HHSC: STAR Kids Managed Care Advisory Committee, September 23, 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 include:

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

Welcome, Introductions, and Opening Remarks. The meeting was convened by Elizabeth Tucker, Chair. Michelle Erwin introduced staff who were present at the meeting and announced that Emily Zalkovsky was promoted to Deputy Medicaid Director

Approval of June 10, 2020, meeting minutes. The minutes were approved as written.

COVID-19 Update.

The HHSC staff shared epidemiology numbers which can be found in detail in the Texas Insight COVID-19 updates provided twice a week.

Updated COVID-19 Response for NFs
... Long-term Care Regulation has updated the Nursing Facility **COVID**-19 **response** plan. The document provides guidance to NFs on **response** actions in the event of a **COVID**-19 exposure. Read the full document here (PDF)...

Guidance on COVID-19 Response to HCSSAs
... Regulatory has issued Provider Letter 20-16 Guidance on **COVID**-19 **Response**. The letter provides guidance and directives to ...

Guidance on COVID-19 Response in PPECCs
... Regulatory has published Provider Letter 20-15 Guidance on **COVID**-19 **Response** in PPECCs. HHSC issues this guidance to Prescribed...

Updated COVID-19 Response Plan for Nursing Facilities
HHSC has updated the **COVID**-19 **response** plan (PDF) for nursing facilities...

Updated COVID-19 Response Plan for NFs
... Long-term Care Regulation has updated the Nursing Facility **COVID**-19 **response** plan. The document provides guidance to NFs on **response** actions in the event of a **COVID**-19 exposure. Read the full document here (PDF)...

COVID-19 Webinars: Response Plan for Nursing Facilities
This webinar is designed to review the elements of **COVID**-19 preparedness, **response** and mitigation outlined in the **COVID**-19 **Response** Plan for nursing facilities. The course...

Guidance on COVID-19 Response in ICF/IID Facilities
... Regulatory has published Provider Letter 20-18 Guidance on **COVID**-19 **Response** in Intermediate Care Facilities for Individuals with...

Guidance on COVID-19 Response in DAHS Facilities
... Regulatory has published Provider Letter 20-14 Guidance on **COVID**-19 **Response** in DAHS Facilities. The letter provides guidance ...

Guidance on COVID-19 Response in Nursing Facilities
... Regulatory has published Provider Letter 20-11 Guidance on **COVID**-19 **Response** in Nursing Facilities (NF). HHSC issues this...

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QIPP NSGO Active Partnership COVID-19 Response
...the Parkland Health and Hospital System has developed a **COVID**-19 Action Plan. It communicates expectations and ... NFs: Seek and receive federal authorization to use excess **COVID**-19 tests to test NF residents and select numbers of NF... Additionally, HHSC Regulatory has published the **COVID**-19 **Response** Plan for Nursing Facilities (PDF). Best practices.

HHSC Issues NF COVID-19 Mitigation and Response Emergency Rules
HHSC has issued enhanced **COVID**-19 emergency rules requiring additional actions by nursing facilities to mitigate the spread of **COVID**-19. Read the NF **COVID**-19 **Response** Emergency Rules...

HHSC Issues ICF COVID-19 Mitigation and Response Emergency Rules
HHSC has issued enhanced **COVID**-19 emergency rules requiring additional actions by ICF/IIDs to mitigate the spread of **COVID**-19. Read the ICF **COVID**-19 **Response** Emergency Rules (PDF)...

TxHmL COVID-19 Mitigation and Response Emergency Rules Issued
HHSC has issued enhanced **COVID**-19 emergency rules. The rules require additional ... by TxHmL program providers to mitigate the spread of **COVID**-19. Read the TxHmL **COVID**-19 **Response** Emergency Rules (PDF)...

HCS COVID-19 Mitigation and Response Emergency Rules Issued
HHSC has issued enhanced **COVID**-19 emergency rules. The rules require additional ... actions by HCS program providers to mitigate the spread of **COVID**-19. Read the HCS **COVID**-19 **Response** Emergency Rules (PDF)...

August 18 Updated COVID-19 Response Plan for NFs
...Long-term Care Regulation has updated the Nursing Facility **COVID**-19 **response** plan. The document provides guidance to NFs on **response** actions in the event of a **COVID**-19 exposure. Read the updated **COVID**-19 **Response** for NFs...

COVID-19 Response Plan for HCS Residential Providers - Update
HHSC Long-term Care Regulation has updated the **COVID**-19 **Response** Plan for HCS residential providers (PDF). The... provides guidance on **response** actions in the event of a **COVID**-19 exposure...

Updated Guidance on COVID-19 Response in Assisted Living Facilities
... Regulatory has published Provider Letter 20-23 Guidance on **COVID**-19 **Response** in Assisted Living Facilities (Replaces PL 20-13)... of the latest information and directives regarding **COVID**-19...

Emergency Rule for Certain Day Care Operations in Response to COVID-19
... rule for Child Day Care Operations related to the **response** to **COVID**-19 is now in effect. View the rule at §745.10001. ... Rule for Certain Day Care Operations in **Response** to **COVID**-19 . This rule applies to: School-age programs Before ...

Form 3220, COVID-19 Response Off-Site Facility Application

FEMA COVID-19 Response: PPE Packages for Nursing Homes

The Chair asked what the vaccination plan will look like. HHSC stated that they will look to the federal government for guidance and HHSC hopes to have more detail in the future.

Ms. Erwin commented on the flexibilities that have been implemented… a recent list of these can be found in the box below. At a high level these included:

- Appeals and fair hearings
- Provider enrollment
- EVV requirements
- Pharmacy benefits (PA and signature issues)
- PAs extended for medical services
- Documentation requirements relaxed
- Suspending face-to-face requirements
- Remote delivery and telehealth for services
- Texas Health steps for over 24 months of age
- Assessments extended for aging out children

All extended through the public health emergency which is declared by the Governor.

There has been impact to the waiver. Suspending release under the MDCP waiting list issues. We are enrolled over our target for some waivers. Timing on the MDCP and ISP is being extended to twelve months. Resetting the date to get back on track to get back to the original ISP date. We will work with MCOs if a reassessment is required during the pandemic. MCOs are being asked to help families with limited technology to get that technological support. This guidance does not apply to youth aging out of MDCP and they are brainstorming the best way to address these needs. HHSC is looking at all the flexibilities to see what can be continued after the pandemic.

The Chair inquired about children aging out during the pandemic and if HHSC would extend the timeline for MCOs to assess for STAR+Plus waiver. HHSC stated they would take that back for review.

Procurement Updates. Aetna was awarded the contract for the Dallas service area and they have gone live. All members who had been with CMC were notified. 7,500 members have transitioned to Aetna. HHSC is ensuring the transitions are going smoothly. The office of the

ombudsman is working with any complaints that come in. United Health Care Dental has become active with dental care across the state.

CMC notified HHSC that they were going to terminate their contract. That resulted in the emergency procurement.

Legislative updates

Ms. Erwin stated that SB1207 has parts important to STAR Kids. HHSC took this committee's feedback to address the tool and the handbook for the assessment. They are starting conversations with TMHP about the system changes. There was a suggestion to do a dry-run with some families. They will be outreaching to identified families and doing follow-up with MCOs to let them know which of their members will be participating. There will be a survey from families who participate.

HHSC has finalized the changes in the STAR Kids guidebook. They have been working with the MCOs to ensure readiness by December.

There is also to be a helpline that will go live October 15th.

HHSC must implement an independent medical review for denials. This was supposed to go live September 1. They are open to receiving applications, but no organization has applied.

There are other parts of 1207 that are still being developed and implemented.

Government Code, Section 531.0601 Interest List Placement

- Government Code, Section 531.0601 applies only to a child who becomes ineligible for MDCP on or after December 1, 2019.
- The statutory provisions in Government Code, Section 531.0601 expire December 1, 2021.
- An individual who is enrolled in the MDCP waiver program but becomes ineligible for MDCP services because the individual no longer meets the level of care (LOC) criteria for medical necessity for nursing facility care may request:
    - To be returned to the MDCP interest list, in the first position; or
    - If the individual is or has previously been on another 1915(c) waiver program interest list, the individual may request to apply the date of their initial MDCP interest list request to the other program interest list, if it is earlier; or
- An individual who is enrolled in the MDCP waiver program but becomes ineligible for MDCP services because the individual no longer meets the level of care (LOC) criteria for medical necessity for nursing facility care may request:
    - If the individual is not on, nor previously was on, another 1915(c) waiver program interest list, the individual may request to be placed on a 1915(c) interest list but will not be given a placement priority.

- An individual who is enrolled in MDCP but becomes ineligible for services under MDCP due to their age may:
    - If the individual is or has previously been on another 1915(c) waiver program interest list, the individual may request to apply the date of their initial MDCP interest list request to the other program interest list, if it is earlier; or
    - If the individual is not on a 1915(c) waiver program interest list, nor has previously been on another 1915(c) waiver program interest list, may request to be placed on a 1915(c) interest list and will not be given a placement priority.

SB 1207 Project Update

- Federal approval to implement 531.0601 received in March 2020.
- System modifications allowing 531.0601 interest list under this section are set to deploy.
    - Modifications include internal monitoring and reporting capabilities.
- Operational policies and procedures and notices to communicate interest list placement options have been finalized.
- Implementation date for SB 1207, Section 531.0601 Long-Term Care Services Waiver Program Interest Lists was originally planned for March 2020. Because of COVID-19 and declaration of the public health emergency (PHE), implementation for this provision was postponed.
- HHS is currently evaluating a new implementation date planned for Fall 2020 for this provision to align with the PHE and current HHS flexibilities under COVID-19.

Questions/Answers/Comments

Specialty providers could still be accessed. Have we identified specialty providers? HHSC stated that they are still working on this.

Interest list is going back to December 2019. There was a slide missing about face-to-face assessment; is this changing because of COVID? HHSC stated that the assessment modalities are modalities part of the guidance communicated to the MCOs. Telehealth is being evaluated to see how long that shall remain in place.

MDCP interest list date is being maintained and the data is retrievable. Nothing in this provision changes automatic admission when transitioning out of MDCP. There is an automatic bridge and will go on the interest list. The high needs are addressed immediately.

Section of the handbook requiring the signature should be sent to this committee.

Where will the help line be located? Part of Managed Care Compliance and Operations.

