TAHP
The Texas Association of Health Plans

Texas Association of Health Plans
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November 1, 2022

Re: *HHSC Cost Containment Recommendations*

Thank you for the opportunity to submit cost containment initiative recommendations for the 2022-2023 fiscal year. We believe the Texas Health and Human Services Commission (HHSC) can continue to reform the state's Medicaid system, increase efficiency, and control costs by embracing the innovation and efficiency of the private market. We encourage the state to continue embracing the proven managed care model and to continue moving away from paying for the volume of services delivered. Instead, we should focus on paying for quality of care. To that end, we offer the following areas for additional efficiency and cost-containment for your consideration.

We support the Legislature's recommendation to encourage the use of telemedicine, telehealth, or phone services. We also support HHSC's initiative to achieve administrative savings by writing more concise materials and reducing printing and mailing costs. We suggest this be achieved through enhanced electronic communications. Additional cost savings to the state's Medicaid program could be found by consideration of site neutral payments and making permanent the Case Assistance Affiliate program.

We also continue to recommend past cost containment initiatives recommended by health plans, including:

- **Encourage preferred provider arrangements**. Texas currently has barriers to using preferred provider arrangements in the Medicaid program. TAHP recommends HHSC change policies to encourage and allow MCOs to use these arrangements to contain costs and improve quality of care.
- **Improve the PCP assignment process**. TAHP recommends HHSC align Medicaid and CHIP processes and honor existing statutory requirements to allow MCOs to make primary care physician assignments. This change should reduce costs paid to the Enrollment Broker to perform this function.
- **Improve the coordination of benefits for Medicaid and Medicare dual eligible clients**. HHSC should move responsibility for payment of wrap coverage for dual clients from TMHP to MCOs to further align accountability, enable better coordination of services for clients, and streamline processes and payment for providers. Having a single

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entity responsible for payment of all Medicaid services simplifies processes for providers and further reduces costs at TMHP while improving access to care for members.

- **Address private duty nursing (PDN) costs by aligning licensing for personal care services (PCS) and PDN services**. PDN is one of the largest cost drivers in the Medicaid program. If the licensing of PCS services could be modified to require a nurse on staff who has the authority to delegate and supervise the attendees, it would reduce the reliance on PDN and result in a cost savings to the state.

- **Review DME fee-for-service rates**. TAHP recommends HHSC conduct a review of the DME FFS fee schedule to determine if there are areas for cost containment for the state.

- **Fully carve all nursing facility (NF) payment and administration processes into managed care**. TAHP recommends HHSC adopt a new, simpler, more transparent payment model that leverages best practices from other state Medicaid programs, rewards quality, and achieves administrative simplification for NFs, HHSC, and STAR+PLUS MCOs and removes payment processes from TMHP.

- **Improve the Vendor Drug Program**. HHSC should adopt policies allowing and encouraging the use of biosimilars when appropriate. Biosimilars, especially the new insulin biosimilars, could decrease cost in the Medicaid program. TAHP also recommends HHSC review the policy and explore opportunities for MCOs to provide OTCs, either as a VAS or through another authority. Finally, we recommend HHSC review options to reduce the costs associated with clinician-administered drugs. Texas should explore options to allow the agency and MCOs to target certain drugs with growing costs in any given year and explore options to allow flexibility for the MCO to adopt additional utilization controls for targeted drugs.

New this year, we make the following additional cost containment initiative recommendations.

1. Encourage the use of telemedicine, telehealth, or phone services. We agree with the Legislature that HHSC should be focusing efforts on increasing the use of telemedicine and telehealth within Medicaid managed care. We applaud the Legislature's work with HB 4, expanding telehealth for use in assessments and service coordination, further modernizing Texas Medicaid. By expanding telehealth options, HB 4:

- Empowers members with more health care delivery options,
- Provides additional protections and options for at-risk patients and families who view in-home assessments as unnecessary risks,

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- Provides a strategy to address nursing workforce shortages, including allowing regions with more significant nursing shortages to be supported virtually by nurses in other areas of the state, and
- Improves the timeliness of assessments by making it easier to increase access.

In HB 4, the Legislature also instructed HHSC, "to the extent permitted by federal law," to establish policies allowing MCOs to conduct virtual assessments.[1] Not only does federal law permit virtual assessments, but when HHSC requested written guidance from CMS regarding whether assessments should be conducted virtually or in-person, the agency responded by saying that the state can make that determination. "In either case," CMS noted, "the state must meet the health and welfare assurance for each participant."[2]

The Legislature acknowledged that there are situations where virtual assessments are not "appropriate under the circumstances,"[3] and we agree. However, the Legislature instructed HHSC to consider "whether the recipient consents" to receiving the virtual assessment[4] and to consider "whether the recipient requests" a virtual assessment.[5] 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.

The COVID-19 crisis has demonstrated the importance of telehealth in the Medicaid program. Over the past few years, we have learned that telehealth is an effective and safe tool to ensure patients receive the care they need. 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.

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[1] Tex. Gov't Code Sec. 533.039(b).

[2] CMS advised, "The state must deploy an assessment method that is adequate to develop the person-centered service plan which meets requirements at 42 CFR §441.301(c)(2). The state's assessment tool or process may require the visual observations to discern if the individual can or cannot achieve a test. The state must assess its assessment tool and process and determine if only specific assessment questions require in-person observation or if it can be accomplished virtually or a hybrid model (virtually and face-to-face). In either case, the state must meet the health and welfare assurance for each waiver participant. If the beneficiary cannot be assessed by video, the state would need to utilize in-person."

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

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

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

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Further, the State Medicaid Managed Care Advisory Committee (SMMCAC) strongly supports telehealth assessments. SMMCAC includes a wide variety of stakeholders and serves as the central source for stakeholder input on the implementation and operation of Medicaid managed care. SMMCAC 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."

