HHSC: Medical Care Advisory Committee, November 12th, 2020

The Medical Care Advisory Committee is a federally mandated committee that reviews and makes recommendations to the state Medicaid director on proposed rules that involve Medicaid policy or affect Medicaid-funded programs. Members are listed below.

Colleen Horton, Chair Advocate, Mental Health Austin	**Diana Strupp, HPAC Chair** Hospital Representative Dallas
Mary Helen Tieken, RN, BSN, Vice Chair Registered Nurse Floresville	**Doug Svien** Provider Stephenville
Salil Deshpande, M.D. Managed Care Organization Representative Houston	**Susan Swartz, R.N.** Registered Nurse San Angelo
Lou Driver Nursing Home Administrator Houston	**Edgar A. Walsh, Jr., R.Ph.** Pharmacy Harlingen
Robert Hilliard, Jr., M.D. Physician, Ob/Gyn Houston	**Non-voting Members**
Cynthia Jumper, M.D., M.P.H. Physician, Internal Medicine Lubbock	**Ryan D. Van Ramshorst, M.D.** Texas Health and Human Services Commission Austin
Donna S. Smith Physical Therapist Austin	**Peter Hajmasy** Texas Department of State Health Services Austin

Welcome, introductions, and opening remarks. The meeting was convened by the Chair, Colleen Horton. A quorum was present.

Approval of August 13, 2020, meeting minutes. The minutes were approved as written.

Medicaid and Children's Health Insurance Program (CHIP) Activities.
The focus has been on the COVID-19 response as well as managed care issues and initiatives that came out of the last session including:

- Medicaid transportation carve-in
- LTSS for IDD and a pilot implementation
- SB1207 complex medical needs and a specified provider aligning rule timeline with the contract timeline in March 2021; proposed rule mid-late December with a public hearing prior to February
- 1115 Waiver and DSRIP transition in 2022

Questions/Answers/Comments

Directed Payment Programs as replacement for DSRIP payments. How many projects will continue to be funded if the directed payment programs are approved by CMS? DSRIP has been in transition to a performance-based approach. HHSC is still determining the issues around the DSRIP transition.

There is a vast amount of interest in Telehealth and Telemedicine. HHSC stated that there is a good foundation that was built upon by COVID and SB 670. HHSC is assessing the services through remote delivery and determining what makes sense to continue. There may be a need for some face-to-face component (ie. assessment, etc.)

Do you have a document that outlines the changes in 670? HHSC stated that there is a legislative report that will be out by January 1, 2021.

Texas managed care quality strategy. **(Follow the link for the full report.)**

Since 1991, Texas Health and Human Services Commission (HHSC) has overseen and coordinated the planning and delivery of health and human service programs in Texas. HHSC was established in accordance with Texas Government Code Chapter 531 and is responsible for the oversight of all Texas health and human service agencies. It is the goal of HHSC to use its Managed Care Quality Strategy to:

- Transition from volume-based purchasing models to a pay-for-performance model
- Improve member satisfaction with care
- Reduce payments for low quality care

It is the intention of HHSC to achieve these goals through the mechanisms described in this Strategy, including:

- Program integrity monitoring through both internal and external processes
- Implementation of financial incentives for high performing managed care organizations and financial disincentives for poor performing managed care organizations
- Developing and implementing targeted initiatives that encourage the adoption by managed care organizations of evidence-based clinical and administrative practices

HHSC's fundamental commitment is to contract for results. HHSC defines a successful result as the generation of defined, measurable, and beneficial outcomes that satisfy the contract requirements and support HHSC's missions and objectives.

In accordance with Code of Federal Regulations (CFR) Title 42, Chapter IV, Subchapter C, Part §438.340, the State must implement a quality strategy for assessing and improving the quality of healthcare and services provided through managed care. The State must also

review and update the quality strategy no less than every three years. The CFR includes requirements outlining the components of a state quality strategy.

The Managed Care Quality Strategy encompasses numerous programs, the HHSC divisions below, as well as advisory committees, and the external quality review organization (EQRO). This section describes each of these groups and their role in the Quality Strategy.

The strategy must be updated every three years and is due for an update in March of 2021. This is a tool that increases federal funding through intergovernmental transfers. UHRIP and Nursing Home Quality Incentive Program is currently in place. Directed payment programs must be identified and further information will be presented at the next meeting.

A revised quality publication will go out for public hearings. The current quality strategy is available by following the link above. There have been updates in the past three years.

