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

As a lifelong Texan, I am honored to serve as the State Medicaid Director, especially during these unprecedented times. Our organization’s impact is significant. Over 4 million individuals rely on Texas Medicaid and the Children’s Health Insurance Program (CHIP) to deliver quality, cost-effective services to improve their health and wellbeing.

I am proud of this team’s commitment to our mission and their tenacity, which have been amplified in our response to the COVID-19 public health emergency. As we move forward, our stakeholders want to know the future of Texas Medicaid and CHIP. That begins by looking at where we’ve been and where we are now.

With this 13th edition of the Texas Medicaid and CHIP Reference Guide, we hope you find a valuable resource for understanding the work we do. Our organization has a history of innovation and national leadership. We aim to continue this legacy and achieve our goals for the people we serve, their families and their providers.

Thank you to all our partners that support our programs every day. Our success is only possible with you.

Onwards and upwards,

Stephanie Stephens
State Medicaid Director

Texans living healthy and fulfilling lives.
The Data in This Guide

Below outlines the details about the data referenced throughout the 13th edition. Information contained in this book was current as of August 2020, unless otherwise noted. Program and financial information may change after publication due to unforeseen changes to federal and state regulations, the state of the economy, and other factors.

<table>
<thead>
<tr>
<th>About</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Time period</strong></td>
<td>All data is state fiscal year (SFY) 2019, unless otherwise noted.</td>
</tr>
<tr>
<td></td>
<td>Income limits are effective as of March 1, 2020.</td>
</tr>
<tr>
<td><strong>Caseload count</strong></td>
<td>Caseload trends and numbers are based on the monthly average number of clients covered by Medicaid or CHIP.</td>
</tr>
<tr>
<td></td>
<td>The unduplicated count, which is the total number of individual Texans who received Medicaid or CHIP services over a period of time, is noted if used.</td>
</tr>
<tr>
<td></td>
<td>Total caseload numbers combine Medicaid and CHIP, unless otherwise noted.</td>
</tr>
<tr>
<td><strong>Cost information</strong></td>
<td>Costs include both partial- and full-benefit clients, unless otherwise noted.</td>
</tr>
<tr>
<td></td>
<td>Funds exclude Disproportionate Share Hospital (DSH), Uncompensated Care (UC), and Delivery System Reform Incentive Payment (DSRIP) funds, unless otherwise noted.</td>
</tr>
<tr>
<td><strong>Sources</strong></td>
<td>Health and Human Services Commission (HHSC) Financial Services, including Forecasting, provided the majority of data contained in this book. Their primary sources are:</td>
</tr>
<tr>
<td></td>
<td>• Premiums Payable System data provides a summary of all Medicaid-eligible clients each month. Both monthly Premiums Payable System files and final eight-month files, which contain all retroactive adjustments, are used in the analyses.</td>
</tr>
<tr>
<td></td>
<td>• Expenditure information is obtained from the Texas Medicaid &amp; Healthcare Partnership through the databases in the Vision 21 platform, which includes paid claims, managerial reporting of cash flow, provider and client information, and managed care encounter data. Expenditures include direct payments to physicians, hospitals and entities that provide ancillary services. Financial information is provided using the Form CMS 64-Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program and the Medicaid Program Budget Report-CMS 37. Additional financial information is provided by the Medicaid Statistical Information System.</td>
</tr>
<tr>
<td></td>
<td>• Unpublished analyses conducted by HHSC Financial Services staff are also used to provide financial information.</td>
</tr>
<tr>
<td></td>
<td>Alternative sources are noted throughout the book.</td>
</tr>
</tbody>
</table>
## Helpful Websites

<table>
<thead>
<tr>
<th>Website Name</th>
<th>Link</th>
<th>What You’ll Find</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and Human Services Commission (HHSC)</td>
<td>HHS.Texas.gov/Services/Health/Medicaid-CHIP</td>
<td>The Medicaid and CHIP landing page provides access to descriptions about programs and services, resources for members (including managed care report cards, Service Delivery Area maps, etc.), topics for business partners, and general information about Medicaid and CHIP, including enrollment statistics.</td>
</tr>
<tr>
<td>Health Care Payment Learning and Action Network (HCP-LAN)</td>
<td>HCP-LAN.org</td>
<td>A website with resources focused on increasing the percentage of U.S. health care payments tied to quality and value, including the HCP-LAN Alternative Payment Model (APM) framework, a consensus framework for classifying APMs. HHSC uses this framework for its Texas Medicaid value-based payment requirements for managed care organizations (MCOs).</td>
</tr>
<tr>
<td>Office of the Ombudsman</td>
<td>HHS.Texas.gov/About-HHS/Your-Rights/HHS-Office-Ombudsman</td>
<td>The Office of the Ombudsman manages and resolves complaints submitted by Texans receiving Health and Human Services benefits, including Medicaid.</td>
</tr>
<tr>
<td>Report Texas Fraud</td>
<td>ReportTexasFraud.com</td>
<td>The public, clients and providers may refer potential fraud, waste and abuse on this website or call the Office of Inspector General’s (OIG) fraud hotline at 800-436-6184.</td>
</tr>
<tr>
<td>Texas Healthcare Learning Collaborative (THLC) Portal</td>
<td>THLCPortal.com</td>
<td>A public reporting platform and a tool for contract oversight and MCO quality improvement efforts, including MCO report cards and other key performance data.</td>
</tr>
<tr>
<td>Your Texas Benefits</td>
<td>YourTexasBenefits.com</td>
<td>A self-service website where Texans can apply for HHSC programs and manage their benefits.</td>
</tr>
<tr>
<td>Uniform Managed Care Manual</td>
<td>HHS.Texas.gov/Services/Health/Medicaid-CHIP/Provider-Information/Contracts-Manuals/Texas-Medicaid-CHIP-Uniform-Managed-Care-Manual</td>
<td>Defines procedures that MCOs must follow to meet certain requirements in HHSC managed care contracts.</td>
</tr>
<tr>
<td>Vendor Drug Program (VDP)</td>
<td>TxVendorDrug.com</td>
<td>Information about VDP, including the Texas Formulary, the Preferred Drug List (PDL), prior authorizations, enrollment in the program and resources for providers.</td>
</tr>
</tbody>
</table>
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<td>People Eligible for Medicare and Medicaid</td>
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<td>Supplemental Security Income Recipients</td>
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# Quick Facts About Medicaid and CHIP

## General Information

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<tr>
<th><strong>Medicaid</strong></th>
<th><strong>CHIP</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>A health care and long-term services program for certain groups of low-income persons.</td>
<td>A similar program for children whose families earn too much to qualify for Medicaid.</td>
</tr>
<tr>
<td>Serves children and their caretakers, pregnant women, and individuals over age 65 or those with disabilities.</td>
<td>Serves children and the unborn children of pregnant women (CHIP Perinatal).</td>
</tr>
<tr>
<td>Funded through state funds, matched with uncapped federal dollars at a set percentage rate.</td>
<td>Funded through state funds, matched with capped federal dollars at a set percentage rate.</td>
</tr>
</tbody>
</table>

91% of total enrollment

9% of total enrollment

## Snapshot of Texas Medicaid and CHIP Clients

<table>
<thead>
<tr>
<th>Enrollments</th>
<th>Certificate</th>
<th>Growth</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.3 million Texans receiving services</td>
<td>53% of Texas births covered by Medicaid</td>
<td>+12%</td>
<td>15% of Texans covered</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicaid Ages</th>
<th>CHIP Ages</th>
</tr>
</thead>
<tbody>
<tr>
<td>65+ 6%</td>
<td>&lt;1 02%</td>
</tr>
<tr>
<td>21-64 18%</td>
<td>15-18 20%</td>
</tr>
<tr>
<td>15-20 15%</td>
<td>15-18 24%</td>
</tr>
<tr>
<td>6-14 34%</td>
<td>6-14 56%</td>
</tr>
<tr>
<td>1 02%</td>
<td></td>
</tr>
</tbody>
</table>

*The take-up rate, or the estimated percentage of eligible people who choose to enroll, is calculated based on FY18 Medicaid and CHIP caseloads and projected 2018 census by Texas Demographic Office using latest American Community Survey and migration analysis.*
Quick Facts About Medicaid and CHIP

### Funding

- **60% Federal and Other Funds**
- **40% State General Revenue Funds**

**Funding**

- **$65.3 billion**
- **Medicaid 97%**
- **CHIP 3%**

27% of the Texas biennial budget

### Spending

#### Trends in Caseload and Spending for Major Medicaid Client Categories

<table>
<thead>
<tr>
<th>Category</th>
<th>Caseload Growth</th>
<th>Cost per Client*</th>
<th>10-year Enrollment Growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-disabled Children</td>
<td>68%</td>
<td>$256</td>
<td>21%</td>
</tr>
<tr>
<td>Non-disabled Adults</td>
<td>7%</td>
<td>$685</td>
<td>24%</td>
</tr>
<tr>
<td>Age &amp; Disability-related</td>
<td>25%</td>
<td>$1,794</td>
<td>9%</td>
</tr>
</tbody>
</table>

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

#### Spending by Category

- **Client Services 78%**

#### Spending by Service Type

- **52%** Acute Care
- **34%** Long-term Services and Supports
- **14%** Prescription Drug
- **5%** Behavioral Health (within service types)

Other: includes DSH, UC and DSRIP
Acute Care: includes Medicare, MTP, Dental and HIIT
Prescription Drug: includes Clawback
Behavioral Health: excludes DSH, UC, DSRIP and agency administration costs
Quick Facts About Medicaid and CHIP

Service Delivery Model

4.3M Texans Served

94% Managed Care

4.1M Managed Care

6% Fee-for-Service

200K Fee-for-Service

Key Attributes of the Managed Care Service Delivery Model

- Delivers services through MCOs that are paid a fixed amount per member enrolled per month
- Achieves value by incentivizing MCO improvements in quality of care and cost-effectiveness
- Serves as the member’s “medical home” by providing comprehensive preventive and primary care

Managed Care Product Lines

**STAR**
- 68% Children, pregnant women and some families

**STAR Kids**
- 4% Children and youth with disabilities

**CHIP**
- 9% Children and youth who don’t qualify for Medicaid due to family income

**STAR Health**
- 0.8% Children who get Medicaid through the Department of Family and Protective Services and young adults previously in foster care

**STAR+PLUS**
- 13% Adults with a disability, people age 65 and older (including those dually eligible for Medicare and Medicaid), and women with breast or cervical cancer

CHIP includes CHIP-Perinatal. Remaining percentage is FFS.
Texas Medicaid managed care enrollment has increased by 56%

**Preventative Care Improved**

- **Early Childhood Health**
  - Children receiving six or more well visits in the first 15 months of life +24%

- **Adolescent Health**
  - Adolescents receiving an annual well visit +26%

- **Maternal Health**
  - Timeliness in prenatal care +14%

**Cost Growth Contained**

Increased enrollment and improved preventative care within managed care keeps Texas Medicaid costs contained—13 percentage points lower than the U.S. national average.

**Cost per Person Increase**

- **U.S. Health Care**
  - +32%

- **Texas Medicaid**
  - +19%

*Source: CMS, Office of the Actuary—data is for CY09 to CY18.*
Chapter 1

Who can get Medicaid or CHIP, and how can they get it?
Who can get Medicaid or CHIP?

Medicaid provides health care and long-term services and supports (LTSS) to low-income children and their families, pregnant women, former foster care youth, individuals with disabilities and people age 65 and older.

The Children’s Health Insurance Program (CHIP) provides health care to children who are not eligible for Medicaid based on their family’s income. Texans who apply for benefits and do not qualify for Medicaid are automatically tested for CHIP eligibility.

How can Texans get Medicaid or CHIP?

Four ways to apply:
- YourTexasBenefits.com
- Local eligibility offices and community partners
- 2-1-1 phone service
- Mail or fax

Eligibility is determined by:
- Household income
- Citizenship and residency
- Program requirements

Most clients are enrolled in managed care, where they:

1. Choose a health plan
2. Pick a primary care provider
3. Receive a Your Texas Benefits Card and health plan ID card
Residency and Citizenship

To qualify for Medicaid, an applicant must:
- Live and intend to remain in Texas.
- Have a Social Security number (SSN) or apply for one.
- Be a citizen of the U.S. or meet alien status requirements.

All U.S. citizens and nationals are entitled to apply for and get Medicaid if they meet all eligibility requirements and can provide proof of citizenship.

Qualified Aliens

Most non-citizens cannot qualify for regular Medicaid or CHIP benefits. Qualified aliens are usually subject to limited eligibility or to a waiting period. The following categories do not have limited eligibility or a waiting period:
- Veterans; active duty members of the U.S. armed forces, including their spouses and dependent children; and Canadian-born American Indians.
- Victims of human trafficking.
- Aliens with Supplemental Security Income (SSI) and lawful permanent residents (LPRs) admitted before August 22, 1996.

Limited Eligibility

Some aliens may qualify for Medicaid, but only for up to seven years. These include asylees, refugees, Cuban/Haitian entrants, Amerasians, and aliens whose deportations are being withheld.

Lawful Permanent Residents

LPRs are non-citizens who are lawfully authorized to live permanently within the U.S. LPRs who arrived on or after August 22, 1996, are typically subject to a five-year waiting period.

Some qualified immigrant and non-immigrant alien children lawfully residing in the U.S. may qualify for Medicaid or CHIP regardless of their date of entry (see Appendix A, page 118, for The Children’s Health Insurance Program Reauthorization Act [CHIPRA] of 2009).

Emergency Medicaid

Undocumented aliens and certain LPRs may qualify for Emergency Medicaid coverage, if all other eligibility requirements are met except for alien status. Undocumented aliens are not required to provide a SSN. If determined eligible, Medicaid only covers their care until the emergency medical condition is stabilized.
Financial Eligibility

Financial eligibility for the Medicaid and CHIP programs is primarily based on how an applicant’s household income compares to the U.S. Department of Health and Human Services’ definition of the federal poverty level (FPL). The FPL is updated yearly.

Federal law requires financial eligibility for most Medicaid and CHIP applicants to be determined through the Modified Adjusted Gross Income (MAGI) methodology. MAGI uses federal income tax rules to decide if an applicant qualifies based on how they file their taxes and their countable income.

Some groups are excluded from MAGI, including:

- People who are age 65 and older.
- Individuals with disabilities.
- People receiving SSI.

These groups must report and give proof of property such as vehicles, bank accounts or rental homes.

Mandatory vs. Optional Coverage

Federal law requires states to cover Medicaid-eligible groups up to a minimum percentage of the FPL and allows states the option to expand eligibility beyond federal standards.

The following figure depicts the 2020 Texas Medicaid income levels for the most common Medicaid eligibility categories. Mandatory levels identify the coverage required by the federal government. Optional levels show the coverage Texas has implemented.
Chapter 1 — Who can get Medicaid or CHIP, and how can they get it?

Texas Medicaid Income Eligibility Levels for Selected Programs, March 2020 (as a Percent of the FPL)

This figure reflects eligibility levels as of March 2020. In 2014, the Affordable Care Act (ACA) required states to adjust income limits for pregnant women, children, and parents and caretaker relatives to account for MAGI changes.

*For Parents and Caretaker Relatives, maximum monthly income limit in SFY20 was $230 for a family of three, or about 13 percent of the FPL.

**For Medically Needy pregnant women and children, the maximum monthly income limit in SFY20 was $275 for a family of three, or about 15 percent of the FPL.
Children and Youth

Children’s Medicaid

Most Medicaid clients are children. To qualify for Children’s Medicaid, a child must be age 18 or younger.

Newborns (under 12 months) born to mothers getting Medicaid for Pregnant Women are automatically eligible for Children’s Medicaid and remain eligible through the month of their first birthday.

The table shows the Children’s Medicaid monthly income limits by household size.

<table>
<thead>
<tr>
<th>Household Size (Adults Plus Children)</th>
<th>Household Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>1*</td>
<td>$1,415</td>
</tr>
<tr>
<td>2</td>
<td>$1,931</td>
</tr>
<tr>
<td>3</td>
<td>$2,408</td>
</tr>
<tr>
<td>4</td>
<td>$2,904</td>
</tr>
<tr>
<td>For each additional person, add:</td>
<td></td>
</tr>
</tbody>
</table>

*A family of one might be a child who does not live with a parent or other relative.

