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Managed Medicaid: Navigating the complexities and ensuring quality health care delivery

Data-driven strategies to combat MCO denial tactics

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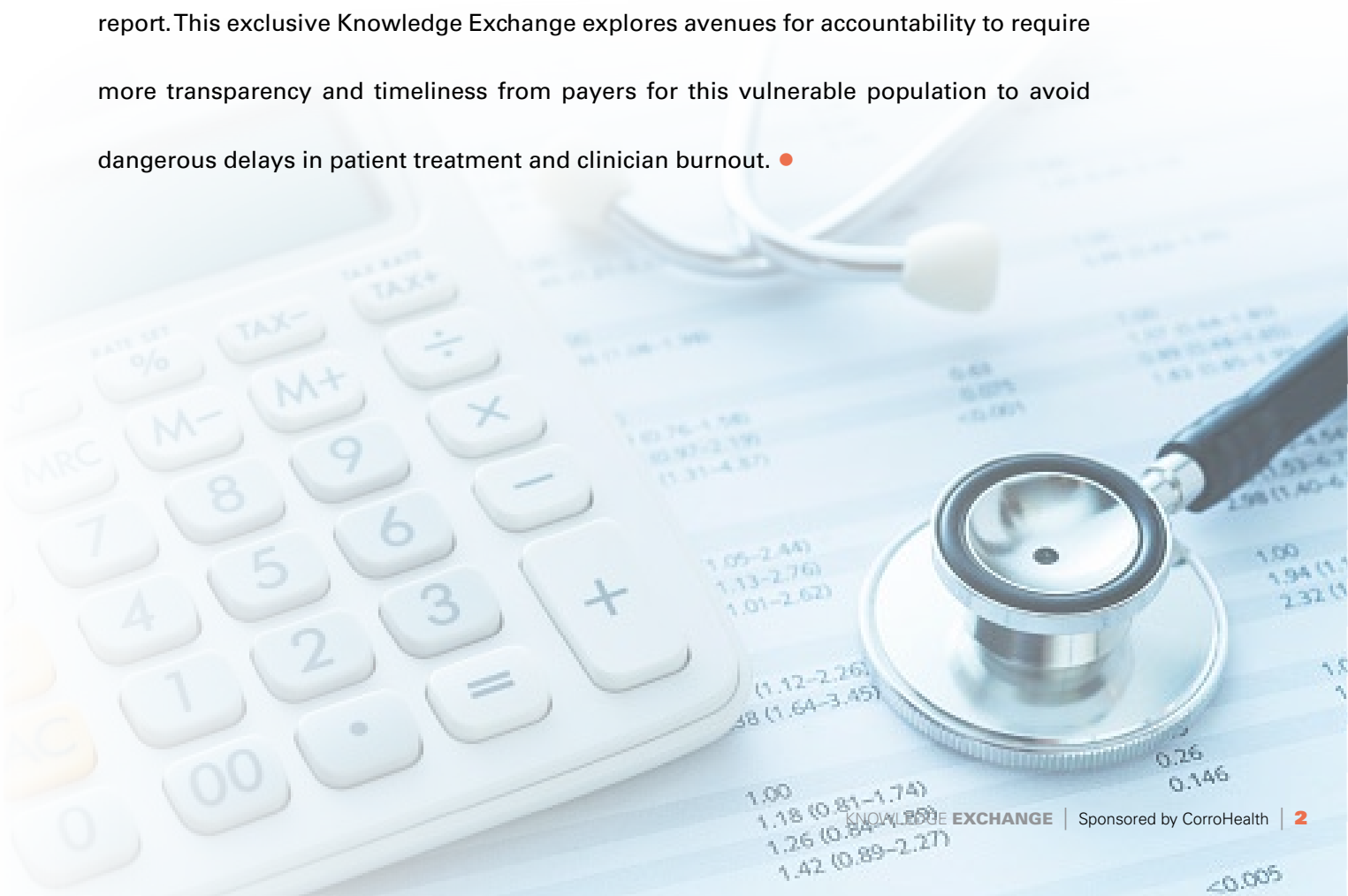
Introduction

Managed Medicaid: Navigating the complexities and ensuring quality health care delivery

