

# Mental Health Service Utilization Review Patterns in a Medicaid Managed Care Program

Thomas E. Smith, MD; Maria Pangilinan, PhD, MS; Ian Rodgers, MPH; Xian Li, PhD; Genevieve Claverie, BA; and Joe Katagiri, DrPH, MPA

**P**rior authorization and concurrent review (hereafter referred to as utilization review [UR]) of treatment services are hallmarks of mental health managed care. Managed care organizations (MCOs) commit substantial staff and financial resources to UR activities and claim that they promote evidence-based practices, improve clinical outcomes, and are a highly effective means of managing mental health care costs.<sup>1</sup> Critics have argued, however, that UR activities create unnecessary obstacles to care.<sup>2,3</sup> Mental health clinicians dislike these requirements because they consume substantial time and effort and can delay or interrupt treatment at critical moments, especially in inpatient settings where there is constant pressure to limit length of stay.

Despite this longstanding practice, few data exist regarding UR activities and outcomes.<sup>4</sup> Information regarding these activities is especially relevant given national efforts to enforce parity among mental health and medical benefits and management practices. This report describes the scope and outcomes of mental health UR activities over a 2-year period during which the New York State (NYS) Medicaid program transferred management of adult behavioral health services from a fee-for-service delivery system to MCOs. The NYS Medicaid oversight team required the MCOs to submit these data to support monitoring and ensure that Medicaid recipients with serious mental illnesses did not encounter unnecessary obstacles to care during this period of transition of the benefit management to MCOs.

## METHODS

Beginning in 2016, all 18 Medicaid MCOs (MMCOs) operating in NYS were required to periodically report utilization management data including counts of authorization requests and denials for all mental health services covered in the state's Medicaid benefit package. MMCOs were also required to report reasons for each denial using a predefined reasons list developed collaboratively between NYS and the MMCOs. Additional required reporting elements included the number of appeals, external reviews, and reversals of denials. The state separately collected data regarding administrative denials

## ABSTRACT

**OBJECTIVES:** The current study investigated mental health utilization review (UR) clinical service authorization requests, denials, and reasons for denial in a statewide Medicaid managed care organization (MMCO) program.

**STUDY DESIGN:** Retrospective analysis of utilization review data reported by MMCOs in New York State.

**METHODS:** Data from the utilization review practices of 15 MMCOs were collected and analyzed for calendar years 2017 and 2018. The data reported are specific to mental health services and include the number of authorization requests, number of clinical denials, and the reasons specified for each denial. Analyses were undertaken to determine the UR denial rates and most common reasons for denials.

**RESULTS:** A total of 264,901 requests for inpatient mental health service authorizations and 53,687 requests for outpatient mental health service authorizations were made in 2017 and 2018. Of these, 1.5% of inpatient authorization requests and 0.4% of outpatient authorization requests were denied for reasons related to medical necessity. The most common reason for inpatient mental health service denials was that the patient no longer met the standard for the requested level of care.

**CONCLUSIONS:** Low UR denial rates warrant further examination of the relationship between UR and both quality of care and patient outcomes in mental health care. With the substantial resources spent on UR, findings could point to areas of potential reforms to the system that may minimize these costs and improve care for patients with mental illness.

