Medical Review of Medicaid Service Denials For Foster Care Youth Report

As Required by
Texas Government Code Section
531.024165

Texas Health and Human Services
December 2022

TEXAS
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Executive Summary

The Texas Health and Human Services Commission (HHSC), in collaboration with the Department of Family and Protective Services (DFPS), submits the *Medical Review of Medicaid Service Denials for Foster Care Youth Report*, in compliance with Texas Government Code, Section 531.024165. Section 531.024165 requires:

> (a) Using existing resources, the commission shall coordinate with the Department of Family and Protective Services to develop and implement a process to review a denial of services under the Medicaid managed care program on the basis of medical necessity for foster care youth.
>
> (b) Not later than December 31, 2022, the commission and the Department of Family and Protective Services shall submit a report to the legislature that includes a summary of the process developed and implemented under Subsection (a).

Medicaid is provided to individuals in DFPS conservatorship through the managed care program, STAR Health. Superior Health Plan (Superior), the STAR Health managed care organization (MCO), is required to provide copies of the notices of denial to HHSC and DFPS beginning in 2018. This requirement is intended to give HHSC and DFPS insight into trends and potential deficiencies in denials Superior is making of STAR Health claims.

Superior sends specific types of denials to DFPS and HHSC. These types of denials were identified by HHSC and DFPS as being significant to the care received by children in foster care through an existing review process that was established in 2018. At the time of this report, no findings have been identified; however, DFPS, HHSC, and Superior maintain an ongoing dialogue allowing DFPS to modify the types and categories of denial letters received from Superior. There are venues in place allowing for questions and clarifications to be addressed by Superior during HHSC and DFPS' review.

Introduction

HHSC and DFPS collaboratively prepared this report in compliance with Section 531.024165. Section 531.024165 requires HHSC and DFPS to develop and implement a process to review denial of services under managed care based on medical necessity for foster care youth. HHSC and DFPS reviewed existing denial processes and determined new processes are not needed at this time because the current process allows for open dialogue between the agencies to review and address any trends or deficiencies.

This report describes current processes related to the review of STAR Health denial of a prior authorization request for services for Medicaid recipients in foster care based on medical necessity including:

- HHSC Contractual Review Process and Utilization Management Denial Review Processes, and
- DFPS Denial Review Process.

This report also explains why existing processes are sufficient and development of new processes are not needed. For example, DFPS and HHSC receive copies of denial letters in which services are denied on the basis of medical necessity, allowing for review of these cases.

Background

STAR Health, a managed care program for children in state conservatorship, implemented in 2008 and is administered by a single, statewide MCO. HHSC is the state agency responsible for administration and oversight of the Texas Medicaid program, including Medicaid managed care and STAR Health.

DFPS works with communities to promote safe, healthy families and protect children and vulnerable adults from abuse, neglect, and exploitation. DFPS completes investigations, services, referrals, and prevention programs. Child Protective Services (CPS) strengthens and stabilizes families so that they can safely care for their children at home. When care at home is not safe, CPS works with the courts and communities to find permanent homes or other places for children to live. CPS ensures appropriate placements for children and comprehensive services for families to stabilize and reunite families when possible. While in DFPS conservatorship, most children receive behavioral health and medical services through STAR Health.

HHSC is responsible for ensuring MCOs adhere to the contract and performance standards outlined in the managed care contracts. Staff monitor routine deliverables and ad-hoc reports to identify performance trends and contractual non-compliance.

HHSC also provides oversight of the MCO's Utilization Management (UM) functions. HHSC initiated MCO oversight activities in fiscal year 2017 with operational reviews of UM requirements and clinical consults related to complaints. HHSC also incorporated readiness reviews of UM-related system changes and targeted reviews based on specific UM-related concerns in fiscal year 2019. These reviews expanded in fiscal year 2020.

HHSC and DFPS have existing processes in place to review denial of services under the STAR Health program. The agencies work collaboratively to identify and address potential issues through data review.

Health and Human Services Commission (HHSC)

HHSC has two distinct processes related to reviews of denials for STAR Heath, the Contractual Denial Review Process and UM Denial Review Process. They are detailed below.

Contractual Denial Review Process

HHSC receives notice of denials when they are issued from the STAR Health MCO, Superior. Superior was required to provide copies of the notices of denial to HHSC beginning in 2018. HHSC reviews the denial letters to ensure they are mailed timely and the following required elements, established by HHSC and DFPS leadership, are included:

- Denial date
- Date of request
- Member name
- Member ID
- Date of Birth
- Requester (Specific individual's name or name of facility)
- Benefits and Services
- Service requested/denied – (Speech therapy, sleep study, supplemental nutrition)
- DFPS region
- City
- Comments/Links (Not medically necessary, open authorization with another provider, missing information required)

HHSC reviews each denial letter to ensure it was mailed to the member within ten days of the denial date and to ensure that the letter contains all of the required elements. The denials are assessed to determine if significant trends or patterns exist in Superior's process for the denial of medical services. Criteria for trends or

patterns include denial by service type, denial by geographical area, and/or reason(s) for denial.

The denial letter should also include information in both English and Spanish about how the member can access Superior's Complaint, Appeal, and Fair Hearing processes. If HHSC identifies any deficiencies or trends, staff discuss with Superior for further review and clarification. Unresolved deficiencies may result in financial penalties. No deficiencies or trends have been identified at the time of this report.

