

# Chapter 6: Medicaid Benefits

*Medicaid covers a diverse array of medical and long-term services and supports.*

## Medicaid Benefits

The Social Security Act specifies a set of benefits that state Medicaid programs must provide and a set of optional benefits that states may choose to provide. **Table 6.1** displays the current set of benefits covered by the Texas Medicaid program.

Federal law allows states to define what constitutes reasonable sufficient amount, duration, and scope of Medicaid benefits. This means that state Medicaid programs can, for example, limit the number of visits per year for a certain service or limit a service to outpatient settings. The following limits are not applicable to children under 21 whenever there is a medical necessity for additional services.

Limits on Texas Medicaid services include:

- A 30-day annual limit for adults on inpatient hospital stays per spell of illness. 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 annual limit does not apply to State of Texas Access Reform (STAR) enrollees or for a prior-approved transplant that is medically necessary because of an emergent, life-threatening condition. This exception allows an additional 30 days of inpatient care that begins with the date of the transplant.
- Three prescriptions per month for adults in fee-for-service (FFS). This applies to outpatient drugs. Family planning drugs are exempt from the three-drug limit. There are no limits on drugs for children under age 21, adults enrolled in managed care, clients in nursing facilities, or clients enrolled in certain 1915(c) waiver programs.

**Table 6.1: Mandatory and Optional Services Covered by Texas Medicaid**

The state may choose to provide some, all, or no optional services specified under federal law. Some optional services Texas chooses to provide are available only to clients under age 21, and one optional inpatient service is available for clients who are under 21 or are 65 or over in an institution for mental disease (IMD). *Note: If the client is under age 21, all federally allowable and medically necessary services must be provided as required by federal law.*

Mandatory and optional services provided in Texas include:

| <b>Mandatory Acute Care Services</b>  | <b>Optional* Acute Care Services</b>  |
|---|---|
| <ul style="list-style-type: none"> <li>• Inpatient hospital services</li> <li>• Outpatient hospital services</li> <li>• Laboratory and x-ray services</li> <li>• Physician services</li> <li>• Medical and surgical services provided by a dentist</li> <li>• Early and periodic screening, diagnostic, and treatment (EPSDT) services for individuals under 21</li> <li>• Family planning services and supplies</li> <li>• Federally Qualified Health Centers (FQHC)</li> <li>• Rural health clinic services</li> <li>• Nurse-midwife services</li> <li>• Certified pediatric and family nurse practitioner services</li> <li>• Home health care services</li> </ul> | <ul style="list-style-type: none"> <li>• Prescription drugs</li> <li>• Medical or remedial care furnished by other licensed practitioners:               <ul style="list-style-type: none"> <li>○ Physician extenders</li> <li>○ Nurse practitioners/certified nurse specialists</li> <li>○ Certified registered nurse anesthetists</li> <li>○ Physician assistants</li> <li>○ Mental health providers</li> <li>○ Psychologists</li> <li>○ Licensed professional counselors</li> <li>○ Licensed marriage and family therapists</li> <li>○ Licensed clinical social workers**</li> </ul> </li> <li>• Podiatry***</li> <li>• Limited chiropractic services</li> <li>• Optometry, including eyeglasses and contacts</li> <li>• Hearing instruments and related audiology</li> <li>• Renal dialysis</li> <li>• Rehabilitation and other therapies               <ul style="list-style-type: none"> <li>○ Mental health rehabilitation</li> <li>○ Rehabilitation facility services</li> <li>○ Substance use disorder treatment</li> <li>○ Physical, occupational, and speech therapy</li> </ul> </li> <li>• Clinic services               <ul style="list-style-type: none"> <li>○ Maternity service clinics</li> </ul> </li> <li>• Targeted case management for pregnant women</li> </ul> |

**Table 6.1: Mandatory and Optional Services Covered by Texas Medicaid (Continued)**

| <b><i>Mandatory Long-Term Services and Supports (LTSS)</i></b>  | <b><i>Optional* Long-Term Services and Supports (LTSS)</i></b>   |
|---|--|
| <ul style="list-style-type: none"> <li>• Nursing facility (NF) services for clients 21 or over</li> </ul> | <ul style="list-style-type: none"> <li>• Intermediate Care Facility services for an Individual with Intellectual Disability or Related Conditions (ICF/IID)</li> <li>• Inpatient services for clients under age 21 or 65 and over in an institution for mental diseases (IMD)</li> <li>• Services furnished under a Program of All-Inclusive Care for the Elderly (PACE)</li> <li>• Day Activity and Health Services</li> <li>• Home and community-based waiver services</li> <li>• Attendant services               <ul style="list-style-type: none"> <li>○ Primary Home Care</li> <li>○ Community Attendant Services</li> </ul> </li> <li>• Targeted case management for individuals with intellectual disabilities and mental health conditions</li> <li>• Hospice services</li> </ul> |

Notes: \*Includes optional Medicaid services provided in Texas. Does not include all optional services allowed under federal policy.

\*\*Except when delivered in an FQHC setting.

\*\*\*Except when delivered by a M.D. or D.O.

## Coverage for Children

Children with Medicaid coverage are eligible to receive a broader array of health care services than commercial health insurance policies or Medicaid services for adults. Medicaid for children provides certain health care services including long-term physical, occupational, and speech therapies, and comprehensive dental services. If a child is enrolled in Medicaid medical or dental managed care, they will receive these services through the managed care model.

## Texas Health Steps

EPSDT, known in Texas as Texas Health Steps (THSteps), provides medical and dental preventive services and treatment for children of low-income families from birth through age 20. THSteps' mission is to provide preventive medical and dental care to

Medicaid children to allow early treatment of any identified problems. THSteps offers comprehensive and periodic screening of children's, adolescents', and young adults' physical, developmental, mental health, and nutritional status, as well as vision, hearing, and dental screenings and care.

The foundation of THSteps is preventive health care checkups. The medical checkup is preferably conducted by a primary care provider, or "medical home," and the dental checkup is preferably conducted by a primary dental care provider or "dental home." Medical and dental home providers have accepted the responsibility for providing accessible, continuous, comprehensive, and coordinated care to the child, including referrals to other health care providers as necessary. Medicaid providers, such as physicians, dentists, advanced practice nurses, school clinics, migrant health clinics, and other community clinics such as FQHCs enroll specifically as THSteps providers of medical and dental checkups and treatment.

THSteps medical and dental checkups are provided periodically. The interval between scheduled medical checkups depends on the child's age. More medical checkups are scheduled for the birth through 2 years of age population, and annual checkups are indicated for children ages 3 through 20. A THSteps medical checkup includes these federally mandated components:

- Comprehensive Health and Developmental History;
- Comprehensive Unclothed Physical Examination;
- Immunizations;
- Laboratory Screening; and
- Health Education/Anticipatory Guidance.

In addition to a medical checkup, as a state requirement, children are referred to a dentist at six months of age and every six months thereafter until a dental home has been established.

Families receiving Temporary Assistance for Needy Families (TANF) benefits may lose cash assistance for failing to take their children to regularly scheduled THSteps medical checkups and/or failing to keep their children's immunizations current. This sanction applies until the family is in compliance with THSteps medical checkups and immunization requirements.

THSteps provides periodic dental checkups and preventive care for children 6 months through 20 years of age. The intervals between dental checkups depend on the child's age and risk for dental disease. THSteps supports the initiative to reach children with preventive oral health screening and care at the earliest appropriate age (six months) and to establish a dental home for them. The objective is to identify those at high risk of

developing dental disease, start preventive services, treat decay early, and educate families about the importance of good oral health habits. More frequent dental checkups are available for children 6 through 35 months of age with semi-annual checkups available for children, adolescents and young adults 3 through 20 years of age. Recipients or their caretakers may self-refer for dental care at any time and any age from birth through 20 years of age.

THSteps services include more than the provision of medical and dental checkups. THSteps outreach staff provide coordinated services to expand family awareness of health services, increase use of preventive services, and help families obtain comprehensive services available through a network of private and public providers.

**Table 6.2** highlights THSteps program services and outreach activities.

### **Table 6.2: THSteps Program Highlights and Outreach Activities**

*Services provided in 2013:*

- 1,869,728 THSteps eligible recipients<sup>1</sup> received at least one initial or periodic medical checkup.
- 65 percent<sup>2</sup> of the population eligible for services received services.
- At least one preventive dental service was provided to 1,641,234 children.
- Therapeutic dental services were provided to 949,577 recipients.

*Outreach and Education:*

THSteps operates an outreach program designed to contact the parents and caretakers of children receiving Medicaid to inform them of the benefits under the program, including:

- The value of using preventive health services and reinforcing the concept of the medical home and dental home.
- How to effectively access and use the medical, dental, and case management care systems.
- How to use the medical transportation system and other related services available to them (e.g., Women, Infants and Children (WIC), immunizations, and Children's Health Insurance Program).

**Table 6.2: THSteps Program Highlights and Outreach Activities  
(Continued)**

To promote the efficient and effective use of THSteps, THSteps program staff proactively liaison with related children’s health programs and agencies such as:

- Head Start;
- Independent school districts;
- Institutions of higher education;
- Other state programs such as Immunizations, Childhood Lead Poisoning Prevention Program (CLPPP), Children with Special Health Care Needs Services Program (CSHCN), WIC, Maternal and Child Health, and Early Childhood Intervention (ECI);
- Community-based organizations; and
- Medical, dental, and case management providers and their professional organizations

Source: Form CMS-416: Annual EPSDT Participation Report, Federal Fiscal Year 2013.

<sup>1</sup> THSteps population and service recipients refer to children who were enrolled in the THSteps Program for at least 90 continuous days during the reporting year. This change has been implemented for CMS-416 reporting since 2011.

<sup>2</sup> This statistic is not a simple percentage, but an index that takes account of the periodicity of medical checkups and the average enrollment length for the eligibles.

Federal changes made in the Omnibus Budget Reconciliation Act of 1989 (OBRA 89) expanded Medicaid services and EPSDT/THSteps services, in particular. Under OBRA 89, children and youth younger than 21 years of age are eligible for any medically necessary and appropriate health care service that is covered by Medicaid, regardless of the limitations of the state’s Medicaid program. The state is responsible for defining the phrase “medically necessary and appropriate.” In Texas, this expanded benefits portion of THSteps is known as the Comprehensive Care Program (CCP). THSteps-CCP services include benefits which were not available to children before OBRA 89, including, but not limited to:

- Treatment in freestanding psychiatric hospitals;
- Oral health care;
- Developmental speech therapy;
- Developmental occupational therapy; and
- Private duty nursing.

