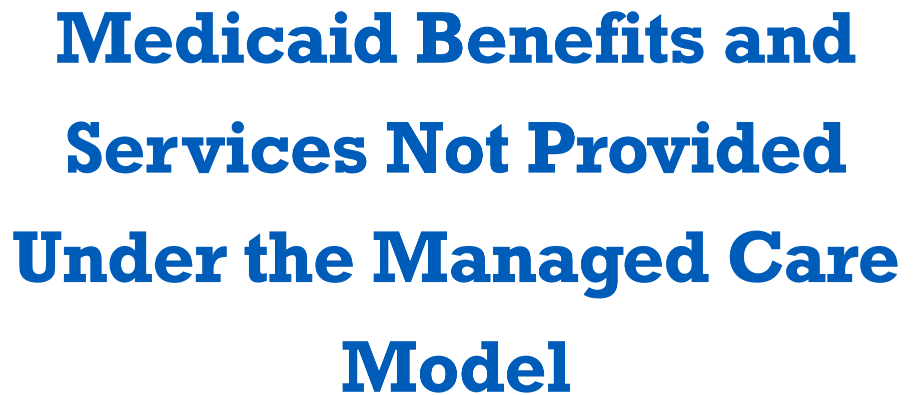

Medicaid Benefits and Services Not Provided Under the Managed Care Model

As Required by
House Bill 2658, Section 11, 87th Legislature, Regular Session, 2021

Texas Health and Human Services
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TEXAS
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Executive Summary

The Health and Human Services Commission (HHSC) submits the *Medicaid Benefits and Services Not Provided Under the Managed Care Model* report in compliance with House Bill (H.B.) 2658, Section 11, 87th Legislature, Regular Session, 2021. H.B. 2658, Section 11 requires HHSC to identify Texas Medicaid benefits and services that are not provided under the managed care model. Section 11 also requires HHSC to evaluate the feasibility, cost-effectiveness, and impact on Medicaid recipients of providing the identified benefits and services through the managed care model and to make recommendations as to whether HHSC should provide any of the identified benefits or services under the managed care model. This report satisfies the requirement in the bill to report on the evaluation by December 1, 2022 and make recommendations as to whether HHSC should implement providing any of the identified benefits or services under the managed care model.

HHSC identified 16 benefits and services not provided under the managed care model. When considering providing the identified benefits and services through the managed care model, HHSC first evaluated the feasibility and impact to clients. For services where HHSC determined it was not feasible or that clients would be negatively impacted, cost-effectiveness was not considered. If HHSC determined that a benefit or service could feasibly be provided under managed care without negatively impacting clients, other considerations and cost-effectiveness were also analyzed. HHSC reviewed the administrative costs of providing the services under a capitated model and other factors to identify an eight percent savings to medical benefits costs as the threshold for cost-effectiveness to the state.

Based on this analysis, HHSC does not recommend providing any of the identified benefits or services under the managed care model.

1. Background

HHSC currently operates five Medicaid managed care programs: STAR, STAR+PLUS, STAR Kids, STAR Health, and the Dual Demonstration. The Centers for Medicare and Medicaid Services (CMS) is requiring states to phase out financial alignment initiatives, like Texas' Dual Demonstration program, no later than calendar year 2025; therefore, this report does not consider providing additional benefits or services under the Dual Demonstration.

In fiscal year 2021, 96 percent of Medicaid-eligible individuals in Texas were enrolled in, and could receive at least some services through, managed care. For those enrolled in managed care, most Medicaid services are provided through that delivery model. The services that are not delivered through managed care, either for some or all populations, are analyzed in this report. This report does not address the few populations that are not enrolled in managed care.

The managed care contracts identify non-capitated services, which are services a managed care organization (MCO) is not responsible for paying for out of the capitation rate received to pay for a member's services. The contracts were used to identify the benefits and services not provided under the managed care model. HHSC also identified a few additional services not explicitly identified in the contracts.[1] The identified benefits and services are as follows:

- Medicaid services not covered under Medicare for dually-eligible clients, including mental health Targeted Case Management and mental health rehabilitative services
- 1915(c) waiver services for individuals with intellectual disability (Community Living Assistance and Support Services, Deaf Blind with Multiple Disabilities, Texas Home Living, and Home and Community-based Services)
- Intermediate Care Facility for Individuals with Intellectual Disability (ICF-IID) services
- Texas Health Steps Environmental Lead Investigations
- Tuberculosis (TB) services provided by Department of State Health Services (DSHS) approved providers

[1] HHSC considers the Program of All-Inclusive Care for the Elderly (PACE) to be a capitated alternative to STAR+PLUS and excluded it from any further analysis.

