HHSC: STAR Kids Managed Care Advisory Committee, March 4th, 2020

The STAR Kids Managed Care Advisory Committee advises on the establishment and implementation of the STAR Kids Medicaid managed care program which provide services for children with disabilities who have Medicaid coverage to improve coordination and customization of care, access to care, health outcomes, cost containment and quality of care. Members appear below:

Elizabeth Tucker, Chair Advocate for children with special healthcare needs Austin, TX **Rahel Berhane, M.D.** Physician Provider Austin, TX **Josh Britten** Durable Medical Equipment and Services Representative Amarillo, TX **Rosalba Calleros** Family Member Austin, TX **Catherine Carlton** Family Member Arlington, TX **Terri Carriker** Family Member Austin, TX **Tara Hopkins** Managed Care Organization Representative, Dental Austin, TX **Alice Martinez** Advocate San Antonio, TX	**Glen Medellin, M.D.** Physician San Antonio, TX **Ricardo Mosquera** Family Member Houston, TX **Katherine Ostermaier, M.D.** Managed Care Representative Houston, TX **Jose Pereida** Parent Robstown, TX **David Reimer** Pediatric Therapy Provider, PDN Dallas, TX **Blake Smith** Therapy Provider Denison, TX **Shawnett Viani** Advocate Denton, TX **Beanca Williams** Home and Community-Based Provider Stafford, TX

1. Call to order. The 26th meeting of this advisory committee was convened by Elizabeth Tucker, Chair on March 4th, 2020.

2. Roll Call. A quorum was established.

3. Approval of December 11, 2019, and January 28, 2020, meeting minutes. The minutes for both meetings were approved as written.

4. Medicaid updates impacting the STAR Kids program.

HHSC has been working on an initiative to revise the Star Kids Screening and Assessment Instrument (SK-SAI) to optimize the tool and streamline the assessment process. HHSC made changes to the SK-SAI based on previous stakeholder feedback and requested feedback from STAR Kids stakeholders (STAR Kids Advisory Committee, advocates, providers and MCOs) in August 2019. The STAR Kids stakeholders provided their feedback and recommendations in October 2019. HHSC has incorporated the recommended changes into the draft SK-SAI and aggregated all recommendations and responses in a spreadsheet. The following is a summary of the comments and responses, and next steps.

Total comments: 401

- HHSC has accepted 75 recommendations.
- HHSC has accepted but modified 52 recommendations.
- HHSC has declined 84 recommendations.
- HHSC has clarified 183 recommendations that will require an update to the manual.
- There are 7 recommendations that require further clarification.

Next Steps:

- Determine the time and resources needed for TMHP and MCOs to make system changes.
- Work on updating the SK-SAI Instruction Manual in March & April 2020.
- Begin drafting the scope of work for the needed system changes.

Below is a list of categories for most of the feedback.

Living Arrangements

Comment 1: Several commenters asked for the rewording of this section to better capture the preferred living arrangement of individuals.

Response 1: HHSC accepted with some modifications. Assisted living facility (ALF) was removed. HCS waiver host home and college or school housing was added.

Comment 2: Several commenters asked for clarification on skip logic if there is no change in the individual's living arrangement since the last assessment.

Response 2: HHSC acknowledges, and information can be pre-populated, but verification still needs to happen.

Comment 3: Several commenters wanted a clarification on referrals and flags/triggers that would result due to the responses for living arrangements, as well as how this information is utilized and who takes responsibility for notifying and/or informing the family if, how, and with whom their information is being shared.

Response 3: HHSC acknowledges and will ensure a flag/trigger is required so referrals will be made to the appropriate entity.

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Medical Provider Information

Comment 1: Several commenters wanted us to be aware that this information may not be known to families, and that it would be difficult to obtain the physician license number.

Response 1: HHSC acknowledges the concern and clarifies that the family is only responsible for any doctor's information they have available and is not required to have the physician license number. HHSC has added city, state, and zip codes as identifiers to facilitate license look up for the MCOs.

Comment 2: Several commenters found the wording confusing and want clarification on who can be listed for the "Name of Physician". The commenters said it is not clear to families that this means their pediatrician or a physician who will serve as the primary care provider and point of contact for the MCOs, and that a specialist can serve in this role.

Response 2: HHSC will update the manual to clarify that the members physician of their choice is entered here.

Consistent Timeframes/Lookback Periods

Comment 1: There were several comments regarding the lack of consistency and the broad variations for lookbacks throughout the document and the concern that the timeframes did not adequately capture the child's long-term condition(s). The recommendation was to change to a minimum of 12-month lookback period for everything except diagnoses, hospitalizations, and surgeries.

Response 1: HHSC acknowledges but cannot change the timeframes in the assessment, as the look back periods are integral in determining medical necessity for a nursing home level of care. The workgroup did not change any of the questions related to the determination of medical necessity on the SK-SAI.

Comment 2: Several commenters suggested modifying the instructions on the form itself regarding timeframes to decrease the chances of missing key information. The recommendation is that, if any time frames are maintained that are less than a year, language is added to each section that asks specific information, such as, "intermittent, if not within XX days, explain _____."

Response 2: HHSC acknowledges the request to capture as much relevant medical information as possible, and revisions have been made. HHSC has added additional open fields in each section to prompt the service coordinator to capture an event or change that occurred since the last assessment, but outside of the lookback timeframes.

Barriers/Caregiver Issues

Comment 1: Several commenters want to know why this information is needed and how it is going to be used and they recommended removing the question about the age of the primary caregiver(s).

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Response 1: The questions in this section are used to determine barriers to providing care and have been part of documentation for evaluation of PCS hours. In addition, it can clarify if families are in crisis and if referrals need to be made.

