



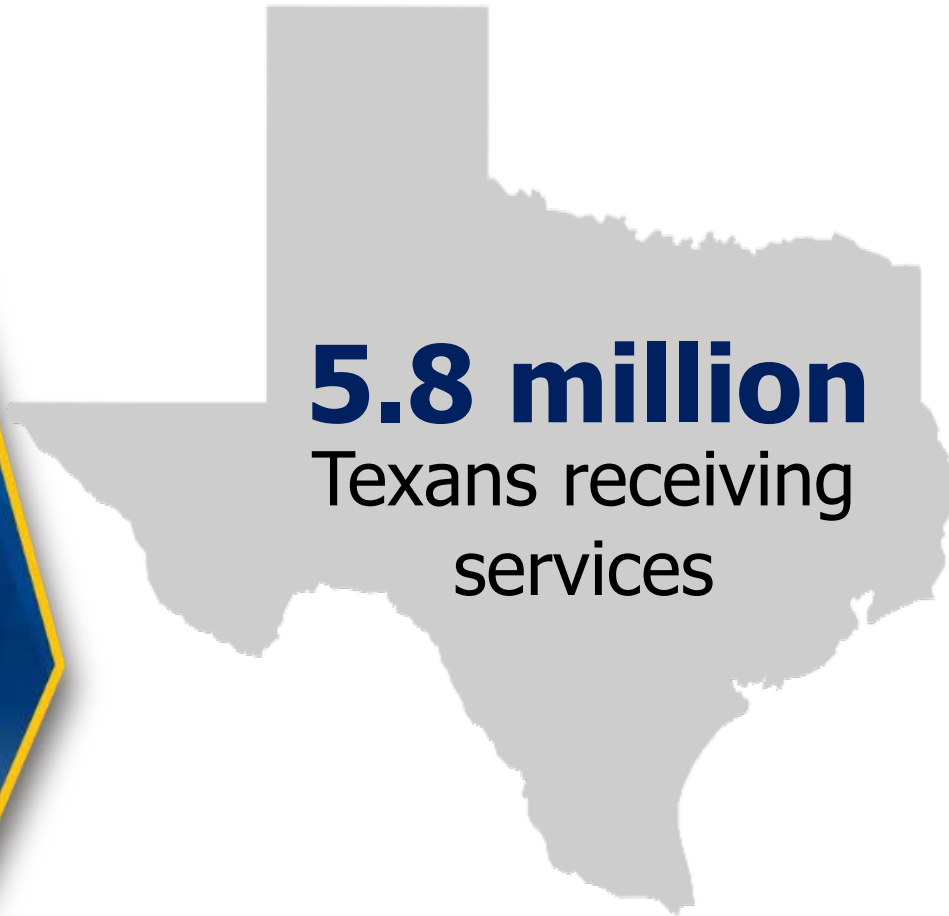
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Medicaid Managed Care in Texas

Emily Zalkovsky, Texas State Medicaid Director

August 2023

Texas Perspective



- 19.5% of Texans covered
- 51% of Texas births covered by Medicaid
- 50% of Texas children on Medicaid or CHIP
- 57% of nursing home residents covered by Medicaid

Note: Medicaid and CHIP caseload data is for November 2022 as of December 2022 and is not final. The Families First Coronavirus Response Act requirement to maintain eligibility for enhanced federal match has increased caseload.

Two Service Delivery Models



Managed Care

Serves 97% of clients



Fee-for-Service (FFS)

Serves 3% of clients



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Major Differences



Managed Care



Fee-for-Service

| | Managed Care | Fee-for-Service |
|-----------------------------|--|---|
| Finance Model | Risk-based: A managed care organization (MCO) is paid a capitated rate for each member enrolled | Non-risk: Providers submit claims directly to HHSC's administrative services contractor for payment |
| Contracting | State contracts with MCOs Providers enroll in Texas Medicaid and contract with MCOs | Providers enroll in Texas Medicaid and contract with the state |
| Access to Services | Members choose an MCO and receive services through their chosen medical/dental home and other providers in their plan's network – the MCO must authorize any providers that are out-of-network. Referrals are required for certain types of specialists | Clients go to any Medicaid provider, but they must find their own health care providers |
| Service Coordination | Provided for certain programs and on request | Limited to persons in waiver programs |
| Benefits | <ul style="list-style-type: none"> Value-added Services Unlimited prescriptions Unlimited hospital stays for most adults | <ul style="list-style-type: none"> Basic Medicaid benefits 3-Prescription limit for adults 30-Day hospital stay limit for adults |



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Why Managed Care?

Goals

- 1 Emphasize preventative care

- 2 Improve access to care

- 3 Ensure appropriate use of services

- 4 Improve client and provider satisfaction

- 5 Establish a medical home for Medicaid clients through a primary care provider

- 6 Improve health outcomes, quality of care and cost effectiveness

- 7 Promote care in the least restrictive, most appropriate setting



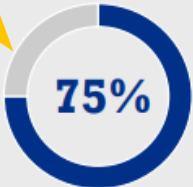
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Texas Managed Care Programs

Managed Care Product Lines

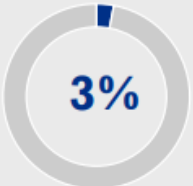


STAR



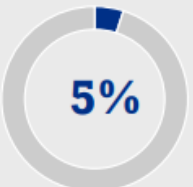
Children, pregnant women and some families

