Health and Human Services Commission
Medical Care Advisory Committee

June 15, 2017
Meeting Minutes

Members Present:
Dr. Gilbert Handal, Chair
Ms. Horton, Vice Chair
Deshpande, Salil, M.D.
Cynthia Jumper
Donna Smith, PT
George Smith, DO
Edgar Walsh, R. Ph
Mary Helen Tieken, RN
Doug Svien
William Galinsky, HPAC Representative

Members Absent:
David Webster, M.D.

1. Opening comments - Dr. Gilbert Handal, Medical Care Advisory Committee Chair.

Dr. Gilbert Handal called the meeting to order at 9:12 am and based upon the members in attendance, a quorum was present.

Pam McDonald, Director of Rate Analysis for Health and Human Services Commission (HHSC), provided an update on a Centers for Medicare & Medicaid Services (CMS) rule which had to be extremely expedited to get in place within certain time constraints. It was proposed and adopted in between MCAC meetings. The rule establishes an additional eligibility period for a program called the Minimum Payment Amounts Program (MPAP) which is a program for nursing homes. Under this program, if a nursing home is publicly owned, it is allowed to provide the non-federal share of the difference between the Medicaid rate and the Medicare rate for Medicaid recipients in nursing homes. The non-federal share draws down the federal match which draws down more than a dollar for each dollar of non-federal share put up and then the funding is intended to be reinvested in the nursing facilities to help improve quality of care. This is a rule amendment that simply adds an additional eligibility period which runs from April, 2017 to August, 2017 and at that point the program will be replaced by a program which ties the funding to quality indicators and is also open to private nursing facilities. That program is called the Quality Incentive Payment Program (QIPP).

Dr. Handal asked if the program is interim or has it already been adopted. Ms. McDonald replied, the rule has already been adopted and became effective around June 14, 2017. Dr. Handal questioned what the financial impact would be for the state. Ms. McDonald replied there is no financial impact to the state because the non-federal share is provided by non-state owned governmental entities, primarily local hospital districts, which have purchased

nursing homes and contracted with the former owner to operate the nursing facilities. Those non-state governmental entities, under Federal regulations, are allowed to put up the non-federal share so there's no general revenue associated with the program. Ms. Horton asked if the new Quality Incentive Payment Program is already approved. Ms. McDonald replied it is approved by CMS and the rules have been adopted and the program implementation date is September 1, 2017.

2. Comments from Jami Snyder, Associate Commissioner for Medicaid and CHIP Services Department, HHSC.

Ms. Snyder provided an overview of the outcomes of the 85th Regular Legislative Session, 2017, including HHSC's Healthy Texas Women's waiver submission, on-going provider re-enrollment work, Children's Health Insurance Program (CHIP) pre-authorization and the HHSC 1115 Waiver discussions. The legislative session, which ended on May 29, 2017, will be followed by a 30-day special session which begins on July 18, 2017. Stemming out of the regular legislative session, are a number of bills which HHSC tracked and which were ultimately approved by the legislature. In total, 55 of the bills HHSC monitored were approved; Governor Greg Abbott has until June 18, 2017 to veto any bills.

There were several bills pertaining to coordination of care around behavioral health benefits. These were House Bill 2466, which was approved by the legislature, relating to the reimbursement of maternal depression screening and referral; House Bill 1486 relating to the development of a new peer specialist benefit; and House Bill 1600 which allows THSteps providers to be reimbursed for mental health screening for young adults ages 12 through 19. HHSC tracked activity around pharmacy benefits. There was much discussion throughout the course of the legislative session on whether to extend the pharmacy benefit as it is currently administered as a combination program, where the Preferred Drug List (PDL) and prior authorization standards are maintained by the states, and the managed care organizations (MCOs) contract independently with pharmacy benefit managers to manage the benefit on their end. House Bill 1917 was passed; this bill extends the administration of the pharmacy benefit by the state.

In addition to bills in the pharmacy arena, there were bills which addressed ensuring continued coverage where members may have a gap in coverage. One of the bills was House Bill 3292 which requires HHSC to continue Medicaid coverage for a person who experiences a temporary increase in income, for a duration of a month or less, which will cause a person to be ineligible for Medicaid.