Former Foster Care Youth

Medicaid for Former Foster Care Children

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

Medicaid for Transitioning Foster Care Youth

Former foster care youths who were not receiving Medicaid when they aged out of foster care at age 18 may still be eligible for Medicaid under Medicaid for Transitioning Foster Care Youth (MTFCY) up to the month of their 21st birthday.

To qualify, an individual must meet residency and citizenship requirements and:

• Not have adequate health coverage.
• Be at or below 413 percent of the FPL (or $4,392 per month for a household of one).

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

**Children’s Health Insurance Program**

CHIP covers children who do not qualify for Medicaid based on household income but do not have other health insurance. To qualify for CHIP, a child must be:

• Age 18 or younger.
• Uninsured for at least 90 days or have a “good cause” exemption.
• Living in a household with an income at or below 201 percent of the FPL.

Enrollment fees and co-pays are determined based on household income. Yearly enrollment fees are $50 or less per family. Co-pays for both doctor visits and medicine range from $3 to $5 for lower-income families and $20 to $35 for higher-income families.

See the table below for the CHIP monthly income limits by household size.

<table>
<thead>
<tr>
<th>Household Size (Adults Plus Children)</th>
<th>Household Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>1*</td>
<td>$2,138</td>
</tr>
<tr>
<td>2</td>
<td>$2,918</td>
</tr>
<tr>
<td>3</td>
<td>$3,639</td>
</tr>
<tr>
<td>4</td>
<td>$4,389</td>
</tr>
<tr>
<td>For each additional person, add:</td>
<td>$751</td>
</tr>
</tbody>
</table>

*A family of one might be a child who does not live with a parent or other relative.

**Incarcerated Youth**

Individuals, including pregnant women, age 18 and younger incarcerated by the Texas Department of Criminal Justice may be eligible for Medicaid coverage for inpatient medical services provided in a “free-world” medical facility not located on the premises of a jail or prison. If determined eligible, Medicaid covers only services provided during the individual’s inpatient stay.

Juveniles receiving Children’s Medicaid may have their coverage suspended upon entrance into a juvenile facility and reinstated upon release. Children who enter a juvenile facility and receive CHIP will have their coverage terminated and must reapply upon release.
Chapter 1 — Who can get Medicaid or CHIP, and how can they get it?

**Women**

**Medicaid for Pregnant Women**
Texas extends Medicaid eligibility to pregnant women with a household income at or below 198 percent of the FPL.

See the table below for the Medicaid for Pregnant Women monthly income limits by household size, which includes unborn children.

<table>
<thead>
<tr>
<th>Household Size</th>
<th>Monthly Household Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$2,106</td>
</tr>
<tr>
<td>2</td>
<td>$2,875</td>
</tr>
<tr>
<td>3</td>
<td>$3,584</td>
</tr>
<tr>
<td>4</td>
<td>$4,323</td>
</tr>
<tr>
<td>For each additional person, add:</td>
<td>$740</td>
</tr>
</tbody>
</table>

**CHIP Perinatal**
CHIP Perinatal services are for the unborn children of uninsured pregnant women who do not qualify for Medicaid for Pregnant Women. To qualify, pregnant women must have an income at or below 202 percent of the FPL.

For CHIP Perinatal clients at or below 198 percent of the FPL, the mother must apply for Emergency Medicaid to cover her labor and delivery. If the mother’s labor and delivery are covered by Emergency Medicaid, her CHIP Perinatal newborn may receive 12 months of continuous Medicaid coverage from date of birth.

CHIP Perinatal newborns in families with incomes above 198 percent of the FPL receive CHIP benefits for 12 months from date of birth.

See the table below for the CHIP Perinatal monthly income limits by household size.

<table>
<thead>
<tr>
<th>Household Size</th>
<th>Monthly Household Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$2,148</td>
</tr>
<tr>
<td>2</td>
<td>$2,933</td>
</tr>
<tr>
<td>3</td>
<td>$3,657</td>
</tr>
<tr>
<td>4</td>
<td>$4,411</td>
</tr>
<tr>
<td>For each additional person, add:</td>
<td>$755</td>
</tr>
</tbody>
</table>
Healthy Texas Women

Healthy Texas Women (HTW) provides free health and family planning services to low-income women ages 18 to 45 who qualify. Women ages 15 through 17 may also qualify for the program, but they must have a parent or legal guardian apply, renew and report changes on their behalf.

To qualify for HTW, a woman must:
- Not be eligible to receive full Medicaid benefits, CHIP, or Medicare Part A or B.
- Not be pregnant.
- Not have any other creditable health coverage—unless filing a claim would cause physical, emotional, or other harm from a spouse, parent or another person.
- Have a household income at or below 200 percent of the FPL.

To provide continuity of care, Medicaid for Pregnant Women clients are automatically enrolled into HTW when their Medicaid coverage ends.

Breast and Cervical Cancer Screening Services

Breast and Cervical Cancer Screening (BCCS) services are diagnostic services for women age 18 and older who either need to be tested for or already have a breast or cervical cancer diagnosis, including pre-cancerous conditions. These services are offered at clinic sites across Texas.

BCCS clinics serve as the point of access for applying for Medicaid for Breast and Cervical Cancer (MBCC). To qualify for diagnostic services, women must:
- Not have health insurance.
- Have a net household income at or below 200 percent of the FPL.

Medicaid for Breast and Cervical Cancer Program

The MBCC program provides full Medicaid benefits, including services beyond the treatment of breast and cervical cancer, to eligible women screened at BCCS clinics. Women cannot apply through a Health and Human Services Commission (HHSC) benefits office. To qualify, a woman must:
- Be age 18 through 64.
- Be uninsured.
- Be diagnosed and in need of treatment for either certain pre-cancerous conditions or a biopsy-confirmed, metastatic, or recurrent breast or cervical cancer.

Women continue to receive full Medicaid benefits, as long as they meet the eligibility criteria at their coverage renewal period and provide proof from their attending doctor that they are receiving treatment for breast or cervical cancer.
Parents and Families

Medicaid for Parents and Caretaker Relatives

Adults who care for a child receiving Medicaid can also be eligible for Medicaid. To qualify, they must be a related caretaker to a child who has Medicaid and meet the program’s income limits. The child must be living with them, and be age 17 or younger, or be age 18 and attending school full-time.

Related caretakers may be:
- A parent or step-parent.
- A sibling or step-sibling.
- A grandparent.
- An uncle or aunt.
- A nephew or niece.
- A first cousin or the child of a first cousin.

See the table below for the monthly income limits by household size.

<table>
<thead>
<tr>
<th>Household Size</th>
<th>Monthly Income for One Parent Household</th>
<th>Monthly Income for Two Parent Household</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$103</td>
<td>------</td>
</tr>
<tr>
<td>2</td>
<td>$196</td>
<td>$161</td>
</tr>
<tr>
<td>3</td>
<td>$230</td>
<td>$251</td>
</tr>
<tr>
<td>4</td>
<td>$277</td>
<td>$285</td>
</tr>
<tr>
<td>For each additional person, add:</td>
<td>$52</td>
<td>$52</td>
</tr>
</tbody>
</table>

Medically Needy with Spend Down Program

The Medically Needy with Spend Down program helps both families with children age 18 and younger and pregnant women who do not qualify for Medicaid to pay for unpaid medical expenses.

To qualify, an individual or family subtracts their health care expenses from their income until they meet the program’s income and asset limits, also called “spending down.” The income limit is $275 per month for a family of three. The asset limit is $2,000 to $3,000 for households with a member who is elderly or has a disability. Assets are not considered for pregnant women.
The spend-down amount is different for each household and is any amount over the income limit. Clients enrolled through this program submit their paid and unpaid medical bills each month. Medical bills greater than the monthly spend-down amount are covered or reimbursed by Medicaid.

**The Health Insurance Premium Payment Program**

The Health Insurance Premium Payment (HIPP) program helps families where at least one person receives Medicaid pay for employer-sponsored health insurance premiums. HIPP reimburses members for their share of their employer-sponsored health insurance premium when the cost of the premium is less than the cost of projected Medicaid expenditures.

HIPP members eligible for Medicaid do not pay out-of-pocket deductibles, co-payments or co-insurance for Medicaid services delivered by a Medicaid provider. If a Medicaid service is not covered by their employer-sponsored health plan, members can still get the service at no cost to them if a Medicaid provider administers the service.

HIPP members not eligible for Medicaid must pay deductibles, co-payments and co-insurance as required.
Chapter 1 — Who can get Medicaid or CHIP, and how can they get it?

Children and Adults with Disabilities

Children and adults with disabilities who get Medicaid are usually in one or more of the following groups:

- They could be or have been placed in a nursing facility or an intermediate care facility for individuals with an intellectual disability or related condition (ICFs/IID).
- They get SSI.
- They get home and community-based services through a waiver program (see also A Closer Look, page 21).

Children with disabilities can get coverage through the Children’s Medicaid program or the Medicaid for the Elderly and People with Disabilities (MEPD) program. To qualify, children with disabilities must be age 20 and younger.

Medicaid for the Elderly and People with Disabilities

Adults with disabilities, some children with disabilities, and people age 65 and older may be able to get health coverage through the MEPD program.

To qualify, individuals with disabilities must meet the income limits for Medicaid. Those with disabilities who do not receive SSI may qualify for MEPD through a facility, such as a nursing facility or ICF/IID, or through a waiver program.

Medicaid Buy-In for Children

The Medicaid Buy-In for Children (MBIC) program offers low-cost Medicaid services to children with disabilities in families that make too much money to get Medicaid. MBIC members make monthly payments, which vary based on household income and health insurance status.

If a member has insurance through an employer, the payment could be up to $230 per month. If they have insurance through an employer and get HIPP, the payment could be up to $70 per month.

Those without health insurance through an employer and who cannot get HIPP do not have to make a monthly payment.
See the table below for the MBIC monthly income limits by household size.

<table>
<thead>
<tr>
<th>Household Size (Adults Plus Children)</th>
<th>Monthly Household Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>1*</td>
<td>$1,595</td>
</tr>
<tr>
<td>2</td>
<td>$2,178</td>
</tr>
<tr>
<td>3</td>
<td>$2,715</td>
</tr>
<tr>
<td>4</td>
<td>$3,275</td>
</tr>
<tr>
<td>For each additional person, add:</td>
<td>$560</td>
</tr>
</tbody>
</table>

*A family of one might be a child who does not live with a parent or other relative.

**Medicaid Buy-In for Adults**

The Medicaid Buy-In (MBI) for Adults program offers low-cost Medicaid services to adults with disabilities who work. Adults may qualify if they meet all of the following criteria:

- They have a disability. The MBI program uses the Social Security disability guidelines to determine if applicants have a disability.
- They are working and meet the income limits for the program.
- They are not living in a state institution or nursing home continuously.
- They are getting home and community-based services through a Medicaid waiver program.

The income limit for MBI is $2,659 per month. Countable assets must be no more than $2,000.

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**How Individuals Can Access Long-term Services and Supports**

**Aging and Disability Resource Centers**

Aging and Disability Resource Centers (ADRCs) provide person-centered services to individuals and caregivers, regardless of age, income and disability. ADRCs partner with a network of local service agencies to coordinate information and referrals for individuals needing access to long-term services and support (LTSS) programs and benefits, including Medicaid and Medicaid waiver programs.

**LIDDDAs and LMHAs**

Local intellectual and development disability authorities (LIDDDAs) serve as the point of entry for publicly funded intellectual and developmental disability (IDD) programs. LIDDDAs help individuals enroll into Medicaid programs.

Local mental health authorities (LMHAs) provide information, recommendations and referrals to individuals seeking mental health services, including Medicaid.
People Age 65 and Older

Medicaid for the Elderly and People with Disabilities

The MEPD program covers people age 65 and older and those with disabilities who do not receive SSI. Applicants must meet income limits for the program. People age 65 and older may qualify for MEPD through a facility, such as a nursing facility or an ICF/IID, or through a waiver program. They may also qualify for MEPD if they are dually eligible for Medicare and Medicaid.

People Eligible for Medicare and Medicaid

Medicare is a federally paid and administered health insurance program. Medicare covers inpatient hospital services (Part A), physician and related health services (Part B), Medicare managed care (Part C), and prescription drugs (Part D).

Some Medicare clients may be eligible for partial or full Medicaid benefits. Medicare clients who qualify for partial, but not full Medicaid benefits may receive assistance through Medicare savings programs.

Medicare Savings Programs

Medicare clients who are eligible for partial Medicaid benefits and meet established income and resource criteria may qualify for the Medicare Savings Program.

Individuals and couples in the program receive assistance with all or a portion of Medicare premiums, deductibles and co-payments through Medicaid. Medicaid also covers their Medicare Part D premiums and deductibles.

Resource limits for 2020 were $7,860 per individual and $11,800 per couple for most dually eligible people. The only exception is for Qualified Disabled Working Individuals, where the resource limits for 2020 were $4,000 for an individual and $6,000 for a couple.

Supplemental Security Income Recipients

SSI is a federal cash assistance program for low-income individuals with disabilities. Low-income individuals age 65 and older may also qualify for SSI. The Social Security Administration sets income eligibility limits, asset limits and benefit rates, and determines eligibility. In Texas, all people eligible for SSI are automatically eligible for Medicaid.
Texas’ waiver programs include:
- Community Living Assistance and Support Services (CLASS).
- Deaf Blind with Multiple Disabilities (DBMD).
- Home and Community-based Services (HCS).
- Medically Dependent Children Program (MDCP).
- STAR+PLUS Home and Community-based Services (STAR+PLUS HCBS).
- Texas Home Living (TxHmL).
- Youth Empowerment Services (YES).

There are a limited number of slots per program. Individuals in reserved capacity groups, such as the Promoting Independence Initiative or Crisis Diversion, are given priority when program slots become available.

Interest List Process

When a program slot opens, the individual at the top of the list is released.

As individuals are released, others move up the interest list.

After an individual is released, they go through the eligibility determination process.

Eligibility Determination

Eligibility determination is based on household income and level of care (LOC) or medical necessity (MN). The criteria for LOC or MN an individual must meet varies by program.
Chapter 2

What Medicaid and CHIP services are available for Texans?
At-a-Glance

What programs and services are available for Texans?

Two Service Delivery Models

<table>
<thead>
<tr>
<th>Managed Care</th>
<th>Fee-for-Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>• HHSC contracts with managed care organizations (MCOs), also called health plans.</td>
<td>6% of Texans who receive services get them through <strong>Fee-for-Service.</strong></td>
</tr>
<tr>
<td>• Health plans must provide all covered, medically necessary Medicaid and CHIP services to members.</td>
<td>• Under the fee-for-service (FFS) model, clients can go to any Medicaid provider.</td>
</tr>
<tr>
<td>• In most cases, members go to providers contracted with their health plan.</td>
<td>• Clients can receive some services through managed care and others through FFS.</td>
</tr>
</tbody>
</table>

94% of Texans who receive services get them through **Managed Care.**

6% of Texans who receive services get them through **Fee-for-Service.**

Main Types of Services

**Acute Care Services**
- Preventive care, diagnostics and medical treatments

**Behavioral Health Services**
- Screening and treatment for mental health conditions and substance use disorders (SUD)

**Long-term Services and Supports**
- Support with ongoing, daily activities for individuals with disabilities and older adults

**Pharmacy Services**

**Medical Transportation Services**

**Programs That Deliver Services**

<table>
<thead>
<tr>
<th>STAR</th>
<th>STAR Kids</th>
<th>STAR Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>68%</td>
<td>4%</td>
<td>0.8%</td>
</tr>
<tr>
<td>Children, pregnant women and some families</td>
<td>Children and youth with disabilities</td>
<td>Children who get Medicaid through the Department of Family and Protective Services and young adults previously in foster care</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>STAR+PLUS</th>
<th>CHIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>13%</td>
<td>9%</td>
</tr>
<tr>
<td>Adults with a disability, people age 65 and older (including those dually eligible for Medicare and Medicaid), and women with breast or cervical cancer</td>
<td>Children and youth who don’t qualify for Medicaid due to family income</td>
</tr>
</tbody>
</table>

9% 6%

Chapter 2 — What Medicaid and CHIP services are available for Texans?
What Medicaid and CHIP Cover

Mandatory vs. Optional Services
Federal law requires state Medicaid programs to provide specific acute care services, long-term services and supports (LTSS), and behavioral health services—and allows states the option to provide additional services. States may choose to provide some, all or no optional services.

