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-----------***-----------
The information presented in this book is intended to provide a helpful reference for the subjects discussed. This book is not meant to be used, nor should it be used, as an official record of Texas Medicaid/CHIP policies. Readers should be aware that the information, including any websites, listed in this book may change.
Foreword

It has been an honor and a privilege to serve as State Medicaid Director during such a dynamic time for Texas Medicaid. We are committed to finding new and innovative ways to build a strong, sustainable program that allows us to deliver quality, cost-effective services to the millions of Texans that rely on us now and in the future. This commitment to continuous improvement requires us not only to work in close partnership with our stakeholders, but to ask ourselves day in and day out, “Is there a better way?”

You will see, as you flip through this 12th edition of our long-standing tradition, that we asked ourselves this same question about the content of this book. It was time to redesign and publish a book that better reflects the way Texas Medicaid has evolved over the years. I am excited to introduce to you our new Texas Medicaid and CHIP Reference Guide. We hope this book will be a valuable resource for anyone who has an interest in the work we do that impacts the lives of so many.

Kind regards,

Stephanie Muth
State Medicaid Director
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# The Data in this Book

Below outlines the details about the data referenced throughout the 12th edition. Information contained in this book was current as of August 2018, unless otherwise noted. Program and financial information may change after publication due to unforeseen changes to federal and state regulations, the state of the economy, and other factors.

<table>
<thead>
<tr>
<th>About</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Time period</strong></td>
<td>All data is state fiscal year (SFY) 2017, unless otherwise noted. Income limits are effective as of March 1, 2018.</td>
</tr>
<tr>
<td><strong>Caseload count</strong></td>
<td>Caseload trends and numbers are based on the monthly average number of clients covered by Medicaid or CHIP. The unduplicated count, which is the total number of individual Texans who received Medicaid/CHIP services over a period of time, will be noted if used. Total caseload numbers combine Medicaid and CHIP unless otherwise noted.</td>
</tr>
<tr>
<td><strong>Cost information</strong></td>
<td>Costs include both partial and full benefit clients, unless otherwise noted. Funds exclude Disproportionate Share Hospital (DSH), Uncompensated Care (UC), and Delivery System Reform Incentive Payment (DSRIP) funds, unless otherwise noted.</td>
</tr>
</tbody>
</table>
| **Sources** | HHSC Financial Services, including System Forecasting, provided the majority of data contained in this book. Their primary sources are:  
- Premiums Payable System data provides a summary of all Medicaid-eligible clients each month. Both monthly Premiums Payable System files and final eight-month files, which contain all retroactive adjustments, are used in the analyses.  
- Expenditure information is obtained from the Texas Medicaid & Healthcare Partnership through the databases in the Vision 21 platform, which includes paid claims, managerial reporting of cash flow, provider and client information, and managed care encounter data. Expenditures include direct payments to physicians, hospitals, and entities that provide ancillary services. Financial information is provided using the Form CMS 64–Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program and the Medicaid Program Budget Report–CMS 37. Additional financial information is provided by the Medicaid Statistical Information System.  
- Unpublished analyses conducted by HHSC Financial Services staff are also used to provide financial information. |

Alternative sources are noted throughout the book.
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## Helpful Websites

<table>
<thead>
<tr>
<th>Website Name</th>
<th>Link</th>
<th>What You’ll Find</th>
</tr>
</thead>
<tbody>
<tr>
<td>Getting Started with EPCS</td>
<td>getepcs.com</td>
<td>How Texas Medicaid providers can learn to start using EPCS</td>
</tr>
<tr>
<td>Health and Human Services Commission (HHSC)</td>
<td>hhs.texas.gov</td>
<td>Locate managed care report cards, information about HHSC services and quality efforts, Medicaid enrollment statistics, Service Delivery Area maps, etc. Access upcoming events, reports, and presentations from the homepage</td>
</tr>
<tr>
<td>Health Care Payment Learning &amp; Action Network (HCP-LAN)</td>
<td>hcp-lan.org</td>
<td>Information and resources about the HCP-LAN Alternative Payment Model (APM) Framework</td>
</tr>
<tr>
<td>Health Information Technology (HIT)</td>
<td>healthit.hhsc.texas.gov</td>
<td>Information about HIT initiatives, including the Electronic Health Record (EHR) Incentive Program and Health Information Exchange (HIE) projects</td>
</tr>
<tr>
<td>How to Get Help</td>
<td>yourtexasbenefits.hhsc.texas.gov/programs/health</td>
<td>Services and eligibility criteria for Medicaid and CHIP, including rates for CHIP annual enrollment fees and co-payments</td>
</tr>
<tr>
<td>Texas Healthcare Learning Collaborative (THLC) Portal</td>
<td>THLCPortal.com</td>
<td>A public reporting platform and a tool for contract oversight and managed care organization (MCO) quality improvement efforts, including MCO report cards and other key performance data</td>
</tr>
<tr>
<td>Your Texas Benefits</td>
<td>YourTexasBenefits.com</td>
<td>A self-service website where Texans can apply for HHSC programs and manage their benefits</td>
</tr>
<tr>
<td>Uniform Managed Care Manual</td>
<td>hhs.texas.gov/services/health/medicaid-chip/provider-information/contracts-manuals/texas-medicaid-chip-uniform-managed-care-manual</td>
<td>Defines procedures that MCOs must follow to meet certain requirements in HHSC managed care contracts</td>
</tr>
</tbody>
</table>
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-----------***-----------
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- Supplemental Security Income Recipients
- Medicaid for the Elderly and People with Disabilities
- People Eligible for Medicare and Medicaid
- Medicare Savings Programs

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Medical Transportation Program

Children and Youth

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- A Closer Look: Texas Health Steps
- CHIP

Women

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  - Healthy Texas Women
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Fundamental Requirements

Statewide Availability
Sufficient Coverage
Service Comparability
  Coverage for Children
  Mental Health Parity
  Behavioral Health Integration
Freedom of Choice

A Closer Look: The Affordable Care Act

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Quick Facts about Medicaid/CHIP
Quick Facts about Medicaid/CHIP

**General Info**

**What it is**
- Medicaid: A healthcare and long-term services program for certain groups of low-income persons
- CHIP: A similar program for children whose families earn too much to qualify for Medicaid but cannot afford health insurance.

**Who it serves**
- Medicaid: Children and their caretakers, pregnant women, and individuals over age 65 or those with disabilities.
- CHIP: Children and the unborn children of pregnant women (CHIP Perinatal).

**How it’s funded**
- Medicaid: State funds, matched with uncapped federal dollars at a set percent rate.
- CHIP: State funds, matched with capped federal dollars at a set percent rate.

**How it’s administered**
- Medicaid: Most services are delivered through managed care, with a small percentage through fee-for-service (FFS).
- CHIP: All services are delivered through managed care.

**Snapshot of Texas Medicaid/CHIP Clients**

- **4.5 million** Texans receiving services.
- **14%** of Texans covered.
- **+35%** Enrollment Growth from 2008 to 2017.

**Births**
- **53%** of Texas births covered by Medicaid.

**Children**
- **44%** of Texas children on Medicaid or CHIP.

**Nursing Home**
- **62%** of nursing home residents covered by Medicaid.

*Data current as of state fiscal year 2016.
### Quick Facts about Medicaid/CHIP

#### Enrollment
- **CHIP**: 9%
- **Medicaid**: 91%

#### Medicaid Ages
- **65+**: 5%
- **21-64**: 18%
- **15-20**: 15%
- **6-14**: 35%
- **0-5**: 27%

#### CHIP Ages
- **15-18**: 41%
- **6-14**: 48%
- **1-5**: <1%

#### Major Medicaid Client Categories

<table>
<thead>
<tr>
<th>Category</th>
<th>Non-Disabled Children</th>
<th>Non-Disabled Adults</th>
<th>Age &amp; Disability-Related</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of Caseload</td>
<td>69%</td>
<td>7%</td>
<td>24%</td>
</tr>
<tr>
<td>10-year Growth</td>
<td>+49%</td>
<td>+39%</td>
<td>+20%</td>
</tr>
<tr>
<td>Cost per Client*</td>
<td>$536</td>
<td>$246</td>
<td>$1,768</td>
</tr>
</tbody>
</table>

*Average cost per client per month is based on full benefit clients only.

#### Funding
- **2016-2017 Medicaid/CHIP Biennial Appropriations**: $61.2 billion
- **60% Federal & Other Funds**
- **40% State General Revenue Funds**
- **29% of the Texas Budget**
- **97% Medicaid**
- **3% CHIP**

#### Pregnant Women
- **8%** of overall caseload
- **90%** Medicaid
- **10%** CHIP Perinatal
- **69%** between age 19 and age 29*

*Medicaid only*
Quick Facts about Medicaid/CHIP

**Spending**

### Spending by Category

- **Client Services**: 77%
  - Admin: 4%
  - Other Services: 19%

Admin includes direct and indirect agency support for the Medicaid Program, excludes MCO administrative expenses. Other services includes funds such as DSH, UC, DSRIP.

### Spending by Service Type

- **53%**: Acute Care*
- **33%**: Long-Term Services and Supports
- **14%**: Prescription Drug**

*Includes Medicare, MTP, Dental, and HIIT expenditures

**Includes Clawback

- **5%**: Behavioral Health

---

**Caseload vs. Spending by Major Medicaid Client Category**

#### Comparison Highlights

- Non-disabled children make up the majority of the caseload (69%) but account for a relatively small portion of spending (30%)
- Age 65+ and disability-related represent 24% of caseload and 61% of spending
- Non-disabled adults, comprised mostly of parents and pregnant women, account for the remaining 7% of caseload and 9% of spending

### Service Delivery Model

#### Percent of Caseload by Service Delivery Model

- **Fee-for-Service**: ~400k Clients
- **Managed Care**: ~4.1M Clients

8% Managed Care
92% Fee-for-Service

**Key Attributes of the Managed Care Service Delivery Model**

- Delivers services through MCOS, who are paid a fixed amount per member enrolled, per month
- Achieves value by incentivizing MCO improvements in quality of care and cost-effectiveness
- Serves as the member’s ‘medical home’ by providing comprehensive preventive and primary care
- Develops and coordinates service plans for members with special health care needs
Quick Facts about Medicaid/CHIP

Managed Care Product Lines

- **STAR Health** 1% of caseload
- **STAR Kids** 3% of caseload
- **CHIP** 10% of caseload
- **STAR+PLUS** 13% of caseload
- **STAR** 66% of caseload

**Managed Care Growth Over Time**

- Managed Care
- FFS

Preventative Care Improved

In the last 10 years, the rate of:

- Children receiving six or more well visits in the first 15 months of life **+24%**
- Adolescents age 12 through 20 receiving a well care visit **+23%**
- Members with diabetes who received hemoglobin A1c (HbA1c) testing **+13%**

Data: STAR only, 2008 vs. 2017. Percentages are estimates due to methodology changes that occurred over the 10-year period.

Cost Growth Contained

In the last 10 years, caseload increased 41% but Texas Medicaid cost per person is lower than the national trend.

- **Texas Medicaid per capita cost growth** **+14%**
- **U.S. healthcare per capita spending growth** **+30%**

Based on full benefit client caseload growth.

*Source: CMS, Office of the Actuary—data is for CY08 to CY16.*
### Quick Facts about Medicaid/CHIP

<table>
<thead>
<tr>
<th><strong>Common Medicaid/CHIP Terms</strong></th>
<th><strong>Key Pages</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute Care Services</strong> focus on preventive care, diagnostics, and treatments, and include, but are not limited to, inpatient and outpatient hospital services, laboratory and x-ray services, and physician services.</td>
<td>Pages 29, 146, 148</td>
</tr>
<tr>
<td><strong>Behavioral Health Services</strong> refer to the treatment of mental health conditions and substance use disorders (SUDs).</td>
<td>Pages 29, 53-54</td>
</tr>
<tr>
<td><strong>Capitation Rates</strong> are the form of payment made to MCOs to deliver health services to Medicaid clients, and are the primary way the state pays for services. Rates are calculated as a 'per member per month' rate for each risk group in each service area based on MCO historical claims experience.</td>
<td>Pages 91-94</td>
</tr>
<tr>
<td><strong>Fee-for-Service (FFS)</strong> is the traditional Medicaid healthcare payment system under which providers receive a payment for each unit of service they provide.</td>
<td>Pages 28, 96-97</td>
</tr>
<tr>
<td><strong>Fundamental Requirements</strong> are the basic principles established by the Social Security Act for all Medicaid programs. The four requirements include state availability, sufficient coverage, service comparability, and freedom of choice.</td>
<td>Pages 110, 113-116</td>
</tr>
<tr>
<td><strong>Long-Term Services and Supports (LTSS)</strong> focuses on providing support with ongoing, day-to-day activities, rather than treating or curing a disease or condition. Clients typically eligible for LTSS are individuals with disabilities and those age 65 and older.</td>
<td>Pages 29, 40-47</td>
</tr>
<tr>
<td><strong>Managed Care Organizations (MCOs)</strong> deliver and manage health services under contract with HHSC. MCOs are often referred to as health plans.</td>
<td>Pages 28-29, 58-81</td>
</tr>
<tr>
<td><strong>Mandatory vs. Optional</strong> refers to 1) the populations state Medicaid programs must cover under federal law and the populations they may extend coverage to; and 2) the set of benefits state Medicaid programs must provide under federal law and the set of benefits the may provide.</td>
<td>Pages 12, 146-148</td>
</tr>
</tbody>
</table>
Quick Facts about Medicaid/CHIP

Pay-for-Quality (P4Q) refers to programs that seek to reward the use of evidence-based practices and promote healthcare coordination and efficacy among MCOs. HHSC implements medical P4Q programs for STAR, STAR+PLUS, and CHIP, and a dental P4Q program.

Providers are healthcare professionals, such as doctors or nurses, and facilities, such as hospitals or clinics. In managed care, clients can receive services from the providers contracting with their health plan, while in FFS, clients can receive services from any Medicaid provider.

State Plans serve as the contract between Texas and Centers for Medicare & Medicaid Services (CMS). State plans describe the scope of the Medicaid program, including administration, eligibility, benefits, and provider reimbursement.

Supplemental Hospital Funding refers to programs that help cover the cost of uncompensated care provided in hospitals, incentivize improvements to care quality, or fund graduate medical education.

Vendor Drug Program (VDP) provides outpatient drug coverage for individuals enrolled in FFS. In addition, the VDP controls aspects of the pharmacy administration for both FFS and managed care, including managing federal and supplemental drug rebates, the Texas Medicaid Preferred Drug List, and clinical prior authorizations.

Waivers allow states to depart from certain Medicaid requirements in order to test and implement new service delivery models, expand eligibility, or provide additional programs and services.

For a full glossary of Medicaid/CHIP terms, see page 167.
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Who can get Medicaid/CHIP and how can they get it?
At-a-Glance

Who can get Medicaid or Children’s Health Insurance Program?

Medicaid and the Children’s Health Insurance Program (CHIP) primarily serve low-income individuals. Texans who apply for Medicaid/CHIP benefits must meet certain financial and non-financial criteria to be eligible for services.

**FINANCIAL CRITERIA**

is generally based on how the applicant’s income compares to the U.S. Department of Health and Human Services’ definition of the federal poverty level (FPL) for annual household incomes. Financial criteria varies by program.

**NON-FINANCIAL CRITERIA**

is based on age, residency, and citizenship or alien status. Applicants must be within the program-specific age limits, reside and intend to remain in Texas, provide a Social Security number (SSN) or apply for one, and meet citizenship or alien status requirements.

Generally, Medicaid-eligible individuals who may receive full benefits are children, parents and caretakers of children receiving Medicaid benefits, pregnant women, adults with disabilities, people age 65 and older, and former foster care youth. Supplemental Security Income (SSI) recipients are also eligible for Medicaid in Texas. Based on income level and age, certain Medicare beneficiaries qualify for partial or full Medicaid benefits, as well.

CHIP-eligible individuals are children whose families earn too much to qualify for Medicaid, but cannot afford health insurance, including the unborn children of pregnant women (CHIP Perinatal).

Non-citizens are not eligible for regular Medicaid/CHIP benefits. They may receive coverage for treatment of emergency services. Non-citizens include, but are not limited to, legal permanent residents or undocumented individuals (see A Closer Look, page 24).
How Can Texans Apply for Medicaid or CHIP?

Texans can apply for Medicaid, CHIP, and other Texas Health and Human Services Commission (HHSC) programs, such as Supplemental Nutrition Assistance Program and Temporary Assistance for Needy Families (TANF), through a variety of channels including:

- A self-service website (YourTexasBenefits.com)
- A network of local eligibility offices and community partners
- The 2-1-1 phone service
- By mail or fax

The application for Medicaid/CHIP benefits is integrated. If applicants are found ineligible for Medicaid, an eligibility determination will be made for CHIP automatically. Through the Your Texas Benefits smartphone app, individuals may also manage, but not apply for, their benefits, view alerts, and find local offices or community partners.

What are Community Partners?
Community partners are a statewide network of nonprofit, faith-based, local, and community groups that help individuals apply for and manage benefits online.

These groups either participate in the program as self-service locations where they provide computers with internet connection or assistance sites where staff and volunteers help clients.

1. APPLY ONLINE AT YourTexasBenefits.com

Texans can apply online for healthcare coverage, Healthy Texas Women (HTW), and other HHSC programs.

2. DETERMINE ELIGIBILITY

HHSC staff use the Texas Integrated Eligibility Redesign System (TIERS) to determine client eligibility for Medicaid, CHIP, and other programs.

Clients can:
- View benefit information and edit and manage personal information
- Select their plan if in a managed care program
- Print a temporary Medicaid card or order a replacement Medicaid card
- Set up and view their Texas Health Steps (THSteps) alerts
- View services and treatments provided by Medicaid

3. MANAGE ACCOUNT AT YourTexasBenefits.com

Clients can: [same as above for APPLY ONLINE AT]
Financial Criteria

Mandatory vs. Optional Coverage

Medicaid primarily serves low-income children and families, pregnant women, people age 65 and older, and adults and children with disabilities. Federal law requires states to cover certain groups, and allows states the option to expand eligibility beyond minimum federal standards. Texas Medicaid covers a limited number of optional groups.

The figure below depicts the current Texas Medicaid income eligibility levels as a percent of the FPL for the most common Medicaid eligibility categories. Mandatory levels identify the coverage levels required by the federal government. Optional levels show the coverage Texas has implemented at higher levels allowed, but not mandated, by the federal government.

Texas Medicaid Income Eligibility Levels for Selected Programs, March 2018 (as a Percent of the FPL)

This figure reflects eligibility levels as of March 2018. In 2014, the Affordable Care Act (ACA) required states to adjust income limits for pregnant women, children, and parents and caretaker relatives to account for Modified Adjusted Gross Income (MAGI) changes.

*For Parents and Caretaker Relatives, maximum monthly income limit in SFY 2018 was $230 for a family of three, which is approximately 14 percent of the FPL. **For Medically Needy pregnant women and children, the maximum monthly income limit in SFY 2018 was $275 for a family of three, which is approximately 16 percent of the FPL.
## Determining Financial Eligibility

<table>
<thead>
<tr>
<th>Modified Adjusted Gross Income (MAGI)</th>
<th>Subject to MAGI</th>
<th>NOT Subject to MAGI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal law requires most financial eligibility be determined through the MAGI methodology</td>
<td>Most Medicaid programs and CHIP</td>
<td>Medicaid programs for people who are:</td>
</tr>
<tr>
<td>MAGI uses federal income tax rules for determining income and household composition</td>
<td></td>
<td>• Age 65 and older</td>
</tr>
<tr>
<td>For Medicaid eligibility, MAGI is calculated by taking current monthly income* and subtracting tax-deductible expenses (such as IRA contributions or alimony payments)</td>
<td></td>
<td>• Disabled</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Receiving Supplemental Security Income (SSI)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>INCOME DISREGARD</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>When other income sources are deducted or disregarded in the financial eligibility determination</td>
<td>After household income is calculated, a standard income disregard equivalent to five percentage points of the FPL (in 2018, an $86.60 disregard for a family of three)</td>
<td>Program-specific disregards may include:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• First $20 of any kind of income is excluded</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Earned income – The first $65 of earned income plus half of the remainder of earned income is disregarded</td>
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<td></td>
<td></td>
<td>• Certain increases in Social Security benefits for persons denied SSI</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Veteran’s Administration Aid and Attendance Allowances and Housebound Allowances</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ASSET TEST</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Counts the resources, such as savings or checking accounts, that applicants may have access to (there is a limit on the amount of assets a household can have to be eligible)</td>
<td>No asset test, except for Medically Needy with Spend Down and Emergency Medically Needy with Spend Down for Children</td>
<td>Yes, asset test is needed</td>
</tr>
</tbody>
</table>

*Current monthly income is a “point-in-time” calculation, not a 12-month average.
To qualify for children’s benefits the age limit is typically age 18 and younger. Youth qualifications on age vary based on the program.

Applicants must also meet non-financial (residence and citizenship) and program-specific financial requirements.

**Children’s Medicaid**

Children comprise the majority of individuals receiving full Medicaid benefits. Newborns (under 12 months) born to Medicaid-eligible mothers are automatically eligible for Medicaid and remain eligible through the month of their first birthday. Children who do not qualify for Medicaid because of income may be eligible for CHIP or may qualify for the Medically Needy with Spend Down program (see page 19).

<table>
<thead>
<tr>
<th>Eligibility Category</th>
<th>FPL% or Income Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children less than 1</td>
<td>At or below 198% - $3,429 for a three person household</td>
</tr>
<tr>
<td>Children 1-5</td>
<td>At or below 144% - $2,494 for a three person household</td>
</tr>
<tr>
<td>Children 6-18</td>
<td>At or below 133% - $2,304 for a three person household</td>
</tr>
</tbody>
</table>

**Former Foster Care Youth**

*Medicaid for Former Foster Care Children*

Children who aged out of the foster care system in Texas at age 18 and older and who were receiving federally-funded Medicaid when they aged out of foster care may continue to be eligible for Medicaid up to the month of their 26th birthday. Income and resource limits do not apply to Medicaid for Former Foster Care Children.

