Prior Auths, Complaints, Appeals & Fair Hearings Process

April 29, 2025

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Complaints, Appeals and Fair Hearings

MCOs must follow all federal and state requirements relating to Complaints, Appeals and Fair Hearings

- Many of the processes and timelines are dictated by federal law
- Detailed requirements are also outlined in the Uniform Managed Care Contract (UMCC), the Uniform Managed Care Manual (UMCM), and Texas Administrative Code
- In 2018: HHSC, the MCOs, and several provider associations held a series of Medicaid Managed Care Summits leading into the 2019 Legislative Session to identify reforms to improve the program
- Most of the reforms were adopted via SB 1207 including:
  - Establishing an external medical review process for Medicaid
  - Creating a process to allow a provider to submit additional information necessary to get a prior authorization approval
  - Improve Member and provider notices to ensure plain and easy to understand language

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Overview

- When a service is requested, the MCO performs utilization review. When utilization review is conducted before a service is rendered, it is called a **prior authorization** (PA).
- If a PA is denied, MCOs are required to give members and providers multiple opportunities to appeal that decision, including:
  - An **internal appeal process**
  - An **external medical review process** (IRO)
  - The HHSC **fair hearing process**
- For issues unrelated to service utilization (like customer service complaints) MCOs are required to provide members access to a **complaint process**

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PA, Appeals, and Fair Hearings Timeline

Prior Authorization (PA)	Internal Appeals	External Review (IRO)	Fair Hearing
3 days	30 days	10 days	90 days
When a service is requested, MCO performs utilization review (PA) within 3 days.	If a PA is denied, MCOs must provide an opportunity for the member to appeal. MCOs must make a determination within 30 days.	Members may seek review by an independent review organization (IRO). IROs must make a determination within 10 days.	Members may request a Fair Hearing from HHSC. HHSC must make a decision within 90 days.

**Timeline reflects standard review timeframes

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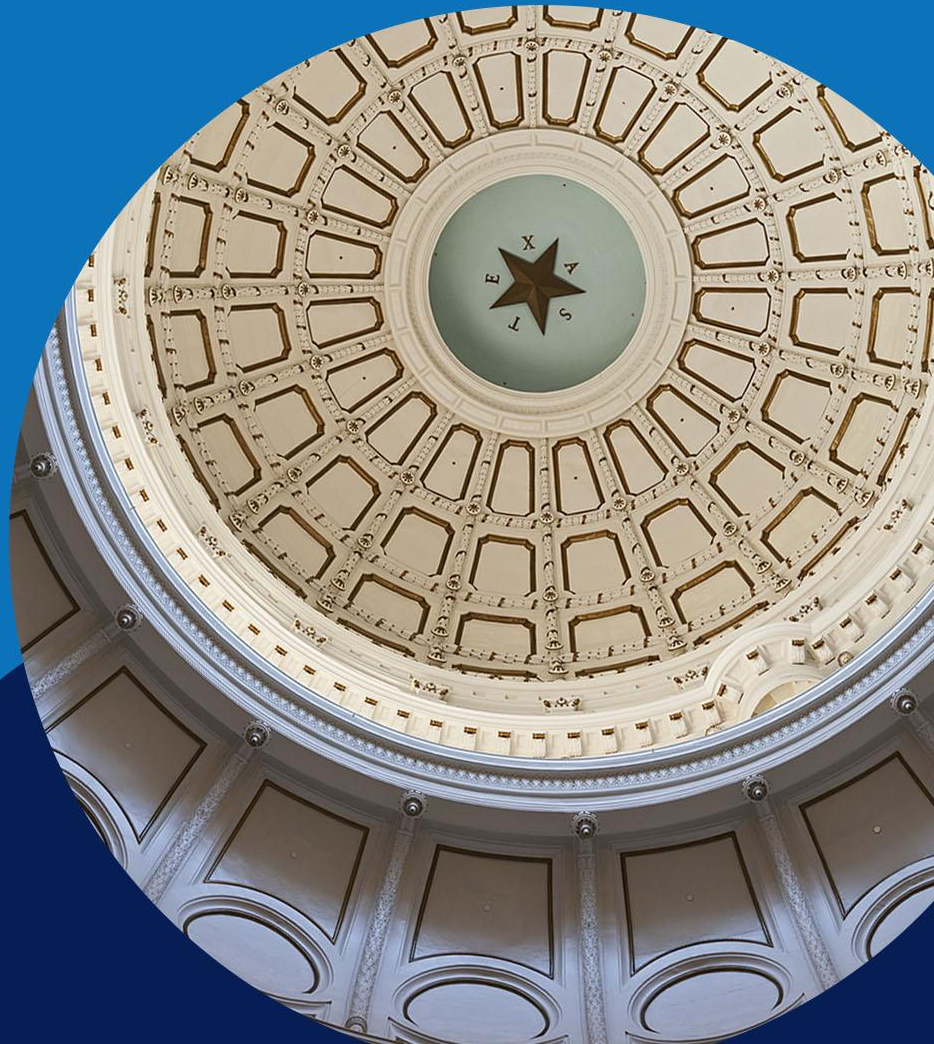
Prior Authorizations



