State Medicaid Managed Care Advisory Committee August 11, 2021

State Medicaid Managed Care Advisory Committee provides recommendations and ongoing input on the statewide implementation and operation of Medicaid managed care. Members include:

David Weden, Chair
Community Mental Health and Intellectual Disability Centers
Buda, TX

Xavier Bañales
Aging and Disability Resource Centers
El Paso, TX

Anthony Brocato
Rural Providers
Wolfforth, TX

Esmeralda Cazares-Baig
Managed Care Organizations
Lakeway, TX

Henry Chu, DDS
Pediatric Healthcare Providers
Helotes, TX

Blake Daniels
Independent Living Centers
Tyler, TX

Christina Davidson, MD
Community-based Organizations
Bellaire, TX

Anne Dunkelberg
Consumer Advocate
Austin, TX

Shauna Glover
Medicaid managed care clients or family members who use mental health services
Corpus Christi, TX

Aron Head
Managed Care Organizations
Arlington, TX

Mary Klentzman
Clients with disabilities
Belton, TX

David Lam, MD
Rural Providers
San Antonio, TX

Ramsey Longbotham
Primary and Specialty Care Providers
Cuero, TX

Valerie Lopez
Hospitals
Uvalde, TX

Beth Rider
Family Member
Round Rock, TX

Leslie Rosenstein, PhD
Non-physician Mental Health Providers
Dallas, TX

Karl Serrao, MD
Managed Care Organizations
Corpus Christi, TX

Patricia "Patsy" Tschudy
Long-term Services and Supports Providers
Spring, TX

Jacob Ulczynski
Area Agencies on Aging
San Antonio, TX

Laurie Vanhoose
Managed Care Organizations
Austin, TX

Lindsey Vasquez, MD
Obstetrical Care Providers
Houston, TX

Alfonso Velarde
Community-based Organizations
El Paso, TX

Jennifer Vincent
Advocates for children with special healthcare needs
La Porte, TX

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Call to order, roll call, and opening remarks. The Chair, David Weden, convened the meeting and made some very moving and informed remarks about COVID prevention.

Consideration of May 27, 2021, meeting minutes. The minutes were approved as written

Advisory Committee chair updates **Please follow the link to access the advisory committee summaries.**

SMMCAC subcommittee updates

Clinical Oversight and Administrative Simplification—there was a brief meeting this morning on dental procedures using anesthesia for children. Prior authorization complaints were reviewed. SB787 is still in limbo awaiting approval from CMS. They have asked about some data on prior authorizations.

Complaints, Appeals, and Fair Hearings—There was a status report on the external medical review (SB1207). Two IROs have applied to conduct the work. The MCOs were given notice of an IRO template. The aim was for a 2022 implementation. In addition to the procurement of the IROs there is work being done with the MCOs. The roll out is now January. There are 14 training modules. We will need training for providers related to the documentation needed for prior authorizations. There will be an important change in process for the medical reviews.

State Medicaid Managed Care Advisory Committee (SMMCAC) subcommittee recommendations
August 10 and 11, 2021

Complaints, Appeals, and Fair Hearings (CAFH) Subcommittee

1. The CAFH subcommittee's recommendation is to assign the topic of implementation of the transition of Healthy Texas Women (HTW) into managed care under HB 133 to an existing SMMCAC subcommittee.

   Subcommittee members:
   Dr. Henry Chu
   Blake Daniels
   Anne Dunkelberg
   Dr. Karl Serrao

The Chair stated that HB133 issues would be assigned to a working subcommittee.

MOTION: Assign the two part scope of HB133 to one of the subcommittees prevailed

Network Adequacy and Access to Care—They elected a new Chair, and the next meeting will be in November. DSRIP milestones were reviewed. There was a general public comment about the fee structure for telehealth but that had to be done by the legislature.

Service and Care Coordination—The reviewed the enhancements to STAR and CHIP management and they reviewed best practices for children with special health care needs. They are seeing 176,000 members who meet the criteria for Special Health Care Needs and service management. They discussed the identification of members eligible for case management and how MCOs identify those members with special healthcare needs.

