HHSC: Medical Care Advisory Committee
June 10, 2021

Welcome, introductions, and opening remarks. The meeting was convened by The Chair, Colleen Horton. The Chair stated that in addition to rule review, the meeting was being used to provide public comment on the 1115 Waiver renewal application. She stated that the MCAC did not have authority over the waiver.

Consideration of February 11, 2021, meeting minutes. The minutes were approved as written

Medicaid and Children's Health Insurance Program (CHIP) activities. The regular legislative session ended May 31. Bills that passed and Exceptional Items were reviewed. **Funded Exceptional Items included:**

- Implied behavioral analysis for Autism
- Removing PA requirements for antivirals for Hep C
- Individualized Skills and Socialization –Day Hab
- Pilot of LTSS through Star Plus managed care
- Release certain interest list slots
- EVV and claims system review

Bills of interest included:

HB4 -- 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 would 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.

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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.

It is unknown how these changes will impact service utilization.

HB133 -- 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 would be required to provide certain information regarding premium subsidies available for health benefit plans to certain women enrolled in HTW. HHSC would be required to work with the Texas Department of Insurance (TDI) to develop this information. Additionally, HHSC would be 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.

HB290 as amended to HB 2658-- The bill requires 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 requires HHSC to develop a procedure for informing Medicaid recipients 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

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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 amends 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 requires 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 time 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 programs 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 requires 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 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 provided 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 would be 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 would be 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 would be 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 would allow 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 managed 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.

The Health and Human Services Commission is required to implement this Act only if the legislature appropriates money specifically for that purpose.

HB3720-- The bill requires the Health and Human Services Commission (HHSC), in consultation with the Intellectual and Developmental Disability System Redesign Advisory Committee, State Medicaid Managed Care Advisory

Committee, and other stakeholders, to develop a questionnaire for individuals on an interest list for a Medicaid waiver program, including: Community Living Assistance and Support Services (CLASS); Home and Community--based Services (HCS); DeafBlind with Multiple Disabilities (DBMD); Texas Home Living (TxHmL); Medically Dependent Children Program (MDCP); and STAR+PLUS Home and Community-Based Services (STAR+PLUS HCBS). An individual who is on an interest list who does not respond to requests for updates to interest list information or does not maintain contact with HHSC would be considered inactive until they make contact with HHSC. This analysis assumes there would be a minimal cost associated with implementing the provisions that could be absorbed within current resources.

The bill requires the executive commissioner of HHSC to appoint an additional member to the Long-Term Care Facilities Council that meets certain criteria. The bill would amend Health and Safety Code Chapter 252 to limit the total amount of administrative penalties that a facility can be assessed. The bill would also require the executive commissioner of HHSC to develop and adopt rules regarding the application of certain administrative penalties no later than December 1, 2021.

This analysis assumes any cost to implement provisions of the bill related to adding a member to the Long-Term Care Facilities Council and rulemaking would be minimal and could be absorbed within available resources. However, according to information provided by HHSC, limiting the amount of administrative penalties that can be assessed on a facility could reduce revenue to the state. An estimate of the reduction in revenue cannot be determined at this time because it is unknown how the provisions of the bill will impact the behavior of facilities in how they address noncompliance without aggregate penalties.

The Health and Human Services Commission is required to implement this Act only if the legislature appropriates money specifically for that purpose.

For these and other bills, implementation plans are being developed.

Nonemergency medical transportation services were transferred June 1 to the MCOs. The transition is being monitored and data will be analyzed.

Federal funding for HCS is increasing through an enhanced match and the deadline is July 12.

The Chair asked if anything is being developed around behavioral health services for people with IDD. HHSC stated that they do not recall anything coming from the Legislature, but they will check with staff.

The chair inquired about a number of items have been submitted for new or expanded services. Will those be receiving focus by HHSC. HHSC stated that there is a review process for benefits review. It is an ongoing process and that will continue. Items have to be prioritized. Proposals should be evidence based and meet other criteria.

COVID-19 update. Vaccines are up, and cases are down. Worldwide there are 174 million confirmed cases, but new cases are steadily declining. There are certain hot spots that continue across the globe. The USA is the

highest in the world with number of cases. While, the United States has the highest number of deaths, the death rate has been declining and seems to have plateaued.

Texas has 2.5 million cases with 50,600 deaths. Hospitalizations have reached a one year low. The positivity rates are now around 3%.

Variants continue to be of great interest. This is an RNA virus and this type of virus often leads to mutations. The Medical Director commented on the different variants. There are activities now that CDC says people can engage in if they are fully vaccinated.

Pfizer has applied for a full FDA license for their vaccine. The age range has been expanded down to age 12. Vaccines are now able to be stable for one month in a refrigerator after thawing.