The budget, as approved by the Governor, plays a big role in HHSC activity on the fiscal and the policy side. Cost containment initiatives included in this year's budget and which HHSC will be exploring over the course of the coming months include:

- A fraud waste and abuse collections initiative.
- The evaluation of reimbursement for dual eligibles to ensure there is no duplicative reimbursement.
- Increasing efficiencies in the vendor drug program, understanding that House Bill 1917 passed and HHSC will be responsible for the ongoing administration of the vendor drug

program. Looking at administrative efficiencies in particular which can be utilized to make the vendor drug program more administratively attractive and feasible for providers.

- Looking at opportunities to increase third party recruitments.
- Implementing a pilot program for motor vehicle subrogation.
- Looking for efficiencies around the production of Medicaid identification cards.

The legislature, through the budget, reduced the current 2 percent risk margin HHSC has in contract for MCOs to 1.75 percent for STAR Kids and STAR+PLUS and to 1.5 percent for STAR and STAR Health.

The legislature advanced an adjustment to provisions and timing around the therapy rate reduction including a 25 percent restoration of reductions made to reimbursement rates for acute care therapies during the 2016 and 2017 biennium as well as a phase-in of reductions for therapy assistant reimbursement. HHSC is working through the details and timing around the restoration and phase-in process.

HHSC has recently administered the Healthy Texas Women program as a General Revenue program only. HHSC is proposing to submit a waiver to CMS to draw down federal funding for a portion of the cost of the program. HHSC's public comment period for the waiver is open and posted on the HHSC website. HHSC is reviewing public comments which were received and is making necessary adjustments to the proposed waiver submission. HHSC plans to submit the waiver to CMS for consideration on June 30, 2017; the proposed effective date is September 1, 2018. HHSC is proposing a five-year period for the extent of the waiver; the five year period would end on August 21, 2023.

HHSC has been engaged in provider re-enrollment in excess of two years; the effort stems from provisions in the Affordable Care Act (ACA) requirement that all providers currently enrolled with the Medicaid system re-enroll. HHSC met the deadline for the initial re-enrollment of Medicaid providers and is now working with ordering and referring physicians to re-enroll with the Medicaid Program; with CHIP providers to re-enroll with the Medicaid Program; and with a few long-term care services and supports (LTSS) providers who are contracted with the MCOs but are not enrolled with Medicaid. The deadline for ordering and referring physicians to enroll is October 1, 2017; the deadline for CHIP providers to re-enroll is December 31, 2017; the deadline for MCO/LTSS providers to re-enroll is January 1, 2018.

Texas has been asked to provide input through testimony to Congress on the CHIP reauthorization effort. The CHIP program is set to expire if not reauthorized on September 30, 2017. With the advent of the ACA and the last reauthorization of the CHIP program, HHSC's federal partners agreed to increase the federal matching percentage by 23 percent which puts HHSC at about 93 percent of the program funding of the provided by our federal partners. There is a great deal of discussion around the ACA and the American Health Care Act (AHCA) regarding the merit of continuing the increase in the federal matching rate of 23 percent. HHSC has the opportunity to testify before the U.S. House of Representatives subcommittee regarding the Federal matching rate.

The 1115 waiver sustains HHSC's managed care system and acts as a vehicle for the Uncompensated Care Pool as well as the Delivery System Reform Incentive Payment (DSRIP) program. In January, HHSC submitted a letter to CMS requesting a 21-month extension beyond the 15-month extension which is due to expire at the end of 2017. HHSC is in ongoing discussions with the federal partners regarding the extension and/or renewal of the waiver. HHSC is actively negotiating and working with CMS.

At Dr. Handal's request, Jami Snyder agreed to send the MCAC Committee a summary of her presentation. Ms. Snyder suggested once the July 18th date has passed for the Governor to officially weigh in on the legislation approved by the House and Senate, the MCAC would be provided with a summary of the bills that will be the priority of HHSC going forward.

Ms. Horton asked how HHSC will appoint the work groups which House Bill 10 on the mental health condition and substance use disorder parity and House Bill 1486 on the peer services require. Jami replied that shortly after Governor Greg Abbott has an opportunity to weigh on legislation, HHSC will be issuing information around the establishment of various work groups which require community or stakeholder input.

