

Congress of the United States
Washington, DC 20515

September 28, 2023

Thomas Hutton
Chief Executive Officer
AmeriHealth Caritas
3875 West Chester Pike
Newtown Square, PA 19073

Dear Mr. Hutton,

As the Ranking Member and Chairman of the Committees with jurisdiction over the Medicaid program, we are troubled by recent findings showing the high use of prior authorization of health care services and subsequent treatment denials by Medicaid Managed Care Organizations (MCOs), including MCOs owned by your organization. A report by the Department of Health and Human Services Office of the Inspector General (HHS OIG) found that numerous Medicaid MCOs had staggeringly high rates of denials of health services from applying prior authorization to provider decisions. Over 70 million low-income Americans are enrolled in Medicaid MCOs, which are responsible for ensuring that vulnerable Medicaid beneficiaries are able to access the critical treatment to which they are legally entitled. While plans may use prior authorization as a means to manage care, this report raises serious questions about whether plans are improperly using prior authorization to deny care. This alarming trend cuts across a range of parent companies, evincing a system-wide problem in need of attention. Building on this report, we are writing to request additional information regarding your use of prior authorization in Medicaid managed care.

The HHS OIG report, titled “High Rates of Prior Authorization Denials by Some Plans and Limited State Oversight Raise Concerns About Access to Care in Medicaid Managed Care,” found that, across all plans surveyed, plans denied one out of every eight prior authorization requests for service. This equates to an overall denial rate of 12.5 percent for all requests.¹ This denial rate is more than double the overall denial rate in Medicare Advantage.² One plan even had a denial rate of 41 percent.³ The report also identified several challenges related to enrollee appeal of denials. Overall, enrollees appealed 11 percent of MCO prior authorization denials, and for 64 percent of these appealed denials, MCOs fully upheld their original denial decisions.

These findings raise serious concerns that Medicaid MCOs are systematically and improperly denying necessary care which they are required by law to provide to the low-income children and families, seniors, and people with disabilities who rely on these plans for access to critical health care services. Further, prior authorization denials can lead to worse health outcomes. A recent survey found that one-third of physicians reported that prior authorization

¹ Department of Health and Human Services, Office of Inspector General, *High Rates of Prior Authorization Denials by Some Plans and Limited State Oversight Raise Concerns About Access to Care in Medicaid Managed Care* (July 2023) (OEI-09-19-00350).

² *Id.*

³ *Id.*

requirements have led to a serious adverse event for a patient in their care and a quarter of physicians reported that prior authorization requirements have led to a patient's hospitalization.⁴ The HHS OIG report is just the latest piece of evidence of Medicaid MCOs denying access to care. As the New York Times reported, doctors and hospitals have previously lodged complaints about excessive and unnecessary red tape from the plans that prevent them from providing patients with the care they need.⁵

Over three-quarters of Medicaid beneficiaries are enrolled in a comprehensive managed care plan to receive services through Medicaid. These plans are operated by MCOs. States pay MCOs an actuarially sound per member per month rate that is designed to cover the expected costs of care for each enrolled beneficiary. Under this arrangement, however, it is critical that MCOs are not improperly denying access to care in an effort to maximize profits given that they are obligated by statute, regulation, and contracts with states to pay network providers for furnishing covered services to enrollees. MCOs should not be prioritizing corporate or shareholder profits ahead of the health and well-being of low-income and middle-class American families.

As the Ranking Member of the House Energy and Commerce Committee and Chairman of the Senate Committee on Finance, which have sole jurisdiction over Medicaid, we request additional documentation and written responses to the following, no later than October 31, 2023.

1. Submit the requested data elements in Appendix A (Table 1) for all of the plans in Attachment B with data from 2018, 2019, 2020, 2021, and 2022.
2. Submit the requested data elements in Appendix A (Table 1) for all of the plans in Attachment B for the requested years of data in Question 1, categorized by eligibility category (children, adults, disabled, aged, and pregnant women).
3. Submit the requested data elements in Appendix A (Table 1) for all of the plans in Attachment B for the requested years of data in Question 1 for the benefit categories listed below. Provide an explanation (and CPT crosswalk if used) of how you classified claims and encounters into each benefit category.
 - a. Private duty nursing and personal care services.
 - b. All behavioral health care services, including but not limited to residential mental health services and substance use disorder (SUD) treatment services.
 - c. Durable medical equipment, including but not limited to wheelchairs, tracheostomies, augmentative and alternative communication devices.
 - d. Out of state care, including supports for out of state care such as lodging and travel.
 - e. Home modifications.

⁴ American Medical Association. 2022 *AMA prior authorization (PA) survey*. (2023).

⁵ *Insurers Deny Medical Care for the Poor at High Rates, Report Says*. New York Times (July 19, 2023).