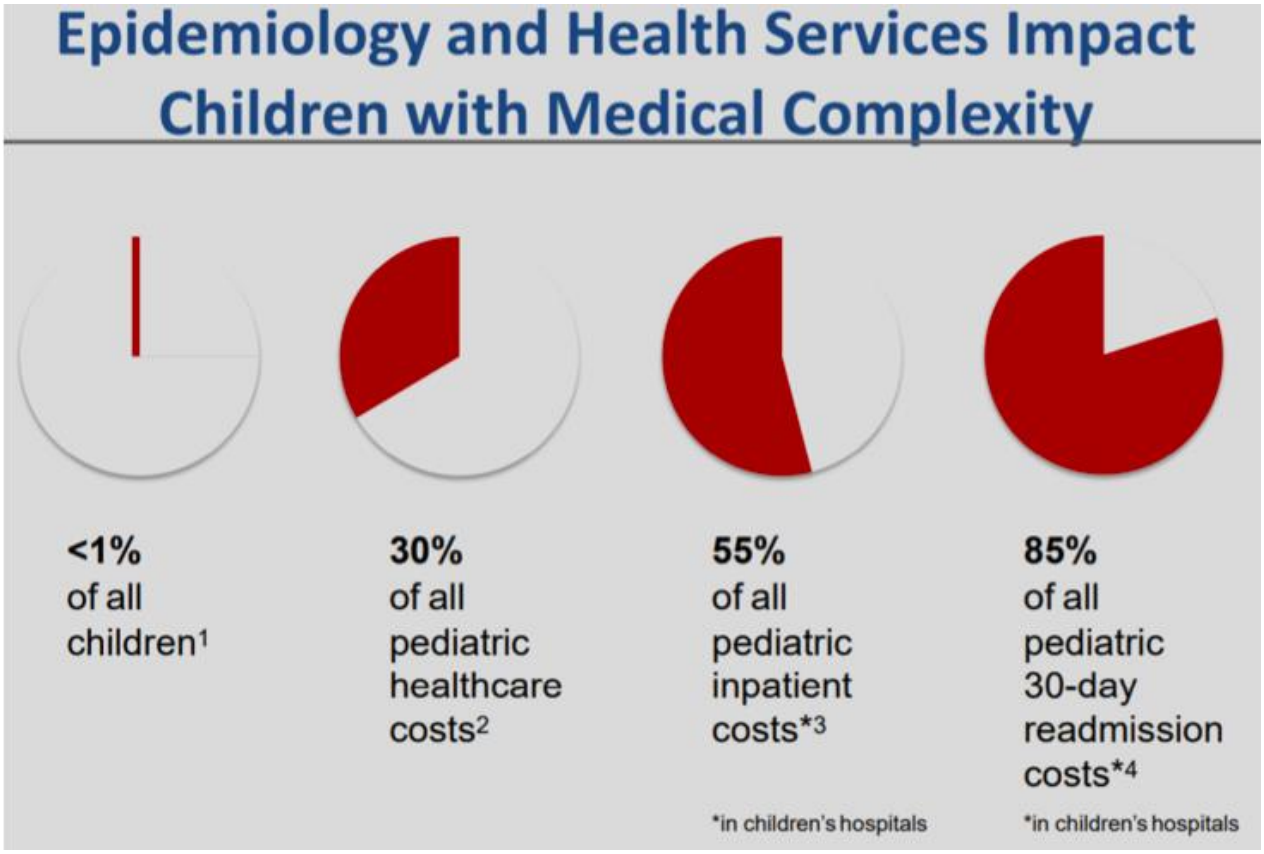
IRO application process: Has there been feedback about the applications and why there is no interest? There have been meetings with TDI and they have been meetings with an IRO in

other states. Direct outreach has been done to all eligible IROs. Adjustments to the solicitation may be needed.

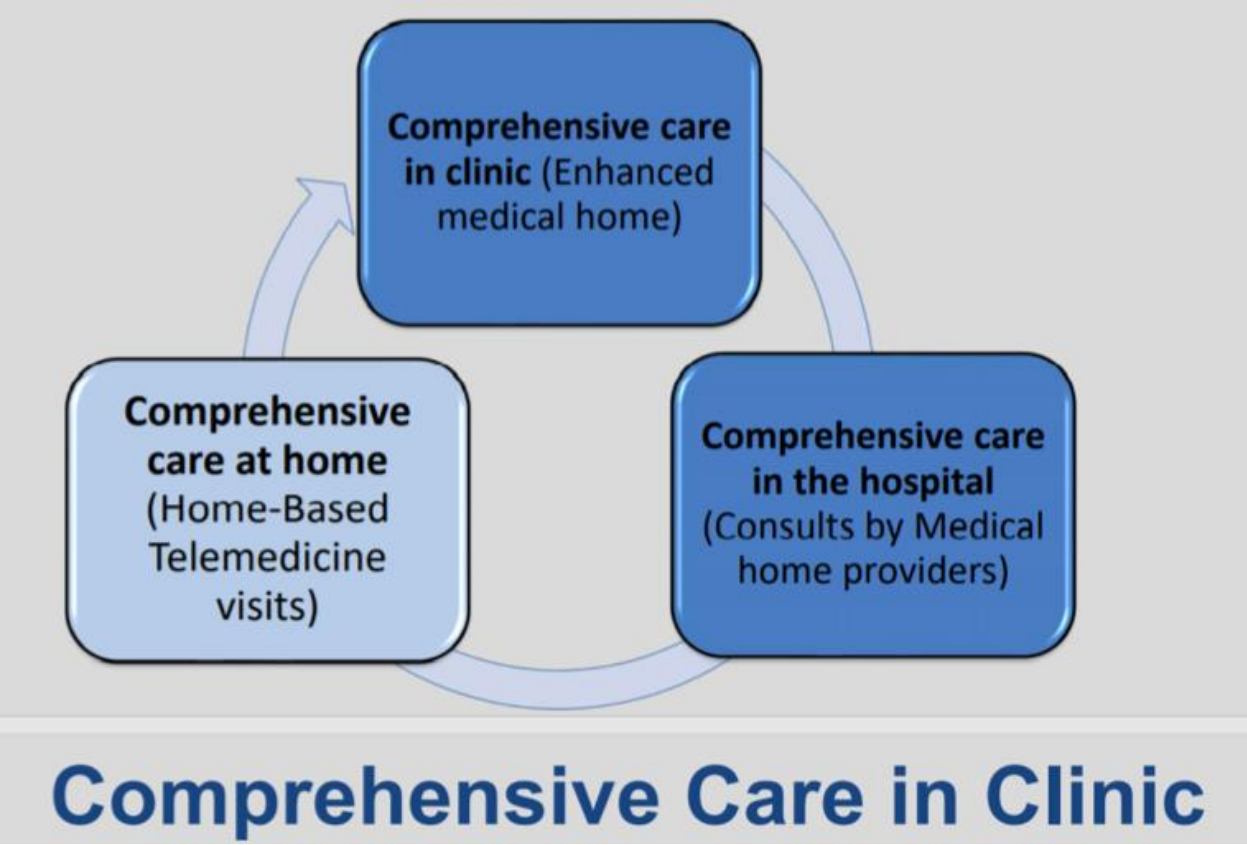
The helpline is for MDCP and Deaf Blind.

Telehealth and Telemonitoring Study Presentation. Managing Children with Medical Complexity (CMC) at Home: A Clinical Trial of Telemedicine as Part of a 360 Degree Approach to Improve Their Outcomes Ricardo Mosquera, MD, MS; Elenir Avritscher, MD, PhD, MBA; Claudia Pedroza, PhD; Kyung Lee, PhD; Tomika Harris, PNP; Julie Eapen, MD; Michelle Poe, PhD, RN; Supriya Ramanathan, MD; Maria Caldas, MD; Diana Martinez, BS; Aravind Yadav, MD; Madelene Ottosen, RN; Jon E. Tyson, MD

Children with Medical Complexity represent less than 1% of all children.



A 360-Degree Approach to Improve Outcomes for Children with Medical Complexity with Benefits Outcomes Demonstrated by RCT.



In the original investigation of this RCT, comprehensive care (CC) reduced ED visits, hospital admissions hospital days, PICU admissions, PICU days & serious illnesses by 47-69%. CC was LAO associated with systematically higher parental ratings of care. Health system costs (conservatively estimated) reduced by $10,258/child-year.

Comprehensive Care in the Hospital. A RCT of Inpatient Consultations for CMC from Their Outpatient Comprehensive Care Providers. We found that an inpatient consultation service from outpatient comprehensive care providers had a:

- 95% likelihood of decrease in total hospital days.
- 80% likelihood of parental rating of 9 or 10 (highest values) for inpatient providers.
- 94% probability of a reduction in mean total health system costs.

Comprehensive Care at Home by Home-Based Telemedicine visits

- "…Patients spend most of their time away from the health care system and the focus has to be on managing their health literally where they live with more wireless monitoring, electronic and phone visits, at-home care, and patient engagement." - Hoffman and Emanuel."

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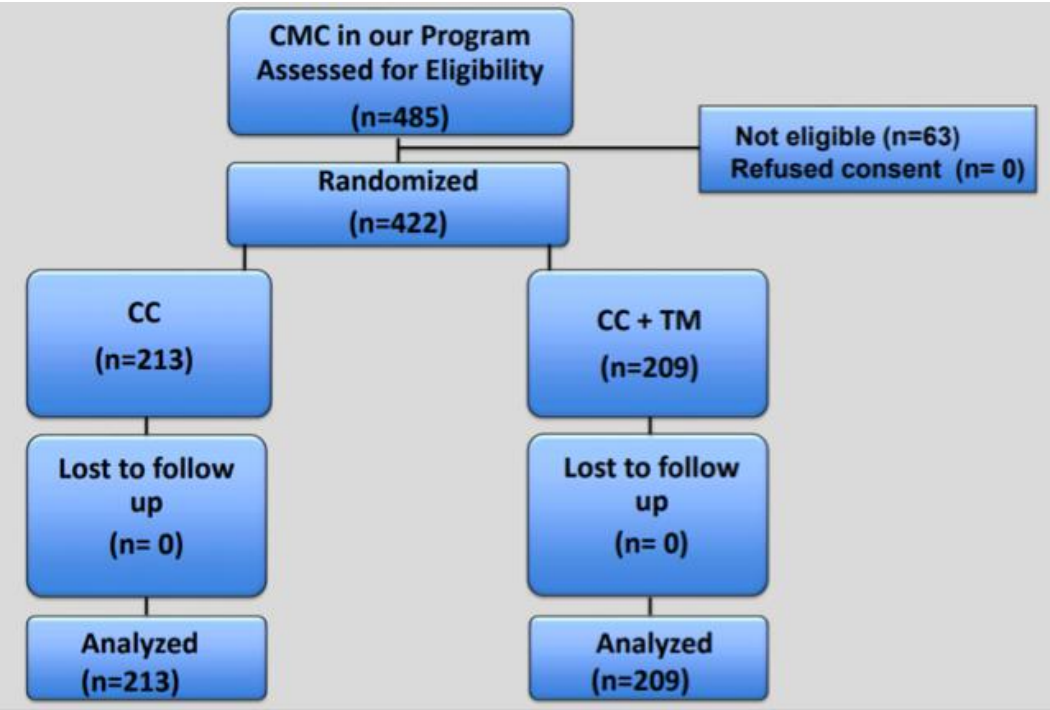
- Likely benefits of telemedicine: Convenient and easy for patients and families, proactively and promptly treating problems day or night, and avoiding exposure to infections and costs of clinic or ED visits and hospitalization.

Objective of Telemedicine RCT: To assess whether the addition of home-based telemedicine to comprehensive care reduces the need for clinic visits and hospitalizations, and the costs for children with medical complexity.

Eligibility:

- CMC in our outpatient comprehensive care (CC) program, which enrolls high-risk chronically ill children with >2 hospitalizations or >1 pediatric ICU admission in prior year and a >50% estimated risk for hospitalization at enrollment.
- Exclusions: Children with DNR status and unrepaired congenital heart disease.

