STAR Kids Managed Care Advisory Committee

June 14, 2023

ADVOCACY UPDATE
TAHP

Agenda

Archived Video

HHSC Updates

88th Legislature, Regular Session (2023)

- Relevant bills:
  - HB 44 (Swanson) - Relating to provider discrimination against a Medicaid recipient or child health plan program enrollee based on immunization status.
  - SB 14 (Campbell) - Prohibits certain procedures and treatments for gender transitioning, gender reassignment, or gender dysphoria for children.
  - HB 3550 (Rose) – Addresses known prescribed pediatric extended care center (PPECC) issues, including issues related to PPECC transportation. Allows PPECC services in a group setting and allows responsible adult signatures on one consent document.
  - HB 4169 (Price) - Adds prevocational services to HCS, TxHmL and DBMD waiver programs, either as part of individualized skills and socialization or as a stand-alone service
  - HB 729 (Rose) –Establishes a statewide IDD coordinating council to ensure Texas develops a strategic approach for the provision of intellectual and developmental disability services.
  - HB 2802 (Rose) - requires HHSC to ensure MCOs may communicate with enrolled Medicaid recipients through electronic means, which now includes telephone, in addition to text message and email, regarding eligibility, enrollment and other health care matters when the member provides their contact information to the MCO outside of the Medicaid application process.

    - SB 26 (Kolkhorst) - Relating to local mental health authority and local behavioral health authority audits and mental and behavioral health reporting, services, and programs.
    - HB 2727 (Price) - Adds FQHCs and RHCs as home telemonitoring providers; allows home telemonitoring services if they are cost effective and clinically effective; changes eligibility for home telemonitoring services.
    - HB 1488 (Rose) - Relating to sickle cell disease health care improvement and the sickle cell task force.
    - HB 1283 (Oliverson) - Relating to prescription drug formularies applicable to the Medicaid managed care program.
    - HB 3286 (Klick) – Relating to certain prescription drug benefits under the Medicaid managed care program.
    - HB 4990 (Bonnen) - Relating to the creation, management, and administration of the Texas Pharmaceutical Initiative.
- Appropriations
    - Rider 30: Base wages were increased for community attendant wages to $10.60. There are varying reimbursement rates, so this is a floor.
    - Rider 33: Increases ground ambulance rates by 25%.
    - Rider 34: Increases PDN reimbursements by 2%.
    - Rider 29: Changes the case management rate for DBMD, changing it from hourly to monthly, consistent with reimbursement in CLASS
    - Rider: 32: Makes it easier for providers, all claims will go to MCOs instead of providers trying to figure out where to submit
- Q: Transition to dual: HCBS waiver, carving into managed care?
    - No, this is not about people. Only if you're currently eligible for managed care.
- Attendant wages: Rate hearings?
    - Yes. State plan services will be impacted. Any place where direct care workers are on the ground. Waiver amendments will be required. Effective Sept. 1 is the goal.
- Q: Rider 26, how many waiver slots?
    - HHSC is still looking at this; no final answer yet. Will be about 160 in MDCP.
- Comment: The 2% is really a partial restoration of past cuts. It's an increase from current reimbursement, but it's still just a partial restoration.

Comprehensive Health Homes for Integrated Care (CHIC) Kids Pilot

- Noted the importance of participation by Nueces providers, as resources are often scarce in this area.
- Participation has increased from 348 to 624 since January.
- HHSC must submit a report by Dec. 31, 2024. Data sources will include member claims, reported data, surveys, and operation observations.
- The caregiver experience survey (pre-pilot) submissions total 148 (new total), and a mid-pilot survey will be launched at the end of the year.
- Hearing from MCOs and health homes about a great impact. New processes, new information sharing with the health home and MCO; members are more involved in their care
- Comment: One of the goals is to reduce administrative burden from MCOs and providers. Want to make sure the evaluation includes how and where this happens, including where waste has been reduced. The surveys don't really get to that. Would be helpful to know how that is being tracked.
- Q: Opportunities to bring all the pilots together would also reduce burden. Any conversation there?
    - Yes. Last month, HHSC held a meeting with all of the MCOs and health homes.