Health and Human Services Commission (HHSC) updates

86th Legislative Session

SB 1207 - Coordination of benefits. The bill requires the Health and Human Services Commission (HHSC) to contract with an external medical review organization to review the resolution of certain appeals of a managed care organization's (MCO's) adverse determination on the basis of medical necessity or an HHSC denial of eligibility based on medical or functional need when the recipient or applicant affirmatively requests an external medical review and would require HHSC to conduct annual surveys and focus groups through the external quality review organization (EQRO) and to calculate an MCO's performance on performance measures using available data if HHSC determines through the EQRO's initial report on the STAR Kids managed care program that additional data and research are necessary to improve the Medically Dependent Children waiver program (MDCP). The bill requires HHSC to submit a quarterly report about access to care for recipients in MDCP. The bill would also require HHSC to develop and maintain a list of services that are not traditionally covered by primary health benefit plans (PHBP) and that a Medicaid managed care organization (MCO) may approve without coordinating with the issuer of the PHBP and that could be resolved through third party liability resolution. The bill requires HHSC to provide certain information on a recipient's third-party insurance, including benefits, limits, copayments, and coinsurance. The bill requires HHSC to develop and implement a process to allow a provider who primarily provides services to a recipient through PHBP coverage to

receive Medicaid reimbursement for services ordered, referred, or prescribed regardless of whether the provider is enrolled as a Medicaid provider. The bill took effect September 1, 2019.

Active Legislation	Description and Status Update
SB 1207: Continuation of Benefits - Specialty Provider Rule	• HHSC must develop a clear managed care policy to ensure coordination and timely delivery of Medicaid wrap-around benefits • Allows recipients with complex medical needs who have an established relationship with a specialty provider to continue receiving care from that provider regardless of whether the provider is part of their MCO's network • SB 1648 (87th Legislature, Regular Session, 2021) included changes to the specialty provider provision in TGC §533.038

The rules have been presented to the Executive Council. SB1648 has given direction to the rules under consideration. A timeline was not available.

SB 1177 – In lieu of Behavioral Health Services. The bill requires 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 require HHSC to prepare and submit an annual report on the number of times during the preceding year one of those services is used.

Active Legislation	Description and Status Update
SB 1177: Behavioral health in-lieu-of services	• Requires HHSC to allow MCOs to offer cost-effective and evidence-based services in lieu of state plan behavioral health services

87th Legislative Session

HB 4 -Telemedicine and Texting provisions. The bill requires the Health and Human Services Commission (HHSC) to ensure a rural health clinic may be reimbursed for the originating site facility fee or the distant site practitioner fee or both, for a covered telemedicine medical service or telehealth service delivered by a health care provider to a Medicaid recipient.

The bill requires HHSC, by January 1, 2022, to ensure individuals receiving services through Medicaid, the Children's Health Insurance Program (CHIP), and other public benefits programs administered by HHSC or another health and human services agency, have the option to receive certain services as telemedicine medical services, telehealth services, or otherwise using telecommunications or information technology, to the extent it is permitted by federal law and is determined cost-effective and clinically effective by HHSC. Covered services include preventative health and wellness services; case management services, including targeted case management; behavioral health services; occupational, physical, and speech therapy services; nutritional counseling services; and assessment services, including nursing services under certain Section 1915(c) waiver programs.

The bill requires HHSC to implement a system that ensures behavioral health services may be provided using an audio-only platform in Medicaid, CHIP, and other public benefits programs administered by HHSC or another health and human services agency and allow HHSC to authorize the provision of other services using an audio-only platform.

The bill allows Medicaid managed care organizations (MCOs) to reimburse for home telemonitoring services not specifically defined in Government Code Section 531.02164.

The bill requires HHSC to implement policies and procedures to allow Medicaid MCOs to conduct assessment and service coordination activities for members receiving home and community-based services through telecommunication or information technology in certain circumstances.

The bill allows an outpatient chemical dependency treatment program to provide treatment using telecommunications or information technology.

The bill takes effect immediately if it receives a vote of two-thirds of all the members elected to each house, as provided by Section 39, Article II, Texas Constitution. Otherwise, the bill would take effect September 1, 2021.

Active Legislation	Impacts
HB 4: Telemedicine, telehealth, and tech-related healthcare services	• Expands the services that may be delivered via telemedicine and telehealth and expands telemonitoring services under certain circumstances • HHSC must establish policies to allow MCOs to conduct assessments and service coordination activities via telecommunications • HHSC must revise Medicaid application and renewal form to collect applicants' preferred method of contact (including phone, text and email), allow consent for members to be contacted by MCOs, and send info to MCOs

HB 133 – Healthy Texas Women Program. The bill requires the Health and Human Services Commission (HHSC) to continue to provide Medicaid to women enrolled during a pregnancy for at least six months after delivery or miscarriage.

