State Medicaid Managed Care Advisory Committee (SMMCAC)

Goal 1 Subcommittee

Proposed Recommendation 1:

Recommend to the State Medicaid Managed Care Advisory Committee the inclusion in the next report to the Executive Commissioner the recommendation that the Health and Human Services Commission work to develop best practices and any necessary rules or contract language regarding efficiencies for coordinating benefits (wrapping benefits) between insurance plans when an individual has dual or tri coverage that includes a Medicaid Managed Care Plan (e.g. Medicaid, Medicare, Private Insurance)

Rationale:

In reviewing information in the media, from families' personal experiences, and in reports of hearings with the Texas Legislature, a thematic issue kept arising regarding denial or delay of services for individuals who had Medicaid Managed Care as well as Private Insurance and/or Medicare. In reviewing the potential issues and in hearing reports on investigative work by the Texas Association of Health Plans, the following was discovered:

- If both Medicaid and Medicare - Medicare won't cover procedure X because determined not medically necessary, Medicaid would not pick it up because Medicare denied it. If denied by Medicaid because not a covered benefit under Medicare then Medicaid will cover.

- Biggest issue relates to the need to wait for a denial from Medicare.

- Often times providers won't submit claim to Medicare because they know it won't meet medical necessity resulting in no Medicare denial to work from. DME provider won't submit to Medicare unless they think it will be covered. They must deliver device/supply to client before they bill Medicare so incentive not to provide benefit unless they know they will be paid and it will be covered by Medicare.

- If Medicare is primary and if it is a Medicaid covered service – for state plan (not waiver) non LTSS services, the claim goes to TMHP but they also need a Medicare denial before they can pay cover the service.

- Many times when Medicare is primary the Medicaid MCO never hears anything because provider is responsible for alerting Medicaid.

- Plans have seen the process work better in other states where the duals are fully carved in.

- Option to consider: move wrap to managed care from TMHP. Issue that needs to be resolved before this option is feasible is the state will need to identify all the wrap services and develop a chart.

- There is a Lack of understanding at TMHP and as to what they are responsible for covering. Also the plans do not have a reliable point of contact at TMHP when there is a need to coordinate.

With the initiation of STARKIDS, this has become a growing issue and would be an additional area of concern as the state considers rolling some additional long-term care waivers into Medicaid Managed Care. While Medicaid is designed to be the payer of last resort, it is imperative that best practices be determined to ensure individuals receive necessary services in a timely manner.

Proposed Recommendation 2:

Recommend to the State Medicaid Managed Care Advisory Committee the inclusion in the next report to the Executive Commissioner a recommendation that the Health and Human Services Commission develop a network adequacy standard for Child Psychiatry.

Rationale:

While we recognize that there is a shortage of Child Psychiatrists in Texas, it is important to denote the importance of the specialty service and its availability within the overall behavioral health system of care. Currently there are Network Adequacy Standards for Pediatricians and Pediatric Dental in the medical and dental areas respectively, but there is not a specific Child Psychiatry standard within the Network Adequacy Standards.

Proposed Recommendation 3:

Recommend to the State Medicaid Managed Care Advisory Committee the inclusion in the next report to the Executive Commissioner the recommendation to have Health and Human Services review the appropriateness and reasonableness of Network Adequacy Standards for:

Provider Type	Metro, Micro or Rural	Standard
Endodontist	Rural	Nearest One Provider**
		Nearest Two Provider**
	Metro	Nearest Two Provider
	Micro	Nearest Two Provider
Oral Surgeon	Rural	Nearest Two Provider**
		Nearest One Provider
Periodontist	Micro	Nearest One Provider **
		Nearest Two Provider**
	Rural	Nearest One Provider**
		Nearest Two Provider**
	Metro	Nearest One Provider
		Nearest Two Provider
Prosthodontist	Metro	Nearest One Provider**
		Nearest Two Provider**
	Micro	Nearest One Provider**
		Nearest Two Provider**
	Rural	Nearest One Provider**
		Nearest Two Provider**

Provider Type	Metro, Micro or Rural	Standard
Orthodontist	Rural	Nearest One Provider
		Nearest Two Provider
Acute Care Hospital	Rural	Nearest Two Provider

Rationale:

Based on subcommittee analysis of the *Geodistance Results FY18Q4 20180822* file, all of the measures Network Adequacy Standards being recommended for review showed that at least 20% of the counties within the category did not have any Medicaid MCO within the program types of Dental Medicaid, STAR, STAR Health (Foster Care), STAR Kids, and STAR Plus that met the 75% standard of the measure. For the measures flagged with ** in the table above, greater than 40% of the counties did not have any Medicaid MCO that met the 75% standard for the measure. Following is a table showing the number and percentage of counties where the geodistance results for the network adequacy report showed that no Medicaid MCO was meeting the 75% standard for the measure:

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Analysis of Percentage of Counties without any MCO Meeting the Current Network Adequacy Standards by Provider Type

	Metro (45 Counties)				Micro (31 Counties)				Rural (176 Counties)*			
	One Provider Pass Fail 75%		Two Provider Pass Fail 75%		One Provider Pass Fail 75%		Two Provider Pass Fail 75%		One Provider Pass Fail 75%		Two Provider Pass Fail 75%	
	# Counties 100% Fail	%age of Counties w/ 100% Fail	# Counties 100% Fail	%age of Counties w/ 100% Fail	# Counties 100% Fail	%age of Counties w/ 100% Fail	# Counties 100% Fail	%age of Counties w/ 100% Fail	# Counties 100% Fail	%age of Counties w/ 100% Fail	# Counties 100% Fail	%age of Counties w/ 100% Fail
Acute Care Hospital	0	0%	0	0%	0	0%	0	0%	12	7%	**46**	**26%**
Behavioral Health-outpatient	0	0%	0	0%	0	0%	0	0%	1	1%	2	1%
Cardiovascular Disease	0	0%	1	2%	0	0%	1	3%	18	10%	24	14%
Endodontist	7	16%	**12**	**27%**	3	10%	**11**	**35%**	**84**	**48%**	**98**	**56%**
ENT (otolaryngology)	0	0%	0	0%	0	0%	1	3%	15	9%	18	10%
General Surgeon	0	0%	0	0%	0	0%	0	0%	8	5%	12	7%
Main Dentist	0	0%	0	0%	0	0%	0	0%	2	1%	4	2%
Nursing Facility	0	0%	0	0%	0	0%	0	0%	5	3%	5	3%
OB/GYN	0	0%	0	0%	0	0%	0	0%	5	3%	11	6%
Ophthalmologist	1	2%	2	4%	2	6%	2	6%	30	17%	33	19%
Oral Surgeon	2	4%	5	11%	1	3%	2	6%	**43**	**24%**	**82**	**47%**
Orthodontist	1	2%	3	7%	2	6%	2	6%	**37**	**21%**	**42**	**24%**
Orthopedist	0	0%	1	2%	0	0%	1	3%	12	7%	22	13%
OT PT ST	0	0%	0	0%	0	0%	0	0%	7	4%	17	10%
Pediatric Dental	0	0%	0	0%	1	3%	1	3%	17	10%	17	10%
Pediatrician	0	0%	1	2%	1	3%	1	3%	2	1%	6	3%
Periodontist	**14**	**31%**	**14**	**31%**	**13**	**42%**	**13**	**42%**	**117**	**66%**	**119**	**68%**
Prenatal	0	0%	1	2%	0	0%	0	0%	6	3%	16	9%
Primary Care Provider	0	0%	0	0%	0	0%	0	0%	1	1%	3	2%
Prosthodontist	**26**	**58%**	**39**	**87%**	**24**	**77%**	**27**	**87%**	**161**	**91%**	**167**	**95%**
Psychiatrist	0	0%	0	0%	0	0%	0	0%	12	7%	19	11%
Urologist	0	0%	1	2%	0	0%	1	3%	18	10%	30	17%

**Rural does not include Kenedy or Loving Counties which both showed all measures as NA*

Greater than 40% of the counties in the category do not have an MCO that meets the standard

Greater than 20% but less than 40% of the counties in the category do not have an MCO that meets the standard

CHIP and CHIP Dental were not included in the analysis or in the results above as it was determined that a portion of the CHIP networks were not reported timely and showed no providers.

In reviewing the suggested Network Adequacy Standards, it is suggested that Health and Human Services Commission:

1. Determine if the information utilized is accurate or if there were network reporting issues that are causing a higher percentage of counties to show as not having an Medicaid MCO that meets the 75% threshold;
2. Review if the network adequacy standard is appropriate or should be adjusted for the particular provider type and county type;
3. Consider if the particular provider type and county type combination is a critical service, and, if so, if the current rates can attract and retain providers in those areas or if special incentive programs need to be considered for additional funding to help attract and retain the critical service providers.