Comment 2: Several commenters wanted to capture the household composition for adult and children as well as adding community first choice (CFC) as one of the listed services, because it is very critical to recognize throughout the assessment that CFC exists.
Response 2: HHSC accepted this suggestion and modified how household composition is captured differentiating between "under 18" and "18 and older". Additionally, CFC was added to the list of services to choose from.

Narrative Sections
Comment 1: Several commenters are concerned that many of the current options do NOT capture important qualifiers, and a Y/N answer does not accurately capture many of our children's ongoing medical needs and disease processes. Especially how ongoing interventions and access to services provided by the program help to attain some form of stability due to ongoing medical interventions.
Response 1: HHSC has added additional open-ended questions at the end of each section to capture any important information not captured elsewhere.

Comment 2: Several commenters stated that there is no place to note that a child can only hear/see with interventions or that sleep patterns may be modified or improved due to interventions.
Response 2: HHSC will update the manual to prompt the service coordinators to ask about certain conditions or needs are modified or improved as a result of an intervention, such as sleep patterns, hearing, and vision. This information can be noted in the added open-ended question at the end of each section.

Comment 3: Several commenters asked about the character limit in the narrative sections.
Response 3: HHSC is working to see if the character limit can be expanded.

Reduce Redundancy and Consolidate
Comment 1: Several commenters suggested that in order to reduce redundancy, similar items should be consolidated.
Response 1: HHSC agrees and has removed any redundancy to the extent feasible.

Comment 2: There were several comments regarding the Personal Care Assistance Module (PCAM) and how it should be combined with the PCAM triggers and provided to all STAR Kids participants.
Response 2: HHSC agrees and the PCAM will be a required element for all STAR Kids members except for those that receive services through the 1915 (c) IDD waivers.

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Transparency

Comment 1: Several commenters suggested that every question which contributes to medical necessity and eligibility, nursing services, personal care services, and Community First Choice should be identified. There are a number of simple ways in which this could be accomplished (color-coding, written designation, etc.), but knowing which questions are triggers and/or are weighted to contribute to eligibility and determination of services, including RUG score calculation, should be marked and easily identifiable for both families and assessors, to improve the transparency of the process.

Response 1: HHSC acknowledges. There are no weights associated with questions for medical necessity determination or eligibility for services. PCS and CFC triggers have been streamlined. HHSC discussed flagging the trigger questions and those used in determining medical necessity versus requiring that all questions have completed responses. The concern is that some questions may be skipped or left unanswered if this was done.

Comment 2: Several commenters asked for the clarification on the school and work section. In general, families want to know how the information in this section is being used, and want to see that included in the instructions if this section is absolutely necessary or contributes to MN/other calculation, triggers referrals, etc.

Response 2: HHSC acknowledges families' concerns and clarifies that this information is beneficial in identifying needed services the MCO must provide or initiate referrals to ensure services are received in the settings in which individuals need them.

Annual Reassessments

Comment 1: Several commenters brought up the annual reassessment process and how the legislature has instructed HHSC to minimize, to the greatest extent possible, the annual re-assessment process for those children who have chronic, long-term conditions. There is also a precedent under DADS when that agency handled HCBS. Our understanding is that it was called "CBA/D Streamlining" and consisted of 6 questions answered via an if/then type flow-chart to determine any significant improvements or declines, or if the patient was stable due to interventions from services accessed through the program, which would determine or trigger the need for a full reassessment.

Response 1: HHSC clarifies that federal guidelines require that each annual assessment must fully represent the child's medical situation and needs at the time of the assessment. HHSC researched the six-question form used in the Community Based Assistance (CBA) program and verified with previous DADS staff that this was a screening tool, but not used to supplant the need for conducting a comprehensive annual assessment. HHSC is still analyzing ways to streamline the reassessment process. HHSC plans to ask MCOs to pre-populate demographic data and historical medical information (such as previous surgeries) and verify if anything has changed.

Utilization of Information

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Comment 1: Several commenters expressed concerns regarding the mental health and behavioral health concerns section. They expressed that families are extremely hesitant to answer these questions and would like clarification and additional information as to how this information is being utilized.
Response 1: HHSC clarifies that these questions are flagged so the MCO can make appropriate referrals for behavioral health services and can add to the justification of need for PCS/CFC services.

Comment 2: Several commenters stated that families have requested clarification as to the intent of the question "Level of Care from Primary Caregiver(s) Is Expected To Decrease Within Next 90 Days" and how is this information utilized.
Response 2: HHSC modified the question to provide more clarity and it will read "Ability of Primary Caregiver To Provide Care Is Expected to Decrease Within Next 90 Days". There will also be an update made in the manual for further clarification. The intent is to alert the assessor of a change in support needs and adjust the service plan accordingly.

Clarifications
Comment 1: Several commenters asked for the clarification on the interpreter information and wanted to ensure that this information is obtained prior to the visit.
Response 1: HHSC will update the manual to require MCOs to obtain this information prior to the visit and clarify that the interpreter must be a certified interpreter provided by the MCOs as stated in the STAR Kids contract.

Comment 2: Several commenters asked for clarification when addressing functional status and Habilitation Needs.
Response 2: HHSC will update the manual with examples and clarify the terms. Functional status is used to determine the amount of assistance provided on a regular basis and it is used to capture the clients current level of performance, not the services that would be provided. Habilitation Needs is only used for individuals authorized for or who are seeking authorization for the Community First Choice (CFC) benefit.

Comment 3: Several commenters wanted clarification or rewording of questions in the mental health and behavioral health concerns section.
Response 3: HHSC reworded H_1, to state "Observed Mental Health Symptoms, and H_2 now states "Observed Behaviors". In addition, HHSC will clarify these terms in the manual.

Comment 4: Several commenters brought up the concern that some parents struggle with answering questions in section E: Strengths and challenges in performing daily tasks. They think the age for this question should be increased and should also apply for questions 3 and 4. Will this change prevent the PCAM from being needed for those individuals who cannot perform their ADLs/IADLs due to age?

