



Health and Human Services

SMMCAC Complaints, Appeals and Fair Hearings Subcommittee

May 12, 2026

This summary contains supplemental information from reliable sources where that information provides clarity to the issues being discussed. Power Point tables used in the presentations may also be used in this summary. Names of individuals may be misspelled but every attempt has been made to ensure accuracy. Tables and Text have been used from executive and legislative agencies and departments' presentations and publications.





The Complaints, Appeals and Fair Hearings subcommittee focuses on complaints data to identify possible problems in the Medicaid program, opportunities for improving MCO contract oversight and increasing program transparency. It also focuses on appeals and fair hearings processes, including implementation of an independent external medical reviewer.

Members: Marcella Ford, Tyra Hinton, Karl Serrao, Shahid Rahman, MD, Robert Shane Kernell

1. Call to order, introductions, and roll call. The meeting was convened by Karl Serrao, MD. A quorum was present.

2. Consideration of November 6, 2025, draft meeting minutes. The minutes were approved as drafted

3. Fair Hearings decisions data for Medically Dependent Children Program (MDCP) eligibility appeals.

Summary MDCP medical necessity (MN) fair hearings are conducted by nurse hearing officers (LVN/RN); there are currently five. Nurse hearing officers review testimony/evidence and issue written decisions that are either sustained (agree with OMD), reversed (disagree with OMD), dismissed (often failure to appear or jurisdiction/timeframes), or withdrawn (often after OMD overturns).

- 2024 (Jan 1–Dec 31): 382 appeals received; 247 decisions issued.
- 2024 outcomes: 15% dismissed, 8% reversed, 49% sustained, 28% withdrawn. (Note: appeals received vs. decisions issued differ due to timing/hearings occurring after year-end).
- 2025: 276 appeals received; 420 decisions issued.
- 2025 outcomes: 13% dismissed, 12% reversed, 38% sustained, 38% withdrawn.

Presentation Materials

- MDCP MN Fair Hearings are conducted by five Nurse Hearings Officers.
- The Nurse Hearings Officer determines if the documents and testimony provided in the hearing support a determination that the appellant meets the medically necessity criteria required for the MDCP.

Total MDCP Appeals Received: 382

Total Decisions Issued: 247

Decision Outcomes	
Dismissed	38 (15%)
Reversed	20 (8%)
Sustained	121 (49%)
Withdrawn	68 (28%)

Total MDCP Appeals Received: 276

Total Decisions Issued: 420

Decision Outcomes	
Dismissed	53 (13%)
Reversed	51 (12%)
Sustained	158 (38%)
Withdrawn	158 (38%)

Discussion

There is a basic skills training for all the hearings officers. There are also mentors who accompany new hearings officers.

4. MDCP eligibility data update. Dr. David Bank

Summary. Initial assessments (members reaching top of interest list): 850 reviews. Initial outcomes: 630 approved; 220 denied; denials require physician determination (nurses cannot deny an appeal). Common denial themes included mental health-only or autism without medical comorbidities; children who are ambulatory/attending school without skilled nursing needs at home.

Data:

- Initial approval/denial rates: 74% approved; 25.8% denied.
- Annual reassessments: 6,161 cases reviewed; 5,934 approvals; 227 denials.
- Reassessment rates: 96% approved; 3.6% denied.

The speaker emphasized the importance of the use automation of the criteria in SKSAI and use of additional documentation (letters, peer-to-peer, medical necessity letters) for ambiguous cases.

At the next meeting thy plan to present approval-denial data for Jan 2026 through (likely) May or June 2026 depending on data availability.