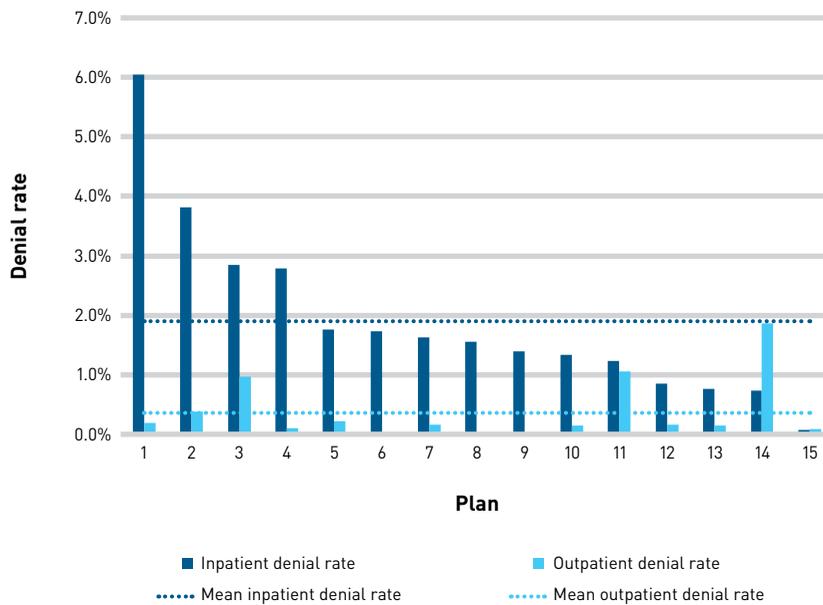
*Am J Manag Care.* 2022;28(2):81-84. doi:10.37765/ajmc.2022.88824

TAKEAWAY POINTS

Medicaid managed care organizations dedicate significant resources to the practice of utilization review for mental health services. We examined data from a large managed care system to determine clinical denial rates for inpatient and outpatient mental health services.

- ▶ More than 300,000 requests for mental health services were made during 2017-2018. Systemwide clinical denial rates for these services were less than 2%.
- ▶ Low denial rates warrant further investigation to determine their relationship with the quality of care provided to individuals with mental illness.
- ▶ Reforms to the current utilization review system based on these investigations could have positive impacts on the quality and cost of mental health care.

**FIGURE 1.** Mental Health Inpatient and Outpatient Service Authorization Denial Rates Over Combined 2-Year (2017-2018) Period for 15 Medicaid Managed Care Organizations



resulting from submitted claims not being paid for reasons unrelated to medical necessity reviews; those data are not included in this report.

NYS created a template for data reporting with detailed definitions and instructions for submission of UR data and offered a series of webinars to train MMCOs on the reporting requirements. UR data for inpatient mental health services were reported monthly whereas outpatient UR data were reported quarterly. NYS created protocols for data cleaning and review for accuracy, with MMCO resubmissions required until all data were approved. Biannual summary reports were created and reviewed by NYS MMCO oversight agencies prior to presentation and review with the MMCOs. This report summarizes UR data for mental health services in calendar years 2017 and 2018.

RESULTS

In 2017-2018, 86,422 NYS Medicaid enrollees accounted for 126,714 inpatient mental health discharges and 545,913 Medicaid enrollees accounted for 6,491,591 total mental health outpatient visits. The total NYS Medicaid enrollment during this time was 1,499,010. NYS hospital mental health inpatient providers made 264,901 requests for inpatient mental health service authorizations: 71,977 were prior authorization requests, 181,010 were for concurrent review, and 3914 were retrospective reviews. The mean MCO authorization request rate was 18.3% (range, 6.5%-39.8%). NYS outpatient mental health providers made 53,687 requests for mental health service authorizations (the MMCOs were not required to break out numbers of requests that represented prior authorization, concurrent review, or retrospective review for outpatient services). NYS MMCOs denied only 1.5% of all inpatient and 0.4% of all outpatient authorization requests.

Figure 1 shows inpatient and outpatient denial rates (all request types combined) for 15 of the 18 MMCOs for which NYS had complete data during the 2-year period. As per standard practice, NYS does not release plan-specific data; therefore, the names of the MMCOs are withheld from this report. Inpatient UR denial rates varied from 0.1% to 6.0% and outpatient UR denial rates varied from 0.0% to 1.9% across MMCOs. There does not seem to be any correspondence between an MMCO's inpatient denial rates and its respective outpatient denial rates. Data showing specific reasons for inpatient mental health concurrent review service denials, which represented 86% of all inpatient mental health denials,

are presented in Figure 2 (reasons for prior authorization and retrospective review denials are available from the authors upon request). Across prior authorization, concurrent, and retrospective reviews, the most common reason for denial was that the patient did not meet the clinical threshold for the requested level of care. For prior authorization denials and concurrent review denials, 34% and 29%, respectively, were denied for insufficient clinical information, the second most common reason for denial in these settings. The second most common retrospective denial reason, at 35%, was that the member did not meet the criteria for continuing care for the number of days the service was provided. Inpatient concurrent reviews were denied for other reasons 4.5% of the time. The 2 most common of these were (1) further acute inpatient

services are not reasonably expected to improve the member's psychiatric condition within a reasonable amount of time (n = 64; 1.8%), and (2) the patient is not making progress toward goals, or there is no expectation of progress (n = 30; 0.8%).

