Feasibility of Maximizing Federal Funds for Children in Foster Care

As Required by
2022-23 General Appropriations Act, Senate Bill 1, 87th Legislature, Regular Session, 2021 (Article II, Special Provisions Relating to All Health and Human Services Agencies, Section 26(e)(3))

Texas Health and Human Services
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TEXAS
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Executive Summary

The Texas Health and Human Services Commission (HHSC) submits the *Feasibility of Maximizing Federal Funds for Children in Foster Care* report in compliance with the 2022-23 General Appropriations Act, Senate Bill (S.B.) 1, 87th Legislature, Regular Session, 2021 (Article II, Special Provisions Relating to All Health and Human Services Agencies, Section 26(e)(3)).[1] Section 26 requires HHSC to report on the feasibility of increasing the use of federal funds in providing behavioral health services to children in foster care.

In 2020, Public Consulting Group (PCG) reported to HHSC on possible changes to the foster care rate methodology. Among many other recommendations, PCG's report included six recommendations for increasing the use of federal funds in delivering behavioral health services to children and youth in foster care. This report analyzed and determined the feasibility of those six recommendations:

- Recommendation 1: Maximizing the use of certain Medicaid Youth Empowerment Services (YES) and 1115 waivers for youth with high behavioral health needs.
  - HHSC will continue to promote the YES waiver, recruit providers, and seek ways to increase slots in the program.
  - HHSC would need additional resources, including funding and staffing, to apply for a Serious Mental Illness/Serious Emotional Disturbance (SMI/SED) 1115 waiver demonstration opportunity and to implement Psychiatric Residential Treatment Facilities (PRTFs) in Texas.
- Recommendation 2: Maximizing the use of in-lieu-of services
  - As required by S.B. 1177, 86th Legislature, Regular Session, 2019, HHSC implemented contract provisions to encourage Medicaid managed care organizations (MCOs) to offer three new behavioral health in-lieu-of services effective December 1, 2022. HHSC will continue to evaluate the other potential in-lieu-of services approved by the State Medicaid Managed Care Advisory Committee (SMMCAC) and monitor implementation of the new services.

[1] See Appendix B for relevant portions of SP 26

- Recommendation 3: Increasing the use of mental health targeted case management/mental health rehabilitation (MHTCM/MHR) services
  - HHSC determined the use of these services increased from state fiscal year 2019 to state fiscal year 2021.
  - HHSC received feedback from stakeholders regarding ways to increase the use of MHTCM/MHR, including barriers that could be addressed to increase access. HHSC will use the feedback to improve these services.
    - Stakeholders included:
      - The Department of Family and Protective Services (DFPS)
      - Local Mental Health Authorities (LMHAs)
      - Local Behavioral Health Authorities (LBHAs)
      - Private providers of MHTCM/MHR services
      - Single Source Continuum Contractors (SSCCs), and
      - MCOs
- Recommendation 4: Continuing the integration of behavioral health and physical health services in Medicaid managed care
  - Most Behavioral Health Integration Advisory Committee (BHIAC) recommendations of S.B. 58, 83rd Legislature, Regular Session, 2013, have been implemented or are in process.
  - HHSC is continuing to address integrated behavioral health and physical health services in the managed care model and alternative payment models (APMs) for integrated care.
- Recommendation 5: Study the costs and implications of bundling MHTCM and MHR into the provider payment structure
  - HHSC determined that the recommendation to bundle Medicaid MHTCM/MHR services into the DFPS payment structure would not be feasible and does not recommend pursuing the recommendation further.
- Recommendation 6: Streamline the Medicaid enrollment and credentialing processes
  - HHSC launched the new Provider Enrollment Management System (PEMS) in December 2021 and is working on development of a consolidated internet portal for Medicaid and CHIP provider data pursuant to S.B. 8, 87th Legislature, Third Special Session, 2021.

- HHSC remains committed to finding new ways to maximize federal funds, leverage Medicaid benefits, review payment structures, and streamline processes to provide children in foster care the best care possible.

Introduction

The 2020-21 General Appropriations Act, House Bill (H.B.) 1, 86th Legislature, Regular Session, 2019 (Article II, Special Provisions Relating to All Health and Human Services Agencies, Section 32), required HHSC to evaluate the methodology for establishing foster care rates to determine whether an alternative methodology would increase the use of federal funds. HHSC contracted with a third-party vendor, PCG, to conduct an evaluation of foster care rate methodology in collaboration with DFPS. PCG submitted the Texas Health and Human Services Commission Foster Care Rate Methodology Study report to HHSC in December 2020 and provided six recommendations for maximizing federal funds.

The 2022-23 General Appropriations Act, S.B. 1, 87th Legislature, Regular Session, 2021 (Article II, Special Provisions Relating to All Health and Human Services Agencies, Section 26(e)(3)) requires HHSC to submit a report by February 1, 2023, on the feasibility of increasing federal funds for use in providing certain behavioral health services to children in foster care. This report contains the findings of HHSC's feasibility analysis of following PCG's six recommendations for maximizing federal funds.

Background

State of Texas Access Reform (STAR) Health

The STAR Health program is a statewide Medicaid managed care program that operates under the authority of Section 1915(a) of the Social Security Act and provides medical, dental, vision, prescription, behavioral health, and long-term services and supports primarily to children and young adults in the conservatorship of DFPS. Services are delivered through a single statewide MCO, which is required to provide all covered, medically necessary services to its members.

Children and young adults in foster care often have multiple and complex medical, physical health, behavioral health, and developmental needs. They also have typical health needs such as routine well-child healthcare, immunizations, developmental surveillance, and the treatment of acute childhood illnesses.

The STAR Health program addresses healthcare needs of children and young adults in foster care and beyond by delivering integrated physical and behavioral health services, centralized service coordination, and effectively managed healthcare data and information.

In partnership with DFPS, Medicaid provides STAR Health for the following groups:

- Children in DFPS conservatorship;
- Children in the Adoption Assistance or Permanency Care Assistance program who are transitioning from STAR Health to STAR or STAR Kids;
- Youth age 21 and younger with voluntary extended foster care placement agreements (Extended Foster Care); and
- Youth age 20 and younger who are Former Foster Care Children or who are enrolled in Medicaid for Transitioning Foster Care Youth.

PCG made six recommendations specifically related to STAR Health funding. This report assesses the feasibility of each recommendation to increase the use of federal funds in the provision of mental health services to children in foster care.

1. Maximizing Use of Medicaid Waivers

Continue the 1915(c) Youth Empowerment Services (YES) Waiver

YES is a 1915(c) Medicaid waiver program that helps children and youth with serious mental, emotional, and behavioral difficulties by providing intensive services delivered within a strengths-based team planning process called wraparound. By expanding available mental health services and supports, YES aims to reduce the time youth spend out of their homes due to mental health needs.

PCG made the following recommendations:

- HHSC (with DFPS) continue the YES waiver program and promote the program to prevent relinquishments and out-of-home placements.
- HHSC work with the STAR Health MCO and with LMHAs to simplify the credentialing process with MCOs to increase the number of YES providers.
- HHSC work with the STAR Health MCO and LMHAs to simplify the process of provider enrollment with the Texas Medicaid & Healthcare Partnership (TMHP) to increase the number of YES providers.

YES services are provided by LMHAs, LBHAs, and HHSC-contracted comprehensive waiver providers (CWPs), all of which are enrolled with TMHP. TMHP serves as Texas Medicaid's third-party vendor for provider enrollment. MCO credentialing is not required because YES waiver services are reimbursed through TMHP on a fee-for-service basis. LMHAs, LBHAs, and CWPs may also subcontract with additional providers to provide waiver services, but these subcontracted providers do not enroll with TMHP or credential with MCOs.

This section addresses how HHSC continues to promote and improve the YES waiver program. "Recommendation 6: Streamlining the Provider Enrollment and MCO Credentialing Processes" provides more information on the provider enrollment process and the MCO credentialing process.

Continue to Promote the YES Waiver Program

As a Medicaid 1915(c) waiver program, YES waiver slots and reimbursement rates are based on appropriated funding and operation of the program requires approval

from the Centers for Medicare & Medicaid Services (CMS). In addition, the program has strict eligibility criteria.

On April 1, 2022, with the beginning of the new waiver year, YES waiver program began operating with an additional 136 slots for eligible children, including those in DFPS conservatorship. Access to the additional 136 slots was part of the planned expansion of the YES waiver and brings the total capacity to 3,591 children. Texas reserves a small percentage (currently 180 slots) for eligible children who are at imminent risk of being relinquished to conservatorship of the state.

HHSC promotes YES services through a team dedicated to the YES waiver program. Specifically, a key participant of the team is the YES Outreach and Engagement Specialist, who attends in-person and virtual conferences and provides promotional materials to community stakeholders. The team has initiated a provider recruitment project to assist LMHAs and LBHAs recruit qualified providers to serve more youth in the program.