*Medicaid for Transitioning Foster Care Youth*

Former foster care youths who were not receiving Medicaid when they aged out of foster care at age 18 and older may still be eligible for Medicaid under Medicaid for Transitioning Foster Care Youth (MTFCY) up to the month of their 21st birthday.
To qualify for MTFCY the individual must meet all of the requirements below:

- Be a Texas resident
- Meet citizenship or alien status
- Have an SSN or have applied for one
- Not have adequate health coverage
- Be at or below 413 percent of the FPL (or $4,179/month for a household of one)

Resource limits do not apply to MTFCY. In addition, individuals under an Interstate Compact on the Placement of Children agreement may be eligible for MTFCY if all other requirements are met.

**Children’s Health Insurance Program**

CHIP covers children in families who have too much income to qualify for Medicaid, but cannot afford to buy private health insurance. CHIP covers similar services as Children’s Medicaid. Enrollment fees and co-pays are determined based on family income.

In addition to the non-financial requirements, to qualify for CHIP a child must be:

- Uninsured for at least 90 days or have a good cause exemption
- Living in a family whose income is at or below 201 percent of the FPL

See the following chart for the CHIP maximum monthly income limits by household size.

<table>
<thead>
<tr>
<th>Household Size</th>
<th>Income Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$2,034</td>
</tr>
<tr>
<td>2</td>
<td>$2,758</td>
</tr>
<tr>
<td>3</td>
<td>$3,481</td>
</tr>
<tr>
<td>4</td>
<td>$4,205</td>
</tr>
<tr>
<td>5</td>
<td>$4,928</td>
</tr>
<tr>
<td>6</td>
<td>$5,652</td>
</tr>
<tr>
<td>7</td>
<td>$6,376</td>
</tr>
<tr>
<td>8</td>
<td>$7,099</td>
</tr>
</tbody>
</table>

For each additional person, add: $724
Incarcerated Individuals
Individuals incarcerated by the Texas Department of Criminal Justice who are age 18 and younger or pregnant may be eligible for Medicaid coverage for inpatient medical services provided in a “free-world” medical facility not located on the premises of a jail or prison. If determined eligible, Medicaid covers only the services provided during the incarcerated individual’s inpatient stay. The University of Texas Medical Branch at Galveston submits applications for Medicaid coverage to HHSC.

Juveniles receiving Children’s Medicaid may have their coverage suspended upon entrance into a juvenile facility and reinstated upon release. Children who enter a juvenile facility and receive any other type of Medicaid or CHIP will have their coverage terminated and must reapply upon release.

Women
There are several types of benefits for which Texas women may be eligible. Applicants must meet program-specific non-financial and financial requirements to receive these services.

Medicaid for Pregnant Women
Texas extends Medicaid eligibility to pregnant women with household income at or below 198 percent of the FPL, well above the federal requirement of 133 percent of the FPL. If certified, a woman receives full Medicaid benefits. The following chart shows the Medicaid for Pregnant Women maximum monthly income limits by household size, which includes unborn children.

<table>
<thead>
<tr>
<th>Household Size</th>
<th>Monthly Income Limits by Household Size</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Income Limits</strong></td>
</tr>
<tr>
<td>1</td>
<td>$2,004</td>
</tr>
<tr>
<td>2</td>
<td>$2,716</td>
</tr>
<tr>
<td>3</td>
<td>$3,429</td>
</tr>
<tr>
<td>4</td>
<td>$4,142</td>
</tr>
<tr>
<td>5</td>
<td>$4,855</td>
</tr>
<tr>
<td>6</td>
<td>$5,568</td>
</tr>
<tr>
<td>7</td>
<td>$6,280</td>
</tr>
<tr>
<td>8</td>
<td>$6,993</td>
</tr>
</tbody>
</table>

For each additional person, add: $713
Pregnant women who do not meet income or non-citizen requirements may qualify for CHIP Perinatal, the Medically Needy with Spend Down program, or the Medically Needy with Spend Down Emergency program. Medically Needy programs are further explained on page 19.

**CHIP Perinatal**

CHIP Perinatal services are for the unborn children of pregnant women who are uninsured and do not qualify for Medicaid due to income or immigration status, and whose household income is at or below 202 percent of the FPL.

For CHIP Perinatal clients at or below 198 percent of the FPL, the mother must apply for Emergency Medicaid to cover her labor and delivery. If the mother received Medicaid or Emergency Medicaid to cover her labor and delivery, her CHIP Perinatal newborn is eligible to receive 12 months of continuous Medicaid coverage from their date of birth.

CHIP Perinatal newborns in families with incomes above 198 percent of the FPL and at or below 202 percent of the FPL remain in CHIP Perinatal and receive CHIP benefits from their date of birth through the remainder of the 12-month coverage period.

The following chart shows the CHIP Perinatal maximum monthly income limits by household size.

<table>
<thead>
<tr>
<th>Household Size</th>
<th>Income Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$2,044</td>
</tr>
<tr>
<td>2</td>
<td>$2,771</td>
</tr>
<tr>
<td>3</td>
<td>$3,498</td>
</tr>
<tr>
<td>4</td>
<td>$4,226</td>
</tr>
<tr>
<td>5</td>
<td>$4,953</td>
</tr>
<tr>
<td>6</td>
<td>$5,680</td>
</tr>
<tr>
<td>7</td>
<td>$6,407</td>
</tr>
<tr>
<td>8</td>
<td>$7,134</td>
</tr>
</tbody>
</table>

For each additional person, add: $728
Healthy Texas Women

Eligible, low income Texas women have access to Healthy Texas Women (HTW), a program that provides women’s health and family planning services at no cost. Though currently funded exclusively through state funds, HTW has submitted a Section 1115(a) demonstration waiver application to seek federal participation in the program.

Women must meet the following qualifications:

- Be age 18 through 44 (women are considered age 18 on the day they turn 18, and age 44 through the last day of the month during which they turn 45)
- Be age 15 through age 17 and have a parent or legal guardian apply, renew, and report changes to her case on her behalf (women are considered age 15 on the first day of the month they turn 15, and age 17 through the day before they turn 18)
- Be U.S. citizens or qualified immigrants
- Reside in Texas
- Not be eligible to receive full Medicaid benefits, CHIP, or Medicare Part A or B
- Not be pregnant
- Not have any other creditable health coverage (unless filing a claim would cause physical, emotional, or other harm from a spouse, parent or another person)
- Have a net family income at or below 200 percent of the FPL

To provide continuity of care, HHSC implemented a policy to automatically enroll women into HTW when their Medicaid for Pregnant Women coverage ends. A month prior to the end of coverage, an eligibility determination for any other Medicaid/CHIP program will be made. If a woman is ineligible for Medicaid or CHIP, she will be certified for HTW, with coverage beginning the day after her Medicaid coverage ends.

Breast and Cervical Cancer Screening Services

Women who meet the qualifications below may access breast and cervical cancer screening and diagnostic services in clinic sites across the state.

- Reside in Texas
- Are age 18 and older
- Do not have health insurance
- Have a net family income at or below 200 percent of the FPL

These clinic sites are the point of access for applying for the Medicaid for Breast and Cervical Cancer (MBCC) program, regardless of how the client was diagnosed with cancer.
**Medicaid for Breast and Cervical Cancer Program**

The MBCC program provides Medicaid to eligible women who are screened under the Centers for Disease Control and Prevention’s National Breast and Cervical Cancer Early Detection Program and are found to have breast or cervical cancer, including pre-cancerous conditions. In 2017, the monthly average number of clients enrolled in MBCC was 4,861.

To be eligible for MBCC, a woman must be 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-cancerous conditions. She must also be uninsured, age 18 through 64, and meet residency and citizenship criteria.

After a woman has received an eligible breast or cervical cancer diagnosis from a provider, she must go to a Breast and Cervical Cancer Services (BCCS) provider who will screen her for Medicaid eligibility. HHSC makes the final Medicaid eligibility determination after the provider submits the application and supporting materials to the state. Application for the program cannot be made through an HHSC benefits office.

A woman eligible for MBCC receives full Medicaid benefits, including services beyond the treatment of breast and cervical cancer. In addition, she can continue to receive full Medicaid benefits as long as she meets the eligibility criteria at her coverage renewal period and provides proof from her treating physician that she is receiving active treatment for breast or cervical cancer.

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**Medically Needy with Spend Down Program**

Children age 18 and younger and pregnant women with unpaid medical bills who are not eligible for Medicaid may qualify for the Medically Needy with Spend Down program. Through this program, Medicaid pays for unpaid medical expenses for medical services provided to individuals who meet the required Spend Down limits.

Spend Down is the difference between an applicant’s household income and the Medically Needy income limit. Applicants must have unpaid medical bills that exceed the Spend Down amount to receive benefits under the program.

The income limit is $275 per month for a family of three. When determining eligibility for children, the asset limit is $2,000 or $3,000 for an applicant with a household member who is aged or has a disability and meets relationship requirements. Assets are not considered when determining eligibility for the Medically Needy with Spend Down program for pregnant women.
Parents and Caretaker Relatives

Adults caring for a related dependent child receiving Medicaid may themselves be eligible to receive Medicaid. The adult must have a child currently eligible for or currently receiving Medicaid. The child must be living with the parent or caretaker relative, and be age 18 and younger, or be age 18 and a full-time student meeting school attendance requirements.

The adult caring for the child must be a parent, step-parent, grandparent, sibling or step-sibling, uncle or aunt, nephew or niece, first cousin, or a child of a first cousin. The following chart shows the parents and caretaker relatives maximum monthly income by family size.

<table>
<thead>
<tr>
<th>Family Size</th>
<th>One Parent</th>
<th>Two Parent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$103</td>
<td>---</td>
</tr>
<tr>
<td>2</td>
<td>$196</td>
<td>$161</td>
</tr>
<tr>
<td>3</td>
<td>$230</td>
<td>$251</td>
</tr>
<tr>
<td>4</td>
<td>$277</td>
<td>$285</td>
</tr>
<tr>
<td>5</td>
<td>$310</td>
<td>$332</td>
</tr>
<tr>
<td>Each additional person, add:</td>
<td>$52</td>
<td>$52</td>
</tr>
</tbody>
</table>

Children and Adults with Disabilities

Supplemental Security Income Recipients

Supplemental Security Income (SSI) is a federal cash assistance program for low-income people with disabilities. Low-income, individuals age 65 and older, may also qualify for SSI. The Social Security Administration sets income eligibility limits, asset limits and benefit rates, and determines eligibility. In Texas, all people eligible for SSI are automatically eligible for Medicaid.
Medicaid for the Elderly and People with Disabilities

Those with disabilities who do not receive SSI may qualify for Medicaid for the Elderly and People with Disabilities (MEPD) programs through a facility, such as a nursing facility or an intermediate care facility for individuals with an intellectual disability or related condition (ICF/IID), or through a community program while living at home. People age 65 and older may also qualify for this program.

Medicaid Buy-In

For Children

The Medicaid Buy-In for Children (MBIC) program allows children age 18 and younger with disabilities to "buy-in" to Medicaid. Children with family countable income at or below 300 percent of the FPL may qualify for the program, and households at or below 150 percent of the FPL will not pay a premium.

MBIC families make monthly payments according to a sliding scale that is based on family income. If a payment is missed, the client has a 60-day grace period to pay the premium before they are disenrolled from the program. Premiums may be waived for a three-month period if the client submits an income hardship and receives approval. Premiums may also be waived in the case of a federally-declared disaster.

For Workers with Disabilities

The Medicaid Buy-In (MBI) Program for Workers with Disabilities enables working persons with disabilities to “buy-in” to Medicaid. Individuals with income below 250 percent of the FPL and resources at or below $5,000 ($3,000 MBI exclusion plus $2,000, the current SSI resource limit) may qualify for the program and may pay a monthly premium in order to receive Medicaid benefits.

People Age 65 and Older

Supplemental Security Income Recipients

As previously stated, SSI is a federal cash assistance program for low-income people with disabilities and those age 65 and older. The Social Security Administration sets income eligibility limits, asset limits and benefit rates, and determines eligibility. In Texas, all people eligible for SSI are automatically eligible for Medicaid.
Medicaid for the Elderly and People with Disabilities

As previously stated, people age 65 and older and those with disabilities who do not receive SSI may qualify for MEPD programs through a facility, such as a nursing facility or an ICF/IID, or through a community program while living at home.

People Eligible for Medicare and Medicaid

Dual eligibles are individuals who qualify for both Medicare and Medicaid benefits. Medicare is a federally-paid and administered health insurance program. Medicare covers inpatient hospital services (Part A), physician and related health services (Part B), Medicare managed care (Part C), and prescription drugs (Part D).

Full dual eligibles are Medicare clients who are eligible for full Medicaid benefits. In 2017, there was a monthly average of 373,516 full dual eligible individuals in Texas. However, Medicaid also provides limited assistance to certain Medicare clients, known as “partial dual eligibles,” who do not qualify for full Medicaid benefits. In 2017, there was a monthly average of 266,626 partial dual eligible individuals in Texas. Individuals who do not qualify for full Medicaid benefits may receive assistance through Medicare savings programs.

Medicare Savings Programs

There are several types of programs for partial dual eligibles who meet established income and resource criteria. These include Qualified Medicare Beneficiaries, Specified Low-Income Medicare Beneficiaries, Qualifying Individuals, and Qualified Disabled Working Individuals (QDWIs).

Individuals in these programs receive assistance with all or a portion of Medicare premiums, deductibles, and coinsurance payments through the Texas Medicaid program. In addition, anyone who qualifies for these programs does not have to pay Medicare Part D premiums or deductibles.

Resource limits for 2018 were $7,560 per individual and $11,340 per couple for most categories of dual eligibles. The only exception is for QDWI, where the resource limits were twice the SSI resource limit, which was $4,000 for an individual and $6,000 for a couple.
What Happens Once a Client is Found Eligible

When a client is found eligible for Medicaid, they will be enrolled into fee-for-service (FFS) or in a managed care plan. Managed care plans cover the same services as FFS, but may also have value-added services not covered by FFS. For more information on managed care and FFS, see Chapter 3.

In general, clients must enroll in the STAR program if they receive cash assistance (TANF), are pregnant, are newborns, or have limited income.

If enrolled in a managed care program, clients choose a health plan from the plans available in their service area (see Appendix D). They must also choose a primary care provider from the list of providers included in their health plan.

Primary Care Providers Can Be One of the Following

- OB/GYN (doctor for women’s health)
- Specialty trained nurse
- Family practice doctor
- Internal medicine doctor
- Pediatrician (children’s doctor)
- Clinic

Clients receive a Your Texas Benefits ID. If clients are enrolled in a managed care program, they will receive an ID card from their selected health plan. This proof of coverage must be brought along to all healthcare appointments and to any trips to the hospital or pharmacy.

For more information on managed care programs including STAR, STAR Kids, STAR Health, and STAR+PLUS, see Chapter 2.

CHIP Managed Care

All CHIP and CHIP Perinatal clients are enrolled into a managed care plan. Just like with Medicaid, clients choose their plan and provider. Clients have a choice of at least two MCOs in each service area.
### Chapter 1 — Who can get Medicaid/CHIP and how can they get it?

#### A Closer Lookqualified Aliens and Non-Citizens

**Categories**

- **Legal Permanent Residents (LPRs):** Any person not a citizen of the U.S. who is residing in the U.S. under legally recognized and lawfully recorded permanent residence as an immigrant. Also known as “Permanent Resident Alien,” “Resident Alien Permit Holder,” and “Green Card Holder” (includes Amerasians)
- **Asylees**
- **Refugees**
- **Aliens paroled into the U.S. for at least one year**
- **Aliens whose deportations are being withheld**
- **Aliens granted conditional entry**
- **Battered alien and children and parents of the battered alien**
- **Cuban/Haitian entrants**
- **Victims of human trafficking**

#### Waiting Periods

<table>
<thead>
<tr>
<th>No Waiting Period, No Limited Eligibility Period</th>
<th>No Waiting Period, Limited to Seven Years Eligibility</th>
<th>Five-Year Waiting Period for Eligibility*</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Veterans, active duty members of the U.S. armed forces, including their spouses and dependent children</td>
<td>- Refugees (including Afghan and Iraqi special immigrants)</td>
<td>- LPRs admitted to the U.S. not included in categories above</td>
</tr>
<tr>
<td>- Canadian born American Indians</td>
<td>- Asylees</td>
<td>- LPRs admitted to the U.S. before August 22, 1996, who do not obtain qualified alien status until on or after August 22, 1996</td>
</tr>
<tr>
<td>- Aliens covered by Medicaid based on receiving SSI cash benefits on August 22, 1996, and lawfully residing in the U.S. on or before August 22, 1996</td>
<td>- Aliens whose deportations are being withheld</td>
<td>- An exception is given to aliens who entered the U.S. before August 22, 1996, and remained continuously present in the U.S. since at least August 21, 1996, until obtaining qualifying immigrant status and meeting the 40 qualifying quarters of Social Security coverage requirement</td>
</tr>
<tr>
<td>- LPRs admitted prior to August 22, 1996, credited with 40 qualifying quarters of Social Security coverage</td>
<td>- Cuban/Haitian entrants</td>
<td></td>
</tr>
<tr>
<td>- Members of federally recognized Indian tribes</td>
<td>- Amerasians</td>
<td></td>
</tr>
</tbody>
</table>

*From date of entry or from date of obtaining qualified alien status.
After the Five-Year Waiting Period

Individuals must meet one of the following categories:

1. Naturalized citizen or meet citizenship status
2. Credited with 40 qualifying quarters of social security coverage
3. Veterans, active duty members of the U.S. armed forces, including their spouses and dependent children
4. Aliens covered by Medicaid based on receiving SSI cash benefit

Other Circumstances to Note

Victims of Human Trafficking

The U.S. Department of Health and Human Services certifies individuals who meet the victims of severe human trafficking requirements to remain in the U.S. up to four years. Law enforcement authorities can extend the status beyond four years for individuals whose presence is required for a continuing investigation.

These individuals meet the alien status criteria to be potentially eligible for benefits without a five-year waiting period and continue to meet the eligibility criteria without a limited eligibility period as long as the law enforcement extension continues, or they adjust to another acceptable alien status.

Children Eligible Based on Children’s Health Insurance Program Reauthorization Act of 2009

Certain qualified immigrant and nonimmigrant alien children lawfully residing in the U.S. may qualify for Medicaid and CHIP, regardless of their date of entry (see Appendix A, page 136).

Emergency Medicaid

Nonimmigrants, undocumented aliens, and certain LPRs may qualify for Emergency Medicaid coverage, if all other eligibility requirements are met, except for alien status. Undocumented aliens are not required to provide an SSN. If determined eligible, the individual is covered by Medicaid only from the start of a qualifying emergency medical condition to when the event is stabilized, as verified by a medical provider.
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* This ReadMe.txt file
* One template file in INDD and IDML formats

If you have InDesign CC 2018 or later, you can open the INDD version of the file. If you have an earlier version of InDesign, please open the IDML version of the file.
Chapter 2

What are the programs and services available to Texans?
At-a-Glance

What is Managed Care?
Under this service delivery model, HHSC contracts with MCOs to provide Medicaid/CHIP services to clients. MCOs are required to provide all covered, medically necessary services to their members. Additionally, MCOs may have value-added services, which are benefits not paid for by Medicaid.

What is Fee-for-Service?
The majority of FFS population is made up of clients who will be, but are not yet, enrolled in managed care, and some waiver programs. Under this model, clients can go to any Medicaid provider and the provider submits claims directly for covered services. Coverage under FFS is mostly the same as managed care, though there may be differences in the delivery of certain services. In some cases, a client may receive acute care services through managed care and long-term services and supports (LTSS) through FFS.

Texas Managed Care Programs

1. **STAR**: Children, newborns, pregnant women, and some families
2. **STAR Kids**: Children and adults age 20 and younger with a disability
3. **STAR Health**: Children who get Medicaid through the Department of Family and Protective Services and young adults previously in foster care
4. **STAR+PLUS**: Adults with a disability, individuals age 65 and older (including those dually eligible for Medicare and Medicaid), and women with breast or cervical cancer
5. **CHIP**: Children and unborn children (CHIP Perinatal) in families that earn too much money to qualify for Medicaid, but cannot afford to buy private health insurance
Three Primary Types of Services

**Acute Care Services**
Focus on preventive care, diagnostics, and treatments. All clients enrolled into one of the Medicaid programs in Texas are eligible for acute care services. Acute care services are typically delivered through managed care, but may also be delivered through FFS.

CHIP provides coverage primarily for acute care services, though CHIP clients may be eligible for certain LTSS programs and services.

*Example Services*
Inpatient and outpatient hospital services, laboratory and x-ray, doctors’ appointments, dental and oral health care, prescription drugs, perinatal care for women, and transportation to covered healthcare services

**Long-Term Services and Supports**
Support an individual with ongoing, day-to-day activities, rather than treat or cure a disease or condition. Clients typically eligible for LTSS include adults age 65 and older and those with physical or intellectual disabilities. LTSS may be delivered through managed care or FFS and may be in conjunction with a waiver program.

*Example Services*
Nursing facility services for clients age 21 and older, prescribed pediatric extended care facilities, community-based care, personal assistance with activities of daily living (e.g., cleaning, cooking) services, and speech and occupational therapy

**Behavioral Health Services**
Treat mental health conditions and substance use disorder (SUD). These services are included in all Medicaid managed care and FFS programs, as well as CHIP, and may be provided by therapists in private practice, physicians, private and public psychiatric hospitals, community mental health centers, comprehensive provider agencies, and substance use treatment facilities.

*Example Services*
Psychiatric diagnostic evaluation, medication assisted therapy for SUD, and psychological and neuropsychological testing

For a full list of services offered in Texas, see Appendix B. For eligibility criteria, see Chapter 1.
**STAR: Texas’ Largest Managed Care Program**

Most people in Texas Medicaid get their coverage through STAR. STAR provides primary care, acute care, behavioral health care, and pharmacy services for low-income families, children, pregnant women, and some former foster care youth.

STAR MCOs also provide service management to members with special health care needs (see A Closer Look on page 55). There are 13 STAR service areas. STAR Medicaid members can select from at least two MCOs in each service area.

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### Prescription Drugs

Texas Medicaid and CHIP cover most outpatient prescription drugs either through an MCO, or for FFS clients, through the Vendor Drug Program (VDP). Clients who are dually eligible for Medicaid and Medicare receive most of their prescription drugs through the Medicare prescription drug benefit known as Medicare Part D.

Medicaid managed care clients and CHIP clients obtain their prescription drug benefits through an MCO. Outpatient prescription drugs are a benefit in all managed care programs. Clients enrolled in the managed care programs are not limited in the number of prescriptions they may obtain. However, drugs must be authorized before they can be dispensed.