Prior Authorizations

- MCOs must have written policies and procedures in place for PAs to ensure **consistent application of review criteria**.
- MCOs may use screening criteria to approve PA requests. Screening criteria must be:
  - Periodically evaluated and updated with involvement from practicing physicians.
  - Objective and clinically valid.
  - Compatible with established principle of health care.
  - Flexible enough to allow deviation on a case-by–case basis.
  - Posted on the MCO's website.
- Screening criteria may only be used for approvals.
- Before issuing an adverse determination, the MCO must offer the provider an opportunity to discuss the request with **another physician in the same or a similar specialty**.

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Prior Authorization Timelines

- Standard PA determinations must be made **within three business days.**
- The MCO must send both Member and Provider a **written notice** of final determination no later than the **next Business Day** after a determination is made.
- CMS rules require expedited requests to be completed within **72 hours**
  - A request can be expedited when "following the standard timeframe could **seriously jeopardize the enrollee's life or health** or ability to attain, maintain, or regain maximum function."
- If an enrollee is hospitalized:
  - **within one business day** after receiving the request
  - **within 72 hours** after receiving the request if the request is submitted by a provider of acute care inpatient services for services or equipment necessary to discharge the patient.
  - **within one hour** after receiving the request if the request is related to post stabilization care or a life-threatening condition.

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PA Reform: SB 1207 (2019)

- TAHP worked with doctors and other stakeholder groups for a year prior to the legislative session to make improvements to the process and help reduce denials. Some reforms included:
- **Timeframes:** before issuing an adverse determination, the MCO must offer the provider an opportunity to discuss the request with another physician in the same or a similar specialty
- **Denial Letters:** prior authorization denials are sent to the member and the provider and must include
  - clear and easy to understand information
  - clinical explanation for the denial
- **Transparency:** MCOs must maintain on their website, in an easily searchable and accessible format:
  - Timelines for PA requirements
  - Description of the denial notice
  - Coverage criteria and PA requirements

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PA Reform cont.

- **External medical reviews (IRO)** to provide a client with an independent clinician to conduct a medical review when there is a reduction or denial based on medical necessity
- **Annual Review:** MCOs must review, solicit, and consider input from in network providers and ensure the PA is based on accurate, up-to-date, evidence based and peer reviewed clinical criteria.
- **PA Reconsideration Process** to give providers additional opportunity to submit documentation when they do not submit adequate information for a MCO to make a determination and to not make the provider start over with a new PA.