STAR Kids



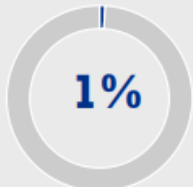
Children and youth with disabilities

CHIP



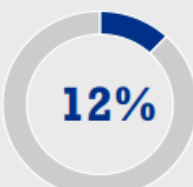
Children and youth who don't qualify for Medicaid due to family income

STAR Health



Children who get Medicaid through the Department of Family and Protective Services and young adults previously in foster care

STAR+PLUS



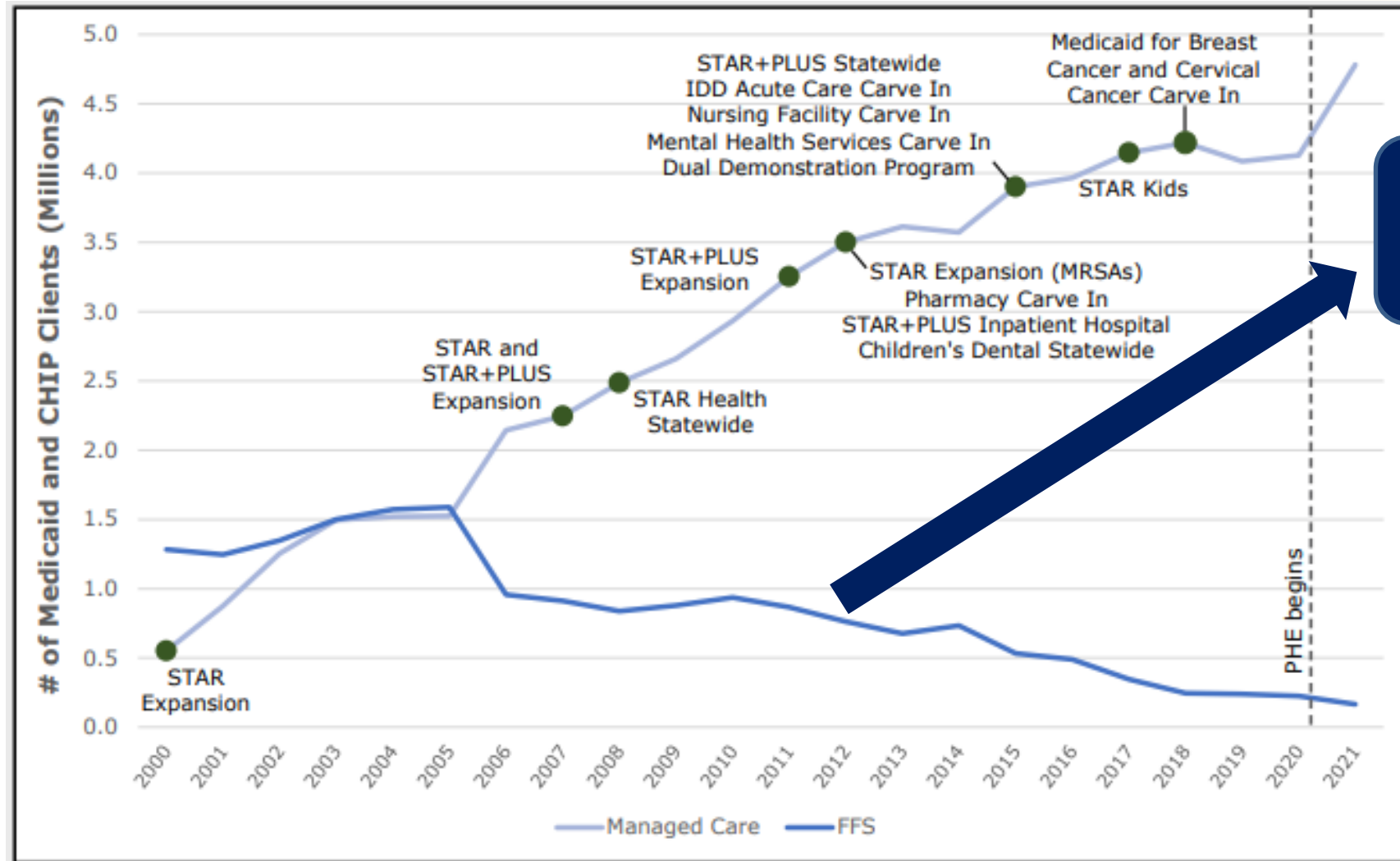
Adults with a disability, people age 65 and older (including those dually eligible for Medicare and Medicaid), and women with breast or cervical cancer

← Dental: Children and adults 20 or younger enrolled in Medicaid or CHIP →



CHIP includes CHIP Perinatal. Remaining percentage is FFS.
Source: Texas Medicaid and CHIP Reference Guide, 14th Edition

