HHSC: State Medicaid Managed Care Advisory Committee

February 10, 2022

The State Medicaid Managed Care Advisory Committee provides recommendations and ongoing input to the Health and Human Services Commission on the statewide implementation and operation of Medicaid managed care. The committee looks at a range of issues, including program design and benefits, systemic concerns from consumers and providers, efficiency and quality of services delivered by Medicaid managed care organizations, contract requirements for Medicaid managed care, provider network adequacy, and trends in claims processing.

The committee also will help HHSC with policies related to Medicaid managed care and serves as the central source for stakeholder input on the implementation and operation of Medicaid managed care.

Members include:

David Weden, Chair Community Mental Health and Intellectual Disability Centers Buda, TX	**Ramsey Longbotham** Primary and Specialty Care Providers Cuero, TX
Xavier Bañales Aging and Disability Resource Centers El Paso, TX	**Beth Rider** Family Member Round Rock, TX
Anthony Brocato Rural Providers Wolfforth, TX	**Leslie Rosenstein, PhD** Non-physician Mental Health Providers Dallas, TX
Esmeralda Cazares-Baig Managed Care Organizations Lakeway, TX	**Karl Serrao, MD** Managed Care Organizations Corpus Christi, TX
Blake Daniels Independent Living Centers Tyler, TX	**Patricia "Patsy" Tschudy** Long-term Services and Supports Providers Spring, TX
Christina Davidson, MD Community-based Organizations Bellaire, TX	**Jacob Ulczynski** Area Agencies on Aging San Antonio, TX
Shauna Glover Medicaid managed care clients or family members who use mental health services Corpus Christi, TX	**Lindsey Vasquez, MD** Obstetrical Care Providers Houston, TX
Aron Head Managed Care Organizations Arlington, TX	**Alfonso Velarde** Community-based Organizations El Paso, TX
Mary Klentzman Clients with disabilities Belton, TX	**Jennifer Vincent** Advocates for children with special healthcare needs La Porte, TX

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David Lam, MD Rural Providers San Antonio, TX	

SMMCAC Subcommittees | Texas Health and Human Services

1. Call to order, roll call, and opening remarks The meeting was convened by David Weden, Chair.

2. Consideration of November 4, 2021, draft meeting minutes. The minutes were approved as written

3. Advisory Committee chair updates

Behavioral Health Advisory Committee (BHAC) Updated January 2022. The purpose of the committee is to provide customer/consumer and stakeholder input to the Health and Human Services (HHS) system in the form of recommendations regarding the allocation and adequacy of behavioral health services and programs within the State of Texas. The Behavioral Health Advisory Committee (BHAC) considers and makes recommendations to the HHS Executive Commissioner consistent with the committee's purpose.

Updates The full BHAC met twice, on August 6, 2021, and November 15, 2021. During these meetings the committee:

- Received updates on 87th legislative session implementations related to behavioral health • Approved their annual report for publication
- Received presentations from HHSC staff on various updates including:
  - HR133 & ARPA funding plan
  - 9-8-8
  - SB 642 (RTC Project)
- Forensic services Additionally, the BHAC subcommittees provided updates on their work. The subcommittees of the BHAC are as follows: • Peer Specialist & Family Partner Services • Access to Care & Community Engagement • Housing • Children & Youth Behavioral Health Services

Upcoming Meeting: February 11, 2022

Drug Utilization Review (DUR) Board Updated January 2022 The Drug Utilization Review (DUR) Board consists of physicians and pharmacists who provide services across the entire population of Medicaid recipients and who represent different specialties, as well as nonvoting members who represent the Medicaid managed care organizations (MCOs), and a consumer advocate representing people enrolled in the Medicaid program. The members of the DUR Board are appointed by the Executive Commissioner and are reflective of the various regions within Texas. The purpose of the DUR program is to improve the quality of pharmaceutical care by ensuring that prescriptions are appropriate, medically necessary, and not likely to result in adverse medical outcomes.

A summary of the November 2021 meeting is now available on the Vendor Drug Program website November 2021 Drug Utilization Review Board Meeting Summary | Vendor Drug Program (txvendordrug.com) This includes:

- A recording of this meeting's webcast
- Approved minutes from the July 23, 2021, meeting
- A summary of clinical prior authorization and preferred drug list recommendations
- The preferred drug list class review schedule for the next meeting

At the November 2021 virtual with in-person attendance meeting the DUR Board reviewed a total of 763 drugs in 27 therapeutic drug classes including seven single drug products. The DUR Board recommended changing the status of 37 drugs. A summary of these changes follows:

- Of the 15 drugs reviewed with no PDL status, six were recommended as preferred and nine were non-preferred.
- Of the 22 drugs with an existing PDL status, three drugs move from preferred to non-preferred, and 19 drugs move from non-preferred to preferred.

