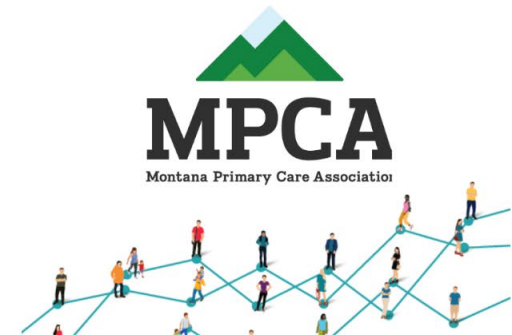
Cover Montana Monthly Webinar
Health Insurance Appeals
May 11, 2022



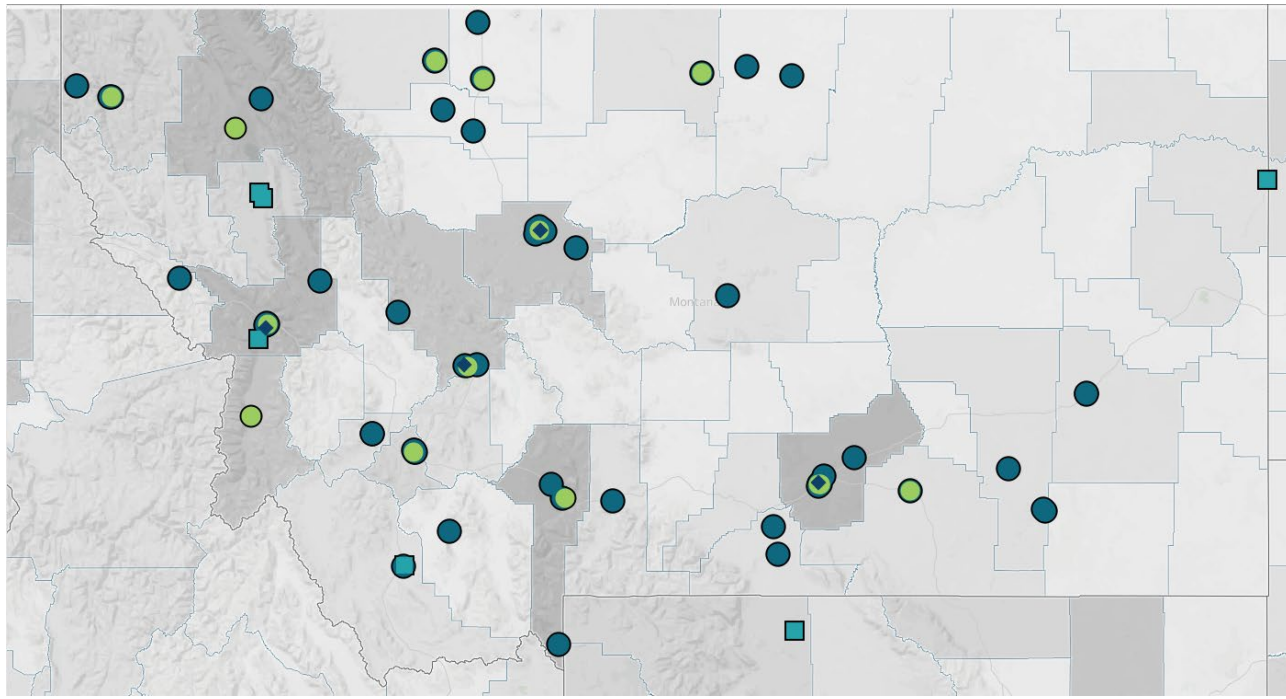
MPCA & Cover Montana

The **Mission** of the Montana Primary Care Association is to promote integrated primary healthcare to achieve health and well-being for Montana's most vulnerable populations.

The **Vision** of MPCA is health equity for all Montanans.

The Montana Primary Care Association supports Montana's 14 Community Health Centers and four Urban Indian Health Centers. MPCA's members serve ~125,000 patients across Montana.