Managed Care Growth



37%
growth in
10 years

Positive Impacts

Preventative Care Improved



Childhood Asthma

Asthma admission rate for children
↓ **65%**



Diabetes in Adults

Admissions for long-term diabetes complications in adults
↓ **48%**

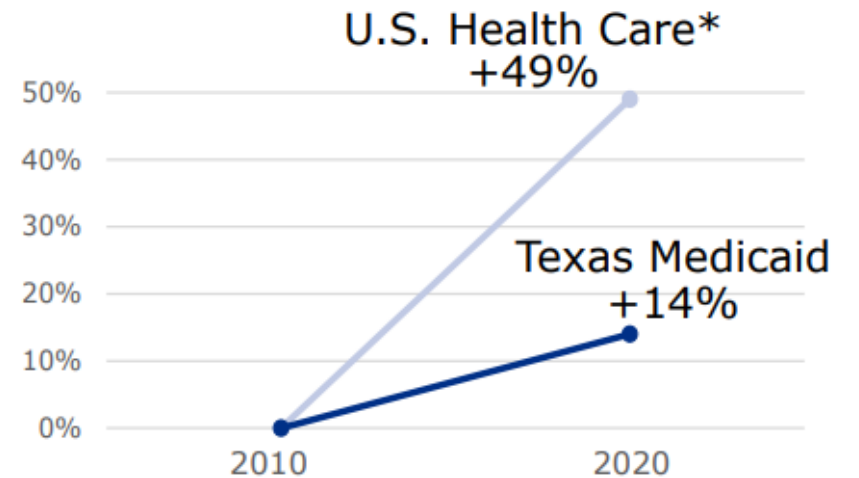


Childhood Behavioral Health

Long-term follow-up care for children prescribed ADHD medication
↑ **12%**

Cost Growth Contained

Cost per Person Increase



Data: STAR only, 2011 vs. 2021. Percentages are estimates due to methodology changes that occurred over the ten-year period.

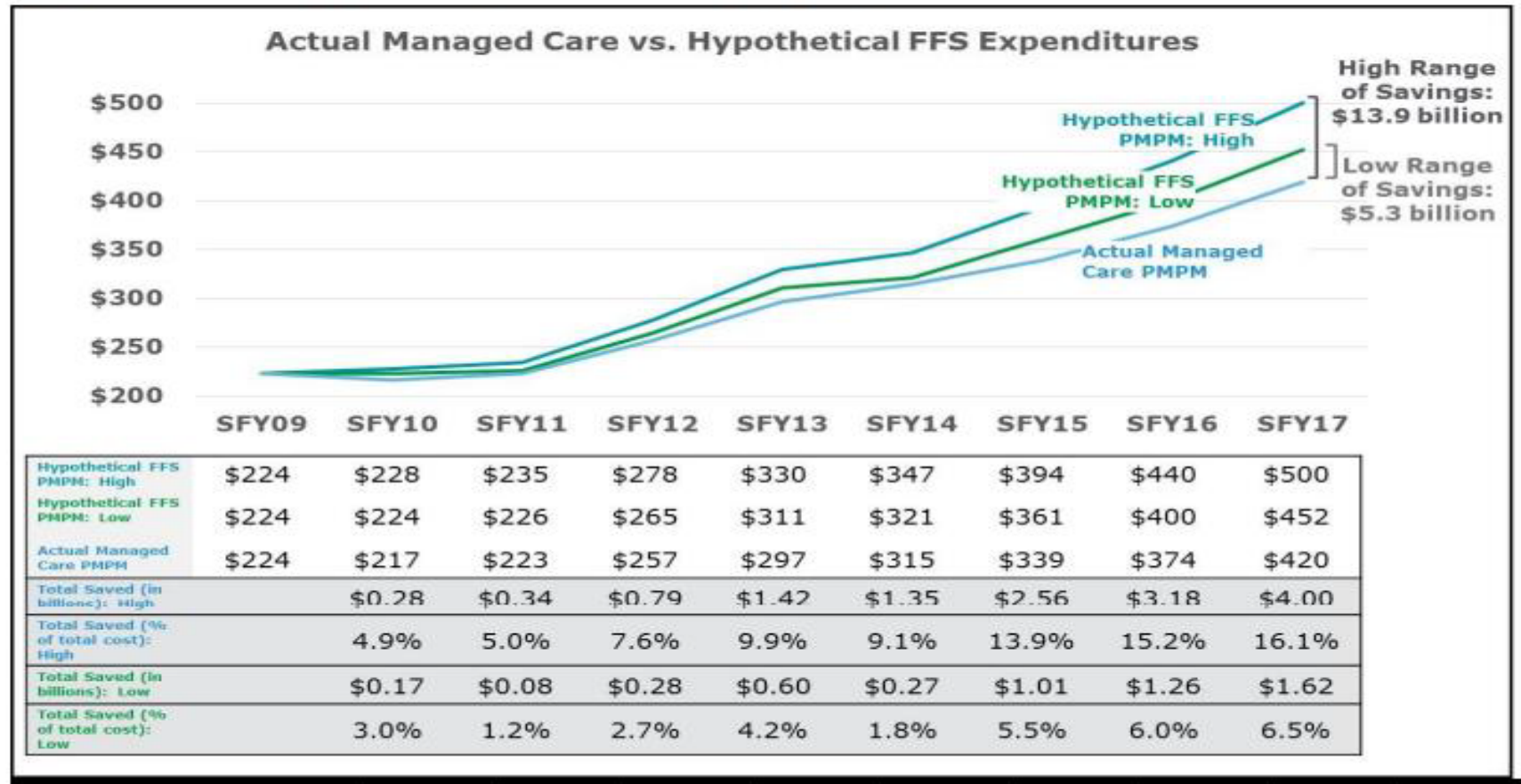
Texas Medicaid is based on full-benefit clients.
*Source: CMS, Office of the Actuary—data is for CY10 to CY20.



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Managed Care Cost Savings

Figure 1. 2009–2017 Managed Care Cost Savings Results.



