



TEXAS  
Health and Human  
Services

# Texas Medicaid and CHIP Reference Guide

FOURTEENTH EDITION

TEXAS HEALTH AND HUMAN  
SERVICES COMMISSION  
2022



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**Medicaid and CHIP**  
**Reference Guide**

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2022

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

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This last May of 2022 I celebrated my second-year anniversary as the State Medicaid Director. Over those two years, the Texas Medicaid program has faced challenging times. We were tested in many ways, and I am proud of our progress and commitment to *delivering quality, cost-effective services to Texans*.

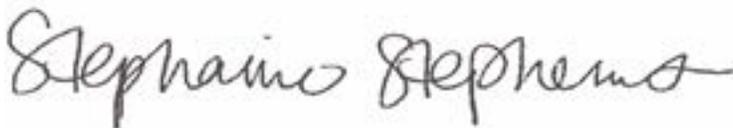
Texas Medicaid is always evolving. In response to the COVID-19 public health emergency (PHE), we extended significant flexibilities to ensure continuity of care for our recipients. We also received enhanced federal funding to maintain Medicaid eligibility for people during the PHE. Where we've found cost-effective improvements to service delivery, access to care and quality of care, we have made flexibilities, such as with teleservices, permanent. Where HHSC must "unwind" changes, we are working with our stakeholders to transition back to normal smoothly and efficiently.

Beyond the PHE, we are strengthening the systems and continuum of services in key areas, such as women's health, pediatric health, behavioral health, and long-term services and supports. We are also incentivizing value through innovation in the service delivery model, further advancing the transition to value-based care and enhancing the quality of services delivered.

We cannot do this work alone. Our success depends on a broad, active stakeholder community collaborating with us. To our stakeholders, thank you for your longstanding partnership and all your work to improve the health and well-being of Texans.

There is no end to the road ahead, but rather ongoing opportunities to improve, innovate and strengthen the program so we can better the health outcomes and lives of those we serve. We hope you find this 14th edition of the Texas Medicaid and CHIP Reference Guide a helpful resource for understanding the work we do now and in the future.

Onwards and upwards,

A handwritten signature in black ink that reads "Stephanie Stephens". The signature is written in a cursive, flowing style.

Stephanie Stephens  
State Medicaid Director



# The Data in This Guide

Below outlines the details about the data referenced throughout the 14th edition. Information contained in this book was current as of August 2022, 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.

About	Details
<b>Time period</b>	<p>All data is state fiscal year (SFY) 2021, unless otherwise noted.</p> <p>Income limits are effective as of March 1, 2022.</p>
<b>Caseload count</b>	<p>Caseload trends and numbers are based on the monthly average number of clients covered by Medicaid or CHIP.</p> <p>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.</p> <p>Total caseload numbers combine Medicaid and CHIP, unless otherwise noted.</p>
<b>Cost information</b>	<p>Costs include both partial- and full-benefit clients, unless otherwise noted.</p> <p>Funds exclude Disproportionate Share Hospital (DSH), Uncompensated Care (UC), and Delivery System Reform Incentive Payment (DSRIP) funds, unless otherwise noted.</p>
<b>Sources</b>	<p>Health and Human Services Commission (HHSC) Financial Services, including Forecasting, provided the majority of data contained in this book. Their primary sources are:</p> <ul style="list-style-type: none"> <li>• Premiums Payable System data provides a summary of all Medicaid-enrolled clients each month. Both monthly Premiums Payable System files and final eight-month files, which contain all retroactive adjustments, are used in the analyses.</li> <li>• 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.</li> <li>• Unpublished analyses conducted by HHSC Financial Services staff are also used to provide financial information.</li> </ul> <p>Alternative sources are noted throughout the book.</p>



# Helpful Websites

Website Name	Link	What You'll Find
Health and Human Services Commission (HHSC) - Medicaid and CHIP	<a href="https://www.hhs.texas.gov/Services/Health/Medicaid-CHIP">HHS.Texas.gov/Services/Health/Medicaid-CHIP</a>	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.
Health Care Payment Learning and Action Network (HCP-LAN)	<a href="https://www.hcp-lan.org">HCP-LAN.org</a>	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).
Office of the Ombudsman	<a href="https://www.hhs.texas.gov/About-HHS/Your-Rights/HHS-Office-Ombudsman">HHS.Texas.gov/About-HHS/Your-Rights/HHS-Office-Ombudsman</a>	The Office of the Ombudsman manages and resolves complaints submitted by Texans receiving Health and Human Services benefits, including Medicaid.
Office of the Inspector General, Texas Health and Human Services	<a href="https://www.oig.hhs.texas.gov">OIG.hhs.texas.gov</a>	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.
Texas Healthcare Learning Collaborative (THLC) Portal	<a href="https://www.thlcportal.com">THLCPortal.com</a>	A public reporting platform and a tool for contract oversight and MCO quality improvement efforts, including MCO report cards and other key performance data.
Your Texas Benefits	<a href="https://www.yourtexasbenefits.com">YourTexasBenefits.com</a>	A self-service website where Texans can apply for HHSC programs and manage their benefits.
Uniform Managed Care Manual	<a href="https://www.hhs.texas.gov/Services/Health/Medicaid-CHIP/Provider-Information/Contracts-Manuals/Texas-Medicaid-CHIP-Uniform-Managed-Care-Manual">HHS.Texas.gov/Services/Health/Medicaid-CHIP/Provider-Information/Contracts-Manuals/Texas-Medicaid-CHIP-Uniform-Managed-Care-Manual</a>	Defines procedures that MCOs must follow to meet certain requirements in HHSC managed care contracts.
Vendor Drug Program (VDP)	<a href="https://www.txvendordrug.com">TxVendorDrug.com</a>	Information about VDP, including the Texas Formulary, the Preferred Drug List (PDL), prior authorizations, enrollment in the program and resources for providers.



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# Quick Facts

Quick facts about Medicaid and CHIP

# Quick Facts About Medicaid and CHIP

## General Information

### Medicaid

A health care and long-term services program for certain groups of low-income persons

Serves children and their caretakers, pregnant women, and individuals over age 65 or those with disabilities

Funded through state funds, matched with uncapped federal dollars at a set percentage rate



### CHIP

A similar program for children whose families earn too much to qualify for Medicaid

Serves children and the unborn children of pregnant women (CHIP Perinatal)

Funded through state funds, matched with capped federal dollars at a set percentage rate

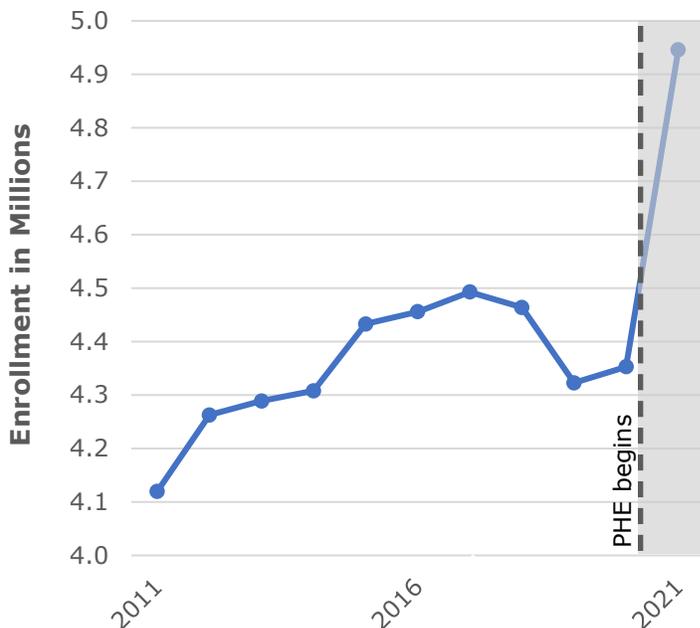
**95% of total enrollment**

**5% of total enrollment**

## Snapshot of Texas Medicaid and CHIP Clients

### Total Medicaid and CHIP Enrollment

Caseloads were impacted by the federal Public Health Emergency (PHE) policy (see Chapter 1, page 12).



**17%** of Texans covered



**51%** of Texas births covered by Medicaid



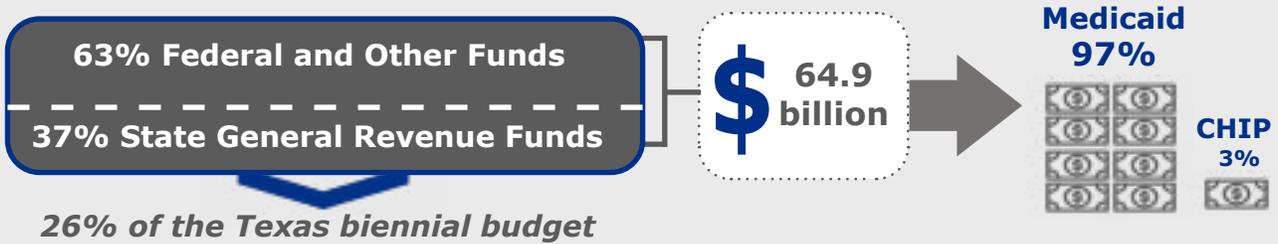
**47%** of Texas children on Medicaid or CHIP



**58%** of nursing home residents covered by Medicaid

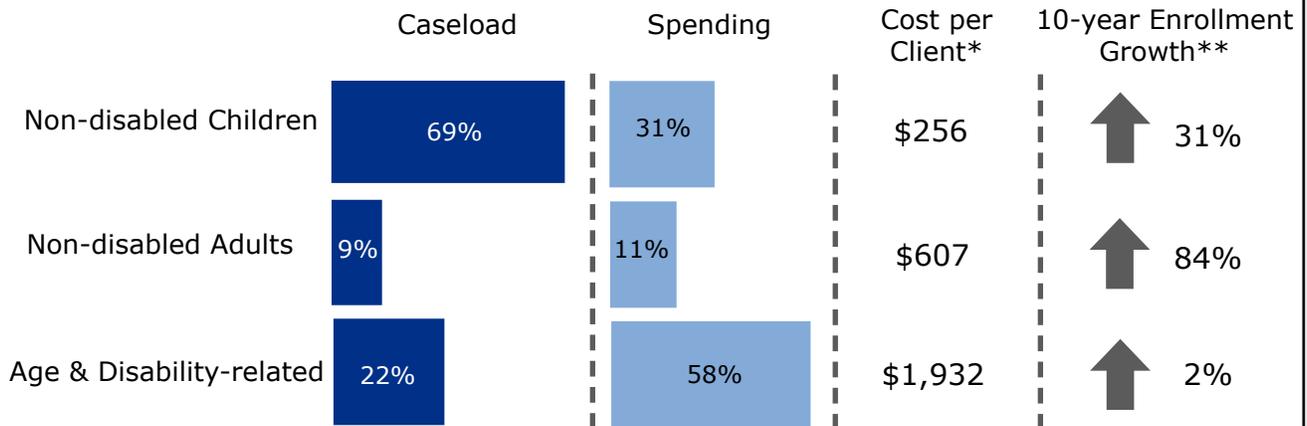
# Quick Facts About Medicaid and CHIP

## Biennial Funding



## Spending

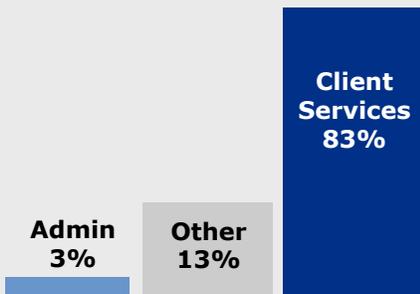
### Trends in Caseload and Spending for Major Medicaid Client Categories



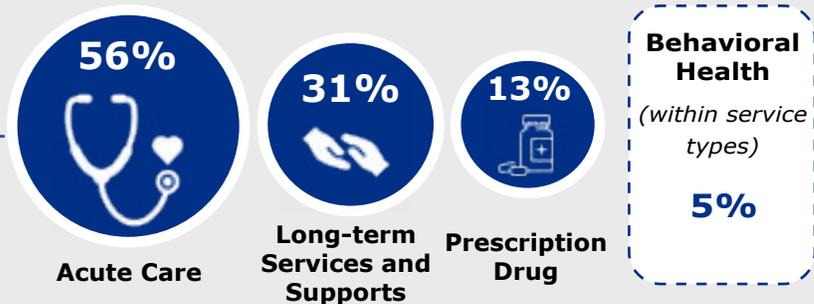
\*Average cost per client per month is based on full-benefit clients only.

\*\* Caseloads were impacted by the federal PHE declared in March 2020 (see Chapter 1, page 12).

### Spending by Category



### Spending by Service Type



Totals are rounded

Other: includes DSH, UC/PHP-CCP, DSRIP, and supplemental payment programs

Acute Care: includes Medicare-related, MTP, Dental, and HIT expenditures

Prescription Drug: includes Clawback

Behavioral Health: excludes DSH, UC, UC/PHP-CCP, DSRIP, Supplemental Payment Program and agency administration costs

# Quick Facts About Medicaid and CHIP

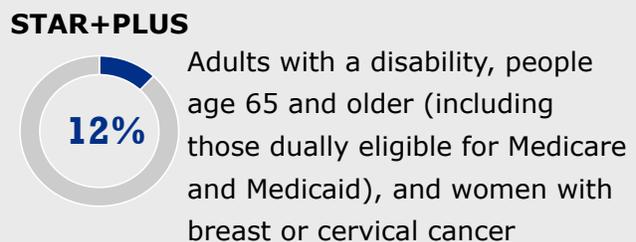
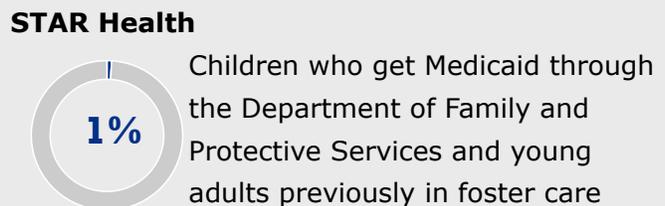
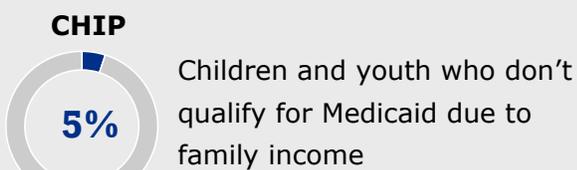
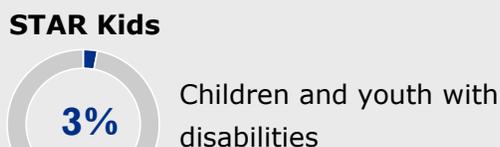
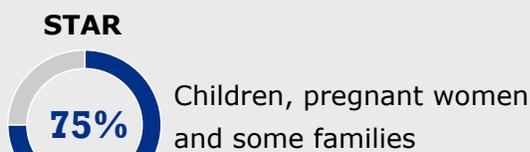
## Service Delivery Model



### 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

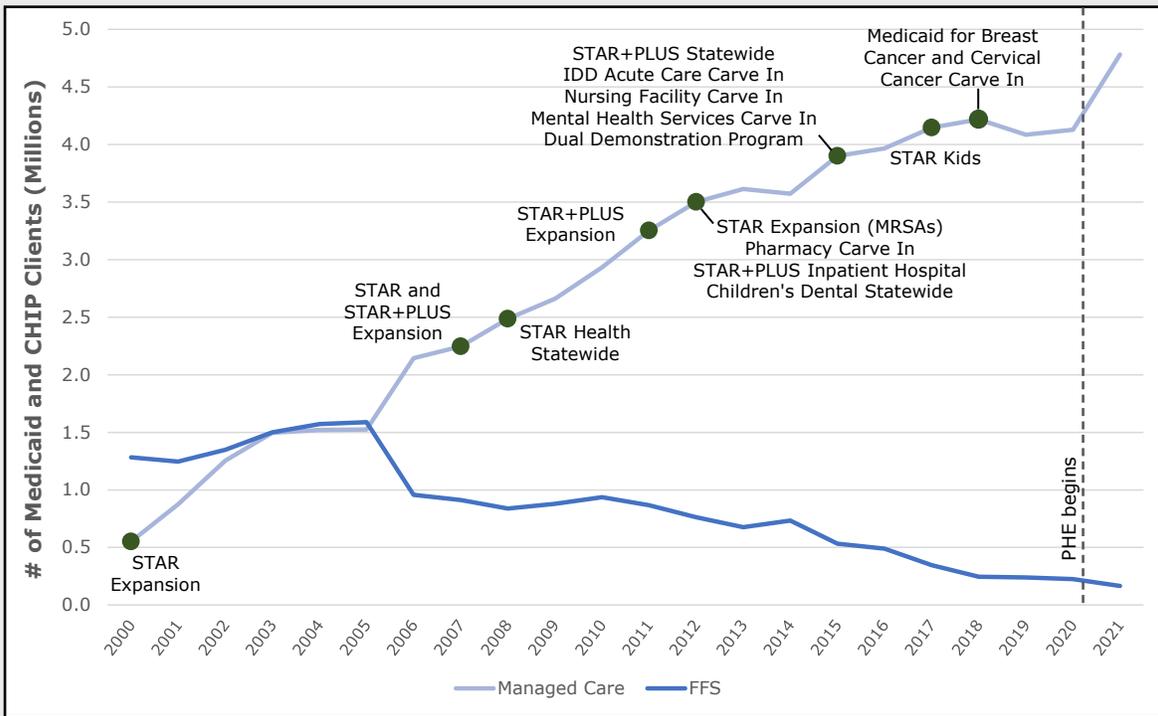
## Managed Care Product Lines



CHIP includes CHIP-Perinatal. Remaining percentage is FFS.

# Quick Facts About Medicaid and CHIP

## Managed Care Growth Over Time



## Over the Past 10 Years

Texas Medicaid managed care enrollment has increased by 37%

### Preventative Care Improved



#### Childhood Asthma

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



#### Diabetes in Adults

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



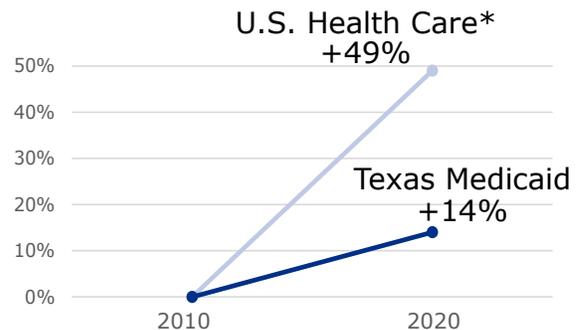
#### Childhood Behavioral Health

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

### Cost Growth Contained

Increased enrollment and improved preventative care within managed care keeps Texas Medicaid costs contained—35 percentage points lower than the U.S. national average

#### Cost per Person Increase



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

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



# Chapter 1

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



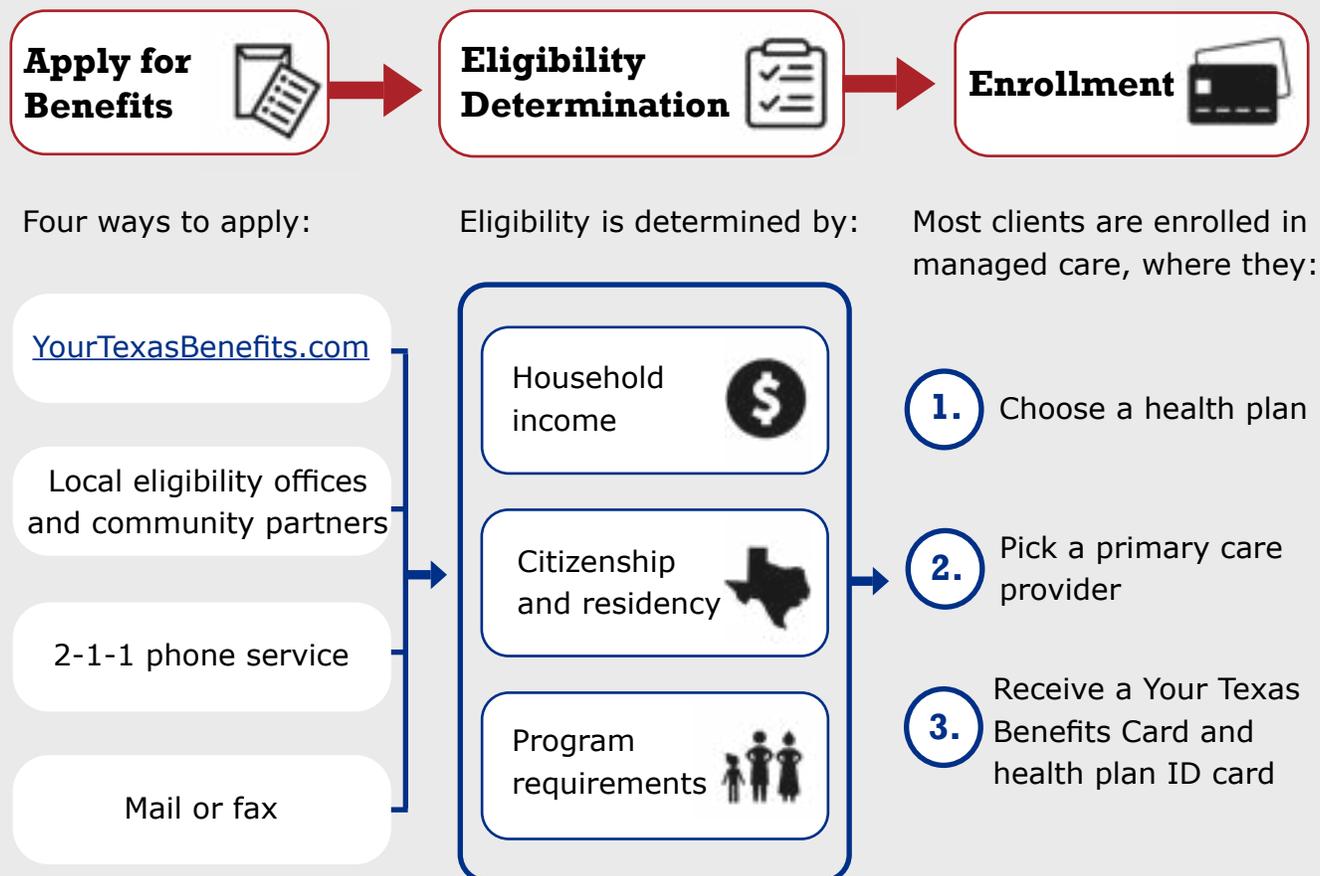
# At-a-Glance

## 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?



# Residency and Citizenship

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To qualify for Texas 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 United States 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 noncitizens 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:

- Compact of Free Association citizens residing in the U.S.
- Veterans; active-duty members of the U.S. armed forces, including their spouses and dependent children; and Canadian-born American Indians.
- Lawful permanent residents (LPRs) who received Supplemental Security Income (SSI), Medicaid or both on August 22, 1996, or can be credited with 40 qualifying quarters of Social Security coverage and have lawfully resided in the U.S. since August 22, 1996.

## ***Limited Eligibility***

Some aliens may qualify for Medicaid, but only for up to seven years. These include asylees, refugees, Afghan and Iraqi Special Immigrants, Cuban/Haitian entrants, Amerasians, and aliens whose deportations are being withheld. Victims of human trafficking are eligible for up to four years from date of entry or until the law enforcement extension expires.

## ***Lawful Permanent Residents***

LPRs are noncitizens 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 133, for the Children’s Health Insurance Program Reauthorization Act [CHIPRA] of 2009).

### ***Emergency Medicaid***

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

## **Financial Eligibility**

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Financial eligibility for Medicaid and CHIP 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 be determined using Modified Adjusted Gross Income (MAGI) methodologies. MAGI uses federal income tax rules to decide if an applicant qualifies based on how they plan to file their taxes and their countable income. Applicants do not have to file federal income taxes to apply or to be determined eligible for Medicaid.

Some groups are excluded from MAGI, including:

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

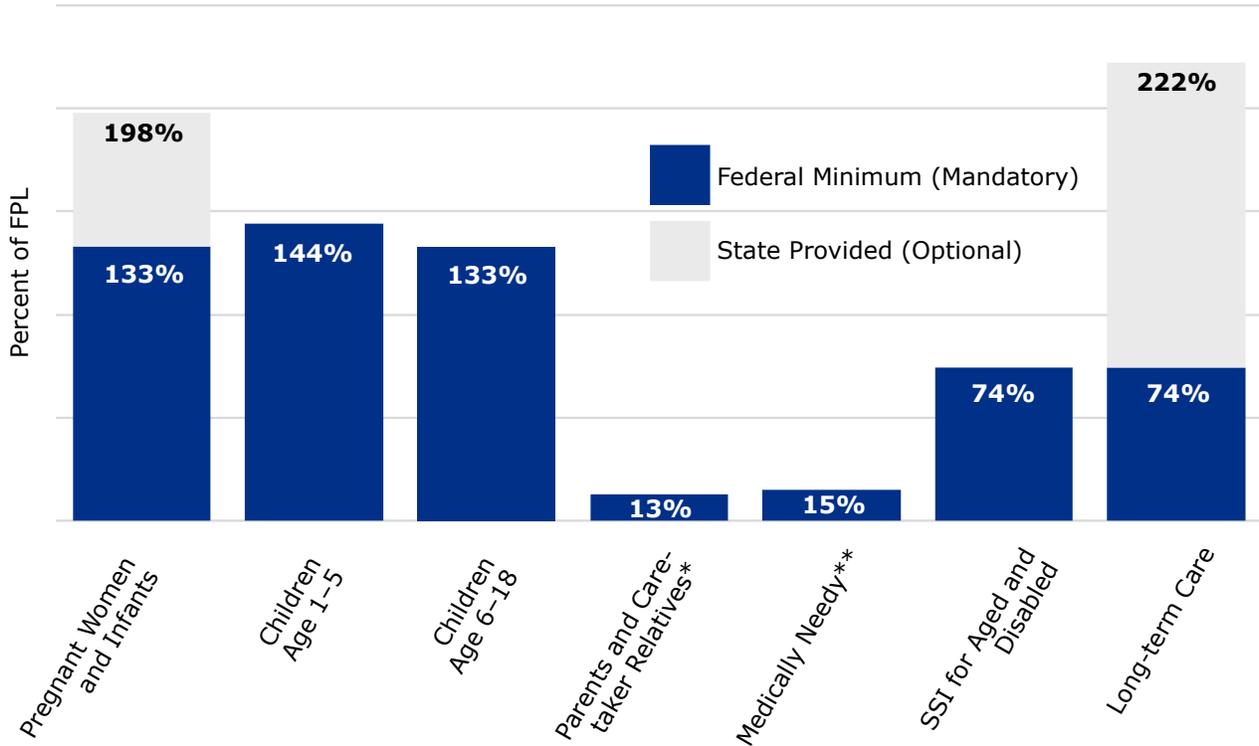
These groups must report and give proof of the resources they own, such as vehicles, bank accounts, life insurance policies, rental homes, etc.

### ***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 chart depicts the 2022 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.

## Texas Medicaid Income Eligibility Levels for Selected Programs, March 2022 (as a Percent of the FPL)



\*For Parents and Caretaker Relatives, maximum monthly income limit in SFY22 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 SFY22 was \$275 for a family of three, or about 15 percent of the FPL.

This figure reflects eligibility levels as of March 2022. 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.

### **Continuous Medicaid Coverage During the COVID-19 Public Health Emergency**

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To receive increased federal funding, federal law requires states to maintain Medicaid coverage for most people active or certified for Medicaid on or after March 18, 2020, until the end of the month in which the federal public health emergency (PHE) ends (see Appendix A, page 125, The Families First Coronavirus Response Act (FFCRA)). States that maintain continuous coverage qualify for an increase in federal funding for the Medicaid program.

Effective March 18, 2020, HHSC has sustained coverage for members in all Medicaid programs, except where the member moved out of state, voluntarily withdrew from the program, or died. Continuous Medicaid coverage during the COVID-19 PHE has greatly impacted Texas Medicaid's caseload.

HHSC will follow federal guidance to review eligibility for clients prior to ending continuous Medicaid coverage. Major parameters set by CMS include:

- Providing up to 12 months to redetermine eligibility for their Medicaid caseload.
- Allowing redeterminations to begin up to 60 days before disenrollments can begin. (Disenrollments cannot be effective until the first of the month after the month the PHE ends.)
- Requiring states to conduct full redeterminations in accordance with federal regulations and to allow members a minimum of 30 days to respond to renewal packets or requests for information.



# 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 at the time of delivery 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 for children 6-18.

Income Limits by Household Size	
Household Size (Adults Plus Children)	Household Income
1*	\$1,510
2	\$2,034
3	\$2,559
4	\$3,083
For each additional person, add:	\$525

\*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 through the end of the month of their 26th birthday. Income and resource limits do not apply.

### *Medicaid for Transitioning Foster Care Youth*

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

To qualify, a person must meet residency and citizenship requirements and:

- Not have adequate health coverage.
- Be at or below 413 percent of the FPL (or \$4,678 per month for a household of one).

Resource limits do not apply to MTFCY. In addition, a person 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 copays 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 \$0 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.

Income Limits by Household Size	
Household Size (Adults Plus Children)	Household Income
1*	\$2,277
2	\$3,067
3	\$3,858
4	\$4,649
For each additional person, add:	\$791

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

## Incarcerated Youth

Certain incarcerated people 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:

- Children age 18 and younger incarcerated by the Texas Department of Criminal Justice, the Texas Juvenile Justice Department, or the Juvenile Probation Department.
- Pregnant women incarcerated by the Texas Department of Criminal Justice.

Juveniles receiving Children’s Medicaid may have their coverage suspended upon admission 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.



## 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.

Household Size	Monthly Household Income
1	\$2,243
2	\$3,022
3	\$3,800
4	\$4,579
For each additional person, add:	\$779

### 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 from date of birth through the remainder of the 12-month original eligibility period.

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

Household Size	Monthly Household Income
1	\$2,288
2	\$3,083
3	\$3,877
4	\$4,672
For each additional person, add:	\$795

## Healthy Texas Women

Healthy Texas Women (HTW) provides free health and family planning services to low-income women ages 15 to 44 who qualify. A woman is considered 44 years old through the last day of the month of her 45th birthday. Women ages 15 through 17 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 204.2 percent of the FPL.

To provide continuity of care, women receiving Medicaid for Pregnant Women are automatically tested for HTW eligibility before their Medicaid for Pregnant Women coverage ends.

## Healthy Texas Women Plus

HTW Plus provides enhanced and targeted postpartum care services to HTW members whose pregnancies ended within the 12 months preceding their enrollment in HTW. Enhanced postpartum benefits include services that address:

- Postpartum depression and other mental health conditions;
- Cardiovascular and coronary conditions; and
- Substance use disorders, including drug, alcohol and tobacco use.

There is no separate eligibility determination for HTW Plus. If a woman is determined eligible for HTW and her pregnancy ended within the 12 months preceding her HTW eligibility date, she is eligible for HTW Plus benefits during her 12-month HTW certification period.

## **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 precancerous 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 precancerous 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 fulltime.

Related caretakers may be:

- A parent or step-parent.
- A sibling or stepsibling.
- 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.

Household Size	Monthly Income for One Parent Household	Monthly Income for Two Parent Household
1	\$103	-----
2	\$196	\$161
3	\$230	\$251
4	\$277	\$285
For each additional person, add:	\$52	\$52

### 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, a person 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 \$3,000 for

households with a member who is elderly or has a disability and \$2,000 for all other households. 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 who are determined eligible must submit their paid and unpaid medical bills. Medical bills greater than the 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, copayments or coinsurance 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, copayments and coinsurance as required.



