when MCOs upheld prior authorization denials at the first level of appeal in 2019.[37] Among these 23 States, 1 reported being in the process of implementing external medical reviews, and 3 reported actively considering adding external medical reviews. The most common reasons that States cited for not offering external medical reviews were resource limitations and a belief that the existing MCO appeals process was adequate.

Exhibit 7: Most States with comprehensive, risk-based MCOs in 2019 did not offer external medical reviews



Source: OIG analysis of surveys of State Medicaid officials and analysis of Kaiser Family Foundation, *Medicaid Enrollment in Managed Care by Plan Type* for 2019, 2023.[38]

When enrollees appealed, MCOs usually upheld their own denials, and enrollees rarely escalated those appeals to State fair hearings

Overall, enrollees appealed 11 percent of MCO prior authorization denials.[39] For 64 percent of these appealed denials, MCOs fully upheld their original denial decision, meaning that patients: (1) did not receive the care requested by their health care providers, (2) paid for the service out of pocket, or (3) elevated their appeals. For the remaining appealed prior authorization denials (36 percent), the MCOs fully or partially reversed the original denial, indicating that the MCO agreed with enrollees and health care providers that the requested services were medically necessary and should be covered.

Further, enrollees rarely appealed upheld denials to State fair hearings. For all States, including the 23 States that did not offer external medical reviews, people enrolled in Medicaid managed care have the right to appeal denials to a State fair hearing, as required by Federal regulations. Of the prior authorization denials in our review that MCOs upheld, only 2 percent were appealed to a State fair hearing in 2019. The low rate of State fair hearing requests raises concerns about the potential burden for enrollees (see exhibit 8). However, when State fair hearings occurred, they fully or partially overturned 38 percent of prior authorization denials in favor of the patient (see Appendix C).

Exhibit 8: State fair hearings involve multiple steps that may be too burdensome for some enrollees

State fair hearings are a level of appeal in which a hearing officer, such as an Administrative Law Judge, reviews an MCO's decision to reduce or deny health care services.

To appeal an MCO's upheld denial to a State fair hearing, enrollees or their providers must:

- know about the option for a State fair hearing;
- submit a request within a required timeframe after the MCO's appeal decision;
- cooperate with any State-required prehearing dispute processes, such as mediation or prehearing conferences;
- compile records and evidence to support their appeal;
- present their case to a hearing officer; and
- wait up to 90 days from the day of their request to receive a decision.

State fair hearings do not occur automatically; rather, they must be requested. **State fair hearings do not** have to involve review by an independent medical expert.

Source: OIG analysis of State fair hearing process and requirements, 2023.

State oversight identified problems with the timeliness of MCO decisions and notices to enrollees

Among the 37 States that we surveyed, 30 reported finding administrative problems with MCO prior authorization decisions and/or appeals processes from 2017 to 2019. Frequently identified problems were related to MCOs not meeting required timeframes for initial prior authorization decisions and appeal decisions, and problems with the content of notices to enrollees about these decisions.

States found that some MCOs were not meeting their State's required timeframes for making prior authorization decisions and informing enrollees about the outcomes of

those decisions. For example, one MCO allowed itself 24 hours to review requests for post-emergency hospital admissions instead of 30 minutes, as required. Another MCO's "expedited appeal resolution did not meet the 72-hour required timeframe and there was no evidence the MCO made reasonable effort to provide oral notice of resolution." This MCO also failed to meet the State's required 14-calendar-day timeframe for standard appeals. When MCOs do not make timely decisions, it may delay enrollees from initiating the appeal or external review process, and ultimately may cause harmful delays in needed care.[40]

[Appeal resolution notices] were not clear and concise, contained inaccuracies, and did not explain why a case did not meet medical necessity.

- State Official

State oversight efforts also identified several types of problems with the content of some MCO prior authorization and appeal decision notices. States reported finding notices that were not written in clear, easy-to-understand language and notices that were missing key information, such as the reason for a denial or how to appeal. In other cases, MCO appeal decision notices did not include correct information about the enrollee's right to appeal to a State fair hearing, including one State that found its MCOs did not provide the deadline to request a hearing.

When MCOs fail to issue clear information about how and when to request an appeal or a State fair hearing, people enrolled in Medicaid managed care and their providers may miss the opportunity to exercise their right to additional review of their case. Although denial notices are not the only way enrollees may be made aware of their right to appeal, insufficient notices to enrollees and health care providers may be one reason why appeals of prior authorization denials were relatively low among the selected MCOs (11 percent).[41]

CONCLUSION AND RECOMMENDATIONS

As Medicaid managed care enrollment continues to grow, MCOs play an increasingly critical role in ensuring that people with Medicaid have access to high-quality health care. In 2020, approximately 58.5 million people relied on Medicaid MCOs to meet their health care needs. MCOs are expected to ensure access to needed care, implement critical program controls, and avoid unnecessary costs. However, capitated payment models, such as the model used in Medicaid managed care, can create an incentive for insurance companies to deny the authorization of services to increase profits.

Despite the risk of inappropriate prior authorization denials in Medicaid managed care, States are not required to conduct targeted oversight of denials. CMS does not require States to review the appropriateness of a sample of denials or to collect and monitor data from MCOs about the extent to which they deny requests for health care services, even though CMS uses these oversight tools in Medicare Advantage. The lack of targeted oversight is concerning because of the high number of prior authorization denials in the program overall and the high denial rates among some MCOs. Further, unlike in Medicare Advantage, most States do not guarantee Medicaid enrollees access to external medical reviews.

These differences in oversight and access to external medical reviews between the two programs raise concerns about health equity and access to care for Medicaid managed care enrollees. Medicaid managed care enrollees are more likely than Medicare Advantage enrollees to be people of color (50 percent versus 32 percent)[42] and are more likely to have lower incomes.[43] Other research has shown that people of color and people with lower incomes are at increased risk of receiving low-quality health care and experiencing poor health outcomes.[44] This makes oversight efforts and enrollee protections particularly critical for the Medicaid population.

Given these findings, more action is needed to improve the oversight of denials in Medicaid managed care and to ensure that enrollees have access to all medically necessary and covered services. While CMS works toward long-term programmatic improvements, it should also take more immediate action to work with States to address the concerns raised in this report.

Therefore, we recommend that CMS:

Require States to review the appropriateness of a sample of MCO prior authorization denials regularly

CMS should require States to review the appropriateness of a sample of MCO prior authorization denials regularly through some mechanism, such as internal audits by the State or reviews by their external quality review organizations. CMS also should provide guidance to States on how to conduct these reviews. For example, appropriateness reviews should include reviewing both whether the request met Medicaid coverage and administrative rules, and whether the request met the applicable medical necessity criteria.

In developing its requirements and guidance, CMS could gather information from States that already use this oversight tool to identify key elements that enable their reviews. CMS could also refer to the current Medicare Advantage audit process that examines denial appropriateness. Such reviews have been effective in identifying inappropriately denied prior authorization requests in both programs and can help States and MCOs to identify and correct the underlying causes of inappropriate denials.

Require States to collect data on MCO prior authorization decisions

CMS should require States to collect prior authorization data from MCOs on an annual basis in accordance with CMS guidance. CMS should require States to collect, at a minimum, the number of prior authorization decisions that each MCO issued that were favorable, partially adverse, and adverse to the enrollee. Such data would support more effective State oversight of MCOs. CMS has already taken some important steps toward this goal. In December 2022, CMS proposed a rule that would require MCOs to publicly report data on prior authorizations, including the percentage of prior authorization requests that were denied and the percentage of denied requests that were overturned upon appeal.[45]

Issue guidance to States on the use of MCO prior authorization data for oversight

Once CMS implements the recommendation to require States to collect prior authorization data, CMS should issue guidance to States on how to use prior authorization denials and appeals data for oversight of MCOs. Although Federal regulations already contain a broad requirement that States must "use data collected from its monitoring activities to improve the performance of its managed care

program,"[46] prior authorization processes are such a critical component of enrollee access to care that CMS should issue specific guidance on the use of prior authorization denials and appeals data for State oversight.