The bill amends Chapter 533 of the Government Code to transition Medicaid case management services for children and pregnant women currently provided by the Department of State Health Services (DSHS) to a Medicaid managed care model.

The bill amends Chapter 32 of the Health and Safety Code to require HHSC to contract with managed care organizations (MCOs) to provide Healthy Texas Women (HTW) program services. HHSC and each MCO participating in the HTW program is required to provide certain information regarding premium subsidies available for health benefit plans to certain women enrolled in HTW. HHSC is required to work with the Texas Department of Insurance (TDI) to develop this information. Additionally, HHSC is required to evaluate the feasibility, cost effectiveness, and benefits of automatically enrolling into a managed care plan a woman who becomes pregnant while enrolled in HTW.

HH

Active Legislation	Impacts
HB 133: Extended postpartum coverage, HTW transition to managed care, and CPW carve-in	• Establishes six months postpartum coverage for women enrolled in Medicaid for Pregnant Women • Directs HHSC to transition Healthy Texas Women (HTW) into managed care • Directs HHSC to carve Case Management for Children and Pregnant Women (CPW) into managed care

HHSC stated that case management is set to begin in 2022 which is sooner than for the transition.

Public Comment on HB133 and SB1207

Erica Ramirez, Texas Women's Healthcare Coalition (HB133) highlighted their written comments. She stated they are hearing a need for provider education. They also want to see same day access to services and the removal of barriers to this.

A question was asked if it was possible to get a list of the historic providers of services for HTW and other information that could be shared.

Sue Burick, parent and advocate (SB1207) she stated that there is no age limit in the legislation nor limitation on providers. But this is not the way the bill is being implemented.

HB 2658 – Omnibus bill - portions applicable to managed care. The bill would require the Health and Human Services Commission (HHSC) to study the feasibility of creating an online portal for an individual to request to be placed on a Medicaid waiver program interest list and monitor their place on an interest list. HHSC would also be required to determine the most cost effective automated method for determining the level of need of an individual on an interest list. The bill would also require the Office of the Ombudsman to improve methods to capture and update contact information for an individual who contacts the office regarding Medicaid

waiver services. According to HHSC, these provisions can be accomplished within existing resources.

The bill would require HHSC to develop a procedure for informing Medicaid recipient s of the Consumer Directed Services (CDS) option and documenting if CDS is declined. This analysis assumes there would be a minimal cost associated with implementing this provision.

The bill requires HHSC to adopt rules establishing minimum performance standards for nursing facility providers that participate in the STAR+PLUS Medicaid managed care program. HHSC would be required to monitor provider performance and share performance data with STAR+PLUS managed care organizations (MCOs) as appropriate. It is assumed HHSC would require 1.0 Program Specialist VII to monitor performance of nursing facilities, at an estimated cost of $0.1 million each fiscal year.

The bill would amend the provisions HHSC is required to include in contracts with managed care organizations. According to HHSC, this provision can be accomplished within existing resources.

The bill would require HHSC to collaborate with Medicaid MCOs to implement medication therapy management (MTM) services and establish a reimbursement rate for MTM. While there would be a cost associated with implementing MTM, the fiscal implications cannot be determined at this ti me due to uncertainty regarding utilization.
It is possible that implementation of MTM could result in cost savings, especially related to decreased adverse drug events, but savings cannot be estimated at this time.
The bill requires HHSC to establish rules to require MCOs with disease management progr ams with low active participation rates to identify the reason for the low participation and develop an approach to increase active participation. According to HHSC, implementing the provision would have no significant impact to the agency.

The bill would require HHSC to provide Medicaid reimbursement for preventive dental services for an adult recipient with a disability who is enrolled in the STAR+PLUS managed care program. This analysis assumes HHSC would create a new dental benefit through a Special Terms and Conditions amendment to the Section 1115 Demonstration Waiver to offer preventative dental services to adults in STAR+PLUS who are not also in STAR+PLUS HCBS or in a 1915(c) intellectual and developmental

