STAR Kids Managed Care Advisory Committee

September 22, 2021

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

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Stafford, TX

1. Welcome, introductions, opening remarks, and logistical announcements. The meeting was convened by the Chair, Elizabeth Tucker.

2. Consideration of June 9, 2021, meeting minutes. The minutes were approved as written.

3. Election of committee chair and vice chair. The Committee adopted the standard election process, and the new chair is Catherine Carlton and vice chair is Terri Carriker.

4. COVID-19 update

Dr. Van Ramshorst stated that we are seeing a decline in cases. We are still seeing 10,000 new cases a day which is ten times that of when there was a lull. We are seeing 200 deaths per day. The total national death count exceeds that of the Spanish Flu. The number of hospitalizations is still very high but is on the decline. Ninety seven percent of the cases are Delta.

There has been a total of 5.5 million children infected and children now account for 25% of the new cases. 5-17 age group out paces any other age group previously.

Vaccines that are available still work against Delta provided a 5-fold reduction in infection and a 10-fold reduction in risk of hospitalizations and deaths. There is an elevated risk in children with special needs. ER risks and hospitalizations of children were higher in states with low vaccination rates.

Vaccines:

- Additional doses for immunocompromised individuals (August 12th)
- First full approval of Pfizer for August 23
- Children less than age 12 is being pursued
- September 17 advice on booster doses was received.
- Pfizer issued a press release on vaccines for children below 12. Initially will address children 5-11 and the below 5.
- Moderna is completing pediatric trials
- NovaVax is nearing application for approval
- 920,000 children have received at least one dose

Questions/Answers/Comments

Can vaccines be combined for the booster? Dr. V stated that it is not preferred but probably allowed. (DSHS had previously stated that it is treated as an immunization adverse event)

How many in the hospital are immunized? That is not known

What about people who have had COVID and recovered. Dr. V stated that there is guidance. These people are still recommended to be vaccinated

Currently the federal government picks up the cost of the vaccine. Administration of the vaccine is being picked up by Medicaid.

COVID Flexibilities. Details on flexibilities can be found at Coronavirus (COVID-19) Provider Information | Texas Health and Human Services. Flexibilities are reviewed on a monthly basis.

- Remote delivery
- Face-to-face requirements
- Authorizations
- Provider revalidation and enrollment
- COVID-19 testing
- Appeals and fair hearings
- Durable Medical Equipment

Ending and Extending Flexibilities

- Reviewed on month-to-month basis
- Flexibilities ended so far have primarily been administrative flexibilities.
- Many Medicaid and CHIP flexibilities have been extended through September 30, 2021.

Information on the flexibilities and extensions can be found on the following webpages:

- TMHP Coronavirus (COVID-19) Information Coronavirus (COVID-19) | TMHP
- HHS Provider (PL) and Information (IL) letters HHS Letters to Long-term Care Providers (texas.gov)
- HHS Coronavirus (COVID-19) Provider Information Medicaid and CHIP Services Information for Providers | Texas Health and Human Services

Telemedicine/Telehealth--HHSC recognizes the importance of telemedicine/telehealth flexibilities.

- Internal workgroup developed to consider current flexibilities related to HB4 and other telemedicine/telehealth flexibilities.

Considering what can be made permanent and establishing timelines.

Individuals who aged out of STAR Kids but who remained in STAR Kids. The process of transferring to STAR Plus has been completed for those aging out of STAR Kids.

Prohibitions on in-person coordination activities were lifted on MCOs. Telehealth flexibilities are still; available

UR teams had a prohibition on in-person visits and this prohibition was lifted.

HHSC went back and looked at MDCP and back log of cases and denials. The February time frame of denials stood out, but it was an anomaly of the timing due to COVID.

Questions/Answers/Comments

What if families are not comfortable with in-person visits? MCOs can offer this as an option but it is not a requirement. This will be discussed with the family.

Will the assessment still be virtual. HHSC stated that it can be.

The Chair inquired about the state of emergency and loss of eligibility. There is a plan to notify families in advance but presently there is not a date.