For those enrolled in FFS, Texas pays for all outpatient drug coverage through the VDP, with the exception of some medications provided as part of outpatient physician services. Adults enrolled in FFS are limited to three prescriptions per month. There are no limits on drugs for children age 20 and younger, adults enrolled in managed care, clients in nursing facilities, and clients enrolled in certain 1915(c) waiver programs.

The VDP is not only responsible for administering drug benefits to FFS clients, but also maintains control of many aspects of the pharmacy administration for both FFS and managed care. Participating MCOs are required to adhere to certain VDP protocols (see Chapter 3, page 68).

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### Medical Transportation Program

The Medical Transportation Program (MTP) is responsible for ensuring consistent, appropriate, reasonably prompt, and cost-effective nonemergency medical transportation (NEMT) services to eligible Medicaid clients who need transportation to covered healthcare services. NEMT services excludes nonemergency ambulance or ambulance services. NEMT services are available to clients who do not have any other means of transportation to covered healthcare services.
MTP is also responsible for arranging and administering NEMT services to Children with Special Health Care Needs clients and Transportation for Indigent Cancer Patients.

Services provided through MTP include:

- Mass transit tickets, including bus, rail, ferry, publicly or privately owned transit that provides general or special service on a regular or continuing basis, and commercial airline transportation services
- Demand response services
- Mileage reimbursement through Individual Transportation Participant (ITP) requests; ITPs must be registered or enrolled with Texas Medicaid & Healthcare Partnership (TMHP) to participate in the mileage reimbursement program
- Meals and lodging when covered healthcare services require an overnight stay outside the county of residence
- Advanced funds for the purpose of funding transportation or travel-related services (e.g., gasoline, meals)
- Out-of-state travel to contiguous counties in adjoining states (Louisiana, Arkansas, Oklahoma, and New Mexico) and travel to states outside of the adjoining states for covered healthcare services that cannot be provided in Texas

**Children and Youth**

Children may be covered through a variety of managed care plans through Medicaid or CHIP, depending on their eligibility and healthcare needs. Most Medicaid-eligible children are enrolled into STAR and receive services like Early and Periodic Screening, Diagnosis, and Treatment services, also known as Texas Health Steps (THSteps).

Children with Medicaid coverage are generally eligible to receive a wider range of healthcare services than adults, including services like physical, occupational, and speech therapy, private duty nursing services, and hearing and vision services. Children who are not eligible for Medicaid due to income may be eligible for CHIP where they will receive similar coverage. In addition, STAR Health covers children in the Texas Department of Family and Protective Services (DFPS) conservatorship or individuals age 18 through 20 previously in foster care, while STAR Kids covers children and youth with disabilities (see page 48).

Children and youth on Medicaid, birth through age 20, also receive comprehensive dental services. Most dental benefits are provided through the Children’s Medicaid Dental Services (CMDs) program, a managed care program provided statewide by two Dental Maintenance Organizations (DMOs). However, if enrolled into the STAR Health program or residing in a long-term care facility, like a nursing facility or a state supported living center, children instead receive these services through their service delivery model.
For more information on Medicaid dental services, see A Closer Look on Texas Health Steps (THSteps) on page 33. For information on dental services provided under CHIP, see page 34. In certain cases, children may also be covered through FFS.

**STAR Health**

The STAR Health program provides primary, acute, and behavioral health care, as well as dental, vision, and pharmacy services to children in Texas DFPS conservatorship. Children in foster care are a high-risk population with greater medical and behavioral health needs than most children in Medicaid. STAR Health provides a medical home for children as soon as they enter state conservatorship, and continues to serve them through two transition categories:

- Youth age 21 years and younger with voluntary extended foster care placement agreements (Extended Foster Care)
- Youth age 20 and younger who are Former Foster Care Children (FFCC) and were in paid placements and receiving Medicaid when they aged out of foster care. FFCC who are eligible for Medicaid will continue coverage through the STAR managed care plan of their choice from age 21 through the month of their 26th birthday

Clients have access to a primary care provider (PCP) who knows their healthcare needs and can coordinate their care through a medical home. STAR Health also offers services, including:

- Service management and service coordination
- A 24/7 nurse hotline for caregivers and caseworkers
- The Health Passport—a web-based, claims-based electronic medical record

In addition, use of psychotropic medication among STAR Health clients is carefully monitored for compliance with the DFPS psychotropic medication utilization parameters, which are best practice guidelines for the use of these medications with children.

STAR Health provides LTSS benefits, as appropriate, for children enrolled in the program (see page 48).

HHSC administers the program under a contract with a single statewide MCO. The MCO delivers services through a trauma-informed network of providers with experience treating children who have been abused or neglected. The STAR Health program trains and certifies behavioral health providers, caregivers, and caseworkers in trauma informed care, including evidence-based practices, such as Trauma-Focused Cognitive Behavioral Therapy.
The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, known in Texas as Texas Health Steps (THSteps), is a benefit for children enrolled in Medicaid. THSteps provides preventive health and comprehensive care services for children, birth through age 20. THSteps recommends yearly checkups for clients, age 3 through 20, and more than one check-up per year for clients younger than age 3. Medical checkups include:

- Comprehensive health and developmental history
- Comprehensive physical examination
- Vaccinations
- Laboratory screening
- Mental health screening
- Health education/anticipatory guidance
- Referral to establish a dental home beginning at 6 months of age

THSteps also includes the Comprehensive Care Program, which expands coverage to any medically necessary and appropriate healthcare services to treat all physical and mental illnesses or conditions found in a screening. These benefits include, but are not limited to, durable medical equipment to improve or maintain medical or functional status, treatment in freestanding psychiatric hospitals, all dental and oral care services, personal care services, developmental speech, physical, or occupational therapy, and private duty nursing.

During each annual preventive medical checkup, adolescents age 12 through 18 may receive mental health screenings by providers who use a validated, standardized screening tool.

Under all Medicaid programs, THSteps offers periodic dental checkups, diagnostics, and medically necessary dental treatment for children 6 months through age 20. These services help identify children at high risk of developing dental disease, start preventive services, treat decay early, and educate families about the importance of good oral health.

THSteps dental checkups are due every six months, starting at 6 months of age. All THSteps dental services are provided through DMOs.

Case Management for Children and Pregnant Women is also a component of THSteps. This Medicaid benefit provides health-related case management services to children through age 20 or pregnant women who are eligible for Medicaid. Case managers assist eligible clients in gaining access to medically necessary medical, social, educational, and other services related to their health condition, health risk or high-risk condition. Services include assessing the needs of eligible clients, developing a service plan with clients and families, making referrals, problem-solving, advocacy, and follow-up regarding client and family needs.

THSteps is not a benefit for children enrolled in CHIP or CHIP Perinatal.
CHIP

The CHIP program provides primary, acute, and behavioral health care, dental services, and pharmacy services for children in families who have too much income to qualify for Medicaid, but cannot afford to buy private health insurance. Children covered through CHIP generally receive the same services as children covered through Medicaid, including, but not limited to, inpatient and outpatient hospital services, laboratory and x-ray, doctor’s appointments, dental and oral health care, prescription drugs, emergency services, and emergency transportation.

Mental health and SUD treatment services are available to CHIP members. Mental health treatment services include:

- Neuropsychological and psychological testing
- Medication management
- Rehabilitative day treatments
- Residential treatment services
- Sub-acute outpatient services (partial hospitalization or rehabilitative day treatment)
- Skills training
- Inpatient mental health services in a free-standing psychiatric hospital, psychiatric unit of a general acute care hospital, or state-operated facility

Additionally, the following SUD treatment services are available to CHIP members:

- Inpatient treatment, including detoxification and crisis stabilization
- Outpatient treatment services, including group and individual counseling
- Intensive outpatient services
- Residential treatment
- Partial hospitalization
- Prevention and intervention services by physician and non-physician providers

While CHIP does not have a defined benefit for medication assisted therapy (MAT), this service may be provided as a prescription drug benefit.

Under CHIP, children receive up to $564 in dental benefits per 12-month enrollment period, not including emergency dental services, to cover preventive and therapeutic services, including periodontic and prosthodontic services. Clients may receive certain preventive and medically necessary services beyond this cap through a prior authorization process.

CHIP MCOs also provide service management to members with special health care needs (MSHCN). CHIP operates statewide with services delivered through MCOs under contract with HHSC. There are 13 CHIP service areas. CHIP members can select from at least two MCOs in each service area.
**Women**

Women may receive services through state healthcare programs, like Medicaid or CHIP, for a variety of reasons including for pregnancy, being a parent or caregiver, receiving reproductive or family planning services, or having a breast or cervical cancer diagnosis. Women are usually covered through STAR.

**Medicaid for Pregnant Women**

The STAR program serves pregnant women and offers a variety of services specifically for women who are pregnant, including prenatal visits, prescription prenatal vitamins, labor and delivery, and postpartum care.

Case Management for Children and Pregnant Women is a Medicaid benefit that provides health-related case management services. More information about this benefit can be found in A Closer Look on THSteps on page 33.

**CHIP Perinatal**

CHIP Perinatal services are for the unborn children of pregnant women who are uninsured and do not qualify for Medicaid. Services include prenatal visits, prescription prenatal vitamins, labor and delivery, and postpartum care. Members receiving the CHIP Perinatal benefit are exempt from the 90-day waiting period and all cost-sharing, including enrollment fees and co-pays, for the duration of their coverage period.

**Family Planning Services**

Texas offers family planning and reproductive healthcare services to eligible women and men through Medicaid. These services are also provided by the Healthy Texas Women (HTW) program and the Family Planning Program (FPP). While these programs differ in costs, funding, and the client populations they serve, both programs offer:

- Pregnancy testing
- Pelvic examinations
- Sexually transmitted infection services
- Breast and cervical cancer screenings and clinical breast examinations
- Screening for cholesterol, diabetes, and high blood pressure
• HIV screening
• Contraceptive care (excluding emergency contraception), including long-acting reversible contraceptives (LARCs), oral contraceptive pills, condoms, diaphragm, vaginal spermicide, injections, and permanent sterilization

**Healthy Texas Women**

HTW provides women’s health and family planning services at no cost to eligible, low-income Texas women age 15 through 44. HTW helps women plan their families, whether it is to achieve, postpone, or prevent pregnancy. In addition to the women’s health and family planning services listed above, HTW offers screening and treatment for postpartum depression and treatment for cholesterol, diabetes, and high blood pressure.

Though currently funded exclusively through state funds, HTW has submitted a Section 1115(a) demonstration waiver application to seek federal participation in the program.

**Family Planning Program**

FPP helps fund clinic sites across the state to provide quality, comprehensive, low-cost, accessible family planning and reproductive healthcare services to eligible women and men. These services help individuals determine the number and spacing of their children, reduce unintended pregnancies, positively affect future pregnancy and birth outcomes, and improve general health.

In addition to all of the women’s health and family planning services listed above, FPP offers limited prenatal benefits. FPP is funded through federal dollars.

For a list of examples of Better Birth Outcomes (BBO) initiatives, see A Closer Look on page 38.

**Breast and Cervical Cancer Services**

The Breast and Cervical Cancer Services (BCCS) helps pay for services at clinic sites across the state to provide quality, low-cost, and accessible breast and cervical cancer screening and diagnostic services to women.

Services for eligible participants include:

• Clinical breast examination
• Mammogram
• Pelvic examination and Pap test
• Diagnostic services
• Cervical dysplasia management and treatment
• Assistance applying for Medicaid for Breast and Cervical Cancer (MBCC)

Medicaid for Breast and Cervical Cancer

A woman eligible for MBCC receives full Medicaid benefits, and she will remain in the program as long as she is receiving active treatment for breast or cervical cancer. Active treatments include chemotherapy and radiation, surgery, disease surveillance for clients with triple negative receptor breast cancer, and hormone treatments. Individuals in MBCC are enrolled in STAR+PLUS.

BCCS contractors are the point of access for the MBCC program regardless of how the client was diagnosed with cancer.
BBO is a collaborative effort between HHSC and the Department of State Health Services (DSHS). BBO aims to improve access to women’s preventive, interconception, prenatal, and perinatal healthcare. The collaboration focuses on meeting a client’s health care needs that impact her ability to have a healthy pregnancy. There are currently more than 30 BBO initiatives. A few of these initiatives are highlighted below.

**Alliance for Innovation on Maternal Health Bundle Implementation**

Known as the TexasAIM Program, the Alliance for Innovation on Maternal Health Bundle Implementation are maternal safety initiatives Texas seeks to implement in hospitals and other settings. DSHS has assembled a multi-disciplinary team to facilitate these initiatives throughout the state. Texas is working to implement the Obstetric Hemorrhage Bundle, followed by the Obstetric Care for Women with Opioid Use Disorder Bundle, and the Severe Hypertension in Pregnancy Bundle.

**Healthy Families Project**

The Healthy Families project is a women’s health disparities and infant mortality risk reduction program that seeks to increase access to family planning services and decrease the risk for infant mortality among African American/Black and Hispanic women. This project provides communities with very flexible resources they can use to implement customized healthcare interventions within a health equity awareness framework.

Through data analysis, Hidalgo and Smith counties were identified to pilot projects with a focus on Hispanic women of childbearing age and African American/Black women of childbearing age, respectively. HHSC has contracted with The University of Texas Health Science Center at Tyler to implement project activities, and HHSC expects to gain valuable insight that can be shared with community initiatives across the state to help reduce infant and maternal mortality.

**Long-Acting Reversible Contraception**

Texas is working to increase access to this method of contraception to avert unintended pregnancies. Long-acting reversible contraception (LARC) devices are highly effective for preventing pregnancy, are easy to use, and last for several years.

In 2016, HHSC established an add-on reimbursement to incentivize utilization of immediate postpartum (IP) LARC, the most effective method of reversible contraception, for women enrolled in Medicaid for Pregnant Women. The American College of Obstetricians and Gynecologists recommends LARC insertions in the postpartum setting, ideally before
leaving the hospital after labor and delivery, to reduce unintended pregnancies and to achieve optimal birth spacing. The add-on reimbursement allows providers to bill for the LARC device and insertion in addition to the labor and delivery service.

In 2018, HHSC updated their IP LARC policies to grant MCOs greater flexibility with regard to the billing mechanism for IP LARC.

**Perinatal Advisory Council**

This council recommends criteria for designating levels of neonatal and maternal care and ways to improve neonatal and maternal outcomes. Levels of care designations are anticipated to improve health outcomes by promoting care in the most appropriate setting.

**Texas Neonatal Intensive Care Unit Project**

The Texas Neonatal Intensive Care Unit (NICU) Project (TNP) is a research collaborative involving Texas Medicaid, DSHS, the Dartmouth Institute for Health Policy and Clinical Practice, The University of Texas Health Science Center at Houston—School of Public Health, and the University of Florida—Institute for Child Health Policy. This study analyzes linked Medicaid, birth certificate, and death certificate data for all Medicaid-paid births in Texas for calendar years 2010-2014 to better understand recent growth in Texas’ NICU capacity and payments. The TNP’s primary research goals are to measure the risk-adjusted probability of NICU discharges and to measure variation in risk-adjusted NICU utilization and outcomes. TNP will also work with Texas newborn care stakeholders to develop a sustainable system of monitoring the care, outcomes, and payments of newborn services in Texas Medicaid.

**Zika Prevention**

Zika Prevention is an ongoing, collaborative effort among healthcare agencies both in Texas and nationally, to reduce and eliminate the spread of the Zika virus. The Zika virus, spread primarily through mosquito bites, has been linked to serious birth defects in infants whose mothers were infected during pregnancy.

In order to reduce the spread of Zika, particularly among expectant mothers, Texas has developed tools and outreach materials to educate the public about the virus, including this regularly updated public information website: hhs.texas.gov/services/health/prevention/zika-medicaid-benefit. Texas covers certain mosquito repellent products as a benefit in Medicaid, CHIP, and other state programs. Additionally, Texas is focused on improving provider capacity around Zika by working with the Association of State and Territorial Health Officials to conduct an environmental scan that identifies family support service needs across the state.
Long-Term Services and Supports

In addition to acute care services, LTSS are provided to children and adults who have physical, mental, or developmental disabilities and people age 65 and older.

Individuals receiving LTSS often need help performing daily living tasks, such as eating, bathing, or grooming, or other life activities like housekeeping, working, or pursuing hobbies. Some LTSS are performed by licensed medical professionals such as nurses or therapists, while others are provided by direct care staff without medical training.

Texans who have disabilities or are older have many options and services available—including choosing where and how they receive their LTSS. The ultimate goal is to ensure individuals have seamless access to services and supports in the most appropriate, least restrictive settings based on the needs of each person.

LTSS in Texas are provided through both FFS and managed care. Below outlines various ways options are made available to both children and adults with disabilities and people age 65 and older.

Where Services Can Be Received

In a Home- or Community-Based Setting

Support for home- or community-based living is made possible through waivers, state plan services, the Promoting Independence (PI) Initiative or a combination of these.

1. Home and Community-Based Services (HCBS) 1915(c) waivers allow states to provide home and community-based services as an alternative for people who meet eligibility criteria for care in an institution (nursing facility, intermediate care facility for individuals with an intellectual disability or related condition, or hospital). Texas HCBS 1915(c) waivers include:
   - Home and Community-based Services (HCS)
   - Community Living Assistance and Support Services (CLASS)
   - Texas Home Living (TxHmL)
   - Deaf Blind with Multiple Disabilities (DBMD)
   - Medically Dependent Children Program (MDCP)
   - Youth Empowerment Services (YES)
2. State plan community-based services support home- or community-based delivery of services. Services include Personal Assistance Services (PAS), Community Attendant Services (CAS), Day Activity and Health Services (DAHS), Community First Choice (CFC), and Personal Care Services (PCS).

For a summary of the services provided through waiver programs or the state plan, see the tables on pages 44-45. For more information about these waivers, see Appendix C.

For services received in the community, the demand for some waiver programs exceeds capacity, and therefore, the programs maintain interest lists. People who may require these services can add their name to the appropriate list at any time. Enrollment into the waiver is based on available resources.

**In a Long-Term Care Facility**

When an individual is unable to or chooses not to receive LTSS in a home- or community-based setting, the other option is a long-term care facility.

1. **Intermediate care facilities** for individuals with an intellectual disability or related condition (ICFs/IID) provide ongoing evaluation and individual program planning, as well as 24-hour supervision, coordination, and integration of health or rehabilitative services to help individuals with an intellectual disability or related condition function to their greatest ability. ICF/IID residential settings vary in size, from community settings serving six to 12 individuals (currently 98 percent of ICFs/IID) to large state supported living centers serving several hundred.

2. **Nursing facilities** provide services to meet the medical, nursing, and psychological needs of persons who have a level of medical necessity requiring nursing care on a regular basis. Nursing facilities are paid a unit rate based on the individual needs of Medicaid-eligible residents and must provide services and activities that enable persons residing in the facility to attain and maintain their highest feasible level of physical, mental, psychological, and social well-being.
In addition to room and board, required services provided under the unit rate include nursing, social services and activities, over-the-counter drugs, medical supplies and equipment, and personal needs items. Prescription drugs are covered through the VDP or Medicare Part D. Add-on services provided in the nursing facility setting and not part of the unit rate include ventilator care, tracheostomy care for residents age 21 and younger, augmentative communication devices, custom power wheelchairs, emergency dental services, and rehabilitative therapies.
Promoting Independence Initiative

The PI Initiative or Money Follows the Person (MFP) policy, provides the opportunity for individuals in need of LTSS to move from facilities to community-based services. This better allows individuals to choose how and where they receive their LTSS. Other support services have since been developed to help identify individuals who want to leave an institutional setting and to assist them in relocating to the community.

The initiative receives funding through the Deficit Reduction Act of 2005 MFP Demonstration award, which will continue through 2020. After the MFP Demonstration ends, Texas will continue to transition individuals from facilities to the community with available funding. As of June 2018, the MFP Demonstration has helped transition over 12,772 individuals from institutional care to community-based care. Another 22,086 individuals transitioned under the MFP/PI policy.

In addition, the MFP Demonstration enhanced funding has created opportunities to fund a variety of projects:

- Community supports for individuals transitioning from nursing facilities with co-occurring behavioral health needs in Bexar County, its contiguous counties, and Travis County
- Training for direct service workers
- An employment project to assist individuals in an ICF/IID or waiver program in achieving integrated employment at local businesses
- A partnership with the Texas Department of Housing and Community Affairs to increase the availability of affordable, accessible housing
- Transition specialists housed at each SSLC to improve the relocation process
- Funding of 22 Aging and Disability Resource Centers (ADRCs) to hire housing specialists to identify affordable, accessible housing and to provide counseling to non-Medicaid nursing facility residents
- A quality reporting office to monitor and create intervention strategies to promote quality across demonstration activities and Medicaid 1915(c) waivers
- Enhanced community coordination to support individuals with intellectual and developmental disabilities transition to the community
### Home and Community-Based Services Waivers: Long-Term Services and Supports Summary

<table>
<thead>
<tr>
<th>Waiver Name</th>
<th>Adaptive Aids &amp; Minor Home Modifications</th>
<th>Medical Supplies</th>
<th>Dental Services</th>
<th>Nursing</th>
<th>Respite</th>
<th>Professional Therapies</th>
<th>Employment Assistance &amp; Supported Employment</th>
<th>Additional Services</th>
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*Professional Therapies may include: physical therapy, occupational therapy, speech and language pathology, audiology, social work, behavioral support, dietary services, and cognitive rehabilitation therapy.
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<th>Program Name</th>
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<th>Instrumental Activities of Daily Living</th>
<th>Escort Services to Medical Appointments</th>
<th>Additional Services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Children</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal Care Services (PCS) (through age 20)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td><strong>Children and Adults</strong></td>
<td></td>
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<tr>
<td>Community Attendant Services (CAS)</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Personal Assistance Services (PAS)</td>
<td>X</td>
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<tr>
<td>Primary Home Care (PHC)</td>
<td>X</td>
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<td>X</td>
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</tr>
<tr>
<td>Day Activity and Health Services (DAHS)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>• Nursing&lt;br&gt;• Noon meals and snacks&lt;br&gt;• Social, educational, and recreational activities</td>
</tr>
</tbody>
</table>
How Services Can Be Delivered

In addition to where LTSS are delivered, individuals have multiple options on how certain LTSS (most commonly, attendant care) may be delivered. Each option requires a different level of responsibility of the individual.

