Presentation to the House Committee on Human Services: Medicaid Managed Care

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Medicaid Managed Care Timeline

1991 - H.B 7, 72nd Legislature, Regular Session, directed the state to establish Medicaid managed care pilot programs

1993 – Pilot project known as LoneSTAR in Travis County for acute care services (now called STAR)

1996 - expanded to include Supplemental Security Income (SSI) and SSI-related clients on a voluntary basis

1997 – STAR+PLUS pilot in the Harris service area, integrating acute care and long-term services and supports

1999 – Medicaid NorthSTAR behavioral health pilot in the Dallas service area

2007 – STAR+PLUS expanded from Harris to four additional service areas

2008 – Statewide Medicaid STAR Health model for children in state conservatorship

2011 - STAR and STAR+PLUS expanded to 28 additional counties

2012 – STAR expands statewide and STAR+PLUS expands to all areas of the state, except the Medicaid rural service areas (MRSA)

2014 - STAR+PLUS expanded to the MRSA

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Enrollment

- How many people receive Texas Medicaid?
  - As of June 2015:
    - 4,030,139 clients enrolled in Texas Medicaid
    - 3,531,587 members are enrolled managed care
      - STAR – 2,916,905
      - STAR Health – 30,789
      - STAR+PLUS – 549,380
      - Dual Demo – 34,513
    - 498,552 clients enrolled in Medicaid fee-for-service (FFS)

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Managed Care Objectives

- Establish a medical home for clients through a Primary Care Provider (PCP)
- Emphasize preventative care
- Improve access to and quality of care
- Ensure appropriate utilization of services
- Improve health outcomes
- Improve client and provider satisfaction
- Improve cost effectiveness
- Provide disease management

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Existing Medicaid Managed Care Programs

- STAR (State of Texas Access Reform)
  - Pregnant women without disabilities and children
  - Provides acute care services
- STAR+PLUS
  - Persons with disabilities and "dual eligibles" (eligible for both Medicare & Medicaid)
  - Integrates acute & Long-Term Services and Supports (LTSS)
- STAR HEALTH
  - Medical, dental, vision, behavioral services for children in foster care
- Dental Maintenance Organizations
  - Provides dental care for children in Medicaid/CHIP
- NorthSTAR
  - Behavioral health services to STAR clients and non-Medicaid eligible residents in Dallas services delivery area.

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Recent Initiatives

- STAR+PLUS available statewide on September 1, 2014
- Individuals receiving intellectual and developmental disabilities (IDD) waiver services began receiving acute care services through STAR+PLUS on September 1, 2014
- Nursing facility services carved into STAR+PLUS on March 1, 2015
- The Medicare-Medicaid Dual Eligible Integrated Care Project (Dual Demonstration) began enrolling individuals on March 1, 2015
- Behavioral health integrated on September 1, 2014
- Community First Choice (CFC) in June 2015
- STAR Kids in November 2016
- IDD pilot in 2016

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Savings Estimates

- Managed Care Savings is estimated by assuming a “what if” scenario, e.g. “What would costs be “if” we did not have managed care?”
  - For this reason, savings estimates need to be done as close to implementation as possible to ensure realistic comparison
- Analysis done after the managed care implementations in fiscal year 2012, reported in the Medicaid Managed Care Expansion Savings Report, July 2012*, showed a savings of $263 million state funds ($645 million all funds) achieved through managed care initiatives in the 2012-2013 biennium.
- The Texas Healthcare Transformation Waiver provides a pool of funds for delivering services to uninsured/underserved populations, based on savings estimates realized through Managed Care.
  - Savings estimates use cost growth assumptions "as if" there was not in-patient hospital carve-in, based on national (i.e. higher) cost-growth trends.

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Increasing Managed Care Participation and Improving Experience

HHSC has convened several stakeholder meetings specifically designed to gather recommendations aimed at improving member experiences and provider participation.