Source: Final Comprehensive Report Rider 61: Evaluation of Medicaid and CHIP Managed Care, August 17, 2018



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Operating Two Models

FFS required functions

| |
|-----------------------------------|
| Claims processing |
| Provider enrollment and education |
| Defining medical benefits |
| Policy development |
| Fraud, waste, and abuse detection |
| Grievances and appeals |
| Utilization review |
| Prior authorization |

Managed Care required functions

| | | | |
|-----------------------------------|---|---|---------------------------|
| Provider enrollment | + | Extensive contract oversight | Actuarial analysis |
| Defining medical benefits | | Encounter data processing and analysis | Pay-for-Quality |
| Policy development | | Financial analysis | Program management |
| Fraud, waste, and abuse detection | | Driving value-based payments | Access monitoring |
| Grievances and appeals | | MCO marketing material review | Enrollment broker |
| Utilization review | | EQRO oversight | Data analysis across MCOs |
| | | Readiness review for all system changes | |

Functions are examples only and not intended to be all inclusive.



Contracting Landscape

16 MCOs



**By program*
By Service Delivery Area
(SDA)**

Minimum of two MCOs by SDA per program

3 Dental
Maintenance
Organizations
(DMOs)



Statewide



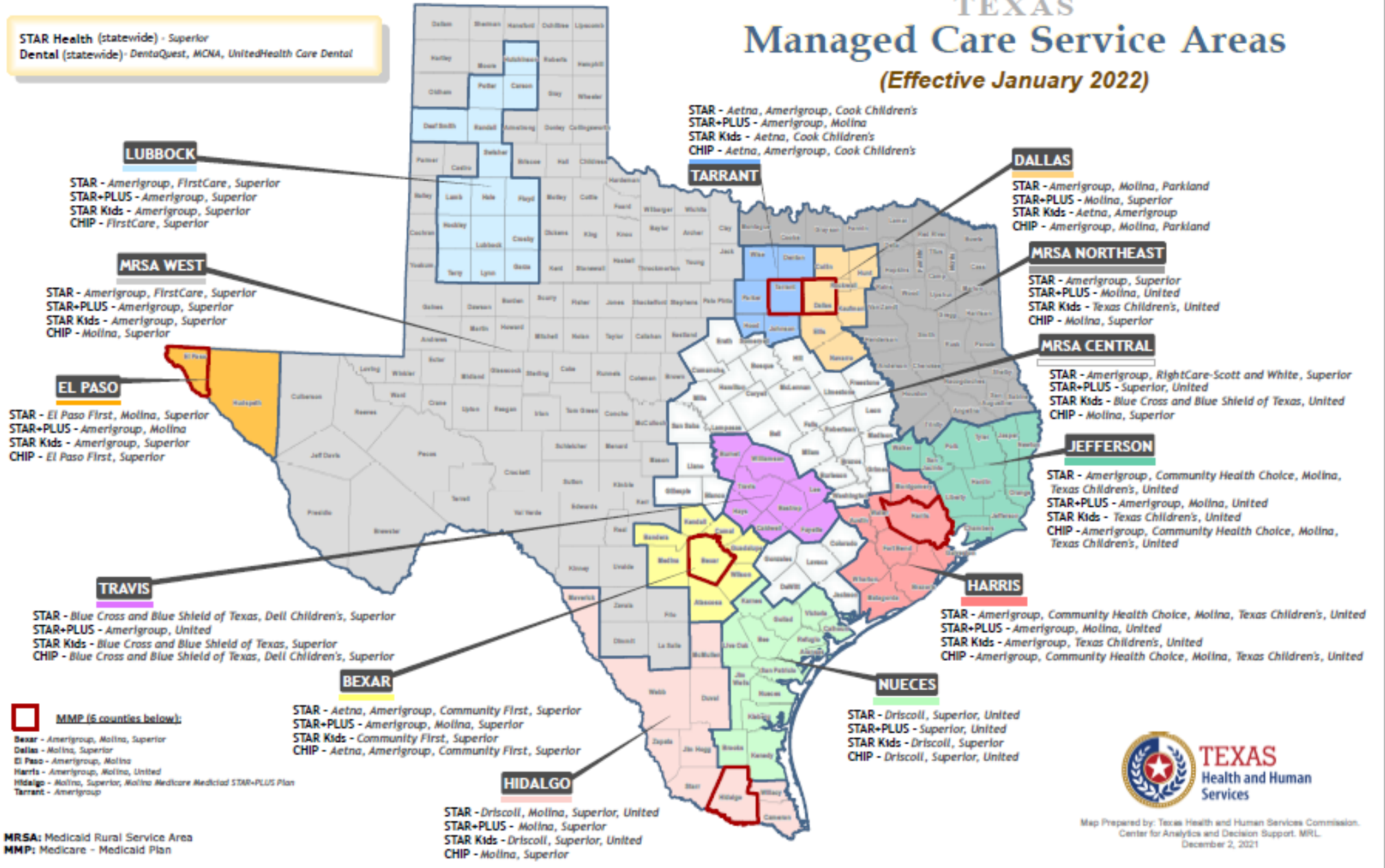
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*STAR Health is the only program with one MCO that is statewide



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TEXAS Managed Care Service Areas (Effective January 2022)



Accountability through Contract Oversight



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**Tools
span
five key
areas**

- 1 Access to services**
Network adequacy, appointment availability, member satisfaction
- 2 Service delivery**
Utilization reviews (UR), drug URs, electronic visit verification (EVV)
- 3 Quality**
Improvement projects, pay-for-quality, alternative payment models, custom evaluations, MCO report cards
- 4 Financial**
Financial statistical reports (FSRs) validation, net profit and experience rebate, independent auditing
- 5 Operations**
Readiness reviews, biennial operational reviews, targeted reviews

Oversight Tool Highlight: Access to Services

Network adequacy is key to ensure members have access to primary and preventative care

1

Contractual Requirements

MCOs must have adequate provider networks

Definition of Adequate:

Ninety percent of their members have access to at least two network providers within specific time or distance requirements.

