HHSC: State Medicaid Managed Care Advisory Committee, June 26th, 2020

The State Medicaid Managed Care Advisory Committee provides recommendations and ongoing input on the statewide implementation and operation of Medicaid managed care. The Advisory Committee provides recommendations and ongoing input to the Health and Human Services Commission on the statewide implementation and operation of Medicaid managed care. The committee looks at a range of issues, including program design and benefits, systemic concerns from consumers and providers, efficiency and quality of services delivered by Medicaid managed care organizations, contract requirements for Medicaid managed care, provider network adequacy, and trends in claims processing.

The committee also will help HHSC with policies related to Medicaid managed care and serves as the central source for stakeholder input on the implementation and operation of Medicaid managed care. Members appear below.

David Weden, Chair Community Mental Health and Intellectual Disability Centers Buda, TX	**Mary Klentzman** Clients with disabilities Belton, TX
Chase Bearden, Vice Chair Consumer Advocate Austin, TX	**David Lam, MD** Rural Providers San Antonio, TX
Michael Adams Obstetrical Care Provider Tyler, TX	**Ramsey Longbotham** Primary and Specialty Care Providers Cuero, TX
Xavier Bañales Aging and Disability Resource Centers El Paso, TX	**Valerie Lopez** Hospitals Uvalde, TX
Henry Chu, DDS Pediatric Healthcare Providers Helotes, TX	**Catherine Mitchell** Managed Care Organizations Houston, TX
Blake Daniels Independent Living Centers Tyler, TX	**Leslie Rosenstein, PhD** Non-physician Mental Health Providers Dallas, TX
Christina Davidson, MD Community-based Organizations Bellaire, TX	**Michelle "Mickey" Schaefer** Rural Provider Sonora, TX
Laura Deming Family Member Richmond, TX	**Patricia "Patsy" Tschudy** Long-term Services and Supports Providers Spring, TX
Anne Dunkelberg Consumer Advocate Austin, TX	**Jacob Ulczynski** Area Agencies on Aging San Antonio, TX
Shauna Glover Medicaid managed care clients or family members who use mental health services Corpus Christi, TX	**Laurie Vanhoose** Managed Care Organizations Austin, TX
Aron Head Managed Care Organizations Arlington, TX	**Alfonso Velarde** Community-based Organizations El Paso, TX

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I. Call to order. The meeting was convened.

II. Roll call. A quorum was present.

III. Adoption of March 12, 2020, minutes (vote required). Approved as written.

IV. Advisory Committee Chair updates

a. ***Hospital Payment Advisory Committee.*** Last meeting was held on February 6th. Two informational-only items presented from HHSC: the first was related to Uncompensated Care secondary reconciliation – HHSC proposes to eliminate the requirement that a secondary reconciliation be performed for a hospital that submitted a request for an adjustment to cost and payment data for their UC application in demonstration year 2; the second item relates to payment caps in the DSRIP program – this proposed rule describes new payment caps for the Disproportionate Share Hospital (DSH) and UC Medicaid supplemental payment programs to reimburse hospitals providing services to predominantly Medicaid and low-income patients. HHSC proposes to implement a full offset methodology for the Texas payment cap, meaning any payment for services provided to a Medicaid client will be included as an offset to all appropriate Medicaid costs.

b. ***Intellectual and Developmental Disability System Redesign Advisory Committee***. The STAR+PLUS Pilot Workgroup has also begun work and is on schedule for implementation on time, September 2023.

c. ***Medical Care Advisory Committee.*** This committee meets to address federal requirements to review proposed Medicaid rules. The speaker commented on the fact that many rules are coming to them as informational-only. The last meeting was in February and the next meeting will be in August. There had been discussion about Medicaid notices to families. The language on the Medicaid notices is often confusing and causes panic in families. They requested a work group be formed to address clarity of language. Management is still looking at the request for the workgroup. They looked at MCO audit coordination to minimize duplication of effort. The rules were developed to clarify roles of OIG involvement. There were two items included in HPAC; attendant minimum wage increase from eight dollars per hour to eight dollars and eleven cents was presented as an informational item.

d. ***Perinatal Advisory Committee.*** It has been a while since they met. Now that the rules are in place, they are focusing on best practices. They discussed the SB 749 report and AIM bundles. There was a request for input related to Level Two and Three facilities which felt that their level should be increased. They are considering a survey to create a database. They discussed having parents involved in the comment period. Telemedicine is an important item for consideration now as well.

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e. ***Policy Council for Children and Families.*** They look at improving long-term services and supports as well as service for children across agencies. Issues:
   - Expanding clinics for comprehensive care for adolescents transitioning into adulthood
   - Provider education plans
   - Expanding access to children with disabilities through policy changes
   - Advocating for more waiver slots
   - Reducing interest lists
   - Crisis intervention services access
   - Access for in home and out of home respite
   - Disaster and emergency preparedness declaration
   - Expansion of flexibilities to provide services to children

Budget cuts were mentioned. There is concern due to COVID-19 pandemic-induced budget crisis.

The Chair stated that budget cuts will be on the next agenda of the SMMCAC.

f. ***STAR Kids Managed Care Advisory Committee.*** They met in January, March, and on June 10th. There are new members and their committee numbers 17. There were seven new members. Telehealth has expanded under COVID-19 and is shown to be beneficial. There will be a pilot to simplify prior authorization for enteral feeding supplies. They are working on quality measures and the assessment instrument improvements. They are looking at how to do a dry run with that instrument. Transition services for young adults is being explored. The ACE Kids Act to develop health homes for children is highly anticipated.

V. State Medicaid Managed Care Advisory Committee subcommittee updates:

Administrative simplification

i. *Update on Texas Government Code §531.024163, as adopted by Senate Bill 1207, 86th Texas Legislature, Regular Session, §3(b), 2019.* There was a framework shared and feedback gathered. The language is still in development and it will be posted soon for comment to be effective September of 2020.

ii. *Medicaid provider enrollment and managed care organization credentialing addressed streamlining*. That process and the recommendation was approved and will be sent to leadership.

iii. *Other administrative simplification topics.* Claims methodology addresses HHSC to look at the opportunities to address claims methodology changes. MCOs have unique claims systems. The current system is not up to current coding standards at HHSC. A feasibility assessment would be a distraction with costs that could be used to address the stress to COVID-19. It was a split vote (2-1).