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Response 4: HHSC will remove age stratification from this question and add to the instructions the following: "(Note: questions in this section should be considered in the context of age appropriateness)."

Comment 5: Several commenters asked for clarification on who assesses change in mental status? Perhaps more examples? What does this trigger?
Response 5: HHSC clarifies that the caregiver provides their assessment of any changes in mental status. HHSC will update the manual with examples for further clarification.

Questions and Comments.

- **The Chair** stated that we discussed testing, but not full-blown testing for validity. Rather, testing with some MCOs to see if this tool works as revised. There is an opportunity to take the tool and work with MCOs to see how this might work. Staff stated that they will take the opportunity to see how this might work at their next meeting.
- We can take a paper form and see how this works for the family and the assessor.
- We should test on children other than MDCP.
- Dr. Medellin stated that we have to be sure that this information is shared with families.
- The families can request that it be mailed to them by the MCO, outside of the portal.
- Families who are not portal savvy should have the opportunity to get the information that they need (assessment). HHSC stated we are looking at ways to get this information to providers directly without having to rely on families.
- Peer to peer discussion cannot happen without the results of the SK-SAI.
- Are you looking at the ISP and how the information is synthesized with the assessment? Can the ISP be made more streamlined? Staff stated that this review is not looking at that, but it should be reviewed.
- We should look at the ISP and the authorization of services.
- Is there a way we can do this without sending the SAI to all families—perhaps, asking families if they need a hard-copy, or providing access electronically? Service coordinators do provide that guidance and it is a contractual requirement.

Corona virus (COVID19) special presentation. Dr. Van Ramshorst stated that they have been coordinating with DSHS. Dr. Stephen Pont, DSHS, provided the update. He stated that the situation continues to evolve. The steps you take for the flu are the same ones you should take for COVID-19. Novel viruses are created, they evolve from animals to humans, and then continue to evolve from human to human. The virus became known in December. The primary symptoms are, fever, cough, and shortness of breath. The infection period is 2-14 days and transmission occurs through droplets. Typical cleaning products are good to fight coronaviruses.

Currently, there is no vaccine for the virus. There are complicated treatments still being developed. Nonpharmaceutical interventions are the best way to prevent the virus. Texas has

not yet experienced community spread. DSHS always recommends these everyday actions to help prevent the spread of respiratory viruses, including:

- Wash your hands often with soap and water for at least 20 seconds, especially after going to the bathroom; before eating; and after blowing your nose, coughing, or sneezing. If soap and water are not available, use an alcohol-based hand sanitizer with at least 60% alcohol.
- Avoid touching your eyes, nose, and mouth with unwashed hands.
- Avoid close contact with people who are sick.
- Stay home when you are sick.
- Cover your cough or sneeze with a tissue, then throw the tissue in the trash.
- Clean and disinfect frequently touched objects and surfaces using a regular household cleaning spray or wipe.
- Follow the CDC's recommendations for using a facemask:
    - The CDC does not recommend that people who are well wear a facemask to protect themselves from respiratory diseases, including COVID-19.
    - Facemasks should be used by people who show symptoms of COVID-19 to help prevent the spread of the disease to others. The use of facemasks is also crucial for health workers and people who are taking care of someone in close settings (at home or in a health care facility).

He stated that hopefully, these practices are already in place for special needs children or people with compromised immune symptoms.

People who are 50 years or older are at the highest risk of death. It is important that only actual and factual information be provided to the citizens of Texas.

Ms. Tucker stated that HHSC should be prepared to address a crisis if it indeed exists. Staff stated that there is a website for coronavirus in Texas.

At the Executive Council meeting, the Commissioner of Health made the following presentation on COVID19:

Novel Coronavirus Update. Dr. Hellerstedt stated that their focus is on preventing the spread of the virus in Texas. They have activated The State Medical Observation Center (SMOC). This entity maintains communication with the public and stakeholders. Coronavirus can infect people and animals. This is called a novel virus because it has not been seen in people before. Therefore, there is no innate immunity. Ninety-nine percent of the deaths have occurred in China. There are 15 confirmed cases in the US, and most are travel related. Texas has one confirmed case and several hundred people in Texas are being monitored because they have traveled to high-risk areas. *From Texas Insight's report on February 20, 2020.*

A novel (new) coronavirus was recently detected in Wuhan City, Hubei Province, China and is causing an outbreak of respiratory disease. On February 11, 2020, the World Health Organization named the disease coronavirus disease 2019 (abbreviated "COVID-19").
Chinese health officials have reported tens of thousands of cases of COVID-19 in China, with the virus reportedly spreading from person-to-person in parts of that country. COVID-19 illnesses, most of them associated with travel from Wuhan, also are being reported in a growing number of international locations, including the United States. Some person-to-person spread of this virus outside China has been detected.

The United States reported the first confirmed instance of person-to-person spread with this virus on January 30, 2020. The Centers for Disease Control and Prevention (CDC) has confirmed one case of COVID-19 in a person who has been under quarantine at JBSA-Lackland in San Antonio since their return from China on a State Department-chartered flight. The individual is currently isolated and receiving medical care at a local hospital. This case does not change the risk of infection for people in San Antonio or other parts of Texas, because the patient has been under quarantine. The risk for all Texans remains low.

The Texas Department of State Health Services (DSHS) is working closely with CDC in monitoring the developing outbreak. See the CDC website for the latest developments on COVID-19, including current case counts.

Current understanding about how the virus that causes coronavirus disease 2019 (COVID-19) spreads is largely based on what is known about similar coronaviruses.
The virus is thought to spread mainly from person-to-person:

- Between people who are in close contact with one another (within about 6 feet).
- Via respiratory droplets produced when an infected person coughs or sneezes.
- These droplets can land in the mouths or noses of people who are nearby or possibly be inhaled into the lungs.

