Texas Association of Health Plans
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March 10, 2022

To Whom It May Concern:

Thank you for the opportunity to comment on the informal draft rule Title 1, Chapter 353, Medicaid Managed Care, Subchapter R, Telecommunications in Managed Care Service Coordination and Assessments, establishing the requirements for the use of telecommunications in Medicaid managed care for service coordination and assessments conducted by managed care organizations (MCOs) contracted with the Health and Human Services Commission (HHSC).

We applaud the work of the Texas Legislature in improving access to care for Medicaid and CHIP members by allowing MCOs to conduct more assessments and service coordination visits through telehealth modalities with the passage of HB 4. HB 4 empowers members with more healthcare delivery options, provides additional protections for at-risk populations who view in-home assessments as unnecessary risks, and improves the timeliness of assessments in part by decreasing no-shows. However, the proposed rule by HHSC lacks this flexibility intended by the legislature.

The proposed rule requires unnecessary in-person assessments that conflict with HB 4.

Recommendation: Eliminate requirements that mandate any assessments beyond the initial assessment be conducted face to face. For all STAR+PLUS and STAR Kids, and STAR Health members, the proposed rules require in-person visits for initial and annual assessments, as well as any change in condition assessment that results in a resource utilization group (RUG) change. However, HB 4 contains no consideration of annual assessments or RUG changes as a determining factor for in-person assessments. Instead, the legislature expressly defers to MCOs, as they consider both the clinical judgment of the MCO registered nurses and the preferences of the beneficiary to determine when an in-person visit is necessary.

The relevant section of HB 4, codified at Government Code Sec. 533.039(e), states:

> A Medicaid managed care organization shall… conduct: (1) at least one in-person visit with the recipient to make an initial waiver eligibility determination; and (2) additional in-person visits with the recipient if necessary, **as determined by the managed care organization**.

The agency has required one in-person visit in the draft rules for the initial assessment, but then goes on to require additional in person visits, regardless of the determination of the MCO. While

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the rule is within the agency's jurisdiction, the language would conflict with the legislature's instructions. In these situations, a rule violates the Administrative Procedures Act when it "(1) contravenes specific statutory language; (2) runs counter to the general objectives of the underlying Act; or (3) imposes additional burdens, conditions, or restrictions in excess of or inconsistent with the relevant statutory provisions."[1] While satisfying just one of these elements is enough for a court to strike down such a rule, this requirement appears to fulfill all three.

If an MCO determines, pursuant to §533.039(e)(2), that an in-person visit is not necessary to conduct an assessment, then the requirements in these rules would directly contravene the specific statutory language. Further, to the extent that HB 4 encourages MCOs to maximize flexibility and remote access for their enrollees, this rule proposal runs counter to the general objectives of the underlying Act. Finally, mandating that the change in condition assessments be conducted in person imposes additional burdens on the MCO, the nursing workforce, and the enrollee, who may agree that remote services are preferable.

There is no current federal requirement that mandates the modality in which assessments or service coordination visits are conducted, nor is there such a requirement for change in condition assessments. During the public health emergency, plans used HHSC's flexibility to safely and successfully conduct all assessments, including those related to changes in condition that resulted in RUG changes, through telehealth. If telehealth is considered safe and effective for medical and psychiatric care, then it should be a safe and effective tool to use for assessments that do not involve a physical assessment, medical care, or hands on care.

Moreover, CMS requires that states provide assurances that necessary safeguards have been taken to protect the health and welfare of the beneficiaries of the services, at 42 CFR 441.302. There is no evidence that conducting assessments via telehealth jeopardizes safety or welfare, and in reality many beneficiaries would be put at greater risk if in-person visits are required. Beneficiaries who have a high risk of contracting or developing serious complications from a communicable disease could be put in serious danger by in-person assessments. Therefore, to comply with CMS rules and protect the health and welfare of beneficiaries, HHSC should provide as much flexibility as possible. HHSC also has an additional oversight tool to ensure member safety, as the HHSC Managed Care LTSS Utilization Review staff complete utilization

[1] Tex. Ass'n of Psychological Assocs. v. Tex. State Bd. of Exam'rs of Psychologists, 439 S.W.3d 597, 603 (Tex. App.—Austin 2014).

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reviews annually in STAR+PLUS HCBS and the STAR Kids Medically Dependent Children Program to determine if MCOs are assessing and enrolling members in services appropriately.

The COVID-19 crisis clearly demonstrated that telehealth is an effective and safe tool that can be used not only for medical care but also to conduct assessments for Medicaid clients. Medicaid MCOs have received feedback that many of their members prefer receiving services delivered remotely. MCOs have learned telemedicine offers the potential to reach vulnerable patient groups and improve access for patients with transportation, parking, or cost barriers to clinic visits. Telehealth has had multiple benefits during the pandemic by expanding access to care, reducing disease exposure for staff and patients, preserving scarce supplies of personal protective equipment, and reducing patient demand on facilities.

Telehealth has also been particularly valuable for those patients who were reluctant to seek in-person care, had difficulty accessing in-person care or who had chronic conditions that place them at high risk for severe COVID-19. We believe the benefits of telehealth significantly reduces gaps in necessary care, supports continuity of care, and promotes the triple aim objectives, and thus should not be limited after the pandemic winds down. There will be a continued desire from many Medicaid members to keep receiving care remotely due the concerns and barriers noted above.

Finally, it's important to consider that the full State Medicaid Managed Care Advisory Committee which includes a wide variety of stakeholders, voted in favor of a recommendation that "HHSC permanently allow service coordination assessments and face-to-face visits to occur by way of a telehealth modality if medically appropriate, is the member's choice, and is technologically and physically feasible for the member; in order to reduce costs, improve access to service coordination, and improve efficiency." We ask that the agency follow this guidance, as well as the instructions from the legislature, by providing MCOs and beneficiaries with as much flexibility as possible.

We also have the following recommendations:
Recommendation on definition "(8) Covered services:" Adjust the definition of covered services to include only those medically necessary based on the federal requirement.

Recommendation on (a)(C)(iii): Clarify that MCOs should be documenting the member's verbal approval to use audio-visual communication in their own systems as this is the least

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administratively burdensome method to capture member approvals and would not require the creation of any new processes.

We appreciate your consideration of the recommendations we have outlined, and we believe it is important for HHSC to adhere to the intent of HB 4. We look forward to working with the agency to ensure that Medicaid members continue to receive the benefits associated with telemedicine, delivered in the most clinical and cost effective manner.

Sincerely,

Jamie Dudensing, RN
CEO, Texas Association of Health Plans