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MOTION *to implement the following*:

Recommendation from Administrative Simplification subcommittee

For full committee consideration on June 26, 2020

"Recommend HHSC review feasibility of where claims processing standardization could occur among managed care entities and TMHP, taking into account contractual and state and federal statute and regulation."

Subcommittee vote:

- Michael Adams – not present
- Valerie Lopez – yes
- Catherine Mitchell – no
- Michelle (Mickey) Schaefer - yes

Comments:

- There's bias in the recommendation that TMHP is the best approach when there were other options that are better
- Providers are experiencing the different ways claims are being handled
- This is a recommendation to move back to fee-for-service (FFS) and I don't know how HHSC would do this
- Cost should be a consideration
- This just looks at reimbursement and not services
- Looking for an industry standard of a best practice
- Clean claims usually go fine but complications make it go past the 95 days sometimes
- This is too broad-based

The MOTION failed on a tie vote.

Clinical oversight and benefits

i. *Update on HHSC's clinical oversight initiative.* Utilization review recommendations have been advanced. They are gathering data on usage with a September 1st deadline for additional data.

ii. *Update on topic nomination form related to complex rehabilitation technology.* They have been working on an updated recommendation for the August meeting to ensure it is complete enough to cover all the right areas.

iii. *Other clinical oversight and benefits topics.* They have been working on telehealth recommendations. They were all in agreement that they would like the committee to continue coverage through the pandemic and beyond (permanently). No-show rates have declined because of the telehealth usage.

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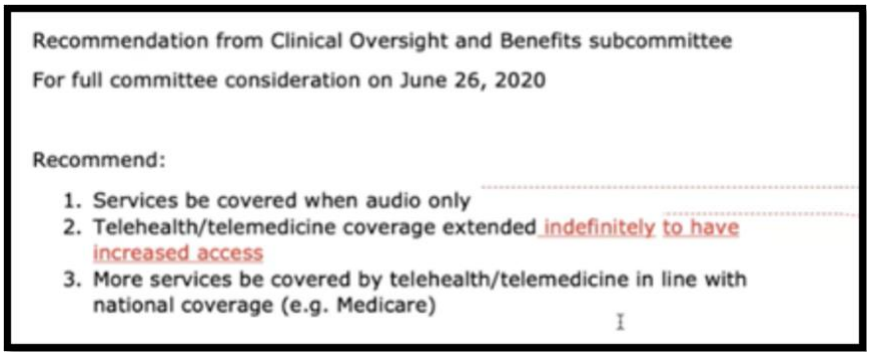
MOTION:


Recommendation from Clinical Oversight and Benefits subcommittee

For full committee consideration on June 26, 2020

Recommend:

1. Services be covered when audio only
2. Telehealth/telemedicine coverage extended indefinitely to have increased access
3. More services be covered by telehealth/telemedicine in line with national coverage (e.g. Medicare)

Amended to have "HHSC look at it."

MOTION: *adopt the recommendation as amended prevailed*.

Complaints, appeals, and fair hearings. The committee met this morning and there are no recommendations

i. *External medical review.* IRO will be doing the medical review. This will be a new option that comes between the internal appeal from a denial, and the fair hearing. The timelines for expedited vs standard were discussed. Forms were also discussed.
ii. *Other complaints, appeals, and fair hearings topics.* Trainings will be provided by HHSC. They hope to get this done before September 1 implementation date. Various and documents and contracts were reviewed. Four sample notices were reviewed and discussed. Each notice will include a letter with specifics; standardized flyer; another form where the enrollee can request what is coming up on their timeline. Conflict of interest will be addressed.

Network adequacy and access to care. They met yesterday.

i. *Telehealth and telemedicine projects.* They had a presentation on how this worked with COVID-19. The medical policies in the provider manual will be coming about. The two-week comment period ends next Monday.
ii. *Delivery System Reform Incentive Program M-9 Milestone: Assessment of telemedicine and telehealth services.* Jimmy Blanton talked about DSRIP. The information provided was pre-COVID-19 and that will probably change things.
iii. *Other network adequacy and access to care topics*. Looking at audio use only was discussed.

He stated they looked at the draft policies for telehealth and telemedicine. These changes were not well advertised, and they should re-examine when the end of the comment period will be.

Service and care coordination

i. *Contract terminology changes.* Update was provided by HHSC. The re-procurement was cancelled. HHSC proposed changing the current contract with the terminology change or delay the change until a new procurement is released. March 1, 2022 for language implementation.

MOTION:

Recommendation from Service and Care Coordination subcommittee

For full committee consideration on June 26, 2020

"Recommend amending the necessary service coordination verbiage targeted to be effective March 1, 2022 to reflect HHSC's standardization of phrases and terminology as previously recommended."

Subcommittee vote:

- Xavier Bañales – yes
- Dr. Christina Davidson – not present
- Laura Deming – not present
- Shauna Glover – yes
- Jacob Ulczynski - yes

MOTION – prevailed.

iv. Results of survey on strengthening service and care coordination between Managed Care Organizations (MCOs) and other case management entities. The agency received a robust response to the survey (3,000 responses). Commission staff was asked for more detailed analysis.

v. Other service and care coordination topics

VI. Prior authorization process and provider burden. *Tabled Until August.*

VII. Health and Human Services Commission updates.

Ms. Stephens stated that they do not know how long the emergency will last and the federal flexibilities have been just month to month. They understand the frustration about the monthly updates. They are looking toward legislation implementation; HB 1576 will now be implemented in June of 2021.

Legislative Update:

Ombudsman Presentation. There were Five Substantiated complaints presented:

- Access to Prescriptions–Member Not Showing Active
- Access to Prescriptions–Other Insurance

- Access to LTSS
- Case Information Error
- Medicaid Eligibility

Access to prescription issues:

- **Members are enrolled with an MCO but not showing as active with the MCO's Pharmacy Benefit Manager (PBM)**
    - A daily file is sent to each MCO for Members retroactively enrolled effective on the first of the month. However, the enrollment file was not uploaded into the MCO's PBM system by the time the Member was trying to obtain prescriptions.

- **Members are active with traditional Medicaid but not showing as having coverage in pharmacy systems**
    - Once certified, it takes three to five business days for a Member's Medicaid coverage to show in pharmacy systems after the Member has been determined eligible for Medicaid.

