OCT 2 2 2009

TO: Charlene Frizzera
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: Stuart Wright
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for Evaluation and Inspections

SUBJECT: Memorandum Report: "Beneficiary Appeals in Medicare Advantage," OEI-01-08-00280

This memorandum report provides information about appeals made by beneficiaries in Medicare Advantage (MA). Specifically, it provides information on: (1) outcomes of organization determinations and first- and second-level appeals of beneficiaries enrolled in MA, (2) Medicare Advantage Organization (MAO) compliance with timeliness requirements for determinations and appeals, and (3) the Centers for Medicare & Medicaid Services (CMS) oversight of the MA appeals system.

We found that MAOs make the vast majority of organization determinations in favor of beneficiaries, and deny very few. Of these denials, called adverse determinations, very few were appealed, and upon appeal, MAOs overturned more than half of their own denials. We also found that MAOs decided 23 percent of adverse expedited determinations, and 18 percent of appeals, late. At the second level of appeal, the Independent Review Entity (IRE) overturned about one in five adverse MAO reconsiderations. Finally, CMS identified many MA contracts that failed to meet appeals-related audit elements.

Our review also raises questions and concerns. We found that beneficiaries appealed fewer than 1 in 10 adverse determinations. Although no rate of appeal is expected or correct, further study could examine factors that might explain this rate. Further study could also identify differences between denials that beneficiaries appeal and those that beneficiaries do not appeal. Particularly concerning are the problems with timeliness in processing adverse expedited determinations and the higher IRE overturn rate of expedited cases. Because expedited cases concern time-sensitive care, it is important that such care be delivered with minimal delays.

BACKGROUND

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 made several important changes to Medicare managed care, including increasing payments to MAOs and renaming the program "Medicare Advantage."[1] As of April 2009, 10.9 million Medicare beneficiaries (about 22 percent of all Medicare beneficiaries) were enrolled in 752 MA contracts.[2] These numbers represent increases of 106 percent and 164 percent, respectively, from 2003, when MA was enacted. An MAO, the parent organization, may hold multiple managed care contracts, which are agreements to provide MA services across a specified geographic area. Each contract may include multiple plans.

A capitated payment system, such as that used by MAOs, could create fiscal incentives to underserve beneficiaries.[3] A properly functioning appeals system provides a vital safeguard to protect against those incentives.

MA Appeals Process

The Social Security Act states that MAOs must have a procedure to determine whether a beneficiary is entitled to receive health services and the amount, if any, a beneficiary is required to pay for these services.[4] It also mandates that MAOs offer beneficiaries the right to appeal an adverse determination.[5] Further, it requires that the Secretary of the Department of Health and Human Services contract with an IRE to review second-level appeals in cases where an MAO has returned an adverse decision to a beneficiary's initial appeal.[6]

If the IRE upholds the MAO's decision, a beneficiary can continue the appeal with an Administrative Law Judge, then with the Medicare Appeals Council, and finally, via judicial review.[7] MAOs can appeal Administrative Law Judge decisions and any higher-level decisions.[8]

Organization Determination. An organization determination is any decision made by an MAO about whether a beneficiary is entitled to receive health services and the amount, if any, a beneficiary is required to pay for these services.[9] For example, MAOs make organization

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[1] P.L. No. 108-173 §§ 211 and 201.

[2] CMS, "Monthly Contract and Enrollment Summary Report." Available online at http://www.cms.hhs.gov/MCRAdvPartDEnrolData/. Accessed on July 14, 2009.

[3] Government Accountability Office, GAO/T-HRD-93-10, "Medicaid: States Turn to Managed Care to Improve Access and Control Costs," 1993. Available online at http://archive.gao.gov/d42t14/148756.pdf. Accessed on July 14, 2009.

[4] Social Security Act, § 1852(g)(1)(A).

[5] Social Security Act, § 1852(g)(2)(A).

[6] Social Security Act, § 1852(g)(4).

[7] Social Security Act, § 1852(g)(5), 42 CFR §§ 422.600, 422.608, and 422.612.

[8] 42 CFR §§ 422.608 and 422.612.