Agency Option

The agency option, the traditional method of service delivery, is where services are delivered through a provider agency. The provider agency is the employer of attendants or other direct service workers, and is responsible for all of the employment and business operations-related activities.

Provider agencies are licensed or certified by HHSC and must comply with HHSC licensure and program rules. The service coordinator, case management agency (for CLASS only) or provider agency (for DBMD only), coordinates with the individual or authorized representative to monitor and ensure the individual is satisfied with their services.

Consumer Directed Services Option

Consumer Directed Services (CDS) is a service delivery option for some individuals receiving LTSS that allows the individual or the individual’s legally authorized representative to be the employer of record of the direct care workers providing services, giving greater choice and control over the delivery of services. The individual or legally authorized representative has the ability to hire, train, supervise, and, if necessary, dismiss the employee. Individuals may appoint a designated representative to assist with some employer responsibilities, like approving time sheets.

Those who use the CDS option are required to select a financial management services agency (FMSA) that provides orientation, writes paychecks for the workers, and pays federal and state employer taxes on behalf of the employer. In addition to an FMSA, individuals who choose the CDS option may request support consultation, if available in their program. Support consultation is an optional support service for individuals who want additional help with understanding and performing employer responsibilities, such as recruiting or managing employees.

CDS is one option for service delivery and does not preclude the use of the traditional agency-based service delivery system for those who prefer it. Individuals may choose the agency option for some services and the CDS option for others. An individual’s case manager or service coordinator is responsible for ensuring the individual and their family understand the risks and benefits of the choice to direct their own services.

CDS is an option for the following programs and services:
• Waivers: HCS, CLASS, TxHmL, DBMD
• State plan services: PAS, PHC, CAS, PCS, Community First Choice (CFC)
• Managed care programs: STAR+PLUS, STAR+PLUS HCBS, STAR Kids, STAR Kids - MDCP, STAR Health, and STAR Health - MDCP

**Service Responsibility Option**

Service Responsibility Option (SRO) is available in Medicaid managed care programs, CAS, and PHC. SRO is a hybrid of the agency option and CDS option in which an individual, the MCO (if applicable), and a provider agency work together to provide the individual with increased control over the delivery of their services. In Medicaid managed care, services with the CDS option also have SRO.

In SRO, the case manager or service coordinator provides the individual or their authorized representative with a list of provider agencies participating in SRO. The agency chosen by the individual then meets with the individual to understand their preferences and service needs. The agency and the individual select their direct care worker and train the providers to meet the individual’s preferences and needs. The providers are employed by the agency and the agency is accountable for all employer-related responsibilities like payroll and employer taxes. The individual selects and trains the providers and works with the agency to develop service back-up plans and to dismiss providers when necessary.

**Key Points of Access for LTSS: Aging and Disability Resource Centers**

Aging and Disability Resource Centers (ADRC) serve as key points of access for individuals seeking specialized information, referral, and assistance for LTSS options in their communities. ADRCs provide person-centered services to individuals and caregivers, regardless of age, income, and disability, including the following populations:

- Individuals who are older
- Individuals with intellectual, developmental, or physical disabilities
- Individuals with chronic diseases
- Family caregivers
- Families with children who have special needs
- Veterans
- Other individuals planning for future LTSS

Each ADRC partners with a network of local service agencies to coordinate information, referrals, and linkages for individuals needing access to both private and public LTSS programs and benefits, including Medicaid. Additionally, ADRCs provide assistance with system navigation and care transition support services through collaboration with hospitals and nursing facilities. Key community partners include area agencies on aging, local HHSC offices, and local intellectual and developmental disability authorities (LIDDAs). There are 22 ADRCs operating throughout the state, ensuring full service to all 254 Texas counties.

Similarly, LIDDAs and local mental health authorities (LMHAs) may also act as access points for people in need of services. For more information on LIDDAs and LMHAs, see Glossary.
Children and Adults with Disabilities

Children

STAR Kids

The STAR Kids program provides acute care services and LTSS benefits to children and youth with disabilities. MCOs operate within 13 service delivery areas, giving members the choice of at least two MCOs in each service area.

Once enrolled, all STAR Kids members have access to service coordination through an MCO. The service coordinator organizes acute care services and LTSS and develops an individual service plan with each client. The program also ensures that each client has a PCP who knows their healthcare needs (see A Closer Look, page 55).

Children and youth who receive Supplemental Security Income (SSI) or SSI-related Medicaid or are enrolled in MDCP receive all of their Medicaid services through the STAR Kids program. Children and youth who receive services through other 1915(c) waiver programs receive their basic Medicaid health services through STAR Kids, while receiving their LTSS through their waiver program.

Children and youth who get services through the Medicaid Buy-In (MBI) Program for Workers with Disabilities or the Medicaid Buy-In for Children (MBIC) program are also required to enroll in STAR Kids.

Children and youth who reside in a long-term care facility receive their acute care services and service coordination through a STAR Kids health plan. Children who are dually eligible receive most of their acute care services through Medicare, but receive LTSS and service coordination through STAR Kids. Children and youth may be on the Health Insurance Premium Payment (HIPP) Program and enrolled in STAR Kids at the same time.

Prescribed Pediatric Extended Care Centers

Prescribed Pediatric Extended Care Centers (PPECCs) provide non-residential, facility-based care during the day as an alternative to private duty nursing for individuals under age 21 who are medically or technologically dependent. When prescribed by a physician, the child or young adult can attend a PPECC up to a maximum of 12 hours per day to receive medical, nursing, psychosocial, therapeutic, and developmental services appropriate to their medical condition and developmental status. PPECCs also provide transportation if ordered by a physician or the client has a stated need.
STAR Health

As previously stated, STAR Health provides primary, acute, and behavioral health care, as well as dental, vision, and pharmacy services for children in Texas DFPS conservatorship. However, children and youth may receive LTSS benefits, such as PCS or CFC, through STAR Health. Members who qualify may also receive MDCP benefits. They may also receive LTSS services through other 1915(c) waiver programs, while receiving their basic Medicaid health services through STAR Health.

Early Childhood Intervention

Early Childhood Intervention (ECI) is a statewide program that provides services to families with children age 3 and younger with developmental delays or disabilities. HHSC contracts with local agencies to provide services in all Texas counties. Contractors include community centers, school districts, education service centers, and private nonprofit organizations. ECI contractors must enroll with Texas Medicaid to receive reimbursement for ECI targeted case management, specialized skills training, therapy services, and other benefits for children on Medicaid.

Blind Children’s Vocational Discovery and Development Program

The Blind Children’s Vocational Discovery and Development Program supports children and youth from birth to age 22 who have vision impairments. This program serves eligible children, including Medicaid/CHIP clients, and coordinates case management services and payment with these programs to ensure that children have access to services. The clients, in partnership with the program, develop a pathway for a successful future through independent living skills, assistive technology, and support services.

School Health and Related Services Program

The School Health and Related Services (SHARS) program allows independent school districts, including public charter schools, to receive federal reimbursement for providing Medicaid services to participating Medicaid-eligible students age 20 and younger. Management of the SHARS program is a cooperative effort between the Texas Education Agency and HHSC. This program covers certain health-related services documented in a student’s Individualized Education Program. Services include:

- Audiology services
- Physician and nursing services
- Physical, speech, and occupational therapies
- Personal care services
- Psychological services, including assessments, and counseling
- Transportation in a school setting
**Adults**

Adults with disabilities may access the same LTSS described above based on their level of need (see tables, pages 44-45). These services may be provided through 1915(c) waiver programs, CFC, STAR+PLUS, or the Dual Demonstration program.

**STAR+PLUS**

The STAR+PLUS program provides primary, acute, and behavioral health care, pharmacy services, and LTSS for adults who have a disability or who are age 65 and older. Enrollment in STAR+PLUS is mandatory for eligible individuals. Services are delivered through MCOs under contract with HHSC. Clients have the choice of at least two STAR+PLUS MCOs in each service area.

Clients have access to a PCP who is familiar with their medical needs, provides medical care, and can coordinate their care by facilitating relationships with other providers. Clients with complex medical conditions are assigned a service coordinator who develops an individual service plan with the client and manages the client’s acute care and LTSS.

The STAR+PLUS program serves adults with SSI, SSI-related Medicaid, those who receive services through the STAR+PLUS HCBS program, and individuals in the MBCC program. STAR+PLUS members who are dual eligible for Medicaid and Medicare receive LTSS through STAR+PLUS and their acute care services through Medicare. Adults with disabilities may be in the HIPP program and enrolled in STAR+PLUS at the same time.

All dually eligible individuals who are currently living in an ICF/IID or receiving intellectual and developmental disability (IDD) waiver services, individuals enrolled in Programs of All-inclusive Care for the Elderly (PACE), and individuals residing in an SSLC are excluded from participation in the STAR+PLUS program. Those individuals residing in a state veteran home are also excluded from STAR+PLUS.

**STAR+PLUS Home and Community-Based Services Program**

The STAR+PLUS Home and Community-Based Services (HCBS) program provides a cost-effective alternative to living in a nursing facility to clients who are elderly or who have disabilities. Services include nursing, PAS, adaptive aids, medical supplies, and minor home modifications to make members’ homes more accessible. To be eligible for STAR+PLUS HCBS, a member must be age 21 and older, meet income and resource requirements for Medicaid nursing facility care, and receive a determination from HHSC that they meet the medical necessity criteria to be in a nursing facility.
Medicaid Hospice Services
Hospice services provide palliative care to terminally ill individuals for whom curative treatment is no longer desired and who have a physician’s prognosis of six months or less to live.

A team of doctors, nurses, home health aides, social workers, counselors, and trained volunteers work together to help the individual and their family cope with the terminal illness. Services include physician services, nursing, PAS, therapies, prescription drugs, respite care, and counseling—including supportive care for their loved ones. These services can be administered in the home or in community settings, long-term care facilities, or in hospital settings.

In accordance with federal law, children age 20 and younger receiving hospice services may continue to receive curative care from non-hospice acute care providers.

Dual Demonstration
The Dual Eligible Integrated Care Demonstration Project, or Dual Demonstration, is a fully integrated managed care model for individuals age 21 and older who are dually eligible for Medicare and Medicaid and required to be enrolled in the STAR+PLUS program. This capitated model involves a three-party contract between an MCO with an existing STAR+PLUS contract, HHSC, and the Centers for Medicare & Medicaid Services (CMS) for the provision of the full array of Medicaid and Medicare services. Dual Demonstration is testing an innovative payment and service delivery model to alleviate fragmentation and improve coordination of services for dual eligibles, enhance quality of care, and reduce costs for both the state and the federal government.

Under this initiative, the MCO is responsible for the full array of Medicare and Medicaid covered services, including acute care and LTSS. Eligible clients are passively enrolled into the program if they do not actively opt in, and also have the opportunity to opt-out on a monthly basis. The demonstration does not include clients who reside in an ICF/IID and individuals with IDD who receive services through CLASS, DBMD, HCS, or TxHmL waivers. The demonstration operates in Bexar, Dallas, El Paso, Harris, Hidalgo, and Tarrant counties.

Medicare Advantage Dual Eligible Special Needs Plan
A Dual Eligible Special Needs Plan (D-SNP) is a managed care delivery model specifically designed to coordinate care between Medicare and Medicaid covered services for individuals that are dually eligible for both programs.

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.
People Age 65 and Older

Adults age 65 and older are also served through STAR+PLUS or the Dual Demonstration program (as previously described). Unlike other programs, PACE is available for adults age 55 and older in certain service areas. If you are a non-disabled adult, age 65 and older and need LTSS, these services are provided either through STAR+PLUS, Dual Demonstration, or PACE.

Program of All-Inclusive Care for the Elderly

PACE is a comprehensive care approach providing an array of services for a capitated monthly fee below the cost of comparable institutional care. PACE participants must be age 55 and older, live in a PACE service area, qualify for nursing facility level of care, and be able to live safely in the community at the time of enrollment. PACE participants receive all medical and social services they need through their PACE provider.

PACE offers all health-related services for a participant, including inpatient and outpatient medical care, specialty services (e.g., dentistry, podiatry, physical therapy and occupational therapy), social services, in-home care, meals, transportation, and day activity services. PACE is available in Amarillo/Canyon, El Paso, and Lubbock, with future expansion planned for San Antonio. Individuals in these service areas who are also eligible for STAR+PLUS may choose to receive services either through STAR+PLUS or PACE, but not both.
Behavioral Health Services

Texas Medicaid covers behavioral health screening and treatment services for mental health conditions and SUD. State plan services are provided through Medicaid managed care, FFS programs, and CHIP. Behavioral support is also available through some 1915(c) waivers.

Screening Services for Children and Adults

Health and Behavior Assessment and Intervention

Medicaid clients who are age 20 and younger are eligible for Health and Behavior Assessment and Intervention (HBAI) services. These services are designed to identify the psychological, behavioral, emotional, cognitive, and social factors that are important to prevent, treat, or manage physical health symptoms. Services are provided by licensed practitioners of the healing arts who are co-located in the same office or building as the client’s PCP. HBAI services help promote physical and behavioral health integration.

Screening, Brief Intervention and Referral to Treatment

Screening, Brief Intervention and Referral to Treatment is a comprehensive public health approach to the delivery of early intervention and treatment services for clients who are age 10 and older and who have alcohol or substance use disorder, or who are at risk of developing such disorders. The benefit also allows providers to be reimbursed for screening only sessions as well as brief intervention, and is available in community-based settings and hospitals. Brief intervention is provided for those identified as needing assistance to address problems with alcohol or substance use disorder.

Treatment Services

Medicaid mental health treatment services include:

- Psychiatric diagnostic evaluation and psychotherapy
- Psychological and neuropsychological testing
- Inpatient psychiatric care in a general acute care hospital
- Inpatient care in psychiatric hospitals (for people age 20 and younger and age 65 and older)
- Psychotropic medications and pharmacological management of medications
- Mental health targeted case management and rehabilitative services for adults with severe and persistent mental illness or children with severe emotional disturbance
- Care and treatment of behavioral health conditions by a PCP
Medicaid SUD benefits available to adults and children include:

- Assessment
- Outpatient treatment (e.g., individual and group outpatient counseling)
- Medication assisted therapy (MAT) (e.g., methadone for opioid use disorder)
- Residential detoxification
- Ambulatory detoxification

Medicaid SUD services must be provided by a chemical dependency treatment facility (CDTF) licensed and regulated by HHSC, with the exception of MAT services. MAT services may be provided by a licensed CDTF or a physician. MAT is primarily used for opioid use disorder, but can also be used for alcohol use disorder.

Medicaid also offers treatment options for individuals with opioid use disorder. Eligible members may obtain treatment through an HHSC-licensed treatment facility and may obtain MAT from an opioid treatment program or physician. Certain FDA-approved medications for opioid use disorder are covered as recommended by the Texas Drug Utilization Review (DUR) Board and approved by the Executive Commissioner.

MAT treatment options for individuals with alcohol use disorder are available through the pharmacy benefit by prescription. These medications include disulfiram, acamprosate, and naltrexone. Individuals may also obtain treatment through an HHSC-licensed treatment facility.

**Home and Community-Based Services—Adult Mental Health**

The Home and Community-Based Services—Adult Mental Health (HCBS-AMH) program helps individuals with serious mental illness remain in the community. Many adults with a diagnosis of serious mental illness have complex needs that lead to extended psychiatric hospitalizations, repeated arrests, and frequent emergency department visits.

The HCBS-AMH program provides an array of intensive HCBS tailored to an individual’s assessed needs, in consideration of the individual’s preferences and goals. HCBS-AMH provides the following services: host home/companion care, supervised living services, assisted living, supported home living, psychosocial rehabilitative services, employment services, minor home modifications, home-delivered meals, transition assistance services, adaptive aides, transportation services, community psychiatric supports and treatment, peer support, short-term respite care, SUD services, nursing, and recovery management.

Services are provided in CMS-approved settings, which may include an individual’s home or apartment, an assisted living setting, or small community-based residence.
Chapter 2 —What are the programs and services available to Texans?

### A Closer Look: Different Types of Case Management

Texas Medicaid covers several types of case management services, which may be administered by MCOs or providers. The type of services available to clients depends on the program they are enrolled in.

<table>
<thead>
<tr>
<th>Case Management Type</th>
<th>Provided by</th>
<th>What it is</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service Coordination</strong></td>
<td>STAR Kids and STAR+PLUS MCOs, available to all members</td>
<td>Service coordination is specialized care management. MCO service coordinators: • Identify physical health, mental health, and LTSS needs and develop a service plan • Assist members in receiving timely access to providers and covered services • Coordinate covered services with non-managed care programs, such as FFS waivers</td>
</tr>
<tr>
<td><strong>Service Management</strong></td>
<td>STAR and CHIP MCOs, available to MSHCN MSHCN are individuals with a serious, ongoing illness, a chronic or complex condition, a disability, or who require regular ongoing therapeutic intervention and evaluation by appropriately trained personnel</td>
<td>Service management is an administrative service. MCO service managers: • Work with members to develop a service plan and coordinate services with the member’s PCP, specialty providers, and non-medical providers • Assist MSHCN in gaining access to, and appropriately utilizing, medically necessary covered services, services with non-managed care programs, such as FFS waivers, and other services and supports</td>
</tr>
<tr>
<td><strong>STAR Health Service Coordination and Service Management</strong></td>
<td>The STAR Health MCO Service coordination available to members with a medical or behavioral need, or as requested Service management available to members with a complex medical or behavioral need, or as requested</td>
<td>In STAR Health, service coordination and service management have distinct functions different from the other managed care programs: • Service coordination is an administrative service to help caregivers manage information, such as medical information for court hearings, and to coordinate services with non-managed care programs, such as FFS waivers • Service management is a clinical service performed for members with a complex medical or behavioral need to implement a service plan and coordinate services among the member’s PCP and specialty care providers to ensure access to, and appropriate utilization of, medically necessary covered services</td>
</tr>
<tr>
<td><strong>Provider-Administered Care Coordination</strong></td>
<td>Healthcare and LTSS providers</td>
<td>Several types of care coordination are administered at the provider level. These services are not duplicative of service coordination or service management by MCOs. Care coordination services include targeted case management for: • ECI • Individuals with IDD • Members with mental illness • Children and pregnant women • CLASS and DBMD • HCBS-AMH recovery management</td>
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</table>
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Chapter 3

How does HHSC make sure clients get good care?
Chapter 3 — How does HHSC make sure clients get good care?

At-a-Glance

4.5 million Texans served

92% served through managed care

18 Managed Care Organizations (MCOs)
2 Dental Maintenance Organizations (DMOs)
4 Medical Transportation Organizations (MTOs)

40+ Contracts

Tools span a multitude of areas, administered by various expertise.

Access to services:
Network adequacy monitoring, appointment availability studies, member satisfaction studies

Service delivery:
Acute care utilization module in operational reviews, managed care long-term services and supports utilization reviews, drug utilization reviews, electronic visit verification

Quality of care:
Performance indicator dashboard for key quality measure indicators, custom evaluations, improvement projects, pay-for-quality, alternative payment models, MCO report cards

Operations:
Readiness reviews prior to serving members, biennial operational reviews, targeted reviews conducted on-site

Financial:
Validation of financial statistical reports, administrative expense and profit limits, independent auditing

Contractual Non-Compliance:
There are multiple stages of remedies for non-compliance discovered through oversight tools, each with an increased level of impact. Remedy issued is contingent on the type of non-compliance, and is not necessarily sequential.

1. Plans of Action
2. Corrective Action Plans
3. Liquidated Damages
4. Suspension of Default Enrollment
5. Contract Termination

Numbers are subject to change. Number of MCOs and contracts current as of November 2018.
HHSC has shifted its service delivery method for the Medicaid and CHIP programs to managed care. While a small percentage of Texans on Medicaid still receive services via the FFS model, in 2017, 92 percent of Medicaid clients and all CHIP clients received services through the managed care delivery system. HHSC continuously strengthens its business practices under the managed care model and maintains support for services delivered under FFS.

**The Managed Care Delivery System**

The value of managed care relies on the care coordination provided by the MCOs, also known as health plans. The integrated delivery system allows health plans to oversee the various services that their members receive and the effectiveness of each one.

Under the managed care model, HHSC contracts with MCOs and pays them a per member per month (PMPM) rate, called a capitation rate, to coordinate care and reimburse providers for health services provided to Medicaid or CHIP members enrolled in their health plan (see Rate Setting, page 91).

MCOs are responsible for providing all services in an amount, duration, and scope (the nature of the service, such as provider type, benefit location, and procedures) that is available in FFS, as medically necessary.

Value-added services vary from one MCO to another. Examples include diapers for newborns and adult dental services for members in the STAR+PLUS Home and Community-Based Services (HCBS) program.

The Texas Medicaid and CHIP managed care delivery systems are intended to enhance care by providing members a ‘medical home’ while improving access to care and quality of care.

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**Transformation Waiver Managed Care Authorization**

The Texas Health Care Transformation and Quality Improvement Program 1115 Waiver, known as the 1115 Transformation Waiver, allows Texas to operate and expand Medicaid managed care while preserving hospital funding, provides incentive payments for healthcare improvements, and directs more funding to hospitals that serve large numbers of uninsured patients. To read more, see A Closer Look, page 102.
**Medical Home**

Medicaid managed care members choose a primary care provider (PCP), usually a family or general practice doctor, a pediatrician, or an OB/GYN, 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.

MCOs must provide chronic care management, or disease management, programs and services. Disease management programs and services must be part of a person-centered approach and address the needs of high-risk members with complex chronic or co-morbid conditions. 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.

**Access to Care**

MCOs must ensure their members have access to covered services on a timely basis. They are required to have a defined network of providers to meet member needs, and to provide support to members who need help finding a doctor or setting up appointments.

MCOs must 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. MCOs must:

- Have sufficient capacity to serve the expected enrollment
- Meet service area needs with geographic distribution of preventive care, primary care, and specialty service providers
- Establish and maintain networks that provide access to all contracted services by ensuring providers are located within a prescribed time and distance from members and are physically accessible for members with disabilities
- Submit out-of-network utilization reports

HHSC follows benchmarks for out-of-network utilization and establishes standards for reasonable reimbursement rates as required in the Texas Administrative Code.
Quality of Care

The goal of transitioning from FFS to managed care is to provide value-based care. Value is achieved by delivering services in a cost-effective manner and improving quality of care, such as providing adequate preventive care and moving toward member health stabilization or improvement. MCOs are paid a fixed amount per member in advance based on historical costs. This payment model places MCOs at financial risk if the cost of care exceeds this rate and thus, incentivizes them to provide value-based care.