Medically Dependent Children Program Utilization Review

- Pattern of general compliance. Raising the threshold each year until 95% compliance is achieved in 2024.
- Overall performance in 2021 was 95% and nearly 97% in 2022. In conduct of assessment, MCOs achieved 92$ in 2021 and 99% in 2023.
- Measures that MCOs scored below 85% were: members who identified needs were addressed on service planning documents – this is a new measure for CMS reporting requirements, and a lower threshold is typical. HHSC works with each MCO to improve compliance (80%)
- ***Note that in the chart for service coordination, the years need to be switched. Significant improvements occurred, they did not decrease.
    - 3B.2: Service coordination follow-up has increased significantly (should be within 4 weeks of the assess

- Referrals center around DME in a time manner, the second highest referral rate is therapy services being received in a timely manner. Note that members are receiving these products and services, but may not be meeting timeliness requirements.
- Member experience surveys are largely consistent from 2021-22. They are now conducted without the MCO service coordinators present.
    - No one expressed they have difficulty getting their needed services.
    - 96% say services make a positive difference in their lives.
    - 97% believe their service plan meets their needs.
- Future targeted reviews the next three years include: CHIC Kids Pilot, transitions to adult programs, and SK with BH and IDD needs.
- Elizabeth Tucker: I'm hearing something very different from families than what these survey results show. Is it just the waiver services that are examined?
    - Look at any services listed on the service planning document. Don't compare claims or data encounters. We really work directly with the member.
- Elizabeth Tucker: Families may be saying something different to the state. We know families are grateful, but I'm having a hard time seeing that 99% are getting enough. Surveys aren't always great tools.
- Dr. Rahel Berhane: One question we like to ask is "what is the one thing we could do to help the next 6 months?" We always hear that families are exhausted and not getting enough help. We hear it so often and rarely can address it, that it can be a challenge to ask. The fact that that observation isn't surfacing may be that there's another way to ask some of these questions.
- Terri Carriker: I want to echo these concerns. I personally only have a fraction of my attendant hours staffed. And we see the same on the online boards. Attendant care nursing is needs are never met. We want a copy of the survey to see how the questions are framed. It's not really a survey, the nurses ask these questions over the phone, in the home, or remotely. Then those comments are recorded.
- Catherine Carlton: Who are the families taking the surveys? The ones who have time? I personally have been having a nightmare of time doing surveys. I'm getting very little attendant help and this week it took me 47 minutes to do a survey that I was promised would only take a few minutes. So it seems like the ones who do the surveys may be the ones who are getting their needs met and thus have time to do these surveys.
- Comment: It seems like the focus of the surveys is whether the assessments are getting done and whether the assessments reflect the needs. It seems like if this is

the focus of the survey, then it's really about a yes/no for whether the assessment is going well.
- Additional pushback and comments from the committee.
- Tucker: Can we look at authorized hours versus what is delivered? Can they be a part of that?
    - Michelle Erwin: We don't have authorization data—
    - Tucker: But the MCO does. Desk reviews would find this using the ISPs.
    - Erwin: We do have a plan to collect authorization data by a larger group. But collecting the data in a consistent and right way, it has to be meaningful.

Private Duty Nursing Data

- Analyzed encounters from 2016-2021 from TMHP for SK members receiving PDN.
- Average PDN reimbursement was $9.20 in 2017 to $10.40 in 2021. Last time this was presented it was blended, this time it's been broken down:
    - RN in 2017 was $11.46 and in 2021 was $12.11.
    - LVN in 2017 was $8.18 and in 2021 was $8.65.
- PDN usage of RNs has increased significantly, by nearly 500%:
    - In 2017, there were 7,004,176 RN units paid, for a total cost of $80,275,293.
    - In 2021, there were 34,282,208 RN units paid, for a total cost of $415,124,995.
- PDN usage of LVNs has increased significantly, by roughly 300%:
    - In 2017, there were 13,873,159 LVN units paid, for a total cost of $113,514,224.
    - In 2021, there were 42,405,244 LVN units paid, for a total cost of $366,742,972.

End of Continuous Medicaid Coverage

- Emphasized that when an individual responds, HHSC does screen them for everything. The interest list does require a referral, and HHSC coordinates with MCOs.
- Carricker: Individuals who are receiving renewal packets are being treated as new SSI populations, having to send in volumes of paperwork. Is there a way to have a team trained on the waivers to process those reauthorizations/redeterminations?

    - HHSC: Two processes: there could be a disability being reviewed as part of redetermination, or based on a waiver. Thus it could be coming from two different parts of the agency, since regular renewals are also going on.
    - Carricker: I guess what I'm asking is that some of our families are getting requests for information that they have never received before. These should be waivers as usual. Is there an across-the-board recommendation?
    - HHSC: Depends on who is asking. Waiver or Medicaid coverage.
    - Carricker: Medicaid, not waiver. 2-1-1 is not trained well on this.
- Online Q: We are receiving reports where YTB eligibility status is different than 2-1-1. YTB showing they are no longer enrolled, but 2-1-1 showing they are.
    - HHSC: Send these directly to us because these should be in alignment.

Alternative Payment Methodology Update

- While APMs began in 2017, participation for SK MCOs began in 2019. In those first three years, MCOs exceeded 25% APM targets (28%, 32%, 46%). In year 4, SK MCOs must reach 50%.
- A majority of APMs in SK occur with primary care providers (52%), followed by home health (27%).