The January 2022 meeting was held on January 21, 2022, and updates will be provided at the next SMMCAC. PDL recommendations approved by the Executive Commissioner from the July and Nov meetings have been implemented on January 27, 2022, and are available on the Texas Vendor Drug Program website (DUR Board Meetings | Vendor Drug Program (txvendordrug.com)

PDL recommendations approved by Executive Commissioner for Jan and April meeting will be implemented on July 28. 2022. The Board is now at full membership with all 20 positions filled but we will be soliciting for two positions due to term August 31, 2022

e-Health Advisory Committee (eHAC) Updated January 2022. The committee advises the Executive Commissioner and Health and Human Services system agencies (HHS agencies) on

strategic planning, policy, rules, and services related to the use of health information technology, health information exchange systems, telemedicine, telehealth, and home telemonitoring services.

Updates

- Most recent meeting conducted December 6, 2021. New Chairs elected:
    - Chair: Mari Robinson, JD
    - Vice-Chair: Phil Beckett, PhD
- Continued to discuss implementation of SB 670 (86th Legislature, Regular Session, 2019), HB 1063 (86th Legislature, Regular Session, 2019), SB 922 (85th Legislature, 2017, Regular Session), and HB 1697 (85th Legislature, Regular Session, 2017)/Rider 94 (86th Legislature, Regular Session, 2019) – Pediatric Telemedicine Resource program for rural Texas, SB 640 (87th Legislature, Regular Session), and HB 4 (87th Legislature, Regular Session). Telemedicine and telehealth continue to be significant components of the response to COVID-19.
    - The eHAC's Behavioral Health (BH) Subcommittee is collaborating with the Office of e-Health Coordination (OeHC) in the implementation of SB 640 which requires HHSC conduct an assessment of the interoperability needs and technology readiness of behavioral health providers in Texas. Two BH Subcommittee members represent the full Subcommittee on the SB 640 Workgroup and have been instrumental in the development of the survey tool and in collaborating with other BH-related committees within the agency, as well as the Social Determinants of Health Workgroup.
    - The eHAC's Telemedicine, Telehealth and Telemonitoring Subcommittee provided input to the agency's telemedicine program in the implementation of HB 4.
    - The eHAC's has also provided input to the agency on HIT planning and is scheduled to provide input on the biennial interoperability report. eHAC also consists of an Interoperability Subcommittee.
- eHAC Currently has eight vacancies and the OeHC is working with the Advisory Committee Coordination Office to post the application 9 process. The vacancies are a result of member terms expiring at the end December 2021.
- Disaster Response in Health Information Technology (HIT)
- Health Information Exchange Connectivity Project
- DSHS interoperability and data activities
- HHS Integration and Data Exchange Capabilities Center of Excellence (iCoE) • Annual ethics training for new appointees
- Submitted proposed rules amendment to move from annual report to biennial report

Upcoming Meeting: March 7, 2022

Hospital Payment Advisory Committee (HPAC) Updated November 2021
The Hospital Payment Advisory Committee is a subcommittee of the Medical Care Advisory Committee. HPAC advises HHSC on hospital payment issues for Medicaid inpatient and outpatient services as well as advise HHSC on supplemental payment programs/methodologies (e.g., Medicaid Disproportionate Share; Texas 1115 Waiver Uncompensated Care payments; Texas 1115 Waiver Delivery System Reform Incentive Payment program; Uniform Hospital Rate Increase Program; Graduate Medical Education, etc.).

Updates In the August 5, 2021, meeting, HHSC introduced and presented a new fee for service supplemental payment program – Hospital Augmented 11 Reimbursement Program ("HARP"). HARP is a statewide supplemental program providing Medicaid payments to hospitals for inpatient and outpatient services which serve Texas Medicaid fee-for-service (FFS) patients. This program will be subject to approval from CMS. The pool size for this program is 1.395B and the State Plan Amendments were submitted to CMS on September 14, 2021. Under this program, the maximum payment a hospital can receive before any reductions will be their Medicare payment gap.

No other informational items were presented. All other items discussed were issues the HPAC committee asked HHSC to present updates on, such as, the CHIRP, TIPPS, and RAPPS, and Private hospital GME programs. These were status updates only and no new information on the programs was presented.