It may be possible that a person can get COVID-19 by touching a surface or object that has the virus on it and then touching their own mouth, nose, or possibly their eyes, but this is not thought to be the main way the virus spreads.

People are thought to be most contagious when they are most symptomatic (the sickest). Some spread might be possible before people show symptoms; there have been reports of this with this new coronavirus, but this is not thought to be the main way the virus spreads. Early on, many of the patients in the COVID-19 outbreak in Wuhan, China had some link to a large seafood and live animal market, suggesting animal-to-person spread. However, it is now clear that person-to-person spread is occurring. There is much more to learn about the transmissibility, severity, and other features associated with COVID-19, and investigations are ongoing.

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Patients with COVID-19 have reportedly had mild to severe respiratory illness. Symptoms can include:

- Fever
- Cough
- Shortness of breath

At this time, CDC believes that symptoms of COVID-19 may appear in as few as 2 days or as long as 14 days after exposure. This is based on what has been seen previously as the incubation period of MERS coronaviruses.

There is currently no vaccine to prevent COVID-19. The best way to prevent infection is to take precautions to avoid exposure to this virus, which are similar to the precautions you take to avoid the flu. DSHS always recommends these everyday actions to help prevent the spread of respiratory viruses, including:

- Wash your hands often with soap and water for at least 20 seconds, especially after going to the bathroom; before eating; and after blowing your nose, coughing, or sneezing. If soap and water are not available, use an alcohol-based hand sanitizer with at least 60% alcohol.
- Avoid touching your eyes, nose, and mouth with unwashed hands.
- Avoid close contact with people who are sick.
- Stay home when you are sick.
- Cover your cough or sneeze with a tissue, then throw the tissue in the trash.
- Clean and disinfect frequently touched objects and surfaces using a regular household cleaning spray or wipe.
- Follow the CDC's recommendations for using a facemask:
    - The CDC does not recommend that people who are well wear a facemask to protect themselves from respiratory diseases, including COVID-19.
    - Facemasks should be used by people who show symptoms of COVID-19 to help prevent the spread of the disease to others. The use of facemasks is also crucial for health workers and people who are taking care of someone in close settings (at home or in a health care facility).

5. Texas Government Code, Chapter 533, as amended by Senate Bill 1207, 86th Legislature, Regular Session, (2019) Coordination of Benefits update.

SB 1207 bill analysis: Many children enrolled in the Medically Dependent Child Program (MDCP) are also covered by commercial primary insurance or another primary insurance, meaning the Medicaid managed care program provides secondary coverage. In these situations, Medicaid is always the payer of last resort.

Before a managed care organization (MCO) will act on a claim or an authorization, it must first be acted upon by the commercial primary if there is one. This can create significant delay between the determination on the part of the primary, notification to the provider, re-submittal by the provider to the MCO, and the time the MCO processes the claim. Many

times these authorizations are time-sensitive, and children have had major surgeries cancelled, critical medications denied, and medically necessary services or equipment significantly delayed, resulting in the child's condition deteriorating and causing further complications or increased ER visits.

S.B. 1207 will put in place parameters and framework to remove some of the barriers that are causing delays, conflicts, and lack of coordination, and will require the agency and managed care organizations to implement policies and procedures that will (1) allow maximum utilization of commercial insurance coverage, thus increasing cost-effectiveness; and (2) reduce unnecessary delays and conflicts in processing the child's Medicaid claims under the managed care program.

S.B. 1207 amends current law relating to the operation and administration of Medicaid, including the Medicaid managed care program and the medically dependent children (MDCP) waiver program.

From the LBB Fiscal Note: The bill would require the Health and Human Services Commission (HHSC) to contract with an external medical review organization to review the resolution of certain appeals of a managed care organization's (MCO's) adverse determination on the basis of medical necessity or an HHSC denial of eligibility based on medical or functional need when the recipient or applicant affirmatively requests an external medical review and would require HHSC to conduct annual surveys and focus groups through the external quality review organization (EQRO) and to calculate an MCO's performance on performance measures using available data if HHSC determines through the EQRO's initial report on the STAR Kids managed care program that additional data and research are necessary to improve the Medically Dependent Children waiver program (MDCP). The bill would require HHSC to submit a quarterly report about access to care for recipients in MDCP. The bill would also require HHSC to develop and maintain a list of services that are not traditionally covered by primary health benefit plans (PHBP) and that a Medicaid managed care organization (MCO) may approve without coordinating with the issuer of the PHBP and that could be resolved through third party liability resolution. The bill would require HHSC to provide certain information on a recipient's third-party insurance, including benefits, limits, copayments, and coinsurance. The bill would require HHSC to develop and implement a process to allow a provider who primarily provides services to a recipient through PHBP coverage to receive Medicaid reimbursement for services ordered, referred, or prescribed regardless of whether the provider is enrolled as a Medicaid provider. The bill would take effect September 1, 2019.

The bill requires HHSC to develop policy guidance related to ensuring timely service delivery for recipients who have Medicaid and private insurance. Contract language has been developed as well. There are seven parts to this effort:

- Utilization of prior authorizations across the two care systems; CMS has some concerns about comparability of services across systems and a waiver could be required.
- **Section C** addresses reducing provider and recipient abrasion and related payment issues that address evidence of noncoverage. HHSC has been working on reviewing the feedback they have received on this.