[9] 42 CFR § 422.566(a).

determinations about whether to pay for temporarily out of the area renal dialysis services, emergency services, poststabilization care, or urgently needed services; whether to pay for any other health services furnished by a provider other than the MAO that the enrollee believes are covered under Medicare (or, if not covered under Medicare, should have been furnished, arranged for, or reimbursed by the MAO); or discontinuation or reduction of a service if the enrollee believes that continuation of the service is medically necessary.[10]

The parties that can request an organization determination are: the beneficiary or an authorized representative, the beneficiary's provider, or the legal representative of a deceased beneficiary's estate (in this memorandum report we refer to all of these parties as the beneficiary).[11]

Beneficiaries can request three types of organization determinations: a standard service request, an expedited service request, and a payment request.[12] Organization determinations have three possible outcomes for the beneficiary: favorable, partially adverse, or wholly adverse. When the MAO notifies a beneficiary of a partially or wholly adverse determination, it must inform the beneficiary, in writing, of the right to appeal a wholly or partially adverse determination.[13]

Table 1 shows the timeframes by which MAOs must provide their decisions on organization determinations.[14] If an MAO fails to meet these timeframes, the determination is considered adverse to the beneficiary and the beneficiary may appeal.[15]

Table 1: Timing for Organization Determinations and Appeals

Type of Request	Organization Determination	First-Level Appeal	Second-Level Appeal
Standard Service Request	14 days	30 days	30 days
Expedited Service Request	72 hours	72 hours	72 hours
Payment Request	In accordance with Prompt Payment Standards*	60 days	60 days

* See 42 CFR § 422.520.

[10] 42 CFR § 422.566(b).

[11] 42 CFR § 422.566(c)(1)

[12] 42 CFR §§ 422.568(a), (b), and 422.572.

[13] Social Security Act, § 1852(g)(1)(B), and CMS, "Medicare Managed Care Manual," Pub. No. 100-16, ch. 13, § 40.2.2.

[14] 42 CFR §§ 422.568(a), 422.568(b), and 422.572(a). For standard and expedited service requests, an MAO must make its determination and notify the beneficiary as expeditiously as the beneficiary's health requires, but no later than the timeframes set forth in Table 1. 42 CFR §§ 422.568(a) and 422.572(b) allow for an extension to the timeframes under certain circumstances.

[15] 42 CFR § 422.568(f).

First-Level Appeal. Beneficiaries have 60 days to appeal an MAO's adverse organization determination.[16] The same parties that can request a determination can also file an appeal with the MAO.[17] Appeals, like organization determinations, fall into one of these three categories:

- Standard Service Request: A beneficiary can appeal an MAO's refusal to authorize provision of a service.[18]

- Expedited Service Request: A beneficiary or a physician may request an expedited reconsideration of a determination.[19] The MAO does not have to grant a beneficiary's request for an expedited reconsideration, unless the MAO determines that the standard timeframe could jeopardize the life or health of the beneficiary or the beneficiary's ability to regain maximum function.[20] However, if a physician requests or supports an expedited reconsideration and states that the standard timeframe could jeopardize the life or health of a beneficiary or the beneficiary's ability to regain maximum function, the MAO must expedite the reconsideration.[21]

- Payment Request: A beneficiary can appeal the MAO's denial of payment for a service that a provider has already performed.[22]

Table 1 also shows the timeframes by which MAOs must provide their decisions on first-level appeals.[23]

The MAO must designate a person other than the one involved in making the organization determination to decide the outcome of the appeal.[24] This outcome is called a reconsideration. The MAO's reconsideration is either favorable, partially adverse, or wholly adverse to the beneficiary. If the reconsideration is partially or wholly adverse, the MAO must forward it to the IRE.[25] The MAO must also notify the beneficiary that it has forwarded the case.[26]

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[16] 42 CFR § 422.582(b).

[17] 42 CFR § 422.578.

[18] 42 CFR § 422.590(a).

[19] 42 CFR § 422.584(a).

[20] 42 CFR § 422.584(c)(2)(i).

