Medicaid Managed Care Denial and Appeals Process Study

As Required by 2022-23 General Appropriations Act, Senate Bill 1, 87th Legislature, Regular Session, 2021 (Article II, HHSC, Rider 36)

Texas Health and Human Services
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Health and Human Services

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Executive Summary

The 2022-2023 General Appropriations Act, Senate Bill 1, 87th Legislature, Regular Session, 2021 (Article II, HHSC, Rider 36) requires the Health and Human Services Commission (HHSC) to conduct a study of the denial and appeals process, including but not limited to, the administrative hearing process within the managed care networks for STAR+PLUS, STAR Health, and STAR Kids programs.

- The STAR+PLUS program, implemented in 1996, provides acute care, behavioral health care, and long-term services and supports (LTSS) for adults who have a disability or are age 65 and older.
- The STAR Health program, implemented in 2008, provides coordinated health care services to:
  - Children and young adults in DFPS conservatorship,
  - Young adults aged 18 through the month of their 22nd birthday who voluntarily agree to continue in a foster care placement, and
  - Young adults aged 18 through the month of their 21st birthday who are participating in the Former Foster Care Children (FFCC) program or are participating in the Medicaid for Transitioning Foster Care Youth (MTFCY) Program due to ineligibility for the FFCC program.

    The program is jointly monitored by the Department of Family and Protected Services and HHSC.
- The STAR Kids program, implemented in 2016, provides acute care services and LTSS to children and youth 20 years and younger with disabilities.

This study contains data and information for state fiscal years 2014-2020. In conducting the study, Rider 36 requires HHSC to consider:

- The percentage of denials that were upheld or overturned on appeal;
- The best practices and outcomes of other states;
- Qualifications of hearing officers;
- Timeliness of the appeal and fair hearing review process;
- The denial notification process; and

- Input from stakeholders, including the STAR Kids Managed Care Advisory Committee (SKMCAC) and the State Medicaid Managed Care Advisory Committee (SMMCAC).

Rider 36 also requires HHSC to submit a report of the study's findings, including steps the agency has taken to implement Texas Government Code, §531.024164 to the Governor, Legislative Budget Board, Lieutenant Governor, and the Speaker of the House of Representatives by December 11, 2022

1. Background

In accordance with 42 Code of Federal Regulations (C.F.R.) §438.406, 42 C.F.R. §438.410, and the managed care contracts, managed care organizations (MCO) are required to develop, implement, and maintain a system for tracking, resolving, and reporting member appeals when there is a denial or limited authorization of a requested service. Within the process, the MCO must fully and completely respond to each appeal and document its status and final disposition.

Medicaid members have the right to request an appeal when an MCO denies, reduces, suspends, or terminates services. Once the member requests an MCO internal appeal, the MCO must review the appeal and all supporting documentation submitted to determine if it will uphold, partially overturn, or fully overturn the original decision.

Members have the right to access the State Fair Hearing process only after exhausting the MCO internal appeal process. Members may also request an external medical review (EMR) prior to the State Fair Hearing. The EMR is an optional third-party review of the MCO's adverse benefit determination conducted by an Independent Review Organization (IRO) contracted with HHSC. The EMR occurs between the MCO internal appeal and the State Fair Hearing.

2. Percentage of Denials Upheld or Overturned on Appeals

Federal regulations found at 42 C.F.R. §438.408 (b)(2) and (3) require each state to establish time frames for the resolution of standard and expedited appeals. HHSC managed care contracts state that MCOs must resolve a standard appeal within 30 days and resolve an expedited appeal within 72 hours after receipt of the appeal. An appeal may be extended up to 14 calendar days if requested by the member or member's authorized representative, or the MCO identifies a need for additional information that may cause a delay that is in the member's interest.

