TAHP
The Texas Association of Health Plans

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TACHP | Texas Association of Community Health Plans

October 26, 2018

The Honorable Richard Raymond
Texas House of Representatives
P.O. Box 2910
Austin, Texas 78768

Dear Chairman Raymond:

On behalf of the 18 Medicaid and CHIP Managed Care Organizations (MCOs), we would like to thank you for the opportunity to provide our recommendations on ways to improve the Medicaid program. The Texas Association of Health Plans (TAHP) and the Texas Association of Community Health Plans (TACHP) have worked closely with key stakeholders to identify reforms that will improve our clients' and providers' experience with the Medicaid managed care program.

Over the past 20 years, the Texas Legislature has tasked Medicaid MCOs with transforming what was a costly, outdated and broken fee-for-service (FFS) program — one marked by fragmented care and poor outcomes — into a modern, integrated health insurance program, leveraging private sector innovation and expertise. The recently released independent evaluation of managed care (Rider 61 report) found that expanding Medicaid managed care in Texas resulted in approximately $5.3 to $13.9 billion in savings since 2009. On top of these savings, the report shows that Texas MCOs generated an additional $800 million in revenue to help fund the Medicaid program.

The report highlights the high quality of care being delivered in Texas and demonstrates that Texas' Medicaid managed care model is an efficient system. The MCOs' focus on prevention and care coordination ensures Texans receive the care they need to get healthy and stay healthy, translating into fewer hospitalizations and lower costs for Texas Taxpayers compared to the old FFS model of care. Texas caps MCO profits and administrative spending, resulting in an efficient Medicaid program with administrative expenses lower than the national average. Additionally, the Medical Loss Ratio, or the percent of funds the plans receive and spent directly on patient care, for Texas MCOs is approximately 90 percent, substantially higher than the 85 percent required by the federal government and higher than the national average. The Rider 61 report also highlights important areas in which HHSC and the MCOs can strengthen the Texas Medicaid program.

In addition to the recommendations outlined below, the Texas Medical Association (TMA), the Texas Association of Hospitals (THA), TACHP and TAHP held a Medicaid Managed Care Summit earlier this month with the goal of collaboratively identifying and addressing areas for improvement in the Medicaid program. In our initial meeting, we committed to address

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administrative burdens, improve prior authorization processes, and improve access to care. The meeting highlighted many areas that can be improved through better communication between MCOs and providers, as well as improvements that can be made without legislative action. We are scheduling additional meetings this Fall to continue the conversation and develop solutions for the issues we identified. The groups plan to submit joint recommendations to HHSC and the Legislature after we work through the potential solutions and identify which recommendations require legislation to implement.

The MCOs are also engaging with other stakeholders, including organizations such as the Texas Association of Home Care and Hospice, nursing facility groups, assisted living facility groups, therapy providers and advocacy groups, and discussing ways to improve their experience with the Medicaid managed care program. Many of the recommendations below resulted from that dialogue. Continued discussions may result in additional legislative or regulatory recommendations.

As the Legislature and HHSC take a closer look at the managed care system and its oversight, we look forward to being a part of the conversation and offer these initial ideas for consideration.

Access to Care

Managed care places an important focus on preventive health care – taking proactive steps to keep Texans healthy and avoid common illnesses. MCOs are dedicated to ensuring clients can access the right care, at the right time and at the right place.

1. Improve Maternal Health: Texas has one of the highest maternal mortality rates in the country due to poor access to care for pregnant women before pregnancy and following delivery. Texas Medicaid only covers women for 60 days past delivery, and research shows the majority of maternal deaths in Texas occur after the mother loses her Medicaid coverage.

   Recommendation: The Legislature should extend coverage for women on Medicaid to 12 months post-delivery to improve maternal health and ensure healthier babies.

Patient Protections

It should be easy for Medicaid clients to register complaints when they feel they are not receiving the quality of care they need from HHSC, a provider or an MCO. Additionally, HHSC must have an efficient, streamlined complaint and appeals process to ensure accurate data for contract oversight, help identify access to care issues and inform policy decisions.

