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Texas Medicaid provides health care services through two service delivery models: fee-for-service (FFS) (traditional Medicaid) and managed care. Texas Medicaid provides health care services to most clients through the managed care model.

Medicaid Fee-for-Service

Some Medicaid clients are served through a traditional FFS delivery system in which health care providers are paid for each service they provide, such as an office visit, test, or procedure. The FFS model allows access to any Medicaid provider. The provider submits claims directly to the Texas Medicaid claims

administrator for reimbursement of Medicaid-covered services.

Each state must describe its specific FFS payment methodologies for mandatory and optional Medicaid services in its Medicaid state plan. The Centers for Medicare & Medicaid Services (CMS) reviews all state plan amendments to make sure reimbursement methodologies are consistent with federal statutes and regulations.

Because services can be coordinated and delivered more efficiently through the managed care model, there has been an effort underway to transition the majority of Texas Medicaid clients who remain in FFS to managed care.

Care Coordination

The Texas Medicaid Wellness Program is a whole-person care management service that supports Medicaid clients' individual health needs and challenges. The program serves clients receiving Medicaid through the FFS system who are not in another Medicaid waiver program.

The Texas Medicaid Wellness Program focuses on three main components: client self-management, provider practice and delivery system design, and technological support. Under client self-management, a client becomes an informed and active participant in the management of his

or her physical and mental health conditions and co-morbidities. Under the provider practice and delivery system design approach, medical home providers take an active role in helping their patients make informed health care decisions. Lastly, the foundation for the success of the program includes technology, such as the use of predictive modeling, to identify potential program patients and providers.

Historically, the majority of clients served by the Wellness Program were children under the age of 21 who receive Medicaid due to qualifying for Supplemental Security Income (SSI). With the implementation of the STAR Kids managed care program on November 1, 2016, children under the age of 21 with SSI Medicaid began receiving service coordination through their STAR Kids managed care organization (MCO).

Since the implementation of STAR Kids, the majority of individuals served in the Wellness Program are women ages 18 and older who are in the Medicaid for Breast and Cervical Cancer (MBCC) program and children previously in the care of the Department of Family and Protective Services (DFPS) who have been adopted or who are in permanent placements and now receive Adoption Assistance (AA) or Permanency Care Assistance (PCA) Medicaid. The contract for the Wellness Program is scheduled

to end on August 31, 2017, when the MBCC, AA, and PCA populations begin receiving services in Medicaid managed care.

Medicaid Managed Care

As shown in **Figure 11.1**, most people in Texas who have Medicaid get their services through managed care (also see **Appendix D, Managed Care History in Texas**). In state fiscal year 2015, the average monthly enrollment of managed care members receiving full Medicaid benefits was 3.5 million, or 87 percent of the state's 4.06 million Medicaid full benefit clients. Clients are referred to as "members" in managed care.

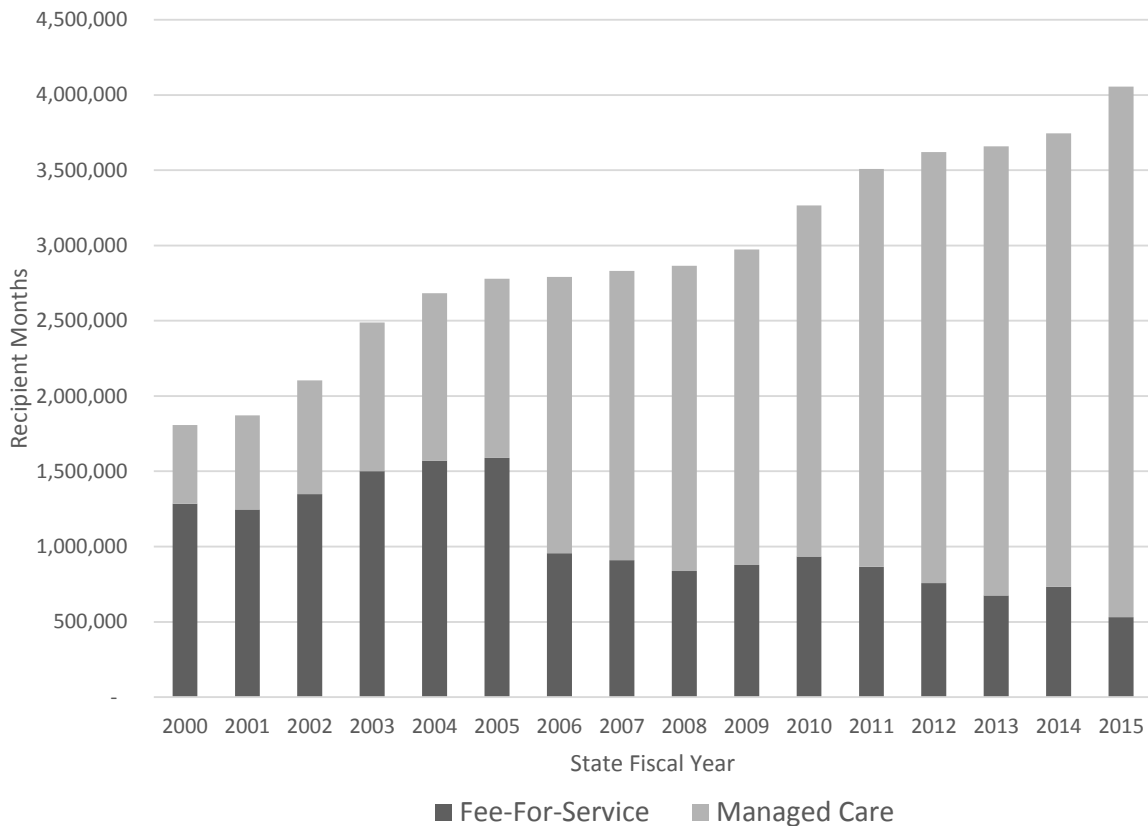
Under the managed care model, the Health and Human Services Commission (HHSC) contracts with MCOs, also known as health plans, and pays them a monthly amount to coordinate and reimburse providers for health services for Medicaid members enrolled in their health plan. MCOs are required to provide all covered medically necessary services to their members. Each member receives Medicaid services through an MCO's network of providers. Members may choose an MCO, or have one selected for them by HHSC if they do not. MCOs vary by service area and program and there are at least two MCOs for members to choose from in each

service area (see **Appendix B, Medicaid and CHIP Service Areas**).

