MEMORANDUM

FROM: Richie Farran, V.P. of Government Services, Health Care Association of Michigan
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SUBJECT: Managed Care Challenges for Long-Term Care

With the continued expansion of managed care across the nation and in Michigan specifically, long-term care providers continue to face significant challenges in receiving appropriate payment for the vital services they provide to Michigan residents.

Nursing facilities regularly report issues in dealing with managed care organizations, such as timely and appropriate authorization for care, appropriate payment for care, and retroactive denial and payments clawed back for care previously approved and already provided.

A recent United States Senate Subcommittee Investigation into the barriers facing seniors enrolled in managed care sought documents and information from the largest managed care insurers in the country – United Healthcare, Humana, and CVS. The inquiry found each health plan denied prior authorization requests for post-acute care at far higher rates than they did for other types of care, resulting in diminished access to post-acute care for beneficiaries

Michigan is among the leaders in the country in managed care. The state has the highest penetration of Medicare Advantage in the country. Additionally, the Michigan Department of Health and Human Services (MDHHS) is expanding the dual-eligible pilot program – MI Health Link (MHL) – to a statewide, permanent program for citizens who are eligible for both Medicare and Medicaid coverage for long-term care, which will be called MI Coordinated Health. As managed Medicare and Medicaid continues to become more pervasive across Michigan, it is important that managed care entities are held to a high standard to ensure Michigan residents receive the care they are entitled to.

Issues

Proper and Timely Payment

Significant reimbursement challenges continue with managed care in Michigan, not just for providers of long-term care services, but also for managed care organizations and the state. Much of this is because of a lack of experience with the Michigan nursing facility Medicaid reimbursement system and its many nuances outside of the formal rate structure – such as the Provider Tax and the Patient Pay Amount. For example, although over 90 percent of the current dual-eligible pilot MI Health Link program beneficiaries live in the community, the reimbursement system for long-term care services provided to SNF residents is vastly different from the system for those community-dwelling beneficiaries.

The time and effort that has gone into assuring proper reimbursement to skilled nursing facility providers throughout MI Health Link comes at the expense of efforts and resources that should be devoted elsewhere. Additionally, delays in payment can create cash flow issues for providers seeking reimbursement for care already rendered.

Solution: The best way to ensure prompt payment is to establish a protocol for claims payments that includes a financial incentive to adhere to it, such as assessing interest if violated.

Bill language

- *Managed Care plans must ensure ninety-nine percent (99%) of clean claims from providers are adjudicated within fourteen (14) calendar days of receipt of the clean claim, and one hundred percent (100%) are*

adjudicated within thirty (30) calendar days, for covered services rendered to covered Members who are enrolled with health plan at the time the service was delivered. A clean claim that is not paid within 14 calendar days will bear a simple interest payment of 12% per annum. (MI Coordinated Health contract language, penalty language from DIFS)

- *Managed Care plans must ensure that nursing facility and long-term supports and services providers are paid no less than the current Medicaid fee for service rate. (MI Coordinated Health contract language)*
- *Quality Assurance Supplement (QAS) must be paid to nursing facility and long-term supports and services providers on a similar timeframe to fee for service Medicaid, which is currently monthly.*

Prior Authorization for Services

Delays in receiving prior authorization for necessary care have been part of the timely and proper reimbursement challenges throughout managed care in Michigan, but its implication for quality care merits separate consideration. Care delayed is often care denied. According to the U.S. Senate Subcommittee Investigation, the authorization denial rate for one MCO for post-acute care surged from 10.9 percent in 2020, to 16.3 percent in 2021, to 22.7 percent in 2022. During this time, it was implementing multiple initiatives to automate the process.

Solution: Ensure timely and fair prior authorization processes for both patients and providers. Such provisions help ensure access to necessary care for our state's most vulnerable population, reduce administrative burdens, and minimize potential harm from delays.

Bill language:

Managed Care Plans are required to send standard prior authorization decisions within 7 calendar days and expedited prior authorization decisions within 72 hours. Payers must provide specific information about prior authorization denials, regardless of how the prior authorization request is submitted. Any prior authorization request not authorized within the time frames specified will be deemed approved. (CMS interoperability and PA rule, 2024 (outside of deeming provision)

Post Payment Review Protection

Oftentimes, services will be approved by the managed care plan and rendered by the provider, only to be retroactively disapproved or payment rescinded. This creates operational and financial issues for providers who previously depended on the approval to serve their residents. Once coverage determination is made and services are both authorized and provided, reimbursement should not be denied under the guise of a post-payment audit.