# Children and Adults with Disabilities

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

- They reside 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 23).

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, people with disabilities must meet the income and resource 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 may 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.

Household Size (Adults Plus Children)	Monthly Household Income
1*	\$1,699
2	\$2,289
3	\$2,879
4	\$3,469
For each additional person, add:	\$590

\*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 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 facility continuously.

The 2022 income limit for MBI is \$2,832 per month. Countable assets must total no more than \$2,000.

### How People Can Access Long-term Services and Supports

#### Aging and Disability Resource Centers

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

#### LIDDAs and LMHAs

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

Local mental health authorities (LMHAs) provide information, recommendations and referrals to people seeking mental health services, including Medicaid.



## People Age 65 and Older

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### **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 and resource 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 beneficiaries 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.

The Medicare Savings Programs provide assistance with all or a portion of a person's Medicare premiums, deductibles and co-payments through Medicaid. Medicaid also covers their Medicare Part D premiums and deductibles.

Resource limits for 2022 are \$8,400 for one person and \$12,600 for a couple for most dually eligible people. The only exception is for the Qualified Disabled Working Individuals program, where the resource limits for 2022 are \$4,000 for one person and \$6,000 for a couple.

### **Supplemental Security Income Recipients**

SSI is a federal cash assistance program for low-income people with disabilities. Low-income people 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.

**A Closer Look**

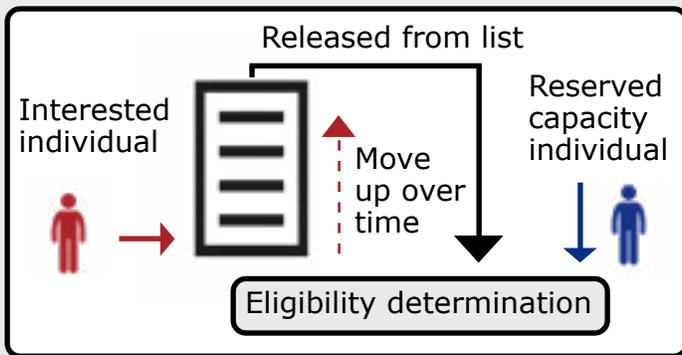
## Waiver Program Interest List and Eligibility Process

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. People in reserved capacity groups, such as the Promoting Independence Initiative or Crisis Diversion, are given priority when program slots become available. People waiting on an interest list are contacted regularly to make sure they still want to be on the interest list and provide any new information about their situation.

### Interest List Process



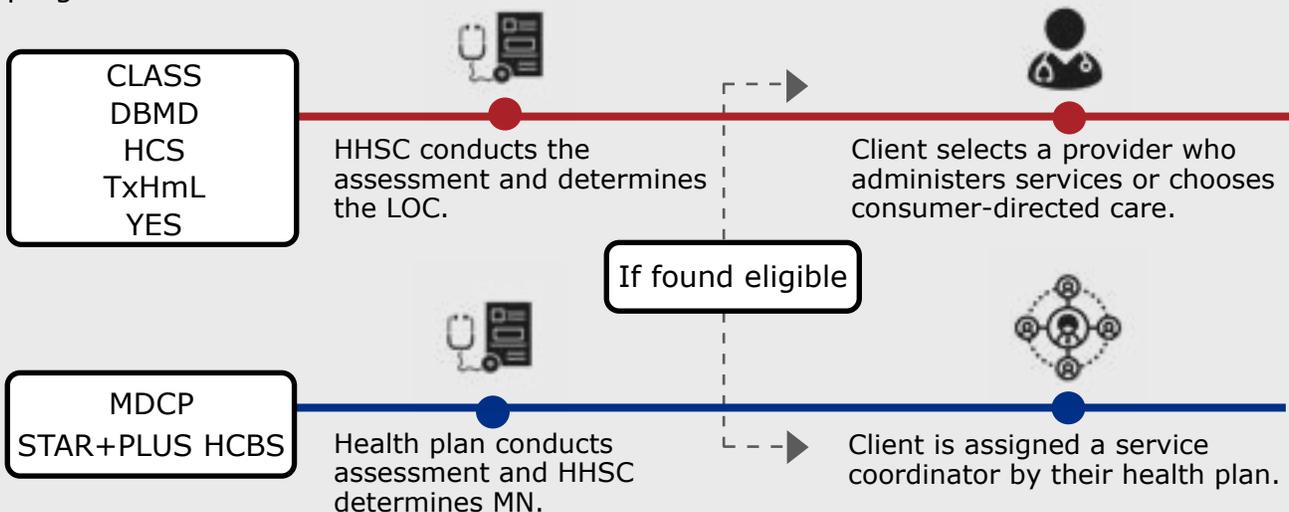
When a program slot opens, the person at the top of the list is released.

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

After a person is released, they go through the eligibility determination process.

### Eligibility Determination

Eligibility determination is based on household income, resources and level of care (LOC) or medical necessity (MN). The criteria for LOC or MN a person 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

**97%** of Texans who receive services get them through **Managed Care**.

- HHSC contracts with managed care organizations (MCOs), also called health plans.
- Health plans must provide all covered, medically necessary Medicaid and CHIP services to members.
- In most cases, members go to providers contracted with their health plan.

**3%** of Texans who receive services get them through **Fee-for-Service**.

- Under the fee-for-service (FFS) model, clients can go to any Medicaid provider.
- Clients can receive some services through managed care and others through FFS.
- Most FFS clients transition to managed care.

### 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

#### STAR



Children, pregnant women and some families

#### STAR Kids



Children and youth with disabilities

#### STAR Health



Children and youth currently or previously in the conservatorship of the Department of Family Protective Services

#### STAR+PLUS



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

#### CHIP



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

#### Fee-for-Service



Totals are rounded

# What Medicaid and CHIP Cover

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## Mandatory vs. Optional Services

Federal law requires state Medicaid programs to provide acute care and behavioral health services and long-term services and supports (LTSS). 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 145, for a full list of Medicaid programs and services and CHIP benefits.)

## 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. In response to the COVID-19 Public Health Emergency (PHE), Medicaid now covers COVID-19 testing, vaccines and treatment.

## 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:

- Screening, brief intervention and referral to treatment.
- Residential and outpatient withdrawal management.
- Mental health rehabilitation services.
- Peer specialist services.
- Individual, family and group psychotherapy.
- Psychological, neurobehavioral and neuropsychological testing.
- Mental health targeted case management.
- Psychiatric diagnostic evaluation.
- Medication management.
- Collaborative care model services.

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. Services may be delivered through managed care, fee-for-service (FFS) or both.

The types of LTSS individuals receive are 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.
- Medical supplies, equipment, and accessories.
- Over-the-counter drugs.
- Personal-need items.
- Social services and activities.

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

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

#### **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.

## 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 149, 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)

\*MDCP operates as a 1915(c) waiver concurrent with the 1115 Healthcare Transformation Waiver authority.  
 \*\*STAR+PLUS HCBS operates like a 1915(c) waiver but is provided through the 1115 Healthcare Transformation Waiver (see Chapter 5, page 110).

### **How Home and Community-Based Services are Delivered**

Individuals who receive home and community-based 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 as the employer of record. Individuals using the Consumer Directed Services (CDS) option are required to select a Financial Management Services Agency (FMSA) who provides orientation, issues payment to the individual's employees, and pays federal and state 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 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 deliver 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, limited home health supplies, and select vitamin and mineral products; 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 61). 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. Texas currently requires Medicaid and CHIP MCOs to use the formulary, the PDL, and prior authorization requirements. This requirement expires on August 31, 2023 under statute. With the expiration, MCOs will operate their own formularies, PDLs, and prior authorization requirements, as well as negotiate and collect drug rebates.

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 Medicaid program or CHIP, adults enrolled in managed care, clients in nursing facilities, and clients enrolled in certain Medicaid waiver programs. For Medicare clients dually eligible for Medicaid, Medicare Part D covers their prescription drugs.

## Medical Transportation Services

Nonemergency medical transportation (NEMT) services provide cost-effective medical transportation to a doctor or specialist, a pharmacy, or other providers for covered health care services. NEMT services are only for people enrolled in managed care or FFS Medicaid, Children with Special Health Care Needs, and qualified low-income cancer patients.

NEMT services include:

- Demand response transportation—curb-to-curb transportation using dispatched vehicles, including shared rides and transportation network company 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 for children and youth age 20 and younger.
- Advanced funds for transportation or travel-related services for people age 20 and younger.
- 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.

NEMT services for managed care members are coordinated by their MCO. NEMT services for FFS clients are coordinated by HHSC through the Medical Transportation Program.

In addition to the NEMT services above, MCOs and HHSC are 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 the pharmacy, urgent care services, or discharge from a healthcare facility.

**A Closer Look**

## Medicaid and CHIP Telehealth and Telemedicine

Telemedicine was introduced in the Texas Medicaid program in 1997, and telehealth in 2011. Beginning in 2019, with the goal of increasing access to care, MCOs were authorized to allow telehealth and telemedicine for all services if clinically effective and cost effective, and could not refuse to pay for services based on delivery method.

### Main Types of Services

	<p><b>Telemedicine</b> Medical care delivered using audio-visual or audio-only* telecommunications.</p>
	<p><b>Telehealth</b> Non-medical, non-dental health services, like behavioral health services, delivered using audio-visual or audio-only telecommunications.</p>
	<p><b>Teledentistry</b> Dentistry delivered using audio-visual telecommunications.</p>

### Expansion During the COVID-19 PHE

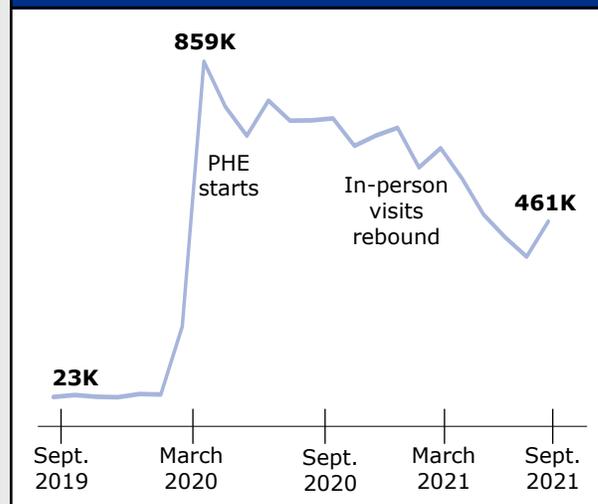
In response to the COVID-19 PHE, HHSC implemented flexibilities for telehealth and telemedicine services to ensure client access to medically necessary services. This included allowing audio-only telemedicine and telehealth services in addition to audio-visual, with exceptions for certain therapies like speech, occupational, and physical therapy.

In 2021, new state legislation (House Bill 4; see Appendix A, page 137) passed requiring HHSC to permanently expand telemedicine and telehealth services if clinically effective and cost effective. Certain Medicaid and CHIP services are now available beyond the end of the PHE via telemedicine and telehealth, including:

- Behavioral health services.
- HTW and HTW Plus services. Speech therapy, occupational therapy, physical therapy, and specialized therapies.
- School health and related services (SHARS).
- Rural Health Clinic and Federally Qualified Health Center services.
- Certain case management services.

The Texas Legislature also passed requirements for HHSC to implement teledentistry services in the Medicaid program. See Appendix A, page 137, for more on telehealth and teleservices legislation.

### Teleservices Delivered per Month



\*Source: HHSC, Texas Medicaid & CHIP Teleservices Monthly Trend dashboard

### Managed Care in Texas

#### STAR

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 coordination to members with special health care needs (see A Closer Look, page 47). There are 16 MCOs delivering the STAR program across 13 STAR service areas.

Other managed care programs in Texas include STAR Health, STAR Kids, STAR+PLUS, and CHIP.

#### Value-added Services

Value-added services are extra services that MCOs can choose to provide to their members. These services vary from one MCO to another. Examples include diapers for newborns and adult dental services for members in the STAR+PLUS program.



## 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 respectively.

## 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 40).

## 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 (AA) or Permanency Care Assistance (PCA) 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 47).
- 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 waiver and receive their MDCP services through STAR Health (see MDCP, page 41).

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.

### **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 Medicaid state plan. Beginning in February 2022, Applied Behavior Analysis, a treatment for autism spectrum disorder (ASD), became available for children and youth with ASD through Texas Health Steps-CCP.

Texas Health Steps also provides case management for eligible children and pregnant women (see page 36). Case managers help individuals access services they may need, including assistance with school or special education needs, transition planning, and issues such as substance use, homelessness or domestic violence. Texas Health Steps is not a benefit option for children enrolled in CHIP.

## **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 transitional services. (See Appendix B, page 152, 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 no cost mental health and SUD screening and treatment services, including 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. CHIP members may receive certain preventive and medically necessary services beyond this cap through a prior authorization process.



## Women

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. While enrolled, they receive full Medicaid benefits as well as coverage for perinatal services including:

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

Women with high-risk pregnancies may receive service coordination through their STAR MCO. They may also receive case management services through Case Management for Children and Pregnant Women.

#### Case Management for Children and Pregnant Women

Case Management for Children and Pregnant Women (CPW) services transitioned to managed care in September 2022. CPW services are delivered by case managers who are registered nurses or licensed social workers. Case managers assist pregnant women with high-risk health conditions and children with a health condition or health risk to use medically necessary health, social, educational and other services related to their health condition.

Before the transition to managed care, these services were available through Medicaid FFS providers or Department of State Health Services (DSHS) regional case managers. To request CPW services, clients could call Texas Health Steps or reach out to any CPW provider in their area. While there is no change in this process for FFS clients, clients enrolled in managed care now must call their MCO to request CPW services or reach out to an in-network CPW provider.

## CHIP Perinatal

CHIP Perinatal (CHIP-P) coverage provides care to unborn children of pregnant women who are not eligible for Medicaid and who have household income up to 202 percent of the federal poverty level (FPL). Once born, the child will receive Medicaid or CHIP benefits, depending on their income. CHIP-P provides a basic prenatal care package.

Services include:

- Up to 20 prenatal visits.
- Prescription drugs, including prenatal vitamins.
- Some laboratory testing, assessments, planning services, education and counseling.
- Some diabetic supplies available through pharmacies with a physician prescription.
- Labor and delivery.
- Two postpartum care visits within 60 days after delivery or end of pregnancy.

Members receiving CHIP-P benefits are exempt from the 90-day waiting period and all cost-sharing, including enrollment fees and copays, for the duration of their coverage period (for more information about CHIP cost-sharing see Chapter 1, page 14).

## Healthy Texas Women

Healthy Texas Women (HTW) is a Medicaid 1115 Demonstration program that provides women's health, preventive health, and family planning services at no cost to eligible women. HTW services include:

- Annual family planning exam.
- Pregnancy testing and counseling.
- Pelvic examinations.
- Sexually transmitted infection (STI) services.
- HIV screenings.
- Breast and cervical cancer screenings and diagnostic services.
- Treatment of cervical dysplasia.
- 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 (PPD).
- Vaccinations.

In January 2020, the Centers for Medicare and Medicaid Services (CMS) approved the Texas 1115 Demonstration 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 5, page 111).

## 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 PPD or SUDs, and cardiovascular conditions. To receive HTW Plus, an HTW client must have been pregnant within the 12 months prior to their enrollment. HTW Plus services include:

- Individual, family and group psychotherapy services.
- Peer specialist services.
- Cardiovascular evaluation imaging and laboratory studies; blood pressure monitoring equipment; and anticoagulant, antiplatelet and antihypertensive medications.
- Screenings, brief interventions and referrals to treatment for SUDs.
- Outpatient substance-use counseling.
- Smoking cessation services.
- Medication-assisted treatment.
- Additional injectable insulin options; blood glucose testing and monitoring supplies.
- Asthma medications and supplies.

In December 2020, HHSC submitted an amendment to the HTW 1115 demonstration to receive federal funds for HTW Plus. At the time the amendment was submitted, HHSC requested an effective date of April 1, 2021. The amendment is pending with CMS.

## 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, while also serving as a point of access for MBCC.

**A  
Closer  
Look**

## Better Birth Outcomes

Better Birth Outcomes (BBO) 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 (OUD) who are 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 with OUD enrolled in Medicaid.

This 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, but not limited to:

- 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 (PPD)**

PPD is a common and potentially serious mental health condition affecting some women after pregnancy. The impact of PPD and related maternal mental health 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. HHSC has launched several initiatives and has published a five-year PPD strategic plan to increase awareness, education and continuity of care for women with PPD.

### **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, 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 28).

## 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 34).

## 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 47). 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, FFS, 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 a nursing facility.

Individuals enrolled in MDCP receive all services through their STAR Kids or STAR Health MCO. (See Appendix B, page 151, for a full list of services available through MDCP.)

### **School Health and Related Services Program**

The School Health and Related Services (SHARS) program allows Local Education Agencies (LEAs), 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 who qualify, including, but not limited to, children with Medicaid.

**A  
Closer  
Look****Waiver Programs for People with Intellectual and Developmental Disabilities**

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

There are four waiver programs for people with IDD, described below, which are delivered through the FFS model. These programs deliver many of the same services (see Appendix B, page 149).

Demand for some waiver programs exceed capacity. The programs maintain interest lists that people can join at any time (see A Closer Look, page 23).

**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, residential habilitation transportation, specialized therapies, 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\*, residential habilitation (including transportation), 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 as an alternative to living in an ICF/IID. Services include day habilitation\* and residential services, supported home living (including 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 (including transportation) and day habilitation.\*

\*To comply with CMS regulations governing HCBS settings, HHSC will replace day habilitation with a new, integrated service called Individualized Skills and Socialization by Spring 2023.

## 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. As with 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 Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs) (see People Age 65 and Older, page 45).

## 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 Transformation Waiver that provides a cost-effective alternative to living in a nursing facility for 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 151).

### **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.

#### **Medicaid Substance Use Disorder 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 43). People who are aging and need LTSS can also get these services through MMPs, D-SNPs or PACE.

### **The Dual Demonstration (Medicare-Medicaid Plans)**

The Dual Demonstration provides a fully integrated managed care model for people who are dually eligible for Medicare and Medicaid. Both Medicare and Medicaid services are provided under a single Medicare-Medicaid plan (MMP).

The model involves a three-party contract between an MMP, HHSC, and CMS. MMPs are available in only six Texas counties: Bexar, Dallas, El Paso, Harris, Hidalgo and Tarrant. If eligible, individuals are automatically or passively enrolled into an MMP, but may choose to opt out. Other dual-eligible STAR+PLUS members not passively enrolled and living in one of the six counties can choose to enroll.

The Dual Demonstration excludes dual-eligible individuals receiving Medicaid services provided through an ICF/IID or through a Medicaid Intellectual or Developmental Disability waiver program, such as CLASS, DBMD, HCS, or TxHmL.

In June 2022, CMS published rules indicating they are ending Dual Demonstration. HHSC is currently planning the details and timeline for the transition.

### **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 are delivered through FFS and 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)***

D-SNPs are Medicare Advantage managed care plans designed to provide Medicare services to individuals who are also fully or partially eligible for Medicaid (dual-eligible).

Full dual-eligible individuals are Medicare beneficiaries who can receive the full array of Medicaid benefits. Partial dual-eligible individuals are Medicare beneficiaries who are not eligible to receive the full array of Medicaid benefits, but may receive Medicaid assistance for their Medicare Part A or B premiums and cost-sharing expenses.

HHSC contracts with D-SNPs to cover the Medicare cost-sharing obligations for partial dual-eligible members in the Qualified Medicare Beneficiary (QMB) Program and full dual-eligible members. HHSC-contracted D-SNPs must also coordinate care between Medicare and Medicaid.

### **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, and both physical and occupational therapy), social services, in-home care, meals, transportation, and day activity services.

PACE is available in the cities of 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.

**A  
Closer  
Look****Service Coordination in Managed Care****STAR Kids and STAR+PLUS**

All STAR Kids members are 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 coordination. 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.

A service coordinator in STAR or CHIP helps ensure members with special health care requirements get the services they need from their health plan. They can also help members get non-capped 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 (CFC) 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.

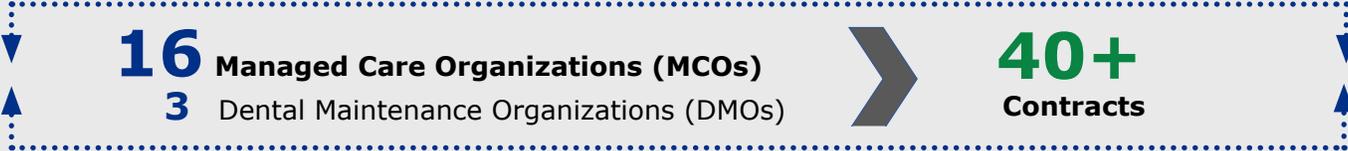
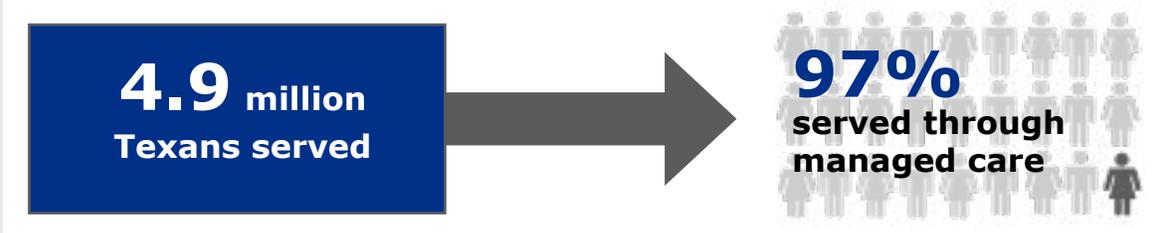


# Chapter 3

How does HHSC make sure clients get good care?



# At-a-Glance



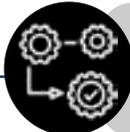
## HHSC Contract Oversight Tools

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, value-based enrollment, 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.



Numbers are subject to change. Number of MCOs and contracts current as of January 2022.

# The Managed Care Delivery System

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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 16 managed care organizations (MCOs) contracted with HHSC to coordinate services for most 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 overutilization of services, 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 Medicaid and CHIP are improving health outcomes and MCOs are delivering quality, cost-effective services.

HHSC contracts with MCOs to coordinate services for 97 percent of Medicaid clients and all (100 percent) of 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.



## Access to Services

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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 76).

#### ***Time and Distance Standards***

HHSC uses time and distance standards to monitor MCO provider networks and ensure members have timely access to services. These standards were developed based on those used for Medicare Advantage and by the Texas Department of Insurance (TDI) and are either consistent with or more stringent than state and federal requirements.

HHSC is continually evaluating and updating network adequacy standards as part of an ongoing effort to ensure members have access to a choice of quality health care providers and services.

- In September 2018, HHSC adopted new time and distance standards for long-term services and supports (LTSS) and pharmacy.
- In 2020, HHSC adopted new provider network standards for outpatient chemical dependency treatment facilities and outpatient opioid treatment programs.
- In 2021, additional provider access standards for personal attendant services were implemented. These standards focus on timeliness and service coordinator turnover.

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

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.

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.

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.

For the third quarter of SFY 2022, analysis of MCO provider networks has shown:

- Except for some rural counties, MCOs in all programs performed above the 90 percent standard for primary care providers across all counties.
- Regardless of county size, more than 94 percent of members are within the distance standards for main dentists.
- In all programs, the majority of MCOs comply with distance standards for most specialists.

Building a strong network of providers is an ongoing effort, and HHSC continues to work with MCOs to achieve this goal. In rural areas, telemedicine has become an important tool in bridging the access gap 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 annually. The EQRO performs four studies by provider type in the areas of prenatal, primary care, vision and behavioral health.

The EQRO uses a mystery shopper method, in which a random sample of providers are contacted 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.

Two studies were conducted in 2021 for behavioral health and primary care. While CAPs and LDs are usually assessed when MCOs fail to meet appointment availability standards, they were not assessed in 2020 and 2021 due to the federal PHE which may have impacted or biased the studies' results. HHSC also uses results from these studies to target improvement efforts. For example, HHSC placed greater focus on prenatal care through the 2022 MCO Performance Improvement Projects (PIPs) and Pay-for-Quality (P4Q) measures. 2022 PIP scores will be posted to the HHSC website in 2024.

<b>MCO Appointment Availability Standards</b>	
<b>Level/Type of Care</b>	<b>Time to Treatment</b>
Urgent Care (child and adult)	Within 24 hours
Routine Primary Care (child and adult)	Within 14 calendar days
Preventive Health Services for New Child Members	No later than 90 calendar days after enrollment
Initial Outpatient Behavioral Health Visits (child and adult)	Within 14 calendar days
Preventive Health Services for Adults	Within 90 calendar days
Prenatal Care (not high risk)*	Within 14 calendar days
Prenatal Care (high risk)*	Within five calendar days
Prenatal Care (new member in third trimester)	Within five calendar days
Vision Care (ophthalmology, therapeutic optometry)	None indicated (“Access without primary care provider referral”)

\*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.

Due to impacts of the COVID-19 PHE on provider office staff, HHSC did not conduct quarterly calls through all of 2021 and for the first three fiscal quarters of 2022. Quarterly calls resumed for the fourth quarter of 2022.

**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.

The surveys allow HHSC to monitor and evaluate the quality of care provided to the members, assist members in choosing among health plans, and gather information on the outcomes of quality improvement initiatives. Surveys alternate so that each member group is surveyed every other year, as shown in the table below.

Odd Years	Even Years
<ul style="list-style-type: none"> <li>• Child members in STAR</li> <li>• CHIP</li> <li>• Medicaid and CHIP Dental</li> </ul>	<ul style="list-style-type: none"> <li>• Adults members in STAR</li> <li>• STAR+PLUS</li> <li>• STAR Health</li> <li>• STAR Kids</li> </ul>

CAHPS surveys focus on consumer perceptions of quality, such as the communication skills of providers and ease of access to health care services. Member Survey results can be viewed on the Texas Healthcare Learning Collaborative Portal (THLC). Rates for most Texas Medicaid CAHPS survey composites and ratings were equal to or higher than national averages. HHSC uses these results in its annual MCO report cards, performance indicator dashboards and in P4Q (see Transparency with the Public, page 68).

### **Heightened Scrutiny in Home and Community-based Services Settings**

In 2014, the Centers for Medicare and Medicaid Services (CMS) issued the Home and Community-based Services (HCBS) Settings Rule, which requires states to ensure HCBS settings meet minimum standards for integration and choice. States must comply with these regulations by March 17, 2023.

CMS presumes certain settings are not home and community-based because they have institutional or isolating qualities. These settings must go through a heightened scrutiny review by CMS. This process allows states to demonstrate the settings can overcome this presumption.

HHSC determined assisted living facilities in the STAR+PLUS HCBS program must undergo heightened scrutiny and submitted these settings for CMS review. HHSC has worked closely with STAR+PLUS MCOs to assess each facility for compliance and oversee remediation activities.

Other HCBS settings may also be reviewed for compliance with the rule.



## **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**

Utilization reviews (URs) are overseen by the Office of the Medical Director and are conducted by a team of nurses, clinicians and contract experts. URs examine requests for medical treatments to ensure MCOs are authorizing, justifying and providing appropriate, medically necessary services without overutilization or underutilization. The reviews also ensure 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***

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 73). 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 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, and 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.

In March 2020, in response to the COVID-19 PHE, MLTSS UR moved to 100 percent audio-only telehealth interviews. In June 2022, the team added the option for audio-visual telehealth to conduct interviews. MLTSS UR will continue to use all three modalities, in-person as well as audio-only and audio-visual telehealth, to conduct reviews.

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

Under current regulations, Medicaid and CHIP 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.

Under current state law, MCOs will be able to operate their own formularies, PDLs, and prior authorization requirements, as well as negotiate and collect drug rebates, starting September 1, 2023.

### *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.

### **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.

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.

### **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. Drugs 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 also may perform others at their discretion.

When a PA cannot be obtained and a client needs medication without delay, clients may be able to access a 72-hour emergency supply of the prescribed drug.

### **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 documents and verifies service delivery information, such as the date, time, location and service type for certain Medicaid service visits. EVV helps prevent fraud, waste and abuse, while ensuring Medicaid recipients receive authorized care. Texas requires EVV for certain Medicaid-funded home and community-based services provided through HHSC and MCOs.

### ***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 that require an in-home visit. States that do not implement EVV will receive reduced Medicaid funding.

HHSC implemented EVV for personal care services in 2021. States are required to implement EVV for home health care services by January 1, 2023. In July 2022, HHSC requested a good-faith effort exemption from CMS to extend the deadline by one year. HHSC plans to implement EVV for Medicaid home health care services on January 1, 2024.



## Quality of Care

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HHSC has a strong focus on quality of care in Medicaid and CHIP and uses multiple approaches to measure and improve care quality. Quality-based payment programs and other initiatives, like recently implemented benchmarks and value-based enrollment, incentivize MCOs, DMOs, facilities and other providers to improve care quality and increase value.

HHSC collects data from several sources to support its quality initiatives. The broad range of data available includes measures such as disease prevention, chronic disease management, behavioral health, maternal health and preventable hospitalizations, as well as member and provider experience.

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.

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, if 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.

**A  
Closer  
Look**

## Value-based Enrollment

New clients are encouraged to select a health plan using MCO report cards and other information sent to them once they are found eligible. If a Medicaid client does not choose a plan, HHSC assigns the client to an MCO through a process called default enrollment.

In state fiscal year 2021, HHSC began using value-based enrollment (VBE) in which measures of quality and efficiency are incorporated into the default enrollment process. Under VBE, MCOs that perform better on key risk-adjusted cost and quality measures, and have higher member satisfaction receive a greater share of default assignments.

HHSC scores MCOs to determine each one's monthly target default assignments. Measures included in VBE align with the state's Managed Care Quality Strategy and are weighted to balance incentives for better outcomes, lower costs and higher member satisfaction.

### How Value Score Measures Are Weighted

**40%****Cost and Efficiency***Risk-adjusted actual to expected spending ratio***20%****Cost and Quality***Risk-adjusted potentially preventable events (PPE) ratios***40%****Quality and Member Satisfaction***Composite MCO Report Card Scores*

## Performance Improvement Projects

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, DMO, or a community organization.

For 2022, DMO PIPs were focused on improving preventive care by increasing the number of clients who received sealants for their first permanent molars. MCO topics focused on improving maternal and childhood health, including:

- Improving maternal health by focusing on non-medical drivers of health and reducing health disparities.
- Improving weight assessment and counseling for nutrition and physical activity for children and adolescents.

2023 PIPs for MCOs will focus on potentially preventable admissions for behavioral-health related diagnoses. DMOs' 2023 PIP topics are to increase the percentage of children under 21 who receive a comprehensive or periodic oral evaluation.

## Quality Assessment and Performance Improvement

Federal regulations also require Medicaid MCOs 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.

## Quality-based Payment Reform

Quality-based payment 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. HHSC administers quality-based payment programs in managed care and for healthcare and long-term care facilities, including: the medical and

### 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, dietitians, 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).

dental Pay-for-Quality (P4Q) programs, the Hospital Quality-based Payment Program (see Chapter 4, page 102) and the Quality Incentive Payment Program (QIPP) for nursing facilities (see Chapter 4, page 103), and other directed payment programs (DPPs) targeting specific provider groups, (see A Closer Look, page 100).

More information about quality-based payment programs and reforms can be found on the HHSC website.

### **Benchmarks for MCOs**

HHSC has developed and begun to implement benchmarks to measure MCO performance. The benchmarks complement, and in some cases rely upon, existing initiatives and data sources, and will not replace any current initiatives. The benchmarks target five domains in three broad areas:

- Cost efficiency, both medical and administrative.
- Quality of care, including specific health-related measures such as disease prevention and avoidable hospitalizations.
- Experience of care, including member experience and MCO operational performance.