HHSC recently executed a contract with University of Texas-San Antonio in conjunction with a management consulting firm, ISF, to increase YES waiver service availability through outreach and recruitment of specialist service providers. ISF is in the initial stages of assessing the needs for each LMHA/LBHA and CWP. The ISF team is conducting outreach and surveys to assess the needs to focus outreach and recruitment efforts to implement a provider recruitment project that will assist centers in expanding their provider networks.

Additionally, HHSC has taken steps to increase access to the YES waiver program by waiving some administrative barriers to provider expansion. HHSC is also improving the open enrollment process to encourage a greater pool of potential service providers to apply.

Consider Applying for an 1115 Waiver

PCG recommended HHSC consider whether applying for the SMI/SED demonstration opportunity to draw down federal matching funds for stays in settings designated as Institutions for Mental Diseases (IMD) would be in the best interest of children in the Texas foster care system. PCG noted that the waiver is an option for covering children and youth in conservatorship who require high-cost services and placements who do not meet medical necessity criteria for inpatient psychiatric services or may be placed in settings that are designated as IMDs. PCG also noted that Texas does not utilize PRTFs to fund inpatient psychiatric services.

It is important to clarify that PCG incorrectly reported, "Medicaid does not cover services for children and youth in IMDs." The Texas Medicaid State Plan does cover IMD stays for children and youth ages 20 and younger in Medicare or Medicaid-certified psychiatric hospitals.

Additionally, the SMI/SED demonstration opportunity would not cover the federal Medicaid matching funds for room and board since it does not allow for room and board payments in residential treatment settings unless they qualify as an inpatient facility under section 1905(a) of the Social Security Act.

For inpatient mental health services for children and youth, the only facilities that qualify for the federal Medicaid match for room and board payments are:

- Medicare or Medicaid-certified psychiatric hospitals;
- General hospitals with an inpatient psychiatric program accredited by a CMS-approved national hospital accreditation process; and
- PRTFs certified by a state Medicaid agency.[2]

Texas covers the first two settings under the Texas Medicaid State Plan.

PRTF is a CMS designation for a non-hospital facility that has a provider agreement with a state Medicaid agency to provide inpatient services to people ages 20 and younger. PRTFs are the only non-hospital psychiatric setting eligible for a federal Medicaid match for room and board. The federal Medicaid match is only available for services delivered in PRTFs when the Medicaid member meets the medical necessity requirement for inpatient services.

The PRTF treatment team must certify for each person served that:

- Ambulatory care in the community does not meet treatment needs.
- The child requires inpatient services under the direction of a physician for proper treatment of their psychiatric condition.
- PRTF services can reasonably be expected to improve the condition or prevent further regression, so that the services will no longer be needed.

Currently, Texas does not have a mechanism to certify PRTFs. A certification process and clinical coverage criteria would need to be established to recognize

[2] PRTFs must meet federal requirements in Title 42 Code of Federal Regulations (CFR) §§ 441.151 to 441.182 and Title 42 CFR §§483.350 to 483.376

PRTFs and ensure that the level of service and facility structure meet state and federal standards for the state to be eligible for federal Medicaid matching funds. Additionally, HHSC does not currently have statutory authority to license PRTFs in Texas.

There is also a risk the creation of the PRTF facility type may not create additional beds for children in Texas unless new providers emerge, or current providers increase capacity.

SMI/SED Demonstration Opportunity

Federal law allows states to apply to CMS for permission to deviate from certain Medicaid requirements through waiver applications. 1115 waivers specifically provide states the flexibility to test new ideas for operating Medicaid programs, including implementing statewide health system reforms, providing services not typically covered by Medicaid, or allowing innovative service delivery systems to improve care, increase efficiencies, and reduce costs. 1115 waivers must be shown to be budget neutral to the federal government.

The SMI/SED demonstration opportunity is a specific 1115 waiver that allows states to receive a federal match for services delivered during short-term stays for acute care in psychiatric hospitals or residential treatment settings that qualify as IMDs and can be used to enhance the continuum of mental health services available in Medicaid.

Although it may be possible to cover PRTFs through a general 1115 waiver or an SMI/SED demonstration, state Medicaid agencies typically cover PRTFs through their Medicaid state plan. HHSC staff researched how other state Medicaid agencies authorize PRTFs and were unable to find an example of a state authorizing PRTFs under an 1115 waiver rather than the state plan.[3]

While it may be possible to use an 1115 waiver to limit PRTF services to Medicaid members enrolled in STAR Health, who meet clinical criteria, there may be challenges with building a sufficient statewide provider base of PRTFs given the size of the STAR Health population.[4]

[3] Under the state plan, the services would be available for the entire Medicaid population who meet clinical eligibility and medical necessity criteria.
[4] In State Fiscal Year 2021, the STAR Health population was about 42,143. https://www.hhs.texas.gov/about/records-statistics/data-statistics/healthcare-statistics

SMI/SED demonstrations have additional requirements compared to general 1115 waivers. For example, states must provide a full array of crisis stabilization services, improve transitions to community-based care, and ensure continued access to mental health services once the demonstration has concluded. There are also restrictions on federal Medicaid matching funds if average length of IMD stays, under the waiver, are over 30 days or an individual stay is over 60 days. HHSC estimates there would be additional costs to implement an SMI/SED demonstration 1115 waiver, which would depend on the array of services included under the waiver to comply with federal requirements.

SMI/SED demonstrations also require extensive monitoring and evaluations as well as maintaining coverage for community-based mental health care. CMS requires an evaluation of the demonstration by an outside entity. HHSC would require additional staffing resources to ensure oversight of the waiver and necessary correspondence and submissions to CMS, the quality reporting requirements, and oversight of the evaluation. HHSC assumes it would take one year to negotiate terms and conditions of the waiver once the waiver is developed and submitted to CMS.

Summary

HHSC will continue current work underway and explore additional ways to increase access to the YES waiver and expand the provider network using existing resources. HHSC would need additional resources, including funding and staffing, to apply for an SMI/SED 1115 demonstration opportunity and to implement PRTFs in Texas.

2. Maximizing Use of S.B. 1177 In-Lieu-Of Services

PCG recommended HHSC encourage the STAR Health MCO, LMHAs, and other providers to maximize use of in-lieu-of services required by S.B. 1177. In-lieu-of services are services that MCOs may substitute for Medicaid state plan services or settings, as allowed by 42 Code of Federal Regulations (CFR) Section 438.3(e)(2). Medicaid members cannot be required to use in-lieu-of services, and MCOs cannot be required to provide in-lieu-of services. S.B. 1177 amended Government Code Section 533.005(g), to require HHSC to implement contract provisions to allow Medicaid MCOs to offer medically appropriate, cost-effective, evidence-based behavioral health services in lieu of specified Medicaid state plan services. The list of services must be approved by SMMCAC.

HHSC published a new Uniform Managed Care Manual (UMCM) amendment, UMCM 16.3, effective December 1, 2022, to allow MCOs to begin offering three in-lieu-of services approved by SMMCAC: partial hospitalization, intensive outpatient program services, and coordinated specialty care services. HHSC surveyed MCOs and found that almost all MCOs plan to offer partial hospitalization and intensive outpatient services and the majority plan to offer coordinated specialty care as in-lieu-of services. HHSC continues to work with CMS and to analyze the remaining services approved by SMMCAC. For additional information about S.B. 1177, see the Medicaid Behavioral Health In-Lieu-Of Services Annual Report published in November 2022.

On January 4, 2023, CMS published a State Medicaid Director letter titled, "SMD #: 23-001 RE: Additional Guidance on Use of In Lieu of", which adds new requirements for in-lieu-of services, including new reporting requirements to CMS. HHSC staff are reviewing this new guidance and the impact on S.B. 1177.

Summary

Because MCOs have discretion in whether to offer in-lieu-of services, HHSC can encourage, but not require, MCOs to offer these services. The recommendation to maximize use of S.B. 1177 in-lieu-services can be implemented without additional resources or research. As the new in-lieu-of services implemented December 1, 2022, HHSC took the first step to encourage MCOs to provide the services by conducting a survey to obtain a baseline. HHSC will continue to monitor and address utilization as needed.

3. Increasing Use of MHTCM and MHR

PCG recommended HHSC request feedback from stakeholders about how to increase the use of MHTCM and MHR services within managed care. HHSC worked in consultation with DFPS and other stakeholders, including LMHAs, LBHAs, private providers of MHTCM/MHR services, SSCCs, and MCOs to gather input on increasing the utilization of MHTCM/MHR services.

The goal of MHTCM and MHR services is to improve or maintain a member's ability to remain in the community. In Texas Medicaid, MHTCM and MHR are delivered by LMHAs, LBHAs, and private providers.[5] Some child-placing agencies are enrolled in Texas Medicaid as private providers to provide MHTCM/MHR services. See Appendix C for more information about MHTCM/MHR services and providers.