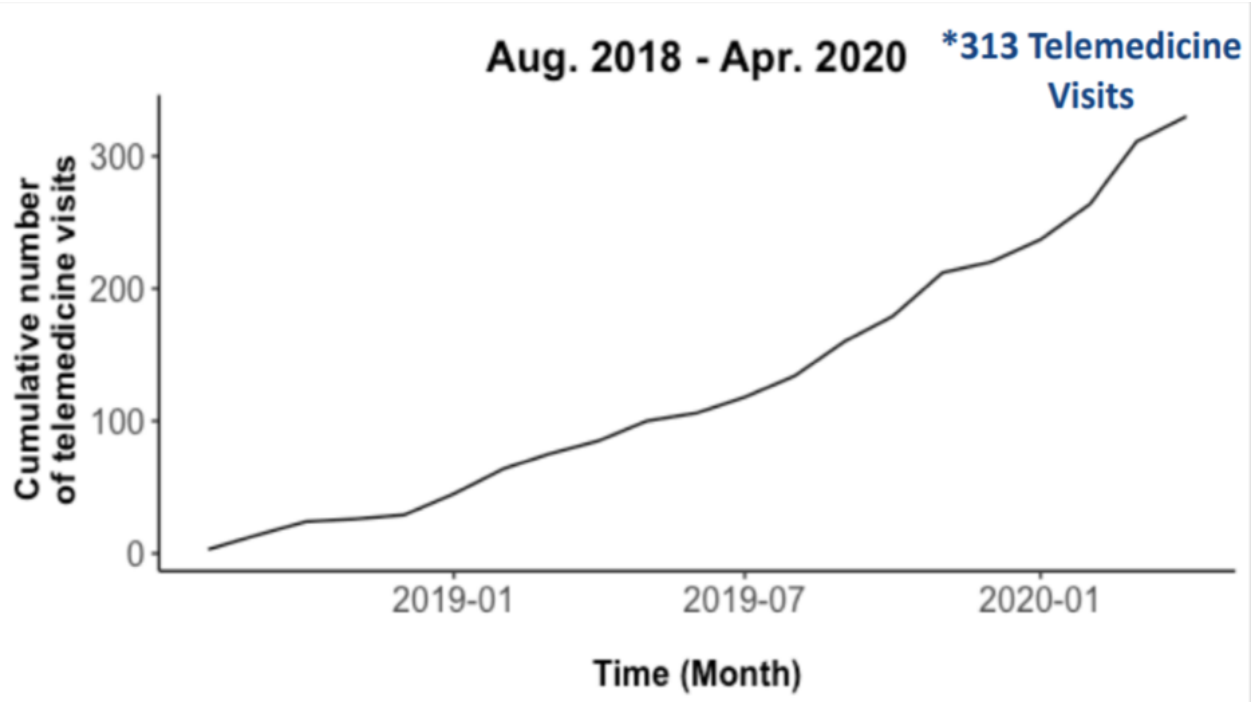
Treatment: We use Zoom for Healthcare platform for telemedicine. With our clinic already equipped with a smart television, web cameras, and an emergency IPhone, no additional equipment is required. With help from clinic staff, families randomized to telemedicine download a free Zoom application to any smartphone when they are in clinic. TM has been used: – During clinic hours for:
1) calls to PCPs during clinic hours from parents who seek medical advice or appointments for their sick child, and
2) selected calls to parents from PCPs as needed to schedule follow-up appointments. – At night and on weekends, following initial contact from parents, telemedicine visit has been performed based on physicians judgement.



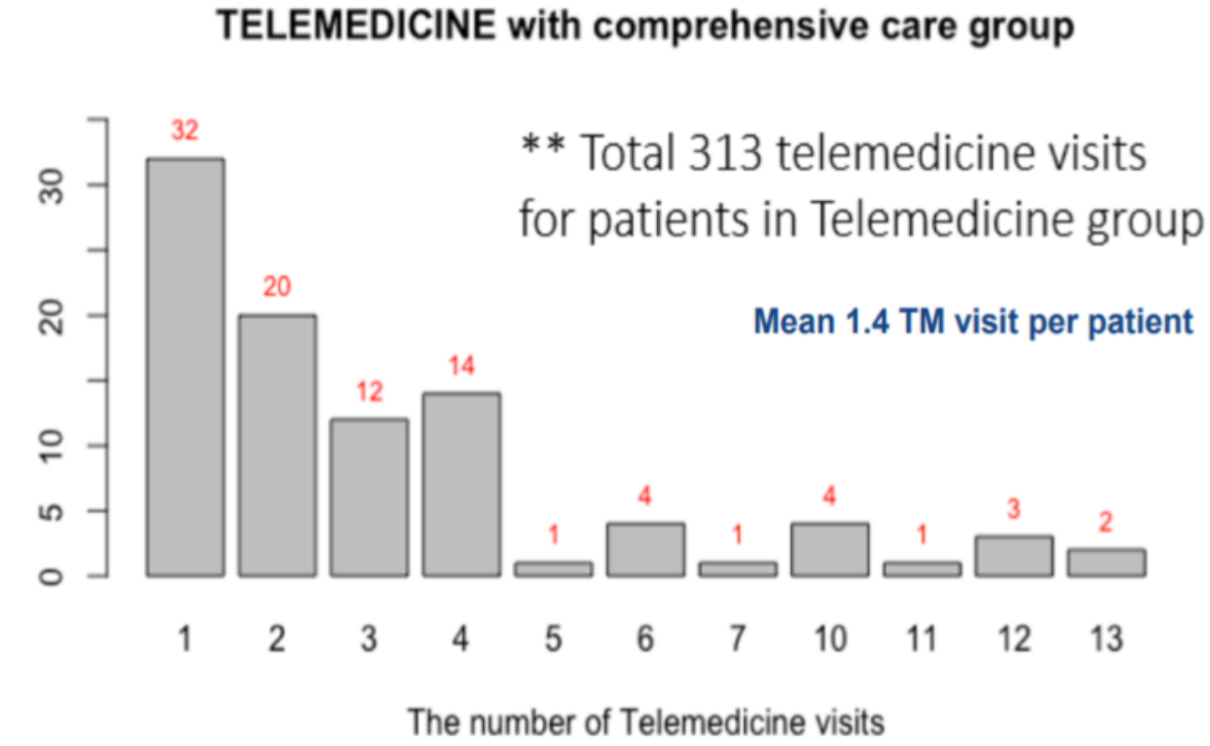
Patient Baseline Characteristics

Characteristic	CC n=213	CC + TM n=209
Age in years, mean (SD)	5.7 (4.5)	6.2 (5.4)
Male, No. (%)	117 (55)	121 (58)
Race/Ethnicity, No. (%)		
African-American	82 (38)	56 (27)
Non-Hispanic White	21 (10)	21 (10)
Hispanic	88 (41)	109 (52)
Other	22 (10)	23 (11)
Clinical Risk, No. (%)		
Level I (mechanical ventilation)	52 (24)	52 (25)
Level II (≥ expected median risk)	70 (33)	67 (32)
Level III (< below expected median risk)	91 (43)	90 (43)

