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House Human Services Committee
via email to Committee Clerk Courtney DeBower, Courtney.DeBower_HC@house.texas.gov

Chairman Frank,

The Texas Association of Health Plans (TAHP) is the statewide trade association representing health insurers, health maintenance organizations, and other related health care entities operating in Texas. Our members provide health and supplemental benefits to Texans through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid.

Thank you for the opportunity to comment on your RFI related to the Medicaid long term services and supports system. Since its inception, the STAR+PLUS program has dramatically improved lives in Texas — improving the quality of care, enhancing access to that care, and providing more choices to beneficiaries — all while saving taxpayer dollars by making sure patients get the right care at the right time and in the right place.

STAR+PLUS first began as a pilot program in Harris County in 1998, tested as a new kind of health care delivery model for individuals age 65 or older and individuals with disabilities in Medicaid. The success of the STAR+PLUS program is due in large part to its structure. Through STAR+PLUS, Texas was one of the first states in the country to create a Medicaid health plan that integrates and coordinates long term care and acute care with a focus on ensuring the least restrictive and most appropriate setting for each individual. As of July 1, 2019, 23 states now cover LTSS under Medicaid managed care organization (MCO) contracts.[1]

Under the previous fee-for-service (FFS) model, Texans with disabilities generally had to navigate services on their own. Today, under the STAR+PLUS managed care program, these Texans have access to a service coordinator who identifies an individual's needs, helps develop a plan of care, coordinates health care benefits, and facilitates access to community resources — whether those resources are covered by Medicaid or not. This includes coordinating efforts like securing attendant care, meals, home modifications, and participation in activities with peers within the community. These critical resources help members lead fuller and more independent lives, and MCO nurse care coordinators help ensure clients get the right care and the right time, which results in improved health and reduced costs for taxpayers. The integration of health care and long term care services also helps seniors with chronic conditions and individuals with disabilities live independently and avoid hospitalization and institutionalization. When their

[1] 10 Things to Know about Medicaid Managed Care, Kaiser Health Foundation, December 2019.

illnesses do require hospital visits, coordinated care means more appropriate follow-up care is arranged for them at home or as needed to prevent readmission.

STAR+PLUS began delivering immediate results for beneficiaries in its initial days. The program made significant strides in reducing the highest cost-drivers in Medicaid and in keeping individuals in their communities, as opposed to long term care facilities. Because of its success and ability to contain costs, the Legislature continued expanding STAR+PLUS. Since Sept. 1, 2014, the program has served elderly and disabled individuals statewide, including acute care for adults with intellectual and developmental disabilities (IDD).

Today, STAR+PLUS' positive trends continue with a dramatic increase in how many Medicaid beneficiaries are able to access community care. Through savings achieved from the shift to managed care, Texas reinvested funding to eliminate the wait time for services for individuals with physical disabilities. Instead of waiting years for community services, these Texans now have access to the services they need when they need them. Between 2004 and 2013, over 60,000 Texans were removed from the wait list and provided access to community care. This means more Texans are able to live independently in their homes and communities as opposed to nursing homes and other institutions. The final evaluation of the 1115 innovation waiver found Medicaid managed care increased access to care for clients in the STAR+PLUS program.[2]

The STAR+PLUS model has been a win-win for the state and consumers. Increased quality of care and improved access to health care and community care services has reduced hospital admissions and costs while improving the lives of Medicaid clients, including dramatic reductions in hospital stays for diabetes and pneumonia. Between 2009 and 2016, STAR+PLUS experienced double-digit reductions in hospital admissions for major common conditions such as diabetes (24-35%), pneumonia (27%), and UTIs (15%).[3] These important efforts place a focus on wellness and prevention, which keeps older individuals out of hospitals where they can become exposed to other illnesses and promotes community-based care alternatives to longer, more expensive hospital stays and institutional care.

