

**Part IV. Delivery****Chapter 12:  
Operations and Support****Texas Medicaid  
Management  
Information System**

To meet its administrative systems and management information system requirements, the state contracts with private organizations to obtain specialized services to support the Texas Medicaid program. The state and its contractors coordinate to support Medicaid clients and Children with Special Health Care Needs (CSHCN) program clients and their health care providers. The administrative functions that comprise the Texas Medicaid Management Information System (TMMIS) are described below.

***Texas Integrated  
Eligibility Redesign  
System***

The Health and Human Services Commission (HHSC) uses an integrated system to determine eligibility for Medicaid, the Children's Health Insurance Program (CHIP), the Supplemental Nutrition Assistance Program (SNAP), and Temporary Assistance for Needy Families (TANF). The eligibility

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system offers access to eligibility services through multiple channels, including a self-service website ([www.YourTexasBenefits.com](http://www.YourTexasBenefits.com)), a mobile application, a network of local eligibility offices and community-based organizations, and the 2-1-1 phone service.

HHSC eligibility staff use the Texas Integrated Eligibility Redesign System (TIERS) to support the eligibility determination process. In December 2011, HHSC completed the transition from the legacy System for Application, Verification, Eligibility, Reports and Referrals (SAVERR) to TIERS.

To continue to improve the efficiency and effectiveness of the eligibility system, HHSC has enhanced the self-service options available to clients through [www.YourTexasBenefits.com](http://www.YourTexasBenefits.com) and the Your Texas Benefits mobile application.

More information about the eligibility application and determination process may be found in **Chapter 3, Eligibility**.

### ***Texas Medicaid & Healthcare Partnership***

Texas Medicaid contracts with vendors to manage the majority of its fiscal agent and claims administrative functions. These vendors are known collectively as the Texas Medicaid & Healthcare

Partnership (TMHP). THMP conducts various duties on behalf of the state, most importantly management of the Medicaid claims administrative and operational functions and the information systems collectively known as TMMIS. These functions include claims and encounters processing, provider enrollment, client outreach, provider outreach, provider and staff training, among many other operational and contractually required duties necessary to effectively manage and administer the Medicaid program. State programs administered by other Health and Human Services system agencies also are served under this arrangement.

THMP currently handles the development and operation of TMMIS including the following functions:

- Encounter processing and reporting for all managed care programs – ongoing support to managed care organizations (MCOs) for successful submission and reporting of encounter and provider data. The claims administrator also collects and validates MCO encounter data for use in service and health plan quality evaluations.
- Medicaid provider enrollment – provider enrollment, provider education and training, as well as development and maintenance of the provider procedures manual.
- Client eligibility verification – verifying items such as client

- eligibility, long-term care medical necessity, long-term care client service plans, and benefit limitation and usage information.
- Financial management and administrative reporting – administrative and infrastructure tasks, such as the development and maintenance of the fee schedule, rate analysis, pricing activities, and other daily operations. This function also supports financial recoupment, adjustment, and accounts receivable maintenance.
  - Medicaid fee-for-service (FFS) claims processing – processes and adjudicates all FFS claims for Medicaid and other state-supported program clients not enrolled in an MCO, including those receiving Medicaid acute care, Medicaid long-term services and supports, Healthy Texas Women (HTW) services, and CSHCN services.
  - FFS provider reimbursement – provider inquiry resolution, electronic claims submission support, incorporation of reference tables (e.g., diagnosis codes, procedure codes, provider tables, recipient tables, claims history tables), as well as ad hoc reporting.
  - FFS medical and dental prior authorizations (PAs) – review, approval, and referral of PA requests; PA administrative reviews; and appeals support and coordination.
  - Fair hearing support – supporting a client’s right to receive due process in an independent, fact-based review of a denied benefit, service, or payment limitation decision made by the vendor.
  - Managing incoming client and provider calls – call center management of provider and client inquiries, supplying information and supporting issue resolution.
  - Third party resources functions and support for identification and verification of non-Medicaid insurance – researching, identifying, and invoicing other payment resources for services provided by Medicaid to assure Medicaid is the payer of last resort.
  - Surveillance and utilization review – analysis and comparison of individual providers to peer groups, thus identifying atypical practices and utilization behaviors, resulting in recognition of trends and development of forecasts used for future planning and decision making. This information is shared with the HHSC Inspector General to identify providers who are potentially committing waste, fraud, or abuse.