HHSC’s Managed Care Oversight

HHSC contracts with MCOs to coordinate services for 4.1 million Medicaid and CHIP recipients. Because of the size, scope, and complexity of managed care contracts and the types of services they provide, there is no single strategy to overseeing these contracts. HHSC employs a number of oversight tools that work collectively to ensure MCOs provide medically necessary services to their members in a cost-effective manner.

These oversight tools enable HHSC to verify MCOs’ compliance with state and federal law, as well as their contract terms throughout the life cycle of the contract.

Every health plan that provides care to Texans is selected through a competitive contracting process. The process has ongoing involvement from staff and leadership across the organization—starting with the solicitation phase, and then throughout the evaluation phase, negotiations, and the formation of the contract. The relationship between HHSC and any selected MCO is best described as a ‘partnership with accountability.’ This is established through robust contract terms at the onset. These terms outline requirements related to MCO responsibilities such as financial reporting, 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 coordination.

The Uniform Managed Care Contract establishes the baseline requirements for all MCOs, and then, additional contract terms are developed specific to the program. HHSC’s role is to ensure the contract requirements are being met throughout contract life cycle.

Contract Management and Oversight

Once selected through the competitive contracting process, the MCO then builds out its operations. Prior to serving members, HHSC conducts a readiness review to ensure the MCO can provide all contracted services.
Major areas examined by HHSC to ensure MCOs are ready to serve members are:

- IT system readiness
- Claims processing
- Complaint and appeal process
- Member education materials
- Member hotlines
- Provider hotlines
- Provider relations
- Website functionality and content for members and providers
- Pharmacy services
- Behavioral health referral process
- Provider network

In addition to the major areas above, program-specific areas are reviewed such as service coordination and management for STAR Kids, STAR+PLUS, and STAR Health.

Once the MCO is actively serving members, HHSC employs a number of contract oversight tools to monitor a multitude of areas, with the contract requirements being the basis. The areas include the MCOs’ financial practices, on-site operations, access to services, and the delivery of services.

Various strategies are used to conduct the monitoring, including reviews of contract deliverables, independent third-party audits, on-site reviews, data analytics, utilization reviews (URs), member surveys, secret shopper studies, and complaint tracking. HHSC also establishes and monitors MCO performance on quality measures. If issues of non-compliance are found, HHSC applies a graduated remedy process.

The ultimate goal of HHSC’s monitoring and oversight is to ensure the Texas Medicaid program is improving the health outcomes and quality of life for the people it serves.

Access to Services

MCOs are contractually required to build adequate networks of providers to ensure Medicaid/CHIP clients can access the right care, at the right place, at the right time.

HHSC continues to enhance its oversight of access to services and uses a variety of tools to monitor MCO provider networks, including time and distance standards, provider referral surveys, appointment availability, and member satisfaction surveys. When deficiencies are discovered, the agency addresses them through its established graduated remedies process (see page 80).

Network adequacy for commercial health plans and Medicaid/CHIP MCOs, in Texas and nationally, is influenced by many factors, including provider availability, administrative complexity, and payment rates.
**MCO Provider Network Standards**

The Medicaid contract requires that 90 percent of plan members have access to at least one network provider within the ranges shown in the table on page 64. For PCPs and dentists, there must be two network providers within range.

**Provider Directory Quality**

HHSC requires MCOs to update online provider directories weekly. MCOs use the information submitted by providers during credentialing for their provider directories, but issues can impact the accuracy and currency of the information in the provider directory. HHSC currently has initiatives under way to address provider directory quality issues.

To validate directory information, HHSC makes quarterly calls to a random sample of providers from MCO directories to determine if provider contact information is accurate, if the provider is accepting patients, if a specialist covers certain age limits, and the availability of an appointment. HHSC shares findings with MCOs and requests MCOs’ plans for addressing any identified issues. As needed, HHSC also uses claims data to validate provider activity and eliminate inactive providers.

Secret shopper studies conducted by the state’s external quality review organization (EQRO) evaluate whether providers met appointment availability standards. Issues identified led to HHSC initiating a project, with assistance from the EQRO, to improve the accuracy and timeliness of provider directory data.

**Time and Distance Standards**

In March 2017, HHSC implemented new access standards on the MCO provider networks. In particular, time and distance standards for certain provider types, as shown in the table on the next page, are now more stringent than those established by CMS. In September 2018, HHSC applied additional time and distance standards for LTSS and pharmacy. The agency uses geo-access mapping to monitor the network access of individual MCOs and to look for areas of the state where there are provider capacity issues.
### Time and Distance Standards

<table>
<thead>
<tr>
<th>PROVIDER TYPE</th>
<th>Distance in Miles</th>
<th>Travel Time in Minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Metro County</td>
<td>Micro County</td>
</tr>
<tr>
<td>Behavioral Health-Outpatient</td>
<td>30</td>
<td>30</td>
</tr>
<tr>
<td>Hospital-Acute Care</td>
<td>30</td>
<td>30</td>
</tr>
<tr>
<td>Prenatal</td>
<td>10</td>
<td>20</td>
</tr>
<tr>
<td>Primary Care Provider*</td>
<td>10</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td><strong>Specialty Care Provider</strong></td>
<td></td>
</tr>
<tr>
<td>Cardiovascular Disease</td>
<td>20</td>
<td>35</td>
</tr>
<tr>
<td>ENT (otolaryngology)</td>
<td>30</td>
<td>60</td>
</tr>
<tr>
<td>General Surgeon</td>
<td>20</td>
<td>35</td>
</tr>
<tr>
<td>OB/GYN</td>
<td>30</td>
<td>60</td>
</tr>
<tr>
<td>Ophthalmologist</td>
<td>20</td>
<td>35</td>
</tr>
<tr>
<td>Orthopedist</td>
<td>20</td>
<td>35</td>
</tr>
<tr>
<td>Pediatric Sub-Specialists</td>
<td>20</td>
<td>35</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>30</td>
<td>45</td>
</tr>
<tr>
<td>Urologist</td>
<td>30</td>
<td>45</td>
</tr>
<tr>
<td>Occupational, Physical, or Speech Therapy</td>
<td>30</td>
<td>60</td>
</tr>
<tr>
<td>Nursing Facility</td>
<td>75</td>
<td>75</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Pharmacy (24-hour)</td>
<td>75</td>
<td>75</td>
</tr>
<tr>
<td>Main Dentist (general or pediatric)</td>
<td>30</td>
<td>30</td>
</tr>
<tr>
<td>Dental Specialists</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pediatric Dental</td>
<td>30</td>
<td>30</td>
</tr>
<tr>
<td>Endodontist, Periodontist, or Prosthodontist</td>
<td>75</td>
<td>75</td>
</tr>
<tr>
<td>Orthodontist</td>
<td>75</td>
<td>75</td>
</tr>
<tr>
<td>Oral Surgeons</td>
<td>75</td>
<td>75</td>
</tr>
</tbody>
</table>

Metro = county with a population of 200,000 or greater; Micro = county with a population between 50,000-199,999; Rural = county with a population of 49,999 or less.

*Services include acute, chronic, preventive, routine, or urgent care for adults and children.
Texas Department of Insurance Requirements Related to Time and Distance

The Texas Department of Insurance (TDI) requires commercial plans and other state-funded plans, such as the Employee Retirement System and the Teacher Retirement System, to meet similar distance standards (e.g., 30 miles to a PCP and 75 miles to a specialist). However, commercial plans are not subject to detailed “time of travel” standards, nor do they break down their access standards by subspecialty like Medicaid. TDI requires plans to file an annual network adequacy report. Because the MCOs are licensed as Health Maintenance Organizations in Texas, they are required to file annual network adequacy reports with TDI.

Appointment Availability Standards

Appointment availability is measured by the time between when a member contacts a provider and the date of the first available appointment. MCOs can reduce the use of emergent care by ensuring members have timely access to regular and preventive care.

As previously stated, the state’s EQRO conducted secret shopper studies to assess compliance with appointment availability standards in 2015 and over a two-year period from 2016 to 2017 to evaluate whether providers were meeting appointment availability standards. Secret shoppers contact network providers, using contact information provided by the MCOs, to see how quickly they can get appointments across all Medicaid programs. The EQRO is repeating the studies over 2018 and 2019.

Because network adequacy and appointment availability are closely related, HHSC is examining how oversight methods may be used to review them together.

HHSC has imposed corrective action plans (CAPs) on all the MCOs in at least one service area for not meeting appointment availability standards. Due to findings from the most current secret shopper studies, the agency has also placed greater focus on prenatal care through the 2018 MCO Performance Improvement Projects (PIPs) and Pay-for-Quality (P4Q) measures. Results for PIPs will be available in 2020 and results for P4Q will be available in 2019.

Texas’ EQRO is also conducting a series of studies on PCP referrals to identify the key barriers PCPs face when making referrals in managed care (STAR, STAR Health, STAR+PLUS, STAR Kids, and CHIP) for specialty care.

These studies identify the key barriers providers face when making specialty referrals, and HHSC uses these findings to develop targeted strategies for improving access to care for Medicaid/CHIP clients.
**MCO Appointment Availability Standards**

<table>
<thead>
<tr>
<th>Level/Type of Care</th>
<th>Time To Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent Care (child and adult)</td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>Routine Primary Care (child and adult)</td>
<td>Within 14 calendar days</td>
</tr>
<tr>
<td>Preventive Health Services for New Child Members</td>
<td>No later than 90 calendar days of enrollment</td>
</tr>
<tr>
<td>Initial Outpatient Behavioral Health Visits (child and adult)</td>
<td>Within 14 calendar days</td>
</tr>
<tr>
<td>Preventive Health Services for Adults</td>
<td>Within 90 calendar days</td>
</tr>
<tr>
<td>Prenatal Care (not high-risk)*</td>
<td>Within 14 calendar days</td>
</tr>
<tr>
<td>Prenatal Care (high risk)*</td>
<td>Within 5 calendar days</td>
</tr>
<tr>
<td>Prenatal Care (new member in 3rd trimester)</td>
<td>Within 5 calendar days</td>
</tr>
</tbody>
</table>

* Prenatal care appointment availability studies are only conducted for STAR.

**Pay-for-Quality Measures**

The medical P4Q program creates incentives and disincentives for MCOs based on their performance on certain quality measures. MCOs that excel in their performance on at-risk measures and bonus measures may be eligible for additional funds, while MCOs that do not meet the established benchmarks for at-risk measures can lose up to three percent of their capitation rate. One example of a P4Q measure related to network access is the prenatal care measure requiring pregnant members to receive a prenatal care visit in the first trimester or within 42 days of enrollment.

**Member Satisfaction**

HHSC reviews results from the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey, results from the National Core Indicators—Aging and Disabilities (NCI-AD) survey, and member complaints to understand the patient experience with health care. CAHPS surveys focus on consumer perceptions of quality, such as the communication skills of providers and ease of access to healthcare services. For example, the 2016 CAHPS survey results showed that 15 MCOs in the STAR program met minimum standard for “good access to routine care” for children. However, only three MCOs in the STAR program met minimum standard for “good access to behavioral health treatment or counseling.” MCOs are subject to contract remedies for failing to meet minimum standards for one-third or more quality measures, which includes member survey measures.

Texas had the highest ranking for key satisfaction measures, ranked higher than most states on community participation and control, and ranked similarly to other states on questions about rights and respect, healthcare services, and safety in the 2015-2016 study, the most recent results available.
Utilization Reviews

A key oversight tool HHSC uses to oversee MCO service delivery compliance is URs. URs are overseen by the Office of the Medical Director and conducted by a team of nurses. The goal of the URs are to ensure MCOs are authorizing, justifying, and providing appropriate, medically necessary services to Medicaid members, without over-utilization or under-utilization. In addition, the reviews assure MCO adherence to federal and state laws and rules, their contracts with HHSC, and their own policies.

UR consists of two review units: the Acute Care Utilization Review (ACUR) and the Managed Care Long-Term Services and Supports (MLTSS) UR.

Acute Care Utilization Review

ACUR is a desk review conducted by a team of nurses on a targeted sample set of medical records. The review includes UR and authorization process, medical necessity determination, timeliness, and accuracy in the resolution. Recent areas of focus have been private duty nursing and speech therapy based on complaints, the severity and frequency of non-compliance instances, and the high volume and cost of these services. Additional services will be added for reviews based on the same criteria.

Managed Care Long-Term Services and Supports Utilization Review

The initial scope of this unit was conducting UR for STAR+PLUS specifically. The MLTSS UR team conducts sampled reviews of STAR+PLUS HCBS to determine MCOs’ conduct of assessments, MCOs’ procedures and related information used to determine appropriateness of member enrollment in the HCBS program. The review includes ensuring MCOs are providing services according to their assessment of service needs. The team conducts desk reviews of MCO documentation and conducts home visits with each of the members in the sample. Findings from MLTSS UR activities in STAR+PLUS are reported annually to the Legislature.

Utilization Review Expansion

In 2018, HHSC submitted a request to transfer positions from within the agency to expand MLTSS UR activities for STAR Kids and STAR Health. The Legislature and the Governor’s Office promptly approved 47 additional UR staff to:

- Support the MLTSS UR team in their reviews of STAR+PLUS HCBS to allow stratified sampling for the five current contracted MCOs
Chapter 3 — How does HHSC make sure clients get good care?

- Initiate reviews for STAR Kids Medically Dependent Children Program (MDCP) and STAR Health MDCP (in 2020), including a review of the authorized amounts for coordinating private duty nursing services
- Support expansion of UR efforts in the managed care operational review process, including:
  - Oversight of prior authorization practices of acute care services
  - Adding oversight of prior authorization practices for LTSS

UR findings inform policy and contract clarifications, MCO consultation and training, internal process improvements, and remediation actions with MCOs. A responsibility of the UR teams is to coordinate and communicate with MCOs to find solutions that are consistent with HHSC’s standards and expectations.

**Drug Utilization Reviews**

HHSC and MCOs perform drug utilization reviews (DURs) before and after dispensing medications to Medicaid clients to evaluate and develop policies that encourage safe and appropriate use of drug therapies, while containing costs. The Vendor Drug Program (VDP), which administers drug benefits for FFS clients and manages rebate administration, also establishes protocols related to drug use management for both FFS and managed care, including regulations over which drugs are covered and DURs.

Prospective DURs are performed before each prescription is filled or delivered to the client or member, typically at the point-of-sale or point-of-distribution. This review evaluates the client’s medication history to ensure appropriate and medically necessary drug utilization. It also includes screening for therapeutic duplication, interactions with other health conditions or drugs, incorrect drug dosage or duration of treatment, and clinical abuse or misuse.

**The Texas Drug Utilization Review Board**

The Texas DUR Board is an HHSC advisory board whose members are appointed by the HHSC Executive Commissioner. The board is composed of physicians and pharmacists who provide services across the Medicaid population and represent a variety of different specialties. In addition, two representatives (one physician and one pharmacist) from the MCOs and one consumer advocate for Texas’ Medicaid members are included on the board. The two representatives from MCOs serve as non-voting members.

The duties of the Texas DUR Board include developing and submitting recommendations to HHSC for the PDL, reviewing and approving clinical prior authorizations, developing and reviewing educational interventions for Medicaid providers, and reviewing drug utilization across the Medicaid program.
Advisory messages concerning clinically significant conditions or situations are part of the point-of-sale claim adjudication process. Upon identifying any clinically significant conditions or situations, the pharmacist should take appropriate steps to avoid or resolve the problem, including consultation with the prescribing provider.

The prospective DUR process may also involve prior authorizations, such as non-preferred prior authorizations and clinical prior authorizations:

- Prescribers who choose "non-preferred" medications for their Medicaid patients must obtain prior authorization from HHSC or the MCO before the drug is dispensed. All Medicaid programs must adhere to the same formulary, a list of CMS-approved drugs enrolled with Texas Medicaid. The Texas Drug Utilization Review (DUR) Board further classifies these drugs as preferred or non-preferred on the Preferred Drug List (PDL). The PDL is arranged by drug class and contains a subset of many, but not all, drugs on the formulary. A drug’s status on the PDL is determined based on its safety, efficacy, and cost-effectiveness. The VDP manages the PDL across all Medicaid programs and requires MCOs to use the PDL in administering pharmacy benefits.

- Clinical prior authorizations—which are conducted using evidence-based clinical criteria and nationally recognized peer-reviewed information—may apply to an individual drug or drug class included on the formulary and may have preferred or non-preferred status on the PDL. With the assistance of the Texas DUR Board, the VDP develops, manages, and reviews clinical prior authorizations for all Medicaid programs. Participating MCOs are required to perform certain clinical prior authorizations, and may perform others at their discretion.

After a client has received the medication, retrospective DURs are conducted to review the drug therapy. Reviews examine claims data to analyze prescribing practices, the client's medication use, and pharmacy dispensing practices. This process allows for active, ongoing educational outreach for prescribing providers and pharmacists with the aim of improving prescribing and dispensing practices. HHSC (for FFS) and MCOs conduct multiple reviews each calendar year on topics such as identifying patterns of drug misuse, medically unnecessary prescribing, or inappropriate prescribing. Intervention letters are sent to physicians to help better manage a person’s drug therapy.

**E-Prescribing**

To reduce adverse drug events and costs incurred in providing prescription drug benefits, HHSC supports electronic prescribing (EPCS) functionality. With EPCS, prescribers spend less time on the phone, and improve security and confidentiality. Pharmacies decrease time spent on phone calls, eliminate verbal misinterpretations and increase prescription accuracy. Patients benefit from improved safety. For the prescribing of controlled substances using EPCS, both the prescriber software system and pharmacy software system must be certified by an independent third party auditor. Texas Medicaid providers can learn how to start using EPCS by going to getEPCS.com.
Electronic Visit Verification

Electronic Visit Verification (EVV) is a computer-based system that electronically verifies the occurrence of personal attendant service visits by documenting the precise time service delivery begins and ends. EVV helps prevent fraud, waste, and abuse with the ultimate goal of ensuring Medicaid recipients receive care that is authorized for them.

In Texas, EVV is required for the below Medicaid-funded home and community-based services:

- 1915(c) Community Living Assistance and Support Services (CLASS) waiver
- 1915(k) Community First Choice (CFC) program
- Community Attendant Services (CAS), Personal Care Services (PCS), Primary Home Care (PHC) and Family Care
- STAR Health
- MDCP in STAR Kids
- STAR+PLUS - state plan as well as the HCBS portion

The 21st Century Cures Act, a federal law enacted on December 13, 2016, describes EVV requirements and federal financial matching participation to support the development of EVV systems for the delivery of all personal care services and home health services under Medicaid. This expands the scope of programs and services HHSC currently requires for EVV to include:

- Individuals participating in a Consumer-Directed Services (CDS) option
- Home health nursing and therapy services
- Deaf Blind with Multiple Disabilities (DBMD), Home and Community-based Services (HCS), and Texas Home Living (TxHmL) 1915(c) waiver providers

The effective date for implementing EVV for all PCS services is January 1, 2020, and January 1, 2023, for home health care services.
HHSC has several related technology initiatives that will allow for the seamless passing of patient clinical data in real-time between service providers. Ultimately, these initiatives will advance care coordination and raise the quality of care Texas Medicaid clients receive.

More information on these initiatives can be found at [healthit.hhsc.texas.gov](http://healthit.hhsc.texas.gov).

**Electronic Health Record (EHR) Incentive Program**
A certified EHR contains the electronic records of individual patients, including patient demographic and clinical health information.

The Health Information Technology for Economic and Clinical Health (HITECH) Act allows HHSC to pay incentives to Medicaid providers for the meaningful use of EHRs.

As of March 2018, over $838 million in federally-funded incentives have been paid to over 10,000 individual providers and hospitals combined.

**Medicaid Provider Health Information Exchange (HIE) Connectivity Project**
HIE is the secure electronic movement of health-related information from EHRs among treating physicians, other care providers, and organizations. Texas is served by several community-based and private HIEs.

This project helps Medicaid service providers connect to local HIEs. These connections will facilitate electronic reporting and data exchange between providers and Texas Medicaid.

**HIETexas**
This project enhances the state’s HIE infrastructure to support connectivity, and assists local HIEs in implementing connections and facilitating the exchange of data for Medicaid and CHIP clients.

By state law, data cannot be stored long term.
Quality of Care

HHSC has a strong focus on quality of care in Medicaid and CHIP through the monitoring of outcomes, payment incentive programs, and other initiatives.

Under federal regulations, HHSC contracts with EQRO. Texas’ EQRO follows CMS protocols to assess access, utilization, and quality of care provided by MCOs participating in all Medicaid and CHIP medical and dental managed care programs.

In addition to ensuring state programs, MCOs, and DMOs are compliant with established regulations, HHSC also uses the EQRO to perform custom evaluations related to quality of care. The EQRO uses a variety of tools and measures, including analyzing administrative data (example: claims and encounter data), MCO documents, and provider medical records, as well as interviewing MCO and DMO administrators, and conducting surveys of member, caregivers of members, and of providers.

EQRO reports allow comparison of results across MCOs in each program and are used to develop overarching goals and quality improvement activities for Medicaid and CHIP managed care programs. MCO and DMO results are compared to HHSC standards and national averages, where applicable.

Accountability for MCO continuous improvement in quality of care for members is primarily accomplished through a variety of improvement projects and payment reform.

Improvement Projects

Performance Improvement Projects

Performance improvement projects (PIPs) are an integral part of Texas’ Managed Care Quality Improvement Strategy. Federal regulations require all states with Medicaid managed care programs to ensure health plans conduct PIPs. PIPs must use ongoing measurements and interventions to achieve significant improvement over time in health outcomes and enrollee satisfaction. Health plans conduct PIPs to improve areas of care identified by HHSC, in consultation with Texas’ EQRO, as needing improvement. Topics are selected based on MCO and DMO performance on quality measures and member surveys. HHSC requires each MCO and DMO to conduct two PIPs per program, each lasting two years, and one PIP per health plan must be a collaboration with another MCO and DMO, a Delivery System Reform Incentive Payment (DSRIP) program, or a community organization.
For 2018, all STAR plans and three STAR+PLUS plans conducted PIPs to improve timeliness of prenatal care (visit in first trimester or within 42 days of enrollment) and postpartum care (visit on or between 21 and 56 days after delivery). Examples of interventions include obstetric case management, free prenatal classes or resources online and in-person, and incentives for completing a timely prenatal visit. Additional information and current PIP topics can be found on the HHSC website.