2

Monitoring and Oversight

- Geo-access mapping used for monitoring MCOs
 - Also used identify areas of the state that have larger provider capacity issues
- Remedies applied as appropriate



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Current Requirements

By Provider Type and County Size

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

★ *HHSC also monitors personal attendant services with a focus on timeliness and service coordinator turn over*

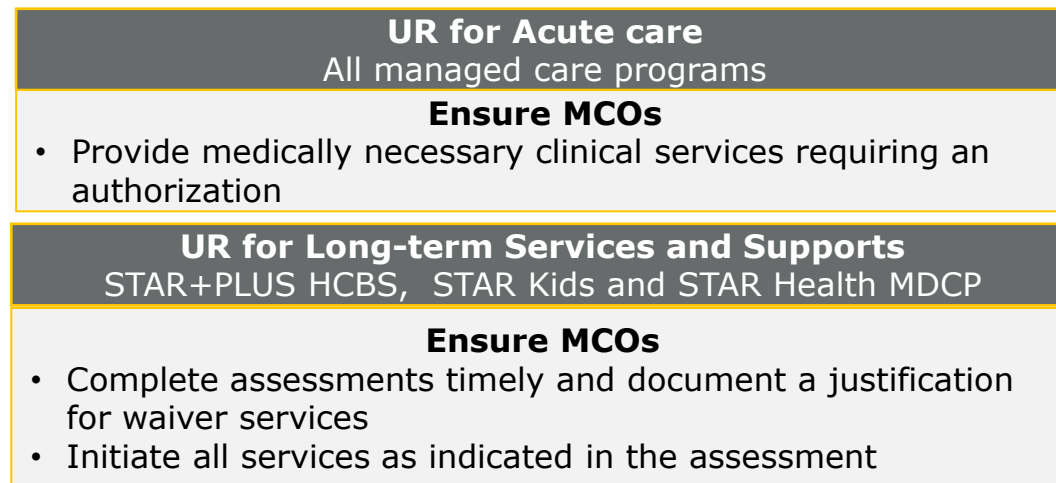
| Time and Distance Standards | | | | | | | |
|---|---|-------------------|--------------|--------------|------------------------|--------------|--------------|
| Provider Type | | Distance in Miles | | | Travel Time in Minutes | | |
| | | Metro County | Micro County | Rural County | Metro County | Micro County | Rural County |
| Behavioral Health-Outpatient | | 30 | 30 | 75 | 45 | 45 | 90 |
| Hospital-Acute Care | | 30 | 30 | 30 | 45 | 45 | 45 |
| Prenatal | | 10 | 20 | 30 | 15 | 30 | 40 |
| Primary Care Provider* | | 10 | 20 | 30 | 15 | 30 | 40 |
| Specialty Care Provider | Cardiovascular Disease | 20 | 35 | 60 | 30 | 50 | 75 |
| | ENT (otolaryngology) | 30 | 60 | 75 | 45 | 80 | 90 |
| | General Surgeon | 20 | 35 | 60 | 30 | 50 | 75 |
| | OB/GYN | 30 | 60 | 75 | 45 | 80 | 90 |
| | Ophthalmologist | 20 | 35 | 60 | 30 | 50 | 75 |
| | Orthopedist | 20 | 35 | 60 | 30 | 50 | 75 |
| | Pediatric Sub-specialists | 20 | 35 | 60 | 30 | 50 | 75 |
| | Psychiatrist | 30 | 45 | 60 | 45 | 60 | 75 |
| | Urologist | 30 | 45 | 60 | 45 | 60 | 75 |
| Occupational, Physical or Speech Therapy | | 30 | 60 | 60 | 45 | 80 | 75 |
| Nursing Facility | | 75 | 75 | 75 | N/A | N/A | N/A |
| Pharmacy | | 2 | 5 | 15 | 5 | 10 | 25 |
| Pharmacy (24-hour) | | 75 | 75 | 75 | 90 | 90 | 90 |
| Substance Use Disorder-Outpatient | Chemical Dependency Treatment Facilities | 30 | 30 | 75 | 45 | 45 | 90 |
| | Opioid Treatment Programs | 30 | 30 | 75 | 45 | 45 | 90 |
| Main Dentist (general or pediatric) | | 30 | 30 | 75 | 45 | 45 | 90 |
| Dental Specialists | Pediatric Dental | 30 | 30 | 75 | 45 | 45 | 90 |
| | Endodontist, Periodontist or Prosthodontist | 75 | 75 | 75 | 90 | 90 | 90 |
| | Orthodontist | 75 | 75 | 75 | 90 | 90 | 90 |
| | Oral Surgeons | 75 | 75 | 75 | 90 | 90 | 90 |

*Services for both adults and children include acute, chronic, preventive, routine or urgent care.