Examples of areas addressed by stakeholders:

- Access to care
- Network adequacy
- Benefit(s) added to Medicaid
- Improving MCO monitoring
- Improving provider credentialing and provider enrollment

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Advisory Committees

HHSC also works with multiple advisory committees to develop recommendations to improve the state's Medicaid managed care programs:

- Medicaid Managed Care Advisory Committee
- Stakeholder feedback sessions
- STAR+PLUS Quality Council
- IDD System Redesign Advisory Committee
- Behavioral Health Integration Advisory Committee
- STAR Kids Managed Care Advisory Committee

Administrative Simplifications

Senate Bill 1150, 83rd Legislature, Regular Session, 2013, directed HHSC to implement a provider protection plan for the purpose of reducing administrative burdens for Medicaid providers. Examples of efforts underway include:

- MCOs were required to add functionality to their provider portals to allow for more electronic submissions of claim attachments, prior authorization
- Changes made to improve the overall provider enrollment processes at Texas Medicaid and Healthcare Partnership (TMHP) include the use of electronic signatures, electronic attachments, and pre-population of re-enrollment applications
- Texas Association of Health Plans (TAHP) released an request for proposal (RFP) in September 2015 to identify a vendor to consolidate the managed care credentialing processes
- Standard process developed for non-emergency ambulance services using a standard prior authorization form and attachment

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Network Adequacy

Senate Bill 760, 84th Legislature, Regular Session, 2015, directed HHSC to implement several network adequacy initiatives in Medicaid managed care.

- Network adequacy modernization including time and distance standards
- Searchable online directory
- Mobile enabled directory
- Helpline number prominent in online and print directories
- Out-of-area provider listings
- Expediting credentialing for specified provider types
- Monitor appointment wait times

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Medicaid Managed Care Contract Oversight

The state imposes contractual requirements on managed care organizations (MCOs), including specifying member's benefit packages, setting services accessibility standards, mandating a sufficient provider network and establishing quality measures. The following are monitored on an ongoing basis as part of contract compliance:

- Claims, member and provider call centers, member and provider complaints, member appeals, encounters, provider network, enrollment data and service coordination
- Network adequacy monitoring
  - Out-of-network utilization
  - Mystery callers for appointments
  - Contract terminations
  - Utilization management
- Remedies and assessed liquidated damages for non-compliance

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Managed Care Quality

- Pay-for-Quality Program
  - Establishes incentives and penalties for managed care organizations based on their performance on certain quality measures
- Managed Care Organization Report Cards
  - Reports cards are included in Medicaid enrollment packets and posted on the HHSC website.
- Nursing Facility Quality Program
  - SB 7 Nursing Facility Quality Program
  - Dual Demonstration Quality Withhold
  - Dual Demonstration Shared Savings
  - Quality Incentive Payment Program

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Vendor Drug Program

The Vendor Drug Program (VDP) provides statewide access to covered outpatient drugs for clients enrolled in:

- Medicaid (managed care and fee-for-service)
- Children's Health Insurance Program (CHIP)
- DSHS Children with Special Health Care Needs (CSHCN) Services Program
- DSHS Kidney Health Care (KHC) program
- Texas Women's Health Program

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Vendor Drug Program

- The cost for drug prescriptions in the Texas Medicaid program is shared by the federal government and the state.
- For Texas to receive federal funds assistance for prescription claims, any drugs prescribed must be produced by a drug manufacturer that participates in the Centers for Medicare & Medicaid Services (CMS) drug rebate program.
- In return for having their drugs covered by state Medicaid programs, the manufacturer agrees to pay rebates according to their state and federal contracts.
- The drug rebates apply to drugs supplied to Medicaid fee-for-service or managed care clients either through a contracted pharmacy or administered by a contracted physician/clinician.
- VDP oversees the collection of these rebates from drug manufacturers.

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Preferred Drug List (PDL)

- Texas Medicaid Drug Utilization Review (DUR) Board (April 2016) recommends drugs for the Preferred Drug List based on their clinical efficacy, safety, and cost effectiveness.
  - Texas uses a "lowest net cost" methodology versus a "generics first" methodology. Net cost (after all rebates) is the total state cost
- Products on the PDL are available without prior authorization. Prior authorization is required for non-preferred products.
  - Texas Prior Authorization Call Center for Medicaid fee-for-service clients
  - MCO administered prior authorization call centers for managed care clients