State Medicaid Managed Care Advisory Committee Annual Report to the 87th Texas Legislature

As Required by

Texas Administrative Code Title 1,

Part 15, Chapter 351, Subchapter B,

Division 1 Rule 351.805(d)(2)

State Medicaid Managed Care

Advisory Committee

December 2020

About This Report

This report was prepared by members of the State Medicaid Managed Care Advisory Committee. The opinions and recommendations expressed in this report are the members' own and do not reflect the views of the Texas Health and Human Services Commission Executive Council or the Texas Health and Human Services Commission.

The information contained in this document was discussed and voted upon at regularly scheduled meetings in accordance with the Texas Open Meetings Act. Information about these meetings is available at: https://hhs.texas.gov/about-hhs/leadership/advisory-committees/state-medicaid-managed-care-advisory-committee

Report Date

December 2020

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1. Letter from the Chair

Dear Members of the Texas Legislature and Health and Human Services Executive Commissioner Cecile Young:

The State Medicaid Managed Care Advisory Committee (SMMCAC) is pleased to submit our biannual report, due by December 31, 2020 in accordance with Texas Administrative Code Title 1, Part 15, Chapter 351, Subchapter B, Division 1 Rule 351.805(d)(2)

On behalf of the SMMCAC, I want to begin by thanking the Texas Legislature, everyone at Health and Human Services Commission (HHSC), everyone with the Medicaid managed care plans, all of the providers throughout the state, and the individuals receiving Medicaid services along with their families and advocates. The changes that have been made over 2020 to ensure some of the most vulnerable citizens in our state were able to receive critical services while maintaining a safe environment due to COVID-19 are some of the most expansive and swiftest changes we have seen in our system of care. The level of effort and cooperation shown throughout the system demonstrate why it takes all of us working together to meet the needs of our citizens. It speaks to the heart of this SMMCAC. The SMMCAC is comprised of representatives from individuals receiving services and their family members or advocates, representatives of Managed Care Organizations, and representatives of provider organizations. Working together, as a system of care, we gain a greater understanding of challenges and collaborate to find ways to continuously improve our system of care in order to more efficiently and effectively serve Texans through Medicaid Managed Care in Texas.

As per the Texas Administrative Code Rule 351.805(b), the purpose of the SMMCAC is as follows:

1. The SMMCAC advises HHSC on the statewide operation of Medicaid managed care, including program design and benefits, systemic concerns from consumers and providers, efficiency and quality of services, contract requirements, provider network adequacy, trends in claims processing, and other issues as requested by the Executive Commissioner.
2. The SMMCAC assists HHSC with Medicaid managed care issues
3. The SMMCAC disseminates Medicaid managed care best practice information as appropriate.

According to the Texas Medicaid and CHIP Reference Guide Twelfth Edition, 92% of individuals in Medicaid and CHIP in Texas, approximately 4.1 million individuals, receive services through managed care. As members of the SMMCAC, it is our honor and privilege to serve these Texans by working together and making recommendations for continued improvement of the managed care service delivery system.

Thank you for this opportunity to serve. The following report includes reporting of SMMCAC activities as well as recommendations of the committee.

Respectfully,

David A. Weden
Chair, State Medicaid Managed Care Advisory Committee

2. Committee Recommendations from 2019

Recommendation 1

The SMMCAC recommends standardizing the service management and service coordination terminology in the managed care contracts to service coordination.

Brief Explanation Regarding Recommendation 1

The 2018-19 General Appropriations Act, Senate Bill 1, 85th Legislature, Regular Session, 2017 (Article II, Special Provisions Relating to All Health and Human Service Agencies, Section 25) required HHSC, in collaboration with Department of Family and Protective Services (DFPS), Department of State Health Services (DSHS), and Medicaid and CHIP managed care organizations (MCOs) to review and report opportunities to streamline case management services. In May 2018, HHSC published the Health and Human Services System and Managed Care Report in response to this requirement. Recommendations stemming from this report include:

1. Further assess service coordination and service management in the context of managed care, taking into account different service coordination and service management structures.
2. Align the use of case management terms that are easily misunderstood or sound duplicative (such as service coordination and service management) to ensure greater understanding of the services.