Cover Montana is MPCA's program focused on connecting Montanans to health insurance coverage options.



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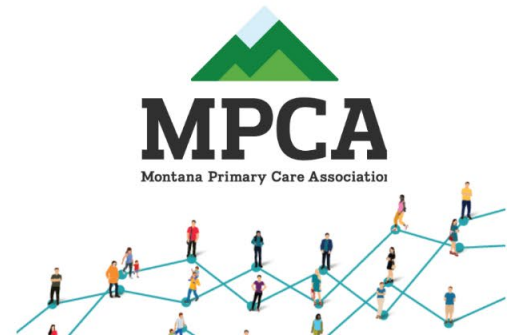
Agenda

Welcome

Brief Updates:

- Updates about the end of the federal Public Health Emergency and what assisters can do right now
- New Cover Montana branding, website, etc.
- Fix to the Family Glitch

The Health Insurance Appeals Process - Christina Goe, JD



Covered by Montana Medicaid?

Take these 4 steps to stay covered:

1. Update you contact info with the Office of Public Assistance.
2. Open your notices!
3. Provide any required info
4. If you lose coverage, reach out to Cover Montana for help!

Need help?
Call the Cover Montana Help Line
(844) 682-6837

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Medicaid/HMK Redeterminations by County

Residence County	Medicaid Population	Total Population	Percentage of Total Population
GLACIER	7816	13778	56.73%
ROOSEVELT	6005	10794	55.63%
BIG HORN	7061	13124	53.80%
ROSEBUD	3606	8329	43.29%
PONDERA	2491	5898	42.23%
HILL	6861	16309	42.07%
GOLDEN VALLEY	327	823	39.73%
BLAINE	2743	7044	38.94%
WHEATLAND	774	2069	37.41%
MINERAL	1654	4535	36.47%
LAKE	11201	31134	35.98%
LINCOLN	6788	19677	34.50%
PHILLIPS	1423	4217	33.74%
MEAGHER	633	1927	32.85%
SANDERS	3999	12400	32.25%
LIBERTY	619	1959	31.60%
MUSSELSHELL	1462	4730	30.91%
SILVER BOW	10729	35133	30.54%

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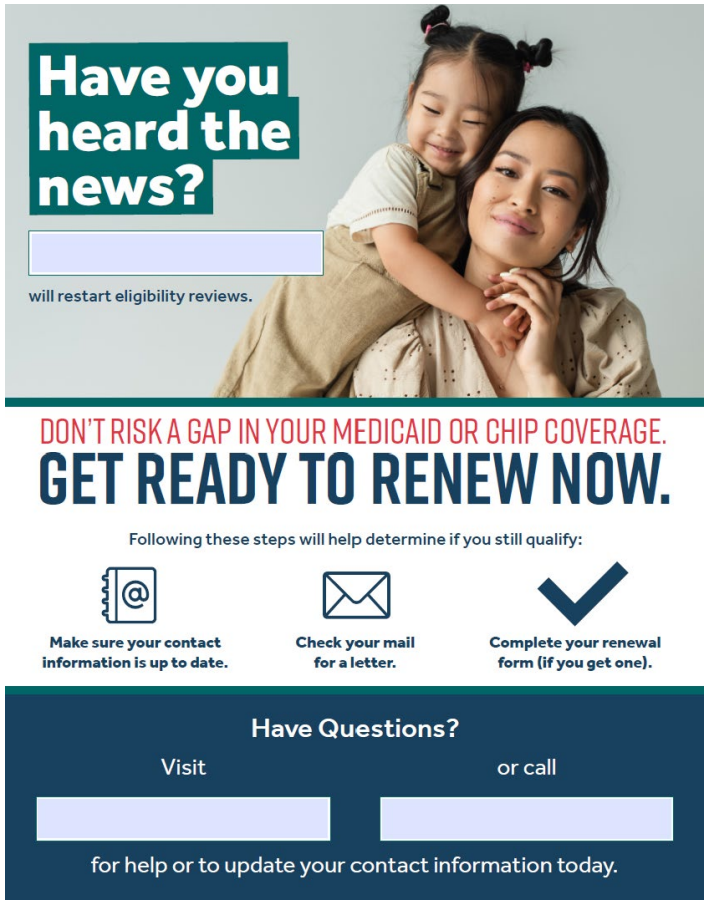
MPCA Partnership w/DPHHS