Presentation Materials

2025 MDCP Initial Review Data



Note: * Green - Approved ** Red - Denied

Approver Type	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Grand Total
MN Approved by Auto Approval	77	55	40	44	33	24	31	16	16	66	66	104	572
MN Approved by Doctor	3	3	7	2	1	1	1	0	0	0	5	7	30
MN Approved by Nurse	1	3	4	2	5	1	0	1	1	4	3	3	28
MN Approved Totals*	81	61	51	48	39	26	32	17	17	70	74	114	630
MN Denied by Doctor (Total)**	5	17	70	16	14	11	8	3	2	5	32	37	220
Total Reviewed	86	78	121	64	53	37	40	20	19	75	106	151	850
Total % Approved	94.19%	78.21%	42.15%	75.00%	73.58%	70.27%	80.00%	85.00%	89.47%	93.33%	69.81%	75.50%	74.12%
Total % Denied	5.81%	21.79%	57.85%	25.00%	26.42%	29.73%	20.00%	15.00%	10.53%	6.67%	30.19%	24.50%	25.88%

2025 MDCP Reassessment Data



Note: * Green - Approved ** Red - Denied

Approver Type	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Grand Total
Reassess Approved by Auto Approval	497	499	462	421	412	378	411	533	350	477	390	452	5282
Reassess Approved by Doctor	19	21	57	79	28	37	29	18	45	24	10	17	384
Reassess Approved by Nurse	15	13	26	19	31	17	19	32	26	31	23	16	268
Total Reassess Approved	531	533	545	519	471	432	459	583	421	532	423	485	5934
Reassess Denied by Doctor (Total)**	9	6	24	58	23	10	11	9	29	11	17	20	227
Total Reassess Reviewed	550	552	564	538	490	451	478	602	440	551	442	504	6161
Total % Reassess Approved	96.55%	96.56%	96.63%	96.47%	96.12%	95.79%	96.03%	96.84%	95.68%	96.55%	95.70%	96.23%	96.32%
Total % Reassess Denied	1.64%	1.09%	4.26%	10.78%	4.69%	2.22%	2.30%	1.50%	6.59%	2.00%	3.85%	3.97%	3.68%
Total Cases Reviewed	626	617	690	641	547	479	510	612	469	618	546	656	7011



Discussion

High Auto-approval Rate is a good thing. The chair expressed his appreciation. He asked of those getting denied, what is the reason or type of patient? Dr. Bank stated they follow the TAC related to eligibility. When members are assessed manually, we ask if this is a child who would end up in a long-term care facility. Sometimes it is clear that a nurse is needed in the home and sometimes it is ambiguous.

5. External Medical Review (EMR) update Terri Frazier

Summary Members may request an EMR after the MCO internal appeal and before a state fair hearing; if they choose state fair hearing only, they cannot later request an EMR. MCOs must upload EMR packets within 72 hours and the EMR can be expedited (1 business day) or standard (decision within 10 days of receipt).

IRO decision types include upheld, overturned, partially overturned. Overturned EMR decisions are final.

Programs covered in this process are: STAR, STAR+PLUS, STAR Health, STAR Kids, and Dental.

FY2025 EMR volume: 634 requests (606 standard; remainder expedited); 10 submitted in error; 7 not considered EMRs due to miscommunication/paperwork; 616 EMR decisions were issued.

FY2025 EMR outcomes: 21% overturned, 2% partially overturned, 77% upheld. MCO portal uploads were 91% timely; 42% were early.

IRO timeliness: There was only one late decision (weather-related).

Overturned/partially overturned by service type: durable medical equipment (21%), medications (10%), personal attendant services (14%), speech therapy (9%), occupational therapy (9%); DME spread across seven plans with no clear trend.



EMR program mix: STAR 23%, STAR Kids 28%, STAR Health 2%, STAR+PLUS 46%, dental 1%.

The top denial types: personal attendant services (188), DME (74), medications (9.2%), private duty nursing (8%), physical therapy (6.49%); no trends were noted.

Some state fair hearing concerns included emphasis on no-shows and the importance of formally withdrawing if you are not going to continue with a fair hearing, to free hearing slots.

Presentation Materials

Background

- Required by Senate Bill (S.B.) 1207, 86th Legislative Session
 - <https://capitol.texas.gov/tlodocs/86R/billtext/html/SB01207F.htm>
- The commission shall contract with an independent review organization (IRO) to conduct external medical reviews (EMRs).

