United States Government Accountability Office

Report to Congressional Requesters

March 2024

MEDICAID MANAGED CARE

Additional Federal Action Needed to Fully Leverage New Appeals and Grievances Data

GAO-24-106627

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GAO Highlights

Highlights of GAO-24-106627, a report to congressional requesters

Why GAO Did This Study

Over 70 percent of Medicaid enrollees receive services through managed care. Because there can be financial incentives for managed care plans to deny or limit services, appeal and grievance systems serve as a safeguard to protect enrollees. States are required to use appeals and grievances data to monitor managed care plans' performance. Beginning in 2022, states were also required to report certain managed care plan appeals and grievance data and other information to CMS annually.

GAO was asked to examine the new appeals and grievances data. This report (1) describes what the first-year data indicate about appeals and grievances, and (2) examines CMS's efforts to address any limitations in the data and its efforts to use the data for oversight.

GAO analyzed appeals and grievances data for state contract year 2022 across 35 states, and interviewed officials from five of these states, selected on the basis of geography and other factors. GAO also reviewed CMS documents, interviewed CMS officials, and assessed CMS's efforts against agency guidance.

What GAO Recommends

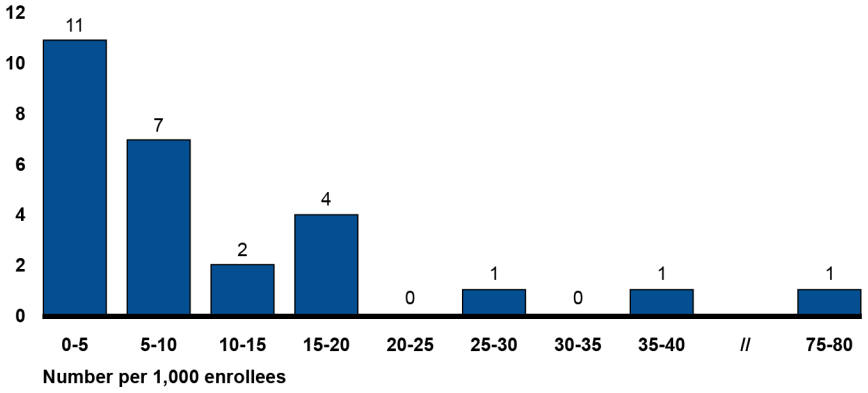
GAO is making two recommendations to CMS: (1) to require states to report on appeal outcomes and number of denials; and (2) to implement planned actions for analyzing, using, and publicly posting the appeals and grievances data. The agency concurred with GAO's recommendations and noted plans to address them.

View GAO-24-106627. For more information, contact Michelle B. Rosenberg, 202-512-7114, RosenbergM@gao.gov

What GAO Found

Managed care plans have some flexibility in determining when to authorize services for enrollees. Managed care enrollees may appeal denials of requested services and file grievances about any dissatisfaction not covered by an appeal. Data on appeals and grievances are an important tool for oversight of managed care, as they can help reveal quality and access issues. The first year of data from state annual managed care reports indicated that rates of appeals and grievances per 1,000 enrollees varied widely across states in 2022. Among other things, this could signal problems with access to needed services.

Medicaid Managed Care Plan Appeal Rates Across States with Reliable Appeals Data, Contract Year 2022



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-24-106627

The Centers for Medicare & Medicaid Services (CMS) has begun taking steps to address limitations in the new appeals and grievances data. For example, as of December 2023, CMS had conducted technical assistance with seven states to address data gaps and inconsistencies. CMS has also outlined its intentions to use these data for oversight and to enhance transparency. However, GAO found:

- **No data on outcomes or number of denials.** CMS does not require states to report on the outcomes of enrollee appeals (e.g., whether a plan overturns its initial denial upon review) or the number of denials. These data elements are key to identifying potential problems with enrollee access to services.
- **Delayed progress on planned actions to use the data.** As of December 2023, CMS had made limited progress on its plans to analyze the data and make data available to the public. Taking these steps would help to inform CMS's data quality efforts and provide incentives for states to focus on quality.

By requiring states to report additional data and implementing planned steps to use the data, CMS would be better positioned to meet its goal to use the data to target program improvement, including around enrollee access to care.

Contents

Abbreviations

CMS Centers for Medicare & Medicaid Services
HHS Department of Health and Human Services
LTSS long-term services and supports

U.S. GOVERNMENT ACCOUNTABILITY OFFICE
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Washington, DC 20548

March 14, 2024

The Honorable Ron Wyden
Chairman
Committee on Finance
United States Senate

The Honorable Frank Pallone, Jr.
Ranking Member
Committee on Energy and Commerce
House of Representatives

Managed care has become the predominant method for delivering services in Medicaid, a federal-state program that finances health care for low-income and medically needy individuals. As of 2021, over 70 percent of beneficiaries nationwide were enrolled in managed care, including populations with complex health needs. Under a managed care delivery model, states contract with managed care plans to provide a specific set of covered services in return for a fixed periodic payment per enrollee—typically per member per month.[1] Managed care plans are expected to ensure their enrollees have sufficient and timely access to needed services and conduct ongoing efforts to improve the quality of care provided.

Federal regulations permit managed care plans to determine, within limits, whether services are medically necessary and manage utilization through controls, such as requiring prior authorization for services or imposing service limits.[2] As a safeguard against the potential financial incentive for managed care plans to deny or limit needed care, each managed care plan must establish an appeal process.[3] Under that process an enrollee or their provider may challenge an adverse benefit determination, such as a plan's denial of a requested service. In addition,

[1]In this report, when we reference managed care, we are referring to comprehensive managed care under which states contract with managed care organizations to provide an array of services under a risk-based payment model. Other forms of managed care include, for example, primary care case management and prepaid ambulatory health plans. For the purposes of this report, references to states includes the 50 states and the District of Columbia.

[2]42 C.F.R. § 438.210(a)(4) (2023). A prior authorization request occurs when a provider requests authorization for a service from a managed care plan before it is provided.

[3]42 U.S.C. § 1396u-2(b)(4); 42 C.F.R. § 438.402(a) (2023).

upon exhausting the managed care plan appeal process, an enrollee has a right to a fair hearing of the adverse benefit determination before the state.[4] Enrollees can also raise concerns about access or quality issues by filing grievances with their managed care plan.

Appeals and grievances data can be used to identify managed care plan performance issues and challenges with quality or access. States are required under federal regulations to monitor their managed care programs and improve their performance using appeals and grievances data, among other sources of information.[5]

Historically, the Centers for Medicare & Medicaid Services (CMS)—the agency within the Department of Health and Human Services (HHS) responsible for overseeing Medicaid—did not consistently collect appeals and grievances information from states. However, in 2021, CMS issued guidance that triggered requirements previously set forth in federal regulations for states to submit annual reports on their managed care programs, including reporting data on appeals and grievances.[6] States began submitting these annual reports, which the agency refers to as Managed Care Program Annual Reports, to CMS in December 2022. The reports include data and information covering a one-year period.

Given the importance of effective appeal and grievance systems in managed care and the value of appeals and grievances data in assessing whether enrollees' rights to timely access to care are being realized, you asked us to review the appeals and grievances data that CMS began collecting in 2022 through states' annual managed care reports. This report

1. describes what the first year of data reported by states to CMS indicate about Medicaid managed care appeals and grievances;

[4]42 U.S.C. § 1396a(a)(3); 42 C.F.R. § 438.402(c)(1) (2023). In addition, an enrollee may be deemed to have exhausted the managed care plan's appeal process and initiate a state fair hearing under certain circumstances.

[5]42 C.F.R. § 438.66(c) (2023).

[6]See Centers for Medicare & Medicaid Services, CMCS Informational Bulletin, *Medicaid and CHIP Managed Care Monitoring and Oversight Tools* (Baltimore, Md.: June 2021). The requirement to submit managed care program annual reports was established in the 2016 Medicaid managed care final rule. See 88 Fed. Reg. 27,498 (May 6, 2016) (codified as amended at 42 C.F.R. § 438.66(e)). For purposes of this report, we refer to these reports as "annual reports."

2. examines any limitations in the first year of appeals and grievances data, and any CMS efforts to address them; and

3. examines CMS's plan for using managed care appeals and grievances data for oversight, and status of implementation.

To describe what the first year of data reported by states to CMS indicates about Medicaid managed care appeals and grievances, we analyzed data reported by states with annual reporting deadlines from December 2022 through June 2023.[7] Specifically, we analyzed appeals and grievances data for comprehensive managed care programs reported by 35 states for contract year 2022.[8] We calculated appeal and grievance rates across states (i.e., the number of resolved appeals or grievances per 1,000 enrollees) and presented the range for both. For appeals, we also analyzed the reasons for appeals and the outcomes of related state fair hearings. We assessed the data for reliability by, for example, checking for completeness and internal inconsistencies. We excluded a state's data from analyses if we determined the data were not sufficiently reliable, as discussed later in the report. We determined that the remaining data were sufficiently reliable for the purposes of our analyses. (See app. I for the list of states included in the analyses.)

To supplement the data analysis, we interviewed Medicaid officials from five states—Arizona, Illinois, New Jersey, Ohio, and South Carolina—to understand factors that contribute to variation in appeal and grievance rates across states and managed care plans. We selected states based on their reporting deadlines and to achieve variation in geography and managed care enrollment.[9]

To examine any limitations in the first year of appeals and grievances data, and CMS's efforts to address them, we reviewed data for the 35 states in our analysis, analyzed CMS documentation, and interviewed CMS and state officials. Specifically, we reviewed the state appeals and grievances data for anomalies and completeness issues to identify common limitations, and interviewed officials from our selected states to

[7]Each state's reporting deadlines were based on the dates of the related contracts between the state and its managed care plans. Reports were due 6 months after the end of the contract year. Contract periods can start at any time within a calendar year.

[8]State contract years varied with some, for example, running from July 1, 2021, through June 30, 2022, and others aligning with calendar year 2022.

[9]All of our selected states had at least 50 percent of total Medicaid enrollment in managed care and together represented nearly 15 percent of comprehensive managed care enrollment nationally in 2021.

understand the reasons for those limitations. We also reviewed CMS documentation of the agency's assessment of the accuracy and completeness of the first year of annual reports. We interviewed CMS officials about data limitations and any steps taken or planned to address those limitations. We also reviewed any related documentation of those steps. We assessed CMS's steps and planned actions in the context of the agency's stated goals for the annual report data.