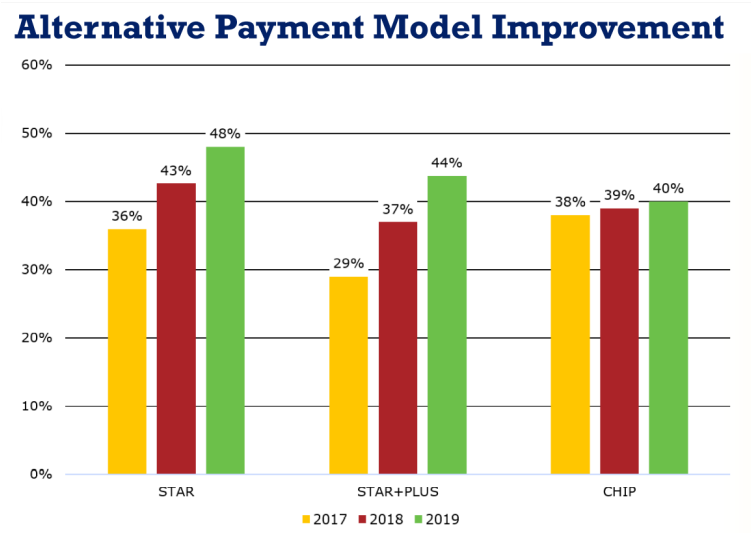
Myocarditis is being investigated related to COVID vaccine. He reviewed some global statistics. 311,000 children have been vaccinated in Texas, 12 years and up.

The Chair inquired about how we have been collecting data showing disparities among different groups and how will the data be used to improve the systems. He stated that DSHS has a breakout of different groups on their dashboard. HHSC is conducting a study looking at disparities among different groups. Phase one has been concluded. Phase one is available on the website.

Extension for the 1115 Waiver: Texas Healthcare Transformation and Quality Improvement Program

Texas has implemented initiatives to improve managed care organization's accountability for quality of care

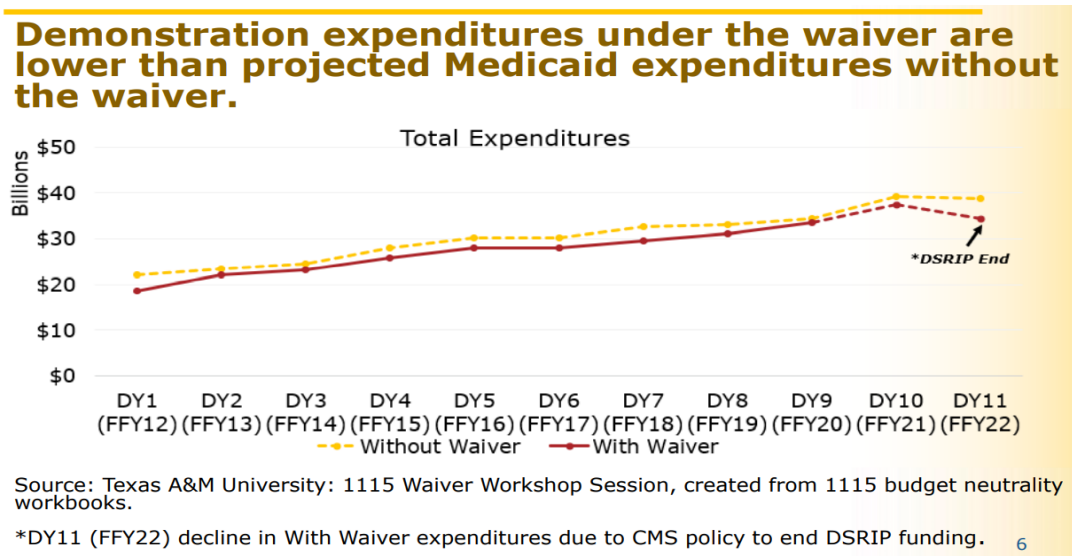
- Medical Pay-for-Quality program
- Dental Pay-for-Quality program
- Performance Indicator Dashboards
- MCO Report Cards
- "Secret shopper" monitoring of provider access and availability



Supplemental Payments

Delivery System Reform Incentive Payments • Ends Sept. 30, 2021 • DSRIP transition continues to advance value-based care and other effective delivery system reforms	Uncompensated Care Payments • Transitioned to charity care on October 1, 2019

Budget Neutrality



Initial Evaluation

December 2011 – September 2016

Domain	Population
Increased access to care	STAR, STAR+PLUS
Increased utilization	STAR, STAR+PLUS
Increased care coordination	STAR+PLUS
Reduced hospitalizations	STAR, STAR+PLUS
Reduced potentially preventable hospitalizations	STAR, STAR+PLUS

Renewal Evaluation

January 2018- September 2022

Domain	Population
Increased access to care	Adoption Assistance, Children's Medicaid Dental Services, Medicaid for Breast and Cervical Cancer, Nursing Facility, STAR Kids
Increased care coordination	Former Foster Care Children, STAR Kids
Increased quality of care	Nursing Facility, STAR Kids
Improved health outcomes	Children's Medicaid Dental Services, Medicaid for Breast and Cervical Cancer, Nursing Facility, STAR Kids
Increased client satisfaction	STAR Kids

Source: Texas A&M University: Preliminary Draft Results, 1115 Waiver Workshop, and Draft Interim Report; The Institute for Child Health Policy, the University of Florida: STAR Kids Program Focus Study Summary Report.