EMR Process

- Member Receives Managed Care Organization (MCO) Notice of Adverse Benefit determination
- Member May Choose to:
 - Accept MCO Decision
 - Request an EMR and State Fair Hearing
 - Request a State Fair Hearing Only

Programs Implemented

Applicable Programs

- STAR
- STAR+PLUS
- STAR Health
- STAR Kids
- Dental

EMRs Received in State Fiscal Year 2025

- 634 EMRs Received**
 - 606 Standard (96%)
 - 28 Expedited (4%)
- 10 EMRs Submitted in Error**
- 8 EMRs Member Withdrew**
- 616 IRO Decisions Rendered**

IRO Decisions (1 of 2)

- 616 Decisions Rendered**
 - 128 Overturned (21%)
 - 15 Partially Overturned (2%)
 - 473 Upheld (77%)

	Overturned	Partially Overturned	Upheld	Total
EMR Decision	128	15	473	616
Percent of Total Decisions Rendered	21%	2%	77%	100%

IRO Decisions (2 of 2)

- TOP Five Overturned or Partial Overturned Denial Types**
 - 30 Durable Medical Equipment (21%)
 - 15 Medication (10%)
 - 14 Personal Attendant Services (PAS) (10%)
 - 13 Speech Therapy (9%)
 - 13 Occupational Therapy (9%)

	Durable Medical Equipment	Medication	Personal Attendant Services	Speech Therapy	Occupational Therapy	Percent of Top Five Denial Types Overturned or Partially Overturned
Count	30	15	14	13	13	85
Percent of All Overturned or Partially Overturned Decisions	21%	10%	10%	9%	9%	59%

Program Stats

- 140 STAR (23%)
- 170 STAR Kids (28%)
- 11 STAR Health (2%)
- 286 STAR+PLUS (46%)
- 9 Dental (1%)

Programs	STAR	STAR Kids	STAR Health	STAR+PLUS	Dental
Totals	140	170	11	286	9
Percent of EMRs	23%	28%	2%	46%	1%

Top Five Plan Denial Types

- 188 Personal Attendant Services (30.52%)
- 74 Durable Medical Equipment (12.01%)
- 57 Medication/Prescription (9.25%)
- 51 Private Duty Nursing (8.28%)
- 40 Physical Therapy (6.49%)

Top 5 Plan Denials	Personal Attendant Services	Durable Medical Equipment	Medication	Private Duty Nursing	Physical Therapy	Percent of All Plan Denials
Count	188	74	57	51	40	410
Percent of All Plan Denials	30.52%	12.01%	9.25%	8.28%	6.49%	66.56%

State Fair Hearing Results (1 of 3)

616 IRO overall decisions

- **State Fair Hearing decision:**
 - 207 Dismissed / abandoned / failure to appear
 - 145 Sustained/sustained with instructions
 - 75 Withdrawn sustained
 - 121 Withdrawn due to favorable action
 - 61 Reversed benefits due / information needed
 - 7 Reversed no benefits due

State Fair Hearing Results (2 of 3)

143 IRO partially overturned or overturned

- **State Fair Hearing decision:**
 - 77 Withdrawn due to favorable action in favor of member
 - 52 Dismissed failure to appear
 - 5 Reversed benefits due / information needed
 - 6 Withdrawn sustained
 - 3 Sustained

State Fair Hearing Results (3 of 3)

IRO upheld 473 MCO decisions

- **State Fair Hearing decision:**
 - 155 Dismissed / abandoned / failure to appear
 - 142 Sustained / sustained with Instructions
 - 69 Withdrawn sustained
 - 44 Withdrawn due to favorable action in favor of member
 - 63 Reversed

Discussion. No discussion

6. Managed care organization complaints report

Matthew Lum, Managing Ombudsman (OMCAT)

Summary Data was presented for Q1–Q2 FY2026. OMCAT works with consumers (not providers) on questions and complaints. Provider complaints go to another HHSC area. The top overall complaints involve billing for Medicaid services; difficulty receiving home health (PAS/nursing); Medicaid profile errors in HHSC/MCO systems.