States with a separate Children’s Health Insurance Program (CHIP), like Texas, have flexibility in determining benefits. The Texas CHIP benefit package focuses on acute care services, but also includes some behavioral health services and dental benefits. (See Appendix B, page 130, for a full list of Medicaid and CHIP programs and services.)

Acute Care Services
Medicaid and CHIP members can receive preventive care, diagnostics and medical treatments called acute care services. Acute care services may include:

- Doctor or clinic visits.
- Prescription drugs.
- Emergency services.
- Hospital inpatient and outpatient care.
- Vaccines.
- Vision and hearing care.
- X-rays and laboratory tests.
- Prenatal care and childbirth.

Both Medicaid and CHIP cover dental services for children and youth.

Behavioral Health Services
Both Medicaid and CHIP cover screening and treatment services for mental health conditions and substance use disorders (SUD), called behavioral health services. These services include:

- Psychiatric diagnostic evaluation.
- Psychological, neurobehavioral and neuropsychological testing.
- Inpatient mental health services in a psychiatric hospital or general acute care hospital.
- Mental health rehabilitation services.
- Peer specialist services.
- Mental health targeted case management.
- Medication management.
- Residential and outpatient withdrawal management.
- Mental health outpatient treatment, including individual and group outpatient counseling and psychotherapy.
- SUD residential treatment.
- SUD group and individual counseling.
- Screening and brief intervention for SUD.
There are two Medicaid programs that provide specialized behavioral health services in Texas: Youth Empowerment Services (YES) and Home and Community-based Services-Adult Mental Health (HCBS-AMH).

**Long-term Services and Supports**

LTSS are provided to adults age 65 and older and individuals of all ages with physical, intellectual or developmental disabilities who require nursing care or need help with tasks of daily living.

Medicaid covers LTSS through the Texas state plan and through waiver programs. Their services may be delivered through managed care, fee-for-service (FFS), or both.

The types of LTSS individuals get is largely related to where the services are delivered. The goal is to ensure individuals have seamless access to services and supports in the most appropriate, least restrictive settings. LTSS may be provided in long-term care facilities, in community settings or within an individual’s home.

**Long-term Care Facilities**

**Nursing Facilities**

Nursing facilities provide services with the goal to maximize resident autonomy, function, dignity and comfort. Required services provided in a nursing facility setting include:

- Room and board.
- Nursing.
- Social services and activities.
- Over-the-counter drugs.
- Medical supplies and equipment.
- Personal-need items.

Add-on services provided in a nursing facility setting may include:

- Ventilator care.
- Tracheostomy care for residents age 21 and younger.
- Emergency dental services.
- Custom power wheelchairs.
- Augmentative communication devices.
- Rehabilitative therapies.

**Intermediate Care Facilities for Individuals with an Intellectual Disability**

Intermediate care facilities for individuals with an intellectual disability or related condition (ICFs/IID) provide ongoing evaluation and individual program planning, 24-hour supervision, coordination, and integration of health or rehabilitative services. ICF/IID residential settings vary in size, from community settings serving six to 12 individuals (currently 98 percent of ICFs/IID) to large state supported living centers (SSLCs) serving several hundred.
Chapter 2 — What Medicaid and CHIP services are available for Texans?

Home and Community-based Services

State Plan Home and Community-based Services

Medicaid covers some home and community-based services like Personal Assistance Services (PAS), Community Attendant Services (CAS), Day Activity and Health Services (DAHS), Community First Choice (CFC), and Personal Care Services (PCS).

These services help individuals with:
- Activities of daily living like bathing, dressing and eating.
- Instrumental activities of daily living like cooking, grocery shopping and cleaning.
- Other essential tasks for home and personal care.
- Some services, like DAHS, include nursing care, meals and community programs.

Medicaid Waiver Programs

Medicaid waiver programs provide individuals alternative settings to placement in an institution, such as a long-term care or psychiatric facility. Most of Texas’ waiver programs are granted through Home and Community-based 1915(c) Waivers.

In Texas, services delivered through these programs may include:
- Adaptive aids and minor home modifications.
- Medical supplies.
- Professional therapies like physical, occupational and speech therapy.
- Nursing.
- Respite.
- Employment assistance and supported employment.

(See Appendix B, page 133, for a list of services provided by each waiver program.)

Texas Medicaid Waiver Programs

1. Community Living Assistance and Support Services (CLASS)
2. Deaf Blind with Multiple Disabilities (DBMD)
3. Home and Community-based Services (HCS)
4. Medically Dependent Children Program (MDCP)
5. STAR+PLUS Home and Community-based Services (STAR+PLUS HCBS)*
6. Texas Home Living (TxHmL)
7. Youth Empowerment Services (YES)

*STAR+PLUS HCBS operates like a 1915(c), but is provided through the 1115 Healthcare Transformation Waiver (see Chapter 5, page 98).
How Home and Community-based Services Are Delivered

Individuals who receive LTSS services can choose how certain services, like attendant care, are delivered.

**Agency Option**
Services are delivered through a provider agency, which employs attendants or other service providers.

**Consumer-directed Services Option**
The individual or their legally authorized representative (LAR) employs the attendants or other service providers. This gives the individual greater choice and control over their services. Individuals using the consumer-directed services (CDS) option are required to select a Financial Management Services Agency (FMSA) that provides orientation, writes paychecks for their employees, and pays federal and state employer taxes on the employer’s behalf. Individuals may choose the agency option for some services and the CDS option for others.

**Service Responsibility Option**
The Managed Care Organization (MCO), if applicable, and a provider agency work with the individual to provide them with increased control over the delivery of their services. The provider agency employs the attendants or other service providers. Individuals choose their provider agency and work with the agency to determine which attendants will provide their services. The individual or their LAR trains the staff to meet the individual’s needs and manages them on a day-to-day basis.

**Prescription Drugs**
People eligible for Medicaid or CHIP receive coverage for prescription drugs. The Vendor Drug Program (VDP) oversees the prescription drug benefit. This includes managing the Texas Formulary, which is a list of all covered drugs, and the Preferred Drug List (PDL). Drugs may be listed on the PDL as “preferred” or “non-preferred” based on their safety, efficacy and cost-effectiveness (see Chapter 3, page 56). Drugs listed as “non-preferred” on the PDL require prior authorization before they can be prescribed.

VDP also delivers outpatient prescription drugs for FFS clients, while MCOs cover the benefit in managed care. The PDL is not required for CHIP, but MCOs are required to use the PDL in administering pharmacy benefits for Medicaid.

Adults enrolled in FFS are limited to three prescriptions per month. There are no limits on prescription drugs that can be authorized for children age 20 and younger enrolled in any
Medical Transportation Services

The Medical Transportation Program (MTP) provides cost-effective, non-emergency medical transportation (NEMT) for Medicaid members who need help going to a doctor or specialist, a pharmacy, or other providers for covered health care services. MTP services are only for Medicaid members, Children with Special Health Care Needs members, and qualified low-income cancer patients.

Services provided through MTP include:

- Demand response transportation—curb-to-curb transportation using dispatched vehicles, including shared rides and transportation network company (TNC) vehicles.
- Mass transit tickets—including bus, rail, ferry, publicly or privately-owned transit providing general or special service on a regular or continuing basis, and commercial airline transportation services.
- Mileage reimbursement through Individual Transportation Participant (ITP) requests. ITPs must register to participate in the mileage reimbursement program.
- Meals and lodging, when covered health care services require an overnight stay outside the county of residence.
- Advanced funds for transportation or travel-related services.
- Out-of-state travel to contiguous counties in adjoining states (Louisiana, Arkansas, Oklahoma and New Mexico) and travel to states outside of the adjoining states for covered health care services not provided in Texas.

Effective June 2021, NEMT services for individuals in managed care will be coordinated by their MCO. In addition to the NEMT services above, MCOs will be required to provide nonmedical transportation (NMT) services, a subset of demand response transportation services, for certain trips requested with less than 48-hour notice. Examples of NMT include trips to obtain pharmacy services or prescription drugs, urgent care services, or upon discharge from a healthcare facility.

The STAR Managed Care Program

STAR is the first and largest managed care program in Texas. Most people who receive Medicaid in Texas are enrolled in STAR. The program primarily covers children, pregnant women and some families. STAR MCOs also provide service management to members with special health care needs (see A Closer Look, page 43). There are 15 MCOs delivering the STAR program across 13 STAR service areas.
Children and Youth

Medicaid

Children eligible for Medicaid can receive a wider range of health care services than adults, including services like physical, occupational and speech therapy; private duty nursing; and hearing and vision care.

Children and youth with Medicaid are eligible for behavioral health care, including Health and Behavior Assessment and Intervention (HBAI) services. These services identify the psychological, behavioral, emotional, cognitive and social factors important to preventing, treating and managing physical health symptoms.

Children and youth also receive comprehensive dental services. Most dental benefits are provided through managed care and delivered by one of three dental maintenance organizations. Children, who are either enrolled in STAR Health or who reside in a long-term care facility, receive dental care through the STAR Health MCO or their assigned facility.

Texas Health Steps

Children enrolled in any Medicaid program receive Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services—also known as Texas Health Steps. This program provides comprehensive medical, dental and case management services for children, birth through age 20, with Medicaid. This includes the Comprehensive Care Program, which expands coverage to any medically necessary services, even if the services are not covered by the state plan.

Texas Health Steps also provides case management for eligible children and pregnant women. Case managers help ensure their clients have access to needed medical, social, educational and other services related to their health condition, health risk or high-risk condition. Examples of services include: developing a service plan with clients and families, making referrals, and advocacy.

Texas Health Steps is not a benefit option for children enrolled in CHIP.
**Children’s Medicaid**

Most children receiving Children’s Medicaid are enrolled in STAR. Children’s Medicaid services—including acute care, pharmacy services, behavioral health and LTSS—are primarily delivered through managed care, although some LTSS may be covered through FFS.

Some individuals with disabilities who receive Children’s Medicaid are enrolled in the STAR Kids managed care program (see STAR Kids, page 36).

**Medicaid for Children in Foster Care**

In partnership with Texas Department of Family and Protective Services (DFPS), Medicaid provides STAR Health, a managed care program for children in state conservatorship. The program is administered by a single, statewide MCO.

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

- Children in the Adoption Assistance or Permanency Care Assistance program who are transitioning from STAR Health to STAR or STAR Kids.
- Some children in the Adoption Assistance or Permanency Care Assistance program who have a disability and who choose to remain in STAR Health.
- Youth age 21 years and younger with voluntary extended foster care placement agreements (Extended Foster Care).
- Youth age 20 and younger who are Former Foster Care Children (FFCC).

STAR Health also offers services, including:

- Service management and service coordination (see A Closer Look, page 43).
- A 24/7 nurse hotline for caregivers and caseworkers.
- The Health Passport—a web-based, claims-based electronic medical record.

Children may be enrolled in the MDCP and receive their MDCP services through STAR Health (see MDCP, page 37).

In addition, STAR Health trains and certifies behavioral health providers, caregivers and caseworkers in trauma-informed care—including evidence-based practices, such as Trauma-Focused Cognitive Behavioral Therapy. Use of psychotropic medication among STAR Health clients is carefully monitored for compliance with the DFPS psychotropic medication utilization parameters.
Chapter 2 — What Medicaid and CHIP services are available for Texans?

**Youth Empowerment Services**

YES is a Medicaid waiver program that provides intensive community-based services for children and youth—who have severe mental, emotional or behavioral disturbances—and their families.

Services include but are not limited to: community living supports, family supports and supportive family-based alternatives, non-medical transportation, paraprofessional services, and transition services. (See Appendix B, page 136, for a full list of services.)

**Children’s Health Insurance Program**

CHIP provides acute care, behavioral health care and pharmacy services for children in families who have too much income to qualify for Medicaid, but cannot afford to buy other health insurance.

CHIP offers mental health and SUD screening and treatment services similar to Medicaid. CHIP also provides SUD prevention and intervention services.

CHIP also provides dental benefits. CHIP members receive up to $564 in dental benefits per 12-month enrollment period—not including emergency dental services—to cover preventive and therapeutic services like periodontics and prosthodontic services. Clients may receive certain preventive and medically necessary services beyond this cap through a prior authorization process.

**Women**

Medicaid covers family planning. Medicaid and CHIP cover reproductive health care services, including: screening and treatment for sexually transmitted infections, contraception, prenatal care services, and labor and delivery. Medicaid also covers breast and cervical cancer screening and treatment. CHIP only covers contraception for medically necessary purposes.

**Medicaid for Pregnant Women**

Women who receive Medicaid for Pregnant Women are enrolled in STAR. Pregnant women who qualify for Medicaid receive full Medicaid benefits and coverage for perinatal services including:
• Prenatal visits.
• Prescription prenatal vitamins.
• Labor and delivery.
• Postpartum care.

Women with high-risk pregnancies may receive service management through their STAR health plan (see page 43). They may also receive case management services through Case Management for Children and Pregnant Women. Case managers assist pregnant women with high-risk health conditions to use medically necessary health, social, educational and other services related to their health condition.

**CHIP Perinatal**

The CHIP Perinatal program is for the unborn children of pregnant women who are uninsured and do not qualify for Medicaid. The program provides a basic prenatal care package. Services include:

• Prenatal visits.
• Prescription prenatal vitamins.
• Labor and delivery.
• Postpartum care.

Members receiving the CHIP Perinatal benefit are exempt from the 90-day waiting period and all cost-sharing, including enrollment fees and co-pays, for the duration of their coverage period.

**Healthy Texas Women**

Healthy Texas Women (HTW) is a Medicaid waiver program that provides women’s health and family planning services at no cost to eligible women. HTW provides women’s health and core family planning services, including:

• Pregnancy testing.
• Pelvic examinations.
• Sexually transmitted infection services.
• HIV screenings.
• Breast and cervical cancer screenings.
• Screening and treatment for cholesterol, diabetes and high blood pressure.
• Contraception, including condoms, birth control pills, long-acting reversible contraceptives and permanent sterilization.
• Screening and treatment for postpartum depression.

In January 2020, the Centers for Medicare and Medicaid Services (CMS) approved the Texas 1115 Demonstration Waiver application for HTW. The Health and Human Services
Commission (HHSC) began receiving federal matching funds for HTW services provided to adults on February 18, 2020 (see Chapter 4, page 75).

**Healthy Texas Women Plus**

HTW Plus is an enhanced postpartum services package. HTW Plus clients are eligible to receive additional services to treat certain health conditions including mental health conditions, like postpartum depression or substance use disorders, and cardiovascular conditions. To receive HTW Plus, an HTW client must have been pregnant within the 12 months prior to their enrollment. Services include:

- Individual, family and group psychotherapy services.
- Peer specialist services.
- Imaging studies; blood pressure monitoring; and anticoagulant, antiplatelet and antihypertensive medications.
- Screenings, brief interventions and referrals to treatment for substance use disorders.
- Outpatient substance use counseling.
- Smoking cessation services.
- Medication-assisted treatment.

**Medicaid for Breast and Cervical Cancer**

Women who receive Medicaid for Breast and Cervical Cancer (MBCC) are enrolled in STAR+PLUS. MBCC covers active cancer treatments, including:

- Chemotherapy and radiation.
- Surgery.
- Disease surveillance for clients with triple-negative receptor breast cancer.
- Hormone treatments.

Women eligible for MBCC receive full Medicaid benefits and remain in the program for the duration of their cancer treatment, if they continue to meet all other eligibility criteria.

Women can apply for MBCC through Breast and Cervical Cancer Screening (BCCS) clinics. BCCS is not a Medicaid program. BCCS clinics provide breast and cervical cancer screening and diagnostic services to women, plus serve as a point of access for MBCC.
Better Birth Outcomes initiatives aim to improve women’s perinatal health care. There are several BBO initiatives, including the following:

**Maternal Opioid Misuse Model**

Opioid use in pregnant women contributes to maternal mortality, preterm birth, low birth weight and neonatal abstinence syndrome in newborns. Senate Bill 750, 86th Legislature, Regular Session 2019, directed HHSC to apply for federal funding to implement a model of care that improves access to care and quality of care for pregnant women with opioid use disorder enrolled in Medicaid.

HHSC partnered with the Harris Health System, Ben Taub Hospital, Baylor College of Medicine, and Santa Maria Hostel to apply for funding under the Maternal Opioid Misuse (MOM) model. The MOM model is a five-year project that seeks to facilitate better integration of prenatal care, addiction medicine and psychiatric care for pregnant women enrolled in Medicaid with an opioid use disorder (OUD).