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disability waiver program. Because this benefit would be limited to certain adults, it is uncertain whether the Centers for Medicare and Medicaid Services would approve the benefit; HHSC may be required to provide preventative dental services to all adults enrolled in Medicaid or may be unable to implement the benefit at all. If implemented for adults enrolled in STAR+PLUS, the total Medicaid client services cost is estimated to be $81.7 million in All Funds, including $31.9 million in General Revenue Funds, in fiscal year 2023, increasing to $91.6 million in All Funds, including $36.3 million in General Revenue Funds, in fiscal year 2026, assuming implementation beginning September 1, 2022. The total Medicaid client services savings due to reduced dental-related emergency room visits is estimated to be $6.2 million in All Funds, including $2.4 in General Revenue Funds, in fiscal year 2023, increasing to $7.5 million in All Funds, including $3.0 million in General Revenue Funds, in fiscal year 2026. The increases in client services payments through managed care are assumed to result in an increase to insurance premium tax revenue, estimated as 1.75 percent of the increased managed care expenditures. Revenue is adjusted for assumed timing of payments and prepayments resulting in assumed increased collections of $0.9 million in fiscal year 2023, $2.3 million in fiscal year 2024, $1.4 million in fiscal year 2025, and $1.0 million in fiscal year 2026. Pursuant to Section 227.001(b), Insurance Code, 25 percent of the revenue is assumed to be deposited to the credit of the Foundation School Fund.

The bill requires HHSC to adopt rules regarding parental consent for services provide d under the School Health and Related Services program. According to HHSC, these provisions can be accomplished within existing resources.

The bill amends the Human Resources Code to require HHSC to provide two consecutive periods of eligibility to a child younger than the age of 19 enrolled in Medicaid between each certification and recertification of the child's eligibility. HHSC is required to perform an income check during the sixth month following the date on which a child's eligibility for medical assistance is certified or recertified. If the review indicates the child's household income does not exceed the maximum income for eligibility, HHSC is required to provide a second period of eligibility. If the review indicates the child's household income does exceed the maximum income for eligibility, HHSC is required to continue to provide medical assistance for a period of not less than 30 days, in order to provide the child's parent or guardian time to provide documentation demonstrating that the child's household income does not exceed the maximum income for

eligibility. If a parent or guardian fails to provide information demonstrating financial eligibility, HHSC is required to provide written notice of termination which must include a statement that the child may be
eligible for enrollment in the Children's Health Insurance Program. Based on the analysis, the duties and responsibilities
of HHSC associated with implementing the provisions could be accomplished by utilizing existing resources.

The bill requires HHSC to utilize existing resources to do the following: review staff rate enhancement programs; review policies regarding the Quality Incentive Payment Program (QIPP); and identify factors influencing participation by Medicaid recipients in disease management programs. While it is assumed HHSC could complete these activities within existing resources, it is possible that other program activities could be affected. The bill allows HHSC to approve a capitation payment system that provides for reimbursement for physicians under a primary care capitation model or total care capitation model. If the capitated model is used to provide new services, then there would be a cost, however the cost cannot be determined at this time due to uncertainty regarding service utilization.

The bill requires HHSC to conduct
separate studies regarding the following: providing certain services to Medicaid recipients with diabetes; providing certain Medicaid benefits and services through managed care; and providing all Medicaid eligible services not covered by Medicare to dually eligible Medicaid recipients through a managed care model and requiring cost-sharing for those services. If HHSC determines providing certain services to Medicaid recipients with diabetes would improve health outcomes and lower costs, HHSC would be required to develop the program and seek approval from the Legislative Budget Board before implementation. It is assumed HHSC would require 1.5 Program Specialist VI to complete the studies. It is assumed the additional FTEs would only be needed in fiscal years 2022 and 2023 at an estimated cost of $0.2 million each fiscal year.

The bill amends the provisions HHSC is required to include in contracts with manage d care organizations and would require the commission to conduct a study regarding STAR+PLUS capitation rates. HHSC indicates it could absorb these costs within existing resources.

Active Legislation	Impacts
HB 2658: Operation and administration of certain health insurance programs and medical assistance program	• HB 2658 covers multiple topics, including: – Protocol for Ombudsman to collect contact information – Nursing Facility minimum performance standards – Medication Therapy Management (MTM) services – Increase participation in MCO disease management programs – Dental services in STAR+PLUS – School Health and Related Services – rules on parental consent – Quality Incentive Payment Program – Staff-to-Resident ratios – MCO capitation rate and related provisions • HHSC must study and report on several topics

SB 672 – Collaborative care. amends current law relating to Medicaid coverage of certain collaborative care management services. S.B. 672 allows for the use of Collaborative Care Model (CoCM) to address mental health conditions in Medicaid. Mental health disorders are often chronic conditions that people experience along with other health conditions, such as heart disease and diabetes. Yet, according to the Centers for Medicare and Medicaid Services, only 25 percent of patients receive effective mental health care, including in primary care settings, where the majority of patients with mental health conditions receive their usual care.