Extension

Maintain Continuity

- Texas Medicaid has a mature 1115 waiver inclusive of:
- 17 Medicaid Managed Care Organizations
- 288 Performing providers in Delivery System Reform Incentive Program (DSRIP)
- 864 Nursing facilities in Quality Incentive Payment Program (QIPP)

- 529 Providers in the Uncompensated Care Program
- 3 Dental Maintenance Organizations
- HHSC will continue to advance the goals of the waiver under this extension and align new programs with overall Medicaid

Requested Programs

- Comprehensive Hospital Increased Reimbursement Program (CHIRP) $5,020,000,000
- Quality Incentive Payment Program (QIPP) $1,100,000,000
- Texas Incentives for Physicians and Professional Services (TIPPS) $600,000,000
- Rural Access Primary and Preventive Services (RAPPS) $18,700,000
- Ambulance Average Commercial Reimbursement Program $150,000,000
- DPP for Behavioral Health Services (DPP BHS) $165,575,152

The chair inquired why we have not included more for people with disabilities. HHSC stated we are looking at the pilot programs. Certain services are not included at this time under the waiver. The chair stated that flexibility is important through the DSRIP projects and as such could accommodate more people with disabilities. The chair stated a concern about managing gaps in service during the transition.

Public Health Providers Extension creates the Public Health Provider Charity Care Program (PHP-CCP)

- Begins on October 1, 2021/End of DSRIP
- Offsets costs associated with care, including behavioral health, immunizations, chronic disease prevention and other preventive services for the uninsured
- Public providers only
- Financed by certified public expenditures
- Year 1 & 2 will be up to $500 million

Uncompensated Care Pool Resizing --The UC Pool will be resized twice

- First re-sizing will take place in DY11 to take effect in DY12 (FY2023)
- In recognition that the PHE will impact FY20 and FY21 cost report data, re-sizing will use the 2019 cost reports and the 2017 DSH payment data
- Second re-sizing will take place in DY16 to take effect in DY17 (FY2028)
- Sizing will use the 2025 cost reports and 2023 DSH payment data
- Re-sizing will allow for adjustments to uncompensated care pool based on actual charity care

Budget Neutrality--Key Principles

- Extension preserves budget neutrality and creates room for DSRIP transition, including directed payment and charity care programs
- Without Waiver expenditures will be rebased and include directed payment program funding
- Adjustment for COVID-19 impact on enrollment and expenditures
- DSRIP Transition Programs and Public Health Provider funding is sustainable
- Extension achieves an estimated $10 billion in vital budget neutrality

Monitoring & Reporting-- New STCs emphasize importance of monitoring and reporting

- COVID-19 disrupted data collection
- Terms negotiated with CMS
- Emphasize the responsibility of the state to provide oversight of funds
- Require additional reporting on sources of funds
- Require new Home and Community Based Services (HCBS) reporting
- Require a new HCBS Quality Assurance Report
- Require more frequent monitoring reports

External Evaluation --New Evaluation Design for the Extension

- Purpose: Provide insight into whether the state is progressing on the overarching goals of the Demonstration
- Main components:
    - Medicaid Managed Care
    - Directed Payment Programs
    - Supplemental Payment Pools
    - Uncompensated Care
    - Public Health Providers Charity Care
    - Cost outcomes for the demonstration as a whole
- Three Interim Evaluation Reports:
    - March 2024
    - March 2027
    - September 2029
- One Summative Evaluation Report: March 203

Waiver Extension -- Potential of $11.4 billion per year on average

- Includes $3.9 billion per year for payments for uncompensated care
- Includes $500 million per year for payments for new Public Health Provider-Charity Care Program
- Includes opportunity for $6.9 billion per year for quality and access improvements
- Saves an estimated $10 billion in taxpayer funds over the life of the waiver

June 15, 2021 / 10:00 am-- 1115 Transformation Waiver: Extension Application Public Hearing (live and virtual). HHSC is taking input through mail, email, public input, virtual input.

MCAC Comment/Questions:

Timeline? There is not a CMS timeline at this time. HHSC is working as fast as they can. The earliest the application can be submitted is July 13th.