Dr. Handal asked what special issues related to health care are being introduced or will be discussed in the special session. Ms. Snyder noted the only issue that may impact HHSC was an item around maternal mortality and specifically around the extension of the state's maternal mortality task force.

3. Approval of February 16, 2017, meeting minutes.

Ed Walsh motioned for approval of the minutes.
Mary Helen Tieken seconded the motion
The motion to approve the minutes passed unanimously

NOTICE OF INFORMATIONAL ITEMS:

4. Inpatient Hospital Reimbursement.

HHSC proposes an amendment to TAC Title 1, Part 15, Chapter 355, Subchapter J, Division 4, §355.8052, relating to Inpatient Hospital Reimbursement, to modify the definition of a rural hospital. The proposed amendment is necessary to comply with the 2018-2019 General Appropriations Act (Article II, Health and Human Services Commission, Senate Bill 1, 85th Legislature, Rider 37). Rider 37 directs HHSC to define a rural hospital as (1) a hospital located in a county with 60,000 or fewer persons according to the 2010 U.S. Census; or (2) a hospital designated by Medicare as a Critical Access Hospital (CAH), Sole Community Hospital (SCH), or a Rural Referral Center (RRC) not located in a Metropolitan Statistical Area (MSA); or (3) a hospital which (a) has 100 or fewer beds, (b) is designated by Medicare as a CAH, an SCH, or an RRC, and (c) is located in an MSA. Current rule language defines a rural hospital as a hospital in a county with

60,000 or fewer persons based on the 2010 Decennial census, a hospital designated by Medicare as a CAH, an SCH, or an RRC.

This rule is expected to result in an avoidance of cost to the state of approximately 45 million dollars in general revenue annually. The proposed rule is being presented at the June 15, 2017 Medical Care Advisory Committee (MCAC) meeting as an informational item in order to meet the September 1, 2017 implementation deadline and has been sent to the Texas Register. HHSC will be taking comments on the rule which has been circulated to stakeholders and the hospital associations requesting them to distribute to their members.

- *Selvadas Govind, HHSC Director of Rate Analysis for Hospitals*

5. Waiver Payments to Hospitals for Uncompensated Care.

HHSC proposes amendments to TAC Title 1, Part 15, Chapter 355, Subchapter J, Division 11, §355.8201, relating to Waiver Payments to Hospitals for Uncompensated Care. The proposed rule amendments are necessary to comply with the 2018-2019 General Appropriations Act (Article II, Health and Human Services Commission, Senate Bill 1, 85th Legislature, Regular Session, 2017, Rider 37) which revises the definition of a rural hospital as: (1) a hospital located in a county with 60,000 or fewer persons according to the 2010 U.S. Census; or (2) a hospital designated by Medicare as a CAH, an SCH, or an RRC not located in a MSA; or (3) a hospital which (a) has 100 or fewer beds, (b) is designated by Medicare as a CAH, an SCH or an RRC, and (c) is located in an MSA. The current rural hospital definition is a hospital located in a county with 60,000 or fewer persons according to the most recent United States Census, a Medicare-designated RRC, an SCH, or an CAH.

This rule is related to rule 355.8201 on waiver payments to hospitals for the UC program. In this rule we have a definition of a Rider 38 hospital and the definition was meant to conform with the definition of a rural hospital in 2014-15 General Appropriations Act (GAA), S.B. 1, 83rd Legislature, Regular Session, 2013 (Article II, Health and Human Services Commission, Rider 38). Since the recently-concluded session 85th Legislature, Regular Session redefined what a rural hospital is, HHSC needed to update the rule to reflect the change. In order to comply with the recent GAA Rider 180 on the definition of a rural hospitals, HHSC has amended this rule to remove references to Rider 38 and instead refer to these hospitals as rural hospitals. For the definition of a rural hospital we have referred back to the inpatient reimbursement rule previously discussed. There is no impact on general revenue **(GR)** because the UC program is entirely IGT funded. This rule has been sent to the Texas Register and has been circulated to stakeholders; there will be a 30 day comment period.