### A Closer Look: Member Complaints

HHSC monitors MCO complaints, grievances, and appeals processes, and uses data as a mechanism to flag for early warnings of potential systemic problems that warrant investigation, point to the need for policy clarifications, or signal larger operational issues.

HHSC continues to evolve the complaint process to improve the member experience and increase the consistency in data for timelier, actionable analysis.

**Complaints Submission**

Members are directed to submit their complaints directly to their MCO. They can also submit complaints to HHSC Office of the Ombudsman. Members may use phone, email, fax, or online portals to submit complaints to HHSC.

**Complaints Resolution**

MCOs are required to resolve complaints within 30 days, regardless of point of entry. If a member is not satisfied with the resolution, the member can meet with the MCO’s Complaint Appeal Panel. After meeting with the panel, a written resolution must be reached within 30 days depending on medical urgency.

If a member is not satisfied with the outcome of the MCO appeal, they can request a fair hearing with HHSC. Members have 90 days from the date on the MCO’s decision letter to request a hearing. Fair hearings are scheduled in the order they are received, unless there is a need to expedite for members whose health would be jeopardized by waiting. HHSC makes a final decision within 90 days from the date of the hearing request.
Quality Assessment and Performance Improvement Programs

Federal regulations also require Medicaid health plans to develop, maintain, and operate quality assessment and performance improvement (QAPI) programs. MCOs and DMOs report on their QAPI programs each year and these reports are evaluated by Texas’ EQRO.

QAPI programs are ongoing, comprehensive quality assessment and performance improvement programs for all the services the MCO provides, while PIPs are time limited interventions targeting a specific aspect of care.

Pay-for-Quality and Payment Reform

The medical P4Q program evaluates MCOs on a set of quality measures with a focus on prevention, chronic disease management (including behavioral health), and maternal and infant health with a percentage of the MCOs’ capitation at-risk, based on their performance. The dental P4Q program places a portion of the DMOs’ capitation at-risk based on their performance on a set of dental care quality measures.

The shift in health care from paying providers for the volume of services delivered to provider payments linked to improvements in quality and efficiency is called health care payment reform or value-based care. It is accomplished by payers implementing alternative payment models (APMs), also called value-based payments. A strong medical P4Q program is a catalyst for MCOs and DMOs to pursue APMs with providers to help them meet or exceed their P4Q performance targets. MCOs and DMOs must have a certain percentage of their overall provider payments associated with an APM. For a certain percentage of these payments, the provider must have some degree of risk. HHSC is using the Healthcare Payment Learning and Action Network (HCP-LAN) Alternative Payment Model Framework (hcp-lan.org) to help guide this effort.

In addition to the medical P4Q program with MCOs, HHSC administers a Hospital Quality-Based Payment Program in which hospitals may experience a percentage of recoupment of their total payments for inpatient stays for high rates of potentially preventable readmissions (PPRs) or potentially preventable complications (PPCs). Conversely, safety net hospitals may receive bonus payments above their base payments for achieving low rates of PPRs or PPCs.

To read more about P4Q, payment reform, and the Hospital Quality-Based Payment Program (see Chapter 4, pages 94-95, 98).

HHSC pays or recoups from hospitals based on their performance in FFS. MCOs pay or recoup from hospitals based on their performance in managed care. Measurement, reporting, and fiscal actions are applied on an annual cycle.
 Transparency with the Public

HHSC is committed to increasing transparency with the public related to managed care performance and quality related measures, including MCO report cards, the HHSC public website, and the Texas Healthcare Learning Collaborative (THLC) portal.

MCO report cards allow members to compare the MCOs on specific quality measures and make an informed selection during the enrollment process. The report cards provide an evaluation of MCOs using a one through five star-rating and are updated annually. MCO report cards are posted on the HHSC website and included in the Medicaid and CHIP enrollment packets to help inform a member’s plan selection.

In addition, HHSC maintains a public website to inform stakeholders about various HHSC initiatives designed to advance quality. Potential improvements to the user experience and information on the website are evaluated on an ongoing basis.

Texas Healthcare Learning Collaborative Portal

This website serves as a public reporting platform, contract oversight tool, and a tool for MCO quality improvement efforts. The website was developed for use by HHSC, MCOs, providers, and the general public to obtain up-to-date MCO and hospital performance data on key quality of care measures, including potentially preventable events (PPEs), Healthcare Effectiveness Data and Information Set (HEDIS®), and other quality of care information.

Providers also have the ability to see performance data by MCO within a service area over time. These data may serve as an important tool for providers to engage MCOs on value-based contracting.

The THLC portal is updated and expanded on an ongoing basis. For example, in 2017, in-depth data visualizations of key quality measures were added.

The THLC portal can be accessed at THLCPortal.com.
# Quality Monitoring Sources and Measures

HHSC tracks and monitors program performance using a combination of established national measures and state-developed measures.

<table>
<thead>
<tr>
<th>Sources</th>
<th>Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Committee for Quality Assurance Healthcare</td>
<td>• Nationally recognized and validated set of measures used to gauge quality of care provided to members</td>
</tr>
<tr>
<td>Healthcare Effectiveness Data and Information Set</td>
<td>• Domains include Effectiveness of Care, Access and Availability of Care, Experience with Care, and Health Care Utilization</td>
</tr>
<tr>
<td>Agency for Healthcare Research and Quality Pediatric Quality Indicators (PDIs) / Prevention Quality Indicators (PQIs)</td>
<td>• PDIs and PQIs use hospital discharge data to measure quality of care for ambulatory care sensitive conditions, which are conditions where good outpatient care or early intervention can prevent hospitalization, complications, or more severe disease • PDIs specifically screen for problems children and youth may experience</td>
</tr>
<tr>
<td>3M® Software for potentially preventable events</td>
<td>The EQRO calculates rates across all MCOs and programs for the following PPEs: • Potentially Preventable Admissions • Potentially Preventable Readmissions • Potentially Preventable Emergency Department Visits • Potentially Preventable Complications • Potentially Preventable Ancillary Services</td>
</tr>
<tr>
<td>Consumer Assessment of Healthcare Providers &amp; Systems (CAHPS) Surveys</td>
<td>• CAHPS Health Plan Survey is a nationally recognized and validated tool for collecting standardized information on members’ experiences with health plans and services • The EQRO alternates CAHPS surveys so that members or caregivers from each program are surveyed every other year</td>
</tr>
<tr>
<td>Dental Quality Alliance (DQA)</td>
<td>• The DQA is an organization convened by the American Dental Association at the request of CMS • DQA has developed national evidence-based oral health care performance measures that have been tested for feasibility, validity, reliability, and usability</td>
</tr>
</tbody>
</table>

The primary tool used for analyzing the quality measures is a performance indicator dashboard. The dashboard provides HHSC a view in to each MCO’s overall quality performance by aggregating a subset of the quality measurement indicators. Dashboard measures include minimum and high performance standards by program. Contracts require MCOs to perform above the minimum standard on more than two-thirds of the dashboard measures.
The way MCOs conduct their business operations can have a direct impact on the care members receive.

**Operational Reviews**

In September 2017, HHSC established an on-site biennial operational review process for MCOs. These operational reviews allow HHSC to conduct an in-depth review of MCO operational compliance and performance across a number of areas to ensure policies and practice align with performance standards. A multi-disciplinary team reviews key functions and requirements as stipulated in the MCO’s contract. Each subject area has their own tools for data collection. The HHSC Office of the Inspector General (OIG) is also invited to participate. MCO staff interviews are also part of the review process.

Examples of operations reviewed when on-site include:

- Claims processing
- Member and provider training
- Complaints/appeals
- Encounter data
- Prior authorization processes

If any problems are discovered during the operational reviews, HHSC takes appropriate steps to address performance. Additionally, operational reviews can inform planned third party performance audits.

**Targeted Reviews**

In addition to the established on-site biennial operational review process for MCOs, HHSC also conducts targeted reviews when a significant or recurring problem with an MCO is identified—as an example, claims timeliness. This can occur in response to complaints from members, providers or other stakeholder groups or review of other compliance deliverables. The scope, entity, and focus of targeted reviews vary based on the topics raised by complaints received and past instances of non-compliance.

**Third Party Performance Audits**

Performance audits are conducted by independent auditors biennially or more frequently if needed (determined by risks). They typically focus on two areas:

1. MCO data
2. Operational processes

The target of the audits vary, but examples of reported data that would be validated by an audit includes complaints and appeals. Examples of operational processes are claims processing or subcontractor monitoring, including Pharmacy Benefit Managers.
The financial requirements of the MCOs are defined in the contract, including the standards for the financial data they have to report to HHSC. The contract also includes limitations on administrative expenses recognized by the Medicaid program and establishes profit sharing provisions to limit profits, also called ‘experience rebates’ (see A Closer Look, page 79).

The financial statistical reports (FSRs) MCOs are required to submit include information on medical and administrative expenses. Because these reports are one source for establishing capitation rates in future years, validation of them is an important component of contract oversight. HHSC financial analysts validate MCO-reported medical expenses to encounter data on a quarterly basis. Independent auditors review the administrative expenses reported by the MCOs and provide additional data validation by comparing medical expenses to paid claims.

The timeline to complete oversight for MCO financial activity for a given year is 18-20 months after the end of that year. This is because a full audit by the independent auditors can only occur after the final books close and all claims have run out for that given year.

Financial Compliance Timeline

While audits occur annually, HHSC financial analysts can also determine the need for any supplemental audits or reviews based on other identified issues.

As mentioned, unlike FFS, managed care is not a “per service” reimbursement model. MCOs are paid PMPM capitation rates for the delivery of services. These capitation rates are established each year based on actual MCO expenditures on medical services from previous time periods. Reductions in spending on medical services will have the effect of reducing future capitation rates. If spending to provide contracted services exceeds their capitation rate payments, MCO profit margins are at risk.
**MCO Administrative Expense Limits**

Contract terms define an allowed and disallowed administrative expense. Additionally, HHSC limits administrative expenses that Medicaid will pay for in the contract, this is referred to as the Admin Cap.

- The cap is compared to MCO’s reported administrative expenses
- Any amounts over the Admin Cap also become disallowed expenses, and the MCO’s net income is increased by that amount

**MCO Profit Limits**

MCOs retain profits of three percent or less of revenue.
- Any profits over three percent are considered ‘excessive profit’ and recovered by HHSC as an experience rebate
- The experience rebate structure is tiered based on the amount of profit

**Graphic Illustration of Administrative Expense and Profit Limits**

While HHSC does not recognize certain MCO expenditures in the Medicaid program, this does not prevent MCOs from spending money on expenses they consider necessary for the successful operation of their business. Examples include certain marketing and legal expenses, lobbying, and bonuses that exceed the compensation limit.
Non-Compliance Remedies

HHSC may use multiple types of enforcement actions, including monetary damages and CAPs, to hold MCOs accountable for not meeting contract terms. As specified in the managed care contracts, at its discretion, HHSC may impose one or more of the following remedies.

Remedies do not have to be issued in sequence. For example, if the MCO fails to perform any of the services described in the contract, HHSC may assess liquidated damages (LDs) for each occurrence of an event. LDs may not be punitive in nature, nor a fine or penalty. Section 12.02(e)(2) of the Uniform Managed Care Contract states that, “Liquidated damages are not intended to be in the nature of a penalty, but are intended to be reasonable estimates of HHSC’s projected financial loss and damage resulting from the MCO’s nonperformance, including financial loss as a result of project delays.”

Assessment of Contract Remedies

While there are a number of remedies available to the agency, CAPs and LDs are the primary remedies HHSC utilizes to address performance issues. The goal of any contract action is to encourage compliance with contract standards.
Corrective Action Plans

HHSC assesses the need for CAPs on a monthly basis. Through the CAP process, MCOs are required to provide HHSC with: 1) a detailed explanation of the reasons for the deficiency; 2) an assessment or diagnosis of the cause; 3) actions taken to resolve the deficiencies, including long- and short-term solutions; and 4) actions taken to prevent future occurrences.

HHSC reviews, approves, and closes the CAP once the MCO demonstrates it has taken appropriate action to address contractual non-compliance. Examples of CAPs include non-compliance with network adequacy standards and issues identified through utilization reviews.

To increase transparency, the issuance of CAPs was added to the HHSC website. This allows the public and other states that are contemplating contracting with an MCO to see their performance history.

Liquidated Damages

HHSC assesses LDs quarterly to address any harm incurred due to MCO contractual non-compliance. Examples of LDs include non-compliance when submitting encounter data, provider payment timeliness, and delivery of appropriate services.

Beginning January 2018, the State Medicaid Director implemented a formal process for LD decisions. All LD decisions and reconsideration determinations require written approval. LDs less than $500,000 are approved by the State Medicaid Director; LDs greater than $500,000, but less than $1 million, must be approved by the Chief Program and Services Officer, and LDs greater than $1 million must be approved by the Executive Commissioner.

Since HHSC’s shift to a more focused managed care oversight business model in 2017, remedies and CAPs are more robust and organized than before. For example, for the first three quarters of state fiscal year 2017, HHSC assessed over $27 million in LDs to MCOs, including $11.7 million based on UR review findings. This is an increase of over 400 percent compared to the first three quarters of state fiscal year 2016. Increased compliance is accomplished through clear and consistent reinforcement of contractual standards. The goal is to have LDs at zero dollars.
The Office of Inspector General

The Office of Inspector General (OIG) is charged with safeguarding state health and human services by detecting and preventing fraud, waste, and abuse and ensuring the health and safety of Texans. Fraud, waste, and abuse impact the provision and delivery of state health and human services in a number of ways, including:

- Preventing or delaying medically necessary care or social services
- Providing care that is not medically necessary and potentially harmful to clients
- Using staff and financial resources from the healthcare system inefficiently, such as making improper payments, which can contribute to the rising cost of health care for all

To address the range of risks to health and human services’ program integrity, the OIG employs several methods to protect Texans and their tax dollars from fraud, waste, and abuse. Because of its financial impact and the large number of Texans it touches, many of the OIG’s efforts focus on evaluating Texas’ Medicaid program. The OIG acts to prevent unqualified and ineligible Medicaid clients, providers, and contractors from using its resources inappropriately by:

- Conducting provider enrollment screenings, audits to determine compliance with rules and regulations or to identify fraud and abuse, and investigations of clients and providers suspected of fraud, waste, and abuse
- Taking enforcement actions, recouping overpayments, and terminating or excluding providers that have committed fraud, waste, or abuse

Several different OIG divisions help ensure Medicaid program integrity—Investigations, Audits, Inspections, and Reviews—each supported by the OIG Data and Technology Division (DAT). DAT uses data research and analytics to identify, monitor, and assess trends and patterns of behavior of providers, clients and retailers participating in Medicaid and other health and human service programs.

Investigations

Provider Field Investigations

Provider Field Investigations look into allegations of fraud, waste, and abuse by healthcare providers. The results of an investigation may lead to recoupment of overpayments, imposition of sanctions or administrative actions, referrals to licensing boards, and referrals to the Office of Attorney General’s Medicaid Fraud Control Unit.

Benefits Program Integrity

Benefits Program Integrity examine clients suspected of abusing HHSC programs, including Medicaid and CHIP, but also the Supplemental Nutrition Assistance Program, Temporary Assistance for Needy Families, and the Women, Infants, and Children program. Findings can include the provision of false information to apply for services or using someone else’s insurance coverage for services. Referrals of potential fraud, waste, and abuse can come from clients, providers, and the general public via OIG’s fraud hotline at 1-800-436-6184.
Audits
The Audit Division identifies program policy gaps and overpayments, and proposes recommendations to prevent fraud, waste, and abuse. Audit staff conduct risk-based performance, provider, and information technology audits related to the accuracy of medical provider payments, the performance of agency contractors, and the programs, functions, processes, and systems within HHSC. Previous audits reviewed providers of speech therapy, the Vendor Drug Program, and durable medical equipment.

Inspections
Inspections are targeted examinations into specific programmatic areas of HHSC programs, systems, or functions that may identify systemic trends of fraud, waste, and abuse. The results from an inspection may result in further review of the topic by another OIG division or HHSC. Topics from past inspections include: opioid over utilization, the effectiveness of EVV, and capitation payments made for deceased clients in the Medicaid system.

Reviews
The Division of Medical Services conducts Medicaid claims and medical record reviews that includes utilization reviews of acute care services (e.g., laboratory and x-ray services), hospital services (e.g., surgical specialists), nursing facility services (e.g., rehabilitation, long-term care), and the Medicaid Lock-in program.

Medicaid Lock-in Program
The Medicaid Lock-in program operates by "locking in" an individual to one provider and pharmacy to prescribe and dispense certain drugs, like controlled substances (e.g., morphine, hydrocodone) to prevent their abuse or overuse. Individuals enrolled can only purchase their prescriptions from the pharmacy to which they are "locked in." Generally, clients are eligible for Medicaid Lock-in programs when a pre-defined threshold of prescriptions of controlled substances, provider visits, or both are reached. Lock-in program enrollment is intended to prevent clients from provider or pharmacy "shopping" or misusing the medications. Payment records (e.g., Medicaid claim data) are used to identify patterns of suspicious use.

Provider Enrollment Screening
In close collaboration with HHSC’s Medicaid and CHIP Services, the OIG’s Provider Enrollment Integrity Screenings (PEIS) team uses preventative measures in the enrollment process for health and human service providers (e.g., doctors, dentists, durable medical equipment suppliers, home health agencies). PEIS staff complete the required state and federal disclosure and screening activities for high-risk providers seeking to enroll, re-enroll, or revalidate their enrollment in Medicaid and other HHSC programs. The general public may refer providers suspected of fraud or abuse to OIG’s fraud hotline.
Premium Member Benefit: Please Do Not Share

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As part of your membership, you're entitled to download and use our InDesign Template of the Month.

This month's template is for a tech manual. Inside the download folder you should find:

* This ReadMe.txt file
* One template file in INDD and IDML formats

If you have InDesign CC 2018 or later, you can open the INDD version of the file. If you have an earlier version of InDesign, please open the IDML version of the file.
Chapter 4

What are the financial features of Medicaid/CHIP?
2016-2017 Total HHSC Biennial Appropriations

$64.4 billion

State General Revenue (GR) Funds

$25.9 billion

Federal and Other Funds*

$38.5 billion

Medicaid/CHIP State GR Funds

$24.5 billion

Medicaid/CHIP Federal and Other Funds

$36.7 billion

Total Funds for Medicaid/CHIP

$61.2 billion

Three Types of Payments

1. MCO Capitation Payments

2. Reimbursements for Providers

3. Supplemental Hospital Funding

*Other funds include, but are not limited to, Appropriated Receipts, Interagency Contracts, Medicaid Subrogation Receipts (State Share), and WIC Rates.
Chapter 4 — What are the financial features of Medicaid/CHIP?

**Expenditure Trends**

Annual Expenditures for Medicaid/CHIP SFYs 2008 - 2017

Example: Total Medicaid/CHIP expenditure for 2017 is $39 billion, CHIP is $1 billion.

**Caseload Trends**

Average Monthly Medicaid/CHIP Enrollment SFYs 2008 - 2017

Example: Total Medicaid/CHIP enrollment for 2017 is 4.5 million, CHIP is 425,000.

**Cost Growth Comparison**

Caseload is the primary driver of cost. However, despite caseload increases, Texas Medicaid cost per person cost growth is substantially lower than the national trend.

**Managed Care Percent of Caseload**

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</tr>
</thead>
<tbody>
<tr>
<td>22,309</td>
<td>24,557</td>
<td>27,651</td>
<td>29,348</td>
<td>29,348</td>
<td>29,348</td>
<td>33,394</td>
<td>36,970</td>
<td>41,954</td>
<td>38,449</td>
</tr>
</tbody>
</table>

Based on full benefit client caseload growth.

*Source: CMS, Office of the Actuary—data is for CY08 to CY16.*
Budget Development

HHSC staff develop the estimates of future Medicaid caseloads and spending that form the basis for state appropriations requests. This process requires projections of the number of people eligible for and applying for the program; estimations of cost trends; analyses of any new federal mandates or state changes affecting eligibility, services, or changes in program policy; and outreach efforts. Ultimately, decisions about funding are determined by the legislature.

In addition, there are several factors that impact the state Medicaid budget, including what types of services Texas chooses to cover and the amount of federal matching funds certain programs will receive.

The budget takes effect at the beginning of the biennium in September of odd numbered years. A significant amount of time elapses between the development of the initial agency budget request and the passage of a finalized appropriations bill.

<table>
<thead>
<tr>
<th>Legislative Appropriations Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>August</strong></td>
</tr>
<tr>
<td><strong>January</strong></td>
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<tr>
<td><strong>April</strong></td>
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<tr>
<td><strong>May</strong></td>
</tr>
<tr>
<td><strong>September</strong></td>
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</tbody>
</table>
Matching Funds

Federal funds are a critical component of healthcare financing for the state of Texas. The amount of federal Medicaid funds Texas receives is based primarily on the federal medical assistance percentage (FMAP), or Medicaid matching rate. With some exceptions, such as waivers or the Disproportionate Share Hospital (DSH) program, there is no cap on federal funds for Medicaid expenditures.

Derived from each state’s average per capita income, the CMS updates the rate annually. Consequently, the percentage of total Medicaid spending that is paid with federal funds also changes annually. As the state’s per capita income increases in relation to the national per capita income, the FMAP rate decreases. For federal fiscal year (FFY) 2019, Texas’ Medicaid FMAP is 58.19 percent.

Texas uses a one-month differential FMAP figure that takes into account differences between the FFY (October through September) and the state fiscal year (SFY) (September through August). The one-month differential FMAP for Texas in SFY 2019 (which includes one month of the FFY 2018 rate of 56.88 percent and 11 months of the FFY 2019 rate of 58.19 percent) is 58.08 percent.

CHIP Matching Funds

Unlike Medicaid, total federal funds allotted to CHIP each year are capped, as are the funds allotted to each state. Each state is allotted a portion of the total federal funds based on a formula set in federal statute and receives federal matching payments up to the allotment. The FFY 2017 allocation is fully expended and the 2018 allocation is estimated to be fully expended in 2019. The federal allocation for Texas in FFY 2017 was $1.10 billion.

In addition, CHIP offers a more favorable federal matching rate than Medicaid. The federal CHIP funds states receive are based on the enhanced federal medical assistance percentage (EFMAP). Derived from each state’s average per capita income, CMS updates this rate annually. Consequently, the percentage of total CHIP spending that is paid for with federal funds also changes annually. The EFMAP for Texas in FFY 2019 is 70.73 percent and in SFY 2019 is 70.65 percent.

