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Texas Health and Human Services Commission
HHSRulesCoordinationOffice@hhs.texas.gov

Re: Comments on Proposed Rule 22R055

To Whom It May Concern:

Thank you for the opportunity to comment on the proposed 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. By expanding telehealth options, HB 4:

- Empowers members with more healthcare delivery options
- Provides additional protections for at-risk populations who view in-home assessments as unnecessary risks
- Provides a strategy to address nursing workforce shortages, especially in rural areas
- Improves the timeliness of assessments by making it easier to increase access

However, the proposed rule by HHSC lacks this flexibility intended by the legislature. The proposed rule requires unnecessary in-person assessments, which conflict with HB 4. **We recommend HHSC eliminate requirements that mandate any assessments be conducted in-person beyond initial waiver eligibility determinations for the home and community-based population**. For all STAR+PLUS, STAR Kids, and STAR Health individuals, 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 initial and annual assessments or RUG changes as a determining factor for in-person assessments, other than an initial assessment for home and

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community-based services recipients. Instead, the legislature expressly defers to MCOs, as they consider both the clinical judgment of MCO registered nurses and the preferences of the individual to determine when an in-person visit is necessary.

The relevant sections of HB 4, state:

> Government Code Sec. 531.02162(b): To the extent permitted by federal law and to the extent it is cost-effective and clinically effective, as determined by the commission, the commission shall ensure that Medicaid recipients, child health plan program enrollees, and other individuals receiving benefits under a public benefits program administered by the commission or a health and human services agency, regardless of whether receiving benefits through a managed care delivery model or another delivery model, have the option to receive services as telemedicine medical services, telehealth services, or otherwise using telecommunications or information technology, including the following services:... (2) case management services, including targeted case management services:... (6) assessment services…
>
> Government Code Sec. 533.039: (b) To the extent permitted by federal law, the executive commissioner by rule shall establish policies and procedures that allow a Medicaid managed care organization to conduct assessments and provide care coordination services using telecommunications or information technology…

While the rule is within the agency's jurisdiction, the proposed rule conflicts 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, the proposed rule appears to fulfill all three.

Texas Government Code Sec. 533.039(e) states that "… a Medicaid managed care organization shall, for a recipient of home and community-based services for which the commission requires in-person visits, conduct: (1) at least one in-person visit with the recipient to make an initial

[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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waiver eligibility determination; and (2) additional in-person visits with the recipient if necessary, as determined by the managed care organization.

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 proposed 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 and the nursing workforce.

It also imposes additional burdens on Medicaid families, who may agree that telehealth is preferable to an in-person visit in their homes. Most importantly, members who decline in-person assessments due to health risk concerns may miss out on the care and services they need to stay healthy in their homes and communities if assessments are not allowed to be conducted via telehealth. Likewise, if a member's condition worsens and they need additional services, that member will be forced to make a difficult decision: risk exposure or forfeit additional health care services and supports. The most concerning scenario under HHSC's proposed rule is that individuals will be disenrolled from Medicaid if they decline an in-person assessment after becoming accustomed to telehealth flexibilities during the pandemic. The state should not be putting members in this position when telehealth is a safe and effective alternative.

The legislature acknowledged that there are situations where virtual assessments are not "appropriate under the circumstances,"[2] and we agree. However, the legislature instructed HHSC to consider "whether the recipient consents" to receiving the virtual assessment[3] and to consider "whether the recipient requests" a virtual assessment.[4] We believe the rules and implementation plan should allow Medicaid families to make this decision for themselves, if it is safe and effective to do so.

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

[2] Tex. Gov't Code Sec. 533.039(b)(5).
[3] Tex. Gov't Code Sec. 533.039(b)(3).
[4] Tex. Gov't Code Sec. 533.039(b)(2).

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successfully conduct all assessments, including those related to changes in condition that resulted in RUG changes, through teleservices. 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 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

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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 353.1502(8), Covered services: Adjust the definition of covered services to include only those medically necessary based on the federal requirement.

Recommendation on documentation: 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 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