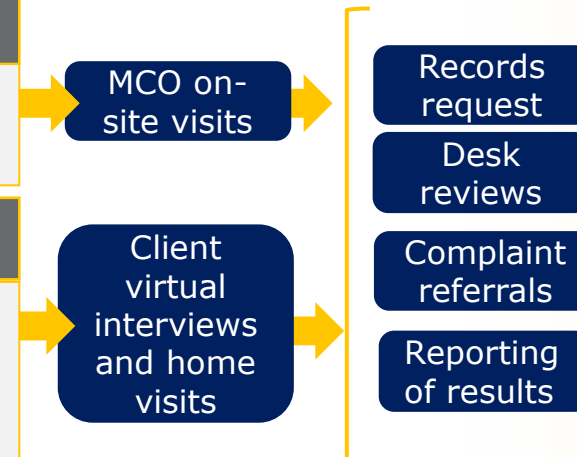
Oversight Tool Highlight: Service Delivery

Utilization reviews (URs) conducted by nurses, overseen by the Office of the Medical Director

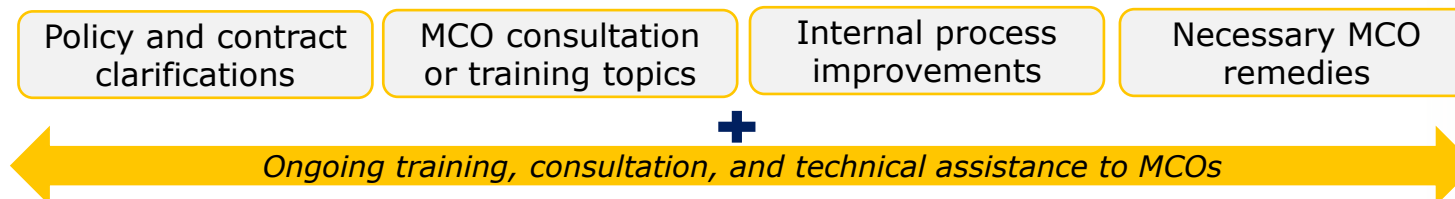
Overall purpose



UR components



Findings inform



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Oversight Tool Highlight: Quality

Overall Quality Performance

- Monitored through a performance indicator dashboard comprised of state and federal measures
- Contracts require MCOs to perform above the minimum standard on more than two-thirds of the dashboard measures

Performance Improvement Projects (PIPs)

- Topics determined by HHSC and External Quality Review Organization
- Each PIP lasts two years, two PIPs per managed care program, staggered schedule
- Example:
 - *Improve follow-up rate after hospital admission for members with mental illness*

Managed Care Report Cards

- One- through five-star MCO rating system
- Developed by surveying current members and analyzing claims data
- Key areas looked at:
 - Experience of care
 - Staying healthy
 - Common chronic conditions
 - Overall plan quality
- Provide transparency for members when selecting or changing plans

Quality Assessment and Performance Improvement (QAPI)

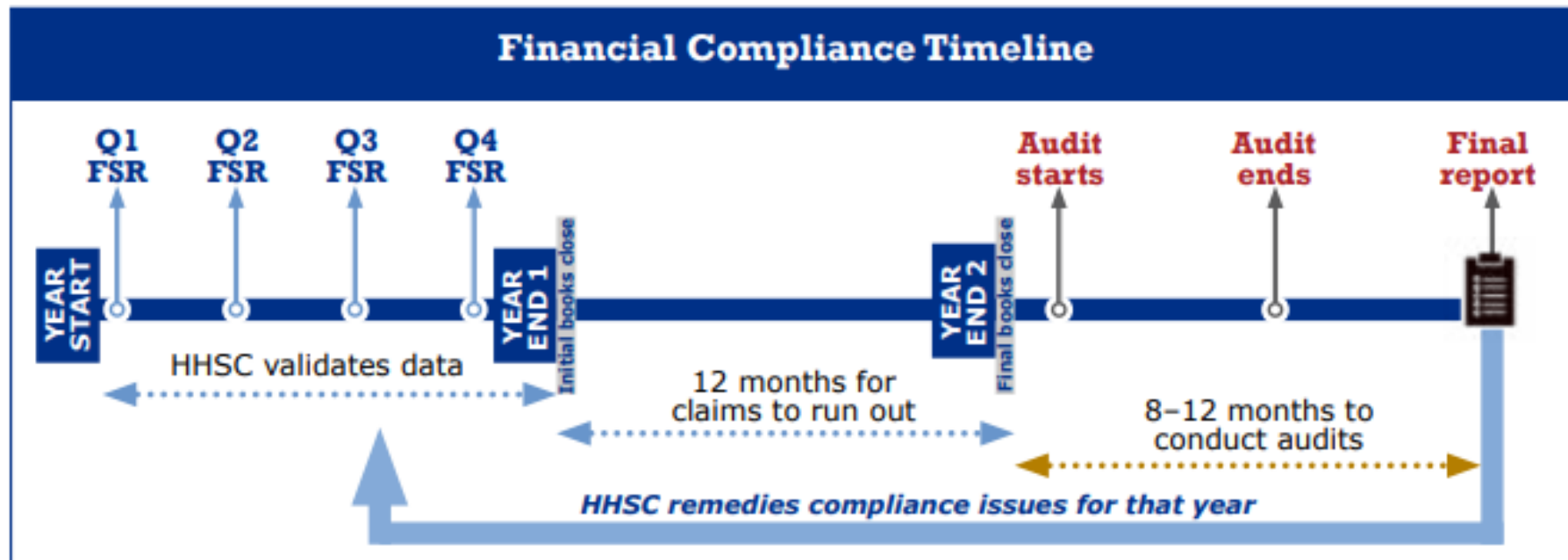
- Ongoing, comprehensive quality-assessment and performance-improvement programs for all the services the MCO provides.
- Not time-limited programs targeting a specific aspect of care like PIPs
- Examples:
 - *Foster data-driven decision-making*
 - *Solicit member and provider input on quality activities*