The federally funded project is being piloted in Harris County. Women who qualify will receive a comprehensive set of acute care and behavioral health services delivered in a coordinated and integrated approach, including:

- Prenatal and postpartum care and family planning services, like long-acting reversible contraception (LARC).
- Mental health and OUD screening and treatments, including medication assisted therapy (MAT), outpatient services, residential treatment and peer specialist services.

**Postpartum Depression**

Postpartum depression (PPD) is a common and potentially serious condition typically diagnosed after pregnancy. The impact of PPD and related conditions can be far-reaching. Numerous studies demonstrate women suffering from PPD develop behaviors that negatively impact their parenting abilities and compromise the mother-child bond. In order to increase awareness, education and continuity of care for women with PPD, HHSC has launched several initiatives and has published a five-year PPD strategic plan.

**Long-acting Reversible Contraception**

Texas is working to increase access to the LARC method of contraception to stop unintended pregnancies. LARC devices are highly effective for preventing pregnancy, are easy to use and last for several years. HHSC incentivizes the use of immediate postpartum (IP) LARC for pregnant women enrolled in Medicaid with add-on reimbursement—allowing providers to bill for the LARC device and insertion, in addition to the labor and delivery service.
Children and Adults with Disabilities

As previously described, individuals with disabilities may receive LTSS through Medicaid.

LTSS may be provided in long-term care facilities, or in home and community-based settings (see Long-term Services and Supports, page 26).

Children

Children with disabilities can receive their acute care, behavioral health services and LTSS through Children’s Medicaid or Medicaid for the Elderly and People with Disabilities (MEPD). Some may receive home and community-based services through a Medicaid waiver program. Children, who are both in foster care and enrolled in STAR Health, receive all their acute care, behavioral health services and LTSS services through the STAR Health MCO (see Medicaid for Children in Foster Care, page 31).

STAR Kids

STAR Kids is a managed care program that provides acute care services and LTSS to children and youth with disabilities. Children and youth are enrolled into STAR Kids if they:

- Receive Supplemental Security Income (SSI) or SSI-related Medicaid.
- Are eligible for MEPD or a Medicaid Buy-in program.
- Are enrolled in a Medicaid waiver program.
- Reside in a long-term care facility.
- Are dually eligible for Medicare.

All STAR Kids members have access to service coordination through their MCO. Their service coordinator organizes acute care services and LTSS (see A Closer Look, page 43). If an individual is enrolled in multiple programs, their STAR Kids service coordinator works with all their other service coordinators or case managers to determine which programs will provide each of their services.

Medicaid for the Elderly and People with Disabilities

Children and adults with disabilities and individuals age 65 and older who do not receive SSI may qualify for Medicaid through MEPD.

Through MEPD, individuals may access programs and services like care in long-term care facilities and state plan home and community-based services—which may be delivered through managed care, fee-for-service or a combination of these models.
While STAR Kids can provide both acute care and LTSS to members, sometimes it may only provide acute care. For example, an individual residing in a long-term care facility may be enrolled in STAR Kids for their acute care only, while their LTSS are provided by their assigned facility and paid for through the FFS model.

In addition, FFS waiver programs can provide many of the same LTSS available through STAR Kids. If an individual needs a service available in both STAR Kids and their waiver program, they must get the service through STAR Kids.

**Medically Dependent Children Program**

MDCP is a Medicaid waiver program delivered through managed care that provides home and community-based services to children and youth age 20 and younger, as a cost-effective alternative to residing in a nursing facility.

Individuals enrolled in MDCP receive all services through their STAR Kids or STAR Health MCO. (See Appendix B, page 135, for a full list of services available through MDCP.)

**School Health and Related Services Program**

The School Health and Related Services (SHARS) program allows independent school districts, including public charter schools, to receive federal reimbursement for providing Medicaid services to participating Medicaid-eligible students age 20 and younger. Management of the SHARS program is a cooperative effort between the Texas Education Agency and HHSC. This program covers certain health-related services documented in a student’s Individualized Education Program or, for audiology services only, a student’s 504 plan. Services include:

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

**Early Childhood Intervention**

Early Childhood Intervention (ECI) is a statewide program that provides services to families with children from birth up to age 3 with developmental delays or disabilities. HHSC contracts with local entities, such as nonprofit organizations and some school districts, to provide services in all Texas counties. ECI provides targeted case management, specialized skills training, therapy services and other benefits for children on Medicaid.
Waiver Programs for Individuals With Intellectual and Developmental Disabilities

Medicaid 1915(c) waiver programs are designed to provide home and community-based services to individuals with intellectual and developmental disabilities (IDD), or related conditions, as an alternative to placement in an ICF/IID.

Demand for some waiver programs exceed capacity. The programs maintain interest lists that people can join at any time (see A Closer Look, page 21).

There are four waiver programs for individuals with IDD, described below, which are delivered through the FFS model. These programs deliver many of the same services (see Appendix B, page 133).

Community Living Assistance and Support Services
CLASS provides home and community-based services to clients who have a related condition diagnosis qualifying them for placement in an ICF/IID. Services include: case management, prevocational services, transportation-residential habilitation, prescriptions, support family services and transition assistance services.

Deaf Blind with Multiple Disabilities
Deaf Blind with Multiple Disabilities (DBMD) provides home and community-based services, as an alternative to residing in an ICF/IID, to people of all ages who have deaf-blindness or have a condition that will result in deaf-blindness and have additional disabilities. Services include: case management, day habilitation, transportation-residential habilitation, assisted living, prescriptions, audiology services, dietary services, behavioral support and intervener.

Home and Community-based Services
HCS provides individualized services to clients of all ages, who qualify for ICF/IID level of care, yet live in their family’s home, their own home, or other settings in the community. Services include: day habilitation and residential services, supported home living, transportation and transition assistance services.

Texas Home Living
TxHmL provides selected services and supports for individuals with IDD who live in their own home or their family’s home. Services include: behavioral support, community support, transportation and day habilitation.
**Adults**

Adults with disabilities can receive their acute care, behavioral health services and LTSS through Medicaid. Some may receive home and community-based services through a Medicaid waiver program. Like children with disabilities, adults may receive their services through managed care, FFS or a combination of these models.

Other programs available to eligible adults with disabilities include: Program of All-inclusive Care for the Elderly (PACE), Medicaid-Medicare Plans (MMP), and Dual Eligible Special Needs Plans (D-SNPs) (see People Age 65 and Older, page 41).

**STAR+PLUS**

The STAR+PLUS managed care program provides acute care, behavioral health care and LTSS for adults who have a disability or who are age 65 and older. STAR+PLUS serves adults who:

- Receive SSI or SSI-related Medicaid.
- Are enrolled in STAR+PLUS HCBS.
- Reside in an ICF/IID, or are enrolled in an IDD waiver program while not dually eligible for Medicare.
- Are enrolled in the MBCC program.
- Are nursing facility residents.
- Are dually eligible for Medicare.

Members who are dually eligible for Medicare receive LTSS through STAR+PLUS and their acute care services through Medicare. Clients with complex medical conditions are assigned a service coordinator, who develops an Individual Service Plan (ISP) with the client and manages the client’s acute care and LTSS.

Individuals can choose whether they participate in STAR+PLUS if they meet one or both criteria:

- Are enrolled in PACE.
- Are a member of Federally Recognized Native American Tribes.

Individuals are excluded from participation in STAR+PLUS if they:

- Are age 20 and younger, except for participants in MBCC who may be ages 18 to 64.
- Are dually eligible and currently living in an ICF/IID or receiving IDD waiver services.
- Reside in an SSLC.
- Reside in a state veteran home or the Truman Smith Care Center.
**STAR+PLUS Home and Community-based Services Program**

STAR+PLUS HCBS is a managed care program delivered through the Texas 1115 Health-care Transformation Waiver that provides a cost-effective alternative to living in a nursing facility to adults age 21 and older who have disabilities or who are elderly.

Individuals enrolled in the program receive all services through their STAR+PLUS MCO. Services offered include but are not limited to: adult foster care, assisted living services, emergency response services, home delivered meals and transition assistance services (see Appendix B, page 135).

**Home and Community-based Services–Adult Mental Health**

HCBS-AMH is a state plan program under Section 1915(i) that helps individuals with serious mental illness remain in their community. Adults with a diagnosis of serious mental illness have complex needs that can lead to extended psychiatric hospitalizations, repeated arrests and frequent emergency department visits. The HCBS-AMH program provides an array of intensive home and community-based services tailored to an individual’s assessed needs and considering the individual’s preferences and goals.

Services include, but are not limited to: host home/companion care, supervised living services, supported home living and psychosocial rehabilitative services. Services are provided in CMS-approved settings, which can be an individual’s home or apartment, an assisted living setting, or small community-based residence.

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**Medicaid Substance Use Disorders Treatment Services**

Medicaid SUD treatment services must be provided by a chemical dependency treatment facility (CDTF) or opioid treatment providers (OTP), either of which must be licensed and regulated by HHSC—except for Medication Assisted Therapy (MAT) services. MAT, including methadone and buprenorphine, is primarily used for opioid-use disorder, but can also be used for alcohol-use disorder. Methadone for an opioid-use disorder may only be provided in an OTP. Buprenorphine treatment may be provided by OTPs, CDTFs, physicians and other qualified prescribers—including nurse practitioners, physician assistants, nurse midwives and nurse anesthetists.

**Screening, Brief Intervention and Referral to Treatment**

Screening, Brief Intervention and Referral to Treatment provides early intervention and treatment services for clients age 10 and older who have a SUD, or who are at risk of developing SUD. The benefit is available in community-based settings and hospitals.
People Age 65 and Older

Adults age 65 and older can receive Medicaid through MEPD, delivered through the STAR+PLUS managed care program (as previously described on page 39). People who are aging and need LTSS can also get these services through MMPs, D-SNPs or PACE.

Medicare-Medicaid Plans

MMPs are designed to provide a fully integrated managed care model for people who are dually eligible for Medicare and Medicaid. Participating individuals may be age 21 and older, with the majority falling into the age 65 and older demographic. If eligible, individuals are required to be passively enrolled into the STAR+PLUS program, but may choose to opt-out.

The model involves a three-party contract between an MMP, HHSC, and CMS for the provision of the full array of Medicaid and Medicare services. All covered services, including acute care and LTSS, are provided by a single health plan. Services provided through an ICF/IID or through a Medicaid waiver program, such as CLASS, DBMD, HCS, or TxHmL, are excluded.

MMPs operate in Bexar, Dallas, El Paso, Harris, Hidalgo and Tarrant counties.

Medicaid Hospice Services

Hospice services provide palliative care to terminally ill individuals for whom curative treatment is no longer desired and who have a physician’s prognosis of six months or less to live.

Services include: physician services, nursing, PAS, therapies, prescription drugs, respite care and counseling—plus supportive care for their loved ones. These services can be administered in the home or in community settings, long-term care facilities, or in hospital settings.

Children age 20 and younger receiving hospice services may continue to receive curative care from non-hospice acute care providers.
Medicare Advantage Dual Eligible Special Needs Plans

D-SNPs are managed care plans specifically designed to coordinate care between Medicare and Medicaid.

The plan must be designed for and offered to individuals who are eligible for Medicare and entitled to medical assistance under the Texas State Plan. D-SNPs can serve both full- and partial-benefit dual eligibles.

D-SNPs can operate within or without the STAR+PLUS program.

If in STAR+PLUS, a D-SNP must deliver Medicaid services through STAR+PLUS. D-SNPs that do not operate in STAR+PLUS are only responsible for covering member cost-sharing payments.

Program of All-inclusive Care for the Elderly

The PACE program provides acute care and LTSS services for a capitated monthly fee below the cost of comparable care in a long-term care facility. PACE participants must be age 55 and older, live in a PACE service area, qualify for nursing facility level of care, and be able to live safely in the community. PACE participants receive all medical and social services they need through their PACE provider.

PACE offers all health-related services for each participant, including: inpatient and outpatient medical care, specialty services (e.g., dentistry, podiatry, physical therapy and occupational therapy), social services, in-home care, meals, transportation, and day activity services.

PACE is available in Amarillo/Canyon, El Paso and Lubbock. Individuals in these service areas who are also eligible for STAR+PLUS may choose to receive services either through STAR+PLUS or PACE, but not both.
**Service Coordination in Managed Care**

**STAR Kids and STAR+PLUS**
All STAR Kids members get connected with a service coordinator through their health plan. STAR+PLUS members with complex medical conditions can also get a service coordinator.

Service coordination helps ensure members get the services they need. Using a person-centered approach, service coordinators help manage the member’s health care and long-term care needs—including access to community resources and help with food and housing. Service coordinators work with the member, their primary care provider, and their specialty and non-medical providers to develop and carry out an Individualized Service Plan.

**STAR and CHIP**
STAR and CHIP members with special health care needs can get help from their health plans through service management. Special health care needs include: serious, ongoing illnesses; chronic or complex conditions; disabilities; and conditions that require therapeutic intervention and evaluation by appropriately trained staff.

Like a service coordinator, a service manager helps ensure members with special health care requirements get the services they need from their health plan. They can also help members get non-capitated services, which are services that might not be covered in STAR or CHIP but are a Medicaid benefit. For example, for STAR members, these services might include programs like Community First Choice or personal care services.

**STAR Health**
STAR Health members with a specific medical and behavioral need get service coordination or service management.

In STAR Health, service coordination helps caregivers manage information like medical records for court hearings or get services from other programs. Service management is for members with complex medical or behavioral needs.

A STAR Health service manager works with the member, member’s caregivers, primary care provider and specialty care providers to create and carry out a service plan. Service managers ensure access to and use of medically needed, covered services.
Chapter 3

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

**At-a-Glance**

- **4.3 million** Texans served
- **94%** served through managed care

**Managed Care Organizations (MCOs)**: 17

**Dental Maintenance Organizations (DMOs)**: 3

**Contracts**: 40+

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

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

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

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

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

- **Financial**
  - Validation of financial statistical reports, administrative expenses cap, profit limits, experience rebate, independent auditing

**Contractual Non-compliance:**

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

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

Numbers are subject to change. Number of MCOs and contracts current as of November 2020.
The Managed Care Delivery System

The Health and Human Services Commission (HHSC) has shifted its service delivery for Medicaid and the Children’s Health Insurance Program (CHIP) from the fee-for-service (FFS) model to managed care. There are now 17 managed care organizations (MCOs) serving 94 percent of Medicaid clients and all CHIP clients.

Managed care is an integrated service delivery system where HHSC contracts with MCOs to provide all covered, medically necessary services to people receiving Medicaid or CHIP benefits. HHSC pays each MCO a monthly capitation rate for every member enrolled in their plan, and MCOs reimburse providers for services provided to their members.

The goal of transitioning from FFS to managed care is to provide value-based care. This is achieved through the care coordination provided by the MCOs—a function that serves to establish a medical home for members; improve access to care; and ensure quality, cost-effective services are delivered.

Achieving Value-based Care

MCOs can achieve value-based care by improving or stabilizing member health and delivering services in a cost-effective manner. MCOs are paid a fixed amount per member per month (PMPM) in advance based on historical costs.

This model places MCOs at financial risk if the cost of care exceeds this rate, which incentivizes them to improve care quality while keeping costs low. The “medical home” leverages the patient-provider relationship to improve health outcomes and ensure appropriate use of covered services.

The Medical Home

When members enroll with an MCO, they choose a primary care provider (PCP)—usually a family or general practice doctor, a pediatrician, or an OB/GYN—who serves as the member’s medical home. PCPs are a central access point for their patients’ health care. They deliver comprehensive preventive and primary care, as well as provide referrals for specialty care and other covered services.

The medical home helps with cost management and service delivery. The system of referrals and emphasis on preventive and primary care can limit over-utilization of care, while still improving access to covered, medically necessary services.
Members with chronic, complex health care needs also benefit from the medical home, as it promotes a patient-centered approach to care. The member’s PCP, specialists and other caregivers directly engage with them to address any high-risk health conditions or other co-morbid conditions.

**HHSC’s Managed Care Contract Oversight**

HHSC’s oversight of managed care seeks to ensure that the Texas Medicaid and CHIP programs are improving health outcomes and MCOs are delivering quality, cost-effective services.