1. Improve the Fair Hearing Process: States are required to have a Fair Hearing process for Medicaid clients to appeal any adverse decision made by the state or an MCO. Federal

requirements are general and only prescribe time periods, leaving room for states to design most of the process. As seen during recent legislative hearing testimony, families are frustrated and confused by the current Fair Hearing process. In response, HHSC and the MCOs have been exploring options to improve the process.

Recommendation: The Fair Hearing process is an important safety net for Medicaid clients. It is imperative that the Legislature pass legislation to improve the Texas Fair Hearing process and ensure the following:

- Clients have access to timely and clear notifications regarding state and MCO determinations. HHSC should amend the notification language to ensure it is clear for Medicaid consumers and families.
- Clients have access to forms of notification other than mail.
- Clients are educated on the process and their right to request a Fair Hearing.
- Fair Hearings include a path to clinical review by qualified clinical staff when a client has a denial or reduction of services due to medical necessity determination from HHSC or its contractors. The clinical staff reviewing the case for the Fair Hearing should be independent of HHSC and the MCO, similar to the process used by commercial health plans and CHIP plans that provides access to an independent review organization (IRO), which engages physicians and other health care providers to review cases.
- Fair Hearings include a clinical review by qualified clinical staff when a client is denied based on HHSC's determination of functional need (some waiver programs are based on functional need and not income). The clinical staff reviewing the eligibility determination should be independent of HHSC, also similar to an IRO.
- Staff knowledgeable of Medicaid issues and managed care processes are involved in the process at HHSC to help make accurate, consistent decisions (e.g., clinical staff for medical necessity reviews and attorneys for complex administrative denials).

2. Improve Complaint Processes: We support HHSC's continued work to improve the complaint process. A standardized and trackable complaint process is important for helping the agency and Legislature identify systemic issues, inform policy changes and perform contract oversight. It is also important to have an easily-navigable complaint process that issues timely responses to both clients and providers. Under the current process, complaints are submitted to different areas of the agency that each use their own definitions, complaint categories and tracking requirements. We applaud HHSC for recognizing these concerns and proactively working to improve the current system.

Recommendation: Improving the complaint process does not require a legislative change, as current statute authorizes HHSC to develop and implement a streamlined complaint process. The work HHSC has already started will improve the complaint process and result in better protections for clients, better oversight for HHSC and more

transparency for all stakeholders. As a part of these changes, HHSC should implement a no-wrong door complaint process with consistent tracking and definitions across the agency that ensures complaint data is accessible and transparent for stakeholders. HHSC should also develop processes to ensure a client can expedite a complaint that is related to an urgent access to care issue.

Processes of Care

There are many HHSC and MCO operational processes that are a fundamental part of the Medicaid program. Improving many of these existing Medicaid operations would result in better access for clients, increased transparency, appropriate accountability and a more efficient program for providers and the state of Texas.

1. Improve Coordination of Benefits for Medicaid and Medicare Dual Eligible Clients:
Medicaid MCOs are required by contract to coordinate benefits for STAR+PLUS clients who receive both Medicaid and Medicare coverage (called "dual eligible" clients). The MCOs are also federally required to ensure Medicaid does not pay for services Medicare should cover. As part of the benefit coordination process, MCOs cannot pay for the Medicare covered service, such as DME, until Medicare denies the service. While MCOs go to extensive efforts to coordinate the delivery of these services, the process is complicated and often delayed due to the majority of dual eligible clients receiving their Medicaid and Medicare services from different health plans or from Medicare FFS. Due to the multiple parties involved, the Medicaid MCO cannot always see the Medicare payments and denials to track services in a systematic way. The Medicaid MCOs are dependent on the cooperation of an external Medicare payer or a Medicare provider (often times not in network with the STAR+PLUS plan) to coordinate and provide ongoing status and supporting information to the MCO. Additionally, per HHSC direction, in some cases when Medicare denies the service or does not fully cover a needed treatment (called "wrap coverage"), Medicaid FFS (TMHP), not the client's MCO, is responsible for paying for the service.