Palliative Care Interdisciplinary Advisory Council (PCIAC) Updated January 2022 The PCIAC assesses the availability of patient-centered and family-focused interdisciplinary-team-based palliative care in Texas for patients and families facing serious illness. The PCIAC works to ensure that relevant, comprehensive, and accurate information and education about palliative care, including complex symptom management, care planning, and coordination needed to address the physical, emotional, social, and spiritual suffering associated with serious illness is available to the public, health care providers, and health care facilities.

Updates In the process of holding scheduled workgroup meetings for the following workgroups:

Pediatric palliative care subcommittee

- This subcommittee will be working on researching how other states provide palliative care to their pediatric population, what service gaps exist in Texas and how Texas can improve utilization of pediatric palliative care.

Senate Bill 916 study workgroup

- HHSC staff are working with the external quality review organization and the SB 916 study workgroup to analyze data on Medicaid decedents to assess potential improvements of supportive palliative care (SPC) on health quality, health outcomes, and cost 21 savings from the availability of SPC services in Medicaid as per the mandate from SB 916 which will require this data to be developed into a report.
- This workgroup is providing input on additional data variables to consider for the analysis and will provide input on the content of the report that is currently being drafted. 2022

Legislative Report Workgroup

- The 2022 legislative report will contain 6 recommendations on various palliative care-related policy issues:
    - Pediatric supportive palliative care
    - Home health licensing regulations o Proposed benefit: advanced care planning
    - Medical cannabis in the hospital setting
    - Reimbursement for Child-Life Specialists
    - Promoting Education and Awareness of SPC

Upcoming Meeting: April 12, 2022

Texas Council on Consumer Direction (TCCD) Updated January 2022 The Texas Council on Consumer Direction (TCCD) advises HHSC on the development, implementation, expansion, and delivery of long-term services and supports through the consumer directed services (CDS) option. The Council is composed of CDS employers, representatives from financial management service agencies (FMSAs), representatives from managed care organizations (MCOs), and advocates for children and older adults using the CDS option. TCCD is established in accordance with Texas Government Code § 531.012 and governed by Texas Administrative Code § 351.817 and Texas Government Code Chapter 2110.

Updates Since the last meeting, the Council finalized and submitted its annual report to the Executive Commissioner. At its December 16 meeting, the Council heard a report regarding Texas' plan to use the funds from the American Rescue Plan Act. HHSC has submitted its initial spending plan and is waiting to receive approval from CMS. The Council review the quarterly utilization report on the number of Medicaid participants utilizing the CDS service delivery option. The number has dropped from the totals in 2020, and the Council plans to discuss ways to encourage more participants to choose consumer direction. The Council also heard a report on the STAR+PLUS Pilot

Program. The Council was updated on the status of electronic visit verification (EVV), with specific emphasis on compliance and the requirements for CDS employers and financial management services agencies.

The Training and Outreach Subcommittee and Processes and Expansion Subcommittee are planning for Disability Awareness Week which is in April. They are also reviewing the CDS Employer Manual which has not been updated for several years, and specifically needs to have EVV requirements added.

Upcoming Meeting: March 24, 2022

Value-Based Payment and Quality Improvement Advisory Committee (VBPQIAC) Updated January 2022. The Value-Based Payment and Quality Improvement Advisory Committee ("Committee") was established by the Executive Commissioner of the Health and Human Services (HHS) system to provide a forum to promote publicprivate, multi-stakeholder collaboration in support of quality improvement and value-based payment initiatives for Medicaid, other publicly funded health services, and the wider health care system. Committee members representing diverse sectors of the healthcare system are tasked with providing input on quality improvement initiatives. By December 1 of each even-numbered year, the committee submits a written report to the executive commissioner and Texas Legislature with recommendations to help Texas achieve the highest value for healthcare in the nation.

Updates The Committee is preparing its legislative report for 2022

The Advisory Committee met February 15th. See the Texas Insight Report.

4. SMMCAC subcommittee updates

Clinical Oversight and Administrative Simplification—They discussed the new approval to implement telehealth in dentistry and discussed updating the provider manual and timeline. In lieu of Services and subsequent delays will be discussed at the next meeting. There is a new service they will discuss about a 911 triage system including telehealth services and referral.

Complaints, Appeals, and Fair Hearings—SB1207 and independent review was discussed, and it will be going live March 1, 2022. Two IROs have been put under contract. Subsequent training was discussed about the IRO process.

Network Adequacy and Access to Care—They discussed their focus on how the network has stretched to meet the needs under the medical emergency. Fewer cancellations and increased flexibility and at home carryover were benefits of the telehealth approach. Overall, the presentation stated that therapies were successful under telehealth for many children and that this should remain a permanent approach. There was a presentation about the ABA provider enrollment with 158 providers presently enrolled. HB133, 87th legislature and the carve in of Healthy Texas Women into managed care. This will be baked into the STAR and CHIP RFP. STPs have been pushing back regarding barriers to the program. Contract enforcement was also discussed.