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Oversight Tool Highlight: Financial

20–24-month audit process post-year end



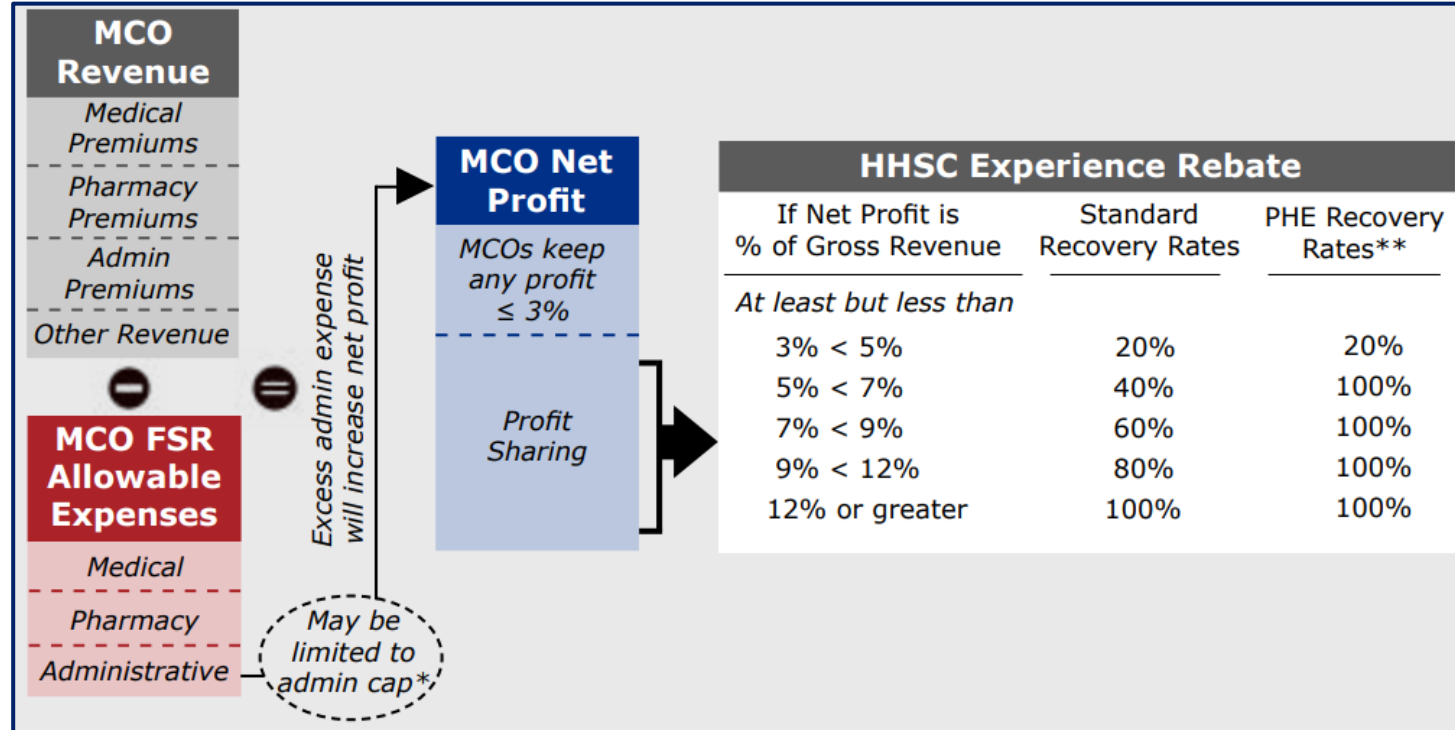
While audits occur annually, HHSC financial analysts can also determine the need for any supplemental audits or reviews based on other identified issues.



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Fiscal Responsibility: Net Profit and Experience Rebate

Major safeguards through caps on administrative expenses and experience rebates on excessive profit



*Admin cap is set by program.

**Changes to eligibility requirements during the COVID-19 PHE contributed to an increase in profits for MCOs during SFYs 2020 and 2021. In response, HHSC has temporarily changed the experience rebates for SFYs 2022-2023.



Oversight Tool Highlight: Operations

Multiple monitoring perspectives

HHSC biennial MCO operational reviews

Critical indicator focus

Claims Processing

Encounter Data

Provider Relations

Prior Authorization Process

Complaints/ Appeals

Utilization Management

Call Center Functioning

Website Critical Elements

3rd party biennial performance audits (or more frequently as determined by risk)

Two areas of focus

MCO self-reported data

Operational processes

Targeted area(s) may vary.