HHSC selected benchmarks that align with other managed care oversight efforts and that are based on established measures. HHSC expects to build upon these benchmarks once the foundation is set. For each domain, benchmarks categorize performance as exceptional, high, satisfactory, marginal, or low.

### **The Medical and Dental P4Q Programs**

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 performance. The dental P4Q program places a portion of the DMOs' capitation at risk based on 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. Additionally, MCOs and DMOs are contractually required to 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 101). HHSC uses the Healthcare Payment-Learning and Action Network (HCP-LAN) alternative payment model framework (HCP-LAN.org) to help guide this effort.

The medical and dental P4Q programs were suspended for 2020 and 2021. MCOs were not subject to any recoupments or distributions based on calendar year 2020 and 2021 performance. The medical and dental P4Q programs resumed in 2022.

## **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 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 encounter data, and are updated annually.

These report cards allow members to compare the health plans in their service area and make informed selections 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 health 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](https://www.thlcportal.com).



## 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. MCOs are subject to contract remedies for failing to meet minimum standards for one-third or more quality measures, which includes member survey measures.

Sources	Measures
<b>National Committee for Quality Assurance Healthcare</b>	<ul style="list-style-type: none"> <li>Nationally recognized and validated set of measures used to gauge quality of care provided to members, including Healthcare Effectiveness Data and Information Set (HEDIS).</li> </ul>
<b>Healthcare Effectiveness Data and Information Set (HEDIS)</b>	<ul style="list-style-type: none"> <li>Domains include effectiveness of care, access and availability of care, experience with care, and health care utilization.</li> </ul>
<b>Agency for Healthcare Research and Quality Pediatric Quality Indicators (PDIs)/ Prevention Quality Indicators (PQIs)</b>	<ul style="list-style-type: none"> <li>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.</li> <li>PDIs specifically screen for problems that children and youth may experience.</li> </ul>
<b>3M Software for Potentially Preventable Events (PPEs)</b>	<p>The EQRO calculates rates across all MCOs and programs for the following PPEs:</p> <ul style="list-style-type: none"> <li>Potentially preventable admissions.</li> <li>Potentially preventable readmissions.</li> <li>Potentially preventable emergency department visits.</li> <li>Potentially preventable complications.</li> <li>Potentially preventable ancillary services.</li> </ul>
<b>Consumer Assessment of Healthcare Providers &amp; Systems (CAHPS) Surveys</b>	<ul style="list-style-type: none"> <li>CAHPS health plan survey is a nationally recognized and validated tool for collecting standardized information on members' experiences with health plans and services.</li> <li>The EQRO alternates CAHPS surveys so that members or caregivers from each program are surveyed every other year.</li> </ul>
<b>Dental Quality Alliance (DQA)</b>	<ul style="list-style-type: none"> <li>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.</li> </ul>

## Member Complaints and Appeals

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

- **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.
- **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, resulting in more reliable data. 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**

In 2022, HHSC implemented an external medical review (EMR) option during the fair hearings process for Medicaid managed care members in the STAR, STAR Kids, STAR+PLUS and STAR Health programs.

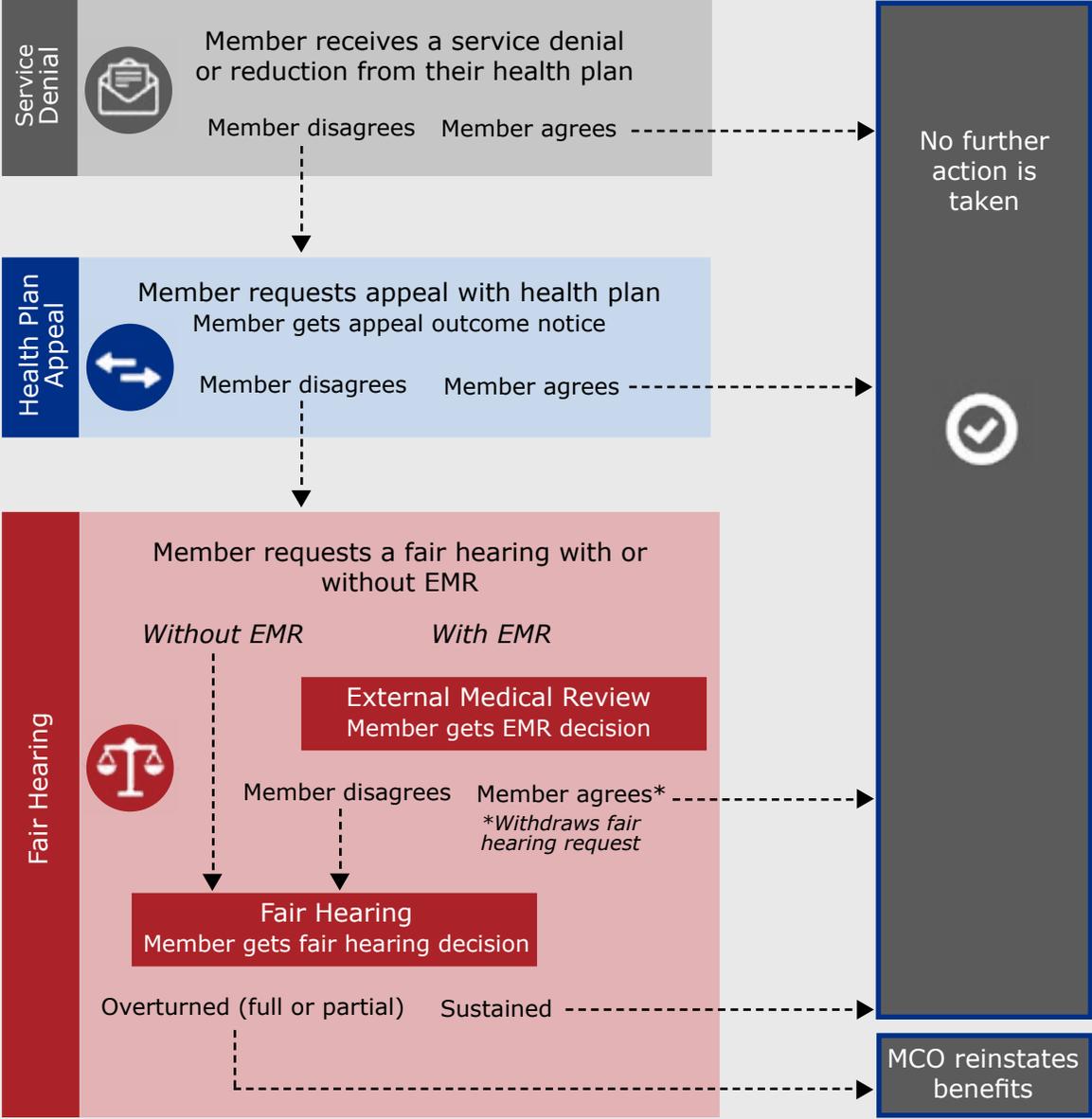
If a member requests to get an EMR, the review occurs before their fair hearing. HHSC sends the member's case to an independent review organization (IRO) where medical experts privately review the MCO's decision. They can uphold or change the MCO's decision. Once the member gets the results of the EMR,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

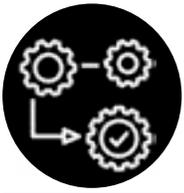
(See A Closer Look, page 72, for a more detailed look at the member's journey through the health plan appeal process.)

**A Closer Look**

## 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 they receive their MCO’s health plan appeal decision.





# Operations

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

## Operational Reviews

HHSC conducts biennial operational reviews of MCOs. These operational reviews are generally 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 part of the review process.

Previously, these reviews were conducted onsite. However, in response to the federal PHE, HHSC moved to conduct these reviews virtually and continues to conduct them virtually.

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.

### Third-party Performance Audits

Performance audits and self-reported data audits are conducted by independent auditors as determined by risk. MCS also works with the Office of the Inspector General to collaborate on audit topics. The target of the audits varies, but typically focuses on two areas:

1. MCO data, such as complaints and appeals.
2. Operational processes, such as claims processing or subcontractor monitoring, including pharmacy benefit managers.

## Targeted Reviews

In addition to the established 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 noncompliance.

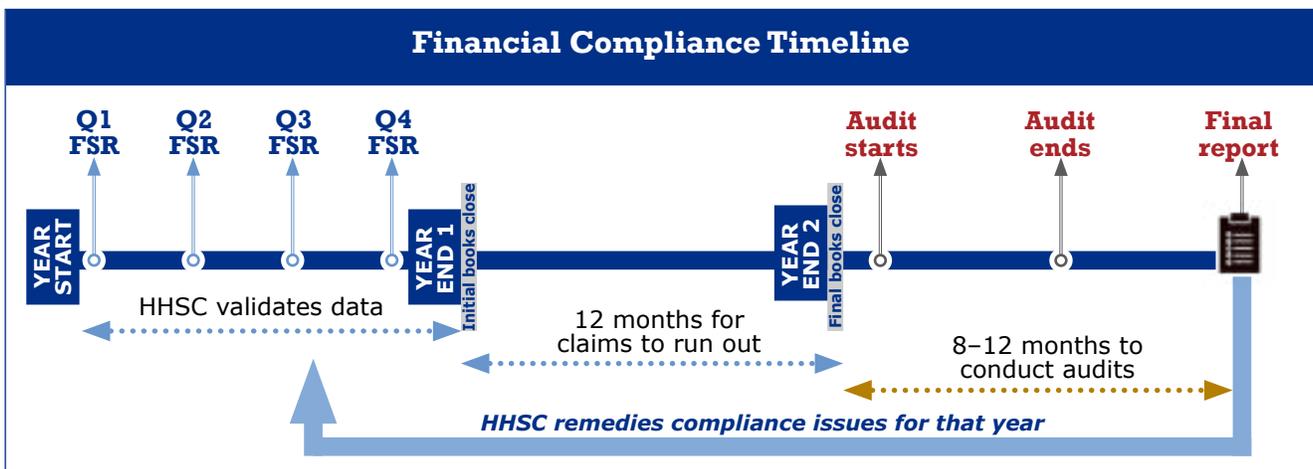


# Financial

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 75).

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. Full audits by independent auditors can only occur after the final books close and all claims have run out for that given year. The timeline may be impacted by workforce changes and the timeliness of audit processes.



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

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



## 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 admin cap set by the program.

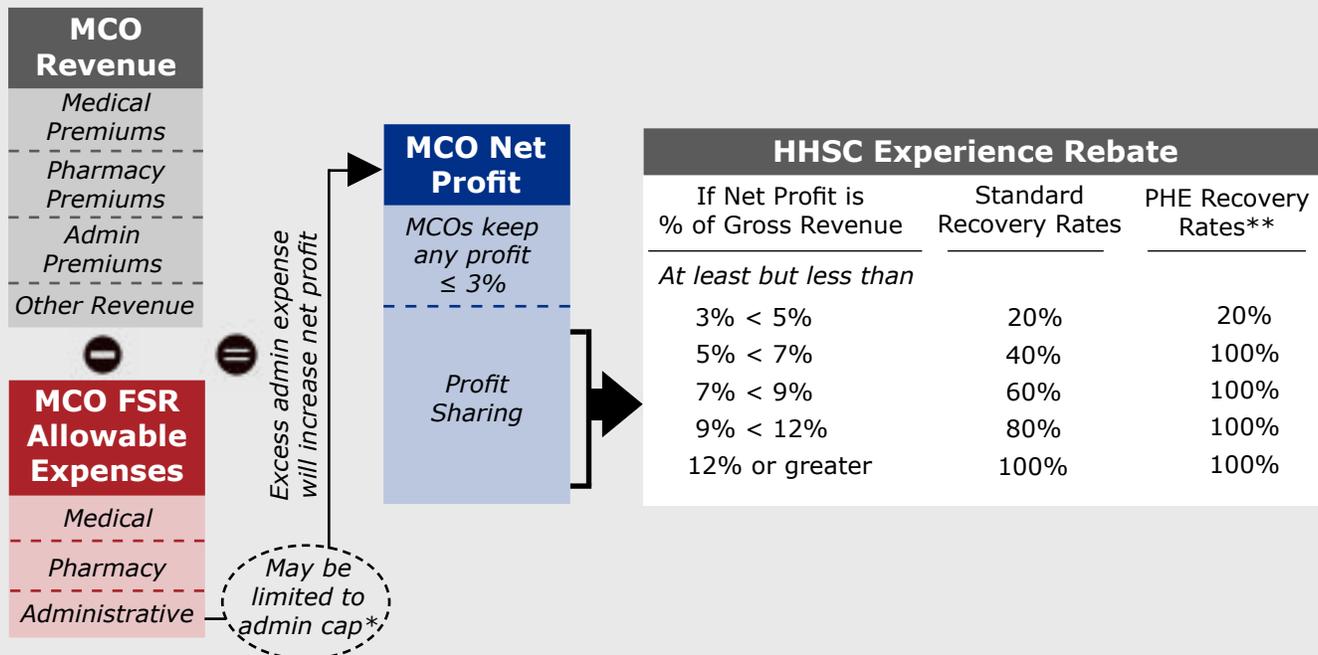
- The cap is compared to MCO’s reported administrative expenses.
- Any amounts over the admin cap also become disallowed expenses, and the MCO’s net income is increased by that amount.

### 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.

Changes to eligibility requirements during the COVID-19 PHE (see Chapter 1, page 12) contributed to an increase in profits for MCOs during SFYs 2020 and 2021. In response, HHSC has temporarily changed the experience rebates for SFYs 2022-2023.

## 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 considered necessary for the successful operation of their business. Examples include certain marketing and legal expenses, lobbying, and bonuses that exceed the compensation limit.

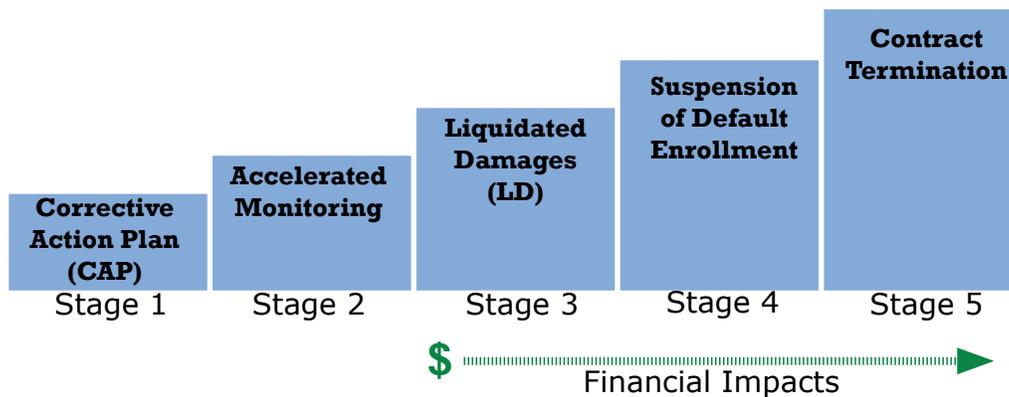
\*Admin cap is set by program.

\*\*Numbers updated post-printing, March 2023



## 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:



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 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 targeted 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.

### ***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 noncompliance.

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.



# 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 and detection of fraud, waste and abuse in publicly funded, state-run health and human services programs. OIG has five main tools for detecting, deterring, and preventing fraud, waste and abuse to ensure taxpayer funds for health and human services are properly spent:

1. Performance audits focus on risk-based topics related to providers, contractors and programs across HHS and the Department of Family and Protective Services.
2. Inspections focus on systemic issues and risk assessment.
3. Investigations focus on alleged fraudulent, wasteful or abusive practices.
4. Reviews focus on fraud, waste and abuse in documentation, billing and payments.
5. Data analytics drive OIG work by identifying trends and outliers for further review.

## Performance Audits

Audits may identify non-compliance with requirements, overpayments, and program policy gaps. OIG auditors may propose recommendations to prevent fraud, waste and abuse. OIG 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 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.

## Investigations

### *Provider Investigations*

This unit investigates 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 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 (SNAP); Temporary Assistance for Needy Families (TANF); and the Women, Infants and Children (WIC) program. Findings can include

the provision of false information to apply for services or using someone else's benefits for services.

### **Reviews**

This unit reviews utilization of acute-care services (e.g., provider office visits, laboratory and x-ray services), hospital services (e.g., surgical specialists), and nursing facility services (e.g., rehabilitation, long-term care).

### ***Medicaid Lock-in Program***

The Medicaid Lock-in program operates by "locking in" a client to one provider and pharmacy to prescribe and dispense certain drugs, like controlled substances (e.g., opioids) to prevent their abuse or overuse. This prevents clients from visiting more than one Medicaid provider to 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. Providers and MCOs also make referrals to the program.

### **Data Analytics**

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.



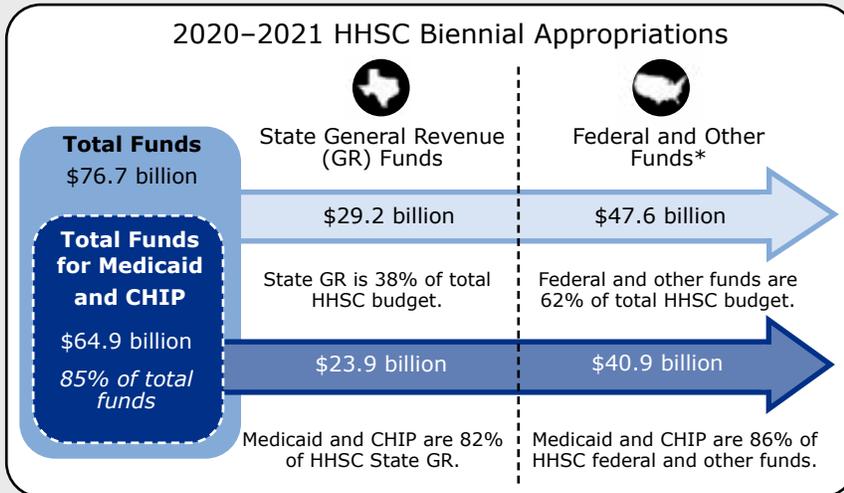
# Chapter 4

What are the financial features of Medicaid and CHIP?



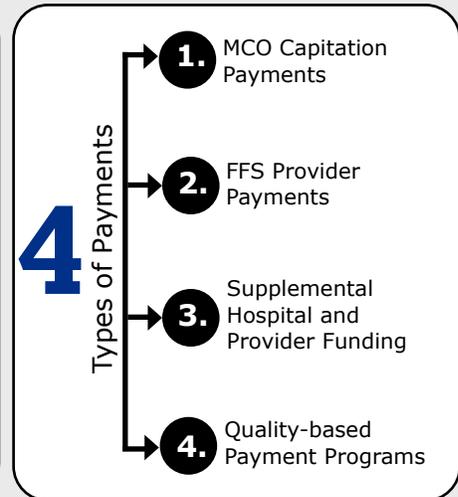
# At-a-Glance

## Funding

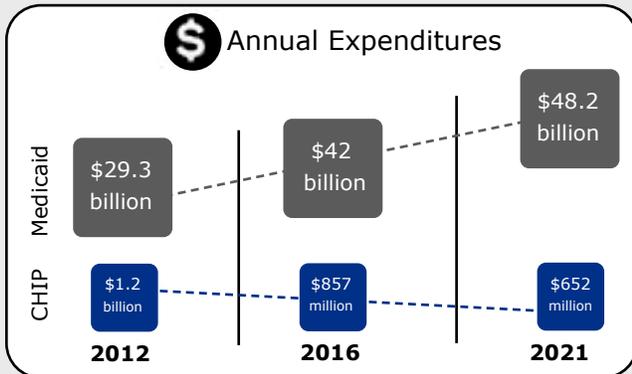


\*Other funds include, but are not limited to, Appropriated Receipts, Interagency Contracts, Medicaid Subrogation Receipts (State Share), and WIC Rates.

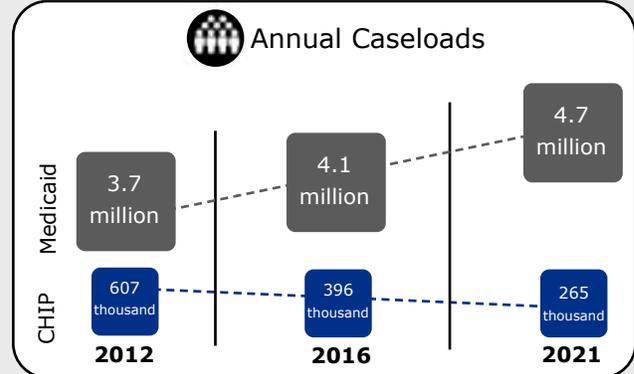
## Payments



## Growth Trends



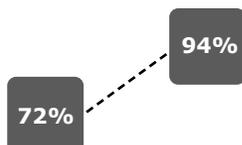
Includes DSH, UC, UC/PHP-CCP, DSRIP, and Supplemental Payment Program expenditures. Full details for annual expenditures and caseloads can be found on page 161.



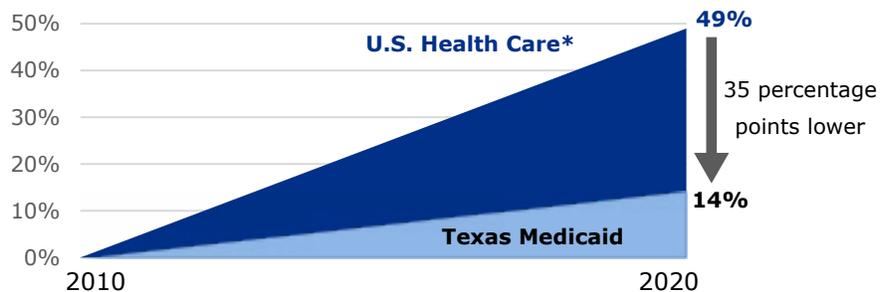
## 10-Year Cost Growth Comparison

The number of Texans enrolled in Medicaid managed care has grown by 1 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



Cost per Person



Texas Medicaid cost per person is based on full benefit clients. \*Source: CMS, Office of the Actuary 2010-2020—data is for CY10–CY20



# 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.

<b>Legislative Appropriations Timeline</b>	
August	State agencies submit legislative appropriations requests for the next biennium
January	Legislature convenes
April	Legislature works on appropriations bills; last chance to provide up-to-date Medicaid projections for bills
May	Legislature finishes appropriations for the next biennium
September	New biennium begins (in odd-numbered years only)

## 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) 2023, Texas' Medicaid FMAP is 61.42 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 2023 is 62.01 percent—which includes one month of the FFY 2022 rate of 67.00 percent and 11 months of the FFY 2023 rate of 61.42 percent.

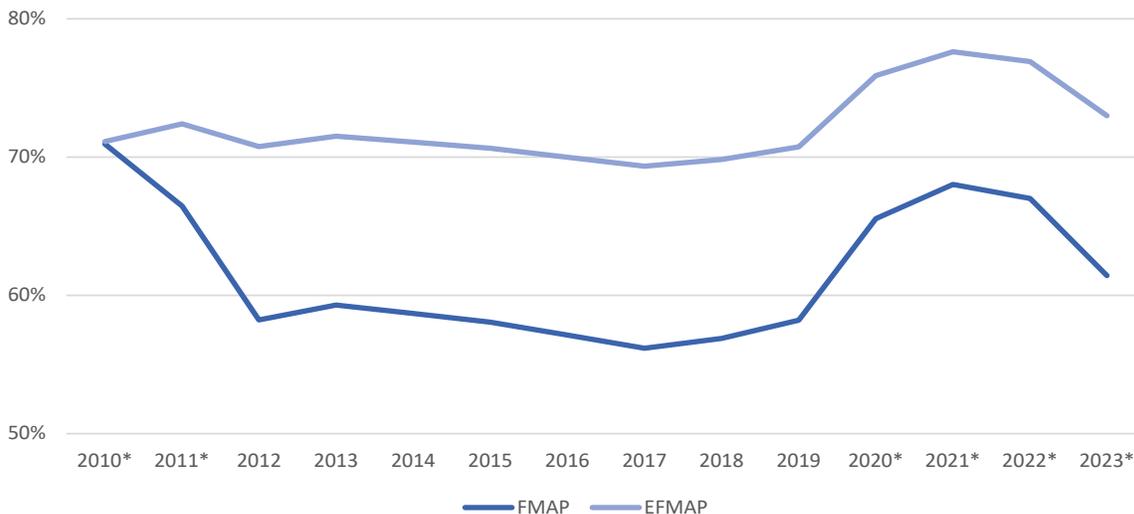
## CHIP Matching Funds

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 2021 allocation was fully expended, and the 2022 allocation is estimated to be fully expended in 2023. The federal allocation for Texas in FFY 2021 was \$1.4 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 2023 is 72.99 percent and in SFY 2023 is 73.41 percent.

## Texas Federal Medical Assistance Percentages, FFYs 2010–2023



\*Indicates stimulus FMAPs in effect. Due to the federal public health emergency (PHE), the 2020-2023 FMAPs include an additional 6.2 percent federal match between January 2020-December 2022. This increase could be extended.

### Deferrals and Disallowances

Deferrals and disallowances impact the availability of federal financial participation:

- **Deferral:** If CMS determines that a state 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.

## **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 146).

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.

## **The Texas 1115 Transformation Waiver and Budget Neutrality**

The Texas 1115 Transformation Waiver, also known the Texas Healthcare Transformation and Quality Improvement Program, provides the federal authority for operations of most of the state's Medicaid managed care programs, including STAR, STAR+PLUS, STAR Kids, and the Children's Dental Program, while preserving supplemental funding for providers including hospitals (see Chapter 5, page 110). On January 15, 2021, CMS approved an extension the waiver through September 2030.

Medicaid spending under a Section 1115 demonstration waiver is required to be budget neutral, meaning that federal spending under the demonstration cannot exceed projected costs in the absence of the demonstration (referred to as the without-waiver baseline). If state spending is below the without-waiver baseline, the difference is considered savings.

The savings accumulated by a state may be used to fund supplemental payments to providers not otherwise permitted under federal regulations. Texas' 1115 waiver originally

contained two such funding pools: the Uncompensated Care (UC) and the Delivery System Reform Incentive Payment (DSRIP) pools. Under the current waiver, these savings support the UC and Public Health Provider-Charity Care pools (see Chapter 4, page 98).

DSRIP ended in September 2021 with funding expiring in January 2023. Under the current waiver, HHSC has implemented a transition plan which preserves budget neutrality and funding for providers, while continuing healthcare transformation in Texas. The Quality Incentive Payment Program (QIPP), Network Access Improvement Program (NAIP), and four new directed payment programs (DPPs) now operate under the waiver (see A Closer Look, page 100). Budget neutrality will go through a rebasing exercise effective in FY23 to incorporate updated CMS policies, including any adjustments for impacts related to the Covid-19 PHE.



## Rate Setting

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### 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 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 all programs, services related to the treatment and prevention of COVID-19 are paid for outside the capitation rate.

HHSC also includes provision for directed payment programs in the STAR, STAR+PLUS, STAR Kids and Dual Demonstration programs' capitation rates, which are used to increase funding for providers and facilities, including hospitals and nursing facilities (see Chapter 4, page 96).

## Children’s Medicaid Dental Services Rates

Children’s Medicaid Dental Services capitation rates are based on claims from the covered population in the base period. The base cost is totaled, and it trends 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 MCOs. 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 Children’s Medicaid Dental Services program.

## **CHIP Perinatal Rates**

Capitation rates for the CHIP Perinatal (CHIP-P) 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-P 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](https://hhs.texas.gov/services/health/medicaid-chip/programs-services/children-families/childrens-medicaid-chip)).

**A Closer Look**

## How HHSC Pays for Prescription Drugs

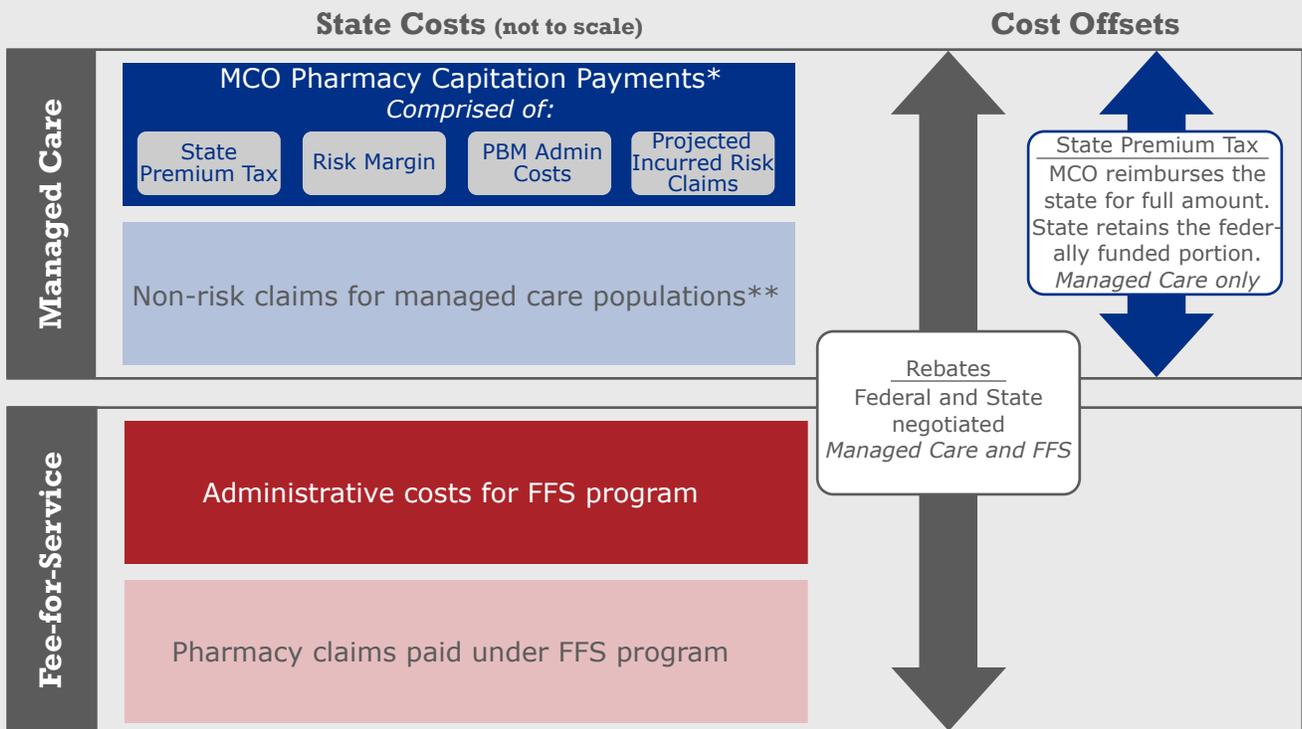
In recent years, prescription drugs have become increasingly associated with rising costs. For Medicaid and CHIP, MCOs administer most of the prescription drug benefit. A small portion of the benefit is administered by HHSC on a FFS basis.

In managed care, pharmacies are paid through pharmacy benefit managers (PBMs) contracted with MCOs (see Chapter 3, page 62). PBMs pay 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. MCO capitation rates do not include the costs of certain drugs for which HHSC makes non-risk payments to the MCO. Non-risk payments are limited to the actual amounts MCOs pay to providers for the ingredient cost of these drugs up to the FFS reimbursement amount.

Pharmacies are paid directly in FFS. 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 overutilization (see Chapter 3, page 61).



\*The ACA Health Insurance Providers Fee was 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, 3 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).

