



STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene

201 W. Preston Street • Baltimore, Maryland 21201

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

November 6, 2014

The Honorable Edward J. Kasemeyer
Chairman
Senate Budget and Taxation Committee
3 West Miller Senate Office Bldg.
Annapolis, MD 21401-1991

The Honorable Norman H. Conway
Chairman
House Appropriations Committee
121 House Office Bldg.
Annapolis, MD 21401-1991

Re: 2014 Joint Chairmen's Report (pp. 88-89) – Report on Independent Review Organization

Dear Chairmen Kasemeyer and Conway:

Pursuant to the 2014 Joint Chairmen's Report (pp. 88-89), the Department of Health and Mental Hygiene submits this report detailing the Secretary's recommendation on developing an independent review organization program that mirrors the appeals and grievance program administered by the Maryland Insurance Administration, which currently applies to carriers in the commercial market. It includes recommendations on alternative financing scenarios; a process by which providers can dispute a managed care organization's denial of a claim on the basis of medical necessity; a process for market conduct investigations when a managed care organization might systematically deny or down-code certain types of claims; and a process of departmental investigation and remedial action regarding patterns of disputes between managed care organizations and patients or providers that are represented to the independent review organization or the Department.

Thank you for your consideration of this information. If you have any questions or need additional information on this subject, please do not hesitate to contact Allison Taylor, Director of Governmental Affairs, at (410) 767-6481.

Sincerely,

Joshua M. Sharfstein, M.D.
Secretary

Enclosure

cc: The Honorable Thomas M. Middleton
The Honorable Peter A. Hammen
Therese M. Goldsmith
Chuck Lehman
Susan Tucker
Rosemary Murphey
Tricia Roddy
Allison Taylor

**Report on Development of an Independent Review Organization and Review Process for
Maryland's Medicaid Managed Care Program (HealthChoice)**

**Submitted by
The Maryland Department of Health
and Mental Hygiene**

2014 Joint Chairmen's Report, p. 88-89

Introduction

This report is submitted in response to the committees' request that the Department of Health and Mental Hygiene (the Department), in conjunction with interested stakeholders, work to alter the Department's Independent Review Organization (IRO) program to more closely mirror the appeals and grievance program administered by the Maryland Insurance Administration (MIA), which currently applies to carriers in the commercial market. The 2014 Joint Chairmen's Report requested that the Department consider a proposal that would include the following provisions:

- A process by which providers can dispute a managed care organization's (MCO) denial of a claim on the basis of medical necessity;
- A process for the initiation of market conduct investigations when an MCO might systematically deny or down-code certain types of claims;
- A process of departmental investigation and remedial action regarding patterns of disputes between MCOs and patients or providers that are presented to the IRO or the Department where the Department determines that education or intervention is warranted;
- A financing strategy not based on a "loser pays" model; and
- An evaluation of the proposed model's fiscal impact.

This report first compares the current MIA appeals and grievance process with the HealthChoice Program's process for medical necessity appeals and then highlights differences between the two processes. Next, it summarizes discussions with stakeholders, including possible alternative financing and cost mitigation strategies. The report concludes with a recommended approach and suggested next steps.

Background

Maryland Insurance Administration: Provider- or Member-Driven IRO Process

In 1998, the General Assembly enacted the appeals and grievance law (HB 3/SB 401 – Ch. 112/111 of the Acts of 1998) to provide a full and fair process for resolving disputes regarding the medical necessity of a proposed or delivered health care service.¹ The appeals and grievance law applies to individuals insured through a health benefit plan but does not apply to Medicare, Medicaid, the Federal Employee Health Benefit Plan, employer group self-funded plans or

¹ MD. CODE ANN., INS. § 15-10A (2014).

contracts subject to the laws of states other than Maryland. The appeals and grievance process begins when a carrier makes an adverse decision, which is defined as a determination that a proposed or delivered health care service is not medically necessary. The member, the member's representative, or the treating provider on behalf of the member has the right to appeal this decision through the carrier's internal review process. If the carrier again concludes that the proposed or delivered health care service was not medically necessary, the member may ask the MIA to review the carrier's decision by filing a complaint. The member has four months from the date of the carrier's decision to file a complaint with the MIA. Once the MIA receives a complaint, it must complete its investigation within 45 days. Complaints involving a medical emergency must be reviewed within 24 hours.

The appeals and grievance law gives the MIA the ability to contract with IROs to review these medical necessity complaints. When the MIA sends a complaint to an IRO for review, Maryland law requires that the review be performed by an unbiased provider in the same specialty as the area or areas appropriate to the subject of review. In addition, an IRO may not be a subsidiary of, or in any way be owned or controlled by, a health benefit plan, a trade association of health benefit plans or a trade association of health care providers. Based on the IRO's medical opinion, the MIA reaches a decision.