Service and Care Coordination----They met February 9th and was well attended. There were three presentations:

- Utilization Review and Service Coordination – expanded to include STAR Kids and STAR Health. MCOs tend to score well on the surveys.
- Learning collaborative website—increase accountability and transparency. Service coordination is not included at this time. HHSC is seeking feedback for service coordination to be added in the future.
- HB133 case management for children and pregnant women carve in. This is slated to go into effect September 1, 2022.

5. Health and Human Services Commission updates

Status on 1115 Waiver extension and transition—Updates included:

- January 15 special terms and condition are in effect
- 300 providers participate ion DSRIP
- 900 nursing facilities who participate in QIPP
- 4.5 million beneficiaries served by 17 MCOs
- 500 providers who participate in UC
- 3 dental organizations participating
- Health Emergency has caused a growth in beneficiaries
- $35 billion annually in expenditures

CMS asked for updates on HCBS with new requirements. A new annual report will go to CMS. There are four directed payment programs.
Behavioral health directed payment program was approved by CMS

HHSC Directed Payment Programs

Uniform Hospital Rate Increase Program

Uniform Hospital Rate Increase Program is a statewide program that provides for increased Medicaid payment for inpatient and outpatient services. Texas Medicaid managed care organizations (MCOs) receive additional funding through their monthly capitation rate from HHSC and are directed to increase payment rates for certain hospitals.

- UHRIP program operational information

Comprehensive Hospital Increase Reimbursement Program

The Comprehensive Hospital Increase Reimbursement Program replaces UHRIP beginning September 1, 2021. HHSC and stakeholders wanted to reform certain aspects of UHRIP, such as improving its tie to the state's Medicaid quality strategy and incorporate the efforts to further healthcare transformation and quality improvement in the Medicaid program. CHIRP continues to be a statewide program that provides for increased Medicaid payments for inpatient and outpatient services to participating Texas hospitals. Texas Medicaid managed care organizations receive additional funding through their monthly capitation rate from HHSC and are directed to increase payment rates for enrolled hospitals. CHIRP is comprised of two payment components:

- The Uniform Hospital Rate Increase Payment
- The Average Commercial Incentive Award

The UHRIP component provides hospitals an increased payment that is based on a percentage of the Medicare gap, which is the difference between what Medicare is estimated to pay for the services and what Medicaid actually paid for the same services. The ACIA component is an optional component and hospitals can choose to participate. It provides hospitals a payment based on a percentage of the average commercial reimbursement gap difference between what an average commercial payor is estimated to pay for the services and what Medicaid actually paid for the same services, less payments received under the UHRIP component.

- CHIRP Program operational information
- CHIRP Program quality requirements

Quality Incentive Payment Program

The Quality Incentive Payment Program (QIPP)is a statewide program that provides for incentive payments to qualifying nursing facilities. STAR+PLUS MCOs are directed to make payments to qualifying nursing facilities once the facilities demonstrate meeting the required goals.

- QIPP operational information
- QIPP scorecards and payment information
- QIPP frequently asked questions
- QIPP resources

Network Access Improvement Program

Network Access Improvement Program is a pass-through payment program designed to further the state's goal of increasing the availability and effectiveness of primary care for persons with Medicaid. NAIP accomplishes this by incentivizing health-related institutions

and public hospitals to provide quality, well-coordinated, and continuous care in exchange for additional funding.

- NAIP Reports

Texas Incentives for Physicians and Professional Services

HHSC created the Texas Incentives for Physicians and Professional Services program to replace Delivery System Reform Incentive Payment program and the Network Access Improvement Program that are ending in state fiscal years 2022 and 2023, respectively. TIPPS is a value-based directed payment program for certain physician groups providing health care services to persons enrolled in the STAR, STAR+PLUS and STAR Kids Medicaid programs. Eligible physician groups include: health-related institution physician groups, physician groups affiliated with hospitals that receive indirect medical education funding and other physician groups. These classifications allow HHSC to direct reimbursement increases where they are most needed and to align with the quality goals of the program. TIPPS payments are paid to MCOs through three components in their capitation rates and distributed to eligible physician groups based on each physician group meeting performance requirements. Component 1 is a monthly performance incentive payment based upon the implementation of quality improvement activities. Component 2 is a semi-annual performance incentive payment based on the achievement of quality metrics focused on primary care and chronic care. Health-related institutions and indirect medical education physician groups are the only classes eligible for Components 1 and 2. Component 3 is a uniform rate increase on paid claims for certain outpatient services based on the achievement of quality metrics that measure aspects of maternal health, chronic care, behavioral health, and social determinants of health. All participating physician groups are eligible for Component 3.