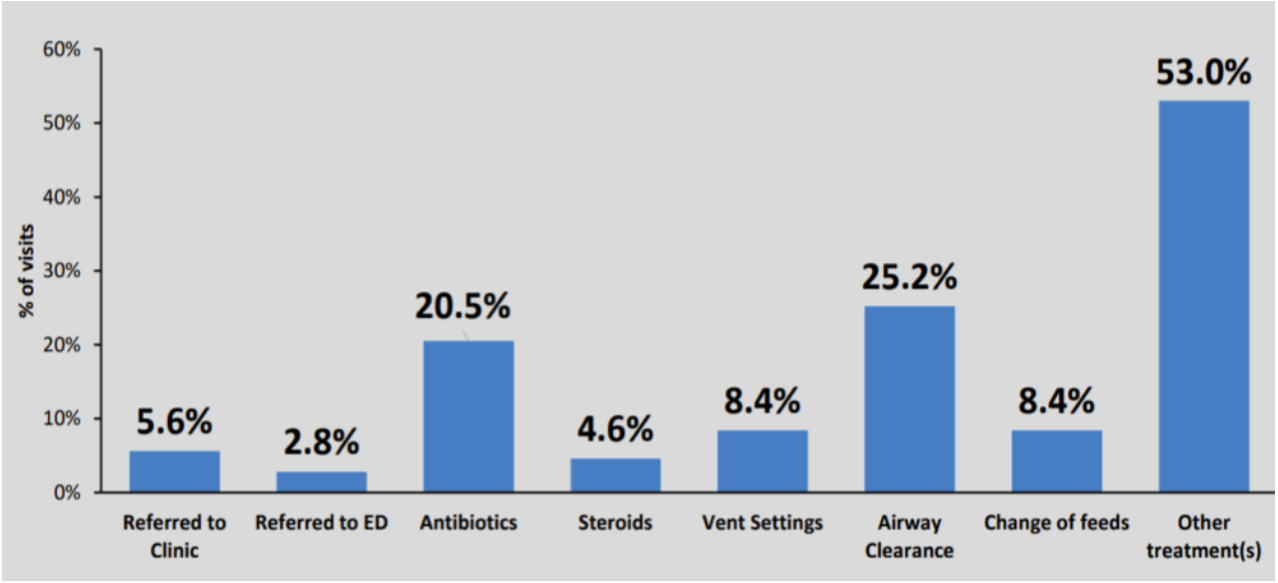
Total TM Visits in the CC + TM Group



TM Visits for Individual Patients in CC + TM group



Specific Interventions Per 100 TM visits



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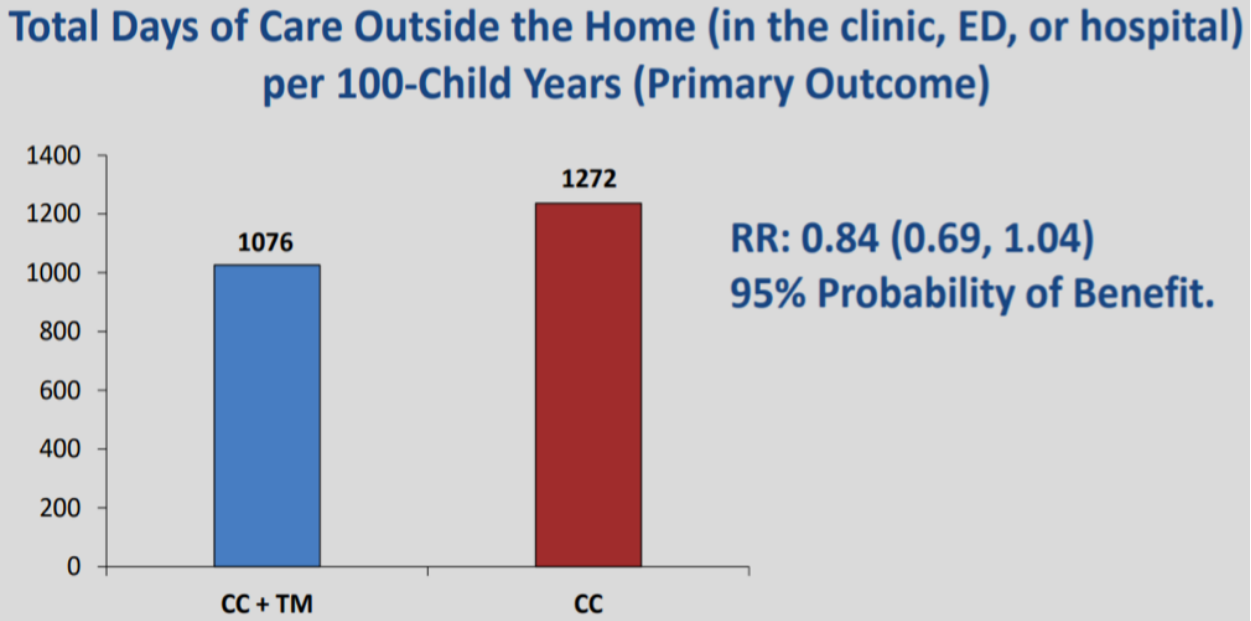
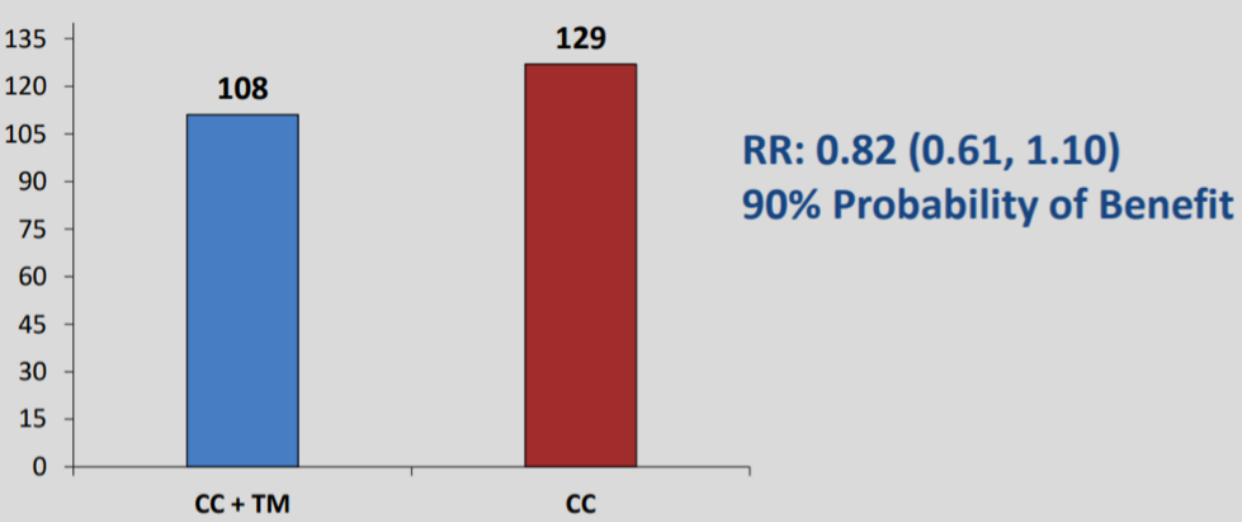
Primary Outcome



Total ED Visits per 100 Child-Years



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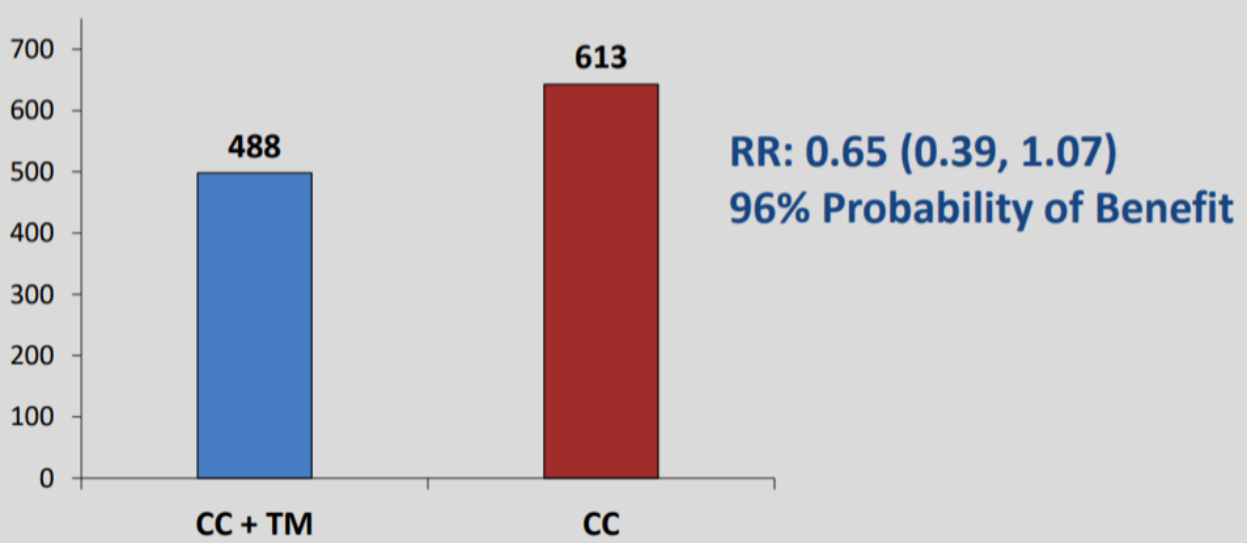
Total Hospital Days per 100-Child Years



Other Outcomes

	Telemedicine with Comprehensive Care Rate/100 Child-Years	Usual Comprehensive Care Rate/100 Child-Years	Rate Ratio (95% CI)	Probability of Benefit
Children with Serious Illnesses (Death, length of hospital stay >7days, or PICU admission)	31	38	0.62 (0.33, 1.17)	93%
Admissions	84	94	0.84 (0.62, 1.14)	87%
PICU Admissions	32	37	0.67 (0.43, 1.06)	96%
30-day re-admissions	17	21	0.67 (0.27, 1.65)	81%
Office visits (excluding well-child checks)	525	588	0.89 (0.76, 1,05)	91%

Why replacing a clinic visit for a telemedicine visit decreases hospital utilization: About 10% of patients who are seen in our clinic for non-sick visits have a sick visit within 15 days after the initial non-sick visit in clinic. The medical intervention resulting from a telemedicine visit is given sooner than a clinic visit.

New Proposed Trial of Enhanced Telemedicine. Since the end of the telemedicine trial on 3/23/2020, all patients have been offered telemedicine, 80% of our CMC visits are now by telemedicine, and our children's total days in the ED or hospital have fallen 60-70%. While conventional TM may work well for most children, an enhanced TM program is likely to be especially important to reduce exposures and care outside the home for high-risk CMC particularly while COVID-19 is surging or becomes endemic.

Enhanced Telemedicine uses FDA-approved, HIPAA compliant, mobile devices in the home to visualize the skin, throat, & ears, auscultate the heart & lungs, and measure temperature & oxygen saturation (TytoCareTM). In the first 12 months of the trial, our patients will be initially randomized to receive either enhanced telemedicine or conventional telemedicine. In year 2, all patients will receive enhanced TM. We are applying for grants to cover the expenses of the TytoCare devices and platform.

Summary. Our interim findings indicate between 93% to 96% probability that home-based conventional telemedicine decreased total days of care outside home, total hospital days, and serous illnesses for CMC. Our findings also suggest a possible reduction in hospital costs (financial data is currently being analyzed).

- Choosing the right platform is key for the successful operation of telemedicine. (Easy to use and accessible at anytime and anywhere).
- Promote interventions that provide care at home (home visits, phone visits, telemedicine, enhanced telemedicine).
- Healthcare facilities can be expected to be one the worst places to be during a pandemic. Avoid clinic visits as much as you can.

Questions/Answers/Comments

The medical community is undergoing a shift in diagnosis and treatment. The comfort level of diagnosis was much higher than was expected.

Telemedicine is here to stay for this population. It has been found to work well. We need to identify the best standards for a telehealth visit. It will be interesting to see what happens during the winter season. The speaker stated that they found in the winter they were able to do a good job… even with antibiotic prescribing and treatment.

We have to help policymakers figure out how to address this, especially in the winter season (flu, COVID, Strep). The subcommittees can take up this issue and collect data for a presentation to HHSC and other policymakers.

Electronic visit verification update

Electronic Visit Verification is a computer-based system that verifies the occurrence of authorized personal attendant service visits by electronically documenting the precise time

a service delivery visit begins and ends. Texas requires EVV for certain Medicaid funded home and community-based services provided through the Health and Human Service Commission and managed care organizations. Learn more about EVV (PDF)

The 21st Century Cures Act Section 12006 (Cures Act) is a federal law requiring Electronic Visit Verification for all Medicaid personal care services and home health care services. HHSC must implement EVV for Medicaid personal care services, including services delivered under the Consumer Directed Services (CDS) Option and the Service Responsibility Option (SRO) by Jan. 1, 2021, or risk the loss of federal Medicaid funding. The Cures Act EVV Expansion:

- Will implement the Jan. 1, 2021 federal Cures Act EVV requirement for Medicaid personal care services not currently required to use EVV per state law.
- Will take place throughout the 2020 calendar year.
- Applies to program providers and FMSAs affected by the Cures Act (Cures Act program providers and FMSAs). See pages 1-2 for the programs, services, and service delivery options affected by the Cures Act.

Q: Are you all tracking entities who have gone out of business or collapsed services because of EVV? HHSC stated they are not tracking that.

To be ready to meet the Jan. 1, 2021 EVV start date, Cures Act program providers and FMSAs must take action during the Cures Act EVV Expansion and:

- Select an EVV vendor or elect to use their own EVV proprietary system by May 1, 2020
- Complete required training
- Practice using the EVV system

Cures Act EVV Expansion Timeline

Action	Date	Description
Select an EVV vendor.	**By May 1, 2020**	Program providers and FMSAs must select an EVV vendor system or elect to use their own EVV proprietary system and begin the onboarding process.
Practice using the EVV system.	**July 1, 2020 - Nov. 30, 2020**	Program providers and FMSAs can practice using the EVV system, EVV Portal, and EVV claims matching. CDS employers can practice using the EVV system and will not use the EVV Portal.
Complete required training.	**By Dec. 1, 2020**	Program providers, FMSAs, and CDS employers must complete System Training, Clock In/Clock Out Methods, EVV Policy, and EVV Portal training. CDS employers do not have to complete EVV Portal training.
EVV claims matching with denials begins.	**Dec. 1, 2020**	When an EVV claim is submitted without a matching EVV visit transaction the claim will be denied. This applies to all program providers and FMSAs required to use an EVV system.

* Dates subject to change.

EVV Vendor Selection

TMHP has selected two EVV vendors on behalf of HHSC:

EVV Vendor	Website	Telephone Number	Email Address
DataLogic Software Inc.	Vesta EVV	844-880-2400	info@vestaevv.com
First Data Government Solutions	AuthentiCare EVV	877-829-2002	AuthentiCareTXSupport@firstdata.com

By May 1, 2020:

- Cures Act program providers and FMSAs must select an EVV vendor system or elect to use their EVV proprietary system and submit the appropriate form to begin the onboarding process.
- If an EVV vendor system or EVV proprietary system is not selected by the May 1 deadline, HHSC will assign an EVV vendor.
- CDS employers will use the EVV system selected by their FMSA.

EVV Practice Period July 1, 2020 – Nov. 30, 2020:

- Cures Act program providers and FMSAs who select an EVV vendor system should begin practicing using the system.
- Some practice activities include:
    - Attendants/employees clocking in and clocking out of the system when delivering services.
    - Reviewing EVV visit transactions to confirm all data elements are correct.
- Practicing gives time to become familiar with the system without negative impact.

The Cures Act program providers and FMSAs who have elected to use their EVV proprietary system do not have to wait for the July 1, 2020 practice period and can begin practicing with their systems at any time. HHSC encourages program providers and FMSAs configure their systems to allow the functionality for attendants to practice clocking in and clocking out of the system when delivering services.