CMS's guidance could include, for example: (1) how to analyze the data to look for trends that may indicate performance issues, such as abrupt increases in denials or changes in appeal outcomes; (2) potential focused oversight steps States can take if they identify concerning data trends, such as targeted audits; and (3) appropriate corrective actions States can consider if their focused oversight confirms performance problems.

Require States to implement automatic external medical reviews of upheld MCO prior authorization denials

As described previously, appeal avenues for people enrolled in Medicaid managed care vary by State, and enrollees in most States do not have access to external medical reviews. CMS should require all States to implement automatic external medical reviews of MCO prior authorization denials that are upheld by MCOs at the first level of appeal. These reviews should not be part of the MCO appeal or State fair hearing processes, but rather should be a separate, independent process. The reviews should be conducted by a clinician with expertise related to the enrollee's case, and the reviewer's decision to approve or deny the request should be binding on the MCO (but should not preclude an enrollee from requesting a State fair hearing). Even where available, we found that enrollees rarely used the optional external medical review process. Implementing external medical reviews as an automatic process could help ensure that enrollees are not inappropriately denied access to medically necessary care. This change would also further align the appeals processes in Medicaid managed care and Medicare Advantage, which was a stated goal in CMS's 2016 Medicaid and CHIP Managed Care Final Rule.[47] According to CMS, aligning the appeal processes in the two programs would reduce confusion for enrollees who are transitioning between Medicare Advantage and Medicaid managed care, and would allow health insurers to adopt more consistent protocols across product lines. In considering how to implement this recommendation, CMS could gather information from States that have already implemented an external medical review process to identify best practices and lessons learned.

Work with States on actions to identify and address MCOs that may be issuing inappropriate prior authorization denials

While it is working toward implementing the program-level recommendations listed previously, CMS should also take more immediate action to work with States to identify and address MCOs that may be issuing inappropriate prior authorization denials. To do this, CMS and States could use our analysis of 2019 data, which OIG will provide, as a starting point and combine it with more recent data. For example,

for States that already collect data on MCO prior authorization denials, CMS could work with those States to analyze the data and identify MCOs with high denial rates. CMS could also work with States to identify other data sources (such as grievances, complaints, and audit findings) that could indicate problems with MCO denials. After analyzing data to identify MCOs that warrant follow up, CMS should encourage States to perform targeted oversight of these MCOs (such as through audits or desk reviews) and determine whether technical assistance or corrective action is warranted.

AGENCY COMMENTS AND OIG RESPONSE

In its response, CMS did not indicate whether it concurred with the first four recommendations; CMS concurred with the fifth recommendation. CMS also stated that it is committed to partnering with States to strengthen the monitoring and oversight of Medicaid managed care programs. As CMS considers the report's findings and develops it Final Management Decision, OIG encourages CMS to indicate whether it concurs with each recommendation and to detail the actions it will take to address them.

CMS did not indicate whether it concurred with the recommendation to require States to review the appropriateness of a sample of MCO prior authorization denials regularly. CMS stated that it will consider additional information to determine whether it agrees that there is a need to require such reviews and noted that regulatory rulemaking likely would be needed to implement the recommendation. Appropriateness reviews are integral to CMS's oversight of managed care companies in Medicare Advantage; yet, despite high prior authorization denial rates in Medicaid managed care, many State Medicaid agencies do not use such reviews for oversight of MCOs. Absent regular appropriateness reviews, States and CMS do not have adequate visibility into whether MCOs are living up to their commitments to ensure coverage of medically necessary health care. In its Final Management Decision, CMS should detail the steps it will take to ensure that all MCOs are held accountable by States through this important oversight mechanism.

CMS did not indicate whether it concurred with the recommendation to require States to collect data on MCO prior authorization decisions. CMS stated that its December 2022 proposed rule, if finalized, would require MCOs to publicly report some prior authorization data, such as the percentage of requests that were approved and denied. OIG agrees that the proposed rule appears to identify relevant data elements regarding prior authorization decisions. However, although public reporting would improve transparency of MCO decisions, the proposed rule does not require that State Medicaid agencies collect this data. In its Final Management Decision, CMS should detail the steps it will take to require State Medicaid agencies to collect the new publicly reported data to support more effective State oversight of MCOs.

CMS did not indicate whether it concurred with the recommendation for CMS to issue guidance to States on the use of prior authorization data for oversight. However, CMS stated that it will consider issuing such guidance if its December 2022 proposed rule is finalized. In its Final Management Decision, CMS should detail the steps it will take to provide guidance to States regarding the use of prior authorization data for oversight.

CMS did not indicate whether it concurred with the recommendation to require States to implement automatic external medical reviews of upheld MCO prior authorization denials. CMS stated that it will consider additional information to determine whether it agrees that there is a need to require automatic external medical reviews and noted that regulatory rulemaking would likely be needed to implement the recommendation. Automatic review of prior authorization denials by Independent Review Entities is an integral level of appeal for Medicare Advantage enrollees; yet, despite high prior authorization denial rates in Medicaid managed care, some State Medicaid agencies do not offer external medical reviews. Absent external reviews, MCO enrollees and their health care providers do not have the opportunity to have medical experts, independent of the MCO and State, assess the appropriateness of MCO decisions to uphold denials. In its Final Management Decision, CMS should detail the steps it will take to ensure that Medicaid enrollees in all States benefit from this important level of review.

CMS concurred with the recommendation to work with States to identify and address MCOs that may be issuing inappropriate prior authorization denials. CMS stated that it will issue guidance and provide technical assistance to States on ways in which prior authorization data could be used for oversight by States. OIG looks forward to details from CMS in its Final Management Decision about its plans to supplement its existing efforts with guidance and technical assistance specific to the oversight of MCO prior authorization denials.

For the full text of CMS's comments, see Appendix E.

DETAILED METHODOLOGY

MCO Parent Company and State Selection

We identified and selected the largest MCO parent companies by summing their enrollment across all the MCOs that they operated in any State. We selected the seven parent companies with at least one million people enrolled in comprehensive, risk-based MCOs in 2019. These 7 parent companies operated 115 MCOs with at least 10,000 enrollees (see Appendix A). The 115 MCOs were located in 37 States and covered 29.8 million people, representing approximately 57 percent of the total enrollment of comprehensive, risk-based MCOs in the States in our review.

Determining the Numbers and Rates of MCO Denials, Appeals, and Appeal Outcomes

Data Collection

We collected MCO-level data on denials, appeals, and appeal outcomes from the seven selected parent companies for 2019. For each of the 115 MCOs that the parent companies operated, we received: (1) enrollment numbers for March and September 2019; (2) the number of prior authorization decisions issued in 2019; (3) the number of requests that were denied, partially denied, or approved; (4) the number of appeals to the MCO, requests for external medical review, and State fair hearings that were adjudicated in 2019; and (5) the outcomes of those appeals and reviews (denials upheld, partially overturned, or fully overturned). In total, MCOs reported 17.4 million prior authorization requests in 2019. Where appropriate, we followed up with parent companies to confirm and/or provide context about submitted data.

Analysis

Prior Authorization Denials. Using the MCO-level data, we calculated the number and rate at which MCOs denied prior authorization requests in 2019 (see Appendices B and C). First, we summed all prior authorization denials (adverse or partially adverse decisions) issued across the 115 selected MCOs. To calculate the overall prior authorization denial rate, we divided the total number of denials by the total number of prior authorization decisions that MCOs issued in 2019.[48] We also calculated prior authorization denial rates by MCO to examine the distribution of rates across MCOs and to identify MCOs with particularly high rates. Finally, we examined whether MCO denial rates varied according to State or parent company (i.e., whether high or low MCO denial rates seemed to cluster among certain States or parent companies) and how many MCOs with denial rates greater than 25 percent operated in States that did not use denial appropriateness reviews or monitoring of denials data as part of their oversight.