   Recent HHSC utilization reviews (UR) and news stories highlighted STAR+PLUS clients not receiving services. However, Medicaid MCOs are responsible for coordinating the Medicare services, not covering them. The MCOs are also often unaware of the Medicare or Medicaid FFS claims, or may have not received the Medicare or Medicaid FFS denials.

   Also challenging is the lack of a clearly documented matrix outlining Medicare services that MCOs or TMHP are responsible to cover once Medicare denies the service. The process is confusing for clients, providers, MCOs and others involved in the process, putting access to care at risk for Medicaid enrollees.

Recommendation: Improving coordination of benefits for Medicaid and Medicare coverage does not require legislation and can be improved by HHSC and the MCOs working together to address existing issues.

- HHSC should develop clear and consistent policy guidance for the MCOs related to the coordination of Medicare and Medicaid services for dual eligible clients.
- HHSC should transition responsibility for payment of wrap coverage from TMHP to MCOs to further align accountability, enable better coordination of client services, and streamline provider processes and payment.

2. Improve Coordination of Benefits for Medicaid Clients with Commercial Coverage: Many of the STAR Kids member complaints point to issues with coordination of benefits for clients who have both commercial and Medicaid coverage. There are many issues making care coordination difficult: 1) the client receives commercial and Medicaid coverage from different health plans, but the Medicaid MCO does not always know which health plan is providing commercial coverage or even if a client has commercial coverage; 2) federal requirements prohibit Medicaid from paying any service the commercial health plan is responsible for paying; 3) Medicaid MCOs have to wait for a denial from the commercial payer before covering; and 4) new federal rules prohibit Medicaid, including MCOs, from paying for services or referrals from non-Medicaid-enrolled providers, which is often the case when Medicaid consumers use providers from their commercial health insurance network.

   Additionally, the MCOs have not received standardized guidance on how to wrap commercial coverage, resulting in health plans coordinating benefits in different ways – some MCOs require prior authorization using the Medicaid medical policy and criteria, while others act like true secondary coverage and wrap the services without prior authorization.

   These coordination variations create access to care issues, contract oversight confusion, unnecessary provider hassle and an incentive for families to drop their commercial coverage, which only increases Medicaid costs.

   Recommendation: HHSC should ensure clients are encouraged to use commercial coverage when available. The Legislature should direct HHSC to adopt uniform policies for MCOs to follow when wrapping commercial benefits. As a part of these policies, the Legislature should require MCOs to act as a traditional secondary payer in the STAR Kids program, which would allow them to cover benefits authorized under commercial coverage and pay co-pays without a prior authorization requirement. When Medicaid patients see a non-Medicaid-enrolled provider from their private health insurance network, HHSC should develop and adopt processes to fast-track these providers' Medicaid enrollment through options such as automatic enrollment based on the

commercial payor's credentialing or the provider's Medicare enrollment status. These reforms will dramatically improve STAR Kid members' ability to receive services in a timely manner, allow them to continue seeing their personal provider, reduce administrative burdens for families and providers, and improve contract oversight.

3. Improve the STAR Kids Screening and Assessment Tool (SK-SAI): Every child in the STAR Kids program receives a screening and assessment to help inform a care plan and determine their service needs. The MCOs are statutorily required to use the screening and assessment tool HHSC hired Texas A&M to develop. While it is important for every child to be screened for services, the current tool is a cumbersome and extremely long form that families and Service Coordinators find difficult to use, resulting in negative member experiences. MCOs and families report that it can take four to six hours to complete the form.

   Recommendation: MCOs, providers and families submitted recommendations for improving the SK-SAI to HHSC last year, including reducing the number of questions in the tool and developing skip logic so clients do not have to answer questions that are not actionable or applicable to the client. HHSC is currently evaluating these recommendations and considering changes to the SK-SAI. HHSC should implement the recommendations they received on the SK-SAI to improve the tool with the goal of improving client experience. Another option is to for the Legislature to remove the statutory requirement that MCOs use the SK-SAI and allow MCOs to use nationally-recognized screening tools to assess clients instead of mandating use of the SK-SAI.