[21] 42 CFR § 422.584(c)(2)(ii).

[22] 42 CFR § 422.590(b).

[23] 42 CFR §§ 422.590(a), 422.590(b), and 422.590(d). For standard and expedited service requests, an MAO must make its reconsideration as expeditiously as the beneficiary's health requires, but no later than the timeframes set forth in Table 1. 42 CFR §§ 422.590(a) and 422.590(d)(2) allow for an extension to the timeframes under certain circumstances.

[24] 42 CFR § 422.590(g).

[25] 42 CFR §§ 422.590(a)(2), (b)(2), and (d)(5).

[26] 42 CFR § 422.590(e).

If an MAO does not provide the beneficiary with a decision within the specified time, the outcome of the case is considered to be adverse to the beneficiary, and the MAO must forward the case to the IRE.[27] The IRE then reviews the case as it would any partial or wholly adverse reconsideration.

Second-Level Appeal. CMS currently contracts with Maximus Federal Services, Inc., as the IRE. The IRE must review wholly or partially adverse MAO reconsiderations.[28] The IRE can either overturn, partially overturn, or uphold the MAO's reconsideration. When it has made its decision, the IRE must notify the beneficiary, the MAO, and CMS.[29] If the IRE overturns the MAO's reconsideration, the MAO then must act within certain timeframes. The IRE can also dismiss the appeal under certain conditions: for example, if the appeal is brought by a party with no standing to do so, if it was not filed timely, or if a preservice appeal has become moot because a beneficiary received the service.[30] MAOs must submit these cases to the IRE; they do not have the authority to dismiss them on their own. Table 1 also shows the timeframes by which the IRE must provide decisions on second-level appeals.[31]

CMS Oversight of MA Appeals Process

CMS oversees MAOs' performance in the appeals process in two ways: through audits of MAOs and through data submitted by MAOs and the IRE. CMS regional offices are responsible for ongoing MAO oversight.

Audits. Prior to 2007, CMS audited every Part C contract every 3 years. However, resource constraints and the growth in the number of MA contracts necessitated changes to this approach. Beginning in 2007, CMS implemented a risk-based approach to identify contracts for audit. These contracts are audited by CMS regional staff. Regional staff can also recommend that contracts receive focused, or for-cause, audits.

CMS also uses an assessment tool called the Targeted Appeals Monitoring System to select contracts for audit, by identifying MA plans that are outliers in performance in processing appeals. This system uses data from the IRE, as well as specific appeals-related questions from beneficiary surveys.

CMS's annual audit strategy details the specific elements that must be reviewed in every routine audit for that year (CMS regional auditors can request additional elements be included during an

[27] 42 CFR §§ 422.590(c) and (f).

[28] 42 CFR § 422.592(a).

[29] 42 CFR § 422.594(a).

[30] Maximus Federal Services, Inc., Medicare Advantage Organization Reconsideration Process Manual, §§ 4.2.5 and 4.7. CMS, "Medicare Managed Care Manual," Pub. No. 100-16, ch. 13, § 70.7.5.

[31] Medicare Part C Qualified Independent Contractor Task Order Statement of Work, § I.A.3. For standard and expedited service requests, the IRE must make its reconsideration as expeditiously as the beneficiary's health requires, but no later than the timeframes set forth in Table 1. Section I.A.3 of the Medicare Part C Qualified Independent Contractor Task Order Statement of Work allows for an extension to the timeframes under certain circumstances.

audit). Specific appeals-related elements include whether MAOs are: meeting timeliness requirements for making organization determinations and reconsiderations, meeting documentation requirements, and designating appropriate MAO staff to decide appeals.

Data submitted by MAOs and the IRE to CMS. Upon request, MAOs must provide beneficiaries with aggregate appeals data including the total number of appeals per 1,000 enrollees as well as the outcome of those appeals.[32] MAOs should provide informational copies of these data to the appropriate CMS regional office.[33] In 2009, CMS began requiring MAOs to submit the number and outcomes of organization determinations and reconsiderations.[34]

The IRE submits reports to CMS that include aggregate MAO appeals data on an ongoing basis. These reports include timeliness of MAO organization determinations and reconsiderations, as well as MAO compliance with the IRE's decisions. The reports are derived from the Medicare Appeals System (MAS), a CMS system containing appeals data.

