

Chapter 7: Medicaid Managed Care

Texas began implementing Medicaid managed care in 1993. This chapter outlines Texas' experience with Medicaid managed care.

What is Managed Care?

Both in Texas and nationally, the Medicaid program has increasingly turned to managed care to deliver services more effectively. The traditional Medicaid payment system, known as fee-for-service (FFS), pays health care providers a fee for each unit of service they provide. This approach may result in extra procedures and costs and a lack of care coordination for the client. In a managed care program, a managed care organization (MCO), sometimes called a health plan, is paid a capped (or capitated) rate for each client enrolled. In managed care, clients receive healthcare services and long-term services and supports through an MCO contracted with a network of doctors, hospitals and other health care providers responsible for managing and delivering quality, cost-effective care. In Texas, Medicaid MCOs must cover the same services as traditional Medicaid. The Health and Human Services Commission (HHSC) continues to expand Medicaid managed care. In State Fiscal Year (SFY) 2013, 80 percent of the state's Medicaid population was enrolled in managed care.

HHSC continually monitors whether the MCOs are successful in creating a more efficient and effective delivery model than FFS. One of the goals of managed care is to emphasize preventative care and early interventions. MCOs assign each member a primary care provider that helps coordinate care by making appropriate referrals to specialty services and providers. Members also benefit from service coordination and management to make sure services address member's needs.

The following features characterize Medicaid managed care in Texas:

Medical Home

Clients in Medicaid managed care choose a primary care provider (PCP) who serves as the client's medical home by providing comprehensive preventive and primary care. The

PCP also makes referrals for specialty care and other services offered by the MCO, such as case management. In Texas Medicaid, the types of providers that generally act as PCPs are family and general practice doctors; pediatricians; internal medicine doctors; obstetricians/gynecologists; physicians' assistants; advanced practice registered nurses; and federally-qualified health centers (FQHCs), rural health centers, and similar community clinics. Occasionally, specialists agree to act as the PCP for clients with special health care needs.

Health Home

MCOs are required to provide health homes to members with chronic conditions. A health home provides comprehensive and high-quality services that are provided by a designated provider and a team of health care professionals to fit the needs of persons with multiple chronic conditions or a serious and persistent mental or health condition. The health home model of service delivery expands on the medical home principles to build linkages to other community and social supports, and to enhance coordination of medical and behavioral health care. Health home services include the following: comprehensive case management; care coordination and health promotion; comprehensive transitional care, including appropriate follow-up from inpatient to other settings; patient and family support; referral to community and social support services; and use of health information technology to link services. The health home model of service delivery expands on the medical home by enhancing coordination and integration of behavioral health care to better meet the needs of patients, particularly those with chronic conditions.

HHSC encourages MCOs to develop incentive programs for designated providers serving as patient-centered medical homes and to structure payments based on quality outcomes or shared savings.

Emphasis on Preventative Care

MCOs are required to ensure that members have timely access to regular and preventive care. By emphasizing preventive care, MCOs can reduce the use of emergent care and non-urgent care. Non-urgent visits to the emergency room include inappropriate visits, avoidable visits, non-emergency visits, and minor illness visits.

Improved Access to Care

In managed care, members must have access to covered services on a timely basis. MCOs are required to have a defined network of providers to meet member needs, and provide support to members who need help finding a doctor or setting up appointments. Through its provider network, MCOs are also required to meet standards for waiting times for appointments.

Defined Network of Providers

Managed care limits clients' choices of providers (with some exceptions) to those under contract with the MCO, also known as in-network providers. The MCO is obligated to maintain access to network providers based on standards developed by the state. HHSC continually monitors the MCO networks for compliance with the standards.

Utilization review and Utilization Management

MCOs use utilization management to review requests for approval of future medical or service needs. Utilization management includes prospective and concurrent utilization review. Utilization management (often used interchangeably with utilization review) includes practices such as preadmission screenings and prior authorization of certain medical services. Concurrent utilization review is usually conducted during a hospital confinement to determine the medical necessity for continued stay.

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

Quality Assessment and Performance Improvement

MCOs must operate quality assessment and performance improvement programs. These programs evaluate performance use objective quality standards, foster data-driven decision-making, and support programmatic improvements.

Managed Care History in Texas

In response to rising health care costs and national interest in cost-effective ways to provide quality health care, the Texas Legislature passed H.B. 7, 72nd Legislature, Regular Session, 1991, which directed the state to establish Medicaid managed care pilot programs. These pilots (implemented in Travis County and in the Tri-County Area of Chambers, Jefferson, and Galveston counties) were initially known as the LoneSTAR (State of Texas Access Reform) Health Initiative. The name was later shortened to STAR. The Travis County pilot was implemented in August 1993. The Tri-County pilot was implemented in December 1993 and was expanded in December 1995 to include three additional counties (Hardin, Liberty, and Orange).

Texas lawmakers passed S.B. 10, 74th Legislature, Regular Session, 1995, and related legislation to enact a comprehensive statewide restructuring of Medicaid, incorporating a managed care delivery system. Texas continued to expand its Medicaid managed care program through 1915(b) waivers under the authority of S.B. 10.

In September 1996, the Travis County pilot was expanded to include surrounding counties. Additionally, the Bexar, Lubbock, and Tarrant service areas were brought under managed care. The STAR program, which primarily serves children, low-income families, and pregnant women, was expanded to include certain Medicaid clients with disabilities (Supplemental Security Income [SSI] and SSI-related) on a voluntary basis when the 1996 expansion occurred.

The Texas Legislature passed H.B. 2913; and S.Bs. 1163, 1164, and 1165, 75th Legislature, Regular Session, 1997, to strengthen Medicaid managed care client and provider protections. In December 1997, the state expanded the STAR program to the Houston area and created a new pilot to integrate acute care and long-term services and supports for SSI and SSI-related Medicaid clients in Harris County. This program is known as STAR+PLUS. The implementation of STAR and STAR+PLUS in the Harris service area doubled the number of Texas Medicaid clients receiving services through the managed care model.

Through S.B. 2896, 76th Legislature, Regular Session, 1999, the Texas Legislature placed a moratorium on further managed care expansion, but allowed the state to complete the Dallas and El Paso service area implementations, which were already underway. The bill directed HHSC to evaluate the effects of the Texas Medicaid managed care program on access to care, quality, cost, administrative complexity, utilization, care coordination, competition, and network retention.

The Dallas and El Paso service area implementations were completed in 1999. In addition to expanding the STAR program in Dallas, the state also implemented a unique behavioral health pilot, NorthSTAR, in the Dallas service area. NorthSTAR provides mental health and substance abuse services to Medicaid clients and certain non-Medicaid clients below 200 percent of the federal poverty level.

Over a 15-month period in 1999 and 2000, HHSC led an analysis of the STAR and STAR+PLUS programs in conjunction with a workgroup composed of representatives from the advocacy, provider, and managed care communities. The resulting Medicaid Managed Care Report concluded that Texas had achieved many, but not all of the goals set for the Medicaid managed care program.¹ The study found that implementation of managed care improved access to providers, produced program savings, and resulted in program accountability and quality improvement standards and measurement not found in the traditional FFS Medicaid program. The report also concluded that managed

care introduced additional program complexity both to providers and to clients. While clients were generally satisfied with the care they received under managed care, Medicaid providers were generally more dissatisfied with the increased administrative complexity and oversight required.

In 2001, following the release of the Medicaid Managed Care Report, the moratorium on managed care was lifted, and HHSC was allowed to expand Medicaid managed care when cost effective.

By 2003, the Texas Legislature faced budget pressures that prompted interest in modifying Medicaid and expanding managed care throughout the state in order to obtain additional cost savings. H.B. 2292, 78th Legislature, Regular Session, 2003, directed HHSC to provide Medicaid managed care services through the most cost-effective models.