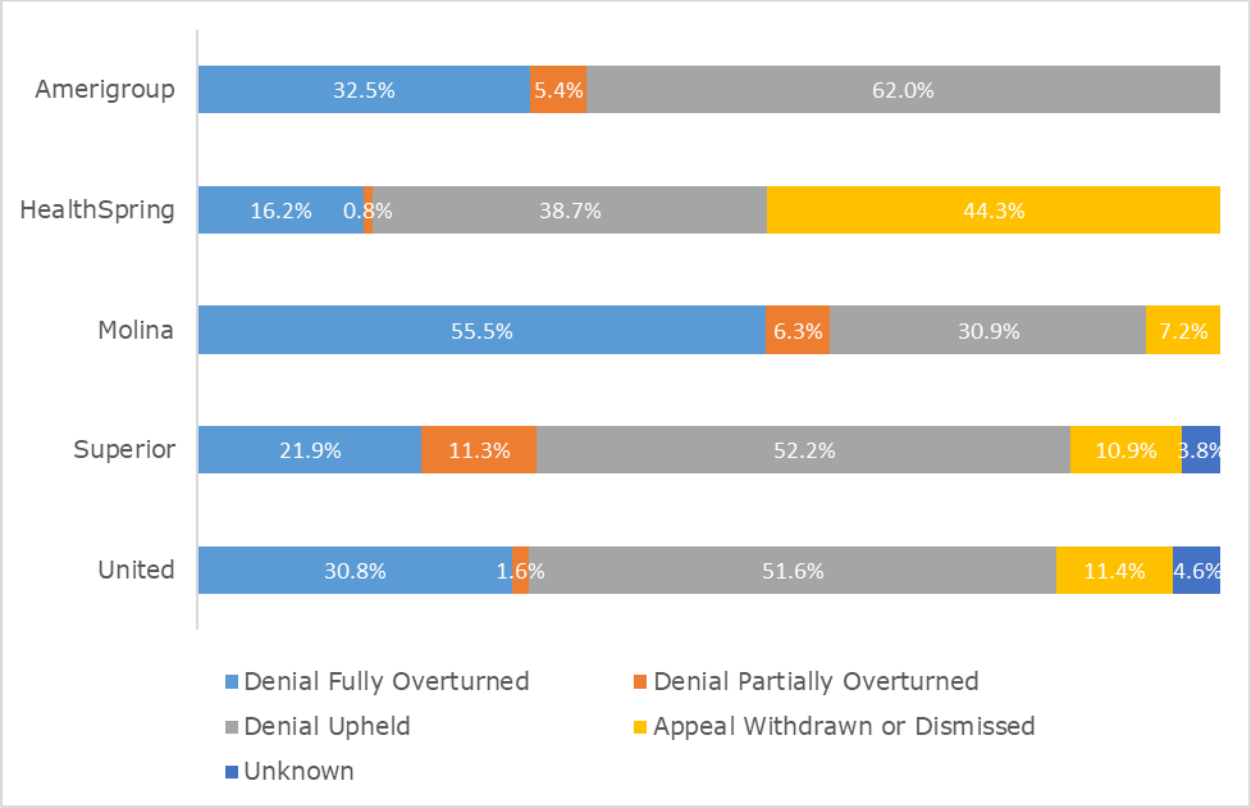
The External Quality Review Organization, Institute for Child Health Policy, used MCO self-reported data to summarize the outcomes of member appeals. The HHSC Fraud and Fair Hearings (FFH) Appeals Division provided the data used for the program level fair hearings reversals. Measurement years are state fiscal years 2014 through 2020 by program and MCO. For this report, outcomes of the appeals are categorized as:

- Denial fully overturned – MCO fully overturned the denial upon member appeal;
- Denial partially overturned – MCO partially overturned the denial upon member appeal;
- Denial upheld – MCO upheld the denial upon member appeal;
- Withdrawn or dismissed – the member withdrew the appeal or the appeal was dismissed by the MCO[1]; and
- Unknown – the MCO-reported data included a data discrepancy that resulted an unknown outcome.

[1] An MCO may dismiss an appeal if the request for an appeal is received outside of required timeframes.

