Children's Alliance

Kentucky's voice for at-risk children and families

Building a Better System:

Transparency and Efficiency in MCO Audits and Appeals

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Providers *Need* Relief, This Bill Delivers It:

In the 2025 session, Rep. Kim Moser introduced HB 787 to reduce administrative burdens on healthcare providers. This bill would establish clear, standardized rules for how MCOs process audits & appeals so time can be spent on treatment services rather than paperwork.

The Facts:

What You Need to Know About MCO Audits and Appeals

- MCOs can *and* have denied claims for any reason, even invalid ones.
- MCOs can *and* have recouped payments arbitrarily, sometimes before an appeal is even processed.
- Audits are vague, excessive, and demand too much too fast.
- Providers sometimes can't obtain clear guidance or answers from MCOs.
- Appeals are unclear and confusing, with missing contact info.
- MCOs can delay appeals indefinitely with no consequences.
- MCOs can audit providers and never share the results of the audit with providers.

The Human Impact

How the Current Process Is Hurting Providers and Families across the Commonwealth

- **"We faced 24 major audits in one year."** Each audit demanded up to 18 months of documentation, often with just 8 to 15 days to respond. The volume and pace were overwhelming for our staff.
- **"We had 20 separate requests from the same MCO for 663 charts within 3 days."** Some of the requests covered 18 months of documentation and we were only given a few days to respond.
- **"$21,000 Recouped Without Notice."** We sent records in response to an audit in May 2024 but never received findings. A year later, $21,000 was recouped without warning—because the recoupment email was sent to a former employee.
- **"We were penalized for not responding to a fax we never got."** An MCO put us on a 10-month pre-payment audit after missed requests went to an unused fax line. Hundreds of claims were delayed, and we faced serious cash flow issues.
- **"$39,000 Lost, No Response After Appeal"** We submitted audit records and later spent $700 to mail 7 boxes for an appeal after a surprise $39,000 recoupment. We never got a denial or update, just silence until we followed up months later.
- **"Audit Sent to the Wrong Agency"** We were told we missed an audit request, but it had been mistakenly sent to another provider **with** our client's information. The MCO eventually completed the audit, and we've still heard nothing back.

- In August 2024, **9 agencies reported 53 requests were made for records for 1,744 clients,** most within a week's time, and none of them have heard back from the MCO about the results.

MCO Started Recouping a Staggering $88,000 Before We Could Appeal

- January 23, 2025

  Provider received an overpayment notice dated 1/11/25 and postmarked 1/15/25. The letter set a proposed overpayment/recoupment refund date of 2/10/25. The document included 376 pages with at least 2 claims on each page. The provider did not know what the overpayment reason meant.

- February 3, 2025

  After trying to understand the overpayment reason and reviewing over 700 claims, the provider called the number listed in the letter to dispute the recoupment. Provider was advised to email an MCO representative the appeal. Provider emailed the appeal and received an automatic reply indicating the representative was on maternity leave.

- February 4, 2025

  MCO's Network Manager replied to a Feb 3 email from the provider. A claims report was shared, and a meeting was requested.

- February 11, 2025

  Despite the letter **allowing the provider 30 days from the time of receipt of the letter** to appeal and appeals emails sent on 2/3/25, and request for meetings were made, claims were recouped beginning 2/11/25.

- March 3-4, 2025

  Provider confirmed a meeting for Mar 4. MCO explained why the recoupment was occurring. Meeting notes, CPT guidance, and claims data were shared. **Recoupment had already started 2-11-25.** Provider was still allowed to appeal.

Provisions in the MCO Audits and Appeals bill would:

- ✓ Require Medicaid Managed Care Organizations (MCOs) to include contact information for their provider relations and contract representatives on their website.
- ✓ Require MCOs to include their internal appeals process and process for requesting an external independent third-party review on their website.
- ✓ Allow providers to file an appeal related to the reduction or denial of the claim within 120 days of the confirmed receipt of a notification from the MCO.
- ✓ Establish a penalty or fine for not meeting the 30-day timeframe for the disposition of an appeal.
- ✓ Provide clear instructions on how to file an appeal and pay providers within 30 days after a favorable appeal determination including 12% interest and, if applicable, attorney's fee.
- ✓ Provide written notification to providers to include the date, purpose, number of records requested, and the time frame of the audit, additionally, the number of days the provider must submit the requested records and contact information for the audit.
- ✓ Require the MCO to use a valid sampling methodology to determine the number of records that may be audited.

Provisions in the MCO Audits and Appeals bill would:

- ✓ Require MCOs to give providers at least 30 days to provide records for an audit and grant additional time if needed.
- ✓ Establish that audited records shall not exceed two years from the date of the claim.
- ✓ Require audits to be completed and notice of the audit findings be given to the providers within 180 calendar days.
- ✓ Ensure when an audit identifies clerical or record keeping errors, the provider is given 30 days to correct the error without recoupment.
- ✓ Ensure MCOs cannot recoup disputed funds until after the appeal process is completed and if they do recoup funds prior to the final disposition of an appeal they are fined.

- ✓ Ensure recoupment of funds are structured in such a way as to not cause a substantial reduction in the cash flow of the provider.
- ✓ Add to the monthly report to the department, the dollar amount of the denials being appealed and a list of provider's names and information, if the appeal is not resolved within 60 days.
- ✓ Require the department to provide an annual report to LRC detailing the number of appeals and dollar amount associated with those appeals, as well as the number of appeals and grievances not resolved in 60 days.

Thank you. For additional information:

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