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Incomplete PAs

- HHSC recently adopted rules relating to **incomplete prior authorization requests**. This process was incorporated into SB 1207 based on the fact that most denials were due to missing or incomplete information.
- The rule implements SB 1207 (86R), which established a reconsideration process for incomplete PAs.
- If an MCO receives an incomplete PA:
  - The MCO must notify the provider **within three business days**
  - If the MCO does not receive the requested information within three business days, must **refer the PA request to the MCO medical director** for review
  - The MCO must offer the requesting provider an opportunity for peer-to-peer consultation **no less than one business day** before issuing an adverse determination
  - Must make a final determination **not later than three business days** after receiving missing information is provided to the MCO

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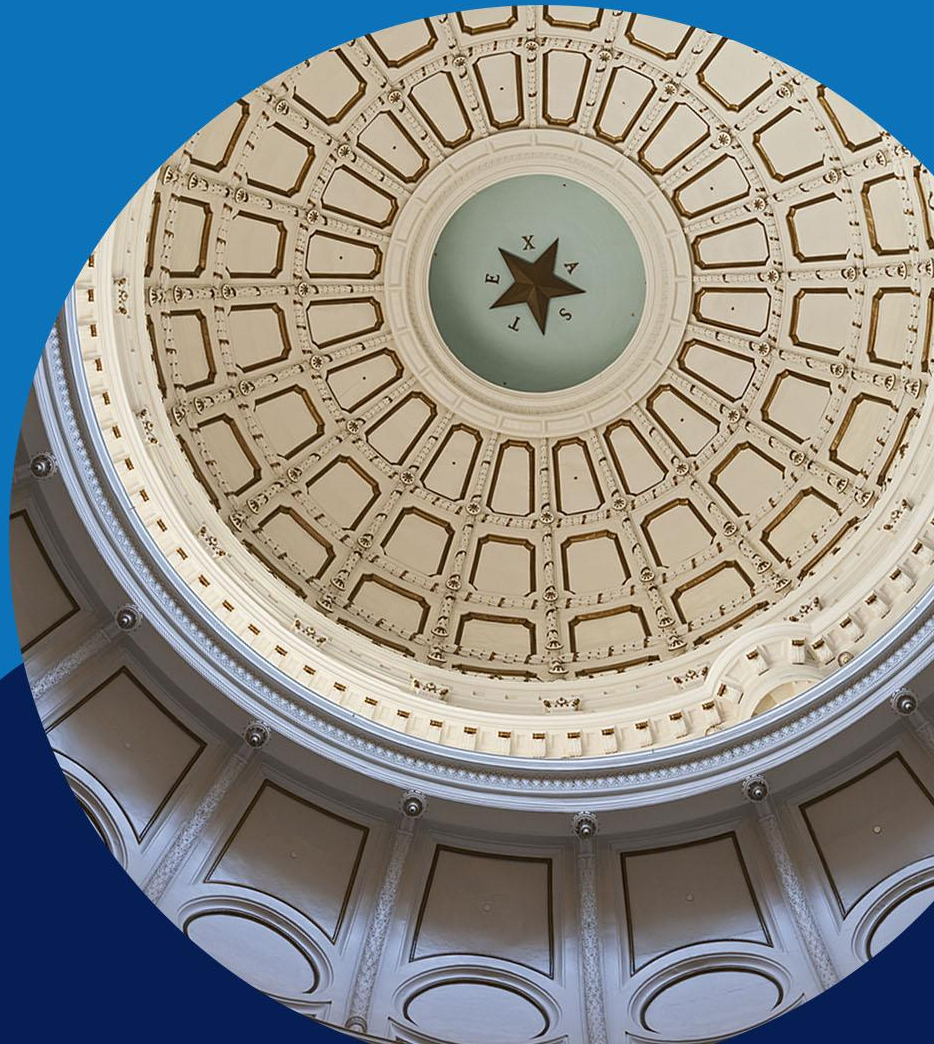
MCO Internal Appeal Process for PA Denial