To examine CMS's plan for using the managed care appeals and grievances data for oversight and status of implementation, we reviewed CMS documentation and interviewed agency officials. We reviewed CMS's draft plan for the annual reports and its contract and available deliverables related to the analysis of the annual reports. We interviewed CMS officials about the agency's planned use of the appeals and grievances data and implementation status, including anticipated time frames. We compared CMS's actions to the agency's stated goals for the use of the annual reports.

We conducted this performance audit from February 2023 to March 2024 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

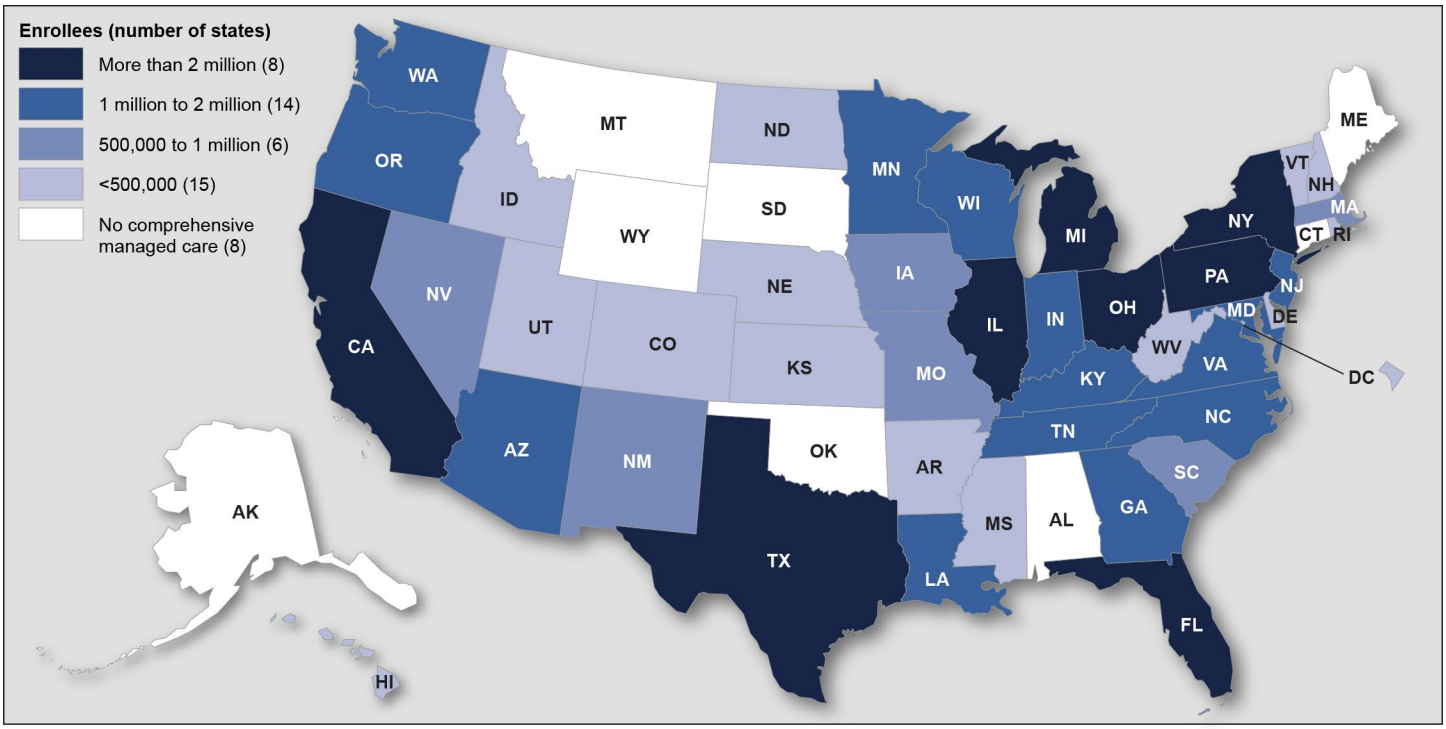
Background

In total, more than 67 million people across 43 states were enrolled in comprehensive Medicaid managed care in 2021.[10] (See fig. 1.) States often administer multiple managed care programs; for example, to serve different populations, such as for Medicaid enrollees needing long-term services and supports (LTSS).[11]

[10]This count includes the District of Columbia. See Centers for Medicare & Medicaid Services, "Enrollment Report," accessed January 5, 2024, https://www.medicaid.gov/medicaid/managed-care/enrollment-report/index.html.

[11]The types of enrollees eligible for managed LTSS programs varies by state, but can include the elderly; adults with physical, intellectual, or developmental disabilities; and children with disabilities. These beneficiaries may have limited ability to care for themselves.

Figure 1: Map of Medicaid Comprehensive Managed Care Enrollment, 2021



Source: GAO analysis of Centers for Medicare & Medicaid Services data; Map Resources. | GAO-24-106627

Note: In comprehensive managed care, states contract with managed care organizations to provide an array of services under a risk-based capitation payment model.

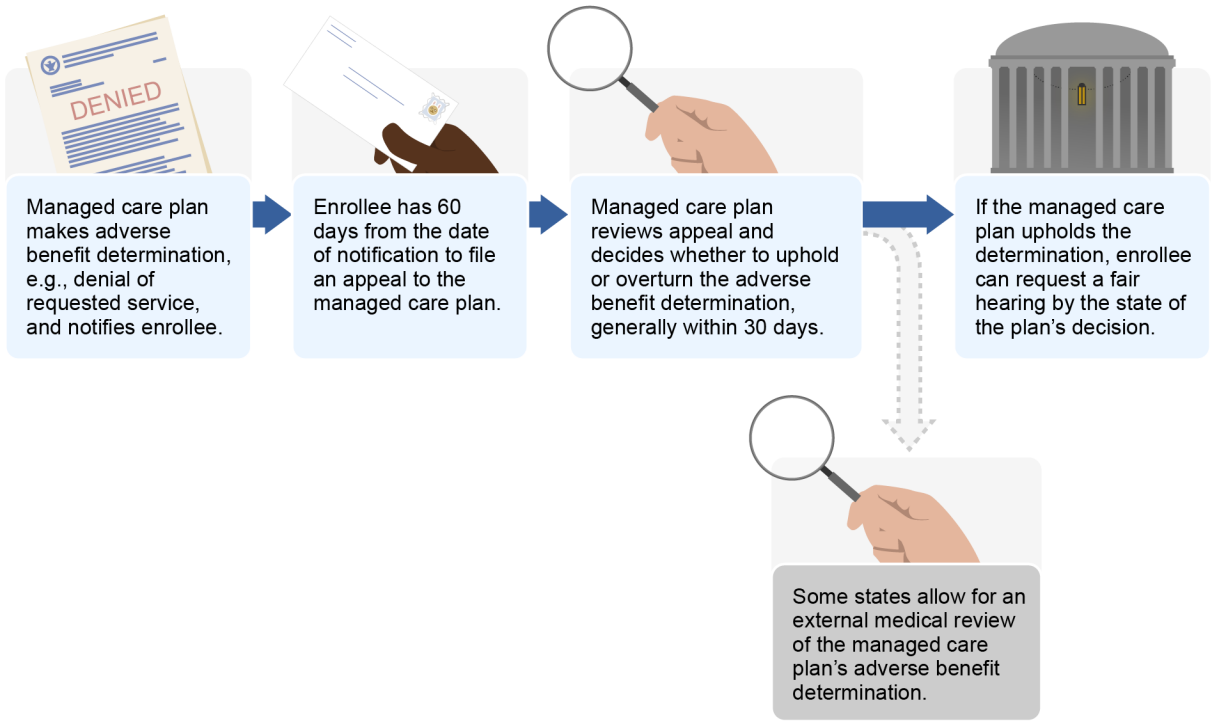
Appeal and Grievance Processes

Managed care enrollees have the right to file an appeal with their managed care plan in response to an adverse benefit determination, such as when the plan fully or partially denies authorization of a requested service, reduces or terminates a service, or denies payment for a service.[12] If the managed care plan upholds its initial decision upon appeal, the enrollee can request a fair hearing with the state in which a state hearing official decides whether to uphold or overturn the plan's

[12]Other types of adverse benefit determinations include (1) failure to provide services in a timely manner; (2) failure of a plan to act within the timeframes provided in regulation regarding the standard resolution of grievances and appeals; (3) denial of a request by an enrollee who lives in a rural area to obtain services outside the network; or (4) denial of an enrollee's request to dispute a financial liability, such as cost sharing. See 42 C.F.R. § 438.400(b) (2023).

decision.[13] Some states also allow for an external medical review whereby an entity that is independent of both the state and the managed care plan reviews the adverse benefit determination.[14] (See fig. 2.)

Figure 2: Medicaid Managed Care Appeal Processes



Source: GAO presentation of federal regulations; GAO (illustrations). | GAO-24-106627

Notes: States must establish a time frame for managed care plans to review appeals that is generally no longer than 30 calendar days for standard appeals. Enrollees may request the managed care plan expedite the appeal under certain circumstances, such as when the enrollee's life or ability to attain maximum function are in jeopardy. Enrollees may also request a state fair hearing if the managed

[13]Enrollees can also request a state fair hearing if the managed care plan fails to adhere to certain notice and timing requirements for resolving the appeal. See 42 C.F.R. § 438.408(f)(1)(i) (2023).

Providers or authorized representatives may file appeals or request state fair hearings on behalf of enrollees if a state's law permits and with the written consent of the enrollee. See 42 C.F.R. § 438.402(c)(1)(ii) (2023).

[14]External medical reviews are a state option. According to an HHS Office of Inspector General study, 14 of 37 states it surveyed offered external medical reviews in 2019. See Department of Health and Human Services, Office of Inspector General, *High Rates of Prior Authorization Denials by Some Plans and Limited State Oversight Rase Concerns About Access to Care in Medicaid Managed Care* (Washington, D.C.: July 2023).

care plan fails to resolve the appeal within the state's required time frame or provide the required notice. States may offer and arrange for an external medical review under certain conditions, including that the review not extend any required time frames.