In September 2005, Primary Care Case Management (PCCM) (formerly known as the Texas Health Network) was removed as a non-capitated plan choice in the STAR service areas. It expanded to 197 primarily rural counties outside of the STAR service areas plus five STAR counties in the southeast region (Chambers, Hardin, Jefferson, Liberty, and Orange). This increased the number of counties covered by PCCM to 202. As a result of this expansion, all Texas counties were served by either STAR or PCCM.

The Texas Legislature passed S.B. 6, 79th Legislature, Regular Session, 2005, which directed HHSC and the Department of Family and Protective Services (DFPS) to develop a statewide health care delivery model for all Medicaid children in foster care. STAR Health was implemented on April 1, 2008. The STAR Health Program is designed to better coordinate the health care of children in foster care and kinship care through one statewide MCO.

The 2006-07 General Appropriations Act (GAA), S.B. 1, 79th Legislature, Regular Session, 2005 (Article II, Special Provisions, Section 49), and H.B. 1771, 79th Legislature, Regular Session, 2005, directed HHSC to use cost-effective models to better manage the care of Medicaid clients who are age 65 and older and those with physical disabilities in certain areas of the state. In response to this direction, HHSC developed the Integrated Care Management model and the STAR+PLUS Hospital Carve-Out model to integrate acute and long-term services and supports. In February 2007, the STAR+PLUS Hospital Carve-out model replaced the existing STAR+PLUS model in the Harris service area and was expanded to the Bexar, Harris Expansion, Nueces, and Travis service areas. The Integrated Care Management model ended in May 2009.

In addition to developing new managed care programs, HHSC has continued to expand existing programs. In 2006, Nueces was added to the STAR service areas. The 2010-

11 GAA , S.B. 1, 81st Legislature, Regular Session, 2009 (Article II, Special Provisions, Section 46), required HHSC to implement the most cost-effective integrated managed care model for Medicaid clients who are with disabilities in the Dallas and Tarrant service areas. After analyzing current managed care models, HHSC determined STAR+PLUS was the most appropriate cost-effective model to meet the legislative mandate. In February 2011, HHSC expanded STAR+PLUS to the Dallas and Tarrant service areas.

In September 2011, STAR and STAR+PLUS expanded to 28 counties contiguous to the existing service areas. STAR expanded to 17 counties contiguous to Bexar, El Paso, Lubbock, Nueces, and Travis service areas and STAR+PLUS expanded to 10 counties contiguous to the Bexar, Harris, Nueces, and Travis service areas. STAR and STAR+PLUS expanded to the newly formed Jefferson service area, which included 11 counties contiguous to the Harris service area. HHSC eliminated the PCCM model in the 28 contiguous counties on August 31, 2011.

In 2013, as part of the passage of S.B. 7, 83rd Legislature, Regular Session, the Texas Legislature approved several expansions of managed care to cover new populations. On September 1, 2014, STAR+PLUS expanded to the Medicaid Rural Service Area (MRSA), integrating acute care and long-term services and supports for individuals 65 and older and those with disabilities. Most adults with intellectual and developmental disabilities (IDD) being served through one of the 1915(c) waivers operated by DADS for individuals with IDD or living in a community-based ICF/IID began receiving acute care services through STAR+PLUS on this date. On March 1, 2015, HHSC will begin to deliver nursing facility services through the STAR+PLUS managed care model to most adults age 21 and over.

As a result of S.B. 58, 83rd Legislature, Regular Session, 2013, other changes implemented effective September 1, 2014 include adding mental health rehabilitation and mental health targeted case management services into managed care. These two behavioral health services have been traditionally delivered through the FFS system.

In March 2015, HHSC will also implement the Texas Dual Eligible Integrated Care Project (known as the Dual Demonstration), a fully integrated managed care model for individuals who are enrolled in Medicaid and Medicaid. The goals of the Dual Demonstration are to: have one health plan be responsible for both Medicare and Medicaid services, improve quality and individual experience in accessing care and promote independence in the community. The Dual Demonstration will be available to individuals ages 21 or older who are eligible for full Medicare and Medicaid benefits and required to receive Medicaid benefits through STAR+PLUS. The Demonstration Project will be limited to six Texas counties: Bexar, Dallas, El Paso, Harris, Hidalgo, and Tarrant.

S.B. 7 also directed HHSC to develop a managed care program, STAR Kids, tailored for children with disabilities, including children who are receiving benefits under the Medically Dependent Children Program (MDCP). STAR Kids has a proposed implementation date of September 1, 2016.

Managed Care Performance Evaluation

Federal regulations require external quality review of Medicaid managed care programs to ensure state programs and their contracted MCOs are compliant with established standards. The external quality review organization (EQRO) is required to validate MCO performance improvement projects, validate MCO performance measures, and assess MCO compliance with member access to care and quality of care standards. In addition, states may also have the EQRO validate member-level data; conduct member surveys, provider surveys, or focus studies; assess performance improvement projects, and calculate performance measures.

Ensuring the delivery of affordable, high-quality health care for beneficiaries of public insurance programs has become increasingly important in recent years, as federal and state agencies seek to address budget deficits while also improving access to health care. Texas has a strong focus on quality of care in Medicaid and the Children's Health Insurance Program (CHIP) that includes initiatives based on significant legislation such as S.B. 7, 83rd Legislature, Regular Session, 2013. S.B. 7 covers a range of health care issues including an emphasis on promoting health care quality.

Pay for Quality

Sections of S.B. 7, 83rd Legislature, Regular Session, 2013, focus on the use of quality-based outcome and process measures in quality-based payment systems by measuring potentially preventable events (PPEs); rewarding use of evidence-based practices; and promoting healthcare coordination, collaboration, and efficacy. To comply with this legislative direction, HHSC redesigned its Performance Based At-Risk/Quality Challenge Initiative, implementing a Pay-for-Quality program (P4Q). The HHSC P4Q encourages incremental improvement in MCO performance for a specified set of measures. P4Q provides financial incentives and disincentives to MCOs participating in the STAR, STAR+PLUS, and CHIP programs by placing a maximum of four percent of an MCO's capitation revenue at risk. MCOs that meet MCO-specific goals are eligible for a bonus of up to four percent of their capitation rate. MCOs demonstrating inadequate performance may lose up to four percent of their capitation rate.

Under the P4Q program, MCOs compete against their own performance from the previous year in a model developed by HHSC and the state's EQRO. Each MCO's

performance is measured using Health Effectiveness Data Information Set (HEDIS®) quality of care and PPE measures. For each measure, HHSC establishes a minimum threshold and an attainment goal. MCOs can then earn positive or negative points according to their progress towards or movement away from this goal. MCOs performing below the minimum threshold cannot receive positive points for improvements made until they have exceeded the minimum threshold, although they can be penalized for declining performance. P4Q is budget neutral to the state; all funds collected through penalties are redistributed to the better performing MCOs.

Managed Care Initiatives

HHSC is implementing several Medicaid managed care initiatives that include service area expansions, extending managed care coverage to new populations, carving in new benefits and services, and establishing a new program.

Expansion

The Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver, known as the 1115 Transformation Waiver, is a five-year demonstration waiver that began in December 2011. It allowed the state to preserve federal hospital funding historically received as upper payment limit (UPL) payments. (See Chapter 4, Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver.)

The 1115 Transformation Waiver enabled the state to conduct a phased transition of Medicaid beneficiaries from FFS to a managed care delivery system based on geographic service areas. This transition included the expansion of the STAR, and STAR+PLUS Medicaid managed care programs to new areas of the state and the elimination of the PCCM program. These changes and others detailed below have resulted in managed care being the primary vehicle through which almost all Medicaid recipients receive medical and dental services.