4. Submit the requested data elements by year, eligibility and service type (the combination of Questions 1, 2, and 3) for all of the plans in Attachment B.
5. Does your company require prior authorization for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services across any of its subsidiary health plans? If so, list the health plans which have this process in place, describe the process, provide a written rationale for the process, and provide the percentage of prior authorization requests for which an algorithm was used at a per plan level for 2018, 2019, 2020, 2021, and 2022 for any and all MCOs that you operated within that time frame.
6. Please describe all algorithms, including machine learning and artificial intelligence algorithms, used in prior authorization decisions separated by approvals, partial denials, and full denials for 2018, 2019, 2020, 2021, and 2022 for any and all MCOs that you operated within that time frame. For each algorithm, describe the algorithm's purpose, company or internal unit that developed the algorithm, how the algorithm was developed including the statistical methods and data used for training and validation, measures of model performance, analyses of safety, effectiveness and equity concerns, how the algorithm is monitored and maintained, and on what percentage of claims it was applied (not included in Question 4)?
7. Please provide information on the rate of appeals by level of appeal and the outcome:
 - a. For Medicaid MCOs, provide the rate of appeal for prior authorization denials by level of appeal and state overall and for the following service categories: EPSDT, preventive care, primary care, specialty medical care, imaging, labs, durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), behavioral health care, inpatient care, and post-acute care.
 - b. For your company's Medicare Advantage products, provide the rate of appeal by level of appeal overall and for the following service categories: preventive care, primary care, specialty medical care, imaging, labs, DMEPOS, behavioral health care, inpatient care, and post-acute care.

Thank you for your attention to this matter.

Sincerely,

Frank Pallone, Jr.

Ron Wyden

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Frank Pallone, Jr.
Ranking Member
House Committee on Energy and Commerce

Ron Wyden
Chairman
Senate Committee on Finance

DATA REQUEST

Attachment A: Request for Medicaid Managed Care Data on Benefit Determinations and Appeals

We are requesting the following data on benefit determinations and appeal decisions issued by the Medicaid managed care organizations (MCOs) indicated in Attachment B, as well as the outcomes of external reviews (if applicable) and State fair hearings.

Submitting the data: Please submit your data as both a Microsoft Excel (.xlsx) file and a Comma-Separated Value (.csv) file. Both should be formatted with a header row following the record layout shown on the following pages. After the header row, each row should contain aggregate data for a single MCO identified in Attachment A for each plan year as requested by year overall (Question 1), then by year and eligibility (Question 1 and 2), year and service type (Question 1 and 3), and then by year, eligibility and service type (Questions 1, 2, and 3).

Attachment A: Request for Medicaid Managed Care Data on Benefit Determinations and Appeals

Instructions for preparing the data file:

We are requesting aggregate data regarding decisions rendered at four stages of possible review:

- **“Benefit determination”** means a decision by an MCO about a request for services (also referred to as “prior authorizations” or “medical necessity reviews”).
 - “Favorable benefit determination” means the full approval of the benefit request.
 - “Partially favorable benefit determination” means the limited authorization or reduction of a benefit determination.
 - “Adverse benefit determination” means the full denial, suspension, or termination of a benefit determination.
 - Note: do not include data on provider credentialing or beneficiary eligibility determinations (e.g., favorable or adverse decisions about whether an individual is eligible to be enrolled in Medicaid).
- **“Appeal”** means a beneficiary or provider request for MCO review of an adverse benefit determination, as defined in 42 CFR §438.400.
 - Note: Some States use the term “grievance” rather than appeal. Please report appeals based on the definition in 42 CFR §438.400(b) regardless of the terminology used in the State contract.
 - MCOs in some States may offer two levels of appeal for payment disputes: an initial claims payment **“reconsideration”** (sometimes called a “Level One” appeal), and then a formal claims payment appeal (or “Level Two” appeal). For MCOs where this is applicable, please provide the related data where indicated on the data request. For MCOs that offer only one level of appeal for payment disputes, please provide the related data in the “appeal” columns listed below (i.e., all MCOs should have entries in the “appeal” columns but only some will have entries in the “reconsideration” columns).
 - Do not include data on complaints, also known as grievances. Grievances are an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights, regardless of whether remedial action is requested.
- **“External review”** means a review of an adverse benefit determination by a qualified entity independent of the MCO and State. **“External medical review”** means a medical necessity review of a denied service request.
- **“State fair hearing”** means a review by the State of an adverse benefit determination at the request of a beneficiary who has received notice that the adverse benefit determination was upheld.

We are requesting data for decisions rendered/issued in calendar year (CY) 2018, 2019, 2020, 2021, and 2022

- Data should be reported based on the date the beneficiary or provider was notified of the decision (i.e., decision mailing date or oral notification date) at the given level of adjudication (MCO benefit determination, MCO appeal decision, the External Review, or the State Fair Hearing).

- Please exclude cases for which a determination was not made based on the merits of the case. For example, exclude:
 - duplicate requests concerning the same service or item,
 - voided or dismissed requests, and
 - withdrawn requests.
- Please exclude data on pharmacy benefit determinations, including those made by the MCO and/or Pharmacy Benefit Management (PBM) entities on behalf of the MCO. Note that the date the request was initiated may fall outside of the calendar year.
 - For example, a State Fair Hearing decision rendered in 2019 may be for a benefit determination that was issued by the MCO in 2018. In this case, the State Fair Hearing decision would be included in the data set, but the original benefit determination (from 2018) would not be included.
 - Similarly, an appeal filed at the end of 2019 may not be adjudicated until 2020, and thus would not be included in the data.