MCO Internal Appeal Process

- Appeals are a formal process by which a member can request a **review of an MCO "adverse benefit determination."**
- An adverse benefit determination is:
  - the **denial or limited authorization** of a requested Medicaid service
  - the **reduction, suspension or termination** of a previously authorized service
  - **denial in whole or in part of payment** for service
  - **failure to provide services** in a timely manner
  - failure of an MCO to **act within applicable time frames**
  - denial of a request for out of network services for **members in a rural area** with only 1 MCO
  - Denial of a member's request to dispute **financial liability**

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MCO Standard Appeal Timeline

- For standard resolution of an appeal and notice to the affected parties, the timeframe must be **no longer than 30 calendar days**
- A MCO may extend the timeframes **up to 14 calendar days** if the enrollee requests the extension or the MCO shows that there is a need for additional information.
- If the MCO extends the timeframes, the MCO must give the enrollee **prompt written notice** of the delay, inform them of their **right to file a grievance**, and resolve the appeal **as expeditiously as the enrollee's health condition requires.**

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MCO Expedited Appeal Timeline

- MCOs must establish and maintain an expedited review process for service-related appeals **when the provider indicates** that taking the time for a standard resolution could seriously **jeopardize the member's life or health.**
- After the MCO receives a request for an expedited appeal, the MCO must notify the member of the outcome of the expedited appeal request **within 72 hours.**
- If the appeal relating to an **ongoing emergency or denial of continued hospitalization**, the MCO must notify the enrollee in accordance with the immediacy of the case, and **not later than one business day**.

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Continuation of Benefits

- The MCO **must continue the individual's benefits** pending the outcome of the appeal if all the following criteria are met:
  - The appeal is filed **by the effective date** of adverse benefit determination
  - The appeal involves **termination, suspension, or reduction** of a previously authorized course of treatment
  - The services were **ordered by an authorized provider**
  - The original period covered by the authorization **has not expired.**
  - The member or his or her representative timely requests an extension of the benefits.

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MCO & Member Communication

- Members must receive all of the same notices of adverse determinations that providers receive, and within the same time frames.
- Notices to members of adverse determinations must include:
  - The **reason** for the denial.
  - The **clinical basis** for the determination.
  - A **description of the criteria** used as guidelines in making the determination.
  - **A description of the complaint and appeal process**, including the right to independent review.
- If an independent review is requested by either the provider or patient, the patient or a person acting on their behalf **must receive a letter explaining the resolution.**

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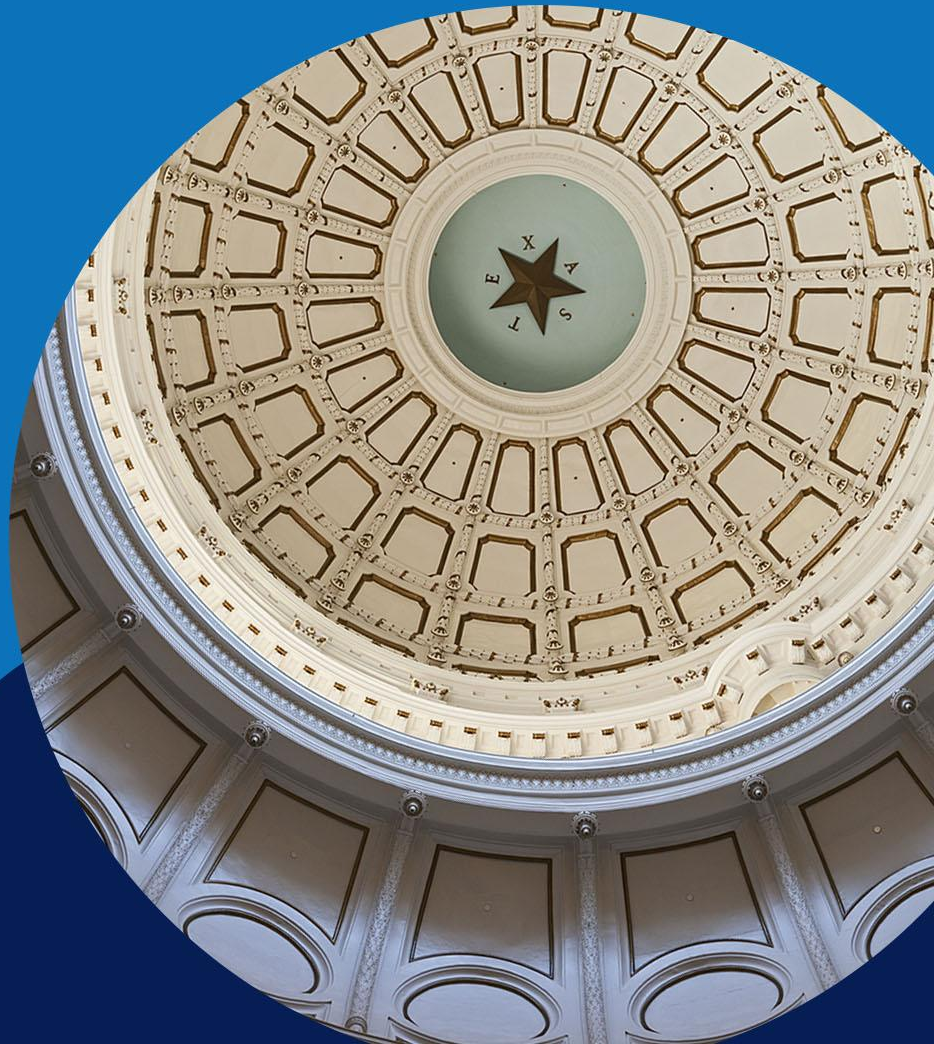
IROs and Fair Hearings