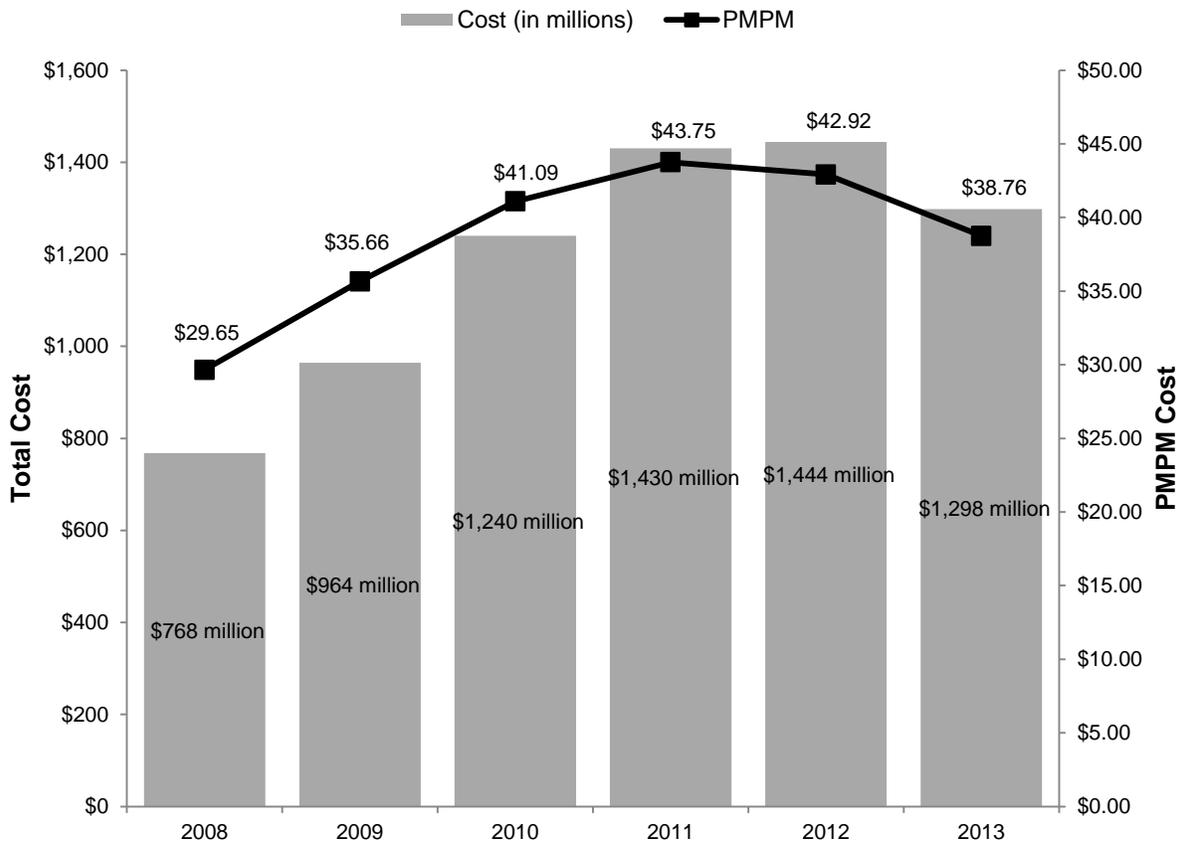
## Texas Health Steps Funding

THSteps medical and CCP service costs are included in capitated managed care organization (MCO) rates for children enrolled in managed care. Children not in

capitated managed care or children receiving retroactive coverage have their medical and CCP costs paid through Medicaid FFS. All THSteps dental costs for children were paid through FFS until the inclusion of dental services in managed care on March 1, 2012.

**Figure 6.1** shows the total dental (and orthodontic) THSteps costs and the cost per client from 2008–2013. From 2008 to 2009, there was a 20 percent increase in the “per member per month” (PMPM) cost. From 2009 to 2010, the PMPM increase was 15 percent, and a 6 percent increase in 2011. Costs peaked at \$44 PMPM in 2011. Overall, cost for dental services has declined to \$39 PMPM in 2013.

**Figure 6.1 THSteps Total Cost and Cost per Recipient Month, Medicaid Dental Services SFYs 2008-2013**



Source: HHSC, Financial Services, HHS System Forecasting.

# Frew, et al. v. Janek, et al.

Filed in 1993, *Frew, et al. v. Janek, et al.* (commonly referred to as *Frew*), was brought on behalf of children birth through age 20 enrolled in Medicaid and eligible for EPSDT benefits. The class action lawsuit<sup>i</sup> alleged that the Texas EPSDT program did not meet the requirements of the federal Medicaid Act.

The Texas EPSDT program, known as THSteps, provides comprehensive and preventive medical and dental services for children through age 20 enrolled in Medicaid.

The parties resolved the *Frew* litigation by entering into an agreed consent decree, which the court approved in 1996.<sup>ii</sup> The decree sets out numerous state obligations relating to THSteps. It also provides that the federal district court will monitor compliance with the orders by the Health and Human Services Commission (HHSC) and the Department of State Health Services (DSHS) and that the federal district court will enforce the orders if necessary. In 2000, the court found the state defendants in violation of several of the decree's sections.

In 2007, the parties agreed to 11 corrective action orders<sup>iii</sup> to bring the state into compliance with the consent decree and increase access to THSteps' services. The corrective action orders touch upon many program areas, and generally require the state to take actions intended to assure access to or measure access to Medicaid services for children. The Texas Medicaid program must consider these obligations in all policy and program decisions for Medicaid services available for persons from birth through 20 years of age.

Since 2007, HHSC and DSHS have actively worked to meet the requirements of each of the corrective action orders. H.B. 15, 80<sup>th</sup> Legislature, Regular Session, 2007, appropriated an estimated \$1.8 billion all funds, including \$706.7 million in general revenue (GR) funds, for the 2008-09 biennium to allow the agencies to implement required activities.

As an example, in September 2007, HHSC increased rates for services provided to individuals with Medicaid under age 21 by Medicaid-enrolled physicians, physician specialists, dentists, dental specialists, and certain other professionals. The *Frew* orders

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<sup>i</sup> *Frew* class members are Medicaid clients, birth through age 20, who have not received all of the Texas Health Steps services to which they are entitled, unless the services were knowingly and voluntarily declined.

<sup>ii</sup> The Consent Decree is available on the HHSC website at:  
<http://www.hhsc.state.tx.us/medicaid/frew/>

<sup>iii</sup> The Corrective Action Orders are available on the HHSC website at:  
<http://www.hhsc.state.tx.us/medicaid/frew/>

do not require a specific level for Medicaid rates. However, the orders do include requirements regarding access to care, and regarding provider rates being sufficient to enlist enough providers to meet the needs of Medicaid recipients under age 21.

The 2007 corrective action orders also required the agencies to implement strategic initiatives intended to expand access to care for children with Medicaid. The 80<sup>th</sup> Legislature, Regular Session, 2007, appropriated \$150 million to be applied to strategic initiatives in 2008-09. The 81<sup>st</sup> Legislature, Regular Session, 2009, authorized use of unexpended funds for the 2010-11 biennium. The state implemented 22 strategic initiatives. A number of these initiatives continue as part of Medicaid client services or agency administrative services (e.g. First Dental Home, Oral Evaluation and Fluoride Varnish in the Medical Home, lab courier service, and migrant services data exchange).

In 2013, the court vacated two of the eleven corrective action orders and related paragraphs of the consent decree after finding the state defendants had complied with the required actions for checkup reports and plans for lagging counties; and prescription and non-prescription medications, medical equipment, and supplies. HHSC and DSHS continue to be bound by the remaining obligations of consent decree and the corrective action orders. The court continues to monitor the agencies' compliance with the orders. The consent decree does not have a specific end date, although the corrective action orders are intended to create potential endpoints for the agencies' obligations.

## **Alberto N. v. Janek**

The federal lawsuit *Alberto N., et al. v. Janek* requires HHSC to comply with Title XIX of the Social Security Act<sup>1</sup> by providing all medically necessary in-home Medicaid services to children under 21 years of age that are eligible for THSteps-CCP. These services include personal care services (PCS), nursing services (including Private Duty Nursing), durable medical equipment (DME), and other Medicaid-covered services that are deemed medically necessary.

HHSC transferred PCS for THSteps-CCP beneficiaries from the Department of Aging and Disability Services (DADS) to HHSC on September 1, 2007. Case managers with DSHS assess THSteps-CCP beneficiaries to determine eligibility for and the amount of PCS to be authorized. PCS are support services provided to a THSteps-CCP beneficiary who requires assistance with activities of daily living (ADLs), instrumental activities of daily living (IADLs), and health-related functions due to physical, cognitive, or behavioral limitations related to the beneficiary's disability or chronic health condition.

The *Alberto N.* agreement required HHSC to develop and implement a new assessment instrument to further improve access to care for THSteps-CCP beneficiaries. Under a

contract with HHSC, the Texas A&M University System Health Science Center's School of Rural Public Health and Texas A&M University's Public Policy Research Institute developed the Personal Care Assessment Form (PCAF). The PCAF was implemented on September 1, 2008. The PCAF provides DSHS case managers with a reliable and valid instrument with which to develop appropriate service plans for children and to identify a child's need for other medically necessary services, such as physical, occupational, and speech therapies; nursing; and DME.

## **Programs for Women and Children**

### **Case Management for Children and Pregnant Women Services**

Case Management for Children and Pregnant Women Services provides health-related case management services to eligible children and high-risk pregnant women. Providers are licensed social workers or registered nurses working as individuals or employed by schools, health departments, counseling agencies, health clinics, and other types of agencies. Providers are approved through DSHS and enrolled with the Texas Medicaid claims administrator as Medicaid providers. Case Management for Children and Pregnant Women services include assessing the needs of eligible clients, formulating a service plan, making referrals, problem-solving, advocacy, and follow-up regarding client and family needs.

### **Medicaid Buy-In for Children**

S.B. 187, 81<sup>st</sup> Legislature, Regular Session, 2009, directed HHSC to implement a Medicaid buy-in program for children (up to age 19) with disabilities and family income up to 300 percent of the FPL. Children in the Medicaid Buy-In for Children program may receive FFS Medicaid or opt-in to managed care. Families in this program "buy in" to Medicaid by making 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 are waived for a three-month period if an income hardship is submitted and approved or due to a federally declared disaster. Federal law requires that a parent enroll in an employer-sponsored health insurance plan if their employer offers family coverage under a group health plan and pays at least 50 percent of the total cost of annual premiums. The Medicaid Buy-In for Children program was implemented January 1, 2011.

## Early Childhood Intervention

Early Childhood Intervention (ECI) is a statewide program that provides services to families with children from birth to three years of age with developmental delays or disabilities. The Department of Assistive and Rehabilitative Services (DARS) 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 targeted case management (TCM), specialized skills training (SST), therapy, and other Medicaid benefits.