### **Pharmacy Administration**

The state also contracts with organizations to administer several

HHSC Vendor Drug Program functions.

### *Pharmacy Claims and Rebate Administrator*

The pharmacy claims and rebate administrator vendor processes and adjudicates all FFS outpatient prescription drug claims for Medicaid and the HTW, Kidney Health Care, and CSHCN programs. The pharmacy claims administrator performs all rebate administration functions including invoicing and reconciliation of federal, state, and supplemental rebates. This vendor also stores MCO encounter data to support program oversight of prescription drug benefits in managed care. The vendor also stores data needed to create the National Drug Codes and Healthcare Common Procedure Coding System crosswalk for clinician-administered drug claim processing.

### *Pharmacy Prior Authorization Vendor*

The pharmacy PA vendor evaluates PA requests submitted through a call center and from the FFS pharmacy point-of-sale system for drugs that are not on the preferred drug list (PDL) or have been selected for clinical edits.

### *Preferred Drug List Vendor*

The PDL vendor provides information to the Drug Utilization Review (DUR) Board on the clinical efficacy, safety,

and cost-effectiveness of drug products; negotiates supplemental drug manufacturer rebates on behalf of the state; and assists HHSC and the board with the development and maintenance of the PDL.

### *Retrospective Drug Utilization Review Vendor*

The retrospective DUR vendor performs retrospective DURs to assist health care providers in delivering appropriate prescription pharmaceutical drugs to FFS Medicaid clients.

### *External Quality Review Organization*

The External Quality Review Organization validates MCOs' performance improvement projects, validates performance measures, and conducts a review to determine MCOs' compliance with certain federal Medicaid managed care regulations (see **Chapter 11, Fee-for-Service and Managed Care** and **Appendix E, Managed Care Quality Assurance Reports** for more information).

### *Transformed Medicaid Statistical Information System*

Until June 2014, Texas reported all Medicaid data to the Centers for Medicare & Medicaid Services (CMS) through a quarterly reporting

system called the Medicaid Statistical Information System (MSIS), which began with the passing of the Balanced Budget Act of 1997. This covered all FFS and managed care claims data and eligibility data.

CMS began Transformed MSIS (T-MSIS) as a 10-state pilot program in 2011 to expand this reporting with additional claims information and incorporate changes such as:

- Including provider and third party liability reporting;
- Increasing the number of data elements by more than 400 percent;
- Removing all error tolerances; and
- Changing the reporting cycle from quarterly to monthly.

A process was also added for states to correct and resubmit data to CMS as necessary, ideally within 30 days. In 2013, the pilot moved to an active program change, expanding to include all 54 states and territories.

## Health Information Technology

### *Electronic Health Record Incentive Program*

The American Recovery and Reinvestment Act of 2009 (ARRA) increased the focus on health information technology (HIT) throughout the public and private health care delivery system. The

Health Information Technology for Clinical and Economic Health (HITECH) Act within ARRA provides funding opportunities to assist physicians and other health care professionals in the adoption and meaningful use of electronic health record (EHR) technology and to advance health information exchange (HIE) between providers and health systems.

A certified EHR contains the electronic records of individual patients' health-related information. Records include patient demographic and clinical health information, such as medical histories, prescription histories, lab tests, and allergies. Certified EHRs have a variety of capabilities including: clinical decision support, physician order entry, capture and query of information relevant to health care quality, and the ability to exchange electronic health information with other sources. ARRA allows state Medicaid agencies to establish programs for paying incentives to Medicaid providers for the meaningful use of EHRs.

To be considered a "meaningful user" of an EHR, an eligible professional or hospital must demonstrate meaningful use of the EHR technology over a specified period of time in a manner that is consistent with the objectives and measures outlined in federal regulation by CMS. These objectives and measures

include use of certified EHR technology that improves quality, safety, and efficiency of health care delivery; patient and family engagement; care coordination; and population and public health. The objectives and measures also include ensuring adequate privacy and security protections for personal health information and reducing health care disparities.

Eligible professionals and hospitals submit self-attested data to demonstrate their compliance with program requirements. States can receive 100 percent federal financial participation for incentive payments to Medicaid providers to adopt, implement, and “meaningfully use” certified EHRs. The HITECH Act also provides for Medicaid agencies to obtain 90 percent federal administrative matching funds to develop and administer the EHR Incentive Program.