Within Medicaid managed care, there currently are four comprehensive programs: STAR, STAR+PLUS, STAR Health, and STAR Kids. These programs serve distinct populations

with varying health care needs as described below. **Table 11.1** and **Table 11.2** show the number and percent, respectively, of Medicaid clients enrolled in FFS and in each managed care program.

Figure 11.1: Medicaid FFS vs. Managed Care Caseloads, SFYs 2000-2015



Source: HHSC, Financial Services, HHS System Forecasting.

Note: Caseloads reflect average monthly recipients.

Table 11.1: Medicaid Clients Enrolled in Managed Care and FFS, SFYs 2011-2015

Service Delivery Type	2011	2012	2013	2014	2015
FFS	866,908	761,964	675,706	733,859	532,121
Managed Care	2,676,149	2,893,965	2,982,923	3,012,265	3,524,581
<i>STAR PCCM*</i>	887,919	402,097	0	0	0
<i>STAR MCO</i>	1,536,422	2,121,651	2,546,683	2,570,545	2,941,333
<i>STAR Health</i>	31,834	31,171	30,293	30,727	30,909
<i>STAR+PLUS</i>	219,975	339,047	405,947	410,994	538,385
<i>Dual Demonstration</i>	0	0	0	0	13,954
Total Medicaid Clients	3,543,057	3,655,930	3,658,629	3,746,124	4,056,702

Source: HHSC, Financial Services, HHS System Forecasting.

*Primary Care Case Management (PCCM) was a managed care option that ended in 2012.

Table 11.2: Percentage Medicaid Clients by Service Delivery Type, SFYs 2011-2015

Service Delivery Type	2011	2012	2013	2014	2015
FFS	24.5%	20.9%	18.5%	19.6%	13.1%
<i>STAR PCCM*</i>	25.1%	11.0%	0.0%	0.0%	0.0%
<i>STAR MCO</i>	43.4%	58.1%	69.6%	68.6%	72.5%
<i>STAR Health</i>	0.9%	0.9%	0.8%	0.8%	0.8%
<i>STAR+PLUS</i>	6.2%	9.3%	11.1%	11.0%	13.3%
<i>Dual Demonstration</i>	0.0%	0.0%	0.0%	0.0%	0.3%

Source: HHSC, Financial Services, HHS System Forecasting.

*PCCM was a managed care option that ended in 2012.

1115 Transformation Waiver Managed Care Authorization

The Texas Health care Transformation and Quality Improvement Program 1115 Waiver, known as the 1115 Transformation Waiver, has allowed Texas to expand its use of Medicaid managed care while preserving

federal hospital funding historically received as supplemental payments under the Upper Payment Limit program. More information about the 1115 Transformation Waiver may be found in **Chapter 15, The 1115 Transformation Waiver**.

Managed Care Delivery System Features

Medical Home

Medicaid managed care members choose a primary care provider (PCP) who serves as the member's medical home by providing comprehensive preventive and primary care. The PCP also makes referrals, when required by the MCO, for specialty care and other services offered by the MCO, such as case management. In Texas Medicaid, the types of providers that generally act as PCPs are family and general practice doctors; pediatricians; internal medicine doctors; obstetricians/gynecologists (OB/GYNs); physician assistants; advanced practice registered nurses; and federally qualified health centers (FQHCs), rural health clinics, and similar community clinics. Occasionally, specialists agree to act as the PCP for clients with special health care needs.

Defined Provider Network

Access to Care

In managed care, MCOs are required to ensure their members have access to covered services on a timely basis. MCOs are required to have a defined network of providers to meet member needs, and provide support

to members who need help finding a doctor or setting up appointments.

MCOs are obligated to maintain access to network providers based on federal and state requirements. If an in-network provider is not available, the MCO is still required to locate a willing provider in order to ensure members have access to medically necessary and appropriate services.

Network Adequacy

According to federal and state requirements, MCOs must:

- Have sufficient capacity to serve the expected enrollment;¹
- Meet service area needs with geographic distribution of preventative, primary care, and specialty service providers;²
- Establish and maintain networks providing access to all services covered under the state contract by looking at the geographic location of providers and Medicaid enrollees and the physical accessibility of the location for Medicaid enrollees with disabilities;³ and
- Submit out-of-network utilization reports; HHSC is required to set benchmarks for out-of-network

¹ SSA §1932(b)(5); Texas Government Code §533.005

² 42 C.F.R. §438.207; Texas Government Code §533.005

³ 42 C.F.R. §438.206

utilization and establish standards for reasonable reimbursement rates.⁴

Medicaid managed care contracts outline requirements for MCOs, including network adequacy standards and benchmarks. HHSC continually monitors MCO compliance with network adequacy standards through various platforms including: readiness review, quarterly performance review, quarterly reports to CMS, and complaints.

- **Readiness Review:** Prior to any Medicaid managed care expansion or new initiative, HHSC will conduct a readiness review to determine each MCO's ability, preparedness, and availability to fulfill its obligations including provider access.
- **Quarterly Performance Review:** MCOs are required to submit quarterly data reports on various measures including: geoaccess, provider networks, provider terminations, and open panels. HHSC staff review data and recommend contractual remedies (e.g., corrective action plans, liquidated damages) for deficiencies.
- **Quarterly Reports to CMS:** The 1115 Transformation Waiver requires HHSC to report network adequacy requirements to CMS, such as member enrollment,

provider networks, access for members with special health care needs and geoaccess.

- **Member Complaints:** HHSC tracks member complaints by category, including access to care.