- Newborn screening
- Early Childhood Intervention (ECI) case management/service coordination and specialized skills training (SST)
- Texas School Health and Related Services (SHARS)
- Blind Children's Vocational Discovery and Development Program
- Hospice services
- Texas Health Steps personal care services (PCS) for STAR members birth through age 20
- Community First Choice (CFC) services for STAR members
- Pre-Admission Screening and Resident Review (PASRR) screenings, evaluations, and specialized services for STAR+PLUS Members
- Youth Empowerment Services (YES) waiver services
- Home and Community-based Services-Adult Mental Health (HCBS-AMH) state plan benefit
- Nursing facility services for STAR Kids members

2. Feasibility, Cost-Effectiveness, and Impact

When considering providing the identified benefits and services through the managed care model, HHSC first evaluated the feasibility and impact to clients. For services where HHSC determined it was not feasible or that clients would be negatively impacted, cost-effectiveness was not considered. If HHSC determined that a benefit or service could feasibly be provided under managed care without negatively impacting clients, other considerations and cost-effectiveness were also analyzed. Some similar benefits or services were grouped and discussed together.

To be deemed “cost-effective,” HHSC determined that savings from providing a benefit or service under managed care would need to be sufficient to offset the costs of capitation, which are the costs that must be included in a managed care premium in addition to the costs of providing the medical service. CMS requires that Medicaid managed care rates be developed according to actuarially sound practices and principles. Actuarially sound capitation rates must be projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract for the time period and population covered under the terms of the contract. Adding benefits or services to managed care requires HHSC to include amounts in the premium for the appropriate and reasonable provision of medical services associated with the newly carved-in benefit or service as well as amounts for variable administrative costs, premium tax, and risk margin.[2] Because each of these components of the premium is a percentage of total premium including medical costs (see Table 1 for percentages of non-medical costs by component and program), as medical costs increase from the addition of new benefits or services, the amounts for these components also increase. The increase in premium tax results in a revenue increase to the state (collected by the state comptroller) that offsets a portion of the other increases when considering the fiscal impact to the state overall; however, these would not be a savings reflected in HHSC’s

[2] The administrative allowance in managed care premiums is split between a fixed and a variable component to allocate a larger percentage of administrative dollars to higher cost groups. Only the variable administrative costs change when a new benefit or service is included in managed care. All insurers and health maintenance organizations licensed by the Texas Department of Insurance are required to pay an insurance premium tax to the state and Medicaid managed care premiums include an allowance to cover the cost of the tax. The risk margin is the component of the managed care premium that provides compensation for the risks assumed by the MCO. These risks may include insurance, investment, inflation, and regulatory risks, as well as risks associated with social, economic, and legal environments.

expenditures because the collection of additional revenue by the state at large does not affect the cost to HHSC.

Table 1. Non-Benefit Variable Costs included in Fiscal Year 2023 Managed Care Premiums by Program

Program	Administrative	Premium Tax	Risk Margin
STAR	5.25 percent	1.75 percent	1.5 percent
STAR+PLUS	5.25 percent	1.75 percent	1.75 percent
STAR Kids	5.25 percent	1.75 percent	1.75 percent
STAR Health	5.25 percent	1.75 percent	1.5 percent

In general, due to these additional costs of capitation, a new carve-in to managed care must achieve efficiencies to be considered cost-neutral or cost-effective. Given the methodology for including amounts in premiums, HHSC estimates at least nine percent in medical benefit savings would be necessary for a carve-in to be cost-effective for HHSC. The premium tax revenue offset is the amount of new federal funds drawn to cover the cost of the premium tax (1.75 percent multiplied by the federal medical assistance percentage or FMAP[3]), which would be approximately 1 percent. Therefore, the medical benefit savings can be reduced from nine to eight percent to be cost-effective for the state and eight percent was the threshold used for determining cost-effectiveness for this report.

This analysis of capitation costs only considers the cost-effectiveness of adding benefits and services to managed care for clients already enrolled in managed care. Additional capitation costs would need to be considered when managed care is expanded to new populations.