IRO, State Fair Hearings, and Judicial Review

- **After the appeal process**, a member has **120 Days** to request either
  - a State Fair Hearing, or
  - both a Fair Hearing and an external medical review (EMR) by an Independent Review Organization (IRO)
  - The Fair Hearing occurs unless the member withdrawals
- If a member is not satisfied with the outcome of the fair hearing, they can ask for a review by an **independent HHS attorney**, and then file for **judicial review** in the Travis County District Courts within **30 days** of the administrative review decision.

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External Medical Review by IROs

- SB 1207 (86th Legislative Session) directed the state to contract with Independent Review Organizations (IROs) to review clinical decisions for Medicaid clients and established EMR process for service denials and reduction and eligibility denials for certain programs based on functional necessity.
- **The external review must:**
  - not be used as a deterrent to proceed to a state fair hearing
  - be conducted as independent of the state and health plan
  - be free to the member; and
  - not extend the time frame of the appeals process, disrupt the continuation of benefits, or delay the Fair Hearing process

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External Medical Review by IROs, cont.

- The MCO must send all documentation used to make its service reduction or denial decision to HHSC no later than **3 business days** after receiving the EMR request, or 1 business day for expedited requests.
- IROs must complete their review **within 10 days** of receiving the information necessary to make the determination.
- For life threatening conditions, the review must be completed within **1 business day.**
- If the IRO determines the client should have received the benefit, **the IRO decisions prevails** over the MCO decision.

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State Fair Hearings

- If a member requests a Fair Hearing, MCOs are required to **submit specific information** to HHSC and the Medical Director or other clinical staff **must participate to explain the reasoning** for the adverse determination.
- Before the hearing, the **enrollee must receive all the information** that will be used in the fair hearing and all policy excerpts and documents to support the action.
- All hearings must be conducted after adequate written notice at a reasonable time and place and by **one or more impartial officials.**

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Fair Hearing Process

- The state must take final administrative action **within 90 calendar days** of a member's request, unless the beneficiary was granted an expedited hearing, in which case the decision must be issued no later than **three business days**.
- Decisions must:
  - be based only on evidence introduced in the hearing
  - be made publicly available
  - notify beneficiaries of their right to seek rehearing or judicial review
- See HHSC policies here and HHSC the website with additional information about Fair Hearing processes and requirements and the posting of previous decisions.