Questions/Answer/Comments
Does the quality strategy only impact on Medicaid? Mr. Vasquez stated that some other GR programs are also commented on.

ACTION ITEMS:

Intellectual and Developmental Disability (IDD) Habilitative Specialized Services- *Anne McGonigle, Program Services Manager, Health and Human Services Commission (HHSC) IDD Services*

Background. The purpose of the proposal is to describe the requirements applicable to a service provider agency providing preadmission screening and resident review (PASRR) IDD habilitative specialized services to Medicaid-eligible nursing facility (NF) residents aged 21 years and older found through PASRR to need such services.

A service provider agency is a community-based provider with experience delivering services to individuals with intellectual disabilities or developmental disabilities. In accordance with the state plan amendment, a service provider agency is eligible to contract with HHSC to provide IHSS if the service provider agency is licensed or certified by HHSC to provide program services for the Home and Community-based Services waiver, Texas Home Living waiver, Community Living Assistance and Support Services waiver, or Deaf Blind and Multiple Disabilities waiver. The services the service provider agencies will be providing are behavioral support, day habilitation, independent living skills training, employment assistance, and supported employment. The proposed new rules also describe the roles and responsibilities of a LIDDA related to the initiation and provision of IHSS.

Fiscal Impact.

	SFY 21	SFY 22	SFY 23	SFY 24	SFY 25
State	($1,637,343)	($2,325,686)	($2,325,686)	($3,262,169)	($3,249,277)
Federal	$2,681,279	$13,903,557	$13,903,557	$5,400,107	$5,438,783
Total	$1,043,936	$11,577,871	$11,577,871	$2,137,938	$2,189,506

Rule Development Schedule
November 12, 2020 - Present to the Medical Care Advisory Committee
November 19, 2020 - Present to HHSC Executive Council
December 2020 - Publish proposed rules in Texas Register
April 2021 - Publish adopted rules in Texas Register
April 2021 - Effective date

One thing that is troubling is we separate out mental health services, addressing only behavioral control, for IDD and they have a higher rate of mental health issues. We only get behavioral plans for IDD. We have to talk in terms of mental health for people with IDD. People should be assessed, diagnosed, and treated.

Public Comment.

Susan Murphree, Disability Rights Texas, stated that these PASRR rules are important to them but they had not been given timely access to the proposals and therefore, their input is limited. It is unclear who will be providing the services. This could limit access. There appears to be parts of the rule that need additional attention given the monumental changes.

The Chair stated that there has not been enough time for stakeholders to adequately review the rule. Another member concurred.

The Chair stated that the rule could be approved and then HHSC can meet with stakeholders in advance of the Executive Council meeting.

MOTION: *Move forward with the rules but subject to stakeholder involvement prior to consideration by the Executive Council – prevailed.*

Medicaid Substance Use Disorder (SUD) - *Meghan Young, Manager, HHSC Policy and Program Development*

Background. HHSC is modifying Rule §354.1311, Benefits and Limitations, to allow SUD treatment services to exceed current limits when medically necessary in response to federal mental health and substance use disorder parity requirements and state Medicaid SUD

medical policy updates. Rule §354.1312, Conditions for Participation, has been updated to remove obsolete references to the Department of State Health Services as the licensing entity for substance abuse treatment facilities, replacing them with references to HHSC. Furthermore, Rule §354.1312 proposes expanding the providers who may deliver medication assisted treatment, consistent with both federal and state legislation.

The proposed amendments update rules for Substance Abuse Dependency and Treatment Services and are necessary to comply with the Mental Health Parity and Addiction Equity Act of 2008 and the Centers for Medicare & Medicaid Services (CMS) Medicaid and CHIP Mental Health Parity Final Rule issued March 2016, related to mental health parity requirements for Medicaid and CHIP managed care organizations. The final CMS Medicaid/CHIP parity rule requires that quantitative treatment limits (limits on scope or duration) for mental health and substance use disorder (SUD) benefits cannot be more restrictive than substantially all medical or surgical benefits in a classification (e.g., outpatient services.) With the proposed amendments, providers may be reimbursed for services for adults that extend beyond benefit limitations with documentation of the supporting medical necessity for continued services. Previously, only children under the age of 21 could exceed benefit limits for these services.

The following treatment limits may be exceeded with documentation of medical necessity:

- SUD residential treatment services: 35 days per episode with a maximum of two episodes per rolling six month period, and four episodes per rolling year.
- SUD individual counseling: a maximum of 104 units (26 hours) of service per calendar year.
- SUD group counseling: a maximum of 135 sessions per year.