Effective March 1, 2012:

- HHSC expands STAR+PLUS into the El Paso and Lubbock service areas, expands STAR and STAR+PLUS into 10 counties in South Texas creating the Hidalgo service area, and replacing PCCM with the STAR program in 164 counties creating the Medicaid Rural Service Area.
- Inpatient hospital services are included in the STAR+PLUS capitation rate.
- Children's Medicaid and the Children's Health Insurance Program (CHIP) dental benefits for most children are administered through a statewide managed care capitated model.

- Pharmacy benefits are administered by MCOs for STAR, STAR Health, STAR+PLUS, and CHIP participants.

Effective September 1, 2014:

- STAR+PLUS expands to the 164 counties in the Medicaid Rural Service Area, making STAR+PLUS a statewide Medicaid managed care program.
- Most adults with intellectual and developmental disabilities receiving services through a 1915(c) IDD waiver or a community-based ICF/IID get their basic health services (acute care) through a STAR+PLUS health plan and continue to get their long-term services and supports through a DADS waiver or ICF/IID program.
- Individuals with Medicaid and Medicare coverage in six counties will receive integrated care through a STAR+PLUS Medicare-Medicaid Plan.

Effective March 1, 2015:

- Most adults living in nursing facilities receive full Medicaid coverage through a STAR+PLUS health plan.
- Individuals with Medicaid and Medicare coverage in six counties will receive integrated care through STAR+PLUS health plan.

Dual Eligibles Integrated Care Demonstration

Federal law created the Federal Coordinated Health Care Office (“Medicare-Medicaid Coordination Office”).ⁱ This office is charged with supporting the coordination of Medicare and Medicaid to allow the two programs to work together more effectively to improve care and lower costs. The Medicare-Medicaid Coordination Office is required to support state efforts to coordinate, contract and align acute care and long-term care services for dual eligibles with other items and services furnished under the Medicare program.ⁱⁱ The Dual Eligibles Integrated Care Demonstration Project, also referred to as the Dual Demonstration, was created by Medicare-Medicaid Coordination Office.

In May 2014, HHSC received federal approval for a fully integrated, capitated model that involves a three-party agreement between an MCO with an existing STAR+PLUS contract, the state, and the Centers for Medicare & Medicaid Services (CMS) for the provision of the full array of Medicaid and Medicare services. The initiative will test an innovative payment and service delivery model to alleviate the fragmentation and improve coordination of services for dual eligibles, enhance quality of care and reduce

ⁱ Section 2606 of the Affordable Care Act

ⁱⁱ Sections 2602(d)(2) and 2602(d)(3) of the Affordable Care Act

costs for both the state and the federal government. The demonstration is scheduled to begin March 1, 2015 and will continue until December 31, 2018.

Under this initiative, one health plan called a STAR+PLUS Medicare-Medicaid Plan will be responsible for the full array of Medicare and Medicaid-covered services. Eligible individuals will have access to an adequate network of medical, behavioral health, and supportive services including acute care services covered under Medicare and long-term care services under Medicaid through one Medicare-Medicaid Plan. This includes any benefits that will be added to the STAR+PLUS service array by March 1, 2015, such as nursing facility services.

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

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

The project will not include clients who reside in ICFs/IID and individuals with developmental disabilities who get services through one of these waivers:

- Community Living Assistance and Support Services (CLASS);
- Deaf Blind with Multiple Disabilities Program (DBMD);
- Home and Community-based Services (HCS); and
- Texas Home Living Program (TxHmL).

The demonstration will operate in Bexar, Dallas, El Paso, Harris, Hidalgo and Tarrant counties. The number of clients that may be served through this model is outlined below.

County	Number of Clients	Health Plans
Bexar	26,452	Amerigroup, Molina, Superior
Dallas	27,941	Molina, Superior
El Paso	19,645	Amerigroup, Molina
Harris	47,160	Amerigroup, Molina, United
Hidalgo	27,090	Health Spring, Molina, Superior
Tarrant	16,986	Amerigroup, Health Spring

STAR Kids

Beginning September 1, 2016, children and youth age 20 or younger who either receive SSI Medicaid or are enrolled in the Medically Dependent Children Program (MDCP) will receive all of their services through the STAR Kids program. STAR Kids is the managed care program that will provide acute and community-based Medicaid benefits to children with disabilities. Children and youth who receive services through other 1915(c) waiver programs will receive their basic health services (acute care) through STAR Kids, but will continue receiving 1915(c) waiver services through the Department of Aging and Disability Services (DADS). Children, youth, and their families will have the choice of at least two STAR Kids MCOs and will have the option to change plans.

A core component of the STAR Kids program will be a standard screening and assessment process used by MCOs to determine each individual's needs as they relate to health and independent living. In addition to traditional Medicaid services, children and young adults enrolled in STAR Kids will receive an individual service plan and service coordination to ensure the delivery of effective, coordinated Medicaid services.

Texas Medicaid Managed Care Programs

STAR

The Medicaid State of Texas Access Reform (STAR) program provides primary, acute care, and pharmacy services for pregnant women, newborns, and children with limited income. Acute care services include doctor's visits, pharmacy, home health, medical equipment, lab, x-ray, and hospital services. The program operates statewide under the authority of the Texas Health Care Transformation and Quality Improvement Program 1115 Waiver. Services are delivered through managed care organizations (MCOs) under contract with the Health and Human Services Commission (HHSC).

Other individuals may be required to enroll in STAR or have the option. Former foster care children ages 18-20 are mandated to enroll into managed care, but may choose to be in either STAR or STAR Health. Former foster care children ages 21-25 are mandated to enroll into STAR as STAR Health is not an option for this population. Individuals under the age of 19 who receive services through the Youth Empowerment Services (YES) program can voluntarily enroll into STAR. Other than those populations described above, individuals who reside in institutions or nursing facilities; receive SSI or Medicare; are in a DADS 1915(c) waiver program; or are medically needy or are in state conservatorship are generally excluded from STAR enrollment. SSI Children may voluntarily enroll in STAR.

STAR program members have access to a PCP that knows their health care needs and can coordinate their care through a medical home. PCPs provide preventive checkups, treat the majority of conditions that STAR members experience, and refer enrollees to specialty care when necessary. STAR also offers additional services not available in traditional FFS. Under the FFS program, adult clients are limited to three prescriptions per month while STAR members can receive unlimited medically necessary prescriptions. Additionally, STAR members are not subject to the 30-day spell of illness limitation for adults that exists in the FFS program.

STAR+PLUS

The Medicaid STAR+PLUS program provides acute care services plus long-term services and supports (LTSS) by integrating primary care, pharmacy services, and LTSS for individuals who are age 65 or older or have a disability. LTSS includes services such as attendant care and adult day health care. The program operates statewide under the authority of the Texas Health Care Transformation and Quality Improvement Program 1115 Waiver. Services are delivered through managed care organizations (MCOs).

The STAR+PLUS MCOs are responsible for coordinating acute care and LTSS for STAR+PLUS members with complex medical conditions. The STAR+PLUS program serves SSI, SSI-related individuals, and adults who qualify for Medicaid because they meet medical necessity criteria and, as a result, receive Home and Community Based Services (HCBS) STAR+PLUS waiver services. If eligible for STAR+PLUS, adults are required to participate in the program while children may choose to participate or receive Medicaid benefits through fee-for-service. STAR+PLUS members with complex medical conditions are assigned a service coordinator who is responsible for coordinating acute care and long-term services and supports. The service coordinator develops an individual plan of care with the member, the individual's family members, and providers and can authorize certain services. The program also ensures that each member has a primary care doctor.