HHSC did not consider feasibility, cost-effectiveness, or impact for the following benefits and services identified as not currently provided through managed care for this report:

- Medicaid services not covered under Medicare for dually-eligible clients, including mental health Targeted Case Management and mental health rehabilitative services, were addressed through the report Dually Eligible Individuals Enrolled in Medicaid Managed Care and its Supplemental Legislative Report required by H.B. 2658, Section 12 (Eighty-seventh Legislature, Regular Session, 2021).

[3] FMAP determines the federal and non-federal share of most Medicaid client services expenditures. It varies by state and is based on a federal statutory formula using a state's per capita personal income relative to national per capita personal income.

- 1915(c) waiver services for Individuals with Intellectual and Developmental Disabilities (IDD) and ICF-IID services were not considered because the timeline for carving these services into managed care is established in Government Code §534.202, Determination to Transition ICF-IID Program Recipients and Certain Other Medicaid Waiver Program Recipients to Managed Care Program. The definition of ICF-IID services applicable to §534.202 does not include State Supported Living Centers (SSLCs); however, clients residing in SSLCs are not enrolled in managed care and this report is limited to addressing carve-in of benefits and services, not populations.

Environmental Lead Investigations, TB Services, and Newborn Screening

Environmental lead investigations, TB services, and newborn screening are public health functions performed by DSHS or providers contracted with DSHS. The services are not provided solely to clients enrolled in Medicaid.

- Environmental lead investigations are covered under Texas Health Steps when a child has an elevated blood lead level and the investigation is recommended by a child's provider. This service includes a one-time investigation to determine the source of lead at the child's home or primary residence.
- TB services are clinic services provided by specially qualified providers. TB services include directly observed therapy, which includes delivery of prescribed anti-TB medication, and nursing assessment.
- Newborn screening identifies infants that may have a specific disorder or medical condition through laboratory bloodspot testing for more than 50 disorders and point-of-care screenings for two additional conditions and provides follow-up, case management, and outreach for infants with out-of-range test results.

While it may be feasible to carve the services into managed care, there would be an additional administrative burden to DSHS to establish contracts with individual MCOs and a mechanism to bill those MCOs. Additionally, it would not be cost-effective to carve these services into managed care because there would not be opportunity for MCOs to achieve savings without negative fiscal consequences for DSHS. MCOs would be unable to achieve savings by reducing the number of services provided because that is determined based on public health need. The other way for MCOs to achieve savings would be to reduce the amount of

reimbursement to DSHS or their contracted providers below the level of reimbursement currently provided in fee-for-service. However, this would reduce available funding to DSHS without reducing the cost to DSHS to operate the programs. Therefore, the funding would need to be made up with another method-of-financing, likely without the benefit of federal matching funds that are available with Medicaid reimbursement.

ECI Case Management and SST

ECI is a statewide program for families with children birth up to 36 months old, with developmental delays, disabilities, or certain medical diagnoses that may impact development. Certain therapies provided to Medicaid children through ECI are already provided under managed care, but ECI case management and SST are not.

While it may be feasible to carve ECI case management and SST into managed care, it would not be cost-effective and there would be other impacts to the program, which serves Medicaid and non-Medicaid children.

Eligibility for services is determined by the ECI program and the frequency with which SST is provided is determined in the individual service plan. Federal regulations require case management for all children enrolled in ECI, and the service is provided based on the individual, often changing, needs of the child. MCOs would not be able to influence who receives these ECI services and how often they receive them, limiting their ability to produce savings by carving these services into managed care.

Additionally, SST is an ECI-specific service provided by early intervention specialists who are credentialed by the ECI program. These providers would need to be enrolled as Medicaid providers, which may require creating a new provider type at a cost to the state. These providers would need to contract with MCOs and may be paid at a rate lower than current reimbursement to produce the savings necessary to be considered cost-effective. This reduction in reimbursement would not lower the costs of operating the ECI program and would therefore shift the costs to another method-of-financing without the benefit of federal Medicaid matching funds. It may be possible to mitigate this risk by requiring MCOs to pay ECI providers at the current SST rate.

Finally, any delay in reimbursement by the MCOs relative to current contract reimbursement could increase the draw on federal funding available pursuant to

Part C of the Individuals with Disabilities Education Act (IDEA), which when exhausted would need to be replaced with an alternative method-of-financing.

All these factors could affect the financial stability of the ECI program without increasing cost-effectiveness or benefits to clients.