Paperwork simplification for providers discussion

Presented by Dr. Glen Medellin

- Applies more to MDCP than anywhere else.
- In most health care, paperwork is incident to a visit. In complex cases, a lot of communication occurs outside of a visit. That outside work is not reimbursed for providers.
- Forms are not designed with children with medical complexity. Information needs to be entered multiple times on the same submissions. Despite no changes in a medical condition, providers still need to resubmit letters of medical necessity (LMN) every single time.
- Unclear what information is truly needed.
- Audits require a lot of redundancy just to check a box for the managed care manual that something has been done.
- LMN are often requested, even when supplies are within approved quantities.
- Agencies receive enough denials on billing that request excessive documentation.

- At University Health CCC, each patient averages 26 faxes per year. It results in each provider receiving 14,327 faxes, which is not reimbursable. University Health CCC is now closed to new patients.
- EX: Supply agencies now require letters of medical necessity every 6 months, regardless of whether a condition is clearly permanent (ex: quadraplegic). Not a simpler way for providers to simply say "no status change."
- EX: Therapy evaluations are good for 60 days. Due to a shortage of therapists, the evaluations are expiring before services can be fully rendered, so additional evaluations are needed.
- It's hard to figure out what the ask even is to HHSC here.

6-month authorizations for continuation of services discussion

Presented by Catherine Carlton

- A policy requiring a doctor's appointment for 6-month PA renewals of DME, PDN, and supplies is burdensome.
- They are not medically necessary.
- The appointments take several hours. There aren't always related billing codes. Not all providers offer telehealth for the 6-month appointment. Routinely need to see several specialists, all every 6 months. When you can't get into these appointments timely, it results in additional delays of care.
- Dr. Berhane: A lot of doctors don't even do this amount of work, which is actually worse. It's a barrier of care. No good answers. Don't want to require this amount of paperwork. But how do we address the balance to ensure we protect against fraud?

Public Comments

Jessica Boston, Texas Association of Home Care and Hospice
Discussed lack of access to nurses and increased hospitalizations. Concerned with new draft policies that would limit the ability to hire nurses with greater experience with ventilators.

Hannah Metha, Representing herself

Echoed same concerns with the utilization results that were brought up during committee. Regarding PHE, wants HHSC to consider a specially-trained team to assist medically dependent families.

Kristen Vitek, RN from Angels of Care
Concerns with PDN policies on specialized nursing policies. The UA modifier allows for additional reimbursements for experienced and trained nurses. These staff typically require a higher wage because respiratory equipment is technically difficult. Masks are often more challenging than traches because they require frequent adjustment. Having a differential is important for a UA modifier. Reducing reimbursement should not be allowed.

Elizabeth Tucker: I'm really concerned about this and the short two-week turnaround for comments. Further, disappointed this did not come to the committee, first. Wants the committee to oppose it.

Shane Adcock, Respiratory Therapist with Angels of Care
Concerned that the new proposed policies dismiss the important distinction between traches and masks.

Dr. Berhane: I am concerned that respiratory kiddos need the most help and this will not help.
Tucker: Can we move to delay the policy?
Michelle Erwin: From a non-process perspective, I'm open to receiving any feedback and reflecting your input.

A motion was made to oppose the policy. The motion passed.

Children's Comprehensive Care Clinic Overview

Presented by Dr. Berhane

- Preventative care is different for this population. Elements for a successful comprehensive system of care include: access to acute care, a narrative approach to preventative visits, provider integration, education and training, and breaking isolation barriers.

- Acute care services: Families want access to clinicians who already know their story and don't have to repeat every medical detail. They also need access to same day appointments. Proactive call backs for sick calls and ED visits must also occur.
- It's a tremendous amount of work, most of which is not reimbursed.
- A whole child visit is important. It's 4.5 hours. But there's not a way to bill for this. However, trying an enhanced payment system with BCBS for the CHIC pilot.
- Integration is harder because it depends on outside teams. There is a level of specialist integration, especially using telehealth for providers to join existing visits. Tried to integrate a signature platform to reduce faxes. May be the only pilot trying to coordinate with MCO service coordination.
- Challenges: Much has been covered today. But there is a home health crisis. Families need more help, especially at night.
- Solutions: We need a new way to look at medically complex kids. A registry to track this. Designate health homes when they are centers of excellence. Coordinate integration, maybe bundled payments. Need a workgroup.
- Q: How does funding work?
    - Their clinic started with DSRP funds for 3 years and had ample funding to build a strong foundation. Highly subsidized by children's hospital, so it's not sustainable. We have an agreement with MCOs to hire our own nurses. But this is such a small population that APMs are impossible and these kids are going to have regular hospital visits.