- *Selvadas Govind, HHSC Director of Rate Analysis for Hospitals*

Bill Galinsky asked how many hospitals are being impacted by this rule; are all but one rural referral centers and is one a sole community center? Mr. Govind replied, there are nine hospitals that will be impacted; eight of them are rural referral centers and one is a

sole community hospital. Mr. Galinsky asked, are there any other hospitals that may be impacted that have not been included in the list? Mr. Govind replied, no, this is the complete list that HHSC is aware of. Mr. Galinsky asked; so the total is approximately $100 million all funds spread across all eight hospitals, what would be the impact to those hospitals on the UC side for not having the designation? Mr. Govind responded, there is one hospital that was treated as a Rider 38 hospital in UC that will no longer qualify. This hospital was paid about $20.7 million as a rural hospital in UC in federal fiscal year 2016; if they had not been classified as a rural hospital they would have been paid $14.7 million dollars instead. Those figures were reviewed, bearing in mind that their payments could have been higher, had they been able to provide additional non-federal funds as IGT; payments were limited by the amount of IGT they had. Mr. Galinsky asked if the Potentially Preventable Hospital Readmission PPR and Potentially Preventable Complication (PPC) based incentive payments will be impacted by this change in definition. Mr. Govind replied yes, non-rural hospitals will have access to the safety net add-ons.

Ms. Horton asked if the rule will result in the closure of any rural hospitals. Mr. Govind replied HHSC does not have any information on hospital closures; that information is at hospital level. The nine hospitals mentioned are large hospitals, all over 200 beds and all in urban settings. **Dr. Cynthia Jumper requested a list of the nine hospitals be sent to the MCAC committee.**

TESTIMONY:

Richard Schirmer, Texas Hospital Association (THA), spoke in opposition of Agenda Item 4 & 5

Mr. Schirmer stated THA felt the need to comment even though Agenda items 4 & 5 are informational. He gave the following two THA recommendations:

- HHSC pay the hospitals already approved as rural hospitals using the current rule payment methodology
- HHSC should provide a transition period if it moves forward with the rule

Mr. Schirmer provided comments on the following:

- Medicare designation should be paid according to the current Medicaid payment methodology.
- HHSC should allow transition periods when complex changes are made, as hospitals set their budget 6 to 9 months in advance

THA requested clarification on the following items:

- Rider 180 does not address inpatient services or uncompensated care and THA is asking for a review of this
- THA is seeking clarification of legislative intent for sole community hospitals

Dr. Handal agreed that transition is always important and asked if HHSC has considered having a transition period while issues are being resolved. Mr. Govind replied, HHSC is

inviting comments and will be responding to comments and the request for a transition period when the final rule is published. Dr. Handal stated that THA's request was reasonable and HHSC should consider the request. Dr. Cynthia Jumper agreed that a transition period is fair.

6. **Federally Qualified Health Centers.**

HHSC proposes amendments to TAC Title 1, Part 15, Chapter 355, Subchapter J, Division 14, §355.8261, relating to Federally Qualified Health Center Services (FQHC) Reimbursement, to comply with *Legacy Community Health Services, Inc. v. Janek,* 184 F. Supp. 3d 407 (S.D. 2016), which requires changes to the Federally Qualified Health Center (FQHC) payment process.

Under federal law (42 U.S.C. § 1396a(bb)), FQHCs must be paid for services provided to Medicaid clients in an amount that is equal to the average of the FQHC's per visit costs. This amount is called its encounter rate, also called a Prospective Payment System (PPS). FQHCs are safety net providers in the community. If an FQHC provides services under a contract with a managed care organization (MCO) or dental maintenance organization (DMO) (also referred to in 1 Tex. Admin. Code § 355.8261 as dental managed care organization), 42 U.S.C. § 1396a(bb)(5) requires the state to make a supplemental, or "wrap," payment to the FQHC in the amount of the difference between the federally required encounter rate and the amount of the payments provided under the contract. Since September 1, 2011, HHSC has required MCOs and DMOs, for both Medicaid and CHIP services, to pay FQHCs their full encounter rate, rather than a contracted rate. HHSC is required to stand up a new process by September 1, 2017. HHSC is not changing the reimbursement amounts paid to FQHCs but ultimately changing who is responsible for ensuring the full encounter rate is paid.