OMCAT recommends HHSC require MCOs to upload daily enrollment files to their systems within one business day of receiving the files.

Members' Medicaid cases showing private insurance or Medicare that the Member either no longer has or never had. Various sources can report the existence of third-party resource information (other insurance) on a Member's case. These can include the Member, a provider, a Member's caseworker, the Member's MCO, the enrollment broker, or data match files from other systems.

OMCAT recommends continued work with HHS Medicaid & CHIP Services to determine the scope and resolution(s) of the issue.

Access to LTSS. Access to Home Health Services

- Home health agencies not able to cover all required attendant/nursing hours
- Issues with obtaining an assessment for home health services
- Issues with how the MCO conducted the assessment
- Issues with obtaining assistance in transitioning from a facility back into the community
- Decrease in home health hours

Case Information Error. Incorrect demographic information

- Misspelling of name
- Incorrect DOB
- Error in residential address
- Incorrect gender

Medicaid Eligibility

- Medicaid case denied/terminated erroneously
- Children not added to case
- Members unaware Medicaid had ended

(866) 566-8989hhs.texas.gov/managed-care-help

- Any HHS Concern (877) 787-8999
- Behavioral Health (800) 252-8154
- Foster Care (844) 286-0769
- Intellectual Disabilities (800) 252-8154
- Long-term Care (800) 252-2412Ombudsman 10

Teleservices

At the March 2020 Meeting a recommendation was made to HHSC.
Committee and Subcommittee Recommendation

- Recommendation to develop list of services excluded from coverage as telemedicine or telehealth services.

Limitations to Exclusionary List

- Changes to clinical practice guidelines and practice environments for remotely delivered services.
- Development of new telecommunications technology.

HHSC will not act on this recommendation.

SB670 Update. **TMPPM Updates**

- Draft Telemedicine and Telehealth Services medical policies posted for public comment.
- Considering additional amendments to formalize coverage expectations for managed care.
- Additional outreach to providers and MCOs concerning coverage expectations.
- Fall 2020 implementation goal.

Comments:

- Audio only was excluded and should be reconsidered
- FQHCs were included in the legislation. Are they being included in this draft policy? HHSC stated this will occur in the future.

Procurement Update: Children's Medical Center health plan. Children's Medical Center Health Plan pulled out of STAR Kids (serving slightly half of the children with 640 MDCP Children). There was an emergency procurement effort and Aetna Better Health of Texas will be under

contract by October 1, 2020. Families will receive an information letter and can choose between Amerigroup or Aetna. There will be targeted outreach during the transition. Members can switch at any time consistent with established processes. They are ensuring continuity of care through exchange of information between the former MCO and Aetna including provisions for out of network providers.

Dental Procurement: September 2020 is the operational start date. The change is that there will be a third choice. Continuity of care will be maintained and people will not be moved from one DMO to another unless they choose to move to another DMO. Letters have been sent out to this effect. There is a default methodology similar to the medical side. If no choice is made there is a default process. For a limited period of time, new members will be default enrolled with United. (unless someone in the family already is enrolled with a DMO). This would be for people who have no connection with a DMO at present and they are newly enrolled.

There is information on the HHSC website. Providers are encouraged to reach out to United.

HHSC Announcement: HHSC intends to award three dental managed care contracts to DentaQuest USA Insurance Company, Inc., MCNA Insurance Company, and United Healthcare Insurance Company for an initial contract period of three years. The award notices will be posted on the Electronic State Business Daily (ESBD) when the contracts are fully executed. That notice of award will trigger the period in which a protest may be filed in accordance with 1 T.A.C. §391.405.

The statewide Dental Program provides dental services to over 3 million Texas Children's Medicaid (Medicaid) and Children's Health Insurance Program (CHIP) eligible children. The principal objective of the Dental Program is to provide quality, comprehensive dental services in a manner that improves the oral health of the Members through preventive care, health education, early intervention and to promote improved access to quality care, thereby significantly improving health outcomes for the target populations. Dental Members' primary and preventive Medicaid and CHIP dental services are provided statewide through dental contractors. Each dental contractor is responsible for contracting with general dentists, pediatric dentists and dental specialists to create a delivery network.

Desk reviews are underway for DMOs. There is a contingency plan being developed related to onsite readiness activities due to COVID issues. There are outreach activities under way and a robust communication strategy was developed. They are on track to reach the operational start date.

Q: As this opens up, do you see any COVID-19 issues? HHSC stated they are working with stakeholders on Coronavirus implementation.

COVID-19 update. Links to key information can be found at the following links:

- Client Information on HHSC Website
- Provider COVID Section on the HHSC Website
- Provider COVID information on TMHP Website

Dr. Van Ramshorst provided a brief update with Michelle Erwin. He provided some high-level worldwide statistics. (For more detailed information see the *Texas Insight COVID-19 Reports.)* Dr. Van Ramshorst provided an update on testing, vaccination, and treatment nationally. He commented on the recent Executive Orders pausing openings and hospital changes in four counties.

He mentioned Pediatric Inflammatory Multisystem Syndrome Temporally associated with SARS-CoV-2 (PIMS-TS). See: https://www.news-medical.net/news/20200608/New-syndrome-associated-with-SARS-CoV-2-is-new-and-distinct-from-Kawasaki-disease.aspx

Ms. Zalkovsky covered some of the flexibilities implemented by HHSC. (*These are also provided in further detail in Texas Insight's COVID-19 Reports*). These could be extended through July.

- Appeals and fair hearings and continuation of benefits including more time to request or investigate related to a fair hearing; follow-up changes;
- Service Coordination activities have been allowed through telehealth;
- Program assessment waivers;
- Aging out Children will stay in STAR Kids for now (EPSDT access);
- Interest lists releases are being looked at;
- Extend Electronic Visit verification flexibilities;
- Extension of prior authorizations for 90 days (as of end of June);
- Not require client signature for DME;
- Extend MDCP program eligibility for 90 days with a plan set to expire in the end of June;
- Provider enrollment flexibilities being allowed;
- Continuing remote delivery through telemedicine;
- Allow initial assessments for MDCP through telehealth, but not reassessments;
- Ensuring continued access to services; and
- Allow Texas Health Steps visits via telemedicine as long as the child is over 24 months.

HHSC is taking these extensions on a month by month basis.