The Affordable Care Act (ACA) increased the federal match rate for CHIP by 23 percentage points (not to exceed 100 percent) from October 1, 2015, until September 30, 2019. For FFY 2020, only 11.5 percentage points will be added to the EFMAP, and for FFYs 2021-2023, the standard EFMAP will resume. The CHIP EFMAP is 93.73 percent in FFY 2019 and 93.65 percent in SFY 2019.
Texas Federal Medical Assistance Percentages, FFYs 2008 - 2019

The American Recovery and Reinvestment Act (ARRA) temporarily increased the FMAP from FFY October 2008 through December 2010.

The ACA temporarily increased the Enhanced FMAP FFY 2016 through 2019.

**Deferrals and Disallowances**

Deferrals and disallowances impact the availability of federal financial participation for the program:

- **Deferral** – If CMS determines that Texas may be out of compliance with federal regulations or its Medicaid state plan, CMS may withhold funds until compliance is proven or until the state provides additional information to support the validity of the claim.
- **Disallowance** – If CMS alleges a claim is not allowable, it can also recoup federal funds.

CMS can impose deferrals or disallowances following a federal audit or a change to the Medicaid state plan.

A deferral or disallowance may be imposed for the federal fiscal quarters for which CMS asserts the state is out of compliance with CMS regulations or its Medicaid state plan. In the case of a disallowance, CMS may retroactively encompass several years of claims. States have the option to appeal the CMS determination with the U.S. Department of Health and Human Services’ Departmental Appeals Board. The Departmental Appeals Board will make a ruling based on the written records provided by both parties or can hold a hearing to discuss the matter prior to making a ruling.
Mandatory and Optional Spending

Texas Medicaid is federally required to provide certain acute care services and LTSS, including inpatient and outpatient care, physician services, family planning services and supplies, extended services for pregnant women, and nursing facility services for clients age 21 and older (see Appendix B).

However, Texas also chooses to cover some of the optional services allowed but not required by the federal government. These optional services do not necessarily increase costs for the state.

In fact, eliminating some optional services and eligibility categories could increase Medicaid costs. For example, dropping the option of covering prescription drugs could ultimately cost Medicaid more. People who do not receive needed drugs may require more physician services, increased hospitalizations, or even LTSS. Similarly, Texas potentially saves money by covering pregnant women up to 198 percent of the FPL because some women may not otherwise receive adequate prenatal care. This coverage helps prevent adverse and costly pregnancy outcomes.

In addition, some of the optional services covered by Texas Medicaid were originally paid with 100 percent state or local funds. By adding coverage for those services through Medicaid, part of the cost is now covered with federal matching dollars. For example, services for persons with intellectual or developmental disabilities provided in state supported living centers and community-based residential settings now receive federal Medicaid matching dollars in addition to state funds.

Rate Setting

Managed Care Organization Rates

Since most Medicaid clients are enrolled in managed care, MCO capitation rates are the primary way the state pays for services. These rates act as the state’s capitation payments to MCOs for contractually required services. MCOs pay providers to administer services to their members and negotiate rates for those services.

Through actuarially sound methodologies, Texas develops a per member per month (PMPM) rate, or capitation rate, for each risk group within each of the state’s service delivery areas. These capitation rates differ across risk groups and service delivery areas, but are the same for each MCO within a service delivery area.
Chapter 4 — What are the financial features of Medicaid/CHIP?

For example, STAR MCO capitation rates are derived primarily from MCO historical claims experience for a particular base period of time, also called encounter data. Encounter data includes records of the healthcare services for which MCOs pay and the amounts MCOs pay to providers of those services. Rates are established each year based on actual MCO expenditures on medical services. Reductions in spending on medical services will have the effect of reducing future capitation rates.

From this, the base cost data is totaled, and trends are calculated for the time period during which the rates will apply. The cost data is also adjusted for MCO expenses, such as reinsurance, capitated contract payments, changes in plan benefits, administrative expenses, and other miscellaneous costs. In case of possible fluctuations in claims cost, a risk margin is also added.

For STAR MCOs, newborn delivery expenses are removed from the total cost rate, resulting in an ‘adjusted capitation rate’ for each service area. A separate lump sum payment, called the ‘delivery supplemental payment,’ is computed for each service area for expenses related to each newborn delivery.

A final adjustment is made to reflect the health status, or acuity, of the population enrolled in each MCO. The purpose of the acuity risk adjustment is to recognize the anticipated cost differential among multiple MCOs in a service area due to the variable health status of their respective memberships. The final capitated premiums paid to the MCOs are based on this risk-adjusted premium for each combination of service area and risk group.

Pharmacy rates are similarly calculated. A small number of high-cost drugs are paid for outside of the capitation rate.

Rates for the other Medicaid managed care programs—STAR+PLUS, STAR Kids, and STAR Health—are also determined using the same methods, with certain exceptions:

- STAR+PLUS, STAR Kids, and STAR Health MCOs do not receive a delivery supplemental payment for newborn deliveries.
- Due to low caseload among risk groups for STAR Kids clients less than age 1 and receiving services through the Youth Empowerment Services (YES) waiver, capitation rates for these risk groups are calculated on a statewide basis.
- There is only one STAR Health MCO. This MCO is reimbursed using a single capitation rate that does not vary by age, gender, or area.
- For the STAR Health MCO, there is a special allowance for the additional administrative services in the program, including the Health Passport.
Children’s Medicaid Dental Services

Children’s Medicaid Dental Services rates are based on claims experience for the covered population in the base period. The base cost is totaled, and trends to the time period for which the rates apply are calculated. A reasonable provision for administrative expenses, taxes, and risk margin is added to the claims component in order to project the total cost for the rating period. These projected total costs are then converted to a set of statewide rates that vary by age group.

CHIP Rates

The rate-setting process for CHIP is similar to the process used for the STAR managed care program. CHIP MCO rates, including pharmacy costs, are derived primarily from MCO historical claims experience for a particular base period of time, also called encounter data.

From this, the base cost data is totaled, and trends are calculated for the time period during which the rates will apply. The cost data is also adjusted for MCO expenses, such as reinsurance, capitated contract payments, changes in plan benefits, administrative expenses, and other miscellaneous costs. In case of possible fluctuations in claims cost, a risk margin is also added.

The removal of newborn delivery expenses from the total cost rate results in an adjusted capitation rate for each service area. A separate lump-sum payment, called the delivery supplemental payment, is computed for expenses related to each newborn delivery. While the delivery supplemental payment can vary by service area for the STAR MCOs, all CHIP MCOs receive the same lump-sum payment of $3,100 for each birth.

The resulting underlying base rates vary by service area and age group. A final adjustment is made to reflect the health status, or acuity, of the population enrolled in each MCO. The purpose of the acuity risk adjustment is to recognize the anticipated cost differential among multiple MCOs in a service area due to the variable health status of their respective memberships. The final capitated premium paid to the MCOs is based on this acuity risk-adjusted premium and covers all non-maternity medical services.

CHIP dental benefits are reimbursed through a separate set of capitation rates. The rate-setting process for these services is also derived from encounter data. This base cost data is totaled, trends are calculated forward as with other programs, and following the final calculation, a risk margin is added. However, trend rates and cost adjustments for programmatic changes, administrative expenses, and other miscellaneous costs are considered specifically for the CHIP dental benefits.
CHIP Perinatal Rates

Capitation rates for the CHIP Perinatal program are derived using a methodology similar to that described for CHIP. CHIP Perinatal covers the unborn children of pregnant women who are uninsured and do not qualify for Medicaid. The more focused scope of benefits and eligibility for CHIP Perinatal clients and the absence of an acuity adjustment do produce some differences in the methodology.

MCO historical claims are totaled, and trends are calculated forward to the time period for which rates are to apply. The cost data is adjusted for MCO expenses, changes in plan benefits, and other miscellaneous costs. Final rates vary by risk group and service area. However, due to low caseload among risk groups with income over 198 percent up to and including 202 percent of the FPL, capitation rates for these risk groups are calculated on a statewide basis.

Pay-for-Quality and Managed Care Payment Reform

In order to reward the use of evidence-based practices and promote healthcare coordination and efficacy among MCOs, HHSC implements medical P4Q programs for STAR, STAR+PLUS, and CHIP, and a dental P4Q program.

The medical P4Q program evaluates MCOs on a set of quality measures with a focus on prevention and chronic disease management, including behavioral health, and maternal and infant health. Plans can earn or lose money based on their level of improvement or decline from the prior year and their performance relative to set benchmarks. For the medical P4Q program, three percent of MCOs’ capitation is at-risk. In the dental P4Q program, one and a half percent of DMOs’ capitation is at-risk.

A strong medical P4Q program incentivizes MCOs to pursue quality-based alternative payment models (APMs) with providers to help them achieve higher performance on P4Q measures.

CHIP Cost-Sharing

Most families in CHIP pay an annual enrollment fee to cover all children in the family. All CHIP families pay co-payments for doctor visits, prescription drugs, inpatient hospital care, and non-emergent care provided in an emergency room setting. CHIP annual enrollment fees and co-payments vary based on family income. The total amount a family can be required to contribute out-of-pocket toward the cost of healthcare services will not exceed five percent of family income.

The rates for cost sharing are published online annually (yourtexasbenefits.hhsc.texas.gov/programs/health/child/childrens-medicaid).
To further accelerate this effort, HHSC also developed contractual requirements for MCOs to have minimum thresholds of their overall payments to healthcare providers be in the form of an APM methodology.

APMs are health care payment models that link a percentage of the provider’s overall payment to a measure of quality or quality and cost. MCOs and DMOs must have a certain percentage of their overall provider payments associated with an APM. For a certain percentage of these payments, the provider must have some degree of risk. MCOs and DMOs are subject to contract remedies, potentially including liquidated damages, if these thresholds are not achieved.

### MCO and DMO APM Payment and Risk Thresholds for Calendar Years 2018 and 2021

<table>
<thead>
<tr>
<th></th>
<th>2018 Payment Threshold</th>
<th>2018 Risk Threshold</th>
<th>2021 Payment Threshold</th>
<th>2021 Risk Threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCOs</td>
<td>25%</td>
<td>10%</td>
<td>50%</td>
<td>25%</td>
</tr>
<tr>
<td>DMOs</td>
<td>25%</td>
<td>2%</td>
<td>50%</td>
<td>10%</td>
</tr>
</tbody>
</table>

If an MCO does not achieve the target APM percentages, but performs better than the state average on potentially preventable emergency department visits (PPVs) and potentially preventable hospital admissions (PPAs) by 10 percent, penalties are waived.

Additionally, MCOs have requirements to:
- Continue reporting to HHSC on APM models that are being deployed or in the planning stage
- Dedicate sufficient resources for provider outreach and negotiation, assistance with data and report interpretation, and other collaborative activities to support APM and provider improvement
- Establish and maintain data sharing processes with providers, require data and report sharing between MCOs and providers, and collaborate on common formats
- Dedicate resources to evaluate the impact of APMs on utilization, quality and cost, as well as return on investment
Health Insurance Premium Payment Program

The Health Insurance Premium Payment (HIPP) program reimburses eligible individuals for their share of an employer-sponsored health insurance premium payment when it is determined that the cost of the premium is less than the cost of projected Medicaid expenditures. In SFY 2018, an average of 9,500 Medicaid clients were enrolled in HIPP.

HIPP enrollees, who are eligible for Medicaid, do not have to pay out-of-pocket deductibles, co-payments, or co-insurance for healthcare services that Medicaid covers when seeing a provider that accepts Medicaid. Instead, Medicaid reimburses providers for these expenses.

HIPP enrollees who are not eligible for Medicaid must pay deductibles, co-payments, and co-insurance required under the employer’s group health insurance policy.

Additionally, if a HIPP enrollee needs a Medicaid-covered service not covered by the individual’s employer-sponsored health insurance plan, Medicaid will provide this wrap-around service at no cost to the enrollee, as long as an enrolled Medicaid provider administers the services.

Fee-for-Service Rates

Even though most Medicaid clients are under managed care, eight percent of clients continue to get services paid through FFS. HHSC is responsible for establishing reimbursement methodologies for FFS. Changes may be authorized by rule or approval from CMS. FFS rates are paid directly to providers—physicians, other medical practitioners, pharmacists, and hospitals.

HHSC consults with stakeholders and advisory committees when considering changes to FFS reimbursement rates. All proposed rates are subject to a public hearing, and all proposed reimbursement methodology rule changes are subject to a 30-day public comment period as part of the approval process. Changes in FFS reimbursement rates will often impact MCO rates. Many contracts between MCOs and providers incorporate payment rates based on a percentage of the FFS rate for the same service. HHSC does not require MCOs to use the FFS rates, and some MCOs use alternate reimbursement models.

Rates for services delivered by physicians and other practitioners are uniform statewide and are either resource-based fees (RBFs) or access-based fees (ABFs) (see Glossary).
These rates encompass payments for services such as laboratory services, x-ray services, radiation therapy services, physical and occupational therapists’ services, dentists’ services, and maternity clinics’ services. Reimbursement rates for most services are evaluated biennially.

For physician-administered drugs and biologicals, physicians are reimbursed at the lesser of their billed charges and the reimbursement rate—an estimate of the provider’s acquisition cost for the specific drug or biological. Rates for physician-administered drugs and biologicals are reviewed semi-annually.

Reimbursements for Hospitals and Other Care Centers

Inpatient and Outpatient Care

General acute care hospital reimbursement rates for FFS clients are set using a prospective payment system (PPS) based on the All Patient Refined Diagnosis Related Groups (APR-DRG) patient classification system. Under this system, each patient is classified into a diagnosis related group (DRG) on the basis of clinical information.

Hospitals are paid a pre-determined rate for each DRG admission. The rate is calculated using a standardized average cost of treating a Medicaid inpatient admission and a relative weight for each DRG. ‘Outlier’ payments are made in addition to the base DRG payment for clients, age 20 and younger, whose treatments are exceptionally costly or who have long lengths of stay.

Outpatient hospital services provided to FFS clients are reimbursed at a portion of the hospital’s reasonable cost, and reimbursements are dependent on the type of hospital and the patient volume.

HHSC has developed several supplemental payment programs to address the difference between rate and facility costs (see pages 101-104).
Rates will Differ Depending on the Type of Hospital:

<table>
<thead>
<tr>
<th>Hospital Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural Hospital</td>
<td>Rates are based on the standard dollar amount to treat a Medicaid inpatient admission and derived from base year costs.</td>
</tr>
<tr>
<td>Children’s Hospital</td>
<td>Rates are established using a statewide standard dollar amount derived from base year costs. Add-ons are used with this base standard dollar amount to make payments for additional services like medical education, geographic location, and safety-net designation.</td>
</tr>
<tr>
<td>Psychiatric Hospital</td>
<td>Reimbursed on a PPS per diem based on the federal base per diem with facility specific adjustments for wages, rural location, and length of stay.</td>
</tr>
<tr>
<td>State-Owned Teaching Hospital</td>
<td>Rates paid are for the reasonable cost of providing care to Medicaid clients using the Tax Equity and Fiscal Responsibility Act of 1982 cost principles.</td>
</tr>
<tr>
<td>Urban Hospital</td>
<td>Rates are established using a statewide standard dollar amount derived from base year costs. Add-ons are used with this base standard dollar amount to make payments for additional services like medical education, geographic location, and safety-net designation.</td>
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Hospital Quality-Based Payment Program

HHSC has initiated an incentive/disincentive program that pays or recoups funds from hospitals according to their performance with FFS and managed care patients, with the goal of improving quality and lowering costs.

Hospitals and MCOs are financially accountable for certain potentially preventable events (PPEs): potentially preventable complications (PPCs) and potentially preventable readmissions (PPRs).

- A PPC is a harmful event or negative outcome, such as an infection or surgical complication, which occurs after the person’s admission and may have resulted from treatment, or lack of treatment, provided rather than from a natural progression of their condition.
- A PPR is a return hospitalization that may have resulted from deficiencies in care or treatment provided during a previous hospital stay or from inadequate post-hospital discharge follow-up.

Uniform Hospital Rate Increase Program

The Uniform Hospital Rate Increase Program (UHRIP) is designed to reduce hospitals’ uncompensated care costs through enhanced payments to hospitals for medically necessary, covered services provided to Medicaid managed care members. UHRIP is voluntary and cannot be implemented in a service delivery area (SDA) unless all MCOs within that SDA, and the hospitals they contract with, commit to participate. Hospital rate increases vary by hospital class, and, in general, both inpatient and outpatient services are included for all hospitals to calculate enhanced rates.
If hospitals fail to meet certain PPC or PPR thresholds, adjustments (reductions) are made to FFS hospital inpatient claims, and similar adjustments are made in each MCO’s encounter data, which affects capitation rates.

However, HHSC also uses these measures to provide safety-net hospitals bonus payments above their base payments for achieving low rates of PPRs and PPCs. To be eligible to receive payments through this program, a safety-net hospital must be a non-rural and non-state owned facility with DSH eligibility. The hospital must also perform at least 10 percent better than the state average and not have any PPR or PPC penalties.

**Nursing Facilities**

Nursing facilities are reimbursed for services provided to Medicaid residents through daily payment rates that are uniform statewide by level of service. Enhanced rates are available for enhanced direct care compensation and staffing. The total daily payment rate for each level of service may be retroactively adjusted based upon failure to meet specific staffing or spending requirements.

Rates would be based on appropriation levels, which historically are below facility average costs. If fully funded, the rates would be based on costs submitted by providers on facility cost reports. Costs are categorized into five rate components:

1. Direct care staff
2. Other resident care
3. Dietary and nutritional services
4. General and administrative
5. A fixed capital asset use fee

Each rate component is calculated separately based on HHSC formulas and may vary according to the characteristics of residents. The total rate for each level of service is calculated by adding together the appropriate rate components.

Nursing facility cost reports are subjected to either a desk review or on-site audit to determine whether reported costs are allowable. MCOs are currently required to reimburse nursing facilities providing services to their members at least the same daily payment rate, including any enhancements, as would have been paid under FFS.
Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Condition

Intermediate care facilities for individuals with an intellectual disability or related condition (ICFs/IID) are reimbursed for services delivered to Medicaid residents through daily payment rates that are prospective and uniform statewide by facility size and level of need. The total daily payment rate may be retroactively adjusted if a provider fails to meet specific direct care spending requirements.

The modeled rates are updated, when funds are available, using the service providers’ most recent audited cost reports. Enhanced rates are available for enhanced attendant compensation.

ICF/IID cost reports are subjected to a desk review or on-site audit to determine whether reported costs are allowable. ICF/IID rates are recalculated biennially.

Federally Qualified Health Centers and Rural Health Clinics

Federally qualified health centers (FQHCs) include all organizations receiving grants under Section 330 of the Public Health Service Act. FQHCs qualify for enhanced reimbursement from Medicare and Medicaid, as well as other benefits. FQHCs serve underserved areas or populations, offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program, and have a governing board of directors.

A rural health clinic (RHC) is a clinic located in a rural area designated by the U.S. Health Resources and Services Administration as a shortage area. Medicare has a number of requirements in order for a clinic to qualify as an RHC, including that it must be located in a non-urbanized area that is medically underserved, as defined by the U.S. Census Bureau (see Glossary).
To participate in the Texas Medicaid program, FQHCs and RHCs must:
- Comply with all federal, state, and local laws and regulations applicable to the services provided
- Sign a written provider agreement with HHSC and comply with the terms of the agreement and all requirements of the Texas Medicaid program
- Bill for covered services in the manner and format prescribed by HHSC

Covered services are limited to services as described in the Social Security Act and other ambulatory services covered by the Texas Medicaid program when provided by other enrolled providers.

FQHCs and RHCs are reimbursed 100 percent of the average reasonable and allowable costs for the clinic in the base year of 2000.

Texas Medicaid reimburses FQHCs through a PPS or an alternative prospective payment system (APPS). PPS rates are inflated annually using the Medicare Economic Index (MEI) for primary care, while APPS rates are inflated annually using 100.5 percent of the MEI. However, if increases in an FQHC’s costs are greater than the inflation amount under PPS and APPS, the provider can request an adjustment to their rate. If an FQHC chooses the APPS method, rates may be prospectively reduced to better reflect the reasonable costs or the PPS rates.

RHCs are reimbursed through a PPS methodology. The intent of the state is to ensure that each RHC is reimbursed at 100 percent of its reasonable costs or the Medicare maximum payment per visit (federal ceiling) as applicable. PPS rates are inflated annually using the MEI for primary care. If the increases in an RHC’s costs are greater than the inflation amount in either system, the provider can request an adjustment to their rate.

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**Hospital Funding**

**Supplemental Hospital Funding**

Historically, rates paid to hospitals are below the average costs facilities incur to provide Medicaid covered services. HHSC administers supplemental hospital payment programs that help cover the cost of uncompensated care, incentivize improvements to care quality, and fund graduate medical education. These programs are designed to help reduce the gap between reimbursements made to hospitals and their actual Medicaid costs.
1115 Transformation Waiver

Historically, Texas hospital funding included Upper Payment Limit (UPL) funding for hospitals to help pay for uncompensated care costs. However, the expansion of managed care has resulted in the end of this program as federal regulations prohibit supplemental payments to providers in a managed care context. In order to preserve federal hospital funding, HHSC submitted and CMS approved a proposal for a five-year Section 1115 demonstration waiver.

The 1115 Transformation Waiver contains several funding pools: the Uncompensated Care (UC) and the Delivery System Reform Incentive Payment (DSRIP) pools, described below, UHRIP (see page 98), and QIPP (see page 100). The Network Access Improvement Program (NAIP), an incentive program linking MCOs and hospitals, was also included. However, CMS determined NAIP payments should ultimately be phased out.

For UC and DSRIP, funding is distributed through these statewide pools worth $29 billion (all funds) over the first five years of the waiver, with $17.6 billion allocated for UC and $11.4 billion allocated for DSRIP. For each program, the non-federal share is provided by local governmental entities. In order to receive UC or DSRIP payments, providers must participate in one of the twenty Regional Health Partnerships (RHPs). A map of the RHP regions can be found in Appendix D.

CMS has approved extensions of the waiver through September 2022.

Uncompensated Care

UC payments are cost-based and help offset the costs of uncompensated care provided by hospitals and other providers. Though previously defined as unreimbursed costs for Medicaid and uninsured patients incurred by hospitals, uncompensated care costs are currently defined as unreimbursed charity care costs. UC payments will be based on each provider’s uncompensated care costs as reported on a UC application.