While the MIA's decision is binding on the carrier, the provider or member may request a hearing to challenge the MIA's decision, if the MIA found in favor of the carrier. No matter the outcome, the carrier that is the subject of the complaint is always responsible for paying the cost of the IRO's fee.

In addition to an IRO process, the MIA also carries out regular market conduct investigations as a key component of its oversight duties. These investigations, performed by dedicated staff in the Compliance and Enforcement Division, include both comprehensive and target market conduct and producer investigations. The examinations present a representative picture of a carrier's current business practices and compliance with Maryland laws and regulations. The Compliance and Enforcement Division also reviews insurance company operations to determine how the company operates in the marketplace. The review includes, but is not limited to, sales practices, advertising materials, underwriting practices and claims handling practices. Examinations often help alert companies to problems and serve as a form of consumer protection. The resulting report presents a detailed analysis of a company's general business practice. Sanctions may be applied in the form of administrative orders, which may be issued against licensees of the MIA for violations of Maryland insurance laws and regulations. Orders may address regulatory compliance issues, or financial examination and audit issues.

Managed Care Program: IRO Process for Provider Medical Necessity Appeals

Historically, the Department's coordinated case resolution unit holds conferences between providers and MCOs in the HealthChoice Program to resolve concerns regarding medical necessity. Since members cannot be charged for services, providers bear the cost of denied services. As a result, providers more commonly appeal medical necessity decisions than Medicaid members themselves.

Since April 28, 2014, when enabling regulations became effective, the Managed Care Administration has directed the implementation of a new Maryland Medicaid Managed Care Program IRO process. Prior to this enactment, the Department issued a request for proposals for the competitive procurement of an IRO to conduct the case reviews. The selected vendor, Maximus Federal (contract effective date February 6, 2014), offers an online portal and has experience managing similar programs in other states. Maximus offered multiple training opportunities to MCOs, members of the provider community, and Department personnel prior to the process going live on July 1, 2014. The case review charge of \$425 is to be paid by the unsuccessful party following the IRO's determination, in a loser pays model. As of October 1, 2014, the IRO had received 16 cases for review from four organizations.²

Mirroring the MIA IRO Process: A Comparison

Differences between the MIA's IRO process and the Department's process pertain to the following areas: 1) appeal rights of IRO determinations; 2) staffing resources available to administer the IRO process; 3) market conduct investigations; 4) transparency and public reporting; and 5) payment model.

Appeal Rights of IRO Determinations

In the MIA process, complaints against carriers are filed by members or by providers acting on a member's behalf. An MIA IRO determination is binding on the carrier but not the member; therefore, the member is able to appeal.

In the Medicaid process, because members are not responsible for any payments, the IRO pathway is available exclusively to providers.³ As a prerequisite for participating in the Medicaid IRO complaint adjudication process, a provider must waive all other administrative and judicial appeal rights and accept the Medicaid IRO's decision as final and binding. While an MCO cannot challenge the IRO's underlying decision regarding the disputed claim, it can file an appeal to protest paying the \$425 case review fee as an imposition of Department sanctions.⁴ This is because the IRO reviews services that were provided to enrollees, but the payment was

² As of 10/1/2014, 3:24PM

³ It is important to note that Medicaid beneficiaries can appeal denial of services, for example a denial of a pre-authorization, with their MCOs or they can appeal directly to the State without utilizing the MCO appeal process.

⁴ COMAR 10.09.72.06

denied to the provider. The Department's authority to charge the \$425 falls under its MCO sanction authority, which provides for appeal rights.

Staffing Resources

The MIA Appeals and Grievance Unit is staffed by six full-time employees: a Chief, an Assistant Chief, three investigators and an administrative assistant. This unit not only oversees the complete IRO process, including initiating investigations as appropriate, but also compiles quarterly reports that allow for a comprehensive annual review of the dispute resolution process. In addition, the unit manages data submitted quarterly by carriers regarding their adverse and grievance decisions.

In contrast, Department staff and resources for its IRO program are limited. The Department does not have a unit dedicated to the IRO program; instead the Managed Care Administration has hired a vendor to implement the reviews—Maximus Federal—whose contract is monitored by existing HealthChoice staff.

Market Conduct Investigations

Market examinations present a representative picture of a carrier's current business practices and compliance with Maryland laws and regulations. Under the MIA's approach, these investigations are triggered primarily by administrative trends—such as delays in the payment of claims—although some trends relate to medical necessity. Market conduct investigations are performed by a separate unit within the Compliance and Enforcement Division of the MIA, which is staffed by seven examiners with jurisdiction over all health insurance entities except MCOs.

The Department does not currently have the infrastructure in place to perform market conduct investigations. Additionally, to implement such a program, triggering criteria or mechanisms would need to be developed.