Research has shown that by not providing early detection and access to behavioral health treatment and/or focusing only on the physical ailment to the detriment of the behavioral health condition, the result is an inefficient system that is producing suboptimal health outcomes at a much higher cost. Significant research spanning three decades has identified one model—the CoCM—in particular, as being effective and efficient in delivering integrated care. Since collaborative care results in earlier diagnoses and treatment—before mental illness reaches a crisis level—it saves taxpayer dollars.

The CoCM uses a team-based, interdisciplinary approach to deliver evidence-based diagnoses, treatment and follow-up care. It integrates physical and mental healthcare under the supervision of a primary care provider with an emphasis on early intervention and measuring progress, just as is done for diabetes or any other

physical health condition. The CoCM can be adapted to rural and urban primary care practices.

Recognizing the effectiveness of this model, many commercial payers and Medicare have already begun reimbursing for this type of care. However, it is not currently covered under Texas Medicaid. By adding a reimbursement for CoCM as proposed by S.B. 672, the state can help improve patient access and outcomes for those suffering from mental health conditions in the Texas Medicaid system, while at the same time, saving taxpayer dollars.

Active Legislation	Impacts
SB 672: Medicaid coverage of collaborative care management services	• Requires HHSC to implement collaborative care management services—behavioral health services provided by a PCP-led team that includes behavioral health providers

Rider 128. Applied Behavior Analysis

Active Legislation	Update
Rider 28: General Appropriations Act includes Federal and General Revenue funding for FY22 and FY23	• Requires implementation by 2/1/22 • HHSC posted responses to public comments on draft policy on 7/30/21 • HHSC posted provider notification with link to Autism Services Policy on tmhp.com on 7/30/21 • Began enrollment of Licensed Behavior Analysts at TMHP on 7/30/21

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Telehealth update

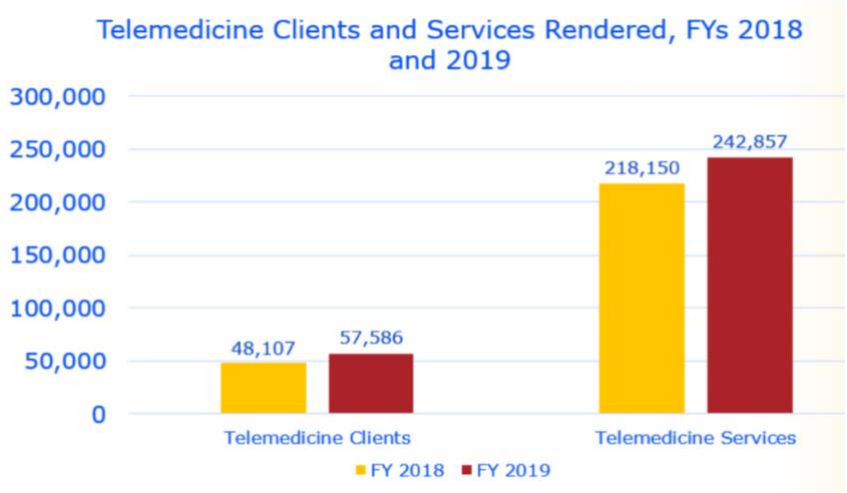
Fee For Service Benefits

Telemedicine Services
- Evaluation and management services
- Psychiatric diagnostic evaluations
- Psychotherapy
- End-stage Renal Disease services
- Inpatient consultation
- Follow-up inpatient consultation
- Federally Qualified Health Center visit

Telehealth Services
- Evaluation and management services
- Psychotherapy services
- Psychotherapy
- End-stage Renal Disease services
- Medical Nutrition Therapy
- Federally Qualified Health Center visit
- School Health and Related Services

S.B. 670, 86th Legislative Session, Regular Session, 2019 prohibits Medicaid health plans from denying reimbursement for telemedicine or telehealth services solely because the service was delivered remotely. Health plans should use clinical and cost effectiveness, among other factors, in making their coverage determinations. Health plans may optionally cover telemedicine or telehealth services delivered as audio-only calls, textonly emails, or faxes.