Enrollees can also file grievances with the managed care plan to express dissatisfaction about any matter not covered by appeals, such as a concern about the quality of their care, difficulty finding a provider, a complaint about a provider, or dissatisfaction with the plan. Grievances may be filed orally or in writing. Federal regulations require managed care plans to resolve grievances within state-established time frames, generally not to exceed 90 days, and notify enrollees of the outcome.[15]

Federal regulations require managed care plans to provide enrollees with reasonable assistance in filing appeals and grievances, such as providing interpreter services upon request.[16] In addition, enrollees may have access to other supports in navigating these processes. For example, states must develop and implement a beneficiary support system that provides education on appeal, grievance, and state fair hearing rights, and assistance in navigating these processes for enrollees who use or express a desire to use LTSS.[17]

Appeal and Grievance Data Reporting

Managed care plans are required to maintain records for each appeal and grievance received, including information about the reason for and resolution of the appeal or grievance, and the date it was received and resolved. CMS requires states to use this information to monitor managed care appeal and grievance systems for purposes of improving managed care plan performance. However, regulations do not specify how states must do this.[18] Officials from all five selected states told us they regularly collect appeals and grievances data from managed care plans and use it to monitor plan performance.

CMS has also indicated that these data are an important component of oversight of managed care programs that cover LTSS, because they help states monitor timely access to care, network adequacy, and other standards of care for these enrollees—a population with significant needs.[19] We have previously reported on variation in the appeals and

[15]42 C.F.R. §§ 438.408(b)(1), (d)(1) (2023).

[16]42 C.F.R. § 438.406(a) (2023).

[17]42 C.F.R. § 438.71(d) (2023).

[18]See 42 C.F.R. § 438.66 (2023).

[19]See Centers for Medicare & Medicaid Services, *Promoting Access in Medicaid and CHIP Managed Care: Managed Long-Term Services and Supports Access Monitoring Toolkit* (Baltimore, Md.: June 2022).

grievances data states require managed care plans to report and how that information is used.[20]

Federal rules issued in 2016 require states to submit annual reports to CMS for each Medicaid managed care program they operate.[21] These reports are to include information and data on a variety of managed care elements, including appeals and grievances.[22] In June 2021, CMS issued guidance with the specific data elements states are required to submit, such as the numbers of appeals and grievances resolved during the year.[23] States are required to report data at the managed care plan level aggregated across all populations, with the exception of several data elements that states are required to report specifically for enrollees using LTSS. The first year of reports were due between December 2022 and September 2023, with due dates depending on each managed care contract period. (See fig. 3.)

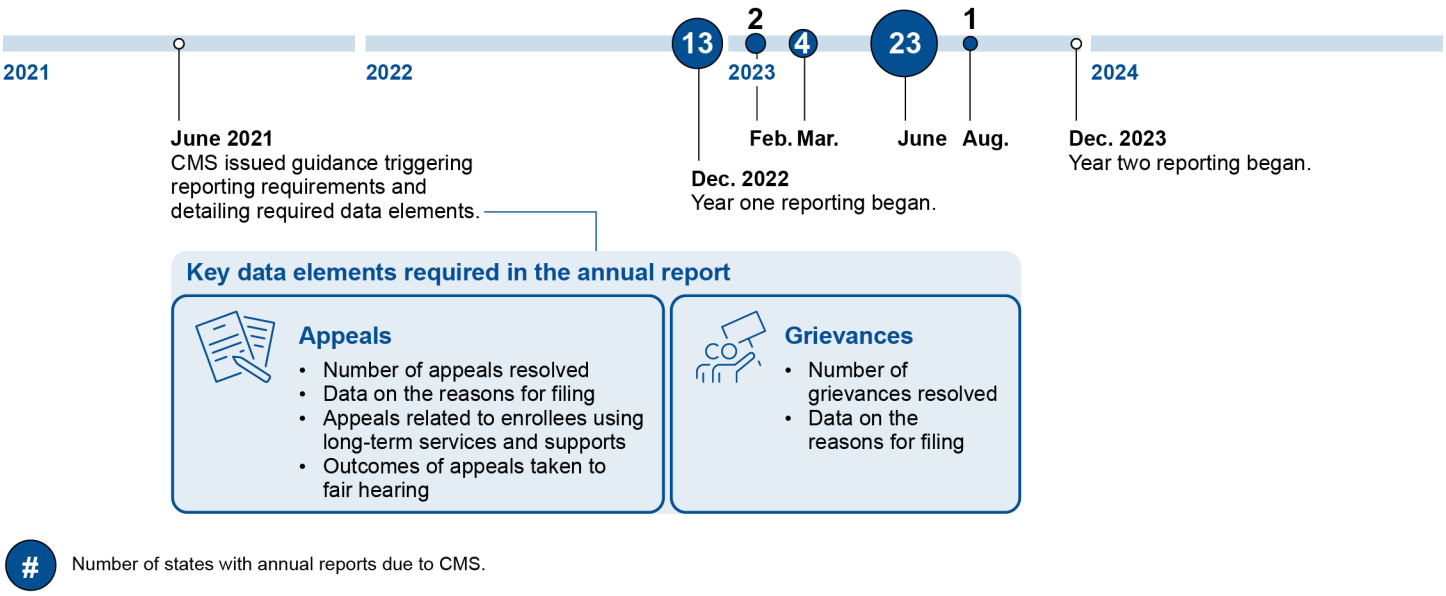
[20]See GAO, *Medicaid Managed Care: CMS Should Improve Oversight of Access and Quality in States' Long-Term Services and Supports Programs*, GAO-17-632 (Washington, D.C.: Aug. 14, 2017).

[21]See 88 Fed. Reg. 27,498 (May 6, 2016) (codified as amended at 42 C.F.R. § 438.66(e)). According to CMS, there were 140 managed care programs nationwide in 2021, including 90 comprehensive programs.

[22]Annual reports also collect data on managed care plan enrollment, network adequacy, quality measures, sanctions, and other topics.

[23]See Centers for Medicare & Medicaid Services, CMCS Informational Bulletin, *Medicaid and CHIP Managed Care Monitoring and Oversight Tools* (Baltimore, Md.: June 2021).

Figure 3: Appeals and Grievances Data Elements of Annual Medicaid Managed Care Reports and Timeline of State Submissions



Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) data; stass111/stock.adobe.com (icons). | GAO-24-106627

Notes: States are required to submit reports—referred to as Managed Care Program Annual Reports—each contract year for each managed care program they operate. Thus, a state with more than one program may have multiple submission deadlines if the programs have different contract years. States with multiple submission deadlines were counted in the month their first report was due. The final month for which year one reports were due was September 2023. One state had a report due in September 2023, but it does not appear on the timeline because the state had a report due earlier in the year for another managed care program. The numbers of states shown reflect states with comprehensive managed care programs, of which there were a total of 43 nationwide in 2022.

First-Year Managed Care Data Indicate Variation in Appeal and Grievance Rates Across States

The first year of managed care data reported to CMS showed that appeal rates varied widely across states during 2022, with a number of possible factors contributing to the variation. Data also showed that at least one-fifth of appeals taken to the state for a fair hearing resulted in outcomes favorable to enrollees. Grievance rates also varied widely, both across and within states, which may have been driven, in part, by differences in how states and managed care plans count grievances.

Appeal Rates Varied Widely across States; at Least One-Fifth of Appeals Taken to Fair Hearing Resulted in Favorable Outcomes for Enrollees

First-year data provided information from contract year 2022 on appeal rates, the reasons enrollees filed appeals, and the outcomes of appeals where enrollees requested a fair hearing from the state.

Appeal Rates

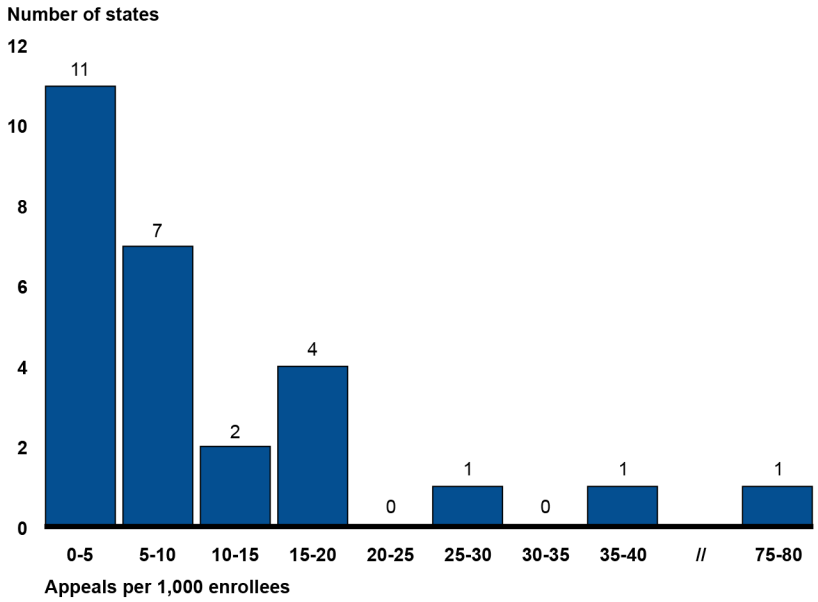
Filing an Appeal

Medicaid managed care enrollees have the right to file an appeal with their managed care plan in response to an adverse benefit determination, such as when the managed care plan fully or partially denies authorization of a requested service, reduces or terminates a service, or denies a payment for a service.

Source: 42 U.S.C. § 1396u-2(b)(4) and 42 C.F.R. § 438.402(a) (2023). | GAO-24-106627

Appeal rates—the number of managed care appeals resolved per 1,000 enrollees—varied widely across states in 2022.[24] Across the 27 states with reliable appeals data, appeal rates ranged from 1.4 to 79.9 appeals per 1,000 enrollees. (See fig. 4.) This large range is due, in part, to two outlier states with appeal rates of 35.4 and 79.9 per 1,000 enrollees. The state with the highest appeal rate had one managed care plan with a significantly higher volume of appeals, which contributed to it being an outlier. CMS officials told us they did not know what was driving the outliers, but noted that outliers could signal a managed care plan performance issue. Officials from CMS and all our selected states said they have not established an acceptable range of appeal rates.