## Blind Children's Vocational Discovery and Development Program

The Department of Assistive and Rehabilitative Services (DARS) Blind Children's Vocational Discovery and Development Program supports children from birth to 22 years of age with vision impairments and their families to develop a pathway for a successful future. Through targeted case management (TCM), the program helps consumers eligible under the state plan and their families gain access to medical, social, educational, developmental, and other appropriate services. Medicaid reimbursement for targeted case management services is limited to children up to age 20.

## Texas Women's Health Program

The Texas Women's Health Program (TWHP) is a state-funded program that provides eligible Texas women with preventive health care, screenings, contraceptives and treatment for certain sexually transmitted infections (STIs).

S.B. 747, 79<sup>th</sup> Legislature, Regular Session, 2005, directed HHSC to establish a five-year Medicaid demonstration project to expand access to women's preventive health care services. After receiving approval from the federal government, HHSC established the Medicaid Women's Health Program (WHP) on January 1, 2007.

As required by the 2012-13 General Appropriations Act (GAA) (Article II, HHSC, Rider 62, H.B. 1, 82<sup>nd</sup> Legislature, Regular Session, 2011), HHSC pursued a renewal of the WHP waiver program beyond its December 31, 2011 expiration date. However, S.B. 7, 82<sup>nd</sup> Legislature, First Called Session, 2011, directed HHSC to ensure that any funds spent for purposes of the WHP or a successor program are not used to perform or promote elective abortions or to contract with an entity that performs or promotes

elective abortions or that affiliates with entities that perform or promote elective abortions.

To implement this statutory requirement, HHSC adopted new rules effective March 14, 2012, barring from participation in the WHP any provider that performs or promotes elective abortions or that affiliates with another entity that performs or promotes elective abortions. Citing the adoption of these rules, the federal government denied the state's request to extend the demonstration waiver.

To prevent the loss of family planning services for Texas women, Governor Perry directed HHSC to create a state-funded program.

TWHP was fully implemented on January 1, 2013.

TWHP is for women who meet the following qualifications:

- Are ages 18 through 44 (women can apply the month of their 18<sup>th</sup> birthday through the month of their 45<sup>th</sup> birthday);
- Are U.S. citizens or qualified immigrants;
- Reside in Texas;
- Are not eligible to receive full Medicaid benefits, CHIP, or Medicare Part A or B;
- Are not pregnant;
- Are not sterile, infertile, or unable to get pregnant due to medical reasons;
- Do not have private health insurance that covers preventive health services (unless filing a claim on the health insurance would cause physical, emotional, or other harm from a spouse, parent or another person); and
- Have a net family income at or below 185 percent FPL. For example, the monthly net income for a woman in a family of two cannot exceed \$2,426.<sup>iv</sup>

Benefits for eligible participants include:

- Annual family planning exam, which may include screening for diabetes, STIs, high blood pressure, cholesterol, tuberculosis, breast and cervical cancers, and other health issues;
- Follow-up visit, if related to a contraceptive method;
- Counseling on family planning methods, including abstinence;
- Birth control, except emergency contraception;
- Female sterilization; and
- Treatment for certain STIs.

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<sup>iv</sup> This amount reflects the 2014 FPL Guidelines.

There were 198,252 women enrolled in TWHP in calendar year (CY) 2013.<sup>2</sup> An unduplicated total of 77,031 women had a paid claim for TWHP services in CY 2013.<sup>3</sup>

In CY 2013, TWHP expenditures totaled \$21 million all funds. The state’s expenditures totaled approximately \$21 million GR, including expenditures for services, administration, and outreach.<sup>v</sup>

The most recent birth and savings data indicated a reduction of 7,395 expected births for CY 2011, and HHSC estimated the decrease in Medicaid costs to be about \$76.7 million all funds. After paying all costs associated with WHP, the services provided in 2011 saved about \$41.6 million all funds. The state share of the reduction in Medicaid costs totaled approximately \$23.1 million GR, and the net state share of savings after paying WHP expenditures totaled approximately \$19.5 million GR.<sup>4</sup>

## Prescription Drugs

The Texas Medicaid program covers most outpatient prescription drugs either through a Medicaid managed care organization (MCO) or through the Vendor Drug Program (VDP). The Texas Medicaid drug benefit is an optional service that has been available to all Texas Medicaid clients since September 1971.

In SFY 2013, an average of 3.7 million clients per month were eligible to receive medications through the program. Texas Medicaid paid \$2.7 billion for over 38.8 million prescriptions that year through FFS and managed care, with an average cost per prescription of \$69.08.

**Table 6.3** lists Medicaid drug benefits by client groups.

**Table 6.3: Drug Benefits by Client Group**

|   |
|---|
| <b>Unlimited Prescriptions:</b>   |
| Children under 21 years of age.   |
| People who are age 65 and older and those with a disability and that reside in a nursing facility.                  |
| People who are age 65 and older and those with a disability that live in the community and receive waiver services. |
| Members enrolled in STAR, STAR Health, or STAR+PLUS.  |
| <b>Limited to Three Prescriptions per Month:</b>  |
| TANF FFS adults.  |

<sup>v</sup> Medicaid claims data for 2012 are incomplete.

## Outpatient Drug Benefit in Fee-for-Service

VDP directly contracts with over 4,800 dispensing pharmacies to provide prescription drugs to clients in Medicaid FFS and managed care. Texas pays for all FFS outpatient drug coverage through VDP, with the exception of some medications provided as part of outpatient physician services.

As of January 1, 2006, clients who are dually eligible for Medicaid and Medicare began receiving most of their prescription drugs through the Medicare prescription drug benefit known as Medicare Part D. (See Chapter 2, Medicaid History and Organization, Medicare Prescription Drug Improvement and Modernization Act of 2003.)

Section 1860D- 2(e)(2)(A) of the Medicare Improvements for Patients and Providers Act of 2008 was amended to include barbiturates “used in the treatment of epilepsy, cancer, or a chronic mental health disorder” and benzodiazepines. Beginning January 1, 2013, Texas Medicaid no longer covers barbiturates and benzodiazepines for dual eligible clients.

## Outpatient Drug Benefit in Managed Care

Most Medicaid clients and all CHIP clients obtain their prescription drug benefits through an MCO as required by S.B. 7, 82<sup>nd</sup> Legislature, First Called Session, 2011. Outpatient prescription drugs are a benefit of CHIP and each Medicaid managed care program: STAR, STAR+PLUS, and STAR Health.

Each MCO has its own participating pharmacy network comprised of pharmacies contracted with VDP to allow local pharmacies to dispense pharmaceuticals to managed care members. The MCO contracts with a pharmacy benefits manager (PBM) to process prescription claims, and the PBM contracts and works with pharmacies that actually dispense medications to CHIP and Medicaid managed care members. MCOs must allow any pharmacy provider willing to accept the financial terms and conditions of the contract to enroll in the MCO’s network. Pharmacy providers must be contracted with VDP before participating in any network.

MCOs and PBMs are required by state law to adhere to the VDP Medicaid and CHIP formularies, and the Medicaid preferred drug list (PDL) until August 31, 2018. Prior authorization (PA) is required for non-preferred drugs and drugs subject to clinical PA edits. MCOs/PBMs may implement any of the VDP’s clinical PA edits, but no more. If the MCO/PBM wants to establish a clinical edit PA on a drug, the clinical PA edit must be submitted to HHSC for review and approval by the VDP Drug Utilization Review Board.

If a drug is neither preferred nor non-preferred on the PDL, the MCO/PBM cannot establish a drug as non-preferred and implement a PDL prior authorization.

## Federal Drug Rebate Program

In the fall of 1990, Congress passed the Omnibus Budget Reconciliation Act of 1990 (OBRA 90). Among the provisions of this Act was the requirement for implementation of a federal Medicaid drug rebate program, to be effective January 1, 1991. Under this law, drug manufacturers are required to pay rebates for drugs dispensed under state outpatient drug programs in order to be included in state Medicaid formularies. States are required to cover all of the drugs for which a manufacturer provides rebates under the terms of the law. The basic drug rebate provisions of OBRA 90 are as follows:

- States must maintain an open formulary (except for a few categories listed in the law) for all drugs of manufacturers that have signed a federal rebate agreement.
- States may require PA of drugs to limit the use of covered drugs, but must provide PAs within 24 hours of receipt of the request. States must also provide up to a 72-hour emergency supply of drugs if a PA cannot be granted within 24 hours.
- Rebate amounts per unit are determined by the Centers for Medicare & Medicaid Services (CMS).
- States perform the rebate billing and collection functions.

Two subsequent pieces of federal legislation further updated the rebate provisions. The Deficit Reduction Act (2005) extended the rebate program to outpatient drugs administered in a physician's office or another outpatient facility. The Affordable Care Act (ACA) increased the minimum federal rebate percentages that drug manufacturers are required to pay to participate in the Medicaid program. The federal government keeps 100 percent of the increased rebate amount. The ACA also expanded the rebate program to cover claims paid by Medicaid MCOs.

The Vendor Drug Program manages the federal manufacturer drug rebate program and collects rebates for medications dispensed by pharmacies and administered by physicians to Medicaid clients in FFS and managed care. Texas negotiates additional state rebates for preferred drugs. VDP also collects rebates for drugs provided to clients in CHIP and three state health programs, including the Texas Women's Health Program. The 2014-15 General Appropriations Act (GAA) (Article II, HHSC, Rider 24, S.B. 1, 83<sup>rd</sup> Legislature, Regular Session, 2013) requires HHSC to submit an annual report to the legislature on rebate revenues and outstanding balances. The 2014-15 General Appropriations Act (GAA) (Article II, HHSC, Rider 5, S.B. 1, 83<sup>rd</sup> Legislature, Regular Session, 2013) establishes collected rebates as the first source of funding for

Medicaid and CHIP prescription drug services, before general revenue. VDP collected approximately \$1.5 billion all funds in Medicaid rebates in SFY 2013.

## Drug Utilization Review

Prospective and retrospective Drug Utilization Review (DUR) plays a key role in how HHSC understands, evaluates, and improves the prescribing, administration, and use of medications.

Prospective DUR evaluates each client's drug history before medication is dispensed to ensure appropriate and medically necessary utilization. Advisory messages concerning clinically significant drug interactions or ingredient or therapeutic duplication are part of the point-of-sale claim adjudication process.

Retrospective DUR reviews the drug therapy after the client has received the medication. Reviews examine claim data to analyze prescribing practices, medication use by clients, and pharmacy dispensing practices. HHSC conducts multiple reviews each calendar year that focus on patterns of drug misuse, medically unnecessary prescribing, or inappropriate prescribing. Intervention letters are sent to physicians to help better manage clients' drug therapy.

The Texas Drug Utilization Review Board is an HHSC advisory board that consists of practicing physicians and pharmacists appointed by the HHSC Executive Commissioner. The DUR Board reviews and approves the therapeutic criteria for prospective and retrospective DUR and clinical prior authorization edits. Board meetings are held quarterly in Austin.