Informational Claims Matching. Informational claims matching is when EVV claims are matched to EVV visit transactions but claims are not denied for a mismatch during the practice period. Cures Act program providers and FMSAs will see claim match result codes in the EVV

Portal with claim match result codes indicating if an EVV claim line item matched or did not match an accepted EVV visit transaction.

By Dec. 1, 2020: Cures Act program providers, FMSAs, and CDS employers must complete the following EVV training requirements:

- EVV System Training before using the EVV system, and then annually.
- Clock In/Clock Out Methods Training before using the EVV system.
- EVV Policy and EVV Portal Training by Dec. 1, and then annually. CDS employers do not have to complete EVV Portal training.
- See the Cures Act EVV Required Training Checklist for more information.

Beginning Dec. 1, 2020:

- All service visits for an EVV-required service must be captured in the EVV system and claims without a matching EVV visit transaction accepted into the EVV Portal will be denied for payment.
- To avoid denials Cures Act program providers and FMSAs should be reviewing informational claims matching results on a regular basis.
- The state is starting EVV claim denials before the Jan. 1, 2021 federal deadline to allow time to address any potential issues and to ensure Texas programs and services maintain federal funding.

COVID-19 Flexibilities Due to the impacts of coronavirus, HHSC relaxed deadlines, where possible by:

- Extending the deadline to select an EVV vendor or EVV proprietary system from April 1 to May 1.
- HHSC must continue to follow the current implementation timeline in order to meet the federal Jan. 1, 2021 effective date.
- Additional changes to the implementation timeline must be passed by Congress.

For more information about:

- The Cures Act EVV Expansion, visit the HHSC Cures Act EVV webpage.
- EVV vendors, visit the TMHP EVV Vendors webpage.
- EVV proprietary systems, visit the HHSC EVV Proprietary Systems and TMHP EVV Proprietary Systems webpages

Questions/Answers/Comments.
The Chair suggested involvement of CDS as an option and discussed the way EVV impacts that utilization. The Chair inquired about benefits. HHSC stated that there are savings from payment only for services received. Other benefits have not been quantified.

STAR Kids Managed Care Advisory Committee bylaws review. Tabled until the next meeting.

Alternative payment models. MCO/DMO contracts include requirements for:

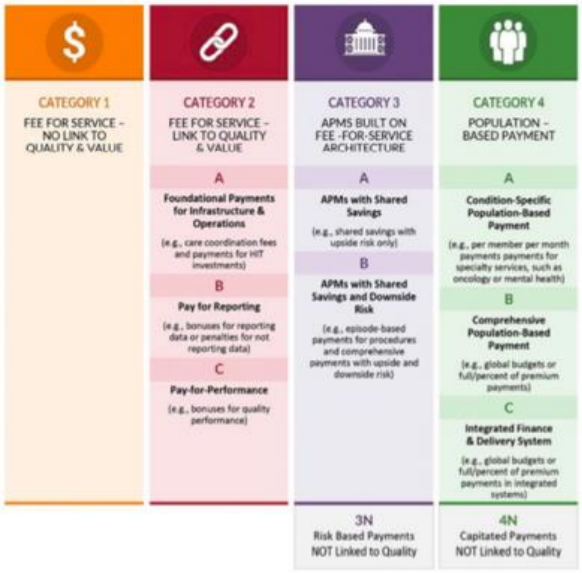
- APM Targets beginning CY 2018 (ratios of $ paid in VBP relative to overall medical expense), increasing over 4 years (overall and risk based)
- STAR Kids APM targets are effective beginning CY 2019
- Data collection by HHSC
- Data reporting by MCO/DMOs with providers
- Dedication of MCO/DMO resources to support VBP
- Ongoing one-on-one dialogue with MCO/DMOs and providers on their VBP efforts and barrier identification

The Health Care Payment Learning & Action Network (HCPLAN, or LAN) is an active group of public and private health care leaders dedicated to providing thought leadership, strategic direction, and ongoing support to accelerate our care system's adoption of alternative payment models (APMs). The LAN mobilizes payers, providers, purchasers, patients, product manufacturers, policymakers, and others in a shared mission to lower care costs, improve patient experiences and outcomes, reduce the barriers to APM participation, and promote shared accountability. Since 2015, health care stakeholders have relied on the LAN to align them around core APM design components, host forums and summits to share information and inspire action, build consensus among leaders, and measure the progress of APM adoption. The LAN will continue to be a trusted partner that connects the public and private sectors, identifies and shares best practices, and guides the field in rapidly moving to value-based payment. https://hcp-lan.org/

HCP LAN Framework for Alternative Payment Models (APMs)*

- This Framework represents:
  - Payments from public and private payers to provider organizations.
  - Payments between the payment and delivery arms of highly integrated health systems.

* https://hcp-lan.org/



- Designed to accommodate payments in multiple categories:
  - Single payer
  - Single provider organizations (receive payments in different categories – potentially from the same payer.)
  - Payments will be classified in discrete categories.
- The Framework captures a continuum of clinical and financial risk for provider organizations.

* https://hcp-lan.org/

Timeline: MCO/DMO APMs with Providers (STAR, STAR PLUS, and CHIP)

Year	Overall VBP target	Risk Based VBP Target
2018	25% of medical expense in a VBP model for MCOs and DMOs	▪ 10% of medical expense in a risk based VBP model for MCOs ▪ 2% for DMOs
2021	50% of medical expense in a VBP model for MCOs and DMOs	▪ 25% of medical expense in a risk based VBP model for MCOs ▪ 10% for DMOs

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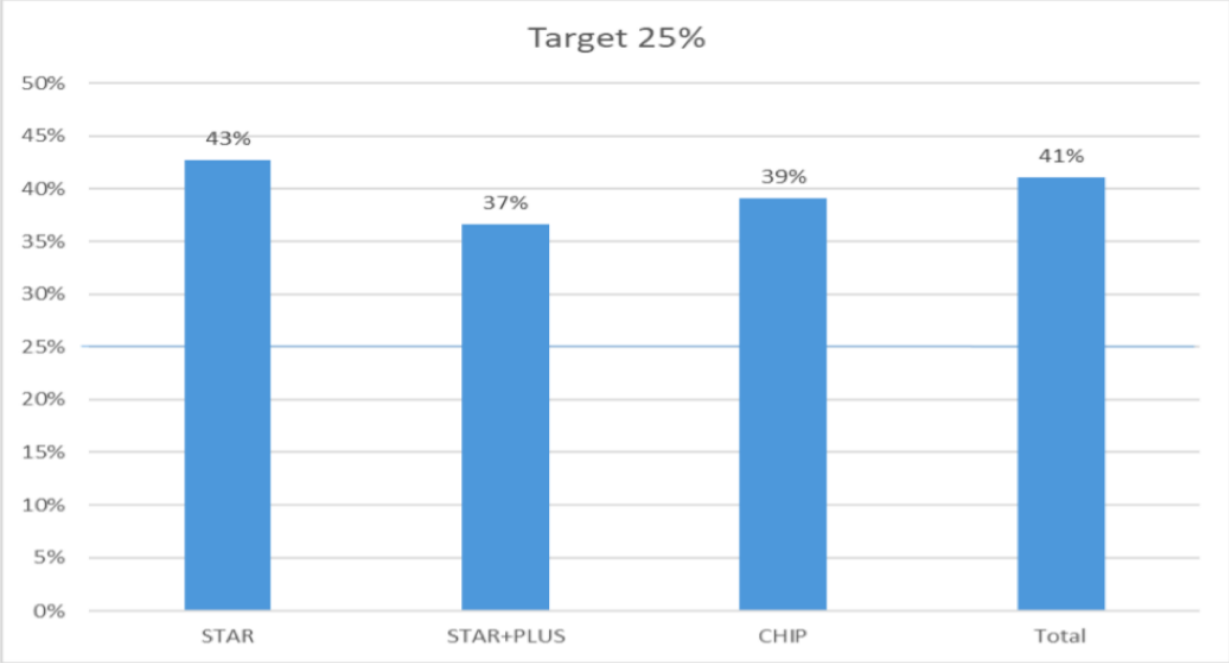
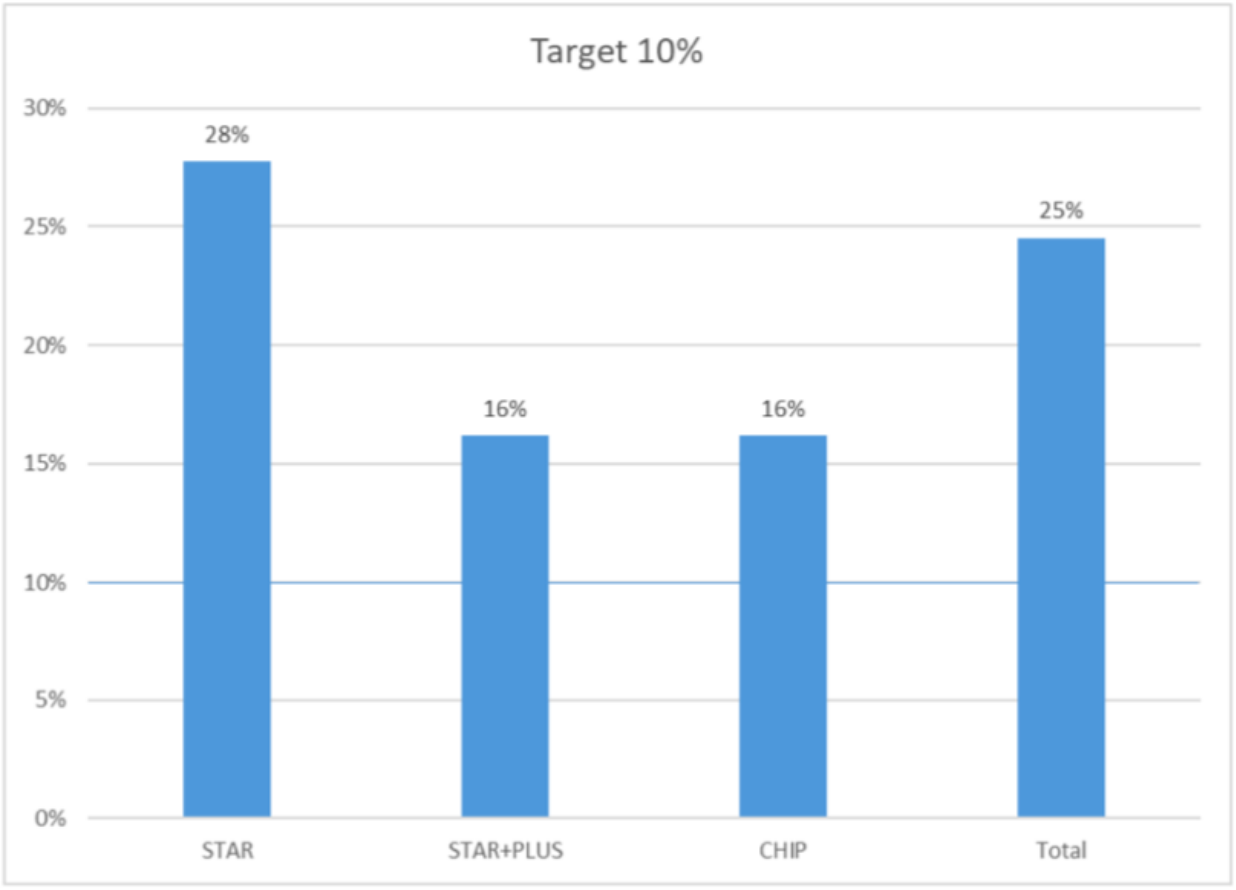
Timeline: MCO APMs with Providers (STAR Kids)