Figure 4: Distribution of Medicaid Managed Care Appeal Rates Across States, Contract Year 2022



Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) data. | GAO-24-106627

Notes: Appeal rates are the number of appeals resolved per 1,000 enrollees. Appeals are considered resolved when the managed care plan has issued a decision on the appeal. This figure includes appeal rates we calculated for 27 states with annual managed care reporting deadlines from December 2022 through June 2023, and where state-reported appeals data were sufficiently reliable to analyze. Data reflect appeals in managed care contract years ending in 2022. State contract years varied with some, for example, running from July 1, 2021, through June 30, 2022, and others aligning with calendar year 2022. To calculate a 12-month appeal rate, we used the average monthly appeal rate in the 11 months of data states were required to report to project the number of appeals in the 12th month of the contract year.

[24]An appeal is resolved when the managed care plan has issued a decision, regardless of whether the decision was wholly or partially favorable or adverse to the enrollee.

In addition to variation across states, the data indicated that wide variation in appeal rates can occur across managed care plans within a state. For example, in one of our two selected states where appeals data were sufficiently reliable for analysis, appeal rates among managed care plans ranged from 4.2 to 62.7 appeals per 1,000 enrollees.[25] Several managed care plans had fewer than 10 appeals per 1,000 enrollees and several had more than 20 appeals per 1,000 enrollees.

Variation in appeal rates was likely driven, in part, by differences in states' appeals processes, including how managed care plans communicate about the appeals process, the supports available for enrollees to navigate the process, and whether a state offers external medical review as part of the process.

- **Communication about appeals process.** How managed care plans communicate about appeal rights could make it easier or more difficult to file an appeal, which could affect the volume of appeals. For example, managed care plans may not uniformly adhere to federal requirements about the communication of enrollees' appeal rights and how to acquire assistance with filing an appeal.[26] According to information on the appeals process that the Medicaid and CHIP Payment and Access Commission collected through focus groups with enrollees and caregivers, the process can be challenging due, in part, to late and unclear denial notices. For example, the enrollee might not receive the notice with enough time to file an appeal or may

[25]In the other state with reliable data, appeals rates across managed care plans ranged from 3.9 to 6.9 appeals per 1,000 enrollees. The remaining three of our five selected states had appeals data that were not sufficiently reliable for our analysis.

[26]Under federal regulations, managed care plans must give enrollees timely and adequate written notice of adverse benefit determinations together with an explanation of the enrollee's right to request an appeal, among other things. See 42 C.F.R. § 438.404(b) (2023).

Federal law requires states to complete external quality reviews of their managed care plans, which must be conducted by an independent organization and involve assessments of plans' compliance with specified regulatory requirements. Recent external quality review reports in two of our selected states (New Jersey and South Carolina) found that some managed care plans did not fully adhere to requirements such as adequately communicating to enrollees their right to appeal. In response, New Jersey's external quality reviewer recommended care managers explain to enrollees their appeals rights and how to file appeals and South Carolina's reviewer recommended that one managed care plan revise its documentation (e.g., member handbook) to reflect current state and federal policies for filing appeals.

not understand the managed care plan's reason for denying the service.[27]

- **Availability of support in navigating the process.** Additional variation among states' and managed care plans' support systems could also affect the volume of appeals. For example, the Medicaid and CHIP Payment and Access Commission reported that many focus group participants found the appeal process to be time consuming and difficult to manage, particularly the gathering of clinical documentation. According to CMS, managed care plans that provide more support to enrollees seeking to file appeals may see higher volumes of appeals.[28] In contrast, they also noted that effective beneficiary support entities, including those that provide support to enrollees receiving LTSS, may help resolve issues before an appeal is necessary, thereby reducing the number of appeals.
- **Availability of external medical reviews.** According to the HHS Office of Inspector General, states that allow external medical reviews—where an independent reviewer with relevant clinical expertise reviews the denial—have the potential to protect enrollees from inappropriate denials by providing an independent check on managed care plans' decisions.[29] This, in turn, could lead to fewer denials and, ultimately, fewer appeals. Data from our analysis indicate that the median appeal rate in states with external medical reviews

[27]See Medicaid and CHIP Payment and Access Commission, *Improving the Managed Care Appeals Process*, Nov. 2, 2023. The commission held focus groups with 22 participants, including a mix of caregivers and Medicaid enrollees. Participants were eligible if they had appealed a managed care denial in the prior 3 years.

[28]Jenna Libersky, Alena Tourtellotte, and Debra Lipson, *Critical Incidents, Grievances, and Appeals: Data to Support Monitoring and Evaluation of Medicaid Managed Long Term Services and Supports (MLTSS) Programs* (Baltimore, Md.: Centers for Medicare & Medicaid Services, Center for Medicaid and CHIP Services, October 2019).

Under CMS regulations, managed care plans must give enrollees any reasonable assistance in completing forms and taking other procedural steps related to the appeal, including auxiliary aids and services upon request, such as providing interpreter services. See 42 C.F.R. § 438.406(a) (2023).

[29]See Department of Health and Human Services, *High Rates of Prior Authorization Denials by Some Plans*.

States may offer and arrange for external medical reviews under certain conditions. See 42 C.F.R. § 438.402(c)(1)(i)(B) (2023).

was 52 percent lower than the median appeal rate in states without such reviews.[30]

Officials from our selected states identified a number of additional factors that could contribute to variation in appeal rates. The factors include the following:

- **Prevalence of prior authorization.** Officials from two states told us that the number of services that require prior authorization in each managed care plan could affect appeal rates. For example, managed care plans that require prior authorization for more services may issue a higher volume of denials, which, in turn, could lead to a higher volume of appeals.
- **Population.** Officials from four states told us that the populations enrolled in managed care plans may impact appeal rates. For example, officials from New Jersey said that it is common to see a higher volume of appeals among enrollees receiving LTSS or behavioral health services. Data from our analysis indicated that the median appeal rate across states that included LTSS in a comprehensive managed care program was 46 percent higher than the median appeal rate across states that did not.
- **Program changes.** Changes to a state's Medicaid program—such as adding a new managed care plan, service, or population—can increase utilization or introduce changes that may increase appeal rates, according to officials from two states.

Reasons for Appeals

Data from 2022 also provided information on the reasons enrollees filed an appeal. Across 136 managed care plans that had reliable data on the reasons appeals were filed, the majority of appeals were filed because of a plan's decision around the authorization of services.[31] Specifically, 53 percent of appeals were related to a denial or limited authorization of a requested service, and 12 percent were related to a reduction, suspension, or termination of a previously authorized service. In addition,

[30]We conducted this analysis based on the states that the HHS Office of Inspector General identified as offering external medical reviews in 2019. We found that 11 of the 27 states in our appeals analysis offered external medical reviews in 2019. See Department of Health and Human Services, *High Rates of Prior Authorization Denials by Some Plans*.

[31]Of the 181 managed care plans across the 27 states with reliable appeals data, 136 plans had reliable data on the reasons appeals were filed.

37 percent of appeals were classified as being related to payment denial, in whole or in part, after a service was provided.[32]

State Fair Hearing Outcomes

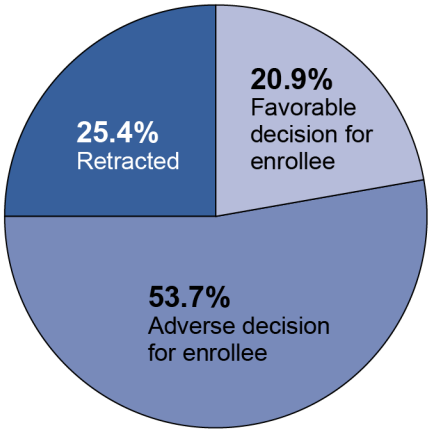
Data from 2022 indicate that, while seldom requested, appeals taken to the state for a fair hearing in the 33 states that reported fair hearing data often resulted in outcomes favorable to the enrollee.[33] About one-fifth resulted in an outcome favorable to the enrollee (i.e., a full or partial overturn of the managed care plan's decision). In addition, some portion of the 25 percent of cases that were retracted prior to the hearing were retracted for reasons that favor the enrollee. Officials from four of our selected states told us that retractions can occur when the managed care plan reverses its decision or reaches a settlement with the enrollee prior to the hearing date.[34] The other half of hearings resulted in the hearing officer upholding the managed care plan's decision. (See fig. 5.)

[32]States also reported the number of appeals related to service timeliness, appeal or grievance response timeliness, the enrollee's right to request out-of-network care, and financial liability disputes; however, these categories each accounted for less than 2 percent of appeals. These numbers sum to greater than 100 percent. While CMS's instructions were that each appeal only have one reason, CMS officials told us that some states may have reported more than one reason for individual appeals.

[33]If the managed care plan upholds its initial decision upon appeal, the enrollee can request a fair hearing with the state in which a state hearing official decides whether to uphold or overturn the plan's decision. First-year data show that 2 percent of appeals resolved at the managed care plan level resulted in a request for a fair hearing.

[34]State officials told us that requests for a hearing may also be retracted if enrollees decide they no longer need the service, come to understand the reason for the denial, or fail to comply with pre-hearing procedures.

Figure 5: State Fair Hearing Outcomes Related to Medicaid Managed Care Appeals, Contract Year 2022



Total = 9,290

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) data. | GAO-24-106627

Notes: This figure includes state fair hearing outcomes for 33 states that reported data to CMS in annual managed care reports from December 2022 through June 2023, and with fair hearing data sufficiently reliable for analysis. Data reflect fair hearing outcomes in managed care contract years ending in 2022. State contract years varied with some, for example, running from July 1, 2021, through June 30, 2022, and others aligning with calendar year 2022.

Fair hearings are available to enrollees after exhausting a managed care plan's appeal process or when the managed care plan fails to adhere to certain notice or timing requirements in resolving the appeal.

The extent to which fair hearings resulted in outcomes favorable to the enrollee varied widely across states in 2022. Specifically, across the 33 states, the percent of decisions in favor of the enrollee ranged from zero to 77 percent, with a median of 17 percent. Because federal rules allow states flexibility, within certain parameters, to establish their own fair hearing processes, it is difficult to interpret the variation in these rates. For example, in South Carolina, where data indicate that the fair hearing process yielded very few decisions in favor of the enrollee, state regulations allow hearing officers to direct enrollees and managed care plans to hold a pre-hearing conference, which could result in the parties reaching a settlement prior to the hearing.[35] Thus, according to state officials, some of the cases that would have been decided in favor of the enrollee were retracted because the situation was settled before the hearing date.