Delivery System Reform Incentive Payment

DSRIP funding provides financial incentives that encourage hospitals and other providers to focus on achieving quality health outcomes. Participating providers develop and implement programs, strategies, and investments to enhance:

- Access to healthcare services
- Quality of health care and health systems
- Cost-effectiveness of services and health systems
- Health of the patients and families served

The waiver’s special terms and conditions require HHSC to develop a DSRIP transition plan to describe how the state will further develop its delivery system reform efforts when DSRIP funding is no longer available. A draft transition plan is due to CMS by October 1, 2019, and will be finalized by the end of March 2020. HHSC will work with CMS and stakeholders to develop this plan.
Graduate Medical Education

Hospitals that operate medical residency training programs incur higher expenses than hospitals without training programs. Historically, the Medicaid share of these additional costs have been covered by Graduate Medical Education (GME) payments to state-owned teaching hospitals. GME payments cover the costs of residents’ and teaching physicians’ salaries and fringe benefits, program administrative staff, and allocated facility overhead costs. An expansion of this program to non-state-owned teaching hospitals has been proposed for state fiscal year 2019.

HHSC is also authorized to spend Appropriated Receipts–Match for Medicaid for GME payments to state-owned teaching hospitals. The payments are contingent upon receipt of intergovernmental transfers of funds from state-owned teaching hospitals for the non-federal share of Medicaid GME payments.

Disproportionate Share Hospital Funding

Disproportionate Share Hospital (DSH) funding is special funding for hospitals that serve a disproportionately large number of Medicaid and low-income patients. DSH funds are not tied to specific services for Medicaid-eligible patients.

Disproportionate Share Hospital Funds as a Percentage of the Total Medicaid Budget, FFYs 1999-2018

*2009 includes $23.5 million in ARRA federal stimulus funds.
**2010 includes $47.6 million in ARRA federal stimulus funds.
Chapter 4 — What are the financial features of Medicaid/CHIP?

There are no federal or state restrictions on how disproportionate share hospitals can use their funds. Hospitals may use DSH payments to cover the uncompensated costs of care for indigent or low-income patients, including Medicaid patients. DSH payments have been an important source of revenue by helping hospitals expand healthcare services to the uninsured, defray the cost of treating indigent patients, and recruit physicians and other healthcare professionals to treat patients.

As in other matching Medicaid programs, the federal government and non-federal sources each pay a share of total DSH program costs. Payments are funded using the same matching rate as medical services. In FFY 2018, federal dollars accounted for 56.88 percent of the DSH allocation for Texas, which totaled $1.89 billion in funding.

In order to qualify for DSH funds, hospitals must meet one of the following criteria:
  • A disproportionate total number of inpatient days are attributed to Medicaid patients
  • A disproportionate percentage of all inpatient days are attributed to Medicaid patients
  • A disproportionate percentage of all inpatient days are attributed to low-income patients

All children’s hospitals in Texas are deemed disproportionate share hospitals provided they meet federal and state qualification criteria.
Effects of the ACA on Disproportionate Share Hospitals

Under ACA, federal DSH allocations are set to decrease in size in anticipation of the reduction of the uninsured population. The ACA requires annual aggregate reductions in federal DSH funding from FFYs 2014-2020. However, through several pieces of legislation, the effective date of these reductions has been delayed.

The most recent legislation, the Bipartisan Budget Act of 2018, delays the implementation of the cuts to FFY 2020 and extends them to FFY 2025. The statutory reductions in the federal share of DSH payments for all states under current law are:

<table>
<thead>
<tr>
<th>FFY</th>
<th>2020</th>
<th>2021</th>
<th>2022</th>
<th>2023</th>
<th>2024</th>
<th>2025</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduction for all states</td>
<td>$4.0 billion</td>
<td>$8.0 billion</td>
<td>$8.0 billion</td>
<td>$8.0 billion</td>
<td>$8.0 billion</td>
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</table>

CMS issued regulations in 2013 addressing the allocation of the cuts by state and developed a methodology to be used for the first two years. The ACA set forth several criteria that must be used in the allocation of the cuts by state, including:

- States with low DSH allotments would receive a smaller proportion of the reduction
- States that have lower uninsured rates relative to other states would receive a larger reduction
- The reductions would be smaller for states that target DSH payments to hospitals with high Medicaid volume, and states that target DSH payments to hospitals with high levels of uncompensated care

Predicting Texas’ share of the DSH reductions is difficult because CMS has yet to update the methodology for FFY 2020 and beyond, and the data inputs used are subject to change. The current state-by-state uninsured rates differ from what they were in 2013. Texas does target DSH payments to hospitals with high Medicaid volumes and those with high levels of uncompensated care.

However, Texas will be judged in relation to all other states, some of which may have more aggressive policies in place or have modified their DSH policies to better target hospitals with high Medicaid volume and uncompensated care to enhance their share of future DSH allotments.
Fund Recovery

The Office of Inspector General (OIG) performs the functions below. To read more about the OIG, see pages 82-83.

Third Party Liability

Under federal law, Medicaid is considered the payer of last resort. This means other sources of coverage a client may have, such as private health insurance, may be required to pay claims before Medicaid will pay for care. This requirement, called third party liability (TPL), makes payment the responsibility of persons, entities, or programs other than the Medicaid client or Medicaid.

To implement the Medicaid TPL requirements, federal and state rules require states to take reasonable measures to identify potentially liable third parties and process claims accordingly. As a condition of eligibility, Medicaid clients also must cooperate with state efforts to pursue other sources of coverage.

States rely on two main sources of information to determine whether a liable third party exists for a particular claim: Medicaid clients and data matches with other insurers or data clearinghouses. HHSC works to reduce Medicaid expenditures by shifting claims expense to third party payers utilizing either cost avoidance or cost recovery:

- Cost avoidance occurs when the state is aware that a Medicaid client has potential third-party coverage when a claim is filed. The state rejects the claim and instructs the provider to submit it to the potential primary payer. After the potential primary payer has processed the claim, the provider may resubmit a claim to Medicaid.
- Cost recovery, also known as ‘pay and chase,’ occurs when Medicaid seeks reimbursement from third parties whenever Medicaid has paid claims for which there are third parties that are liable for payment of the claims.

Texas Medicaid MCOs and DMOs are subject to the state and federal requirements related to cost avoidance and cost recovery. Each MCO and DMO has the obligation to cost avoid claims and cost recover for Texas Medicaid-eligible clients when there is a liable third party.
Medicaid Estate Recovery Program

Texas implements the Medicaid Estate Recovery Program (MERP) in compliance with federal Medicaid laws. Under MERP, the state may recover the cost of Medicaid services provided by filing claims against the estate of certain, deceased Medicaid recipients, who were age 55 and older and had received LTSS benefits on or after March 1, 2005.

Claims include the cost of services, hospital care, and prescription drugs for clients receiving services from nursing facilities, ICFs/IID, Community Attendant Services, or waiver programs.

There are certain exemptions from recovery as required by federal and state law. When no exemptions apply, the heirs may request a hardship waiver if certain conditions are met. A hardship waiver specific to the homestead may be filed when one or more heirs have gross family income below 300 percent of the FPL. When no exemptions or hardship conditions exist, the state files a claim against the descendant’s assets that are subject to probate. The estate representative is responsible for paying the lesser of the MERP claim amount or the estate value after all higher priority estate debts have been paid. This is paid through the estate, not the resources of any heirs or family members.

The claims filing component of the program has been contracted to a private company through a competitive procurement process.
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As part of your membership, you're entitled to download and use our InDesign Template of the Month.

This month's template is for a tech manual.

Inside the download folder you should find:

* This ReadMe.txt file
* One template file in INDD and IDML formats

If you have InDesign CC 2018 or later, you can open the INDD version of the file. If you have an earlier version of InDesign, please open the IDML version of the file.
Chapter 5

What is Medicaid/CHIP's governing framework?
At-a-Glance

Title XIX of the Social Security Act created Medicaid as a program administered by the states in partnership with the federal government. Medicaid, CHIP, and other HHSC programs change in response to federal and state requirements.

Key Federal Concepts

Fundamental Requirements:
Basic principles for Medicaid programs established by the Social Security Act

Centers for Medicare & Medicaid Services (CMS):
Agency within the U.S. Department of Health and Human Services that oversees the Medicaid Program

Single State Agency:
Federal regulations require each state designate a single state agency responsible for the state’s Medicaid Program

Medicaid State Plan:
Submitted by states, a dynamic document that serves as the contract between states and CMS

Waivers:
How states apply to CMS to test new ways to deliver and pay for services

Requirements directed by the Texas Legislature

Medicaid operates according to the following fundamental requirements:

1. Statewide Availability
   All Medicaid services must be available statewide and may not be restricted to residents of particular localities.

2. Sufficient Coverage
   States must cover each service in an amount, duration, and scope that is ‘reasonably sufficient.’

3. Service Comparability
   The same level of services (amount, duration, and scope) must be available to all clients, except where federal law specifically requires a broader range of services or allows a reduced package of services.

4. Freedom of Choice
   Clients must be allowed to go to any Medicaid healthcare provider who meets program standards.

Key Federal Mandate Categories

Services
States must provide mandated services and may provide certain optional services (see Appendix B).

Populations
States must cover certain groups at set percentages of the FPL, and may expand coverage to optional groups (see Chapter 1, page 12).

Limits
States may not impose limits on services for Medicaid clients age 20 and younger, nor may a state arbitrarily limit services for any specific illness or condition.

States may limit utilization of some services, such as placing a limit on the number of prescriptions per month for outpatient drugs.

To see a list of highlights from the Texas Legislature and relevant federal changes to these programs, see Appendix A.
Texas submits a Medicaid state plan that serves as the contract between the state and CMS. The state plan describes the nature and scope of the state’s Medicaid program, including Medicaid administration, client eligibility, benefits, and provider reimbursement. CMS must approve the plan and any amendments to the plan. CMS also approves any waivers for which states can apply. It also gives HHSC, as the single state agency, the authority to administer the Medicaid program in Texas. HHSC’s responsibilities include:

- Serving as the primary point of contact with the federal government, coordinating initiative to maximize federal funding, and administering the Medical Care Advisory Committee, a committee mandated by federal Medicaid law that reviews and makes recommendations on proposed Medicaid rules
- Establishing policy direction for the Medicaid program, administering the Medicaid state plan and waivers, and coordinating with other HHSC departments and state agencies to carry out Medicaid operations
- Determining program eligibility for Medicaid and CHIP
- Establishing Medicaid policies, rules, reimbursement rates, and oversight of Medicaid program operations, including MCO contract compliance

Title XXI of the Social Security Act established CHIP, which like Medicaid, is administered by the states in partnership with the federal government. Texas also submits a CHIP state plan to CMS for approval.

Federal law allows states to apply to CMS for permission to depart from certain Medicaid requirements. Federal law allows three main types of waivers: Research and Demonstration 1115 waivers, Freedom of Choice 1915(b) waivers, and Home and Community-Based Services (HCBS) 1915(c) waivers. These waivers allow states to develop creative alternatives to the traditional Medicaid program. States seek waivers to:

- Provide services above and beyond state plan services to selected populations
- Expand services in certain geographical areas
- Limit free choice of providers
- Implement innovative new service delivery and management models

States must provide regular reports and evaluations showing cost effectiveness and that requirements for the waiver are being met.
Chapter 5 — What is Medicaid/CHIP’s governing framework?

**Research and Demonstration 1115 Waivers**

Section 1115 waivers allow flexibility for states to test new ideas for operating their Medicaid programs, including implementing statewide health system reforms, providing services not typically covered by Medicaid, or allowing innovative service delivery systems to improve care, increase efficiencies, and reduce costs.

The Texas Healthcare Transformation and Quality Improvement Program, known as the 1115 Transformation Waiver, is a five-year waiver allowing the state to expand managed care, including pharmacy and dental services, while preserving federal hospital funding. STAR, STAR+PLUS, STAR Kids, and dental managed care services are covered under this waiver. Participating providers are developing and implementing programs, strategies, and investments to enhance access, quality, and cost-effectiveness of healthcare services and systems, and to improve patient health.

The Healthy Texas Women program is currently seeking a 1115 waiver to receive federal match to cover its services.

**Freedom of Choice 1915(b) Waivers**

Section 1915(b) waivers provide states the flexibility to modify their service delivery systems, and are the authority under which Texas implements a managed care model. How states use 1915(b) authority depends on what the end goals are for the particular program.

For example, the selective contracting authority granted under 1915(b)(4) waivers is used for programs such as Community First Choice (CFC). This allows the state to limit the provider base for CFC clients to their waiver providers. However, since many waivers are still under a FFS delivery system, clients are not required to move into managed care to receive CFC. Texas also uses 1915(b)(1) and 1915(b)(4) authority for the non-emergency medical transportation program in order to implement a managed care model for this program.

**Home and Community-Based Services 1915(c) Waivers**

Section 1915(c) waivers allow states to provide community-based services as an alternative for people who meet eligibility criteria for care in an institution (nursing facility, intermediate care facility for individuals with an intellectual disability or related condition, or hospital).

States may use these waivers to serve people age 65 and older, those with physical disabilities, an intellectual or other developmental disability, mental illness, or more specialized populations, such as individuals with traumatic brain injuries or those with sensory impairment. Texas 1915(c) waivers include the Medically Dependent Children Program (MDCP), Home and Community-based Services (HCS), Texas Home Living (TxHmL), Community Living Assistance and Support Services (CLASS), Deaf Blind with Multiple Disabilities (DBMD), and Youth Empowerment Services (YES) (see Chapter 2, page 44).
Fundamental Requirements

Statewide Availability

Also referred to as ‘statewideness,’ this principle in federal law requires state Medicaid programs to offer the same benefits to everyone throughout the state. Exceptions to this requirement are possible through Medicaid waiver programs and special contracting options. Since the move toward managed care in Texas, statewide availability is primarily assured through federal and state regulations that establish minimum provider network standards and by state oversight of MCO compliance with these standards.

In Texas, recent state legislation has led to the development of new minimum distance, travel time, and appointment availability standards for member access to providers. Now, prior to serving Medicaid recipients, an MCO must demonstrate to HHSC that the MCO provider network offers sufficient access to certain types of care including, but not limited to primary care, preventive care, specialty care, LTSS, and therapy services. In addition, HHSC conducts a variety of oversight activities to ensure members across the state are receiving adequate access to care (see Chapter 3, page 62).

Sufficient Coverage

Federal law specifies a set of benefits state Medicaid programs must provide and a set of optional benefits states may choose to provide. Federal law allows states to determine what constitutes as reasonably sufficient coverage in terms of the amount, duration, and scope of services. Each state defines these parameters, thus state Medicaid plans vary in what they cover and how much they cover. Limits on Texas Medicaid services include:

- A 30-day annual limit on inpatient hospital stays per spell of illness for adults served in FFS and STAR+PLUS. More than one 30-day hospital visit can be paid for in a year if stays are separated by 60 or more consecutive days. The limit does not apply to clients receiving a pre-approved, medically necessary transplant. Clients receiving transplants are allowed an additional 30 days of inpatient care, beginning on the date of the transplant. The limit does not apply to STAR+PLUS members admitted to an inpatient hospital due to a primary diagnosis of a severe and persistent mental illness. This limit is not applicable to children age 20 and younger whenever there is a medical necessity for additional services.

- Three prescriptions per month for adults in FFS for outpatient drugs. Family planning drugs are exempt from the three-drug limit. There are no limits on drugs for children age 20 and younger, adults enrolled in managed care, or for clients in nursing facilities or enrolled in certain 1915(c) waiver programs.
Service Comparability

In general, service comparability requires the state to provide the same level of services to all clients, except where federal law specifically requires a broader range of services or allows a reduced package of services. There are certain demographic groups, such as children and youth, for whom additional steps have been taken to increase access to care.

Coverage for Children

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, known in Texas as Texas Health Steps (THSteps), provides preventive health and comprehensive care services for children and youth age 20 and younger who are enrolled in Medicaid (see A Closer Look, page 33). Federal changes have expanded the benefits of this program such that children and youth age 20 and younger are eligible for any medically necessary and appropriate healthcare service covered by Medicaid, regardless of the limitations of the state’s Medicaid program.

Children’s Health Care Case Law

Court cases have played a significant role in the delivery of children’s health care through the Medicaid program in Texas:

- **Alberto N. v. Smith**, a federal lawsuit settled in May of 2005, requires HHSC to comply with Title XIX of the Social Security Act (42 U.S.C. §1396 et seq.) by providing all medically necessary in-home Medicaid services to children age 20 and younger who are eligible for the EPSDT program.

- **Frew v. Smith**, a class action lawsuit filed against Texas in 1993, alleged that the state did not adequately provide EPSDT services. In 1995, the state negotiated a consent decree that imposed certain requirements on the state. In 2007, the state negotiated a set of corrective action orders with the plaintiffs to implement the consent decree and increase access to EPSDT services. Since 2007, HHSC and the DSHS have actively worked to meet the requirements of the corrective action orders. As a result, some portions of the consent decree and corrective action orders have since been dismissed.

Mental Health Parity

In the past, mental health coverage was treated differently from physical health coverage. However, federal law now prohibits differences in treatment limits, cost-sharing, and in- and out-of-network coverage between mental health and substance use disorder (SUD) benefits and medical and surgical benefits.
In 2016, CMS issued final rules to address the mental health parity requirements for MCOs, Medicaid alternative benefit plans, and CHIP. All states were required to be in compliance with these new regulations by October 2017, though Texas received an extension through December due to the negative impacts of Hurricane Harvey.

Texas evaluated MCO compliance with parity regulations in 2017 through a series of MCO deliverables. MCOs were required to demonstrate compliance with mental health parity standards for several types of treatment limitations. HHSC also evaluated quantitative treatment limitations in mental health and SUD benefits, and found two limitations within the state’s SUD benefit. The state is in the process of amending its SUD services policy to bring it into parity compliance.

House Bill 10, 85th Legislature, Regular Session, 2017, bolsters federal parity requirements in multiple insurance markets, including Medicaid and CHIP. H.B. 10 creates a behavioral health ombudsman in the HHSC Office of the Ombudsman, establishes a mental health condition and SUD parity work group, and requires HHSC and the Texas Department of Insurance to study and report on benefits for medical or surgical expenses and for mental health conditions and SUDs provided by health plans.

**Behavioral Health Integration**

State legislation has also directed HHSC to require Medicaid and CHIP MCOs to comply with several integration measures. Behavioral health requirements target:

- Effectively sharing information between care coordination and service authorization staff, including utilization management data
- Encouraging co-location of behavioral and physical health care coordination staff
- Requiring warm call transfers between physical and behavioral health care coordination staff
- Implementing effective means of clinical information sharing, such as clinical rounds that include both behavioral and physical health MCO staff
- Further linking behavioral health and physical health provider portals for those MCOs that operate separate portals

Effective September 1, 2018, HHSC requires MCOs to enter into value based payment agreements with Certified Community Behavioral Health Clinics (CCBHCs). CCBHCs are a state-run project designed to shift the system towards an efficient and integrated care delivery system. There are currently eight CCBHC pilot sites in the state, with four more under development. Current agreements under development include MCO payments for the delivery of certain services, to payment for practices that reduce emergency room visits and inpatient hospitalizations.

To read more about mental health parity and behavioral health integration, see Appendix A, page 131.
Freedom of Choice

In general, a state must ensure that Medicaid clients are free to obtain services from any qualified provider. Exceptions are possible through Medicaid waivers and special contract options. THSteps clients have freedom of choice with regard to a medical checkup provider, even if that provider is not the child’s primary care provider (PCP).

To maintain freedom of choice under managed care, each service delivery area in the state has at least two health plans or MCOs that clients can choose from once they are found eligible. The exception for this is STAR Health which is administered statewide by a single MCO. Once clients select their health plan, they also choose a PCP from the MCO's provider network.
The Affordable Care Act (ACA) makes broad changes to the U.S. health care system, including new requirements applicable to Medicaid and CHIP.

**Eligibility Changes and Maintenance of Effort**
Under the ACA, each state must have a health insurance marketplace that assists individuals and small businesses with purchasing health care. Texas currently has a federally-facilitated marketplace. Marketplace eligibility determinations must be streamlined and coordinated with eligibility determinations for Medicaid/CHIP programs. States had the option to expand Medicaid eligibility to 133 percent of the FPL for uninsured individuals up to age 65. Texas has not expanded Medicaid eligibility to adults.

The ACA directs states to adopt new financial eligibility requirements, including using the Modified Adjusted Gross Income (MAGI) methodology in eligibility determinations for most Medicaid programs and CHIP (see A Closer Look, page 13). States must have certain eligibility procedures, including a single, streamlined application form for Medicaid, CHIP, and the health insurance marketplace, a passive eligibility renewal process for Medicaid and CHIP, and eligibility redeterminations every 12 months.

In addition, the ACA restricts states’ ability to make changes to existing Medicaid and CHIP programs by extending maintenance of effort (MOE) requirements, which prohibit states from implementing more restrictive eligibility standards, methodologies, or procedures in Medicaid than were in effect on July 1, 2008. Under the ACA, states must comply with Medicaid and CHIP MOE requirements to receive Medicaid funding. MOE requirements for adults on Medicaid ended in 2014. For children, including children in CHIP, MOE continues through September 30, 2019.

**Medicaid Benefit Changes**
The ACA required state Medicaid programs to provide concurrent hospice care and treatment services for children enrolled in Medicaid and CHIP, add birthing centers as a required Medicaid provider, provide Medicaid reimbursement to providers recognized by states as a licensed birth attendant, and implement comprehensive tobacco cessation services for pregnant women.

**Program Integrity**
The ACA established new provider screening and enrollment requirements for providers and suppliers enrolling in Medicare, Medicaid, and CHIP, including, but not limited to database checks, licensure verification, site visits, and criminal background checks.

**Financing**
The ACA made a number of revisions to Medicaid and CHIP financing in support of the ACA policy changes, such as providing federal payment for the first three calendar years for newly eligible adults, for states choosing to implement a Medicaid expansion. This decreases to a 90 percent federal share for 2020 and after. In addition, the ACA impacted hospital funding programs, including decreasing Disproportionate Share Hospital (DSH) allotments in anticipation that the uninsured population would decrease in states implementing Medicaid expansions (see A Closer Look, page 105).