If a Child loses SSI what will happen to Medicaid eligibility under the emergency status. HHSC stated they will get back to the committee on this.

Families should be told what steps they should follow as flexibilities are withdrawn.

5. STAR Kids/Medically Dependent Children Program (MDCP) legislative updates

86th Legislative Session update: SB 1207, Coordination of Benefits and Specialty Providers
87th Legislative Session Update

SB 1648, Specialty Providers
HB 4, Telehealth Services
HB 2658
Dental for Adults in STAR+PLUS

School Health and Related Services (SHARS)
Medication Therapy Management
Interest List Study
SB 1829, Member Directory

Coordination of Benefits

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.
	  • Working through committee and managed care organization (MCO) comments and awaiting CMS feedback.
	• 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.
	  • Texas Administrative Code rule has been adopted.

Continuity of Care

Bill	Impacts

SB 1648: Provision and reimbursement of certain benefits under Medicaid, including the coordination of private health benefits	• Modifies SB 1207 requirements from 86th Session:
	  – Members with complex medical needs can keep their specialty care provider whether or not they have other insurance
	  – Requires MCOs to attempt single-case agreements and that providers be reimbursed by Medicaid fee schedule until one is reached
	• Initiate a pilot program under Advancing Care for Exceptional Kids (ACE)
	• Other amendments: external medical review for STAR Health denials, interest list management, notification of consumer directed services, adult dental benefits

Questions/Answers/Comments

Can you talk about 1207 and children with complex needs and the need for primary insurance. The need for primary insurance cut many families out of the service system. HHSC stated that 1207 limits Medicaid as the secondary insurance source. SB 1648 provides amendments to this. HHSC stated that they are limited to what the legislation allows.

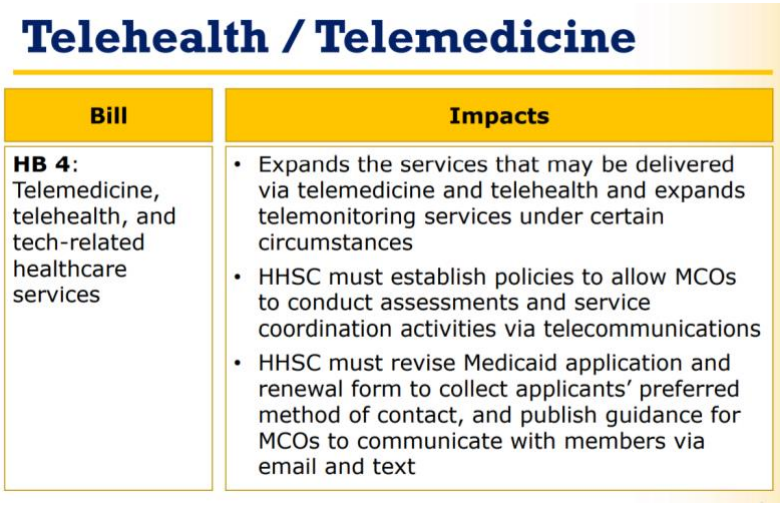
Is there a plan to expedite 1648 given the limitations of 1207. HHSCV stated they are expediting implementation of 1648 but there are activities that will still have to be conducted like contract amendments.

Clarification of "Specialty Providers". HHSC stated that they focused on physicians and used how specialist are defined in managed care contracts. The rule lists out the different provider types. It excludes therapists and specialty

DME providers. HHSC stated the focus was on physicians and the rule was not final until after the session. They are following the guidance in 1648. Provider types was considered during the session.

The Chair stated that they are not happy with the rules. This committee wanted specialty providers to be broadened to include DME and Therapists. Also, the date should not matter when children entered managed care. Children's conditions change and that is not addressed in the rules. The rule did not consider guidance from this committee.

Where do we stand on coordination with insurance companies. HHSC stated this is still being discussed and reviewed and the guidance is still being considered. The Chair stated that families are wondering if they should drop the private insurance, and this would cause a cost to the state and the child. HHSC stated in this regard, they are still awaiting guidance from CMS.