When an MAO makes an adverse reconsideration, it forwards descriptive case information to the IRE. The IRE staff enters this information, without verification, into the MAS. They also enter second-level appeals data, such as date and disposition of the appeal, into the MAS.

METHODOLOGY

Scope

This evaluation is national in scope. We analyzed data on service-related organization determinations made from October 1 to December 31, 2007, and service-related appeals made subsequent to adverse determinations from that timeframe. We did not analyze data on payment determinations or reconsiderations. We also analyzed data on second-level service appeals reviewed by the IRE in which the original determination date was between October 1 and December 31, 2007.

Data Sources

MAO data. To obtain data on organization determinations and first-level appeals, we drew a stratified random sample of 105 MA contracts from the universe of 505 MA contracts in the 50 States and District of Columbia as of October 2007. We excluded demonstration contracts and contracts not subject to the MA appeals requirements. We stratified the 505 contracts based on enrollment:

- high-enrollment contracts: all contracts with more than 60,000 beneficiaries (25 contracts, all included in the sample);

[32] CMS, "Medicare Managed Care Manual," Pub. No. 100-16, ch. 13, §§ 170 and 170.5.1.

[33] Ibid., § 170.5.

[34] CMS, "Medicare Part C Plan Reporting Requirements Technical Specifications Document," Version: July 21, 2009.

- medium-enrollment contracts: contracts with 10,001 to 60,000 beneficiaries (40 contracts sampled out of a universe of 136); and

- low-enrollment contracts: contracts with 10,000 or fewer beneficiaries (40 contracts sampled out of a universe of 344).

IRE data. We analyzed data on second-level appeals from the MAS. We also conducted structured interviews with IRE staff.

CMS data. We analyzed data on audits of MA contracts and summary data on corrective action plans. We also conducted structured interviews with staff at five purposively selected CMS regional offices. We selected the offices based on geographic diversity.

Data Collection

MAO data. To obtain data on organization determinations and first-level appeals, we sent each MAO in our sample a data request. We attempted to contact nonresponsive MAOs three times in writing, and once by telephone, to obtain data. We received data for 101 of the 105 contracts in our sample. Of the four that did not submit data, we dropped two contracts that served dual-eligible populations, effectively reducing our sample to 103 contracts. The beneficiaries from those two contracts could have utilized the Medicaid appeals process, which is outside the scope of this study. Of the remaining 103 contracts, 2 did not respond to our request for data, yielding a 98-percent response rate.[35] We allowed MAOs to report aggregate counts of favorable organization determinations.

IRE data. We obtained the MAS data from CMS. We also visited the IRE's office in Victor, NY, where it reviews the majority of second-level MA appeals, and conducted structured interviews with staff there.

CMS data. We obtained data from CMS on the number of audits conducted in 2007 and 2008, as well as data on corrective action plans resulting from those audits. We also conducted structured interviews with staff at five CMS regional offices, by telephone and in person.

Data Analysis

MAO data. We concatenated all the data submissions from each MAO into two analytic files, one for organization determinations and one for appeals. We then analyzed each file in SAS. Some MAOs provided data outside the scope of our review. Because some MAOs submitted data outside our requested timeframe, we limited the organization determinations to those decided between October 1 and December 31, 2007. Similarly, we limited reconsiderations to those requested between October 1, 2007, and February 29, 2008, (this latter date corresponds to the 60-day limit on appeals of adverse determinations in our requested timeframe).[36] To

[35] We have sent CMS information regarding these two contracts under separate cover.

[36] In limiting reconsiderations by date, we recognize that some could stem from organization determinations made prior to October 1, 2007.

determine the timeliness of determinations and appeals, we compared the request date with the decision date. We weighted the results of our analysis based on the strata described above, making them projectable to the universe of MA contracts. See Appendix A for confidence intervals and point estimates for the results of our analysis of MAO data.