The requirement for paying a wrap payment quarterly is federally mandated; HHSC is making a change to state that payment is to be made *at least* quarterly. The biggest change HHSC is making is adding clarification regarding the payment dispute and the appeal process that FQHCs have with MCOs, DMOs and HHSC. HHSC wants to make it absolutely clear in this rule that ultimately HHSC is responsible for this payment for both in-network and out-of-network claims as part of the rule amendment.

Regarding stakeholder involvement, HHSC has been holding regular workgroup meetings working very closely with MCOs, DMOs FQHCs as well as their trade associations to operationalize the new process.

- *Michelle Erwin, Director of Policy and Program Development, HHSC Medicaid and CHIP Services Department*

Ms. Horton stated, maybe I am missing something, but it seems like this provides a lot of incentive for the MCOs to negotiate very low rates. Ms. Erwin replied, we have not set a floor. In HHSC's contract with the MCOs and DMOs, we make it very clear that they must negotiate a rate that is similar to other providers of similar services; HHSC is also going to

require the MCOs and DMOs to attest to the fact that they are meeting that Federal requirement. If we find they are not doing so, HHSC can contractually assess damages or whatever we need to do.

7. **Nursing Facility Direct Care Staff Enhancement Program Enrollment Electronic Notification.**

HHSC proposes amendments to TAC Title 1, Part 15, Chapter 355, Subchapter C, §355.308, relating to Direct Care Staff Rate Component. Section 355.308 outlines procedures for the Nursing Facility Direct Care Staff Enhancement program. The Direct Care Staff Enhancement program is an optional program that offers contracted nursing facility providers the option to receive increased payments if they meet certain staffing and spending requirements. HHSC offers contracted providers the opportunity to enroll in the program annually.

The proposed amendments allow HHSC to notify contracted providers of (1) the open enrollment period for this program, (2) their enrollment limitations (if any), and (3) recoupments due to failure to meet the spending and staffing requirements (if any), electronically or by other appropriate means as determined by HHSC. The proposed amendments also allow contracted providers to submit requests for revisions or recalculations electronically or by other appropriate means as determined by HHSC. These proposed amendments will allow for the use of a broad array of communication methods between HHSC staff and contracted providers, as the rule currently requires this communication to occur on paper.

- *Sarah Hambrick, HHSC Rate Analyst*

TESTIMONY:

Deseray Matteson, Texas Health Care Association, spoke neutrally regarding Agenda 7

Ms. Matteson stated their response was overwhelmingly positive for this rule change and support any move away from an exclusively paper system into an electronic system that is cost efficient and faster. Ms. Matteson asked for clarification of how the process would be executed. Ms. Hambrick stated it will be via the email process and the source for that information is the State of Texas Automated Reporting System (STAIRS) which is used by nursing facilities to submit their cost report information. THCA questioned how updates will be made in the system. Ms. Hambrick stated the STAIRS system would be used for updates. THCA suggested a transition to the new process via a phased-in paper notification of the new process.

Dr. Handal asked how many facilities are not electronically based. Ms. Matteson replied we are just suggesting one final hand over from the old process to the new process.

Ms. Hambrick explained that the State of Texas Automated Information Reporting System (STAIRS) is where all the cost reporting data is entered. The entire system is web-based; providers must have at least one email contact and that person must be an entity contact, it cannot be someone who is a hired provider or a hired preparer to do their cost reporting, it must be someone who has control over the contract. Secondly, HHSC will put out a notice via GovDelivery which is an electronic system; all providers are required to subscribe to GovDelivery. The notice is going to the entity contact and the financial contact who must both be employees of the agency and will highlight that the rest of open enrollment is going to be electronic. Ms. Hambrick stated that 2016 is the second year that the nursing facilities have been doing their cost reports in STAIRS; HHSC has had incredibly good response.

Ed Walsh asked if HHSC will send out this last notification on paper. Ms. Hambrick responded, no, we will send a GovDelivery notice as it is less cost-prohibitive. All providers are required to subscribe to GovDelivery which provides notifications through their contracts.

8. **Home and Community-based Services (HCS) Supported Home Living Rate Methodology Changes, HCS High Medical Needs Services and Attendant Compensation Rate Enhancement Program Enrollment Electronic Notification.**

HHSC proposes amendments to TAC Title 1, Part 15, Chapter 355, Subchapter A, §355.112, relating to Attendant Compensation Rate Enhancement; and Subchapter F, §355.723, relating to Reimbursement Methodology for Home and Community-based Services and Texas Home Living Programs.