Telehealth / Telemedicine

Bill	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, and publish guidance for MCOs to communicate with members via email and text

Questions/Answers/Comments

The Chair stated that there are telehealth experts on this committee and the subcommittee would be available to consult and advise HHSC.

If we add telemedicine along with in person visits hospitalizations of children with special health care needs was reduced 20%.

HHSC stated they are moving forward as rapidly as possible,

There is pushback on converting more visits to telehealth. Guidelines should be flexible.

Operations

Bill	Impacts
HB 2658: Operation and administration of certain health insurance programs and medical assistance program	• HHSC must develop and implement: – Protocol allowing the Ombudsman to collect contact info from people on interest lists and study online interest list portal – Increase participation in disease management programs – Preventative dental services for adults with disabilities enrolled in STAR+PLUS – Oversight of nursing facility minimum performance standards and staff-resident ratios as quality measure – Implement medication therapy management services – HHSC must study and report on several topics

Dental Services for Adults in STAR+PLUS and SHARS

Active Legislation	Impacts
HB 2658: Operation and administration of certain health insurance programs and medical assistance program	• HB 2658 covers multiple topics, including: • Provides a basic preventive dental benefit for adults in STAR+PLUS who do not currently have coverage for dental services. • Mandates rules requiring parental consent for services provided under the school health and related services (SHARS) program in order for a school district to receive reimbursement for the services.

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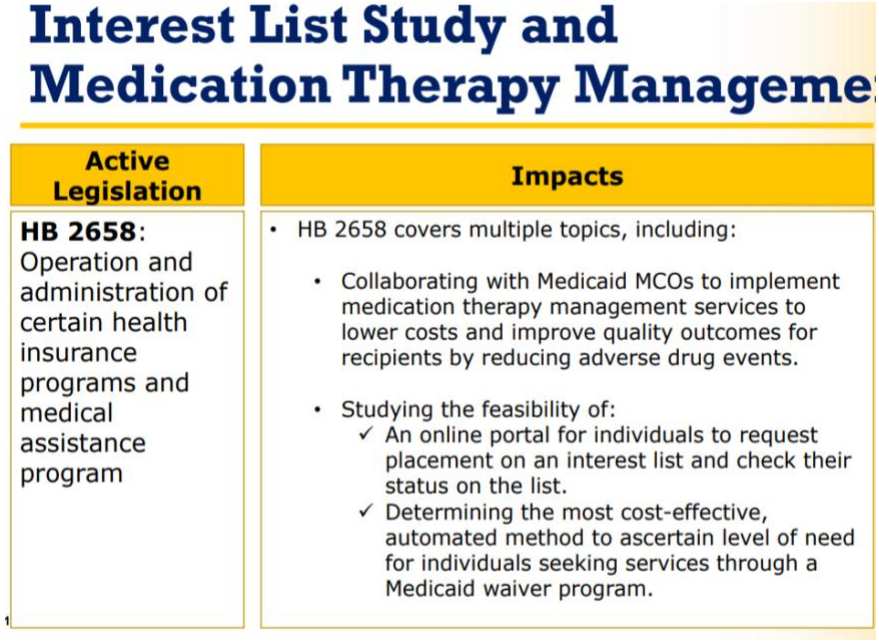

Interest List Study and Medication Therapy Manageme

Active Legislation	Impacts

HB 2658: Operation and administration of certain health insurance programs and medical assistance program	• HB 2658 covers multiple topics, including:
	  • Collaborating with Medicaid MCOs to implement medication therapy management services to lower costs and improve quality outcomes for recipients by reducing adverse drug events.
	  • Studying the feasibility of:
	  ✓ An online portal for individuals to request placement on an interest list and check their status on the list.
	  ✓ Determining the most cost-effective, automated method to ascertain level of need for individuals seeking services through a Medicaid waiver program.