HHSC contracts with MCOs to coordinate services for 4.1 million Medicaid and CHIP clients. Because of the size, scope and complexity of managed care contracts and the types of services MCOs provide, there is no single oversight strategy.

**MCO Selection and Contract Terms**

Each MCO is selected through a competitive contract process that requires ongoing involvement from staff and leadership across the organization—starting with the solicitation phase, and then continuing throughout the evaluation phase, negotiations and contract formation.

The relationship between HHSC and any selected MCO is best described as a “partnership with accountability.” This is established through robust contract terms at the onset, which outline MCO responsibilities, including but not limited to:

- Reporting financial, member enrollment and encounter data.
- Providing member benefit packages that cover services required by the Texas Medicaid or CHIP programs.
- Delivering service management and service coordination to eligible members.
- Establishing adequate and accessible provider networks.
- Timely processing of provider claims.
- Maintaining member and provider call centers.
- Resolving member and provider complaints and appeals.

The Uniform Managed Care Contract establishes the baseline requirements for all MCOs and then additional contract terms are developed specific to the program.

**Readiness Reviews**

After they have been selected through the competitive contracting process, the MCO builds out its operations. Prior to serving members, HHSC conducts readiness reviews to ensure the MCO can provide all contracted services.
Major areas examined by HHSC to ensure MCOs are ready to serve members are:

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

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

**Contract Management and Oversight**

Once the MCO is actively serving members, HHSC employs several oversight tools to monitor MCOs based on the requirements laid out in the contract. The main areas of contract oversight include:

- Access to services.
- Service delivery.
- Quality of care.
- Onsite operations.
- Financial practices.

The oversight tools within these areas enable HHSC to verify MCO compliance with state and federal law and the terms of their contract. If issues of non-compliance are found, HHSC applies a graduated remedy process to address these issues.
MCOs can reduce the use of emergent care by ensuring members have timely access to primary and preventive care. They are contractually required to build adequate networks of providers so their members can access care when needed, near where they live.

In Texas and across the U.S., network adequacy for commercial health plans and Medicaid and CHIP MCOs is influenced by many factors, including provider availability, administrative complexity and payment rates.

**MCO Network Adequacy**

HHSC uses a variety of tools to monitor MCO networks—including time and distance standards, provider directory quality checks, appointment availability studies, provider referral surveys, and member satisfaction surveys. When deficiencies are discovered, HHSC addresses them through its established graduated remedy process (see Non-compliance Remedies, page 69).

**Time and Distance Standards**

In March 2017, HHSC implemented new access standards for MCO provider networks. These access, or time and distance, standards were developed based on those used for Medicare Advantage and by the Texas Department Insurance (TDI). The standards are either consistent with or more stringent than state and federal requirements.

In September 2018, HHSC adopted time and distance standards for long-term services and supports (LTSS) and pharmacy. Standards for personal attendant services will be implemented in 2021.

HHSC is also seeking to improve member access to behavioral health services like substance use disorder (SUD) treatment. In 2020, HHSC adopted new provider network standards for outpatient chemical dependency treatment facilities and outpatient opioid treatment programs.

MCOs must allow each member to choose their network provider to the extent possible. MCOs must also ensure that 90 percent of their members have access to at least two network providers within specific time or distance requirements.
## Time and Distance Standards

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

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

*Services for both adults and children include acute, chronic, preventive, routine or urgent care.
HHSC uses geo-access mapping to monitor the network access of individual MCOs and to look for areas of the state where there are provider capacity issues.

Analysis from the third quarter of SFY 2020 for all MCOs collectively, across all programs has shown:

- Regardless of county size, MCOs perform above the 90 percent standard for primary care providers, OB/GYNs, main dentists, outpatient behavioral health care, prenatal care, and for occupational, physical or speech therapy.
- In larger counties (metro counties), MCOs meet or exceed the standard for the following specialty care providers: cardiovascular disease, psychiatrists, ophthalmologists, orthodontists, pediatric sub-specialties, and urologists.
- Regardless of county size, MCOs fall below the standard for some of the dental specialist provider types including pediatric dentists, prosthodontists, and endodontists.

Building a strong network of providers is an ongoing effort for MCOs. In rural areas, telemedicine has become an important tool in bridging access to services.

**Appointment Availability**

Appointment availability studies monitor the length of time a member must wait between scheduling an appointment with a provider and receiving treatment from the provider. HHSC contracts with an external quality review organization (EQRO) to conduct these studies periodically. Historically, the EQRO performed four studies by provider type, two per year. Due to the public health emergency, three studies were conducted in 2020. Two studies will be conducted in 2021 with the goal of resuming four studies per year in 2022.

The EQRO uses a mystery shopper method, where they call a random sample of providers to determine how soon an appointment can be scheduled. The samples of provider offices for the studies are pulled from member-facing, provider directories submitted by the MCOs.

Previously, HHSC has imposed corrective action plans (CAPs) and liquidated damages (LDs) on all the MCOs in at least one service area for not meeting appointment availability standards.

HHSC also uses results from these studies to target improvement efforts. For example, HHSC placed greater focus on prenatal care through the 2018 MCO Performance Improvement Projects (PIPs) and Pay-for-Quality (P4Q) measures.

STAR MCOs improved on P4Q measures for pregnant members receiving a prenatal care visit in the first trimester or within 42 days of enrollment, moving the program rate from
the national 50th-75th percentile in 2017 to the national 75th-90th percentile in 2018. 2018 PIP scores will be posted to the HHSC website in 2021.

<table>
<thead>
<tr>
<th>MCO Appointment Availability Standards</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Level/Type of Care</strong></td>
</tr>
<tr>
<td>Urgent Care (child and adult)</td>
</tr>
<tr>
<td>Routine Primary Care (child and adult)</td>
</tr>
<tr>
<td>Preventive Health Services for New Child Members</td>
</tr>
<tr>
<td>Initial Outpatient Behavioral Health Visits (child and adult)</td>
</tr>
<tr>
<td>Preventive Health Services for Adults</td>
</tr>
<tr>
<td>Prenatal Care (not high-risk)*</td>
</tr>
<tr>
<td>Prenatal Care (high risk)*</td>
</tr>
<tr>
<td>Prenatal Care (new member in third trimester)</td>
</tr>
</tbody>
</table>

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

Appointment availability is closely related to other network adequacy oversight tools, like provider directory validation. HHSC uses these oversight methods together to help ensure access to care for members.

**Provider Directory Quality**

MCOs use the information submitted by providers during credentialing for their directories. However, inaccurate or out-of-date information can impact members’ ability to access services. HHSC requires MCOs to update online provider directories weekly and monitors their directories for accuracy.

HHSC makes quarterly calls to a random sample of providers from MCO directories to confirm:

- The provider’s contact information is accurate.
- The provider is accepting patients.
- The provider is meeting appointment availability standards.
- The provider covers certain age limits if they are a specialist.

The EQRO also collects data related to provider directory quality when it conducts appointment availability studies.

HHSC and the EQRO share findings with MCOs, and then request plans for addressing any identified issues from MCOs. As needed, HHSC also uses claims data to validate provider
activity and eliminate inactive providers. Improvements to the quality of provider directories are ongoing.

**Member Satisfaction**

To understand the patient experience with health care, HHSC reviews member complaints, as well as results from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) and the National Core Indicators–Aging and Disabilities (NCI-AD) surveys.

CAHPS surveys focus on consumer perceptions of quality, such as the communication skills of providers and ease of access to health care services. The 2018 CAHPS survey results showed that 13 out of 16 MCOs in STAR met the minimum standard for “good access to routine care” for children. However, only four MCOs in the STAR program met the minimum standard for “good access to specialist appointment.” MCOs are subject to contract remedies for failing to meet minimum standards for one-third or more quality measures, which includes member survey measures.

Texas rates for most CAHPS survey composites and ratings were equal to or higher than national averages for Medicaid (child population) in 2019. CHIP rates were lower than national averages for both “Getting Needed Care” and “Getting Care Quickly,” and were equal to or higher than national averages for other composites published by the Agency for Healthcare Research and Quality. HHSC uses these results in its annual MCO report cards, performance indicator dashboards and in P4Q (see Transparency with the Public, page 61).

**Service Delivery**

MCOs are required to provide all covered, medically necessary services to their Medicaid and CHIP members in the appropriate amount, duration and scope. HHSC monitors MCO service delivery compliance through utilization reviews (URs).

**Utilization Reviews**

URs examine requests for medical treatments to confirm MCOs are delivering appropriate, medically necessary services in compliance with their contract requirements. URs are overseen by the Office of the Medical Director and are conducted by a team of nurses, clinicians and contract experts. URs ensure MCOs are authorizing, justifying and providing
services without over-utilization or under-utilization. The reviews also assure MCO adherence to federal and state laws and rules, their contracts with HHSC, and their own policies.

URs consist of two review units: Acute Care Utilization Review (ACUR) and Managed Care Long-term Services and Supports (MLTSS).

**Acute Care Utilization Review**

MCOs must appropriately approve and deny medical services in accordance with state and federal regulations and HHSC contracts. The ACUR unit oversees the authorization of medical benefits—a key component of an MCO’s management of service utilization in Medicaid. This oversight reduces authorizations of unnecessary services, while ensuring members have access to the care they need.

The reviews are typically done as part of HHSC’s comprehensive readiness and operational reviews. They can also be conducted as a targeted review if a need is identified (see Targeted Reviews, page 66). The team is comprised of registered nurses; occupational, speech and physical therapists; behavioral health specialists; and contract specialists. Activities include analysis of prior authorization data for a targeted sample of members to determine whether MCOs appropriately and accurately: deliver medically necessary, requested services; process requests timely; provide contractually required service coordination; and ensure members have appeal and fair hearing opportunities when a service is denied.

**Managed Care Long-term Services and Supports Utilization Review**

The initial scope of the MLTSS UR was for review of the STAR+PLUS program only. In 2018, the Texas Legislature approved additional staff, which expanded the scope to include review of STAR Kids and STAR Health Medically Dependent Children Program (MDCP).

The MLTSS UR team samples STAR+PLUS Home and Community-based Services (STAR+PLUS HCBS), STAR Kids and STAR Health MDCP members to review how MCOs conduct assessments—their procedures and related information used to determine appropriateness of member enrollment in these programs. The review includes ensuring MCOs are providing services according to their assessment of service needs. The team conducts desk reviews of MCO documentation and home visits with each of the members in the sample.

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

**Prescription Drug Oversight**

Medicaid and CHIP programs must adhere to the Texas Formulary—a list of covered, CMS-approved drugs—when administering pharmacy benefits. The Vendor Drug Program (VDP) oversees the Formulary and protocols for drug-use management across Medicaid, CHIP and other HHSC programs.

The VDP also manages the Preferred Drug List (PDL)—a subset of many, but not all drugs on the Formulary. Drugs listed as “preferred” are available without prior authorization, while drugs listed as “non-preferred” require a prior authorization before they may be dispensed. A drug’s status on the PDL is based on its safety, efficacy and cost-effectiveness. The PDL is required in FFS and managed care.

**Drug Utilization Reviews**

HHSC and MCOs perform drug utilization reviews (DURs) before and after dispensing medications to Medicaid clients. These reviews evaluate the safety and appropriate use of drug therapies, while seeking to contain costs.

**Prospective DURs**

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

Advisory messages concerning clinically significant conditions or situations are part of the point-of-sale claim adjudication process. Upon identifying any clinically significant conditions or situations, the pharmacist should take appropriate steps to avoid or resolve the problem, including consultation with the prescribing provider.

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**The Texas Drug Utilization Review Board**

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

The duties of the board include submitting recommendation to HHSC for the PDL, approving clinical prior authorizations, developing and reviewing educational interventions for Medicaid providers, and reviewing drug utilization across the Medicaid program.
Pharmacy Prior Authorizations

There are two types of prior authorizations (PAs) for prescription drugs: non-preferred and clinical.

Non-preferred PAs may occur when prescribers choose medications listed on the PDL as non-preferred for their Medicaid patients. To prescribe the medication, the provider must obtain prior authorization from HHSC or their patient’s MCO before the drug is dispensed.

Clinical PAs may be required for an individual drug or an entire drug class included on the Formulary. The drug(s) may also have preferred or non-preferred status on the PDL. Clinical PAs are determined using evidence-based clinical criteria and nationally recognized peer-reviewed information. Participating MCOs are required to perform certain clinical PAs and may perform others at their discretion.

Retrospective DURs

After a client has received medication, retrospective DURs are conducted to review the drug therapy. Reviews examine claims data to analyze prescribing practices, the client’s medication use and pharmacy dispensing practices. This helps identify patterns of fraud and abuse, gross overuse, and inappropriate or medically unnecessary care. This also allows for active, ongoing educational outreach for prescribing providers and pharmacists with the aim of improving prescribing and dispensing practices.

Pharmacy Benefits Manager Oversight

MCOs contract with pharmacy benefits managers (PBMs), who build the MCOs’ pharmacy networks and negotiate rates with and pay claims to pharmacists. By extension, PBMs are required to comply with state and federal regulations, use the PDL, and follow the prior authorization criteria established by the VDP and the MCO.

Many of the same tools used to monitor MCOs are also used to ensure PBM compliance, including desk reviews, onsite reviews, readiness reviews and targeted reviews. These activities include review of MCOs’ policies, procedures, contract deliverables, and self-reported data for encounters and claims.

HHSC contracts also prohibit “spread pricing”—when a PBM keeps a portion of the reimbursement rates intended for pharmacies instead of passing the full payments from the MCO to pharmacies. Drug prices and dispensing fees paid to the pharmacies from the PBM must be transparent to the state.
**Electronic Visit Verification**

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

Texas requires EVV for certain Medicaid funded home and community-based services provided through HHSC and MCOs. Only services delivered through the agency option are required to use EVV. The following programs and services are currently using EVV:

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

**The 21st Century Cures Act**

The 21st Century Cures Act is a federal law passed in December 2016, requiring the use of EVV for all Medicaid personal care services and home health care services. The law expands the scope of programs and services required to use EVV to include:

- Individuals participating in the Consumer-directed Services (CDS) option or Service Responsibility Option for their service delivery.
- Home health nursing and therapy services.
- Deaf Blind with Multiple Disabilities (DBMD), Home and Community-based Services (HCS), and Texas Home Living (TxHmL) 1915(c) waiver providers.

The effective date for implementing EVV for all PCS services is January 1, 2021.

**Quality of Care**

HHSC has a strong focus on quality of care in Medicaid and CHIP and uses multiple approaches to measure and improve care quality. HHSC collects data from several sources to monitor health outcomes. Quality-based payment programs and other initiatives incentivize MCOs, DMOs, facilities and other providers to improve care quality and increase value.
Under federal regulations, HHSC contracts with EQRO. Texas’ EQRO follows CMS protocols to assess access, utilization and quality of care provided by MCOs participating in all Medicaid and CHIP medical and dental managed care programs.

In addition to ensuring state programs, MCOs and DMOs are compliant with established regulations, HHSC uses the EQRO to perform custom evaluations related to quality of care. The EQRO uses a variety of tools and measures, including analyzing MCO documents, provider medical records, and administrative data, like enrollment and encounter data; interviewing MCO and DMO administrators; and surveying members, caregivers of members and providers.

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

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

**Performance Improvement Projects**

PIPs are an integral part of Texas’ Managed Care Quality Improvement Strategy. Federal regulations require all states with Medicaid managed care programs to ensure health plans conduct PIPs. HHSC, in consultation with the EQRO, determines topics for PIPs based on health plan performance. Health plans create a PIP plan, report on their progress yearly, and provide a final report. The EQRO evaluates the PIPs in accordance with CMS protocols.

Projects must be designed to achieve, through ongoing measurements and interventions, significant improvement over time with a favorable effect on health outcomes and member satisfaction. Each PIP lasts two years—and HHSC requires each MCO and DMO to implement two PIPs per program on a staggered schedule, such that one is implemented each calendar year. One PIP must be a collaborative project with another MCO and DMO, a Delivery System Reform Incentive Payment (DSRIP) program, or a community organization.

For 2020, DMO PIPs used a Dental Quality Alliance measure to aim at rate increases for topical fluoride treatments for children at an elevated risk for tooth decay and cavities. MCO topics focused on behavioral health integration—including follow-up after hospitalization for mental illness, metabolic monitoring for children and adolescents on antipsychotics, and follow-up care for children prescribed ADHD medication. More information and current PIP topics can be found on the HHSC website.
Quality Assessment and Performance Improvement

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

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

Pay-for-Quality and Quality-based Payment Reform

P4Q programs are an integral part of health care payment reform through which provider payments become linked to improved quality and efficiency rather than volume of services delivered.