Utilization Management Denial Review Process

HHSC ensures MCOs provide medically necessary clinical services requiring an authorization. This is accomplished through oversight of UM requirements to ensure elements such as authorization of services, member appeals, and State Fair Hearings, and related service coordination are conducted in accordance with state and federal regulations and applicable HHSC contracts. HHSC assesses contract compliance through desk reviews of the MCO's UM documentation of the processing of authorization requests, policy review of UM processes, assessing MCOs' readiness to implement major changes to UM systems, and procurement-related readiness. Denials are reviewed on an ongoing basis as potential issues are identified by HHSC, DFPS, and stakeholders.

A STAR Health targeted review is currently underway. This review will include a review of denials related to concurrent authorizations for hospital admissions as well as denials for medically necessary post-discharge services such as durable medical equipment, private duty nursing and physical, occupational and speech therapies. HHSC plans on reviewing a sample of authorization denials in the STAR Health program every two years starting in fiscal years 2025-2026.

Medical necessity review is the primary standard for determining the appropriateness of service authorization denials. The medical necessity review includes the following:

- The clinical criteria, as per applicable HHSC contract requirements and related HHSC guidance, is applied in a manner that is compatible with the member's needs and situations to determine medical necessity.
- Court orders pertaining to covered services are not modified or terminated unless approved by the court having jurisdiction over the matter.

- Medicaid managed care services are provided at least in an amount, duration, and scope available to fee-for-service Medicaid beneficiaries.
- The amount, duration, and scope of requested services are not denied or reduced solely based on a beneficiary's diagnosis, type of illness, or condition.
- Medically necessary covered services are provided in the amount, duration, and scope required to correct or ameliorate the physical, behavioral, or developmental condition of a member that is under 21 years of age.
- Medically necessary durable medical equipment (DME) and supplies not otherwise covered as a Texas Medicaid benefit are provided for members 21 years of age or older under the Home Health DME and Supplies Exceptional Circumstances provision.

The Member Appeal and Fair Hearing and Adequate Notice standards include requirements related to the following:

- Communicating appeal and State Fair Hearing rights in the Notice of Action (denial letter).
- Processing the appeal from request to notification of the appeal determination, including continuation of benefits.

If HHSC clinical staff determine the MCO's denial of medically necessary services or items was inappropriate, the case file is reviewed by the clinical manager and the Medical Director physician reviewer. The physician reviewer has access to the case file documentation and indicates either agreement or disagreement with the MCO's medical necessity determination.

Any findings resulting from an inappropriate denial of medically necessary services will be assessed remedies such as a corrective action plan or liquidated damages. A corrective action plan is a detailed written plan the MCO submits to HHSC detailing the plan to correct or resolve a deficiency or event causing the assessment of a remedy or damage against MCO. In the event HHSC issues liquidated damages, the MCO will be liable to HHSC for all monetary damages, in the form of actual, consequential, direct, indirect, special and/or liquidated damages in accordance with the contract.

Department of Family and Protective Services (DFPS)

The CPS Medical Services Division within DFPS receives agreed upon copies of the notice of denials when they are issued from Superior. Superior began providing copies of the notices of denial to the Medical Services Division in 2018 to assist the front-line caseworker in getting needs of children in DFPS conservatorship met. The Medical Services Division support of regional staff can include assisting with the response to the denial, which could include appealing the denial, seeking alternative services, getting additional assessment, or other action.

Medical Services Division staff review the denial, notify primary direct delivery staff, including the Well Being Specialist, of the denial, and track the child-specific and denial-related information received. The regional Well Being Specialist, who acts as a liaison between the MCO and DFPS or Single Source Continuum Contractor when needed, is notified of the denial, in addition to the Medical Consenter and the requesting physician for the child or youth, who receives notification of the denial from the MCO directly. Monthly, staff calculate and review relevant denial data that is statistically calculated and reviewed in order to monitor trends.

Trends and potential issues are discussed with HHSC and Superior. HHSC, DFPS, and Superior have recurring meetings to address health care needs of foster children and serve as a venue to discuss any concerns regarding denial letters.

Conclusion

HHSC and DFPS have existing processes in place to review a denial of services on the basis of medical necessity made by the STAR Health MCO for foster care youth. The two agencies together identify and review potential deficiencies. Therefore, it is not necessary to develop new processes. At the time of this report, no major deficiencies have been identified through the review process. This process assists in ensuring major deficiencies do not develop as concerns are addressed early. HHSC and DFPS continue to review Superior's denial of prior authorizations for foster care youth to ensure that Superior follows HHSC's and DFPS's requirements.

List of Acronyms

Acronym	Full Name
ACUR	Acute Care Utilization Review
CHIP	Children's Health Insurance Program
CPS	Child Protective Services
DFPS	Department of Family and Protective Services
DME	Durable Medical Equipment
HHSC	Health and Human Services Commission
MCCO	Managed Care Contracts and Oversight
MCO	Managed Care Organization
MCS	Medicaid and CHIP Services
MCUR	Managed Care Utilization Review
SME	Subject Matter Expert
STAR	State of Texas Access Reform
UM	Utilization Management
UR	Utilization Review