MAXIMUS Federal Services

Medicare Managed Care Reconsideration Data
2007

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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 2007. 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 2007, ii) if the Managed Care Organization (MCO) is one for which 2007 enrollment was available and iii) 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.

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Partly Overturned* (partial overturn of the plan decision), *Recons Dismissed (dismissal* of the appeal) and *Recons Withdrawn (withdrawal of the appeal)*.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., 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 may be missing in authorization denials. (MCOs are asked to estimate the value of the contested service in such cases.) 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 in which the plan is located for the Service designation. The chart below gives a cross-walk between state and regional office.

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 2007 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, and are either for service authorizations or for situations where care is being discontinued.

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 contracts.

What is commonly considered 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 2007, 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 2007 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 2007, 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 as Table 5, but only on <u>expedited</u> appeals received during 2007.

Cross Walk of CMS Region and State

CMS Region	***States***
01: Boston	Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont
02: New York	New Jersey, New York, Puerto Rico, Virgin Islands
03: Philadelphia	Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia
04: Atlanta	Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee
05: Chicago	Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin
06: Dallas	Arkansas, Louisiana, Oklahoma, New Mexico, Texas
07: Kansas	Iowa, Kansas, Missouri, Nebraska
08: Denver	Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming
09: San Francisco	Arizona, California, Guam, Hawaii, Nevada, Samoa
10: Seattle	Alaska, Idaho, Oregon, Washington