Texas Medicaid implemented the EHR Incentive Program and began disbursement of incentive payments to eligible providers in May 2011. As of July 2016, the Texas Medicaid EHR Incentive Program has disbursed \$794 million in federally-funded incentives to over 10,000 individual providers and hospitals combined. Through this initiative, Texas is laying the groundwork for development of accountable systems of care. Quality data received through providers’ submission of

meaningful use and clinical quality measures may be incorporated into the overall management of the Medicaid program.

### *EHR Incentive Program Audits*

Federal rules require states to conduct audits of EHR Incentive Program payments to limit the risk of fraud and abuse. HHSC conducts post-payment audits of providers to ensure program requirements were met and payments were made appropriately. Any participating provider may be subject to an audit and federal rules require providers to maintain auditable records related to an attestation/payment for at least six years. HHSC utilizes an independent audit firm to conduct audits of EHR Incentive Program payments.

### *Health Information Exchange via Health Information Organizations*

HIE is the secure electronic movement of health-related information among treating physicians and other care providers and organizations according to national and state laws and nationally recognized standards. The purpose of HIE is to improve the quality, safety, and efficiency of health care using HIT to enable health care providers to access their patients’ health information to

ensure the patient receives the right care at the right time. HIE means:

- Less waiting for paper files to be delivered from one treating physician to another when clients are referred for additional treatment or consultations;
- Less paperwork to complete in the doctor's office, with electronically-stored medical records making it faster and easier for a care provider to access and refer to records and reducing the need to fill out multiple, duplicative forms when clients arrive for a visit;
- Better coordination of care between treating physicians;
- Eliminating unnecessary duplicative tests, x-rays, and other procedures, or the possibility of adverse reactions to treatment that conflicts with prior prescribed medications, treatment or allergies because a physician does not have the results of prior care; and
- Ensuring that Texas physicians and hospitals are eligible to receive billions of dollars in available federal meaningful use incentive payments over the next several years for implementing HIE statewide.

In the long-term, Texas has an opportunity to leverage technology to improve the quality, safety, and efficiency of the Texas health care sector while protecting individual privacy.

## **Statewide Health Information Exchange**

The creation of a statewide HIE system will allow health information to be securely exchanged between providers within Texas. This will increase the coordination and quality of care while improving efficiency in the health care system and increasing consumer empowerment and control.

In 2010, HHSC was awarded \$28.8 million through the State Health Information Exchange Cooperative Agreement program. These funds helped the state develop a strategic and operational plan for HIE and supported the implementation of these plans. To assist with the implementation of these strategies, HHSC contracted with the Texas Health Services Authority (THSA), created by H.B. 1066, 80th Legislature, Regular Session, 2007. THSA was established as a public-private non-profit charged with implementing state-level HIT functions and catalyzing the development of a seamless electronic health information infrastructure to support the health care system in the state.

The Texas HIE strategic and operational plans, which guided the implementation of HIE services in Texas, outline and support the implementation of the following three key strategies:

- General State-Level Operations – These are administered jointly by THSA and HHSC to support a transparent and collaborative governance structure to coordinate the implementation of HIE in Texas, develop policies and guidelines, and for THSA to provide state-level shared HIE services.
- Local HIE Grant Program – This grant program partially funded planning, development, and operations of 16 local and regional Texas HIE networks.
- “White space” Strategy – This coverage strategy supports HIE connectivity through Health Information Service Providers in regions of the state without local or regional HIEs.

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As of March 2016, there are six regional Texas HIE networks that were funded through the State Health Information Exchange Cooperative Agreement Program, and THSA continues to operate the state-level shared services.

### ***e-Health Advisory Committee***

In accordance with S.B. 200, 84th Legislature, Regular Session 2015, a new e-Health Advisory Committee was established in August 2016. The purpose of this advisory committee is to advise the Executive Commissioner and HHS agencies on strategic planning, policy, rules,

and services related to the use of HIT, HIE systems, telemedicine, telehealth, and home telemonitoring services.

### ***Medicaid Eligibility and Health Information Services System***

HHSC implemented the Medicaid Eligibility and Health Information Services (MEHIS) system per direction from H.B. 1218, 81st Legislature, Regular Session, 2009. The MEHIS system replaced the previous paper Medicaid identification with a permanent plastic Medicaid ID card and provides access to automated eligibility verification.