## DISCUSSION

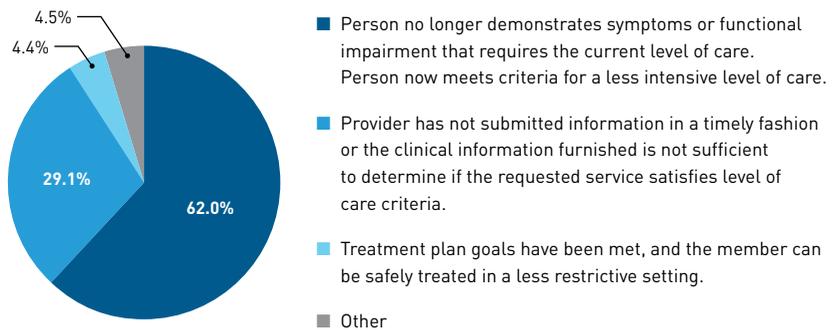
Less than 2% of inpatient and 1% of outpatient mental health authorization requests were denied by UR staff in the first 2 years of the NYS Medicaid managed care implementation for individuals with serious mental illness. These rates are lower than previously published rates, in part due to concerns expressed to the MMCOs by the NYS oversight agency that rigorous UR during implementation of the new managed care program could limit access to services for individuals with serious mental illness. Regardless, our findings indicate that NYS providers were not requesting services that MMCO UR staff would have deemed inappropriate or medically unnecessary.

The range of denial rates across MMCOs does not seem to be fully explained by plan location, enrollment, or inclination to seek authorization requests. Rather, the differences in denial rates appear to be due to individual plan behaviors. For example, plan 1, with a 6.0% inpatient denial rate, and plan 15, with a 0.1% inpatient denial rate, both operate in New York City and the rest of NYS and seek authorizations more than 20% of the time. The behavior of MMCOs operating statewide, as well as those that are more inclined to request authorizations, tends to vary more widely than that of MMCOs that operate only outside New York City or that are not frequent users of the UR process.

The variation in denial rates among MMCOs may be provider related; there may be providers who are more likely to request medically unnecessary services and who serve more individuals in a particular plan. The current report does not examine specific claims data, but rather the aggregate of provider authorization requests denied by plans based upon the plans' medical necessity determination procedures. This possibility is unable to be determined with the current data, but it could be a target of future research.

A key question is whether low UR denial rates reflect in any way the quality of care received by individuals enrolled in MMCOs. One possibility is that the low denial rates indicate that UR is highly effective as providers work collaboratively with MMCO UR staff to ensure that patients receive the appropriate intensity and duration of care. An alternative consideration is that the low denial rates reflect providers' reluctance to request services that they feel are medically indicated due to their belief that MMCO UR staff will deny the request. The second most common reason for denials in this study was that the information furnished was not sufficient to determine whether the current level of care was justified. In many

**FIGURE 2. Mental Health Inpatient Concurrent Review Service Denial Reasons Over Combined 2-Year (2017-2018) Period for 15 Medicaid Managed Care Organizations**



cases when providers submit requests for coverage, MMCOs request more information to make coverage determinations. Rather than continue time-consuming efforts to gather further information and communicate back to the MMCO, providers may be more inclined to withdraw the request.