- **Section D** addresses a waiver on third-party liability; CMS has stated that Medicaid must always be the payer of last resort.
- **Section E** addresses the file that is shared with MCOs weekly. There have been requests for information to be included in the file and HHSC is examining the file to accommodate the requests.
- **Section F** addresses providers being eligible to receive Medicaid payments. CMS has provided guidance that, to be eligible to receive Medicaid, a provider must be enrolled in Texas Medicaid (with minor exceptions). Use of the national provider number in lieu of the state number is being considered.
- **Section G** addresses people with complex needs and relationships with specialty providers, and their ability to continue to receive services from those providers. HHSC has proposed some contract language only for those who are new enrollees in the plan. This will be handled through the contract language.

The Chair asked about the CMS's concerns about comparability across services. Staff stated that there could be exceptions made for STAR Kids, but not other programs. Ms. Erwin stated that the difference revolves around service coordination and the CMS concern is related to access to service.

The Chair stated that she is grateful that they are looking at other acceptable forms of non-coverage. She stated that 110 days is a concern. HHSC stated that for them, timely filing is 95 days and they will be looking at the CMS requirement of 110 days.

The Chair stated that there are needs for which even 95 days is not timely enough.

The Chair sought clarification on Section D. *Section D reads as follows: The executive commissioner may seek a waiver from the federal government as needed to:*
(1) address federal policies related to coordination of benefits and third-party liability; and
(2) maximize federal financial participation for recipients with both primary health benefit plan coverage and Medicaid coverage.

6. Texas Government Code, Chapter 534, Subchapter C, as amended by House Bill 4533, 86th Legislature, Regular Session, (2019) Alternative Delivery Model report update.

The LBB Fiscal Note stated that the bill would require the Health and Human Services Commission (HHSC) to collaborate with the Intellectual and Developmental Disability System Redesign Advisory Committee and to establish and collaborate with a pilot program workgroup to develop and implement a Medicaid pilot program to provide long-term services and supports for certain individuals with intellectual or developmental disabilities (IDD) or certain similar functional needs. The pilot would begin on September 1, 2023 and operate for at least two years. The bill would require HHSC to collaborate and consult with the IDD System Redesign Advisory Committee and the pilot program workgroup to perform

an evaluation and submit a report after the conclusion of the pilot program. The bill would require HHSC to seek a federal waiver or authorization to provide Medicaid benefits to certain medically fragile individuals if HHSC determines it to be cost-effective. The bill would also require managed care plans offered by a Medicaid managed care organization (MCO) to meet certain accreditation requirements and would require HHSC to prepare and submit a report evaluating the feasibility of providing Medicaid benefits to children enrolled in the STAR Kids managed care program under certain alternative models. The bill would take effect September 1, 2019.

The costs associated with developing and implementing the pilot program cannot be determined at this time, as information is not available to determine the criteria for selecting MCOs to participate in the pilot, the eligibility criteria for the pilot, and the exact benefits included in the pilot. Costs could include significant client services and information technology systems changes that could vary depending on the size and scope of the pilot program. This analysis assumes that any costs associated with implementing the provisions of the bill relating to the pilot program would be immaterial and could be absorbed within existing agency resources for the 2020-21 biennium, but there could be administrative and technology-related costs in the 2022-23 biennium related to implementation of the pilot program on September 1, 2023, or related to the provision of Medicaid benefits to certain medically fragile individuals, if HHSC determines that providing benefits would be cost-effective and receives a federal waiver. Based on the LBB's analysis of HHSC, duties and responsibilities associated with implementing the provisions of the bill related to managed care organization accreditation and other reporting requirements could be absorbed using existing agency resources.

HHSC must evaluate the feasibility of using an accountability care organization model, or an alternative model. HHSC presented the following: ACE Kids Act has not resulted in CMS guidance; HHSC is waiting to see what they put out in October of this year with implementation in October of 2022. HHSC believes that the state law was pointing them toward the ACE Kids Act. They are presently looking at the best practices of the COIIN Project. Texas also participates in MED (Medicaid Evidence Decision Project) and HHSC has asked the Oregon organization to do a report for HHSC that identifies:

- Governance structures for ACOs
- Different payment structures for children with complex needs
- Payment models that exist presently within managed care
- How other states have structured ACO or ACO-like models

The report is due at the end of the summer. They also will be publishing an RFI for feedback on ACOs in Texas. The responses are hoped to be back November 1st.

Collaborative Improvement and Innovation Networks (CoIINs) are multidisciplinary teams of federal, state, and local leaders working together to tackle a common problem. CoIINs use technology to remove geographic barriers. Participants with a collective vision share ideas, best practices, and lessons learned. They track their progress toward similar benchmarks and shared goals.

Participants self-organize, forge partnerships, and take coordinated action to address complex issues. They do this via structured collaborative learning, quality improvement, and innovative activities.

- Together, they identify common aims and specific, measurable objectives to describe what they want to achieve;
- Determine and use evidence-based strategies to show how they will accomplish these objectives; and
- Use clear-cut metrics and share real-time data to reveal what's working and determine if they achieved the aim(s).

Topics include:

- Maternal health
- Prenatal and infant/child oral health
- Newborn screening
- Infant mortality
- Home visiting
- Pediatric emergency care
- Child safety
- School-based health
- Children's healthy weight
- Adolescent and young adult health
- Environmental health

The Medicaid Evidence-based Decisions Project (MED)is a collaboration of state agencies. MED produces reports and other tools to help state policymakers make the best, evidence-based decisions for improving health outcomes. The reports provide valuable evidence about effective treatments as well as information about harmful or unnecessary services. MED participants have access to policy and evidence resources that support sound decision-making with unbiased analyses of complex issues.

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Questions and Comments

- There is a national advisory council for COIIN and some entities in Texas have been involved.
- Are there other states that are still using the PCCM model? Texas might want to pursue this.
- Is there a role for telemedicine for this model? HHSC stated that they could include telemedicine in the RFI, but some legislation passed this past session related to telemedicine directing its use across more services.
- The Chair stated we can include this as a topic for the next meeting.
- Payment is tied to an encounter, so for telemedicine, changing this would be a first step. There is a need for a clinically integrated network where everyone works together for an outcome.
- We have to define the subpopulations.