The managed care contracts give HHSC flexibility to impose a number of remedies, up to and including enrollment suspension and termination. The most commonly-enforced remedies are corrective action plans and liquidated damages.

Senate Bill 760

S.B. 760, 84th Legislature, Regular Session, 2015, requires HHSC to establish additional minimum provider access standards for Medicaid MCO provider networks. These requirements include:

- Developing new minimum distance, travel time, and appointment wait time standards for member access to providers;
- Updating the expedited credentialing process to expand the list of provider types eligible for expedited credentialing; and
- Requiring all MCOs to publish provider directories online, with provider information updated at least monthly.

In response to S.B. 760, HHSC is updating Medicaid managed care contractual requirements to implement the bill's provisions and to provide additional enhancements

⁴ Texas Government Code §533.007

to current network access requirements.

CMS Managed Care Regulations

In April 2016, CMS released final regulations revising Medicaid managed care requirements. The regulations include new network adequacy requirements for states including the development of time and distance standards. CMS requires Texas to comply with these access standards by September 2018. HHSC is developing an implementation plan for complying with the requirements.

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Appointment Availability Studies

In 2015, HHSC began performing appointment availability studies which directly monitor MCOs' provider networks and providers using a secret shopper methodology. The appointment availability studies specifically assess compliance with appointment availability and appointment wait times outlined in the Uniform Managed Care Contract for PCP, OB/GYN, vision, and behavioral health providers for members in STAR, STAR+PLUS, and CHIP.

Preventive Care

MCOs are required to ensure members have timely access to regular and preventive care. By emphasizing preventive care, MCOs can reduce the use of emergent care

and non-urgent care. Non-urgent visits to the emergency room include inappropriate visits, avoidable visits, non-emergency visits, and minor illness visits.

Utilization Review and Management

MCO utilization management (often used interchangeably with utilization review) includes prospective, concurrent, and retrospective reviews. Prospective reviews include practices such as preadmission screenings and prior authorization (PA) of certain medical services. Concurrent utilization review is usually conducted during a hospital confinement to determine the medical necessity for continued stay.

MCOs also use utilization review to comprehensively monitor and evaluate the appropriateness, necessity, and efficacy of past medical treatment or health care services delivered to members. This type of review is often referred to as a retrospective review and examines treatment patterns over time.

Chronic Care Management

Medicaid MCOs must provide disease management programs and services consistent with federal and state statutes, regulations, and contract requirements. Disease management programs and services must be

part of a person-based approach and address the needs of high-risk members with complex chronic or co-morbid conditions. The programs must identify members at highest risk of utilization of medical services, tailor interventions to better meet members' needs, encourage provider input in care plan development, and apply clinical evidence-based practice protocols for individualized care.

The MCOs must develop and implement disease management services for members with chronic conditions including, but not limited to: asthma, diabetes, chronic obstructive pulmonary disease, congestive heart failure, coronary artery disease, and other chronic diseases.

Members with Special Health Care Needs

Medicaid MCOs are required to identify and provide service management and develop service plans for members with special health care needs (MSHCN).

An MSHCN is a member who: (1) has a serious ongoing illness, a chronic or complex condition, or disability that has lasted or is anticipated to last for a significant period of time and (2) requires regular ongoing therapeutic intervention and evaluation by appropriately trained personnel.

The MCO is responsible for working with MSHCN, their health care providers, and their families, to develop a seamless package of care in which primary, acute care, specialty care, and long-term services and supports (LTSS) needs are met through a comprehensive service plan. Service management refers to administrative services performed by the MCO to facilitate coordination of services for members. Service management may include assistance with setting up appointments, locating specialty providers, and member health assessments. Service management is available to MSHCN and other populations such as women with high-risk pregnancies, individuals with mental illness and co-occurring substance abuse, children of migrant farmworkers, and former foster care child members. All members in STAR+PLUS and STAR Kids are considered MSHCN.

Value-Added Services

Managed care clients also have access to value-added services and additional benefits not available in the FFS program. Value-added services are additional health care services an MCO voluntarily elects to provide to its clients at no additional cost to the state. The MCOs offer various value-added services such as adult dental services and diapers for newborns to attract new clients.

Additional services may be offered to members on a case-by-case basis at the discretion of the MCO. An MCO may provide these services based on medical necessity, cost-effectiveness, the wishes of the member, and the potential for improved health status of the member. Value-added services and case-by-case services can vary from one MCO to another.

Medicaid Managed Care Programs

STAR

The Medicaid STAR program provides primary, acute care, behavioral health care, and pharmacy services for pregnant women, newborns, and children and parents with limited income. Acute care services include doctor visits, pharmacy, home health, medical equipment, lab, x-ray, and hospital services. In addition, STAR members are eligible for unlimited prescriptions. The program operates statewide under the authority of the 1115 Transformation Waiver. Services are delivered through MCOs under contract with HHSC.

Other individuals may be required to enroll in STAR or have the option. Former foster care children ages 18-20 are mandated to enroll into managed care, but may choose to be in either STAR or STAR Health. Former foster care children ages 21-25 are mandated to enroll in STAR as

STAR Health is not an option for this population.

Individuals who reside in institutions (including nursing facilities (NFs)), receive SSI or Medicare, are in a 1915(c) waiver program, are medically needy, or are in state conservatorship are generally excluded from STAR enrollment.

Additionally, individuals receiving AA or PCA Medicaid will be mandated to enroll in STAR in September 2017, unless they are also enrolled in Medicare, a waiver, or receive SSI.

STAR program members have access to a PCP who knows their health care needs and can coordinate their care through a medical home. PCPs provide preventive checkups, treat the majority of conditions STAR members experience, and refer enrollees to specialty care when necessary. STAR also offers additional services not available in traditional FFS. STAR members are not subject to the 30-day spell of illness limitation for adults that exists in the FFS and STAR+PLUS programs. STAR members also receive service management, which is provided to MSHCN.