Solution: At minimum, third-party independent reviewers (with clinical expertise) should be used for managed care audits, with financial penalties for insurance companies if their determinations are overturned.

Boilerplate language

Managed Care Plans shall initiate administrative action and recover improper payments or overpayments related to claims paid by the plan within six (6) months from the date the claim was paid or from the date of any applicable reconciliation, whichever is later. Except for Overpayments identified under a Credible Allegation of Fraud, the plan shall confer with the applicable state agency before pursuing Overpayment recoveries for Claims where more than six (6) months have passed since the claims were paid or adjudicated. The plan shall not subject these claims to repayment or offset against future claim reimbursements without prior consent from the applicable state agency. Any claim improperly recovered or offset will be subject to penalties of up to $1,000 per claim. (Iowa, penalty language added)

Limited SNF Benefit to 45 days for MI Coordinated Health Program

Managed care plans are designed primarily for, and apply optimally apply to, individuals residing in the community. The needs of institutionalized members, however, are vastly different from the needs of community-resident members. Individuals residing in long-term care (LTC) facilities typically require assistance with three or more activities of daily living, have multiple chronic conditions, physical disabilities, mental illness, or cognitive impairments such as dementia, and need frequent on-site care from medical providers.

A short-term stay in a skilled nursing facility that evolves into a long-term stay requires little in the way of what we typically think of as "managed care" provided by a managed care organization (MCO). The acuity level of a long-term stay resident of a skilled nursing facility typically doesn't change much, and what was once restorative care becomes custodial care. Minimum Data Set (MDS) data shows little change in case-mix throughout a year once on Medicaid.

For managed care beneficiaries in LTC settings, typically more than 93 percent of their cost to Medicaid is the custodial payment paid to their nursing facility for their needed assistance with unscheduled activities of daily living, medical supervision, nursing care, dietary needs, room and board, activities, and social services. This means that states are paying MCOs administrative fees to "manage" very little – less than 7 percent – of a resident's care.

This can be compounded by the fact that MCOs often use a delegated entity for care management, which would add another administrative layer on top of the MCO itself. Extra – and unnecessary – administrative layers are not only costly, but they also can impede communication and even result in care delays.

Evaluations of the MI Health Link demonstration program documented that managed care plans only conducted minimal care coordination of SNF residents. As part of the evaluation, a number of entities that advocate on behalf of residents voiced the concern that the demonstration had not improved the lives of SNF residents – i.e., there was no added value on quality of care.

Solution: This can be effectively addressed by transitioning a managed care plan resident of the nursing facility member to fee for service Medicaid after 45 days. Remaining in the managed care plan would be an unnecessary administrative layer that adds little value to the resident, directs financial resources away from care, and includes unnecessary pre-authorizations.

<u>Bill language:</u>

The state shall limit the nursing home benefit in any managed care plans to 45 days for enrollees who have been designated as long term nursing home stays (LTNHS) in a skilled nursing facility (nursing home). Afterwards, the individual will be involuntarily dis-enrolled from the managed care plan with coverage for nursing home services in the same facility provided by Medicaid fee for service (FFS), as long as the individual qualifies for institutional Medicaid coverage. Institutional eligibility is required for individuals in managed care plans or in Medicaid FFS. Enrollees who are involuntarily dis-enrolled from a plan because they have reached the 45-day nursing home benefit limit in their plan will have the same due process rights as individuals who are involuntarily dis-enrolled from the plan for other reasons. (New York)

Any willing provider protection

MCOs have significant leverage in determining which providers in the state they will contract with for care of the beneficiaries they serve.

Solution: Managed care organizations must contract with any willing provider of skilled nursing services. If quality thresholds are required, all providers should be given the opportunity to meet them.

Bill Language

Any provider who is qualified and willing to meet the terms and conditions of a health plan contract must be allowed entrance as a network provider. (Idaho)

Beneficiary disclosures

Nursing facility providers increasingly face frustration from residents who experience reduced coverage for services than they originally thought when signing up for their managed care plan. Medicare Advantage (MA) plans have continued to decrease the coverage for short-term rehabilitation in nursing facilities, resulting in residents being denied care recommended by their physicians. These stays have decreased to less than 2 weeks, while traditional Medicare covers 100 days of care. As most of these MA plans are the same entities that were rewarded contracts under the MI Coordinated Health program, there is much trepidation amongst providers that such issues will continue for the duals population as well.