7. Texas Government Code, Chapter 533, as amended by Senate Bill 1207, 86th Legislature, Regular Session, (2019) External Medical Review update. Lachelle Thomas made the presentation.

Texas is way ahead of other states in this, so there were no other states to model. There are two categories of review:

1. The resolution of a Medicaid recipient appeal related to a reduction in or denial of services on the basis of medical necessity in the Medicaid managed care program
2. Denial by the commission of eligibility for a Medicaid program in which eligibility is based on a Medicaid recipient's medical and functional needs (applies to STAR+ Plus HCBS, MDCP)

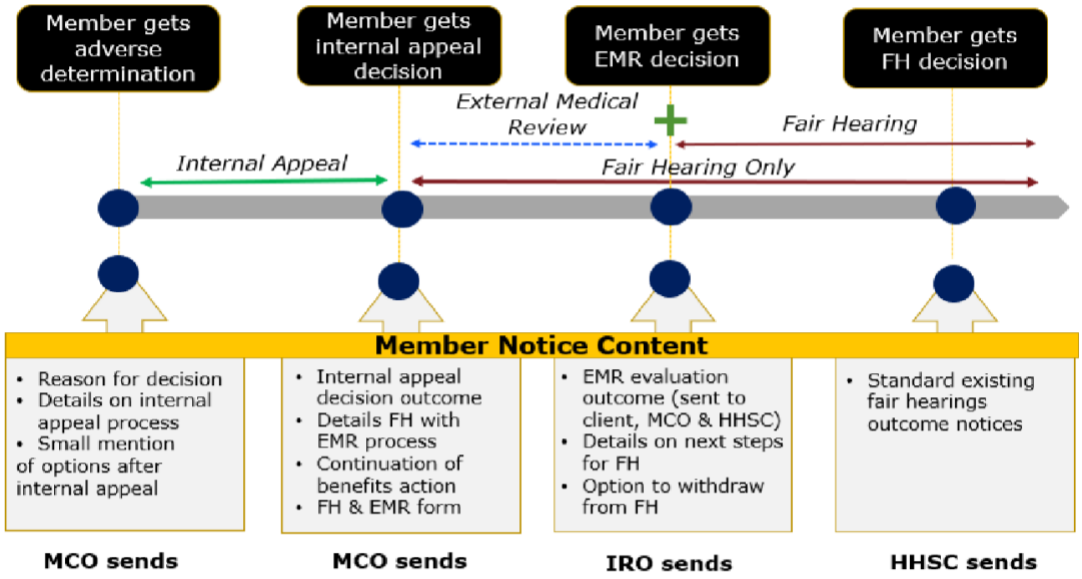
The external medical reviewer shall require a Medicaid managed care organization, in an external medical review relating to a reduction in services, to submit a detailed reason for the reduction and supporting documents. To the extent money is appropriated for this purpose, the commission shall publish data regarding prior authorizations reviewed by the external medical reviewer, including the rate of prior authorization denials overturned by the external medical reviewer and additional information the commission and the external medical reviewer determines appropriate

Completed	In Progress
✓ Received CMS clarifications ✓ Finalized process flows to incorporate EMR ✓ Drafted EMR language to incorporate into notices ✓ Determined IRO contract approach and began drafting open enrollment contract ✓ Defined business requirements for TIERS changes	➢ MCO collaborative work session in early 2020 ➢ Stakeholder input into notice clarity ➢ IRO open enrollment contract, then onboarding ➢ Rules development ➢ HHSC intake team hiring and training ➢ Develop MCO contract changes ➢ Define anticipated reporting needs

Implementation is set for August 2020.

Member EMR Flow

The EMR process occurs within the Fair Hearing timeline



Notice #2: Member Notice of Internal Appeal Decision - Form

Fair Hearing and External Medical Review Request Form

To get a fair hearing and external medical review, you can fill out this form and mail or fax it to <MCO>.

Mail: <MCO address>
Fax: <MCO fax>

You can also call <MCO> at <phone number> to make your request.

If you want your services to continue, you must make your request by <date>.

You have until <date> to make your request.

Mark the Appeal You Want

___ Fair Hearing ___ Fair Hearing and External Medical Review
___ Emergency Fair Hearing ___ Emergency Fair Hearing and External Medical Review

Do You Want Your Services to Continue? ___ Yes ___ No

Your Personal Information

Last Name:	First Name:
Parent or Guardian Last Name:	Parent or Guardian First Name:
Medicaid ID:	Phone Number:
Address:	Address (Box 2):

Your Representative's Information*

Name:
Address:

Form will be paired with flier explaining process.

Final form may vary pending stakeholder input, plain language, and legal review.

Fair Hearing and EMR Timelines

General Assumptions

- Members can have multiple EMR cases in progress.
- Members cannot revisit the same EMR case through another IRO once a decision has been made.
- Member can continue to Fair Hearing or opt-out if satisfied with EMR decision outcome.
- EMR decision outcome will be part of the evidence packet for Fair Hearing.
- A client cannot submit additional information to the IRO.

Comments, Questions and Answers

- One thing not on the flow chart is the non-MCO denials, like the waiver denials coming from the state. Staff stated they are looking at MDCP and STAR+PLUS. The process will be the same standard process, but the parties will be different. HHSC will bring back the process at their next presentation.
- What is the difference between a regular fair hearing and an emergency? Staff stated that it would be a medical emergency/life threatening. (*It did not appear there was a clear definition.*) Emergency fair hearings are already held presently so HHSC stated they will get back in touch with the committee about this.
- The IRO is only looking at the information the MCO submitted but not talking with physicians? HHSC answered in the affirmative. Ms. Tucker stated that this limits the information that goes to the fair hearing. There is a danger that when you look at a medical record, it is only a snapshot in time.
- The MCO file may not be complete, and may possibly not include smaller pieces of information from parents.