Data-driven strategies to combat MCO denial tactics

As Medicaid managed care enrollment continues to grow, Medicaid managed care organizations (MCOs) play an important role in ensuring that people with Medicaid coverage have access to medically necessary, covered services. The high number and rate of prior authorization delays and denials of care by some MCOs, the limited state oversight of Medicaid MCOs and the limited access to external medical reviews were concerns raised in the July 2023 Department of Health and Human Services Office of Inspector General report. This exclusive Knowledge Exchange explores avenues for accountability to require more transparency and timeliness from payers for this vulnerable population to avoid dangerous delays in patient treatment and clinician burnout.



9 WAYS health systems can combat MCO denial tactics

- Use all dispute mechanisms available in your state and, to the extent that existing framework is insufficient, work with hospitals and hospital associations to pursue stronger regulatory protections for Medicaid payments.

- Support clinical staff engagement with Medicaid agency advisory groups, such as the pharmacy and therapeutics committee, or the Medicaid Advisory Committee (MAC).

- Create public reporting around Medicaid plan performance. For example, a payer scorecard or annual report that includes data on payment timeliness, denials, appeals, or other accounts receivable trends.

- Start with due diligence internally and review contracts, data and denials at joint operating committee meetings and escalate cases.

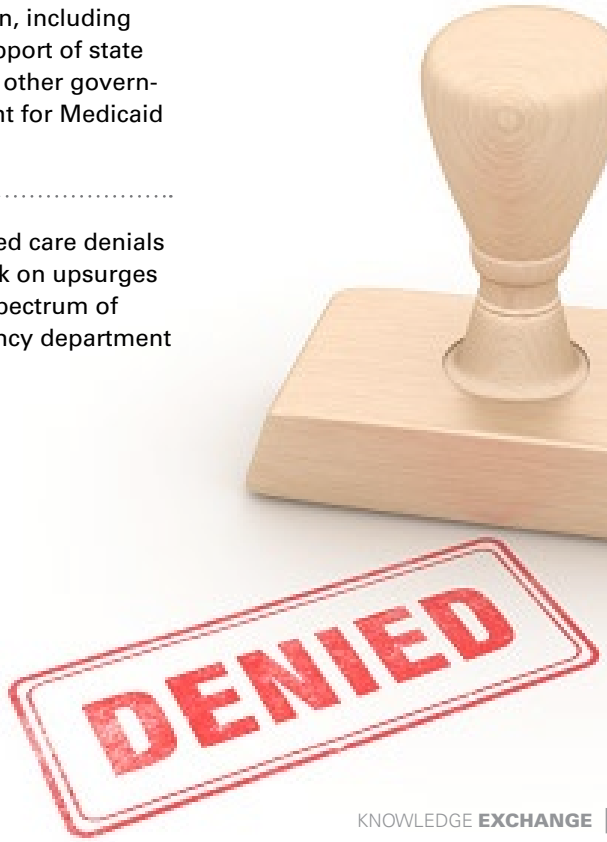
- Document first-level denials, appeals, and activity related to prior authorization, including peer-to-peer reviews to gain the support of state Medicaid agencies, legislators, and other government officials who provide oversight for Medicaid managed care programs.

- Take egregious Medicaid managed care denials to a state fair hearing and push back on upsurges in blanket denials. Pursue the full spectrum of appeals options to combat emergency department downcoding and denials.

- Encourage the state government to pursue health plan accountability, including payer reporting on denials, appeals, peer-to-peer use, and delays in care. Documenting your hospital's experience with these issues can be a critical part of state and federal engagement.

- Provide feedback on your experience with Medicaid plans to state Medicaid officials who are engaged in the MCO procurement process, including your experience with inadequate reimbursement, and plan policies and practices that may compromise beneficiary's access to care.

- Examine whether alternative arrangements, such as direct-to-employer contracting or starting a provider-led health plan, might be a good fit for your organization's strategic goals. Some health systems report that these arrangements allow them to work more closely with the state Medicaid agency to improve health outcomes and reduce cost.