Recommendation: In alignment with SMMCAC recommendations that telehealth reduces costs and improves efficiencies, we recommend that HHSC, to the full extent allowable within statute, allow MCOs to conduct assessments and service coordination activities via telehealth for Medicaid members who can be assessed by video and personally choose to receive non-medical service coordination via telehealth.

2. Achieve administrative savings by reducing printing and mailing costs by allowing for implied consent texting of members by plans. HB 4, SB 1911, and Rider 27(d)(2) within SB 1 this session provide HHSC direction and a unique opportunity for Medicaid members to receive communications through the most effective technology-driven channels available. During this public health crisis, Texas MCOs have been using texts to provide members important health updates such as appointment reminders or about their benefits or direct them to take action in an online account, as well as local COVID-19 updates. Implied consent texting of members who provide their cell phone numbers to managed care plans allows this critical health information to be delivered. Currently, implied consent texting is permitted in 17 states.

It is increasingly evident that outreach via text messaging is one of the most effective means of communicating with members. Ninety-seven percent of individuals with income below $30,000 have a cell phone and 76 percent of those are smartphones. Smartphone owners use text messaging more frequently than any other feature or app. Furthermore, 25 percent of Hispanic people and 17 percent of Black people say their smartphone provides their only access to the internet. Used effectively, text messaging can both enhance existing forms of communication to members and improve the delivery of the State's critical safety net programs. Cell phones are the most common form of communication and text messages are widely used and more accepted than other forms; reach individuals more quickly and accurately than traditional mail; and can rapidly notify members of appointment times, remind them about needed verification documents, notify them of public health emergencies, and even collect information.

Noted in a recent MACPAC Issue Brief on Beneficiary Preferences for Communications Regarding Eligibility, Enrollment, and Renewal, states are starting to use other forms of

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communication with members, such as sending reminders at renewal via text messaging. Unlike email, text messages provide nearly instantaneous information without getting caught in spam filters, do not require smartphones, create a scrollable and easy-to-reference record, and are often not far from a member's fingertips. In December 2020, Montana began sending one-way text and email messages to beneficiaries when it received returned mail asking the member to update their mailing address. They found that individuals who received a text were 40 percent more likely to update their information and about 25 percent of members who received a text responded to specifically update their mailing address.

Federally, the Agriculture Department's Food and Nutrition Service, which oversees the Supplemental Nutrition Assistance Program, recognizes that mobile technology — including text messaging — allows states to "provide better service and more readily reach populations that lack access to a personal computer, enhancing access for those who would otherwise be limited in their ability to access information and complete the certification process."

Recommendation: HHSC should allow for implied consent texting by managed care plans to inform beneficiaries of critical enrollment-related information, including instructions to update their contact information, notices to complete a renewal or report changes, information about benefit changes, and resources for additional health care assistance.

3. Ban inappropriate facility fees. Additional cost savings to the state's Medicaid program could be found by the consideration of site neutral payments. Requiring site neutral payments would halt the inappropriate rapid expansion of hidden facility fees. When a consolidated system or private equity firm takes over a physician's office, patients often see excessive new facility fees added—even though the site of service never changed. Research indicates facility fees are one of the key cost drivers resulting from consolidations.

Site-neutral payments establish that payment for a service provided to a patient is the same regardless of the setting where the service is provided, like in a hospital or physician's office. Medicare already prohibits the use of hospital billing codes and facility fees if a provider is located more than 250 yards from a hospital's campus. But Medicare is projected to spend an excess of $153 billion this decade due to these price variations and implementing site-neutral payments for public and commercial insurance could bring a reduction in healthcare expenditures estimated as much as $672 billion a decade in savings.

Recommendation: HHSC should prohibit site-specific facility fees for Medicaid services rendered at physician practices and clinics located more than 250 yards from a hospital campus. Further, we recommend HHSC prohibit all service-specific facility fees for

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outpatient services that are allowable within Medicaid but billed using evaluation and management codes, even if those services are provided on a hospital campus.

4. Alleviate workforce shortages at HHSC by making permanent the Case Assistance Affiliates program. As case assistance affiliates, MCOs will soon become an enhanced form of community partners during the unwinding of the public health emergency. Being Case Assistance Affiliates allows managed care plans to provide more hands-on, virtual assistance, including walking members through the Your Texas Benefits portal. Plans can assist with applications and case management, including:

- Using YourTexas Benefits
- Submitting online applications for benefits
- Uploading documents and managing benefits
- Upgrading accounts
- Resetting passwords
- Managing benefits

If extended beyond the unwinding of the public health emergency, the Case Assistance Affiliates program has the potential to permanently address additional challenges like alleviating exceedingly long wait times to reset forgotten passwords for online portals that require reset over the phone with 2-1-1, lack of access to and familiarity with verification documents, and challenges in verifying mailing addresses. From a cost containment perspective, the Case Assistance Affiliates program can alleviate the volume of enrollment staff maintained by HHSC at no additional cost to the Medicaid program. Medicaid managed care plans already retain staff to support eligibility efforts–no additional funding is necessary to support these efforts.

Recommendation: To reduce FTE levels for HHSC eligibility staff, HHSC should make the Case Assistance Affiliates program permanent and identify opportunities to improve data sharing and reporting functionality in this program.

Thank you for the opportunity to provide these recommendations. If you need additional information or would like to meet and discuss cost drivers in the Medicaid program and identify solutions to continue to contain costs please feel free to contact us. We look forward to working

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closely with HHSC as it implements cost containment initiatives, policies, or resulting rate changes.

Sincerely,

Jamie Dudensing, RN
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