SHARS

HHSC reimburses independent school districts and public charter schools for the cost of medically necessary Medicaid state plan services provided to children enrolled in Medicaid who are also receiving special education services from their school and have these services prescribed in an Individualized Education Plan (IEP). The public schools provide the non-federal share of the cost as a certified public expenditure and receive federal funds based on the FMAP for the applicable proportion of the cost of the services.

There currently is no mechanism to incorporate the SHARS program, which reimburses schools on a retrospective cost-basis, into managed care, as managed care is structured to reimburse MCOs on a prospective basis.

Additionally, SHARS providers currently enroll in Medicaid specifically as a SHARS provider. There would likely be a significant administrative burden to independent school districts and public charter schools to establish contracts with individual MCOs and to develop a mechanism to bill those MCOs as these providers are not traditional medical providers and likely do not have the infrastructure of other provider types.

Incorporating these services into managed care could limit the ability of the school districts to be reimbursed on a cost-basis, but because the services are included in the student's IEP, the school district would still be required to provide the services. Any potential reduction in the federal funding received by the school district may result in additional state-funded expenditures that may be required to be maintained indefinitely due to federal special education maintenance-of-effort requirements.

If SHARS services were incorporated into managed care, federal consent requirements related to educational records would also present a challenge. The federal Family Educational Rights and Privacy Act (FERPA) protects the privacy of students' education records if an educational entity receives federal funds. Under FERPA, a parent or legally authorized guardian, or the student 18 years and older,

must consent to sharing educational information that would be required for SHARS reimbursement (for example, the student's IEP). In a managed care environment, HHSC would have to create a process to obtain parental consent for the MCO to access educational records under FERPA. Without these records, the MCOs would not be able to cover and reimburse for SHARS services.

Blind Children's Vocational Discovery and Development Program

The Blind Children's Vocational Discovery and Development Program provides services to children from birth to age 22 who are blind or visually impaired. Services are individualized to meet the child and family's unique needs.

The program does not seek Medicaid reimbursement for any services. There is some Medicaid administrative funding associated with the program but there are no services to be carved into managed care.

The program is primarily operated by state employees who provide case management and other services, with some purchased services or items if there is not an alternative payer available such as Medicaid. Not all clients receiving services are enrolled in Medicaid. When Medicaid is the appropriate payer, any medically necessary services the child needs would already be reimbursed, including through managed care as appropriate.

Hospice Services

Hospice services are carved out of managed care for clients enrolled in STAR+PLUS, STAR Kids, and STAR Health. If receiving hospice services, these clients remain in their managed care program, but hospice services are paid through fee-for-service and not by the MCOs. If a client enrolled in STAR begins receiving hospice, they are disenrolled from STAR and all services are paid through fee-for-service.

While it may be feasible to carve hospice services into managed care for STAR+PLUS, STAR Kids, and STAR Health and doing so would not be expected to negatively impact clients, it is unlikely to produce the level of savings necessary to be considered cost-effective.

HHSC Medicaid and CHIP Services currently has a team performing utilization review (UR) of hospice services. Continuous home care (one of the most costly aspects of hospice utilization) and hospice election are 100 percent reviewed and a

random sample is conducted for length-of-stay reviews (length-of-stay is the other most costly aspect). This is the only UR function that recoups funds from providers.

If the services were carved into managed care the process would shift from fee-for-service UR to MCO UR and recovered payments may be received by the MCO and not by the state. While MCOs may be able to reduce hospice utilization, the value of doing so is not expected to be sufficient to offset the loss of recoupments and the costs of capitation. Essentially, it is feasible that recoupments could be replaced with a reduction in utilization but given the high level of review already occurring it would be difficult to reduce utilization further to offset the costs of capitation.

PCS and CFC Services

PCS and CFC services are support services provided to children who require assistance with the performance of activities of daily living, instrumental activities of daily living, and health maintenance activities due to a physical, cognitive, or behavioral limitation related to the client's disability or chronic health condition. PCS and CFC are only provided outside of managed care for a limited number of children enrolled in STAR. In August 2021 in STAR, fewer than 1,000 children received PCS and fewer than 1,000 children received CFC services.[4] PCS and CFC for individuals in other programs such as STAR+PLUS and STAR Kids are already included in the managed care service array.

