August 3, 2020

VBPQIAC Workgroup 5 – COVID Policy Recommendations

Policy Issue:

The VBPQI Committee supports evaluating services provided during the pandemic through waivers and other innovative activities to inform what changes would continue to support patients both during and after the COVID-19 pandemic. This information also can be used to further value-based care through APMs. The VBPQI Committee recommends that:

- HHSC work with stakeholders to evaluate the Medicaid waivers used in telehealth during the pandemic including access to care, patient experience, health outcomes and cost effectiveness to share best practices and determine policy changes that should continue post-pandemic.
    - Consider how telehealth can count toward network adequacy.
- HHSC work with stakeholders to reward and incentivize creative practices that improve health based on the experience during COVID-19, such as prospective payments for primary care providers.
- Texas review the experience of Social Drivers of Health (SDOH) Medicaid members experienced during the COVID-19 pandemic for waivers that could be instituted in an expedited approval process in future emergencies/disasters. Areas of focus could include:
    - Establishing enhanced rates for disaster-related services, such as used by Medicare for COVID-19.
    - Flexibility for additional administrative costs required during a disaster, such as purchase of pre-paid smart phones for beneficiaries to use for telehealth during a disaster.
- HHSC work with stakeholders to align value-based payment measures and incentives as much as possible within each region of Texas to reduce provider administrative burden.

Discussion:

<u>Medicaid Telehealth Waivers</u>

Beginning in March 2020, the Centers for Medicare & Medicaid Services (CMS) approved Texas' request to waive certain Medicaid regulatory requirements to help physicians and other health care professionals more effectively respond to the COVID-19 pandemic.[1] Key telehealth provisions included:

- Telemedicine/audio only delivery of Texas Health Steps "well child" check-ups
- Telemedicine/audio only delivery of certain acute care office visits
- Telemedicine/audio only delivery of certain behavioral health services

[1] https://www.texmed.org/TexasMedicineDetail.aspx?id=53127

- Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) reimbursement for telemedicine and telehealth services

Additional details are available through Texas Medicaid and Healthcare Partnership (TMHP) policies.[2]

Initial experiences with telehealth through discussions with VBPQIAC members include:

- Telephonic options were highly utilized and critical given broadband, cell phone, and data plan limitations of members. This includes the delivery of psychotherapy services via telephone.
- Some health plans worked with providers to increase telehealth capacity very quickly, including helping with start-up costs for providers that did not have telehealth capability prior.
- Providers and health plans needed workflow adjustments, including with Electronic Medical Records (EMRs).
- The State, including the Texas Office of Inspector General (OIG), need to issue good guidelines as well as clear audit plans on documentation required.

Telehealth and COVID-19 in Rural Areas

The Bipartisan Policy Center has studied the challenges of health care in rural areas extensively and published a report in April 2020. Much of the work for the report was completed prior to the onset of the COVID-19 pandemic. However, the recommendations for telehealth in rural areas are applicable for consideration both during and post-pandemic. The recommendations are primarily directed for Medicare consideration, but can also be reviewed for Medicaid purposes. These recommendations "remove restrictions that prevent full utilization of currently available technology in areas without broadband access."

- Expand telehealth services to include non-face-to-face services.
- Allow virtual visits as substitutes to office visits at lengths beyond the currently allowed 5- to 10-minute (Medicare) check-ins.
- Expand asynchronous services beyond images to include written information shared by phone or through text and email.
- Include the home of an individual in the list of authorized originating sites for telehealth in rural areas.[3]

Texas has the opportunity to review data from the use of the Medicaid waivers for telehealth during the pandemic, and additional information, to identify practices that can be more cost effective and improve health care for individuals in Texas through the increased use of telehealth. Texas HHS also could explore other innovative approaches, such as partnering with the Texas Education Agency to

[2] http://www.tmhp.com/Pages/COVID-19/COVID-19-HOME.aspx
[3] https://bipartisanpolicy.org/report/confronting-rural-americas-health-care-crisis/

leverage the initiatives TEA has undertaken to expand broadband access in local communities for patients in need of telehealth services.

Innovative Practices That Further APMs and Improve Health

Providers and health plans had to adapt quickly to the COVID-19 pandemic to safely treat patients, both for COVID-19 and for ongoing care. This has included disruptions in care as well as adaptations to facilitate ongoing care. There is an opportunity to review activities by providers and health plans for "lessons learned" that could strengthen population health.