The proposed amendments also expand the types of providers who may deliver medication assisted treatment, consistent with the Comprehensive Addiction and Recovery Act of 2016; the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act of 2018; Senate Bill 1564, 86th Legislature, Regular Session, 2019; and Medicaid SUD medical policy updates to the Texas Medicaid Provider Procedures Manual that became effective 1 January 1, 2019. In addition to physicians, the proposed amendments allow other qualified prescribers to provide medication assisted treatment in an office setting. These other qualified prescribers include physician assistants, advanced practice registered nurses, clinical nurse specialists, nurse midwives, and nurse anesthetists who meet certain requirements to prescribe buprenorphine for opioid use disorder.

Fiscal Impact.

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	SFY2021	SFY2022	SFY2023	SFY2024	SFY2025
State	$55,289	$62,079	$65,557	$69,176	$72,995
Federal	$97,442	$99,082	$104,500	$110,269	$116,356
Total	$152,731	$161,162	$170,058	$179,445	$189,350

The costs are related to extending beyond the treatment limits.

Rule Development Schedule
November 12, 2020 - Present to the Medical Care Advisory Committee
November 19, 2020 - Present to HHSC Executive Council
January 2021 - Publish proposed rules in Texas Register
April 2021 - Publish adopted rules in Texas Register
April 2021 - Effective date

Public Comment:

Linda Litzinger, Texas Parent to Parent commented on SB1207. She stated that when youth transition to adulthood they have to find new specialists. There are barriers to payment even though people have insurance. Behavioral and substance use supports should be better coordinated. (This actually pertains to Agenda Item 3.)

The Chair stated that this rule also had not been made available in a timely manner to stakeholders. It was made available late last night. She stated that they are in a similar place as with the previous rule.

MOTION: *To move forward as proposed but subject to stakeholder involvement prior to consideration by the Executive Council - prevailed.*

Nurse Aide Training and Competency Evaluation Program (NATCEP) - Tabled for another meeting.

The purpose of the proposal is to allow a NATCEP provider to offer components of required training online in a virtual classroom location. Currently, all NATCEP training is provided in classroom and clinical settings. This initiative is a response to a critical shortage in trained nurse aides in nursing homes. This proposal aims to increase the number of nurse aides qualified for NF employment. Due to the challenges presented by COVID-19 and the need for greater awareness and emphasis on infection control, HHSC is also proposing NATCEP providers increase infection control training and continuing education requirements for nurse aides.
- Catherine Anglin, Program Manager, HHSC Policy Rules and Training

Nursing Facility Administrator Licensing. Tabled for another meeting.

This proposal will amend existing, add new, and repeal portions of the nursing facility administrators (NFA) licensure requirements to correspond with the Nursing Administrators Board (NAB) requirements, including reciprocity. NFAs will be able to take required training and to attain or maintain certification as a preceptor at their convenience and via computer-based training. Allowing reciprocity for individuals credentialed as a Health Services Executive will also streamline the process for obtaining credentialing as an NFA. Due to the challenges presented by COVID-19, HHSC is also proposing that NF providers increase infection control training and continuing education requirements for NFAs.
- Catherine Anglin, Program Manager, HHSC Policy Rules and Training

INFORMATIONAL ITEMS

Behavioral Health Services Disaster Rules. Tabled for another meeting.

The purpose of this proposal is to allow HHSC flexibility to waive certain requirements for the delivery of services in response to a declared disaster. The proposed new rule is based on the existing emergency rule created in 26 Texas Administrative Code §306.1351, relating to COVID-19 Flexibilities. This proposal creates a standing rule, allowing providers subject to the rule to operate with the same flexibilities afforded by the emergency rule and it ensures continuity of services for individuals receiving community-based behavioral health services.
- Lizet Alaniz, Rules Coordinator, HHSC Behavioral Health Services Operations

Federally Qualified Health Care (FQHC) Services Reimbursement (SB 670)

Background. The proposed amendments specify that (1) a new FQHC included on the cost report of another FQHC should be assigned the rate of the other FQHC, and (2) telemedicine and telehealth services are to be included in the definition of "visit" and a "medical visit." This change increases transparency and provides additional detail on the existing reimbursement structure for FQHCs.

The Texas Health and Human Services Commission (HHSC) proposes to amend Texas Administrative Code (TAC) Title 1, Part 15, Chapter 355, Subchapter J, Division 14, §355.8261, related to Federally Qualified Health Center Services Reimbursement to ensure that a Federally Qualified Health Center Services (FQHC) is reimbursed for a covered telemedicine medical service or telehealth service delivered by a health care provider to a Medicaid recipient at the facility.

