Texas Association of Health Plans
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June 13, 2022

Via email to MCCO_Special_Projects@hhsc.state.tx.us

Re: *Rider 36 stakeholder feedback*

To Whom it May Concern:

At its most recent State Medicaid Managed Care Advisory Committee Complaints, Appeals, and Fair Hearings Subcommittee meeting, the Texas Health and Human Services Commission (HHSC) presented an overview of Rider 36 and requested stakeholder feedback. In drafting its report, we strongly encourage HHSC to include updates on recent legislative directives designed to refine the denials and appeals process and improve member experience. We also encourage any recommendations by HHSC to be data-driven.

Rider 36 directs HHSC to conduct a study of the denial and appeals process for the STAR Kids, STAR Health, and STAR+PLUS programs. In part, Rider 36 expressly requires HHSC to include steps the agency has taken to implement external medical reviews. In addition to the recent implementation (May 2022) of medical reviews by an independent review organization, HHSC has recently executed several other initiatives, outlined below. We strongly encourage HHSC to present an overview of the status of these projects and limit any recommendations that may be premature in light of such recent implementation dates.

SB 1207 is a comprehensive Medicaid reform bill that modernizes the Texas Medicaid managed care program by reducing or eliminating unnecessary administrative burdens and red tape, strengthening patient protections, and improving care coordination. In part, SB 1207 requires HHSC to contract with an external medical review organization that has experience providing private duty nursing and long-term services and supports. Clients are able to opt-in to a review if they have been denied a service or Medicaid medical eligibility. The external review will take place after the appeal process and before a State Fair Hearing. If a client chooses the external medical review, the managed care organization (MCO) will be responsible for submitting a detailed reason for the service reduction or denial along with supporting documentation. HHSC is required to post data and statistics on the rate of reviews.

SB 1207 also made significant changes to the prior authorization process. MCOs are required to allow physicians requesting prior authorization a reasonable opportunity to discuss the request with an MCO physician who practices in the same or a similar specialty–although not necessarily the same

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subspecialty–and has experience in treating the same category of population as the recipient for whom the request is submitted. Letters sent by HHSC and MCOs to members and providers for a denial, partial denial, reduction of services, or eligibility must include a clear and easy-to-understand explanation of the reason and medical basis for the decision, applying the policy or accepted standard of medical practice to the recipient's particular medical circumstances; educational information about how to appeal and request a Fair Hearing; and a thorough and detailed clinical explanation of the reason for the decision. HHSC must also establish a reconsideration process similar to the process established under the Alberto N. settlement agreement for MCOs to reconsider an adverse determination on a prior authorization that is solely the result of the provider not submitting sufficient or adequate documentation.

To ensure the appropriateness of prior authorization requirements, under SB 1207, MCOs are required to annually review their prior authorization requirements in consultation with their provider advisory group and ensure each prior authorization is based on "accurate, up-to- date, evidence-based, and peer-reviewed clinical criteria that distinguish, as appropriate, between categories, including age, of recipients for whom prior authorization requests are submitted." HHSC will be required to periodically review MCOs for compliance with this new provision.

Finally, to promote transparency in the prior authorization process, MCOs must make prior authorization requirements and information about the prior authorization process readily accessible by posting the requirements and information on their website. This must include timelines for prior authorization decisions, a description of the notice MCOs are required to provide under the prior authorization reconsideration process, an accurate and up-to-date catalogue of coverage criteria and prior authorization requirements, and a list or description of any supporting or other documentation necessary to obtain prior authorization for a specific service.

Another piece of legislation, HB 4533, also includes prior authorization provisions and client protections. HB 4533 requires that notices sent to members regarding denials of coverage or prior authorization include a clear and easy-to-understand explanation as well as a clinical explanation of the reason for the denial. This was a dual implementation earlier this year with SB 1207.

HB 4533 also creates a new pilot program for members with intellectual or developmental disabilities within STAR+PLUS. The MCOs selected to participate in the pilot program will be required to report quarterly the level of each requested service and the authorization and utilization rates for those services, the timeliness of the authorization of each service, and the number of service denials and State Fair Hearings and the dispositions of those hearings. Because this pilot program is intended to examine improvement to service delivery, which would include the appeals and denials process, we suggest that

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any recommendations regarding appeals and denials involving the STAR+PLUS program would be more appropriately incorporated in the September 1, 2026, report to be submitted to the Legislature.