Recommendation #1 seeks to increase clarity of terminology used in managed care for care-coordination-related functions which aligns with item 2 above. This recommendation would simplify and standardize the terminology used for similar functions. The recommendation is not intended to alter the current definitions and scope of work surrounding the existing terms. Rather, the implementation of this recommendation would create levels of service/stratification within the new terminology.

The recommendation could be implemented with contracting cycles beginning on or after September 1, 2020. The committee believes the recommendation will help consumers/clients and providers by simplifying existing terminology that can be misunderstood or confusing. During discussions, some concerns were raised

regarding potential costs of implementing the recommendation in relation to staff training and publication of materials for MCOs. It is believed that these costs could be minimized based on administrative procedures established by the Health and Human Services Commission (HHSC) regarding implementation of the recommendation. Such administrative procedures could include items such as utilizing current stock of materials but requiring any materials printed after a specific date to align with the new terminology. An update on this recommendation is included in Recommendation 12 in the Committee Recommendations from 2020 section of the report.

Recommendation 2

The SMMCAC approved the list of the following in lieu of behavioral health services for HHSC consideration.

1. Cognitive Rehabilitation
2. Collaborative Care Model
3. Integrated Pain Management Day Program
4. Coordinated Specialty Care (CSC)
5. Functional Family Therapy (FFT)
6. Treatment Foster Care
7. Systemic Therapeutic Assessment Resources and Treatment (START)
8. Mobile Crisis Outreach Team
9. Crisis Respite
10. Crisis Stabilization Units/Extended Observation Units
11. Partial Hospitalization
12. Intensive Outpatient Program
13. Health Behavior Intervention Services
14. Multisystemic Therapy (MST)

Brief Explanation Regarding Recommendation 2

Senate Bill 1177, 86th Texas Legislature, Regular Session, 2019 amended Section 533.005, Government Code by adding Subsection (g) to read as follows:

> (g) In addition to the requirements specified by Subsection (a), a contract described by that subsection must contain language permitting a managed care organization to offer medically appropriate, cost-effective, evidence-based services from a list approved by the state Medicaid managed care advisory committee and included in the contract in lieu of mental health or substance use disorder services specified in the state Medicaid plan. A recipient is not required to use a service from the list included in the contract in lieu of another mental health or substance use disorder service specified in the state Medicaid plan. The commission shall:
>
> (1) prepare and submit an annual report to the legislature on the number of times during the preceding year a service from the list included in the contract is used; and
>
> (2) take into consideration the actual cost and use of any services from the list included in the contract that are offered by a managed care organization when setting the capitation rates for that organization under the contract.

This recommendation provides an initial list approved by SMMCAC for consideration by HHSC in managed care contracts. Documentation regarding the evidence behind each service on the list is being provided by various stakeholders to appropriate HHSC staff for review, and the Clinical Oversight and Benefits Subcommittee of SMMCAC intends to discuss the recommended in lieu of services further in anticipation of helping prioritize potential availability. It is hoped that some of the in lieu of services on the list can be fully vetted with Center for Medicare and Medicaid Services and made available with the contract cycle beginning September 2021 at the latest.

Analysis of potential financial impact will be reviewed for each service in conjunction with HHSC staff. It is anticipated that most, if not all, of the in lieu of services on the list will show a net savings as they are available in lieu of potentially costlier services. Additional updated information on this item may be found under recommendation 13 in the Committee Recommendations for 2020 section of this report.

3. Committee Recommendations from 2020

Recommendation 1

HHSC should develop a list of exceptions to telehealth/telemedicine and ensure fee for service align with the intent of Senate Bill 670 (86th Texas Legislature, Regular Session).

Recommendation 2

HHSC should ensure all telehealth and telemedicine is included in the medical portion of the Medical Loss Ratio.