## Preferred Drug List and Supplemental Rebate Program

A preferred drug list (PDL) is a tool used by many states to control growing Medicaid drug costs while also ensuring program recipients are able to obtain medically necessary medicines. States have taken different approaches to developing PDLs based on federal and state law. In Texas, H.B. 2292, 78<sup>th</sup> Legislature, Regular Session, 2003, provided direction to HHSC on how to implement the Medicaid PDL.

The PDL contains medications in various therapeutic classes that are designated as "preferred" or "non-preferred" based on safety, efficacy, and cost-effectiveness. Prescribers who choose non-preferred medications for their patients must obtain prior authorization. The Texas Pharmaceutical and Therapeutics Committee reviews drugs

and drug classes and recommends to HHSC, which pharmaceuticals should be listed as preferred or non-preferred status on the PDL.

With a PDL, Medicaid clients have access to all of the drugs Medicaid is required to cover under federal law, including those covered before the PDL was established. The PDL controls spending growth by increasing the use of preferred drugs. Unless Texas Medicaid has historical paid claim information that indicates a patient meets the state's authorization criteria, a physician's office must call to obtain approval before a non-preferred drug can be reimbursed. By containing drug costs, the PDL helps to preserve Medicaid's ability to meet clients' increasing prescription drug needs, as well as other health care needs.

The MCOs implemented the VDP's PDL and do not have prior authorization requirements more stringent than those in place for FFS as required by S.B. 7, 82<sup>nd</sup> Legislature, First Called Session, 2011 and the 2012-13 GAA, (Article II, HHSC, Rider 81, H.B. 1, 82<sup>nd</sup> Legislature, Regular Session, 2011).

Supplemental rebates are collected under the PDL provisions of H.B. 2292, 78<sup>th</sup> Legislature, Regular Session, 2003. These rebates are in addition to the rebates collected under the federal drug rebate program on products selected as preferred drugs for the Texas Medicaid formulary. These rebates are based on competitive negotiations that are performed by a contractor that specializes in optimizing rebate offers for supplemental rebates. The rebate offers are used in determining cost effectiveness for possible placement on the PDL. Rebates are collected on both FFS and MCO prescription drug claims. Supplemental rebate revenue is shared with CMS at the same Federal Medical Assistance Percentages used to pay the claims.

HHSC collected approximately \$168.1 million all funds (\$70.5 million in GR) in supplemental rebates in SFY 2013. The ACA increased the minimum federal rebate percentages that drug manufacturers are required to pay to participate in the Medicaid program. The federal government keeps 100 percent of the increased rebate amount.

## **Medical Transportation Program**

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

methods that comply with federal regulations that are efficient, cost effective, and meet client needs.

## Payment Models

### **Managed Transportation Organizations**

S.B. 8, 83<sup>rd</sup> Legislature, Regular Session, 2013, required HHSC to implement a Managed Transportation Organization (MTO) model for the delivery of services. The NEMT delivery model is performed in contiguous counties within a managed transportation service region. The shift in the type of transportation model also includes a change in the payment structure that requires providers to operate under a capitated rate structure and assume financial responsibility under a full risk model.

### **Full-Risk Broker**

The 2010-11 GAA (Article II, HHSC, Rider 55, S.B. 1, 81<sup>st</sup> Legislature, Regular Session, 2009) required HHSC to implement a full-risk brokerage (FRB) model in areas of the state that could sustain the model. The FRB provides an array of transportation services to clients in a specified geographic area. The Texas Health and Human Services system (HHS) has contracted with two FRBs to coordinate transportation using a network of providers in the Dallas/Fort Worth and Houston/Beaumont services delivery areas.

## Transportation and Related Services

### **Mass Transit**

Mass transit is intercity or intra-city transportation by bus, rail, air, ferry, or either publicly or privately owned transit which provides general or special service on a regular or continuing basis. Mass transit also involves using commercial air service to transport eligible program clients to an authorized covered health care service.

### **Demand Response**

Demand response services are contractor provided transportation when fixed route services are either unavailable or do not meet the health care needs of clients. The MTO or Regional Contracted Broker responds to requests for individual or shared one-way trips.

## **Individual Transportation Participant**

Individual Transportation Participant (ITP) services are provided by individuals who volunteer to participate in the MTO Individual Transportation Provider program. ITPs enter into an agreement to receive mileage reimbursement at the state established rate to provide transportation to a Medicaid eligible client. Mileage reimbursement is paid to an individual who drives himself, a family member, friend, or neighbor to and from a Medicaid covered health care service. MTP increased the mileage reimbursement rate for eligible ITPs to match the state employee rate of \$0.56 per mile effective September 1, 2014.

## **Meals and Lodging**

Meals and lodging are provided for Medicaid and CSHCN children and their attendant when health care treatment requires an overnight stay outside the county of residence or beyond adjacent counties. The MTO provides the client and attendant (regardless of age) an allowance of \$25 per day per person.

## **Advanced Funds**

Advanced funds are funds authorized by the MTO in advance of travel and provided to the client or attendant to cover authorized transportation services, i.e., gas money for travel to a medically necessary health care service and lodging and/or meals in connection with a medically necessary health care service.

## **Out-of-State Travel**

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

## **Commercial Airline Transportation Services**

The MTO is responsible for arranging commercial air transportation to meet the client's needs for the client and attendant, when applicable (i.e. out of state, out of client's resident MTO region).

## Program Enhancements

The managed transportation delivery model was implemented to improve the cost effectiveness of program operations and establish efficient transportation systems in each of the designated regions. MTOs began providing NEMT services under the new model on September 1, 2014. MTP Contract Management Operations' primary role is to ensure that the provisions of the NEMT contracts are met, and performance standards and measures are achieved on a consistent basis.

## Behavioral Health Services

Texas Medicaid also funds behavioral health services. Behavioral health services are defined as services used to treat a mental, emotional, or chemical dependency disorder. Services include:

- Therapy by psychiatrists;
- Therapy by psychologists, licensed clinical social workers, licensed professional counselors, and licensed marriage and family therapists;
- Inpatient psychiatric care in a general acute hospital;
- Inpatient care in psychiatric hospitals (for persons under age 21 and age 65 and older);
- Outpatient adolescent chemical dependency counseling by state-licensed facilities;
- Prescription medicines;
- Rehabilitative and targeted case management services for people with severe and persistent mental illness or children with severe emotional disturbance;
- Ancillary services required to diagnose or treat behavioral health conditions;
- Care and treatment of behavioral health conditions by a primary care physician;
- Comprehensive substance use disorder benefits for adults in Medicaid including assessment, medication-assisted therapy, outpatient and residential detoxification, and outpatient and residential treatment; and
- Services through the Youth Empowerment Services (YES) waiver program for children and young adults ages 3 to 19 that are at risk of hospitalization because of serious emotional disturbance.

Behavioral health services are provided by therapists in private practice, physicians, private and public psychiatric hospitals, and by community mental health centers and chemical dependency treatment programs. Behavioral health services are also included in CHIP and Texas managed care programs such as STAR, STAR Health, STAR+PLUS, and NorthSTAR. NorthSTAR is a behavioral health managed care

program that offers a broader array of behavioral health services than other managed care programs. These additional services are paid for through savings derived from better management of services.

## Mental Health Parity

The Mental Health Parity Act was passed by Congress in 1996, requiring that annual or lifetime limits on mental health benefits be no lower than the limits for mental or surgical benefits offered by group health or health insurance plans. In 2008, the U.S. Congress passed the Paul Wellstone and Pete Domenici Mental Health Parity and Addition Equity Act (MHPAEA). MHPAEA requires insurance plans, public and private, to have no greater limitations or financial requirements on mental health and substance use disorder benefits than are placed on medical or surgical benefits. Specifically, MHPAEA requirements include:

- Financial requirements applied to mental health or substance use disorder (SUD) benefits can be no more restrictive than the most common limitations applied to medical or surgical benefits, including copays;
- No separate cost sharing requirements that apply only to mental health or SUD benefits;
- Treatment limitations applied to mental health or SUD benefits can be no more restrictive than treatment limits on medical or surgical benefits;
- No separate treatment limitations that apply only to mental health or SUD benefits;
- The criteria determining medical necessity with respect to mental health or SUD benefits must be made available to a current or potential participant, beneficiary, or contracting provider, and the reason for any denial of reimbursement or payment for services relating to mental health or SUD benefits must be made available within a reasonable timeframe upon request; and
- If out-of-network coverage for medical or surgical benefits is provided, out-of-network coverage for mental health and SUD benefits must also be provided.

The 2009 Children's Health Insurance Plan Reauthorization Act incorporated MHPAEA requirements to CHIP state plans. As of November 2009, all Medicaid state plans, including managed care plans similar to STAR, STAR Health, and STAR+PLUS, were required to comply with MHPAEA. In reviews conducted by HHSC in 2011 and 2014, Texas Medicaid is in full compliance with MHPAEA.

# Mental Health Rehabilitation and Targeted Case Management Service

S.B. 58, 83<sup>rd</sup> Legislature, Regular Session, 2013, requires the Health and Human Services Commission (HHSC) to integrate behavioral health and physical health services into the Medicaid managed care programs by adding mental health targeted case management and mental health rehabilitation services to the array of services provided by managed care organizations (MCOs) by September 1, 2014. The legislation requires MCOs that contract with HHSC to develop a network of public and private providers of behavioral health services and ensure adults with serious mental illness and children with serious emotional disturbance have access to a comprehensive array of services. HHSC must also develop two Medicaid health home pilots programs in two health service areas of the state for persons who are diagnosed with a serious mental illness and at least one other chronic health condition. In addition, HHSC and the Department of State Health Services (DSHS) are required to establish a Behavioral Health Integration Advisory Committee. The Behavioral Health Integration Advisory Committee is charged with providing formal recommendations to HHSC on the implementation of the S.B. 58 requirements.

## Home and Community-Based Services—Adult Mental Health (HCBS-AMH)

A number of adults have resided in Texas state mental health facilities for extended periods of time—in some cases for years. Some of these individuals no longer require an inpatient level of treatment, but need specialized supports that are not otherwise available through existing community-based mental health and disability programs. In 2010, DSHS convened a continuity of care task force of stakeholders to recommend a range of reforms. Among the recommendations was the development of Home and Community-based services (HCBS) for adults with serious mental illness. The 2014-15 GAA (Article II, HHSC, Rider 81, 83<sup>rd</sup> Legislature, Regular Session, 2013), requires DSHS to create a program through a 1915(i) state plan amendment to serve these individuals.

The HCBS-AMH program provides an array of intensive home and community-based services, appropriate to each individual's assessed needs, to adults with extended tenure in state mental health facilities in lieu of their remaining supported home living; HCBS-AMH psychosocial rehabilitation; supported employment; employment assistance; minor home modifications; medical supplies; transition assistance to establish a basic household; adaptive aids; transportation; community psychiatric

supports; peer support; respite care; substance use disorder services; and nursing and recovery management. Services would be provided in a variety of home and community-based settings of the individual's choice, such as an individual's home or apartment, or in an assisted living setting or small community-based residence.