The amendment to this rule is proposed to comply with SB 670, 86th Legislature, Regular Session, 2019, which requires HHSC to ensure that a FQHC may be reimbursed for a covered telemedicine medical service or telehealth service delivered by a health care provider to a

Medicaid recipient. The proposed amendment will also clarify how rates are set for newly enrolled FQHCs that are authorized to be included on a consolidated cost report of another FQHC.

Fiscal Impact. None reported.

Rule Development Schedule.

November 2020 - Publish proposed rules in Texas Register
November 12, 2020 - Present to Medical Care Advisory Committee
November 19, 2020 - Present to HHSC Executive Council
February 2021 - Publish adopted rules in Texas Register
February 2021 - Effective date

Uncompensated care Secondary Reconciliation for Demonstration Years 6–8

Background. This proposal is to revise the secondary reconciliation process applied to hospitals that requested an adjustment to their interim hospital-specific limit for purposes of calculating uncompensated care payments in demonstration years 6 through 8 (October 1, 2016, to September 30, 2019), and to describe the methodology HHSC will use to redistribute recouped funds.

The Texas Health and Human Services Commission proposes to amend Texas Administrative Code Title 1, Part 15, Chapter 355, Subchapter J, Division 11, Section 355.8201, relating to Waiver Payments to Hospitals for Uncompensated Care. The purpose of the proposal is to revise the secondary reconciliation process applied to hospitals that requested an adjustment to their interim hospital-specific limit (HSL) for purposes of calculating uncompensated care (UC) payments in demonstration years (DYs) 6 through 8 (October 1, 2016, to September 30, 2019), and to describe the methodology HHSC will use to redistribute recouped funds. The amendment to the secondary reconciliation is in response to a petition for rulemaking.

As part of the UC application process, a hospital can submit a request for an adjustment to cost and payment data to reflect increases or decreases in costs resulting from changes in operation or circumstance. If a hospital requested an adjustment on its UC application that impacted its interim HSL (now referred to as the state payment cap), it would be subject to an additional reconciliation. The purpose of this secondary reconciliation is to ensure that a hospital that inaccurately adjusts its interim HSL does not benefit from that inaccuracy. Under the current secondary reconciliation process, HHSC compares a hospital's adjusted interim HSL for the demonstration year to its final HSL for the demonstration year. If the final HSL is less than the adjusted interim HSL, the hospital's UC payment is calculated for the demonstration year using the final HSL instead of the adjusted interim HSL, with no other changes being made to the data used in the original calculation of the hospital's UC payment.

HHSC then recoups any payment received by the hospital that is greater than the recalculated payment.

The interim HSL is defined by HHSC and is calculated in the payment year for hospitals that participate in the Disproportionate Share Hospital (DSH) and UC programs. The final HSL is governed by federal law and is calculated two years after the payment year using actual program year data. HHSC's understanding of the federal regulation governing the final HSL has changed since HHSC calculated the adjusted interim HSL for UC payments in DYs 6 through 8 and will require a different methodology to be used to calculate the final HSL for those years.

As a result, there is a risk that a hospital that submitted a request on its UC application to adjust its interim HSL in DYs 6 through 8 could have a final HSL that is less than its adjusted interim HSL due only to the change in HSL methodology. Under the current secondary reconciliation provision, HHSC would recoup any payment received by the hospital that is greater than the recalculated UC payment.

HHSC proposes to amend §355.8201(i)(3) to revise the secondary reconciliation process applied to hospitals that adjusted their interim HSL in DYs 6 through 8. This proposed change is in response to a petition for rulemaking from Texas Children's Hospital and is intended to prevent recoupments from hospitals that are solely the result of a change in the federal regulation related to the final HSL calculation. For DYs 6 through 8, HHSC proposes to compare a hospital's adjusted interim HSL for the demonstration year to a proxy-final HSL for the demonstration year.

The proxy final HSL will be calculated using the same methodology described in §355.8066(c)(2) for the demonstration year, except that it will not offset third-party and Medicare payments for claims and encounters where Medicaid was a secondary payer. If the proxy-final HSL is less than the adjusted interim HSL, HHSC will recalculate the hospital's UC payment for the demonstration year using the proxy-final HSL. HHSC proposes to amend §355.8201(k) to describe the methodology HHSC will use to redistribute recouped funds to providers eligible for additional payments.