Key features of the MEHIS system include:

- [www.YourTexasBenefits.com](http://www.YourTexasBenefits.com) - Where patients are able to view their benefit and case information, print or order a Medicaid ID card, set up and view their Texas Health Steps (THSteps) alerts, and view services and treatments provided by Medicaid;
- [www.YourTexasBenefitsCard.com](http://www.YourTexasBenefitsCard.com) - Where Medicaid providers get timely information on a patient’s Medicaid eligibility, services, and treatments provided by Medicaid;
- Permanent plastic magnetic stripe Medicaid ID cards;

- Multiple access options for Medicaid providers; and
- Provider and client phone help desks and interactive voice response (IVR) systems.

The MEHIS system became operational in June 2011. The initial implementation included electronic eligibility verification using [YourTexasBenefitsCard.com](http://YourTexasBenefitsCard.com), card production and distribution, and a help desk for providers and clients.

### *Your Texas Benefits Medicaid Card*

Medicaid recipients receive a Your Texas Benefits Medicaid card through the mail upon enrollment in Medicaid. This plastic Medicaid ID card is the same size as a credit card. The following information is printed on the front of the card:

- Client's name and Medicaid ID number;
- Issuer ID; and
- Date the card was issued.

The back of the card includes a statewide toll-free phone number and a website where clients can get more information about the card. The Medicaid ID card is not required for clients to access services, but does help accelerate the verification of eligibility. Since possession of the card does not guarantee current eligibility, providers need to verify eligibility at the point-of-service by using the [YourTexasBenefitsCard.com](http://YourTexasBenefitsCard.com)

provider portal, or they can call the associated help desk or IVR.

### *Online Client Portal*

In January 2012, the initial version of the Medicaid client portal was implemented and added the following features:

- Single sign-on at [YourTexasBenefits.com](http://YourTexasBenefits.com);
- Medicaid client benefit and program information and eligibility verification;
- Ability to view and print copies of one or more Medicaid ID cards;
- Ability to view and set up THSteps alerts and email notifications for clients and their families; and
- Ability to "opt out" to block online access to their Medicaid-related health information.

On March 28, 2016, new features were added to improve functionality to the client portal. Adult clients can now see their available health information online which includes:

- Health events
- Prescription drugs
- Vaccination information
- Lab information
- Past Medicaid visits

Clients can use the Blue Button feature to view, print, or download and store their health information online. Patients who use their

health information may become more engaged with their care overall, leading to improved health outcomes.

### *Online Provider Portal*

Another feature of the MEHIS program includes the provider portal. This portal is designed to give providers a way to view a client's Medicaid eligibility and available health information. The specific functions provided by the portal are:

- Ability to view Medicaid patient health information such as past visits, health events (including diagnosis and treatment), lab results, vaccinations, and prescription drugs;
- Ability to view THSteps alerts;
- Verification of Medicaid patient eligibility and the ability to view patient program information;
- Ability to authorize provider-level functionality to a delegate;
- Dental maintenance organization links added to the Health Summary tab; and
- Access to use the Blue Button functionality to request a Medicaid patient's health information in a single tool. [YourTexasBenefitsCard.com](http://YourTexasBenefitsCard.com) is the only state Medicaid portal in the nation offering the Blue Button feature.

## **Managed Care Systems**

### ***Enrollment Broker***

The eligibility support services and enrollment contractors known as the enrollment broker provide business services to support the state's determination of client eligibility for Medicaid, CHIP, SNAP, and TANF programs; operate four customer care centers; assist with eligibility services case support; enroll Medicaid and CHIP clients in MCOs; and provide outreach and informational services to THSteps clients and various community organizations.

### ***Premiums Payable System***

The Premiums Payable System (PPS) is a group of applications that generate capitation payments for clients enrolled in the STAR, STAR Health, STAR+PLUS, Medicare-Medicaid Plan, STAR Kids, CHIP, Children's Medicaid Dental Services, Medical Transportation Program, and Medicare Advantage Programs.

The PPS applications receive client eligibility data from TIERS, the Service Authorization System, and the enrollment broker contractor. Capitation payment files are sent to departments internal to HHSC and administrative contractors serving the program. In addition to

the payment applications, PPS also supports the MCOs' deliverables tracking and performance monitoring.

