State Medicaid Managed Care Advisory Committee Recommendations

"The following recommendations were prepared by members of the State Medicaid Managed Care Advisory Committee. The opinions and suggestions expressed in these recommendations 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."

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.