4. Improve MDCP Eligibility Processes: The Medically Dependent Children's Program (MDCP) is a Medicaid waiver program that provides services and supports to families caring for children and young adults who are medically dependent. The goal of the program is to keep children out of institutions and nursing facilities and allow them to live with their families in the community. To qualify for the program, a child must go through a functional needs assessment used by HHSC to determine if the child meets the same level of care needed to qualify for a nursing facility.

   Eligibility for the program lasts one year. Current program rules require clients be re-assessed every year and require HHSC to make an eligibility determination based on that re-assessment. Some plans have noticed—and we have heard concurring testimony—that some clients who have been on the program for years without any significant change in function are determined to no longer meet a nursing facility level of care during the annual reassessment, resulting in the client losing MDCP coverage. When the client loses coverage, they go to the bottom of the interest list for MDCP or another waiver program and wait for a new slot. As of May 2018, there are 263,405 Texans waiting for coverage on Medicaid waiver interest lists.

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Recommendation: Families and clients in the MDCP program rely on it to keep them at home and out of institutions. It is a rare for these clients to have a significant change in function that would result in them no longer meeting a nursing facility level of care. Instead of requiring an annual assessment and eligibility determination, the Legislature should direct HHSC to explore and implement solutions allowable under federal regulations that would lift the annual determination requirement and allow clients to be re-assessed only if they have a significant change in function.

5. Eliminate 30-Day Spell of Illness in the STAR+PLUS Program: The STAR+PLUS program has a hospital limit of 30 days per spell of illness. This restriction requires the state to rely on hospitals to cover stays lasting longer than 30 days using uncompensated care dollars.

   Recommendation: The Legislature should remove the 30-day spell of illness limit in statute and restore the benefit for STAR+PLUS clients. This will free-up hospital uncompensated care dollars currently used to treat Medicaid clients and allow them to be used on uninsured Texans.

6. Service Coordination: Various stakeholders have raised concerns and confusion around the different definitions and requirements related to service coordination, care coordination and case management. We heard from many clients that they have had great experiences with service coordination and other clients say they do not know how to identify their service coordinator and have not had good experiences.

   Recommendation: The MCOs support current work at HHSC to review service coordination and determine where definitions and processes can be aligned. Additionally, TAHP is developing educational materials for stakeholders that outline the current requirements and definitions in each Managed care program to help inform the conversation. The MCOs are committed to working with HHSC to identify ways to adopt best practices and improve processes for clients so they understand what services are available and how to reach their service coordinator.

Reduce Administrative Burdens

To ensure MCOs can provide high-quality and timely care to Medicaid clients, it is important that providers are encouraged to participate in the Medicaid program. TAHP is dedicated to working with providers to identify ways to reduce administrative burden and improve the efficiency of the Medicaid program.

1. Streamline Provider Enrollment: Most providers enroll in Medicare before they enroll in Texas Medicaid. Providers must go through an extensive and burdensome process—

sometimes taking six months to more than a year—to enroll in FFS Medicaid at TMHP before they can credential and contract with MCOs, even if they are already enrolled in Medicare. Many states have streamlined the process by allowing providers to bypass enrollment with the state by directly credentialing and contracting with an MCO. The MCO credentialing process includes the same federal requirements as the enrollment process (background check, licensure check, etc.). The information obtained through the MCO credentialing process is shared with the state to ensure provider integrity.

Additionally, Texas adopted a second type of provider identifier number, the Texas Provider Indicator (TPI), many years ago. Every other state and Medicare recognizes the National Provider Indicator (NPI) number, and no other requires providers to have a secondary indicator. The TPI causes confusion, inaccurate provider directories and creates inefficiencies for providers and MCOs.

Recommendation: HHSC should improve and simplify the TMHP provider enrollment process. The Legislature should pass no-wrong door legislation allowing Medicare enrollment and/or the MCO credentialing process to count as Medicaid enrollment in addition to the provider enrollment process that currently exists at TMHP. The Legislature should also direct HHSC to remove the provider TPI requirement from the enrollment process.