On September 1, 2022, HHSC implemented S.B. 1921, 87th Legislature, Regular Session, 2021 to allow private providers to be reimbursed for MHTCM/MHR services in fee-for-service. This change allows private providers to begin providing services before the member is enrolled in managed care. For the dual-eligible population, whose MHTCM/MHR is carved out of managed care, MHTCM/MHR is also now billable in fee-for-service for private providers. These changes increase access to MHTCM and MHR for Medicaid clients in fee-for-service and during the transition from fee-for-service to managed care.

MHTCM/MHR Service Utilization in Medicaid

Within STAR Health, STAR, and STAR Kids, the use of MHTCM and MHR services has increased in recent years. The number of MHTCM/MHR claims in STAR, STAR Health, and STAR Kids increased by 32 percent, from 553,418 claims in state fiscal year 2019 to 727,945 claims in state fiscal year 2021. The total number of Medicaid members utilizing MHTCM/MHR services increased by 9 percent, from 52,802 in state fiscal year 2019 to 57,787 in state fiscal year 2021. These numbers indicate that although more members overall are utilizing services, the large increase in claims comes from more MHTCM/MHR claims per member. See Figures 1 and 2.

[5] Prior to the implementation of S.B. 58, 83rd Legislature, Regular Session, 2013, MHTCM/MHR services were only provided by LMHAs and LBHAs. S.B. 58 required HHSC to allow private providers to provide MHTCM/MHR services in managed care.

Figure 1. MHTCM/MHR Claims in STAR Kids, STAR Health, and STAR SFY 2019-2021

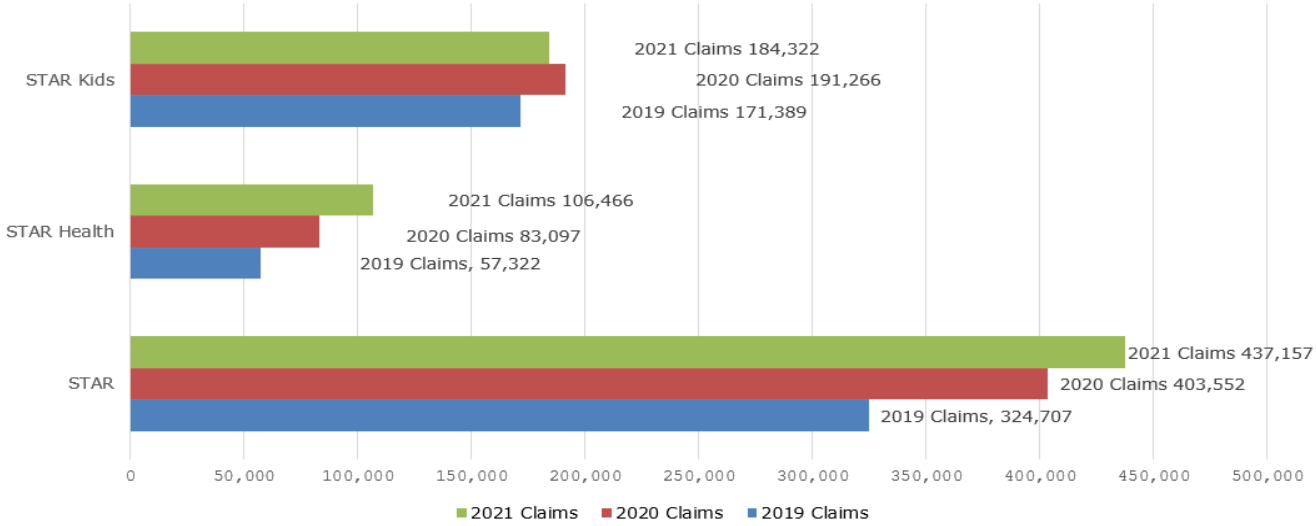
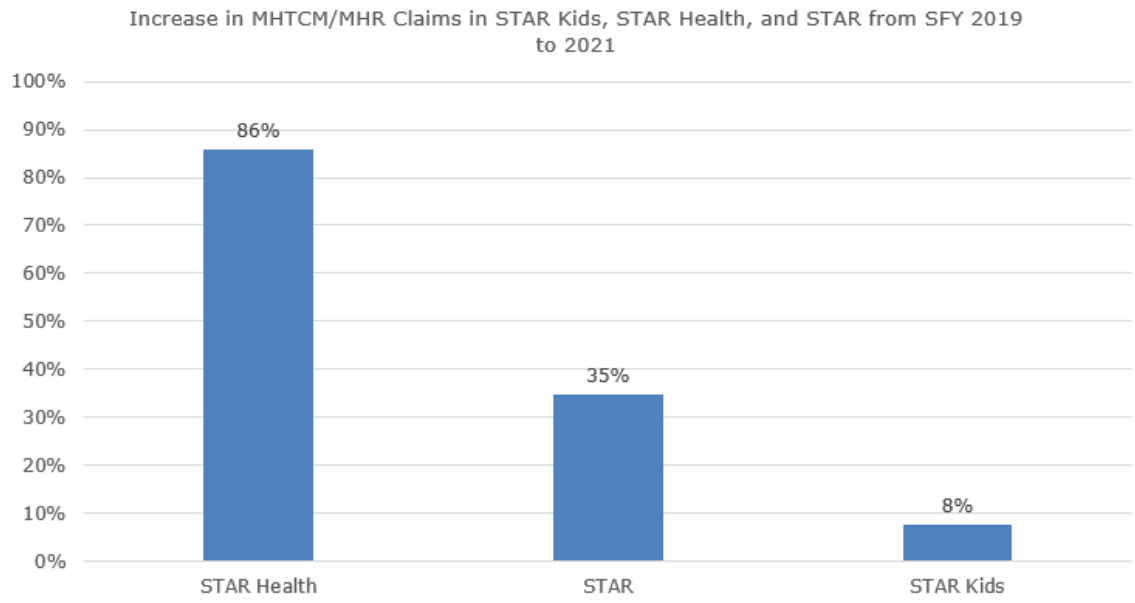


Figure 2. Increase in MHTCM/MHR Claims in STAR Kids, STAR Health, and STAR SFY 2019-2021



STAR Health had the largest increase in the number of MHTCM/MHR claims, from 57,322 in 2019 to 106,466 in 2021. The number of members with at least one MHTCM/MHR claim increased 42 percent in that time period. The largest increase in utilization of MHTCM/MHR came from youth in STAR Health age groups 13-17 and over 18.

Utilization of MHTCM/MHR increased significantly in STAR Health from 2017-2019 compared to the other programs. The number of claims in STAR Health increased 86 percent state fiscal year 2019 to state fiscal year 2021 compared to 26 percent in STAR and 7 percent in STAR Kids.

There are a number of potential explanations for this increase, including that older STAR Health members often have more complex behavioral health care needs and may have had more time to utilize services, since they were likely in Medicaid longer due to the continuous eligibility during the public health emergency.[6] Increased utilization of teleservices by STAR Health members may also have contributed to the increase in overall utilization. Additionally, utilization may have increased due to member outreach by the STAR Health MCO to increase awareness of MHTCM/MHR availability and S.B. 58 increasing access to MHTCM/MHR through private providers.

In terms of overall population, in 2021, 12 percent of STAR Health members had at least one MHTCM/MHR claim, compared to eight percent of members in STAR Kids and 1.1 percent of members in STAR.

Recommendations from Stakeholders

HHSC received feedback from stakeholders about how to increase the use of MHTCM and MHR services within managed care. Stakeholders reported barriers to utilization to include: payment rates, workforce shortages, assessment and curriculum issues, and a lack of awareness about services.

Payment Rates and Workforce Shortages

When asked about barriers to the utilization of MHTCM/MHR services, multiple stakeholder groups spoke about low Medicaid payment rates for mental health services and the nationwide behavioral health workforce shortage. Stakeholders also pointed out that the Covid-19 public health emergency has contributed to both higher acuity levels for mental health and workforce challenges.

Some stakeholders observed that there are new challenges related to Qualified Mental Health Professionals - Community Services (QMHP-CS) providers being competitive in other areas in the labor market and a high number of vacancies for

[6] Families First Coronavirus Response Act (FFCRA) requires States to maintain continuous Medicaid eligibility during the federal PHE period as a condition of receiving enhanced federal funding.

QMHP-CS providers across the state. Providers also noted that online therapy platforms, which accept self-pay and private insurance, recruit licensed clinical social workers (LCSWs), licensed professional counselors (LPCs), and licensed marriage and family therapists (LMFTs) by offering a much higher rate than provider groups serving Medicaid members.

In December 2020, the Behavioral Health Workforce Workgroup, a subcommittee of the Statewide Behavioral Health Coordinating Council, published their findings and recommendations for improving the behavioral health workforce in a report titled *Strong Families, Supportive Communities: Moving Our Behavioral Health Workforce Forward*. The report was not authored by and does not reflect the views or opinions of the Texas Health and Human Services System, its component agencies, or staff. Their recommendations largely centered around reimbursement for behavioral health services, including ensuring pay equity when services are provided via telehealth or telemedicine or when different professionals are providing the same service; ensuring reimbursement rates reflect the cost of delivering services; expanding what type of professional can provide services; and creating incentives for value-based arrangements between providers and MCOs.