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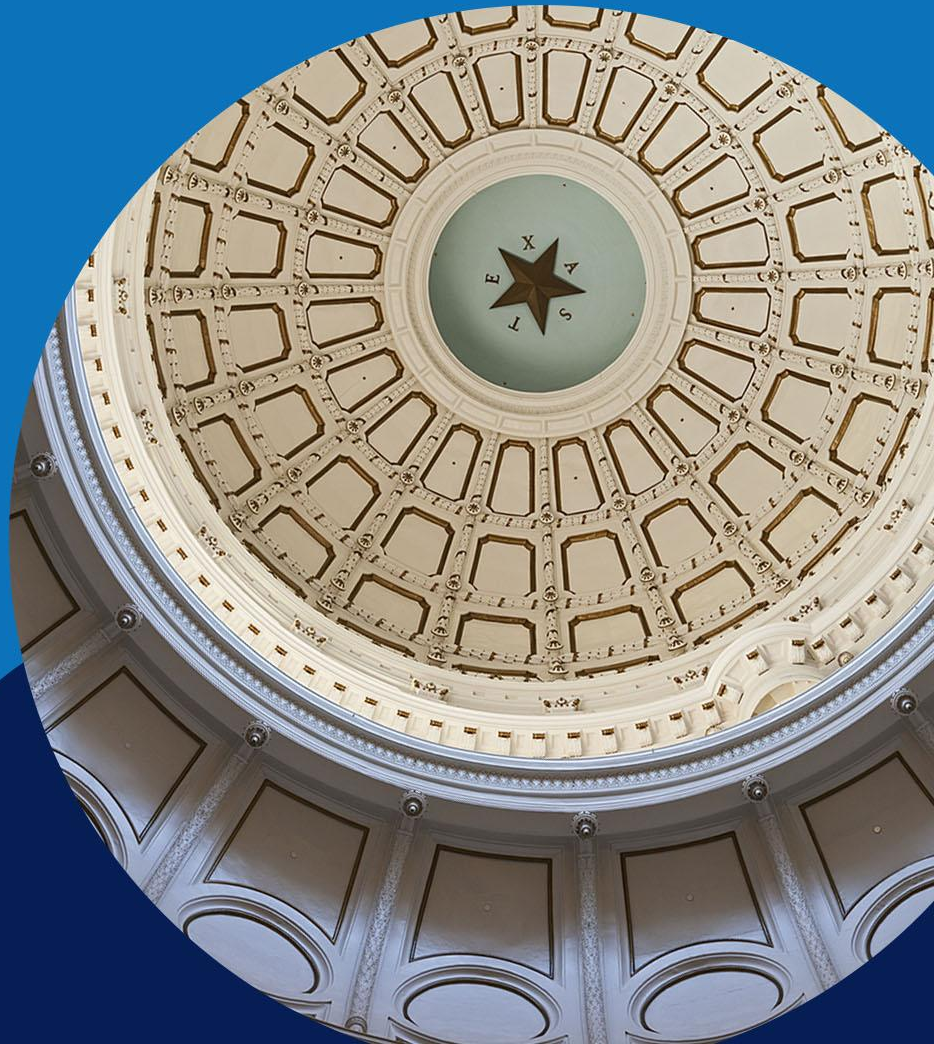
Complaints



Complaints

- A complaint is an expression of dissatisfaction expressed by a member about **any matter other than an Adverse Benefit Determination**. For example, this could include:
  - the quality of care
  - rudeness of a provider or employee
  - failure to respect the Medicaid Member's rights
- The MCO must provide a **designated member advocate**, who assists the member in writing or filing a complaint, and monitoring the complaint throughout the process until the issue is resolved.
- If the member is not satisfied with the outcome of the MCO complaint process, they **may send a written request to HHSC** to investigate the complaint.