Cover MT info included in DPHHS notices

Cover MT buckslip/mailer sent to those losing coverage

Cover Montana is creating a communication toolkit:

- Tiered messaging
- Sample social
- Printed materials: posters, postcards
- Printable (customizable) one-pager
- Paid & earned media (looking for local folks to speak to local media)



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How to update contact info:

Portal at appy.mt.gov

NEW simple form!
https://bit.ly/DPHHSform

Call the Montana Public Assistance Help Line: (888) 706-1535

Stop by your local Office of Public Assistance

By mail: PO Box 202925, Helena, MT, 59620 or by fax: 1-877-418-4533.

Changes are coming to Medicaid!
Update your contact info with the Montana Office of Public Assistance.

Easy.
Fast.
Free.

Questions?
Call the Cover Montana Help Line
(844) 682-6837

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Medicaid Change of Address Form

Have you moved in the past three years? Has your address or contact information changed? Please make sure Medicaid/Healthy Montana Kids has your current mobile phone number, email, and mailing address so our records are up to date. It's important to make sure we can reach you with information about changes to your Medicaid/Healthy Montana Kids health insurance.

Update your contact information using the form below. You can also call us at 1-888-706-1535, or create an online account to update your information. Creating an online account will also allow you to get notices right away, renew your benefits online and report changes. Go to apply.mt.gov to create your account.

Last Name *

First Name *

Date of Birth *

MM-DD-YYYY

Case Number

Please list all all additional household members

Last Name

First Name

+ Add another household member

Old Mailing Address *

Address Line 1

Address Line 2

City

Zip

Old Phone Number

(999) 999-9999

New Mailing Address *

Address Line 1

Address Line 2

City

Zip

New Phone Number

(999) 999-9999

Email Address

email@example.com

Save and Exit

Submit

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Communications toolkit, coming soon!

COVER MONTANA

CONNECTING YOU TO HEALTH INSURANCE COVERAGE

Medicaid & HMK Continuous Coverage Unwinding: Communications Toolkit

Overview

What is the Public Health Emergency and how does it impact Montana Medicaid? During the COVID-19 public health emergency, Montana Medicaid wasn't processing redeterminations. Throughout the pandemic, individuals on Medicaid and Healthy Montana Kids didn't have to worry about providing updated information to DPHHS in order to keep their health care coverage.

Now that the pandemic emergency is ending, they are starting to process redeterminations. This is often referred to as the "end of the Public Health Emergency (PHE)" or the "PHE unwind." The Montana Office of Public Assistance will soon be reaching out to Medicaid and Healthy Montana Kids enrollees, but they need up-to-date addresses in order to reach people! There are currently more than 270,000 Montanans who are covered by Montana Medicaid and Healthy Montana kids and all of them will be redetermined over the next 12 months.

What do people need to do? Starting now, everyone who gets their health insurance through Montana Medicaid or Health Montana Kids should update their contact information and make sure to open their mail or they risk losing coverage. For those Medicaid enrollees who lose coverage, there may be affordable insurance options on the Health Insurance Marketplace.

When is the timeline? The redetermination process will begin in June 2022, but will happen over a number of months. Not all Montanans will be redetermined at the same time and communication and reminders must happen continuously throughout the redetermination period.

Who can help if my patients, or clients have questions? In addition to local Office of Public Assistance and the Montana Public Assistance Help Line, Cover Montana is a resource for Montanans who need help making sense of changes. Cover Montana is a project of the Montana Primary Care Association and connects Montanans to health insurance coverage. Cover Montana provides free, confidential enrollment help with Medicaid, Healthy Montana Kids, and the Health Insurance Marketplace. Cover Montana provides virtual, phone, and in-person enrollment help. Call our toll-free help line at **(844) 682-6837 or** find local in-person enrollment help at www.covermt.org/help.