The HCBS STAR+PLUS waiver is also part of the STAR+PLUS program. The STAR+PLUS HCBS waiver provides additional LTSS to clients who are elderly or who have disabilities as a cost-effective alternative to living in a nursing facility. These services are non-traditional long-term services and supports such as nursing, personal assistance services, adaptive aids, medical supplies, and minor home modifications to make member's homes more accessible. These clients must be age 21 or older, be a Medicaid recipient, or be otherwise financially eligible for waiver services. To be eligible for HCBS STAR+PLUS waiver services, a member must meet income and resource

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

STAR+PLUS enrollees who are eligible for both Medicaid and Medicare receive LTSS through STAR+PLUS and most acute care services through Medicare. If enrollees meet the medical necessity criteria to be in a nursing facility, they may receive the additional LTSS through the HCBS STAR+PLUS waiver.

The STAR+PLUS program provides only acute care services to non-dual eligible members receiving services from an intermediate care facility for individuals with intellectual disabilities or related conditions (ICF/IID) or a 1915(c) waiver program for individuals with intellectual and developmental disabilities (IDD) operated by DADS. Adults in an IDD waiver or residing in an ICF/IID are required to participate in STAR+PLUS for acute care services only while children may choose to participate. All dual eligible individuals who are currently living in an ICF-IID or receiving IDD waiver services or individuals residing in a state supported living center are excluded from participation in the STAR+PLUS program.

Children and young adults under the age of 21 who receive services through the YES program can voluntarily enroll into STAR+PLUS. Children and young adults under the age of 21 who receive services through MDCP cannot voluntarily enroll into STAR+PLUS unless they disenroll from MDCP.

NorthSTAR

NorthSTAR is an integrated behavioral health delivery system in the Dallas service area, serving people who are eligible for Medicaid or who meet other eligibility criteria. It is an initiative of the Department of State Health Services (DSHS). Services are provided via a fully capitated contract with a licensed behavioral health organization. STAR clients in Dallas and six contiguous counties (Collin, Ellis, Hunt, Kaufman, Navarro, and Rockwall) around Dallas receive behavioral health services through NorthSTAR.

NorthSTAR was created in 1999 to integrate the publicly funded systems of mental health and substance use disorder services. Using Medicaid, state general revenue, federal block grant funds, and some local funds, NorthSTAR is designed to create a better coordinated and more efficient and flexible system of public behavioral health care.

Most Medicaid eligible recipients who reside in the service area are automatically enrolled in the program based on their Medicaid status. Non-Medicaid eligible

individuals who reside in the service area and meet clinical and income criteria are eligible to receive services through NorthSTAR via an application process.

NorthSTAR is administered through a DSHS contract with a behavioral health organization (BHO). The BHO contract includes outcome and performance measures specifically designed for behavioral health. The BHO is required to subcontract with a specialty provider network for the provision of a set of specialty treatment services and service coordination for enrollees with serious mental illness and serious emotional disturbance. The BHO is also contractually required to maintain an adequate network for other provider specialties for behavioral health. These include psychiatrists, psychologists, licensed therapists, substance use treatment facilities, and hospitals.

The North Texas Behavioral Health Authority, which was specifically formed for the NorthSTAR project, ensures that there is local oversight and that local communities are given a voice in the delivery of publicly funded managed behavioral health care. The North Texas Behavioral Health Authority represents both mental health and substance use disorder interests and concerns

In 2008, DSHS collaborated with the University of Illinois at Chicago to develop a Self-Directed Care (SDC) pilot program within NorthSTAR. SDC is a new way of providing mental health services in which adults with serious mental illnesses directly manage funds to assist in their recovery. With assistance from an SDC advisor, the Texas SDC participants create a person-centered recovery plan and a budget for the purchase of traditional mental health services and non-traditional goods and services in the community that are tied to their recovery. The project study with the University of Illinois ended in December of 2012. In a randomized controlled trial, the SDC model achieved superior client outcomes for no greater service delivery expenditures than those resulting from the traditional service delivery system. The North Texas Behavioral Health Authority was able to continue the program through January of 2013.

STAR Health

STAR Health is a statewide program designed to provide medical, dental, vision, and behavioral health benefits, including unlimited prescriptions, for children and youth in conservatorship of the Department of Family and Protective Services (DFPS), including those in foster care and kinship care. Services are delivered through a single managed care organizations (MCO) under contract with the Health and Human Services Commission (HHSC).

HHSC, in collaboration with DFPS, implemented STAR Health on April 1, 2008. The STAR Health program serves children in state conservatorship; young adults up to the month of their 22nd birthday who have voluntary foster care placement agreements;

young adults up to the month of their 21st birthday who were formerly in foster care and are receiving Medicaid services under the titles Former Foster Care Children (FFCC) and Medicaid for Transitioning Foster Care Youth (MTFCY), and young adults up to the month of their 23rd birthday not eligible under the aforementioned categories, but who enroll in higher education. Clients can begin receiving services as soon as they enter state conservatorship.

STAR Health members receive services through a medical home. Additional benefits include service management, service coordination, value-added services, and the Health Passport, which is a web-based, claims-based electronic medical record. Service management is for members who have complex or high priority needs. Service managers must be licensed clinicians such as registered nurses, licensed professional counselors (LPCs), or licensed clinical social workers (LCSWs). Service coordination is for stable members who require minor assistance with a health need. Service coordinators must be degreed professionals. The program also includes a seven-days-per-week, 24-hours-per-day nurse hotline for caregivers and caseworkers. Use of psychotropic medications is carefully monitored for compliance with the *DFPS Psychotropic Medication Utilization Parameters* (known as "The Parameters"). The Parameters are best practice guidelines for the use of psychotropic medication in children. In 2010, the program began training and certifying behavioral health providers in Trauma Focused Cognitive Behavioral Therapy (TF-CBT) and training in trauma-informed care was made available to all caregivers and caseworkers in order to effectively manage behavior issues that can destabilize children's health status and foster family placement.

Health Passport

The Health Passport is an essential element of the STAR Health program that improves medical information sharing and promotes coordination of care with the child's healthcare providers, DFPS staff, and caregivers. The Health Passport is a web-based repository of claims-based data and other healthcare services data for each STAR Health member, which facilitates online access to a child's medical data and history to promote continuity of care if the child moves to a new location as the result of a placement change.

Health Passport information is available to authorized users through a secure, password-protected website administered by the STAR Health MCO. Health care data available for viewing in the Health Passport includes current as well as historical claims data for STAR Health members that may have been prior enrolled in CHIP or Texas Medicaid. The system is regularly updated to ensure the most up-to-date information is posted to the child's records. Pharmacy, dental, vision, physical, and behavioral health claims are uploaded on a daily basis; immunization data from the state is received and

loaded weekly. In addition, providers and other authorized individuals have the ability to add certain medical forms, patient allergy information, and patient vitals directly into the Health Passport system; access to the information is available immediately upon entry.

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

Service Management

The STAR Health MCO conducts a telephonic screening for each child within the first month of enrollment. The screening gathers information about each child's physical and behavioral health medical history and status from the medical consentor. The MCO's service management team uses this information to determine the physical and behavioral health needs of all STAR Health members. Depending upon the severity of the identified needs, the MCO will assign a service manager or service coordinator to the child. The service manager or coordinator will then assist the medical consentor in obtaining any necessary services. Updates to the telephonic screening are completed every time a child changes placements, and periodically according to their level of need, throughout their enrollment with STAR Health.

The STAR Health MCO has developed specialty service management programs that can assist children with complex behavioral health needs. Complex Case Management supports children with the highest level of behavioral health needs, including those with dual diagnoses and/or a history of inpatient admissions. The Intellectual Developmental Disabilities Management program identifies and supports those with a diagnosis of autism, Asperger's syndrome, intellectual disability, or pervasive developmental disorder.