HHSC also establishes reimbursement rates for services such as laboratory and x-ray services, radiation therapy, physical and occupational therapy, 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 and Provider Funding, page 96).

<b>Reimbursement Rates by Hospital Type</b>	
<b>Rural Hospital</b>	Rates are based on the standard dollar amount required to treat a Medicaid inpatient admission and is derived from base year costs.
<b>Children's Hospital</b>	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.
<b>Psychiatric Hospital</b>	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.
<b>State-owned Teaching Hospital</b>	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.
<b>Urban Hospital</b>	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—such as medical education, geographic location and safety-net designation.

## **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.

### ***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 several requirements a clinic must meet 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.

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 adjusted 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 and Provider 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.

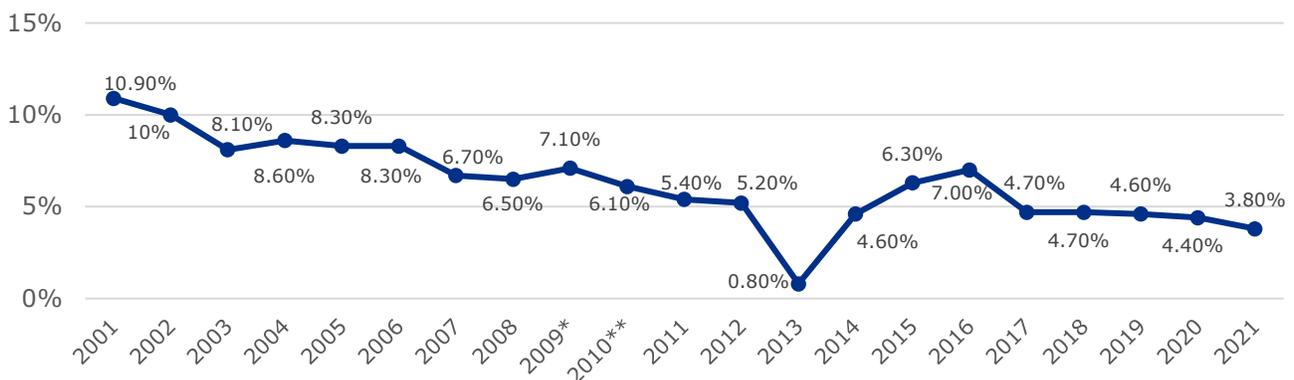
To comply with federal regulations and to preserve federal hospital funding while expanding managed care, HHSC submitted a five-year Section 1115 Transformation Waiver in 2011. On January 15, 2021, CMS approved the most recent extension of the waiver through September 2030 (see Chapter 5, page 110).

Through the Texas 1115 Transformation Waiver, also known the Texas Healthcare Transformation and Quality Improvement Program, HHSC administers supplemental funding for hospitals and other facilities to help cover the cost of uncompensated care, incentivize improvements to service delivery, and fund graduate medical education. These programs also include quality-based payment programs (see Quality-based Payment Programs, page 101).

## 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 2001–2021**



\*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 2020 \$4 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:

FFY	2020	2021	2022	2023	2024	2025
Reduction for all states	\$4.0 billion	\$8.0 billion				

DSH Payment Information reports are published annually online at: [RAD.HHS.Texas.gov/Hospitals-Clinic/Hospital-Services/Disproportionate-Share-Hospitals](https://rad.hhs.texas.gov/hospitals-clinic/hospital-services/disproportionate-share-hospitals).

## Uncompensated Care Funding

Created under the 1115 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 155).

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.

### **The Public Health Provider-Charity Care Program**

Authorized under the current 1115 Transformation Waiver, the Public Health Provider-Charity Care Program (PHP-CCP) is designed to allow qualified providers to receive reimbursement for the cost of delivering uncompensated health care services, including behavioral health services, immunizations, and other preventative services.

Eligible providers include Community Mental Health Clinics (CMHCs), Community Centers, Local Behavioral Health Authorities (LBHAs), Local Mental Health Authorities (LMHAs), Local Health Departments (LHDs) and Public Health Districts (PHDs).

The PHP-CCP began operating on October 1, 2021. The first year of the program consisted of uncompensated care. In its second year, the program has transferred to charity care only. Total funding is set not to exceed \$500 million over these first two years of the program. In future years, this pool will be subject to resizing based on actual charity care costs incurred by eligible providers.

### **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.

### **Directed Payment Programs**

DPPs are supplemental payment programs for providers and are designed to advance at least one of the objectives of the Texas' Managed Care Quality Strategy. Enrolled providers submit qualitative and quantitative data on quality measures that are used to evaluate the

programs. Previously, the following DPPs were authorized under the 1115 Transformation Waiver:

- The Network Access Improvement Program (NAIP), a “pass-through” payment program to help fund public hospitals and health-related institutions and increase access to primary and specialty care for managed care members. Under federal law, NAIP will sunset. Pass-through payments to physicians have been phased out as of July 1, 2022. Pass-through payments must be phased out by July 1, 2027.
- The Uniform Hospital Reform Increase Program (UHRIP), a DPP designed to reduce hospitals’ uncompensated care costs through enhanced payments to hospitals for medically necessary, covered services provided to Medicaid managed care members. The Comprehensive Hospital Increase Reimbursement Program (CHIRP) replaced UHRIP as of September 1, 2021.
- The Quality Incentive Payment Program (QIPP), a DPP focused on improving quality of care in nursing facilities (see Chapter 4, page 103). QIPP is now in its fifth year of operation.

### ***The DSRIP Transition***

The Delivery System Reform Incentive Payment (DSRIP) program was created by the 1115 Transformation Waiver. DSRIP provided financial incentives to encourage hospitals and other providers to focus on achieving quality health outcomes and delivery system reforms. The program ended in September 2021.

In transitioning away from DSRIP and under the authority of the current 1115 Transformation Waiver, HHSC has implemented four new directed payment programs (DPPs) to continue healthcare transformation initiatives (see A Closer Look, page 100).

All currently operating DPPs require annual approval from the Centers for Medicare and Medicaid Services (CMS).



## New Directed Payment Programs

### **Comprehensive Hospital Increase Reimbursement Program (CHIRP)**

CHIRP is a DPP for hospitals providing healthcare services to adults and children enrolled in STAR and STAR+PLUS. Eligible hospitals include children’s hospitals, rural hospitals, mental health hospitals, state-owned hospitals, and urban hospitals. CHIRP funds are paid through two components: 1) the UHRIP component which enhances payments to hospitals and 2) an optional incentive award component.

CMS approved CHIRP on March 25, 2022 (FY 22) and August 1, 2022 (FY 23).

### **Directed Payment Program for Behavioral Health Services (DPP BHS)**

The DPP BHS looks to improve community mental health centers and local behavioral health authorities intended to promote and improve access to behavioral health services, care coordination, and successful care transitions. It also incentivizes the Certified Community Behavioral Health Clinic (CCBHC) model of care.

CMS approved DPP BHS on November 15, 2021 (FY 22) and August 1, 2022 (FY 23).

### **Rural Access to Primary and Preventive Services Program (RAPPS)**

RAPPS is a directed payment program for rural health clinics (RHCs) that provide primary care and long-term care services to STAR, STAR+PLUS, and STAR Kids members. Eligible providers include hospital-based RHCs, which include non-state government-owned and private RHCs, and free-standing RHCs.

CMS approved RAPPS on March 25, 2022 (FY 22) and August 1, 2022 (FY 23).

### **Texas Incentives for Physicians and Professional Services (TIPPS)**

TIPPS is a directed payment program for certain physician groups providing health care services to children and adults enrolled in the STAR, STAR+PLUS and STAR Kids Medicaid programs. Eligible physician groups include health-related institutions, indirect medical education physician groups affiliated with hospitals and other physician groups.

CMS approved TIPPS on March 25, 2022 (FY 22) and August 1, 2022 (FY 23).



# Quality-based Payment Programs

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## 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 and dental P4Q programs were suspended for 2020 and 2021. MCOs were not subject to any recoupments or distributions based on calendar year 2020 and 2021 performance. The medical and dental P4Q programs resumed in 2022.

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.

<b>MCO and DMO APM Payment and Risk Thresholds for Calendar Years 2018 and 2022</b>				
	2018 Payment Threshold	2018 Risk Threshold	2022 Payment Threshold	2022 Risk Threshold
<b>MCOs</b>	25%	10%	50%	25%
<b>DMOs</b>	25%	2%	50%	10%

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 operates an incentive program that adjusts payments to 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 more than 950 of the state's 1,200 nursing facilities are enrolled for SFY 2023.

The program's budget increased from approximately \$400 million in SFY 2018, the first year of the program, to \$1.1 billion in SFY 2021 and has remained constant through SFY 2023. 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 SFYs 2020 and 2021, HHSC adopted new quality measures, eligibility requirements and financing components. QIPP quality components during this biennium included workforce development; an infection control program; and long-stay quality measures focused on pressure ulcers, antipsychotic medication, urinary tract infections, and independent mobility.

Beginning in SFY 2022, HHSC refined requirements in two components to incorporate performance improvement projects (PIPs) as conditions of participation in the program year. Facilities that do not meet conditions of participation may be subject to removal from the program and recoupment of program funds. HHSC also expanded the program's infection control component to require designated elements of antibiotic stewardship, infection control training for both nursing facility administrators and directors of nursing, and two CMS-approved vaccination quality measures.



## Fund Recovery

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The Office of Inspector General (OIG) performs the functions listed below (see page 78 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 a third party is identified after a claim is filed or paid. HHSC must promptly seek reimbursement from the liable third party.

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?



# At-a-Glance

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

## Key Federal Concepts

### Fundamental Requirements:

The basic principles for Medicaid programs established by the Social Security Act (SSA).

### Centers for Medicare & Medicaid Services (CMS):

The agency within the U.S. Department of Health and Human Services that oversees the Medicaid program.

### Single State Agency (SSA):

Federal regulations require each state to designate a single state agency responsible for that state’s Medicaid program.

### Medicaid State Plan:

Submitted by states individually, this is a dynamic document that serves as the contract between each state and CMS.

### Waivers:

States apply to CMS for waivers to test new ways to deliver and pay for services.

## + 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.

### Key Federal Mandate Categories

Populations



Services



Limits



See Appendix A, page 135, for a list of highlights from the Texas Legislature and relevant federal changes.

# How Texas Administers Medicaid and CHIP

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Texas submits a state plan for both Medicaid and the 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 program and CHIP—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 Medicaid and CHIP in Texas. HHSC’s responsibilities include:

- Serving as the primary point of contact with the federal government.
- Coordinating initiatives to maximize federal funding and administering the Medical Care Advisory Committee (mandated by federal Medicaid law to advise the Medicaid agency about health and medical care services).
- Establishing policy direction for the Medicaid program and CHIP, 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 (including medical and dental benefits policies), rules, reimbursement rates and oversight of Medicaid program operations, including managed care organization (MCO) contract compliance.

## ***CHIP State Plan***

States can design their CHIP plan using one of three frameworks established by federal law. States can either include CHIP within their Medicaid program, create a separate CHIP plan, or create a combination of these two options. Texas operates CHIP separately.

## **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.

### ***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, allowed Texas to expand managed care—including pharmacy and dental services—while preserving federal hospital funding. STAR, STAR+PLUS, STAR Kids and dental managed care services are covered under this waiver.

CMS has approved an extension of the waiver through September 2030.

The waiver, first approved in 2011, originally included two funding pools: the Uncompensated Care (UC) and Delivery System Reform Incentive Payment (DSRIP) pools. The UC pool is available to help cover the actual uncompensated care costs incurred by hospitals and other eligible providers for serving uninsured individuals in the state. The DSRIP pool provided incentive payments to providers to support their efforts to enhance access to care, improve quality and reform the health care delivery system. DSRIP ended in September 2021 with funding expiring in January 2023.

Managed care directed payment programs operate in conjunction with the waiver to support the managed care model by funding rate increases directed to certain providers through managed care organizations and advancing at least one goal and objective of the Texas Managed Care Quality Strategy.

The directed payment programs include Comprehensive Hospital Increase Reimbursement Program (CHIRP), Directed Payment Program for Behavioral Health Services (DPP BHS), Quality Incentive Payment Program (QIPP), Rural Access to Primary and Preventive

Services (RAPPS), and Texas Incentives for Physicians and Professional Services (TIPPS) (see A Closer Look, page 100).

### **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, 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, including screening and treatment for hypertension, diabetes, and high cholesterol to positively impact maternal health and reduce maternal mortality.
- Increase access to women’s breast and cervical cancer services 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 within the continuum of care or services, and to avoid the direct or indirect use of state funds to promote or support elective abortions.
- Reduce the overall cost of publicly funded health care by providing low-income Texans with access to safe, effective services consistent with the goals above.

In December 2020, HHSC submitted an amendment to the HTW 1115 demonstration to receive federal funds for HTW Plus. At the time the amendment was submitted, HHSC requested an effective date of April 1, 2021. As of December 2022, the amendment is pending with CMS.

### ***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 in an Intellectual or Developmental Disabilities (IDD) waiver 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 a 1915(b) waiver for the Medical Transportation Program (MTP). Texas previously delivered nonemergency medical transportation (NEMT) services through both FFS and managed care under the authority of a 1915(b)(4) and a 1915(b)(1) waiver, respectively. Effective June 1, 2021, as part of carving NEMT services into managed care, Texas uses an 1115 waiver. MTP, which remains in FFS, continues to operate under the authority of the state plan and a 1915(b)(4) waiver.

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

Section 1915(c) waivers allow states to provide home and 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 A Closer Look, page 42).



## **Fundamental Requirements**

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### **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 54).

## 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 and how much they cover. There are two main limits on Texas Medicaid services:

- A 30-day annual limit on inpatient hospital stays per spell of illness for adults served in FFS Medicaid or in the STAR+PLUS managed care program. Exceptions include:
  - More than one 30-day hospital visit can be paid for if the stays are separated by 60 or more consecutive days.
  - Clients receiving a pre-approved, medically necessary transplant 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.
  - The limit does not apply to children age 20 or younger.
- Three prescriptions per month for outpatient drugs for adults in FFS Medicaid. Exceptions to this limit include:
  - Family planning drugs are not limited.
  - The limit does not apply to children age 20 or younger, adults enrolled in managed care or 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 ages 20 and younger who are enrolled in Medicaid (see Chapter 2, page 35). Federal changes have expanded the benefits of this program so that children and youth ages 20 or 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 Texas Medicaid program:

- *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 regarding a medical checkup provider, even if they are not the child's primary care provider.

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 primary care provider from the MCO's provider network.

# Appendix A

Key Medicaid and CHIP legislation

Texas Medicaid and the Children’s Health Insurance Program (CHIP) change in response to legislative requirements at the state and federal levels. This appendix provides a brief legislative history of Medicaid and CHIP, including highlights of key federal and state legislation by topic.

# Medicaid

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## Founding Legislation

In 1965, the Social Security Act (SSA) of 1935 was amended to add Title XIX, which created Medicaid as a state-administered health care program, jointly funded by the federal government. The SSA was further amended in 1967 to mandate inclusion of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program for children in Medicaid, and again in 1972 to allow states to cover care for children and youth in inpatient psychiatric care. In 1977, the Centers for Medicare and Medicaid (CMS) was created to oversee and manage Medicare, Medicaid and CHIP.

The SSA dictates the principles that state Medicaid programs must fulfill, including:

- **Section 1902(a)(1):** required that state Medicaid programs be in effect “in all political subdivisions of the state.”
- **Section 1902(a)(10):** required that state Medicaid programs provide services to people that are comparable in amount, duration and scope.
- **Section 1902(a)(23):** required that state Medicaid programs ensure that clients have the freedom to choose any qualified provider to deliver a covered service.

Also included within the SSA are sections that allowed states to waive various Medicaid requirements and implement different service delivery models, eligibility criteria and benefits:

- **Section 1115(a):** allows states to waive provisions of Medicaid law to test new concepts consistent with the goals of the Medicaid program. System-wide changes are possible under this provision. CMS must approve waivers.
- **Section 1903(m):** allows state Medicaid programs to develop risk contracts with managed care organizations (MCOs) or comparable entities.
- **Section 1915(b):** allows states to waive freedom of choice. States may require that beneficiaries enroll in MCOs or other programs. CMS must approve waivers.
- **Section 1915(c):** allows states to waive various Medicaid requirements to establish alternative, home and community-based services for individuals who qualify to receive services in an intermediate care facility for individuals with an

intellectual disability or related condition (ICF/IID), nursing facility, institution for mental disease, or inpatient hospital. CMS must approve waivers.

- **Section 1915(i):** allows states to offer a variety of services under a state plan Home and Community-based Services (HCBS) benefit. Individuals must meet state-defined criteria based on need and typically get a combination of acute-care medical services and long-term services in home and community-based settings.
- **Section 1929:** allows states to provide a broad range of home and community-based care to individuals with functional disabilities, as an optional state plan benefit. In all states but Texas, the option can serve only people age 65 and older. In Texas, individuals of any age may qualify to receive personal care services through Section 1929 if they meet the state’s functional disability test and financial eligibility criteria.

## Program Reforms

Federal and state laws also determine which populations are eligible for Medicaid and what Medicaid covers. Federal and state legislation have reformed and expanded the program over time—adjusting program eligibility criteria, as well as the type, amount, duration and scope of services provided through Medicaid.

### *Federal Legislation*

Historically, all Medicaid clients either had Supplemental Security Income (SSI) or welfare. Beginning in the 1980s, several federal laws were passed that expanded Medicaid coverage to populations ineligible for SSI or Temporary Assistance for Needy Families (TANF) and, eventually, de-linked financial assistance from Medicaid eligibility. A few of these federal laws are highlighted below:

#### **The Omnibus Budget Reconciliation Act of 1986 (OBRA of 1986):**

- Mandated states cover emergency care services, including labor and delivery, for undocumented immigrants and required them to cover homeless people.
- Allowed states to cover infants and pregnant women under 100 percent of the federal poverty level (FPL); to create a phase-in for children age 4 and younger under 100 percent of the FPL; and to cover prenatal care while a Medicaid application is pending, along with guaranteed coverage for the full term of pregnancy and postpartum care. States may waive asset tests for this group.

#### **The Omnibus Budget Reconciliation Act of 1987 (OBRA of 1987):**

- Required states to extend coverage to children age 6 and younger born after September 30, 1983, whose families meet TANF financial standards—even if the family does not qualify for TANF. Extension through age 7 is at the state’s option.

- Allowed states to cover infants age 1 and younger and pregnant women under 185 percent of the FPL, with immediate coverage (no phase-in) for children age 4 and younger under 100 percent of the FPL.
- Mandated sweeping changes in nursing facility standards, including the creation of the Preadmission Screening and Resident Review process—a requirement that all current and prospective nursing facility clients be screened for mental illness, intellectual disability or related conditions.

**The Medicare Catastrophic Coverage Act of 1988:**

- Expanded Medicaid coverage for infants, young children and pregnant women.
- Provided phased-in coverage of infants through their first birthday and pregnant women under 100 percent of the FPL.
- Required more comprehensive coverage of hospital services for infants, and expanded payments for hospital services for infants in all hospitals, and for children age 5 and younger in disproportionate share hospitals.
- Amended eligibility criteria and services provided to dually eligible Medicare clients—including providing phased-in coverage of out-of-pocket costs (premiums, deductibles and coinsurance) for Qualified Medicare Beneficiaries under 100 percent of the FPL and establishing minimum standards for income and asset protection for spouses of Medicaid clients in nursing homes.
- Expanded Medicaid coverage for students with disabilities who meet eligibility requirements for special education described in the Individuals with Disabilities Education Act (IDEA).

**The Omnibus Budget Reconciliation Act of 1989 (OBRA of 1989):**

- Prohibited states from limiting the amount, duration, scope or availability of state plan services to children on Medicaid.

**The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996:**

- De-linked cash assistance and Medicaid eligibility. While Medicaid financial eligibility is determined using the FPL, the TANF monthly cap is based on a set dollar amount, and each state sets its income eligibility guidelines for TANF cash assistance. Prior to PRWORA, children age 18 and younger and their related caretakers, who qualified for TANF cash assistance, were also automatically qualified for Medicaid. Under PRWORA, if households need both TANF cash assistance and Medicaid, they must apply for both. Otherwise, they can only apply for TANF cash assistance or Medicaid.
- Required TANF clients to participate in work activities within two years of entering the program and prohibited them from receiving federally funded TANF benefits

- for more than 60 months over a lifetime. This requirement is thought to be partly responsible for the drop in the Medicaid caseload in Texas in the mid-to-late 1990s.
- Gave states the option to decide whether to continue providing Medicaid to most legal immigrants. Most immigrants entering the U.S. after August 22, 1996, are subject to a five-year wait period, during which no federal Medicaid funds can be accessed for their care. The Balanced Budget Act (BBA) of 1997 restored SSI benefits for legal immigrants who arrived in the U.S. prior to August 22, 1996, but limited the benefit until after the first seven years of a person’s residence in the U.S. (see below).

Various laws have been passed to extend PRWORA beyond its initial expiration in September 2002. **The Deficit Reduction Act (DRA) of 2005** reauthorized TANF through 2010, and continuing resolutions have extended the program since then.

The DRA also reduced federal Medicaid and Medicare spending by \$39 billion from 2006–2010, through changes to prescription drug regulations and long-term services and supports (LTSS) eligibility rules, among others.

### **The Balanced Budget Act (BBA) of 1997:**

A landmark piece of federal legislation that:

- Created CHIP and changed Medicaid and Medicare rules and regulations.
- Added several new eligibility options including:
  - **Guaranteed Eligibility:** allowed states to choose to guarantee Medicaid coverage for up to 12 months for all children, even if they no longer meet Medicaid income eligibility tests.
  - **Medicaid Buy-in:** allowed states to offer individuals with disabilities, and income below 250 percent of the FPL, an opportunity to buy in to the Medicaid program.
  - **Medicaid Buy-in for Children:** allowed states to offer children age 18 and younger with disabilities an opportunity to buy in to the Medicaid program.
- Repealed the Boren Amendment from the Omnibus Budget Reconciliation Act of 1980 (OBRA of 1980), which linked Medicaid nursing home rates to federal and state quality-of-care standards.
- Allowed states to require most Medicaid-eligible individuals to enroll in managed care plans without a waiver, such as an 1115 or 1915(b)—but mandated all states with Medicaid managed care programs to ensure MCOs conduct Performance Improvement Projects (PIPs) (see Chapter 3, page 65).

The BBA was later amended by the Balanced Budget Refinement Act (BBRA) of 1999, which provided approximately \$17 billion in “BBA relief” over five years. The BBRA also extended the phaseout of cost-based reimbursement for Federally Qualified Health

Centers (FQHCs) and rural health clinics (RHCs) and changed Medicaid Disproportionate Share Hospital (DSH) payments and rules. It also prohibited states from using CHIP federal funds for DSH.

### **The Affordable Care Act (ACA) of 2010:**

Made several important changes to the health care system in the U.S., including:

- Prohibiting coverage denials based on a preexisting condition.
- Allowing children to remain on their parent's health plan until age 26.
- Requiring persons to have health insurance or pay a penalty; however, the **Tax Cut and Jobs Act of 2017** eliminated this penalty starting in 2019.
- Requiring states to establish health insurance marketplaces or refer people to the federally facilitated marketplace to assist individuals and small employers in accessing health insurance. Texas currently utilizes the federally facilitated marketplace.
- Mandating states modify their Medicaid program and CHIP plan, including their state plans and financial eligibility criteria.
- Giving states the option to expand Medicaid eligibility up to 133 percent of the FPL for individuals age 64 and younger, with federal funds paying 100 percent for the first three calendar years of the expansion. Effective in 2017, the federal matching rate decreased gradually each year. From 2020 onward, the matching rate will be 90 percent. Texas has not expanded Medicaid eligibility to this optional adult group.

Additionally, in anticipation that the uninsured population would decrease following Medicaid expansions and the implementation of the state health insurance marketplaces, the ACA intended to decrease DSH allotments. Since 2010, various pieces of legislation have delayed the implementation of DSH funding cuts under the ACA and changed the amounts of the reductions.

The **Coronavirus Aid, Relief and Economic Security (CARES) Act** of 2020 delayed the reductions in DSH allotments for FFY 2020 until December 1, 2020 (see Chapter 4, page 96).

The ACA also made changes to the federal drug rebate program created under OBRA of 1990—increasing the minimum federal rebate percentages that drug manufacturers are required to pay to participate in the Medicaid program, while expanding the rebate program to cover claims paid by Medicaid MCOs (see page 122).

## ***State Legislation***

### **Senate Bill (S.B.) 11, 85th Legislature, Regular Session, 2017:**

- Required the Department of Family and Protective Services (DFPS) to ensure that children taken into state conservatorship receive an initial medical exam within three business days, if they are removed from their home as the result of:
  - Sexual abuse, physical abuse or an obvious physical injury.
  - A chronic medical condition, a medically complex condition or a diagnosed mental illness.
- Prohibited a physician or other health care provider from administering a vaccination as part of the required exam—except for an emergency tetanus vaccination—without parental consent and until DFPS has been named managing conservator.
- Required DFPS to ensure that any child who enters state conservatorship receives any necessary emergency medical care as soon as possible.

### **House Bill (H.B.) 2466, 85th Legislature, Regular Session, 2017:**

- Required Medicaid and CHIP to cover a maternal depression screening for mothers of children who are eligible for Medicaid. This screening occurs during the covered well-child visit, which takes place before the child's first birthday.

## Women's Health in Texas

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### **S.B. 750, 86th Legislature, Regular Session, 2019:**

Required HHSC to:

- Apply for federal funds to implement a model of care to improve the quality and accessibility of care for pregnant women with opioid use disorder. (CMS awarded HHSC funding under the Maternal Opioid Misuse (MOM) Model, see Chapter 2, page 39).
- Develop a postpartum depression treatment network.
- Collaborate with MCOs to develop and implement cost-effective, evidence-based, and enhanced prenatal services for high-risk pregnant women covered under Medicaid.
- Assess the feasibility of providing services in the Healthy Texas Women (HTW) program through managed care and implement policies to improve the quality of maternal health in managed care.
- Develop an enhanced, cost-effective and limited postpartum care services package in HTW, called HTW Plus.
- Implement strategies to ensure continuity of care for women transitioning from Medicaid to the HTW program.
- To develop or enhance statewide initiatives to improve the quality of maternal health care services and outcomes for women in Texas.

### **S.B. 748, 86th Legislature, Regular Session, 2019:**

- Established two separate pilot programs for pregnant women. One will provide services to pregnant women through a pregnancy medical home, while the other will provide prenatal and postpartum services through telemedicine and telehealth.
- Required a variety of program evaluations related to maternal health.

## **Prescription Drugs**

### ***Federal Legislation***

#### **The Omnibus Budget Reconciliation Act of 1990 (OBRA of 1990):**

- Established the Federal Rebate Program, which required drug manufacturers to pay rebates for drugs dispensed under state outpatient drug programs to be included in state Medicaid formularies.
- Required states to cover all drugs for which a manufacturer provides rebates under the terms of the law and to maintain an open formulary for all drugs of manufacturers that have signed a federal rebate agreement. CMS determines rebate amounts per unit.

OBRA of 1990 was later amended under the DRA of 2005, which extended the rebate program to outpatient drugs administered in a physician’s office or another outpatient facility.

The ACA also made changes by increasing the minimum federal rebate percentages that drug manufacturers are required to pay to participate in the Medicaid program, and by expanding the rebate program to cover claims paid by Medicaid MCOs. The federal government keeps 100 percent of the increased rebate amount.

The Vendor Drug Program (VDP) manages the federal manufacturer drug rebate program and collects rebates for medications—that are dispensed by pharmacies and administered by physicians—to people enrolled in fee-for-service (FFS) and managed care. Texas negotiates additional state rebates for preferred drugs. HHSC also collects rebates for drugs provided to people enrolled in CHIP and three state health programs, including HTW.

### **The Medicare Prescription Drug Improvement and Modernization Act (MMA):**

- Created a new Medicare prescription drug benefit (Part D) and made other program and payment changes. Medicare Part D is a voluntary Medicare prescription drug benefit, where people in traditional Medicare may choose a private, drug-only plan. Those who choose to enroll in an MCO may choose a plan offering a drug benefit. Medicare Part D is available to dual eligibles receiving Medicaid.
- Amended provider payments, some of which had been reduced or constrained by previous legislation. Major provisions affecting the Medicaid program include:
  - Recoupment of part of the federal cost of the drug benefit by requiring states to refund a portion of their savings that result from Medicare providing drug coverage to dual eligibles (referred to as the “clawback” provision).
  - Addition of preventive benefits to Medicare and the elimination of co-pays for home health services, some of which were previously covered by Medicaid.
  - Increased premiums for Medicare Part B, which covers physician services, lab services, etc. Medicaid pays these premiums on behalf of certain clients who are dually eligible for Medicare and Medicaid.

### ***State Legislation***

#### **H.B. 2292, 78th Legislature, Regular Session, 2003:**

- Directed HHSC on how to implement the Medicaid Preferred Drug List (PDL)—a tool used by many states to control growing Medicaid drug costs (see Chapter 3, page 61).

- Required HHSC to collect supplemental rebates. Rebates are collected from both FFS and MCO prescription drug claims. Supplemental rebate revenue is shared with CMS at the same federal medical assistance percentage used to pay claims.

**H.B. 1917, 85th Legislature, Regular Session, 2017:**

- Provided that the PDL will carve into managed care, allowing each MCO to determine the drugs that are on their preferred drug list on September 1, 2023.

**S.B. 1096, 86th Legislature, Regular Session, 2019:**

- Required HHSC to make changes to pharmacy benefit requirements for the Medicaid STAR Kids population to:
  - Remove all Preferred Drug List (PDL) prior authorizations (PAs).
  - Require coverage of any drug without PA – including those produced by a manufacturer that has not entered into a federal rebate agreement with CMS.
- CMS approval is required prior to implementing these changes.

**S.B. 1780, 86th Legislature, Regular Session, 2019:**

- Allowed HHSC to enter into a value-based arrangement with a prescription drug manufacturer.

## **Economic Crises and Public Health Emergencies**

Since Medicaid primarily serves low-income individuals, a rise in unemployment can result in an increase in the number of people eligible for Medicaid. During the 2008 economic recession, for example, the rise in unemployment—and subsequent federal legislation passed to meet the crisis—caused sudden growth in Medicaid enrollment.

Similarly, the recent public health crisis caused by COVID-19 spurred federal legislation to address an economic recession and assist state and local governments, which included changes to Medicaid and CHIP.

**The American Recovery and Reinvestment Act (ARRA) of 2009:**

- Temporarily increased the Federal Medical Assistance Percentage (FMAP) from October 2008 through December 2010.
- Temporarily prohibited states from making changes to any Medicaid eligibility standards, methodologies or procedures that were more restrictive than those in effect July 1, 2008.
- Extended the TANF Supplemental Funds, created a new TANF Emergency Fund and increased the DSH allotment.

ARRA also included reforms and financial incentives for health care technology under the Health Information Technology for Economic and Clinical Health (HITECH) Act (see page 129).

### **The Families First Coronavirus Response Act (FFCRA) of 2020:**

- Required private and public health insurers—including Medicare, Medicaid and CHIP—to provide coverage for COVID-19 testing.
- Temporarily increased the Medicaid FMAP by 6.2 percentage points from January 1, 2020, throughout the duration of the emergency period. As a condition of receiving the increased FMAP, states were required to maintain eligibility and services for any Medicaid recipients eligible as of March 18, 2020.
- Provided paid emergency sick leave and family medical leave for individuals and families impacted by the public health emergency.