Telemedicine Utilization FY 2018 and FY 2019



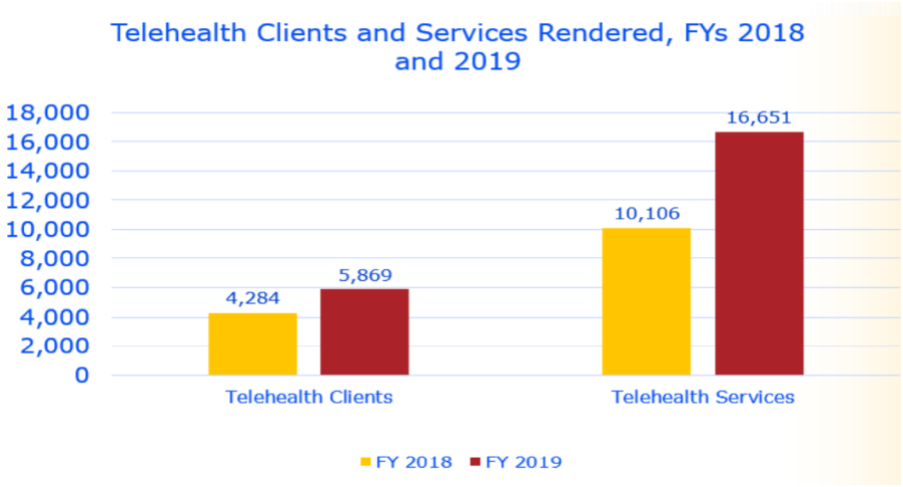
Most common primary diagnoses

- Attention-Deficit Hyperactivity Disorder (ADHD)
- Schizophrenia
- Schizoaffective disorder
- Bipolar disorder

Most common services

- Outpatient office visit
- Psychiatric Diagnostic Evaluation with a medical service
- Psychiatric Diagnostic Evaluation
- Outpatient office visit: Psychotherapy

Telehealth Utilization FY 2018 and FY 2019



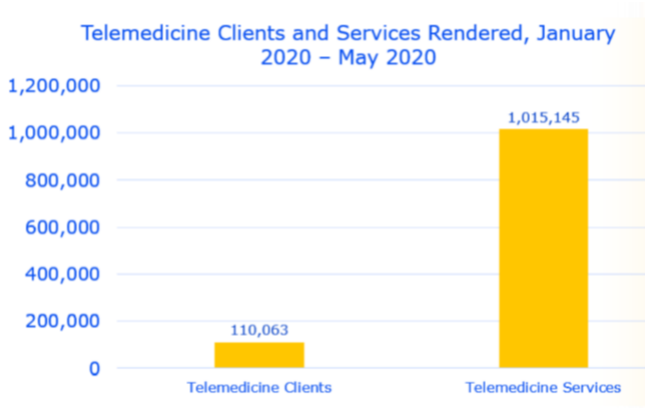
Most common primary diagnoses

- Attention-Deficit Hyperactivity Disorder (ADHD)
- Major depressive disorder
- Schizophrenia
- Bipolar disorder

Most common services

- Outpatient office visit
- Psychiatric Diagnostic Evaluation
- Outpatient office visit: Psychotherapy

Telemedicine Utilization, January 2020 – May 2020



Telemedicine Utilization, January 2020 – May 2020

Most common primary diagnoses

- Hypertension
- Allergic rhinitis
- Major depressive disorder
- Acute upper respiratory infection
- Generalized anxiety disorder

Most common services

- Outpatient office visit
- Clinic visit

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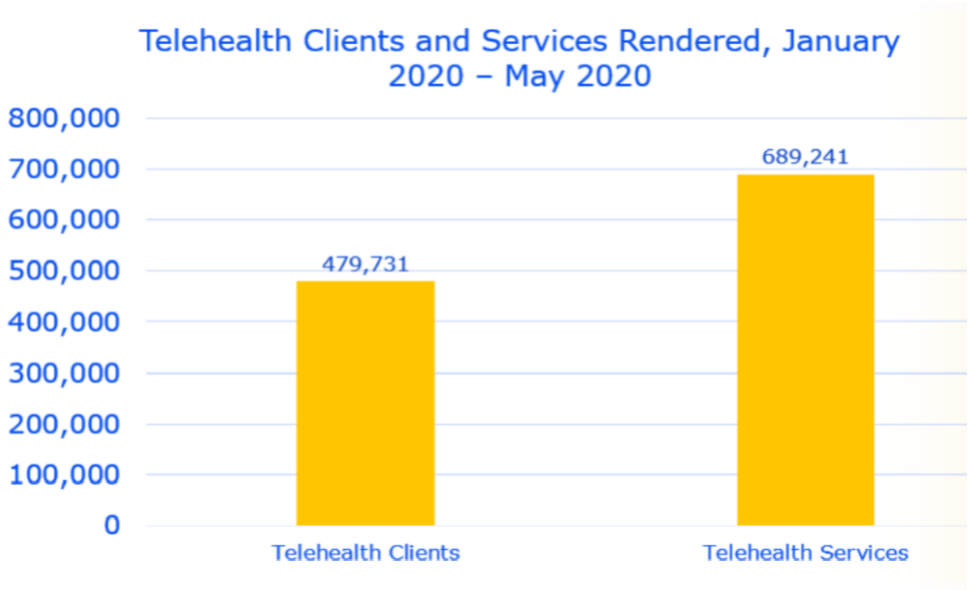
Telehealth Utilization, January 2020 – May 2020