Disparities and inequities—how are we building into the processes the ability to identify and remediate these. HHSC stated that there are built in data categories and the design of the categories will be included in the application. HHSC has the ability to create better feedback loops for action.

How is psychiatry involved in the secret shopping and time required to access services? HHSC stated they will follow up on the question.

Compliance is important, but it can stifle innovation.

Public Comment/Testimony (Three-minute time limit)

Bob Kafka, ADAPT of Texas and Personal Attendant Coalition of Texas stated that the MCAC has an opportunity to comment on HCS and managed care. Currently Medicaid Managed Care is the largest provider of services to people with disabilities. HHSC can reform the LTSS critical issues of:

- Shortage of primary workers
- Community attendant shortages (average salary is $9-$9.50 tops. Base is $8.11)
- Congregate care is not where people need to be. People are dying in nursing facilities
- Hospital to Home services are available

The waiver is focused on the acute side. Texas has been a leader integrating LTSS into managed care. The residential congregate settings pay better for attendant care than the community programs can do.

The Chair asked HHSC if there is a place to address reimbursement rates. HHSC stated that under the waiver they are confined to the appropriation provided.

The general discussion was around the need to include to the extent possible, LTSS into the waiver.

Bolivar Fraga stated that this waiver should be used to provide medical coverage for people who are low income workers (too much money for Medicaid and not enough to purchase insurance).

John Asbury, MD stated the majority of his patients are Medicaid covered. He stated that jail diversion was beneficial. We have to address the issue of access to care. Effort should go to the funding for a medical home for the individual. We have got to do better. Adequate funding for basic care should precede enhanced care. Bureaucracy has bogged down the practice of medicine.

Flora Brewer, Paulist Foundation commented on people with health problems and who have experienced trauma. There are housing access problems. Most in their program do not have SSI or SSDI. Medicaid provides a better quality of care than under the waiver for their clients. She provided an example of a client with a chronic condition. She encouraged Medicaid expansion.

Christina Hopi, Children's Hospital Association stated that they support the extension of the waiver as approved by CMS in January 2021. About half of the children in Texas are covered by Medicaid or CHIP. Children have not been the focus under the present waiver, though some services are available. She emphasized the following:

- Budget neutrality should be at the same level or better than January 2021
- Continue funding for the UC pool

- Prioritize children

Ramirez called but no testimony was provided

John Hawkins, THA stated their support for the extension. Coverage expansion for the uninsured would be the best approach. We would still have uncompensated care. The budget neutrality is key, and we have to capitalize in the savings and redirect that to other areas as we transition out of DSRIP. The waiver needs a state share and the state has not put in GR. We need a strong UC pool.

Anne Keehan stated that people are struggling because they don't have insurance.

Amy Hoard, Nonprofit mental health organization stated that the 1115 waiver has been key in addressing mental illness. She commented on school-based programs and identification efforts. Jail diversion makes a difference to the community.

Chris Garcia stated he has experienced employment separation. He cannot afford medical insurance. He hopes Medicaid expansion or the waiver could help him get medical care.

For Action Items and Information Items, only items with a live link were presented. Others were postponed.

Action Items:

WITHDRAWN Health and Human Services Commission (HHSC) Interest Lists waiver programs- *Jennifer Chancellor-Hurd, Long Term Services and Supports Policy Unit Manager, HHSC*

The primary purpose of the proposed rule amendments is to implement Texas Government Code §531.0601, Long-term Care Services Waiver Program Interest Lists. They provide that individuals who are enrolled in but become ineligible for the Medically Dependent Children Program may have their names returned to the interest list or placed on that of Home and Community-based Services, Texas Home Living, Deaf Blind with Multiple Disabilities, or Community Living Assistance and Support Services. The proposed amendments describe the circumstances under which these actions may be taken.

Drug Utilization Review Board (DURB) and conflict of interest *- Stacey Johnston, Director of Pharmacy Operations, HHSC Vendor Drug Program*

The proposed amendments to Title 1, Texas Administrative Code (TAC), §354.1941 and §354.1942 strengthen current conflict-of-interest policies applicable to the DURB. These strengthened policies increase transparency by requiring DURB members to disclose financial relationships with drug manufacturers or labelers with products before the DURB; minimize the opportunity for pharmaceutical manufacturers or labelers to influence a member of the DURB when making recommendations about the Medicaid Preferred Drug List; and increase public

confidence in DURB decisions.

Background. To increase transparency about financial and other relationships members of the Texas Drug Utilization Review Board (DUR Board) may have with drug manufacturers with business before the DUR Board, HHSC determined to strengthen the conflict-of-interest provisions to which the members of the DUR Board are subject. In Texas, the DUR Board makes recommendations about the drugs that should be included on the Medicaid Preferred Drug List (PDL) and whether drugs will be subject to PDL prior authorizations and suggestions on clinical prior authorizations.