While it may be feasible to carve the services into managed care for children enrolled in STAR, it is not recommended because it would not be cost-effective. DSHS case managers, who are licensed social workers or registered nurses, process referrals, determine medical necessity for services, and approve service hours for PCS. These DSHS case managers perform similar functions for CFC services, with staff from Local Intellectual and Developmental Disability Authorities (LIDDAs) and nurses from HHSC Access and Eligibility Services (AES) performing some additional assessment duties specific to CFC.

If these functions were to be performed by MCOs, each of the 16 MCOs participating in STAR would need to employ higher level staff (social workers and/or nurses), which would be expected to increase capitation costs. No staff savings to DSHS or HHSC would be expected since staff performing these functions are not dedicated solely to these tasks.

[4] Children may have received both PCS and CFC Services.

Given the review that already occurs before services are authorized, it is not expected that the MCOs would be able to reduce utilization or reimbursement rates to the level necessary to offset the costs of capitation and the additional administrative costs associated with hiring higher level staff. If only payment of the services were carved into managed care with DSHS, LIDDA, and HHSC AES staff maintaining their current functions, no change to utilization would be expected and a reduction to reimbursement rates would need to occur to offset the costs of capitation, which could compromise access to care.

PASRR Screenings, Evaluations, and Specialized Services

PASRR is a federally mandated program that requires all states to prescreen all people, regardless of payer source or age, seeking admission to a Medicaid-certified nursing facility. Medicaid reimburses for PASRR evaluations and nursing facility specialized services such as habilitative therapy services and durable medical equipment.

Currently the state's PASRR program is involved in active federal court litigation and HHSC has determined that the current fee-for-service system should be maintained. While the litigation is pending, HHSC recommends that all existing processes and funding mechanisms remain intact. Additionally, providing the services through a managed care model would insert an additional entity into an already administratively complex process.

YES Waiver

YES is a 1915(c) Medicaid waiver that serves children and youth with serious emotional disturbances as an alternative to care in an institution. YES services are family-centered, coordinated services aimed at preventing out-of-home placement and promoting lifelong independence and self-defined success. The program provides services such as specialized therapies, family supports, respite, adaptive aids, community living supports, and others.

To be eligible for YES, children must meet certain eligibility criteria including having a qualifying mental health diagnosis and meeting a psychiatric hospital level of care. YES serves a relatively small number of clients with approximately 1,500 children and youth enrolled statewide as of August 2022. More than 85 percent are

enrolled in STAR Kids with the remainder in fee-for-service, STAR, and STAR Health.

Carving these services into managed care would affect multiple programs and the total number in any one MCO in some of the programs could be exceedingly small. Developing the infrastructure to serve children receiving specialized services through specialized provider networks could be challenging and costly for MCOs, which would be an additional barrier to cost-effectiveness (particularly if the costs cannot be spread across a sufficient number of members).

Additionally, HHSC is currently engaged in efforts to recruit additional providers to deliver YES waiver services. HHSC recently posted a revised Open Enrollment Application, which streamlines the process for potential providers to contract with HHSC to provide YES waiver services. The new process is expected to lead to additional provider applications for private Comprehensive Waiver Providers (CWPs). In addition to the Open Enrollment efforts, HHSC has partnered with the University of Texas Health Science Center at San Antonio on a provider expansion and recruitment project. The project provides targeted outreach and technical assistance to local mental and behavioral health authorities and CWPs that have been impacted by provider shortage. Expansion strategies and testimonial videos will be provided to the identified service providers. In an effort to expand the availability of telehealth services in rural areas, HHSC has provided federal American Rescue Plan Act Technology Funds to service providers to purchase equipment for use in remote service delivery. Funds have been used to purchase tablets and laptops that may be used by providers for service delivery outside of their immediate geographical area, thus increasing utilization. If a carve-in were to be contemplated, it may be worth revisiting in two years to not impact these recruitment efforts.

Because clients receiving YES waiver services are part of a vulnerable population with complex needs, HHSC does not expect that MCOs could produce the level of savings necessary to offset the costs of capitation. Savings would need to be achieved through reductions in utilization, shifts to lower cost services, or reductions to reimbursement rates, which could negatively impact clients and providers. If a carve-in were to be contemplated after provider recruitment efforts are complete, it may be possible for HHSC to undertake a more comprehensive review and analysis of utilization to evaluate the cost impact and whether carve-in might be beneficial for connecting members to services.