In 2015, when the state added the Community First Choice program to STAR+PLUS, the wait for community attendant and habilitative services ended for more than 12,000 individuals with IDD and other persons with disabilities. This benefit helps individuals maintain their independence in the community without having to spend years on a wait list, increases federal matching dollars, and reduces reliance on more expensive institutional care. That same year, the STAR+PLUS and Dual Eligible Demonstration programs began providing nursing facility (NF) services to Texas Medicaid recipients. The carve-in of this population has ensured these clients have access to care coordination and assistance transitioning to the community. Last year, TAHP worked with NF associations to initiate a streamlined process that reduces the administrative burden required for credentialing. This initiative resulted in a streamlined process for the submission of credentialing applications, significantly reducing paperwork and consolidating the recredentialing process so that only one application is required from the provider for all

[2] (Waiver Years: 2011-2016) - Final Evaluation Report of the 1115 Waiver

[3] Analysis of HEDIS results in HHSC's Portal. Also see Final Evaluation Report of the 1115 Waiver

contracted MCOs. This initiative also demonstrates that by working together, MCOs and NFs can bring greater efficiencies to the program.

While significant strides have been made, there is more work to be done to ensure older Texans and Texans with disabilities are receiving the highest quality care. **Efforts to eliminate remaining wait lists for services and help individuals with disabilities maintain or gain their independence should be continued.** The long term care workforce should be strengthened through recruitment and retention efforts, including improving wages for community attendants who serve as the backbone for community care. Providing services that allow clients to live safely in the community can reduce overall Medicaid costs and improve clients' lives, but it requires having enough attendants. Additionally, long term cost savings could be achieved by reducing reliance on expensive nursing services when attendant services are more appropriate, but that requires an upfront investment in attendant wages to ensure a strong workforce. HHSC was directed to evaluate the attendant workforce via Rider 157 in the 2020-2021 General Appropriations Act. That evaluation should provide the Legislature with an overview of existing issues and potential solutions, and **the Legislature should ensure competitive wages to incentivize attendants to participate in the Medicaid program.**

Medicaid STAR+PLUS MCOs are committed to continuing to find areas for improvement and ways to increase administrative efficiency in the program, but the only way we are going to further reform the system is to stop trying to fit the managed care program into the FFS infrastructure. Payment and administration of the Medicaid NF services that straddle both FFS and managed care involve multiple, confusing, and inefficient processes. For example, NFs submit admission and discharge notices to HHSC instead of to the MCO, which can delay the initiation of MCO service coordination. **The Legislature should direct HHSC to fully carve all NF payment and administration processes into managed care.**

Per statutory requirements — and unlike other services carved into managed care — HHSC sets the NF daily rates for the STAR+PLUS program rather than allowing MCOs to negotiate directly with the NF. The process for developing payments involves HHSC, TMHP (Medicaid FFS), and the MCOs and is extremely cumbersome. The statutory provision mandating this requirement sunsets on Sept. 1, 2021, and should not be extended. This would allow HHSC to improve payment methodologies that create efficiencies for NFs, MCOs to negotiate pay-for-quality contracts, and the state to move toward paying for quality rather than volume.

HHSC's rate methodology uses a complicated set of rules that generates *over 1,000* different NF payment combinations based on the client's level of need, which can change daily, resulting in a constantly adjusting rate, and MCOs must rely on information from TMHP for that rate. This process creates administrative complexity and budgeting challenges for NFs, which are compounded by frequent retroactive payment adjustments based on the constant changing rate and conflicts between TMHP, MCO, and HHSC files and systems. The volume of retroactive adjustments is much higher in Texas' STAR+PLUS program than in other managed care programs because of these frequently changing rates. Frequent retroactive payment adjustments and inefficient processes result in NFs, HHSC, and MCOs spending countless hours on claims payments, adjustments, and reconciliations. NFs bill anywhere from 300,000 to 350,000 claims per month with over 125,000 of those resulting in payment adjustments. One STAR+PLUS plan analyzed its claims to demonstrate the administrative burden and found that on average, it

processed 46,000 NF room/board claims in a given month with 37% of those claims needing to be adjusted, compared to 15% in other markets. And 54% of those adjustments yielded a payment difference of just $10 or less. This example from just one plan demonstrates MCOs' and NFs' complaints and concerns with the current processes.