The proposed amendments strengthen current conflict-of-interest policies applicable to the DUR Board. These strengthened policies increase transparency by requiring DUR Board members to disclose financial relationships with drug manufacturers or labelers with products before the DUR Board, minimize the opportunity for pharmaceutical manufacturers or labelers to influence a member of the DUR Board when making recommendations about the PDL, and increase public confidence in DUR Board decisions.

Other proposed amendments ensure DUR Board membership aligns with the Social Security Act §1927(g)(3) and Texas Government Code §531.0736; define terms; and align language with state and federal definitions.

Fiscal Impact: No fiscal impact reported.

Rule Development Schedule

June 10, 2021	Present to the Medical Care Advisory Committee
June 24, 2021	Present to HHSC Executive Council
July 2021	Publish proposed rules in Texas Register
November 2021	Publish adopted rules in Texas Register
November 2021	Effective date

Questions and Comments

The chair inquired why family members were not included in definition. HHSC stated they will follow up with that. The Chair commented on the mitigation section and conflict of interest.

MOTION: Approval of the rule prevailed

WITHDRAWN State Medicaid Managed Care Advisory Committee (SMMCAC) - *Michelle Erwin, Deputy Associate Commissioner, HHSC Medicaid/CHIP Services*

The primary purpose of amending TAC, Title 1, §351.805 is to implement changes recommended by SMMCAC in March 2020 and to make additional changes recommended by HHSC staff. These edits reorganize and format the rule so that the SMMCAC rule is consistent with other HHSC advisory committee rules established under Texas Government Code §531.012.

WITHDRAWN Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions Legislative Implementation and Updates. *- Diana Conces, Director of HHSC Long Term Care Policy & Rules*

The amendments and repeals to Title 26, TAC, Chapter 551 are intended to implement the changes made to Texas Health and Safety Code Chapters 81 and 252, by House Bills (HBs) 1848 and 3803, 86th Legislature, Regular Session, 2019. HB 1848 amends the requirements of a long-term care facility's infection prevention and control program to include monitoring key infectious agents, including multidrug-resistant organisms and procedures for making rapid influenza diagnostic tests available to facility residents. HB 3803 sets the maximum amount of an administrative penalty assessed each day a violation occurs or continues to occur. Additionally, the amendments and repeals reflect the transition from paper applications to the use of the online licensure portal, called the Texas Unified Licensure Information Portal, and clarify other processes relating to licensure.

Informational Items:

Public Health Provider Charity Care Program (PHP-CCP) - *Mohib* Nawab, Senior Financial Analyst, HHSC Provider Finance

This rule authorizes HHSC to implement the PHP-CCP under the 1115 waiver to reimburse certain costs for qualifying providers that provide care, including behavioral health, immunizations, chronic disease prevention and other preventative services for the uninsured. This program was created as part of the 1115 waiver extension and will provide an opportunity for reimbursement of charity care costs (or Medicaid shortfall in the first year of the program). The rule describes the requirements for participation in the PHP-CCP.

Background. The purpose of the new rule is to authorize HHSC to implement the PHP-CCP under the 1115 waiver to reimburse certain costs for qualifying providers associated with providing care, including behavioral health, immunizations, chronic disease prevention and other preventative services for the uninsured. This program was created as part of the 1115 waiver extension and will provide an opportunity for reimbursement of charity care costs (or Medicaid shortfall in the first year of the program).

The rule describes the requirements for participation in the PHP-CCP. In accordance with the Special Terms and Conditions of the 1115 waiver, to participate in the program, providers must be funded by a unit of government to be able to certify public expenditures. Publicly-owned and operated Community Mental Health Clinics (CMHCs), community centers, Local Behavioral Health Authorities (LBHAs) and Local Mental Health Authorities (LMHAs) that are established under the Texas Health and Safety Code Chapters 533 or 534 and are primarily providing behavioral health services, and Local Health Departments (LHDs) that are established under the Texas Health and Safety Code Chapter 121 are eligible to participate

Fiscal Impact. HHSC anticipates there may be a fiscal impact to state and local governments for reimbursement to qualified providers for the cost of delivering behavioral health and other qualifying services to include

uncompensated care costs or uninsured costs. HHSC has insufficient information to provide an estimate as participation in the program is voluntary.

Rule Development Schedule.