Psychotropic Medication Utilization Reviews (PMUR)

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

In 2005, the best practice guidelines, Psychotropic Medication Utilization Parameters for Foster Children, were released. The second edition was released in 2007, the third edition in 2010, and the fourth edition in 2013. These parameters include general principles for optimal practice, reference material, and a listing of commonly used

psychotropic medications with dosage ranges and indications for use in children (both U.S. Food and Drug Administration-approved and literature-based).

The STAR Health MCO conducts ongoing Psychotropic Medication Utilization Reviews (PMURs) on children in foster care whose medication regimens fall outside of the guidelines set forth by the parameters. Representatives from DFPS, HHSC, DSHS, and the STAR Health MCO formed a Psychotropic Medication Monitoring group which meets quarterly to review the monitoring conducted by the STAR Health MCO and its behavioral health subcontractor. The Psychotropic Medication Monitoring group also oversees an annual report on psychotropic utilization and the biennial review and update of the parameters.

Starting in 2011, prior authorization is required for dispensing an antipsychotic medication for any Medicaid member that is taking more than two different antipsychotic medications concurrently or under age three. The carve-in of prescription drug coverage into managed care in 2012 provided the STAR Health MCO with opportunities to enhance its psychotropic medication monitoring. Annual analysis of how Medicaid prescribing practices align with the guidelines set forth in the parameters has revealed that psychotropic prescribing to children in foster care has steadily decreased since the release of the parameters in early 2005, both in terms of the percentage of children in foster care taking psychotropic medication and in the overall number of children receiving medication regimens outside of the recommended criteria.

Children's Medicaid Dental Services

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

- Medicaid clients age 21 and over;
- All Medicaid clients, regardless of age, residing in Medicaid-paid facilities such as nursing homes, state supported living centers, or ICF/IID; and
- STAR Health program clients.

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

- Providing routine preventive, diagnostic, urgent, therapeutic, initial, and primary care;
- Maintaining the continuity of patient care; and

- Initiating referrals for specialty care.

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

Additional Services Offered in Managed Care

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

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

Managed Care Organization Requirements for Chronic Care Management

Medicaid MCOs must provide disease management programs and services consistent with federal and state statutes, regulations, and contract requirements. Disease management programs and services must be part of a person-based approach and holistically address the needs of high-risk members with complex chronic or co-morbid conditions. The programs must identify members at highest risk of utilization of medical services, tailor interventions to better meet members' needs, encourage provider input in care plan development, and apply clinical evidence-based practice protocols for individualized care.

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

Members with Special Health Care Needs

Medicaid MCOs are required to identify and provide service management and service plans for members with special health care needs (MSHCN). A member with special health care needs is a member, including a child, who: (1) has a serious ongoing illness, a chronic or complex condition, or disability that has lasted or is anticipated to last for a

significant period of time and (2) requires regular ongoing therapeutic intervention and evaluation by appropriately trained personnel.

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

Managed Care Enrollment

Table 7.1: Percentage of Medicaid Clients Enrolled in Managed Care SFYs 1994-2014

State Fiscal Year	Service Areas and Implementation Dates	Total Medicaid Managed Care Enrollment	% of Medicaid Population in Managed Care
1994	STAR Implementation: Travis County (8/93) & Tri-County Area (12/93)	58,243	2.86%
1995	Same as above	65,388	3.16%
1996	Travis County and SE Region (Tri-County expanded to 3 additional counties 12/95 and renamed)	71,435	3.46%
1997	Travis (expanded 9/96), SE Region, Bexar (9/96), Lubbock (10/96), Tarrant (10/96)	274,694	13.82%
1998	Same as above, with Harris STAR (12/97), Harris STAR+PLUS (3/98)	364,336	19.56%
1999	Same as above, with STAR expansion to Dallas (7/99)	425,069	23.45%
2000	Same as above with STAR expansion to El Paso (12/99)	523,832	28.98%
2001	Same as above	623,883	33.35%
2002	Same as above	755,698	35.92%
2003	Same as above	988,389	39.71%
2004	Same as above	1,112,002	41.43%
2005	Same as above	1,191,139	42.85%
2006	Same as above, with STAR expansion to 197 counties (PCCM Only)	1,835,390	65.72%

Table 7.1: Percentage of Medicaid Clients Enrolled in Managed Care SFYs 1994-2014 (Continued)

State Fiscal Year	Service Areas and Implementation Dates	Total Medicaid Managed Care Enrollment	% of Medicaid Population in Managed Care
2007	Same as above with STAR HMO expansion to Nueces (09/2006) and STAR+PLUS expansion to Bexar, Travis, Nueces, and Harris Contiguous (02/2007). Urban areas shift from PCCM to HMO Only (12/2006)	1,921,651	67.83%
2008	Same as above, with ICM rollout in Dallas and Tarrant (Aged & Disability Related Clients) (02/2008) and STAR Health Foster Care Managed Care rollout statewide (04/2008)	2,039,340	70.86%
2009	Same as above, but with ICM removed in May 2009	2,127,382	70.78%
2010	Same as above	2,362,091	71.62%
2011	Same as above but with STAR+PLUS expansion to Dallas and Tarrant (2/2011).	2,676,149	75.53%
2012	Expansion to Medicaid Rural Services Area (MRSA) for non-full dual eligible clients, March 2012; Shift from PCCM to HMO for all remaining areas; Carve-in of Vendor Drug, Inpatient Hospital for all STAR+PLUS (March 2012); Dental Capitation (March 2012)	2,893,965	79.16%
2013	Same as above	2,982,923	81.53%
2014	Same as above (data not final until February 2015)	3,012,262	80.40%
2015	<i>FORECAST: STAR+PLUS expansion statewide, IDD Clients Acute Care carved into STAR+PLUS, (September 2014); Nursing Facility and Dual-Demonstration Carve-in, March 2014</i>	3,627,616	86.69%

Sources: HHSC, Financial Services, HHS System Forecasting. Average Monthly Recipient Months including STAR, STAR+PLUS, PCCM, ICM and STAR Health.

Note: In the Dallas Service Area, most Medicaid-eligible individuals receive Medicaid acute care services through the STAR program. They receive their behavioral health services through a separate program, NorthSTAR.

Table 7.2: Medicaid Clients Enrolled in Managed Care and Fee-for-Service SFYs 2010-2014

Medicaid Clients by Service Delivery Type

Service Delivery Type	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Fee-for-Service	936,008	866,908	761,964	675,706	734,427
Managed Care Total	2,362,091	2,676,149	2,893,965	2,982,923	3,012,262
<i>Managed Care: STAR PCCM</i>	805,836	887,919	402,097	0	0
<i>Managed Care: STAR MCO</i>	1,359,957	1,536,422	2,121,651	2,546,683	2,570,531
<i>Managed Care: STAR Health</i>	29,762	31,834	31,171	30,293	30,732
<i>Managed Care: STAR+PLUS</i>	166,536	219,975	339,047	405,947	410,999
<i>Managed Care: ICM</i>	0	0	0	0	0
Total Medicaid Clients	3,298,099	3,543,057	3,655,930	3,658,629	3,746,689

Percentage Medicaid Clients by Service Delivery Type

Service Delivery Type	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Fee-for-Service	28.4%	24.5%	20.8%	18.5%	19.6%
<i>Managed Care: STAR PCCM</i>	24.4%	25.1%	11.0%	0.0%	0.0%
<i>Managed Care: STAR MCO</i>	41.2%	43.4%	58.0%	69.6%	68.6%
<i>Managed Care: STAR Health</i>	0.9%	0.9%	0.9%	0.8%	0.8%
<i>Managed Care: STAR+PLUS</i>	5.0%	6.2%	9.3%	11.1%	11.0%
ICM	0.0%	0.0%	0.0%	0.0%	0.0%

Source: HHSC, Financial Services, HHS System Forecasting.