STAR+PLUS

Figure 1. STAR+PLUS Member Appeals Outcome Breakdown (2014-2020)



In Figure 1, of the appeals received for state fiscal years 2014-2020, Molina had the greatest number of member appeal denials fully overturned at 55.5 percent. HHSC will work with Molina to determine if any further actions are needed. Superior and United trended similarly with upheld denials just over 51 percent. HealthSpring[2] saw the greatest number of appeals withdrawn or dismissed at 44.3 percent.

[2] HealthSpring voluntarily terminated their contract with HHSC effective December 31, 2021

Table 1. Count of STAR+PLUS Reversed and Sustained Appeals (2014-2015)

STAR+PLUS	2014 Reversed	2014 Sustained	2014 Reversed	2014 Sustained	2015 Reversed	2015 Sustained	2015 Reversed	2015 Sustained
Amerigroup	34	36	15.96%	16.90%	27	61	9.25%	20.89%
HealthSpring	40	60	14.23%	21.35%	26	37	12.62%	17.96%
Molina	114	87	25.56%	19.51%	44	55	15.44%	19.30%
Superior	226	180	26.71%	21.28%	140	163	18.21%	21.20%
United	43	7	86.00%	14.00%	26	17	60.47%	39.53%
TOTAL	**457**	**370**	**24.89%**	**20.15%**	**263**	**333**	**16.49%**	**20.88%**

Table 2. Count of STAR+PLUS Reversed and Sustained Appeals (2016-2017)

STAR+PLUS	2016 Reversed	2016 Sustained	2016 Reversed	2016 Sustained	2017 Reversed	2017 Sustained	2017 Reversed	2017 Sustained
Amerigroup	27	64	9.09%	21.55%	18	49	8.29%	22.58%
HealthSpring	20	25	13.25%	16.56%	32	34	16.00%	17.00%
Molina	44	47	15.77%	16.85%	53	29	25.12%	13.74%
Superior	87	167	11.23%	21.55%	264	278	19.88%	20.93%
United	25	37	40.32%	59.68%	40	63	38.83%	61.17%
TOTAL	**203**	**340**	**12.98%**	**21.74%**	**407**	**453**	**19.77%**	**22.00%**

Table 3. Count of STAR+PLUS Reversed and Sustained Appeals (2018-2019)

STAR+PLUS	2018 Reversed	2018 Sustained	2018 Reversed	2018 Sustained	2019 Reversed	2019 Sustained	2019 Reversed	2019 Sustained
Amerigroup	22	29	14.57%	19.21%	27	38	15.00%	21.11%
HealthSpring	27	36	19.01%	25.35%	32	46	17.39%	25.00%
Molina	34	24	21.79%	15.38%	15	17	8.06%	9.14%
Superior	269	328	21.08%	25.71%	209	249	22.55%	26.86%
United	40	49	44.94%	55.06%	44	74	37.29%	62.71%
TOTAL	**392**	**466**	**21.61%**	**25.69%**	**327**	**424**	**20.50%**	**26.58%**

Table 4. Count of STAR+PLUS Reversed and Sustained Appeals (2020)

STAR+PLUS	2020 Reversed	2020 Sustained	2020 Reversed	2020 Sustained
Amerigroup	9	39	8.41%	36.45%
HealthSpring	12	45	9.60%	36.00%
Molina	7	23	5.39%	19.49%
Superior	70	285	22.55%	26.86%
United	22	62	26.19%	73.81%
TOTAL	**120**	**454**	**9.93%**	**37.58%**

Tables 1-4 show the breakdown of the member appeals upheld or overturned by a state fair hearing between fiscal year 2014 through fiscal year 2020. Superior has the largest membership population; it is expected that they will have a greater number of appeals than other MCOs. The data shows that Superior's percentage of member appeals reversed or sustained were equally distributed from one fiscal year to the next. Although Superior consistently received the highest number of appeals, Molina was second to Superior in 2014-2017; United became second from 2018 forward.