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

These programs incentivize health plans and providers to implement alternative payment models (APMs)—also called value-based payments—which help them meet or exceed their P4Q performance targets. MCOs and DMOs must have a certain percentage of their overall provider payments associated with an APM. For a certain percentage of these payments, the provider must have some degree of risk (see Chapter 4, page 90). HHSC is using the Healthcare Payment-Learning and Action Network (HCP-LAN) alternative payment model framework (HCP-LAN.org) to help guide this effort.

Long-term Care Facility Monitoring

HHSC oversees the quality of care received by Texans in long-term care (LTC) facilities and helps providers optimize the care they deliver. Staff use several tools for monitoring, including onsite visits, technical assistance and training.

HHSC nurses, dieticians, pharmacists and qualified intellectual development professionals conduct onsite quality monitoring visits. These visits help staff understand the changing needs of individuals living in the LTC facility and identify otherwise unseen problems. Staff use an early warning system to identify medium to high-risk LTC facilities and dispatch a rapid response team to facilities identified as an immediate risk to the health and safety of residents.

HHSC program staff research and connect providers statewide with training, tools and best practices, including in-service events and annual conferences. Staff also help facilities comply with state and federal regulations, including Pre-Admission Screening and Resident Review (PASRR).
HHSC also administers similar programs for health care and long-term care facilities, like the Hospital Quality-based Payment Program and the Quality Incentive Payment Program (QIPP) for nursing facilities (see Chapter 4, pages 91-92). The Hospital Quality-based Payment Program holds hospitals and MCOs financially accountable for potentially preventable events (PPEs). Through QIPP, payments are made by STAR+PLUS MCOs to nursing facilities based on their improvement activities and performance on certain quality measures.

Measurement, reporting and fiscal actions are applied on an annual cycle. More information about P4Q programs and quality-based payment reform can be found on the HHSC website.

**Transparency with the Public**

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

**Managed Care Report Cards**

HHSC uses a one- through five-star rating system to evaluate MCOs on their overall performance and on specific measures—such as the quality of care provided for chronic conditions, like asthma or diabetes. Ratings are developed by surveying current members and analyzing claims data, and are updated annually.

These report cards allow members to compare the health plans in their service area and make an informed selection during their enrollment or if they want to change health plans. MCO report cards are posted on the HHSC website and are included in the Medicaid and CHIP enrollment packets.

**Texas Healthcare Learning Collaborative Portal**

This website serves as a public reporting platform, contract oversight tool and a tool for MCO quality improvement efforts. HHSC, MCOs, providers and the public can use the site to get up-to-date MCO and hospital performance data on key quality-of-care measures—including PPEs, Healthcare Effectiveness Data and Information Set (HEDIS), and other care quality information.

Providers can also see performance data by MCO within a service area over time. This data may serve as an important tool for providers to find unmet needs they can address—and those who excel in an area of care in which an MCO needs improvement may find common ground to engage the MCO on value-based contracting. The THLC portal can be accessed at [THLCPortal.com](http://THLCPortal.com).
Chapter 3 — How does HHSC make sure clients get good care?

Quality Monitoring Sources and Measures

HHSC tracks and monitors program performance using a performance indicator dashboard—a combination of national and state-developed measures by program. Contracts require MCOs to perform above the minimum standard on more than two-thirds of the dashboard measures.

<table>
<thead>
<tr>
<th>Sources</th>
<th>Measures</th>
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<tbody>
<tr>
<td>National Committee for Quality Assurance Healthcare</td>
<td>• Nationally recognized and validated set of measures used to gauge quality of care provided to members, including Healthcare Effectiveness Data and Information Set (HEDIS).</td>
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<tr>
<td>Healthcare Effectiveness Data and Information Set (HEDIS)</td>
<td>• Domains include effectiveness of care, access and availability of care, experience with care, and health care utilization.</td>
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</tbody>
</table>
| Agency for Healthcare Research and Quality Pediatric Quality Indicators (PDIs)/Prevention Quality Indicators (PQIs) | • PDIs and PQIs use hospital discharge data to measure quality of care for ambulatory care sensitive conditions—which are conditions where good outpatient care or early intervention can prevent hospitalization, complications or more severe disease.  
  • PDIs specifically screen for problems that children and youth may experience. |
| 3M Software for Potentially Preventable Events (PPEs) | The EQRO calculates rates across all MCOs and programs for the following PPEs:  
  • Potentially preventable admissions.  
  • Potentially preventable readmissions.  
  • Potentially preventable emergency department visits.  
  • Potentially preventable complications.  
  • Potentially preventable ancillary services. |
| Consumer Assessment of Healthcare Providers & Systems (CAHPS) Surveys | • CAHPS health plan survey is a nationally recognized and validated tool for collecting standardized information on members’ experiences with health plans and services.  
  • The EQRO alternates CAHPS surveys so that members or caregivers from each program are surveyed every other year. |
| Dental Quality Alliance (DQA) | • The DQA is an organization convened by the American Dental Association at the request of CMS. DQA has developed national evidence-based oral health care performance measures that have been tested for feasibility, validity, reliability and usability. |
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**Member Complaints and Appeals**

When members are unhappy with their Medicaid services, they can formally let their MCO and HHSC know. The process they follow depends on what the issue is.

1. **Submit a complaint:** A member can submit a complaint if they have an issue with the care they receive. Examples include concerns with customer service, delays in getting an appointment, prior authorization issues, finding an in-network doctor, and problems contacting their MCO.

2. **File an appeal:** A member can file an appeal if they have an issue with an MCO’s denial to cover a service, medical supply, durable medical equipment or prescription.

HHSC monitors member complaints and appeals as an oversight tool to look for early warnings of potential systemic problems, larger MCO operational issues or the need for policy clarifications.

**Member Complaints**

Over the last few years, HHSC has focused on improving the member complaints experience and the data available for analysis.

HHSC has centralized all member managed care complaint intake with the Office of the Ombudsman. This reduces confusion for members about who they should contact to submit a complaint and where they can find resources that explain how to submit a complaint and what to expect.

Centralization with the Ombudsman also allows for more comprehensive tracking. Standard definitions for categories have been established to improve trending and identification of systemic issues. For example, now MCOs, DMOs and HHSC track access to care, customer service, and quality of care complaints the same way, making the data more reliable. To align with the new approach, MCOs and DMOs submit complaint data more frequently to allow for timelier analysis and action.

**Submission and Resolution**

Members are encouraged to first submit their complaints directly to their MCO. If they still need assistance, they can also submit complaints to the Ombudsman.

MCOs are required to resolve complaints within 30 days, regardless of point of entry. Complaints regarding urgent access to care concerns are escalated for a faster resolution. CHIP MCO complaints are submitted to TDI. FFS complaints are handled through the Medicaid helpline.
**Provider Complaints**

Providers can also submit complaints. The most common provider complaints are related to aspects of MCO or DMO administrative functions, including claims or billing disputes and service authorizations.

Providers are encouraged to first exhaust the relevant MCO complaints process before submitting a complaint to HHSC. Provider managed care complaints are addressed by Medicaid and CHIP Services. Provider complaints not related to managed care are submitted to the Texas Medicaid and Healthcare Partnership.

**Member Appeals**

When a member gets a letter from their MCO letting them know a service, medical supply, durable medical equipment or prescription is not covered or denied, they can ask the MCO to reconsider by asking for a ‘Health Plan Appeal’.

If the member still disagrees with their MCO’s decision after their appeal, they can ask for a fair hearing with HHSC. Members can request to keep getting services during the health plan appeal and fair hearings process that follows.

**External Medical Reviews**

HHSC plans to implement an external medical review (EMR) option for members who request a fair hearing. Once available, a member will be able to ask for a fair hearing with or without an EMR.

If a member requests an EMR, the review will occur before their fair hearing. HHSC will send the member’s case to an independent review organization (IRO) where medical experts will privately review the MCO’s decision. They can uphold or change the MCO’s decision. Once the member gets the results of the EMR, they can decide if they want to cancel or move forward with their fair hearing.

(See A Closer Look, page 65, for a more detailed look at the member’s journey through the health plan appeal process.)
Below is a high-level visual illustration of the member’s journey through the health plan appeal process. A member can ask for a fair hearing with or without an EMR* after he or she gets their MCO’s health plan appeal decision.

*EMR will be effective 2021, pending the outcome of the IRO contracting process.
Chapter 3 — How does HHSC make sure clients get good care?

Operations

The way MCOs conduct their business operations can have a direct impact on the care members receive.

Operational Reviews

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

Examples of operations reviewed when on-site include:

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

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

Targeted Reviews

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

Financial requirements of the MCOs and DMOs are defined in the contract, including the standards for the financial data they must report to HHSC. MCOs submit financial statistical reports (FSRs) that include information on medical and administrative expenses. MCO contracts include limitations on administrative expenses recognized by the Medicaid program and establish profit-sharing provisions to limit profits. The process of determining the amount of profit sharing with the state is called experience rebates (see A Closer Look, page 68).

FSRs are one source for establishing capitation rates in future years, making the validation of them an important component of contract oversight. HHSC financial analysts validate MCO-reported medical expenses to encounter data on a quarterly basis. Independent auditors review the administrative expenses reported by the MCOs and provide additional data validation by comparing medical expenses to paid claims.

The timeline to complete oversight for MCO financial activity for a given year is 20–24 months after the end of that year. This is because a full audit by the independent auditors can only occur after the final books close and all claims have run out for that given year.

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

As mentioned, unlike FFS, managed care is not a “per service” reimbursement model. MCOs are paid PMPM capitation rates for the delivery of services. These capitation rates are established each year based on actual MCO expenditures on medical services from previous time periods. Reductions in spending on medical services will have the effect of

Financial Compliance Timeline

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<th>YEAR</th>
<th>EVENT</th>
<th>DESCRIPTION</th>
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<tr>
<td>START</td>
<td>FSR</td>
<td>Q1</td>
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<tr>
<td>END</td>
<td></td>
<td>FFSC validates data</td>
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<tr>
<td>START</td>
<td>FSR</td>
<td>Q2</td>
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<tr>
<td>END</td>
<td></td>
<td>12 months for claims to run out</td>
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<tr>
<td>START</td>
<td>FSR</td>
<td>Q3</td>
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<tr>
<td>END</td>
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<td>8–12 months to conduct audits</td>
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<tr>
<td>START</td>
<td>FSR</td>
<td>Q4</td>
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<tr>
<td>END</td>
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<td>Final report</td>
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HHSC remedies compliance issues for that year
Chapter 3 — How does HHSC make sure clients get good care?

reducing future capitation rates. If spending to provide contracted services exceeds their capitation rate payments, MCO profit margins are at risk.

A Closer Look

Administrative Expense and Profit Limits

MCO Administrative Expense Limits
Contract terms define an allowed and disallowed administrative expense. Additionally, HHSC limits administrative expenses that Medicaid will pay in the contract, and this is referred to as the admin cap.
- The cap is compared to MCO’s reported administrative expenses.
- Any amounts over the admin cap also become disallowed expenses, and the MCO’s net income is increased by that amount.

MCO Profit Limits
- MCOs will retain all their net income before taxes that is equal to or less than 3 percent of the total revenues received.
- Net income greater than 3 percent of total revenues will be shared based on a graduated experience rebate method.
- The experience rebate structure is tier-based.

Net Profit and Experience Rebate

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

*Admin cap is set by program.
**Non-compliance Remedies**

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

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<th>Contract Suspension</th>
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<td>Corrective Action Plan (CAP)</td>
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<td>Accelerated Monitoring</td>
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<td>Liquidated Damages (LD)</td>
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<td>Suspension of Default Enrollment</td>
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<td>Contract Termination</td>
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<th>Stage 4</th>
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<td>Contract Termination</td>
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Financial Impacts

The type of remedy issued is contingent upon the type and severity of the non-compliance. Remedies may not be issued sequentially.

**Assessment of Contract Remedies**

CAPs and LDs are the primary remedies HHSC uses to address performance issues or contractual non-compliance. The goal of any contract action is to encourage compliance with contract standards.

**Corrective Action Plans**

HHSC assesses the need for CAPs monthly. Through the CAP process, MCOs are required to provide HHSC with:

1. A detailed explanation of the reasons for the deficiency.
2. An assessment or diagnosis of the cause.
3. Actions taken to resolve the deficiencies.
4. Actions taken to prevent future occurrences.

HHSC reviews, approves and closes the CAP once the MCO demonstrates it has taken appropriate action to address contractual non-compliance. Examples of CAPs include non-compliance with network adequacy standards and issues identified through utilization reviews.
To increase transparency, the issuance of CAPs was added to the HHSC website. This allows the public and other states that are contemplating contracting with an MCO to see its performance history.

**Accelerated Monitoring**

HHSC can implement accelerated monitoring practices on an MCO, which are more frequent or extensive than standard monitoring practices.

Examples of accelerated monitoring practices include additional reporting requirements, escalated CAPs and onsite reviews.

**Liquidated Damages**

LDs are not intended to be a penalty but are meant to assess and recover HHSC’s projected financial loss and damage resulting from MCO non-compliance, including losses due to project delays.

HHSC assesses LDs quarterly. Examples of LDs include non-compliance when submitting encounter data, provider payment timeliness and delivery of appropriate services.

All LD decisions and reconsideration determinations require written approval. LDs less than $1 million are approved by the State Medicaid Director, and LDs greater than $1 million must be approved by the Chief Program and Services Officer.

Starting in 2017, HHSC shifted to a more focused managed care business model that included more standardized processes, refined reporting and enhanced training for staff. Remedies and CAPs have become more robust as oversight has improved and become more stringent. For example, in 2018, HHSC assessed over $13 million in LDs, compared to $5.2 million in 2016. Increased compliance is accomplished through clear and consistent reinforcement of contractual standards. The goal is to have LDs at zero dollars.

**Suspension of Default Enrollment**

Members who do not proactively choose an MCO are automatically assigned one through a process known as default enrollment. Every MCO receives a percentage of their members through default enrollment, and HHSC may suspend default enrollment for a MCO with persistent contractual non-compliance.

The executive commissioner must approve the suspension of default enrollment, and it is effective either for a minimum of 90 days or until HHSC determines the issue is resolved or identifies another appropriate timeline.
Chapter 3 — How does HHSC make sure clients get good care?

The Office of Inspector General

The mission of the Office of Inspector General (OIG) is to ensure the health and safety of Texans through the prevention, detection, audit, inspection and investigation of fraud, waste and abuse. Fraud, waste and abuse impact the provision and delivery of state health and human services in several ways, including:

- Preventing or delaying medically necessary care or social services.
- Providing care that is not medically necessary and potentially harmful to clients.
- Using staff and financial resources from the health care system inefficiently, which contributes to the rising cost of health care.

To address the range of risks to health and human services’ program integrity, the OIG employs several methods to prevent and detect fraud, waste and abuse. Because of its financial impact and the large number of Texans it touches, many of the OIG’s efforts focus on evaluating Texas’ Medicaid program. Investigations, audits, inspections and reviews are several of the tools the OIG uses in its work within the Medicaid program. The OIG uses data research and analytics to identify, monitor and assess trends and patterns of behavior of clients, providers and other vendors (or contractors) participating in Medicaid.

The OIG acts to prevent unqualified and ineligible Medicaid clients, providers and contractors from using its resources inappropriately and takes enforcement actions in cases of fraud, waste and abuse.

Investigations

Provider Field Investigations

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

Benefits Program Integrity

This unit examines clients suspected of abusing HHSC programs—including Medicaid; CHIP; the Supplemental Nutrition Assistance Program; Temporary Assistance for Needy Families; and the Women, Infants and Children program. Findings can include the provision of false information to apply for services or using someone else’s insurance coverage for services.

Audits

The audit division identifies program policy gaps and overpayments, as well as proposes recommendations to prevent fraud, waste and abuse. Staff conduct risk-based performance audits, including audits of HHSC agencies, contractors and providers. Those audits cover a
range of topics, such as the accuracy of medical provider payments; the performance of HHSC contractors; information technology; and the functions, processes and systems within HHSC programs. Examples of previous audits include providers, MCOs and DMOs effectiveness in complying with contract requirements, achieving related contract outcomes, and financial and performance reporting to HHSC.