Year	Overall VBP target	Risk Based VBP Target
2019	**25%** of medical expense in a VBP model for MCOs	▪ **10%** of medical expense in a risk based VBP model for MCOs
2022	**50%** of medical expense in a VBP model for MCOs	▪ **25%** of medical expense in a risk based VBP model for MCOs

Overall APM Achievement CY 2018



Risk-based APM Achievement CY 2018

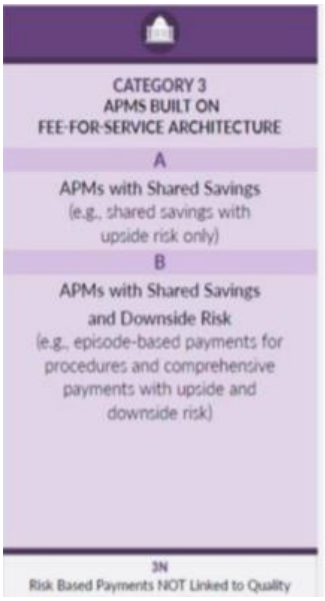


Distribution of APMs by HCP LAN Type CY 2018

CATEGORY 2 FEE-FOR-SERVICE - LINK TO QUALITY & VALUE
A
Foundational Payments for Infrastructure & Operations (e.g., care coordination fees and payments for health information technology investments)
B
Pay for Reporting (e.g., bonuses for reporting data or penalties for not reporting data)
C
Pay-for-Performance (e.g., bonuses for quality performance)

Cat.	APM Type	Number	Percent
2A	**Foundational Payments for Infrastructure & Operations** (e.g. care coordination fees and payments for HIT investments)	30	8.5%
2B	**Pay for Reporting** (e.g. bonuses for reporting data or penalties for not reporting data)	13	3.7%
2C	**Pay for Performance** (e.g. bonuses for quality performance)	141	40.2%
	TOTAL	184	52.4%

Distribution of APMs by HCP LAN Type CY 2018



Cat.	APM Type	Number	Percent
3A	**APMs with Shared Savings** (e.g. shared savings with upside risk only)	47	13.4%
3B	**APMs with Shared Savings and Downside Risk** (e.g. episode-based payments for procedures and comprehensive payments with upside and downside risk)	79	22.5%
	Total	126	35.9%

Distribution of APMs by HCP LAN Type CY 2018

Cat.	APM Type	Number	Percent
4A	**Condition-Specific Population-Based Payment** (e.g. per member per month payments for specialty services, such as oncology or mental heath)	21	6.0%
4B	**Comprehensive Population-Based Payment** (e.g. global budgets or full/percent of premium payments)	3	0.9%
4C	**Integrated Finance and delivery Systems** (e.g. global budgets or full/percent of premium payments)	0	0%
4N	Capitated Payments NOT Linked to Quality	17	4.8%
	Total	41	11.7%

Distribution of APMs by Financial Risk CY 2018

Financial Risk	Number	Percent
Provider has no downside risk	249	71%
Provider has upside incentives and downside risk	102	29%
TOTAL	351	100%

Distribution of APMs by Provider Type CY 2018

Provider Type	Number	Percent
Primary Care	143	40.7%
Hospitals	62	17.7%
Specialist, Behavioral, Mental	50	14.3%
ACO	36	10.3%
Ob/Gyn	27	7.7%
Pharmacy and Lab	17	4.8%
Health Home, Nursing Facilities and Home Care	9	2.6%
Emergency Services and Urgent Care	7	2.0%
Total	351	100%

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Distribution of Total Payments, Claims and (Dis)Incentives by Provider Type CY 2018

Provider Type	Total Payments	Percentage of Total Payments	Claims Paid	Percentage of Claims Paid	(Dis)Incentives	Percentage of (Dis)Incentives
Hospitals (Inpatient and Outpatient)	$3,557,412,089	43.8%	$3,579,011,096.00	44.5%	($21,599,007)	-27.4%
Primary Care	$2,273,571,575	28.0%	$2,228,567,050.70	27.7%	$45,004,524	57.1%
Health Home, Nursing Facilities, and Home Care	$1,030,636,509	12.7%	$1,026,391,034.00	12.8%	$4,245,475	5.4%
ACO	$747,481,553	9.2%	$739,403,054.54	9.2%	$8,078,498	10.2%
Pharmacy and Lab	$250,474,188	3.1%	$250,426,565.42	3.1%	$47,623	0.1%
Obstetrics & Gynecology	$172,254,774	2.1%	$169,413,560.89	2.1%	$2,841,213	3.6%
Specialist, Behavioral & Mental Health	$87,333,702	1.1%	$47,311,311.01	0.6%	$40,022,391	50.8%
Emergency Services and Urgent Care	$4,518,763	0.1%	$4,293,048.45	0.1%	$225,715	0.3%
Total	$8,123,683,154	100%	$8,044,816,721.01	100%	$78,866,433	100%

Summary

- State overall met or exceeded first year (2018) APM targets
- STAR Kids APMs are not yet considered in the target achievement since they started in 2019
- Meeting APM targets is not the ultimate goal – rather to achieve high quality, efficient care
- MCOs appear to be leveraging the initiative to provide incentive dollars to providers
- HHSC is currently compiling data for CY 2019, including for STAR Kids
- HHSC will continue to seek ways to advance the APM Initiative, including by:
    - Revising the state's VBP Roadmap to reflect changes since the initiative started
    - Obtaining stakeholder input on opportunities to strengthen the initiative
    - Working with stakeholders to reduce administrative complexity

The focus of the APM initiative is to increase performance by improving quality of care and efficiency in a member centered system of care. HHSC will work with MCO/DMOs and Providers to evolve the program based on initial data, stakeholder input, and other developments in the field. For more information follow this link.

Questions/Answers/Comments

The STAR and CHIP programs afford us an opportunity to learn and apply policies to the STAR Kids program. There have been checkboxes in the EMR and are we measuring the health of the children and whether or not it's improving. A lot of the outcomes may not be meaningful, and there has to be care in defining them. We have to incentivize differently perhaps.

Utilization review of the Medically Dependent Children's Program

Sylvia Salvato, Director Managed Care Utilization Review Sylvia.Salvato@hhsc.state.tx.us

The MLTSS team conducts desk reviews of MCO assessment and service planning documentation and conducts interviews with members to ensure:

- The MCO conducts assessment-driven service planning
- The member is receiving the services they need
- The MCO is adhering to additional contract requirements around the assessment for and coordination and provision of MLTSS

Standard 1 – Conduct of Assessment: MCO must complete the assessment documentation and all required forms identified in the STAR Kids Contract

Standard 2 – Assessment Driven Service Planning: MCOs must address identified needs from required assessments, service planning documents and other MCO documentation

Standard 3A - Timeliness of Assessments: MCOs must meet timeliness requirements of initial assessments and re-assessments for STAR Kids MDCP, including completion of the SK-SAI and submission of ISP

Standard 3B – Follow-Up: MCOs must contact the STAR Kids member to follow-up no later than four weeks of the start of the ISP

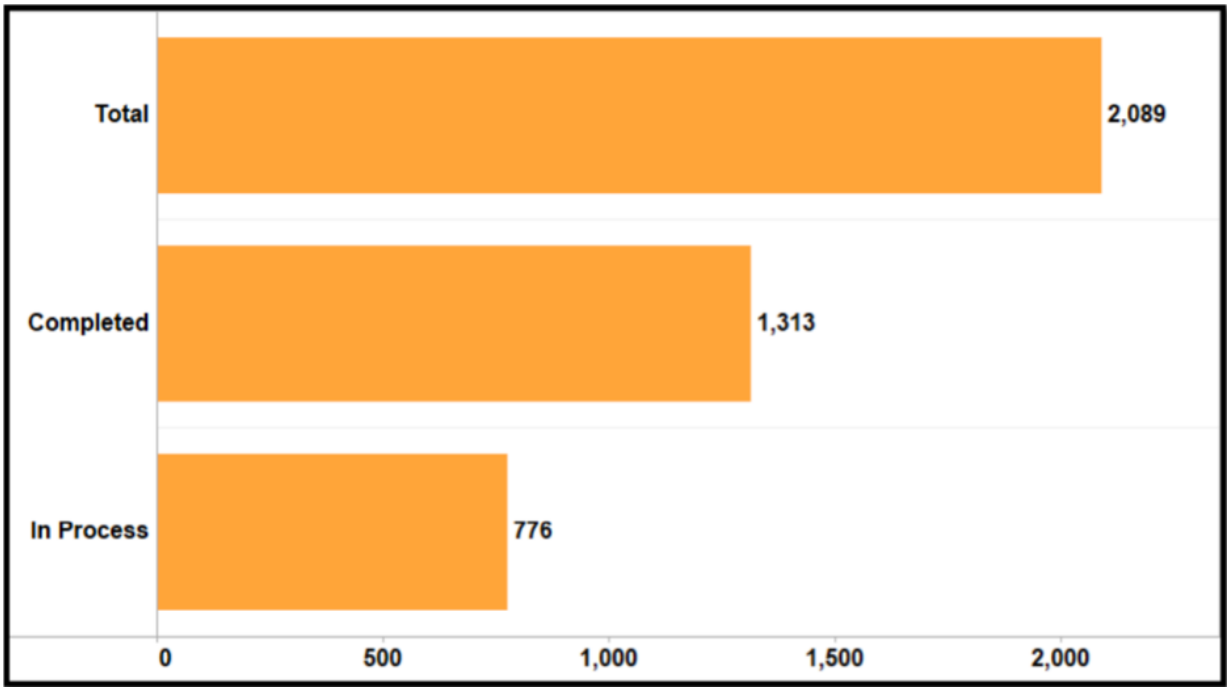
Standard 4A – Service Delivery Patterns: Referral findings across MCOs can reveal patterns in MCO support of member needs for Access to Care and Health and Safety.