Outcomes of external medical reviews, which are completed by an independent third party with clinical expertise, analyzed by the HHS

[35]S.C. Code Ann. Regs. 126-156 (2023).

Office of Inspector General indicated higher levels of decisions in favor of the enrollee than did the first year of fair hearing data. Specifically, the Office of Inspector General found that 46 percent of external medical reviews related to prior authorization denials in 2019 resulted in decisions that fully or partially overturned the denial.[36]

Grievance Rates Varied; Managed Care Plans May Count and Report Grievances Differently

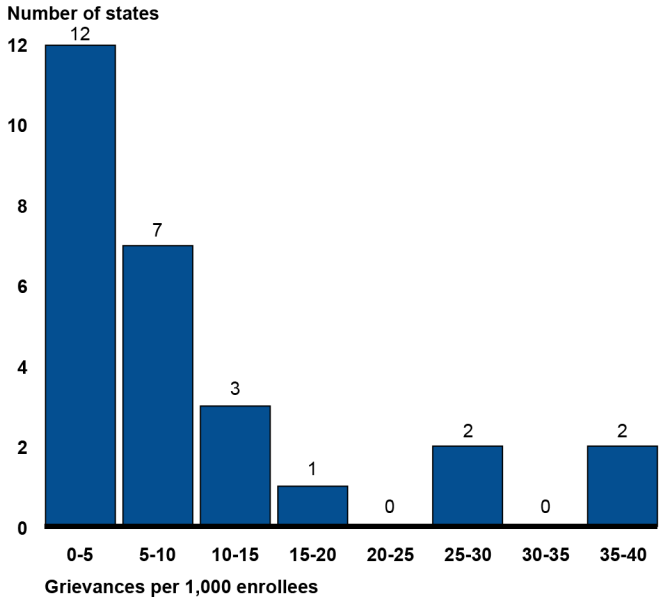
Filing a Grievance

Medicaid managed care enrollees can file a grievance with their managed care plan to express dissatisfaction about any matter other than an adverse benefit determination (e.g., denial of a requested service). For example, a grievance could be about the quality of care they received or difficulty finding a provider in their network.

Source: 42 C.F.R. §§ 438.400(b), 438.402(a) (2023). | GAO-24-106627

First-year data show that grievance rates varied widely across states in 2022. Specifically, grievance rates ranged from 0.4 to 38.0 grievances per 1,000 enrollees across the 27 states with reliable data. More than half of states' rates were below 10 grievances per 1,000 enrollees, while four states had rates that exceeded 25 grievances per 1,000 enrollees. (See fig. 6.)

Figure 6: Distribution of Medicaid Managed Care Grievance Rates Across States, Contract Year 2022



Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) data. | GAO-24-106627

Notes: Grievance rates are the number of grievances resolved per 1,000 enrollees. A grievance is resolved when the managed care plan has addressed and closed the grievance. This figure includes grievance rates we calculated for 27 states that reported data to CMS in annual managed care reports from December 2022 through June 2023, and where state-reported grievance data were sufficiently reliable to analyze. Data reflect grievances in managed care contract years ending in

[36]The HHS Office of Inspector General reviewed over 3,000 external medical review requests in 14 states. See Department of Health and Human Services, *High Rates of Prior Authorization Denials by Some Plans*.

2022. State contract years varied with some, for example, running from July 1, 2021, through June 30, 2022, and others aligning with calendar year 2022.

The data also indicate wide variation in plan-level grievance rates within some states. (See table 1.) For example, in one of our five selected states, the grievance rates among its managed care plans ranged from 2.8 grievances per 1,000 enrollees to 89.5. Among the five selected states, the two with 10 or more managed care plans had significantly wider ranges in grievance rates across plans.

Table 1: Range in Grievance Rates Across Medicaid Managed Care Plans within Selected States, Contract Year 2022

State	Minimum grievance rate per 1,000 enrollees	Median grievance rate per 1,000 enrollees	Maximum grievance rate per 1,000 enrollees
A	0.3	0.6	1.0
B	0.2	3.7	19.6
C	2.7	6.7	24.3
D	2.8	8.1	89.5
E	13.0	54.7	151.0

Source: GAO analysis of Centers for Medicaid & Medicaid Services (CMS) data. | GAO-24-106627

Notes: Grievance rates are the number of grievances resolved per 1,000 enrollees. A grievance is resolved when the managed care plan has addressed and closed the grievance. This table includes grievance rates we calculated for all managed care plans from five selected states that reported data to CMS in annual managed care reports from December 2022 through June 2023, and where state-reported grievance data were sufficiently reliable to analyze. Data reflect grievances in managed care contract years ending in 2022. State contract years varied with some, for example, running from July 1, 2021, through June 30, 2022, and others aligning with calendar year 2022.

According to state officials from three selected states, variation in the grievance rates may be related to differences in how managed care plans count and report grievances.[37] For example, South Carolina officials told us that one plan reports any expression of dissatisfaction as a grievance, while other managed care plans may only report grievances that could not be resolved within 24 hours. In addition, officials from New Jersey and Ohio said that determining the difference between a grievance and a customer service inquiry can be subjective. Officials from two of these states said they intend to clarify with managed care plans the definition of a grievance.

Additionally, grievance rates may vary based on the population and geographic location of enrollees. For example, grievance rates in Arizona's managed care plans that cover long-term care services and

[37]CMS defines a grievance as an expression of dissatisfaction about any matter other than an adverse benefit determination. See 42 C.F.R. § 400(b) (2023). CMS officials told us in December 2023 that they were aware of possible differences in how managed care plans count grievances and planned to clarify this in future technical assistance to states.

services for people with serious mental illness were higher than for plans that do not have enrollees eligible for those services. According to Arizona officials, this could be due, at least in part, to these populations having more complex care needs and family members who are involved in their care. Data from our analysis indicated that the median grievance rate across states that include LTSS in a comprehensive managed care program was 81 percent higher than the median grievance rate across states that do not. In addition, Arizona officials told us that grievance rates for enrollees living in rural areas may be higher than of those living in urban areas, perhaps due to challenges accessing services.

CMS Has Taken Some Steps to Improve Managed Care Appeals and Grievances Data Quality, but Data Limitations Persist

The first year of appeals and grievances data reported to CMS had a number of limitations. CMS had taken some actions as of December 2023 to begin to address those limitations. However, CMS does not collect information on appeal outcomes or number of denials, limiting the usefulness of the data.

Appeals and Grievances Data Had Gaps and Inconsistencies; CMS Has Taken Some Actions to Address Them

The first-year appeals and grievances data submitted by states through managed care annual reports had a number of gaps and inconsistencies. In addition, national data were limited because several states did not submit required annual reports.

Gaps and inconsistences in submitted data. As of October 2023, CMS—through a contractor—had reviewed the first year of state annual reports submitted for 2022 for the completeness and accuracy of more than 50 data elements related to appeals and grievances.[38] CMS found incomplete reporting across a number of data elements related to appeals and grievances, including the reasons for filing appeals or grievances. Our review of the data also identified limitations. In addition to incomplete reporting, we found inconsistent reporting across states; for example, in the time frames of the data states reported for resolved appeals. (See table 2.)

[38]In September 2022, CMS executed a contract for assistance with reviewing and analyzing the annual reports, among other tasks. The contract period is up to 5 years—consisting of one base year and four option years (September 2022 through September 2027).

Table 2: Examples of Limitations in First Year of State-Reported Medicaid Managed Care Appeals and Grievances Data

Data limitation	Description
Incomplete data on reasons and the services involved for appeals and grievances	Among states for which we analyzed appeals and grievances data, 10 reported incomplete data for appeal reasons and service types, and 13 did so for grievance reasons and service types. In addition, states frequently selected "other" as the service type, which officials in one state said they used because the state's service categories did not align with the categories CMS asked states to report.
Inconsistent time frames for data on resolved appeals	CMS officials told us that they suspected that some states reported a 12-month total for the number of resolved appeals, even though CMS intended for states to report an 11-month total. Officials from one state told us that they interpreted CMS's instructions as asking for one month of resolved appeals and that is what the state reported.
Internal inconsistencies in numbers	In cases where a number was supposed to be a subset of another number, the subset number was sometimes higher. For example, eight out of 35 states reported that more appeals were resolved on time than the total number resolved during the year.
Ambiguous use of zeros and not applicable	In some cases, it was difficult to distinguish between a true zero versus a missing data point. CMS officials noted that some states entered "N/A" even though a question was applicable to their state and program.

Source: GAO analysis of data from the Centers for Medicare & Medicaid (CMS) and interviews with CMS and state officials. | GAO-24-106627

Note: Data limitations were identified by GAO in assessing the reliability of annual report data submitted by 35 states for contract year 2022 or by CMS in its assessment of completeness and accuracy of states' annual report submissions.

Data elements that were related to managed care enrollees using LTSS also had a number of limitations. We have previously reported on quality and access issues in LTSS provided under managed care and about weaknesses in state and federal oversight, including the lack of consistent data on appeals and grievances and critical incidents for that population.[39] CMS had indicated that the annual reports would provide consistent data specific to LTSS to enhance oversight; however, we found the following limitations in those data:

- **Incomplete data on appeals and grievances linked to enrollees using LTSS.** Six of 21 states with LTSS in managed care did not report data on the number of appeals or grievances made by or on behalf of enrollees who used LTSS despite it being a required element of the annual report. Even for the states that did report these data, the data may be of limited use because states were not required to include in the annual report (1) the number of LTSS users within each managed care plan, and (2) the number of appeals and

[39]See GAO, *Medicaid Long-Term Services and Supports: Access and Quality Problems in Managed Care Demand Improved Oversight*, GAO-21-49 (Washington, D.C.: Nov. 16, 2020); and GAO-17-632.

grievances resolved on behalf of LTSS users during the year.[40] As a result, the data cannot be used to calculate the percentage of appeals and grievances resolved on behalf of enrollees who used LTSS.

- **Incomplete data on critical incidents for enrollees who also filed an appeal or grievance.** CMS required states to report the number of critical incidents filed by or on behalf of an LTSS user who previously filed an appeal or a grievance.[41] We found that these data were incomplete (e.g., the state reported "not applicable" when they should have reported a number) for at least 11 of the 21 states that included LTSS in their comprehensive managed care programs. Officials from three of our selected states said that while they track reports of critical incidents, they were unable to link them with data on appeals or grievances because they are stored in different data systems. In 2018, we recommended that CMS establish standard Medicaid reporting requirements for all states to annually report key information on critical incidents.[42] The agency agreed with the recommendation, but had not taken action to address it as of January 2024.