IRE data. We analyzed MAS data on outcomes of second-level appeals. To maintain consistency with the MAO data, we only analyzed appeals associated with contracts in the universe from which we drew our sample. We analyzed all appeals from this universe. The IRE reviewed 2,212 service-related appeals that had an original determination date between October 1 and December 31, 2007. It dismissed 223 appeals, beneficiaries withdrew 91 appeals, and disposition data were missing for 2 appeals. Our analysis includes the remaining 1,896 appeals. The numbers of appeals reviewed by the IRE does not match the number of adverse reconsiderations made by MAOs. This discrepancy is likely because we analyzed the universe of data for IRE appeals, whereas our analysis of MAO data comes from a sample of contracts, with projected results.

CMS data. We analyzed the number of contracts CMS audited in 2007 and 2008. We matched data on contracts audited with data on unmet audit elements and corrective action plans. We analyzed elements related to organization determinations and reconsiderations as specified in "Chapter 13: Claims, Organization Determinations, Appeals and Grievances" of CMS's Medicare Advantage Audit Guide Version 4.

Limitations

We did not independently verify any of the information submitted by MAOs or in the MAS. Further, we cannot verify that MAOs provided data on all organization determinations in our requested timeframe, or that they provided data on all reconsiderations associated with adverse determinations. Though we requested that MAOs provide only reconsiderations of adverse determinations that were made between October 1 and December 31, 2007, we did not match reconsiderations to their initial determinations. We did not verify whether MAOs forwarded all adverse reconsiderations to the IRE. Our analysis of MAO timeliness did not include whether or not the MAO received an extension. Finally, because we allowed MAOs to submit aggregate counts of favorable organization determinations, we could not analyze their timeliness.

Standards

This study was conducted in accordance with the "Quality Standards for Inspections" approved by the Council of the Inspectors General on Integrity and Efficiency.

RESULTS

MAOs decided the vast majority of organization determinations in favor of beneficiaries; they denied very few

MAOs processed over 3.2 million organization determinations from October 1 to December 31, 2007. High-enrollment contracts processed about 1.3 million determinations, medium-enrollment contracts processed about 1.6 million, and low-enrollment contracts processed about 400,000. Overall, MAOs decided 98 percent of organization determinations in favor of beneficiaries, with minimal variation by contract enrollment. See Table 2 for the disposition of organization determinations.

Table 2: Outcome of Organization Determinations

Disposition	Number of Organization Determinations	Percentage of Organization Determinations
Favorable to member	3,196,469	97.8%
Wholly adverse to member	65,430	2.0%
Partially adverse to member	7,593	0.2%
Overall total	3,269,492	100%

Source: Office of Inspector General (OIG) analysis of MA contract data, 2009.

Of the more than 3.2 million determinations MAOs processed, just over 73,000 were wholly or partially adverse to beneficiaries. Standard determinations comprised 93 percent of these denials; 7 percent were expedited.

Although most denials were timely, MAOs decided 23 percent of adverse expedited determinations late. MAOs must process expedited service requests within 72 hours.[37] Expedited service requests are those in which the MAO or the beneficiary's physician determines that the standard 14-day timeframe could jeopardize the life or health of the beneficiary or the beneficiary's ability to regain maximum function.[38] Our analysis does not examine whether the MAO received an extension to the mandated timeframe.

In contrast with expedited denials, MAOs processed only 4 percent of standard service denials late. Of these late denials, one in four was more than 16 days late. Because the timeliness threshold is 14 days, this means at least 1 month had elapsed since the original service request.

[37] 42 CFR § 422.572(a).

[38] 42 CFR § 422.570(c)(2).

Of those adverse organization determinations, very few were appealed, and upon appeal, MAOs overturned more than half of their own denials

Beneficiaries can appeal a wholly adverse or partially adverse organization determination made by the MAO. Of the 73,023 adverse determinations, MAOs received only 5,478 appeals (8 percent). However, when beneficiaries did appeal, MAOs overturned their own denial 54 percent of the time, and partially overturned an additional 2 percent of denials (see Table 3). Beneficiaries appealed 5 percent of the standard service-related determinations that MAOs denied, versus 35 percent of adverse expedited determinations.

