State Medicaid Managed Care Advisory Committee
FINAL DRAFT November 9, 2017
10:00 a.m.

Health and Human Services Commission
Brown-Heatly Building
Public Hearing Room
4900 N. Lamar Blvd
Austin, TX 78751

Agenda Item 1: Call to order

Mr. Chase Bearden, Vice Chair called the third meeting of the State Managed Care Advisory Committee (SMMCAC) meeting at 10:03 a.m. Mr. Chase Bearden presiding as vice chair welcomed committee members and the public. He informed committee members that today would once again be dedicated to follow-up on the SMMCAC strategic plan and the committee's annual report to the executive commissioner.

Agenda Item 2: Roll Call

Mr. John Chacón, HHSC Stakeholder Relations, conducted a member roll call and announced the presence of a quorum.

Mr. John Chacón, HHSC Stakeholder Relations, announced that the meeting was being conducted in accordance with the Texas Open Meetings Act and that today's meeting was being webcasted. Table 1 denotes committee member attendance.

Table 1: The State Medicaid Managed Care Advisory Committee member attendance at the Thursday, November 9, 2017 meeting.

MEMBER NAME	YES	NO	MEMBER NAME	YES	NO
Abraham, Deanna		X	Gore, John		X
Adams, Michael	X		Fagen, Janice	P	
Asbury, John M.D.	X		Klein, Sandy (Chair)		X
Bearden, Chase (Vice-Chair)	X		Michelsen, Soad MD		X
Borrego, Fabian	X		Schaefer, Michelle	X	
Carter, Troy	X		Weden, David	X	
Deming, Laura		X	VACANT (Consumer)		
Dunkelberg, Anne	X				

Yes: Indicates attended the meeting
No: Indicates did not attend the meeting
P: Indicates attended via phone

Agenda Item 3: Adoption of August 17, 2017 meeting minutes

Mr. Bearden called for a motion to approve the minutes of the August 17, 2017 meeting minutes.

Motion:

Dr. John Asbury moved to approve the minutes from the August 17, 2017 meeting as presented. Mr. David Weden seconded the motion. The Committee members unanimously approved the minutes by voice vote, with nine Yea's, no nays and no abstentions.

Agenda Item 4: State and federal legislative actions that affected Medicaid managed care

Ms. Michelle Erwin provided an update on the state and federal legislative actions that affected Medicaid Managed Care. Highlights of presentation and member discussion include:

- Ms. Erwin stated that the HHS staff came across 1761 bills and of those 600 were Medicaid related and of those there were 55 bills that ended up impacting Medicaid.
- Legislation and riders impacting Medicaid Managed care that were presented included the following:
    - Mental Health screening and Behavioral Health
        - HB2466 allows reimbursement for mental health screening during a well child visit. There was also a requirement for new questions on the application related to first pregnancy.
        - HB1486 requires a peer specialist benefit. This was specific to behavioral health.
        - HB1600 allows mental health screening whenever needed and reimbursed.
        - HB10 MH parity does a lot of things but in Medicaid it addresses requirements related to parity. HHSC has been working on this for a while and the deadline is December 7th.
    - Ensuring Continued coverage
        - HB337 requires HHSC to suspend Medicaid eligibility if a person is in jail and then reinstate after release. This is contingent on funding.
        - HB3292 Medicaid level coverage if a temporary increase in income for a month or less occurs (it can happen periodically in SSI in some months). Individuals receiving services through a waiver or ICF has stipulations that narrow the scope.
    - Pharmacy Benefits
        - HB1917 extends the preferred drug list at HHSC until 2023.
        - HB1296 requires MCOs and HHSC to address requests for partial refills addressing synchronization.
    - Telemedicine
        - SB922 relating to the reimbursement of certain providers, including school providers, under the Medicaid program for the provision of telehealth services.
        - SB1107 updated occupations code to allow telemedicine for these.
    - Foster care
        - SB11. STAR Health for Foster care DFPS notification after a placement change and notify PCP of a placement change. Foster Children in custody more than three business days receive a medical exam if there was abuse. Contract standards must follow contract.
        - HB5 Makes DFPS a stand-alone agency.
    - Budget Rider Requirements
        - Rider 27 Evaluation of Medicaid Data.
        - Rider 187 consumer direction.
        - Rider 165 coordination of services between dental services organizations and MCOs (MCO is responsible for emergency dental services and there is also interplay in anesthesia.
        - Rider 205 evaluate EVV program with report due March 31.
        - Rider 219 study potential cost savings and the prescription drug benefit (single processor model, guaranteed risk margin, capitation changes, pricing methodology based on national average drug acquisition cost.