March 2021	Publish proposed rules in Texas Register
May 2021	Publish adopted rules in Texas Register
May 2021	Effective Date
June 3, 2021	Present to the Hospital Payment Advisory Committee
June 10, 2021	Present to the Medical Care Advisory Committee
June 24, 2021	Present to HHSC Executive Council

Payments to Public Health Providers for Charity Care Program – Year 2 and Beyond - *Mohib Nawab, Senior Financial Analyst, HHSC Provider Finance Department*

This proposal establishes enhanced supplemental payments to publicly owned ground emergency ambulance service providers. These providers currently receive both fee-for-service and supplemental payments to cover uncompensated care costs. Subject to approval by the Centers for Medicare and Medicaid Services, the proposed amendment will make publicly owned ground emergency ambulance providers eligible for additional payments for services up to the average rate payable by commercial insurers for those services.

Background. The Texas Health and Human Services Commission (HHSC) proposes new Section 355.8217, concerning Payments to Public Health Providers for Charity Care. The purpose of the new rule is to authorize HHSC to implement the Public Health Provider – Charity Care Program (PHP-CCP) payments to be available for eligible providers. These payments will help defray the uncompensated costs of charity care, beginning October 1, 2022. PHP-CCP uncompensated care payments to eligible providers before October 1, 2022, are described in 1 TAC Section 355.8215, Public Health Provider – Charity Care Program. The PHP-CCP under the 1115 waiver reimburses certain costs for qualifying providers associated with providing care, including behavioral health, immunizations, chronic disease prevention, and other preventative services for the uninsured. This program was created as part of the 1115 waiver extension and will provide an opportunity for reimbursement of charity care costs (or Medicaid shortfall in the first year of the program). In accordance with the Special Terms and Conditions of the 1115 waiver, to participate in the program, providers must be funded by a government unit able to certify public expenditures. Publicly-owned and operated providers eligible to participate include:

The following providers established under Texas Health and Safety Code Chapters 533 or 534 and primarily providing behavioral health services:

- Community Mental Health Clinics (CMHCs)
- Community Centers
- Local Behavioral Health Authorities (LBHAs)
- Local Mental Health Authorities (LMHAs)
- Local Health Departments (LHDs);
- and Public Health Districts (PHDs) established under the Texas Health and Safety Code Chapter 121

Fiscal Impact. No fiscal impact was reported.

Rule Development Schedule

May 2021	Publish proposed rules in Texas Register
June 3, 2021	Present to the Hospital Payment Advisory Committee
June 10, 2021	Present to the Medical Care Advisory Committee
June 24, 2021	Present to HHSC Executive Council
September 2021	Publish adopted rules in Texas Register
September 2021	Effective Date

Disproportionate Share Hospital Reimbursement Methodology - *Rene Cantu, Director of Hospital Finance, HHSC Provider Finance Department*

HHSC proposes to amend Title 1, §355.8065 of TAC, concerning Disproportionate Share Hospital Reimbursement Methodology. Historically, HHSC has allowed State Institutions for Mental Diseases (IMDs) to participate in the Disproportionate Share Hospital program, and they are treated in the same way as state hospitals. However, the rule does not explicitly reference State IMDs or state that State IMDs have been recognized as providers for years. The amendment broadens the definition of state-owned hospitals to include these hospitals.

Background. The Texas Health and Human Services Commission (HHSC) proposes to amend §355.8065, concerning Disproportionate Share Hospital Reimbursement Methodology. Historically, HHSC has allowed State Institutions for Mental Diseases (IMDs) to participate in the Disproportionate Share Hospital (DSH) program, and they are treated in the same way as state hospitals. However, the rule does not explicitly reference State IMDs, or that State IMDs have been recognized as providers for years. The amendment broadens the definition of state-owned hospitals to include these hospitals.

The definition of Urban public hospital – Class one is being amended to clarify that the providers in this class must be owned and operated by an entity listed in the definition.

The DSH rule currently requires providers to maintain a Trauma system designation or actively pursue one, but there are several providers that do not have them because this designation does not fit the hospital's function. Children's hospitals, IMDs, and State IMDs generally fall into this misalignment category. The rule makes no mention of an exemption for these providers, and HHSC the amendment will explicitly exempt these providers.

The DSH rule has no provision for the DSH advanced payment methodology and leaves it up to HHSC's discretion. The Provider Finance Department has been using a methodology for several years to accomplish this payment and the proposal incorporates the established methodology into the rule. The existing rule provides that HHSC can redistribute recouped funds to eligible providers but does not describe the method of the calculation. HHSC is proposing two methods of calculation. The first method will be used in DSH years 2011-2017 and 2020 and after and would redistribute funds proportionately to remaining Hospital Specific Limit (HSL) room for eligible hospitals.

For DSH years 2018-2019 HHSC will use a second method. Recouped funds from non-state providers will be redistributed to eligible providers using a weighted allocation methodology.