2. Nursing Home Payment Reform: Nursing Facilities (NFs) were carved-in to STAR+PLUS in 2015, but instead of allowing MCOs to negotiate rates directly with the NFs, HHSC sets NF rates for the MCOs using a complicated set of rules that generate more than 1,000 different NF payment combinations. These numerous payment combinations create administrative challenges and unnecessary administrative burden for HHSC, MCOs and NFs.

   Recommendation: The Legislature should amend current statute and require HHSC to develop a simplified payment and administrative process for NF providers.

3. Generic First Legislation: The Texas Medicaid drug formulary consists of preferred and non-preferred prescriptions. Preferred drugs do not require prior authorization, while non-preferred drugs do. Because Texas' formulary tends to favor name brand drugs and leave generic versions on the non-preferred list, providers are forced to go against the common practice of prescribing generics and prescribe a name brand even when a generic form is available. This leads to denials at the pharmacy for clients, administrative burden for providers and pharmacists, and access to care issues for Medicaid consumers. When a client does not receive the medication they need in a timely manner, it is difficult for MCOs to improve that client's health outcomes and prevent unnecessary hospital admissions.

Recommendation: The Legislature should adopt generic first legislation and require HHSC to ensure that when available, a generic drug is the preferred drug on the formulary and does not require prior authorization. Eliminating prior authorizations for low-cost generic drugs will improve care coordination for Medicaid consumers and dramatically reduce administrative burden and hassle for providers.

Continue to Modernize the Medicaid Program

Texas has been a national leader in Medicaid managed care, and it is important that we continue to improve and modernize the program. MCOs are working closely with providers to implement new alternative payment models that focus on paying for quality instead of quantity. The Rider 61 report shows we are ahead of many states when it comes to the processes HHSC uses to set MCO rates. There are many things we are doing well, but to continue improving the program, HHSC must fully transition their infrastructure to a managed care model and move away from FFS processes that result in confusion, create inefficiencies and restrict innovation.

1. Prospective Payments: HHSC often makes FFS rate and policy changes without providing timely information about those changes to the MCOs. Many MCOs base their reimbursement rates on the FFS fee schedule and are often required to implement FFS policy changes. The inability for MCOs to implement changes on the same date as TMHP and HHSC often results in the need for MCOs to retroactively recoup payment from a provider. These unnecessary recoupments add costs for MCOs and providers (sometimes more than the amount recouped), increases administrative hassle and causes provider abrasion.

   Recommendation: Now that the majority of clients are served through the managed care delivery system, HHSC should modernize systems and ensure all Medicaid payments are prospective with no retroactive changes. This can easily be addressed through better planning and timely notification, ensuring providers better understand effective dates and MCOs have timely notice to align implementation of rate and policy changes with HHSC. The Legislature should include a Budget Rider directing the agency to ensure payments are prospective.

2. Reduce Recoupments and Improve Eligibility Systems: Providers and MCOs have consistently complained about recoupments due to eligibility issues. As a reminder, Medicaid MCOs are not responsible for eligibility. These eligibility problems create access to care issues and provider burden. When a client does not appear as eligible on the HHSC client file, the MCO is not paid for that client's services in their premium and is not federally allowed to pay a provider for services rendered. This means that a consumer may not get access to services or a provider may not get paid for these

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services. If a client does show as eligible on the file but is later determined to have not been eligible, the entire MCO premium is recouped, and the MCO is required to recoup payments made to the provider for that client. This means a provider will not get paid for services that were originally approved.

Recommendation: The Legislature should fund a major overhaul of the Medicaid eligibility system with the goal of having the most accurate eligibility information available for each member. This will ensure MCOs and providers are paid appropriately, provide clients with access to care when eligible for services and reduce the need to recoup payments to providers.

The Rider 61 report provided the state with a road map to improve the system. In addition to the recommendations we list above, the Legislature and HHSC should use the recently released Rider 61 report to inform goals and establish a vision for the Texas Medicaid managed care program.

Thank you for the opportunity to share our initial recommendations. We look forward to working with all stakeholders to improve the Texas Medicaid managed care program before, during and after the 86th Texas Legislative Session.

Sincerely,

Jamie Dudensing

Kay Ghahremani

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CEO
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Cc: Representative James Frank
Representative Stephanie Klick
Representative Toni Rose