STAR+PLUS

The Medicaid STAR+PLUS program provides both acute care services and LTSS by integrating primary care, behavioral health care, pharmacy services, and LTSS for

individuals who are age 65 or older or adults who have a disability. LTSS includes services such as attendant care and day activity and health services. In addition, STAR+PLUS members are eligible for unlimited prescriptions. The STAR+PLUS MCOs are responsible for coordinating acute care and LTSS for STAR+PLUS members with complex medical conditions. For more information about the STAR+PLUS program, please see **Chapter 7, Long-Term Services and Supports**.

STAR+PLUS HCBS Program

The STAR+PLUS Home and Community-Based Services (HCBS) program is part of the STAR+PLUS program. The STAR+PLUS HCBS program provides additional LTSS to clients who are elderly or who have disabilities as a cost-effective alternative to living in a NF. In addition to STAR+PLUS services and service coordination, the HCBS program includes LTSS such as nursing, personal assistance services, adaptive aids, medical supplies, and minor home modifications to make members' homes more accessible. These clients must be age 21 or older, be a Medicaid recipient, or be otherwise financially eligible for waiver services. To be eligible for STAR+PLUS HCBS program services, a member must meet income and

resource requirements for Medicaid NF care, and receive a determination from HHSC that they meet the medical necessity criteria to be in a NF.

STAR Kids

The STAR Kids program provides acute and LTSS benefits, including private duty nursing and personal care services, to children and young adults with disabilities. STAR Kids implemented statewide on November 1, 2016. There are 13 STAR Kids service areas and 10 MCOs. STAR Kids Medicaid members can select from at least two MCOs in each service area. For more information on STAR Kids, see **Chapter 7, Long Term Services and Supports**.

STAR Health

STAR Health is a statewide program designed to provide a comprehensive array of health care services for children and youth in conservatorship of DFPS, including those in foster care and kinship care. Services include:

- Primary care
- Acute care
- Behavioral health care
- Dental
- Vision
- Pharmacy

- LTSS

Services are delivered through a single MCO under contract with HHSC.

HHSC, in collaboration with DFPS, implemented STAR Health on April 1, 2008. The STAR Health program serves children in state conservatorship, young adults up to the month of their 22nd birthday who have voluntary foster care placement agreements, and young adults up to the month of their 21st birthday who were formerly in foster care and are receiving Medicaid services under the Former Foster Care Children and Medicaid for Transitioning Foster Care Youth eligibility categories. Clients can begin receiving services as soon as they enter state conservatorship.

STAR Health program members have access to a PCP who knows their health care needs and can coordinate their care through a medical home. STAR Health also offers additional services not available in traditional FFS, including service management; service coordination; a seven-days-per-week, 24-hours-per-day nurse hotline for caregivers and caseworkers; and the Health Passport, a web-based, claims-based electronic medical record.

Use of psychotropic medications among STAR Health members is carefully monitored for compliance with the DFPS Psychotropic

Medication Utilization Parameters.

The parameters are best practice guidelines for the use of psychotropic medication in children. In 2010, the STAR Health program began training and certifying behavioral health providers in Trauma Focused Cognitive Behavioral Therapy and training in trauma-informed care was made available to all caregivers and caseworkers.

Trauma-informed care training provides education about how to effectively manage behavior issues that can destabilize children's health status and foster family placement and how to create an environment that promotes healing from trauma associated with abuse or neglect. In 2015, the program also began training and certifying behavioral health providers in other evidence-based and promising practices such as Parent Child Interaction Therapy, Trust-Based Relational Intervention, and Child Parent Psychotherapy.

Service Management

The STAR Health MCO conducts a telephonic screening for each child within the first month of enrollment. The screening gathers information about each child's physical and behavioral health medical history and status from the medical consentor. The MCO's service management team uses this information to determine the physical and behavioral health needs of each STAR Health member. Depending

upon the severity of the identified needs, the MCO will assign a service manager or service coordinator to the child.

Service management is for members who have complex or high priority needs. Service managers must be licensed clinicians such as registered nurses, licensed professional counselors, or licensed clinical social workers. Service coordination is for moderate to low risk members who require minor assistance with a health need. Service coordinators must be degreed professionals. The service manager or coordinator will reach out telephonically to assist the medical consentor in obtaining any necessary services. Updates to the telephonic screening are completed every time a child changes placements, and periodically according to their level of need, throughout their enrollment with STAR Health.

The STAR Health MCO has also developed specialty service management programs that can assist children with complex behavioral health needs. Complex Case Management supports children with the highest level of behavioral health needs, including those with dual diagnoses and/or a history of high emergency department utilization or inpatient admissions. The Intellectual and Developmental Disabilities Management program identifies and supports those with

a diagnosis of autism, Asperger's syndrome, intellectual disability, or pervasive developmental disorder.

Health Passport

The Health Passport is an essential element of the STAR Health program that improves medical information sharing and promotes coordination of care with the child's health care providers, DFPS staff, and caregivers. Health Passport information is available to authorized users through a secure, password-protected website administered by the STAR Health MCO.

The Health Passport is a web-based repository of health care services data for each STAR Health member. It displays a summary of care; a visit list for medical, behavioral health, vision, and dental care; a list of medications filled; and documents such as health care service plans, psychotropic review, and Child and Adolescent Needs and Strengths assessments. The Health Passport facilitates online access to a child's medical data and history to promote continuity of care if the child moves to a new location as the result of a placement change. Health care data viewable in the Health Passport includes current as well as historical health care services data for STAR Health members who may have been previously enrolled in CHIP or Texas Medicaid.

The system is regularly updated to ensure the most up-to-date information is posted to the child's records. Pharmacy, dental, vision, physical, and behavioral health claims are uploaded on a daily basis; immunization data from the state is received and loaded weekly; and assessments are viewable the day they are uploaded. In addition, providers and other authorized individuals have the ability to add certain medical forms, patient allergy information, and patient vitals directly into the Health Passport system; access to the information is available immediately upon entry.