**Inspections**

Inspections are targeted examinations into specific programmatic areas of HHSC programs, systems or functions that may identify systemic trends of fraud, waste and abuse. Findings from an inspection may result in the OIG’s use of another tool to further review the topic or actions by HHSC to address the OIG’s observations. Topics from past inspections include attendant background checks, power wheelchairs and the program integrity efforts of PBMs.

**Reviews**

Medicaid claims and medical record reviews include utilization reviews of acute care services (e.g., provider office visits, laboratory and x-ray services), hospital services (e.g., surgical specialists), nursing facility services (e.g., rehabilitation, long-term care), and the Medicaid Lock-in program.

**Medicaid Lock-in Program**

The Medicaid Lock-in program operates by “locking in” an individual to one provider and pharmacy to prescribe and dispense certain drugs, like controlled substances (e.g., opioids) to prevent their abuse or overuse. This makes it difficult for clients to visit multiple providers and deceptively attain prescriptions for controlled substances. The OIG analyzes Medicaid claims data to identify clients who reach a pre-defined threshold of prescriptions or provider visits. Treating providers and MCOs also make referrals to the program.

**Provider Enrollment Screening**

The OIG uses preventative measures in the enrollment and re-enrollment of health and human service providers (e.g., medical and dental providers, durable medical equipment suppliers, home health agencies) into Medicaid, CHIP and other HHSC programs. Preventive measures include activities such as completion of required federal and state disclosure activities for high-risk providers.
Chapter 4

What are the financial features of Medicaid and CHIP?
Chapter 4 — What are the financial features of Medicaid and CHIP?

**At-a-Glance**

### Funding

**2018–2019 HHSC Biennial Appropriations**

- **Total Funds**
  - $77.3 billion
  - $65.3 billion (85% of total funds)
  - WAC is 84% of HHSC State GR.
  - Medicaid and CHIP

<table>
<thead>
<tr>
<th>Source</th>
<th>Appropriations</th>
<th>2018-19</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>State General Revenue (GR) Funds</strong></td>
<td>$30.8 billion</td>
<td>$25.9 billion</td>
</tr>
<tr>
<td><strong>Federal and Other Funds</strong></td>
<td>$46.5 billion</td>
<td>$39.4 billion</td>
</tr>
</tbody>
</table>

*Other funds include, but are not limited to, Appropriated Receipts, Interagency Contracts, Medicaid Subrogation Receipts (State Share), and WIC Rates.

### Payments

1. **MCO Capitation Payments**
2. **Reimbursement for Providers**
3. **Supplemental Hospital Funding**

### Growth Trends

**$ Annual Expenditures**

<table>
<thead>
<tr>
<th>Year</th>
<th>Medicaid</th>
<th>CHIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>$27.7 billion</td>
<td>$1.1 billion</td>
</tr>
<tr>
<td>2014</td>
<td>$33.4 billion</td>
<td>$1.1 billion</td>
</tr>
<tr>
<td>2019</td>
<td>$42.6 billion</td>
<td>$928 million</td>
</tr>
</tbody>
</table>

**Annual Caseloads**

<table>
<thead>
<tr>
<th>Year</th>
<th>Medicaid</th>
<th>CHIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>3.3 million</td>
<td>570 thousand</td>
</tr>
<tr>
<td>2014</td>
<td>3.7 million</td>
<td>561 thousand</td>
</tr>
<tr>
<td>2019</td>
<td>3.9 million</td>
<td>408 thousand</td>
</tr>
</tbody>
</table>

Full details for annual expenditures and caseloads can be found on page 145.

### 10-Year Cost Growth Comparison

The number of Texans enrolled in Medicaid managed care has grown by 1.3 million in 10 years. The value of managed care is demonstrated by Texas Medicaid’s cost per person growth trending lower than U.S. national average.

**Managed Care Percent of Caseload**

- Managed Care: 72% to 94%

**Cost per Person**

- **Texas Medicaid**
  - 2% avg. growth per year
  - 2010 to 2019
  - +19%

- **U.S. Health Care**
  - 3.1% avg. growth per year
  - 2010 to 2019
  - +32%

Texas Medicaid cost per person is based on full benefit clients.

*Source: CMS, Office of the Actuary—data is for CY09–CY18*
Budget Development

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

Health and Human Services Commission (HHSC) staff develop the estimates of future Medicaid caseloads and spending that, in turn, form the basis for state appropriations requests. Estimates are based on:

- Projections of the number of people eligible for and applying for the program.
- Estimations of cost trends.
- Analyses of any new federal mandates or state changes affecting eligibility, services or program policy.

Ultimately, decisions about funding are determined by the Texas Legislature.

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

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

Current biennium varied due to public health emergency.

Medicaid Matching Funds

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

Derived from each state’s average per capita income, the Centers for Medicare and Medicaid Services (CMS) updates the rate annually. Consequently, the percentage of total Medicaid spending that is paid with federal funds also changes annually. As the state’s per capita income increases in relation to the national per capita income, the FMAP rate decreases. For federal fiscal year (FFY) 2021, Texas’ Medicaid FMAP is 64.91 percent.

Texas uses a one-month differential FMAP figure that considers differences between the FFY, which runs October through September, and the state fiscal year (SFY), which runs September through August. The one-month differential FMAP for Texas in SFY 2021 is 65.35 percent—which includes one month of the FFY 2020 rate of 65.54 percent and 11 months of the FFY 2021 rate of 64.91 percent.

**CHIP Matching Funds**

Unlike Medicaid, Children’s Health Insurance Program (CHIP) is a federal block program rather than an entitlement program. Total federal funds allotted to CHIP each year are capped, as are the funds allotted to each state. Each state is allotted a portion of the total federal funds based on a formula set in federal statute, and each state receives federal matching payments up to the allotment. The FFY 2019 allocation was fully expended, and the 2020 allocation is estimated to be fully expended in 2021. The federal allocation for Texas in FFY 2019 was $1.5 billion.

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

The Affordable Care Act (ACA) temporarily increased the EFMAP for FFYs 2016 through 2019. Following the end of this increase, the EFMAP rate was decreased by 23 percentage points. The EFMAP for Texas in FFY 2021 is 75.44 percent and in SFY 2021 is 75.75 percent.
Deferrals and Disallowances

Deferrals and disallowances impact the availability of federal financial participation:

- **Deferral**: If CMS determines that Texas may be out of compliance with federal regulations or its Medicaid state plan, then CMS may withhold funds until compliance is proven or until the state provides additional information to support the validity of the claim.

- **Disallowance**: If CMS alleges a claim is not allowable, then it can recoup federal funds.

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

A deferral or disallowance may be imposed for the federal fiscal quarters for which CMS asserts the state is out of compliance with CMS regulations or its Medicaid state plan. In the case of a disallowance, CMS may retroactively encompass several years of claims.

States have the option to appeal the CMS determination with the U.S. Department of Health and Human Services’ Departmental Appeals Board. The Departmental Appeals Board will make a ruling based on the written records provided by both parties or can hold a hearing prior to making a ruling.
Chapter 4 — What are the financial features of Medicaid and CHIP?

Mandatory and Optional Spending
Texas Medicaid is federally required to provide certain acute care services and long-term services and supports (LTSS)—including inpatient and outpatient care, physician services, family planning services and supplies, extended services for pregnant women, and nursing facility services for clients age 21 and older (see Appendix B, page 130).

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

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

In addition, some of the optional services covered by Texas Medicaid were originally paid with 100 percent state or local funds. By adding coverage for those services through Medicaid, part of the cost is now covered with federal matching dollars.

For example, services for individuals with intellectual or developmental disabilities (IDD), that are provided by state supported living centers and community-based residential settings, now receive federal Medicaid matching dollars in addition to state funds.

Rate Setting

Managed Care Organization Rates
Since most Medicaid clients are enrolled in managed care, managed care organization (MCO) capitation rates are the primary way that the state pays for services. These rates act as the state’s payments to MCOs for contractually required services. MCOs then negotiate rates for services with providers and pay them to administer services to members. Payment rates to MCOs are developed using actuarially sound practices and principles. Payments are based on a “per member per month” (PMPM) rate for each risk group within each service delivery area, and the MCOs membership enrollment. PMPM rates differ
across risk groups and service delivery areas, and differ by MCO based on the acuity of the MCOs’ membership.

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

From this, the base cost data are totaled, and trends are calculated for the prospective time period during which the rates will apply. The cost data are also adjusted for MCO expenses, such as re-insurance, capitated contract payments and changes in plan benefits. A reasonable provision for administrative expenses, taxes and risk margin is also added to the claims component in order to project the total cost for the rating period. A risk margin is included to recognize financial risk.

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

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

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

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

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

In addition to the above, HHSC includes provision for three directed payment programs in the STAR, STAR+PLUS, and Dual Demonstration programs’ capitation rates: Network Access Improvement Program (NAIP), the Uniform Hospital Rate Increase Program (UHRIP), and Quality Incentive Payment Program (QIPP).

NAIP is a directed payment program in STAR and STAR+PLUS designed to increase the availability and effectiveness of primary care for members by incentivizing various institutions to provide high quality, well-coordinated and continuous care.

UHRIP is a supplemental payment program for hospitals (see page 89). QIPP is a quality-based payment program for nursing facilities (see Nursing Facility Quality Incentive Payment Program, page 92).

**Children’s Medicaid Dental Services Rates**

Children’s Medicaid Dental Services (CMDS) capitation rates are based on claims from the covered population in the base period. The base cost is totaled, and it trend to the time period for which the applicable rates are calculated. A reasonable provision for administrative expenses, taxes and risk margin is added to the claims component to project the total cost for the rating period. These projected total costs are used to set statewide rates that vary by age group.

**CHIP Rates**

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

From this, the base cost data are totaled, and trends are calculated for the prospective time period during which the rates will apply. The cost data are also adjusted for MCO expenses, such as re-insurance, capitated contract payments and changes in plan benefits. A reasonable provision for administrative expenses, taxes and risk margin is also added to the claims component to project the total cost for the rating period. A risk margin is included to recognize financial risk.

The removal of newborn delivery expenses from the total cost rate results in an adjusted capitation rate for each service area. A separate lump-sum payment, called the delivery supplemental payment, is computed for expenses related to each newborn delivery. While the delivery supplemental payment can vary by service area for the STAR MCOs, all CHIP MCOs receive the same lump-sum payment of $3,100 for each birth.
The resulting underlying base rates vary by service area and age group. A final adjustment is made to reflect the health status, or acuity, of the population enrolled in each MCO. The purpose of the acuity risk adjustment is to recognize the anticipated cost differential among multiple MCOs in a service area due to the variable health status of their respective memberships. The final capitated premium paid to the MCOs is based on this acuity risk-adjusted premium and covers all non-maternity medical services.

CHIP dental benefits are reimbursed through a separate set of capitation rates, and dental maintenance organizations (DMOs) manage this benefit. The rate-setting process for these services is similar to the CMDS program.

**CHIP Perinatal Rates**

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

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

**CHIP Cost-sharing**

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

CHIP cost-sharing rates are published online annually (HHS.Texas.gov/Services/Health/Medicaid-CHIP/Programs-Services/Children-Families/Childrens-Medicaid-CHIP).
In recent years, prescription drugs have become increasingly associated with rising costs. For Medicaid and CHIP, MCOs administer most of the prescription drug benefit. A small portion of the benefit is administered by HHSC on a FFS basis.

In managed care, pharmacies are paid through Pharmacy Benefit Managers (PBMs) contracted with MCOs (see Chapter 3, page 57). PBMs negotiate ingredient costs and dispensing fees with pharmacies. MCO pharmacy capitation rates are developed to cover pharmacy claims and administrative costs and to include a risk margin. As part of the capitation rate, MCOs must pay the state premium tax through which HHSC receives federal matching dollars.

In FFS, pharmacies are paid directly. Rates for prescription drugs include fees to cover the cost of ingredients—which are determined using the National Average Drug Acquisition Cost (NADAC) or the wholesale acquisition cost, and a dispensing fee.

The primary drivers of cost are rising drug prices and client utilization. HHSC offsets some of these costs through the state premium tax in managed care and through federal and state rebate programs. HHSC also regulates how MCOs administer the prescription drug benefit to manage costs and limit over-utilization (see Chapter 3, page 56).

*The ACA Health Insurance Providers Fee will be repealed as of January 1, 2021.
**Certain drugs are not included in the capitation rate and are paid on a cost-settlement basis with the MCO.
Fee-for-Service Rates

Even though most Medicaid clients are under managed care, 6 percent of clients continue to get services paid through FFS. HHSC is responsible for establishing FFS reimbursement methodologies. Changes may be authorized by rule or approval from CMS. FFS rates are paid directly to providers, physicians, other medical practitioners, pharmacists and hospitals.

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

Rates for services delivered by physicians and other practitioners are uniform statewide and are either access-based fees (ABFs) or resource-based fees (RBFs) (see Glossary, page 150 and page 189, respectively).

HHSC also establishes reimbursement rates for services such as laboratory services, x-ray services, radiation therapy services, physical and occupational therapy services, dental services, and maternity clinic services. Reimbursement rates for most services are evaluated biennially.

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

Fee-for-Service Pharmacy Rates

The Vendor Drug Program (VDP) administers prescription drugs under the FFS model. Rates for prescription drugs include fees to cover the cost of ingredients, which are determined using the NADAC or the wholesale acquisition cost. After the ingredient cost is calculated, the dispensing fee is calculated and added to the total reimbursement amount. Costs will differ based on the type of pharmacy.

Pharmacies that provide free delivery services to FFS clients may be eligible for a delivery incentive per prescription. Another incentive may be added if the pharmacy dispenses a premium preferred generic. Reimbursements are reduced to a pharmacy’s reported “Usual and Customary” or “Gross Amount Due” price, if either is less than the total reimbursement.
Fee-for-Service Rates for Inpatient and Outpatient Hospital Care

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

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

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

HHSC has developed several supplemental payment programs to address the difference between rate and facility costs (see Supplemental Hospital Funding, page 87).

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

Nursing Facilities

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

Rates are calculated based on costs submitted by providers on applicable Medicaid cost reports collected by HHSC. The rates are limited by appropriation level. Costs are categorized into five rate components:

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

Each rate component is calculated separately, based on HHSC formulas. Direct care and other resident care components vary according to residents’ acuity. The total rate for each level of service is calculated by adding together the appropriate rate components.

Nursing facility cost reports are subjected to either a desk review or on-site audit to determine whether reported costs are allowable. MCOs are currently required to reimburse nursing facilities, at a minimum, the same daily payment rate—including any enhancements—as would have been paid under FFS.

Intermediate Care Facilities for Individuals With an Intellectual Disability or Related Condition

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

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

ICF/IID cost reports are subjected to a desk review or on-site audit to determine whether reported costs are allowable. ICF/IID rates are recalculated biennially.
Chapter 4 — What are the financial features of Medicaid and CHIP?

**Federally Qualified Health Centers and Rural Health Clinics**

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

A rural health clinic (RHC) is a clinic located in a rural area, designated by the U.S. Health Resources and Services Administration as a shortage area. Medicare has a number of requirements in order for a clinic to qualify as an RHC, including that it must be located in a non-urbanized area that is medically underserved, as defined by the U.S. Census Bureau (see Glossary, page 190).

To participate in the Texas Medicaid program, FQHCs and RHCs must:

- Comply with all federal, state, and local laws and regulations applicable to the services provided.
- Sign a written provider agreement with HHSC, and then comply with the terms of the agreement and all requirements of the Texas Medicaid program.
- Bill for covered services in the manner and format prescribed by HHSC.

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

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

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

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

Historically, rates paid to hospitals for services have been below the average costs facilities incur to provide Medicaid covered services. In addition, the expansion of managed care has greatly impacted the way hospitals are funded in Texas.

To comply with federal regulations and to preserve federal hospital funding while expanding managed care, HHSC submitted a five-year Section 1115 Transformation Waiver known as the 1115 Healthcare Transformation Waiver. CMS has approved extensions of the waiver through September 2022 (see Chapter 5, page 98).

Through various funding programs, including those under the 1115 Healthcare Transformation Waiver, HHSC administers supplemental hospital funding to help cover the cost of uncompensated care, incentivize improvements to service delivery, and fund graduate medical education. These programs also include some quality-based payment programs (see Quality-based Payment Programs, page 90).