A provider is eligible for an additional payment if it has allowable uncompensated costs that were not reimbursed through its initial UC payment for the demonstration year. Recouped funds from state providers will be redistributed proportionately to eligible state providers based on the percentage that each eligible state provider's remaining final uncompensated cost of care (UCC) calculated in the reconciliation described in §355.8201(i) is of the total remaining final UCC of all eligible state providers. Recouped funds from non-state providers will be redistributed proportionately to eligible non-state providers, except for in DYs 7 and 8 (October 1, 2017 to September 30, 2019).

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For DYs 7 and 8, recouped funds from non-state providers will be redistributed to eligible non-state providers using a weighted allocation methodology. First, HHSC will calculate a weight that will be applied to all non-state providers. The weight is calculated based on the provider's final remaining UCC with and without the offset of payments for third-party and Medicare claims and encounters where Medicaid was a secondary payer to determine how significantly the provider's UCC was impacted by not offsetting these payments. Providers who did not have a significant change in their UCC will receive a larger weight.

Then, HHSC will make a first pass allocation to determine a provider's additional payment amount. HHSC will limit a provider's payment to the amount of the provider's final remaining UCC. If a provider is allocated a payment amount that is higher than its remaining UCC, HHSC will make a second pass allocation to redistribute the excess funds using the remaining UCC for all non-state providers without applying the weight.

Fiscal Impact. There is no anticipated fiscal impact on state government. HHSC does not have sufficient data to determine how specific hospitals would be impacted by this rule amendment. The proposed rule will have both a positive and negative impact on local governments, depending on the amount of Medicare and third-party payments each local governmental hospital had. The fiscal impact will not be known until the final UC reconciliation is completed for each of the affected demonstration years.

Rule Development Schedule.
October 2020 - Publish proposed rules in Texas Register
November 5, 2020 - Present to the Hospital Payment Advisory Committee
November 12, 2020 - Present to the Medical Care Advisory Committee
November 19, 2020 - Present to HHSC Executive Council
December 2020 - Publish adopted rules in Texas Register
December 31, 2020 - Effective date

Rate Increase Attestation Process COVID-19 – *Brook Ellison, Deputy Director, HHSC Provider Finance*

The proposed new rule outlines the process wherein HHSC will restrict eligible Medicaid providers from using temporarily increased reimbursement rates to increase hourly wages paid to direct care staff on an ongoing basis. In accordance with the contingencies placed upon use of the funds for staff compensation, they are limited to overtime payments, lump sum bonuses, bonuses for hazard pay, or other types of compensation that will not result in future reductions to hourly wages when the emergency temporary reimbursement rate increase is discontinued.

The Texas Health and Human Services Commission (HHSC) proposes in Texas Administrative Code (TAC) Title 1, Part 15, Chapter 355, Subchapter B, §355.205, relating to Rule for

Emergency Temporary Reimbursement Rate Increases and Limitations on Use of Emergency Temporary Funds for Medicaid in Response to Novel Coronavirus (COVID-19), to describe the process by which HHSC will restrict providers from using the increased reimbursement rates to increase hourly wages paid to direct care staff on an ongoing basis in accordance with the contingencies placed upon use of the funds. Use of the funds for staff compensation is limited to overtime payments, lump sum bonuses, bonuses for hazard pay, or other types of compensation that will not result in future reductions to hourly wages when the emergency temporary reimbursement rate increase is discontinued.

Reimbursement rates were increased effective April 1, 2020, to ensure that these providers are able to purchase personal protective equipment, ensure adequate staff-to-client ratios, and take other necessary steps to serve clients individually rather than in congregate settings to protect the health and safety of the clients in their care. This new rule is based on an existing emergency rule adopted in response to the COVID-19 pandemic: §355.205, Emergency Rule for Emergency Temporary Reimbursement Rate Increases and Limitations on Use of Emergency Temporary Funds for Medicaid in Response to Novel Coronavirus (COVID-19). The provisions of this new rule are the same as the emergency rule. Except for a minor edit in the title of the rule and a clarifying edit in the text, there are no changes.

Fiscal Impact. None reported

Rule Development Schedule
October 23, 2020 - Publish proposed rules in Texas Register
November 12, 2020 - Present to the Medical Care Advisory Committee
November 19, 2020 - Present to HHSC Executive Council
December 2020 - Publish adopted rules in Texas Register
December 2020 - Effective date

Proposed next meeting: February 11, 2021, at 9:00 a.m.

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

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