VIII. Update on Rider 32: Autism Services

Rider Direction: **32. Intensive Behavioral Intervention**. Contingent on the Health and Human Services Commission (HHSC) adding intensive behavioral intervention (IBI) as a Medicaid benefit for persons under age 20 with a diagnosis of Autism Spectrum Disorder,

HHSC may expend funds appropriated above in Strategy A.1.5, Children, to reimburse for provision of IBI services.

86. Autism Program Provisions. Out of funds appropriated above in Strategy D.1.6, Autism Program:

a. Expenditures for Applied Behavioral Analysis (ABA) treatment services shall be only for children enrolled in the focused program; and
b. Health and Human Services Commission shall provide support to the Texas Autism Council and the Texas Autism Research and Resource Center.

Autism Services Policy: Incorporation of Applied Behavioral Analysis (ABA) including Intensive Behavioral Intervention (IBI) into existing service packages for:

- Children & Youth (Birth through age 20)
- With a diagnosis of Autism Spectrum Disorder (ASD)
- Service to be delivered in:
    - Home
    - Community
    - Clinic Settings

The policy focuses on utilization of an interdisciplinary model of care including individual & legal guardian. Also including, but not limited to, the following disciplines:

- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Outpatient Behavioral Health Services

The Implementation Plan includes:

A New Medicaid Benefit

- Establish payment rate
- Public rate hearing (not yet scheduled)
- Seek approval from Centers for Medicare & Medicaid Services (CMS), as needed

Draft Policy for Public Comment

- Was posted in September 2019, responses to comments forthcoming
- Ensure sign up for GovDelivery in order to be notified about policy implementation

Implementation goal: Spring 2020

HHSC plans on engaging external and internal stakeholders throughout the implementation process. Stakeholders include:

- Parents/Caregivers/Legal Guardians
- Provider groups
- Children's advocacy organizations
- Other interested parties

HHSC Web Information: The HHS Children's Autism Program provides focused ABA services through local community agencies and organizations.

Focused ABA treatment is targeted to address a few specific outcomes instead of all developmental needs of the child. It is particularly useful when children have challenging behaviors and when improvements in social and adaptive skills are sought. Focused ABA treatment is used to target specific behaviors. The treatment might be to:

- Minimize a challenging behavior; or
- Maximize a social or adaptive skill in a specific area.

A trained therapist provides treatment on the specific behavior. The level and intensity of treatment should be driven by the child's needs. Since the therapist is focusing on specifically defined behavior, the treatment period is shorter. The treatment through the HHS Children's Autism Program is limited to 180 hours within a 12-month period. The length of treatments received is limited to a maximum of 720 hours during the child's lifetime.

Participation in parent training is a required part of the service. Attendance for the child and the parents must be maintained at 85 percent of scheduled treatment.

Who is Eligible for Services?

A child is eligible for treatment through the Autism Program if the child:

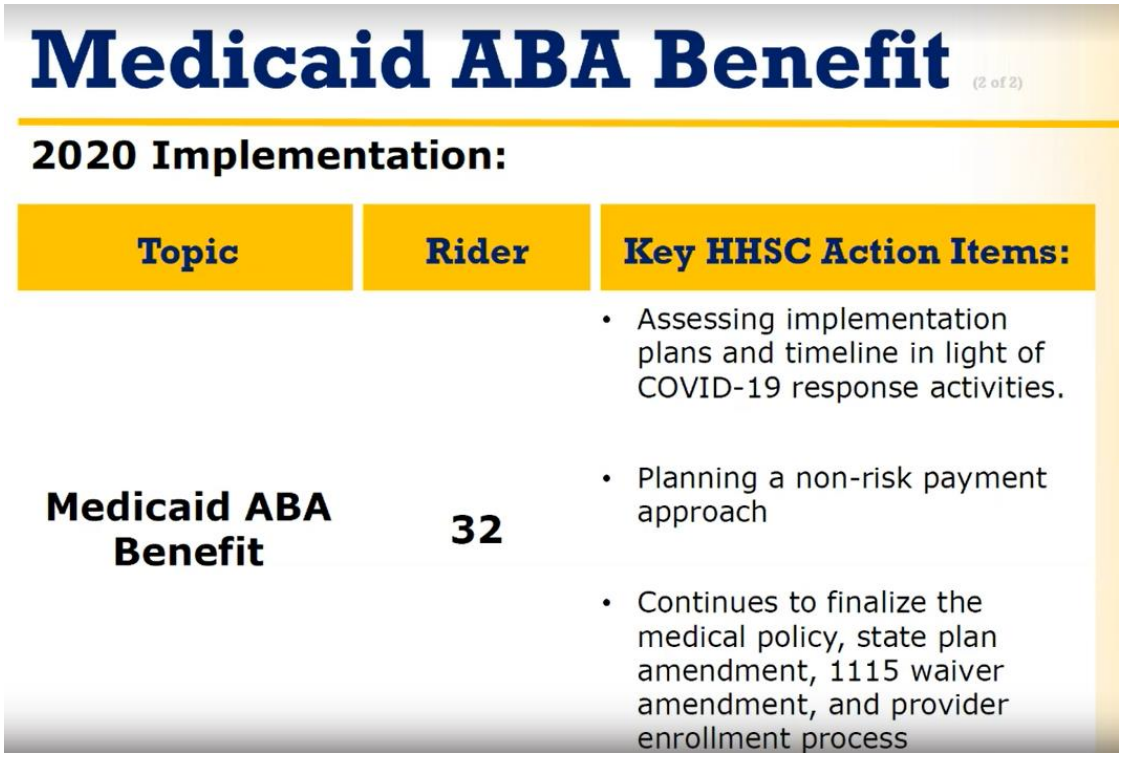
- Has a documented diagnosis on the autism spectrum made by a qualified professional.
- Is 3 to 15 years old (services end on the child's 16th birthday).
- Is a Texas resident.

How to Find Services and Apply?

All services are provided by contractors located in communities around the state. Please call the contractor closest to your area to access services and complete the enrollment process.

HHSC stated that the draft policy has been posted and there was a record braking number of responses.