Awareness about MHTCM/MHR services

Stakeholders reported a lack of general awareness about MHTCM/MHR services. It was noted that members, caregivers, the court system or Child Protective Services caseworkers may not be aware of the services and the value they can provide to members. This can lead to information not being shared with a member or caregiver about the benefits of the services. It was also reported that there is not always an understanding of the difference between MHTCM/MHR and traditional psychotherapy.

Assessments

Initial Assessments

Stakeholders reported that by the time a child comes in to be evaluated by a MHTCM/MHR provider, they typically have a high need for services. Thus, requiring the assessment and development of a treatment plan before the delivery of services may pose a barrier on the front end of treatment.

Providers suggested that an alternative approach may be the Treat First clinical model, used by New Mexico Medicaid, and designed to prioritize treatment and

reduce assessment requirements. New Mexico's model allows for up to four encounters with a provisional diagnosis without a comprehensive assessment and treatment plan. Providers reported that potential benefits of the Treat First model may include earlier initiation of treatment and increased accuracy and quality of the assessments due to the providers learning more about the child and family through the initial services. Providers suggested they may also build trust more quickly with the child and caregivers if services are initiated first. Further evaluation would be needed for HHSC to review the Treat First model and determine feasibility and any cost impacts.

Assessment Timing

Multiple stakeholders stated the LMHA drop-in system for assessments resulted in lengthy wait times, and the unpredictable time requirement was a barrier to care due to both work and school schedules. Stakeholders recommended doing the assessments while the members are still inpatient at the facility before the members transition to outpatient with the goal to reduce inpatient readmissions from members not following through to get the assessment and continuing a cycle of acute care.

Current state policies prohibit the reimbursement for MHTCM/MHR services while the Medicaid member is a resident of an IMD or a patient of a general medical hospital.[7] Further evaluation of federal and state policies would be needed to determine whether policy changes could allow reimbursement to providers for the assessments before the member transitions from inpatient to outpatient services.

Additional Assessments and Documentation

Stakeholders accurately reported that the current HHSC policy requires providers of MHTCM/MHR to reassess children under age 18 every 90 days. Providers said that they are also expected to conduct additional assessments for other funding sources and accreditations, such as being certified as Texas-Certified Community Behavioral Health Clinics (T-CCBHCs).[8] Providers reported that while recovery plans are important to helping members set goals and determine services, the assessments used to create recovery plans can become an administrative burden. Stakeholders also said that workforce shortages exacerbate the administrative burden.

[7] 1 TAC §354.2651(c) and 1 TAC §354.2701(c)
[8] Please see "Recommendation 4: Behavioral Health Integration" for more information about T-CCBHCs.

Additionally, providers expressed concerns that MCOs may recoup payments if they disagree with or feel the documentation, such as assessments or recovery plans do not contain enough information.

Curriculum

Stakeholders reported that the required curricula for MHTCM/MHR presents a barrier to the utilization of services. For example, UMCM 15.3 "Mental Health Targeted Case Management and Mental Health Rehabilitative Services Training Requirements", requires all MHTCM/MHR providers to undergo specific training outlined in the chapter. Providers said these requirements limit the modalities that providers can offer.[9] Providers recommended that the state create a process for expanding the list of approved evidence-based curricula, including a process by which stakeholders can propose additional curricula for inclusion or HHSC identify other credible sources that vet evidence-based practices, such as the Substance Abuse and Mental Health Services Administration and allow inclusion of these identified curricula by reference instead of a static list.

Multiple Providers, Systems, and Policies

Some stakeholders reported that because the Texas mental healthcare system was originally designed with LMHAs and LBHAs as the primary mental health providers, it can be difficult for members to receive services from multiple provider groups. Since private providers are now allowed to provide MHTCM/MHR, LMHAs and LBHAs are no longer a standalone system in Texas Medicaid, especially for children in foster care. Often, children in foster care may receive some services delivered by their child-placing agency and receive some from an LMHA. Children in foster care may also need to switch providers if they move to different parts of the state for placement.

An example of how the system was originally designed for LMHAs is that Clinical Management of Behavioral Health Services (CMBHS) does not currently allow for multiple providers to have an episode of care open for the same person. Stakeholders reported that this limitation causes delays in services when members switch from one provider to another, and the former provider does not close out the episode of care in a timely manner. Additionally, stakeholders reported this limitation prevents private providers from opening an episode of care for MHTCM/MHR, if an LMHA has an episode of care open for other types of services.

[9] Other policies that stakeholders noted as examples were Texas Administrative Code §306.319(b)(4) and TRR Utilization Management Guidelines.

To update CMBHS to allow for multiple providers for the same person, a large-scale system change and additional funding would be required. HHSC is exploring whether a smaller scale system change, or policy and operational changes could improve the process.

Stakeholders also reported confusion between the varying policies from different departments of HHSC regarding MHTCM/MHR. For instance, the Texas Resilience and Recovery Utilization Management Guidelines, which HHSC requires LMHAs, LBHAs and private providers to use, includes some Texas Medicaid services and some services not covered in Texas Medicaid. Providers reported that it is unclear which services in the document apply to private Medicaid providers.

Other Barriers to Accessing MHTCM/MHR Providers

Stakeholders reported some additional barriers to accessing MHTCM/MHR providers, including: language barriers; reluctance to provide services due to effort and time it takes to become a credentialed provider and receive reimbursement for services; travel time and distance to the location of the provider (particularly in rural areas); children in foster care may change location and need new providers more frequently; indirect barriers such as obtaining transportation and childcare for other children, and taking time away from work; and the need to minimize taking a child in conservatorship out of school for appointments.

MCO Survey

In a survey on MHTCM and MHR services sent to the MCOs, the most commonly cited suggestion on how to improve MHTCM and MHR services was providing the LMHAs with more funding or support to expand staffing capacities.

Other suggestions included: continuing use of telemedicine; improving access for rural counties; reexamining provider qualifications, enrollment process, and provider reimbursement; using a directed payment program for behavioral health services; offering scheduled appointments and offer after-hours and weekend appointments for intake and assessments; providing education to private providers, members and caregivers on the array of services; encouraging peer support; and enabling electronic referrals for treating providers, MCOs, and the validation process.

Summary

HHSC found the use of MHTCM and MHR services increased from state fiscal year 2019 to 2021. HHSC plans to further evaluate the suggestions and information on existing barriers provided by stakeholders to improve these services in policymaking. Some recommendations may be implemented with existing resources, but some recommendations would need additional funding, such as updating CMBHS to allow for multiple providers for the same person.

4. Behavioral Health Integration

PCG recommended that HHSC revisit the S.B. 58 BHIAC recommendations for integrating care and determine which recommendations were implemented and address any recommendations that were not implemented. PCG also recommended that HHSC continue to identify ways to use APMs in integrated health settings.

BHIAC Recommendations

S.B. 58 required HHSC to establish BHIAC until it expired in September 2017. BHIAC was charged with providing HHSC with formal recommendations addressing the planning and development needs of integrating Medicaid behavioral health services, including MHTCM and MHR services, and physical health services into Medicaid managed care.

HHSC staff reviewed the BHIAC Phase I and Phase II recommendations. HHSC has at least partially implemented all 41 recommendations in BHIAC's report. Of the 41 recommendations, HHSC completed 24 and partially completed 16. One recommendation is no longer applicable.

See Appendix D for the full list of BHIAC Recommendations.

Integrated Care

In addition to addressing the integration of behavioral health services from a fee-for-service model into managed care, BHIAC's recommendations also addressed integrating behavioral and physical health services with each other.

The subsections below outline examples of HHSC initiatives addressing integrated care, which tie into multiple BHIACs recommendations.

CCBHCs

The Certified Community Behavioral Health Clinics (CCBHCs) model integrates primary care screenings and substance use disorder services into mental health care settings clinically, financially, and administratively, with the goal of improving overall health outcomes.[10] The model is comprised of comprehensive array of

[10] Congress established CCBHCs through Section 223 of the Protecting Access to Medicare Act of 2014, which authorized demonstration grants in states to improve community behavioral health services.

services, including: crisis mental health services; screening, diagnosis, and assessment; patient-centered treatment planning; and comprehensive outpatient mental health services.

HHSC launched the T-CCBHC initiative in 2016. The T-CCBHC initiative aligns the goals of CCBHCs within the current Medicaid and behavioral health environment in Texas and demonstrates a commitment to using CCBHCs as a best practice for service delivery in behavioral health settings. As of July 2022, all Texas counties are served by at least one T-CCBHC. All LMHAs and LBHAs are certified as T-CCBHCs, in addition to a few other provider types.