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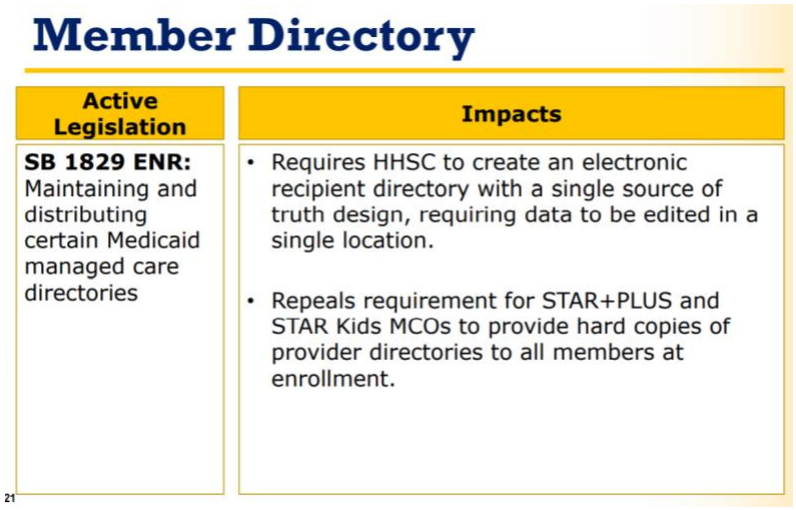
Questions/Answers, Comments

What diagnoses will be included? HHSC stated we have to still get stakeholder comments and speak with the Medical Director. The Chair stated that this should be discussed with the subcommittee



Member Directory

Active Legislation	Impacts
SB 1829 ENR: Maintaining and distributing certain Medicaid managed care directories	• Requires HHSC to create an electronic recipient directory with a single source of truth design, requiring data to be edited in a single location. • Repeals requirement for STAR+PLUS and STAR Kids MCOs to provide hard copies of provider directories to all members at enrollment.

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6. Applied Behavioral Analysis update

Implementation

- Medicaid Autism Services scheduled for implementation on February 1, 2022.

- MCOs will be reimbursed using non-risk payment, up to the fee-for-service amount.
- MCOs are expected to follow the posted policy.

Actions To Date

- Posted medical policy and responses to public comments on policy on July 30, 2021.
- Launched provider enrollment July 30, 2021.
- Posted public notices of intent to submit state plan and 1115 waiver amendments.
- Submitted state plan amendment to CMS September 3, 2021.
- Holding biweekly implementation meetings since July 22, 2021 with MCOs.

Next Steps

- Submit 1115 waiver to CMS by October 1, 2021.
- MCOs will start credentialing no later than October 31, 2021.
- TMHP provider webinar training by December 1, 2021.
- Will send provider notice about implementation for February 1, 2022, in December 2021.
- Ongoing monitoring of provider enrollment, MCO networks and outreach to potential providers.

This is a new benefit while also rolling out a new provider type. It is being rolled out also as a non-risk benefit (payment).

7. Non-emergency medical transportation update

Nonemergency medical transportation services are available for a Medicaid beneficiary or their child. These services include rides to doctor's office, dentist's office, hospital, drug store or any place that provides covered health care services.

Types of rides include:

- Public transportation, like the city bus.
- A taxi or van service.
- Commercial transit, like a bus or plane, to go to another city for an appointment.

Services may also include:

- Money for gas.
- Meals and lodging for children and youth 20 and younger staying overnight to get covered health care services.
- Payment for some out-of-state travel to neighboring states (Louisiana, Arkansas, Oklahoma and New Mexico).

Services do not include making arrangements for emergency or nonemergency transportation by ambulance.

Can I get a ride?

- To get a ride, you must be enrolled in one of the following programs and not have any other means of transportation
- Medicaid
- Children with Special Health Care Needs
- Transportation for Indigent Cancer Patients

How do I get a ride?

- First, set up an appointment with your doctor or provider.