Prior Authorization Appeals. Using the MCO-level data that the selected parent companies reported, we calculated the numbers and rates of prior authorization appeals and the rates at which appeals were successful (i.e., the denial was fully or partially overturned in favor of the enrollee) or unsuccessful (i.e., the denial was upheld) in 2019 (see Appendix C).

- To calculate the total number of external medical reviews, we summed the number of external medical review decisions issued for enrollees in all selected MCOs. To calculate the appeal rate to external medical review, we divided the total number of reviews by the total number of upheld prior authorization denials issued in States with an external medical review option. We also calculated the rate at which external medical review decisions were favorable to the enrollee (i.e., the MCO's denial was fully or partially overturned).
- To calculate the total number of State fair hearings, we summed the number of State fair hearing decisions issued for enrollees in all selected MCOs. To calculate the appeal rate to State fair hearings, we divided the total number of hearings by the total number of upheld prior authorization denials issued by all MCOs. We also calculated the rate at which State fair hearing decisions were favorable to the enrollee (i.e., the MCO's denial was fully or partially overturned).
- To calculate the total number of appeals to MCOs, we summed the number of MCO appeal decisions issued across all selected MCOs that were able to provide reliable appeals data.[49] To calculate the appeal rate to MCOs, we divided the total number of appeals by the total number of denials (adverse or partially adverse decisions) issued across all MCOs. To calculate the denial uphold rate at the first level of appeal, we summed the total number of fully adverse appeal decisions and divided by the total number of appeal decisions issued across all MCOs.

Comparison of Medicaid Managed Care Denial and Appeal Rates to Medicare Advantage

For added context, we compared the overall Medicaid managed care prior authorization denial rate and overall MCO appeal uphold rate to the corresponding rates in the Medicare Advantage program in 2019. To calculate the Medicare Advantage rates, we used data from CMS available at: https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/ReportingRequirements.

Examining State Oversight of Medicaid Managed Care Denials and Appeals

To examine State oversight of MCO prior authorization denials and appeals processes, we surveyed State Medicaid officials from all 37 States in which at least 1 MCO from

our selected parent companies operated. We received initial responses from all 37 States. We then followed up by email to determine the extent to which State Medicaid agencies conducted reviews of denials for appropriateness. We received responses to our followup questions from 35 States. Where appropriate, we followed up with State officials for clarification about any survey responses that were incomplete or needed further context for our analysis.

Denial Appropriateness Reviews

We analyzed the State survey responses and followup email responses to determine the extent to which State Medicaid agencies regularly reviewed a sample of MCO denials for clinical appropriateness (see Appendix D). We conducted qualitative analysis to code State responses into one of three categories: (1) the State reported conducting such reviews on a regular basis; (2) the State reported it sometimes conducted such reviews in response to specific problems or complaints, but not on a regular basis; or (3) the State reported that it did not conduct such reviews. We also identified the number of States that reported identifying instances of MCOs inappropriately denying prior authorization requests as a part of their oversight from 2017 to 2019.

Denials Data Collection and Analysis

We analyzed the State survey responses to determine how many State Medicaid agencies collected data on MCO denials of prior authorization requests and used it for oversight (see Appendix D). For those States that did collect the data, we examined how they used it for oversight and identified the most common types of analysis that States performed (e.g., analyzing the data by service type, enrollee category, and/or looking at broader trends and rates in the data).

State-Identified Problems With MCO Appeals Processes

We analyzed the State survey responses to identify common administrative problems that States reported finding with MCO prior authorization and/or appeals processes from 2017 to 2019 through any oversight mechanism (including through their external quality review organization or direct State oversight).[50] We reviewed their responses to identify the most common types of problems that States identified.

Comparison of Oversight Requirements in Medicaid Managed Care to Medicare Advantage

For added context, we compared requirements for State oversight of denials in Medicaid managed care to CMS's oversight of denials in the Medicare Advantage program. To do this comparison, we reviewed CMS's requirements for Medicare Advantage Organizations to report annual performance data, including data on denials and appeals,[51] and information about the annual program audits that CMS conducts of Medicare Advantage Organizations.[52]

Examining State Requirements for External Medical Reviews

We analyzed the State survey responses to determine the number of States that reported offering external medical reviews as an option for enrollees when MCOs upheld prior authorization denials at the first level of appeal (see Appendix D). We also identified States that reported being in the process of implementing external medical reviews and States that reported considering adding such reviews. We reviewed and identified the key benefits that States reported from having external medical reviews and the reasons that States reported for not offering such reviews. Finally, we compared the appeals processes available to people enrolled in Medicaid managed care to the processes available to people enrolled in Medicare Advantage.

APPENDICES

Appendix A: Characteristics of MCO Parent Companies Included in This Study, 2019

MCO parent company	Enrollment	MCOs	Number of States in which the parent company operated
Aetna Inc.	1,766,252	14	13
AmeriHealth Caritas	1,827,402	11	7
Anthem Inc.	6,119,212	19	18
CareSource	1,535,600	3	3
Centene Corporation	10,844,182	33	27
Molina Healthcare Inc.	2,459,253	12	12
UnitedHealthcare	5,279,616	23	23
Total	**29.8 million**	**115**	**37***

Source: OIG analysis of 2019 parent company enrollment and operations data, 2023.

*Note: Column sums to more than 37 States because multiple parent companies often operate in a single State.

Appendix B: Characteristics of MCOs Included in This Study, 2019

Parent company	MCO name	State	2019 average enrollment	2019 prior authorization denial Rate
Aetna	Mercy Care Plan	AZ	412,479	10.9%
Aetna	Aetna Better Health of California	CA	16,388	29.4%
Aetna	Aetna Better Health of Florida	FL	85,411	10.1%
Aetna	Aetna Better Health of Kansas	KS	91,839	4.7%
Aetna	Aetna Better Health of Kentucky	KY	215,353	17.9%
Aetna	Aetna Better Health of Louisiana	LA	127,995	13.3%
Aetna	Aetna Better Health of Maryland	MD	23,290	17.7%
Aetna	Aetna Better Health of Michigan	MI	38,141	20.0%
Aetna	Aetna Better Health of New Jersey	NJ	60,716	13.7%
Aetna	Aetna Better Health of Pennsylvania	PA	198,217	14.6%
Aetna	Aetna Better Health of Texas	TX	75,617	10.0%
Aetna	Parkland Community Health Plan, Inc.	TX	154,219	6.4%
Aetna	Aetna Better Health of Virginia	VA	139,229	8.7%
Aetna	Aetna Better Health of West Virginia	WV	127,361	13.7%
AmeriHealth Caritas	AmeriHealth Caritas District of Columbia	DC	124,022	20.0%
AmeriHealth Caritas	AmeriHealth Caritas Delaware - Diamond State Health Plan	DE	58,785	13.5%
AmeriHealth Caritas	Prestige Health Choice	FL	77,182	10.4%
AmeriHealth Caritas	AmeriHealth Caritas of Louisiana	LA	213,540	9.1%

Parent company	MCO name	State	2019 average enrollment	2019 prior authorization denial Rate
AmeriHealth Caritas	Blue Cross Complete of Michigan	MI	207,979	16.0%
AmeriHealth Caritas	AmeriHealth Caritas Northeast	PA	90,114	11.9%
AmeriHealth Caritas	AmeriHealth Caritas Pennsylvania	PA	190,740	11.1%
AmeriHealth Caritas	AmeriHealth Caritas Pennsylvania Community HealthChoices	PA	15,102	1.9%
AmeriHealth Caritas	Keystone First Community HealthChoices	PA	74,043	2.2%
AmeriHealth Caritas	Keystone First Health Plan	PA	420,761	8.7%
AmeriHealth Caritas	First Choice by Select Health of South Carolina	SC	348,280	6.3%
Anthem	Blue Cross of California & Delegates	CA	1,194,381	7.8%
Anthem	Amerigroup District of Columbia, Inc.	DC	42,994	14.1%
Anthem	Simply HealthCare Plans, Inc.	FL	457,851	10.5%
Anthem	AMGP Georgia Managed Care Company, Inc.	GA	381,831	33.7%
Anthem	Amerigroup Iowa, Inc.	IA	266,142	6.2%
Anthem	Anthem Insurance Companies, Inc.	IN	453,865	12.7%
Anthem	Anthem Kentucky Managed Care Plan, Inc.	KY	133,859	11.7%
Anthem	Community Care Health Plan of Louisiana, Inc.	LA	258,971	12.5%
Anthem	Amerigroup Maryland, Inc.	MD	233,424	26.8%
Anthem	Amerigroup New Jersey, Inc.	NJ	175,998	9.8%
Anthem	Community Care Health Plan of Nevada, Inc.	NV	176,122	13.1%
Anthem	HealthPlus HP, LLC	NY	383,975	6.1%
Anthem	AMERIGROUP Tennessee, Inc.	TN	407,131	7.0%