State non-reporting. In addition to the limitations noted above, national data are incomplete because a number of states did not submit reports as required. As of December 2023, six states had not submitted any of their annual reports, with those reports being 6 to 9 months overdue.[43] CMS officials said the delays in some states were due to reasons such as limited state resources and staff turnover. However, as of December 2023, CMS officials said they did not know why other states had not submitted their reports.[44]

[40]Instead, the annual report asked for the total numbers of appeals and grievances that were filed by or on behalf of LTSS users during the year. However, for the overall managed care enrollee population, the annual report asked for the total number of appeals and grievances resolved. Thus, the reports do not provide consistent information across populations.

[41]Critical incidents are incidents that may cause harm to a person's health or welfare, such as abuse, neglect, or exploitation.

[42]See GAO, *Medicaid Assisted Living Services: Improved Federal Oversight of Beneficiary Health and Welfare is Needed*, GAO-18-179 (Washington, D.C.: Jan. 5, 2018).

[43]According to CMS, six states—Florida, Kentucky, New Mexico, Oregon, Tennessee, and Vermont—had not submitted any required annual reports. Two states began working on their annual reports but did not complete them as of December 2023.

[44]Officials told us several states requested extensions on their annual reporting deadlines, which CMS did not grant.

CMS took some actions in late 2023 to address gaps and inconsistencies in the data and planned additional steps for calendar year 2024. CMS officials told us that enhancing the quality of the appeals and grievances data is a priority because they believe those data have high value. The officials also said that it would likely take several years to do so and that such time frames are common with new reporting efforts. CMS's actions should help address identified issues, such as the time frames of the data and problems with the use of zeroes and "not applicable."

CMS has begun or planned the following actions to address data limitations in future annual reports:

- CMS held a webinar in September 2023 to discuss common data quality issues they found while reviewing annual reports. Following the webinar, the agency shared a technical assistance resource with states in December 2023 that included common questions and answers about the annual report. CMS requested feedback from states and planned to publish this resource after incorporating states' comments in calendar year 2024.
- CMS officials told us that they began providing individualized technical assistance to states in late 2023 to provide feedback on observed data quality issues, which could include incomplete or inconsistent data. Officials said they prioritized states with the earliest year-two reporting deadline. By December 2023, CMS officials told us they had provided feedback to seven states. This feedback occurred later than originally planned and after states had begun collecting data from managed care plans for the second year. CMS officials attributed the delay to multiple reasons, including the work of reviewing the annual reports taking longer than anticipated, working with a contractor new to CMS, and limited staffing resources.[45]
- CMS made minor adjustments to the year-two annual report template in December 2023. Revisions included updated data element instructions and time frames, clarifying instructions about the appropriate use of "not applicable," and adding new functionalities to reduce state reporting burden. For example, CMS revised the time frames in questions related to resolved appeals to request 12-month, rather than 11-month, totals, which should address inconsistent reporting across states.

[45]CMS officials told us that the contractor reviewing the reports did not initially have access to the data in a file format that could easily be analyzed. Therefore, the contractor had to spend about 1.5 months converting the files into machine readable data. Officials told us that in the future the agency hoped to provide technical assistance to states more quickly following report submission.

- CMS officials told us in December 2023 that contractors had begun developing an additional reference document for states to help them with appeals and grievances data reporting, which the agency plans to issue sometime in calendar year 2024.
- Regarding nonreporting states, CMS officials told us they had emailed states that missed their reporting deadlines to alert them of the need to report, and planned to engage state leadership as a next step if needed.

Some of the limitations in the data will likely persist as CMS continues to work with states on collecting and reporting complete data. CMS's written instructions to the annual report included a note indicating that states may need to update their contracts with managed care plans to collect some of the data required in the annual report. CMS officials told us in December 2023 that they reminded states of this potential need via technical assistance.

Our selected states were in different stages of making changes to managed care reporting requirements. Officials from four of our selected states told us that they did not modify their managed care plan reporting requirements to conform with the first year of the annual report elements, with officials in three of those states indicating that they were unable to report certain data elements as a result.[46] Officials from two of those states—Arizona and South Carolina—indicated that they had made changes to their managed care reporting requirements to align with the data elements in the annual report for year two. Officials from the remaining two states—New Jersey and Ohio—told us they had not made changes for year-two reporting, but were considering what changes to make to better align with the annual report in future years. CMS officials told us they are considering additional avenues to communicate the agency's expectation that states take the needed steps to collect and submit complete data for the annual reports.

CMS Does Not Collect Information on Appeal Outcomes or Number of Denials, Limiting the Usefulness of the Data

CMS's annual report does not require states to report data on two key data elements that could assist with managed care oversight: the outcomes of appeals and the number of denials by managed care plans.

Appeal outcomes. Although the annual report asks for data on the number of resolved appeals, it does not ask for information about the resolution or outcome of those appeals. Specifically, the annual report

[46]Officials from Arizona, New Jersey, Ohio, and South Carolina told us they submitted the first annual report using data they were already collecting from managed care plans. Officials from Illinois told us they asked managed care plans to provide them with all data necessary to complete the annual report.

does not collect data on the number of resolved appeals where managed care plans upheld versus overturned initial adverse benefit determinations. As a result, CMS only has outcome information for state fair hearings; our analysis found that about 2 percent of appeals were taken to fair hearing across the 27 states with reliable appeals data.

Appeal outcome data may be readily available. CMS requires managed care plans to maintain records of appeal resolutions and some states already collect these data from plans.[47] Four of our selected states collected information on the outcome of appeals from managed care plans. For example, Ohio's online dashboard showed that 55 percent of appeals made to one of its plans in one quarter of 2021 resulted in a favorable outcome for the enrollee—that is, the appeal led the managed care plan to overturn the initial denial determination. New Jersey's data show that 35 percent of appeals during contract year 2021 in its managed care program that covers LTSS resulted in a favorable outcome for the enrollee (a full or partial overturn of the initial denial).

What is a Denial?

Denial refers to any of the following adverse benefit determinations by a managed care plan: (1) the denial or limited authorization of a requested service; (2) reduction, suspension, or termination of a previously authorized service; or (3) denial, in whole or in part, of payment for a service.

Source: GAO. | GAO-24-106627

Number of denials. CMS also does not require states to report the number of managed care plan denials. Collecting denial data would increase the usefulness of the annual report as a tool to monitor enrollee access and the managed care plan's appeals system. For example, it would enable CMS to understand the proportion of denials resulting in an appeal. Further, if CMS collects both denial numbers and appeal outcome data, as discussed above, the agency would be able to understand the proportion of denials overturned on appeal. For example, after collecting this type of data, the HHS Office of Inspector General reported in July 2023 that Medicaid managed care enrollees appealed 11 percent of denials of prior authorization of services, and 36 percent of them were fully or partially overturned upon appeal.[48]

Many states have experience collecting data on managed care plan denials, even though they are not required to do so under federal rules. For example, four of our selected states required managed care plans to report such information, and the Medicaid and CHIP Payment and Access Commission reported in 2023 that 26 states—including the four selected states—required plans to report some data related to denials.[49]

[47]42 C.F.R. § 438.416(b)(4) (2023).

[48]See Department of Health and Human Services, *High Rates of Prior Authorization Denials by Some Plans*.

[49]See Medicaid and CHIP Payment and Access Commission, *Denials and Appeals in Managed Care: Background and State Scan Findings*, Jan. 26, 2023.

It is unclear whether CMS will require states to report information on appeal outcomes and the number of denials in the annual reports going forward. CMS officials told us they did not include these data elements in the annual reporting tool because they wanted to strike a balance between collecting necessary information without over-burdening states. However, the officials told us they will be reassessing the data elements in future years following the finalization of proposed rules related to Medicaid managed care, and will consider if they will add appeal outcomes and denials at that time.[50]

There is precedent for transparency around the outcomes of appeals and frequency of denials. CMS requires health plans participating in Medicare Advantage, the private plan option in Medicare, to disclose data on the outcomes of appeals upon request by a Medicare Advantage-eligible individual.[51] Additionally, CMS requires health plans participating in a health insurance exchange to report data on denials to HHS, state insurance commissioners, and the public.[52] More recently, CMS issued a final rule in 2024 that requires Medicaid managed care and Medicare Advantage plans to annually report certain aggregate metrics on their websites about prior authorization denials beginning in 2026, including the percentage of prior authorizations that were denied and the percentage that were approved after appeal.[53]

Collecting data on appeal outcomes and denials would further CMS's stated goals of using managed care data, including annual report data, to target efforts to assist states in program improvements and ensure compliance with federal requirements, including ensuring access to care. Without these data, and without addressing the data limitations described above, the appeals and grievances data are of limited usefulness to identify problems with quality or access within managed care.

[50]CMS issued a proposed rule in May 2023 related to Medicaid managed care access, finance, and quality. See 88 Fed. Reg. 28,092 (proposed May 3, 2023). The rule had not been finalized as of December 2023.

[51]42 C.F.R. § 422.111(c) (2023). Medicare is the federal health insurance program for people who are 65 or older, certain younger people with disabilities, and people with end-stage renal disease.

[52]45 C.F.R. § 156.220 (2023). Exchanges are markets that operate within each state that help individuals, families, and small businesses shop for and enroll in medical insurance.

[53]See 89 Fed. Reg. 8,758 (Feb. 8, 2024). CMS stated that publicly reporting these metrics could contribute to improvements in the prior authorizations process, help consumers compare plans, and enable plans to learn about their own performance.

CMS Has Yet to Implement its Plans to Use Managed Care Appeals and Grievance Data for Oversight and to Enhance Transparency

CMS has not implemented planned actions to use appeals and grievances data for improving managed care oversight and enhancing transparency. Deferring these actions is inconsistent with CMS's stated goals for the annual reports. Specifically, in its June 2021 guidance, CMS stated its intention to use the annual reports, along with other required managed care reports, to (1) identify target areas where the agency can assist states in making managed care program improvements; and (2) ensure compliance with federal requirements.[54] CMS also previously stated publicly the agency's belief that the annual report will improve transparency for consumers, providers, and other stakeholders interested in managed care program operations.[55] To that end, CMS stated in July 2022 guidance that it will make all reports publicly available after the agency completes its initial review.[56]

In April 2023, CMS developed a draft plan for processing and analyzing annual report data that included (1) launching an analytic dashboard, (2) publishing summary reports, (3) publishing state-level data, and (4) developing and implementing an oversight plan. However, CMS had made limited progress implementing these actions, and the agency had not set time frames for next steps as of December 2023.