### **The American Rescue Plan Act (ARPA) of 2021:**

- Required mandatory coverage of COVID-19 vaccines and administration and treatment under Medicaid.
- Provided states the option to modify certain coverage under Medicaid for pregnant and postpartum women.
- Provided states the option to provide qualifying community-based mobile crisis intervention services.

## **Rights and Entitlements for People with Disabilities**

### *Federal Legislation and Policy*

#### **The Americans with Disabilities Act (ADA) of 1990:**

- Prohibited discrimination based on disability in the areas of employment; public services provided by state and local governments; and public services operated by private entities, transportation and telecommunications.

#### **The Ticket to Work and Work Incentives Improvement Act (TWWIIA) of 1999:**

- Expanded the eligibility options and funding for Medicaid Buy-in programs for individuals age 16 through age 64.
- Extended Medicare coverage for disabled individuals returning to work.
- Created the Ticket to Work Program, which enables SSI and Social Security Disability Insurance (SSDI) recipients to obtain employment services from both private and public providers.

## ***State Legislation and Policy***

### **Texas Government Code, Chapter 534 (established by S.B. 7, 83rd Legislature, Regular Session, 2013):**

- Directed HHSC to implement an acute care and LTSS system for individuals with intellectual and developmental disabilities (IDD), a managed care delivery system, and the federal Community First Choice (CFC) option.
- Authorized HHSC to operate a pilot program by September 1, 2018, to test one or more managed care service delivery models to deliver Medicaid LTSS to individuals with IDD.

### **H.B. 3295, 85th Legislature, Regular Session, 2017:**

- Extended completion of the managed care pilot program for individuals with IDD (under Chapter 534) from September 1, 2018, to September 1, 2019.
- Changed the transition of the Texas Home Living (TxHmL) waiver program from September 1, 2018, to September 1, 2020. The transition date of the TxHmL program into managed care was amended again to September 1, 2027 by H.B. 4533, 86th Legislature, Regular Session, 2019.

### **S.B. 547, 85th Legislature, Regular Session, 2017:**

- Allowed state supported living centers (SSLCs) to provide certain nonresidential Medicaid services to support individuals with IDD and directed HHSC to establish reimbursement rates for SSLCs for these services.

### **H.B. 4533, 86th Legislature, Regular Session, 2019:**

- Required HHSC to develop and implement a 24-month pilot program by September 1, 2023, for individuals with intellectual and developmental disabilities (IDD), traumatic brain injury, and similar functional needs in STAR+PLUS.
- Required HHSC to conduct a pilot to test the feasibility and cost efficiency of transitioning HCS and DBMD residential services and community-based ICF/IID services to managed care.
- Updated the plan to transition waiver program services to managed care:
  - Texas Home Living (TxHmL) will transition by September 1, 2027
  - Community Living Assistance and Support Services (CLASS) will transition by September 1, 2029.
  - Home and Community-based Services (HCS) and Deaf-Blind with Multiple Disabilities (DBMD) services will transition by September 1, 2031.

### **H.B. 706, 86th Legislature, Regular Session, 2019:**

- Expands audiology services as a benefit under the School Health and Related Services (SHARS) Program to students with a Section 504 Plan.

## Home and Community-based Services and Promoting Independence

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The 1999 Supreme Court decision, *Olmstead v. L.C.*, determined that individuals with intellectual disabilities or serious mental illnesses have the right to live in community-based settings rather than in institutions. The ruling mandated that publicly run programs provide the option for community-based services to individuals with disabilities, when such services are appropriate and can be reasonably accommodated. In response to the *Olmstead* decision and other federal policy priorities, Texas Medicaid has expanded coverage for a broad range of LTSS.

The General Appropriations Act, S.B. 1, 77th Legislature, Regular Session, 2001 (Article II, HHSC, Rider 37) established the Promoting Independence Initiative—also called Money Follows the Person—whereby the funding for individuals moving from nursing facilities to community-based services could be transferred from the nursing facility budget to the community-based services budget. Rider 37 was later codified by H.B. 1867, 79th Legislature, Regular Session, 2005.

The Promoting Independence Initiative received a demonstration award through the DRA of 2005. Federal authorization of the demonstration ended in September 2016, but states were given supplemental grants through September 30, 2020. The Medicaid Extenders Act of 2019 extended authorization of the demonstration through July 31, 2024. Even though the authorization extends to 2024, there may not be funds for each year. The available funds will depend on re-obligation and congressional appropriations.

In March 2014, CMS issued a rule for the delivery of Medicaid home and community-based services, to ensure individuals receive services in fully integrated community settings. The rule requires that Home and Community-based Services (HCBS) settings provide full access to the greater community, opportunities to work in integrated settings, and opportunities for individuals to control their schedules and activities. HCBS settings must also ensure an individual's right to privacy, dignity and respect, and freedom from coercion and restraint, and allow for choice regarding services and providers. States must achieve full compliance with the rule by March 17, 2023.

## **Behavioral Health**

### ***Federal Legislation***

#### **The Paul Wellstone and Pete Domenici Mental Health Parity and Addition Equity Act (MHPAEA) of 2008:**

- Required group health plans, that offer behavioral health benefits, to provide those services at parity with medical and surgical benefits. This does not impact FFS, but does apply to Medicaid and CHIP managed care programs.

#### **The Substance Use Disorder Prevention That Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act of 2018:**

- Directed funding to federal agencies and states to increase access to addiction treatment and to take mitigating steps, such as preventing overprescribing opioids.
- Required Medicaid to report on adult behavioral health outcome measures, expand drug utilization reviews, share data between Medicaid and the state's prescription drug monitoring databases, expand the "qualified practitioners" who can prescribe buprenorphine for opioid treatment, and ensure health insurance coverage continuity for former foster youth to age 26 in any state they reside.

### ***State Legislation***

#### **S.B. 1, 81st Legislature, Regular Session, 2009 (Article IX, Health-Related Provisions, Section 17.15):**

- Authorized HHSC to add comprehensive substance use disorder (SUD) benefits for adults in Medicaid to reduce medical expenditures related to substance abuse.

#### **S.B. 58, 83rd Legislature, Regular Session, 2013:**

- Required HHSC to integrate behavioral health and physical health services into Medicaid managed care programs, by adding both mental health targeted case management and mental health rehabilitative services to the array of services provided by MCOs by September 1, 2014.

#### **H.B. 10, 85th Legislature, Regular Session, 2017:**

- Created a behavioral health ombudsman in the HHSC Office of the Ombudsman and established a mental health condition and SUD parity work group.
- Required HHSC and the Texas Department of Insurance to study and report on benefits provided by health benefit plans, both for medical or surgical expenses and for mental health conditions and SUDs.

**S.B. 1, 85th Legislature, Regular Session, 2017 (Article II, HHSC, Rider 45):**

- Required HHSC to develop performance metrics to increase accountability of MCOs for members with severe mental illness (SMI). These metrics must include integrated care, jail and emergency department diversion, post-release linkage to care, homelessness reduction, supportive housing, and medication adherence.
- Required HHSC to improve outcomes, care integration and enhanced cost control against an established baseline for members with SMI. If shown to be cost-effective, HHSC must develop and procure a managed care program in at least one service area to serve members with SMI. After conducting extensive research, HHSC did not procure a managed care program for members with SMI. As required, HHSC submitted a report outlining the results to the Legislative Budget Board.

**Technology, Patient Privacy and Fraud Prevention*****Federal Legislation*****The Health Insurance Portability and Accountability Act (HIPAA) of 1996:**

- Mandated that all health plans, health care clearinghouses and health care providers must protect all individually identifiable health information that is held or transmitted by a covered entity or business associate. Protected health information includes digital, paper and oral information.
- Required standardized electronic exchange of administrative and financial health services information for all health plans, including Medicaid. All health care organizations must implement secure electronic access to health data and remain in compliance with privacy regulations set by the U.S. Department of Health and Human Services.
- Implemented the National Provider Identifier (NPI) system—in which each health care entity, including individuals, employers, health plans and health care providers—must have a unique 10-digit NPI number.

**The Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009:**

- Incentivized providers to adopt and meaningfully use electronic health records (EHRs) and advance health information exchange (HIE) systems. The EHR incentive program ended December 31, 2021.
- Established health information exchange and data breach notification rules that build upon HIPAA privacy and security regulations.

**The 21st Century Cures Act of 2016:**

- Expands the scope of programs and services required to use Electronic Visit Verification (EVV), including consumer-directed services (CDS) option or service responsibility option, home health nursing and therapy services, and the following 1915(c) waivers: the Deaf Blind with Multiple Disabilities (DBMD), the Home and Community-based Services (HCS) and the Texas Home Living (TxHmL) program
- Requires the use of EVV for all Medicaid personal care services and home health care services by January 1, 2021.
- Requires states to implement EVV for Medicaid home health care services by January 1, 2023.

HHSC will request a good faith effort exemption from the Centers for Medicare and Medicaid Services (CMS) to extend this deadline by one year. HHSC plans to implement EVV for Medicaid home health care services on January 1, 2024.

***State Legislation***

**S.B. 7, 82nd Legislature, First Called Session, 2011:**

- Required HHSC to pilot EVV.
- As of 2015, EVV has been required by state rule (15 TAC §354.1177) for attendant services in certain Medicaid FFS and managed care home and community-based programs—including CFC and some waivers.

**S.B. 1107, 85th Legislature, Regular Session, 2017:**

- Standardized requirements for telemedicine and telehealth services by specifying acceptable telemedicine and telehealth service delivery requirements.
- Directed the Texas Medical Board, Texas Board of Nursing, Texas Physician Assistant Board, and Texas State Board of Pharmacy to jointly develop administrative rules for valid prescriptions generated during a telemedicine visit.

**H.B. 1063, 86th Legislature, Regular Session, 2019:**

- Expanded home telemonitoring to pediatric patients who have been diagnosed with end-stage solid organ disease; have received an organ transplant; or require mechanical ventilation.
- Directed HHSC to assess whether telemedicine, telehealth and home telemonitoring services are cost-effective for the Medicaid program in its biennial report on telemedicine, telehealth and home telemonitoring services.

**H.B. 4533, 86th Legislature, Regular Session, 2019:**

- Required HHSC to phase out use of the Texas Provider Identifier (TPI) and switch to only using the NPI to identify providers.

**S.B. 1991, 86th Legislature, Regular Session, 2019:**

- Allowed service providers to utilize their own proprietary EVV system and to be reimbursed by MCOs.
- Required HHSC to adopt rules that amend the MCO payment recovery and recoupment efforts process.

**S.B. 670, 86th Legislature, Regular Session, 2019:**

- Ensure that MCOs do not deny reimbursement for a covered health care services or procedure solely because the covered service was delivered through telemedicine or telehealth.
- Ensured MCOs' utilization of telemedicine or telehealth services promotes and supports patient-centered medical homes by allowing a Medicaid recipient to receive telemedicine or telehealth services from a provider other than the recipient's primary care physician or provider in certain circumstances.
- Authorized HHSC to reimburse Federally Qualified Health Centers (FQHCs) for the patient-site facility fee and distant-site practitioner fee for covered telemedicine medical services and telehealth services delivered by a health care provider to a Medicaid recipient.
- Directed HHSC to develop, document, and implement a monitoring process to ensure that a Medicaid MCO's use of telemedicine medical services or telehealth services promotes and supports patient-centered medical homes and care coordination.

# Children's Health Insurance Program

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## Founding Legislation

### *Federal Legislation*

The Balanced Budget Act (BBA) of 1997 created the State Children's Health Insurance Program (SCHIP) under Title XXI of the Social Security Act (SSA) and appropriated nearly \$40 billion for the program for federal fiscal years 1998–2007. SCHIP offered states three options when designing a program:

- Use SCHIP funds to expand Medicaid eligibility to children who were previously ineligible for the program.
- Design a separate state children's health insurance program approved by the U.S. Secretary of Health and Human Services.
- Combine both the Medicaid and separate state program options.

States that chose to expand their Medicaid programs were required to provide all mandatory and optional services covered under their Medicaid state plan and follow the Medicaid cost-sharing rules. States that choose to implement a separate program have more flexibility. Within federal guidelines, they may determine their own SCHIP benefit packages.

Texas originally opted to expand Medicaid eligibility using SCHIP funds. In July 1998, Texas implemented Phase I of SCHIP, providing Medicaid to children age 15 through age 17 whose family income was under 100 percent of the FPL. Phase I of SCHIP operated from July 1998 through September 2002. The program was phased out as Medicaid expanded to cover those children.

### *State Legislation*

**Senate Bill (S.B.) 445, 76th Legislature, Regular Session, 1999**, enacted Phase II of SCHIP, which created Texas CHIP. S.B. 445 specified that coverage under CHIP be available to children in families with incomes up to 200 percent of the FPL. Coverage under Phase II of the program began on May 1, 2000.

Texas CHIP was designed and operates as a separate child health program. Texas elected secretary-approved coverage for CHIP.

## Program Reforms

### *Federal Legislation*

#### **The Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000:**

- Allowed states to retain unexpended federal fiscal year (FFY) 1998–99 federal allocations through FFY 2004.
- Granted states additional time to spend 50 percent of unused FFY 2000 and FFY 2001 federal allocations through FFY 2004 and FFY 2005, respectively.

#### **The Children’s Health Insurance Program Reauthorization Act (CHIPRA) of 2009:**

- Appropriated nearly \$69 billion for FFY 2009–2013 and redesigned the allocation formula, so that it more closely reflected state spending.
- Required states to verify a CHIP applicant’s citizenship.
- Mandated that states apply mental health parity standards established under the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008.
- Allowed states to cover pregnant women above 185 percent of the FPL and up to the income eligibility level for children in CHIP.
- Allowed states to provide Medicaid and CHIP coverage to qualified immigrant children and pregnant women—without the previously required five-year delay.

Texas has implemented additional changes in accordance with CHIPRA guidance—including applying certain Medicaid managed care safeguards to CHIP, expanding dental services, and implementing mental health parity in CHIP.

Following CHIPRA, the Affordable Care Act (ACA) of 2010 extended federal funding for CHIP through FFY 2015 and increased the federal match rate for FFYs 2016–2019. Maintenance of effort (MOE) requirements prohibited states from restricting CHIP eligibility standards, methodologies or procedures through September 30, 2019. Medicaid payments are contingent upon meeting this CHIP MOE requirement. The ACA eliminated asset tests and most income disregards in CHIP financial eligibility determinations.

#### **The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015:**

- Extended federal funding for CHIP through FFY 2017, and fully funded state CHIP allotments through September 30, 2017, including funding the 23 percentage-point increase in federal matching funds authorized by the ACA.
- Extended CHIPRA outreach and enrollment grants and CHIPRA quality provisions, plus maintained MOE for children’s coverage in Medicaid and CHIP through 2019.
- Made permanent the authorization for Transitional Medical Assistance, which provides time-limited Medicaid to low-income parents transitioning to employment at higher wages that otherwise would make them ineligible for Medicaid.

**Children’s Health Insurance Program Reauthorization Act (CHIPRA) of 2018:**

- Reauthorized CHIP funding through FFY 2027. The reauthorization legislation also extended the MOE provision, but phased out the associated super-enhanced federal match rate. In FFY 2020, the 23 percent bump reduced to 11.5 percentage points, and in FFY 2021, the match will return to the standard CHIP enhanced rate.
- Federal funding for CHIP lapsed from October 2017 through February 2018. While some state received additional grant funding from the Centers for Medicare and Medicaid (CMS), Texas continued to fund CHIP using FFY 2017 carry-over funds.

**The Substance Use Disorder Prevention That Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act of 2018:**

- Required mental health and substance use disorder (SUD) services to be included as a category for basic services in CHIP (Section 5022). These services include inpatient and outpatient services, psychosocial rehabilitation, and crisis stabilization.

***State Legislation***

**The 2006–07 General Appropriations Act, S.B. 1, 79th Legislature, Regular Session, 2005 (Article II, Health and Human Services Commission [HHSC], Rider 70):**

- Authorized HHSC to expend funds to provide unborn children with health benefit coverage under CHIP. The result was CHIP Perinatal, which began in January 2007.
- Determined that CHIP Perinatal services are for the unborn children of pregnant women, who are uninsured and do not qualify for Medicaid due to income or immigration status.

# Recent Medicaid and CHIP State Legislation

The table below highlights key pieces of state legislation passed during the 87th Texas Legislature.

<b>87th Legislature, 2021</b>	
<b><i>Applied Behavior Analysis</i></b>	
S.B. 1 (Article II, HHSC, Rider 28)	(86th and 87th Legislative Session) Required HHSC to create a new children’s Medicaid Applied Behavior Analysis medical benefit as soon as possible, but not later than February 1, 2022.
<b><i>Behavioral Health</i></b>	
S.B. 1 (Article II, HHSC, Rider 34)	Required HHSC to apply to CMS for an 1115 Demonstration Waiver, if it would ensure net savings to the state, to secure federal funds for acute psychiatric care services provided in a hospital or residential treatment settings to Medicaid clients.
S.B. 672	Required HHSC to reimburse Medicaid providers for collaborative care management services for children and adults.
<b><i>Emergency Health Care</i></b>	
S.B. 1 (Article II, HHSC, Rider 42)	Required HHSC to implement the Emergency Triage, Treat, and Transport Model (ET3) in Medicaid to reimburse Medicaid-enrolled emergency ambulance services providers for: <ul style="list-style-type: none"> <li>• Transporting Medicaid clients to alternative destinations, other than an emergency department, as approved by HHSC.</li> <li>• Facilitating appropriate treatment in place at the scene.</li> <li>• Facilitating appropriate treatment in place via telehealth.</li> </ul>
<b><i>Home and Community-based Services</i></b>	
H.B. 3720	Required HHSC to develop a questionnaire for individuals who are on an interest list for any of the home and community-based services Medicaid waiver programs.
S.B. 1 (Article II, HHSC, Rider 9)	Required HHSC to educate members enrolled in the STAR+PLUS Home and Community-based Services (HCBS) about the Consumer Directed Services (CDS) option and seek to increase the percentage of clients who choose CDS.

<p>S.B. 1 (Article II, HHSC, Rider 23/ Exceptional Item 9)</p>	<p>Required HHSC to gain comply with the CMS issued regulations governing the settings in which home and community-based services (HCBS) are provided.</p> <p>CMS requires that a setting must support a person’s full access to the community, including opportunities to engage in community life, work in competitive integrated settings, and control personal resources.</p> <p>Day habilitation services provided in some HCBS programs are not compliant with the federal regulations. HHSC will replace day habilitation with a new, more integrated service called Individualized Skills and Socialization.</p>
<p>H.B. 2658/ S.B. 1648</p>	<p><i>(86th and 87th Legislative Session)</i></p> <p>Required HHSC to:</p> <ul style="list-style-type: none"> <li>• Conduct a pilot to enhance health homes and care coordination for children with medically complex conditions to improve health outcomes (Comprehensive Health Homes for Integrated Care (CHIC) Kids pilot).</li> <li>• Allow Medicaid managed care members with complex medical needs to continue receiving care from a specialty provider they have an established relationship with, regardless of whether the member also has primary health benefit plan coverage.</li> </ul>
<p>Exceptional Item 4</p>	<p>HHSC received approval from the Centers for Medicare and Medicaid Services (CMS) to fund additional waiver program slots through Section 9817 of the American Rescue Plan Act.</p>
<p><b><i>Managed Care Operations and Oversight</i></b></p>	
<p>S.B. 1 (Article II, HHSC, Rider 20)</p>	<p>Required HHSC to develop quality of care and cost efficiency benchmarks for managed care organizations (MCOs) participating in Medicaid and the CHIP by September 1, 2022.</p>
<p>S.B. 1 (Article II, HHSC, Rider 27(b)) &amp; S.B. 8, Sec. 14, Third Session</p>	<p>Rider 27(b) requires HHSC to streamline managed care enrollment by automatically placing new members into a health plan once they are found eligible for Medicaid.</p> <p>S.B. 8 appropriated \$5 million to HHSC for Medicaid eligibility system upgrades.</p>
<p><b><i>Member Communication</i></b></p>	
<p>S.B. 1 (Article II, HHSC, Rider 27 (c))</p>	<p>Required HHSC to reduce paper waste by promoting the use of electronic provider directories for Medicaid and CHIP.</p>
<p>S.B. 1 (Article II, HHSC, Rider 27 (d) (2))</p>	<p>Required HHSC to modernize member communication and improve member access to care by authorizing Medicaid and CHIP MCOs to communicate with members with their consent through text messaging and email.</p>

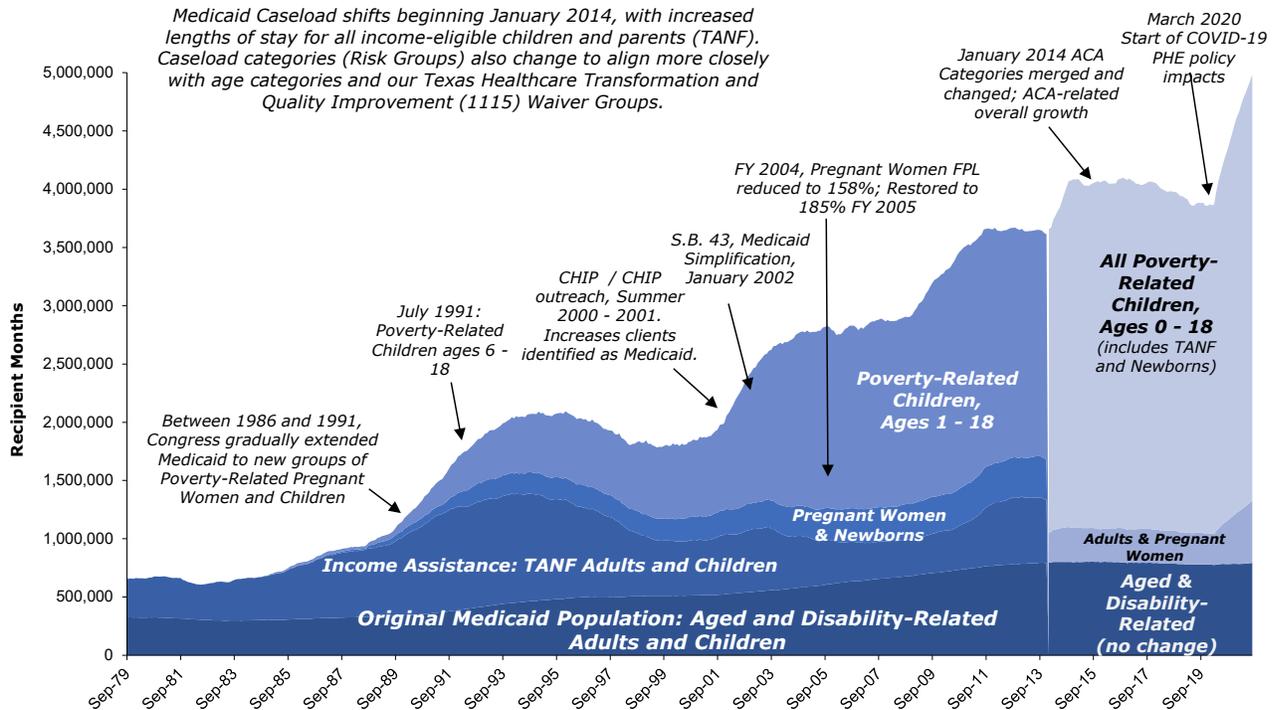
<b>Prescription Drugs</b>	
S.B. 1 (Article II, HHSC, Rider 22/ Exceptional Item 3)	Appropriated funds for HHSC to expand access to direct acting antiviral medications for Medicaid clients with chronic Hepatitis C by entering into a cost-effective rebate agreement with a drug manufacturer.
H.B. 2822	<p>Required HHSC to automate prior authorization for drugs in the antipsychotic class and to issue specific messaging for prior authorization denials for drugs in the antipsychotic class.</p> <p>Allows adult Medicaid members to bypass preferred drug prior authorizations in certain circumstances.</p>
<b>Providers</b>	
S.B. 1 (Article II, HHSC, Rider 27(a))	<p>Required HHSC to:</p> <ul style="list-style-type: none"> <li>• Deploy Provider Enrollment Management System (PEMS) allowing for online NPI based enrollment and revalidation.</li> <li>• Streamline managed care enrollment and disenrollment via implementation of automatic enrollment into managed care.</li> <li>• Reduce paper waste by promoting the use of electronic provider directories for Medicaid and CHIP.</li> <li>• Authorize Medicaid and CHIP MCOs to communicate with members with their consent through text messaging and email.</li> </ul>
S.B. 1 (Article II, HHSC, Rider 39)	Required that if Medicaid provider rates are increased as a result of a legislative appropriation, MCOs reimburse the full amount of the appropriated funds to providers, to the extent allowed by federal laws and regulations.
S.B. 8, Sec. 13, Third Session	Required HHSC to implement a streamlined provider portal for enrollment and credentialing information.
<b>Teleservices</b>	
H.B. 4	<p>Required HHSC to expand the use of telemedicine, telehealth, and audio-only platforms to deliver a range of services, including but not limited to office visits, behavioral health audio-only services, assessments, and case management.</p> <p>Required HHSC to make permanent the flexibilities that are authorized during the COVID-19 public health emergency where it is clinically effective and cost effective.</p>
S.B. 1 (Article II, HHSC, Rider 33)	Authorizes Medicaid to continue reimbursement for select behavioral health services to be delivered via audio-only modalities, as well as any other benefit HHSC determines to be clinically and cost-effective.

H.B. 2056	Required Medicaid to cover teledentistry services. Synchronous teledentistry allows a dentist or other health care profession, such as a dental hygienist, to provide a dental service to a patient at a different physical location using synchronous audiovisual technology.
<b><i>Women’s Health</i></b>	
H.B. 133	<p>Required HHSC to:</p> <ul style="list-style-type: none"> <li>• Transition Case Management for Children and Pregnant Women (CPW) services to managed care.</li> <li>• Transition Healthy Texas Women (HTW) into managed care.</li> <li>• Extend postpartum coverage for Medicaid for pregnant women from 60 days to six months.</li> </ul>

# Legislative Impacts on Caseload

Enrollment in Texas Medicaid and CHIP can change in response to federal and state legislative requirements (see figure below).

## A.1: Texas Medicaid Caseload by Group, SFYs 1979–2021



Medicaid eligibility was historically linked to receiving financial assistance. In the 1980s, several federal laws extended coverage to populations ineligible for financial assistance. This expansion—to include a greater number of people with disabilities, children, pregnant women and older individuals—fueled the growth of the Medicaid program.

Caseloads declined in the 1990s after Medicaid eligibility was de-linked from financial assistance. In 2002, the number of children enrolled in Medicaid grew sharply when the application process was simplified. The Affordable Care Act (ACA) of 2010 also contributed to caseload growth because of required eligibility changes.

To receive increased federal funding, the FFCRA required states to maintain Medicaid coverage for most people active or certified for Medicaid on or after March 18, 2020, until the end of the month in which the federal public health emergency (PHE) ends (see Chapter 1, page 12). This has contributed to increases in caseload.

# Managed Care in Texas

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## State Legislation

### **Senate Bill (S.B.) 10, 74th Legislature, Regular Session, 1995:**

- Directed HHSC to enact a comprehensive statewide restructuring of Medicaid, incorporating a managed care delivery system. HHSC began expanding, and continues to expand, its Medicaid managed care program through 1915(b) waivers under the authority of S.B. 10.

### **S.B. 6, 79th Legislature, Regular Session, 2005:**

- Directed HHSC and the Department of Family and Protective Services (DFPS) to develop a statewide health care delivery model for all Medicaid children in foster care. STAR Health was implemented on April 1, 2008.

### **House Bill (H.B.) 1, 82nd Legislature, Regular Session, 2011, and S.B. 7, 82nd Legislature, First Called Session, 2011:**

- Instructed HHSC to expand its use of Medicaid managed care. The Legislature directed HHSC to preserve federal hospital funding historically received as supplemental payments under the upper payment level (UPL) program.

### **S.B. 7, 83rd Legislature, Regular Session, 2013:**

- Directed HHSC to implement cost-effective options for delivering basic attendant care and a voluntary long-term services and supports (LTSS) managed care pilot program, expand STAR+PLUS to the Medicaid Rural Service Area, and integrate acute care and LTSS for individuals age 65 and older and those with disabilities. Most people being served through one of the 1915(c) waivers for individuals with intellectual and developmental disabilities (IDD)—and living in community-based settings or in an intermediate care facility for individuals with an intellectual disability or related condition (ICF/IID)—are now receiving acute care services through STAR+PLUS or STAR Kids.
- Directed HHSC to develop the STAR Kids managed care program, tailored for children with disabilities—including children receiving Medically Dependent Children Program (MDCP) waiver benefits. STAR Kids was implemented statewide on November 1, 2016.
- Directed HHSC to develop quality-based outcome and process measures in quality-based payment systems by measuring potentially preventable events; rewarding use of evidence-based practices; and promoting health care coordination, collaboration and efficacy. HHSC initially implemented the medical and dental pay-for-quality (P4Q) programs in 2014. The programs were

subsequently redesigned in 2016 and 2017. New medical P4Q programs were implemented in 2018 for STAR, STAR+PLUS and CHIP, as well as a new dental P4Q program. STAR Kids was added for 2020. Due to the federal PHE, HHSC suspended medical and dental P4Q for 2020 and 2021. P4Q resumed in 2022. Results for previous years are on the Texas Healthcare Learning Collaborative Portal ([THLC-Portal.com](https://www.thlc-portal.com)).

**S.B. 1, 83rd Legislature, Regular Session, 2013 (Article II, HHSC, Rider 51b[15]):**

- Directed HHSC to transition remaining Medicaid fee-for-service (FFS) populations into managed care, as a cost containment measure. The rider stated that this reduction should be achieved through the implementation of a plan to improve care coordination through a capitated managed care program.

**H.B. 72, 86th Legislature, Regular Session, 2019:**

- Directed HHSC to change managed care enrollment rules for children and young adults in the Adoption Assistance (AA) and Permanency Care Assistance (PCA) programs.
- As of September 1, 2020, children who transition from foster care to AA or PCA remain in STAR Health for an additional two months to improve continuity of care. Certain AA and PCA children with disabilities have a choice between enrolling in STAR Kids or staying in STAR Health.

**H.B. 1, 86th Legislature, Regular Session, 2019 (Article II, HHSC, Rider 43):**

- Required HHSC to create an incentive program that allows MCOs to increase the percentage of default enrollment clients they receive based on quality, efficiency and effectiveness, and performance metrics.

**H.B. 4533, 86th Legislature, Regular Session, 2019:**

- Required HHSC to standardize and implement consistent definitions for MCO grievance processes, as well as reporting and data collection for Medicaid.
- Required HHSC to implement a pilot program for individuals with intellectual and developmental disabilities (IDD), traumatic brain injury, and similar functional needs in STAR+PLUS. Established new timelines and processes for transitioning IDD long-term services and supports (LTSS) into managed care.
- Required HHSC to expand the availability of the Consumer Directed Services (CDS) option in the MDCP waiver program.

**H.B. 1576, 86th Legislature, Regular Session, 2019:**

- Required HHSC to add non-emergency transportation services to managed care for coordination by the MCO.

- Nonmedical transportation services, which are a subset of demand response transportation services, will be provided for certain trips requested with less than 48-hour notice.

**H.B. 3041, 86th Legislature, Regular Session, 2019:**

- Required MCOs to publish information about submitting a PA and the process for communicating with the MCO about a PA request on their website.
- Required HHSC to allow, if practicable, renewal of a PA within 60 days of expiration for managed care and FFS.