STAR Health

Figure 2. STAR Health Member Appeals Outcome Breakdown (2014-2020)

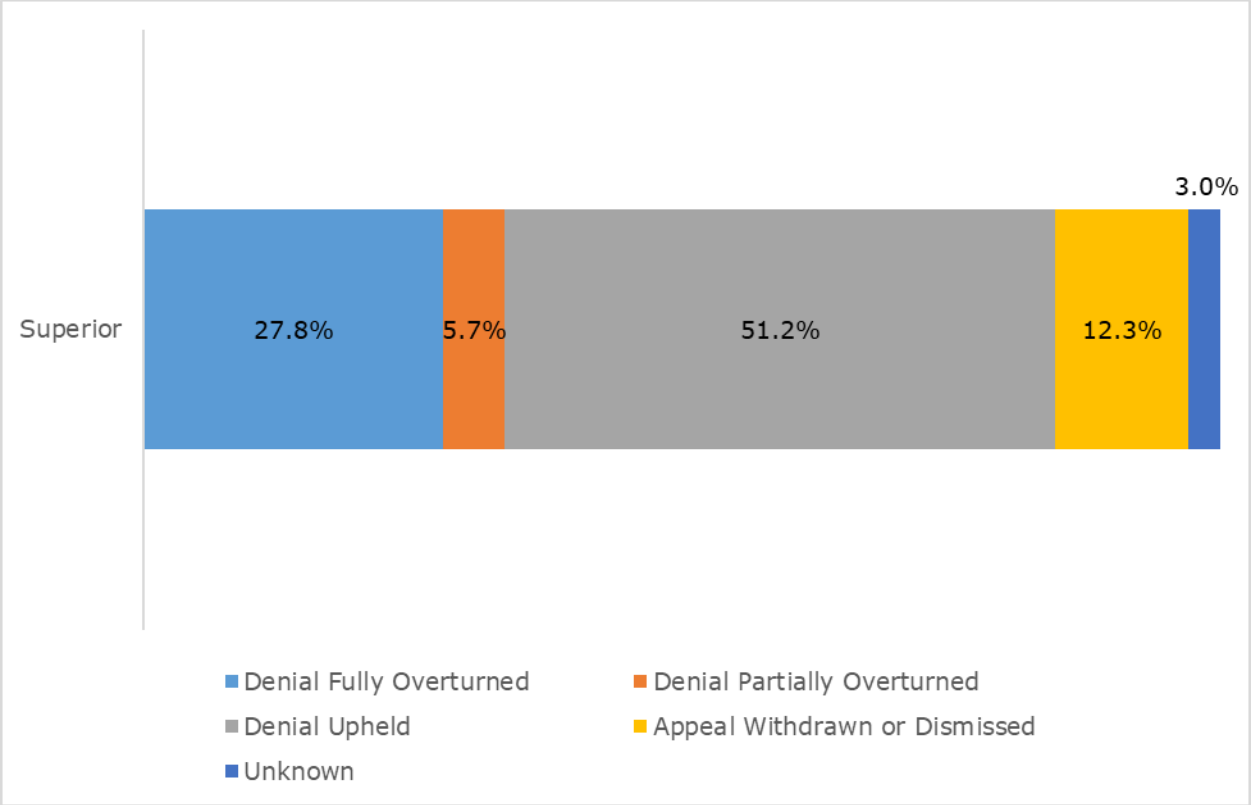


Figure 2 provides an overview of member appeals received by Superior, the sole MCO delivering STAR Health services, between 2014-2020. Of the total appeals received, 51.2 percent were upheld and over a quarter were fully overturned.

Figure 3. STAR Health State Fair Hearings Reversed and Sustained Decisions by State Fiscal Year