Quality of Care

Federal law requires state Medicaid programs to contract with an external quality review organization (EQRO) to help evaluate Medicaid managed care programs. The EQRO produces reports to support HHSC's efforts to ensure managed care clients have access to timely and quality care in each of the managed care programs. The results allow comparison of findings across MCOs in each program and are used to develop overarching goals and quality improvement activities for Medicaid and CHIP managed care programs. MCO findings are compared to HHSC standards and national averages, where applicable.

The EQRO assesses care provided by MCOs participating in STAR, STAR+PLUS (including the STAR+PLUS home and community-based services waiver), STAR Health, NorthSTAR, CHIP, and the Medicaid and CHIP dental managed care programs. The EQRO conducts ongoing evaluations of quality of care primarily using MCO administrative data, including claims and encounter data. The EQRO also reviews MCO documents and provider medical records, conducts interviews with MCO administrators, and conducts surveys of Texas Medicaid and CHIP members, caregivers of members, and providers.

STAR-Significant Quality Findings

Quality of Care

The quality of care studies conducted in calendar year 2012 by the EQRO indicate 73 percent of STAR children received one or more well-child visits in their 3rd, 4th, 5th and 6th years of life compared to the 71 percent HHSC standard for this measure. Fifty-eight percent of adolescents 12 to 21 years of age enrolled in the STAR program had one or more well-care visits, exceeding the HHSC standard of 51 percent.

Also, in calendar year 2012, measurement of women's access to prenatal and postpartum care in STAR identified that 74 percent of pregnant women in the STAR program received prenatal care in their first trimester, falling below the HHSC standard of 83 percent. The rate of postpartum care visits (66 percent) was slightly greater than the national mean of 64 percent.

In 2013, actual expenditures for potentially preventable events (PPEs) were as follows:

- Potentially preventable admissionsⁱⁱⁱ (PPAs): \$87,726,161
- Potentially preventable readmissions^{iv} (PPRs): \$39,042,858
- Potentially preventable emergency department visits^v (PPVs): \$270,489,647

Satisfaction with Care

The SFY 2012 STAR Adult Member Survey assesses members' experiences and satisfaction with their health care related to access to and timeliness of care, patient-centered medical home, and health plan information and customer service.

ⁱⁱⁱ Inpatient stays that may have been avoidable had the patient received high quality primary and preventive care prior to the admission.

^{iv} Return hospitalizations that may result from deficiencies in the process of care and treatment during the initial hospital stay; and/or poor coordination of services at the time of discharge and during follow-up.

^v Emergency room visits for conditions that could be treated effectively with adequate patient monitoring and follow-up, rather than requiring emergency medical attention.

Greater than half of survey respondents rated the service of their health care, personal doctor, specialist, and health plan as a nine or ten on a ten-point scale. Each rating met or surpassed the Medicaid national average.

Other positive findings reported by members were:

- *Good access to special therapies.* Approximately two out of three members who needed special therapies said that it was usually or always easy to get the therapy they needed (62 percent). This rate exceeds the HHSC Dashboard standard of 58 percent.
- *Access to prescription medicines.* Approximately half of members reported that they received new prescription medicines or refilled a medication during the past six months (53 percent). Among these members, 81 percent reported that it was usually or always easy to get the medicine they needed from their health plan.
- *Shared decision-making.* Nearly four out of five members said that they were usually or always involved as much as they wanted in their health care (79 percent) and that they usually or always felt it was easy to get their doctors to agree on how to manage their health care problems (79 percent).
- *Care coordination.* Nearly two out of three members reported that they had someone helping to coordinate their health care (61 percent). Among these members, a vast majority reported that they were satisfied or very satisfied with the assistance they received (93 percent).

Areas that offer an opportunity for improvement are:

- *Getting Care Quickly.* Seventy percent of members usually or always had positive experiences with *Getting Care Quickly*, which is lower than the national Medicaid rate of 80 percent for this measure.
- *Good Access to Routine Care.* Approximately two-thirds of members reported that they had good access to routine care (67 percent). This rate is lower than the HHSC Dashboard standard for this indicator (80 percent).
- *Office Wait.* About 1 in 5 members reported having no wait greater than 15 minutes before being taken to the exam room (21 percent). This rate is lower than the HHSC Dashboard standard of 42 percent.
- *Getting Needed Care.* Sixty-six percent of members usually or always had positive experiences with *Getting Needed Care*. This percentage is lower than the national Medicaid rate of 78 percent.
- *Good Access to Specialist Referral.* Approximately two-thirds of members who needed a referral to a specialist said it was usually or always easy to get a

referral (64 percent). This rate is lower than the HHSC Dashboard standard for this indicator (73 percent).

- *Emergency department utilization.* Thirty-eight percent of members visited the emergency department at least once in the past six months. Among these members, 70 percent said they did *not* contact their personal doctor before going to the emergency department.
- *Advising Smokers to Quit.* Among members who reported they smoke cigarettes, half said that a doctor or other health provider had advised them to quit smoking in the last six months (51 percent). This rate is lower than the HHSC Dashboard standard for this indicator (70 percent).

The SFY 2011 STAR Child survey evaluates caregivers' experiences and satisfaction with their children's health care while enrolled in the STAR program.

The majority of caregivers provided high ratings of their child's health care, doctors, and health plan, indicated by a rating of nine or ten on a ten-point scale. These ratings were greater than those reported in Medicaid national data.

Other positive findings reported by members were:

- *Access to Specialist Referral.* The majority of caregivers reported that they were usually or always able to get a referral for their child to see a specialist (69 percent). All MCOs except one met the HHSC Dashboard standard of 59 percent for good access to specialist referrals.
- *Health Plan Customer Service.* Most caregivers reported that they usually or always had positive interactions with customer service at their child's health plan (84 percent).

Areas that offer an opportunity for improvement are:

- *Getting Needed Care.* Seventy-two percent of STAR caregivers usually or always had positive experiences with *Getting Needed Care*, compared to the 79 percent reporting for Medicaid plans nationally.
- *Getting Care and Assistance for Children with Special Healthcare Needs (CSHCN).* Caregivers of CSHCN were significantly less likely than caregivers of non-CSHCN to report positive experiences with their child's health plan and getting needed care for their child, such as appointments with specialists and tests and treatment, through the health plan.

- *Getting Specialized Services.* Although less than ten percent of caregivers reported that their child needed specialized services, access to these services in STAR was lower than reported nationally (66 percent versus 74 percent).
- *HHSC Performance Dashboard Indicators.* Results of the following performance indicators indicate that few health plans are meeting HHSC Dashboard standards for good access to routine care, no delays in health care while waiting for health plan approval, and no exam room wait greater than 15 minutes.

STAR+PLUS-Significant Quality Findings

Quality of Care

The quality of care studies conducted in calendar year 2012 by the EQRO provide descriptive information about the STAR+PLUS population and evaluation of members' quality of care based on certain outcome measures.

Rates for Effective Acute Phase Treatment and Effective Continuation Phase Treatment for Antidepressant Medication Management, a HEDIS[®] measure that assesses the percentage of members 18 years or older who were diagnosed with major depression and were newly treated with antidepressant medication, were positive. The rate for Effective Acute Phase Treatment was 60 percent, compared to the 43 percent HHSC standard for this measure. The rate for Effective Continuation Phase Treatment was 47 percent, compared to the 24 percent HHSC standard for this measure.

Program and MCO-level performance data on the HEDIS[®] Comprehensive Diabetes Care measure show this is an area that needs improvement, with the rate of HbA1c control among STAR+PLUS members with diabetes falling below the HEDIS[®] tenth percentile. Agency for Healthcare Research and Quality Prevention Quality Indicator rates of potentially avoidable admissions for diabetes short-term complications were 399 per 100,000 population, and diabetes long-term complications were 634 per 100,000 population, although a net decrease was observed for both measures across the four-year period, indicating that performance has improved.