Recommendation 3

HHSC is encouraged to conduct an environmental scan regarding any barriers administratively that may limit or discourage utilization of telehealth and telemedicine.

Recommendation 4

HHSC should review potential means for including telehealth and telemedicine in network adequacy standards.

Recommendation 5

Recommend HHSC consider covering audio only, telehealth/telemedicine services and extending indefinitely the modalities to have increased access to care, and more services be covered by telehealth/telemedicine in line with national coverage standards (e.g. Medicare).

Recommendation 6

Recommend that HHSC permanently allow service coordination assessments and face-to-face visits to occur by way of a telehealth modality if medically appropriate, is the member's choice, and is technologically and physically feasible for the member; in order to reduce costs, improve access to service coordination, and improve efficiency.

Brief Explanation Regarding Recommendations 1 through 6

Recommendations 1 through 6 deal with availability of telemedicine and telehealth for various services throughout the Medicaid managed care system. As allowances have been made during the public health emergency related to COVID-19, the managed care system has pivoted to have available virtual and telephonic services, helping ensure the safety and care of Texans with Medicaid coverage. As we move forward, the committee believes it is imperative that we retain appropriate flexibility in service delivery models to help ensure individuals receive appropriate services in a manner that is clinically appropriate as well as convenient to the individual receiving services. Video as well as telephonic contacts are being encouraged to be considered for continuation as individuals at high risk for COVID-19 need to maintain as much isolation as possible and not all individuals have direct access to video technology or appropriate broadband for video services. In addition, maintaining the various modalities can help address availability of services within Health Professional Shortage Areas.

In reviewing the interactive maps of Health Professional Shortage Areas (HPSA) at https://dshs.texas.gov/tpco/HPSADesignation/, the following HPSAs are noted:

- Primary Care HPSA Designations – 199 Full Counties and 14 partial counties
- Mental Health HPSA Designations – 206 Full Counties and 4 partial counties
- Dental HPSA Designations – 80 Full Counties and 3 partial counties

Maintaining telehealth and telephonic services as clinically appropriate would help make services more readily available for individuals with Medicaid coverage. The service delivery options would help remove some challenges with transportation or time needed to travel for services, thereby encouraging individuals to reach out for more appropriate access to routine services instead of waiting until a more critical need arose before reaching out for service.

In addition, the Centers for Medicare & Medicaid Services (CMS) recently passed new rules that encourage the utilization of telehealth as well as flexibility within Medicare to count telehealth providers in certain specialty areas toward meeting CMS network adequacy standards. With the number of HPSAs across the state, the committee also believes consideration of similar means to include telehealth and telemedicine in Medicaid Managed Care network adequacy standards should be considered.

Recommendation 7

Recommend review for relief from the duplicative and burdensome (provider) enrollment and credentialing process, request a more streamlined and tighter sequencing of processes, review federal requirements and best practices to streamline the process so that providers can start providing services more quickly, and to allow retro date for service reimbursement to date of enrollment and allow one enrollment to be completed for approval by all MCOs and TMHP.

Brief Explanation Regarding Recommendation 7

Positive changes in the provider enrollment process have been accomplished in the recent past, such as the credentialing verification for MCO applications. There continues, however, to be a burdensome and delayed enrollment with TMHP and then a provider must credential with MCOs. Providers are asking for consideration of steps or progress that can be taken toward a single application for enrollment and credentialing that is required for reimbursement. In addition, a review should be completed regarding the possibility for reimbursement back to the application or enrollment date of the provider who provided treatment to Medicaid Managed Care patients.

Recommendation 8

Recommend HHSC consider and explore any potential access and quality issues due to issues resulting from reimbursement rates set for Durable Medical Equipment (DME) and if there is a need for establishing a separate recognition and coverage for Complex Rehab Technology products and the services that incorporate the customized nature of the technology and the broad range of services necessary to meet the unique medical and functional needs of people with significant disabilities and complex medical conditions.