- TIPPS Operational Information
- TIPPS Quality Requirements

Rural Access to Primary and Preventive Services

The Rural Access to Primary and Preventive Services is a directed payment program that incentivizes primary and preventive services for persons in rural areas of the state enrolled in the STAR, STAR+PLUS and STAR Kids Medicaid programs. RAPPS focuses on the management of chronic conditions. Two classes of Rural Health Clinics are eligible to participate:

- Hospital-based RHCs, which include non-state government-owned and private RHCs
- Free-standing RHCs

Eligible RHCs must serve an annual minimum volume of 30 Medicaid managed care encounters. RAPPS is comprised of two payment components: Component 1 is a monthly prospective uniform dollar increase paid to all participating RHCs to promote improvement activities with a focus on improving access to primary and preventive care services. Providers report semi-annually on certain structure measures that include electronic health record use, telemedicine/telehealth capabilities, and care coordination. Component 2 is a uniform percent rate increase for certain services. Providers will report

their progress on process measures for preventive care and screening and management of chronic conditions.

- RAPPS Operational Information
- RAPPS Quality Requirements

Directed Payment Program for Behavioral Health Services

HHSC created the Directed Payment Program for Behavioral Health Services to incentivize the Certified Community Behavioral Health Clinic model of care for persons enrolled in the STAR, STAR+PLUS and STAR Kids Medicaid programs. Eligible providers include Community Mental Health Centers. The Certified Community Behavioral Health Clinic model provides a comprehensive range of evidence-based mental health and substance use disorder services with an emphasis on offering 24-hour crisis care, care coordination with local primary care and hospital providers and integration with physical health care. The DPP BHS is comprised of two payment components. Component 1 provides a monthly uniform dollar increase paid to all participating community mental health center providers in the program. Providers must report their progress towards gaining or maintaining certification for the Certified Community Behavioral Health Clinic model and other activities foundational to quality improvement, such as telehealth services, collaborative care, integration of physical and behavioral health, and improved data exchange. Component 2 is a uniform percent increase applied to certain Certified Community Behavioral Health Clinic services based on achieving quality metrics that align with its measures and goals.

- DPP BHS Operational Information
- DPP BHS Quality Requirements

QIPP was also approved. Reporting and payment systems for approved programs are in effect and fully operational.

HHSC is continuing to work to secure approval of three other directed payment programs:

- Comprehensive Hospital Increase Reimbursement Program
- Texas Incentives for Physicians and Professional Services
- Rural Access to Primary and Preventive Services

The uncertainty around reporting for these programs remains challenging and providers must secure resources to prepare for implementation. The reporting portal will be opened 35 days for the programs following CMS approval. The second round of IGT will be collected about 21 days after final approval.

Around the Charity Care Program, attachment T was approved by CMS. HHSC is working on this first year of implementation with providers realizing that transitions will be occurring due to implementation of required changes effective October 1st.

A resizing exercise was required for the uncompensated care program. The work with CMS has begun in 2022 and will take effect in 2023.

Regarding applied behavioral analysis services, The amendment was withdrawn because it was not necessary. The program is now in effect.

The 1115 waiver will undergo a rebasing exercise (different from resizing), using 2022 data. This is a new CMS policy and is a first of its kind looking at budget neutrality.

The waiver is a matter pending in federal court. The monitoring has been posted to the HHSC website.

Questions/Answers/Comments

On resizing, are they allowing adjustments because of the expanded Medicaid pool due to the medical emergency? HHSC stated they will get back to the committee on this.

Provider Enrollment and Management System (PEMS)

Went live on December 13th . The new system will modernize, consolidate, and streamline provider enrollment into Texas Medicaid

- Eliminates the need for multiple Texas Provider Identifiers (TPIs), allowing providers to interact with all Texas Medicaid records in a single, easy-to-use system.
- Will allow for Texas Medicaid enrollment in multiple state health-care programs from a single application.
- Real-time data validation will reduce errors and expedite the enrollment process.
- The message dashboard will provide timely online email notifications and related correspondence.
- Offers real-time availability to changes made to provider information and offers instant access to the status of provider enrollment applications.
- PEMS will allow clients to locate providers faster with the expanded Online Provider Lookup search functionality.

Provider Enrollment on the Portal (PEP) and the Provider Information Management System (PIMS) will be replaced with PEMS and will no longer be available. Paper applications for Texas Medicaid provider enrollment will be eliminated with the new online system so providers should create TMHP accounts. As such, providers must have access to the

internet to utilize PEMS and use up-to-date internet browsers for optimum performance of the PEMS portal.