Almost every other state has adopted simpler NF payment methodologies. CMS adopted a new NF payment methodology for Medicare called the Medicare Patient-Driven Payment Model (PDPM) — a major overhaul to the current payment system designed to address concerns that current payments are based on the volume of services provided creating inappropriate financial incentives. HHSC also understands the importance of adopting a simplified payment methodology, so created a workgroup to review what Medicare and other states have adopted and to develop recommendations for a new payment methodology.

NFs have advocated for a single portal at TMHP as a way to reduce administrative complications and improve payment processes, but this would have a significant cost, move processes back to FFS, and not reduce administrative burdens. Furthermore, HHSC currently allows NFs to submit claims via an existing TMHP portal to comply with language in SB 7, but less than 2% of providers use it because it does not have the same functions as MCO portals, such as allowing for submission of NF claims and clinical data, obtaining electronic admittance advice, and obtaining explanation of MCO payment statements and other standardized reports. It also does not make sense for the state to invest in upgrading the TMHP portal because these services have been carved into managed care, and MCOs have implemented an extensive amount of functionality and changes to their portals to accommodate NF requests. Moving to one portal does not achieve the goal of creating more timely payment — it just moves us back to FFS. The only way to ensure faster payment and reduced burden for both MCOs and NFs is to reduce the number of claims that have to be adjusted. **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.**

In addition to the daily NF rate, the Quality Incentive Payment Program (QIPP) serves as a resource to help NFs achieve transformation. This performance-based program encourages NFs to improve the quality and innovation of their services through implementation of program-wide improvement processes for which facilities are compensated for meeting or exceeding certain goals. Improvement is based upon several indices of success, including quality metrics that are collected by CMS. To assist nursing facilities during the public health emergency in improving infection control protocols and other quality measures, HHSC temporarily increased NF rates and increased the pool size for QIPP for SFY 2021 to $1.1 billion. HHSC had previously announced a pool size for SFY 2021 of $800 million. With the additional funding, NFs can focus on improving quality of care and satisfaction.

Another way to improve processes between NFs, MCOs, and other providers is to improve the coordination of benefits for Medicaid and Medicare dual eligible clients. Medicaid MCOs are required by contract to coordinate benefits for STAR+PLUS clients who receive both Medicaid and Medicare coverage (called "dual eligible" clients). The MCOs are also federally required to ensure Medicaid does not pay for certain services that Medicare should cover. As part of the benefit coordination process, MCOs cannot pay for the Medicare-covered service until

Medicare denies the service. While MCOs go to extensive efforts to coordinate the delivery of these services, the process is complicated and often delayed due to the majority of dual eligible clients receiving their Medicaid and Medicare services from different health plans or from Medicaid FFS. Due to the multiple parties involved, Medicaid MCOs cannot see the Medicare payments and denials to track services in a systematic way. Medicaid MCOs are dependent on the cooperation of an external Medicare payor or provider (oftentimes not in network with the STAR+PLUS plan) to coordinate and provide ongoing status and supporting information to the MCO with no incentive. In some cases, per HHSC direction, when Medicare does not pay for the service or fully cover a needed treatment (called "wrap coverage"), TMHP — not the MCO — is responsible for paying for the service.

Past HHSC utilization reviews found that some STAR+PLUS clients did not receive certain services. The MCOs are often either unaware of the Medicare or Medicaid FFS claims or may have not received the Medicare or Medicaid FFS denials. As a result, MCOs are unaware clients are not receiving services that should have been covered by either Medicare or Medicaid FFS. Also challenging is the lack of a clearly documented matrix outlining which Medicare services TMHP and MCOs are responsible to cover once Medicare denies the service. The process is confusing for clients, providers, MCOs, and others involved in the process, and it puts access to care at risk for Medicaid enrollees.

Last session, the Legislature passed Senate Bill 1207 directing HHSC to improve the coordination of benefits process, but there are still many other complicated processes. **The Legislature should direct HHSC to 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 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.

Thank you for the opportunity to provide these comments. Please feel free to contact me if you have questions or need additional information. We look forward to continuing to work with HHSC, providers, and the Legislature to improve the managed care program.

Sincerely,

Jamie Dudensing, RN
CEO, Texas Association of Health Plans
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