Transparency and Public Reporting

The MIA provides an annual report reviewing the State's dispute resolution process that is posted publicly, as are all final market examination reports for the past ten years. The State would need to develop a similar report for the Medicaid MCO's dispute resolution process, both for IRO medical necessity appeal cases, as well as for the results from any market conduct investigations performed or actions taken.

Payment Model

In the MIA process, the carrier always bears the cost of the IRO review and market conduct investigations. Medicaid currently employs a loser pays approach; however, the General Assembly requested that the Department investigate alternative payment models. If the Department shifts to a payment model that mirrors the MIA's process, then MCOs will be responsible for all IRO case review fees and the cost of market conduct investigations. Unlike commercial insurance, where the premium costs are paid by individuals or employers, the Department sets and pays the MCO capitation rates. These rates are required to be certified by an actuary. This means that although the MCOs would bear the direct costs of the IRO or market investigation, the Department would ultimately absorb them through the rate-setting process.

Additionally, the Department anticipates that a higher volume of provider complaints will be subject to review by the Medicaid IRO than those subject to the MIA process.

Meetings with Stakeholders and Maryland Insurance Administration

The Department met with stakeholders—including representatives of provider groups—on two occasions between July and October 2014 to discuss their concerns and address them to the extent possible within this proposed framework. In addition, the Department met with representatives of the MIA's Appeals and Grievance Unit and Compliance and Enforcement Division to: 1) better understand the MIA's processes; 2) solicit feedback on the payment model framework under development; 3) identify appropriate triggering mechanisms for market conduct investigations; and 4) assess opportunities for collaboration and alignment on market conduct investigations for the Medicaid Managed Care Program moving forward.

Market Conduct Investigations

The Department does not currently have the technical expertise to perform the market conduct investigations proposed under this model. As a result, additional resources or outside assistance will be required. In the past, the Department has contracted with the MIA to perform market conduct investigations of Medicaid MCOs to review for timely claims management. However, at this time, the MIA does not have the capacity to conduct this work without the allocation of additional resources. In addition, the MIA does not have regulatory authority over the MCOs, meaning that if the MIA were to conduct the reviews through a Memorandum of Understanding, the Department would need to enforce any action against the MCO. Finally, while the Department has broad-based authority to sanction MCOs, it does not have authority to charge the MCOs for market conduct investigations. Statutory changes would be required.

Medical Necessity Reviews

Discontinuing a loser pays model for the IRO program has the potential to increase the volume of claims appeals significantly. With the financial burden of the appeals process borne exclusively by the MCOs, there would no longer be a financial disincentive to discourage providers from pursuing frivolous or questionable claims. Further, as providers' understanding of the IRO process becomes more sophisticated, it is possible that MCOs could be flooded with numerous small claims appeals. Even in cases where the appeal of a small claim is valid, the cost of the review process would far exceed the claim's value. Again, this could result in a significant fiscal burden for the Department, because although the MCOs would bear the direct costs, the Department would ultimately absorb them through the rate-setting process. Given these fiscal concerns, certain strategies should be considered to help mitigate costs.

Establishing a Minimum Claim Threshold

The current case review charge assessed by the Medicaid IRO is \$425. One option looking forward would be to consider setting a minimum claim value that meets or exceeds the case review charge. This action would disincentivize providers from filing numerous appeals for small or frivolous claims that would be better resolved through other avenues. Further, by independently monitoring claims that fail to meet the minimum claim threshold, the Department would still be able to rectify problems of this nature without hampering the IRO process needlessly or causing undue expense to the Department.

Recommendations on Changing the IRO Process

Based on discussions with stakeholders, the IRO vendor and Department staff, the following funding approaches have been identified:

- *Scenario 1: Continue to use and monitor the current system, soliciting feedback from payers and providers*
- *Scenario 2: Identify additional funds to: 1) remove the "loser pays" component of the current IRO process, and 2) operate a process for market conduct investigations*
- *Scenario 3: Implement a process for market conduct investigations and continue to use and monitor the current IRO system, while considering cost mitigation strategies*

Given that the Department only began accepting cases through its IRO process in July 2014, the Department feels that it would be prudent to allow more time to monitor the current system—**Scenario 1**. The Department will continue to work with and solicit feedback from stakeholders from the payer and provider communities on the functioning of its IRO process.

The Department will also work with stakeholders to explore a formalized process to conduct market conduct investigations on the HealthChoice MCOs. Pursuing this option has statutory and fiscal implications. At its current staffing level, the MIA cannot assist the Department; conversely, the Department does not have the technical expertise or staffing capacity to conduct investigations that mirror the standard of quality set by the MIA. Nonetheless, a formalized structure for market conduct investigations would have the potential to improve provider satisfaction and participation with the HealthChoice program. A strong provider network continues to be an important objective of the Medicaid program, especially in light of the recent and projected growth in enrollment due to the Patient Protection and Affordable Care Act.