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MODERATOR SUZANNA HOPPSZALLERN *(American Hospital Association):* **How have delays in access to care affected the quality of care for Medicaid enrollees in your hospital?**

LARRY SHACKELFORD *(Washington Regional Medical System)*: Arkansas is a state that does not have managed Medicaid, but will likely be looking at managed options in a special legislative session. We were one of the first states that chose Medicaid expansion in a public-private partnership. However, after COVID-19 and the disenrollment process, we led the nation in having the largest percentage of Medicaid recipients disenrolled in the fastest period of time.

Because of the private option, when Medicaid recipients come back in after being disenrolled, it's on the Medicaid fee-for-service (FFS) side and they find that their primary care provider doesn't accept FFS Medicaid or aren't credentialed with the plan, and they're stuck. Access, particularly primary care, is a big deal.

CARLY SALAMONE *(Fisher-Titus Health):* We are an independent community rural hospital. In Ohio, more than 90% of Medicaid patients have Medicaid managed care. The biggest issues are payer credentialing, reimbursement and prior authorization. It's time-consuming and cumbersome for our providers to become credentialed with our Medicaid managed care plans. We have contracts with five plans. It's been almost a year, and several of our providers are still not payer-credentialed with specific Medicaid managed care plans.

Reimbursement rates with our Medicaid managed care plans are similar to Medicaid FFS, but significantly lower than both Medicare and traditional commercial plans. Their prior authorization requirements are more challenging, making Medicaid patients and our teams jump through additional hoops for a basic procedure, an admission or a test, delaying care for weeks at times until it becomes urgent and more costly for everyone.

KENNETH MORRIS *(St. Joseph's Health):* We are the second-highest provider of Medicaid services in New Jersey. These delays increase length of stay for our Medicaid patients and prevent the appropriate transfer of these patients into rehabilitation and other post-acute care facilities. Additionally, we aren't reimbursed for the additional cost associated with the extended stay and services we provide, which limits our ability to address the health care needs of some of New Jersey's most vulnerable patients.

St. Joseph's Health is a mission-driven organization and, as one of the state's few safety net providers, we have an obligation to treat the Medicaid population. However, not being reimbursed appropriately adversely impacts our mission and the health care of New Jersians.

DOUG SKRZYNIARZ *(Community Health Systems):* We have about 70-plus hospitals in 15 states. Credentialing is increasingly more of an issue with payer delays. The states complete their part in a few weeks, and then the payers take an extra three to six months. These tactics can delay reimbursement and have a big impact on patients, especially those in subspecialty care.

JASON KRUSE *(Broadlawns Medical Center):* Managed care organization (MCO) denials have surged in our practices. Low Medicaid payment rates have limited skilled facilities willingness to take on additional Medicaid patients.

One of our major multispecialist groups couldn't come

CLARA EVANS | RADY CHILDREN'S HOSPITAL–SAN DIEGO

"More than 50% of our kids in California are covered by Medicaid. This creates a difficult dynamic for pediatric providers because of poor reimbursement, and we're starting to see a real impact. For example, in this year's National Residency Match, about a third of all pediatric slots were left open."

to contract terms with one of the MCOs. All those patients are scrambling to figure out if they need to change MCOs or if they need to change specialists. It takes a long time to find a specialist who is credentialed on Medicaid. They're not being prioritized. That's a huge pain point for us.

CLARA EVANS *(Rady Children's Hospital–San Diego):* California has the largest Medicaid program in the country, and more than 90% of Medicaid patients are on Medicaid managed care. The state goal is for all Medicaid beneficiaries to be enrolled in a managed care plan.

More than 50% of kids in California are covered by Medicaid. This creates a difficult dynamic for pediatric providers because of poor reimbursement, and we're starting to see a real impact. For example, in this year's National Residency Match, about a third of all pediatric slots were left open. While there is an increasing number of applicants for residency programs, the number of medical school graduates applying for pediatrics dropped by more than 6% — the largest single decline in the last 10 years of a steady reduction. We have a difficult time recruiting pediatricians and pediatric specialists. This is particularly challenging for providers in high-cost areas like San Diego.

GERARD GRIMALDI *(University Health):* Our latest concern is prior authorization and the delay game. Half our revenue is Medicaid, so it's a big issue for us because Medicaid is a less than ideal payer to begin with.