A Step-by-Step Guide is available (Provider Enrollment and Management System (PEMS) | TMHP) that will guide applicants through the process of enrolling as a provider using TMHP's Provider Enrollment and Management System (PEMS) tool. Additional helpful resources are available on the Enrollment Help page and the TMHP YouTube channel

As of January 24th, 1,143 applications have been successfully submitted through PEMS. Adjustments are being made to the system based on provider feedback. Help pages have been completed.

A presentation was referenced by the speaker but was not presented nor was it made available to the public. Texas insight did the supportive research found above.

Questions/Answers/Comments. No comments or questions were offered.

Status of Proposed In-Lieu of Services

SB1177, 86th legislature.

Intensive mental health services for children and youth are critical. Currently, in our state there are substantial gaps in the availability of intensive home and community based mental health services for children and youth with the most serious mental health challenges. There are many intensive, evidence-based practices that are known to have good outcomes for children and youth with the highest mental health needs that are not covered by the state under Medicaid even though these services can be cost-effective, especially when compared to inpatient hospitalization or residential care. Under this current system, there are few community-based treatment options accessible for children and youth with intensive needs.

In order to address gaps in the availability of intensive community-based services for children and youth with intensive mental health needs, Texas should make evidence-based practices available in Medicaid managed care. S.B. 1177 would update the managed care contracts to include mental health evidence based practices "in lieu of" other services. Instead of adding in new services into Medicaid managed care, which is a cost to the state, these "in lieu of" services are added to give providers options in treatment. These services will be cost-effective, medically appropriate and will not be up to the recipient to receive, all while allowing flexibility at the managed care organization level. (Original Author's/Sponsor's Statement of Intent)

The fiscal note states that the bill would require the Health and Human Services Commission (HHSC) to allow a Medicaid managed care organization to offer certain medically appropriate, cost-effective, evidence-based services from a list approved by the State Medicaid Managed Care Advisory Committee in lieu of mental health or substance use disorder services specified in the state plan. The bill would also require HHSC to prepare and submit an annual report on the number of times during the preceding year one of those services is used. It is assumed implementing the provisions of the bill would not have a significant fiscal impact.

For a more detailed analysis of "In Lieu of Services" See ***Texas Insight Report from February 15, Value-Based Payment and Quality Improvement Advisory Committee***.

HHSC is operationalizing this in phases. Phase one – services in lieu of inpatient services:

- Coordinated specialty care
- Crisis respite
- Crisis stabilization units
- Extended observation units
- Partial hospitalization
- Intensive outpatient program
- Extended observation services.

HHSC is still working with CMS to secure approval of these services. Pending approval, HHSC requested that CMS allow certain services to proceed while discussion is continuing:

- Partial hospitalization
- Intensive outpatient program
- Coordinated specialty care

No decision has been made at this point.

Phase two services are to include:

- Cognitive rehabilitation
- Multisystemic therapy
- Functional family therapy

All these services have been determined to be evidence based. Multisystemic Therapy has been nominated as a topic nomination as a potential Medicaid benefit, and this is working its way through that topic nomination process.

Members of the public, state agencies and others may request that the Texas Health Human Services Commission (HHSC) consider coverage of a new service, technology or other benefit.

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Please fill out and submit a Topic Nomination form in order to propose a topic for review and consideration of coverage. the Topic Nomination Form It takes 12 to 18 months to approve a benefit.

Phase three – Additional in lieu of services:

- Collaborative care model
- Integrated Pain Management Day Program
- Health and behavior assessment and intervention (HBAI)
- Systemic, therapeutic, assessment, resources, and treatment
- Treatment/therapeutic foster care
- Mobile crisis outreach team (MCOT)

These will require some additional analysis by HHSC.

Question/Answers/Comments

Are there any plan for altering strategies with CMS to expedite approval of the phases? HHSC stated they have learned the types of information they will need for approval. If phase two and three services are analyzed and complete, then they may use a staggered approach within the phases.

House Bill (HB) 4, 87th Legislature, Regular Session (2021) update The Texas Health and Human Services Commission (HHSC) allowed the use of telemedicine, telehealth, and audio-only for many new Medicaid services during the COVID-19 Public Health Emergency (PHE). HB4 re quires HHSC to allow more services to be delivered using telemedicine, telehealth, and audio-only methods on a permanent basis after the PHE ends if clinically appropriate and cost-effective.