- To request a ride, call at least two workdays before your appointment, or five days before the appointment if it is outside your county. Phones are answered Monday through Friday, 8 a.m.-5 p.m. local time.
- You may be able to be approved for same day rides when:
- Your doctor or dentist must see you on the same day.
- You are released from a hospital, clinic, or other health care facility.
- You need a ride to a drugstore.
- If you or your child have a Medicaid health plan:
- Call your health plan's medical transportation contact number.
- If you or your child do not have a health plan:
- Call **877-633-8747 (877-MED- TRIP)**.
- Children 14 and younger may not travel without a parent or guardian. Children 15 through 17 may travel without a parent, but the parent must provide written permission before the trip is scheduled.

When requesting a ride, make sure to have the following information:

- Medicaid ID or Social Security number for the person with the appointment
- Name of the medical professional you or your child will be seeing
- Address, and phone number of your appointment location
- Address and phone number of your pickup location
- Reason for the visit
- Date and time of appointment
- If you or your children have any unique needs including wheelchair, lift, or a walker, so we can send the right type of vehicle
- Affirmation that other means of transportation are unavailable

I have a car, but no money for gas. What can I do?

- Call us just like you would to schedule a ride, using the steps outlined above. When you call, tell the representative you have a car but need help with gas money. They will mail you an application form to become an Individual Transportation Participant (ITP).
- Medicaid can also pay someone else to drive you to your appointments, like a relative, friend or neighbor, if they sign up to become an ITP.
- You or your driver must have a current driver's license, license plates, up-to-date inspection sticker and car insurance.

Post implementation monitoring

- Call volumes are being reviewed for each MCO
- Hold times have reduced significantly at the call centers
- Volume of trips are being monitored
- Monitoring complaint trends (with Ombudsman)
- Telemeetings with MCOs continue

Policy clarifications are occurring to address specific identified issues.

Questions/Answers/Comments

Ride share has been working well

Some MCOs have told clients that the only way they can get reimbursement is using payment cards that have fees. What about Western Union? HHSC stated that there should not be fees and asked for some specifics they can follow up on. The fees are coming from the card services company.

Hospital Discharge? HHSC stated it is included but there are limitations on where they are going (Nursing home exclusion)

Some MCOs are telling families they cannot use advanced funds and they are not being provided any more.

8. SKMCAC subcommittee updates

Health homes and outcome measures—There is a home health crisis concerning shortage and quality of services. They looked at other states. They want to have another meeting to look at the possibility of developing a mid-tier provider and make recommendations regarding this. The second issue is they have sent a request for information related to ACO like arrangements for children with medical complexity. They want to get information on how to set up a system for the mot complex of the STAR Kids population. Other states are having problems related to the **ACE Kids Act.** They are requesting an extension of the deadline to be sure the information is useful.

Advancing Care for Exceptional Kids Act (Public Law No. 116-16) On April 18, the ACE Kids Act was signed into law as part of a package of Medicaid bills, the Medicaid Services Investment and Accountability Act of 2019 (P.L. 116-16). Lead congressional co-sponsors include Sens. Charles Grassley, R-Iowa, and Michael Bennet, D-Colo., and Reps. Kathy Castor, D-Fla., Gus Bilirakis, R-Fla., Anna Eshoo, D-Calif., and Jaime Herrera Beutler, R-Wash.

The ACE Kids Act is designed to improve care for children with medically complex conditions in Medicaid. This new law addresses existing challenges—identified by families and physicians—facing children with medically complex conditions by expanding access to patient-centered, pediatric focused coordinated care models tailored for these children across multiple providers and services, and by easing access to out-of-state care. New State Option: Provide Coordinated Care through Health Homes for Children with Complex Medical Conditions

The legislation builds off current law to establish specially designed health homes for children with medically complex conditions beginning on Oct. 1, 2022. Participation is voluntary for children and their families, providers and states. States that opt to create these health homes will receive a higher federal matching rate (15 percent above regular matching rate for the state, not to exceed 90 percent) for six months. The bill also provides $5 million for state planning grants.