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The Health Passport also has the functionality to check for interactions between medications based on a child's known allergies indicated in the system. If a STAR Health member is taking medications that interact with each other or may cause any reported allergies, an alert is presented on the child's Health Passport medical record and is accompanied with clinical information on the possible interaction.

In 2015, enhancements were made to the Health Passport to make the application more user friendly. The application now has a redesigned look; mobile access capability; the ability to enter future scheduled appointments and provider referrals; and an interactive growth chart that displays height and weight entries.

Psychotropic Medication Utilization Review

In 2004, a report released by the U.S. Office of Inspector General raised concerns regarding the use of psychotropic medications among Texas children in foster care. Since then, HHSC, DFPS, and the Department of State Health Services (DSHS) have coordinated efforts to obtain a more detailed assessment of the problem and to assist providers in using psychotropic medication appropriately, both for children in foster care and for all children enrolled in Medicaid.

In 2005, the best practice guidelines, *Psychotropic Medication Utilization Parameters for Foster Children* were released. Several new editions have been released since 2005. These parameters include general principles for optimal practice, reference material, and a listing of commonly used psychotropic medications with dosage ranges and indications for use in children (both U.S. Food and Drug Administration-approved and literature-based).

The STAR Health MCO conducts ongoing psychotropic medication utilization reviews on children in foster care whose medication regimens fall outside the guidelines set forth by the parameters. Representatives from DFPS, HHSC, DSHS, and the STAR Health MCO formed a Psychotropic Medication Monitoring group which meets

quarterly to review the monitoring conducted by the STAR Health MCO and its behavioral health subcontractor. The group also oversees an annual report on psychotropic utilization and the biennial review and update of the parameters.

Starting in 2011, PA was required to dispense an antipsychotic medication to Medicaid members under age three and those taking more than two different antipsychotic medications concurrently. The carve-in of prescription drug coverage into managed care in 2012 provided the STAR Health MCO with opportunities to enhance its psychotropic medication monitoring. Since the release of the parameters in early 2005, the percentage of children in foster care taking psychotropic medication and the number of children whose medication regimens fall outside of the parameters' recommendations have decreased.

Children's Medicaid Dental Services Program

As of March 1, 2012, Children's Medicaid Dental Services (CMDS) program benefits are provided through a managed care model for most children and young adults birth through age 20. The following Medicaid clients are not eligible to participate in the CMDS program and continue to receive dental services

through their existing service delivery models:

- Medicaid clients age 21 and over;
- All Medicaid clients, regardless of age, residing in Medicaid-paid facilities such as NFs, state supported living centers, or intermediate care facilities for individuals with an intellectual disability or related condition (ICFs/IID); and
- STAR Health program clients.

Members who receive their dental services through a Medicaid managed care dental plan are required to select a dental plan and a main dentist. A main dentist serves as the member's dental home and is responsible for:

- Providing routine preventive, diagnostic, urgent, therapeutic, initial, and primary dental care;
- Maintaining the continuity of patient care; and
- Initiating referrals for specialty care.

Provider types that can serve as main dentists are FQHCs and individuals who are general or pediatric dentists.

Medicare Advantage Dual Eligible Special Needs Plan

A Medicare Advantage (MA) Dual Eligible Special Needs Plan (D-SNP)

is a managed care delivery model specifically designed to provide targeted care to individuals who are dually eligible for both Medicare and Medicaid. Eligible individuals who live in an area in which these MA plans operate may choose to receive their Medicare and Medicaid services through such a plan. Under this managed care delivery option, D-SNPs are responsible for the coordination of care between Medicare and Medicaid covered services. D-SNPs that also operate in STAR+PLUS deliver Medicaid services through the STAR+PLUS program. D-SNPs that do not also operate in STAR+PLUS are only responsible for paying beneficiary cost-sharing.

11

Recent Initiatives

In addition to the establishment of the STAR Kids program on November 1, 2016, HHSC has implemented the following managed care initiatives since the 10th Edition of *Texas Medicaid and CHIP in Perspective* (February 2015).

Nursing Facility Carve-in

S.B. 7, 83rd Legislature, Regular Session, 2013, directed HHSC to provide Medicaid benefits to recipients who reside in NFs through the STAR+PLUS Medicaid managed care program. Effective March 1, 2015, NF services became a statewide covered benefit under the STAR+PLUS managed care

program for clients age 21 years and older. The goal of the NF carve-in was to improve quality of care and health outcomes for NF residents by coordinating health care and access to services, ensuring client needs are addressed in the least restrictive, most appropriate setting, and reducing unnecessary hospitalizations and potentially preventable events (PPEs). Approximately 47,000 NF residents transitioned from FFS Medicaid to the STAR+PLUS program and receive their Medicaid through a STAR+PLUS MCO.

The three Medicaid populations excluded from the NF carve-in were clients age 20 and younger, those living in the Truman W. Smith Children's Care Center, and those living in a Veterans Land Board Texas State Veterans Home.

NF residents who are participants in the Texas Dual Eligible Integrated Care Demonstration Project (known as the Dual Demonstration) receive their Medicaid and Medicare services through one Medicare-Medicaid Plan (MMP) plan, including NF services (see the Dual Demonstration section below).

All STAR+PLUS NF residents are assigned an individual MCO service coordinator, who visits residents at least quarterly.

As directed by S.B. 7, HHSC set a ten day adjudication period for clean

claims, and a minimum protected NF unit rate of reimbursement based on the NF resident's Minimum Data Set resource utilization group level. MCOs pay negotiated rates for other medically necessary acute care and add-on services. Add-on NF services include:

- Emergency dental services;
- Physician-ordered rehabilitation services (e.g., goal directed therapy); and
- Durable medical equipment such as customized power wheelchairs and augmentative communication devices.

S.B. 7 also required HHSC to establish credentialing and minimum performance standards for NF providers seeking to participate in STAR+PLUS. MCOs must use state-identified credentialing criteria for NFs and may only contract with an NF with a valid certification, license, and contract with the state. Additionally, HHSC developed a process for measuring quality of care provided to individuals residing in NFs. Measures are included in the 2015 Performance Indicator Dashboard for Quality Measures, found in the Uniform Managed Care Manual.