In 2013, actual expenditures for potentially preventable events (PPEs) were as follows:

- Potentially preventable admissions^{vi} (PPAs): \$74,214,571
- Potentially preventable readmissions^{vii} (PPRs): \$49,922,346

^{vi} Inpatient stays that may have been avoidable had the patient received high quality primary and preventive care prior to the admission.

^{vii} Return hospitalizations that may result from deficiencies in the process of care and treatment during the initial hospital stay; and/or poor coordination of services at the time of discharge and during follow-up.

- Potentially preventable emergency department visits^{viii} (PPVs): \$84,638,638

Satisfaction with Care

The SFY 2012 STAR+PLUS Adult Member Survey assesses members' experiences and satisfaction with their health care related to access to and timeliness of care, patient-centered medical home, service coordination, and health plan information and customer service. The majority of STAR+PLUS members provided high ratings of their health care, doctors, and MCO, indicated by a rating of nine or ten on a ten-point scale. These ratings were comparable to those published from Medicaid national data.

Other positive findings reported by members were:

- *Access to Prescription Medicines.* Eighty-two percent of members who received prescription medication (new or refill) said it was “usually” or “always” easy to get prescription medications.
- *Preventive Care and Health Promotion.* Among members who reported that they smoke cigarettes, nearly three-quarters said that their doctor advised them to quit smoking during the last six months (69 percent), which is approximately equal to the HHSC Dashboard standard of 70 percent.
- *Shared Decision-Making.* A majority of members reported they “usually” or “always” were involved as much as they wanted in decisions about their health care (81 percent). Seventy-three percent of members reported that it was “usually” or “always” easy to get their doctors to agree on how to manage their health care problems.
- *Good Access to Service Coordination.* Among members who needed service coordination, 67 percent reported that they “usually” or “always” received service coordination as soon as they thought they needed it. This percentage exceeds the HHSC Dashboard standard of 63 percent for this indicator.
- *Satisfaction with Service Coordination.* Eighty-three percent of members who had a service coordinator said they were “satisfied” or “very satisfied” with their service coordinator.

Areas that offer an opportunity for improvement are:

- *Good Access to Urgent Care.* Seventy-seven percent of members reported that they “usually” or “always” received urgent care as soon as they needed. Only

^{viii} Emergency room visits for conditions that could be treated effectively with adequate patient monitoring and follow-up, rather than requiring emergency medical attention.

three MCO service areas performed at or above the HHSC Dashboard standard of 81 percent for this indicator.

- *Good Access to Routine Care.* While approximately three in four members reported that they usually or always received an appointment for routine care as soon as it was needed (73 percent), only one MCO service area group met the HHSC Dashboard standard of 80 percent for this indicator.
- *Getting Needed Care.* Sixty percent of members “usually” or “always” had positive experiences on the CAHPS® composite Getting Needed Care, which is below the national Medicaid average (76 percent). Scores for Getting Needed Care varied by service area, with the lowest scores reported in the Bexar and Dallas service areas.
- *Communication with Providers’ Office Personnel.* Slightly more than half of members reported that someone in their provider’s office spoke with them about specific goals for their health (58 percent). This aspect of patient-centered care varied by service area, with rates in the Travis service area higher than others.
- *Health Plan Information and Customer Service.* Sixty-eight percent of members said they “usually” or “always” had positive experiences on the CAHPS® composite Health Plan Information and Customer Service, which is below the national average of 80 percent.
- *Health Plan Approval.* Thirty-eight percent of members reported having no delays in health care while waiting for health plan approval, which is below the HHSC Dashboard standard of 57 percent. None of the MCO service area groups met the HHSC Dashboard standard for this indicator.
- *Awareness of Service Coordination.* Less than half of respondents were aware that their health plan offers service coordination to its members (46 percent), although it is a service available for all STAR+PLUS members who request it.
- *Having Service Coordination.* Only 31 percent of STAR+PLUS members reported that they have a service coordinator.
- *Involvement in Service Coordination.* Although members generally had high levels of satisfaction with their service coordinators, two-thirds (64 percent) said their service coordinator involved them in making decisions about their services.

It is important to note that these survey findings were collected prior to HHSC making changes to the STAR+PLUS service coordination standards aimed at improving service coordination for members.

NorthSTAR-Significant Quality Findings

Quality of Care

The quality of care studies conducted in calendar year 2012 by the EQRO provide descriptive information about the quality of care for NorthSTAR members based on certain outcome measures. Behavioral health organization findings are compared to HHSC standards and national averages, where applicable.

Rates for Effective Acute Phase Treatment and Effective Continuation Phase Treatment for Antidepressant Medication Management, a HEDIS[®] measure that assesses the percentage of members 18 years or older who were diagnosed with major depression and were newly treated with antidepressant medication, were positive. The rate for Effective Acute Phase Treatment was 51 percent, compared to the 51 percent national mean for this measure. The rate for Effective Continuation Phase Treatment was 37 percent, compared to the 34 percent national mean for this measure.

For the HEDIS[®] measure Follow-Up Care for Children Prescribed ADHD Medication, the EQRO assesses the percentage of children six to 12 years of age with newly prescribed ADHD medication who received two types of follow-up care during 2012: first, the Initiation Phase, which reports the percentage of children with an ambulatory prescription dispensed for ADHD medication who had a follow-up visit with a provider during the 30-day initiation phase; and second, the Continuation and Maintenance Phase, which reports the percentage of children with an ambulatory prescription dispensed for ADHD medication who continued taking the medication for at least 210 days (30 weeks), and who had at least two follow-up visits with the provider within nine months after the initiation phase ended. The rate of Follow-Up Care for Children Prescribed ADHD Medication, Initiation Phase was 27 percent, compared to the 39 percent national mean for this measure. The rate of Follow-Up Care for Children Prescribed ADHD Medication, Continuation and Maintenance Phase was 37 percent, compared to the 46 percent national mean for this measure.

The HEDIS[®] measure Follow-Up after Hospitalization for Mental Illness assesses the percentage of members six years of age or older who were hospitalized for treatment of mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or a partial hospitalization with a provider during 2012. This measure provides follow-up rates for two time periods: (1) the percentage of members who received follow-up care within 7 days of discharge; and (2) the percentage of members who received follow-up care within 30 days of discharge. NorthSTAR rates of 25 percent follow-up within 7 days of discharge and 51 percent for follow-up within 30 days of discharge were lower than the national means of 47 percent and 65 percent, respectively.

The HEDIS[®] measure Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment assesses the percentage of adolescents and adults with an AOD diagnosis who, during the measurement period initiated treatment within 14 days of diagnosis and had two or more additional services (e.g., inpatient treatment, outpatient treatment) within 30 days of the initiation visit. NorthSTAR rates of 17 percent initiation of AOD treatment and 5 percent engagement of AOD treatment were lower than the national means of 39 percent and 12 percent, respectively.

Satisfaction with Care: MCO findings are compared to HHSC standards and national averages, where applicable. The SFY 2012 STAR Adult Behavioral Health Survey assessed the experiences and satisfaction with health care related to access to and timeliness of care, patient-centered medical home, service coordination, and health plan information and customer service for adults 18 to 64 years old who were enrolled in STAR or NorthSTAR and who had a record of one or more mental health/chemical dependency diagnoses and procedure combinations between July 2011 and December 2011. The data includes both NorthSTAR and STAR data.

Positive findings:

- *Patient Information about Treatment and Management of their Condition.* Seventy-six percent of members felt they could refuse a medicine or treatment suggested by their clinician.
- *Ratings of Clinician.* Members were satisfied with their primary clinicians, giving them a mean rating of 8.7 out of 10, with 68 percent of members giving a rating of 9 or 10.
- *Getting Treatment, Information, and Assistance.* The vast majority of members that spoke with office staff said that they were treated with courtesy and respect.
- *Perceived Improvement.* Almost half of members said they were helped a lot by their care (44 percent).