Eligible children include those with at least one chronic condition—cumulatively affecting three or more organ systems and severely reducing cognitive or physical functioning—who also require medication, durable medical equipment, therapy, surgery or other treatments. Children with one life-limiting illness or rare pediatric disease—as defined in the Food, Drug, and Cosmetic Act—are also eligible. The law allows the Secretary of U.S. Department of Health and Human Services (Secretary) discretion to operationalize the definition.

To qualify as a health home, providers and health teams must demonstrate the ability to coordinate prompt care for children with medically complex conditions, develop an individualized comprehensive pediatric family-centered care plan, coordinate access to subspecialized care, and coordinate appropriate

care with out-of-state providers. The Secretary must establish standards for qualification as a health home, including those outlined above.

States must develop a plan to educate providers on the availability of health home services for children with medically complex conditions, including the process by which such providers can refer these children to a health home. States must also develop a plan to educate families with children eligible to receive health home services about the availability of these services through family-to-family entities and other family outreach organizations.

States have flexibility to develop their own methodology for determining payment, including the use of alternative payment models. Guidance, Monitoring, Data Collection, and Reporting

By Oct. 1, 2020, the legislation requires the Secretary to issue guidance to state Medicaid directors on best practices for ensuring this population receives prompt care from out-of-state providers when medically necessary.

Participating states must develop a methodology for tracking reductions in inpatient days and reductions in total cost of care resulting from improved care coordination and management, a proposal for the use of health information technology in providing health homes services and a methodology for tracking prompt and timely access to medically necessary care from out-of-state providers.

Participating states must collect and share with CMS:

- o Data on the number of children with medically complex conditions who are enrolled in a health home
- o The nature, number and prevalence of chronic conditions, illnesses, disabilities and rare conditions that the children have
- o The type of delivery systems and payment models used
- o The number and characteristics of providers and health professionals designated as health homes under this legislation
- o The extent to which the children receive health care services from out-of-state providers (including whether provided on an emergency or non-emergency basis)
- o Quality measures developed specifically with respect to heath care items and services provided to this population of children

STAR Kids-Screening and Assessment Instrument Medically Dependent Children Program, prior authorizations, and Intellectual and Developmental Disability waiver carve-in—The majority of the time has been reviewing the SKSAI dry run. Making changes in the manual will help convey information to families. They are looking at the CFC tool for referrals. The committee will meet on this to provide feedback. They looked at the AG request for information of the term specialty provider and provided feedback. They are recommending against a waiver. The Chair suggested sending information to the AG related to information that had been done in the past.

Transition from children's services to adult services—There has been a lot of work going on with The National Alliance to Advance Adolescent Health. They have looked at Value Based Payments and it would be good to hear from this group. Technical assistance has been provided to the state through HHSC.

The National Alliance to Advance Adolescent Health is devoted to education, policy analysis, technical assistance, and advocacy in support of long-term, systemic improvements in comprehensive health care and insurance coverage for adolescents.
Fifteen years ago, our founders – Harriette Fox and Peggy McManus -- recognized that there were too many underserved adolescents, too little attention to policy and practice innovations, and too few

champions to advance their cause. Moreover, most organizations working to address adolescent needs focused on single issues – teen pregnancy, suicide, bullying, substance abuse, obesity.

Thus, The National Alliance to Advance Adolescent Health was formed as a 501c3 nonprofit in 2006, with a mission to achieve long-term, systemic improvements in comprehensive health care and insurance coverage for adolescents.
The organization is uniquely positioned as the only national nonprofit dedicated solely to advancing adolescent health care delivery and financing system changes through education, policy analysis, technical assistance, and advocacy. As a national alliance, they work in collaboration with federal and state agencies, academic institutions, health professional organizations, health care systems, public and private payers/plans, and consumer and disability groups.