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Cover Montana Rebrand

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HEALTH INSURANCE APPEALS

Christina Lechner Goe, J.D.

May 11, 2022

History of Health Coverage Appeal Rights

- Before the Affordable Care Act (ACA) was passed in 2010, some states had an internal appeal process and many had an independent review process for disputed claims, but those protections varied from state to state.
- ERISA required employer group health plans to have an internal appeal process.
- Montana had an independent review process, but it was clunky and administered by the DPHHS.
- In 2010, the ACA required all states to conform to the NAIC model law for grievance procedures and external review. If a state did not adopt that model, federal law would preempt any existing state law.

History, cont.

- In 2015, the Montana legislature finally adopted a law that conformed to the NAIC model and was approved by CMS.
- Mont. Code Ann., Title 33, Chapter 32 (2016) covers utilization review, internal appeals and external review of health insurance claims.
- This law brought the state into compliance with the minimum federal standards of the ACA.
- Federal law preemption was lifted.

Overview of the Claim Review and Appeal Process

UTILIZATION REVIEW

- The initial claim review process, which includes prior authorization for certain services.

INTERNAL APPEALS

- The Affordable Care Act and Montana law ensures a consumer's right to appeal health insurance plan decisions—to ask a plan to reconsider a decision to deny payment for a claim, deny eligibility for coverage or to rescind coverage—an "adverse benefit determination."

EXTERNAL REVIEW

- If a plan upholds its initial decision, consumers may be eligible for a review of this decision by an independent third-party reviewer for certain kinds of claim denials.
- APPLIES TO: Fully insured individual and employer group health plans, AND "self-funded" private and public employer health plans.

Types of Appeals in each Step of the Process

- Pre-Service (prior-authorization or prospective);
- Post-service (retrospective);
- Concurrent review—during a previously approved course of treatment or in-patient stay;
- Expedited (urgent care request)—decision required as soon as possible because a delay could seriously jeopardize the life or health of the covered person or his/her ability to regain maximum function;
- ***Experimental/investigational.***

*****Do not confuse consumer appeals with provider appeals***

Initial Claim Determination--**Utilization Review** Defined

The formal techniques used to evaluate the clinical necessity, appropriateness, efficacy of health care services, procedures or settings—includes prospective, concurrent and retrospective review.

If the initial claim determination results in a denial of claim payment, also known as an adverse benefit determination, the appeal process is triggered.

ADVERSE BENEFIT DETERMINATION--DEFINED

- A determination by a health plan or its designated utilization review organization that denies, reduces, or terminates a requested benefit in whole or in part because it does not meet the health insurance issuer's requirement for medical necessity, appropriateness, health care setting, level of care, or level of effectiveness or is determined to be experimental or investigational. Includes:
  - Determinations of eligibility for coverage and whether a health care service is a covered benefit under the plan/insurance contract;
  - Prospective (prior authorization), concurrent or retrospective review; and
  - Rescission of coverage (retroactive cancelation of the coverage back to the date of issue).

Timeline for required notices of Initial Claim Determination

- Prospective—within 7 business days from date of request OR not later than 7 business days after the plans receives all necessary information to make the determination.
- Retrospective--No later than 30 days after receiving the request—may be extended.
- Concurrent--Sufficient time to allow the covered person time to appeal and receive a determination before terminating previously approved course of treatment.
- Expedited—24 – 48 hours, depending on circumstances; can be extended is sufficient information not provided.

Content requirements for Adverse Benefit Determination Notices

Health Plans must justify and notify in a culturally and linguistically appropriate manner and :

1. Describe reason(s) including specific plan provisions, rationale for denial and explanation for scientific judgment;
2. Describe any additional information needed to improve or complete the claim;
3. Provide sufficient information to identify the claim; including, upon request, the diagnosis code;
4. Notify of internal and external review rights;
5. Provide information about where consumer assistance is available; in Montana, the Office of the Commissioner of Securities and Insurance (CSI).