The HCBS-AMH program includes indigent services not covered by Medicaid. Services for indigent individuals enrolled in HCBS-AMH will be funded using general revenue only, as they will not be eligible for the federal match. Full implementation of the HCBS-AMH program requires approval by CMS.

## Medicaid Substance Abuse Benefit

The 2010-11 GAA (Article IX, section 17.15, S.B. 1, 81<sup>st</sup> Legislature, Regular Session, 2009), authorized HHSC to add comprehensive substance abuse benefits for adults in Medicaid. The Legislature assumed that the treatment of substance abuse disorders would result in cost savings in the Medicaid program through a reduction in other medical expenditures.

The Medicaid substance abuse benefits were implemented in two phases, beginning September 1, 2010 with outpatient benefits and concluding January 1, 2011 with residential benefits and ambulatory detoxification. These benefits apply to Medicaid clients enrolled in traditional Medicaid, STAR, and STAR+PLUS. Clients in STAR Health already had access to these benefits. The benefits include the following services:

- Assessment to determine a client's need for services;
- Individual and group outpatient substance use disorder treatment counseling;
- Medication assisted therapy;
- Outpatient detoxification;
- Residential detoxification; and
- Residential treatment.

## Youth Empowerment Services Waiver

The YES waiver is a Medicaid 1915(c) Home and Community-based (HCS) waiver that allows for more flexibility in the funding of intensive community-based services for children and adolescents ages 3 to 19 with serious emotional disturbances and their families. Children may enroll in Medicaid managed Care to receive their non-YES waiver services.

The YES waiver is currently available in a limited geographic area (Bexar, Brazoria, Cameron, Ft. Bend, Galveston, Harris, Hidalgo, Tarrant, Travis, and Willacy counties). Under legislative direction, HHSC and DSHS are working to expand the program to

additional counties. Children are determined financially eligible for the YES waiver using the same standards used to determine eligibility for Medicaid in psychiatric institutions. Parental income is not counted.

## Texas Wellness Incentives and Navigation (WIN) Project

CMS is conducting a national demonstration to evaluate the effectiveness of providing incentives to Medicaid clients to adopt healthy behaviors. Texas, one of ten states awarded a demonstration grant, chose to focus on adult STAR+PLUS members with mental health and substance use conditions. Individuals with these conditions are more likely to suffer chronic physical health problems, experience debilitating chronic physical conditions earlier in life, and have elevated health care costs.

The Texas WIN project includes over 1,250 voluntary participants, aged 21-55, in the Harris County service delivery area, randomized into intervention and control groups.

Project goals include: improved health self-management, increased use of preventive services, and more appropriate use of health care services. Examples of individual goals include increased activity, weight loss, improved stress management, improved diabetes management, and reduced tobacco use. WIN employs a complement of research-based incentives to help intervention group participants manage their chronic health conditions. These include:

- Wellness planning and navigation facilitated by trained, professional health navigators, who use Motivational Interviewing techniques to help participants define and achieve their health goals;
- Individual flexible wellness accounts to support specific health goals defined by the participant, with purchases authorized through the navigator; and
- Wellness Recovery Action Planning (WRAP) training to help individuals stay mentally well, increase personal responsibility, and improve their quality of life. Participants electing WRAP develop strategies to help maintain wellness, such as a daily maintenance plan, identifying triggers/early warning signs of illness, and a crisis plan.

DSHS manages WIN on a day to day basis, with oversight by the state Medicaid office. WIN is independently evaluated by the same entity that serves as the Medicaid/CHIP managed care external quality review organization. WIN will conclude by December 2015, with a final report due to the CMS in October 2016.

# Long-term Services and Supports

Long-term services and supports (LTSS) help people age 65 and older and those with physical, mental, intellectual, or developmental disabilities. These services may be provided in an institution such as a nursing facility (NF) or Intermediate Care Facility for Individuals with an Intellectual Disability or Related Conditions (ICF/IID), in the individual's own home (e.g., Primary Home Care or home and community-based waivers), or in other settings (e.g., Day Activity and Health Services).

The demand for LTSS in Texas continues to grow and is influenced by two key trends: the aging of the population and the continuing prevalence of individuals with co-occurring behavioral health needs.

The population of people age 65 and older is projected to increase from 3.1 million in 2015 to 7.5 million in 2040. The percentage of the total population that is 65 years of age or older is projected to increase from 11 percent in 2015 to 17 percent in 2040.

The incidence of behavioral health issues is increasing for persons with a physical or intellectual/developmental disability and in the aging population. Nearly one-fourth of individuals across all DADS waiver programs have a dual diagnosis. The additional challenge of a behavioral health diagnosis can further limit these individuals' ability to become fully integrated into the community. The more capacity that exists in the community system to serve individuals with behavioral health needs, the less likely it is those individuals will end up in institutional services, and the easier it will be for such individuals to transition back to the community.

In Texas, LTSS accounts for approximately 30 percent of the overall Medicaid budget.<sup>vi</sup>

## Institutions

DADS oversees facilities that provide LTSS to individuals who are age 65 and older and those with disabilities. NFs provide services for individuals whose medical conditions require the skills of a licensed nurse on a regular basis. ICFs/IID provide LTSS for persons with an intellectual disability or related conditions requiring residential, medical, and habilitative services.

## Home and Community-Based Waivers

Federal law allows states to apply for waivers to exempt them from certain Medicaid requirements. One of these, called a 1915(c) waiver after the particular section of the

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<sup>vi</sup> HHSC Financial Services Analysis.

Social Security Act that is waived, allows states to provide home and community-based services to individuals who qualify for institutional care but who can be served at home or in the community to maintain independence and prevent institutionalization. States may also offer home and community-based services to individuals who qualify for institutional care through an 1115 waiver.

Home and community-based waivers allow the state to provide a broader array of support services than are available under the state plan. Examples of waiver services provided include nursing, personal attendant services, habilitation, minor home modifications, dental services, respite, therapies, adaptive aids, medical supplies, and emergency response services.

According to federal rules, home and community-based waivers cannot cost any more than institutional care would have cost for the group served by the waiver. Waivers enable states to serve people in the community rather than in institutions. However, because of funding limitations, the number of individuals wanting to receive waiver services generally far exceeds the number of individuals funded by the state. Most home and community-based waiver programs have lengthy interest lists of people who wish to enroll. This growth has occurred despite significant increases in waiver funding by the 80<sup>th</sup> and the 81<sup>st</sup> Texas Legislature, reflecting the public's increasing awareness of and desire for community-based LTSS.

The Medicaid 1915(c) waiver programs include:

- Community Living Assistance and Support Services (CLASS);
- Deaf-Blind with Multiple Disabilities (DBMD);
- Home and Community-based Services (HCS);
- Medically Dependent Children Program (MDCP);
- Texas Home Living (TxHmL); and
- Youth Empowerment Services (YES).

The Home and Community-based Services STAR+PLUS waiver is operated under an 1115 waiver and replaced the former Community Based Alternatives (CBA) 1915(c) waiver which was administered by DADS and allowed Texas to provide community-based services to adults as an alternative to nursing facility care. (See Appendix E, Texas Medicaid Waivers.)

# Programs for People age 65 and Older and People Under age 65 with Physical Disabilities

LTSS for people age 65 and older, and people under age 65 with physical disabilities include home and community-based services and NF services. If eligible for Medicaid, they may receive an array of services, from non-skilled personal care to skilled nursing services. Services may be provided in peoples' homes, in community settings (e.g., adult day care or hospice), or in NFs, which provide services for people with medical conditions that require the skills of a licensed nurse on a regular basis.

As noted previously, the population of Texans age 65 and older is projected to increase from 3.1 million in 2015 to 7.5 million in 2040. The number of Texans under age 65 with physical disabilities is also expected to increase from 924,000 in 2015 to 1.4 million in 2040. Over time, LTSS caseloads are expected to increase to meet the growing demand for Medicaid services by these two groups.

## **Community Services and Supports—Medicaid State Plan Services**

Medicaid state plan community services and supports programs provide Medicaid-covered supports and services in homes and community settings, which enables people age 65 and older and those with physical disabilities who can be served at home or in the community to maintain their independence and prevent institutionalization. The community services and supports Medicaid state plan programs for people age 65 and older and those with physical disabilities are Primary Home Care (PHC), Community Attendant Services (CAS) and Day Activity and Health Services (DAHS).

### **Primary Home Care (PHC)**

PHC is administered by DADS and is a Medicaid community-based entitlement service. An entitlement program means that the state must provide those services to all individuals who request such services and are determined eligible. PHC is a non-technical, non-skilled service providing in-home attendant services to individuals with an approved medical need for assistance with personal care tasks. PHC is available to eligible adults whose health problems cause them to be functionally limited in performing activities of daily living according to a practitioner's statement of medical need. Covered services include an escort to obtain a medical diagnosis or treatment or both, home management assistance such as laundry and housekeeping, and personal care services such as bathing, dressing, grooming, and preparing meals. Personal care services are often the critical factor in keeping individuals in their own homes and out of

institutions. In SFY 2013, the average number of individuals served per month was 11,127 with an annual expenditure of \$91.1 million.

### **Community Attendant Services (CAS)**

The CAS program is administered by DADS and is also an entitlement program. This program takes advantage of special provisions in Medicaid law that allow the state to provide personal care without other Medicaid benefits to individuals in the community whose income is too high to qualify for Medicaid, but who meet the higher NF income limit, which is 300 percent of the SSI federal benefit rate.

CAS is a non-technical, non-skilled service providing in-home attendant services to individuals with an approved medical need for assistance with personal care tasks. CAS is available to eligible adults and children whose health problems cause them to be functionally limited in performing activities of daily living according to a practitioner's statement of medical need.

Covered services include an escort on trips to obtain a medical diagnosis or treatment or both, assistance with home management such as laundry and housekeeping and personal care services such as bathing, dressing, grooming and preparing meals. In SFY 2013, the CAS program served an average of 47,964 individuals per month with an annual expenditure of \$500.3 million all funds.

### **Day Activity and Health Services (DAHS)**

DAHS provides daytime service up to a maximum of ten hours per day, Monday through Friday, to individuals residing in the community in order to provide an alternative to placement in NFs or other institutions. Services are designed to address the physical, mental, medical, and social needs of individuals and include nursing and personal care; noon meals and snacks; transportation; and social, educational, and recreational activities. The individual must have a medical diagnosis and a physician's order requiring care or supervision by a licensed nurse, a functional disability related to the medical diagnosis, and the need for assistance with one or more personal care tasks. In SFY 2013, DAHS facilities provided services to a monthly average of 1,886 individuals with an annual expenditure of \$11.1 million.