Examples include:

- MCO Hotlines
- Complaints and Appeals
- Claims processing
- Subcontractor monitoring (including pharmacy)

Can inform the focus of the 3rd party audit or the need for an incremental one

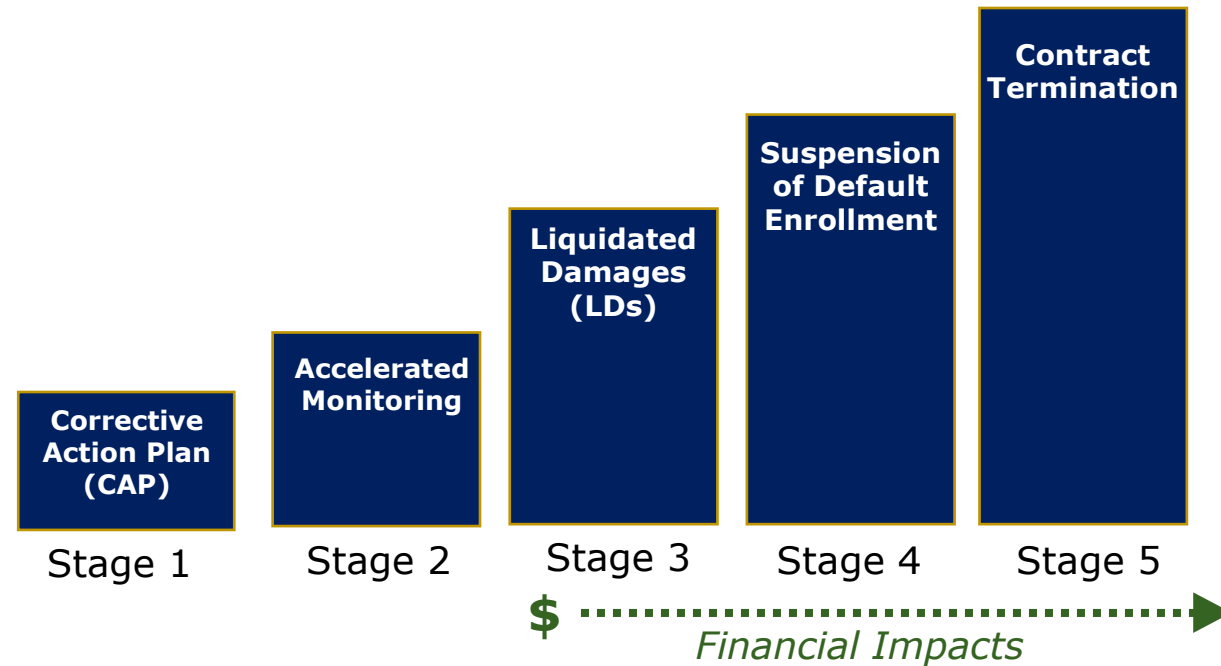


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Addressing Non-Compliance

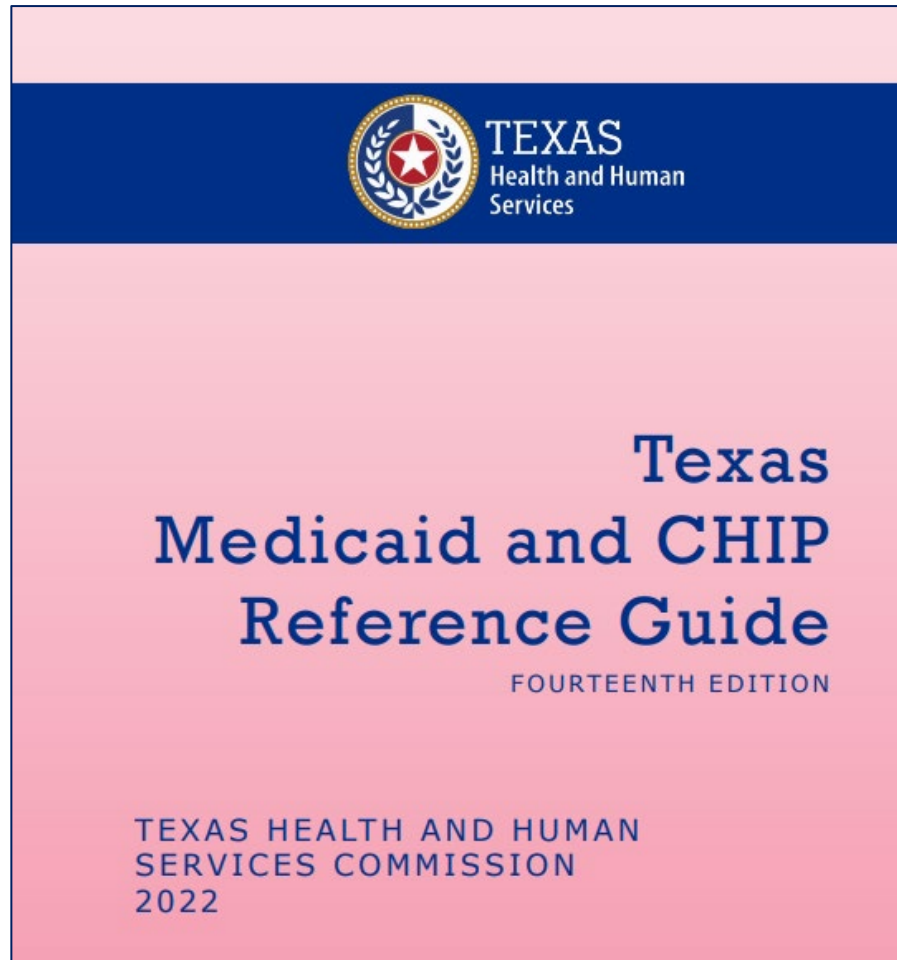
Multiple stages of remedies

- Increased levels of impact for MCOs
- Remedy issued is contingent on type of non-compliance and not necessarily sequential



A Great Resource on Texas Medicaid

Published every two years



<https://www.hhs.texas.gov/sites/default/files/documents/texas-medicaid-chip-reference-guide-14th-edition.pdf>





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Thank You