In Missouri, the plans all use similar tactics in terms of not paying on time. On the payment side, the rules change in the middle of the game; they'll ask for more medical records, and everything goes into a big black hole. We're a large mental health provider and also have challenges with payments on the mental health side.

ODETTE BOLANO *(Saint Agnes and Saint Alphonsus):* In Idaho, we work with the state on a value care organization, and we are advocating that hospitals, as value care organizations, can drive care without a middleman. In Eastern Oregon, our managed Medicaid is a relationship in which providers are owners of the managed Medicaid and we have been able to work with the state.

GRIMALDI: The Missouri Hospital Association (MHA) has done a fabulous job of encouraging the local CEOs and leaders to meet with their state legislators. A bill was passed by the Missouri House of Representatives that helps us on prior authorization. Prior authorization would not be required if 90% of prior authorization requests submitted by the physician were or would have been approved in the previous evaluation period. If the provider is a licensed physician, the determination is to be made by a licensed physician with the same or similar specialty. (NB. The legislation did not pass the Missouri Senate.)

TINA GRANT *(Trinity Health):* As one of the largest Catholic health systems in 27 states with more than 100 hospitals, we have varying experiences depending on the state and Medicaid director, and insurance commissioner. Unfortunately, it is not uncommon for Medicaid plans to abuse utilization management programs or change rules mid-contract that delay patient care and frustrate clinicians. At Trinity Health, 8% to 10% of our total hospital encounters are routinely denied on first submission.

The key to quality Medicaid managed care is state

JASON KRUSE | BROADLAWNS MEDICAL CENTER

"In Iowa, one of my big pushes is about how much prior authorization is too much prior authorization and what's the process? There should be transparency on hold times. It's mandatory that every insurance company list how much hold time they have, how many transfers, how many phone calls. They track all that; they just don't share the data."

engagement. States should be actively engaged in bringing in insurers and providers, listening, having hearings and holding plans accountable. In Massachusetts, the state has a one-third share in the Medicaid accountable care organization. The state is there every day asking for data. That's helpful versus a hands-off approach.

CHARLTON PARK *(University of Utah Hospitals and Clinics):* In Utah, we have been successful with our managed care organizations enhancing the Medicaid payment over the past couple of years through hospital assessments and IGTs [intergovernmental transfers — a transfer of funds from a public agency to the state Medicaid agency], which has been helpful for the health system.

JULIE PETERSEN *(Kittitas Valley Healthcare):* We're a rural independent hospital in the center of Washington state. Washington's managed Medicaid is slowing credentialing down, denying it and asking for additional information. It takes forever.

We've been overrun with prepayment audits recently. If Medicaid hasn't paid the bill yet, hospitals receive a request for 200 pages of paper medical records to submit. They need to submit it within 30 days or the claim is automatically denied, and the Medicaid plan gives itself 120 days to review the submission. That's new.

MODERATOR: How are Medicaid managed care denial disputes escalated and remediated?

KRUSE: Depending on the dispute, we try and get to the peer-to-peer reviews quickly. We prioritize notification of providers with first level of denials, to make those phone calls and stay aggressive. Providers are burdened with a lot of hold times.

We've been taking Medicaid managed care denials to a state fair hearing, and we were winning almost all of them. Their denials slowed down for a while after that, but we periodically get a denial boom — everything gets denied all the way across. They're clearly not reviewing any of your materials, and you have to push back right away.

In Iowa, one of my big pushes is about how much prior authorization is too much prior authorization and what's the process? There should be transparency on hold times. It's mandatory that every insurance company list how much hold time they have, how many transfers, how many phone calls. They track all that; they just don't share the data. The insurers are understaffing the call centers intentionally and making confusing phone trees to nowhere.

Most state MCOs or state Medicaid agencies have public representation including having a physician on the pharmacy and therapeutics committee. The committee is responsible for reviewing information on drug effectiveness and issuing evidence-based recommendations on coverage criteria, such as placement of drugs on the preferred drug lists and utilization controls. Engage your physicians to sign up to be on those boards as part of the formulating process. Give them the time they need to prep for and attend those meetings. That's where, as one of five to 10 voices at the table, you can change the prior authorization process and make life a little better.

