HEALTH SYSTEMS DIVISION

Kate Brown, Governor

Oregon Health Authority

500 Summer Street NE
Salem, OR 97301
Voice: 503-945-5763
Fax: 503-378-8467
www.oregon.gov/OHA/

Memorandum

To: Coordinated Care Organizations (CCOs) and Dental Care Organizations (DCOs)

From: Dana Hittle, Interim Medicaid Director
Dave Inbody, CCO Operations Manager
Veronica Guerra, Quality Assurance and CCO Contract Oversight Manager

Date: August 9, 2021

Subject: Notice of Adverse Benefit Determination Notice Requirements

---

This memo is to clarify the long-standing Medicaid and Children's Health Insurance Program Managed Care regulation requirement to issue written notices for full or partial denial of a payment for service and to formally rescind any prior guidance from OHA to the contrary.

Background

In 2015, OHA issued incorrect guidance to managed care entities (MCE) exempting them from the federal Medicaid requirement to issue members a written notice for claims denied for payment of service. In a March 23, 2010, Centers for Medicare and Medicaid Services (CMS) federal report following a 2009 CMS On-Site Review, OHA Division of Medicaid Assistance Programs (DMAP) was placed on a Corrective Action Plan which included appeal and grievance system findings, including the failure of MCEs to issue notices of adverse benefit determination, previously referred to as a Notice of Action. In the CMS Corrective Action Plan for DMAP, CMS indicated MCEs should issue notices to members that did not previously receive their appeal rights upon denial of the service or payment. In May 2010, OHA DMAP management issued a letter to a non-compliant MCE requesting that the MCE mail letters to those members that did not previously receive a notice of adverse benefit determination.

In 2017 and 2018, CCOs and OHA engaged in further discussions about claim denial notice requirements. During those discussions, OHA reiterated its 2015 guidance stating MCEs did not have to send members written denial notices for full or partial denial of a payment for service.

Between January to March 2020, the OHA Quality Assurance and CCO Contract Oversight Unit (QA Unit) reviewed and approved CCOs' Appeal and Grievance member notice templates. At that time, the QA Unit reminded CCOs of the requirement to send out claim denial notices to members.

In March 2021, the QA Unit convened a CCO and DCO workgroup to revise the member notice templates for service denials, claim denials, and appeal resolutions. During workgroup meetings, the QA Unit reiterated the federal Medicaid requirement to issue members a written notice for full or partial denial of a payment for a service. The CCOs and DCOs raised concerns about the administrative burden imposed by the federal requirement and stated OHA previously agreed not to require CCOs to send claim denial notices to members. The QA Unit reinforced the federal requirement and stated any prior guidance should be considered rescinded because it was non-compliant with federal Medicaid regulations.

CMS Requirements

Since 2002, the Medicaid and Children's Health Insurance Program Managed Care regulations require MCEs to provide enrollees timely written notice of an adverse benefit determination. An adverse benefit determination may include but is not limited to the following: a denial or limited authorization of a requested service; reduction, suspension, or termination of a previously authorized service; and a full or partial denial of a payment for service.

On June 14, 2002, CMS clarified that a denial for payment of a service would always trigger a notice of adverse benefit determination irrespective of whether the member is held financially liable or not for a claim. In the Medicaid Managed Care preamble, CMS states a notice should be triggered when a claim has been denied for payment to ensure the member is made aware of his or her appeal rights in case the member is billed by a third party. CMS disagreed with the premise that notice rights are triggered only when a beneficiary is actually held liable for a particular claim.

Effective December 13, 2020, CMS finalized amendments to the Medicaid Managed Care regulations that revised the definition of an adverse benefit determination to exclude claims that do not meet the definition of a 'clean claim' at § 447.45(b), which are primarily denied for purely administrative reasons (such as missing the National Provider Identifier or being a duplicate claim). Claims denied for administrative reasons no longer require managed care plans to issue a written notice of adverse benefit determination.

In the December 2020 preamble, CMS clarifies "claim denial notices are an important beneficiary protection as they may be the only notification an enrollee receives alerting them that a claim has been submitted on their behalf. If the enrollee then begins to receive bills from the provider, they are already aware of the situation and have the information needed to appeal or obtain information from the managed care plan about their cost sharing rights and responsibilities. Further, the provision of these notices when there is a denial of coverage (or payment), is consistent with the principle that enrollees are entitled to be active participants in their health care; without a full understanding of what is covered, enrollees are not able to make knowledgeable decisions about their health care coverage and their use of health care."

The preamble declined to expand on the reasons that a claim may be rejected as not a "clean claim" because "[t]he potential number of reasons for denying a claim because it does not meet the definition of clean claim is unlimited and any attempt to create an exhaustive list of examples would likely cause ambiguity and confusion." In CMS's view, "[t]he obligation to determine if a claim meets the definition in §447.45(b), that is, is a claim that can be processed without obtaining additional information from the provider of the service or from a third party rests with the managed care plan and must be determined for each claim, regardless of whether notices were required for previously submitted claims."

Current OHA Guidance

OHA fully acknowledges that the federal requirement to provide enrollees timely written notice of a post-service adverse benefit determination cannot be waived and formally rescinds any previous guidance, oral or written, issued to that effect. MCEs must issue members a written notice for claims denied for payment of service. Non-compliance with this requirement presents a risk to members, MCEs, and OHA.

The QA Unit will ensure MCEs have revised their Appeal and Grievance Policies and Procedures (P&Ps) to reflect the final changes to the Medicaid Managed Care regulations, effective on December 13, 2020. State regulations were updated on July 1, 2021 to reflect the updates to federal Managed Care regulations defining a "clean claim" and clarifying the claim denial notice requirement applicability to "clean claims."

MCEs that have not sent the required notices at any point since OHA first issued the erroneous guidance in 2015 must take steps to identify the number of notices not issued to members upon denial of the service or payment. OHA will obtain this information from MCEs to report to CMS. Failure to do so could result in action as set forth in Exhibit B, Part 9 of the CCO and DCO contracts.