Most recent update is as follows:



IX. Stakeholder input from the Texas Dental Association and Texas Academy of Pediatric Dentistry.


Senate Bill 1207 (86th Regular Legislative Session)
Sec. 531.024162, NOTICE REQUIREMENTS REGARDING MEDICAID COVERAGE OR PRIOR AUTHORIZATION DENIAL AND INCOMPLETE REQUESTS
Sec. 531.024163, ACCESSIBILITY OF INFORMATION REGARDING MEDICAID PRIOR AUTHORIZATION REQUIREMENTS
ADMINISTRATIVE SIMPLIFICATION
TDA TEXASDENTAL association
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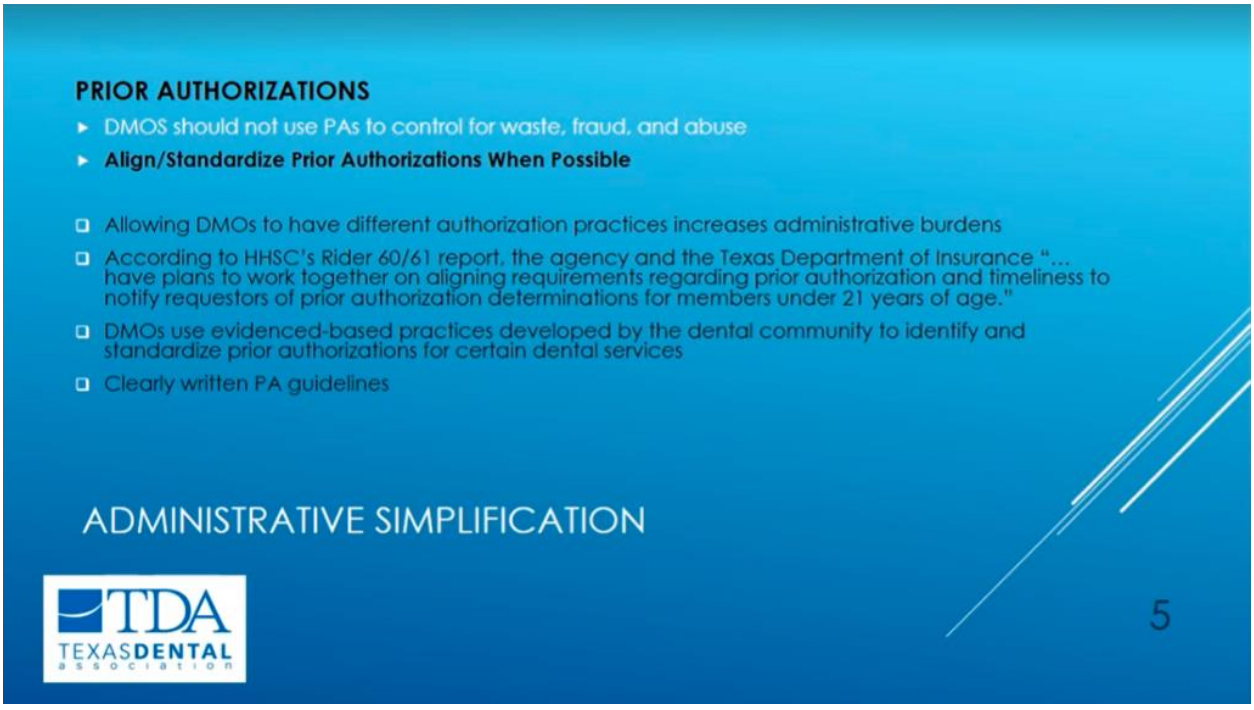
PRIOR AUTHORIZATIONS
DMOS should not use PAs to control for waste, fraud, and abuse
Align/Standardize Prior Authorizations When Possible
Allowing DMOs to have different authorization practices increases administrative burdens
According to HHSC's Rider 60/61 report, the agency and the Texas Department of Insurance "... have plans to work together on aligning requirements regarding prior authorization and timeliness to notify requestors of prior authorization determinations for members under 21 years of age."
DMOs use evidenced-based practices developed by the dental community to identify and standardize prior authorizations for certain dental services
Clearly written PA guidelines
ADMINISTRATIVE SIMPLIFICATION
TDA TEXASDENTAL association
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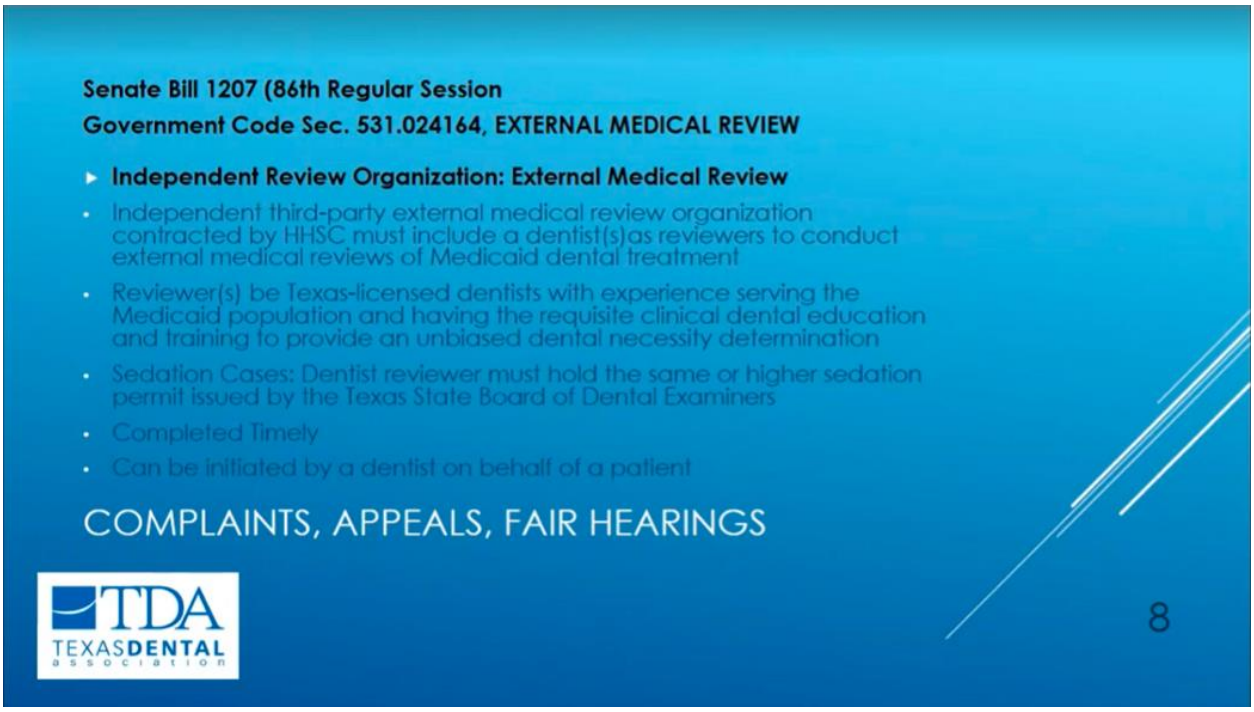
Change in periodicity schedule has been made.