- The fair hearing has the potential to have more information than the EMR.

8. Subcommittee updates.

A. Health homes and outcome measures. They have been meeting once a month and determined that the work was similar to the COIIN, so they joined efforts. They are focused on looking at the system as a whole to see about developing a clinical integrated network. They also want to work with MCOs to see how some of those functions can be conducted in the medical home. The coordinators have been hired and there is a lot of learning that has to occur. They are able to discuss what an ideal system will look like.

The Chair stated that if people are interested, they can have up to nine members. Currently there are only three members. They stated that they especially need a parent. This committee will be taking on the ACE Kid Act.

B. STAR Kids-Screening and Assessment Instrument Medically Dependent Children Program, prior authorizations, and Intellectual and Developmental Disability waiver carve-in. Previously discussed above, item 4. They also work on the reassessment and denial notices and MDCP and waiver carve ins. This group only has 4 members.

There has been discussion about paperwork reduction but that has not happened. Service coordination is separated from paperwork. As an example, continued documentation for a child in a wheelchair for incontinence supplies makes little sense and delays the child getting the supplies. Some forms require to be signed three times as opposed to one time at the bottom of the page.

C. Transition from children's services to adult services. Dr. Van Ramshorst stated that this is an important issue for him. HHSC is considering looking at a potential pilot around value-based payments for transition of care. The Chair stated that the National Alliance has made some suggestions around value based payments for transition services.

National Alliance to Advance Adolescent Health. To promote the effective transition from pediatric to adult health care, The National Alliance to Advance Adolescent Health runs Got Transition, the federally-funded national resource center on health care transition. Go to www.GotTransition.org, for sample tools, resources, articles, and the Six Core Elements of Health Care Transition.

The committee is looking at standardized training opportunities for awareness about transition. They are looking at the service delivery areas and representation of children by age group. They have been looking at benefit recommendations as well.

The Chair stated that conversations between MCOs when children change MCOs is still an issue during transition. This is a problem for children with support needs. HIPPA has to be addressed but there could be an earlier enrollment and the file being shared early in the application period. This would open communication lines earlier.

9. Managed Care Organization' s capitation rate overview. Rachel Butler, ASA, MAAA HHSC Chief Actuary

A Capitation Rate is an agency rate:

- Fixed amount paid per member per month (PMPM) over a 12-month period.
- Rates are developed prospectively.
- Paid in advance to the MCO for the delivery of health care services.
- Paid whether or not that member seeks healthcare services in the month.

Federal Requirements	**State Requirements**
• CMS and Office of the Actuary Review. • Actuarial Soundness and Certification. (Rudd and Wisdom, Actuaries)	• All capitation rates are submitted to Legislative Budget Board and Governor's Office.

Rudd and Wisdom, Inc. is the oldest actuarial consulting firm in the State of Texas, operating continuously since 1945. They provide actuarial and consulting services for public and private concerns of all sizes. Our clients include large corporations, governmental entities, insurance companies, and utility companies. They also provide financial advice and expert witness to individuals. They assist clients in their long-term success by applying our analytical and technical expertise to the design and execution of sound management, financial and operational strategies.

Capitation Rates are intended to provide reasonable and appropriate compensation, and include the following costs:

- Client Services
- Acute, Long-Term Care, Pharmacy, MDCP Waiver Services
- Administrative Costs
- Service Coordination
- Premium Taxes
- Risk Margin

STAR Kids rates are updated each state fiscal year and are developed using actual STAR Kids costs. The rates include the most current cost data available. Capitation Rates vary by the following categories:

- Geographic Service Area
- Risk Group: Examples include: MDCP, YES Waiver, Children ages 1 to 5
- MCO to recognize additional member acuity differences within each risk group

STAR Kids Risk Groups (or rating populations) used in the analysis are as follows:

- Medically Dependent Children Program (MDCP) waiver members
- Youth Empowerment Services (YES) waiver members
- Intellectual and Developmental Disabilities (IDD) waiver members
- Children under age one year
- Children ages 1-5
- Children ages 6-14
- Children ages 15-20

SFY 2020 Average Capitation Rate by SDA and Risk Group

SDA	MDCP	IDD	YES	Children 1yr and under	Children 1 - 5	Children 6 - 14	Children 15 - 20
Bexar	$14,488.54	$2,424.71	$2,073.08	$6,228.73	$3,754.12	$1,183.72	$680.68
Dallas	$10,634.07	$3,243.60	$2,073.08	$6,228.73	$4,076.22	$1,173.75	$790.64
El Paso	$8,398.96	$2,519.14	$2,073.08	$6,228.73	$3,327.06	$1,196.34	$1,183.17
Harris	$10,345.02	$3,071.59	$2,073.08	$6,228.73	$3,490.30	$1,254.23	$1,027.20
Hidalgo	$13,829.55	$3,693.05	$2,073.08	$6,228.73	$3,619.22	$1,353.62	$1,049.71
Jefferson	$11,927.09	$2,022.36	$2,073.08	$6,228.73	$3,378.04	$843.13	$855.43
Lubbock	$7,821.62	$1,913.32	$2,073.08	$6,228.73	$4,428.14	$1,073.25	$794.00
MRSA Central	$12,495.52	$2,926.97	$2,073.08	$6,228.73	$3,036.83	$863.26	$787.79
MRSA Northeast	$14,780.42	$3,048.16	$2,073.08	$6,228.73	$3,687.16	$1,083.14	$742.93
MRSA West	$9,645.56	$2,219.38	$2,073.08	$6,228.73	$2,139.83	$878.87	$959.07
Nueces	$12,216.22	$2,577.42	$2,073.08	$6,228.73	$4,054.19	$1,052.26	$938.76
Tarrant	$9,068.79	$1,624.52	$2,073.08	$6,228.73	$3,183.06	$1,212.12	$833.92
Travis	$10,670.82	$1,863.34	$2,073.08	$6,228.73	$3,156.59	$1,263.64	$878.72