Most common primary diagnoses

- Mixed receptive-expressive language disorder
- Delayed milestone in childhood
- Attention Deficit Hyperactivity Disorder (ADHD)
- Unspecified lack of expected normal physiological development in childhood

Most common services

- Treatment of Speech, Language, Voice, Communication, and/or Auditory Processing Disorder
- Therapeutic Activities, Direct Patient Contact
- Targeted Case Management
- Skills Training and Development

COVID-19 Flexibilities

Extensions are considered on a month-to-month basis

Authorized the following services to be delivered via audio-only modalities:

- Evaluation and Management Services
- Select Behavioral Health Services:
- Psychiatric Diagnostic Evaluation
- Psychotherapy

- Peer Specialist Services
- Screening, Brief Intervention, and Referral to Treatment (SBIRT)
- Substance Use Disorder Services • Mental Health Rehabilitation

Authorized remote delivery for the following services:
• Targeted Case Management •
Authorized remote delivery for Occupational Therapy, Physical Therapy, and Speech Therapy
• Rural Health Center reimbursement for telemedicine and telehealth services
• Federally Qualified Health Center Reimbursement for telemedicine and telehealth services

Texas Medicaid Provider Procedures Manual

Medicaid reimbursement information

- Outlines Medicaid minimum fee-for-service (FFS) medical and dental benefits.
- Procedure codes, places of service, provider types, and any benefit restrictions.
- Available through the Texas Medicaid & Healthcare Partnership (TMHP): http://www.tmhp.com/Pages/Medicaid/Medicaid_P ublications_Provider_manual.aspx

Home and Community Based Services (HCBS) program update on the Electronic Visit Verification (EVV) system. They have fully implemented the CURES Act requirements.
Permanently extend the time from 60 days to 95 days
Cost survey now includes cost items for FMSAs
Working on guidance for FMSAs and employers; guidance is directed to noncompliance through an information letter
Use of EVV when EVV service is used next to a non EVV services
Look at compliance issues to consider the CDS option as well
Revisions have been made to training for CDS options (Also in Spanish)
EVV mailbox has been simplified EVV@HHS.Texas.Gov

Why is transportation not an EVV covered services? The CARES Act requires a definition of a personal care service. Some programs allow transportation, but others do not.

1115 Waiver update. On July 14th the 1115 extension application was submitted. January 28th CMS sent back a completeness letter. There were over 1,000 public comments received. There were numerous comments on budget neutrality. Where we have statutory authority HHSC is proceeding. There is a quarterly monitoring report that will address several the

issues of concern to this group. They are working to address communications. STCs from January are still operational presently. The extension application requests approval by September 30th.

Intellectual or developmental disability redesign and impact to managed care

Chapter 534, Texas Government Code, directs a redesign of Medicaid services for people with intellectual and developmental disabilities (IDD).

- Establish IDD System Redesign Advisory Committee (2014).
- Acute care transition to managed care (2014-2016).
- Community First Choice (2015).
- Evaluations by UT Health and Deloitte (2019).
- Ongoing annual report

House Bill (HB) 4533 Directed the development, implementation and evaluation of a pilot program through the STAR+PLUS Medicaid managed care program to test personcentered managed care strategies and improvements under a capitated model.

Stage one:

- Establish Pilot Program Workgroup (PPW).
- Coordinate and collaborate with PPW and IDD System Redesign Advisory Committee (IDD SRAC).
- Evaluate dental services for pilot participants.
- Develop and implement STAR+PLUS Pilot by September 1, 2023.

Stage two:

Develop and implement a plan to transition the following programs:

- September 2027 - Texas Home Living (TxHmL).
- September 2029 - Community Living Assistance and Support Services (CLASS).
- September 2031 - Nonresidential services provided under Home and Community-based Services (HCS) and Deaf-blind with Multiple Disabilities (DBMD).
- Implement pilot to evaluate feasibility and cost efficiency of transitioning residential services.