### **Community Services and Supports–Waivers**

Medicaid community services and supports waiver programs provide supports and services in homes and community settings that enable people with an intellectual disability and related conditions who qualify for an ICF/IID, to be served at home or in a community-based setting in order to maintain and improve their independence and prevent institutionalization. The community services and supports waivers for people

with an intellectual disability or related conditions are HCS, CLASS, DBMD, and TxHmL. (See Appendix E, Texas Medicaid Waivers.)

### **Long-Term Services and Supports for STAR+PLUS Members**

STAR+PLUS MCOs are responsible for providing a benefit package to members that includes all medically necessary services covered under the traditional FFS Medicaid programs. They are also responsible for providing LTSS to their members who need support living in the community as opposed to an institution. The MCOs coordinate all STAR+PLUS Medicaid services, including LTSS. STAR+PLUS MCOs serve members receiving LTSS services available to all Medicaid members and those receiving additional LTSS under the STAR+PLUS Home and Community Based Services waiver.

The following is a non-exhaustive, high-level listing of LTSS covered services, including those delivered under the STAR+PLUS Medicaid managed care program.

- LTSS for all members:
  - Personal attendant services (PAS)
  - Day Activity and Health Services (DAHS)
- Home and Community-based STAR+PLUS waiver services for those who would otherwise qualify for NF care:
  - PAS
  - In-home or out-of-home respite services
  - In-home nursing services
  - Emergency response services (e.g., emergency call button)
  - Home delivered meals
  - Minor home modifications
  - Adaptive aids and medical equipment
  - Medical supplies not available under Medicaid
  - Physical, occupational, and speech therapy
  - Adult foster care
  - Assisted living
  - Transition assistance services limited to a maximum of \$2,500
  - Dental Services limited to a maximum of \$5,000 per waiver plan year
  - Cognitive Rehabilitation Therapy
  - Financial Management Services
  - Support Consultation
  - Employment Assistance
  - Supported Employment

- Targeted for June 1, 2015, the state will provide the following Community First Choice (CFC) services to members who would otherwise qualify for care in a NF, an ICF/IDD, or an Institution for Mental Disease:
  - PAS
  - Habilitation
  - Emergency Response Service (Emergency call button)
  - Support Management (Voluntary training in selection, managing, and dismissing attendants)

### **Medically Dependent Children Program**

The Medically Dependent Children Program (MDCP) provides home and community-based services to children and young adults under 21 years of age as an alternative to residing in a NF. Services include respite, flexible family supports, adaptive aids, and minor home modifications. In SFY 2013, MDCP served an average of 5,593 individuals per month with an annual expenditure of \$97.2 million all funds.

### **Nursing Facilities**

The NF program provides services to meet medical, nursing, and psychological needs of persons meeting a level of medical necessity requiring 24-hour care. NFs are paid a daily 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 include nursing, social services and activities, over-the-counter drugs (prescription drugs are covered through Medicaid VDP or Medicare Part D), medical supplies and equipment, personal needs items, and rehabilitative therapies.

Effective March 1, 2015, most Medicaid clients age 21 and over receiving NF services will be enrolled in STAR+PLUS, a Texas Medicaid managed care program that combines acute care and LTSS. STAR+PLUS benefits for NF residents will include service coordination and value added services. The STAR+PLUS MCOs will be responsible for adjudicating claims, including prescription drug claims for NF services. Dual eligible members with Medicare Part D will continue to have their prescriptions covered under Medicare Part D.

Texas has adopted optional eligibility standards that allow people with incomes of up to 300 percent of the SSI federal benefit rate to qualify for Medicaid-funded NF care, although most of their income must be used toward the cost of their care.<sup>vii</sup>

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<sup>vii</sup> The SSI federal benefit rate is the maximum amount an individual can receive in Supplemental Security Income on a monthly basis. See [www.ssa.gov/ssi/text-general-ussi.htm](http://www.ssa.gov/ssi/text-general-ussi.htm).

In SFY 2013, NFs served approximately 56,327 individuals per month through Medicaid. Also in SFY 2013, an average of 5,831 individuals per month had their Medicare Skilled NF co-insurance paid by Medicaid.

## **Hospice**

The hospice program, administered by DADS, provides palliative care in the home or in community settings, long-term care facilities (e.g., NF or ICF/IID), or in hospital settings 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. Children under 21 years of age receiving hospice services may continue to receive curative care from non-hospice acute care providers.

The goal of hospice is to provide care for individuals and their families, not to treat or cure terminal illness. A team of doctors, nurses, home health aides, social workers, counselors, and trained volunteers works together to help the individual and their family cope with the terminal illness. Hospice services include physician services, nursing, counseling, personal attendant services, therapies, prescription drugs, and respite care. In SFY 2013, the program served an average of 6,917 individuals, of whom 88.9 percent received hospice services in NFs. The remaining 11.1 percent were served in the community.

## **Program of All-Inclusive Care for the Elderly (PACE)**

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 or older, live in a PACE service delivery area, qualify for NF level of care, and be able to live safely in the community at the time of enrollment. 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, day activity services, and housing assistance. PACE participants receive all medical and social services they need through the PACE provider. PACE service areas are Amarillo/Canyon, El Paso, and Lubbock. 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.

For SFY 2013, the average number of participants per month receiving PACE services was 1,046. Passage of the 2013-14 GAA, 83<sup>rd</sup> Legislature, Regular Session, 2013 (Article II, Special Provisions, Section 48), expanded the program by adding a total of 96 additional slots to the existing PACE sites, and it also authorized three additional sites with up to 150 participants each.

# Programs for People with an Intellectual Disability or Related Conditions

Medicaid funded LTSS for individuals with an intellectual disability or related conditions includes home and community-based waiver services and services in an ICF/IID.

Home and community-based waivers provide individualized services and supports to people who live in their family's home, their own homes, or other community settings such as small group homes where no more than four to six individuals reside, depending on the waiver program.

Residential and habilitation services are provided in ICFs/IID that vary in size, serving as few as six people up to several hundred.

## **Community Services and Supports–Waivers**

Medicaid community services and supports waiver programs provide supports and services in homes and community settings that enable people with an intellectual disability and related conditions who qualify for an ICF/IID, to be served at home or in a community-based setting to maintain and improve their independence and prevent institutionalization. These waiver programs are HCS, CLASS, DBMD, and TxHmL. Non-dual eligible adults enrolled in these waiver programs are enrolled in the STAR+PLUS Medicaid managed care program to receive their basic health services while they receive their waiver services outside of STAR+PLUS. Children under age 21 enrolled in these waiver programs have the option to enroll in STAR+PLUS for their basic health services. LTSS will continue to be provided through the waiver programs.

### **Home and Community–based Services (HCS)**

The HCS waiver provides individualized services to individuals of all ages who qualify for ICF/IID level of care up to \$305,877 per year, depending on the individual's level of need. Individuals live in their family's home, their own homes, or other settings in the community. Services include adaptive aids, minor home modifications, dental treatment, nursing, supported home living, respite, day habilitation, residential services, employment assistance, supported employment, and professional therapies.

Professional therapies include physical therapy, occupational therapy, speech and language pathology, audiology, social work, behavioral support, dietary services, and cognitive rehabilitation therapy. Financial management services and support consultation are available to individuals who use the consumer-directed services option. Residential service options include host home/companion care, supervised living, and residential support services. During SFY 2013, based on information reported by providers, about 39 percent of individuals served in HCS had a diagnosis of some type

of mental illness. In SFY 2013, HCS served an average of 20,171 individuals per month with an annual expenditure of \$844.8 million all funds.

### **Community Living Assistance and Support Services (CLASS)**

The CLASS waiver provides home and community-based services to clients who have a diagnosis of a “related condition” by a licensed physician qualifying them for placement in an ICF/IID. A related condition is a disability other than an intellectual disability (ID) or mental illness which originates before age 22 and is found to be closely related to ID because the condition substantially limits life activity similar to that of individuals with an ID and requires treatment or services similar to those required for individuals with an ID. Related conditions include disabilities such as cerebral palsy, epilepsy, spina bifida, and head injuries.

Services include case management, prevocational services, residential habilitation, respite (in-home and out-of-home), employment assistance, supported employment, adaptive aids/medical supplies, dental treatment services, occupational therapy, physical therapy, prescriptions, skilled nursing, speech and language pathology, behavioral support, minor home modifications, specialized therapies, support family services, continued family services, and transition assistance services. Financial management services and support consultation are available to individuals who use the consumer-directed services option.

During SFY 2013, based on information reported by providers 22.5 percent of individuals served in CLASS had a diagnosed mental illness. In SFY 2013, CLASS served an average of 4,716 individuals per month with an annual expenditure of \$204.2 million all funds.

### **Deaf-Blind with Multiple Disabilities (DBMD)**

DBMD provides home and community-based services as an alternative to residing in an ICF/IID to people of all ages who are deaf, blind, or have a condition that will result in deaf-blindness, and who have an additional disability. Services include case management; day habilitation; residential habilitation; respite; supported employment; prescription medications; financial management services; adaptive aids/medical supplies; assisted living; audiology services; behavioral support; chore service; dental treatment; dietary services; employment assistance; intervener; minor home modifications; nursing; orientation and mobility; physical, speech, hearing, and language therapy services; and transition assistance services. Support consultation is also available to individuals who use the consumer-directed services option.

During SFY 2013, based on information reported by providers, 10.2 percent of individuals served in DBMD had a diagnosed mental illness. In SFY 2013, 151 individuals per month were served with an annual expenditure of \$7.8 million all funds.

## **Texas Home Living (TxHML)**

TxHmL waiver provides selected services and supports up to \$17,000 per year for individuals who qualify for ICF/IID level of care and live in their family homes or their own homes. Services include adaptive aids, minor home modifications, behavioral support, dental treatment, nursing, community support (similar to supported home living in HCS), respite, day habilitation, employment assistance, supported employment, and specialized therapies. Specialized therapies include physical therapy, occupational therapy, speech and language pathology, audiology, and dietary services. Financial management services and support consultation are available to individuals who use the consumer-directed services option. During SFY 2013, based on information reported by providers, 27.1 percent of individuals served in TxHmL had a diagnosed mental illness. In SFY 2013, TxHmL served an average of 4,629 individuals per month with an annual expenditure of \$48.5 million all funds.

## **Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions (ICF/IID)**

The ICF/IID program provides 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 relation conditions function to their greatest ability. A related condition is a severe and chronic disability, other than an intellectual disability (ID) or mental illness, which originates before age 22 and is found to be closely related to ID because the condition substantially limits life activity similar to that of individuals with an ID and requires treatment or services similar to those required for individuals with an ID. Related conditions include disabilities such as cerebral palsy, epilepsy, spina bifida, and head injuries. Adults receiving services through the ICF/IID program will be enrolled in the STAR+PLUS Medicaid managed care program to receive their basic health services through this model. Children under age 21 receiving services through the ICF/IID program have the option to enroll in STAR+PLUS for their basic health services. LTSS will continue to be provided through the ICF/IID program.