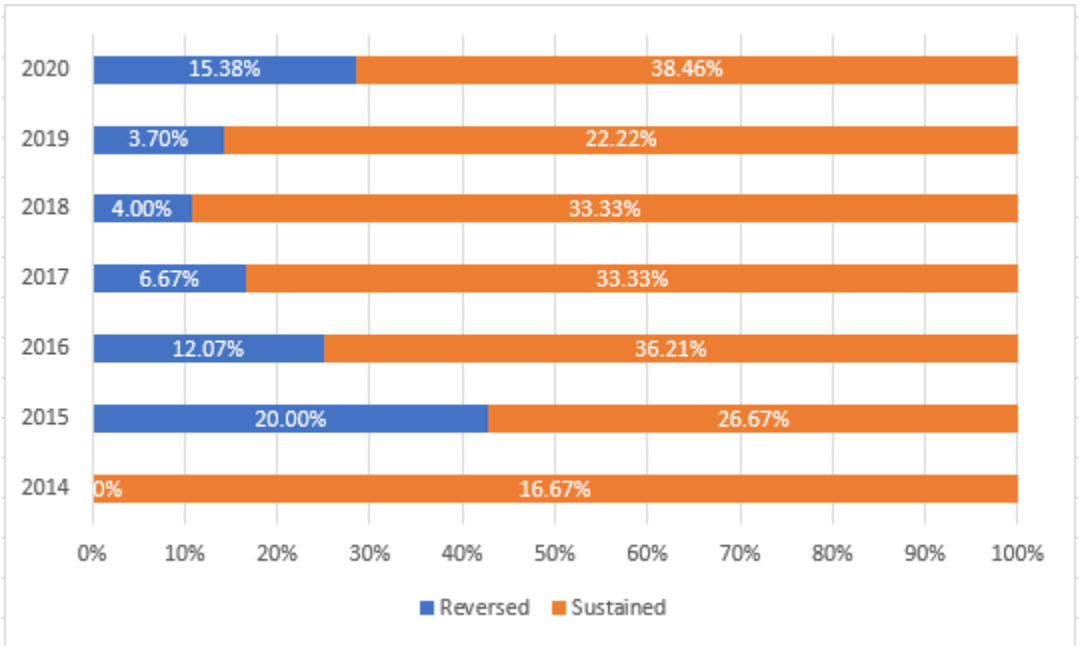


Figure 3 represents combined data received from Superior Health Plan and the HHS FFH Appeals Division. The data demonstrates that there were no reversed member appeals in state fiscal year 2014. From 2015 to 2019, there was a steady decrease in the percentage of reversed appeals. Reversal decisions remain lower than sustained decisions meaning that Superior's initial documentation review was correct. In 2020, the increase in reversals were the result of extended certification periods related to the COVID-19 public health emergency.

STAR Kids

Figure 4. STAR Kids Outcome of Member Appeals (2017-2020)