SKRZYNIARZ: In multiple states, we've increasingly been experiencing the downcoding for ED visits. In Indiana, we took them to court and won. Litigation is a new tool for us.

JERILYN MORRISSEY *(CorroHealth):* Different approaches are failing in some states and succeeding in other states. This is working well in my state and I'm

DOUG SKRZYNIARZ | COMMUNITY HEALTH SYSTEMS
"In multiple states, we've increasingly been experiencing the downcoding for ED visits. In Indiana, we took them to court and won. Litigation is a new tool for us."

going to my state legislature where I have an advocate. We've all identified the hurdles. We know that we have to be paid and resources are limited. In your organizations, as you look at these problems for Medicaid and managed Medicaid, what are your strategies?

MORRIS: We start with the initial peer-to-peer review, and depending on where that lands, we end up escalating our requests to the New Jersey Department of Banking and Insurance (DOBI). MCOs often employ a strategy of deny, deny, deny in the hopes that we will eventually give up. However, we remain vigilant. Our flagship facility is based in New Jersey's third poorest city. Most of our patients depend on Medicaid and charity care in our host community of Paterson. Therefore, we must be persistent in pushing back on denials.

We follow the appeal process as denials come in, including sending appeal letters to third-party vendors. When the appeals end up at DOBI, I will begin advocating with our state representatives.

EVANS: In the pediatric space in California, we deal with the Medicaid plans as well as California Children's Services, which is a California-specific program that covers kids with certain diagnoses and income levels, and counties have some responsibilities for coverage as well. It then becomes a game of who's responsible — the county, the state or the managed care plan, and chasing those payments down. Nearly a third of our outstanding accounts receivable (AR) are from public programs.

We also care for a good number of out-of-state Medicaid patients, who come to us for high-cost, specialty care like proton therapy or transplants. Those are high-dollar cases that require single-case agreements that are often difficult to negotiate and require dedicated staff.

MODERATOR: What data-driven strategies is your hospital implementing to quantify and hold MCOs accountable for timely prior authorization decisions and denial information to support providing patients with necessary care in a timely manner and reduce administrative burden?

MORRISSEY: Another area where data plus regulatory come together is on what you're doing with appeals, because you can't boil the ocean. Your data can lead you and stratify which payers are worse than others.

KRUSE: In Iowa, there are hospital and provider complaint lines. If Medicaid receives multiple comments about a specific concern or even if the hospital has a well-delineated complaint with data, it still takes months to work through the whole process to achieve resolution and change.

We have three MCOs, but if one of them is a particular bad actor, we will get on the phone and say, 'We're getting these denials that are totally unreasonable,' and start asking pointed questions: 'What are your incentives internally? What are your expectations for denials per reviewer or what is the percentage of denials per reviewer?'

Usually, after we have one of those conversations, things will improve for at least a year. But you must be willing to get on the phone and ask for resolution. Otherwise, we'll start going to the legislature to demand transparency.

MODERATOR: What is your experience at state fair hearings? What is your experience with state oversight of Medicaid managed care denials and appeals?

CARLY SALAMONE | FISHER-TITUS HEALTH

"Over the last decade there has been so much emphasis on infant mortality in our state. We look at the managed care plans' HEDIS measures. Our biggest successes in working through Medicaid concerns have been in building cases for pregnant women, babies and children."

PETERSEN: In Washington state, there's a health plan perspective on issues. When you go to the insurance commissioner, appeals go nowhere. When you call our health care authority, you're appealing to the authority informally to contact the plan. There is no formal process that's not a legal process. Occasionally, we have gone to the state attorney general with particularly egregious denials, and that gets the attention of the plans.

SALAMONE: The Ohio Department of Medicaid is responsible for the managed care plans and has been a great advocate. We can call the Medicaid director when we have issues. In Ohio, we don't have to go to the Department of Insurance for Medicaid concerns.