ICF/IID residential settings range in size from six beds to several hundred. In SFY 2013, an average of 5,510 Medicaid-eligible individuals per month received services from non-state operated ICFs/IID. All ICFs/IID must be certified by DADS, and the majority must also be licensed by DADS. All ICFs/IID also must meet the State Standards for Participation in Title 40, Chapter 9, Subchapter E, Texas Administrative Code, concerning ICF/IID programs.

The State Supported Living Centers (SSLCs), described below, are operated by DADS and are an example of ICFs/IID that are certified.

## **State Supported Living Center Services (SSLCs)**

SSLCs serve people with an intellectual disability who have significant medical or behavioral health needs in a residential campus-based community. SSLCs provide 24-hour residential services, comprehensive behavioral treatment, and health care, such as medical, psychiatry, nursing, and dental services. Other services include skills training; occupational, physical and speech therapies; adaptive aids; day habilitation, vocational programs, and employment services; participation in community activities; and services to maintain connections between residents and their families and natural support systems. Services and supports are provided at 12 SSLCs operated by DADS and the ICF/IID component of the Rio Grande State Center operated by DSHS. Each center is certified as an ICF/IID, with approximately 60 percent of the operating funding from the federal government and 40 percent from state GR and third-party revenue resources. Individuals receiving services through a SSLC are excluded from enrollment in the STAR+PLUS Medicaid managed care program.

Nearly two-thirds of the overall SSLC population has a dual diagnosis in which an individual has been diagnosed with an intellectual disability and a mental health disorder. In May 2014, 3,400 individuals lived in SSLCs.

## **LTSS Resources**

### **The Promoting Independence Initiative and Money Follows the Person**

LTSS includes both institutional settings such as NFs and ICFs/IID, and community-based services. Historically, NF appropriations could not be used to fund community-based services when individuals expressed their desire to receive services in a more home-like setting. However, in response to *Olmstead vs. L.C.*, the 1999 U.S. Supreme Court decision, the state launched the Promoting Independence Initiative, which provided the opportunity to change this policy.

The 2002-03 GAA (Article II, HHSC, Rider 37, S.B. 1, 77<sup>th</sup> Legislature, Regular Session, 2001), established a Money Follows the Person (MFP) policy whereby the funding for individuals moving from NFs to community-based services could be transferred from the NF budget to the community-based services budget. MFP allows individuals to be able to choose how and where they are to receive their LTSS. Other support services have subsequently been developed to help in the identification of individuals who want to leave an institutional setting and to assist them in their relocation back to the community. Rider 37 was codified by H.B. 1867, 79<sup>th</sup> Legislature, Regular Session, 2005, and a separate budgetary line item for MFP was established.

The MFP policy has been very successful. As of July 2014, over 41,000 individuals have chosen to move out of institutional settings and relocate back into the community to receive community-based LTSS.

HHSC and DADS successfully competed for a Deficit Reduction Act of 2005 MFP demonstration award to build upon and enhance the Promoting Independence Initiatives. The demonstration began on February 1, 2008 and will continue through 2020.

Under the demonstration, the state works with individuals residing in NFs, community ICFs/IID with nine beds or more, and SSLCs who want to relocate to the community. The state receives enhanced funding for 365 days for each individual who enrolls in the demonstration. In order to be a demonstration participant, the individual must have been in an institutional setting for at least 90 days (exclusive of Medicare billable days) and be willing to sign an informed consent to enroll in the demonstration. As of July 2014, approximately 8890 individuals had enrolled in the MFP demonstration.

The demonstration funds a variety of different projects, including direct service provision as well as information technology, staff resources, and other infrastructure-related functions. Some of these projects include:

- Community supports (e.g., cognitive adaptation services, substance abuse services) for individuals transitioning from NFs with co-occurring behavioral health needs in Bexar County and its contiguous counties, and Travis county.
- Incentives for providers of community ICFs/IID with nine or more beds who want to close their facilities voluntarily and provide residential choice for their current residents.
- Hands-on assistance from relocation contractors to assist in the transition back to the community as well as short-term post-relocation contacts for individuals who have moved back into the community to ensure a more successful relocation.
- Enhancement of data collection, reporting and quality assurance systems, and provider monitoring.
- Financial assistance to local Long-term Care Ombudsmen to assist NF residents who want to learn more about community-based alternatives.
- A customized employment project for providers who want to assist individuals receiving services in an ICF/IID or an ICF/IID waiver program to achieve integrated employment at local businesses.
- Administrative assistance for Relocation Contractor Services and Direct Service Workforce Development.
- Transition specialists housed at each SSLC to improve the quality of the relocation process.

- Funding of 14 Aging and Disability Resource Centers (ADRCs) to hire housing specialists who will concentrate their efforts on the identification and expansion of affordable, accessible, and integrated housing.
- Funding for 14 ADRCs to provide options counseling to non-Medicaid nursing facility residents interested in learning about community LTSS.
- Establishment of a Quality Reporting Office to provide additional in-house capabilities to monitor, discover, describe, and create intervention strategies to promote quality across demonstration activities and Medicaid 1915(c) waivers.
- Establishment of a crisis intervention team staffed by Austin-Travis County Integral Care for individuals who reside in Travis County who have left an SSLC within the previous five years and who (1) are experiencing a behavioral or mental health crisis; or (2) have a history of intermittent behavioral challenges; and (3) require the establishment of a proactive action plan to maintain stability.

## **Aging and Disability Resource Centers**

Aging and Disability Resource Centers (ADRC) provide a “no wrong door” approach to accessing services. Each ADRC is comprised of a network of local service agencies that coordinate information, referrals, and linkages to public and private LTSS programs and benefits. ADRCs use person-centered options counseling to assist individuals with decision-making about service choices tailored to meet their needs. ADRCs also provide assistance with system navigation and care transition support services through collaboration with hospitals and NFs.

Key community partners include DADS three “front door” programs: area agencies on aging (AAAs), community services (CS) regions, and local intellectual disability authorities (LAs). There are 14 ADRCs operating in 10 of the 11 health and human services regions in Texas:

- *Alamo Service Connection*—serving Bexar County (San Antonio)
- *Central Texas Aging and Disability Resource Center*—serving Central Texas (Bell, Coryell, Hamilton, Lampasas, and Milam counties)
- *Aging and Disability Resource Center of Tarrant County*—serving Tarrant County
- *Care Connection Aging and Disability Resource Center*—serving Harris County/Houston and 12 surrounding counties (Austin, Brazoria, Chambers, Colorado, Fort Bend, Galveston, Harris, Liberty, Matagorda, Montgomery, Walker, Waller, and Wharton counties)
- *Lubbock County Aging and Disability Resource Center*—serving Lubbock County

- *East Texas Aging and Disability Resource Center*—serving East Texas (Gregg, Harrison, Marion, Panola, Rusk and Upshur counties)
- *North Central Texas Aging and Disability Resource Center*—serving North Central Texas (Collin, Denton, Hood, and Somervell counties)
- *Connect to Care Aging and Disability Resource Center*—serving Dallas County
- *Aging, Disability, and Transportation Resource Center: El Paso & Far West Texas*—serving El Paso/West Texas (Brewster, Culberson, El Paso, Hudspeth, Jeff Davis, and Presidio counties)
- *Coastal Bend Aging and Disability Resource Center*—serving Coastal Bend (Aransas, Bee, Brooks, Duval, Jim Wells, Kenedy, Kleberg, Live Oak, McMullen, Nueces, Refugio and San Patricio counties)
- *RIO-Net Aging and Disability Resource Center*—serving Lower Rio Grande (Cameron, Hidalgo, and Willacy counties)
- *West Central Texas Aging and Disability Resource Center*—serving West Central Texas (Callahan, Jones and Taylor counties)
- *Brazos Valley Aging and Disability Resource Center*—serving Brazos Valley (Brazos, Burleson, Grimes, Leon, Madison, Robertson, and Washington counties)
- *Concho Valley Aging and Disability Resource Center*—serving Concho Valley (Coke, Concho, Irion, Runnels, Schleicher, Sterling, and Tom Green counties)

## **Opportunities for Self-Direction of Services**

### **Consumer Directed Services Option**

Consumer Directed Services (CDS) is a LTSS delivery option in which individuals receiving services, parents of minor-aged children, or guardians have increased choice and control over the delivery of services. The CDS option allows the individual or the individual's legally authorized representative to be the employer of record of the personal assistance or habilitation services provider; respite services provider; or, in some programs, professional services provider (nursing, physical therapy, occupational therapy, and speech therapy). The individual or legally authorized representative has responsibility for hiring; training; supervising; and, if necessary, terminating the

employee. Individuals may appoint a designated representative to assist with employer responsibilities.

Those who use the CDS option are required to select a Financial Management Services Agency (FMSA) that will provide an orientation, pay employees, and pay federal and state employer taxes on their behalf. Support consultation is an optional support service for individuals who want additional coaching and training on employer-related skills and activities.

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. Informed choice is critical to the concept of consumer direction. The case manager or service coordinator is responsible for ensuring that individuals and families understand the risks and benefits of the choice to direct their own services.

CDS is an option for certain services in each of the following programs:

***Medicaid Home and Community-Based Waiver Programs***

- CLASS
- DBMD
- MDCP
- HCS
- TxHmL

***Medicaid State Plan Services***

- CAS
- PCS
- PHC

***Medicaid Managed Care Programs***

- STAR+PLUS
- STAR Health

***Social Services Block Grant (Title XX) Programs***

- Consumer Managed Personal Assistance Services (CMPAS)

**Medicaid Estate Recovery Program**

On March 1, 2005, Texas implemented the Medicaid Estate Recovery Program (MERP) in compliance with federal Medicaid laws. MERP provides the authority for the state to file a claim against the estate of a deceased Medicaid recipient, age 55 or older, who applied for certain long-term care services on or after March 1, 2005. Claims include the

cost of services, hospital care and prescription drugs supported by Medicaid under the following programs:

- NFs;
- ICFs/IID, which includes SSLCs;
- CAS; and
- Medicaid waiver programs.
  - CLASS
  - DBMD
  - HCS
  - TxHmL
  - STAR+PLUS

There are certain exemptions from recovery as required by federal and state law. When no exemptions apply, the heir(s) 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. DADS is responsible for MERP program policy and procedures.

## Supporting Independence and Employment

### **Medicaid Buy-In Program for Workers with Disabilities**

In September 2006, HHSC implemented a statewide Medicaid Buy-In program to enable working persons with disabilities to receive Medicaid services. Based on direction from S.B. 566, 79<sup>th</sup> Legislature, Regular Session, 2005, the program is available to individuals with countable earned income less than 250 percent of FPL. Medicaid Buy-In participants may be required to pay a monthly premium, depending on their earned and unearned income. Medicaid Buy-In participants eligible for STAR+PLUS will be enrolled in the STAR+PLUS Medicaid managed care program to receive their Medicaid services.