Parent company	MCO name	State	2019 average enrollment	2019 prior authorization denial Rate
Anthem	Amerigroup Insurance Company	TX	150,159	14.6%
Anthem	AMERIGROUP Texas, Inc.	TX	593,798	17.0%
Anthem	HealthKeepers, Inc.	VA	384,282	25.6%
Anthem	AMERIGROUP Washington, Inc.	WA	185,714	14.0%
Anthem	Compcare Health Services Insurance Corporation	WI	93,798	11.0%
Anthem	Unicare Health Plan of West Virginia, Inc.	WV	144,924	17.0%
CareSource	CareSource	GA	237,254	8.4%
CareSource	CareSource	IN	90,020	14.9%
CareSource	CareSource	OH	1,208,326	16.3%
Centene	Arkansas Total Care	AR	10,974	5.9%
Centene	Care 1st Health Plan of Arizona, Inc.	AZ	175,427	10.2%
Centene	Health Net Access, Inc dba Arizona Complete Health	AZ	238,014	16.2%
Centene	California Health & Wellness	CA	196,107	19.4%
Centene	Health Net Community Solutions, Inc.	CA	1,737,879	18.6%
Centene	Sunshine State Health Plan	FL	533,398	13.6%
Centene	Wellcare of Florida, Inc.	FL	764,156	9.3%
Centene	Peach State Health Plan	GA	327,263	14.7%
Centene	WellCare of Georgia, Inc.	GA	438,074	16.8%
Centene	Ohana Health Plan, Inc.	HI	40,105	6.7%
Centene	Iowa Total Care	IA	120,029	2.9%

Parent company	MCO name	State	2019 average enrollment	2019 prior authorization denial Rate
Centene	Meridian Health Plan of Illinois, Inc.	IL	795,186	15.1%
Centene	Coordinated Care Corporation d/b/a Managed Health Services	IN	233,061	13.9%
Centene	Sunflower State Health Plan, Inc	KS	123,112	6.1%
Centene	WellCare Health Insurance Company of Kentucky, Inc	KY	263,958	15.7%
Centene	Louisiana Healthcare Connections, Inc.	LA	475,752	9.1%
Centene	Meridian Health Plan of Michigan, Inc	MI	490,380	9.3%
Centene	Home State Health Plan, Inc	MO	204,882	8.5%
Centene	Magnolia Health Plan, Inc.	MS	202,191	13.2%
Centene	Nebraska Total Care, Inc	NE	72,330	9.4%
Centene	Granite State Health Plan dba New Hampshire Healthy Families	NH	81,029	11.2%
Centene	WellCare of New Jersey, Inc.	NJ	68,346	23.2%
Centene	Western Sky Community Care, Inc	NM	59,463	14.8%
Centene	SilverSummit Healthplan, Inc	NV	40,502	19.6%
Centene	New York Quality Healthcare Corporation d/b/a Fidelis	NY	1,269,740	9.5%
Centene	WellCare of New York, Inc.	NY	146,525	16.0%
Centene	Buckeye Community Health Plan	OH	328,841	20.4%
Centene	Trillium Community Health Plan, Inc	OR	90,847	11.2%
Centene	Absolute Total Care	SC	121,618	11.8%
Centene	WellCare of South Carolina, Inc.	SC	81,518	15.4%
Centene	Superior HealthPlan, Inc.	TX	838,407	13.0%

Parent company	MCO name	State	2019 average enrollment	2019 prior authorization denial Rate
Centene	Coordinated Care of Washington, Inc	WA	195,863	8.4%
Centene	Managed Health Services Insurance Corp	WI	79,214	13.3%
Molina	Molina Healthcare of California Inc.	CA	422,873	7.3%
Molina	Molina Healthcare of Florida Inc.	FL	95,207	16.6%
Molina	Molina Healthcare of Illinois Inc.	IL	212,446	41.4%
Molina	Molina Healthcare of Michigan Inc.	MI	336,185	32.1%
Molina	Molina Healthcare of Mississippi Inc.	MS	57,313	27.4%
Molina	Molina Healthcare of New York Inc.	NY	29,449	19.5%
Molina	Molina Healthcare of Ohio Inc.	OH	277,250	28.5%
Molina	Molina Healthcare of South Carolina Inc.	SC	126,186	32.5%
Molina	Molina Healthcare of Texas Inc.	TX	178,509	34.2%
Molina	Molina Healthcare of Utah Inc.	UT	56,162	24.6%
Molina	Molina Healthcare of Washington Inc.	WA	609,920	19.3%
Molina	Molina Healthcare of Wisconsin Inc.	WI	57,757	25.1%
United Healthcare	UHC Community Plan of AZ	AZ	393,463	14.3%
United Healthcare	Rocky Mountain Health Plan	CO	36,436	7.1%
United Healthcare	UHC Community Plan of FL	FL	238,926	21.9%
United Healthcare	UHC Community Plan of HI	HI	47,677	11.8%
United Healthcare	UHC Community Plan of IA	IA	190,490	9.5%
United Healthcare	UHC Community Plan of KS	KS	125,283	8.2%

Parent company	MCO name	State	2019 average enrollment	2019 prior authorization denial Rate
United Healthcare	UHC Community Plan of LA	LA	440,891	8.4%
United Healthcare	UHC Community Plan of MD	MD	145,875	12.7%
United Healthcare	UHC Community Plan of MI	MI	248,892	10.7%
United Healthcare	UHC Community Plan of MO	MO	148,021	13.9%
United Healthcare	UHC Community Plan of MS	MS	173,565	12.2%
United Healthcare	UHC Community Plan of NE	NE	69,600	10.8%
United Healthcare	UHC Community Plan of NJ	NJ	428,820	27.0%
United Healthcare	Health Plan of Nevada Medicaid	NV	232,066	9.6%
United Healthcare	UHC Community Plan of NY	NY	562,832	9.3%
United Healthcare	UHC Community Plan of OH	OH	304,969	17.1%
United Healthcare	UHC Community Plan of PA	PA	220,342	17.0%
United Healthcare	UHC Community Plan of RI	RI	87,488	13.9%
United Healthcare	UHC Community Plan of TN	TN	421,131	8.8%
United Healthcare	UHC Community Plan of TX	TX	296,898	10.9%
United Healthcare	UHC Community Plan of VA	VA	117,388	11.8%
United Healthcare	UHC Community Plan of WA	WA	175,153	11.5%
United Healthcare	UHC Community Plan of WI	WI	165,930	12.5%

Appendix C: Numbers and Rates of Denials, Appeals, and Reviews for the MCOs Included in This Study, 2019

Prior authorization requests and outcomes	N=115 MCOs
Total number of prior authorization requests	**17,400,540**
Number of fully adverse prior authorization decisions	1,628,648
Number of partially adverse prior authorization decisions	541,797
Number of fully favorable prior authorization decisions	15,230,095
Overall prior authorization denial rate (fully adverse + partially adverse prior authorization decisions / fully adverse + partially adverse + fully favorable prior authorization decisions)	**12.5%**

Prior authorization appeal and review rates		
Rate of prior authorization appeals to MCOs (total number of MCO prior authorization appeal decisions / number fully adverse + partially adverse prior authorization decisions)	N=103* MCOs	**11.2%**
Rate of prior authorization requests for external medical reviews (total number of external medical review decisions / number of fully adverse + partially adverse MCO appeal decisions)	N=41** MCOs	**4.9%**
Rate of prior authorization requests for State fair hearings (total number of State fair hearing decisions / number of fully adverse + partially adverse MCO appeal decisions)	N=103* MCOs	**2.1%**

* We were unable to include appeals data from one parent company (12 MCOs) in our analysis of appeal rates and MCO appeal outcomes because the parent company was unable to report the number of unique appeal cases to their MCOs.