Health Homes

A "Health Home" is a primary care provider (PCP) practice, or if appropriate, a specialty care provider practice, incorporating several features, including comprehensive care coordination, family-centered care, and data management, focused on improving outcome-based quality of care and increasing patient and provider satisfaction under Medicaid.

Medicaid MCOs must provide health home services with designated providers to serve as the health home. Health home services must be part of a person-based approach and holistically address the needs of persons with multiple chronic conditions or a single serious and persistent mental or health condition.

S.B. 58 required the creation of two health home pilot programs for people diagnosed with an SMI and at least one other chronic health condition. As recommended by BHIAC, HHSC partnered with LMHAs participating in the CCBHC initiative and four MCOs to conduct a qualitative case study of provider and MCO experiences developing and implementing these programs. The pilot included two sites and the evaluation took place over a two-year study period from January 2017 through December 2019.[11]

Collaborative Care Model

The Collaborative Care Model is a systematic approach to the treatment of behavioral health conditions in primary care settings. The model integrates the services of behavioral health care managers and psychiatric consultants with PCP oversight to proactively manage behavioral health conditions as chronic diseases,

[11] Site 1 served clients living in a semi-urban and rural area of Texas. Site 2 served a large, rural, indigent population in addition to its Medicaid population.

rather than treating acute symptoms. The Collaborative Care Model was added as a Texas Medicaid benefit in June 2022.

Medicaid MCO Requirements Addressing Integrated Care

The following are examples of existing MCO requirements that address integrated care:

- Effectively share and integrate care coordination, service authorization, and utilization management data between the MCO and the entity contracted with the MCO to manage behavioral health services;
- Implement joint rounds for physical health and behavioral health services network providers or some other effective means for sharing clinical information;
- Ensure a seamless provider portal is available for both physical health and behavioral health services network providers; and
- Require, to the extent feasible, the co-location of physical health and behavioral health coordination staff and ensure warm call transfers between the teams.

Continue to Identify APMs for Integrated Settings

APMs are a payment system that gives added incentive payments to provide high-quality and cost-efficient care. APMs can pertain to a clinical condition, a care episode, or a patient population type. Populations vary by APM. These arrangements between MCOs and providers are designed to improve health outcomes for members, empower members, improve experience of care, lower healthcare cost trends, and incentivize providers.

HHSC requires MCOs to transition the provider payment methodologies from volume-based payment approaches (fee-for-service) to value-based alternative APMs, increasing year-over-year percentages of provider payments linked to measures of quality or efficiency, or maintaining every year the percentage achieved the year before.

Starting with calendar year 2018, 25 percent of an MCO's payments to providers must be in APMs. The percentage increased to 50 percent in 2021, for each MCO by program type (STAR, STAR+PLUS, STAR Health, STAR Kids, and CHIP) with certain exceptions.

HHSC has encouraged MCOs to look at APMs that facilitate the integration of physical and behavioral health, focusing on value-based purchasing models that use quality measure outcomes as payment incentives. As of 2020, 12 MCOs had implemented their own behavioral health focused value-based payment programs involving over 41,000 providers. The models are primarily focused on the integration of medical records between behavioral and primary care, administrative streamlining for high performing providers, and reducing inpatient readmissions and expenditures (through better outpatient services and coordination).

As of September 1, 2021, MCOs are required to work with T-CCBHCs to establish an APM arrangement. HHSC releases annual summaries of the APMs submitted by MCOs. The annual summary for calendar year 2021 will be available in 2023. Examples of APMs in STAR Health, which may be available to providers serving children in foster care, include:

- 3 in 30 Program: PCPs earn incentive payments for coordinating the timely completion of all required 3 in 30 Program checkups.[12]
- Prenatal & Postpartum Care Program: Obstetrician-gynecologists earn incentive payments for actions that contribute to the delivery of timely prenatal and postpartum care, including for members with a history of preterm delivery, psychosocial issues, or other conditions that can complicate the course of pregnancy.
- Trauma-Informed Care APM: Providers earn incentive payments for completing trauma informed care training; using evidence based, trauma informed practices; and improving relevant quality measures.
- Behavioral Health Pay for Performance: Fee-for-service base payments and bonuses for quality performance.

[12] 3 in 30 combines three important tools for assessing the medical, behavioral, and developmental strengths and needs of children and youth entering DFPS custody within 30 days: the 3-day medical exam, Child and Adolescent Needs and Strengths Assessment, and the Texas Health Steps medical checkup.

Summary

HHSC implemented many of the recommendations from the BHIAC report. Most are complete, while staff continue to address some partially completed recommendations, and one is no longer applicable. HHSC will continue to address integrated behavioral health and physical health services in the managed care model and APMs for integrated physical and behavioral health care using existing resources.

5. Bundling TCM and Medicaid Mental Health Rehab into the Provider Payment Structure

PCG recommended HHSC conduct a feasibility study to determine the costs and implications of bundling MHTCM/MHR[13] into the foster care provider payment structure. According to PCG, "A bundled provider payment structure would incorporate costs associated with [MH]TCM and Medicaid mental health services directly into DFPS's payment rates. Providers would then be required to offer or contract for a standard level of these services for every child they serve, which could improve access to services and reduce the provider burden to bill Medicaid. Significant effort would need to be expended to make this happen and the MCO model in Texas cannot be changed without affecting numerous stakeholders and STAR Health enrollees that are not involved in the DFPS foster care system." PCG recommended the feasibility study consider state fiscal impact, member and provider fiscal impact, quality of care assessment, and impact on operations.

HHSC does not believe it would be feasible to bundle MHTCM/MHR into the foster care provider payment structure without operational issues. Additionally, bundling is not expected to improve quality of care. HHSC has identified the following specific concerns:

- HHSC has been directed to operate Medicaid through a managed care model with the intent of having MCOs coordinate the services a person receiving Medicaid is accessing. This is intended to promote timely provision of the most cost-effective and medically necessary services. If MHTCM/MHR were moved out of managed care for some or all foster care children, it would directly conflict with these goals. Recommendation 3 relates to increasing utilization of MHTCM/MHR within managed care. Bundling services into the foster care provider payment structure, outside of managed care, may interfere with those efforts and impact member access to services. In order to comply with legislative direction and preserve oversight, HHSC advises that greater focus and resources be directed to Recommendation 3 and improving services provided in managed care.
- Not all STAR Health members are in state conservatorship and HHSC does not know if all foster care providers would have the ability and/or desire to provide some level of MHTCM/MR services. If some level of services were

[13] See Appendix C for more information about MHTCM/MHR services and providers.

incorporated into the foster care payment structure, some members would continue to receive all of their MHTCM/MHR services through STAR Health, some would receive services from their foster care provider and through STAR Health, and some may receive services exclusively from their foster care provider.

This could present challenges for establishing premiums for the STAR Health program as each of the identified groups would be expected to have a different level of expense in STAR Health and the case mix between the groups could shift over time. Additionally, there is a risk of lack of clarity on whether the foster care provider or MCO is responsible for delivering services, which could result in duplication of services and/or payments by foster care providers and MCOs.

Finally, there could be negative consequences for oversight and quality. Neither HHSC nor the STAR Health MCO would have visibility into the level of services STAR Health members are receiving if some of the services are provided outside of the STAR Health program. As noted, the STAR Health MCO may not have awareness of when an individual has an unmet need for services, which could result in negative health outcomes. An example of a negative outcome could be that the STAR Health MCO is not aware a child has stopped accessing these critical mental health services and is at risk of hospitalization.

HHSC does not believe bundling payments would have the effect of maximizing federal funds or otherwise resulting in a positive fiscal impact to the state. Services would be expected to be federally matched at the same rate regardless of whether they are provided through STAR Health or bundled for payment through the foster care rate. The only increase to federal funding would come from an overall increase in services, which would also result in a cost to the state for the non-federal share.

HHSC also does not expect the bundling of rates alone would have a positive impact on the quality of care provided and could create a less efficient and more disjointed system. HHSC would also not have the same level of oversight over services provided by foster care providers compared to Medicaid providers.

Summary

HHSC determined that the recommendation to bundle Medicaid MHTCM/MHR services into the DFPS payment structure would not be feasible and does not recommend pursuing the recommendation further.

6. Streamlining Provider Enrollment and the MCO Credentialling Process

PCG recommended HHSC review federal requirements and identify areas that can be improved to make it easier for providers to become credentialed.

In Texas Medicaid, credentialing refers to the process of collecting, assessing, and validating qualifications and other relevant information from health care providers to determine eligibility for managed care network participation and to deliver services in Medicaid managed care.

It is important to clarify that PCG's recommendation referred to "the Medicaid credentialing process (with the Medicaid agency's contractor, the Texas Medicaid Healthcare Partnership (TMHP))." TMHP is Texas Medicaid's third-party vendor for provider enrollment and fee-for-service claim administration. Medicaid providers first enroll with TMHP before they credential with MCOs in their service area.

To fully answer this recommendation and "Recommendation 1: Maximizing Use of Medicaid Waivers," HHSC addresses both the provider enrollment process with TMHP and the credentialing process with MCOs in the section.