In addition to recent legislation, there are additional state regulations guiding the denials and appeals process. Within the STAR+PLUS program, Texas Government Code § 533.00251 prohibits prior authorization for a nursing facility resident in need of emergency hospital services. Within the STAR Kids managed care program and in accordance with Texas Government Code §533.00253, MCOs are instructed to enable help line staff to provide information related to service coordination and prior authorization denials. Within that same statute, HHSC is required to biannually conduct a utilization review on a sample of cases to ensure that all imposed clinical prior authorizations are based on publicly available clinical criteria and are not being used to negatively impact a member's access to care.

Texas Government Code § 533.005 includes a requirement that MCOs submit to HHSC and make publicly available a report containing specific data with respect to access to primary care, specialty care, long-term services and supports, nursing services, and therapy services on the average length of time between the date a provider requests prior authorization for the care or service and the date the organization approves or denies the request and the date the organization approves a request for prior authorization for the care or service and the date the care or service is initiated. With regard to prescription drug prior authorizations, Texas Government Code § 533.005 requires contract provisions related to the state's vendor drug program. A MCO may not implement a prior authorization on a preferred drug that is more strict than the preferred drug list and does not require a clinical, nonpreferred, or other prior authorization for any antiretroviral drug, or a step therapy or other protocol, that could restrict or delay the dispensing of the drug except to minimize fraud, waste, or abuse and does not require prior authorization for a nonpreferred antipsychotic drug prescribed to an adult recipient.

Lastly, we have some comments regarding HHSC's requested feedback from stakeholders. Texas Association of Health Plans (TAHP) managed care plan members encourage feedback from Medicaid members on obstacles that may prevent them from receiving medically necessary services in a timely manner. However, in developing its report, we suggest that individual complaints HHSC receives through this process that are not associated with a trend experienced by multiple members should be addressed through the complaints process at HHSC. Similarly, any recommendations considered by HHSC for implementation should be substantiated with data showing that there is indeed a systemic issue.

What issues have you (or the members you represent) experienced with the managed care denial and appeals process? This could be a denial of benefits such as a prior-authorization request. It might also be a reduction in services by the MCOs for which a member files an appeal or a fair hearings request.

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We are concerned the explanation for this question is misleading. The explanation seems to imply that if a member experiences a denial or reduction of services, it was made inappropriately. MCOs are prohibited from arbitrarily denying or reducing the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary. MCOs are restricted by the state to only place appropriate limits on a service on the basis of criteria applied under the state plan, such as medical necessity and for the purpose of utilization control as long as the services furnished can reasonably achieve their purpose. Medical necessity can be no more restrictive than what is used in the state's Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in state statutes and regulations, the state plan, and other state policy and procedures.

How easy or difficult is it to navigate the managed care denial and appeals process? Are the MCO's instructions easy to understand and follow?

These questions are more appropriately asked utilizing a Likert-type scale, which is effective in measuring attitudes and perceptions. Open-ended questions more commonly evoke single experience responses, which is not helpful in gauging the success of the state's managed care programs.

Separately, we ask HHSC to share specific complaint data and any trends identified as a result of this set of questions so that we may immediately begin addressing members' comments and improve their overall user experience.

When filing appeals for denial of services, how responsive are the MCOs to those requests? Are there examples of delays that caused hardship for a member that can be provided to HHSC?

Again, the first question would be more effective utilizing a Likert scale. MCOs are held to timeframes established in the Uniformed Managed Care Contract. Further, MCOs must maintain an expedited review process for service-related internal appeals when the MCO determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life or health.

Separately, for this series of questions, we again ask HHSC to share specific complaint data and any trends identified as a result so that we may immediately begin addressing members' comments and improve their overall user experience.

How successful have you (or the members you represent) been in the appeals process? Are there examples of appeals or fair hearings that resulted in a restoration of benefits that can be provided to HHSC?

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We find this question unnecessarily burdensome to members, as this data is already captured by the agency.

Thank you for providing this opportunity to engage in stakeholder feedback. Rider 36 is an important opportunity for HHSC to highlight the extensive recent improvements to the denials and appeals process for Medicaid members.

Sincerely,

Jamie Dudensing, RN
CEO
Texas Association of Health Plans