Table 3: Outcome of First-Level Appeals (Reconsiderations)

Disposition	Number of First-Level Appeals	Percentage of First-Level Appeals
Favorable to member	2,966	54.1%
Wholly adverse to member	2,428	44.3%
Partially adverse to member	84	1.5%
Overall total	5,478	100%*

* Column does not add to total because of rounding.
Source: OIG analysis of MA contract data, 2009.

MAOs decided 18 percent of first-level service appeals late. MAOs must decide standard service appeals within 30 days and expedited appeals within 72 hours.[39] When MAOs do not meet specified timeframes for appeals, the outcome is considered adverse to the beneficiary and the MAO must forward the case to the IRE.[40] Our analysis does not examine whether the MAO received an extension to the mandated timeframe.

At the second level of appeal, the IRE overturned about one in five adverse MAO reconsiderations

The IRE received 2,212 service reconsiderations in which the MAO's adverse organization determination occurred in the last calendar quarter of 2007.[41] The IRE dismissed 10 percent of these cases; beneficiaries withdrew their appeal in an additional 4 percent. Our analysis excluded these withdrawals and dismissals. The IRE reviewed 1,896 service appeals in which it rendered a decision, and decided in favor of the beneficiary in 19 percent of them. Of these cases where the IRE overturned the MAO's decision, appeals for practitioner services (30 percent) were the most common; clinic, lab, or x-ray services (19 percent) were the second most common. The IRE decided about 3 percent of service appeals partially adverse to the beneficiary. See Table 4 for the breakdown of dispositions for second-level appeals.

[39] 42 CFR §§ 422.590(a)(1), 422.590(a)(2), 422.590(d)(1).

[40] 42 CFR §§ 422.590(c) and (f).

[41] To determine the outcome of IRE reconsiderations, we analyzed data from the MAS. We did not match these data with data we received from MA contracts. Further, the results of our analysis of MA contracts are projections. Therefore, the exact number of adverse MAO reconsiderations does not match the number of cases reviewed by the IRE.

Table 4: Disposition of Second-Level Service Appeals

Disposition	Number of Second-Level Appeals	Percentage of Second-Level Appeals
Favorable to member	363	19.1%
Wholly adverse to member	1,481	78.1%
Partially adverse to member	52	2.7%
Overall total	1,896	100%*

* Column does not add to total because of rounding.
Source: OIG analysis of MAS data, 2009.

IRE staff told us that the most frequent reason they overturn an MAO's decision is because it was not in accordance with Medicare coverage requirements. On occasion, IRE reviewers need additional information from the MAO to render a decision. In the event that an MAO does not provide requested data, the reviewer typically makes a decision favorable to the beneficiary.

The IRE overturned 25 percent of adverse expedited service reconsiderations, compared with 16 percent of standard service reconsiderations. About 35 percent of the overturned expedited appeals concerned nursing home care; 23 percent related to clinic, lab, or x-ray services; and 15 percent were for practitioner services.

IRE staff told us that their review process worked well overall, although they did raise some concerns. When MAOs submit case file data to the IRE, they include a standard form that includes the type and description of the appeal. In some cases, IRE staff cannot determine from the form whether a case is a standard or expedited appeal, because the MAO marked both in different places. In these cases, IRE staff review the entire case file to make an appropriate determination about the type of appeal.

CMS identified many MA contracts that failed to meet appeals-related audit elements

In 2007, the first year of CMS's new audit strategy, it audited 106 MA contracts. Its strategy specified that all routine audits would include all audit elements related to organization determinations and first-level appeals.

In 2008, CMS adjusted its methodology for selecting contracts to audit, moving from a focus on contracts to larger managed care entities. For example, rather than auditing a single contract from a large MAO, CMS's audit included multiple contracts operated by that MAO. As a result, CMS almost tripled the number of contracts it audited, auditing 279 MA contracts in 2008. As in 2007, routine audits in 2008 included all appeals-related audit elements.