The MCO Credentialing Process

Medicaid MCOs must comply with federal regulations (42 CFR § 438.214), which require MCOs to implement policies and procedures for selection and retention of network providers. The federal policy also requires each state to establish a uniform credentialing and recredentialing policy, which HHSC includes in contracts with MCOs.

Since August 2018, Texas Medicaid MCOs have used a credentialing verification organization (CVO), Verisys Corporation, as the primary source verification vendor for provider credentialing. The CVO collects and independently verifies submitted data and distributes the resulting verification information to requesting MCOs. In addition to data collected and verified by the CVO, each MCO collects additional information from providers to complete the credentialing process. Each MCO credentials providers independently into its network.

In some cases, MCOs may delegate credentialing to a third party. For instance, MCOs that subcontract with a behavioral health organization to contract with

behavioral health providers. In these cases, the credentialing must be maintained in accordance with the National Committee for Quality Assurance delegated credentialing requirements and any comparable requirements defined by HHSC.

After the CVO receives documentation from the provider, the process of credentialing and contracting with providers is handled entirely by the individual MCOs. HHSC monitors the timeliness of credentialing based on ad hoc reports received by the agency. MCOs are contractually required by HHSC to complete credentialing applications within 90 days of receiving a complete application for initial credentialing and recredentialing.

MCOs must have an expedited credentialing process that allows providers, including LCSWs, LPCs, LMFTs, and psychologists, to provide services to members on a provisional basis. If a qualifying provider is joining a Medicaid-enrolled health care provider group that is already credentialed and contracted with the MCO, the application should be handled via the expedited credentialing process. If a provider qualifies for expedited credentialing, MCOs are required to treat the provider as an in-network provider upon submission of a complete application. The MCO claims system must be able to process claims from the provider no later than 30 days after receipt of a complete application.

STAR Health Credentialing

As of September 2022, 99 percent of STAR Health providers are credentialed within 90 days of the STAR Health MCO receiving a complete application. In September 2022, 100 percent of providers were re-credentialed within 90 days of the STAR Health MCO receiving a complete application. HHSC is seeking additional information from the STAR Health MCO about the percent of providers credentialed within 30 days when pursuing the process through a group already credentialed with STAR Health MCO.

The Provider Enrollment Process

Federal regulations (42 CFR §455.400 – 455.470) establish federal requirements for associated provider screening and enrollment requirements, fees associated with provider screening, and temporary pauses on enrollment of providers.

In compliance with these requirements, HHSC requires:

- Upon initial enrollment, revalidation, and re-enrollment, all participating providers are screened based on their categorical risk level.

- All providers are required to revalidate at least every three to five years based on risk categories and other considerations.
- Institutional providers who are enrolling, revalidating, or reenrolling are required to pay an application fee if one has not already been paid to Medicare or another state's Medicaid program or CHIP.

S.B. 200, 84th Legislature, Regular Session, 2015, requires HHSC to consolidate and streamline provider enrollment and data management processes. H.B. 4533, 86th Legislature, Regular Session, 2019 also requires HHSC to implement a system for enrolling providers with National Provider Identifiers. In addition, H.B. 4533 requires HHSC to transition from using local identifiers, such as the Texas Provider Identifier, as part of the provider enrollment process for Texas Medicaid and other HHSC programs. On December 13, 2021, HHSC and TMHP began managing the provider enrollment process using PEMS. All changes, including ending the use of the Texas Provider Identifier, were intended to streamline the enrollment process for providers.

Future Systems Changes

HHSC is working on establishing a single provider portal to allow providers to submit both Texas Medicaid and CHIP enrollment applications to HHSC and credentialing information for MCOs or dental maintenance organizations (DMOs) in a single process. The single portal will share data with MCOs, DMOs and the CVO to allow for completion of the credentialing process, lessening the administrative burden on providers. Each MCO and DMO will continue to credential providers independently into their networks.

Summary

HHSC launched PEMS in December 2021 is working to further streamline both enrollment and MCO credentialing. The responsibility of credentialing will remain with the CVO and the MCOs, but HHSC is anticipating enhanced data alignment, to increase ease-of-use for providers by preventing discrepancies.

List of Acronyms

Acronym	Full Name
APM	Alternative Payment Model
BHIAC	Behavioral Health Integration Advisory Committee
CCBHC	Certified Community Behavioral Health Center
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CMBHS	Clinical Management of Behavioral Health Services
CMS	Centers for Medicare & Medicaid Services
CVO	Credentialing Verification Organization
CWP	Comprehensive Waiver Providers
DFPS	Department of Family and Protective Services
DMO	Dental Maintenance Organizations
H.B.	House Bill
HHSC	Health and Human Services Commission
IMD	Institutions for Mental Diseases
LAR	Legally Authorized Representative
LBHA	Local Behavioral Health Authority
LCSW	Licensed Clinical Social Worker
LMFT	Licensed Marriage and Family Therapist
LMHA	Local Mental Health Authority
LPC	Licensed Professional Counselor
MCO	Managed Care Organization
MH	Mental Health
MHR	Mental Health Rehabilitative (MHR) Services
MHTCM	Mental Health Targeted Case Management
PCG	Public Consulting Group, Inc.
PCP	Primary Care Provider
PEMS	Provider Enrollment and Management System
PRTF	Psychiatric Residential Treatment Facility
QMHP-CS	Qualified Mental Health Professional - Community Services
S.B.	Senate Bill
SFY	State Fiscal Year
SMI	Serious Mental Illness
SMMCAC	State Medicaid Managed Care Advisory Committee
SSCC	Single Source Continuum Contractor
STAR	State of Texas Access Reform
TAC	Texas Administrative Code
T-CCBHC	Texas-Certified Community Behavioral Health Center
TCM	Targeted Case Management
TMHP	Texas Medicaid & Healthcare Partnership
UMCM	Uniform Managed Care Manual
YES	Youth Empowerment Services

Appendix A. Full Text of PCG Recommendations

1. Maximize use of Medicaid waivers for youth with high behavioral health needs.

Continue 1915(c) YES Waiver: The YES waiver is a 1915(c) Medicaid program that helps children and youth with serious mental, emotional and behavioral difficulties. It provides intensive services delivered within a strengths-based team planning process called Wraparound. As a preventative service, HHSC and DFPS should continue to promote this service in an effort to prevent out-of-home placements. HHSC should also work with STAR Health and local mental health authorities to simplify the credentialing process to increase the number of YES providers. Specifically, this refers to streamlining the processes for both provider enrollment with the Texas Medicaid & Healthcare Partnership (TMHP) and credentialing with MCOs.

Apply for 1115(a) Waiver for IMD Payment Exclusion: Texas does not utilize psychiatric residential treatment facilities (PRTFs) to fund inpatient psychiatric services.[14] Currently, Medicaid provides inpatient psychiatric services to beneficiaries under age 21 if they meet medical necessity requirements, but there are a subset of children and youth in DFPS custody, who require high-cost services and placements, who don't meet medical necessity criteria and/or may be placed in settings that are designated as Institutes for Mental Disease (IMDs.) Medicaid does not cover services for children and youth in IMDs.[15] One option for Medicaid support for these youth may be to apply for a demonstration project waiver under Section 1115(a) of the Social Security Act. Four (4) states have approved 1115(a) waivers for IMD payment exclusion, and three (3) have pending waivers.[16] While these waivers eliminate some requirements, they add others. For example, 1115(a)

[14] CMS defines PRTFs as a non-hospital facility that has a provider agreement with a state Medicaid agency to provide inpatient service benefits to individuals 20 years and younger. Texas does not have a mechanism for certifying PRTFs. A certification process and clinical coverage criteria would need to be established to recognize PRTFs and ensure that the level of service and facility structure meet state and federal standards for the state to be eligible for federal Medicaid matching funds

[15] Note that facilities with fewer than 16 beds (for children and youth) are not IMDs.

[16] Idaho, Indiana, Vermont and Washington State have approved waivers. Massachusetts, Oklahoma and Utah have pending waivers (all as of December 3, 2020), according to the Kaiser Family Foundation

waivers are required to be budget neutral and must be renewed every five years. Texas would also need to contract with independent evaluators to conduct periodic evaluations of waiver outcomes. In short, this waiver would eliminate some requirements while adding others, so the costs and implications should be considered in determining whether this waiver would be in the best interest of children in the Texas foster care system.

2. Encourage STAR Health, Local Mental Health Authorities and providers to maximize use of S.B. 1177 In-Lieu-Of Services.

In 2019, Texas S.B. 1177 was passed, which states that HHSC will allow MCOs to have more flexibility in offering medically appropriate, cost-effective, evidence-based behavioral health services in lieu of covered Medicaid State Plan services. This two-stage process consists of in-lieu-of inpatient services to be implemented in March 2021 and in-lieu-of outpatient services to be implemented by September 2022.