Senate Bill (SB) 670 (86th Legislative Session, 2021) mandated that Managed Care Organizations (MCOs) have the responsibility to determine which services could be delivered through telemedicine, telehealth, and audio only methods. Under SB670 MCOs cannot: − Deny reimbursement to health care providers for a Medicaid service or procedure just because it was delivered via telemedicine or telehealth, nor can they deny or reduce reimbursement for a covered health care service or procedure based upon the network provider's choice of platform; and must ensure that telemedicine and telehealth services promote and support patient-centered medical homes.

Phase I: Analysis - Winter 2022

- HHSC will release guidance about certain services that are approved for telemedicine, telehealth, and audio-only delivery methods on an ongoing basis.
- HHSC will begin releasing draft rules and other policy updates.

Phase II: Analysis - Spring 2022

- HHSC will ask stakeholders for input about additional services that were available for remote delivery during the PHE to help determine whether permanent telemedicine, telehealth, and audio-only delivery methods would be cost-effective and clinically appropriate.
- HHSC will release guidance about additional services that are approved for telemedicine, telehealth, and audio-only delivery methods.

Phase III: Rulemaking - Summer 2022

- Rules required by legislation will be posted for public comment.

Phase IV: Finalizing Policy - Fall 2022 HHSC expects to finalize formal policy changes after providing an opportunity for stakeholder input on posted rules and policies.

Teleservices

Winter Notices Issued

- Medicaid MCO Reminder – SB 670
- CHIP Notice
- Behavioral Health Audio-Only Services MCO Notice--Audio-only and audio-visual delivery of behavioral health services day programming for adult acute care needs to end Feb. 28, 2022.
- Phase 1 Fee-For-Service Interim Guidance: Behavioral Health, Therapies, Healthy Texas Women.
- Medicaid and CHIP Teleservices Website for Updates Medicaid and CHIP Teleservices | Texas Health and Human Services

Next Steps

- Policy updates and stakeholder engagement
- Rural Health Clinics
- Home Telemonitoring

Managed Care Assessments & Service Coordination Draft Policy

Managed Care Assessments		
In-Person Required	**Audio-Visual (A/V) Allowed**	**Audio-Only Allowed**
• All initial assessments and annual reassessments for medical necessity and level of care must be done in-person • Functional assessments for personal care services or personal assistance services and CFC must be done in-person • Change in condition off-cycle assessments for medical necessity and level of care that may result in a Resource Utilization Group (RUG) change must be done in-person	• Change in condition assessments that primarily involve adjustments in services (e.g., more hours of nursing or personal care services/personal assistance services for persons following a hospital stay) may be done A/V • Members must be offered a choice to receive the assessment in-person, consent to A/V must be documented, and the A/V must be done in a HIPAA compliant manner	• Only in a future Public Health Emergency/Disaster

Managed Care Service Coordination		
In-Person Required	**Audio-Visual (A/V) Allowed**	**Audio-Only Allowed**

• Service Coordination visits where an assessment will be conducted must be done in-person
• All STAR+PLUS Level 1 & 2 members and STAR Kids Level 1, 2 and 3 members must receive at least 1 in-person Service Coordination visit per year*
• Nursing facility residents:
  • One in-person service coordination visit per year for service planning purposes is required
  • Discharge planning visits must occur in-person, including transitioning to STAR+PLUS HCBS
*The visit where an assessment occurs satisfies this minimum requirement
	• Service Coordination visits where no assessment is being conducted may be done A/V
	• Members must be offered a choice to receive the service in person, consent to A/V must be documented, and the A/V must be done in a HIPAA compliant manner
		• Only in a future Public Health Emergency/Disaster

Service Coordination – HHSC may, on a case-by-case basis, require a MCO to discontinue service coordination or assessments by telecommunication if HHSC determines discontinuation is in the best interest of the member (HB 4, Section 6(f)).

- No changes to pre-COVID telephonic service coordination contacts.
- Audio-only in place of in-person visits allowed only in an emergency or state of disaster.

- Information technology, such as text or email, can supplement service coordination, but cannot be the sole means of conducting service coordination.

Dedicated mailbox to receive input HHSC_MCS_HOUSE_BILL_4@hhs.texas.gov
Web access Medicaid and CHIP Teleservices | Texas Health and Human Services

Questions/Answers/Comments

Are you looking at the new 911 requirements? HHSC stated they will have to get back with the committee on this.

There is one service coordination per year. Does the MCO determine which contact is in person? HHSC stated that the SKSAI must happen in person and that would satisfy the in person visit, there for the others can be done through teleservices.

Was it considered doing the SKSAI remotely after the first assessment for lower acuity members. HHSC stated that it was determined that the SKSAI must be in person to establish the most accurate picture.