First, HHSC will calculate a weight that will be applied to all providers. The weight is calculated based on the provider's final remaining HSL with and without the offset of payments for third-party and Medicare claims and encounters where Medicaid was a secondary payer to determine how significantly the provider's HSL was impacted by not offsetting these payments. Providers who did not have a significant change in their HSL will receive a larger weight. After calculating the weighting factor, HHSC will make a first pass allocation by multiplying the weight by the provider's final remaining HSL with the offset of payments for third-party and Medicare claims and encounters where Medicaid was a secondary payer. HHSC will divide the product by the total remaining HSLs for all providers and multiply the quotient by the total amount of recouped dollars available for redistribution. HHSC will limit a provider's payment to the amount of the provider's final remaining HSL.

If a provider is allocated a payment amount that is higher than its remaining HSL, HHSC will make a second pass allocation to redistribute the excess funds using the remaining HSL for all providers without applying the weight. Recouped funds from state providers will be redistributed proportionately to eligible state providers based on the percentage that each eligible state provider's remaining final HSL calculated in the reconciliation described in §355.8065(q) is of the total remaining final HSL of all eligible state providers.

The low-income utilization rate (LIUR) is a ratio that represents the hospital's volume of inpatient charity care relative to total inpatient services. As currently defined, several providers have a LIUR of over one hundred percent, and HHSC proposes to amend the rule to address this.

The rule is also being amended to align with federal statute. LIUR methodology currently inflates the LIUR for providers and results in unreasonably large LIURs guaranteeing qualification. The federal LIUR methodology better represents a provider's low-income utilization and results in more accurate qualifications. Accordingly, fewer providers qualify solely on their LIUR; however, providers may still qualify for DSH with one of the other two qualifications. A potential issue that could arise is the possibility of some providers not qualifying that would have qualified under the previous LIUR.

A workgroup has been formed with stakeholders to ensure the DSH program is viable. HPAC did not have any comments or concerns raised.

Fiscal Impact. No fiscal impact reported

Rule Development Schedule

March 2021	Publish proposed rules in Texas Register
May 2021	Publish adopted rules in Texas Register
May 15, 2021	Effective date
June 10, 2021	Present to the Medical Care Advisory Committee
June 24, 2021	Present to HHSC Executive Council

Quality Incentive Payment Program (QIPP) Accelerated Payment and Metric Rule Change
- Samuel West, Manager, HHSC Research, Development and Methodology

HHSC is proposing to amend the QIPP quality year as well as certain component funding allocations beginning in program year five. Title 1, §353.1302 of TAC would adjust QIPP funding to increase the allocation from 30 percent to 40 percent in Component 2 and decrease the allocation from 70 percent to 60 percent in Component 3. The additional proposed amendments would discontinue an unnecessary requirement, provide increased clarity, and ensure that the language in this section corresponds to similar language in other sections. Title 1, TAC, §353.1304would be amended to remove set types of quality metrics and related performance requirements for each program year in favor of a public notice and hearing process.

Background. The Texas Health and Human Services Commission (HHSC) proposes to amend Texas Administrative Code (TAC) Title 1, Part 15, Chapter 353, Subchapter O, Section 353.1302, relating to Quality Incentive Payment Program for Nursing Facilities on or after September 1, 2019, and Section 353.1304, Quality Metrics for the Quality Incentive Payment Program for Nursing Facilities on or after September 1, 2019. The proposed amendments to Section 353.1302 adjusts the Quality Incentive Payment Program (QIPP) funding allocation to increase the allocation percentage from 30 percent to 40 percent in Component 2 (paid monthly) and decrease the allocation percentage from 70 percent to 60 percent in Component 3 (paid quarterly).

The additional proposed amendments would discontinue an unnecessary requirement, provide increased clarity, and ensure that the language in this section corresponds to similar language in other sections of Subchapter O. The proposed amendments to Section 353.1304 remove set types of quality metrics and related performance requirements for each program year in favor of a public notice and hearing process. This proposed change allows the program to be adapted on an annual basis to ensure quality objectives are continually improved. This amendment would also clarify HHSC's validation requirements for reviews of self-reported data in the program.

It does not change the overall cost to the program, it provides more cash in a timelier manner. The total amount does not change.