Because CMS may not have much data on new contracts, it might not select them for routine audits until they have been in operation for some time. As a result, staff from one CMS region

told us it holds regular conference calls with MAOs that operate contracts in its purview. The region uses these calls to identify issues that can lead to a focused audit.

To audit the various elements, CMS regional staff request data from the MAO. Regional staff we spoke with told us that obtaining accurate, complete data is often a challenge, requiring multiple requests from CMS. According to one region, the quality of data varies across contracts, with newer contracts requiring more assistance from CMS. If a contract fails to provide the requested data, CMS will deem it noncompliant with that audit element.

The content of beneficiary notices was the most commonly unmet audit element regarding organization determinations, and unmet timeliness elements were the most common for appeals. In 2007, 68 contracts had at least one unmet appeals-related audit element (64 percent of all MA contracts audited that year). The three most commonly unmet elements were all related to organization determinations: the content of beneficiary notices of claim denials (unmet by 41 percent of audited contracts), making correct claim determinations (27 percent), and content of beneficiary notices of standard preservice denials (25 percent). The most commonly unmet elements related to reconsiderations addressed timeliness: timeliness of favorable claims reconsiderations, and of requests for expedited reconsiderations, both unmet by 22 percent of audited contracts.

In 2008, 197 contracts did not meet at least one appeals-related audit element (70 percent of all MA contracts audited that year). The most frequently unmet element was again related to organization determinations: 50 percent of audited contracts did not meet the element for content of beneficiary notices of claim denials. Other commonly unmet elements for determinations included timeliness of requests for expedited determinations (unmet by 39 percent of audited contracts), and making correct claim determinations (38 percent). The most commonly unmet audit elements for reconsiderations all concerned timeliness: adverse standard preservice reconsiderations (unmet by 39 percent of audited contracts), requests for expedited reconsiderations (38 percent), and favorable claims reconsiderations (34 percent). See Table 5 for the 10 most frequently unmet elements in 2007 and 2008.

When a contract does not meet an audit element, it must develop a corrective action plan and submit it to the CMS regional office for approval. CMS staff told us that, to approve a corrective action plan, they look for a "credible plan with supporting documentation" that is "workable and doable." Once CMS accepts the corrective action plan, the contract must successfully complete it and submit data to CMS demonstrating improvement.

For example, CMS required one contract that did not meet the audit element for content of claim denial notices to complete a corrective action plan. The contract had to establish policies and procedures to ensure that a denial notice is issued each time a claim is denied, train staff on these policies and procedures, and audit denied claims monthly.

Table 5: Most Frequently Unmet Audit Elements From 2007 and 2008 CMS Audits

Unmet Audit Elements, 2007		
Audit Element	**Number of Contracts Not Meeting Element N = 106**	**Percent of Contracts Not Meeting Element N = 106**
Claim Denials (Notice Content)	43	40.6%
Correct Claim Determinations	29	27.4%
Standard Preservice Denials (Notice Content)	26	24.5%
Favorable Claims Reconsiderations (Timeliness)	23	21.7%
Requests for Expedited Reconsiderations (Timeliness)	23	21.7%
Interest on Clean Claims Paid Late	22	20.8%
Timely Payment of Noncontractor Clean Claims	20	18.9%
Adverse Standard Preservice Reconsiderations (Timeliness)	20	18.9%
Favorable Standard Preservice Reconsiderations (Timeliness)	20	18.9%
Adverse Claims Reconsiderations (Timeliness)	17	16.0%
Unmet Audit Elements, 2008		
Audit Element	**Number of Contracts Not Meeting Element N = 279**	**Percent of Contracts Not Meeting Element N = 279**
Claim Denials (Notice Content)	141	50.5%
Adverse Standard Preservice Reconsiderations (Timeliness)	110	39.4%
Requests for Expedited Organization Determinations (Timeliness)	108	38.7%
Requests for Expedited Reconsiderations (Timeliness)	107	38.3%
Correct Claim Determinations	106	38.0%
Standard Preservice Denials (Notice Content)	98	35.1%
Favorable Claims Reconsiderations (Timeliness)	96	34.4%
Standard Preservice Denials (Timeliness)	93	33.3%
Adverse Claims Reconsiderations (Timeliness)	91	32.6%
Effectuation of Third-Party Expedited Reconsideration Reversals	53	19.0%

Source: OIG analysis of CMS audit data, 2009.