Brief Explanation Regarding Recommendation 8

The Durable Medical Equipment (DME) benefit was created over forty years ago to address the medical equipment needs of older individuals. Over the years, available technology has advanced and now includes complex rehab power wheelchairs, highly configurable manual wheelchairs, adaptive seating and positioning systems, and other specialized equipment, such as standing frames and gait trainers.

This technology, called Complex Rehab Technology(CRT), is prescribed and customized to meet the specific medical and functional needs of individuals with disabilities and medical conditions such as, but not limited to, Cerebral Palsy, Muscular Dystrophy, Multiple Sclerosis, Spinal Cord Injury, Amyotrophic Lateral Sclerosis (Lou Gehrig's disease), and Spina Bifida. Suppliers who furnish this highly specialize technology provide products and services which are unique and different than standard DME.

CRT requires a broader range of services and more specialized personnel than what are required for standard DME. The provision of CRT is done through an interdisciplinary team consisting of, at a minimum, a Physician, a Physical Therapist or Occupational Therapist, and a Rehab Technology Professional. Devices in this category require a technology assessment completed by a certified Rehab Technology Professional employed by a Complex Rehab Technology Company. This involves matching the medical and functional needs of the individual with the appropriate products. Simulations or equipment trials are often used to ensure that the items are appropriate and meet the person's identified needs. Because the equipment is complex and becomes an extension of the person, fitting, training, and education requires more time than standard DME items.

At a federal level, Congress has acknowledged CRT products are unique and more specialized than standard DME. In 2008 Congress passed legislation exempting complex rehab power wheelchairs from inclusion in the Medicare DME competitive bidding program recognizing that such inclusion would jeopardize access to this customized technology. It is our understanding that a topic nomination form has been submitted to HHSC for consideration.

Recommendation 9

HHSC should consider any potential barriers to ensuring people receive appropriate treatment with respect to COVID-19, analyze the impact of existing policy changes on access to care, and determine which temporary policy changes should remain in the Medicaid program following the public health pandemic.

Recommendation 10

Recommendation that HHSC move to extend the SMMCAC member terms from two years to three years.

Recommendation 11

Recommend that HHSC review the composition of the SMMCAC for more balance between the three primary groups of SMMCAC membership and ensure representation of the adult Medicaid population.

Brief Explanation Regarding Recommendations 10 and 11

The recommendations address the need for a more balanced approach between patients and advocates, providers, and MCOs in order to ensure a balance in discussions and proposed changes regarding the managed care system in Texas. It is currently challenging to ensure a balanced representation in the work groups that have discussion and bring recommendations to the full committee. In addition, it has been noted that it takes new members a good year to get up to speed on the managed care system and to begin to feel comfortable with their overall understanding of the system and making recommendations. As such, it is being recommended that three-year terms be considered for the committee members. HHSC currently has draft rules out for public comment that address these recommendations.

Recommendation 12

Recommend amending the necessary service coordination verbiage (utilizing service coordination for what is currently service coordination and service management) targeted to be effective March 1, 2022 to reflect HHSC's standardization of phrases and terminology as previously recommended in 2019.

Brief Explanation Regarding Recommendation 12

SMMCAC previously made recommendation to HHSC to "standardize the service management and service coordination terminology in the managed care plans to "service coordination". HHSC provided an update on 6/25/2020 to the Service and Care Coordination subcommittee regarding the contract terminology change that was initially planned for implementation with the previous re-procurement expected to go into effect September 2020, which has subsequently been cancelled. HHSC staff provided 2 options: 1. To amend the current contract to incorporate the terminology change to be effective no sooner than 9/1/2021; or 2. To delay incorporation of the terminology change to a new procurement, which has yet to be announced at this time. The Service and Care Coordination subcommittee discussed

these options and heard feedback that managed care plans would struggle to meet a timeline of 9/1/2021. The subcommittee is proposing a timeline of 3/1/2022 to incorporate the terminology change in order to allow plans sufficient time to make necessary changes to their systems and to reduce cost associated with implementation of changes.