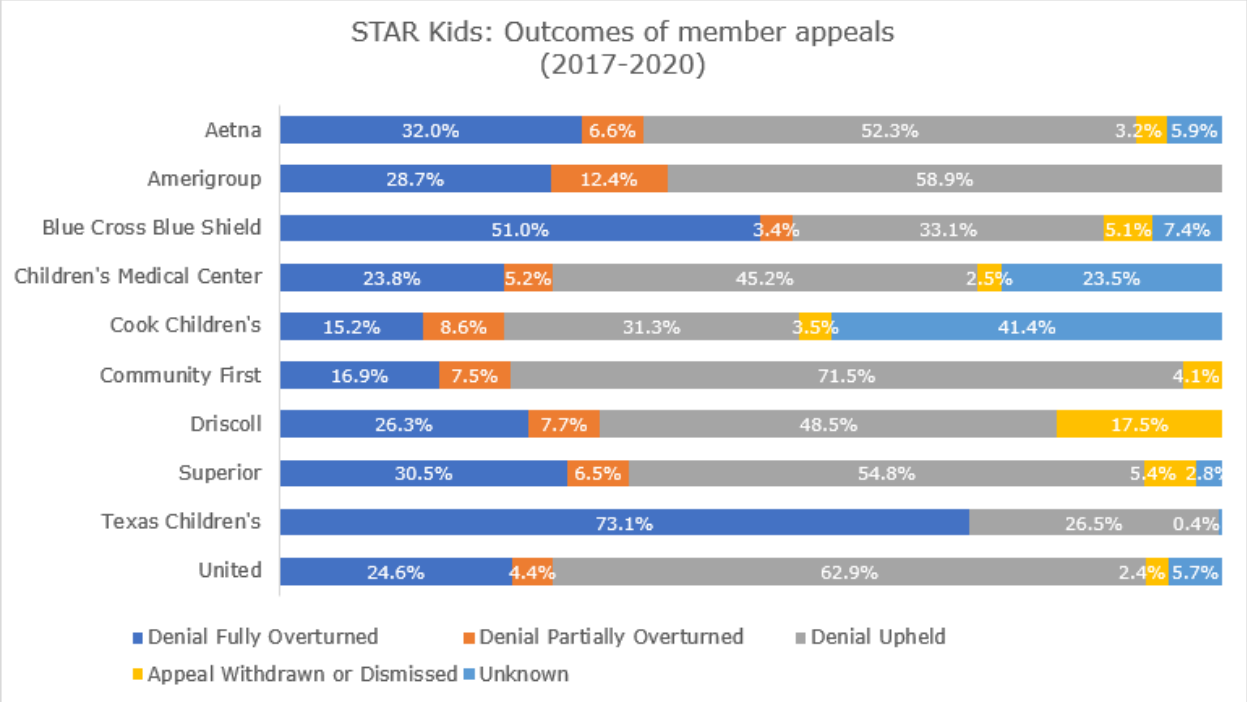


Figure 4 demonstrates that Texas Children's Health Plan and Blue Cross Blue Shield fully overturned the largest number of member appeals from state fiscal years 2017 to 2020 for STAR Kids members.

Table 5. Count of STAR Kids Reversed and Sustained Appeals (2017-2018)

STAR Kids	2017 Reversed	2017 Sustained	2017 Reversed	2017 Sustained	2018 Reversed	2018 Sustained	2018 Reversed	2018 Sustained
Aetna	2	0	4.55%	0.00%	3	4	2.80%	1.64%
Amerigroup	12	11	27.27%	7.97%	15	28	14.02%	11.48%
Blue Cross Blue Shield	1	2	2.27%	7.97%	6	9	5.61%	3.69%
Children's Medical Center	1	3	2.27%	2.17%	7	8	6.54%	3.28%
Cook Children's	1	6	2.27%	4.35%	3	14	2.80%	5.74%
Community First	2	0	4.55%	0.00%	5	5	4.67%	2.05%
Driscoll	0	4	0.00%	2.90%	2	4	1.87%	1.64%
Superior	15	62	34.09%	44.93%	31	98	28.97%	40.16%
Texas Children's	4	31	9.09%	22.46%	24	40	22.43%	16.39%
United	6	19	13.64%	13.77%	11	34	10.28%	13.93%
TOTAL	**44**	**138**	**100.00%**	**100.00%**	**107**	**244**	**100.00%**	**100.00%**

Table 6. Count of STAR Kids Reversed and Sustained Appeals (2019-2020)

STAR Kids	2019 Reversed	2019 Sustained	2019 Reversed	2019 Sustained	2020 Reversed	2020 Sustained	2020 Reversed	2020 Sustained
Aetna	3	4	5.66%	2.67%	0	2	0.00%	1.74%
Amerigroup	9	13	16.98%	8.67%	2	4	5.26%	3.48%
Blue Cross Blue Shield	0	5	0.00%	3.33%	0	2	0.00%	1.74%
Children's Medical Center	0	4	0.00%	2.67%	0	5	0.00%	4.35%
Cook Children's	2	10	3.77%	6.67%	2	4	5.26%	3.48%
Community First	1	4	1.89%	2.67%	1	4	2.63%	3.48%
Driscoll	1	4	1.89%	2.67%	1	2	2.63%	1.74%

STAR Kids	2019 Reversed	2019 Sustained	2019 Reversed	2019 Sustained	2020 Reversed	2020 Sustained	2020 Reversed	2020 Sustained
Superior	13	55	24.53%	36.67%	5	38	13.16%	33.04%
Texas Children's	11	24	20.75%	16.00%	6	11	15.79%	9.57%
United	13	27	24.53%	18.00%	21	43	55.26%	37.39%
TOTAL	**53**	**150**	**100.00%**	**100.00%**	**38**	**115**	**100.00%**	**100.00%**