- Rider 220 Independent comprehensive review of managed care in Texas dues September 1. This dovetails with the responsibilities of this committee.
- Rider 34 Cost Containment rider requiring $350 million in general revenue.
- Rider 158 risk margins addressed for cost savings.

- Question was asked by a committee member whether HHSC would end up looking at therapies and networks and how much is being lost and Ms. Erwin responded that Rider 218 requires restoration of 25% of reductions. She stated that HHSC, from the beginning of the rate cuts, has implemented a process for monitoring the rate cuts. She also stated that there is also another rider that requires reporting rate cuts when they occur and that HHSC will take the monitoring the therapy rate cut a step further.
- A committee member stated that some providers dig into their own pockets to keep services open and that this has to be accounted for. HHSC stated that there is a process for monitoring the adequacy of services at MCOs.
- Question was asked by a committee member that with the restoration of rates that if MCOs were required to pass on to the providers and Ms. Erwin responded that it will be reflected in the capitation rates and so there is an expectation that they will comply.
- Committee member made a comment that MCOs are dependent on the rate schedules published by TMHP.
- Committee member made a comment regarding post-partum depression screenings and that the committee needs details on how this will operationalize. Committee member stated that the benefits to mothers expire after two months. Committee member asked what happens if the screen is positive and Medicaid is non-functional. Committee member suggested extending out the benefit an additional 4 months.
- Committee member made a comment that one cannot get children in for mental health benefits because there are not enough providers. Committee member stated that while one has to screen teen mothers there are not enough providers to address the results of the screen.
- Ms. Erwin stated that this is a recurring issue. HHSC plans to do what they can about referrals and next steps when Medicaid ends. Ms. Erwin stated that HHSC is working to address that concern.
- Committee member stated that one can use the child's eligibility to address the post two months Medicaid eligibility for the mother.

Agenda Item 5: Discussion of agency operational plan

Ms. Michelle Erwin lead the of the agency operational plan and referred to PowerPoint/Handout entitled MCS Operational Plan and Medicaid Org. Chart. Highlights of presentation and member discussion include:

- Ms. Erwin stated that it is the intent of HHSC to align the agency's Medicaid CHIP operational plan with that of the Statewide Medicaid Managed Care Advisory Committee's strategic plan.
- Ms. Erwin stated that Ms. Stephanie Muth would be stepping in as the new Medicaid Director at the end of November 2017.
- Ms. Erwin laid out the following priorities of the operational plan:
    - Advancement of Value-based Health Care
    - Encounter Data Integrity
    - Enrollment Eligibility
    - Maternal Depression Screening
    - Medicaid and CHIP Policy Modernization

    - Medicaid System Modernization
    - MCO Prior Authorization Impact to Access to Care
- Committee member made a comment that this MCO Pay for Quality program is revenue neutral and providers who meet these criteria get ten percent more and those that don't divide the rest of the pot putting them at a 60% rate. Committee member stated that providers will drop out if they hit 60% and the program will end up with less and less providers.
- Committee member made a comment that value based purchasing is supposed to dovetail with pay for quality.
- Committee member made a comment that the recipient of care has a portion of this that the provider cannot control.
- Committee member made a comment that HHSC/MCOs should sit down with providers that are not achieving the targets to see how to fix it and that the funds should be diverted to make this happen at the MCO and provider level.
- Committee member made a comment that there may be some areas that providers cannot compete because providers are different. Ms. Erwin stated she will take that back for discussion.
- Committee member made a comment it was good that prior authorization is being watched and reviewed. Committee member stated that PAs can often not do what they are intended for patient care and transparency is needed and HHSC has to see where this is over used. Committee member stated that disincentives for MCOs should be applied when they are overused.
- Committee member made a comment that some authorizations happen in 72 hours and others require lengthy paper work and as such patients are left waiting for services. HHSC stated that MCOs have expectations in their contracts about prior authorization response times.
- Committee member made a comment that there are programs where over use cost reductions really are minimal and to reduce costs you have to provide fewer benefits.
- Committee member made a comment that HHSC has told the committee over and over that MCOs are all aligned but prior authorization is an area where they are not the same. Committee member stated that consistency is needed. HHSC stated that MCOs are not required to have the same prior authorizations and that this committee has discussed prior authorization over and over. HHSC stated that different PAs is one thing but getting in the way of access or service is something else.
- Committee member stated that the committee has talked about standard authorization forms and that is not the focus of this.
- Question was asked by a committee member regarding the date that will be used and Ms. Erwin responded that HHSC will go on site with the MCO and they will look at MCO encounter data.
- Committee member stated that timeliness is a critical issue. HHSC stated they will be looking at timeliness and HHSC has not always had a utilization review unit so this is the first time down this path, especially for acute care.
- Committee member stated that there are a lot of advisory groups interested in these topics and that after the December 2nd deadline for parity, the SMMCAC committee will need a briefing on implementation efforts that would be open to all.