**S.B. 1207, 86th Legislature, Regular Session, 2019:**

- Required HHSC and MCOs to issue notices to providers and members with clear and detailed information regarding either a denial, reduction or termination of coverage or a denial of a prior authorization (PA) request.
- Required that HHSC contract with an independent external medical reviewer (see Chapter 3, page 71).
- Directed, for MDCP only, that the MCOs implement measures to ensure STAR Kids service coordinators provide results of the STAR Kids Screening Assessment Instrument (SK-SAI) to the child's parent or legally authorized representative (LAR). The legislation also required MCOs to offer an opportunity for a peer-to-peer with a physician whom the member chooses.
- Required HHSC to establish time-frame guidelines for MCOs to issue decisions on PA requests, which must be published on MCO websites.
- Required HHSC to establish a uniform process and timeline for MCOs that receive an insufficient or inadequate PA request.

<b>A.2: Development of Managed Care in Texas, 1994–2021</b>			
<b>State Fiscal Year</b>	<b>Service Areas (SA) and Implementation Dates</b>	<b>Total Medicaid Managed Care Enrollment</b>	<b>% of Medicaid Population in Managed Care</b>
1994	STAR implemented in Travis County and in the tri-county area	58,243	2.86%
1995	No change	65,388	3.16%
1996	The tri-county area was expanded to include three additional counties (renamed to STAR)	71,435	3.46%
1997	STAR expanded to the Bexar, Lubbock and Tarrant SAs The Travis County area was expanded to include surrounding counties	274,694	13.82%
1998	STAR expanded to the Harris SA STAR+PLUS implemented in the Harris SA	364,336	19.56%
1999	STAR expanded to the Dallas SA	425,069	23.45%
2000	STAR expanded to the El Paso SA	523,832	28.98%
2001	No change	623,883	33.35%
2002	No change	755,698	35.92%
2003	No change	988,389	39.71%
2004	No change	1,112,002	41.43%
2005	No change	1,191,139	42.85%
2006	Primary Care Case Management (PCCM) implemented in 197 counties	1,835,390	65.72%
2007	STAR expanded to the Nueces SA STAR+PLUS expanded to the Bexar, Travis, Nueces and Harris contiguous SAs STAR replaced PCCM in all urban areas	1,921,651	67.83%
2008	Integrated Care Management (ICM) implemented in the Dallas and Tarrant SAs STAR Health implemented statewide	2,039,340	70.86%
2009	The ICM program was discontinued	2,127,382	70.78%
2010	No change	2,362,091	71.62%
2011	STAR+PLUS expanded to the Dallas and Tarrant SAs	2,676,149	75.53%

A.2: Development of Managed Care in Texas, 1994–2021			
State Fiscal Year	Service Areas (SA) and Implementation Dates	Total Medicaid Managed Care Enrollment	% of Medicaid Population in Managed Care
2012	STAR expanded to Medicaid Rural Service Areas (MRSAs), replacing and discontinuing PCCM in all rural areas  Pharmacy benefits were carved into all managed care programs, and inpatient hospital benefits were carved into STAR+PLUS  The Children’s Medicaid Dental Services program implemented statewide	2,893,965	79.16%
2013	No change	2,982,923	81.53%
2014	No change	3,012,265	80.41%
2015	STAR+PLUS expanded to all areas of the state  Non-dual eligible clients, IDD waivers and nursing facility benefits were carved into STAR+PLUS  Mental health targeted case management and mental health rehabilitative services were carved into all managed care programs  Dual Demonstration program implemented in Bexar, Dallas, El Paso, Harris, Hidalgo and Tarrant counties	3,524,581	86.88%
2016	No change	3,570,411	87.93%
2017	STAR Kids implemented statewide  NorthSTAR was discontinued	3,721,646	91.50%
2018	Adoption Assistance and Permanency Care Assistance were carved into STAR, and the Medicaid for Breast and Cervical Cancer program was carved into STAR+PLUS	3,776,096	93.89%
2019	No change	3,676,441	93.91%
2020	No change	3,760,023	94.36%
2021	No change	4,517,225	96.46%

FY 2021 data is final.

Figures are Average Monthly Recipient Months and include STAR, STAR+PLUS, STAR Health, STAR Kids, PCCM, and ICM.

In the Dallas Service Area, most Medicaid eligible individuals receive Medicaid acute care services through the STAR program. Until FY 2017, they received their behavioral health services through NorthSTAR.

Source: June 2022 Forecast Update, HHSC Forecasting, August 2022

# Appendix B

Texas Medicaid and CHIP services

# Medicaid State Plan

## Mandatory and Optional Services

The Social Security Act specifies a set of benefits that state Medicaid programs must provide and a set of optional benefits that states may choose to provide. A state may choose to provide some, all or no optional services specified under federal law. Some optional services that Texas chooses to provide are available only to clients (a) age 20 and younger, or (b) age 20 and younger or age 65 and older and who are in an institution for mental disease. If the client is age 20 and younger, all federally allowable and medically necessary services must be provided.

Mandatory and optional state plan services provided by Texas Medicaid include:

<b>B.1: Acute Care Services</b>	
<b>Mandatory</b>	<b>Optional*</b>
<ul style="list-style-type: none"> <li>• Inpatient hospital services</li> <li>• Outpatient hospital services</li> <li>• Laboratory and x-ray services</li> <li>• Physician services</li> <li>• Medical and surgical services provided by a dentist</li> <li>• Early and Periodic Screening, Diagnosis and Treatment services for individuals age 20 and younger</li> <li>• Family planning services and supplies</li> <li>• Federally Qualified Health Center services</li> <li>• Rural health clinic services</li> <li>• Nurse-midwife services</li> <li>• Certified pediatric and family nurse practitioner services</li> <li>• Home health services</li> <li>• Freestanding birth center services (when licensed or otherwise recognized by the state)</li> <li>• Transportation to medically necessary services</li> <li>• Tobacco cessation counseling for pregnant women</li> <li>• Extended services for pregnant women</li> </ul>	<ul style="list-style-type: none"> <li>• Prescription drugs</li> <li>• Medical or remedial care by other licensed practitioners:                             <ul style="list-style-type: none"> <li>▫ Nurse practitioners/certified nurse specialists</li> <li>▫ Physician assistants</li> <li>▫ Licensed midwife</li> <li>▫ Certified registered nurse anesthetists</li> <li>▫ Anesthesiologist assistants</li> <li>▫ Psychologists</li> <li>▫ Licensed clinical social workers**</li> <li>▫ Licensed professional counselors</li> <li>▫ Licensed marriage and family therapists</li> <li>▫ Licensed Behavior Analysts</li> </ul> </li> <li>• Podiatry***</li> <li>• Limited chiropractic services</li> <li>• Optometry (including eyeglasses and contacts)</li> <li>• Telemedicine</li> <li>• Home telemonitoring</li> <li>• Hearing instruments and related audiology</li> <li>• Home health supplies provided by a pharmacy</li> <li>• Clinic services:                             <ul style="list-style-type: none"> <li>▫ Maternity clinic services</li> <li>▫ Renal dialysis facility services</li> <li>▫ Ambulatory surgical center services</li> </ul> </li> <li>• Tuberculosis clinic services</li> <li>• Peer specialist services</li> <li>• Rehabilitation and other therapies:                             <ul style="list-style-type: none"> <li>▫ Mental health rehabilitative services</li> <li>▫ Rehabilitation and other therapy services</li> </ul> </li> </ul>

<b>B.1: Acute Care Services, Con't</b>	
<b>Mandatory</b>	<b>Optional*</b>
	<ul style="list-style-type: none"> <li>▫ Substance use disorder treatment</li> <li>▫ Physical, occupational and speech therapy</li> <li>▫ Autism services, to include Applied Behavior Analysis</li> <li>• Case management services for pregnant women with high-risk conditions</li> <li>• Pregnancy-related and postpartum services for 60 days after the pregnancy ends</li> <li>• Services for any other medical conditions that may complicate pregnancy</li> <li>• Respiratory care services</li> <li>• Ambulance services</li> <li>• Emergency hospital services</li> <li>• Private duty nursing</li> </ul>
<b>B.2: Long-term Services and Supports</b>	
<b>Mandatory</b>	<b>Optional*</b>
<ul style="list-style-type: none"> <li>• Nursing facility services for clients age 21 and older</li> </ul>	<ul style="list-style-type: none"> <li>• Intermediate care facility services for individuals with an intellectual disability or related condition (ICF/IID)</li> <li>• Inpatient services for clients who are in an institution for mental diseases and who are either age 21 and younger or age 65 and older</li> <li>• Services furnished under a Program of All-Inclusive Care for the Elderly</li> <li>• Day Activity and Health Services</li> <li>• 1915(i) Home and Community-based Services-Adult Mental Health Services</li> <li>• 1915(k) Community First Choice services: <ul style="list-style-type: none"> <li>▫ Attendant care (including habilitation)</li> <li>▫ Emergency response services</li> </ul> </li> <li>• Attendant services: <ul style="list-style-type: none"> <li>▫ Personal care/assistance services</li> <li>▫ Community attendant services</li> </ul> </li> <li>• Targeted case management for: <ul style="list-style-type: none"> <li>▫ Infants and toddlers with intellectual or developmental disabilities</li> <li>▫ Adults with intellectual or developmental disabilities</li> <li>▫ Individuals with chronic mental illness</li> </ul> </li> <li>• Nursing facility services for individuals age 20 and younger</li> <li>• Prescribed Pediatric Extended Care Centers</li> <li>• Services provided in religious non-medical health care institutions</li> </ul>

\*Includes optional Medicaid services provided in Texas. Does not include all optional services allowed under federal policy.

\*\*Except when delivered in a Federally Qualified Health Center setting.

\*\*\*Except when delivered by a medical doctor (MD) or doctor of osteopathic medicine (DO).

# CHIP State Plan

States can design their Children’s Health Insurance Program (CHIP) using one of three frameworks established by federal law. States can either include their CHIP plan within their Medicaid program, create a separate CHIP plan, or create a combination of these two options. Texas CHIP operates as a separate program, but many CHIP services are the same as Texas Medicaid services.

Services provided by Texas CHIP include:

## B.3: Services Covered by Texas CHIP

- Surgical services
- Transplants
- Skilled nursing facilities (including rehabilitation hospitals)
- Outpatient hospital, comprehensive outpatient rehabilitation hospital, clinic (including health center), and ambulatory health care center services
- Physician/physician extender professional services (including well-child exams and preventive health services, such as immunizations)
- Laboratory and radiological services
- Durable medical equipment, prosthetic devices and disposable medical supplies
- Home and community-based health services
- Federally Qualified Health Center services
- Rural Health Clinic services
- Nursing care services
- Inpatient mental health services
- Outpatient mental health services
- Inpatient and residential substance abuse treatment services
- Outpatient substance abuse treatment services
- Rehabilitation and habilitation services (including developmental assessments and physical, occupational and speech therapy)
- Hospice care services
- Emergency services (including emergency hospitals, physicians and ambulance services)
- Emergency medical transportation (ground, air or water)
- Care coordination
- Case management
- Prescription drugs
- Dental services
- Vision
- Chiropractic services
- Tobacco cessation

# Home and Community-based Waiver Programs

Federal law allows states to apply to the Centers of Medicare and Medicaid Services (CMS) for permission to depart from certain Medicaid requirements. These waivers allow states to develop creative alternatives to the traditional Medicaid program. The table below provides a list of Texas Medicaid waiver programs.

<b>B.4: Texas Medicaid Waivers</b>		
<b>Waiver</b>	<b>Description</b>	<b>Services Covered</b>
Community Living Assistance and Support Services (CLASS)	CLASS provides home and community-based services to individuals who have related conditions, as an alternative for placement in an ICF/IID. A related condition is a disability other than an intellectual or development disability, which originates before age 22 and which substantially limits life activity.	<ul style="list-style-type: none"> <li>• Adaptive aids and minor home modifications</li> <li>• Medical supplies</li> <li>• Dental services</li> <li>• Nursing</li> <li>• Respite</li> <li>• Professional therapies*</li> <li>• Auditory integration/enhancement training</li> <li>• Specialized therapies</li> <li>• Employment assistance and supported employment</li> <li>• Case management</li> <li>• Prevocational services</li> <li>• Residential habilitation transportation</li> <li>• Prescriptions</li> <li>• Support family services</li> <li>• Transition assistance services</li> <li>• Continued family services</li> <li>• Financial management services and support consultation**</li> </ul>

<b>B.4: Texas Medicaid Waivers</b>		
<b>Waiver</b>	<b>Description</b>	<b>Services Covered</b>
Deaf Blind with Multiple Disabilities (DBMD)	DBMD provides home and community-based services as an alternative to residing in an intermediate care facility for individuals with an intellectual disability or related condition (ICF/ IID) to people of all ages who are deaf, blind or have a condition that will result in deafblindness—and who also have an additional disability. The program focuses on increasing opportunities for individuals to communicate and interact with their environment.	<ul style="list-style-type: none"> <li>• Adaptive aids and minor home modifications</li> <li>• Medical supplies</li> <li>• Dental services</li> <li>• Nursing</li> <li>• Respite</li> <li>• Professional therapies*</li> <li>• Employment assistance and supported employment</li> <li>• Case management</li> <li>• Residential habilitation transportation</li> <li>• Assisted living</li> <li>• Prescriptions</li> <li>• Transition assistance services</li> <li>• Intervener</li> <li>• Orientation and mobility</li> <li>• Audiology services</li> <li>• Day habilitation***</li> <li>• Individualized skills and socialization</li> <li>• Chore Service</li> <li>• Financial management services and support consultation**</li> </ul>
Home and Community-based Services (HCS)	HCS provides home and community-based services as an alternative to residing in an ICF/IID to individuals of all ages who qualify for ICF/IID level of care, yet live in their family’s home, their own home, a small HCS residential home or other settings in the community.	<ul style="list-style-type: none"> <li>• Adaptive aids and minor home modifications</li> <li>• Prescribed Drugs</li> <li>• Dental services</li> <li>• Nursing</li> <li>• Respite</li> <li>• Professional therapies*</li> <li>• Employment assistance and supported employment</li> <li>• Day habilitation***</li> <li>• Residential assistance services</li> <li>• Supported Home Living Transportation</li> <li>• Transition assistance services</li> <li>• Financial management services and support consultation**</li> </ul>

### B.4: Texas Medicaid Waivers

Waiver	Description	Services Covered
Medically Dependent Children Program (MDCP)	MDCP provides community-based services to children and youth age 20 and younger as an alternative to residing in a nursing facility.	<ul style="list-style-type: none"> <li>• Adaptive aids and minor home modifications</li> <li>• Respite</li> <li>• Employment assistance and supported employment</li> <li>• Flexible family support services</li> <li>• Transition assistance services</li> <li>• Financial management services</li> </ul>
STAR+PLUS Home and Community-based Services (STAR+PLUS HCBS)	STAR+PLUS HCBS provides community-based services to adults (21 years of age and older) with disabilities and people age 65 and older, as an alternative to residing in a long-term care facility. These services are delivered through the STAR+PLUS managed care program.	<ul style="list-style-type: none"> <li>• Adaptive aids and minor home modifications</li> <li>• Medical supplies</li> <li>• Respite</li> <li>• Employment assistance and supported employment</li> <li>• Dental services</li> <li>• Adult foster care</li> <li>• Assisted living services</li> <li>• Emergency response services</li> <li>• Home-delivered meals</li> <li>• Transition assistance services</li> <li>• Personal assistance services</li> <li>• Nursing services</li> <li>• Physical, occupational and speech therapies</li> <li>• Cognitive rehabilitation therapy</li> <li>• Financial management services and support consultation**</li> </ul>

<b>B.4: Texas Medicaid Waivers</b>		
<b>Waiver</b>	<b>Description</b>	<b>Services Covered</b>
Texas Home Living (TxHmL)	TxHmL provides selected services and supports as an alternative to residing in an ICF/IID to individuals of all ages who qualify for ICF/IID level of care who live in their own homes or their family's home.	<ul style="list-style-type: none"> <li>• Adaptive aids and minor home modifications</li> <li>• Dental services</li> <li>• Prescription medications</li> <li>• Nursing</li> <li>• Respite</li> <li>• Professional therapies*</li> <li>• Employment assistance and supported employment</li> <li>• Community support transportation</li> <li>• Day habilitation***</li> <li>• Financial management services and support consultation**</li> </ul>
Youth Empowerment Services (YES)	YES is a home and community-based waiver that allows for more flexibility in the funding of intensive community-based services for children and adolescents with severe emotional disturbances and their families.	<ul style="list-style-type: none"> <li>• Adaptive aids and supports</li> <li>• minor home modifications</li> <li>• Respite</li> <li>• Specialized therapies</li> <li>• Employment assistance and supported employment</li> <li>• Community living support</li> <li>• Family supports and supportive family-based alternatives</li> <li>• Non-medical transportation</li> <li>• Paraprofessional services</li> <li>• Transitional services</li> </ul>

\*Professional therapies may include: physical therapy, occupational therapy, speech and language pathology, audiology, social work, behavioral support, dietary services, and cognitive rehabilitation therapy.

\*\*These services are only available to individuals using the Consumer Directed Services (CDS) delivery option.

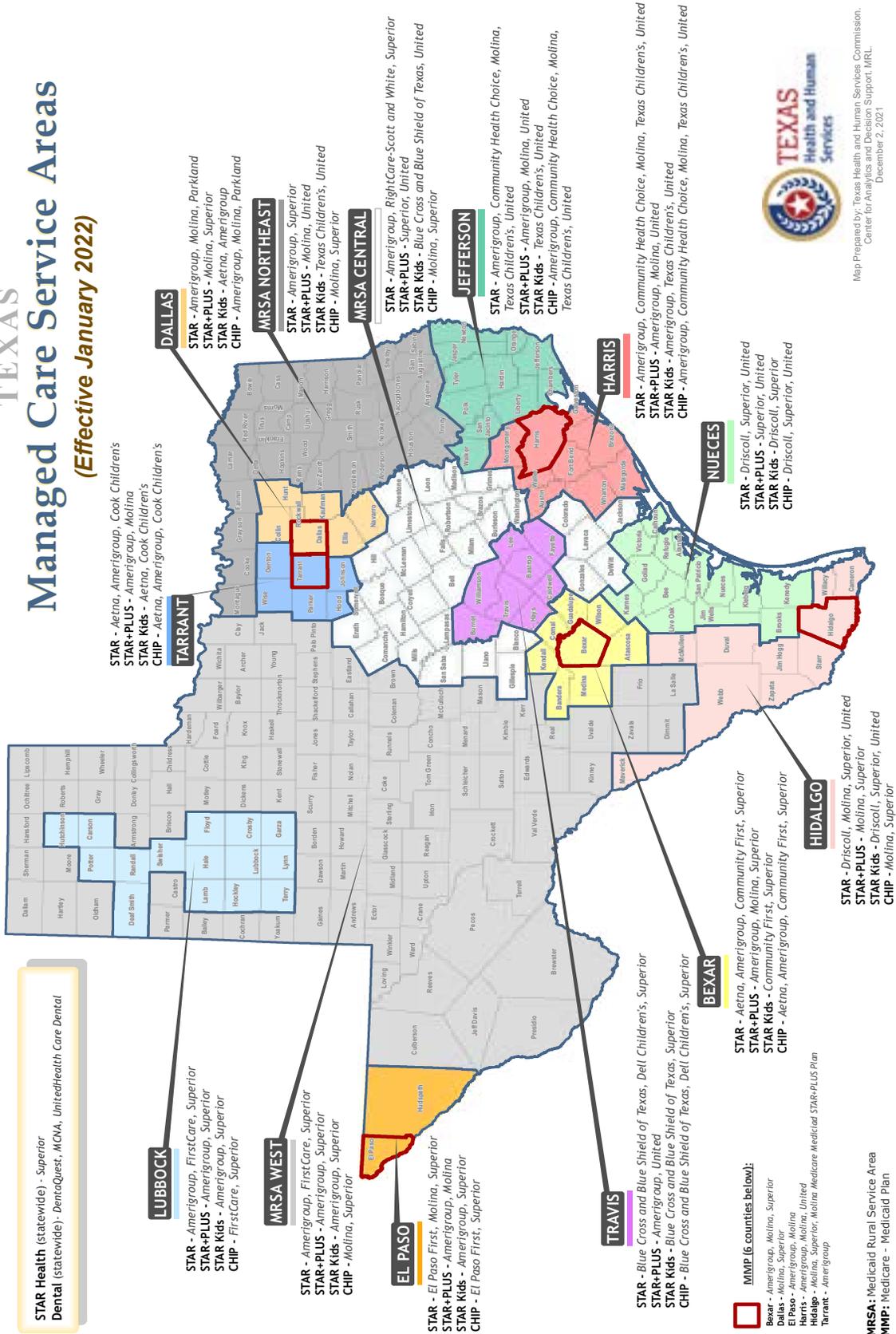
\*\*\* To comply with CMS regulations governing HCBS settings, Day habilitation will be replaced with Individual Skills and Socialization on March 1, 2023.

# Appendix C

Texas Medicaid and CHIP maps and figures

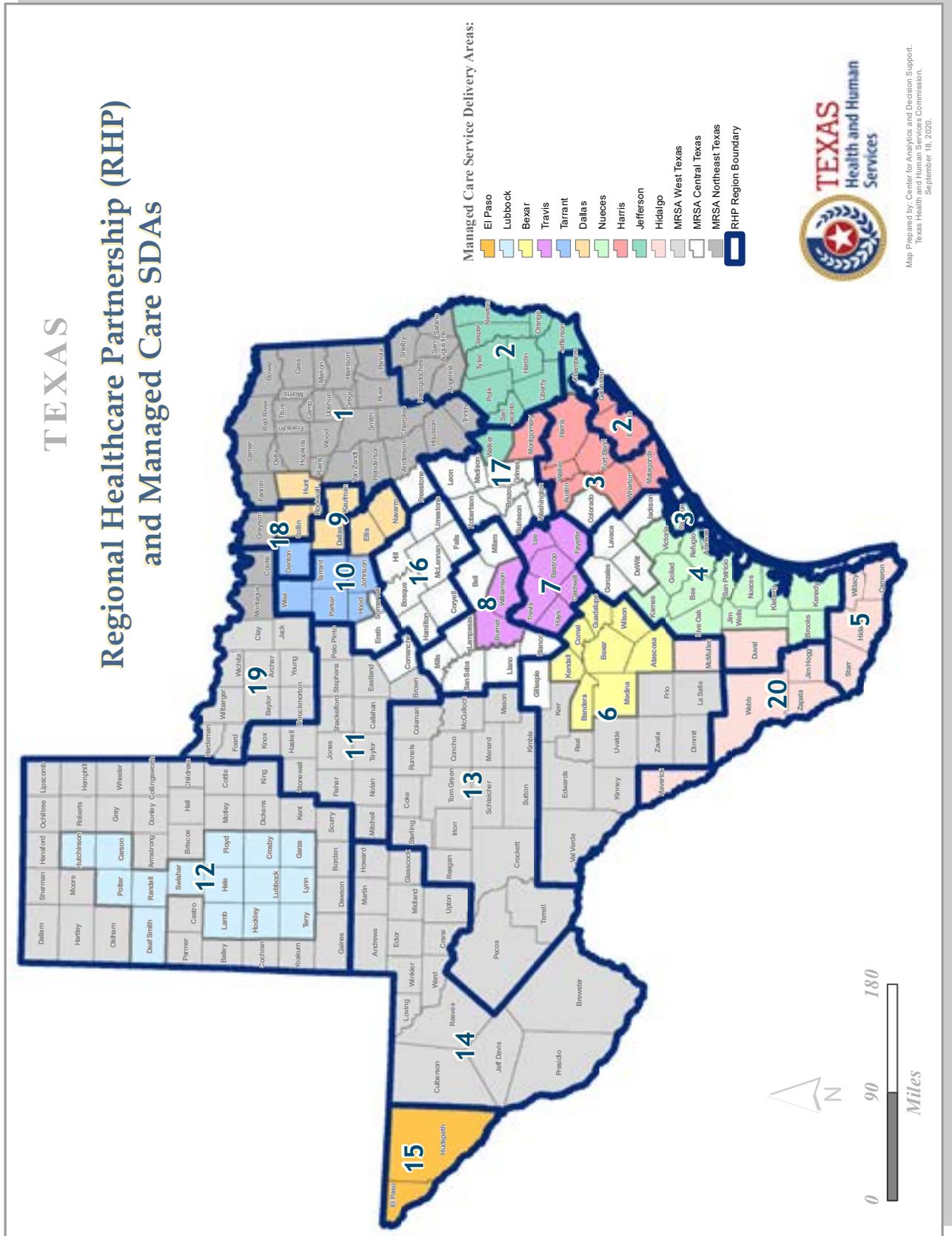
C.1: Texas Managed Care Services Delivery Map

TEXAS  
Managed Care Service Areas  
(Effective January 2022)



Map Prepared by: Texas Health and Human Services Commission,  
Center for Analytics and Decision Support, MRL  
December 2, 2021

C.2: 1115 Transformation Waiver Regional Healthcare Partnership Regions Map



# Regional Healthcare Partnership Regions by County

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**RHP 1:** Anderson, Bowie, Camp, Cass, Cherokee, Delta, Fannin, Franklin, Freestone, Gregg, Harrison, Henderson, Hopkins, Houston, Hunt, Lamar, Marion, Morris, Panola, Rains, Red River, Rusk, Smith, Titus, Trinity, Upshur, Van Zandt, and Wood.

**RHP 2:** Angelina, Brazoria, Galveston, Hardin, Jasper, Jefferson, Liberty, Nacogdoches, Newton, Orange, Polk, Sabine, San Augustine, San Jacinto, Shelby, and Tyler.

**RHP 3:** Austin, Calhoun, Chambers, Colorado, Fort Bend, Harris, Matagorda, Waller, and Wharton.

**RHP 4:** Aransas, Bee, Brooks, DeWitt, Duval, Goliad, Gonzales, Jackson, Jim Wells, Karnes, Kenedy, Kleberg, Lavaca, Live Oak, Nueces, Refugio, San Patricio, and Victoria.

**RHP 5:** Cameron, Hidalgo, Starr, and Willacy.

**RHP 6:** Atascosa, Bandera, Bexar, Comal, Dimmit, Edwards, Frio, Gillespie, Guadalupe, Kendall, Kerr, Kinney, La Salle, McMullen, Medina, Real, Uvalde, Val Verde, Wilson, and Zavala.

**RHP 7:** Bastrop, Caldwell, Fayette, Hays, Lee, and Travis.

**RHP 8:** Bell, Blanco, Burnet, Lampasas, Llano, Milam, Mills, San Saba, and Williamson.

**RHP 9:** Dallas, Denton, and Kaufman.

**RHP 10:** Ellis, Erath, Hood, Johnson, Navarro, Parker, Somervell, Tarrant, and Wise.

**RHP 11:** Brown, Callahan, Comanche, Eastland, Fisher, Haskell, Jones, Knox, Mitchell, Nolan, Palo Pinto, Shackelford, Stephens, Stonewall, and Taylor.

**RHP 12:** Armstrong, Bailey, Borden, Briscoe, Carson, Castro, Childress, Cochran, Collingsworth, Cottle, Crosby, Dallam, Dawson, Deaf Smith, Dickens, Donley, Floyd, Gaines, Garza, Gray, Hale, Hall, Hansford, Hartley, Hemphill, Hockley, Hutchinson, Kent, King, Lamb, Lipscomb, Lubbock, Lynn, Moore, Motley, Ochiltree, Oldham, Parmer, Potter, Randall, Roberts, Scurry, Sherman, Swisher, Terry, Wheeler, and Yoakum.

**RHP 13:** Coke, Coleman, Concho, Crockett, Irion, Kimble, Mason, McCulloch, Menard, Pecos, Reagan, Runnels, Schleicher, Sterling, Sutton, Terrell, and Tom Green.

**RHP 14:** Andrews, Brewster, Crane, Culberson, Ector, Glasscock, Howard, Jeff Davis, Loving, Martin, Midland, Presidio, Reeves, Upton, Ward, and Winkler.

**RHP 15:** El Paso and Hudspeth.

**RHP 16:** Bosque, Coryell, Falls, Hamilton, Hill, Limestone, and McLennan.

**RHP 17:** Brazos, Burleson, Grimes, Leon, Madison, Montgomery, Robertson, Walker, and Washington.

**RHP 18:** Collin, Grayson, and Rockwall.

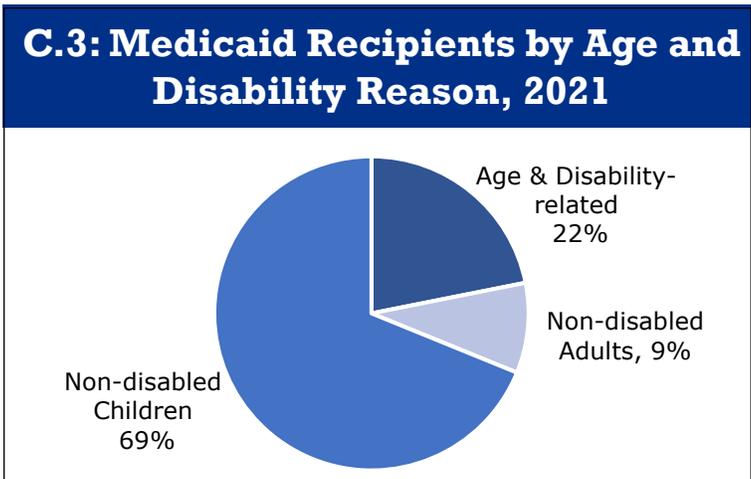
**RHP 19:** Archer, Baylor, Clay, Cooke, Foard, Hardeman, Jack, Montague, Throckmorton, Wichita, Wilbarger, and Young.

**RHP 20:** Jim Hogg, Maverick, Webb, and Zapata.

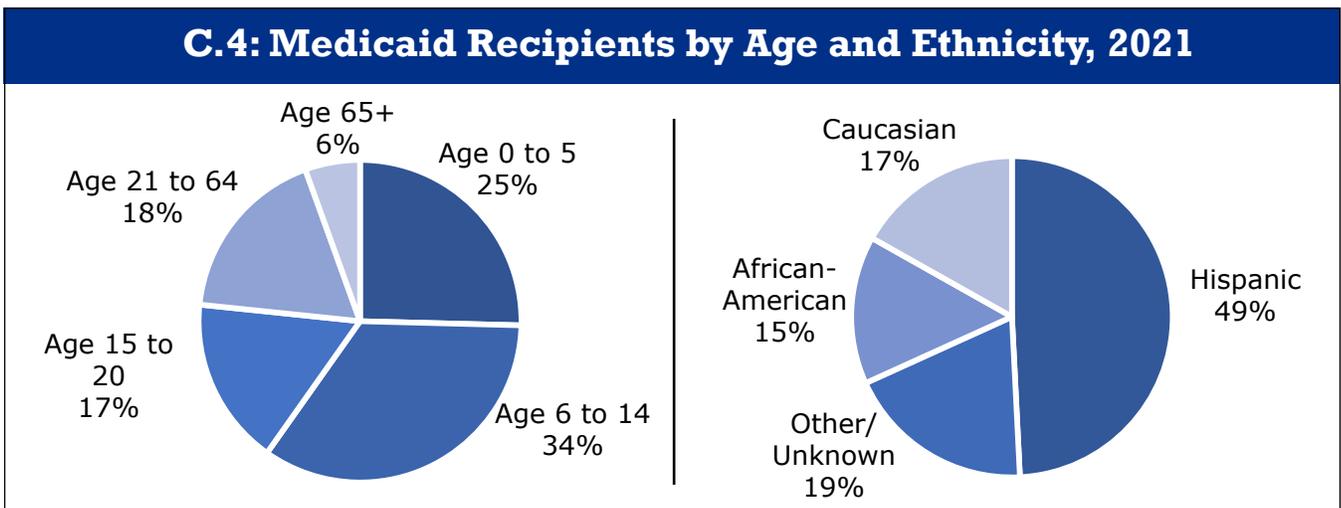
# Demographics

The number of Texas Medicaid and Children’s Health Insurance Program (CHIP) clients can be expressed as a monthly average count or an annual unduplicated count. The monthly average count is the average number of clients on Medicaid or CHIP per month. The unduplicated count is the total number of individual Texans who received Medicaid or CHIP services over a period of time. In 2021, the monthly average count for Medicaid was 4,682,819 clients, and the monthly average count for CHIP was 264,765 clients.