Standard 4B – Provision of Attendant and Other Services:

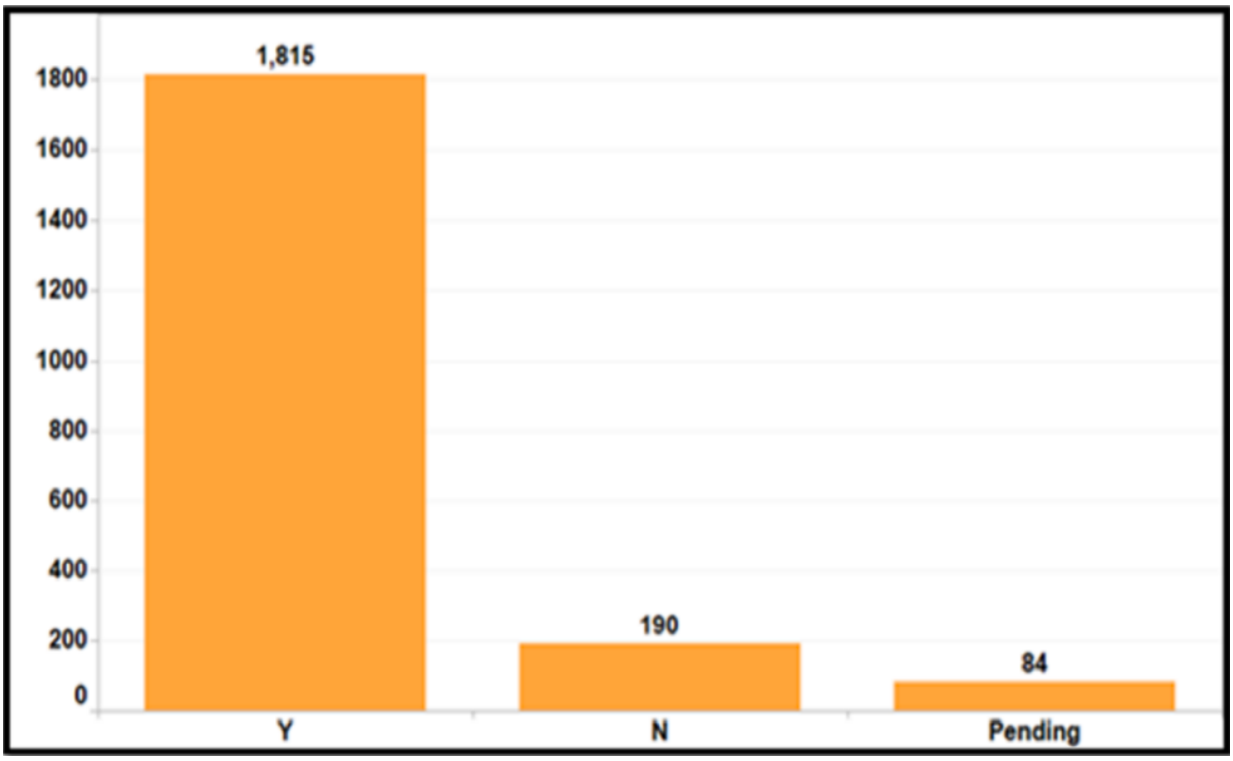
- MDCP services delivered per the service plan
- Members who had a need for CFC services and received those services

Standard 5 – Member Experience: MCO provides a Member Experience per documentation provided and per Utilization Review Home Visit/Phone Interview

Status of FY20 Review



Members Interviewed



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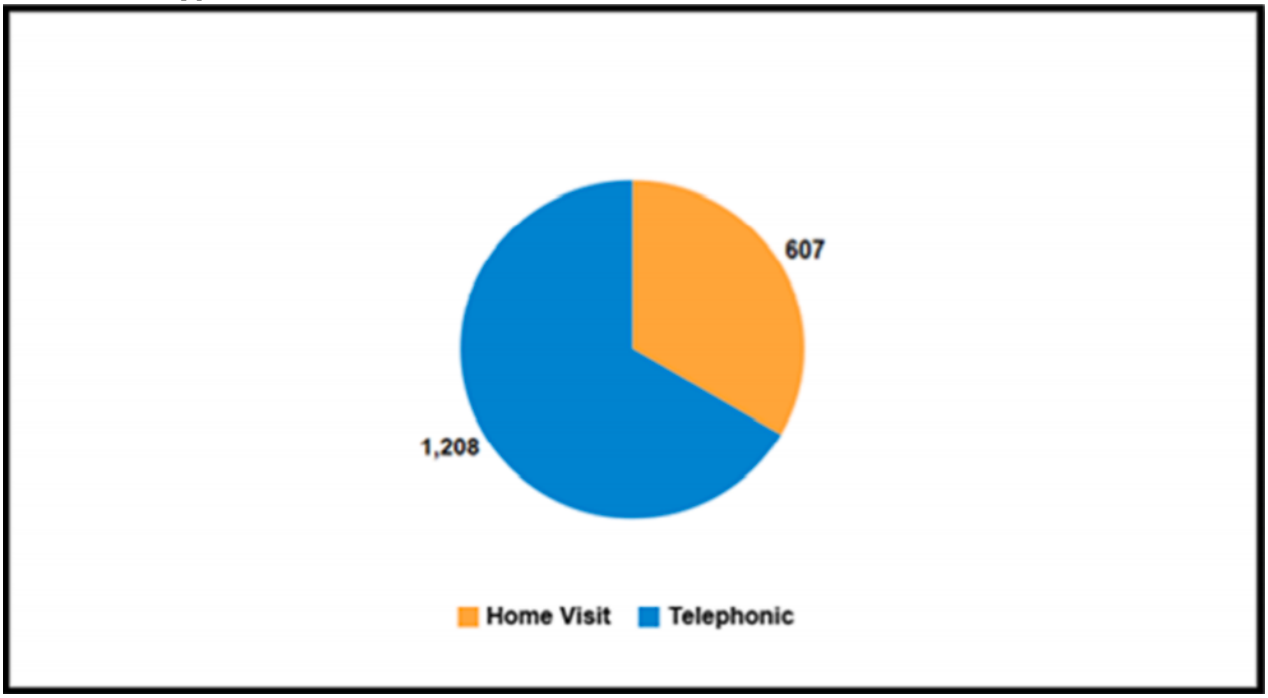
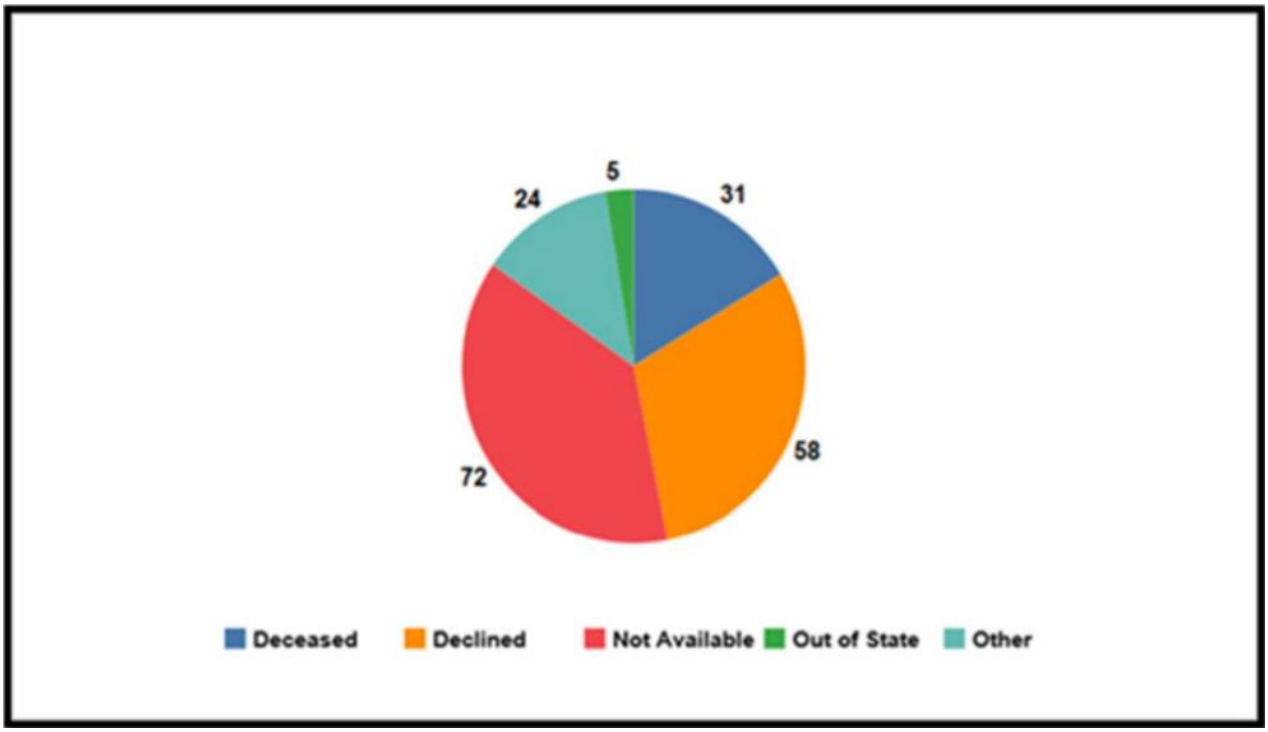
Interview Type



No Interview Reason



Successes

- Completion of required service planning documents
- Consideration of member goals in service planning
- Timeliness of SAI assessments and ISPs
- Provision of CFC and MDCP services
- Member Experience

Areas of needed improvement

- Justification of waiver service
- Documenting needs on the service plan
- Consideration of caregiver goals in service planning
- Follow-up of service initiation
- Monthly member contacts
- Access to care issues

Questions/Answers/Comments

There should be some flexibility in understanding what we are trying to get at: was the wheelchair delivered; were services delivered. The process can take a life of its own and create more work.

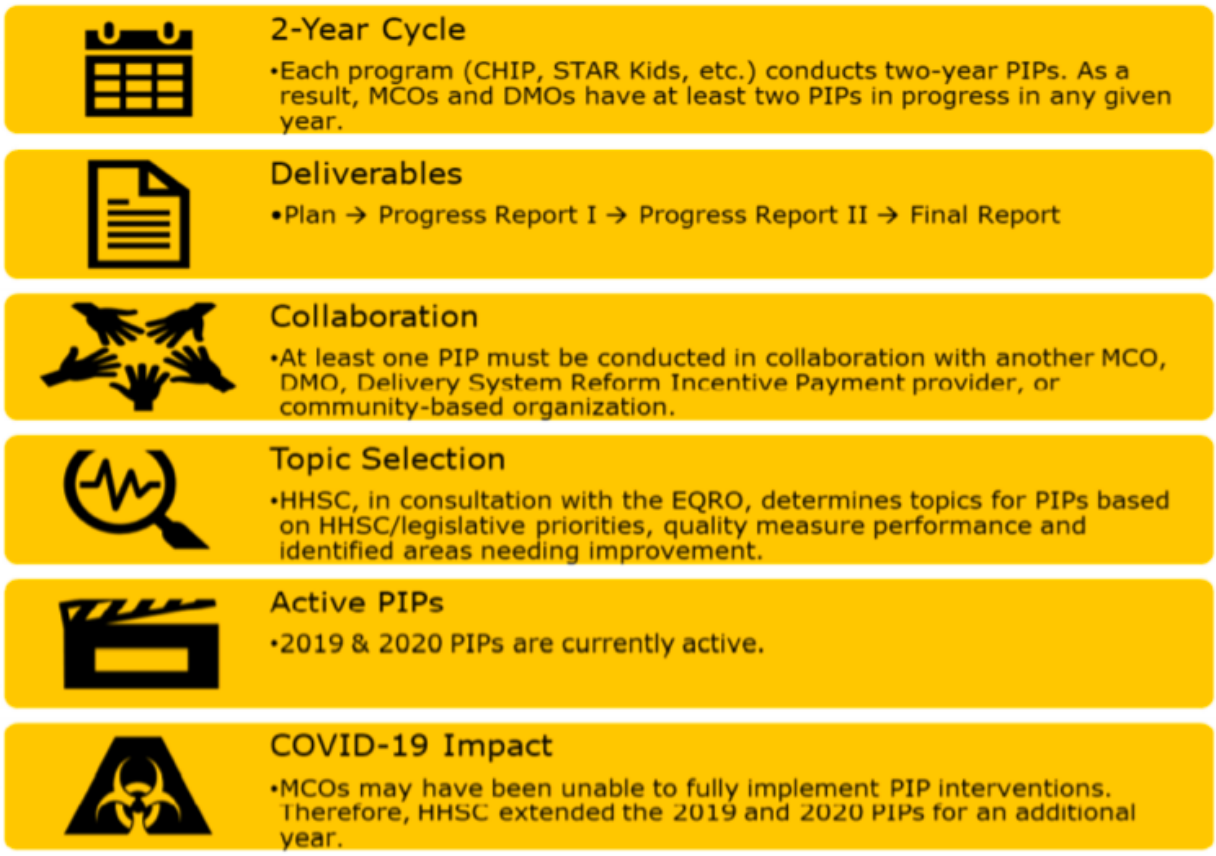
The Chair stated that the areas of improvement should include justification for waiver services. Respite is the major need in MDCP. We should not put a heavy burden on MCOs to justify these.