Over the last decade there has been so much emphasis on infant mortality in our state. We look at the managed care plans' HEDIS [Healthcare Effectiveness Data and Information Set] measures. Our biggest successes in working through Medicaid concerns have been in building cases for pregnant women, babies and children. The state medical director or any of the Medicaid staff are attuned to how denials impact a woman's pregnancy or birth outcome. Once we were able to show how this behavior is negatively impacting the mom and baby, an entirely new process was developed as to how we can not only get that medical need approved, but expedited, because it's such a time-sensitive situation. It's all about relationships. It's about the population that they're prioritizing and having the data prove it.

MORRIS: We often enlist our patients to provide testimonials at legislative hearings. The patient's voice is compelling and is perceived as sincere by the legislative body. Legislators have grown accustomed to hospitals telling their stories. However, it makes a difference when patients share their experiences and how they and their families have been impacted by decisions that adversely affect their health. This approach has led to some success at legislative hearings.

GRANT: There's a political undercurrent to Medicaid in all our states, whether it's our Medicaid directors who are on the hot seat, the insurance commissioners or legislators. There's pressure to curb their Medicaid spend. Medicaid programs are always under pressure to constrain the growth, and these MCOs see that.

There is an important role for small employers. When we were working to get Medicaid expansion passed in some of our states, and more recently with the Medicaid redeterminations, some of the small employer groups provided another strong voice at the table. They benefit when their employees are covered, healthy and able to work. There have been occasions where we've partnered with them to come to the table and be part of oversight discussions.

MORRISSEY: Overarching this entire process is the Centers for Medicare & Medicaid Services. Medicaid authority has been delegated to the states, but in some states the responsibility is with the payers. While many states don't have oversight policies or activities, some do.

My approach to most things in life are to tackle problems according to the three Cs: what's common, what's costly and what's confusing. We could all agree on the top 80% of our priorities. There are probably three things that will count for 80% of the issues we're having.

GRIMALDI: There is minimal such oversight in Missouri but MHA has hospital self-reported performance scorecards on plans and denials. I would encourage anyone to contact the MHA and learn about their Payer Performance Scorecards. In the most recent score-

JERILYN MORRISSEY | CORROHEALTH

"If you look at the Office of Inspector General report from last year, there were seven parent companies that had 115 different MCOs throughout the states that had denial rates — the same parent company, the same MCO, anywhere from 2% to 41%. How do you justify that kind of discrepancy?"

cards for the last six months of 2023, the managed care payers were the worst and of those the Medicaid payers were the worst.

SALAMONE: A lot of Medicaid plans that use different names in each state are national, e.g., Centene, AmeriHealth, Anthem, Humana and United HealthCare Community Plan.

MORRISSEY: If you look at the Office of Inspector General report from last year, there were seven parent companies that had 115 different MCOs throughout the states that had denial rates — the same parent company, the same MCO, anywhere from 2% to 41%. How do you justify that kind of discrepancy?

KRUSE: We need to be able to show where we are spending money appropriately, but if we're not recovering it, we have to recoup it somewhere else to provide health care in the community. It's a narrative that's worth building.

SALAMONE: I did that on the Medicare Advantage (MA) side. For my legislators on the federal level this year, I said, 'In 2023, here was our denial rate for traditional Medicare. If Medicare Advantage had paid at the same rate as traditional Medicare, we would have had an additional $4.4 million in revenue to show that MA does not pay like traditional Medicare.'

It's harder to do Medicaid. The commercial insurance companies are the same payers that are paying you on the MA care side.

GRANT: When we're talking about prior authorization and about post-acute placement, you have health plan representatives who have never met the patient, have never been at the bedside, or practiced medicine but are now making treatment decisions. If we don't push back, hospitals will become a place where payers simply do their business at the expense of our patients' health.

Trinity Health supports the move to coordinated care models where providers assume even more accountability for the total cost of care and outcomes for designated Medicaid participants. Today, Medicaid plans are profiting from providers' hard work on population health. If providers retained these savings, we could reinvest them in programs that bridge clinical and social care and improve health equity. PACE and health homes are two successful examples of providers assuming risk with impressive results. ●

TINA GRANT | TRINITY HEALTH

"Health plan representatives who have never met the patient, have never been at the bedside or practiced medicine are now making treatment decisions. If we don't push back, hospitals will become a place where payers simply do their business at the expense of our patients' health."

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