1. **Launch an analytic dashboard based on report data:** CMS originally expected its contractor to design an analytic dashboard using multiple data sources in the first year of the contract. However, that task was delayed. As of December 2023, CMS officials told us that they had started working with their contractors on this, but did not have a new time frame for completion.
2. **Publish quarterly summary reports on the CMS website:** As of December 2023, CMS had not published any summary reports. Officials told us that they were focused on identifying which data are high enough quality to use for monitoring and oversight, versus data elements that require more technical assistance with states.
3. **Publish state-level data available for download:** As of December 2023, CMS had not posted any state-level data. Agency officials said they were in the process of determining what data to post given

[54]See Centers for Medicare & Medicaid Services, CMCS Informational Bulletin, *Medicaid and CHIP Managed Care Monitoring and Oversight Tools* (Baltimore, Md.: June 2021).

[55]See 81 Fed. Reg. 27,498, 27,722 (May 6, 2016).

[56]See Centers for Medicare & Medicaid Services, CMCS Informational Bulletin, *Medicaid and CHIP Managed Care Monitoring and Oversight Tools* (Baltimore, Md.: July 2022).

known data limitations and hoped to post states' annual reports on its website in 2024.

4. **Develop and implement an oversight plan based on findings from the analytic dashboards:** CMS had not begun developing an oversight plan as of December 2023.[57] Officials told us they had considered, but not decided on, data indicators that would trigger follow-up with states to determine whether there were performance issues, such as thresholds of unacceptable appeal or grievance rates. CMS also had not determined specific actions it might take to help states improve their oversight of managed care appeals and grievances. The officials said that the agency has no targeted time frames for developing the oversight plan.

CMS officials told us they have deferred these actions as they prioritized improving the quality of the annual report data. They noted that their current approach is to focus on time frames for conducting data quality reviews and technical assistance with states rather than time frames for the planned actions related to data use. In addition, the officials noted in December 2023 that the agency had limited internal resources to manage the annual reporting, including overseeing contractor work, which officials said has contributed to delays in implementing plans to use the data for oversight.

CMS has prioritized improving data quality. However, it is equally important for CMS to move forward on its other planned actions. For example, analyzing the data and developing an oversight plan for its use would help guide and focus data improvement efforts. Further, CMS officials told us that posting the data may provide necessary incentives for states to improve the quality of the data. By implementing the four planned actions, CMS would be better positioned to achieve its goals of using the data to target areas for program improvement and enhance transparency in managed care in a timely manner.

Conclusions

Having state- and plan-level appeals and grievances data is an important new resource for CMS to enhance oversight and transparency in managed care, which has become the predominant service delivery model in Medicaid in most states. Our analysis of the first year of data from state annual reports indicated wide variation in appeal and grievance rates across and within states. This variation could indicate problems with the accessibility of appeals and grievances processes, the quality of the

[57]CMS officials told us that they anticipated that the oversight plan will incorporate data from the annual reports and other state managed care reporting.

data states use to monitor the performance of managed care plans, and enrollee access to services.

Our analysis was hampered by a number of gaps in the first-year data that, unless addressed, will limit CMS's ability to use the data for oversight going forward. CMS is taking some steps to improve the quality and completeness of the appeals and grievances data. However, CMS's decision not to collect data on appeal outcomes or the number of denials made by managed care plans weakens its ability to attain a complete picture of plan performance, including potential problems with quality or access. In addition, taking steps to analyze the appeals and grievances data and make it available to the public will help CMS fully leverage the data for managed care oversight.

Recommendations for Executive Action:

We are making the following two recommendations to CMS:

The Administrator of CMS should require states to report on the outcomes of Medicaid managed care appeals (e.g., the extent to which they were decided in favor of enrollees) and number of denials. (Recommendation 1)

The Administrator of CMS should implement its planned actions for analyzing the Medicaid managed care appeals and grievances data, using it for oversight, and making it publicly available. (Recommendation 2)

Agency Comments

We provided a draft of this report to HHS for review and comment. In its written comments, reproduced in appendix II, HHS concurred with both of our recommendations and described planned actions to address them. With regard to our first recommendation, HHS indicated it would work to include data fields on the outcomes of appeals and denials in future years of reporting. In doing so, it will be important to collect the number of denials as indicated in our recommendation. With regard to our second recommendation, HHS confirmed its commitment to continue working toward its goals of analyzing the appeals and grievances data, using it for oversight, and making it publicly available.

HHS also provided technical comments, which we incorporated as appropriate.

We are sending copies of this report to the appropriate congressional committees, the Secretary of Health and Human Services, and other interested parties. In addition, the report is available at no charge on the GAO website at https://www.gao.gov.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or RosenbergM@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix III.

Michelle B. Rosenberg
Director, Health Care

Appendix I: Scope and Methodology for Analysis of Medicaid Managed Care Appeals and Grievances Data

To describe what the first year of data submitted by states in their Medicaid managed care annual reports indicate about appeals and grievances, we obtained data from the Centers for Medicare & Medicaid Services (CMS). These data included information about appeals, grievances, and state fair hearings at the plan level for each state's managed care programs during the program's contract year ending in 2022.[1] We limited our review to data from annual reports for states' comprehensive managed care programs that were due to CMS between December 2022 and June 2023.[2] We accepted late reports that states submitted to CMS through September 30, 2023.

We assessed the reliability of the data by interviewing knowledgeable officials from CMS and examining the data for logical errors and missing values. We also reviewed data elements related to appeals and grievances that CMS's contractor identified as being incomplete or inaccurate, and conducted specific data reliability tests for each of our analyses as explained below. Based on this, we determined that the data from 35 states were sufficiently reliable for the purposes of describing what the first year of annual reports indicated about Medicaid managed care appeals and grievances during contract year 2022.[3] In total, we reviewed data for 57 comprehensive managed care programs across these 35 states.

We completed the following analyses of the data from the 35 states, which included assessing the reliability of the data elements involved and excluding states from a given analysis if the data did not meet reliability criteria. (See table 3.)

- **Appeal rates:** To determine the range in the rate of appeals across states, we calculated the number of appeals resolved per 1,000

[1]Each state submitted data for their contract year ending in 2022. State contract years varied, with some beginning on July 1, 2021, and ending on June 30, 2022, and others beginning on January 1, 2022, and ending on December 31, 2022.

[2]Comprehensive managed care programs must cover inpatient hospital services and any of the following services, or at least three 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. See 42 C.F.R. § 438.2 (2023).

[3]We received data from a total of 36 states but excluded data from one state (Pennsylvania) because it had several plans with incomplete or inaccurate enrollment data, according to a review conducted by CMS's contractor. We determined that the accuracy issues that CMS identified for other states' data did not impact our analysis.

States often administer multiple managed care programs; for example, to serve different populations, such as for Medicaid enrollees needing long-term services and supports.

enrollees (appeal rates) for contract year 2022 for each state. Because CMS requested that states report resolved appeals for an 11-month period, for each state we used its average number of appeals resolved in the first 11 months as an estimate of the number of appeals for the 12th month. We assessed the reliability of the number of resolved appeals by comparing it to the total number of appeals resolved timely. We excluded the eight states for which the number of appeals resolved timely exceeded the total number of resolved appeals by more than five and the difference was greater than 5 percent, resulting in analysis for 27 states.

- **Appeal reasons:** We calculated the percentage of resolved appeals that were filed for each possible reason.[4] We assessed the data for completeness and excluded data from managed care plans for which the state could not categorize 11 percent or more of the appeals for that plan. As a result, we included 136 managed care plans in the analysis and excluded 45 plans across the 27 states included in the appeal reasons analysis.
- **Fair hearing outcomes:** We analyzed the outcomes of state fair hearings, specifically whether a decision was made in favor of or against the enrollee, or if the request was retracted prior to the hearing. Two of the 35 states did not report any data on state fair hearing outcomes. Thus, in total, we analyzed data from 33 states.
- **Grievance rates:** To determine the range in the rate of grievances across states, we calculated the number of grievances resolved per 1,000 enrollees (grievance rates) for contract year 2022 in each state. We assessed the reliability of the number of resolved grievances by comparing it to the total number of grievances resolved timely. We excluded one state that did not report data on grievances and seven states where the number of grievances resolved timely exceeded the total number of resolved grievances. In total, we analyzed grievance rates for 27 states.

[4]CMS collected data on seven possible reasons for filing an appeal. See 42 C.F.R. § 438.400(b) (2023). These include denial or limited authorization of a requested service; the reduction, suspension, or termination of a previously authorized service; the denial of payment for a service; the failure to provide services in a timely manner; the failure of a plan to act within the time frames provided regarding the standard resolution of grievances and appeals; the denial of an enrollee's request to obtain services outside of network (for residents of a rural area with only one plan); and the denial of an enrollee's request to dispute financial liability.

In addition, we selected five states—Arizona, Illinois, New Jersey, Ohio, and South Carolina—for additional analysis.[5] We calculated appeal and grievance rates by managed care plan for the selected states that passed our reliability tests to identify any within-state variation in rates. Specifically, we analyzed plan-level appeal rates for two of our five selected states, and plan-level grievance rates for all five selected states.[6]

Table 3: States with Comprehensive Managed Care and Their Inclusion in GAO Analysis of Medicaid Managed Care Appeals and Grievances Data

State	State submitted required data before September 30, 2023	Included in appeal rate analysis	Included in grievance rate analysis	Included in state fair hearing analysis	Number of plans included in appeal reason analysis
Arizona	Yes	No	Yes	Yes	-
Arkansas	Yes	Yes	Yes	Yes	3
California[a]	Some	No	Yes	Yes	-
Colorado	Yes	Yes	Yes	Yes	2
Delaware	Yes	Yes	Yes	Yes	0
District of Columbia[a]	Some	Yes	Yes	Yes	2
Florida[a]	No	-	-	-	-
Georgia	Yes	Yes	Yes	Yes	7
Hawaii	Yes	Yes	Yes	Yes	0
Idaho	Yes	Yes	Yes	No	0
Illinois	Yes	Yes	Yes	Yes	5
Indiana[b]	Yes	Yes	Yes	Yes	7
Iowa	Yes	Yes	No	Yes	2
Kansas	Yes	Yes	Yes	Yes	2
Kentucky[a]	No	-	-	-	-
Louisiana	Yes	Yes	Yes	Yes	5
Maryland	Yes	Yes	Yes	Yes	9
Massachusetts	Yes	Yes	No	Yes	15
Michigan	Yes	No	No	Yes	-
Minnesota	Yes	Yes	Yes	Yes	22
Mississippi	Yes	Yes	Yes	Yes	2

[5]We selected the five states based on geographic variation, annual report due dates, and managed care penetration, among other factors.