** Calculation of the appeal rate to external medical reviews includes only MCOs that were able to report complete appeals data and that operated in States where external medical reviews were offered as an option.

Prior authorization appeals to MCOs	N=103* MCOs
Total number of prior authorization appeals	**229,520**
Number of prior authorization denials upheld (fully adverse appeal decisions)	147,428
Number of prior authorization denials partially overturned (partially adverse appeal decisions)	4,487
Number of prior authorization denials fully overturned (fully favorable appeal decisions)	77,605
Rate of denials fully or partially overturned by MCOs (fully overturned + partially overturned appeal decisions / total number of appeal decisions)	**35.8%**
Rate of prior authorization denials upheld by MCOs (fully adverse appeal decisions/ fully adverse + partially adverse + fully favorable appeal decisions)	**64.2%**

* We were unable to include appeals data from one parent company (12 MCOs) in our analysis of appeal rates and MCO appeal outcomes because the parent company was unable to report the number of unique appeal cases to their MCOs.

Outcomes of external medical reviews of prior authorization denials	N=49* MCOs
Total number of external medical review requests	**3,645**
Number of denials upheld by external medical reviewers	1,958
Number of denials partially overturned by external medical reviewers	176
Number of denials fully overturned by external medical reviewers	1,511
Rate of denials fully or partially overturned by external medical review (fully overturned + partially overturned external medical review decisions / total number of external medical review decisions)	**46.3%**

*Includes only MCOs that operated in States that offered external medical review as an option.

Outcomes of State fair hearings of prior authorization denials	N=115 MCOs
Total number of State fair hearing requests	**3,547**
Number of prior authorization denials upheld by State fair hearings	2,189
Number of prior authorization denials partially overturned by State fair hearings	76
Number of prior authorization denials fully overturned by State fair hearings	1,282
Rate of denials fully or partially overturned by State fair hearings (fully overturned + partially overturned State fair hearing decisions / total number of State fair hearing decisions)	**38.3%**

Source: OIG analysis of 2019 MCO prior authorization and appeals data, 2023.

Appendix D: Characteristics of States Included in This Study

State	State regularly reviewed prior authorization denials for **appropriateness**	State used **denials data** for oversight	State offered **external medical reviews**	**MCOs** in study	People **enrolled** in MCOs in study (2019)	**Percentage** of State's Medicaid managed care enrollees covered by MCOs in study
AR	*Ad hoc*			1	10,974	24%
AZ	✓	✓		4	1,219,382	77%
CA	✓		✓	5	3,567,627	34%
CO	✓			1	36,436	31%
DC	*Ad hoc*			2	167,016	86%
DE	*Ad hoc*	✓		1	58,785	29%
FL		✓		7	2,252,129	76%
GA	*No response*			4	1,384,422	98%
HI	✓	✓		2	87,782	27%
IA	✓			3	576,661	96%
IL		✓	✓	2	1,007,632	47%
IN	*Ad hoc*	✓	✓	3	776,945	72%
KS	*Ad hoc*	✓		3	340,233	100%
KY	*Ad hoc*	✓	✓	3	613,169	50%
LA	*No response*	✓		5	1,517,149	100%
MD	✓	✓		3	402,588	34%
MI	*Ad hoc*		✓	5	1,321,576	54%
MO	✓			2	352,902	59%
MS			✓	3	433,068	99%
NE		✓		2	141,930	57%

State	State regularly reviewed prior authorization denials for **appropriateness**	State used **denials data** for oversight	State offered **external medical reviews**	**MCOs** in study	People **enrolled** in MCOs in study (2019)	**Percentage** of State's Medicaid managed care enrollees covered by MCOs in study
NH		✓		1	81,029	47%
NJ			✓	4	733,879	49%
NM		✓		1	59,463	9%
NV				3	448,689	90%
NY		✓	✓	5	2,392,520	54%
OH	✓	✓		4	2,119,385	89%
OR		✓		1	90,847	10%
PA	✓	✓	✓	7	1,209,317	50%
RI	*Ad hoc*	✓	✓	1	87,488	34%
SC	✓	✓		4	677,601	85%
TN	✓			2	828,262	58%
TX	✓	✓		7	2,287,604	64%
UT			✓	1	56,162	26%
VA				3	640,898	50%
WA	✓	✓	✓	4	1,166,649	77%
WI			✓	4	396,699	52%
WV	*Ad hoc*	✓	✓	2	272,285	70%
Total	**Regular - 13** **Ad hoc - 9**	**22**	**14**	**115**	**29,817,183**	**57%**

Source: OIG analysis of 2019 MCO enrollment data, 2019 State enrollment data, and survey responses from State officials, 2023.

Appendix E: Agency Comments

Following this page are the official comments from CMS.

DEPARTMENT OF HEALTH & HUMAN SERVICES — Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: May 02, 2023

TO: Juliet T. Hodgkins
Principal Deputy Inspector General

FROM: Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Office of Inspector General (OIG) Draft Report: CMS Should Strengthen State Oversight Requirements and Expand Enrollee Appeal Options for Prior Authorization Denials in Medicaid Managed Care (OEI-09-19-00350)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report. CMS is committed to partnering with states to help strengthen the monitoring and oversight of Medicaid managed care programs.

The increased prevalence of the use of managed care delivery systems over the past several years underscores the continued need for strong federal and state oversight of Medicaid managed care. CMS has taken a number of steps to support states, including developing a series of technical assistance tools and toolkits that states are encouraged to use to improve the monitoring and oversight of their managed care programs. For example, CMS has created a Managed Long-Term Services and Supports Access Monitoring Toolkit,[1] Behavioral Health Provider Network Adequacy Toolkit,[2] Managed Care Quality Strategy Toolkit,[3] and a toolkit for Ensuring Provider Network Adequacy and Service Availability.[4] As required by the 2016 Managed Care Final Rule, states are required to submit to CMS several reports on their managed care programs and operations.[5] CMS has developed reporting templates that states must use when submitting the Managed Care Program Annual Report (MCPAR) required in 42 CFR §

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[1] CMS, Promoting Access in Medicaid and CHIP Managed Care: Managed Long-Term Services and Supports Access Monitoring Toolkit. 2022. Accessed at: https://www.medicaid.gov/medicaid/managed-care/downloads/mltss-access-toolkit.pdf
[2] CMS, Promoting Access in Medicaid and CHIP Managed Care: Behavioral Health Provider Network Adequacy Toolkit. 2021. Accessed at: https://www.medicaid.gov/medicaid/downloads/behavior-health-provider-network-adequacy-toolkit.pdf
[3] CMS, Medicaid and Children's Health Insurance Program (CHIP) Managed Care Quality Strategy Toolkit. 2021. Accessed at: https://www.medicaid.gov/medicaid/downloads/managed-care-quality-strategy-toolkit.pdf
[4] CMS, Promoting Access in Medicaid and CHIP Managed Care: A Toolkit for Ensuring Provider Network Adequacy and Service Availability. 2017. Accessed at: https://www.medicaid.gov/medicaid/downloads/adequacy-and-access-toolkit.pdf
[5] *Federal Register*: "Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability"; Final Rule (81 FR 27497) (May 6, 2016).