The top inquiries relate to Medicaid benefits/policy questions and verifying coverage type; accessing/changing PCP.

Complaint resolution outcomes: 23% substantiated, 47% unsubstantiated, 29% unable to substantiate.

Top substantiated complaints overall: Medicaid profile errors (41), profile changes not processed timely (32), Medicaid applications incorrectly denied (22). Access-to-care substantiated examples included home health (21), DME (18), and non-emergency medical transportation (16).

STAR program: highest complaint category was access to care and common complaints included PCP access, specialist access, and prescription issues tied to incorrect active-inactive coverage status in systems. STAR substantiated examples included newborns not added timely, address changes not updated timely, and incorrect DOB/name entries. STAR trends included consumers with active Medicaid, but dental plan suspended due to a system issue; affected consumers were re-enrolled and the system issue was corrected.

STAR+PLUS: reported a 54% increase in access-to-care complaints from Q1 to Q2 with no single complaint-category trend identified. STAR+PLUS substantiated issues included home health enrollment file problems, DME (including incontinence supplies and claims denied despite authorization), service coordination issues, and transportation problems. A transportation trend was noted with a contractor starting Jan 1, 2026. There were 16 substantiated transportation complaints tied to that contractor by end of Q2, with decreases seen beginning in Q3.

STAR Kids: access to care was the top complaint category. There were small numbers noted for home health, DME, out-of-network access; substantiated examples included incorrectly denied Medicaid application (income counting/processing) and ABA-related issues.

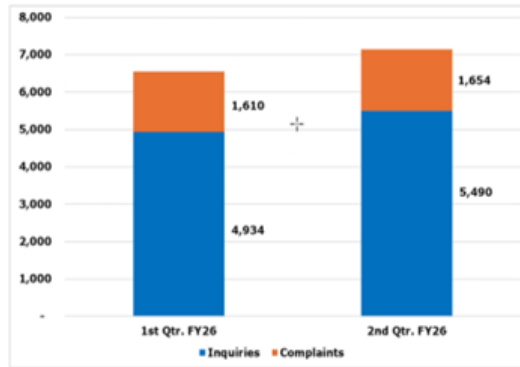
STAR Health: top complaint category was prescription services; no substantiated trend.

Presentation Materials

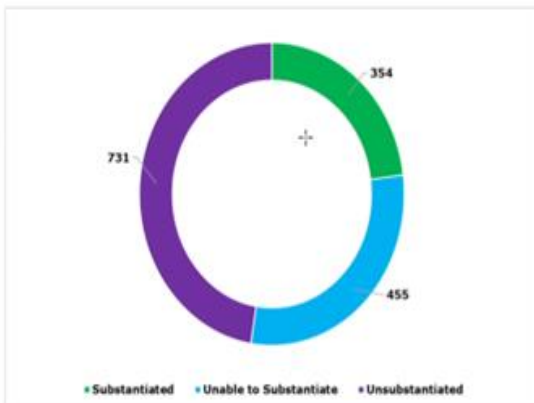
Ombudsman Managed Care Assistance Team (OMCAT)

- Navigate the managed care system
- Understand Medicaid coverage
- Understand rights
- Advocate for themselves
- Resolve problems, including access to care