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Complaint Improvement Project

- In 2018 HHSC started a complaints project to **improve the process by**:
  - streamlining intake and tracking
  - more effectively leveraging data to identify risk and
  - improving quality of service.
- HHSC also made changes to the program to align it with federal requirements, revised reporting requirements from MCOs to HHSC, and **began posting complaint information** on the HHSC website quarterly.
- Reports include **aggregated data from HHSC and MCOs** to provide a more complete picture on complaint trends.

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Complaints Timeline

- MCOs must resolve complaints **within 30 days** of receipt, and **subject to liquidated damages, if 98% of complaints are not resolved** within that time frame.
- For each MCO Program bid, a respondent must:
  - **Describe the process** the MCO will put in place for the review complaints, including which staff will be involved;
  - **Provide a flowchart that depicts the process** that will be employed;
  - **Document the MCO's average time for resolution over the past 12 months** for Member Complaints and Appeals (excluding Expedited Appeals), from date of receipt to date of notification of disposition; and
  - For STAR and STAR+PLUS only, describe the **number and job descriptions of Member Advocates**, how Members are informed of the availability of Member Advocates, and how Members access Advocates.

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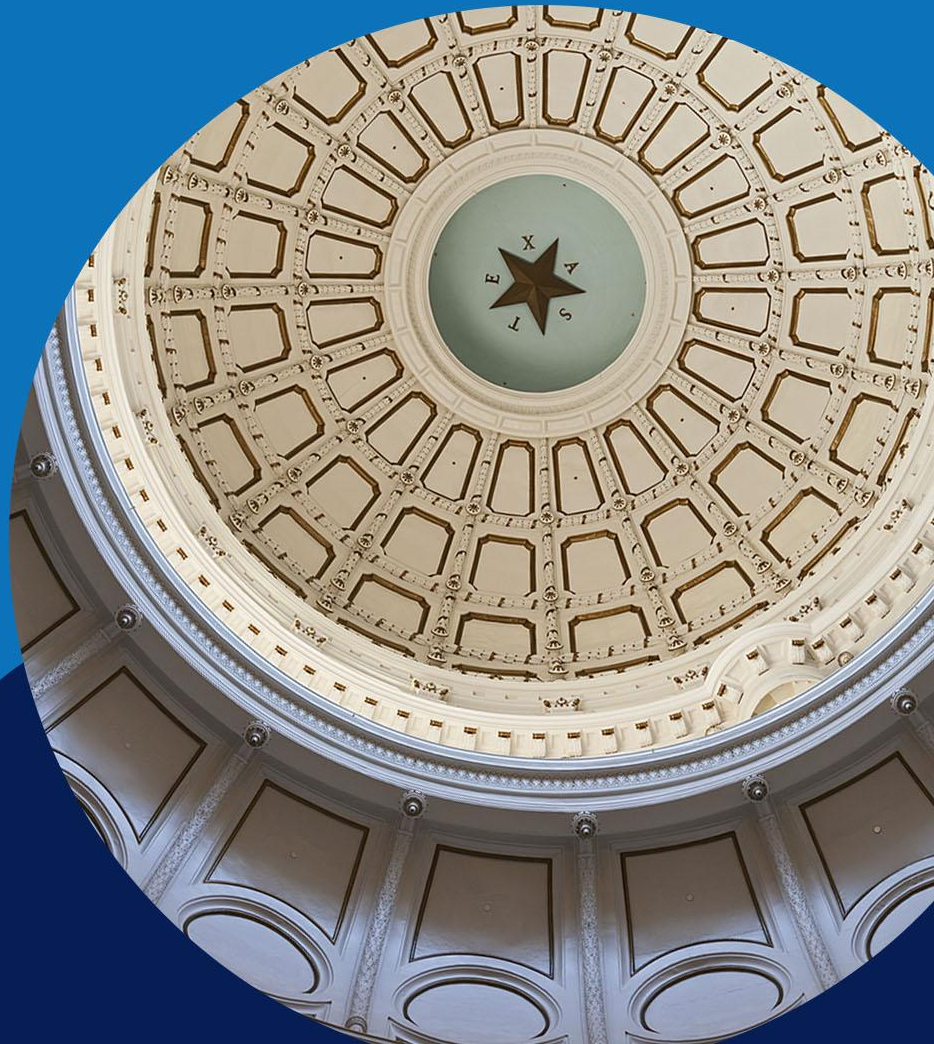
Medicaid Prompt Pay