Medicaid Buy-In participants are eligible for the same services available to adult Medicaid recipients, including office visits, hospital stays, x-rays, vision services,

hearing services, and prescriptions. They also are eligible for attendant services, day activity health services, and home and community-based services waivers if they meet the functional requirements for these programs.

## Health Information Exchange

Health Information Exchange (HIE) is the secure electronic movement of health-related information among treating physicians and other care providers and organizations according to national and state laws and nationally recognized standards. The purpose of HIE is to improve the quality, safety, and efficiency of health care using health information technology (HIT) to enable health care providers to access their patients' health information to ensure that the patient receives the right care at the right time. HIE means:

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

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

HHS currently has several HIE-related initiatives underway:

- *Texas Medicaid Electronic Health Record Incentive Program:* HHSC administers the Medicaid EHR Incentive Program, which incentivizes Medicaid healthcare providers to adopt, implement, and upgrade to certified electronic health record technology and use it meaningfully. HHSC's goal is to assist providers to connect to the regional and state level Health Information Exchanges.
- *Statewide Health Information Exchange:* In 2010, HHSC was awarded \$28.8 million through the State Health Information Exchange Cooperative Agreement Program to develop a HIE network in Texas. This program concluded in early

2014 and included three strategies: funding for local health information exchange organizations to connect health care providers regionally; funding the development of a strategy for those areas of the state not covered by a local HIE, known as the “white space”; and funding certain statewide shared services to help facilitate exchange.

- *E-Prescribing*: HHSC upgraded its pharmacy benefits system to provide e-prescribing functionality.
- *Medicaid Eligibility and Health Information Services System (MEHIS)*: The Texas Legislature directed HHSC to ensure the development of a HIE system to support improved quality of care for Medicaid patients by giving providers more and better information about their patients.

## Electronic Health Information Exchange System Advisory Committee

The Electronic Health Information Exchange System Advisory Committee for the Texas Medicaid agency was established under the authority of H.B. 1218, 81<sup>st</sup> Legislature, Regular Session, 2009, and commenced in February 2010. The Advisory Committee was abolished by statute August 31, 2013 and reinstated April 2, 2014.

The purpose of this advisory committee is to advise the HHSC regarding the development and implementation of the electronic HIE system. In addition to any issue specified by HHSC, specific issues addressed include:

- Data to be included in an electronic health record;
- Presentation of data;
- Useful measures for quality of service and patient health outcomes;
- Federal and state laws regarding privacy and management of private patient information;
- Incentives for increasing health care provider adoption and usage of an electronic health record and the HIE system; and
- Data exchange with local or regional health information exchanges to enhance (a) the comprehensive nature of the information contained in electronic health records; and (b) health care provider efficiency by supporting integration of the information into the electronic health record used by health care providers.

The HHSC Executive Commissioner appoints to the advisory committee at least 12 and not more than 16 member representatives from a broad range of health professionals, consumers, advocacy groups, and individuals with knowledge and expertise in health information technology who have experience in serving persons receiving health care through the state’s Medicaid and CHIP programs.

The advisory committee collaborates with the Texas Health Services Authority to ensure that the HIE system is interoperable with, and not an impediment to, the electronic health information infrastructure that the authority assists in developing.

The Health Information Exchange Advisory Committee's recommendations are based on public comment or testimony taken at committee meetings and the members' own knowledge of and experience with HIE and health information technology. Materials reviewed by the advisory committee are made available to the public before or after the meetings. The Health Information Exchange Advisory Committee has no administrative authority in the operation of the Medicaid program.

## Texas Medicaid Electronic Health Record Incentive Program

The American Recovery and Reinvestment Act (ARRA) of 2009 increased the focus on health information technology (HIT) throughout the public and private health care delivery system. The Health Information Technology for Clinical and Economic Health (HITECH) Act within ARRA provides funding opportunities to assist physicians and other health care professionals in the adoption and meaningful use of electronic health record (EHR) technology and to advance HIE. A certified EHR contains the electronic records of individual patients' health-related information. Records include patient demographic and clinical health information, such as medical histories and problem lists.<sup>viii</sup> Certified EHRs have a variety of capabilities including: clinical decision support, physician order entry, capture and query of information relevant to health care quality, and the ability to exchange electronic health information with other sources. ARRA allows state Medicaid agencies to establish programs for paying incentives to Medicaid providers for the meaningful use of EHRs.

To be considered a "meaningful user" of an EHR, an eligible professional or eligible hospital must demonstrate meaningful use of the EHR technology over a specified period of time in a manner that is consistent with the objectives and measures outlined in federal regulation by CMS. These objectives and measures include the use of certified EHR technology that improves quality, safety, and efficiency of health care delivery; reduces health care disparities; engages patients and families; improves care coordination; improves population and public health; and ensures adequate privacy and security protections for personal health information. States can receive 100 percent

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<sup>viii</sup> Maintaining a "problem list" for a patient is one of the meaningful use criteria for an EHR. CMS established criteria that a provider must maintain an up-to-date problem list of current and active diagnoses for more than 80 percent of the patients seen by the provider. It is only one of many meaningful use criteria specified in CMS rules.

federal financial participation for incentive payments to Medicaid providers to adopt, implement, and “meaningfully use” certified EHRs. The HITECH Act also provides for Medicaid agencies to obtain 90 percent federal administrative matching funds to develop and administer the EHR Incentive Program.

Texas Medicaid implemented the EHR Incentive Program and began disbursement of incentive payments to eligible providers in May 2011. Through this initiative, Texas has laid the groundwork for the development of accountable systems of care. Quality data received through providers’ submission of meaningful use and clinical quality measures may be incorporated into the overall management of the Medicaid program.

## **Statewide Health Information Exchange**

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

In 2010, HHSC was awarded \$28.8 million through the State Health Information Exchange Cooperative Agreement Program. These funds helped the state develop a strategic and operational plan for HIE and supported the implementation of these plans through the first quarter of 2014. To assist with the implementation of these strategies, HHSC contracted with the Texas Health Services Authority (THSA), an entity created through H.B. 1066, 80<sup>th</sup> Legislature, Regular Session, 2007, as a public-private non-profit charged with implementing state-level health information technology functions and catalyzing the development of a seamless electronic health information infrastructure to support the health care system in the state.

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

- **General State-Level Operations:** These are administered jointly by THSA and HHSC to support a transparent and collaborative governance structure to coordinate the implementation of HIE in Texas, develop policies and guidelines, and provide statewide HIE services. Following the conclusion of grant funding through the Cooperative Agreement Program, THSA continues to operate the State-Level Shared Services which spans the entire state and enables health care providers to electronically exchange patient health information across Texas and the nation.
- **Local HIE Grant Program:** This grant program partially funded planning, development, and operations of local and regional Texas HIE networks. At the

conclusion of this program in March 2014, ten local HIEs in various stages of operation continue to provide services throughout the State of Texas.

- “White space” Strategy: This coverage strategy supports HIE connectivity through Health Information Service Providers in regions of the state without local or regional HIEs.

## **Electronic Prescribing (E-Prescribing)**

To reduce adverse drug events and costs incurred in providing prescription drug benefits, HHSC upgraded its pharmacy benefits system to provide e-prescribing functionality. New functions became available to pharmacies and providers in December 2011.

- The Medicaid/CHIP drug formulary and preferred drug list are available to FFS and MCO prescribers electronically. Prescribers' EHR systems can download regularly updated formulary information that is seamlessly integrated into their prescribing interface.
- Client prescription benefit eligibility is also integrated into prescribers' EHR systems as well as pharmacies' management software. Medicaid/CHIP client eligibility will be verified in a timely manner by providers and pharmacies, ensuring clients receive the full benefit of their enrollment and speeding access to prescription drugs.
- Medication histories of Medicaid/CHIP clients are available for providers and pharmacies, integrated alongside formulary and benefit eligibility information.

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

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

Some of the key features of the MEHIS system include:

- Plastic magnetic stripe Medicaid ID cards;
- Rapid client check-in with automated eligibility verification using near real-time data;
- Multiple configuration/access options for providers;

- Prescription and lab data;
- Provider and client portals with access to program and health information;
- Provider and client help desks; and
- Support for future HIE.

## Online Client Portal

The MEHIS system, known publically as the “Your Texas Benefits Medicaid Card” system, became operational on June 29, 2011. The initial implementation included electronic eligibility verification using [YourTexasBenefitsCard.com](http://YourTexasBenefitsCard.com), card production and distribution, and a help desk for providers and clients.

On January 23, 2012, the initial version of the Medicaid client portal was implemented and added the following features:

- Single-sign-on at [YourTexasBenefits.com](http://YourTexasBenefits.com);
- View client Medicaid eligibility information and Texas Health Steps data;
- View and print copies of one or more Medicaid ID cards;
- Online card replacement requests; and
- Clients have the option of “opting out” or blocking online access to their Medicaid-related health history.

New features added and planned to improve functionality to the client portal include electronic health history, detailed claims information, and the on-line explanation of benefits. Subsequent releases are planned that will allow clients to access the client portal via a mobile device.

## Your Texas Benefits Medicaid Card

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

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

The back of the card includes a statewide toll-free phone number and a website where clients can get more information on the Your Texas Benefits Medicaid card. The card is not required for clients to access services, but does help accelerate the verification of eligibility. Since possession of the card does not guarantee current eligibility, providers

need to verify eligibility at the point of service by using the [YourTexasBenefitsCard.com](https://YourTexasBenefitsCard.com) provider portal, or they can call the associated help desk.

## Online Provider Portal

One aspect of the Your Texas Benefits Medicaid card project is the provider portal. The Medicaid ID card and system are designed to give providers another way to verify the client's Medicaid coverage. Providers may use the portal to access their Medicaid patient's Medicaid-related:

- Claims and encounter data (i.e., dates, doctors, diagnosis, procedures);
- Prescription drug history;
- Lab results; and
- Immunization information.

The provider portal is currently being pilot-tested.

Additional features, such as Blue Button, have been planned for the provider and client portals. This feature will give providers electronic access to their patient's medical records with a click of a button and allow them to print the patient's available records with ease. Blue Button will also help empower patients to access, use and share their health information more easily. Patients who use their health information may become more engaged with their care overall, leading to improved health outcomes.

# Endnotes

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<sup>1</sup> 42 U.S.C. §1396 et seq.

<sup>2</sup> Texas Medicaid and Healthcare Partnership (TMHP) Ad Hoc Query Platform Client Universe, retrieved on July 11, 2014.

<sup>3</sup> TMHP Ad Hoc Query Platform Claims Universe, retrieved on July 11, 2014.

<sup>4</sup> Women's Health Program Final Report to CMS, 1115(a) Research and Demonstration Waiver, Family Planning Project Number 11-W-00233/6, Health and Human Services Commission.