The following are being considered for inclusion in Phase 1 in-lieu-of inpatient services:

- Coordinated specialty care
- Crisis respite
- Crisis stabilization
- Extended observation units
- Partial hospitalization
- Intensive outpatient program

The following are being considered for inclusion in Phase 2 in-lieu-of outpatient services:

- Cognitive rehabilitation
- Multisystemic therapy
- Functional family therapy

3. Increase use of TCM and MH Rehab Service within current MCO model.

Texas Medicaid reimburses TCM services; however, despite positive trends in recent years with increased encounters, utilization of these services indicates limitation (for the FY2019, TCM encounters represented less than one (1) percent (.44 percent) of the total medical services encounters). HHSC and DFPS should investigate the reasons for this limitation. Questions can be asked at the state, MCO, LMHA and provider levels. Addressing and improving this type of systemic issue would require insight from all involved parties. Feedback from stakeholders involved in Medicaid service provision would provide HHSC and DFPS with a strategy to increase the use of Medicaid TCM and MH Rehab in Texas without disrupting the MCO system and other populations outside of foster care that rely on it. Stakeholder questions could include the following, which stem from provider feedback given to PCG:

- Number of Providers: Do the regions lack a sufficient number of providers to render these services?
- Credentialing Barriers: What factors prevent providers from enrolling in TMHP or getting credentialed with the MCO to provide services directly?
- TCM In Residential Care: Are TCM services not readily accessible to children placed in residential settings? What are the obstacles?
- TCM Overlap in Case Plans: How do the residential care agencies or SSCCs incorporate the use of TCM services into their case plans?
- Non-Covered Therapeutic Services: Are there non-covered therapeutic services that should be covered MH Rehab services? Note that expanding the scope of what is covered in MH Rehab would have broader impacts beyond the STAR Health program.
- Medicaid Rate Sufficiency: What costs are not covered in the current Medicaid rates?
- Necessary Family Services: Are there necessary services for the family that are not covered?
- Regulatory Changes: What regulatory changes would make it easier for providers to offer and/or access more TCM and MH Rehab services?

4. Follow-up on S.B. 58 Integration of Behavioral Health and TCM Services into Managed Care Model.

Texas S.B. 58 states that to the extent possible, behavioral health services, including TCM and psychiatric rehabilitation services and physical health services are to be integrated into the Medicaid managed care program. The MCO must develop a network of public and private providers of behavioral health services and ensure adults with serious mental illness and children with serious emotional disturbance have access to a comprehensive array of services.[17] HHSC should revisit the S.B. 58 Behavioral Health Integration Advisory Committee (BHIAC) recommendations for integrating care. HHSC can then determine which recommendations were implemented and address recommendations that were not implemented. S.B. 58 also required HHSC to implement a health home pilot program. Pilot sites implemented an integrated care model where providers collaborate and coordinate care for Medicaid members with complex health conditions and established value-based alternative payment models (APMs) with Medicaid MCOs. Developing alternative payment models was identified as a challenge for pilot sites and MCOs. Barriers include:

- Integrated care practices are still maturing,
- Standard reimbursement models do not adequately fit the integrated care model, and
- Few alternative payment models exist for integrated care, and development of these models takes time.

Results of this pilot study suggest it is worth continuing to identify methods to utilize APMs in an integrated behavioral health setting.

[17] See the 83(R) S.B. 58 - Enrolled version for additional information.

5. Conduct a feasibility study to determine costs and implications of bundling TCM and Medicaid Mental Health Rehab into the provider payment structure.

A bundled provider payment structure would incorporate costs associated with TCM and Medicaid mental health services directly into DFPS's payment rates. Providers would then be required to offer or contract for a standard level of these services for every child they serve, which could improve access to services and reduce the provider burden to bill Medicaid. Significant effort would need to be expended to make this happen and the MCO model in Texas cannot be changed without affecting numerous stakeholders and STAR Health enrollees that are not involved in the DFPS foster care system. Therefore, PCG recommends a feasibility study as a first step at objectively weighing the pros and cons of a shift to statewide Medicaid services bundled into existing or modified provider payment structures. Specifically, HHSC should review the following in a feasibility study:

- State fiscal impact: State net revenue or costs of incorporating TCM and MH Rehab services into provider payment rates (outside of the MCO model)
- Member and provider fiscal impact: Net revenue and cost impacts to members and providers
- Quality of care assessment: The impact the bundled payment model would have on the frequency, duration and quality of services that children in foster care could receive.
- Impact on operations: The operational impact on the system that integrating TCM and MH Rehab would have. This may include the impact to HHSC in data reporting and monitoring as well as the latent impact to non-foster care populations. This could also affect the Medicaid program more broadly (beyond STAR Health) depending on current Medicaid State Plan requirements.

States that include Medicaid-eligible services directly in payments to providers assume responsibility for monitoring and compliance. Providers expressed an interest in this model during PCG's stakeholder engagement sessions. Providers should be included in this process as key stakeholders.

6. Streamline the Medicaid credentialing process

SSCCs noted the administrative and cost difficulties associated with the Medicaid credentialing process (with the Medicaid agency's contractor, the Texas Medicaid Healthcare Partnership (TMHP)). Legacy providers noted that the process is supposed to take 30 days but actually takes several months or even a year. While many of these requirements stem from federal requirements that HHSC must comply with, HHSC should review the federal requirements against its own, and identify areas that can be improved to make it easier for providers to become credentialed.

Appendix B. Relevant Portions of Special Provision 26

(e) HHSC shall submit to the Legislative Budget Board, the Governor, the Chair of the House Appropriations Committee, the Chair of the Senate Finance Committee, the Speaker of the House, the Lieutenant Governor, the permanent standing committees in the House of Representatives and the Senate with jurisdiction over health and human services, and DFPS:

(1) a plan for the development of pro forma modeled rates and cost-report based rates, using the service descriptions described in subsection (c) of this rider, including key milestones and identified interagency dependencies, and for the implementation of all other recommendations related to reimbursement rate methodologies made in the report entitled "Foster Care Methodology as required by the 2020-21 General Appropriations Act, House Bill 1, 86th Legislature, Regular Session, 2019 (Article II, Special Provisions Relating to All Health and Human Services Agencies, Section 32)" no later than September 30, 2021;

(2) a report that includes the pro forma modeled rates using the new methodology, including the fiscal estimate of implementing such rates, no later than December 1, 2022;

(3) a report on the feasibility of increasing federal funds for use in providing these services by February 1, 2023; and

(4) a semi-annual progress report of all related activities undertaken by HHSC every six months beginning on February 28, 2022.

Appendix C. MHTCM/MHR Services and Providers

MHTCM and MHR services require an initial assessment including historical, social, behavioral, functional, psychiatric, developmental, or other information from the person seeking services to determine specific treatment and support needs.

Functioning is assessed using one of the following tools:

- The Child and Adolescent Needs and Strengths Assessment for persons who are 17 years of age and younger; and
- The Adult Needs and Strengths Assessment and any necessary supplemental assessments for persons who are 18 to 20 years of age.

MHTCM

MHTCM services are case management services to persons of all ages with a diagnosis of mental illness or SED. MHTCM services assist persons in gaining access to needed medical, social, behavioral, educational, and other services and supports.

MHTCM activities and services include:

- A comprehensive initial assessment and periodic reassessment, as medically necessary, of the person's needs to determine the need for any medical, educational, social, behavioral, or other services.
- The development, and periodic revision, as medically necessary, of a trauma-informed and person-centered plan of care.
- Making referrals and performing other related activities, such as scheduling an appointment on behalf of the person, to help an eligible person obtain needed services and supports.
- Monitoring and performing the necessary follow-up that is necessary to ensure the plan of care is implemented and adequately addresses the needs of the person.

MHTCM activities may be with the person, family members, legally authorized representative (LAR), providers, or other entities.

MHR Services

MHR services are provided to people with an SMI to assist in maintaining or improving functioning and may be considered rehabilitative when necessary to help a person achieve a rehabilitation goal as defined in their plan of care.

MHR services may include:

- Medication training and support services
- Psychosocial rehabilitative services
- Skills training and development
- Crisis intervention services
- Day programs for acute needs

MHTCM/MHR Providers

QMHP-CS providers are eligible to deliver most MHTCM/MHR services and must meet the following minimum credentialing requirements:

- Completed a standardized training curriculum
- Demonstrated competency in the work to be performed
- Obtained one of the following:
  - A bachelor's degree from an accredited college or university with a minimum number of hours that are equivalent to a major in psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human growth and development, physician assistant, gerontology, special education, educational psychology, early childhood education, or early childhood intervention; or
  - A license as a registered nurse.

Physicians, physician assistants, advanced practice registered nurses, psychologists, LCSWs, LMFTs, and LPCs are automatically certified as QMHP-CS providers.

Certain MHR services may be provided by peer providers or certified family partners. The family partner services are provided to parents or LARs for the benefit of the Medicaid eligible child. See Table 2.