9. FY 2021 STAR Kids/MDCP Long-Term Services and Supports Utilization Review results

Sylvia Salvato, Director Managed Care Utilization Review Sylvia.Salvato@hhs.texas.gov

The Long-Term Services and Supports (LTSS) Utilization Review team conducts desk reviews of Managed Care Organization (MCO) assessment and service planning documentation and conducts interviews with members to ensure:

- MCO conducts assessment-driven service planning;
- Member receives all needed services; and
- MCO adheres to additional contract requirements around assessment for and coordination and provision of LTSS.

Outcomes

- Statistically valid random sample of 339 STAR Kids members at the level of the MCO.
  - Reviewed individuals with reduced physical function (Resource Utilization Groups [RUGs] PA1, PA2, PB1)
  - Also reviewed most frequent RUG categories for FY20 referrals.
- 80% benchmark for compliance
  - Benchmarks will increase starting with FY22 reviews by 5% each year until 95% is reached in 2024.
- Overall average across MCOs and all measures: 93.11%.

Standard 1: Assessment Completion: 92.52% (FY 20: 99.61%)

- MCO must complete assessment and all contractually required forms (Individual Service Plan [ISP] tracking tool & narrative).
- Performance measure 1.3 – Number of members for whom Form 2605, STAR Kids Screening Assessment Instrument (SK-SAI), MDCP Review Signature, completed: 77.58% (new measure).

Standard 2 – Assessment Driven Service Planning: 94.12% (FY 20: 80.5%)

- MCOs must address needs identified in required assessments, service planning documents and other MCO documentation:

- PM 2.1 - Justification for at least one MDCP service for initial assessments: 86.21% (FY 20: 75.51%).
- PM 2.2 - Justification for at least one MDCP service for reassessments: 90% (FY 20: 77.97%).
- PM 2.3 - Members whose identified needs were addressed on service planning documents: 100% (FY20: 62.62%)

Standard 3A - Timeliness of Assessments: 96.78% (FY20: 95.27%)

- MCOs must meet timeliness requirements for initial assessments and re-assessments for MDCP, including STAR Kids Screening and Assessment Instrument (SK-SAI) completion and ISP submission.

Standard 3B – Follow-Up: 73.14% (FY 20: 67.95%)

- PM 3B.1 - MCOs must contact member to follow up no later than four weeks of the start of ISP: 66.96%(FY 20 was 61.64%).
- PM 3B.2 - Members received monthly phone calls unless otherwise requested: 80.53% (FY20: 74.26%).
- PM 3B.3 – Number of reassessment members with at least four face to face visits: 71.94% (new measure).

Standard 4A – Service Delivery Patterns

- Referral findings across MCOs can reveal patterns in MCO support of member needs for Access to Care and Health and Safety: 93.5% (FY20: 82.5%).

Standard 4B – Provision of Attendant and Other Services

- PM 4B.1 - MDCP services delivered per member's service plan: 99.15% (FY20: 98.76%).
- PM 4B.2 - Members who had a need for Community First Choice (CFC) services and received them: 98.7% (FY20: 89.29%).

Standard 5 – Member Experience (FY20: 99.02%)

- Home Visits/Member Interviews conducted in person or by telephone asking series of questions
  - PM 5.1 - Offered choice of waiver services: 100% (FY20: 98.93%).
  - PM 5.2 - Offered choice of providers: 99.68% (FY20: 99.17%).
  - PM 5.3 - Knew how to contact MCO Service Coordinator: 99.36% (FY20: 98.82%).

Standard 5 – Member Experience (FY20: 99.02%)

- Home Visits/Member Interviews conducted in person or by telephone through asking series of questions (cont.)
  - PM 5.4 - Notified when Service Coordinator changes: 96.85% (FY20: 99.17%)
  - PM 5.5 - Asked about their preferences: 100% (FY20 was 99.29%)
  - PM 5.6 – Members helping develop ISP: 100% (new)

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Standard 6 – Member Experience: Quality of Life (new). (Percentage does not total 100% - 8% of sample not interviewed)