Dual Demonstration

In May 2014, HHSC received federal approval for a fully integrated, capitated model that involves a three-party contract between an MCO with an existing STAR+PLUS contract, the state, and CMS for the provision of the full array of Medicaid and Medicare services. The Dual Demonstration is testing an innovative payment and service delivery model to alleviate the fragmentation and improve coordination of services for dual eligibles, enhance quality of care, and reduce costs for both the state and the federal government. The demonstration began March 1, 2015.

Under this initiative, an MCO called an MMP is responsible for the full array of Medicare- and Medicaid-covered services. MMP members receive primary, acute care, behavioral health care, pharmacy, and LTSS.

The Dual Demonstration serves individuals age 21 or older who are dually eligible for Medicare and Medicaid and required to receive Medicaid services through the STAR+PLUS program. Eligible clients are passively enrolled into the demonstration with the opportunity to opt-out on a monthly basis. Clients can be enrolled in the Dual Demonstration if they meet all of these criteria:

- Age 21 or older;
- Eligible for Medicare Part A, B, and D, and receiving full Medicaid benefits; and
- Eligible for the Medicaid STAR+PLUS program, which serves Medicaid clients who have disabilities or are age 65 and older, including those who receive STAR+PLUS HCBS Program services.

The Dual Demonstration does not include clients who reside in ICFs/ IID and individuals with intellectual and developmental disabilities (IDD) who receive services through the Community Living Assistance and Support Services, Deaf-Blind with Multiple Disabilities, Home and Community-based Services, or Texas Home Living waivers.

The demonstration operates in Bexar, Dallas, El Paso, Harris, Hidalgo and Tarrant counties.

NorthSTAR Transition

NorthSTAR was an integrated behavioral health delivery system in the Dallas service area serving people who were eligible for Medicaid or who met other eligibility criteria. The program was overseen by DSHS and services were provided via a fully capitated contract with a licensed behavioral health organization.

STAR clients in Dallas and six contiguous counties (Collin, Ellis, Hunt, Kaufman, Navarro, and Rockwall) around Dallas received behavioral health services through NorthSTAR.

In accordance with the 2016-17 General Appropriations Act (GAA), H.B. 1, 84th Legislature, Regular Session, 2015 (Article II, DSHS, Rider 85), the state terminated the NorthSTAR program on December 31, 2016. Upon termination of the program, individuals began receiving all of their Medicaid services through managed care programs, including STAR, STAR+PLUS and STAR Kids.

Health Insurance Premium Payment Carve-In

Information on the Health Insurance Premium Payment program's managed care carve-in may be found in **Chapter 14, Finances**.

Upcoming Initiatives

Adoption Assistance and Permanency Care Assistance Carve-Ins

Adoption Assistance

AA is a program designed to facilitate the adoption of children defined as having special needs. In Texas Child Protective Services cases, adoption

becomes an option if DFPS and the child's birth parents cannot resolve issues that made it unsafe for the child to live at home. Adoption is the legal process through which a child joins a family different from his or her birth parents and is a permanent, lifelong commitment to a child.

To be eligible for this program, the child must have special needs as defined by the Texas Administrative Code (TAC), Title 40, §700.804. Extended AA is also available for eligible individuals on behalf of certain children over the age of 18, as provided by TAC, Title 40, §700.851. Three types of benefits may be provided under this program:

- Medicaid health coverage for the child;
- Monthly payments to assist in meeting the child's needs; and
- Reimbursement for certain adoption fees up to \$1,200.

Permanency Care Assistance

PCA is a program available to persons who assume managing conservatorship of a child who was previously in the temporary or permanent managing conservatorship of DFPS. Extended PCA is also available for eligible individuals on behalf of certain children over the age of 18, as provided under TAC, Title 40, §700.1053. Three types of benefits may be provided under this program:

- Monthly cash assistance benefits through the last day of the month of the child's 18th birthday;
- Medicaid coverage on behalf of the child; and
- A one-time reimbursement of nonrecurring expenses relating to the legal process of becoming the managing conservator of the child, not to exceed \$2,000 per child.

STAR Carve-In

The 2014-15 GAA, S.B. 1, 83rd Legislature, Regular Session, 2013 (Article II, HHSC, Rider 51(b)(15)), directs HHSC to transition remaining Medicaid FFS populations into managed care. HHSC determined children and young adults receiving AA and PCA Medicaid could benefit from a managed care model.

Most individuals in the AA or PCA programs will transition into STAR beginning September 1, 2017. Children and young adults under age 21 in AA or PCA who also receive services through a 1915(c) waiver for individuals with IDD, Medicare, or SSI will transition to STAR Kids.

Children and young adults transitioning to STAR will receive the full array of Medicaid benefits and additional services offered through the STAR program and MCOs. STAR MCOs will be required to provide additional assistance to AA and PCA members related to service management, continuity of

care, medical history sharing and psychotropic drug utilization review.

Medicaid for Breast and Cervical Cancer Carve-In

The Breast and Cervical Cancer Prevention and Treatment Act of 2000 gave states the option to provide Medicaid medical assistance to women who were screened through the Centers for Disease Control and Prevention's National Breast and Cervical Cancer Early Detection Program and found to have breast or cervical cancer.

To be eligible for MBCC, women must meet the following criteria:

- Diagnosed and in need of treatment for a biopsy-confirmed breast or cervical cancer, a metastatic or recurrent breast or cervical cancer, or certain pre-cancer conditions;
- Must not have creditable coverage (health insurance coverage for breast or cervical cancer);
- Be a Texas resident; and
- Be a U.S. citizen, or an immigrant with a qualifying status.

MBCC clients will continue to receive full Medicaid benefits as long as they are eligible, and every six months provide:

- Proof of active treatment for breast or cervical cancer from the treating

physician (Form H1551, Treatment Verification); and

- A completed Form H2340, MBCC Renewal.