Tables 5 and 6 demonstrate the reversed (overturned) and sustained (upheld) member appeals received for STAR Kids members from state fiscal year 2017 through state fiscal year 2020. Overall, more decisions were sustained than reversed. In state fiscal year 2017, all appeals received for Aetna and Community First were reversed (two appeals per MCO) and all appeals were sustained for Driscoll (four appeals). Although the numbers were low, state fiscal year 2017 represents the first set of data reported for STAR Kids. Results show all appeals sustained in state fiscal year 2020 for Blue Cross Blue Shield and Aetna (two and three appeals respectively).

3. Best Practices and Outcomes in Other States

Rider 36 requires HHSC to review best practices and outcomes in other states. HHSC developed the questions below to survey other states regarding best practices and outcomes related to their appeals and fair hearing processes.

- Do members continue to receive denied services while awaiting an appeal decision?
- What is the timeframe for managed care organizations to complete the appeals process?
- What is the denial notification process for members (e.g., do MCOs use the explanation of benefits, upload it to a member portal, or us other method(s) of communication)?
- What is the administrative hearing process for denials upheld or overturned on appeal?

Four states responded to the survey: Kentucky, Maine, Massachusetts, and Tennessee. Like Texas, all four states require members to continue receiving services while awaiting an appeal decision. Although Maine does not have managed care, its fee-for-service Medicaid allows 30 days to resolve an appeal request, which is consistent with Texas and those of other responding states. When an appeal decision is not in the member's favor, all states send notification via letter providing the member's rights to request an administrative hearing.

4. Qualifications of Hearing Officers

The FFH Appeals Division receives appeal requests from applicants and members contesting actions taken regarding benefits and services for various programs. Hearing Officers must meet the requirements outlined in 42 C.F.R §438.406 to be deemed qualified to participate in the appeals process. These individuals have experience in analyzing and interpreting federal and state regulations and applying them to specific situations.

Within the FFH, there are multiple categories of State Fair Hearing Officers, based on qualifications, that preside over cases received by HHSC. State Fair Hearing Officers conduct fair hearings and administrative disqualification hearings statewide for 169 programs within HHSC, including waiver programs.

Hearings Officer Categorizations

Fair Hearings Officers I, II, and III (FHO I, FHO II, FHO III) act as a neutral party to conduct administrative or State Fair Hearings while issuing just and impartial decisions with respect for the dignity of individuals and their due process rights.

- An FHO II requires one additional year of experience than an FHO I.
- An FHO III (Lead Hearings Officer) requires two additional years of experience than an FHO I.

Nurse Hearings Officers (Hearings Officer V) handle hearings for complex Medicaid programs that involve disability rights and high dollar amounts for A minimum of two years of experience as a Licensed Vocational Nurse or Registered Nurse and demonstrated ability to write clear and concise legal documents is required to be an HHSC Nurse Hearings Officer.

5. Timeliness of the Review Process

Medicaid members must file a request for an appeal within 60 days from the date of the notice of the adverse benefit determination. To ensure continuation of currently authorized services, the member must file the appeal on or before the later of: (1) ten days following the MCO's sending of the notice of the adverse benefit determination, or (2) the intended effective date of the proposed adverse benefit determination. The member will receive an adverse benefit determination including a letter, a flyer, and a form to be sent in accordance with the timeframes established in each MCO contracts. The HHSC Uniform Managed Care Manual Chapter 3.21 outlines required language that MCOs must include in adverse determination notices.

The MCO must send an acknowledgement letter to the member within five business days of receiving an appeal. The MCO must complete the standard appeal process within 30 days of receiving the initial request unless an extension is requested. An appeal may be extended up to 14 days if requested by the member or member's authorized representative, or the MCO identifies a need for additional information that may cause a delay that is in the member's interest.

The MCO must also have a process for expedited internal appeals when the MCO determines that taking the time for a standard resolution could seriously jeopardize the member's life, physical, ore mental health, or ability to attain, maintain or regain maximum function. Medicaid members have the right to request an expedited appeal, and the MCO must notify the member of the outcome within 72 hours.