Areas that offer an opportunity for improvement:

- *Body mass index (BMI).* Over two-thirds of members were overweight or obese (72 percent), half of all members were obese (48 percent), and obesity rates were particularly high among women (50 percent).
- *Getting timely telephone counseling.* Timeliness of care for telephone counseling was low. Among members who reported they tried to get counseling on the telephone, 37 percent said they usually or always got telephone counseling in a timely manner, with 30 percent of members saying that they never got telephone counseling when needed.

- *Benefits.* Twenty-one percent of members indicated that they used up all of their benefits. Of this group, 68 percent said that they still needed counseling or treatment services, and less than half reported being told of other ways to receive counseling or treatment (41 percent).
- *Getting Treatment, Information, and Assistance.* Among members who reported they needed approval for counseling or treatment in the last six months, over a third said that they had a “big problem” with delays in treatment while they awaited approval (37 percent).

Additional information on various quality and performance measures that are tracked by DSHS can be found in the NorthSTAR data book and trending reports at <http://www.dshs.state.tx.us/mhsa/northstar/databook.shtm> (July 2014).

STAR Health-Significant Quality Findings

Quality of Care

MCO findings are compared to HHSC standards and national averages, where applicable. The quality of care study conducted in calendar year 2012 by the EQRO indicates 87 percent of STAR Health children received one or more well-child visits in their 3rd, 4th, 5th and 6th years of life compared to the 70 percent HHSC standard for this measure. Seventy-four percent of adolescents 12 to 21 years of age enrolled in the STAR program had one or more well-care visits, compared to the HHSC standard of 45 percent.

In 2013, actual expenditures for potentially preventable events (PPEs) were as follows:

- Potentially preventable admissions^{ix} (PPAs): \$7,596,095
- Potentially preventable readmissions^x (PPRs): \$4,442,868
- Potentially preventable emergency department visits^{xi} (PPVs): \$3,552,813

Satisfaction with Care

MCO findings are compared to HHSC standards and national averages, where applicable. The SFY 2012 STAR Health Caregiver Survey assesses caregivers’ experiences and satisfaction with health care related to access to and timeliness of

^{ix} Inpatient stays that may have been avoidable had the patient received high quality primary and preventive care prior to the admission.

^x Return hospitalizations that may result from deficiencies in the process of care and treatment during the initial hospital stay; and/or poor coordination of services at the time of discharge and during follow-up.

^{xi} Emergency room visits for conditions that could be treated effectively with adequate patient monitoring and follow-up, rather than requiring emergency medical attention.

care, patient-centered medical home, service coordination, and health plan information and customer service.

A majority of caregivers provided high ratings of their child's health care, doctors, and health plan, indicated by a rating of 9 or 10 on a 10-point scale. These ratings were comparable to those published from Medicaid national data.

Other positive findings reported by members were:

- *Getting Care Quickly*. Ninety percent of caregivers usually or always had positive experiences with *Getting Care Quickly*, which is higher than the Medicaid national average of 87 percent.
- *Good Access to Urgent Care*. A vast majority of caregivers reported that their child usually or always received care for an illness, injury, or condition as soon as they thought their child needed care (96 percent). This percentage exceeds the HHSC Dashboard standard of 88 percent.
- *Good Access to Routine Care*. Eighty-four percent of caregivers reported that they usually or always were able to make a routine appointment as soon as they thought their child needed care. This percentage is greater than the HHSC Dashboard standard of 76 percent.
- *Good Access to Specialist Referral*. Eighty-four percent of caregivers reported it was usually or always easy to get a referral to a specialist for their child, which is higher than the HHSC Dashboard standard of 75 percent.

Areas that offer an opportunity for improvement are:

- *Body mass index (BMI)*. Nearly one third of children were classified as obese (30 percent). This rate is higher than the national and Texas averages for child/adolescent obesity (17 percent and 20 percent, respectively).
- *Preparing caregivers and children with special health care needs for transition to adulthood*. Among children 11 years of age and older, 13 percent of providers spoke with caregivers about their child having to eventually see providers who treat adults.
- *Service management*. Approximately one-third of caregivers said they received a call asking whether their child needed service management (38 percent). However, when service management was recommended by the service manager, nearly all caregivers agreed to participate in the program (96 percent).
- *Health plan information and customer service*. Seventy-five percent of caregivers usually or always had positive experiences on the CAHPS® composite *Health*

Plan Information and Customer Service (75 percent), which is below the national average of 83 percent.

Medicaid and Children's Health Insurance Dental Programs

Quality of Care

The quality of care studies conducted in calendar year 2012 by the EQRO provide an evaluation of access to dental care services among members enrolled in Medicaid dental services and CHIP. On December 1, 2012, one of the three dental contracts was terminated affecting the results of the quality of care measures for calendar year 2012. Some of the presented measures include data from the third contractor.^{xii}

Medicaid Dental

The overall Medicaid rates of annual dental visits were higher than their respective national rates for all age groups. For all ages combined, the overall Medicaid rate was 73 percent compared to the national mean of 45 percent. The rate of THSteps dental checkups among newly enrolled members was also low, at approximately one-quarter of members within 90 days of enrollment.

The overall Medicaid rates for the Use of Preventive Dental Services, including and excluding the third contractor, were 58.4 percent and 56.9 percent, respectively. The American Academy of Pediatric Dentistry (AAPD) recommends preventive dental services for all children and adolescents every six months, which suggests that rates of preventive dental services in Texas Medicaid could be improved.

The percentage of children and adolescents that received dental sealants was 21 percent.

CHIP Dental

The overall CHIP rates of annual dental visits including the third contractor were equal to or higher than their respective HHSC Dashboard standards with an overall rate of 64 percent for all age groups. However, the overall CHIP rates excluding the third contractor were lower than respective HHSC Dashboard standards for all age groups with an overall rate of 56 percent for all age groups.

^{xii} Measures include TMHP data from FFS Medicaid Dental. MCO data incorporated beginning 3/1/2012.

The overall CHIP rate for Use of Preventive Dental Services was 61 percent, which is higher than the HHSC Dashboard standards. However, the overall CHIP rate excluding the third contractor was 52 percent, which fell below the HHSC Dashboard standard.

Eighteen percent of CHIP members received dental sealants in 2012.

The overall utilization rate of dental services in CHIP (excluding the third contractor) was 51 percent, which fell below the HHSC Dashboard standards for this measure.

Chronic Care Management

Texas Medicaid Wellness Program for Children with Disabilities

The Texas Medicaid Wellness Program is a community-based, holistic care management program that enrolls high-risk adults and children with disabilities with complex, chronic, or co-morbid conditions receiving Medicaid in the fee-for-service system. Wellness Program nurses help program participants with finding a main doctor, managing their health between doctor visits, learning more about their health conditions, knowing how to take their medicines, and selecting the best medical care for their health. Extensive case management focuses on the whole person, rather than the disease, through telephone and face-to-face conversations that aim to improve health outcomes. The client's care team is led by a registered nurse that can include social workers, community health workers, pharmacists, and behavioral health specialists, among others. In addition to working on the client's care plan with the provider and client's family and provider, the care team also assists with transportation and housing issues, medical equipment assistance, and education on disease management and nutrition. Wellness clients receive one or two telephone and/or face-to-face visits per quarter, and receive educational mailings quarterly. Program eligible clients and participants also have access to a 24-hour nurse advice line.

Endnotes

¹ Texas Health and Human Services Commission, "Texas Medicaid Managed Care Review," November 1, 2000.