Fiscal Impact. No fiscal impact reported

Rule Development Schedule

May 2021	Publish proposed rules in Texas Register
June 10, 2021	Present to the Medical Care Advisory Committee
June 24, 2021	Present to HHSC Executive Council
August 2021	Publish adopted rules in Texas Register
September 1, 2021	Effective date

Inpatient Hospital Reimbursement - *Megan Wolfe, Deputy Director, HHSC Provider Finance*

The aim of this amendment to Title 1, TAC, § 355.8052 is to comply with Texas Government Code §531.02194, as

adopted Senate Bill (SB) 170, 86th Legislature, Regular Session (2019), and Texas Health and Safety Code Chapter 241, Subchapter K, as adopted by SB 1621, 86th Legislature, Regular Session (2019), and to make other amendments to enhance clarity, consistency, and specificity. In accordance with Texas Government Code §531.02194, HHSC is required, to the extent allowed by law, to calculate Medicaid rural hospital inpatient rates using a cost-based prospective reimbursement methodology. Additionally, HHSC must calculate rates for rural hospitals once every two years, using the most recent cost information available. The current rule does not require a biennial review of the rural hospital rates. Rates have not been realigned or rebased since state fiscal year 2014. The proposed amendment adds a Medicaid minimum fee schedule for all rural hospitals to conform the rule to the contracts; arranges the rule by hospital type; adds and modifies definitions, including "rebasing" and "realignment"; and specifies a policy for updating Diagnosis Related Group statistical calculations.

Background. The Texas Health and Human Services Commission proposes to amend §355.8052, relating to Inpatient Hospital Reimbursement. The purpose of the proposed amendment to Section 355.8052 is to comply with S.B. 170, 86th Legislature, Regular Session 2019 and S.B. 1621, 86th Legislature, Regular Session, 2019. HHSC is required by S.B. 170, to the extent allowed by law, to calculate Medicaid rural hospital inpatient rates using a cost-based prospective reimbursement methodology. Additionally, HHSC must calculate rates for rural hospitals once every two years, using the most recent cost information available. The current rule does not require a biennial review of the rural hospital rates. Rates have not been realigned or rebased since state fiscal year 2014. Previously, HHSC converted the rural hospital reimbursement from the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) to the prospective payment All Patient Refined Diagnosis Related Group (APR-DRG) methodology.

Pursuant to S.B. 170 and S.B. 1621, HHSC's managed care contracts require MCOs to reimburse rural hospitals using a minimum fee schedule for services delivered through the Medicaid managed care program. The proposed amendment adds subsection (e)(4), requiring a Medicaid minimum fee schedule for all rural hospitals, to conform the rule to the contracts.

Presently, §355.8052 explains the standard dollar amount (SDA) rate setting process by addressing the multiple hospital types (rural, urban, and children's) concurrently. The proposed amendment arranges the rule by hospital type to enhance clarity, consistency, and specificity. The amendment adds and modifies definitions, including rebasing and realignment. The proposed amendment also specifies a policy for updating DRG statistical calculations to align with 3MTM Grouper changes

Fiscal Impact. No fiscal impact reported

Rule Development Schedule

June 2021	Publish proposed rules in Texas Register
June 3, 2021	Present to the Hospital Payment Advisory Committee
June 10, 2021	Present to the Medical Care Advisory Committee
June 24, 2021	Present to HHSC Executive Council
August 2021	Publish adopted rules in Texas Register
September 1, 2021	Effective date

The chair inquired about the winners and losers under the realignment. HHSC stated that there were public comments sought in 2020 specifically for rural hospitals. There is a rebasing and a realignment… these are different things. The rebasing is more complex.

WITHDRAWN Disaster Rule Flexibilities for Community Behavioral Health Providers - *Corliss Powell, Director, HHSC Behavioral Health Services Operations*

The purpose of this proposal is to allow HHSC flexibility to waive certain requirements for the delivery of services in response to a declared disaster. The proposed new rule is based on the existing emergency rule created in 26 TAC §306.1351, relating to COVID-19 Flexibilities. This proposal creates a standing rule, allowing providers subject to the rule to operate with the same flexibilities afforded by the emergency rule and ensuring continuity of services for individuals receiving community-based behavioral health services.

WITHDRAWN Medicaid Bed Reallocation
- Diana Conces, Director of HHSC Long Term Care Policy & Rules

This proposed new rule is to implement Texas Health and Safety Code §533A.062, as amended by HB 3117, 86th Legislature, Regular Session, 2019, requiring HHSC to develop a process to redistribute Medicaid beds in existing intermediate care facilities for individuals with an intellectual disability or related conditions as per the authority of the State Plan for Individuals in Intermediate Care Facilities Intellectual and Developmental Disorders (ICF/IDD). Adding a new rule to 26 TAC Chapter 261 will enable HHSC to reallocate available beds reverted to HHSC due to provider closure or expiration of beds in suspension. With the addition of new §261.220, ICF/IID providers can apply to HHSC to request up to a maximum of six additional beds if they choose. This new rule formalizes the current process for Medicaid bed reallocation authorized by the Long-Term Care Plan for Individuals with Intellectual Disabilities and Related Conditions, based on Texas Health and Safety Code §533A.062(b-1), relating to Plan on Long-Term Care for Persons with an Intellectual Disability.

Public comment. Several people registered but did not call in by the time of public comment agenda item.

Proposed next meeting: August 12, 2021, at 9:00 a.m.

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

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