Recommendation 13

Recommend HHSC work with stakeholders such as Texas Association of Health Plans (TAHP), Meadows Mental Health Policy Institute, and Texas Council of Community Centers during the review of cost effectiveness of proposed in lieu of services in order to ensure appropriate aspects are being considered, including factors that may be unique to Texas.

Brief Explanation Regarding Recommendation 13

SB1177, 86th Texas Legislature, Regular Session, included a requirement that the SMMCAC provide a list of potential in-lieu of services for HHSC to consider incorporating into Medicaid Managed Care. A listing of services for consideration was provided by the SMMCAC in 2019. Of the recommended services, the following services in-lieu-of inpatient hospitalization are under consideration for incorporation into Managed Care in Texas beginning March 1, 2021:

- Coordinated Specialty Care (CSC)
- Crisis Respite
- Crisis Stabilization Units
- Extended Observation Units
- Partial Hospitalization
- Intensive Outpatient Program

In addition, the following services are under review for consideration by HHSC as Phase 2 services in-lieu-of outpatient services with cost-effectiveness analysis to be completed by September 1, 2022:

- Cognitive Rehabilitation
- Multi-systemic Therapy (MST)
- Functional Family Therapy (FFT)

And the following are in a category that requires further consideration:

- Collaborative Care Model
- Integrated Pain Management Day Program
- Health & Behavior Assessment & Intervention
- Systemic, Therapeutic, Assessment, Resources, and Treatment (START)
- Treatment/Therapeutic Foster Care
- Mobile Crisis Outreach Team (MCOT)

As consideration is made of Phase 2 services as well as services needing further I consideration, the SMMCAC encourages HHSC to coordinate with the recommended resources to ensure all potential aspects of cost-savings are considered as Texas may have unique circumstances from other states.

Recommendation 14

Recommend HHSC to convene a workgroup of dentists representing dental school faculty, Medicaid practicing dentists, state policy staff, and the dental maintenance organizations to thoroughly review and comprehensively update the amount, duration, and scope of the Medicaid dental benefit policies as they impact DMOs.

4. Meeting Dates

Following are the 2020 meeting dates of the State Medicaid Managed Care Advisory Committee as well as the meeting dates of the subcommittees:

State Medicaid Managed Care Advisory Committee (Full Committee)

- March 12, June 26, August 26, and November 19

SMMCAC Clinical Oversight & Benefits Subcommittee

- February 3, March 12, June 26, August 26, and November 19

SMMCAC Service & Care Coordination Subcommittee

- March 11, June 25, August 25, and November 18

SMMCAC Network Adequacy Subcommittee

- March 11, June 25, August 25, and November 18

SMMCAC Administrative Simplification Subcommittee

- March 11, June 18, August 25, and November 18

SMMCAC Complaints, Appeals & Fair Hearings Subcommittee

- March 12, June 26, August 26, and November 19

5. Members as of December 2020

Following is a list of members of the SMMCAC as of the beginning of December 2020.

Name	Area Represented
Michael Adams	Obstetrical Care Provider
Xavier Banales	Aging and Disability Resource Centers
Chase Bearden (Vice-Chair)	Consumer Advocate
Henry Chu	Pediatric Healthcare Providers
Blake Daniels	Independent Living Centers
Christina Davidson	Community-based Organizations
Laura Deming	Family Member
Anne Dunkelberg	Consumer Advocate
Shauna Glover	Medicaid managed care clients or family members who use mental health services
Aron Head	Managed Care Organizations
Mary Klentzman	Clients with disabilities
David Lam	Rural Providers
Ramsey Longbotham	Primary and Specialty Care Providers
Valerie Lopez	Hospitals
Catherine Mitchell	Managed Care Organizations
Leslie Rosenstein	Non-physician Mental Health Providers
Michelle Schaefer	Rural Provider
Patricia "Patsy" Tschudy	Long-term Services and Support Providers
Jacob Ulczynski	Area Agencies on Aging
Laurie Vanhoose	Managed Care Organizations
Alfonso Velarde	Community-based Organizations
David Weden (Chair)	Community Mental Health and Intellectual Disability Centers
Vacant	Managed Care Organizations