The member may request an EMR by an IRO within five days of the member's request for a State Fair Hearing. An EMR is an independent review of the same information the MCO used when making the adverse benefit determination based on functional necessity or medical necessity. Pursuant to Texas Government Code §531.024164, HHSC implemented the EMR option in May 2022 and reports EMR requests and outcomes quarterly in the Medically Dependent Children Program Monitoring Report. The EMR takes place between the MCO internal appeal and the State Fair Hearing. The MCO is responsible for implementing the IRO EMR decisions of "overturned" or "partially overturned" within 72 hours of receiving the EMR decision from the IRO.

6. Denial Notification Process for Families

An MCO adverse benefit determination letter is provided to Medicaid members as notification of any service request that results in a denial, reduction, suspension, or termination of services. The MCO must notify the member, in accordance with 1 Texas Administrative Code, Chapter 357, whenever the MCO makes an adverse benefit determination. The notice must, at a minimum, include any information required in the HHSC managed care contracts regarding notices of actions and/or incomplete prior authorization requests, if applicable.

The MCO's notification must include:

1. A clinically based explanation for the decision;
2. An explanation of how the requested service does not meet the criteria; and
3. The state or federal guidance used for the determination. Members may file an appeal by submitting the Health Plan Appeal Request Form received with the adverse benefit determination packet or by calling their MCO.

Once the appeal is complete, the MCO sends the member a new letter informing the member of the final decision. The appeal may be upheld, fully overturned, or partially overturned. The member may choose to accept the MCO's decision, request an EMR and a State Fair Hearing, or request a State Fair Hearing only. If a member requests an EMR, HHSC will send the member's case to an IRO where medical experts of the same or similar specialty will review the MCO's decision and supporting documentation. The IRO can uphold or overturn the MCO's decision. If, after the EMR, the member decides not to continue with the appeal, the member can withdraw the request for a State Fair Hearing. A member cannot request an EMR if a State Fair Hearing has taken place.

7. Input from Stakeholders

As required by Rider 36, HHSC sought feedback regarding the denial and appeal processes from three HHS Advisory Committees: Aging Texas Well Advisory Committee, SKMCAC, and SMMCAC. Below are the questions posed to each of the committees:

- 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?
- 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?
- Are there examples of appeals or fair hearings that resulted in a restoration of benefits that can be provided to HHSC

Stakeholder feedback revealed that members and providers had minimal issues with the MCO's appeal process. Overall, members and providers' primary concerns were understanding that certain services are not covered benefits, disputing partial denials for therapy services, and difficulties providing additional supporting documentation for review. Additional stakeholder feedback was not indicative of general trends. HHSC staff followed up with each stakeholder that submitted specific issues to obtain member level data to ensure that no access to care or other ongoing concerns existed.

8. Conclusion

In compiling data for this report, HHSC discovered that the percentages of appeals reversed or upheld did not reveal any trends from year to year or MCO to MCO. Early reporting was presented in an aggregate leading HHSC to make significant changes to the MCO Member appeals deliverable. Now, reporting provides member level data that allows HHSC to more closely monitor actions taken by MCOs. The MCO information can also be used to supplement the documentation received when an appeal is going to a fair hearing.

HHSC implemented the EMR option in May 2022, therefore it is not necessary to create a detailed timeline and plan for implementing the provisions of Government Code §531.024164.

List of Acronyms

Acronym	Full Name
C.F.R.	Code of Federal Regulations
EMR	External Medical Review
FFH	Fraud and Fair Hearings
FHO	Fair Hearings Officer
HHSC	Health and Human Services Commission
ICHP	Institute of Child Health Policy
IRO	Independent Review Organization
LTSS	Long Term Services and Supports
MCO	Managed Care Organization
RN	Registered Nurse
SKMCAC	STAR Kids Managed Care Advisory Committee
SMMCAC	State Medicaid Managed Care Advisory Committee
UMCM	Uniform Managed Care Manual