Grievance Procedures

Internal Appeals

INTERNAL APPEALS—(grievance procedures)

The covered person has **180 days** from the date of receipt of an adverse benefit determination to file a grievance with the health plan.

- The plan must have an established internal review process that is independent and impartial.
- A health care professional with appropriate expertise must review the grievance.
- Some group health plans may have TWO levels of internal appeal—if it does, both levels must be exhausted before external review is available.

INTERNAL APPEALS, cont.

- Covered person must be given an opportunity to see and respond to any evidence/ rationale under consideration.
- Concurrent care (ongoing course of treatment): the plan must provide an opportunity to appeal or review BEFORE reducing or terminating the care.
- Covered person may have a right to expedited review when the standard timeframe would seriously jeopardize claimant's life or health or ability to regain maximum function.
  - May be filed orally and decision received orally.
  - Expedited external review may be initiated at the same time as expedited internal appeal.

Internal Appeals Timeline for Health Plan Response

- Pre-service(prior authorization): 30 calendar days;
- Post-service: 60 calendar days;
- Urgent care: maximum 72 hours (or less, depending on medical urgency of case.)

INTERNAL APPEAL NOTICE OF DECISION

The decision must be calculated to be understood by the covered person and include:

- Credentials of the persons reviewing the appeal.
- The contract basis or medical rationale in sufficient detail, including all specific reasons and reference to the documentation or evidence used as a basis for the decision.
- Notice that the covered person is entitled to receive free copies of all documents and records relied upon.
- Notice of the right to external review and where to obtain help with that. (CSI)

Health Plan Accountability—Internal Appeals

- Health insurance issuers must maintain a written records that document grievances/internal appeals during the calendar year and make those records available to covered persons, the commissioner and appropriate federal agencies.
- Issuers must keep a record of all grievances/ internal appeals and documentation regarding the outcome.

External review

Review by a third- party Independent Review Organization (an IRO)

External Review of Claim Denial After Internal Appeal

- External review must be done by an “independent review organization” [IRO].
- IROs must be chosen by the health plan using a random selection process that is fair and impartial.
  - Must be chosen from a list of approved IRO’s established by the commissioner.
- External review decisions are binding on both the health plan and the claimant (except under certain circumstances).

Timeline for External Review

- In most cases, internal appeal options must be exhausted first.
- Request for external review must be made within four months following internal appeal decision.
- Strict timelines for response vary for “standard,” “expedited,” or “experimental or investigational treatment” claims.

External Review is only available for certain kinds of claim denials

Any denial that involves medical judgment where you or your provider may disagree with the health plan, including: medical necessity, appropriateness, health care setting, level of care, or effectiveness.

Any denial that involves a determination that a treatment is experimental or investigational.

Cancellation of coverage based on your insurer’s claim that you gave false or incomplete information when you applied for coverage (rescission).

External Review is NOT available for:

Determinations that involve only contractual or legal interpretation and DO NOT involve medical judgment.

Determinations related to eligibility for coverage under the terms of a group health plan.

Experimental and Investigational Treatment

Every health plan excludes coverage for experimental/investigational treatment—but that is not always the end of the story.

These types of denials are appealable and are eligible for external review because there are so many gray areas. Medical experts will disagree.

These appeals often involve life or death situations, and therefore are often the most important appeals.

This area of the law is complicated and will require medical expertise and often legal advice.

Timeline for response from an IRO

Standard external reviews are decided as soon as possible, but no later than 45 days after the request was received.

Expedited external reviews are decided as soon as possible, but no later than 72 hours after the request was received, depending on the medical urgency of the case.

How IROs are chosen

- Health plans must contract with IROs from the approved list and rotate external review assignments among them.
  - Must choose from a list of accredited IROs approved by the CSI, but also chose one with appropriate expertise.
- The plan must not provide financial incentives to IROs based on the likelihood that the IRO will support the denial of benefits.