For example, tracking total cost of care and reduced ER utilization could be measures to allow greater flexibility for health plans and providers to manage population health. Capitated provider payment models instead of fee-for-service could be developed for improved population management. Information from health plans indicates that there has been an uptick in prospective, capitated payments to primary care providers since the outset of the COVID-19 public health emergency to enable providers to innovate to better manage care for their patients.

- Health plans and providers may be spending the same amount of time in different ways during the pandemic, and increased use of technology has a cost to stand up and maintain.
- Follow-up compliance to health care should be a focus of review. For example, transportation challenges could impede patients from getting needed follow-up care. Innovative practices including telemedicine/telehealth/telemonitoring and increased services at home, which are being used at much higher levels during the pandemic, could be supporting better follow-up care.
- Nursing home experience considerations include increased investment in Personal Protective Equipment, testing, and hazard pay to protect residents and staff.
- How rates are set will be important. The health plans need to be able to pay timely (and sometimes up front) for innovation, as illustrated by the COVID-19 experience, and have those costs recognized in future rate setting cycles.
- Data challenges would need to be reviewed for these approaches to be successful.
- Coordination is needed with the OIG for upfront information on fraud monitoring.

Some Medicaid health plans instituted APMs during the pandemic that provided flexibility to providers and also stabilized revenue. These VBP arrangements included flexibility as well as measurement requirements such as utilization of telehealth, access to care and quality measures such as immunizations and well-check visits. These arrangements should be reviewed to study the efficacy of continuing such arrangements to further value-based care. These arrangements

were easier with larger provider practices but could also be considered for smaller providers as well as FQHCs and RHCs.

COVID-19 has shown the resilience of value-based care during disruptions and emergencies: A health care organization's ability to respond to COVID-19 is driven in part by its payment structure. Organizations operating primarily under fee-for-service (FFS) payment are experiencing significant drops in revenue and often do not have the capabilities in place to respond to the pandemic. On the other hand, organizations engaged in value-based payment (VBP) models (especially those receiving prospective payments) have more stable revenue streams, and frequently have care coordination, telehealth, and data analysis capabilities in place that allow them to respond more effectively.[4]

Social Drivers of Health During a Health Emergency/Disaster

The COVID-19 pandemic has brought longstanding issues to the forefront regarding health disparities through the disproportionate impact of COVID-19 on certain racial and ethnic minority groups. HHSC is studying these disparities and developing a plan of actionable steps, with an initial report planned for the Fall of 2020. These issues are not just specific to Medicaid.

With respect to the Medicaid program, challenges occurred with timely direction from HHSC/TDI/OIG in enacting rules that provided flexibility to health plans and providers to implement strategies to help members/patients with medical and SDOH services during the pandemic.

Texas could consider pre-written rules that could be activated to give during any disaster for the health care delivery system to have a head start on implementing pandemic/disaster strategies. These rules could include an expedited approval process to address SDOH needs that are not otherwise allowed under Medicaid and CHIP. Certain guidelines may need to be lifted during these times to allow the system to properly handle unexpected SDOH needs. For example, to utilize telehealth/telephonic services, pre-paid phones with an adequate data plan may need to be provided to members. These rules would need to include the financial mechanisms for payment for allowing more non-covered services to be recognized as medical and administrative expense during the disaster declaration periods.

Align value-based payment measures and incentives as much as possible within each region of Texas to reduce provider administrative burden

The COVID-19 public health emergency has illustrated the need for a stronger primary care system, more integration of primary and preventive care with the broader health care system, and increased telemedicine/telehealth. As HHSC works to advance APMs in Medicaid, it should consider endorsing standardized models to reward high-value primary care in Medicaid.

[4] https://healthpolicy.duke.edu/news/enabling-health-care-resilience-during-and-after-covid-19-pandemic

HHSC should work with stakeholders to endorse certain standardized models that can be utilized for APMs with smaller providers (aligning with Medicare where possible). This recommendation would support providers that have smaller Medicaid patient panels, including rural providers.

It would benefit health plans and providers to have more standard programs available. Anti-trust provisions often prohibit health plans from sharing specific models. The state could provide a menu of approved options that could be used that could enable more consistency for providers across health plans and reduce administrative burdens for both Medicaid health plans and providers.