SFY 2019 Caseload by SDA, MCO, Risk Group

	MDCP	IDD	YES	Children 1yr and under	Children 1 - 5	Children 6 - 14	Children 15 - 20
Bexar Community First	380	279	70	61	814	3,763	2,343
Bexar Superior	159	215	45	60	615	3,019	2,285
Dallas Amerigroup	238	353	69	103	1,234	6,392	4,124
Dallas CMC	635	361	32	65	950	4,113	2,659
El Paso Amerigroup	25	24	5	9	174	708	444
El Paso Superior	82	73	17	21	399	1,763	1,193
Harris Amerigroup	122	181	33	49	693	3,818	2,694
Harris Texas Children	835	677	129	160	2,374	9,826	5,566
Harris United	313	315	70	93	844	4,346	3,535
Hidalgo Driscoll	47	65	87	33	542	3,308	2,236
Hidalgo Superior	110	133	106	38	721	4,280	2,645
Hidalgo United	82	91	60	18	854	4,061	2,007
Jefferson Texas Children's	107	64	46	16	276	1,261	788
Jefferson United	44	33	28	9	200	1,161	880
Lubbock Amerigroup	75	59	7	16	183	772	526
Lubbock Superior	46	55	14	13	181	797	516
MRSA Central BCBS	111	77	32	19	418	2,110	1,407
MRSA Central United	119	112	25	22	454	2,384	1,568
MRSA NE Texas Children	139	96	29	22	429	2,114	1,285
MRSA NE United	251	208	65	26	592	3,138	2,288
MRSA West Amerigroup	112	102	27	15	360	1,653	1,109
MRSA West Superior	91	120	59	21	339	1,682	1,191
Nueces Driscoll	40	92	30	27	414	1,943	1,349
Nueces Superior	26	28	13	5	120	588	563
Tarrant Aetna	144	183	47	35	455	2,117	1,726
Tarrant Cook Childrens	614	461	114	66	1,016	4,403	2,646
Travis BCBS	259	312	79	26	432	1,586	1,040
Travis Superior	110	197	70	27	319	1,622	1,105

MCO Payment Methodology

- Average cost (PMPM) that when applied to total membership is intended to provide reasonable and appropriate compensation to the MCOs.
- Paid Monthly to MCOs, i.e., Membership x Capitation Rates (PMPM) equals the aggregate payment.
- HHSC pays a much higher capitation rate for children in the MCDP Waiver, so an MCO with more MDCP membership will receive a higher payment.

Comments, Questions and Answers

- Are the costs used to determine the rates actual MCO covered costs and does that include the cost of covered but denied services? The client care costs will only include the costs that were paid. There are different components—like administration, which has a cost even if the services are not provided.
- The actual costs are not an accurate reflection of the child's needs.
- So, the capitation rate will change every year? HHSC answered in the affirmative, and stated that the rates have risen about 8% per year.
- There is no incentive for MCOs to maintain a medical home to cut costs. Ms. Trahan stated that many MCOs have taken significant losses in the STAR Kids program.
- If a child falls into more than one risk group, do they get the combination of the groups? Staff stated that they do not. There is a hierarchy of payment and risk.
- There are a number of children that should receive private duty nursing (PDN) who may not be on MDCP and those children gravitate toward plans that will meet their needs. As a result, those plans have a disproportionate number of significantly involved children.
- Families know which plans are best at serving children with complex needs. These are usually the smaller, community-based, non-profit MCOs.
- The costs are accounted for but there is a need for discussion on this subject.
- Not all children receiving PDN are in MDCP.
- Very few children are receiving YES services, but there are many children cycling in and out of mental health facilities. We have to get the right capitation rate for those children, or they will be at risk of not getting the services they need.
- These categories are very crude and do not identify the complexity of the issues.
- These are not medical categorizations and for a true actuarial analysis, we have to rely on more than "who is qualified for a waiver." We have to sub-stratify the population on a logical basis.
- Have you all looked at the amount before STAR Kids and after STAR Kids? The speaker stated that the increases are about the same as under fee-for-services. There are increases in PDN that may be offset by hospitalization reductions.

10. Public comment.

807 BRAZOS ST, SUITE 607, AUSTIN, TX 78701 TEL: 512-708-8424, WWW.THBI.COM

Hannah Mehta stated that access to prescription drugs is a problem, as contractual requirements are not being addressed by the PBMs. She stated that her son's medications have been denied even though he has been getting them for years. Outside the prescription issue, coordination of benefits with private insurance is still a problem. There is confusion surrounding the way MCOs are handling those. The waiver for third-party liability is an issue for families. Payments are being held while the primary is being billed. HHSC should look beyond the ACO model. The Medicaid annual renewal process has resulted in a deluge of notices to parents that their children are ineligible because of processing issues. She received phone calls related to the utilization reviews and how they are being conducted. Reviewers have been reported as being hostile. She asked if there is a plan for the renewal of STAR Kids contracts.

Dana Danaher, CHAT, stated that on the actuarial piece, only a portion of the MDCP data is sent, so the decisions are being made without complete data; they are analyzing claims data. Getting additional data is a problem, and would have to be addressed. This is a fully at-risk model, so that is the opportunity to stop plans from bleeding. Transitions of care are a focus for CHAT. There is a piece in SB 1207 on a PPE study and what hospitals have seen; they see a disproportionate share of STAR Kids patients and therefore, have a disproportionate share of penalty.

11. Adjourn and Thank You. There being no further business, the meeting was adjourned.

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