438.66(e),[6] the Medical Loss Ratio (MLR) Summary Report required in 42 CFR § 438.74(a),[7] and the Network Adequacy and Access Assurance Report (NAAAR) required in 42 CFR § 438.207(d) and (e).[8] CMS is also creating a web-based reporting portal for states to use when submitting these reports, thereby creating a single submission process and repository for all state reporting requirements related to managed care.

As part of the Managed Care Program Annual Report required in 42 CFR § 438.66(e), states report to CMS on several appeals, grievances, and state fair hearings data elements, including the number of appeals resolved at the plan level, state fair hearing requests, and external Medicaid reviews by decision type. States began submitting these reports to CMS in December 2022, and as of March 2023, CMS has received reports for 41 managed care programs from a total of 24 states, with data included for 232 managed care plans. CMS expects to receive more than 75 additional MCPAR reports by June 30, 2023. CMS has developed a strategy for review of the MCPARs that prioritizes the analysis of MCPAR submissions in the short-term, with the addition of proactive technical assistance to states in the future. In addition, the regulations at 42 CFR § 438.66(d) require that states conduct a readiness review of each managed care plan that they contract with to assess its ability to perform satisfactorily in several areas, including appeals and grievances. [9] Appeals and grievances data collected through this process provide critical insight into the performance of a managed care plan, especially during the first year of implementation of a new program or new eligibility group. To that end, CMS is currently piloting a standard appeals and grievances data collection tool to be used for the first year of implementation as a part of a state's readiness review.

As described in the OIG's report, the regulations at 42 CFR § 438.210 allow managed care plans to implement prior authorization processes, so long as certain requirements are met. Managed care plans must also comply with the grievance and appeal system requirements laid out in 42 CFR § 438 Subpart F, including the requirement that they can only have one level of appeal. The 2016 Final Rule clarified that states could offer enrollees the option of an external medical review, as long as the review is provided at the enrollee's option, is not a requirement, and is not used as a deterrent to proceeding to the state fair hearing.[5] Further, if states want to offer enrollees the option of an external medical review, it must be independent of both the state and managed care plan, and must be offered without any cost to the enrollee. While not a regulatory requirement, the OIG report shows that some states utilized this flexibility and chose to offer an external medical review to enrollees when the managed care plan upheld the initial prior authorization denial.

In addition to the regulations at 42 CFR § 438.210, CMS recently proposed a rule in December 2022 that, if finalized, would require managed care plans to publicly report certain aggregated metrics about prior authorization.[10] These metrics would include, among others, the percentage of standard prior

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[6] CMS, Managed Care Program Annual Report (MCPAR) Workbook. Accessed at: https://www.medicaid.gov/medicaid/managed-care/downloads/amcpr-reporting-template.xlsx

[7] CMS, Medical Loss Ratio (MLR) Reporting Template. Accessed at: https://www.medicaid.gov/medicaid/managed-care/downloads/mlr-reporting-template.xlsx

[8] CMS, Network Adequacy and Access Assurances Report Template. Accessed at: https://www.medicaid.gov/medicaid/managed-care/downloads/network-assurances-template.xlsx

[9] "Managed care plan" as used here includes managed care organizations, prepaid inpatient health plans, and prepaid ambulatory health plans, as defined in 42 CFR § 438.2

[10] *Federal Register*: "Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Advancing Interoperability and Improving Prior Authorization Processes for Medicare Advantage Organizations, Medicaid Managed

authorization requests that were approved, denied, or that were approved after appeal. State Medicaid agencies and managed care plans would also be required to report certain metrics to CMS annually, which would support CMS's oversight, evaluation, and administration of the Medicaid program. The rule also proposes requirements for managed care plans to make detailed information about prior authorization requests and decisions for items and services (excluding drugs) available to providers electronically, significantly shorten response times for the managed care plan to respond to a prior authorization request, and make prior authorization status available to enrollees electronically within one business day. Further, in the case of a prior authorization denial, the managed care plan would have to provide a specific reason for all denied requests.

Additionally, current CMS regulations also require that states have a monitoring system for their managed care programs. While states have flexibility in how they design their monitoring system, it must address the performance of the 14 specific program areas enumerated at 42 CFR § 438.66(b), which include, among other things, the state's appeals and grievance system. The regulations further require that each state uses the data collected from its monitoring activities to improve the performance of its managed care program. CMS regulations do not include an exhaustive list of performance areas in which data may be used for oversight; however, 42 CFR § 438.66(c) describes several areas that are fundamental to every managed care program, including member grievance and appeal logs. States have flexibility in determining how to operationalize their monitoring system, and in their report the OIG found that some states chose to regularly conduct appropriateness reviews of Managed Care Organization (MCO) prior authorization denials, and others chose to conduct reviews as necessary on an ad hoc basis.

As noted above, CMS has developed a series of technical assistance tools, toolkits, and reporting templates to assist states in complying with various managed care standards and regulations. CMS looks forward to engaging and collaborating with states to improve their managed care programs, and anticipates issuing additional tools, guidance, and technical assistance to continually improve monitoring and oversight activities. CMS appreciates the information shared in the OIG's report, and will take it into consideration in future work with states.

The OIG's recommendations and CMS's responses are below.

OIG Recommendation

Require States to review the appropriateness of a sample of MCO prior authorization denials regularly.

CMS Response

CMS will consider the OIG's findings and recommendation, along with other available information, to determine whether there is a need to require states to review the appropriateness of a sample of MCO prior authorization denials regularly, which would likely require notice and comment rulemaking.

Care Plans, State Medicaid Agencies, Children's Health Insurance Program (CHIP) Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges, Merit-Based Incentive Payment System (MIPS) Eligible Clinicians, and Eligible Hospitals and Critical Access Hospitals in the Medicare Promoting Interoperability Program"; Proposed Rule (87 FR 76238) (December 13, 2022).

OIG Recommendation
Require States to collect data on MCO prior authorization decisions.

CMS Response
As mentioned above, in December 2022, CMS proposed a rule that, if finalized, would improve the electronic exchange of health care data and streamline processes related to prior authorization. [11] Specifically, it would require managed care plans to publicly report certain aggregated metrics about prior authorization. These metrics would include, among others, the percentage of standard prior authorization requests that were approved, denied, or that were approved after appeal. State Medicaid agencies and managed care plans would also be required to report certain metrics to CMS annually, which would support CMS's oversight, evaluation, and administration of the Medicaid program.

The rule also proposes requirements for managed care plans to make detailed information about prior authorization requests and decisions for items and services (excluding drugs) available to providers electronically, significantly shorten response times for the managed care plan to respond to a prior authorization request, and make prior authorization status available to enrollees electronically within one business day. Further, in the case of a prior authorization denial, the managed care plan would have to provide a specific reason for all denied requests. If finalized, CMS believes the data and metrics that managed care plans would be required to report, both publicly and to CMS, will address the intent of the OIG's recommendation.

OIG Recommendation
Issue guidance to States on the use of MCO prior authorization data for oversight.

CMS Response
In December 2022, CMS proposed a rule that, if finalized, would improve the electronic exchange of health care data and streamline processes related to prior authorization.[12] If finalized, CMS will consider issuing guidance to states on ways in which the prior authorization data that is reported could be used for oversight by states, which CMS believes will address the intent of the OIG's recommendation.

OIG Recommendation
Require States to implement automatic independent medical reviews of upheld MCO prior authorization denials.

CMS Response
CMS will consider the OIG's findings and recommendation, along with other available information, to determine whether there is a need to require states to implement automatic independent medical reviews of upheld MCO prior authorization denials, which would likely require notice and comment rulemaking.

[11] *Federal Register*: "Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Advancing Interoperability and Improving Prior Authorization Processes for Medicare Advantage Organizations, Medicaid Managed Care Plans, State Medicaid Agencies, Children's Health Insurance Program (CHIP) Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges, Merit-Based Incentive Payment System (MIPS) Eligible Clinicians, and Eligible Hospitals and Critical Access Hospitals in the Medicare Promoting Interoperability Program"; Proposed Rule (87 FR 76238) (December 13, 2022).
[12] Ibid

OIG Recommendation
Work with States on actions to identify and address MCOs that may be issuing inappropriate prior authorization denials.