Senate Bill 1207 (86th Regular Session
Government Code Sec. 531.024164, EXTERNAL MEDICAL REVIEW
Independent Review Organization: External Medical Review
Independent third-party external medical review organization contracted by HHSC must include a dentist(s)as reviewers to conduct external medical reviews of Medicaid dental treatment
Reviewer(s) be Texas-licensed dentists with experience serving the Medicaid population and having the requisite clinical dental education and training to provide an unbiased dental necessity determination
Sedation Cases: Dentist reviewer must hold the same or higher sedation permit issued by the Texas State Board of Dental Examiners
Completed Timely
Can be initiated by a dentist on behalf of a patient
COMPLAINTS, APPEALS, FAIR HEARINGS
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DENTIST PROVIDERR GRIEVENCES
Section 2 of House Bill 4533 (86th Regular Session)
Government Code Sec. 531.02131, GRIEVANCES RELATED TO MEDICAID
Define "grievance" as it relates to Medicaid include Medicaid dental care and that the grievance process include dentist providers
TDA supports HHSC developing a no wrong-door grievance process that allows for expeditious grievance resolution
Dentist provider grievances should not be resolved by simply asking a managed care organization for their position and then adopting it on behalf of the agency. Instead, HHSC should diligently investigate grievances brought both providers and members.
Make aggregate grievance data easily available to the public
COMPLAINTS, APPEALS, FAIR HEARINGS
TDA
TEXASDENTAL association
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DENTIST PROVIDERR GRIEVENCES

- MCNA Dental "Recoupments" December 2019
- Dr Susan Jolliff testified to SMMCAC December 12, 2019
- **Without any prior notification or warning**, many dentists across the state, received an explanation of benefits statement (EOB) from MCNA Dental showing recouped money tied to dental care performed in 2016, 2017, and 2018
- This "standard of care" recoupment was done to target waste, fraud, and abuse and not to improve the oral health of Medicaid dental recipients
- MCNA's recoupments were without notice, blatantly unfair, and interfere with the ability of dentists to effectively treat Medicaid patients

COMPLAINTS, APPEALS, FAIR HEARINGS

TDA TEXASDENTAL association

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MANAGED CARE REPORT CARDS

- Include DMOs as part of the "Managed Care Report Cards," available on HHSC's website

NETWORK ADEQUACY

- DMOs must keep accurate network rosters
- Listing main dentists in the roster should be limited to 3

NETWORK ADEQUACY AND ACCESS TO CARE

TDA TEXASDENTAL association

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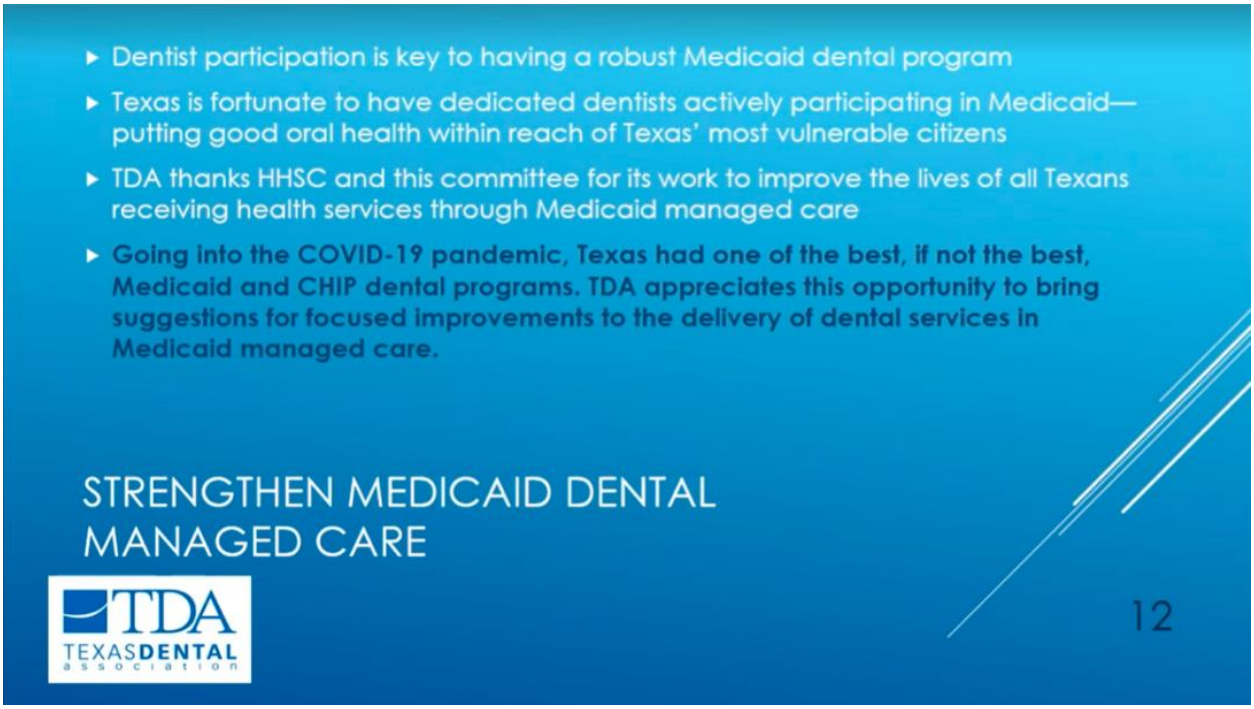
Dentist participation is key to having a robust Medicaid dental program
Texas is fortunate to have dedicated dentists actively participating in Medicaid—putting good oral health within reach of Texas' most vulnerable citizens
TDA thanks HHSC and this committee for its work to improve the lives of all Texans receiving health services through Medicaid managed care
Going into the COVID-19 pandemic, Texas had one of the best, if not the best, Medicaid and CHIP dental programs. TDA appreciates this opportunity to bring suggestions for focused improvements to the delivery of dental services in Medicaid managed care.
STRENGTHEN MEDICAID DENTAL MANAGED CARE
TDA
TEXASDENTAL association
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Texas Academy of Pediatric Dentistry