CONCLUSION

We found that MAOs decided the vast majority of organization determinations in favor of beneficiaries, and that MAOs overturned more than half of their own denials upon appeal. We also found that MAOs decided 18 percent of first-level appeals late. Our review also showed that CMS audits have identified many MA contracts that did not meet its timeliness standards for determinations and first-level appeals.

However, our review raises questions and concerns. We found that beneficiaries appealed fewer than 1 in 10 adverse organization determinations. Although no rate of appeal is expected or correct, further study could examine factors that might explain this rate. For example, some beneficiaries may be unaware of their right to appeal an adverse determination. This concern is reflected in CMS's audit findings, which showed that many MAOs failed to use CMS-approved notices when informing beneficiaries of a service denial. These notices are important because they inform beneficiaries why the MAO denied their request and how to file an appeal. Further study could also identify differences between denied requests that beneficiaries appeal and those that beneficiaries do not appeal.

Particularly concerning are the problems with timeliness in processing adverse expedited determinations and the higher IRE overturn rate of expedited cases. Because expedited cases concern time-sensitive care, it is important that such care be delivered with minimal delays.

This report is being issued directly in final because it contains no recommendations. If you have comments or questions about this report, please provide them within 60 days. Please refer to report number OEI-01-08-00280 in all correspondence.

APPENDIX A

Table A-1: Confidence Intervals

Variable	Unweighted N	Weighted N	Point Estimate	95-Percent Confidence Interval	
				Lower Bound	Upper Bound
Outcome of Service Requests, Percentage Favorable to Member	1,751,010	3,196,469	97.8%	97.2%	98.4%
Outcome of Service Requests, Percentage Partially Or Fully Adverse to Member	35,450	73,023	2.2%	1.7%	2.8%
Type of Adverse Service Requests, Percentage Standard Service Denials	32,587	67,944	93.0%	90.4%	95.7%
Type of Adverse Service Requests, Percentage Expedited Service Denials	2,863	5,079	7.0%	4.3%	9.6%
Timeliness of Adverse Service Requests, Percentage Expedited Decided Timely	2,284	4,051	76.9%	69.6%	84.3%
Timeliness of Adverse Service Requests, Percentage Expedited Not Decided Timely	771	1,215	23.1%	15.7%	30.4%
Timeliness of Adverse Service Requests, Percentage Standard Decided Timely	33,686	68,214	96.1%	95.3%	97.0%
Timeliness of Adverse Service Requests, Percentage Standard Not Decided Timely	1,803	2,746	3.9%	3.0%	4.7%
Timeliness of Adverse Service Requests, Percentage Standard 16 Days Late	553	705	25.7%	22.8%	28.5%
Outcome of Reconsiderations, Percentage Favorable to Member	1,284	2,966	54.1%	45.8%	62.5%
Outcome of Reconsiderations, Percentage Partially Favorable to Member	40	84	1.5%	0.7%	2.4%
Timeliness of Reconsiderations, Percentage Service Reconsiderations Not Decided Timely	395	991	18.2%	7.7%	28.7%
Count of Service Requests, Total Number of Service Requests	1,786,460	-	3,269,492	2,483,317	4,055,667
Count of Service Requests, Number of Service Requests Processed by Low Enrollment Plans	46,158	-	396,959	-47,091	841,009
Count of Service Requests, Number of Service Requests Processed by Medium Enrollment Plans	471,763	-	1,603,994	857,125	2,350,863
Count of Service Requests, Partially or Fully Adverse to Member	35,450	-	73,023	56,039	90,007
Count of Reconsiderations, Total Number of Reconsiderations Processed by Medicare Advantage Organizations	2,630	-	5,478	4,096	6,859

Source: Office of Inspector General analysis of Medicare Advantage contract data, 2009.