HCBS-AMH State Plan Benefit

The HCBS-AMH state plan benefit provides home and community-based services to adults with serious mental illness. Individuals are eligible due to long-term psychiatric hospitalization (spent three or more of the prior five years in an inpatient psychiatric hospital), jail diversion (had four arrests and two psychiatric crises in the prior three years), or emergency room diversion (15 or more emergency room visits and two psychiatric crises in the prior three years). The program is designed to support long-term recovery from mental illness and support individuals to live successfully in their communities. The program provides services including recovery management, residential services, psychosocial rehabilitation, community psychiatric supports and treatment, nursing services, peer support, substance use disorder services, respite, home-delivered meals, minor home modifications, adaptive aids, transportation, and employment services.

HCBS-AMH serves a very small number of clients, with approximately 400 clients enrolled statewide as of August 2022. Adults receiving HCBS-AMH may be enrolled and receiving services, but not full Medicaid benefits, pending a Medicaid eligibility determination. During this period, federal Medicaid matching funds are not available and if services were carved into managed care, a fee-for-service structure would need to be maintained, which would increase administrative complexity. Additionally, the individuals enrolled in Medicaid could be enrolled across a variety of MCOs and the number enrolled in any one MCO could be exceedingly small, which would present the same challenges as described above for YES waiver.

Like the YES waiver, clients in HCBS-AMH are a vulnerable population with complex needs, and HHSC does not expect that MCOs could produce the level of savings necessary to offset the costs of capitation.

STAR Kids and Nursing Facility Services

Children enrolled in Medicaid who reside in a nursing facility in the pediatric care facility class of nursing facilities are not enrolled in managed care. There is a very small number of Medicaid-eligible children receiving services in other nursing facilities who are enrolled in STAR Kids; however, their nursing facility services are carved out of managed care and paid through fee-for-service.

As of August 2022, there are fewer than 10 STAR Kids members in non-pediatric care nursing facilities in Texas; therefore, there would not be an opportunity to

produce sufficient medical benefit savings by reducing nursing facility utilization for carve-in to be cost-effective.

There is already a robust system to bring these members into the community if that aligns with the family’s wishes. Every Child, Inc., a non-profit organization, works with families of children with disabilities who are in a facility to safely move children into the community. HHSC contracts with Every Child, Inc. to lead the permanency planning and family supports for these children that includes helping the families choose a STAR Kids health plan and working with the STAR Kids health plan to keep services in place for when these children transition into the community.

3. Recommendations

HHSC does not recommend providing any of the identified benefits or services under the managed care model. In general, services fall into two broad categories that make carving into managed care challenging.

- Services that involve other government agencies or HHSC programs outside of Medicaid where administration and financing at those agencies or of those programs could be adversely impacted. These services include environmental lead investigations, TB services, newborn screening, ECI, SHARS, and PCS/CFC.
- Services that are provided to a limited number of people where the total number in any one MCO could be exceedingly small and developing the infrastructure to provide the new services could be challenging and costly for MCOs (particularly if the costs cannot be spread across a sufficient number of members). These services include YES waiver services, HCBS-AMH, and PCS/CFC (falls into both categories).

For one program, the Blind Children's Vocational Discovery and Development Program, HHSC determined there was no service to carve into managed care. For two of the services, hospice and nursing facility services for members in STAR Kids, HHSC determined that it may be feasible to carve the services into managed care, but it would not be cost-effective.

List of Acronyms

Acronym	Full Name
AES	Access and Eligibility Services
CFC	Community First Choice
CMS	Centers for Medicare and Medicaid Services
CWP	Comprehensive Waiver Provider
DSHS	Department of State Health Services
ECI	Early Childhood Intervention
FERPA	Family Educational Rights and Privacy Act
FMAP	Federal Medical Assistance Percentage
H.B.	House Bill
HCBS-AMH	Home and Community-based Services-Adult Mental Health
HHSC	Health and Human Services Commission
ICF-IID	Intermediate Care Facility for Individuals with Intellectual Disability
IDD	Intellectual and Developmental Disabilities
IDEA	Individuals with Disabilities Education Act
IEP	Individualized Education Plan
LIDDA	Local Intellectual and Developmental Disability Authority
MCO	Managed Care Organization
PACE	Program of All-Inclusive Care for the Elderly
PASRR	Pre-Admission Screening and Resident Review
PCS	Personal Care Services
SHARS	School Health and Related Services
SSLC	State Supported Living Center
SST	Specialized Skills Training
TB	Tuberculosis
UR	Utilization Review
YES	Youth Empowerment Services