In 2021, about 22 percent of Texas Medicaid clients were recipients due to age and disability-related reasons, 9 percent of clients were non-disabled adults, and 69 percent were non-disabled children. CHIP covers children, birth through age 18, who are not eligible for Medicaid due to income, but cannot afford private health insurance.



The following figures breakdown the total statistics for unduplicated clients, who received Medicaid in 2021, by age group and ethnicity. As previously indicated, most Medicaid clients in any given year are children. In addition, Hispanics accounted for the largest portion of Medicaid clients, comprising 49 percent of the population.

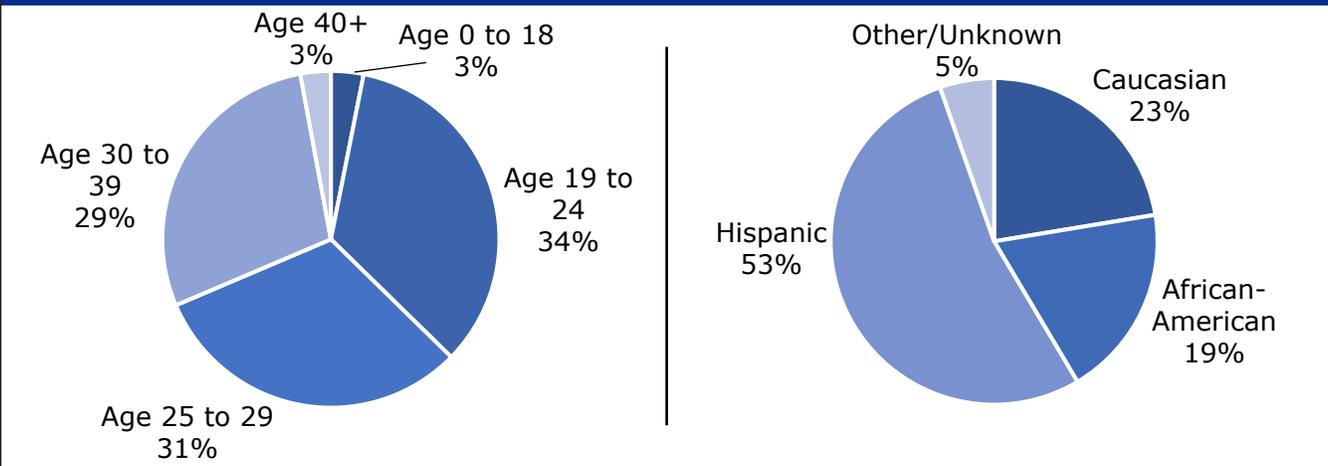


Meanwhile, for CHIP: 19 percent of CHIP clients were age 5 and younger, 59 percent were age 6 through age 14, and 22 percent were age 15 through age 18.

Medicaid covers low-income women for pregnancy-related services and newborns in low-income families. Pregnant women make up 6 percent of the Texas Medicaid and CHIP caseload. The following figures illustrate the distribution of pregnant women on Medicaid by age group and ethnicity. Sixty-five percent of the pregnant women in the Texas Medicaid program are between age 19 and age 29, while only 3 percent are age 18 and younger. Reflective of the Medicaid population as a whole, just over half, or 53 percent, of pregnant women receiving Medicaid are Hispanic.

Of the pregnant women enrolled in Texas Medicaid or CHIP, 92 percent receive services from Medicaid. The remaining eight percent receive services from CHIP Perinatal.

### C.5: Pregnant Women on Medicaid by Age and Ethnicity, 2021



CHIP Perinatal covers the unborn children of pregnant women who do not qualify for Medicaid due to income, but cannot afford private health insurance. In 2021, the monthly average caseload for CHIP Perinatal was 25,916.

Beginning in 2010, newborns under 185 percent of the federal poverty level (FPL) began moving out of CHIP Perinatal into Medicaid due to changes in eligibility. The Affordable Care Act (ACA) changed this income limit to 198 percent of the FPL effective January 2014 (see Appendix A, page 120).

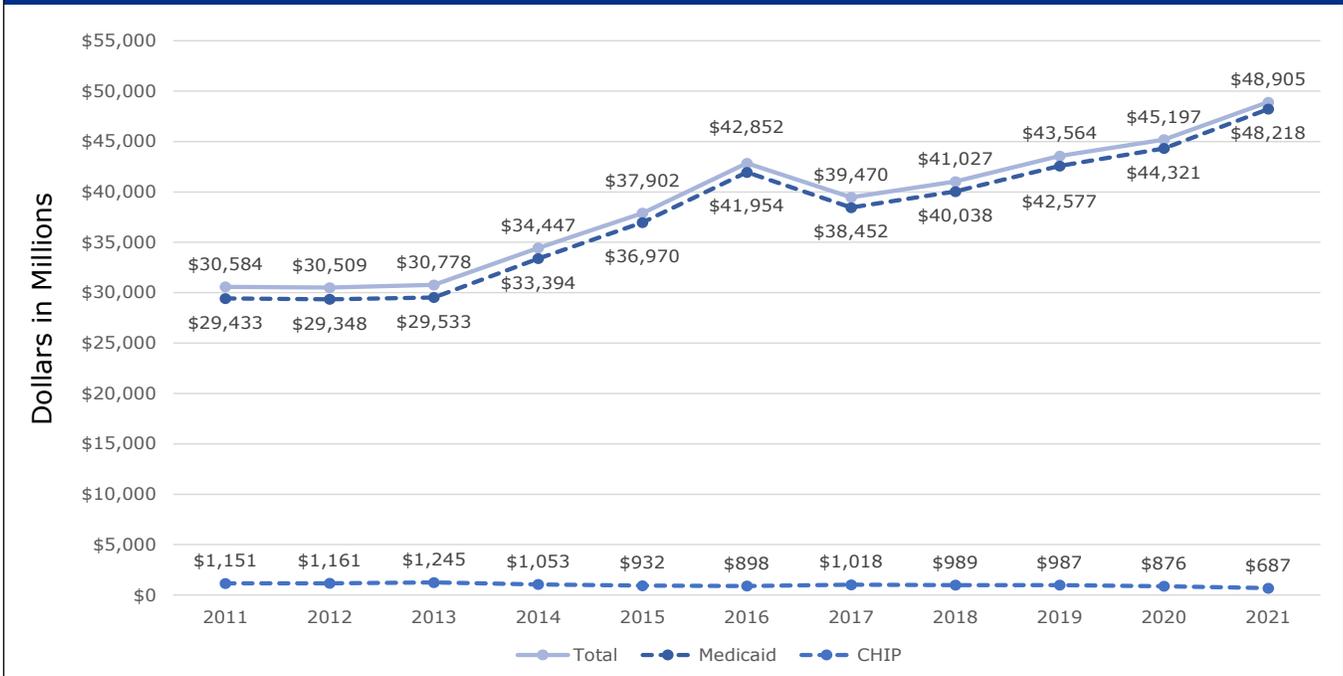
The following table shows the total average monthly caseload for the CHIP Perinatal population from 2011 to 2021—including the number of perinates and newborns below 185 percent of the FPL prior to the 2014 change, and the number of perinates and newborns below 198 percent of the FPL after the 2014 change.

<b>C.6: CHIP Perinatal Caseload Summary, 2010–2021</b>					
<b>State Fiscal Year</b>	<b>Total Caseload</b>	<b>Perinates 0%–184% FPL</b>	<b>Perinates 185%–200% FPL</b>	<b>Newborns 0%–184% FPL</b>	<b>Newborns 185%–200% FPL</b>
2011	44,214	36,775	546	6,582	310
2012	37,190	36,238	652	0	300
2013	37,027	36,068	640	0	319
<b>State Fiscal Year</b>	<b>Total Caseload</b>	<b>Perinates 0%–197% FPL</b>	<b>Perinates 198%–202% FPL</b>	<b>Newborns 0%–197% FPL</b>	<b>Newborns 198%–202% FPL</b>
2014*	36,800	36,203	509	0	88
2015	36,535	35,703	742	0	90
2016	35,071	34,638	329	0	104
2017	34,458	33,969	389	0	100
2018	32,696	32,158	417	0	121
2019	30,856	30,272	445	0	139
2020	28,670	28,134	358	0	178
2021	25,916	25,524	263	0	129

\*ACA income limit changes effective January 1, 2014. Income limits do not include a five percentage point income disregard.

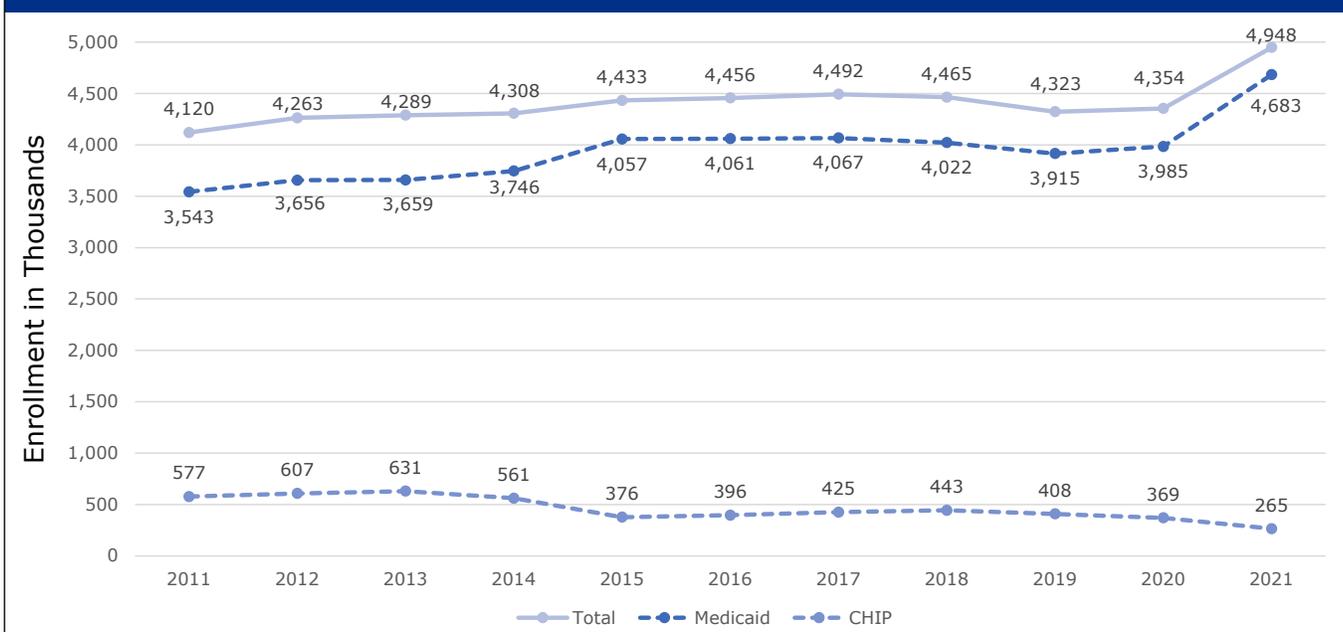
# Budget and Enrollment

**C.7: Annual Expenditures for Medicaid and CHIP, 2010-2021\***



\*Data is for FFYs 2010-2021.

**C.8: Average Monthly Medicaid and CHIP Enrollment, SFYs 2010-2021**



**C.9 Medicaid Expenditure History, FFYs 2016–2021**

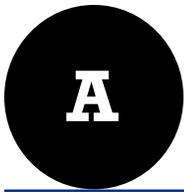
	Payer	Grant Benefits	Dispropor- tionate Share Hospital	Uncompensated Care	Upper Payment Level	DSRIP	Clawback	MCHIP	Administra- tion	Survey and Certification	Total Medicaid
2021	FED	--	1,131,887,983	969,320,168	0	1,844,928,510	0	--	957,506,308	29,030,662	29,725,086,947
2021	FED-ARRA	--	0	0	0	0	0	--	8,663,541	0	8,663,541
2021	FED-COVID	--	113,505,723	98,244,081	0	185,109,398	--	--	0	0	2,772,740,295
2021	NONFED	--	585,343,759	517,017,707	0	954,826,982	395,729,425	--	620,498,480	9,676,887	15,711,473,157
2021	TOTAL	--	1,830,737,465	1,584,581,956	0	2,984,864,890	395,729,425	--	1,586,668,330	38,707,549	48,217,963,940
2020	FED	--	1,147,547,071	2,305,253,510	0	1,756,478,472	0	--	902,797,147	31,732,309	26,984,511,674
2020	FED-ARRA	--	0	0	0	0	0	--	8,215,900	0	8,215,900
2020	FED-COVID	--	113,505,723	245,779,277	0	182,814,252	0	--	0	0	2,000,536,633
2020	NONFED	--	704,874,796	1,406,065,048	0	1,002,620,058	388,870,566	--	587,743,987	10,587,588	15,327,492,733
2020	TOTAL	--	1,965,927,590	3,957,097,835	0	2,941,912,782	388,870,566	--	1,498,757,034	42,319,897	44,320,756,941
2019	FED	18,648,468,575	1,135,454,021	2,087,928,703	0	1,489,493,368	0	527,505,019	880,280,799	34,755,055	24,803,871,441
2019	FED-ARRA	0	0	0	0	0	0	0	12,697,190	0	12,697,190
2019	NONFED	13,261,596,951	815,280,033	1,517,288,370	0	1,070,166,468	481,830,280	35,391,653	567,268,631	11,589,907	17,760,407,593
2019	TOTAL	31,910,065,526	1,950,734,054	3,605,217,073	0	2,559,659,836	481,830,280	562,896,672	1,460,246,620	46,344,962	42,576,976,224
2018	FED	17,106,627,997	1,081,579,027	1,540,814,930	0	1,754,634,974	0	507,257,806	822,708,662	29,036,137	22,842,659,533
2018	FED-ARRA	0	0	0	0	0	0	0	22,003,400	0	22,003,400
2018	NONFED	12,777,021,171	819,932,090	1,174,000,086	0	1,330,166,318	489,795,321	40,162,197	532,639,351	9,976,953	17,173,693,487
2018	TOTAL	29,883,649,168	1,901,511,117	2,714,815,016	0	3,084,801,292	489,795,321	547,420,003	1,377,351,413	39,013,090	40,038,356,420
2017	FED	15,949,253,442	1,017,299,170	1,540,241,906	0	1,604,753,947	0	733,099,118	924,173,410	31,011,499	21,790,823,137
2017	FED-ARRA	0	0	0	0	0	0	0	42,830,813	0	51,840,168
2017	FED-ACA	(41,561)	0	0	0	0	0	0	0	0	(41,561)
2017	NONFED	12,290,313,332	793,261,567	1,198,100,572	0	1,251,691,974	462,902,271	60,944,177	540,679,435	11,292,410	16,609,185,738
2017	TOTAL	28,239,525,213	1,810,560,737	2,738,342,478	0	2,856,445,921	462,902,271	794,043,295	1,507,683,658	42,303,909	38,451,807,482
2016	FED	16,030,379,491	1,680,300,179	3,513,327,443	0	1,510,079,934	0	406,135,213	920,274,804	31,487,209	24,082,253,523
2016	FED-ARRA	0	0	0	0	0	0	0	47,920,889	0	57,651,639
2016	FED-ACA	(5,829,324)	0	0	0	0	0	0	0	0	(5,829,324)
2016	NONFED	11,879,923,210	1,239,498,723	2,582,312,821	0	1,133,154,677	406,131,303	31,185,078	536,844,295	11,224,325	17,820,274,432
2016	TOTAL	27,904,473,377	2,919,798,902	6,095,640,264	0	2,643,234,611	406,131,303	437,320,291	1,505,039,988	42,711,534	41,954,350,270

## C.10: Medicaid Expenditure History, FFYs 2010–2015

Federal Fiscal Year	Payer	Grant Benefits	Disproportionate Share Hospital	Uncompensated Care	Upper Payment Level	DSRIP	Clawback	MCHIP	Administration	Survey and Certification	Total Medicaid
2015	FED	15,442,364,936	1,367,834,218	2,080,629,579	0	1,432,632,157	0	297,843,117	886,094,144	22,605,040	21,530,003,191
2015	FED-ARRA	0	0	0	0	0	0	0	86,157,065	0	86,157,065
2015	FED-ACA	106,855,855	0	0	0	0	0	0	0	0	106,855,855
2015	NONFED	10,789,116,883	970,120,562	1,466,393,531	0	1,035,305,295	370,092,170	123,939,980	484,172,478	7,535,012	15,246,675,911
2015	TOTAL	26,338,337,674	2,337,954,780	3,547,023,110	0	2,467,937,452	370,092,170	421,783,097	1,456,423,687	30,140,052	36,969,692,022
2014	FED	14,982,927,389	905,058,004	1,451,339,911	0	1,348,925,140	0	117,437,709	737,229,930	19,236,614	19,562,154,776
2014	FED-ARRA	0	0	0	0	0	0	0	146,532,831	0	146,532,831
2014	FED-ACA	101,838,600	0	0	0	0	0	0	0	0	101,838,600
2014	NONFED	10,027,061,825	621,178,089	997,553,985	0	949,464,943	372,286,605	47,794,335	562,215,287	6,412,204	13,583,967,274
2014	TOTAL	25,111,827,814	1,526,236,093	2,448,893,976	0	2,298,390,083	372,286,605	165,232,044	1,445,978,048	25,648,818	33,394,493,481
2013	FED	14,209,243,885	133,812,750	1,885,406,398	0	287,667,948	0	28,657,109	646,050,231	22,731,210	17,213,569,531
2013	FED-ARRA	(2,722,794)	0	0	0	0	0	0	185,694,886	0	182,972,092
2013	FED-ACA	82,774,190	0	0	0	0	0	0	0	0	82,774,190
2013	NONFED	9,540,324,425	92,935,191	1,325,138,105	0	197,438,203	376,596,140	11,728,774	502,399,429	7,577,070	12,054,137,337
2013	TOTAL	23,829,619,706	226,747,941	3,210,544,503	0	485,106,151	376,596,140	40,385,883	1,334,144,546	30,308,280	29,533,453,150
2012	FED	13,773,119,669	882,595,210	0	1,400,669,919	0	0	27,808,056	651,723,257	22,796,293	16,759,012,404
2012	FED-ARRA	6,301,635	0	0	12,501,171	0	0	0	209,039,020	0	227,841,826
2012	NONFED	9,833,604,615	633,370,455	0	981,318,763	0	344,689,503	11,494,337	549,535,172	7,598,764	12,361,311,609
2012	TOTAL	23,613,025,919	1,515,965,665	0	2,394,489,853	0	344,689,503	39,302,393	1,410,297,449	30,395,057	29,348,165,839
2011	FED	14,093,145,087	956,328,092	0	1,829,711,562	0	0	20,859,639	589,699,290	23,918,822	17,513,662,492
2011	FED-ARRA	1,395,373,748	0	0	231,747,606	0	0	0	167,790,509	0	1,794,911,863
2011	NONFED	7,741,106,553	622,813,407	0	977,218,223	0	277,468,044	7,982,215	490,315,493	7,912,940	10,124,816,875
2011	TOTAL	23,229,625,388	1,579,141,499	0	3,038,677,391	0	277,468,044	28,841,854	1,247,805,292	31,831,762	29,433,391,230
2010	FED	12,670,015,218	991,515,974	0	1,849,499,135	0	0	0	585,452,634	23,347,881	16,119,830,842
2010	FED-ARRA	2,599,216,338	0	0	366,322,520	0	0	0	1,368,805	0	2,966,907,663
2010	NONFED	6,231,480,571	696,673,993	0	925,963,561	0	188,351,774	0	513,545,911	7,782,627	8,563,798,437
2010	TOTAL	21,500,712,127	1,688,189,967	0	3,141,785,216	0	188,351,774	0	1,100,367,350	31,130,508	27,650,536,942



# Glossary



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***Abuse***

Provider or client practices that result in unnecessary costs to Medicaid—including reimbursements for services that are not medically necessary or that fail to meet professionally recognized standards for health care, and actions that are inconsistent with sound fiscal, business or medical practices.

***Accelerated Monitoring***

A contractual noncompliance remedy that utilizes more frequent or extensive monitoring than standard monitoring practices. Examples of accelerated monitoring practices include additional reporting requirements, escalated corrective action plans (CAPs) and onsite reviews.

***Access-based Fee (ABF)***

Under the fee-for-service (FFS) delivery model, access-based fees (ABFs) are a type of Medicaid rate used to pay physicians and other practitioners for services. Rates for physicians and other practitioners are uniform statewide and are categorized as either resource-based fees (RBFs) or ABFs. ABFs are calculated based on the following: historical charges, the current Medicare FFS rates, reviews of Medicaid fees paid by other states, surveys of providers' costs to deliver a service, and Medicaid fees for similar services. ABFs account for deficiencies in RBF methodology to ensure access to health care services for Medicaid clients. Reimbursement rates for services outlined above are evaluated at least once every two years as a part of a biennial fee review process. See also Fee-for-Service (FFS) Rates and Resource-based Fee (RBF).

***Activities of Daily Living (ADLs)***

Activities of Daily Living (ADLs) are activities essential to daily personal care—including bathing or showering, dressing, getting in or out of a bed or a chair, using a toilet, and eating. Assistance with ADLs is a service offered through state plan long-term services and supports (LTSS) programs, including Primary Care Services (PCS), Community Attendant Services (CAS), Personal Assistance Services (PAS), Primary Home Care (PHC), and Day Activity and Health Services (DAHS). See also Long-term Services and Supports (LTSS).

### ***Acuity Risk Adjustment***

Before capitation rates for managed care organizations (MCOs) are finalized, an acuity risk adjustment is made to reflect the health status, or acuity, of the population enrolled in each MCO. This adjustment recognizes the anticipated cost differential among multiple MCOs in a service area due to the variable health status of their respective memberships. See also Capitation Rates.

### ***Acute Care Services***

Acute care services focus on preventive care, diagnostics and treatments. Acute care services covered by Medicaid include but are not limited to inpatient and outpatient hospital services, laboratory and x-ray services, and physician services. Medicaid covers acute care services for all clients. See also Appendix B, page 145, for a full list of acute care services offered in Texas.

### ***Acute Care Utilization Review (ACUR)***

Acute Care Utilization Reviews (ACUR) are designed to monitor managed care organizations (MCOs) and ensure they are authorizing, justifying and providing appropriate, medically necessary services to Medicaid clients. For this review, a team of nurses conducts a desk review of a targeted sample set of medical records. This sample set is selected based on complaints, the severity and frequency of non-compliance instances, and the volume or cost of specific services. Nurses from the ACUR team conduct an in-depth review of the sample cases—including their authorization process, medical necessity determination, timeliness and accuracy of the resolution.

### ***Administrative Expense Limits (Admin Cap)***

The amount of allowable Medicaid administrative expenses by managed care organizations (MCOs) are limited by administrative expense limits (Admin Cap). The Admin Cap is compared to reported administrative expenses by the MCO. Any amounts over the Admin Cap become disallowed expenses and are added to the MCO's net income. MCOs are not prevented from incurring expenses that they consider necessary to the successful operation of their business. The Admin Cap only pertains to their ability to record those expenses on their financial statistical reports (FSRs). See also Financial Statistical Report (FSR).

### ***Agency Option***

The agency option refers to one option Medicaid clients have in determining how they receive certain long-term services and supports (LTSS), where services are delivered through a provider agency. The provider agency is the employer of attendants or other

direct service workers and is responsible for all employment and business operations. Either the service coordinator case management agency (for the Community Living Assistance and Support Services [CLASS] waiver program) or provider agency (for Deaf Blind with Multiple Disabilities [DBMD]) coordinates with the individual or authorized representative to monitor and ensure clients are satisfied with their services. See also Provider Agency.

### ***Aging and Disability Resource Center (ADRC)***

Aging and Disability Resource Centers (ADRCs) provide older adults, people with disabilities, and their family members with educational information about long-term services and supports (LTSS) and serve as a point of access for LTSS programs. Each ADRC partners with a network of local service agencies to coordinate information and referrals for individuals needing access to both private and public LTSS programs and benefits, including Medicaid. There are 22 ADRCs operating throughout Texas.

### ***Alberto N. v. Young***

A federal lawsuit settled in May 2005 that requires Health and Human Services Commission (HHSC) to comply with Title XIX of the Social Security Act (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 Medicaid Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program.

### ***All Patient Refined Diagnosis Related Group (APR-DRG)***

All Patient Refined Diagnosis Related Group (APR-DRG) comes from the Diagnosis Related Group (DRG) classification system, which provides a means of relating the type of patients a hospital treats to the costs incurred by the hospital. APR-DRGs are an expansion of the basic DRGs to be more representative of non-Medicare patients and to incorporate severity of illness subclasses. See also Diagnosis Related Group (DRG).

### ***Alternative Payment Model (APM)***

An alternative payment model (APM) is a payment approach that rewards providers for delivering high-quality, cost-efficient care. APMs link a percentage of the provider's overall payment to a measure of either quality or quality and cost. As part of building a strong pay-for-quality (P4Q) program that incentivizes managed care organizations (MCOs) to achieve better performance, the Health and Human Services Commission (HHSC) developed contractual requirements for MCOs to have minimum thresholds of their overall payments to health care providers be in the form of an APM. For a certain percentage of these payments, the provider must have some degree of risk, called the risk threshold. See also Pay-for-Quality (P4Q).

### ***Alternative Prospective Payment System (APPS)***

Like prospective payment systems (PPS), alternative prospective payment systems (APPS) are methods of reimbursement in which payment is made based on a predetermined, fixed amount—which is based on the classification system of that service. However, where PPS rates are inflated annually for primary care using the Medicare Economic Index (MEI), APPS rates are inflated annually using 100.5 percent of the MEI. APPSs may be used by Federally Qualified Health Centers (FQHCs). If an FQHC chooses the APPS method, rates may be prospectively reduced to better reflect the reasonable costs or the PPS rates.

### ***Amount, Duration and Scope***

Amount, duration and scope refer to how a Medicaid benefit is defined and limited in a state Medicaid plan. Each state defines these parameters, so state Medicaid plans vary in what they cover.

### ***Applied Behavior Analysis***

Applied behavior analysis (ABA) is a type of therapy commonly used for children diagnosed with autism spectrum disorder (ASD). ABA therapy helps people with autism improve their social skills and reduce negative behaviors. Beginning February 2022, ABA services became available to children and youth with ASD and receiving Medicaid through Texas Health Steps—Comprehensive Care Program. ABA services are delivered by a licensed behavior analyst (LBA). See also Licensed Behavior Analyst (LBA) and Texas Health Steps.

### ***Appointment Availability***

Appointment availability is a measurement used to assess client access to care within the managed care delivery system. It is measured by the time between when a member contacts a provider and the date of the first available appointment. Managed care organizations (MCOs) can reduce the use of emergent care by ensuring members have timely access to regular and preventive care. The Health and Human Services Commission (HHSC) contractually requires MCOs to follow appointment availability standards—for STAR, Children's Health Insurance Program (CHIP), STAR Kids, STAR Health, and STAR+PLUS—based on the type of medical appointment requested. Texas' external quality review organization (EQRO) conducts secret shopper studies to evaluate MCO compliance with these availability standards. See also Mystery Shopper Method.

## ***Audits***

An audit is an official inspection of performance or finances that is conducted by independent contractors or outside agencies, such as the Office of Inspector General (OIG). See also Office of Inspector General (OIG).

# **B**

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## ***Behavioral Health Services***

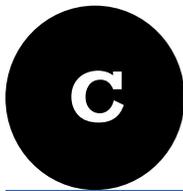
Behavioral health services refer to the treatment of mental health conditions and substance use disorders (SUDs). These services may be provided by the following: therapists in private practice, physicians, private and public psychiatric hospitals, community mental health centers, comprehensive provider agencies, and substance use treatment facilities. Screening services include Health and Behavioral Assessment and Intervention (HBAI) and Screening, Brief Intervention and Referral to Treatment (SBIRT). Treatment services include but are not limited to psychiatric diagnostic evaluation and psychotherapy, psychological and neuropsychological testing, mental health targeted case management, psychotropic medications, and medication assisted therapy for SUDs. See also Health and Behavioral Assessment and Intervention (HBAI); Screening, Brief Intervention and Referral to Treatment (SBIRT); and substance use disorder (SUD).

## ***Better Birth Outcomes***

Better Birth Outcomes (BBO) initiatives aim to improve access to women's preventive, interconception, prenatal and perinatal health care. There are several BBO initiatives in Texas. See also Long-acting Reversible Contraception (LARC), Maternal Opioid Misuse (MOM) Model, and Postpartum Depression (PPD).

## ***Breast and Cervical Cancer Services (BCCS)***

Breast and Cervical Cancer Services (BCCS) clinic sites provide quality, low-cost, and accessible breast and cervical cancer screening and diagnostic services to women. These clinic sites are the point of access for women applying to the Medicaid Breast and Cervical Cancer (MBCC) program. See also the Medicaid Breast and Cervical Cancer (MBCC) program.



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### ***Capitation Rate***

Through actuarially sound methodologies, Texas develops a per member per month (PMPM) rate, or capitation rate, for each risk group within all state service areas for its various Medicaid and Children’s Health Insurance Program (CHIP) managed care programs. These capitation rates differ across risk groups and service areas, but they are the same for each managed care organization (MCO) within a service area. The managed care rate-setting process involves a series of mathematical adjustments to arrive at the final rates paid to the MCOs. Capitation rates are derived primarily from MCO historical claims experience, also called encounter data. A risk margin is typically added in case of possible fluctuations in claims cost. How capitation rates are determined varies by program, though the calculation method remains largely the same. Capitation rates, paid monthly to MCOs, constitute the primary method the state pays for services. See also Encounter Data and Per Member Per Month (PMPM).

### ***Care Coordination***

The value of managed care relies on care coordination provided by managed care organizations (MCOs). Care coordination includes services performed by MCOs or by primary care providers—such as assistance with setting up appointments, locating specialty providers and member health assessments. In particular, MCOs are required to identify and provide care coordination for members with special health care needs (MSHCN). The MCO is responsible for working with MSHCN and their families, as well as their health care providers, to develop a seamless package of care in which all needs are met through a comprehensive service plan. This coordination is available to MSHCN, including women with high-risk pregnancies, members with high-cost catastrophic cases, and individuals with mental illness and co-occurring substance abuse. See also Members with Special Health Care Needs (MSHCN).

### ***Case Management for Children and Pregnant Women***

Case Management for Children and Pregnant Women (CPW) services are for children and youth age 20 and younger and pregnant women who are eligible for Medicaid. Case managers assist eligible clients in gaining access to medically necessary medical, social and educational services—as well as other services related to their health condition, health risk or high-risk condition. Services include assessing the needs of eligible clients, developing a service plan with clients and families, making referrals, problem-solving,

advocacy, and follow-up regarding client and family needs. CPW services were carved into managed care in September 2022.