Medicaid Prompt Pay Timelines

- **Payment timelines:**
  - 10 days for nursing facility claims
  - 18 days for pharmacy claims
  - 30 days for all other claims (Paper & Electronic)
- **Claim Payment Standards:**
  - MCO must adjudicate 98% of all claims within 30 days,
  - 99% of all claims within 90 days
  - 100% of all claims within 24 months
- **Provider Timely Billing Requirements:**
  - must file a claim with the MCO or its subcontracted claims processor within 95 Days from the date of service.
  - If a claim is not received by the MCO within 95 Days, the MCO must deny the claim unless excepted from filing deadline

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Medicaid Prompt Pay Penalties

Penalties for Failure to Pay Promptly:

- Pay interest to the provider at 18% per annum, calculated daily for the full period in which the Clean Claim (or portion of the Clean Claim) remains unadjudicated beyond the 30-Day claims processing deadline.
- Pay liquidated damages to HHSC for:
  - Failure to adjudicate 98% of clean claims in 30 days & 99% in 90 days.
  - $1,750 first occurrence per month, per program, per claim type. Subsequent violations up to $8,500.

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Medicaid Prompt Pay Penalties

Penalties for Failure to Pay Interest Promptly:

- Interest owed to the provider must be paid on the same date as the claim.
- If the MCO fails to pay interest in a timely manner, they are subject to additional liquidated damages of $1,000 per month, per claim, per program.
- This includes Clean Claims that the MCO initially processes but later determines an additional amount should have been paid.
- These administrative penalties are paid to HHSC (not the provider).

The MCO must keep an accurate & sufficient audit trail for each interest payment & its corresponding claims docs and provide a detailed report to HHSC upon request.

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Audits and Recoupments

- **MCOs must complete provider audits within two years after receiving a claim, except when:**
  - Fraud, Waste, or Abuse is discovered after two-year limit.
  - Audits initiated by Recovery Audit Contractor (RAC) or other government authorities exceed two years.
  - HHSC recovers payments due to member's program ineligibility.
  - MCOs must recover payments from a liable third party vs. the provider themselves, unless applicable.

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Audits and Recoupments

- **Clear Audit and Recoupment Appeals Rights:**
  - Providers have contractual rights to appeal audit recoupments.
  - MCO must notify providers of recoupment in writing within 30 days of audit completion, including detailed reasons.
  - MCOs must also notify providers that they have 120 Days from the date of disposition to appeal the claim.
  - The MCO must process an appealed claim and adjudicate the claim within 30 days from the date of receipt of the appeal.
  - A provider may appeal any disposition of a claim.
  - Providers can exhaust all appeals before repayment occurs

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Texas Prompt Pay Act Already Exempts Medicaid

- SB 418 from the 78th Session created the Texas Prompt Pay Act.
- The law had a provision, **Article 21.30, which provides that if the commissioner of insurance, in consultation with the HHSC commissioner, determines** that any of the stated provisions of Texas Insurance Code Article 3.70-3C, Chapter 843, or Article 21.52Z **will cause a negative fiscal impact to the state** with respect to providing benefits or services under the Medicaid or CHIP programs, the insurance commissioner **shall by rule waive application of those provisions**.
- The **HHSC commissioner has advised the commissioner of insurance** that application of the provisions of SB 418 to Medicaid and CHIP plans **would have a negative fiscal impact on the state** and has requested a waiver of the statute and rules for those plans.
- Based on this, the commissioner has determined that there would be a negative fiscal impact on the state and has adopted §21.2826, which provides that the provisions of the statute and rules stated therein **do not apply to Medicaid and CHIP plans** provided by a carrier to persons enrolled in those programs."

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Questions?