CMS Response
CMS concurs with this recommendation. CMS is committed to partnering with states to help strengthen the monitoring and oversight of Medicaid managed care programs and has already taken a number of steps to support states in these efforts. CMS provides guidance, as well as individualized technical assistance, to states in order to support them in developing, enhancing, implementing, and evaluating their managed care programs. CMS will issue guidance and provide technical assistance to states on ways in which prior authorization data could be used for oversight by states, which CMS believes will address the intent of the OIG's recommendation.

ACKNOWLEDGMENTS AND CONTACT

Acknowledgments

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This report was prepared under the direction of Blaine Collins, Regional Inspector General for Evaluation and Inspections in the San Francisco regional office, and Rosemary Rawlins Bartholomew, Subject Matter Expert for Health Care Quality.

Contact

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ABOUT THE OFFICE OF INSPECTOR GENERAL

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ENDNOTES

[1] In addition to the comprehensive, risk-based MCO health plans, which are the focus of this study, Medicaid managed care programs may also provide services through other entities, such as Prepaid Inpatient Health Plans (PIHPs) and Prepaid Ambulatory Health Plans (PAHPs).

[2] 42 CFR § 438.210(a)(3)(ii).

[3] 42 CFR § 438.2.

[4] Chad Terhune, "Coverage Denied: Medicaid Patients Suffer as Layers of Private Companies Profit," *Los Angeles Times*, December 19, 2018. Accessed at https://www.latimes.com/business/la-fi-medicaid-denial-nurse-20181219-story.html on March 20, 2023. Jason Clayworth, "'Stubborn and Absurd.' Iowa's Ombudsman Slams Private Medicaid Managers for Denying Medical Care to Disabled," *Des Moines Register*, April 2, 2018. Accessed at https://www.desmoinesregister.com/story/news/investigations/2018/04/02/iowa-medicaid-service-denials-disabled-absurd-ombudsman-says/478077002/ on March 20, 2023. "Years of Poor State Oversight Have Allowed Companies to Skimp on Essential Care for Sick Kids and Disabled Adults," *The Dallas Morning News*, June 3, 2018. Accessed at https://interactives.dallasnews.com/2018/pain-and-profit/part2.html#_ga=2.262496396.142881624.1551293707-1471592254.1551293707 on April 1, 2022.

[5] Kevin H. Nguyen, Ira B. Wilson, Anya R. Wallack, and Amal N. Trivedi, "Racial And Ethnic Disparities In Patient Experience Of Care Among Nonelderly Medicaid Managed Care Enrollees," *Health Affairs*, Vol. 41, No. 2, February 2022. Accessed at https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.01331 on January 5, 2023.

[6] In 2020, median income eligibility in Medicaid expansion States was 266 percent of the Federal poverty level for children and 138 percent of the Federal poverty level for nonpregnant adults. Kaiser Family Foundation, *Medicaid and CHIP Eligibility, Enrollment, and Cost Sharing Policies as of January 2020: Findings from a 50-State Survey*, March 26, 2020. Accessed at https://www.kff.org/coronavirus-covid-19/report/medicaid-and-chip-eligibility-enrollment-and-cost-sharing-policies-as-of-january-2020-findings-from-a-50-state-survey/ on January 5, 2023.

[7] Kaiser Family Foundation, *Disparities in Health and Health Care: 5 Key Questions and Answers*, April 21, 2023. Accessed at https://www.kff.org/racial-equity-and-health-policy/issue-brief/disparities-in-health-and-health-care-5-key-question-and-answers/ on May 31, 2023.

[8] Medicare Advantage is the managed care option available to people in the Medicare program and serves more than 28 million older adults and people with disabilities. Although Medicaid managed care and Medicare Advantage serve different populations and have different coverage rules, they have similar incentive structures, and many insurance companies offer health plans in both programs.

[9] CMS, *May 2022 Medicaid and CHIP Enrollment Trends Snapshot*, May 2022, page 5. Accessed at https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/downloads/may-2022-medicaid-chip-enrollment-trend-snapshot.pdf on February 15, 2023. Kaiser Family Foundation, *Medicaid Enrollment: June 2012 Data Snapshot*, August 21, 2013. Accessed at https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-june-2012-data-snapshot/#:~:text=In%20June%202012%2C%20Medicaid%20enrollment,turn%20to%20Medicaid%20for%20coverage on February 15, 2023.

[10] CMS, *Medicaid Managed Care Enrollment and Program Characteristics, 2020*, Spring 2022, page 12. Accessed at https://www.medicaid.gov/medicaid/managed-care/downloads/2020-medicaid-managed-care-enrollment-report.pdf on November 16, 2022.

[11] The most common Medicaid managed care arrangement is comprehensive, risk-based managed care. Comprehensive, risk-based contracts must cover inpatient hospital services and any of the following services, or any three or more of the following services: (1) outpatient hospital; (2) rural health clinic; (3) Federally Qualified Health Center; (4) laboratory and x-ray; (5) nursing facility; (6) early and periodic screening, diagnostic, and treatment; (7) family planning; (8) physician; or (9) home health. 42 CFR § 438.2. As of July 2020, there were 285 MCOs that offered comprehensive risk-based coverage in 40 States. See: Kaiser Family Foundation, *Total Medicaid MCOs*. Accessed at https://www.kff.org/medicaid/state-indicator/total-medicaid-mcos/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D on November 16, 2022.

[12] Kaiser Family Foundation, *Total Medicaid MCO Spending*. Accessed at https://www.kff.org/other/state-indicator/total-medicaid-mco-spending/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D on November 16, 2022.

[13] States determine the capitated amount paid to MCOs according to Federal requirements. The capitation payment must be adequate for MCOs to provide for all contracted Medicaid benefits to enrollees. Capitation rates must be developed to reasonably achieve a medical loss ratio standard where at least 85 percent of the total amount paid to an MCO by the State is spent on patient care and quality improvements rather than profits, advertising, or similar expenses. 42 CFR § 438.4 and § 438.8.

[14] 42 CFR § 438.210(a)(4). MCOs may use prior authorization in accordance with the State plan or for utilization control within certain parameters.

[15] 42 CFR § 438.210(a)(2).

[16] 87 FR 76238, 76238-76371 (December 13, 2022).

[17] 42 CFR § 438.404(b) and 42 CFR § 438.228. People enrolled in Medicaid have 60 days from the date on the denial notice to file an appeal with the MCO. 42 CFR § 438.402(c)(2)(ii). The MCO must continue the appellant's benefits throughout the appeals process if the following conditions are met: (1) the appeal involves the termination, suspension, or reduction of previously authorized services; (2) the appellant files the request for an appeal in a timely manner; (3) the services were ordered by an authorized provider; (4) the period covered by the original authorization has not expired; and (5) the appellant files for continuation of benefits in a timely manner. 42 CFR § 438.420(b). States can establish their own timeframes for resolution of the appeal, but these timeframes must not exceed 30 days for standard appeals or 72 hours for expedited appeals. 42 CFR §§ 438.408(a) and (b).

[18] As specified in 42 CFR § 438.400, adverse benefit determinations include "the denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit." For the purposes of this report, we refer to adverse benefit determinations as "denials."

[19] If State law permits and with the written consent of the enrollee, a provider or an authorized representative may request an appeal, or request a State fair hearing, on behalf of an enrollee. 42 CFR § 438.402(c)(1)(ii). For the purposes of this report, we consider all appeals filed on behalf of an enrollee to be an enrollee appeal.

[20] People enrolled in Medicaid managed care may also request a State fair hearing if the MCO fails to issue a decision on the appeal according to the timeframe and notice requirements. 42 CFR § 438.408(f)(1)(i). For State fair hearing requirements, see 42 CFR § 438.408(f).

[21] 42 CFR § 438.400(b) defines "appeal" as a review by a health plan of an adverse benefit determination. For the purposes of this report, we use the term "appeal" to mean reviews by the MCOs or State fair hearings.