Methods of Communication between HHSC and Contracted Providers

Section 355.112 outlines procedures for the Attendant Compensation Rate Enhancement program. The Rate Enhancement program is an optional program that offers contracted providers increased payments if they meet certain spending requirements. HHSC offers contracted providers the opportunity to enroll in the program annually. The proposed amendments allow HHSC to notify contracted providers of (1) the open enrollment period, (2) their enrollment limitations (if any), and (3) recoupments due to failure to meet spending requirements (if any), electronically or by other appropriate means as determined by HHSC. The proposed amendments also allow contracted providers to submit requests for revisions or recalculations electronically or by other appropriate means as determined by HHSC. These proposed amendments allow for the use of a broad array of communication methods between HHSC staff and contracted providers, as the rule currently requires this communication to occur on paper.

Aligning Certain Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Rates with Costs and Rates for Similar Services

TxHmL is projected to be carved-in to Medicaid managed care under STAR+PLUS effective September 1, 2018, and HCS is projected to be carved-in effective September 1, 2021. Currently, STAR+PLUS covers attendant and habilitation services for individuals

with disabilities through STAR+PLUS Community First Choice (CFC), including services for individuals with intellectual and developmental disabilities. When TxHmL and HCS are carved-in to Medicaid managed care, attendant care and habilitation services will be provided through STAR+PLUS CFC. There will be no differential between individuals receiving additional waiver benefits and those receiving only CFC services with respect to those services.

Currently, payment rates for TxHmL Community Support Services (CSS) and HCS Supported Home Living (SHL) services are higher than the STAR+PLUS CFC rate and the costs of providing these services. In preparation for the managed care carve-in of these services, HHSC proposes amendments governing their rate determination to more closely align them with the STAR+PLUS CFC rate.

As outlined in 1 Tex. Admin. Code § 355.112(l), the attendant compensation rate component for nonparticipating contracts is frozen at the rates in effect August 31, 2010, for the HCS and TxHmL programs. Currently, 1 Tex. Admin. Code § 355.112(l) requires the attendant compensation rate component for nonparticipating contracts to remain constant over time, except in the case of increases mandated by the Texas Legislature or necessitated by an increase in the federal minimum wage. HHSC is amending this rule to indicate that the attendant compensation rate component for nonparticipating contracts for HCS SHL and TxHmL CSS is equal to $14.52 per hour, which is the level currently justified by HCS and TxHmL provider cost reports.

Section 355.723 establishes the rate methodology for all other HCS SHL and TxHmL CSS cost components. HHSC is amending this rule to align its rate methodology for these cost components with rate methodologies for similar services. Specifically, HHSC is tying the HCS SHL and TxHmL indirect cost component (also known as the administration and facility cost component) to the administrative and facility cost component of the Community Living Assistance and Support Services (CLASS) waiver program residential habilitation service and deleting the other direct service staffing cost component. The CLASS residential habilitation service has similar requirements for these cost areas and was incorporated in the calculation of the STAR+PLUS CFC proxy rate as described in 1 Tex. Admin. Code § 355.9090, relating to Reimbursement Methodology for Community First Choice. Specifically, 1 Tex. Admin. Code § 355.9090(b)(1) states that the STAR+PLUS CFC rate will be equal to a weighted average of rates established for CLASS habilitation services and proxy rates for attendant services under the Community-based Alternatives waiver prior to its termination.

Rate Methodology for HCS High Medical Needs Services and Correction to Rate Methodology for HCS Nursing Services

As indicated above, 1 Tex. Admin. Code § 355.723 establishes the reimbursement methodology for the HCS and TxHmL waiver programs. Additional proposed amendments include: (1) adding the new HCS High Medical Needs Support, High Medical Needs Registered Nurse (RN), and High Medical Needs Licensed Vocational Nurse (LVN) services to the list of non-variable rates; (2) adding the rate methodology for the new HCS

High Medical Needs Support Services; and (3) correcting an error in the projected weighted units calculation for nursing services.

