State Medicaid Managed Care Advisory Committee

Complaints, Appeals, and Fair Hearings Subcommittee
February 8, 2024

Summary

The Complaints, Appeals, and Fair Hearings Subcommittee's session provided an in-depth examination of Texas Medicaid's MCO internal appeal requirements and the process for addressing provider complaints. John Huffine from the Office of Policy, MCS, HHSC, detailed the internal appeals and External Medical Review (EMR) processes, while Esmeralda Rodriguez discussed the management of provider complaints. TAHP MCOs will be presenting their internal appeals processes at the May meeting.

Subcommittee Agenda

MCO Internal Appeal Requirements

John Huffine provided a comprehensive overview of what constitutes an adverse benefit determination. Presentation

This includes:

- Denials or limited authorizations of requested services by members or providers, touching on the type, level, medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
- Reductions, suspensions, or terminations of previously authorized services.
- Partial or full denials of payment for services.
- Failures to provide timely services as defined by the state.
- MCO's failure to act within the contractual timeframes, including those outlined in 42 C.F.R. §438.408(b).

- For rural residents with only one MCO, denials of requests to obtain services outside the network.
- Denials of requests to dispute financial liabilities, such as copayments, premiums, deductibles, coinsurance, and other financial responsibilities of the member.

Huffine then outlined the appeals process, which begins with the member receiving an adverse benefit determination notice and can progress through several stages, including filing an MCO internal appeal, receiving a decision, requesting an external medical review (EMR), and potentially filing for a state fair hearing.

The initial MCO notice packet sent to members includes:

- A letter explaining the service denial or reduction.
- A flyer detailing appeal deadlines, member rights, and resources.
- An appeal form, with options to file via phone, mail, fax, or orally.

He clarified the MCO internal appeal process for both Medicaid and CHIP:

- **For Medicaid:** It's a formal request by a member or their representative for the MCO to review its adverse benefit determination.
- **For CHIP:** The process involves the MCO or a utilization review agent reevaluating its adverse benefit determination.

The formal MCO internal appeal process is outlined in the Uniform Managed Care Contract and Manual, specifying procedures for standard and expedited appeals and the involvement of Independent Review Organizations (IROs).

Upon concluding an MCO internal appeal, members receive a decision packet containing:

- A letter from the MCO explaining its decision to either uphold or overturn the adverse benefit determination.
- A flyer outlining the processes for non-emergency and emergency EMR and state fair hearings.

- A form for requesting an EMR and/or state fair hearing, with options to submit requests via phone, mail, fax, or orally.

External Medical Review (EMR) Process

The EMR serves as an independent review of the MCO's decision related to an adverse benefit determination, focusing on the functional or medical necessity of the service in question. This review is conducted by Independent Review Organizations (IROs), which are third-party entities contracted by HHSC. The EMR process is initiated after a member has exhausted the MCO internal appeal process, requiring the member to contact the MCO to request both an EMR and a state fair hearing simultaneously. It's important to note that an EMR cannot be requested after a state fair hearing has taken place.

EMR Process Steps:

- The MCO is responsible for sending all relevant documentation used in the service denial or reduction decision to the HHSC EMR intake team.
- The IRO then has specific timeframes to render a decision:
  - Expedited EMR Request: Decision made no later than the next business day following receipt of the MCO's documentation.
  - Standard EMR Request: Decision made within ten days following receipt of the documentation.
- The IRO's decision can be:
  - Upheld: The IRO agrees entirely with the MCO's determination.
  - Partially Overturned: The IRO approves part of the service request that the MCO denied.
  - Overturned: The IRO disagrees with the MCO's decision in its entirety, approving all services that were denied or reduced.

Following the EMR, the IRO notifies the member of the decision, and the HHSC EMR intake team updates the decision in TIERS, including uploading a copy of the decision notice.

Requesting a State Fair Hearing

If the EMR decision is not fully favorable to the member, or if it upholds the MCO's internal appeal decision, the member has the right to request a state fair hearing. Upon this request:

- A hearings officer is assigned within one day.
- The member receives a notice of the hearing in the mail within ten calendar days.

State Fair Hearing Process:

- Hearings are typically held by phone, but an in-person hearing can be requested for valid reasons.
- The member has the right to access any information the MCO plans to use at the hearing, which must be sent to the member within ten calendar days after the hearing request.
- Members can submit new facts about their case to HHSC, which will be shared with the MCO before the state fair hearing.

After the State Fair Hearing:

- HHSC may agree with or modify the MCO or IRO decision but cannot reduce benefits below what was decided in the EMR.
- The final decision is mailed to the member within 90 calendar days after the hearing request was made. This notice also explains the member's right to have the case reviewed by an HHSC attorney if they disagree with the state fair hearing decision.

MCO Provider Complaints Reporting

Esmeralda Rodriguez highlighted the Research and Resolutions Team's (RRT) role in managing provider complaints against MCOs. She shared statistics for fiscal year 2024,

noting common issues like claim denials and payment disputes, and addressed challenges in handling complaints related to third-party authorizations.

Presentation

Overview of Complaints Received

From September 1, 2023, to January 11, 2024, the MCCO RRT recorded 1,164 total provider contacts/complaints for State Fiscal Year 2024. Of these, 593 have been resolved, 306 were confirmed or substantiated, and 571 remain pending. The average time to close a case is 29 days, contingent upon the RRT specialist confirming resolution with the complainant and notifying the relevant MCO. Complex cases typically demand more time for a thorough resolution.

Breakdown of Complaints by Program Type

- CHIP: 14 complaints
- Dental: 18 complaints
- DSNP: 12 complaints
- Medicare Medicaid Plan: 12 complaints
- STAR: 643 complaints, the highest among all programs
- STAR Health: 62 complaints
- STAR Kids: 81 complaints
- STAR+PLUS: 282 complaints
- Fee For Service, Medicare Advantage Plan: Not specified
- Referrals to other areas: 40 complaints

Complaint Trends

- **Denial of Claim:** The most common reason for contact, with 582 complaints. Of these, 163 were confirmed/substantiated. The majority of these complaints originated from Dallas, Hidalgo, and Harris service areas. Notably, 156 complaints led to claims being reprocessed for payment post-complaint.

- **Payment Dispute:** Received 125 contacts, with 30 confirmed/substantiated, resulting in reprocessed payments. No specific trends were identified in service areas for this category.

- **Timely Filing:** There were approximately 89 contacts related to timely filing denials, with 33 resulting in claims reprocessing.
- **Claim Recoupment:** Received about 52 contacts, with 15 resulting in reprocessed claims for payment.