December 31, 2019

State Medicaid Managed Care Advisory Committee (SMMCAC)
Texas Health & Human Services
Brown-Heatly Building
4900 N. Lamar Blvd.
Austin, TX 78751

Via email at OPP_SMMCACIssues@hhsc.state.tx.us

RE: State Medicaid Managed Care Advisory Subcommittees

Dear SMMCAC members:

The Texas Academy of Pediatric Dentistry (TAPD) is an organization of professionals with its primary focus on specialized oral healthcare for children through private practice, educational resources, research and community based programs. Our organization represents approximately 80 percent of practicing pediatric dentists in the state of Texas, with the goal of promoting oral health for Texas children.

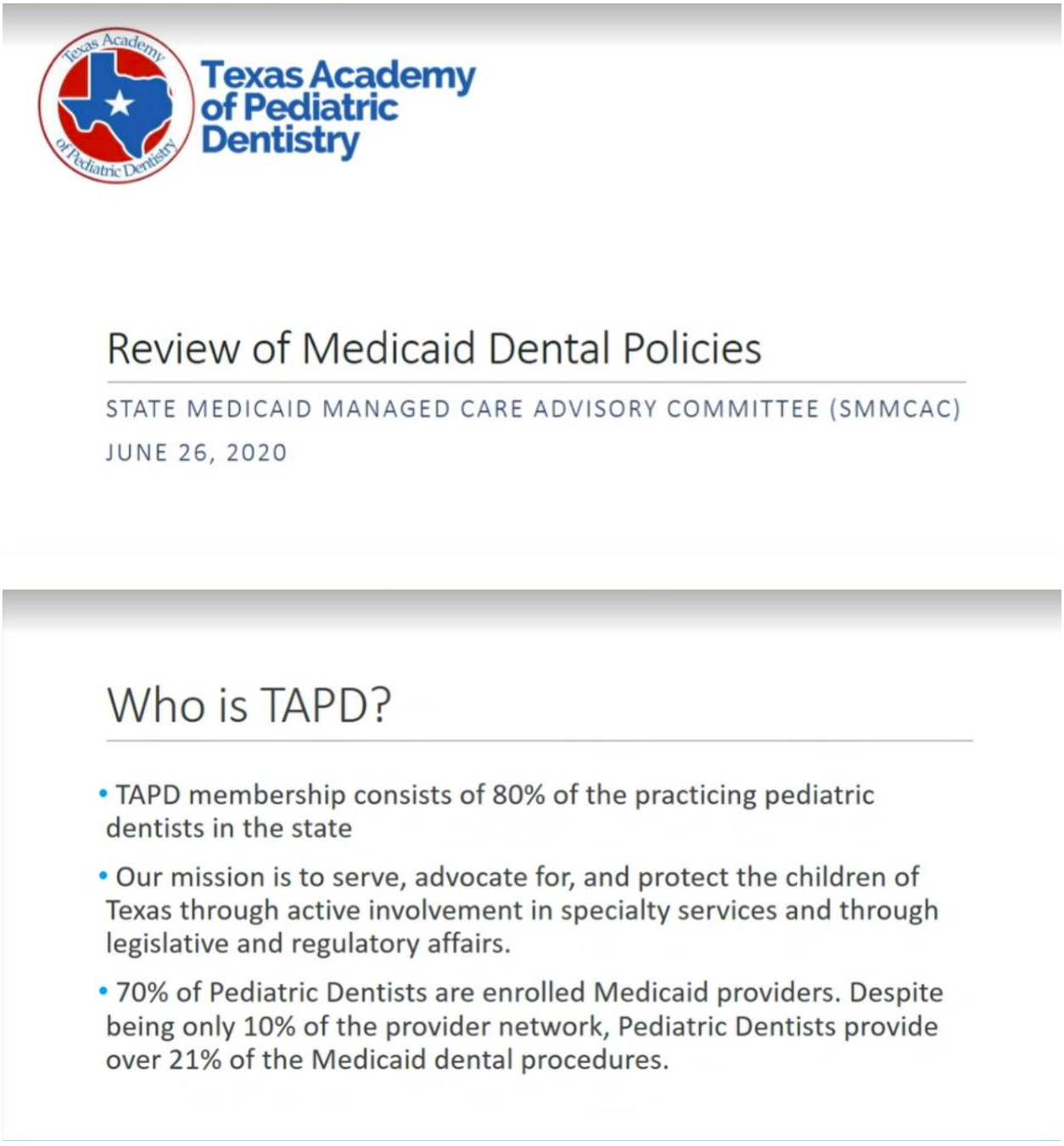
Because most people under the age of twenty-one with Medicaid or under 19 years of age with CHIP coverage receive dental services through a managed care dental plan, TAPD applauds the State Medicaid Managed Care Advisory Committee (SMMCAC) for its commitment in seeking feedback and offering solutions to some of the obstacles that providers and patients currently face within the Medicaid system.

As we enter a new year, TAPD asks that the SMMCAC subcommittees continue to pursue opportunities to improve the oversight of dental managed care plans. The Texas Dental Association (TDA) recently submitted recommendations to the Administrative Simplification, Complaints, Appeals and Fair Hearings, Clinical Oversite and Benefits, and the Network Adequacy and Access to Care subcommittees. TAPD agrees with all of TDA's recommendations and asks that the respective subcommittees consider these suggestions throughout their discussions in 2020 and beyond.

Again, TAPD thanks the SMMCAC for their work in reviewing the operations of Medicaid managed care in Texas. We look forward to working together for the betterment of all Texas children.

Sincerely,

Refugio Gonzalez, III, DDS
President, Texas Academy of Pediatric Dentistry
M: 361-246-0553 | E-mail: rgonzalezdds@gmail.com


Texas Academy of Pediatric Dentistry
Review of Medicaid Dental Policies
STATE MEDICAID MANAGED CARE ADVISORY COMMITTEE (SMMCAC)
JUNE 26, 2020
Who is TAPD?
• TAPD membership consists of 80% of the practicing pediatric dentists in the state
• Our mission is to serve, advocate for, and protect the children of Texas through active involvement in specialty services and through legislative and regulatory affairs.
• 70% of Pediatric Dentists are enrolled Medicaid providers. Despite being only 10% of the provider network, Pediatric Dentists provide over 21% of the Medicaid dental procedures.