High Medical Needs Support, High Medical Needs RN, and High Medical Needs LVN services will provide additional support for eligible persons who have medical needs that exceed the service specification for existing HCS services and who need additional support in order to remain in a community setting. However, these services have not been added as reimbursable services by HHSC. While the rate methodology for High Medical Needs Support, High Medical Needs RN, and High Medical Needs LVN will be effective with the effective date of the rule, the associated rate cannot be paid until the services are reimbursable.

The indirect cost component per unit of service for each HCS service is determined by calculating the projected weighted units of service for each service type, and then using the projected weighted units to allocate administration and operation costs to the specific service type. These weights are codified in the reimbursement methodology; however, the weighting factor for nursing services is incorrect in the rule and does not match the weighting factor used in the calculation of the rates. The proposed amendments correct this error.

Other Changes

The proposed amendments to 1 Tex. Admin. Code § 355.112 also correct punctuation and an outdated rule reference.

- *Sarah Hambrick, HHSC Rate Analyst*

TESTIMONY:

Erin Lawler, Texas Council of Community Centers, spoke in opposition of Agenda Item 8

Ms. Lawler recognized that the stage has been set for the rate cut and urged delay of the effective date of the cut to September, 2017. Ms. Lawler stated the August 1, 2017 date does not allow a reasonable time frame for providers, affected workers or individuals and families to prepare for the cuts. The cost of health care in Texas is going up; however, regarding long term services and supports for persons with intellectual disabilities, the HCS program is cost-effective, due in large part to the development of alternatives to group home settings. From 2005 to 2015, the monthly cost to support an individual in the HCS program decreased by 3%. A stable workforce, including direct service workers, is vital to a provider's ability to successfully support a person with intellectual disabilities (ID) in the community. Stability in the direct service workforce results in improved health outcomes, quality services and continuity of care, while instability risks in exposure to abuse and neglect, skill regression and poor health outcomes. This runs counter to the state's goal to more effectively support the un-met mental health needs of individuals with ID. The

average monthly cost to support a person in a SSLCs was 5 times higher than community services.

Carole Smith, Private Providers Association of Texas (PPAT), spoke neutrally regarding Agenda 8

Ms. Smith noted the movement of Texas Home Living into STAR+PLUS is delayed until September 1, 2020. The hearing on the rates (Consumer Directed Services ((CDS)) and non-CDS) had fairly equal representation; the general consensus was the rates needed to be kept whole. The rule should be postponed until September 1, 2017. Many providers use contract staff for the Community First Choice (CFC) direct service provider and many of the contracts require 30-45 day notice of a contract change.

Ms. Horton asked what the impetus for the reduction was. Ms. Hambrick replied, the direction came from the internal HHSC Executive Staff. **Ms. Horton stated she would appreciate it if the committee would send a message to the Executive Commissioner requesting the rule be delayed till September 1, 2017.**

Dr. Handal supported Ms. Horton's suggestion and stated that he wishes to have a report from HHSC Rate Analysis on the effect of cutting these rates within 6 months to 12 months from now; the report should show if any providers have been lost. Doug Svien asked HHSC to identify how many providers give up their contracts because of the rate reduction, how many people go to the CES program that are currently getting it through the providers (therefore the cost will go up to the program as well) and how many people transfer to the more expensive programs like institutional settings, residential care, foster care, etc. and see how it actually did affect them. Ms. Horton expressed concern that the expedited rule making does not make sense given this was an internal decision to move forward and was not a legislative directive or a judicial decision.

ACTION ITEM:

9. **Pharmacy Claims.**

HHSC proposes amendments to TAC Title 1, Part 15, Chapter 353, Subchapter J, §353.905, Managed Care Organization Requirements; Chapter 354, Subchapter F, relating to Prescription Requirements. 42 C.F.R. § 455.410 requires that all ordering and referring physicians or other professionals providing services under the Medicaid state plan or under a waiver of the plan be enrolled as participating providers. The proposed amendments clarify, for both managed care and fee-for-service Medicaid, that a prescribing provider must be enrolled in Medicaid for the pharmacy to be reimbursed for filling the prescription.

Ms. Parrilla stated HHSC received feedback which requested clarification be made as to how the rule impacts residents and interns in teaching hospitals**. HHSC will be adding language that clarifies that teaching positions are not required to co-sign orders written by a resident and that those prescriptions will be honored and filled as well.**

HHSC started outreach in mid-2016 utilizing various medical associations to gauge impact. Outreach was implemented again in April of 2017 focusing on prescribers who are not enrolled and reaching out to clients who are utilizing prescribers who are not enrolled.