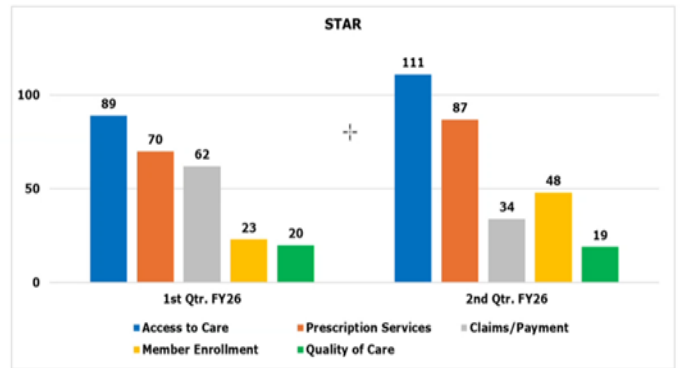
OMCAT Quarterly Contacts



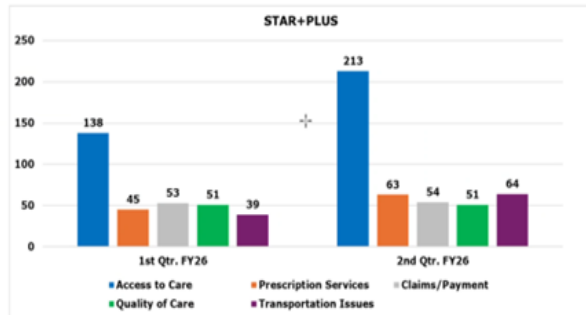
OMCAT Complaints by Resolution



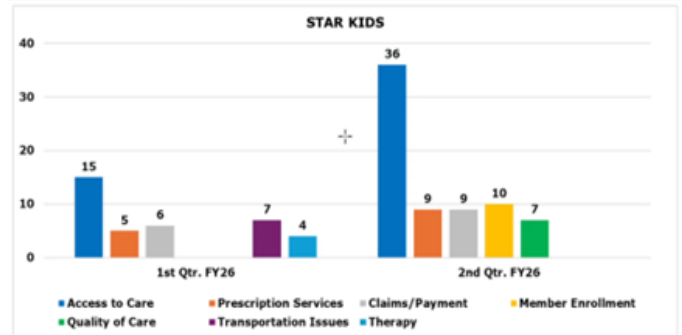
Top Complaints by Managed Care Program



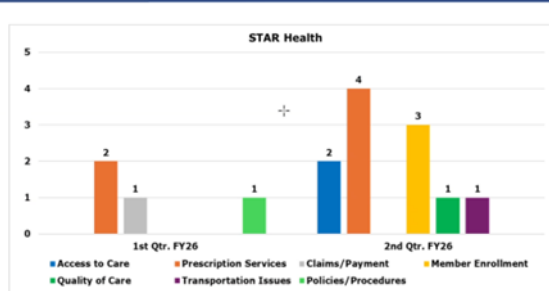
Top Complaints by Managed Care Program



Top Complaints by Managed Care Program



Top Complaints by Managed Care Program



Contact us

Phone (Toll-free)

- Main Line: 877-787-8999
- Managed Care Help: 866-566-8989
- Foster Care Help: 844-286-0769
- Behavioral Health: 800-252-8154
- IDD: 800-252-8154
- Relay Texas: 7-1-1

Online

<https://hhs.texas.gov/omcat>

Fax (Toll-free)

888-780-8099

Mail

HHS Ombudsman
P. O. Box 13247
Austin, Texas 78711-3247

Discussion

The Chair asked about how OMCAT handles trends. HHSC described their internal analysis process, contacting program areas to verify issues, making systems improvement recommendations, and tracking in the Ombudsman annual report (released in December).

Is there a trend with specialists? You had referenced OBs. The speaker stated it does not seem to be a trend, but that specialist appears more than others.

We have had pregnant moms getting disenrolled in Medicaid. Have you seen complaints along those lines? HHSC stated they have not seen this as a trend, but more information might provide a different answer. The eligibility complaints that they get are people who call "the line". There are other avenues of complaint that are not reflected in these data..

7. Public comment. No public comment was offered.

8. Review of action items and agenda items for next meeting.

Action and Agenda Items

Hear more on member eligibility issues especially as it relates to access to care (Dental, OB and other)

Complaints from providers regarding enrollment



Future Meetings

- Aug. 13, 2026
- Nov. 5, 2026

9. Adjourn. There being no further business, the meeting was adjourned.

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