Background

- Dentists are critical partners in the success of Medicaid and the Children's Health Insurance Program (CHIP)
- More than $1.5 billion is spent annually on Children's Medicaid Dental Services.
- More than 3 million Texas children are currently eligible for Medicaid dental services.
- The Office of the Inspector General and the Health & Human Services Commission have been studying ways to reduce fraud, waste, and abuse in dental services.

- In February 2019, dental stakeholders met with OIG and HHSC to address ways to reduce unnecessary restorations and improper dental solicitations.

- TAPD requested a complete review of the Texas Medicaid Provider Procedures Manual chapters listing all program dental benefits and limitations. Updating the program benefits and tightening benefit limitations can help avoid over-treatment while still providing comprehensive care that meets all medically necessary requirements of the program's recipients without putting undue burden on the dental providers.

- Last session, TAPD supported HB 4530 by Rep. Lucio (D-Brownsville) which would have required the OIG and dental stakeholders to conduct a thorough review of Texas Health Steps.

- In December 2019, TDA and TAPD wrote letters to SMMCAC in support of a thorough review of Medicaid dental policies

Why is a review needed?

- A thorough and complete review hasn't been completed in over two decades.
- Current dental policies were written before Managed Care was in place.
- Dental offices have changed. Current policies were written when most dental care was provided by small 1 and 2 dentist offices. Today we are witnessing a rapid, steady growth of large multi-site group practices.
- With our new understanding of the dental disease process, it is time to prioritize preventive care, and move away from the "Drill, fill and bill" practice model.

What would this look like?

- Need for a broad ad hoc working group to evaluate the diagnostic, preventive and therapeutic codes.
  - Dentists who see Medicaid patients and represent organized dentistry
  - Academia
  - OIG
  - HHSC
  - Dental Managed Care Organizations
- Working group should meet regularly to address and revise relevant sections.
- Inclusion of the American Academy of Pediatric Dentistry clinical guidelines and other specialty input where appropriate.
- Complete review by September 2021 and submit recommendations to HHS for consideration and implementation.

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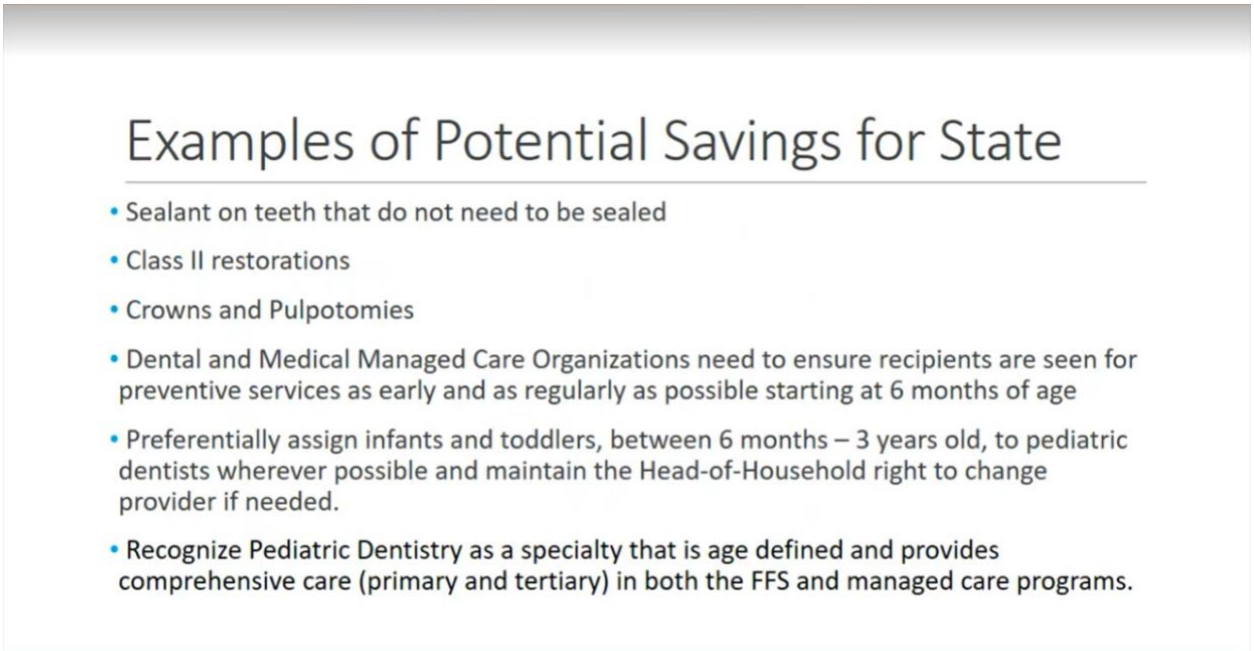

X. Public comment. Mr. Chacon read from a submitted written comment summarized below:

Ms. Marilyn Hartman[1] (Austin, Texas) stated:

- Network insufficiency is a problem
- Only one cleaning per year
- Dentist stated he could not continue in the program because of restrictions in the Managed Care program
- People pay out of pocket even with Medicaid rates

Rani Thoman[2] Texas Association for Behavioral Analysis Policy Group. They are advocating for

- 51,000 people should be able to access treatment
- Timeline has passed
- Must include telehealth
- Expedite credentialing within 30 days
- Rates for ABA must be sufficient

Summer Adami, Medicaid Taskforce (ABA organization), expressed her support for the previous speaker. She addressed three critical elements:

- Telehealth

[1] Spelling uncertain.
[2] Spelling uncertain.

- Expediting credentialing
- Rates that will support the provider base needed. There are 2,500 licensed behavioral analysts

Christa Stevens, Autism Speaks, advocated for Rider 32. They appreciate the interdisciplinary focus. 85,000 children are waiting for medically necessary treatment including ABA. We are behind schedule.

XI. Review of action items and agenda items for future meeting.

- Budget impact
- Subcommittees provide recommendations for policy review for dentistry among others.

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

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