Managed Care plans for when COVID flexibilities expire Many Medicaid and CHIP flexibilities are extended through February 28, 2022, unless the federal Public Health Emergency ends sooner. Certain flexibilities are extended through April 30, 2022, to allow for further analysis of clinical appropriateness and cost-effectiveness in accordance with HB4. − If the federal public health emergency ends sooner than April 30, 2022, HHSC will provide more information.

Flexibilities Ended Jan. 31, 2022: (Ended because these were transferred to ongoing policy)

- Guidance for Consumer Directed Services Option − Effective Feb. 1, 2022, FMSAs can permanently conduct new employer orientation audio-visual or in-person (phone not allowed).
- MCO COVID 19 Guidance: Telehealth for Physical, Occupational and Speech Therapies − Replaced with Interim guidance under HB4
- Claims for Telephone (Audio-Only) Behavioral Health Services − Replaced with Interim guidance under HB4

Flexibilities Ending Feb. 28, 2022:

- Provider Enrollment Revalidation Extensions

− Postpone all revalidation actions (including VDP pharmacy provider revalidation); and continue to allow postponement of revalidation screening including fingerprint-based criminal background checks, disclosures, site visits, and application fees.
− In order to resume provider revalidation on March 1, 2022, HHSC began issuing 120-day advanced notice to providers on November 1, 2021. On a rolling basis, providers will receive notices 120-days in advance of their revalidation date.

Resources:
Coronavirus (COVID-19) | TMHP
Long-term Care Providers | Texas Health and Human Services
Medicaid and CHIP Services Information for Providers | Texas Health and Human Services

Questions/Answers/Comments No questions or comments were offered

Health and Human Services Coordinated Strategic Plan Status update for 2021-2025 plan including any initiatives addressing managed care in proposed 2023-2027 plan currently out for public comment

HHS Coordinated Strategic Plan for 2023–2027 Goals and Objectives as of December 9, 2021

Goal 1: Improve health outcomes and well-being.
Objective 1.1: Enhance quality of direct care and value of services.
Objective 1.2: Prevent illness and promote wellness through public- and populationhealth strategies.
Objective 1.3: Encourage self-sufficiency and long-term independence.

Goal 2: Ensure efficient access to appropriate services.
Objective 2.1: Empower Texans to identify and apply for services.
Objective 2.2: Provide seamless access to services for which clients are eligible.
Objective 2.3: Ensure people receive services and supports in the most appropriate, least restrictive settings based on individual needs.
Objective 2.4: Strengthen consumers' access to information, education, and support.

Goal 3: Protect the health and safety of vulnerable Texans.

Objective 3.1: Optimize preparation for and response to disasters, disease threats, and outbreaks.
Objective 3.2: Prevent and reduce harm through improved education, monitoring, inspection, and investigation.

Goal 4: Continuously enhance efficiency and accountability.
Objective 4:1: Promote and protect the financial and programmatic integrity of HHS.
Objective 4.2: Strengthen, sustain, and support a high-functioning, efficient workforce.
Objective 4.3: Continuously improve business strategies with optimized technology and a culture of data-driven decision-making

Every two years, the Texas Health and Human Services system updates its Strategic Plans, which describe its work to address multifaceted and evolving factors affecting health and human services. Each of the system's divisions contributes to the development of the Strategic Plans. For more information, see Instructions for Preparing and Submitting Agency Strategic Plans, Fiscal Years 2021 to 2025 (PDF), published by the Legislative Budget Board and the Office of the Governor. Strategies are now being developed to address the objectives.

Questions/Answers/Comments

Can you common on how accomplishment of objectives will be determined? HHSC stated that will depend on the action items that come in from the program areas. Action items will have a date for completion.

Will there be public input for the evaluation process? HHSC stated that there is input every two years for the coordinated strategic plan. Comments about accomplishment and measuring can be accomplished through that process. The strategic plan and the annual business plan are synchronized.

6. Public comment.

Leah Joiner, Texas Women's Healthcare Coalition commented on Healthy Texas Women transition into managed care. A smoother transition is encouraged through:

- Use of evidenced based family based services with appropriate payment to establish a strong network of providers

- Consider the non-postpartum clients who may need assistance navigating the system
- Consider the family planning providers and the percentage of women these providers serve.
- Health plans develop strategies to respond to concerns of enrollment and other issues.

7. Review of action items and agenda items for future meeting,

- Strategic plan and action items for Medicaid managed care
- Eligibility impacts related to public health emergency
- Presentation on the Gold Card legislation and how it does not involve Medicaid
- 911 triage
- EVV 2022 survey results and policy issues
- Update on PEMS and impact on providers
- Election of Chair since current chair's term expires

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

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