- PM 6.1 – Report little to no difficulty receiving needed services
  - 71.75% easy/very easy
  - 8% difficult/very difficult
  - 12% neutral
- Performance Meausure (PM) 6.2 – Report services changed when their needs changed
  - 46.97% yes
  - 4.32% no
  - 2.88% unsure
  - 37.75% needs did not change
- PM 6.3 – Feel that services have made a positive difference in their lives
  - 89.34% yes
  - .58% no
  - 2.02% unsure
- PM 6.4 – Agree that service plan reflects their needs
  - 86.17% yes
  - 3.46% no
  - 2.31% unsure

Member Interviews Members interviewed – 311

- All completed by telephone
- FY22 will have capability of completing via remote audiovisual means

Members not interviewed – 28

- Deceased – 2
- Declined – 8
- Unable to reach/unavailable – 18

Questions/Answers/ Comments

Would like to see the raw data and MCO specific numbers. HHSC stated they have the numbers and will check to see if the data can be released

Would you have been able to see the latest challenges in staffing levels of providers and therapies? HHSC stated that their questions may not have addressed if they received all the hours in the ISP. They could possibly look at this in the next survey/evaluation. The Chair stated that it would be good to dig a little deeper on the next evaluation. The Chair stated it is important to ask the question to parents if they are getting what they need.

Behavioral health reviews can be included in the future and LTSS (and not just with the MDCP population) also.

Families have stated that they thought if they got MDCP they would have their problems solved, but they are finding other problems pop up.

10. Public comment.

Adrian Trigg, Texas Medical Equipment Providers Association stated that they object to key aspects in Administrative rules and that the rules do not match intent of 1207 and 1648. They agree with the subcommittee recommendations from January. Members are being dropped by MCOs without cause. DME should be included as specialty providers.

Specialty providers of DME have no protection from cancellation. The chair stated that the reliance on national providers delays services. We need to ensure state providers are available.

Laurie Bacerack, Texas Medical Equipment Providers Association stated that she has concerns about 1207 and 1648 because they are left out of the definition.

Hannah Mettah, Texas Protects Fragile Kids stated that families are reluctant to provide information because of concerns that MCOs will react negatively. HHSC stated the MCO service coordinator is present during the first set of questions but the quality of life questions are conducted with the parent in private.

On the medical transportation, there are still problems for families. They often are told that their child is not in the system. The cards that are given out to families are not true reimbursement.

On the legislative update, they have been told that 2658 would not be available to children with complex needs.

She expressed concern that SB1207 and HB2658 rules do not meet legislative intent.

Linda Litzinger stated that schools under SHARS provide a Medicaid number and a billing agent bills. The billing allows federal funds to be money laundered to be used to replace state funds. Regarding Medical Transportation a parent had to wait twenty-four hours in an ER for medical transportation. On SB1207, coordination has to work for a lifetime. 1207 was designed to encourage coordination between Medicaid and private insurance.

11. Review of action items and agenda for December 8, 2021, meeting

- Telehealth activities and the subcommittee
- Working with HHSC on the vendor drug part of medication management
- Provide a recap on specialty providers
- HHSC follow up on Access and Eligibility and paperwork related to STAR PLUS
- Follow up with the MCOs on mileage reimbursement and the fees associated
- New members and participation on subcommittees
- ABA and the associated delays
- Utilization review related follow up

12. Adjourn. Next meeting is December 8th. There being no further business, the meeting was adjourned.

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This summary contains supplemental information from third-party sources where that information provides clarity to the issues being discussed. Not every comment or statement from the speakers in these summaries is an exact transcription. For the purpose of brevity, their statements are often paraphrased. These documents should not be viewed as a word-for-word account of every meeting or hearing, but a summary. Every effort has been made to ensure the accuracy of these summaries. The information contained in this publication is the property of Texas Insight and is considered confidential and may contain proprietary information. It is meant solely for the intended recipient. Access to this published information by anyone else is unauthorized unless Texas Insight grants permission. If you are not the intended recipient, any disclosure, copying, distribution or any action taken or omitted in reliance on this is prohibited. The views expressed in this publication are, unless otherwise stated, those of the author and not those of Texas Insight or its management.