STAR+PLUS Carve-In

In accordance with Rider 51(b)(15), HHSC determined women in MBCC could benefit from a managed care model.

Women, ages 18 through the end of the month when the woman turns 65, participating in the MBCC program, will transition into STAR+PLUS beginning September 1, 2017.

MBCC clients will receive the full array of Medicaid benefits and other services offered through the STAR+PLUS program. MBCC members will receive the highest level of service coordination available in STAR+PLUS. Coordination provides specialized care management services including two face-to-face visits annually. The service coordinator has the opportunity to align visits to assist with the MBCC eligibility renewal process to help prevent delays in services due to untimely form submission.

Intellectual and Developmental Disabilities Pilot

Information on the IDD Pilot, a program which will use a managed

care model to deliver Medicaid LTSS to individuals with IDD, may be found in **Chapter 7, Long-Term Services and Supports**.

CHIP Managed Care Programs

There are 10 service areas with a total of 17 MCOs delivering services to CHIP members statewide.

Enrollees residing in a CHIP service area have a choice of at least two MCOs in each service area (see **Appendix B, Medicaid and CHIP Service Areas**).

Managed Care Contract Oversight

HHSC routinely monitors MCO performance through managed care contracts. These contracts outline requirements related to MCO responsibilities such as member benefit packages, provider network adequacy and accessibility, member and provider call centers, claims processing, member and provider complaints and appeals, encounter submission, member enrollment data, and delivery of service management or service coordination.

HHSC receives approximately 100 deliverables from each MCO on a quarterly basis. These deliverables provide data related to each of the

requirements above and assist HHSC in monitoring MCO compliance. HHSC also researches complaints received directly from members and providers to immediately address any concerns. In addition, HHSC monitors the financial performance of each MCO and their subcontractors and affiliates.

If an MCO fails to meet a contractual requirement, the managed care contracts give HHSC the authority to use a variety of disciplinary remedies such as corrective action plans, financial remedies, contract restrictions, and contract termination. MCOs not in compliance with contractual requirements are required to immediately address any identified instances of non-compliance.

HHSC also requires MCOs to submit to various third party audits. An independent contractor audits the MCO on an annual basis and the results are submitted to HHSC. Third party risk assessments are conducted biannually, and, at HHSC's discretion, third party performance audits are conducted as a result of the risk assessment findings. In addition, the HHSC Inspector General is statutorily mandated to conduct a number of inspections and audits on an ongoing basis to investigate potential areas of waste, fraud, and abuse.

Medical Transportation Program

The Medical Transportation Program (MTP) is responsible for arranging and administering cost-effective, non-emergency medical transportation (NEMT) services to eligible Medicaid clients, Children with Special Health Care Needs (CSHCN) clients, and Transportation for Indigent Cancer Patients (TICP) clients who are diagnosed with cancer or cancer-related illness and meet program financial and residential eligibility criteria and who have no other means of transportation. MTP uses several transportation methods that comply with federal regulations to meet client needs.

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Payment Models

Managed Transportation Organizations

S.B. 8, 83rd Legislature, Regular Session, 2013, required HHSC to implement a managed transportation organization (MTO) model for the delivery of MTP services. The MTO delivery model operates in contiguous counties within a managed transportation service region. The shift in the type of transportation model included a change in the payment structure. The MTOs operate under a capitated

rate structure and assume financial responsibility under a full-risk model.

Full-Risk Broker

The 2010-11 GAA, S.B. 1, 81st Legislature, Regular Session, 2009 (Article II, HHSC, Rider 55), required HHSC to implement a full-risk broker (FRB) model in areas of the state that could sustain the model.

The FRB provides an array of transportation services to clients in a specified geographic area. HHSC contracted with two FRBs to coordinate transportation using a network of providers in the Dallas/Fort Worth and Houston/Beaumont service areas.

Transportation and Related Services

Mass Transit

Mass transit is intercity or intra-city transportation by bus, rail, air, ferry, or publicly or privately owned transit that provides general or special service on a regular or continuing basis. Mass transit tickets are issued when it is determined to be the appropriate mode of transportation for the client, ensuring the client does not live more than a quarter mile from a public fixed route stop, the appointment is not more than a quarter mile from a public fixed route stop, and mass transit tickets are received by the client before the client's appointment. Mass transit

also involves using commercial air service to transport eligible program clients to an authorized covered health care service.

Demand Response

Demand response services are contractor-provided transportation when fixed route services are either unavailable or do not meet the health care needs of clients. The MTO or FRB responds to requests for individual or shared one-way trips. Services must be timely and provided by licensed, qualified, and trained personnel.

Individual Transportation Request

Individual Transportation Participant (ITP) services are provided by individuals who register to participate in the MTO or FRB ITP program. An ITP is an individual who has been approved for mileage reimbursement at a prescribed rate to provide transportation for a prior authorized MTP client to a prior authorized health care service. Mileage reimbursement is paid to an individual who drives himself or herself, a family member, friend or neighbor to and from a Medicaid-covered health care service. ITPs are paid the mileage reimbursement rate adopted by HHSC.

Meals and Lodging

Meals and lodging are provided for Medicaid children and their attendant

when health care treatment requires an overnight stay outside the county of residence or beyond adjacent counties. The MTO or FRB provides the client and attendant (regardless of age) an allowance of \$25 per day per person.

Advanced Funds

Advanced funds are funds authorized by the MTO or FRB and are provided in advance of travel and disbursed to the eligible recipient, responsible party, or ITP for the purpose of funding transportation or transportation-related services (e.g., gasoline, meals).

Out-of-State Travel

The MTO or FRB provides transportation to contiguous counties or bordering counties in adjoining states (Louisiana, Arkansas, Oklahoma, and New Mexico) that are within 50 miles of the Texas border if the services are medically necessary and it is customary or general practice of clients in a particular locality within Texas to obtain services from the out-of-state provider. The MTO or FRB can arrange and pay for out-of-state travel for clients who need to travel to states outside of the adjoining states for medically necessary health care services that cannot be provided within the state of Texas.