A health plan that fails to follow the law or fails to supply all necessary documentation is subject to consequences.

If the health plan fails to comply with all the requirements of the internal appeals process, the internal appeal may be deemed exhausted and the appeal may go straight to external review.

- The violation must be more than “de minimis.”

During the external review process, if the health plan fails to supply in a timely manner the necessary documentation or records that are required by the IRO, the IRO may decide to reverse the adverse benefit determination and find in favor of the covered person.

Health Plan Accountability—External Review

- Issuers must submit to the commissioner at least annually by March 1, a report that includes in the aggregate by state and by health plan, the number of requests for external review;
  - Including the number of requests determined eligible for external review;
- The number of external review requests resolved;
  - Including the number upholding the adverse determination and the number reversing the adverse determination;
- The average length of time for resolution;
- A summary of the types of cases for which external review was sought; and
- The number of external reviews terminated as the result of reconsideration by the issuer after receipt of additional information.

IRO Accountability

- Each IRO shall maintain written records by state and by health insurance issuer and submit to the Commissioner at least annually on March 1 a report that includes:
  - Total number of requests for external review;
  - The total number upholding the adverse determination and the total number reversing the adverse determination;
  - The average length of time for resolution;
  - A summary of the types of cases for which external review was sought; and
  - The number of reviews terminated as a result of reconsideration by the issuer after receiving additional information from the covered individual.

Appeal rights under the No Surprises Act

- The NSA added appeal rights for claim disputes involving consumer rights guaranteed under the No Surprises Act.
- Disputes over coverage of surprise medical bills are eligible for both internal appeal and external review starting in 2022.

Shortcomings of the Law as it Functions Today

- In Montana and under federal law (self-funded plans), the health plan chooses and pays the IRO, which opens the door for a conflict of interest.
  - In many states, the commissioner assigns the IRO.
- Studies show that plans uphold most adverse benefit determinations that are internally appealed.
- By contrast, denials that are externally reviewed tend to be overturned.
  - A study in Maryland shows a 64 % reversal rate.
- Federal data shows that fewer than 1 % of claim denials are based on medical necessity, so very few claim denials are eligible for external review.
- The health plan decides whether a denied internal appeal is eligible for external review;
  - Although in Montana, that decision can be appealed to the Commissioner.

Shortcomings, cont.

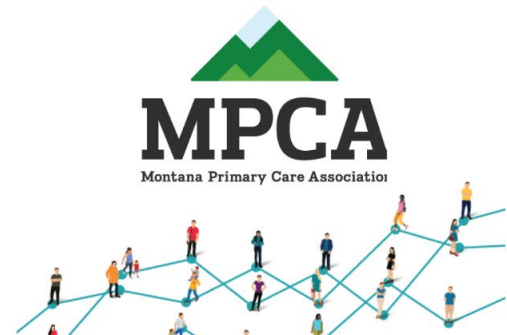
- The federal government does not require self-funded plans or IROs to report on the number or outcomes of external reviews requested, which is a significant issue for data transparency.
  - Fortunately, Montana law does require recordkeeping from health insurers, which may be available upon request.
- EOBs often contain insufficient information to enable complete understanding of the reason for a claim denial.
  - Specific diagnosis codes and their meanings are available—but only upon request. One study found that 14 % of all claim denials are based on coding errors.
- Low rates of health insurance literacy means that most consumers don't understand their appeal rights.
- Consumers appeal less than two tenths of one percent of denied claims internally to their health plan—and less than 3 % of denied internal appeals go to external review.

BOTTOM LINE

- Most consumers need help navigating appeals.
- Assisters can learn the basics about appeals and help consumers understand their rights.
- The Commissioner’s office is available to provide more in-depth assistance.
- Health care providers can also help and often their assistance is required in order to achieve a successful outcome.

Next steps

June Cover Montana Webinar:
Understanding Behavioral Health Access and Coverage
June 9, 2022, 11am



Thank you for joining us!

Slides and a recording will be posted to
the MPCA website very soon!