

State Medicaid Managed Care Advisory Committee Subcommittees: Alignment with Medicaid & CHIP Services Initiatives

A brief description follows of the Health and Human Services Commission's (HHSC) focused initiatives for improving managed care oversight which align with subcommittees within the State Medicaid Managed Care Advisory Committee (SMMCAC). In addition, HHSC will seek input from SMMCAC on the implementation of various legislative requirements identified below.

Administrative Simplification

This initiative focuses on reducing Medicaid provider burden through administrative improvements in four areas: claims payments, eligibility information, provider enrollment processes, and prior authorization submissions. HHSC will seek feedback on these areas and others as specific projects are proposed and developed.

Complaints, Appeals, and Fair Hearings

This initiative focuses on more effectively leveraging complaints data to identify potential problems in the Medicaid program, opportunities for improved managed care organization (MCO) contract oversight and increasing program transparency. Objectives addressed in this initiative include:

- Improve data collection and system processes used to trend and analyze managed care member complaints.
- Standardize complaint categories used by HHSC and MCOs for more accurate trending of complaints-related data to more quickly identify potential problems within managed care.
- Improve the complaints member experience so they are tracked and resolved consistently.

HHSC will seek feedback on items such as:

- Review of recently implemented changes to the member complaints process.
- Identify areas for improvement for provider complaints.
- Implement the independent external medical reviewer required by SB 1207, 86th Texas Legislature, Regular Session, 2019. The independent external medical reviewer will conduct external medical reviews of the resolution of a Medicaid recipient appeal related to a reduction in or denial of services, or a denial by HHSC of eligibility for Medicaid programs where eligibility is based on medical and functional need.

Network Adequacy and Access to Care

This initiative supports a comprehensive monitoring strategy to ensure members have timely access to the services they need. Objectives addressed include:

- Improve the accuracy of provider directories, including more robust MCO validation requirements and improvement of critical processes that impact accuracy.
- Incentivize the use of telemedicine, telehealth, and telemonitoring services to improve access for members in underserved areas of the state.
- Reduce administrative burdens related to network adequacy reporting and monitoring.
- Integrate network adequacy reporting to include additional measures, such as appointment availability studies and targeted encounter data.

HHSC will seek feedback on items such as:

- Best use of telemedicine, telehealth, and telemonitoring services, and which services provide the best value.
- Impact of provider directory accuracy on members.
- Development of a new network adequacy measure for in-home personal care services.

Clinical Oversight and Benefits

This initiative seeks to strengthen the oversight of utilization management practices to include prior authorization policies and processes used by MCOs. Objectives addressed in this initiative include:

- Develop a new, standardized prior authorization data collection tool and process that will use member-level data.
- Identify trends and anomalies for Medicaid services using prior authorization data and focus on trends within specific Medicaid programs.
- Develop an enhanced process to trend utilization data for specific programs.
- Expand staffing model to allow for increased scope and sample size for Utilization Review activities.

This subcommittee may also discuss specific medical benefits for certain programs within Medicaid, as needed.

HHSC will seek feedback on items such as:

- Oversight of utilization management, including development of new MCO deliverables.
- Service utilization trending and analysis.
- Discussion of potential behavioral health services to be delivered under the "in lieu of" option, per SB 1177, 86th Texas Legislature, Regular Session, 2019.

Service and Care Coordination

This initiative is focused on improvements related to service and care coordination within managed care. Objectives addressed in this initiative include:

- Analyze other state Medicaid programs to assess best practices for care coordination within Texas' managed care programs.
- Address any state-level barriers that hinder MCO delivery of care coordination services.
- Clarify terminology and definitions of service coordination and service management activities across Medicaid managed care programs.
- Identify possible improvements to ensure service coordination and service management is consistent within HHSC contract requirements.

HHSC will seek feedback on items such as:

- Terminology changes within managed care contracts to better clarify and align service and care coordination.
- HHSC oversight activities to better monitor the provision of service and care coordination.
- Clarifying service and care coordination components for members and providers.