It is also possible that there is no relationship between UR denial rates and quality of care. When first widely implemented in the 1990s, MMCO UR practices were highly effective at identifying medically unnecessary care and were critical to efforts to reduce health care costs.<sup>5,6</sup> If UR practices have consistently succeeded in curbing unnecessary care, however, it may be that they have no current impact on quality of care or patient outcomes. The data reported herein do not allow us to identify causal relationships between UR denial rates and the quality of care, and more research is needed to better understand the impact of MMCO UR practices on key patient- and provider-level outcomes. A potential limitation of the current study is the state's reliance on MMCOs to submit quality data. Even with good reporting of the data, provider behavior in the UR process may not be totally captured. If providers do not request authorizations, for a number of reasons, those potential authorizations and denials cannot be captured in the state's data. We do not believe this to substantially affect our results. Although plans self-report their UR data, NYS has instituted procedures for checking accuracy and has often required multiple resubmissions before data are accepted. Further, informal discussions with MMCO leadership indicate accurate data submission. NYS is considering creating an audit program in the future to ensure accuracy.

Because this analysis looked at aggregated data reported by the plans to the state mental health authority, we are unable to examine patient-level data. A potential future analysis could include examining patient-level data and comparing MMCO denial rates with certain patient characteristics, as well as the likelihood of experiencing subsequent adverse outcomes following a denial.

## CONCLUSIONS

The data in this report show low UR denial rates across a statewide MMCO program. The relationship between these rates and the effectiveness of the UR system and subsequent quality of care remains to be determined. Future research should examine how rates of medical necessity denials for inpatient and outpatient mental health care affect patient- and provider-level outcomes. Because MMCOs allocate substantial resources to UR activities, these findings could inform areas of potential reform to the UR system and improvement of mental health care overall. ■

**Author Affiliations:** Division of Managed Care (MP, XL, GC, JK) and Behavioral Health Integrated Performance Measurement Center (IR), New York State Office of Mental Health (TES), New York, NY; Department of Psychiatry, Vagelos College of Medicine, Columbia University (TES), New York, NY.

**Source of Funding:** None.

**Author Disclosures:** The authors report no relationship or financial interest with any entity that would pose a conflict of interest with the subject matter of this article.

**Authorship Information:** Concept and design (TES, MP, JK); acquisition of data (MP, XL); analysis and interpretation of data (TES, MP, IR, XL, GC); drafting

of the manuscript (TES, MP, IR); critical revision of the manuscript for important intellectual content (TES, MP, IR, GC); statistical analysis (MP, XL, GC); provision of patients or study materials (GC); administrative, technical, or logistic support (TES, XL, JK); and supervision (TES, MP, JK).

**Address Correspondence to:** Ian Rodgers, MPH, New York State Psychiatric Institute, 1051 Riverside Dr, New York, NY 10032. Email: [Ian.rodgers@nyspi.columbia.edu](mailto:Ian.rodgers@nyspi.columbia.edu).

## REFERENCES

1. Beronio K, Glied S, Frank R. How the Affordable Care Act and Mental Health Parity and Addiction Equity Act greatly expand coverage of behavioral health care. *J Behav Health Serv Res*. 2014;41(4):410-428. doi:10.1007/s11414-014-9412-0
2. Lazar SG, Bendat M, Gabbard G, et al. Clinical necessity guidelines for psychotherapy, insurance medical necessity and utilization review protocols, and mental health parity. *J Psychiatr Pract*. 2018;24(3):179-193. doi:10.1097/PRA.0000000000000309
3. Murray ME, Henriques JB. A test of mental health parity: comparisons of outcomes of hospital concurrent utilization review. *J Behav Health Serv Res*. 2004;31(3):266-278. doi:10.1007/BF02287290
4. Foote SB, Virnig BA, Bockstedt L, Lomax Z. External review of health plan denials of mental health services: lessons from Minnesota. *Adm Policy Ment Health*. 2007;34(1):38-44. doi:10.1007/s10488-006-0074-y
5. Koike A, Klap R, Unützer J. Utilization management in a large managed behavioral health organization. *Psychiatr Serv*. 2000;51(5):621-626. doi:10.1176/appi.ps.51.5.621
6. Wickizer TM, Lessler D, Travis KM. Controlling inpatient psychiatric utilization through managed care. *Am J Psychiatry*. 1996;153(3):339-345. doi:10.1176/ajp.153.3.339

Visit [ajmc.com/link/88824](https://ajmc.com/link/88824) to download PDF