Solution: It is crucial that managed care applicants, enrollees, and other stakeholders have ready access to information about managed care programs, including the services covered, the providers who participate in the plan, their rights to enroll and dis-enroll, to receive notices of adverse actions, to file grievances and to obtain an impartial hearing.

Bill Language

Upon enrollment, managed care organizations must make the following information available to beneficiaries:

- *Identity, location, qualifications, and availability of participating providers;*
- *Enrollee rights and responsibilities;*
- *Grievance and appeal procedures; and*
- *Covered items and services*

Managed Care Plan Transparency in Coverage Determinations, Payment Practices, and Provider-Specific Utilization Management

Nursing facility providers have experienced payment issues since the inception of the MI Health Link pilot program, and those same issues have persisted for MA beneficiaries as MA plans proliferate across the state. While HCAM, individual providers, and beneficiaries are able to share the challenges of navigating managed care, data can offer empirical evidence of the delays, inconsistencies, and financial strain that managed care plans can impose on providers and their residents.

Solution: Require reporting on coverage determinations, payment practices, and utilization by MCOs to the Michigan Department of Health and Human Services and the Michigan Legislature to ensure managed care programs are implemented in an efficient, fair, and timely manner.

Bill Language

(a) Reporting Requirements for Managed Care Organizations

*Beginning no later than January 1, 2026 each managed care organization shall submit to the state agency, quarterly data on the following, **disaggregated by provider type** (including but not limited to hospitals, physicians, skilled nursing facilities, home health agencies, hospices, and durable medical equipment suppliers):*

1. ***Prior Authorization Activity***

(A) Total number of prior authorization requests received

(B) Number of requests approved

(C) Number of requests denied

(D) Number of denied requests that were appealed

(E) Outcome of appealed decisions, including the number reversed in whole or in part

2. Concurrent Review Activity

(A) Total number of concurrent review requests received

(B) Frequency of concurrent review requests by service type and provider type

(C) Number of concurrent review requests approved in full

(D) Number of concurrent review requests denied in whole or in part

(E) Number of denied requests that were appealed by the enrollee or provider

(F) Outcome of appealed decisions, including the number of denials reversed in full, in part or upheld

3. Post-Service Payment Activity

(A) Number of claims denied after services were rendered

(B) Number of such denials that involved services previously authorized or approved

(C) Number and outcome of provider or enrollee appeals related to post-service denials

4. Timeliness and Delay Metrics

(A) Average and median time to decision for initial prior authorization requests

(B) Number and percentage of delayed authorizations that exceeded CMS timeliness standards

*All metrics under this subsection shall be **reported separately for each provider type** in a manner enabling comparative analysis across provider categories.*

(b) Public Availability of Data

The state agency shall make the data submitted under subsection (a) available to the public on the MDHHS website in a format that:

(A) Enables beneficiaries and providers to compare plans by prior authorization and denial metrics

*(B) Disaggregates data by **provider type**, **service category**, and **geographic region** where feasible*

(C) Protects personally identifiable information and proprietary trade secrets

(D) Is searchable, downloadable, and updated at least quarterly

(c) Consumer-Friendly Summary

The state agency shall develop and publish a consumer-facing summary for each managed care plan that includes:

(1) Overall denial rate for prior authorization requests

(2) Percentage of denials overturned on appeal

(3) Percentage of post-service payment denials

(4) Timeliness of decisions

(5) Any relevant compliance actions or corrective action plans imposed on the plan by CMS relating to utilization management practices

*(6) Clear indicators showing how the plan performs **across different provider types***

(d) Definitions

For purposes of this section:

(1) ***"Prior authorization"** means any requirement imposed by a managed care plan for approval of coverage before a service or item is furnished to a beneficiary.*

(2) ***"Concurrent review"** means a utilization management process conducted by a Managed Care Organization or any of its delegated entities during the course of an enrollee's ongoing receipt of healthcare services, for the purpose of determining the continued medical necessity, appropriateness, or level of care of such services in real time or near real time.*

(3) ***"Payment denial"** means a refusal to pay, in whole or in part, for services rendered by a provider, regardless of prior authorization status.*

(4) ***"Provider type"** means the category of provider furnishing services, as defined by CMS, including hospitals, skilled nursing facilities, home health agencies, hospice providers, physicians, and other entities.*

(5) ***"Appeal"** includes all levels of reconsideration or review initiated by the beneficiary or provider, including external review entities.*

HCAM is a statewide trade association representing proprietary, not for profit, county medical and hospital-based long-term skilled nursing and rehabilitation facilities, and licensed and unlicensed assisted living communities.