Appendix D. BHIAC Recommendations

Holistic Treatment

1. All Managed Care Organizations (MCOs) must have integrated technology systems and care coordination systems for physical and behavioral health, even when the MCO subcontracts for behavioral health services.

   A. HHSC completed this recommendation.

2. Technology should be leveraged to allow all providers and MCOs to have electronic access to a member's full medical record without compromising confidentiality.

   A. HHSC partially completed this recommendation and continues to identify additional ways to implement this recommendation.

3. Care transitions from inpatient to outpatient and from outpatient to inpatient settings must be well coordinated. MCOs must emphasize coordinated discharge planning. HHSC should provide focused attention and oversight on the contract requirements related to discharge planning.

   A. HHSC completed this recommendation.

4. HHSC should use the term "Medicaid member" rather than "consumer" in written materials and oral presentations when discussing Medicaid beneficiaries, regardless of their health condition or diagnosis.

   A. HHSC completed this recommendation.

Member Activation

1. Medicaid members must receive clear and linguistically appropriate information on their options in selecting a managed care plan and a provider, along with accurate information on which in-network providers are accepting new members.

   A. HHSC completed this recommendation.

2. Medicaid members should have easy access to understandable information on physical and behavioral health conditions, and how to maintain health and wellness. This should include innovative technology solutions for accessing individual health records and opportunities for self-care.

A. HHSC partially completed this recommendation and continues to identify additional ways to implement this recommendation.

3. MCOs should encourage and provide support for enhanced communication with the member and, when appropriate, the member's family.

   A. HHSC partially completed this recommendation and continues to identify additional ways to implement this recommendation.

4. Information provided to Medicaid members should include contact information for the HHSC Ombudsman as a point of contact for questions, concerns or complaints.

   A. HHSC completed this recommendation.

5. Program or health plan changes should be clearly conveyed to members, advocacy groups and providers. MCOs should be encouraged to include members, advocacy groups and providers on their board or advisory groups.

   A. HHSC partially completed this recommendation and continues to identify additional ways to implement this recommendation.

6. Medicaid members should be encouraged and incentivized to seek help to improve overall health.

   A. HHSC partially completed this recommendation and continues to identify additional ways to implement this recommendation.

Access

1. MCOs should be encouraged to develop a continuum of care for Medicaid members with serious mental illness in lieu of traditional inpatient and outpatient Medicaid benefits.

   A. HHSC partially completed this recommendation and continues to address this recommendation.

2. MCOs must have an adequate network of public and private behavioral health providers.

   A. HHSC completed this recommendation and continues to monitor.

3. When the level of care requested by the providers is recommended by the assessment instrument, the in-network provider should notify the MCO within one business day and no prior authorization is required to deliver the service package. Only deviations from the assessment instrument may require

authorization by the MCO and all prior authorizations must meet parity requirements.

A. HHSC completed this recommendation.

4. HHSC should develop a system, in collaboration with MCOs, to improve the efficiency and consistency of the credentialing process and to ensure prompt payment for in-network provider organizations that hire new staff, starting on the date the new staff person is available to see the MCOs' members.

A. HHSC partially completed this recommendation and continues to identify additional ways to implement this recommendation.

Administrative Simplification

1. HHSC should require a uniform Prior Authorization process across all MCOs.

A. HHSC completed this recommendation.

2. HHSC should require MCOs to respond to authorization requests within 2 business days and authorizations should be retroactive to the date and time of the request for Mental Health Rehabilitation and Targeted Case Management services.

A. HHSC completed this recommendation to the extent allowable by state and federal requirements. HHSC requires authorizations be retroactive to the date and time of the request for MHTCM/MHR services. However, at this time, Medicaid MCOs will continue to be required to issue prior authorization requests within three business days after receipt or complete requests, which aligns with 42 CFR § 438.214, Texas Government Code 533.00282, Texas Insurance Code 4201.304, and 28 TAC §19.1709.

3. HHSC should require MCOs to follow authorization guidelines for services and determination of medical necessity as defined by the State for Mental Health Rehabilitation and Targeted Case Management services. These guidelines should be developed in conjunction with MCOs, providers and other stakeholders.

A. HHSC completed this recommendation.

4. HHSC should require MCOs to have a robust and simple formulary and a standard process across plans.

A. HHSC completed this recommendation.

5. MCOs should be transparent with HHSC and providers on their utilization management policies and practices.

   A. HHSC completed this recommendation.

Payment Mechanisms

1. MCO and provider contracts should align financial incentives across physical and behavioral health. Payments should align with improvements in overall health quality and slowing of overall healthcare costs.

   A. HHSC partially completed this recommendation and continues to identify additional ways to implement this recommendation.

2. Payment rules and requirements should facilitate expansion of models of care that encourage behavioral health providers and physical health providers to co-manage members in a team-based model.

   A. HHSC partially completed this recommendation and continues to identify additional ways to implement this recommendation.

3. Integrated provider sites should be reimbursed through one contract with the MCO, even when the MCO subcontracts with a Behavioral Health Organization (BHO).

   A. HHSC partially completed this recommendation and continues to identify additional ways to implement this recommendation.

4. In pilot sites, new payment structures should incentivize and support person-centered care, member satisfaction, provider-to-provider communication, care coordination and care of members with complex health conditions to achieve recovery.

   A. HHSC completed this recommendation.

Outcome Measurement

1. Outcome measures should support a positive continuous quality improvement process and incentivize accountability at the state, MCO, provider and member level. A biennial review of metrics should be considered to ensure the metrics being gathered are fostering a successful integrated health care delivery model. MCOs and providers, with the support of HHSC, must develop mechanisms to share data on common members while Health Information Exchanges (HIE) in local communities are under development.

A. HHSC partially completed this recommendation and continues to identify additional ways to implement this recommendation.

2. Measures should be tailored to meet the needs of children, young adults, adults, and the elderly.

   A. HHSC completed this recommendation.

3. All MCOs should assess their baseline level of integration, identify strategies to address areas needing improvement, and periodically assess integration improvement and its quality.

   A. HHSC partially completed this recommendation and continues to work on implementing this recommendation.

4. Member, provider, and MCO satisfaction measures should be monitored and openly distributed to facilitate feedback and transparency.

   A. HHSC partially completed this recommendation and continues to work on implementing this recommendation.

5. HHSC's philosophy in outcome reporting should be a public, transparent process to increase dialogue on integration, track changes over time, identify strategies to increase integration and describe what is happening in a community.

   A. HHSC partially completed this recommendation and continues to work on implementing this recommendation.

State Oversight

1. HHSC should develop a coordination plan for behavioral health services that includes all HHS agencies, along with other partnering agencies such as housing, education and criminal justice.

   A. HHSC completed this recommendation.

2. HHSC should routinely evaluate the adequacy of the MCO's network through a structured review process, with a focus on whether or not the provider is accepting new members.

   A. HHSC partially completed this recommendation and continues to identify additional ways to implement this recommendation.

3. HHSC Ombudsman staff should be thoroughly trained on the MCO contracts and have the ability to answer questions and assist with complaints in a timely and responsive manner.

A. HHSC completed this recommendation.

4. HHSC Contract Management department should more actively engage Medicaid members and organizations when a complaint is filed against a MCO. The Medicaid member, provider and MCOs should all play an equal role in the process.

   A. HHSC completed this recommendation.

5. The Behavioral Health Integration Advisory Committee should continue to advise HHSC on integration as the Medicaid program continues to integrated care.

   A. This recommendation is no longer applicable since BHIAC expired in September 2017.

6. HHSC should actively seek stakeholder input on the Medicaid Benefit Policy Review for utilization management practices related to S.B.58. The process should move as expeditiously as possible.

   A. HHSC completed this recommendation.

Health Home Pilots

1. HHSC should determine the outcome measures for assessing health home pilots in advance of operations. This process should include an informed group of stakeholders, including Medicaid members with mental illness, MCO, providers, advocates, peers, and academia.

   A. HHSC completed this recommendation.

2. Health homes should be comprehensive and should have the capacity to provide holistic, person-centered care with a focus on recovery.

   A. HHSC completed this recommendation.

3. New payment structures should incentivize and support person-centered care, member satisfaction, provider-to-provider communication, care coordination and care of members with complex health conditions to achieve recovery.

   A. HHSC completed this recommendation.

4. A quantitative and qualitative evaluation of the pilots must be built in from beginning to end. The evaluation should address process and outcomes clinically, administratively, and financially to facilitate the decision of taking lessons learned from the pilots to scale.

A. HHSC completed this recommendation.

5. Health homes, and their MCO partners, must establish a continuous quality improvement program and report on outcome measures to support evaluation of the model.

   A. HHSC completed this recommendation.

6. Learning collaboratives and other support structures should be developed to assist provider practices in the development of a health home pilot.

   A. HHSC partially completed this recommendation.

7. In selecting pilot sites, HHSC should include both urban and rural areas when feasible.

   A. HHSC completed this recommendation.