Table 1: Benefit Determinations and Appeals Record Layout

Column ID	Variable Name	Variable Description	Data format
A	MCO_Name	The name of the Medicaid managed care organization	Text
B	Plan_Name	Unique name for the Medicaid managed care plan	Text
C	State	The State in which the MCO operates	Two-letter State abbreviation
D	Year	Calendar year (e.g., 2018, 2019... 2022)	Number
E	Eligibility_Category	All, Children, Adults, Disabled, Aged, Pregnant Women	Text
F	Benefit_Category	All, Private Duty Nursing, Personal Care Services, Behavioral Health, Durable Medical Equipment, Out of State Care, Home Modifications	Text
G	Enrollment_March	Number of beneficiaries enrolled in comprehensive, risk-based plans with the MCO on 3/1/[YEAR]	Number
H	Enrollment_September	Number of beneficiaries enrolled in comprehensive, risk-based plans with the MCO on 9/1/[YEAR]	Number
I	Plan_type(s)	Description of the type(s) of comprehensive, risk-based Medicaid managed care plans this MCO offers (e.g., HMO, PPO, etc.)	Text
J	Duals_YN	Does this MCO plan cover beneficiaries who are dually eligible for both Medicaid and Medicare?	Y/N

K	MLTSS_YN	Does this MCO plan provide Medicaid Long Term Services and Supports (MLTSS) as part of the comprehensive, risk-based plan?	Y/N
L	BD_Serv_Total	The number of benefit determinations issued by the MCO for <u>service authorization</u> requests (i.e., prior authorization decisions) (note, should equal the sum of variables M, N, and O)	Number
M	BD_Serv_Favorable	Of the total in L, the first number of service authorization determinations that were fully favorable to the requestor	Number
N	BD_Serv_Part_Favorable	Of the total in L, the number of service authorization determinations that were partially favorable to the requestor	Number
O	BD_Serv_Adverse	Of the total in L, the number of service authorization determinations that were fully adverse to the requestor	Number
P	App_Serv_Total	Total number of appeal decisions issued in the calendar year listed in column D by the MCO, by the MCO for <u>service authorization appeals</u> (i.e., appeals of adverse prior authorization determinations) (note, should equal the sum of variables Q, R, and S)	Number
Q	App_Serv_Favorable	Of the total in P, the number of service authorization appeals that were fully favorable to the appellant	Number
R	App_Serv_Part_Favorable	Of the total in P, the number of service authorization appeals that were partially favorable to the appellant.	Number
S	App_Serv_Adverse	Of the total in P, the number of service authorization appeals that were fully adverse to the appellant	Number
T	Ext_Med_YN	Are external medical reviews available in the State in which the MCO operates?	Y/N
U	Ext_Med_Total	If yes in T, the total number of external medical review decisions issued in the calendar year listed in column D for beneficiaries enrolled in the MCO, regardless of the initial date of request (note, should equal the sum of variables V, W, and X)	Number

V	Ext_Med_Favorable	Of the total in U, the number of external medical review decisions that were fully favorable to the requestor	Number
W	Ext_Med_Part_Favorable	Of the total in U, the number of external medical review decisions that were partially favorable to the requestor	Number
X	Ext_Med_Adverse	Of the total U, the number of external medical review decisions that were fully adverse to the requestor	Number
Y	SFH_Serv_Total	The total number of State fair hearing decisions issues in the calendar year listed in column D for <u>service authorization</u> requests (i.e., prior authorization) (note, should equal the sum of variables Z, AA, and AB)	Number
Z	SFH_Serv_Favorable	Of the total in Y, the number of hearings for service authorization requests that were fully favorable to the appellant	Number
AA	SFH_Serv_Part_Favorable	Of the total in Y, the number of hearings for service authorization requests that were partially favorable to the appellant	Number
AB	SFH_Serv_Adverse	Of the total in Y, the number of hearings for service authorization requests that were fully adverse to the appellant	Number

Attachment B: List of Medicaid MCOs

Parent Company	MCO Name	State
AmeriHealth Caritas	AmeriHealth Caritas District of Columbia	DC
AmeriHealth Caritas	AmeriHealth Caritas Delaware – Diamond State Health Plan	DE
AmeriHealth Caritas	Prestige Health Choice	FL
AmeriHealth Caritas	AmeriHealth Caritas of Louisiana	LA
AmeriHealth Caritas	Blue Cross Complete of Michigan	MI
AmeriHealth Caritas	AmeriHealth Caritas Northeast	PA
AmeriHealth Caritas	AmeriHealth Caritas Pennsylvania	PA
AmeriHealth Caritas	AmeriHealth Caritas Pennsylvania Community HealthChoices	PA
AmeriHealth Caritas	Keystone First Community HealthChoices	PA
AmeriHealth Caritas	Keystone First Health Plan	PA
AmeriHealth Caritas	First Choice by Select Health of South Carolina	SC