MAXIMUS Federal Services

Medicare Managed Care Reconsideration Data
2008

50 Square Drive
Victor, NY 14564

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Notes on CMS Reconsideration Data

The enclosed reports reflect data on appeals conducted under Medicare's Managed Care and PACE Reconsideration Program for the period 2008. A brief description of the data follows

Table 1

Table 1 displays the distribution of final reconsideration decisions, and the dollar value of those decisions, by general service classification.

Reconsideration cases are included in this table if i) the case was received at MAXIMUS Federal during 2008, and ii) the case is decided as of this writing. The decisions that are contained in the table reflect MAXIMUS FEDERAL's determination, including reopening decisions if applicable. Please note that updates for later levels of appeals are not reflected in these data (e.g., Administrative Law Judge hearings). At the national level, the impact of subsequent appeals is not great. But the reader should be aware that the appeal process allows for further actions not reflected herein.

Service is a global classification of the contested care, based on the dollar value of the most expensive service in conflict. A not insignificant portion of cases involve multiple contested services. The classification of a case employed here is based on the plan's account of the dollar value of contested care. Reconsiderations are assigned to the category that corresponds to the most expensive service contested. This has obvious limitations, but serves as a crude descriptor of the contested situation.

Not all cases coming into the reconsideration system are reflected in the table. Cases that have yet to be decided are excluded. These numbers may be obtained from Table 5.

The five outcomes of appeal presented in the table are *Recons Upheld* (uphold of the plan decision), *Recons Overturned* (overturn of the plan decision), *Recons Partly Overturned* (partial overturn of the plan decision), *Recons Dismissed* (dismissal of the appeal), and *Recons Withdrawn* (*withdrawal* of the appeal). Cases may be dismissed because MAXIMUS FEDERAL does not have jurisdiction (e.g., in the instance where the enrollee is not eligible for benefits under a managed care plan), or because the appeal does not meet other requirements. The latter include appeals brought by representatives without a properly executed appointment of representative form, or appeals brought by providers not under contract with the MCO without a properly executed Waiver of Liability form, or appeals in which there is no beneficiary liability. Withdrawn cases are valid appeals that have not been decided because a party to the appeal has requested that the appeal not go forward. Typically this occurs when an MCO provides a contested service that was requested by the enrollee, making the appeal unnecessary.

The footnote on Table 1 explains the handling of dollar values, which typically are missing in authorization denials. All missing values have been set to the average for appeals of the same service classification where the dollar value of the dispute is known.

Table 2

The second table uses the same conventions as Table 1, substituting the CMS Region responsible for oversight of the MCO. Please note this is a change from prior years' data reporting. In the past, region referred to the region in which the MCO was located; now region reflects the CMS Regional office responsible for oversight. In some instances, these 2 regional designations are not the same.

Table 3

Table 3 presents the distribution of reconsideration decisions by service category within CMS region.

Table 4

Table 4 shows the distribution of appeals in 2008 by appeal priority and service category. Standard service denials refer to denials of authorization that do not meet requirements of expedited appeals.

Standard claim denials are denials of payment (after a service has been consumed). Expedited appeals are those that must be completed within 72 hours of receipt of a valid request for appeal.

Table 5

Table 5 contains plan specific reconsideration data, sorted by CMS region. Note that the designation of a plan is really a specific contract with CMS. These include Medicare Advantage (MA) plans (coordinated care plans, Medical Savings Account (MSA) plans, and Private Fee-for-Service (PFFS) plans), Cost Contracts, Health Care Prepayment Plans (HCPPs), Demonstration Projects and PACE plans.

What we commonly think of as a single MCO, may have multiple contracts at a given time. This is particularly true of the large chain MCOs. In some cases such MCOs will have multiple contracts within a given region, as well as contracts in different regions.

Plans are included in Table 5 if i) the reconsideration was **received** during 2008, or ii) if the plan had any members enrolled as of July of the year. Enrollment figures are those from the mid-year point (i.e., July). Use of the mid-year figure is an arbitrary convention, employed because many reconsiderations (namely all retrospective denials) lag by months the actual enrollment underlying the dispute.

Some plans with reconsiderations during 2008 may have no enrollment during that calendar period. These reconsiderations reflect prior enrollments in specific contracts, and point to the lag between enrollment and a conflict over care being represented in the reconsideration system. The contract in question may have been terminated, or converted to a new contract (say, of a different type).

Still other plans do have enrollment during 2008, but have no reconsiderations received during the same time frame. This may also be a reflection of the lag issue, as in the case of new contracts.

Table 5 presents a calculation of the rate of reconsideration per 1,000 members per year. This calculation is based on the sum of reconsiderations received during the year, divided by the mid-year enrollment, multiplied by 1000. The presentation of a rate allows the reader to compare activity across plans even though the plans have widely different enrollment.

The distribution of reconsideration decisions is calculated using the base of cases completed as of this writing. Counts are also given of cases not yet completed as of this writing.

The last line of Table 5 gives totals across all plans and regions. Hence the reader can obtain counts of appeals, enrolled beneficiaries, and aggregate data on the rate of appeals nationally and distribution of final decisions.

Table 5A

Table 5A contains information about appeals that are overturned or partly overturned. The two categories are combined, and the sum is given, along with the percent of appeals that are overturned and the rate of overturns per 1,000 members. Data are presented by MCO within CMS Region.

Table 6

The final table contains comparable data to Table 5, but only on expedited appeals received during 2008.