Disproportionate Share Hospital Funding

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

**DSH Funds as a Percentage of the Total Medicaid Budget, FFYs 2001–2020**

*2009 includes $23.5 million in American Recovery and Reinvestment Act (ARRA) federal stimulus funds.
**2010 includes $47.6 million in ARRA federal stimulus funds.*
There are no federal or state restrictions on how disproportionate share hospitals can use their funds. Hospitals may use DSH payments to cover the uncompensated costs of care for low-income patients, including Medicaid patients. DSH payments have proven an important source of revenue by helping hospitals expand health care services to the uninsured, defraying the cost of treating low-income patients, and recruiting physicians and other healthcare professionals.

To qualify for DSH funds, hospitals must meet one of the following criteria:

- A disproportionate total number of inpatient days are attributed to Medicaid patients.
- A disproportionate percentage of all inpatient days are attributed to Medicaid patients.
- A disproportionate percentage of all inpatient days are attributed to low-income patients.

All children’s hospitals in Texas are deemed disproportionate share hospitals, provided they meet federal and state qualification criteria.

As in other matching Medicaid programs, the federal government and non-federal sources each pay a share of total DSH program costs. Under the ACA, federal DSH allocations were set to decrease in size—in anticipation of the reduction of the uninsured population.

The Coronavirus Aid, Relief and Economic Security Act (CARES Act) delayed the FFY $4.0 billion DSH allotment reduction until December 1, 2020. Currently, the statutory reductions in the federal share of DSH payments for all states from FFY 2020 through FFY 2025 are:

<table>
<thead>
<tr>
<th>FFY</th>
<th>2020</th>
<th>2021</th>
<th>2022</th>
<th>2023</th>
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<tr>
<td>Reduction for all states</td>
<td>$4.0 billion</td>
<td>$8.0 billion</td>
<td>$8.0 billion</td>
<td>$8.0 billion</td>
<td>$8.0 billion</td>
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DSH Payment Information reports are published annually online at: RAD.HHS.Texas.gov/Hospitals-Clinic/Hospital-Services/Disproportionate-Share-Hospitals.

**Uncompensated Care Funding**

Created under the 1115 Healthcare Transformation Waiver, the Uncompensated Care (UC) Pool includes $38.5 billion in allocated funds over the period of the waiver. To receive UC payments, providers must participate in one of the 20 Regional Healthcare Partnerships (RHPs) (see Appendix C, page 140).
UC payments are cost-based and help offset the costs of uncompensated care provided by hospitals and other providers. Though previously defined as unreimbursed costs for Medicaid and uninsured patients incurred by hospitals, uncompensated care costs are currently defined as unreimbursed charity care costs. UC payments will be based on each provider’s UC costs, as reported on a UC application.

**Uniform Hospital Rate Increase Program**

The UHRIP program is a directed payment program designed to reduce hospitals’ uncompensated care costs—through enhanced payments to hospitals for medically necessary, covered services provided to Medicaid managed care members. UHRIP is voluntary and cannot be implemented in a service delivery area (SDA)—unless all MCOs within that SDA, and the hospitals they contract with, commit to participate. Hospital rate increases vary by hospital class, and in general, both inpatient and outpatient services are included for all hospitals to calculate enhanced rates.

**Delivery System Reform Incentive Payment Program**

The Delivery System Reform Incentive Payment (DSRIP) program was also created by the 1115 Healthcare Transformation Waiver and had $11.4 billion in allocated funds for the first five years of the waiver. The DSRIP program was renewed for five more years (through FFY 2021) with an additional $14.7 billion in funding.

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

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

The waiver’s special terms and conditions require HHSC to develop a DSRIP transition plan to describe how the state will further advance its delivery system reform when DSRIP funding ends in September 2022. HHSC submitted a draft transition plan to CMS in September 2019. The plan outlines the research, data analyses and partner engagement HHSC will complete to develop new programs, policies and Medicaid strategies. HHSC is analyzing populations served by DSRIP and interventions associated with improvements in key health outcomes to continue healthcare transformation and to advance alternative payment models (APMs) in Texas. Ongoing updates to DSRIP transition planning are on the HHSC website at [HHS.Texas.gov/Laws-Regulations/Policies-Rules/Waivers/Waiver-Renewal](http://HHS.Texas.gov/Laws-Regulations/Policies-Rules/Waivers/Waiver-Renewal).
Graduate Medical Education

Hospitals that operate medical residency training programs incur higher expenses than hospitals without training programs. Historically, the Medicaid share of these additional costs have been covered by graduate medical education (GME) payments to state-owned teaching hospitals. GME payments cover the costs of program administrative staff, allocated facility overhead, and salaries and fringe benefits for residents and teaching physicians.

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

Quality-based Payment Programs

Pay-for-Quality and Managed Care Payment Reform

To reward the use of evidence-based practices and promote health care coordination and efficacy among MCOs, HHSC implements medical pay-for-quality (P4Q) programs for STAR, STAR+PLUS, STAR Kids, CHIP and a dental P4Q program.

The medical P4Q program evaluates MCOs on a set of quality measures—with a focus on prevention and chronic disease management, including behavioral, maternal and infant health. Plans can earn or lose money based on their level of improvement or decline from the prior year and their performance relative to set benchmarks. For the medical P4Q program, three percent of MCOs’ capitation is at-risk. In the dental P4Q program, 1.5 percent of DMOs’ capitation is at-risk.

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

To further accelerate this effort, HHSC also has implemented contractual requirements to advance the use of APMs between MCOs and providers.
APMs are health care payment models that link a percentage of the provider’s overall payment to a measure of either quality or quality and cost. MCOs and DMOs must have a certain percentage of their overall provider payments associated with an APM. For a certain percentage of these payments, the provider must have some degree of risk. MCOs and DMOs are subject to contract remedies, potentially including liquidated damages, if these thresholds are not achieved.

<table>
<thead>
<tr>
<th>MCO and DMO APM Payment and Risk Thresholds for Calendar Years 2018 and 2021</th>
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<tbody>
<tr>
<td>2018 Payment Threshold</td>
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<tr>
<td>------------------------</td>
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<tr>
<td>MCOs</td>
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<td>DMOs</td>
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If an MCO does not achieve the target APM percentages, but performs better than the state average on potentially preventable emergency department visits (PPVs) and potentially preventable admissions (PPAs) by 10 percent, then penalties are waived. Additionally, MCOs have requirements to:

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

**Hospital Quality-based Payment Program**

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

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

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

If hospitals fail to meet certain PPC or PPR thresholds, then adjustments in the form of reductions are made to FFS hospital inpatient claim payments. Similar adjustments are made for each MCO’s encounter data that affects MCO capitation rates.

**Nursing Facility Quality Incentive Payment Program**

QIPP, a directed payment program, seeks to improve quality and innovation in nursing facility services. Both public and private nursing facilities can participate in the program, and over 880 of the state’s 1,200 nursing facilities are enrolled for SFY 2021.

As a directed payment program, local governmental entity funds are used to match federal Medicaid funds. The program’s budget has increased from approximately $400 million in SFY 2018, the first year of the program, to $1.1 billion in SFY 2021. Funds are built into the MCO capitation payments and are then paid out to eligible providers.

Payments are made monthly and quarterly by the STAR+PLUS MCOs to the nursing facilities, based on their completion of required quality improvement activities and their performance on CMS-approved quality measures. For SFY 2018 and SFY 2019, the measures indicated whether a nursing facility reduced the following: use of restraints, inappropriate use of antipsychotic medication, development of pressure ulcers, and occurrence of falls with major injury.

HHSC adopted new quality measures, eligibility requirements and financing components for QIPP in SFYs 2020 through 2021. QIPP quality components during this biennium include workforce development; an infection control program; and long-stay quality measures focused on pressure ulcers, antipsychotic medication and independent mobility. HHSC will review the proposed revisions to quality measures during workgroups, which will include internal and external stakeholders for SFY 2022.
Fund Recovery

The Office of Inspector General (OIG) performs the functions listed below (see page 71 for more about the OIG).

Third-party Liability

Under federal law, Medicaid and CHIP are the payer of last resort. This means other sources of health insurance that a client may have—such as commercial health insurance or medical coverage under car insurance—may be responsible to pay for Medicaid and CHIP clients. This requirement, called third-party liability (TPL), ensures the responsible party other than Medicaid or CHIP pays for care.

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

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

- Cost avoidance occurs when the state is aware that a client has potential third-party coverage when a claim is filed. The state rejects the claim and instructs the provider to submit it to the potential primary payer. After the potential primary payer has processed the claim, the provider may resubmit a claim for any portion of the claim not covered by the primary payer.
- Cost recovery, also known as “pay and chase,” occurs when the state seeks reimbursement from third parties for which third parties are liable for payment of the claims.

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

Texas implements the Medicaid Estate Recovery Program (MERP) in compliance with federal Medicaid laws. Under MERP, the state may recover the cost of Medicaid services provided by filing claims against the estate of certain, deceased Medicaid clients—who were age 55 and older and had received LTSS benefits on or after March 1, 2005. Claims may include certain Medicaid long-term care services and related costs of hospital and prescription drug services for clients in nursing facilities, ICFs/IID, Community Attendant Services or waiver programs.

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

The claims filing component of the MERP program has been contracted to a private company through a competitive procurement process.
Chapter 5

What is the governing framework for Medicaid and CHIP?
Chapter 5 — What is the governing framework for Medicaid and CHIP?

At-a-Glance

Medicaid and the Children’s Health Insurance Program (CHIP) change in response to federal and state requirements.

<table>
<thead>
<tr>
<th>Key Federal Concepts</th>
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<tr>
<td><strong>Fundamental Requirements:</strong></td>
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<tr>
<td><strong>Centers for Medicare &amp; Medicaid Services (CMS):</strong></td>
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<td><strong>Single State Agency:</strong></td>
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<td><strong>Medicaid State Plan:</strong></td>
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<td><strong>Waivers:</strong></td>
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Requirements Directed by the Texas Legislature

**Requirements Established by the SSA**

Medicaid operates according to the following fundamental requirements:

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

2. **Sufficient Coverage**
   States must cover each service in amount, duration and scope that is “reasonably sufficient.”

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

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

See Appendix A, page 103, for a list of highlights from the Texas Legislature and relevant federal changes.
How Texas Administers Medicaid and CHIP

Texas submits a state plan for both Medicaid and Children’s Health Insurance Program (CHIP) that serves as the contract between the state and Centers for Medicare and Medicaid Services (CMS). These state plans describe the nature and scope of the Medicaid and CHIP programs—including administration, client eligibility, benefits and provider reimbursement.

The state plans give the Health and Human Services Commission (HHSC), as the single state agency, the authority to administer the Medicaid and CHIP programs in Texas. HHSC’s responsibilities include:

• Serving as the primary point of contact with the federal government. HHSC coordinates initiatives to maximize federal funding and administers the Medical Care Advisory Committee, a committee mandated by federal Medicaid law that reviews and makes recommendations on proposed Medicaid rules.
• Establishing policy direction for the Medicaid and CHIP programs, administering the state plans, and coordinating with other HHSC departments and state agencies to carry out operations.
• Determining program eligibility for Medicaid and CHIP.
• Establishing Medicaid policies, rules, reimbursement rates and oversight of Medicaid program operations, including managed care organization (MCO) contract compliance.

Medicaid Waivers

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

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

States must provide regular reports and evaluations showing cost-effectiveness, cost neutrality or budget neutrality (based on the type of waiver), and that requirements for the waiver are being met.
Chapter 5 — What is the governing framework for Medicaid and CHIP?

**Research and Demonstration 1115 Waivers**

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

**The Texas Healthcare Transformation and Quality Improvement Program**

The Texas Healthcare Transformation and Quality Improvement Program, also known as the 1115 Healthcare Transformation Waiver, allows Texas to expand managed care—including pharmacy and dental services—while preserving federal hospital funding. STAR, STAR+PLUS, STAR+PLUS Home and Community-based Services (STAR+PLUS HCBS), STAR Kids and dental managed care services are covered under this waiver. CMS has approved extensions of the waiver through September 2022.

The waiver contains several funding pools, including Uncompensated Care (UC) and Delivery System Reform Incentive Payment (DSRIP). Three managed care directed payment programs also operate under the waiver: Network Access Improvement Program (NAIP), Uniform Hospital Rate Increase Program (UHRIP), and Quality Incentive Payment Program (QIPP) (see Chapter 4, page 80).

**Healthy Texas Women**

In January 2020, CMS approved an 1115 Demonstration Waiver for the Healthy Texas Women (HTW) program. HHSC began receiving federal funds for HTW in February 2020, and the waiver is approved through December 2024. The demonstration waiver allows HTW to receive federal matching funds and requires HTW to comply with certain Medicaid requirements—including eligibility application, verification and demonstration regulations.

The goals and objectives of the HTW Demonstration Waiver are to:

- Increase access to women’s health and family planning services, in order to avert unintended pregnancies and positively impact the outcome of future pregnancies, as well as the health and well-being of women and their families.
- Increase access to preventive health care, in order to positively impact maternal health and reduce maternal mortality.
- Increase access to women’s breast and cervical cancer services, in order to promote early cancer detection.
- Implement the state policy to favor childbirth and family planning services that do not include elective abortions or the promotion of elective abortions.
- Reduce the overall cost of publicly funded health care by providing low-income Texans with access to safe, effective services consistent with these above goals.
Chapter 5 — What is the governing framework for Medicaid and CHIP?

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

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

For example, the selective contracting authority granted under 1915(b)(4) waivers is used for programs and services such as Community First Choice (CFC) Medicaid state plan services. This allows the state to limit the provider base for CFC clients to their waiver providers. However, since many waivers are still under a fee-for-service (FFS) delivery system, clients are not required to move into managed care to receive CFC.

Texas also uses 1915(b) waivers for the Medical Transportation Program (MTP). Texas currently delivers MTP services through both FFS and managed care under the authority of a 1915(b)(4) and a 1915(b)(1) waiver, respectively. As part of carving MTP into managed care, beginning June 2021, Texas will use 1915(b)(4) for FFS and an 1115 waiver for managed care.

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

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

States may use these waivers to serve people age 65 and older and those with physical disabilities; an intellectual or other developmental disability; mental illness; or more specialized populations, such as individuals with traumatic brain injuries or sensory impairment.

Texas 1915(c) waivers include the Medically Dependent Children Program (MDCP); Home and Community-based Services (HCS); Texas Home Living (TxHmL); Community Living Assistance and Support Services (CLASS); Deaf Blind with Multiple Disabilities (DBMD); and Youth Empowerment Services (YES) (see Chapter 2, page 27).
Chapter 5 — What is the governing framework for Medicaid and CHIP?

Fundamental Requirements

Statewide Availability
Also referred to as “statewideness,” this principle in federal law requires state Medicaid programs to offer the same benefits to everyone throughout the state. Exceptions to this requirement are possible through Medicaid waiver programs and special contracting options. Since the move toward managed care in Texas, statewide availability is primarily assured through federal and state regulations that establish minimum provider network standards and by state oversight of MCO compliance with these regulations. Texas has implemented access standards, including time and distance standards and appointment availability standards (see Chapter 3, page 50).

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

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

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

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

**Coverage for Children**

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program—known in Texas as Texas Health Steps—provides preventive health and comprehensive care services for children and youth age 20 and younger who are enrolled in Medicaid (see Chapter 2, page 30). Federal changes have expanded the benefits of this program, such that children and youth age 20 and younger are eligible for any medically necessary and appropriate health care service covered by Medicaid, regardless of the limitations of the state’s Medicaid program.

**Children’s Health Care Case Law**

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

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

- *Frew v. Young*, a class action lawsuit filed against Texas in 1993, alleged that the state neither adequately informed parents and guardians about nor provided EPSDT services. In 1995, the state negotiated a consent decree that imposed certain requirements on the state. In 2007, the state negotiated a set of corrective action orders with the plaintiffs to implement the consent decree and increase access to EPSDT services. Since 2007, Texas HHSC and Department of State Health Services (DSHS) have actively worked to meet the requirements of the corrective action orders. As a result, some portions of the consent decree and corrective action orders have since been dismissed.

**Freedom of Choice**

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

To maintain freedom of choice under managed care, each service delivery area in the state has at least two health plans or MCOs from which clients can choose, once they are found eligible. The exception for this is STAR Health, which is administered statewide by a single MCO. Once clients select their health plan, they also choose a PCP from the MCO’s provider network.