What about follow-up? HHSC hopes to provide feedback of results at the next meeting.

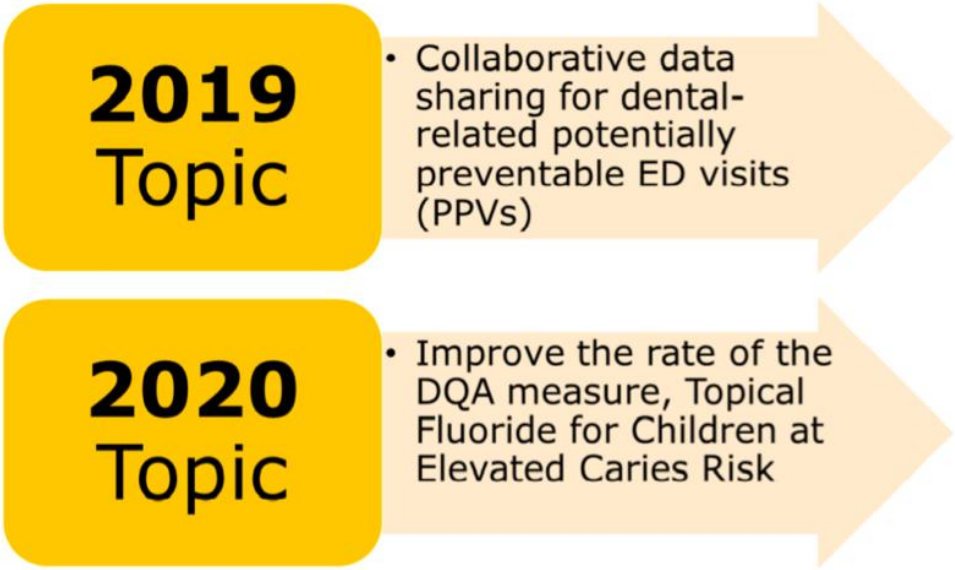
Performance improvement projects. Sara Snowden.

Sara.Snowden@hhsc.state.tx.us Performance improvement projects (PIPs) are an integral part of Texas Medicaid's 1115 quality improvement strategy. Their purpose is to assess and improve processes, and ultimately outcomes, of care. Federal regulations require states to ensure managed care organizations (MCOs) and dental maintenance organizations (DMOs) conduct PIPs. The Texas Medicaid and CHIP external quality review organization (EQRO) evaluates PIPs from each MCO and DMO in accordance with state and federal regulations.

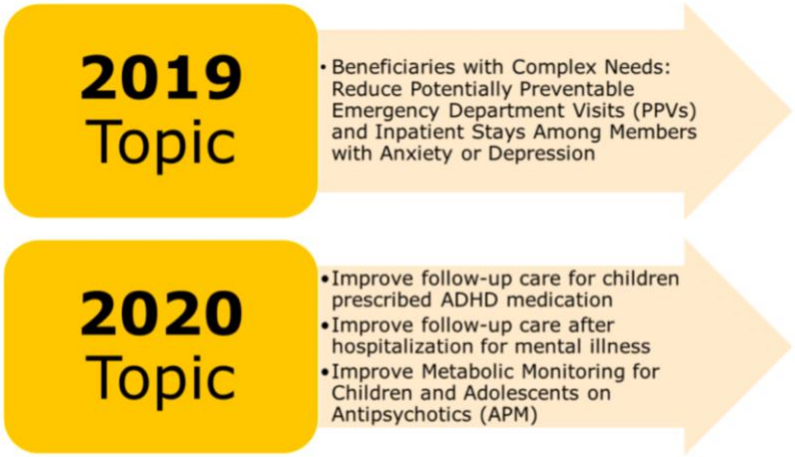
Current Status



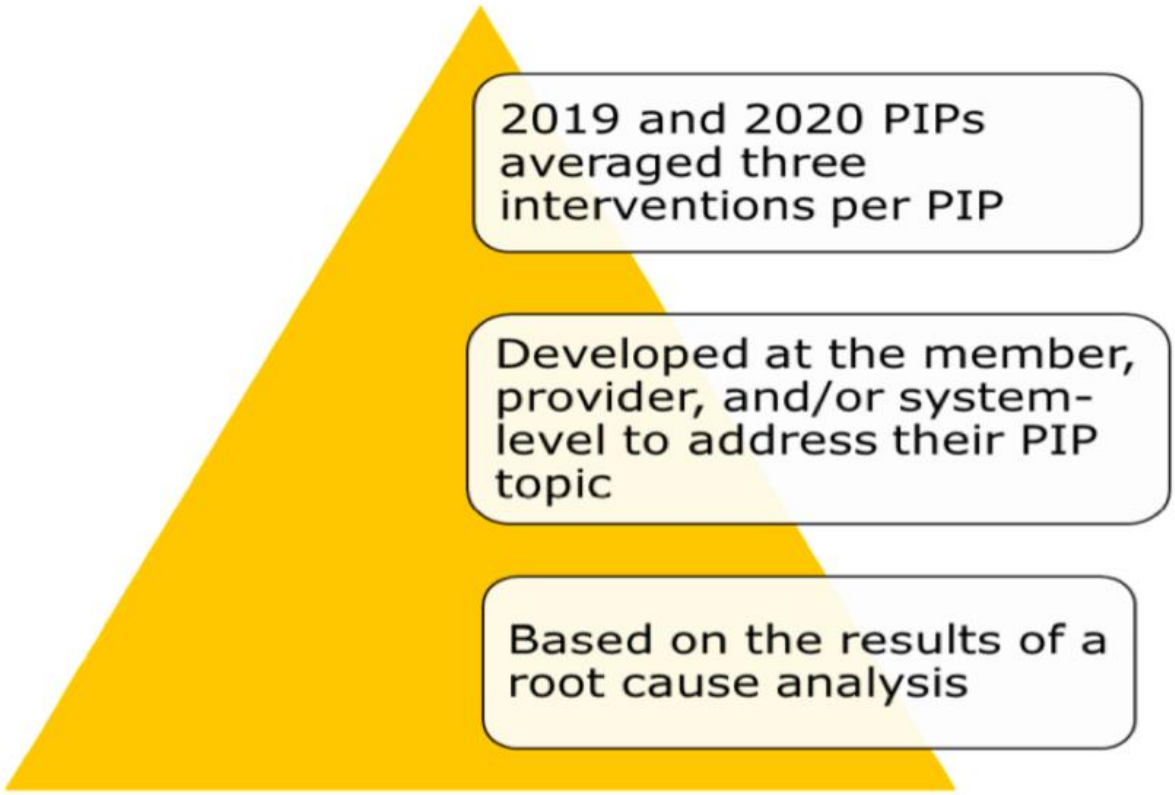
DMOs – All Programs.



Active PIP Topics: MCOs – STAR Kids



PIP Interventions

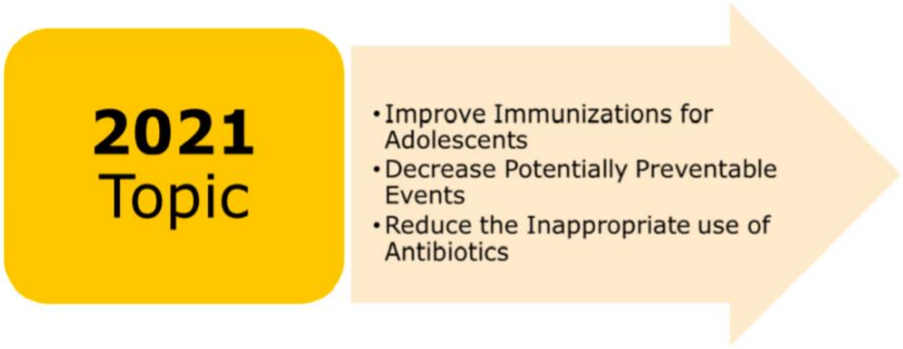


2019 PIP Interventions

- Anxiety and Depression Dashboard
- Behavioral Health Case Manager Outreach

- Prescribing Patterns Education
- Proactive Member Outreach
- Improved Integration of Behavioral and Physical Health
- Telehealth Visits
- Enhanced FUH (follow-up) Member Outreach
- Service Management Outreach for Newly Diagnosed ADHD Members
- Member Notification (antipsychotic and metabolic monitoring information)

Looking Ahead:



Questions/Answers/Comments

Will the telehealth mental health benefit for post hospitalizations be continued past October 31? HHSC stated they would get back to the committee on that.

The Chair inquired about the 2022 PIP interventions. HHSC stated the PIP topics are determined by the Spring of the following intervention. The feedback from this group would be welcome.

Public Comment.

Joanne Charmin, commented on communication and accountability. The DSAs have become a barrier to service because they do not maintain timelines. It would appear that they are not accountable to anyone. We need the frontline staff to be better trained.

Jesse Chang, Mother of a medically complex child discussed the Dallas area transfer to Aetna. There is a continuity of care provision so there would not be any lapse in coverage. Aetna began denying medication to her child. The provisions of continuity of care are not being followed. HHSC will follow up.

Holly Cheeseboro, Mother of a medically dependent child, commented on the transition to Aetna in Dallas. Their problem related to nursing services and began before the Aetna transfer. However, there were problems with the actual transfer as well.

Adrienne Trigg, Mother and company representative inquired about prior authorization and coordination of care. There is an undue burden when providers are eliminated from the service array. Not all MCOs are being held to the 90-day continuity of care standard. Payors are not being held to the federal mandate. They want guidance on escalation of issues related to continuity of care.

The Chair stated they have looked at continuity of care and the 90-day issue. A blanket 90 days was suggested by the subcommittee along with other 1207 provisions related to specialty providers.

Linda Litzinger, Texas Parent to Parent discussed EVV. The CURES Act has been the focus of HHSC. No one is looking at the whole picture. You are only on the clock for some services under EVV. Parts of attendant work are not on the EVV system. We will have employees quitting because of the process. Section six (6) of 1207 roll-out does not appear to be happening.

Amy Litzinger, Self-Advocate commented on telemedicine and noticed that there was little reference to children in transition. Notes are provided in the patient portal. The health care provider will often look to the attendant for her health needs. Telemedicine will help with children transitioning into adult care. Attendants and emergency PPE are problems as well.

The Chair stated that STAR Kids has the most in-depth requirements on MCOs and there should be a view of telehealth and creative financing issues.

Hannah Metah, Parent and Protect Texas Fragile Kids, expressed her appreciation for the flexibilities and the implementation of 1207. She commented on the need for family input. She asked if there is a possibility for an agenda item to look at the other section of 1207 and other related legislation.

Review of action items and agenda for future meeting.

- We have to find a new chair for the subcommittee for transition. We can focus on this at the December meeting.
- All three subcommittees must meet to look at the status of recommendations.
- 1207 and other legislative updates.
- EVV should continue as an item.
- Update on durable medical equipment pilot.
- Autism benefit update.
- Quality measures for subcommittee consideration and parental input.

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

***