STAR+PLUS Pilot Purpose

Test the delivery of long-term services and supports (LTSS) for adults in STAR+PLUS Medicaid managed care with:

- IDD-- Pilot excludes people currently enrolled in an IDD 1915(c) waiver or a community-based intermediate care facility for individuals with an intellectual disability (ICF/IID).
- Traumatic brain injury (TBI) that occurred after the age of 21.
- People with similar functional needs without regard to age of onset or diagnosis.
- Evaluate the pilot and inform the plan to transition all or a portion of services provided through IDD waiver and ICF/IID programs into managed care.

Comprehensive analysis due by Sept. 1, 2026.

- Analyze the experiences and outcomes of system changes.
- Include feedback on the pilot based on personal experiences of pilot participants, families, and providers.
- Include recommendations on:
  - A system of programs and services for consideration by the legislature;
  - Necessary statutory changes; and
  - Whether to implement the pilot statewide under STAR+PLUS for eligible members.

STAR+PLUS Pilot Operation

- One service area selected by the Health and Human Services Commission (HHSC). • HHSC will contract with up to two STAR+PLUS Medicaid managed care organizations (MCOs).
- Pilot participants will have a choice of service delivery options including:
  - Consumer Direction Model; and
  - Comprehensive LTSS Providers
- Term includes 1915(c) IDD Medicaid waiver program providers and ICF/IID program providers.

STAR+PLUS Pilot Enrollment

- Enrollment will be open for a limited time to ensure statistically viable and consistent population.
- Pilot participants will be automatically enrolled with the ability to opt out.
- Informational materials are necessary for pilot participants to make an informed choice to stay in the pilot or opt out.
- Participants will be able to transition to a Medicaid waiver program if their slot becomes available during pilot operation.

STAR+PLUS Pilot Benefits

Benefits listed in statute (Section 534.1045) include:

- Medicaid state plan acute care benefits and LTSS available under STAR+PLUS

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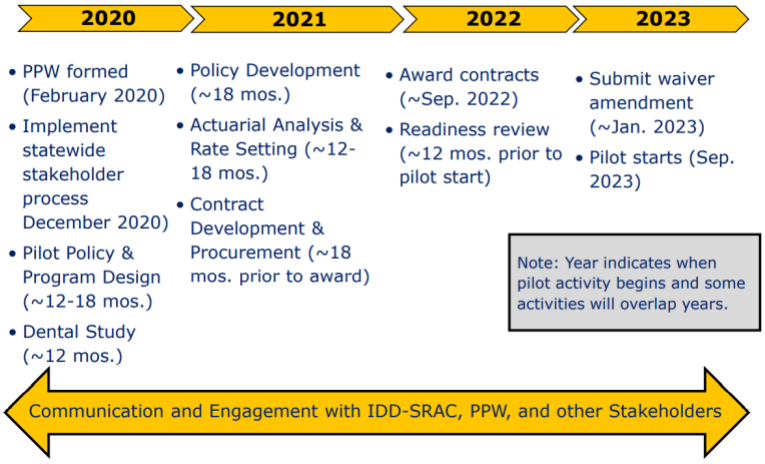
- STAR+PLUS HCBS • LTSS currently provided by 1915(c) waivers
- New LTSS for Texas
- Other non-residential LTSS determined by HHSC and stakeholders to be appropriate for the pilot

Pilot Considerations

Elements of the pilot needing specific consideration per the statute:

- Increasing the use and flexibility of Consumer Directed Services (CDS).
- Improving and increasing access and availability by modifying the following services:
- Adult Foster Care
- Employment Assistance
- Supported Employment

Estimated STAR+PLUS Pilot Timeline



January 2021 -- 87th legislative session exceptional item is focusing on development of the pilot and requisite infrastructure to ensure the pilot is operational by Sept. 1, 2023.

January 2023 • 88th legislative session will focus on operation of the pilot.

Next Steps

- Continue collaboration with IDD SRAC and SP3W in planning the STAR+PLUS Pilot Program.
- Current and upcoming pilot topics include:
  - Outreach and education plan for potential participants and providers;
  - Innovative technologies;

- Process to ensure pilot participants remain eligible for Medicaid for 12 consecutive months during the pilot operation;
- Alternate payment methodologies; and
- Measurable goals and evaluation.

Questions/Answers/Comments

Is it possible for some services to remain outside of Managed Care? HHSC stated that is a very real possibility.

Public comment. No public comment was offered

Review of action items and agenda items for future meeting

- Discussion and update of the directed payment programs
- Information about COVID funding

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

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