Commercial Airline Transportation Services

When necessary, such as for medically necessary services outside a client's MTO region of residence, the MTO or FRB is responsible for arranging commercial air transportation for the client and, when applicable, the client's attendant.

Managed Care Quality Assurance

Ensuring the delivery of cost-effective, high-quality health care for beneficiaries of public insurance programs has become increasingly important in recent years, as federal and state agencies seek to address budget deficits while also improving access to health care. Texas has a strong focus on quality of care in Medicaid and CHIP that includes initiatives based on legislation such as S.B. 7 (2013) and S.B. 7, 82nd Legislature, First Called Session, 2011.

External Quality Review Organization

Federal regulations require external quality review of Medicaid managed care programs to ensure state programs and their contracted MCOs are compliant with established standards. The external quality review organization (EQRO) performs three CMS-required functions

related to Medicaid managed care quality. The EQRO validates MCOs' performance improvement projects (PIPs), validates performance measures, and conducts a review to determine MCOs' compliance with certain federal Medicaid managed care regulations. In addition, states may also contract with the EQRO to validate member-level data; conduct member surveys, provider surveys, or focus studies; and calculate performance measures. The Institute for Child Health Policy (IHP) has been the EQRO for HHSC since 2002. HHSC's EQRO follows CMS protocols to assess access, utilization, and quality of care for members in Texas' CHIP and Medicaid programs.

The EQRO produces reports to support HHSC's efforts to ensure managed care clients have access to timely and quality care in each of the managed care programs. The results allow comparison of findings across MCOs in each program and are used to develop overarching goals and quality improvement activities for Medicaid and CHIP managed care programs. MCO findings are compared to HHSC standards and national averages, where applicable.

The EQRO assesses care provided by MCOs participating in STAR, STAR+PLUS (including the STAR+PLUS HCBS Program), STAR Health, CHIP, STAR Kids, and the Medicaid and CHIP dental managed care programs. The EQRO conducts

ongoing evaluations of quality of care primarily using MCO administrative data, including claims and encounter data. The EQRO also reviews MCO documents and provider medical records, conducts interviews with MCO administrators, and conducts surveys of Texas Medicaid and CHIP members, caregivers of members, and providers.

Quality Indicators

A combination of established sets of national measures and state-developed measures validated by the EQRO are used to track and monitor program and MCO performance. Measures include:

- National Committee for Quality Assurance Healthcare Effectiveness Data and Information Set (HEDIS®) – A nationally recognized and validated set of measures used to gauge quality of care provided to members. HEDIS domains include Effectiveness of Care, Access and Availability of Care, Experience with Care, and Health Care Utilization.
- Agency for Healthcare Research and Quality Pediatric Quality Indicators (PDI)/Prevention Quality Indicators (PQIs) – PDIs use hospital discharge data to measure the quality of care provided to children and youth. PQIs use hospital discharge data to measure quality of care for specific conditions known as “ambulatory care sensitive conditions”

(ACSCs). ACSCs are conditions for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications or more severe disease.

- 3M® Software for PPEs – HHSC uses and collects data on Potentially Preventable Admissions, Potentially Preventable Readmissions, Potentially Preventable Emergency Department Visits, Potentially Preventable Complications, and Potentially Preventable Ancillary Services.
- Consumer Assessment of Health care Providers & Systems (CAHPS®) Surveys – CAHPS Health Plan Survey is a nationally recognized and validated tool for collecting standardized information on members’ experiences with health plans and services. ICHP conducts CAHPS surveys biannually.

Pay-for-Quality

S.B. 7 (2013) focused on the use of quality-based outcome and process measures in quality-based payment systems by measuring PPEs, rewarding use of evidence-based practices, and promoting health care coordination, collaboration, and efficacy. As directed by S.B. 7, HHSC implemented the Pay-for-Quality (P4Q) program in 2014. The P4Q program created financial incentives and disincentives for health plans

and dental plans to promote incremental improvement on a set of quality measures, including PPE and HEDIS measures. The P4Q program is currently being redesigned and a revised P4Q model will be implemented on January 1, 2018.

Performance Improvement Projects

PIPs are an integral part of Texas Medicaid's Quality Improvement Strategy. The Balanced Budget Act of 1997 requires all states with Medicaid managed care programs to ensure MCOs conduct PIPs. Federal regulations require PIPs to use ongoing measurements and interventions to achieve significant improvement over time on health outcomes and enrollee satisfaction. Health plans conduct PIPs to examine and improve areas of service or care identified by HHSC in consultation with Texas' EQRO as needing improvement. Topics are selected based on MCO performance on quality measures and member surveys. HHSC requires each MCO to conduct two PIPs per program, and one PIP per health plan must be a collaboration with another MCO or a Delivery System Reform Incentive Payment project.

MCO Report Cards

S.B. 7 (2011) requires HHSC to provide information on outcome and process measures to Medicaid

and CHIP members regarding MCO performance during the enrollment process. To comply with this requirement and other legislatively mandated transparency initiatives, HHSC develops report cards for each managed care program service area to allow members to compare the MCOs on specific quality measures. These report cards are intended to assist potential enrollees in selecting an MCO based on quality metrics. Report cards are posted on the HHSC website and included in the Medicaid enrollment packets. Report cards are updated annually.

Quality Assessment and Performance Improvement Programs

Federal regulations also require Medicaid MCOs to operate quality assessment and performance improvement (QAPI) programs. These programs evaluate performance using objective quality standards, foster data-driven decision-making, and support programmatic improvements. MCOs report on their QAPI programs each year and these reports are evaluated by Texas' EQRO.

Performance Indicator Dashboards

The Performance Indicator Dashboards include a series of measures that identify key aspects

of MCO performance to support MCO accountability. Dashboard measures include standards of performance for MCOs. The dashboards are shared on the HHSC website with the program-level performance on each measure included for comparison.