- *Priscilla Parrilla, HHSC Director of VDP Pharmacy Operations and Contract Oversight*

Dr. Handal expressed appreciation that HHSC will be adding the clarification language. Dr. Deshpande questioned regarding Medicaid members who may be seeking care in an emergency setting and are prescribed something by an emergency room physician who may not have a Medicaid Texas Provider Identifier (TPI). Ms. Parrilla stated HHSC is focusing on reaching out to all of the hospitals and ensuring that their physicians are enrolled. In those cases the claim would reject if the prescriber was not enrolled unless it was the resident intern teaching, then they could use the supervising physician's National Provider Indicator (NPI).

Dr. Deshpande responded, this is going to be a problem. We are not going to get ER doctors to sign up with Medicaid.

Ed Walsh noted that before managed care and before NPI numbers, physicians could use a hospital designated number. How will does HHSC plan to solve this problem.
Ms. Parrilla replied that she did not have an answer to the question but will discuss with the team as to how to mitigate the risk; and will get back with the committee.
Mr. Walsh stated as far as the rules that the provider has to be enrolled in Medicaid; this has been an ongoing problem for pharmacy.

Ms. Parrilla stated that the regulation that requires HHSC to implement this rule, 42 Code of Federal Regulations §455.410, specifically requires all ordering and referring physicians or other professions providing services under the Medicaid State Plan or under a waiver of the Medicaid State Plan to be enrolled as participating providers. Dr. Deshpande suggested that HHSC should explore how other states have implemented this. Dr. Handal stated that the problem in Texas is that there are many physicians who do not accept Medicaid and are not enrolled in Medicaid. Dr. Cynthia Jumper expressed that a lot of the emergency rooms are staffed by locom tenens. It will be impossible to cover the Medicaid patients if the training staff, emergency room staff and the locom tenens do not have a special consideration in this rule.

Dr. Handal expressed concern that there are so many exceptions in the rule. The rule as written can't be accepted and should be re-written. Tamela Griffin with HHSC asked for clarification from the Committee: If, under the Federal guideline, HHSC is confident there is no exception for ED physicians, HHSC is to come back to the Committee, if there is no exception, to confirm that HHSC arrives at the best solution.

HHSC is to:

1. Confirm it has to happen
2. Talk about what can be done operationally to encourage the unique physicians groups

Ms. Parrilla noted that HHSC has been audited for compliance with this requirement and received a finding. In response, HHSC informed CMS that HHSC would be implementing rule updates and adjustments to be effective October, 2017.

Donna Smith asked if HHSC is ready for the rush of enrollment. HHSC stated they are ready, the application is shorter and there will be no fee for enrollment. Mary Helen Tieken expressed concern that this is not a failsafe system.

Dr. Cynthia Jumper moved to accept the rule (with as much feedback as possible).
Ed Walsh seconded the motion (with the caveat that the Hospital NPI number be added to the prescription)
Dr. Deshpande opposed the Rule
Ms. Horton abstained
The rule passed with the exceptions as noted above

Dr. George Smith moved that the Committee direct the Chair, Dr. Gilbert Handal to send a letter to the (Governor, Lieutenant Governor HHSC Executive Commissioner) stating that the MCAC is supposed to advise, and the purpose of the committee is being bypassed, denying the committee input. Secondly, by continuing to cut reimbursements on the Medicaid side to all providers, providers are being driven away due to rate cuts. The Legislature needs to know that healthcare in Texas is being jeopardized. Ed Walsh supported Dr. Smith's concerns. The motion was not acted upon.

Concern was voiced that the Medical Care Advisory Committee is being bypassed by the process of presenting rules as informational items. A further concern was raised that the public is are coming to testify on items that are already decided upon.

The Chair stated he would write a letter to the Associate Commissioner, Medicaid and CHIP Services and the Executive Commissioner regarding the concerns of the Committee.

10. Public Comment

No additional Public Comment was received.

11. Proposed next meeting: August 17, 2017, at 9 a.m.

12. Adjourn