[6]Three of our selected states did not pass the reliability test for appeals-related analyses.

Missouri	Yes	Yes	Yes	Yes	3
Nebraska	Yes	Yes	Yes	Yes	3
Nevada	Yes	Yes	Yes	Yes	4
New Hampshire	Yes	No	No	Yes	-
New Jersey	Yes	No	Yes	No	-
New Mexico[a]	No	-	-	-	-
New York[b]	-	-	-	-	-
North Carolina	Yes	Yes	No	Yes	4
North Dakota	Yes	Yes	No	Yes	1
Ohio	Yes	Yes	Yes	Yes	10
Oregon[a]	No	-	-	-	-
Pennsylvania[c]	Yes	-	-	-	-
Rhode Island	Yes	Yes	Yes	Yes	0
South Carolina	Yes	No	Yes	Yes	-
Tennessee[a]	No	-	-	-	-
Texas[a]	Some	No	Yes	Yes	-
Utah[a]	Some	Yes	Yes	Yes	1
Vermont[a]	No	-	-	-	-
Virginia	Yes	No	Yes	Yes	-
Washington	Yes	Yes	No	Yes	0
West Virginia[a]	Some	Yes	No	Yes	2
Wisconsin	Yes	Yes	Yes	Yes	25
Total	**36**	**27**	**27**	**33**	**136**

Legend: -- = not applicable

Source: GAO analysis of data states submitted to the Centers for Medicare & Medicaid Services. | GAO-24-106627

Note: In comprehensive managed care, states contract with managed care organizations to provide an array of services under a risk-based capitation payment model.

[a]State had not submitted a first-year report for one or more of its managed care programs as of September 30, 2023, because the state missed the reporting deadline.

[b]One of Indiana's programs and all of New York's programs had reporting deadlines outside of the time frame of our analysis.

[c]Pennsylvania submitted the required reports, but we excluded the state's data from all analyses because of reliability concerns.

Appendix II: Comments from the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

February 23, 2024

Michelle B. Rosenberg
Director, Health Care
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Ms. Rosenberg:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, **"MEDICAID MANAGED CARE: Additional Federal Action Needed to Fully Leverage New Appeals and Grievances Data" (GAO-24-106627).**

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

Melanie Anne Egorin

Melanie Anne Egorin, PhD
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH & HUMAN SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT – MEDICAID MANAGED CARE: ADDITIONAL FEDERAL ACTION NEEDED TO FULLY LEVERAGE NEW APPEALS AND GRIEVANCES DATA (GAO-24-106627)

The Department of Health and Human Services (HHS) appreciates the opportunity to review and comment on the Government Accountability Office's (GAO) draft report. HHS is committed to partnering with states to help strengthen the monitoring and oversight of their Medicaid managed care programs.

The 2016 Medicaid and Children's Health Insurance Program Managed Care final rule (2016 Final Rule) strengthened federal oversight of state managed care programs in several ways, one of which was the establishment of new reporting requirements for states on their managed care programs and operations.[1] For example, the 2016 Final Rule established the regulations at 42 CFR § 438.66(e) which requires state submission of the Managed Care Program Annual Report (MCPAR). The MCPAR provides HHS with the opportunity to evaluate state managed care programs through a robust set of qualitative and quantitative indicators. Currently, the MCPAR includes more than 150 data fields and collects information on a variety of program characteristics including, but not limited to, program and plan enrollment, network adequacy operations, appeals and grievances, and sanctions. For example, states must report on the number of appeals resolved at the plan level, state fair hearing requests, and external medical reviews by decision type. States are required to submit a report for each managed care program administered by the state, including for behavioral health plans and managed Long-Term Services and Supports (LTSS) plans.

In June 2021, HHS issued guidance to states covering the content and form of the MCPAR, along with a template for states to use, triggering the reporting requirement for states.[2,3] This meant that the initial MCPARs were due from states for the contract year starting on or after June 2021, and the deadline for state submission was dependent upon the contract year of each of the managed care programs administered by the state. As specified at 42 CFR § 438.66(e)(1), states must submit MCPARs to CMS no later than 180 days after each contract year. Given the variation in contract years, the year 1 MCPARs were submitted to HHS at various times between December 2022 and September 2023. HHS acknowledges that many states experienced challenges with reporting the required data during the first year of reporting. The MCPAR was the first time states were required to report on certain appeals and grievances metrics, and some states needed to modify their managed care contracts to ensure plans could provide the required information. In order to support states in submitting the necessary data, HHS has provided technical assistance in the form of webinars and a written resource tool to improve state submissions for year 2. Beginning in June 2021, HHS also offered states technical assistance on

[1] *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)
[2] CMS, Medicaid and CHIP Managed Care Monitoring and Oversight Tools. 2021. Accessed at: https://www.medicaid.gov/sites/default/files/2021-12/cib06282021.pdf
[3] CMS, MCPAR Reporting Template. 2021. Accessed at: https://www.medicaid.gov/media/124631

completing the report, and in December 2023 HHS began providing targeted, one-on-one technical assistance to states with year 2 MCPAR submission deadlines in early 2024. Based on the initial data provided, as well as state feedback, HHS has also made several wording changes to the MCPAR to clarify questions, expected responses, and the appropriate use of "not applicable" as a response to questions.

In late 2022, HHS launched a web-based submission portal, known as the Medicaid Data Collection Tool for Managed Care Reporting (MDCT-MCR), to collect the MCPARs from states. The MDCTMCR collects the same information that was included in the previously provided MCPAR Excel template. The MDCT-MCR also collects states' Medical Loss Ratio (MLR) summary reports, as required by 42 CFR §§ 438.74(a) and 457.1203(e), and HHS plans to incorporate other required managed care reports into the MDCT-MCR system over time. As the quality of the data states submit with the MCPAR improves, the structured data captured by the MDCT-MCR will allow HHS to generate and analyze state-specific and nationwide data across the universe of managed care programs and requirements. This data analysis will allow HHS to identify areas in need of technical assistance and to target efforts to assist states in improving their managed care programs while also ensuring compliance with managed care statutes and regulations, including those related to ensuring access to care.

Ensuring that enrollees can access covered services is a critical function of the Medicaid program and a top priority for HHS. In April 2023, HHS proposed a rule that, if finalized, would improve access to care, quality, and health outcomes, and better address health equity issues for Medicaid managed care enrollees.[4] For example, HHS proposed establishing national maximum appointment wait time standards for routine primary care, including pediatric primary care, obstetric/gynecological services, and outpatient mental health and substance use disorder services. In addition, HHS recently finalized a rule to improve the electronic exchange of health information and prior authorization processes.[5] Specifically, beginning with rating periods that start on or after January 1, 2026, Medicaid managed care plans will be required to send prior authorization decisions for non-drug medical items and services to providers as well as enrollees within State established time frames that cannot exceed 72 hours for urgent requests and seven calendar days for non-urgent requests. In addition, Medicaid managed care plans will need to include a specific reason for denying such prior authorization requests in their provider notices,[6] which will help facilitate resubmission of the request or an appeal when needed. Lastly,

[4] *Federal Register*: Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality; Proposed Rule (88 FR 28092) (May 3, 2023)
[5] *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; Final Rule (89 FR 8758) (February 8, 2024)
[6] Managed care plans are already required at 42 CFR 438.404(c)(2) to provide a reason for adverse benefit determinations in enrollee notices.

Medicaid managed care plans will be required to publicly report certain prior authorization metrics, including approvals, denials, and appeals beginning with 2026; the reports are required to be submitted by March 31 for the prior calendar year.

GAO Recommendation 1

The Administrator of CMS should require states to report on the outcomes of Medicaid managed care appeals (e.g., the extent to which they were decided in favor of enrollees) and number of denials.

HHS Response

HHS concurs with this recommendation. HHS, in collaboration with states and other stakeholders, will work to incorporate data fields on the outcomes of Medicaid managed care denials and appeals into the MCPAR for future years. As noted above, HHS recently finalized a rule to improve the electronic exchange of health information and prior authorization processes.[7] The requirement for managed care plans to publicly report prior authorization metrics, including approvals, denials, and appeals for non-drug covered items and services will improve both access to care and transparency regarding prior authorization processes. Reporting on the services that require prior authorizations, the number of denials, those approved, and those overturned after appeal, will give enrollees and providers important information on a plan's performance in those categories, and over time, of the changes in performance in those categories.

GAO Recommendation 2

The Administrator of CMS should implement its planned actions for analyzing the Medicaid managed care appeals and grievances data, using it for oversight, and making it publicly available.

HHS Response

HHS concurs with this recommendation. HHS remains committed to utilizing the MCPAR data for monitoring and oversight purposes. HHS is currently working with states to improve the completeness and accuracy of their MCPAR data and anticipates that the quality of the data will improve as states become more familiar with the reporting requirements. HHS will continue to work towards its goals of being able to analyze the MCPAR appeals and grievances data, use it for oversight, and make it publicly available.

[7] Ibid

Appendix III: GAO Contact and Staff Acknowledgments

GAO Contact:

Michelle B. Rosenberg, (202) 512-7114 or RosenbergM@gao.gov.

Staff Acknowledgments:

In addition to the contact named above, Susan Barnidge (Assistant Director), Laura Tabellion (Analyst-in-Charge), and Patricia Broadbent make key contributions to this report. Also contributing were Giselle Hicks, David Jones, Drew Long, Jenny Rudisill, and Ravi Sharma.

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