Agenda Item 6: September 1, 2017, Medicaid managed care carve-in update

a. Adoption assistance and permanency care assistance into STAR

b. Medicaid for breast and cervical cancer into STAR+Plus

Ms. Marisa Luera, Manager, Policy & Program Development, MCS, provided an update on adoption assistance and permanency care assistance into STAR and STAR Kids, and Ms. Estelle Brooks provided an update on the Medicaid for Breast and Cervical Cancer program into STAR+PLUS, and referenced PowerPoints/Handouts entitled "Adoption Assistance and Permanency Care Assistance" and "Medicaid for Breast and Cervical Cancer Program Updates" respectively. Highlights of presentation and member discussion include:

- Ms. Luera stated on September 1, 2017, more than 50,000 children and young adults in Department of Family and Protective Services Adoption Assistance and Permanency Care Assistance programs enrolled in STAR and STAR Kids managed care. She stated that most AA and PCA members are enrolled in STAR and receive service management, including biannual outreach.
- Committee member made a comment that the transition was very easy for his children and all the services are in place. He expressed appreciation.
- Ms. Brooks stated that on Sept. 1, 2017, more than 4,000 women in the Medicaid Breast and Cervical Cancer (MBCC) program enrolled in STAR+PLUS managed care. She stated that women eligible for Medicare effective September, October or November 2017 remained in fee-for-service.
- Ms. Brooks stated that to get into the program women go through contracted providers for completion of the application, and eligibility determination process to determine the women meet the qualifications for the program.
- After noting the benefits of the STAR+PLUS for MBCC clients, which includes unlimited prescriptions, a question was asked by a committee member regarding prescription limits. Ms. Brooks responded in fee for service there is a three prescription per month limitation. Committee member stated that there are not very many people in fee for service and Ms. Brooks agreed and noted there is a small populations of adults who remain in fee for service, but most are in managed care.

Agenda Item 7: Discussion and adoption of changes to the committee's strategic plan

Ms. Rebecca Alejandro led the discussion on suggested changes to the committee's strategic plan and referenced handout entitled "Draft State Medicaid Managed Care Advisory Committee (SMMCAC) Strategic Plan May 2017". Highlights of member discussion include:

- Ms. Alejandro stated that edits were included from subcommittees and HHSC management was pleased with the draft and did not make any changes.
- Ms. Anne Dunkelberg stated some of her suggestions did not get into the draft and HHSC staff acknowledged the oversight and incorporated her edits during lunch and presented to full committee.
- Ms. Dunkelberg's concerns included tracking system for timeliness and eligibility denials and recommended they be moved. She stated that there was an action 3.1.2 that said ensured enrollment system was seamless for applicants… She stated that there was a 3.1.3 that was in original draft that was now removed. She stated that the committee and HHSC has worked hard to get people a denial notice that is clear to understand.
- It was noted that the suggestion was related to Goal 3.1.2 that included the following bullets (paraphrased).
    - Develop a tracking system clear for applicants
    - Improve timeliness of application response
    - Clearly defined reasons for denials

- Mr. Bredwell stated that this will be a living document so changes can be made down the line but hopefully without a long agenda item each meeting. HHSC stated it will look at the process to make such changes.

Mr. Bearden called for a motion to adopt the SMMCAC Strategic Plan.

Motion:

Mr. David Weden moved to adopt the SMMCAC Strategic Plan (version 2 presented) with edits from Ms. Anne Dunkelberg to add 3 bullets back to 3.1.2 and language that addresses eligibility and enrollment. Ms. Anne Dunkelberg seconded the motion. The Committee members unanimously adopted the SMMCAC Strategic Plan by voice vote, with nine Yea's, no nays and no abstentions.