[22] 42 CFR § 438.66(c), 42 CFR §§ 438.66(e)(1) and (2)(v). The requirement to produce this report was contingent on the publication of CMS guidelines. On June 28, 2021, CMS issued guidance to States specifying what should be included in the report. The deadlines for issuing the reports depend upon each State's contract period with its MCOs, with the first reports (for the 2021–22 contract year) due on December 27, 2022. (See *CMCS Informational Bulletin* available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib06282021.pdf).

[23] States must also collect other data from MCOs that may provide insight into denial and appeal processes, including enrollee grievances, provider complaints, and enrollee and provider surveys.

[24] 42 CFR § 438.350(a). The State may exempt an MCO from external quality review under certain circumstances. See 42 CFR § 438.362.

[25] 42 CFR § 438.358(b)(1)(iii). The MCO standards related to authorization decisions are found at 42 CFR § 438.210.

[26] OIG, *Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials*, OEI-09-16-00410, September 2018, available at https://oig.hhs.gov/oei/reports/oei-09-16-00410.asp.

[27] OIG, *Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care*, OEI-09-18-00260, April 2022, available at https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf.

[28] OIG, *Keystone First Should Improve Its Procedures for Reviewing Service Requests That Require Prior Authorization*, A-03-20-00201, December 2022, available at https://oig.hhs.gov/oas/reports/region3/32000201.pdf.

[29] For this study, we chose to focus on comprehensive, risk-based MCOs because they provide a more comprehensive set of services than other managed care arrangements, such as PIHPs and PAHPs, and to allow comparison of prior authorization rates across similar entities.

[30] Council of the Inspectors General on Integrity and Efficiency, *Quality Standards for Inspection and Evaluation*, December 2020, available at https://www.ignet.gov/sites/default/files/files/QualityStandardsforInspectionandEvaluation-2020.pdf.

[31] The three MCOs with the highest denial rates in these States were operated by three different parent companies.

[32] 42 CFR § 422.592. The Independent Review Entity is a CMS contractor that employs physicians and other consultants to review denials to determine whether the requests are medically necessary and meet relevant Medicare requirements.

[33] OIG analysis of Medicare Advantage annual performance data. CMS, 2019 Parts C and D Reporting Requirements PUF, accessed at https://www.cms.gov/files/zip/2019-parts-c-and-d-reporting-requirements-puf-not-incl-part-d-mtm-data.zip on October 18, 2022.

[34] Prior OIG work found that the Independent Review Entity overturned just 9 percent of denials that Medicare Advantage Organizations forwarded to the second level of appeal in Medicare Advantage in 2016. OIG, *Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials*, OEI-09-16-00410, September 2018, available at https://oig.hhs.gov/oei/reports/oei-09-16-00410.asp.

[35] States varied in terms of when external medical review may be requested in the appeal process. For example, some States reported that external medical reviews are a distinct level of review between an MCO appeal and a State fair hearing. Other States reported that external reviews may occur as part of a State fair hearing.

[36] Per 42 CFR § 438.402(c)(1)(i)(B), external medical reviews, when offered, are not automatic but can be initiated by enrollees or their providers with enrollee permission.

[37] In some cases, MCOs may choose to offer the option of an external medical review as part of their appeals process, despite not being required to do so by the State in which they operate.

[38] Kaiser Family Foundation, *Medicaid Enrollment in Managed Care by Plan Type* for 2019, July 1, 2020. Accessed at https://www.kff.org/medicaid/state-indicator/enrollment-by-medicaid-mc-plan-type/?currentTimeframe=1&selectedDistributions=mco&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D on January 5, 2023.

[39] We were unable to include appeals data from one parent company (12 MCOs) in our analysis of appeals to MCOs because the parent company was unable to report the number of unique appeal cases.

[40] Although delayed decisions and notices may delay enrollees in filing an appeal, 42 CFR § 438.402(c)(1)(A) does permit enrollees to initiate a request for a State fair hearing immediately if the MCO fails to adhere to notice and timing requirements.

[41] 42 CFR § 438.10(g)(2)(xi). MCOs are required to provide all enrollees an enrollee handbook that contains information about grievance, appeal, and fair hearing procedures and timeframes, including the right to request a State fair hearing after an MCO has upheld a denial on appeal.

[42] Kevin H. Nguyen, Ira B. Wilson, Anya R. Wallack, and Amal N. Trivedi, "Racial And Ethnic Disparities In Patient Experience Of Care Among Nonelderly Medicaid Managed Care Enrollees," *Health Affairs*, Vol. 41, No. 2, February 2022. Accessed at https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.01331 on January 5, 2023. Milliman, *Comparing the Demographics of Enrollees in Medicare Advantage and Fee-For-Service Medicare*, October 2020. Accessed at https://bettermedicarealliance.org/wp-content/uploads/2020/10/Comparing-the-Demographics-of-Enrollees-in-Medicare-Advantage-and-Fee-for-Service-Medicare-202010141.pdf on January 5, 2023. Note that the Medicaid managed care data on race and ethnicity is from 2014 to 2018, and the Medicare Advantage data is from 2019.

[43] In 2020, median income eligibility in Medicaid expansion States was 266 percent of the Federal poverty level for children and 138 percent of the Federal poverty level for non-pregnant adults. Kaiser Family Foundation, *Medicaid and CHIP Eligibility, Enrollment, and Cost Sharing Policies as of January 2020: Findings from a 50-State Survey*, March 26, 2020. Accessed at https://www.kff.org/coronavirus-covid-19/report/medicaid-and-chip-eligibility-enrollment-and-cost-sharing-policies-as-of-january-2020-findings-from-a-50-state-survey/ on January 5, 2023. In comparison, only 50 percent of Medicare Advantage enrollees had incomes below 200 percent of the Federal poverty level in 2019. Better Medicare Alliance, *Medicare Advantage Outperforms Traditional Medicare on Cost Protections for Low- and Modest-Income Populations*, January 2021. Accessed at https://bettermedicarealliance.org/wp-content/uploads/2020/04/Medicare-Advantage-Outperforms-Traditional-Medicare-on-Cost-Protections-for-Low-and-Modest-Income-Populations2.pdf on January 5, 2023.

[44] Kaiser Family Foundation, *Disparities in Health and Health Care: 5 Key Questions and Answers*, April 21, 2023. Accessed at https://www.kff.org/racial-equity-and-health-policy/issue-brief/disparities-in-health-and-health-care-5-key-question-and-answers/ on May 31, 2023.

[45] 87 FR 76238, 76304-76305 (December 13, 2022).

[46] 42 CFR § 438.66(c).

[47] 81 FR 27497, 27505 (May 6, 2016). See section I.B.1.b. Appeals and Grievances.

[48] We asked MCOs to report data based on the date that an initial request or appeal decision was issued. This means, for example, that a prior authorization request that the MCO received at the end of December, but had not yet issued a decision for by December 31, 2019, would not be included in the number of prior authorization decisions issued by the MCO in 2019. Similarly, decisions issued by MCOs in January 2019 may include decisions for requests that were received at the end of 2018.

[49] We were unable to include appeals data from one parent company (12 MCOs) in our analysis of appeals to MCOs because the parent company was unable to report the number of unique appeal cases.

[50] We did not inquire solely about the specific MCOs in our study population, but rather State Medicaid agencies' oversight of all MCOs in their States.

[51] CMS has the authority to establish data reporting requirements for Medicare Advantage Organizations as described in 42 CFR § 422.516(a). Additional details about the data that Medicare Advantage Organizations are required to report are available on CMS's website at: https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/ReportingRequirements.

[52] CMS conducts program audits each year to evaluate a sample of Medicare Advantage Organizations' delivery of health care services to Medicare Advantage enrollees. For more information, see the *2021 Part C and Part D Program Audit and Enforcement Report* available at https://www.cms.gov/files/document/2021-program-audit-enforcement-report.pdf and CMS's website https://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/ProgramAudits.