Public comment

No public comment was offered.

Agenda Item 8: Subcommittee reports:

a. Subcommittee on Goal 1 (Provide HHSC leadership with an accurate and balanced view of both challenges and opportunities identified in the Medicaid managed care delivery system, and offer innovative and operationally practical solutions)

b. Subcommittee on Goal 2 (Develop sound recommendations that directly affect Medicaid managed care clients by prioritizing quality health outcomes, patient safety, and fiscal responsibility in the delivery of programs and services)

c. Subcommittee on Goal 3 (Advise Health and Human Services on activities related to ensuring clients or members are receiving timely care coordination for medically and functionally necessary services across all Medicaid managed care programs. This will include recommendations for continuous collaborative communication between Health and Human Services, managed care organizations, members, and providers, as well as for the rapid resolution of eligibility and enrollment issues.

d. Managed care organization automated telephone system subcommittee

Mr. David Weden, Ms. Michelle Schaefer, Ms. Anne Dunkelberg and Mr. Troy Carter provided an update on each of the subcommittees listed above. Highlights of updates member discussion include:

- Regarding the Goal #1 subcommittee, Mr. David Weden stated that there has not been a lot of progress since the last meeting. He indicated that the subcommittee had made two pages of document requests from HHSC.
- Regarding the Goal #2 subcommittee, Ms. Michelle Schaefer stated that they have been successful in meeting on two occasions. She stated that the subcommittee had addressed some concerns related to providers not knowing the different categories; value based payment and that it is a balancing act. She stated that it is the intent to be fair and effective (not a punishment). She stated that the subcommittee discussed the deadlines and the need to be clear about contracts. She also stated that the subcommittee had been given a reference from Billy Milwee to assist the group.

- Regarding the Goal #3 subcommittee, Ms. Anne Dunkelberg stated that she has overcommitted and has not taken any action. She indicated that this is the bottom of her priorities so she is seeking someone to take over the chairmanship. She stated that the subcommittee wanted to get the perspective of some MCOs and wanted to bring the knowledge of the managed care working group to this effort. She stated that the subcommittee wanted quality improvement information and representation. She stated they needed a care coordination crosswalk type document related when people move from one program in managed care to another. She stated that there seems to be silos from one program to another. She stated that there is difficulty in identifying best practices in care coordination and that there are not a lot of best practices out there for care coordination.
- Regarding the managed care organization (MCO) automated telephone system subcommittee, Mr. Troy Carter stated that they have not had a chance to meet. He stated that the subcommittee is going to move forward to create a template for asking questions related to phone trees.
- Mr. Bredwell stated that HHSC had proposed sit down subcommittee meetings before the full committee quarterly meetings as well as in between full committee quarterly meetings and wanted to put this on members radar as an option.

Agenda Item 9: Discussion and adoption of the committee report to the Executive Commissioner

Ms. Janice Fagen led the discussion on the committee's report to the Executive Commissioner and referenced draft handout entitled "The State Medicaid Managed Care Advisory Committee Report to the Executive Commissioner". Highlights of member discussion include:

- Mr. Charles Bredwell opened the discussion by stating that a report would be sent to the Executive Commissioner this year and a vote would be required by the committee to adopt and submit report to the Executive Commissioner.
- Question was asked by a committee member if this report was being submitted directly to the Executive Commissioner and Mr. Bredwell responded "Yes".
- Question was asked by a committee member regarding if there are changes down the line does the committee re-submit to the Executive Commissioner and Mr. Bredwell responded that any future changes would be sent to the Executive Commissioner in the next report.

Mr. Bearden called for a motion to adopt the committee report to the Executive Commissioner.

Motion:

Mr. Michael Adams moved to adopt the committee report to the Executive Commissioner with edits from the SMMCAC Strategic Plan (version 2 presented) previously adopted during agenda item # 7. Mr. Troy Carter seconded the motion. The Committee members unanimously adopted the committee report to the Executive Commissioner by voice vote, with nine Yea's, no nays and no abstentions.

Public comment

No public comment was offered.

Agenda Item 10: Adjournment

Mr. Chase Bearden, Vice Chair adjourned the meeting at 2:00 p.m.