### ***Centers for Medicare and Medicaid Services (CMS)***

The Centers for Medicare and Medicaid Services (CMS) is the federal agency within the U.S. Health and Human Services responsible for administering Medicare and overseeing state administration of Medicaid. States submit a Medicaid state plan that serves as the contract between the state and CMS. CMS must approve the plan and any amendments to the plan. CMS also approves any waivers for which states can apply. See also State Plan.

### ***Chemical Dependency Treatment Facility (CDTF)***

Chemical dependency treatment facilities (CDTFs) are any facilities that offer treatment for persons with a substance use disorder (SUD). CDTFs must be licensed and regulated by the state, except for Medication Assisted Therapy (MAT) services.

### ***Children's Health Insurance Program (CHIP)***

The Children's Health Insurance Program (CHIP) provides acute care, behavioral health care, dental services and pharmacy services for children in families with too much income to qualify for Medicaid but cannot afford to buy private health insurance. Children covered through CHIP receive similar services as children covered through Medicaid. See also Children's Health Insurance Program (CHIP) Perinatal.

### ***Children's Health Insurance Program (CHIP) Perinatal***

Children's Health Insurance Program (CHIP) Perinatal services are for the unborn children of pregnant women who are uninsured and do not qualify for Medicaid. Services include prenatal visits, prescription prenatal vitamins, labor and delivery, and postpartum care.

### ***Children's Hospital***

According to the Centers of Medicare and Medicaid Services (CMS), a certified children's hospital is a freestanding or hospital-within-hospital that treats individuals mostly age 20 and younger.

### ***Children's Medicaid***

Children's Medicaid serves children age 18 and younger who meet the program's household income limits. Children's Medicaid provides acute care, behavioral health services, dental services, prescription drug benefits, and long-term services and supports. Children in the program are typically enrolled in the STAR managed care program, although some children with disabilities may be enrolled in STAR Kids. Children's Medicaid

recipients also receive Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program services, known in Texas as Texas Health Steps. See also Early and Periodic Screening, Diagnosis and Treatment (EPSDT); STAR; STAR Kids; and Texas Health Steps.

### ***Children’s Medicaid Dental Services (CMDS) Program***

The Children’s Medicaid Dental Services (CMDS) program is a managed care program that provides dental benefits for children and youth on Medicaid, birth through age 20. There are two dental maintenance organizations (DMOs) operating statewide. See also Dental Maintenance Organization (DMO).

### ***Chronic Care Management***

Under managed care, managed care organizations (MCOs) must provide chronic care management programs and services. These programs and services must be part of a person-centered approach and address the needs of high-risk members with complex chronic or co-morbid conditions. See also Care Coordination.

### ***Client***

A client is an individual who has applied for and is enrolled in Medicaid, Children’s Health Insurance Program (CHIP), or both. If enrolled with a managed care organization (MCO), they may also be referred to as a member.

### ***Clinical Prior Authorization***

Clinical prior authorizations are evidence-based reviews designed to ensure the clinical appropriateness of a drug or drug class based on factors such as age, availability of alternative medications, or possible drug interactions. They may apply to an individual drug or a drug class that is included on federal formulary and may have preferred or non-preferred status on the Preferred Drug List (PDL). With the assistance of the Texas Drug Utilization Review Board, the Vendor Drug Program develops, manages and reviews clinical prior authorizations across both fee-for-service (FFS) and the managed care programs. Participating managed care organizations (MCOs) are required to perform certain clinical prior authorizations and may perform others at their discretion. See also Non-preferred Prior Authorization, Preferred Drug List (PDL), Prior Authorization, Texas Formulary, and Vendor Drug Program (VDP).

### ***Community Attendant Services (CAS)***

Community Attendant Services (CAS) are state plan, home and community-based, long-term services and supports (LTSS) that include assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). These services are available to eligible adults and children.

***Collaborative Care Model (CoCM)***

The collaborative care model (CoCM) is an integrated approach to behavioral health care that seeks to manage mental health conditions as chronic conditions rather than focusing treatment on acute symptoms. The model involves greater service coordination between behavioral health care providers and primary care providers to increase the availability of behavioral health care, improve patient outcomes and reduce health care costs.

***Community First Choice (CFC)***

Community First Choice (CFC) is a federal option that allows states to provide home and community-based attendant services and supports to Medicaid recipients with disabilities. To be eligible, an individual must require an institutional level of care (LOC). Individuals can receive CFC services and keep their spot on an interest list or continue to receive services in a waiver program. CFC services must be provided in community-based settings.

***Community Living Assistance and Support Services (CLASS)***

Community Living Assistance and Support Services (CLASS) is a 1915(c) waiver program that provides home and community-based services to people who have a related condition diagnosis qualifying them for placement in an intermediate care facility for individuals with an intellectual disability or related condition (ICF/IID). A related condition is a disability other than an intellectual or developmental disability, which originates before age 22 and substantially limits life activity. See also Appendix B, page 133, for a full list of services offered through CLASS. Eligibility determinations for CLASS are based on level of care (LOC) criteria outlined in the Texas Administrative Code. CLASS has an interest list. See also Intermediate Care Facility for Individuals with an Intellectual Disability or Related Condition (ICF/IID) and Interest List.

***Complaints***

The Health and Human Services Commission (HHSC) monitors managed care organization (MCO) complaints, grievances and appeals processes for both members and providers. Data is used as a mechanism to flag for early warning of potential systemic problems that warrant investigation, point to the need for policy clarifications, or signal larger operational issues.

***Comprehensive Care Program (CCP)***

Federal law expanded the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program, known in Texas as Texas Health Steps, to cover any medically necessary and appropriate health care services used for treating all physical and mental illnesses or conditions found in a screening. These benefits are included in Texas Health Steps,

but are referred to in Texas as the Comprehensive Care Program (CCP). See also Texas Health Steps.

### ***Comprehensive Hospital Increase Reimbursement Program (CHIRP)***

CHIRP is a directed payment program for hospitals providing healthcare services to adults and children enrolled in STAR and STAR+PLUS. Eligible hospitals include children's hospitals, rural hospitals, mental health hospitals, state-owned hospitals, and urban hospitals. The program includes 2 components, including portions from the Uniform Hospital Rate Increase Program (UHRIP), currently in its fourth year of operation.

### ***Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey***

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey is a nationally recognized and validated tool for collecting standardized information on member experiences with health plans and services. This survey focuses on consumer perceptions of quality, such as the communication skills of providers and ease of access to health care services. See also National Core Indicators-Aging and Disabilities (NCI-AD) Survey.

### ***Consumer Directed Services (CDS) Option***

Consumer Directed Services (CDS) is a service delivery option for some individuals receiving long-term services and supports (LTSS) that allows the individual or the individual's legally authorized representative to be the employer of record for the direct care workers providing services—giving greater choice and control over the delivery of services. The individual or legally authorized representative can hire, train, supervise and dismiss the employee when necessary. Individuals may appoint a designated representative to assist with some employer responsibilities, like approving time sheets.

### ***Continuous Medicaid Coverage***

Also referred to as continuous eligibility, continuous Medicaid coverage refers to maintaining Medicaid coverage for people active or certified on or after March 18, 2020. Instituted as a part of the COVID-19 public health emergency (PHE), this was a federal requirement for Texas Medicaid to qualify for an increase in federal funding for the program. Continuous Medicaid coverage led to a large increase in caseload.

### ***Contractor***

A person or organization with which the state has successfully negotiated an agreement for the provision of required tasks.

***Corrective Action Plan (CAP)***

In cases of contractual noncompliance, the Health and Human Services Commission (HHSC) may use corrective action plans (CAPs) to hold managed care organizations (MCOs) accountable. The CAP process requires MCOs to provide HHSC with the following: a detailed explanation of the reasons for the deficiency; an assessment or diagnosis of the cause; actions taken to cure or resolve the deficiencies, including short- and long-term solutions; and actions taken to prevent future occurrences. HHSC administers CAPs monthly, and reviews, approves and closes CAPs once appropriate actions have been taken to address the noncompliance.

***Cost-sharing***

Cost-sharing refers to a co-paying arrangement, in which the state shares the cost of care with another party. Most families participating in Children's Health Insurance Program (CHIP), for example, pay an annual enrollment fee and pay co-payments for doctor visits, prescription drugs, inpatient hospital care and non-emergent care provided in an emergency room setting. See also Children's Health Insurance Program (CHIP).

***COVID-19***

Coronavirus disease (COVID-19) is an infectious disease caused by the novel SARS-CoV-2 virus, first identified in 2019. The rapid spread of COVID-19 led to a global pandemic beginning in 2020. In response to the pandemic, the United States federal government declared a public health emergency (PHE). Texas Medicaid and CHIP have experienced many programmatic impacts because of the PHE. See also Public Health Emergency (PHE).

***Crisis Diversion***

Crisis Diversion is a reserved capacity group for the Home and Community-based Services (HCS) program. Individuals qualify as members of this reserved capacity group if they have an intellectual or developmental disability and are at imminent risk of being admitted or re-admitted to an institution. See also Home and Community-based Services (HCS) and Reserved Capacity Group.



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***Day Activity and Health Services (DAHS)***

Day Activity and Health Services (DAHS) are state plan, community-based, long-term services and supports (LTSS). DAHS is offered during the day, Monday through Friday, to clients residing in the community. Services provided at licensed day activity and health services centers include nursing and personal care, meals, transportation, and social and recreational activities.

***Deaf Blind with Multiple Disabilities (DBMD)***

Deaf Blind with Multiple Disabilities (DBMD) is a 1915(c) waiver program that provides community-based services to people who are deaf and blind, and have a third disability (e.g., an intellectual disability), as an alternative to institutional care in an intermediate care facility for individuals with an intellectual disability or related condition (ICF/IID). See also Appendix B, page 149, for a full list of services offered through DBMD. Eligibility determinations for DBMD are based on level of care (LOC) criteria outlined in the Texas Administrative Code. DBMD has an interest list. See also Intermediate Care Facility for Individuals with an Intellectual Disability or Related Condition (ICF/IID).

***Default Enrollment***

Default enrollment occurs when clients do not exercise their right to choose a managed care organization (MCO) and are automatically assigned to a health plan.

***Deferral***

A deferral refers to the withholding of federal funding, if the Texas Medicaid or Children's Health Insurance Program (CHIP) is determined to be out of compliance with federal regulations by the Centers of Medicare and Medicaid Services (CMS).

***Delivery Supplemental Payment***

Delivery supplemental payments are separate lump sums paid to managed care organizations (MCOs), as part of their capitation payments, to cover newborn delivery expenses. This payment is computed for each service area.

***Delivery System Reform Incentive Payment (DSRIP) Pool***

The Delivery System Reform Incentive Payment (DSRIP) pool was one of two hospital funding pools under the 1115 Transformation waiver along with Uncompensated Care (UC) pool. DSRIP funding provided financial incentives that encourage hospitals and other providers to focus on achieving quality health outcomes. Participating providers would develop and implement programs, strategies and investments to enhance the following: access to health care services, quality of health care and health systems, cost-effectiveness of services and health systems, and the health of the patients and families served. To earn DSRIP funds, providers undertook projects from a menu of projects agreed upon by Centers for Medicare and Medicaid Services (CMS) and Health and Human Services Commission (HHSC) within the Regional Healthcare Partnership (RHP) planning protocol. The DSRIP program ended in September 2021. HHSC has implemented a transition plan which preserves funding for providers and will continue health-care transformation. See also Directed Payment Programs (DPPs) and Regional Healthcare Partnership (RHP).

***Dental Maintenance Organization (DMO)***

Dental maintenance organizations (DMOs) deliver and manage comprehensive dental services to eligible Medicaid and Children's Health Insurance Program (CHIP) clients. For Medicaid and the Children's Health Insurance Program (CHIP), there are two DMOs that operate throughout Texas.

***Dental Quality Alliance (DQA)***

The Dental Quality Alliance (DQA) is an organization convened by the American Dental Association at the request of Centers for Medicare and Medicaid Services (CMS). The DQA has developed national evidence-based oral health care performance measures that have been tested for feasibility, validity, reliability and usability.

***Diagnosis Related Group (DRG)***

The Diagnosis Related Groups (DRGs) are a patient classification system that provide a means of relating the type of patients a hospital treats to the costs incurred by the hospital. The system was originally used by the Centers for Medicare and Medicaid Services (CMS) for hospital payment for Medicare clients, and it has been expanded to be more inclusive of non-Medicare clients. Under this system, each patient is classified into a DRG based on clinical information. Hospitals are paid a pre-determined rate for each DRG admission. For fee-for-service (FFS) clients receiving inpatient or outpatient care, the rate is calculated using a standardized average cost of treating a Medicaid inpatient admission and a relative weight for each DRG.

### ***Directed Payment Programs (DPPs)***

Directed payment programs (DPPs) are designed to help Medicaid managed care programs achieve delivery system and payment reform and performance improvement. Following the end of the Delivery System Reform Incentive Payment (DSRIP) program, HHSC implemented four new DPPs to preserve provider funding and continue healthcare transformation. HHSC currently administers five DPPs in Medicaid and CHIP. Each DPP must be approved annually by the Centers for Medicare and Medicaid Services (CMS). See also Comprehensive Hospital Increase Reimbursement Program (CHIRP), Directed Payment Program for Behavioral Health Services (DPP BHS), Quality Improvement Payment Program (QIPP), Rural Access to Primary and Preventive Services (RAPPS) program, and the Texas Incentives for Physicians and Professional Services (TIPPS) program.

### ***Directed Payment Program for Behavioral Health Services (DPP BHS)***

The DPP BHS is a directed payment program for community mental health centers to promote and improve access to behavioral health services, care coordination, and successful care transitions. It also incentivizes continuation of care for STAR, STAR+PLUS, and STAR Kids members using the Certified Community Behavioral Health Clinic model of care.

### ***Disallowance***

A disallowance refers to the recoupment of federal funds by the Centers for Medicare and Medicaid Services (CMS), should CMS allege that certain claims are not allowable.

### ***Disproportionate Share Hospital (DSH)***

Disproportionate Share Hospital (DSH) is a designation for hospitals that serve a higher-than-average number of Medicaid and other low-income patients. See also Disproportionate Share Hospital (DSH) Funding.

### ***Disproportionate Share Hospital (DSH) Funding***

Disproportionate Share Hospital (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. There are no federal or state restrictions on how disproportionate share hospitals may use their funds. They may use the payments to cover the uncompensated costs of care for low-income patients, including Medicaid patients. DSH payments have been an important source of revenue by helping hospitals expand health care services to the uninsured, defray the cost of treating

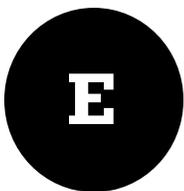
low-income patients, and recruit physicians and other health care professionals to treat patients.

### ***Drug Utilization Review (DUR)***

Drug utilization reviews (DURs), prospective and retrospective, are used by the Health and Human Services Commission (HHSC) and managed care organizations (MCOs) to evaluate client use of prescription drugs. See also Prospective Drug Utilization Review (DUR), Retrospective Drug Utilization Review (DUR), and Texas Drug Utilization Review (DUR) Board.

### ***Dually Eligible***

Individuals who are dually eligible qualify for both Medicare and Medicaid benefits. Medicare is a federally paid and administered health insurance program. Medicaid is a state-administered health care and long-term care program jointly funded by the state and the federal government. Dually eligible individuals or couples may get partial or full Medicaid benefits. If only getting partial Medicaid benefits, an individual or couple will be enrolled into the Medicare Savings Program. Dually eligible individuals typically qualify for Medicaid for the Elderly and People with Disabilities (MEPD) and receive benefits through the STAR+PLUS managed care program. Dually eligible MEPD recipients may also be enrolled into a Medicaid-Medicare Plan (MMP) or a Dual-Eligible Special Needs Plans (D-SNP). See also Dual-Eligible Special Needs Plan (D-SNP), Medicaid for the Elderly and People with Disabilities (MEPD), Medicaid-Medicare Plan (MMP), Medicare Savings Program, and STAR+PLUS.



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### ***Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program***

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program is a required Medicaid state plan benefit for eligible children and youth, birth through age 20. In Texas, this program is referred to as Texas Health Steps. See also Texas Health Steps.

### ***Early Childhood Intervention (ECI)***

Early Childhood Intervention (ECI) is a statewide program that provides services to families with children age 3 and younger who have developmental delays or disabilities.

***Electronic Visit Verification (EVV)***

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

***Emergency Medicaid***

The Emergency Medicaid program provides medical coverage designed to meet a sudden, critical health condition. Most covered individuals apply for this benefit only after an emergency occurs. If determined eligible, the individual is covered by Medicaid only from the start of a qualifying emergency medical condition to when the event is stabilized, as verified by a medical provider.

***Encounter Data***

Used in the calculation of managed care organization (MCO) capitation rates, encounter data refers to the historical claims experience of MCOs for a base period. Encounter data includes the records of the health care services for which MCOs pay and the amounts MCOs pay to providers of those services. See also Capitation Rates.

***Enhanced Federal Medical Assistance Percentage (EFMAP)***

The enhanced federal medical assistance percentage (EFMAP) is used to determine federal matching funds for Children's Health Insurance Program (CHIP). Derived from each state's average per capita income, the Centers for Medicare and Medicaid Services (CMS) updates this rate annually. Consequently, the percentage of total CHIP spending that is paid for with federal funds also changes annually. The EFMAP for Texas in FFY 2023 is 72.99 percent and in SFY 2023 is 73.41 percent. See also Federal Medical Assistance Percentage (FMAP) and Matching Funds.

***Experience Rebate***

Experience rebate is the process of determining the amount of profit earned through the Medicaid managed care program that a managed care organization (MCO) must share with the state of Texas.

***External Medical Review (EMR)***

Medicaid clients who are denied services or program eligibility can appeal directly to the Health and Human Services Commission (HHSC) by requesting a "fair hearing." As part of that request, they have the option to ask for an external medical review (EMR) before their fair hearing. During an EMR, an independent review organization (IRO)

examines the client's case and can uphold or change the service denial or eligibility determination. Unlike a fair hearing, EMRs are privately conducted, and the member, the MCO or HHSC cannot submit additional evidence. EMRs must occur after a health plan appeal if a managed care organization (MCO) made the original decision to deny services or eligibility. See also Fair Hearing and Independent Review Organization (IRO).

### ***External Quality Review Organization (EQRO)***

An external quality review organization (EQRO) assesses managed care organization (MCO) performance on several metrics—access to care, utilization of care and quality of care—for all MCOs participating in Medicaid and Children's Health Insurance Program (CHIP) medical and dental managed care programs. The Institute for Child Health Policy at the University of Florida has been the EQRO for Texas since 2002.



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### ***Fair Hearing***

Medicaid clients who are denied services or program eligibility can appeal directly to the Health and Human Services Commission (HHSC) by requesting a fair hearing. During a fair hearing, an HHSC fair hearings officer publicly reviews evidence submitted by the client, the MCO, or HHSC program staff—and can uphold or change the original eligibility decision. While additional evidence may be submitted by either party, evidence submitted by the MCO or HHSC must be presented to the client before the hearing. Fair hearings must occur after a health plan appeal if a managed care organization (MCO) made the original decision to deny services or eligibility. See also External Medical Review (EMR) and Health Plan Appeal.

### ***Federal Medical Assistance Percentage (FMAP)***

The federal medical assistance percentage (FMAP) determines the amount of federal matching funds Texas receives for Medicaid. 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 2023, Texas' Medicaid FMAP was 61.42 percent. See also Enhanced Federal Medical Assistance Percentage (EFMAP) and Matching Funds.

***Federal Poverty Level (FPL)***

The Federal Poverty Level (FPL) is a measure of income set by the U.S. Department of Health and Human Services used to determine eligibility for government programs and services, like Medicaid and Children's Health Insurance Program (CHIP). The FPL is updated yearly.

***Federally Qualified Health Center (FQHC)***

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.

***Fee-for-Service (FFS)***

Fee-for-service (FFS) is a healthcare payment system under which providers receive a payment for each unit of service they provide. Under FFS, clients can go to any Medicaid provider, and the provider will submit claims directly for Medicaid covered services. Currently, only eight percent of Medicaid clients in Texas still receive services through FFS. The remaining 92 percent of clients are enrolled into one of the managed care programs. See also Managed Care.

***Fee-for-Service (FFS) Rates***

Fee-for-service (FFS) is a healthcare payment system under which providers receive a payment for each unit of service they provide. Under FFS, clients can go to any Medicaid provider, and the provider will submit claims directly for Medicaid covered services. Currently, only 3 percent of Medicaid clients in Texas still receive services through FFS. The remaining 97 percent of clients are enrolled into one of the managed care programs. See also Managed Care.

***Financial Criteria***

Texans who apply for Medicaid or the Children's Health Insurance Program (CHIP) must meet certain financial criteria to be eligible for services. Financial eligibility is generally measured by comparing an applicant's income to the U.S. Department of Health and Human Services definition of the federal poverty level (FPL) for annual household incomes. Federal law currently requires that Modified Adjusted Gross Income (MAGI) be the primary measurement tool used to calculate financial eligibility for most Medicaid applicants. See also Federal Poverty Level (FPL) and Modified Adjusted Gross Income (MAGI).

***Financial Statistical Report (FSR)***

Managed care organizations (MCOs) are required to submit quarterly financial statistical reports (FSRs). FSRs include information on medical and administrative expenses and are one source for establishing future capitation rates. Validation of these reports is an important component of contract oversight, and FSRs are audited yearly.

***Fraud***

Fraud refers to an intentional deception or misrepresentation made by a person or entity with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. This term does not include unintentional technical, clerical or administrative errors.

***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.

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

Section 1915(b) waivers allow states to use a central broker (e.g., enrollment broker) to assist people with choosing a managed care organization (MCO), to use cost savings to provide additional services, or to limit client choice of Medicaid providers by requiring Medicaid clients join MCOs. Texas has used these waivers to provide an enhanced benefit package—beyond what is available through the state plan—with cost savings from managed care.

***Frew v. Young***

A class action lawsuit filed against Texas in 1993, which alleged that the state did not adequately provide Medicaid Early and Periodic Screening, Diagnosis and Treatment (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, the Health and Human Services Commission (HHSC) and the Department of State Health Services (DSHS) have actively worked to meet the requirements of the corrective action orders.

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***Graduate Medical Education (GME) Payments***

Graduate medical education (GME) payments to state-owned teaching hospitals cover the costs of program administrative staff, allocated facility overhead, and salaries and fringe benefits for residents and teaching physicians. See also State-owned Teaching Hospitals.

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***Health and Behavior Assessment and Intervention (HBAI)***

Health and Behavior Assessment and Intervention (HBAI) services are designed to identify the psychological, behavioral, emotional, cognitive and social factors that are important to prevent, treat or manage physical health symptoms for children and youth, age 20 and younger. HBAI services help promote physical and behavioral health integration. See also Behavioral Health Integration.

***Health and Human Services Commission (HHSC)***

The Health and Human Services Commission (HHSC) is the single state agency implementing and overseeing Medicaid and the Children's Health Insurance Program (CHIP) for Texas. See also Single State Agency.

***Health Insurance Premium Payment (HIPP) Program***

The Health Insurance Premium Payment (HIPP) program reimburses people for their share of an employer-sponsored health insurance premium when it is determined that the cost of the premium is less than the cost of projected Medicaid expenditures. To be eligible for HIPP, an individual must be eligible for Medicaid or have a family member who is eligible or already receives Medicaid. The employer-sponsored health insurance must provide comparable coverage to Medicaid.

***Health Plan***

Managed care organizations (MCOs) are often referred to as health plans—a term which describes their function in providing medical coverage and coordinated care to

Medicaid and Children’s Health Insurance Program (CHIP) clients. See also Managed Care Organization (MCO).

### ***Health Plan Appeal***

Medicaid members who are denied services or eligibility by their managed care organization (MCO) can ask for a health plan appeal. During a health plan appeal, the MCO reconsiders their original decision and can change or uphold it. If the member disagrees with the outcome of their health plan appeal, they have the right to appeal directly to the Health and Human Services Commission (HHSC) through a fair hearing. See also Fair Hearing.

### ***Healthcare Effectiveness Data and Information Set (HEDIS)***

The Healthcare Effectiveness Data and Information Set (HEDIS) is a widely used set of performance measures for managed care organizations (MCOs). HEDIS data for Texas Medicaid and Children’s Health Insurance Program (CHIP) managed care programs is posted and regularly updated on the Texas Healthcare Learning Collaborative (THLC) portal. See also Texas Healthcare Learning Collaborative (THLC) portal.

### ***Healthcare Payment Learning and Action Network (HCP-LAN)***

The Health and Human Services Commission (HHSC) is using the Healthcare Payment Learning and Action Network (HCP-LAN) to accelerate the transition to alternative payment models (APMs) within managed care organizations (MCOs) in Texas Medicaid and the Children’s Health Insurance Program (CHIP). See also Alternative Payment Model (APM) and Pay-for-Quality (P4Q).

### ***Healthy Texas Women (HTW)***

Healthy Texas Women (HTW) is a women’s health and family planning program for low-income women age 15 through 44. To ensure continuity of care, HTW auto-enrolls women into the program when their Medicaid for Pregnant Women coverage ends. Women can still apply for HTW like they would for other programs. HTW was previously a state-administered, state-funded program. Through an 1115 Demonstration Waiver, HTW is now a Medicaid program that receives federal matching funds. See also Healthy Texas Women Plus (HTW Plus).

### ***Healthy Texas Women Plus (HTW Plus)***

Healthy Texas Women Plus (HTW Plus) is an enhanced postpartum service for eligible Healthy Texas Women (HTW) clients. HTW Plus services include treatment for mental

health conditions, including postpartum depression and substance use disorders (SUDs), and cardiovascular conditions. To receive HTW Plus, an HTW client must have been pregnant within the 12 months prior to their enrollment. In December 2020, HHSC submitted an amendment to the HTW 1115 demonstration to receive federal funds for HTW Plus. As of July 2022, the amendment is pending with CMS.

### ***Heightened Scrutiny***

Heightened scrutiny is a review process for ensuring home and community-based services (HCBS) settings are following federal regulations. Under the 2014 HCBS Settings Rule, states are required by the Centers for Medicare and Medicaid Services (CMS) to ensure HCBS settings meet minimum standards for integration and choice. States must comply with these regulations by March 17, 2023.

### ***Home and Community-based Services (HCS)***

Home and Community-based Services (HCS) is a 1915(c) waiver program that provides community-based services to people with intellectual disabilities, as an alternative to institutional care in an intermediate care facility for individuals with an intellectual disability or related condition (ICF/IID). See also Appendix B, page 150, for a full list of services offered through HCS. Eligibility determinations for HCS are based on level of care (LOC) criteria outlined in the Texas Administrative Code. HCS has an interest list. See also Interest List and Intermediate Care Facility for Individuals with an Intellectual Disability or Related Condition (ICF/IID).

### ***Home and Community-based Services–Adult Mental Health (HCBS-AMH)***

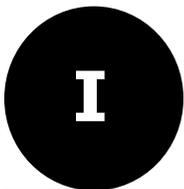
The Home and Community-based Services–Adult Mental Health (HCBS-AMH) program helps individuals with serious mental illness remain in the community. The HCBS-AMH program provides an array of intensive HCBS tailored to an individual's assessed needs, preferences and goals.

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

Home and Community-based Services (HCBS) 1915(c) waivers allow states to provide home and community-based services as an alternative for people who meet eligibility criteria for care in an institution. See also Community Living Assistance and Support Services (CLASS), Deaf Blind with Multiple Disabilities (DBMD), Home and Community-based Services (HCS), Medically Dependent Children Program (MDCP), Texas Home Living (TxHmL), and Youth Empowerment Services (YES).

### ***Hospital Quality-based Payment Program***

The Hospital Quality-based Payment Program is an incentive program that pays or recoups funds from hospitals according to their performance with fee-for-service (FFS) and managed care Medicaid patients—with the goal of improving quality and lowering costs. Through the program, hospitals and managed care organizations (MCOs) are financially accountable for certain potentially preventable events (PPEs) and can receive bonus payments for achieving low PPE rates. See also Potentially Preventable Event (PPE).



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### ***Income Disregards***

An income disregard refers to an income source or amount that is deducted or disregarded in a financial eligibility determination. For applicants subject to the Modified Adjusted Gross Income (MAGI) methodology, a standard income disregard of 5 percent of the federal poverty level (FPL) is granted. For applicants not subject to MAGI, there are program-specific income disregards. See also Federal Poverty Level (FPL) and Modified Adjusted Gross Income (MAGI).

### ***Income Limits***

Income limits are used in financial eligibility determinations. They are calculated based on household size and a certain percentage of the federal poverty level (FPL), which varies by program. Medicaid and Children's Health Insurance Program (CHIP) applicants must meet income limits to be eligible for services. See also Federal Poverty Level (FPL).

### ***Independent Review Organization (IRO)***

An independent review organization (IRO) is a group of medical experts, who are unaffiliated with a managed care organization (MCO) or the Health and Human Services Commission (HHSC), contracted to conduct external medical reviews (EMRs). During an EMR, an IRO can uphold or change an MCO's or HHSC's decision to deny services or program eligibility. See also External Medical Review (EMR).

### ***Inspection***

Inspections, such as those conducted by the Office of Inspector General (OIG), are targeted examinations into specific areas of Health and Human Services Commission

(HHSC) programs, systems or functions that may identify systemic trends of fraud, waste and abuse.

### ***Instrumental Activities of Daily Living (IADLs)***

Instrumental activities of daily living (IADLs) are activities essential to independent daily living—including preparing meals, shopping for groceries or personal items, performing light housework, and using a telephone. Assistance with IADLs is a service offered through state plan long-term services and supports (LTSS) programs—including Personal Care Services (PCS), Community Attendant Services (CAS), Personal Assistance Services (PAS), Primary Home Care (PHC), and Day Activity and Health Services (DAHS). See also Long-Term Services and Supports (LTSS).

### ***Interest List***

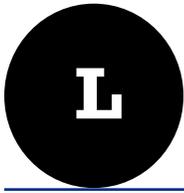
Demand for 1915(c) waiver programs, like Home and Community-based Services (HCS) and Community Living Assistance and Support Services (CLASS), often exceed capacity. Many Medicaid waiver programs maintain interest lists, which individuals can join at any time. When a program slot becomes available, the next person on the interest list may undergo an eligibility determination for the program. If they are found eligible, they may take the open slot. An individual can be on multiple interest lists at the same time and may stay on a program's interest list while enrolled in a different Medicaid program.

### ***Intermediate Care Facility for Individuals with an Intellectual Disability or Related Condition (ICF/IID)***

Intermediate care facilities for individuals with an intellectual disability or related condition (ICFs/IID) provide ongoing evaluation and individual program planning—as well as 24-hour supervision, coordination, and integration of health or rehabilitative services—to help individuals with an intellectual disability or related condition function to their greatest ability.

### ***Interstate Compact on the Placement of Children (ICPC)***

The Interstate Compact on the Placement of Children (ICPC) is an agreement between all 50 states, the District of Columbia, and the U.S. Virgin Islands, authorizing them to work together to ensure children placed across state lines for foster care or adoption receive adequate protection and support services. It establishes procedures for the placement of children across state lines and responsibilities for the agencies and individuals involved.



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***Lawful Permanent Resident (LPR)***

Legal permanent residents (LPRs) are non-citizens who are lawfully authorized to live permanently within the U.S. They are often called “green card holders.”

***Level of Care (LOC)***

Level of care (LOC) refers to the type and amount of care required by a resident of either a nursing facility or an intermediate care facility for individuals with an intellectual disability or related condition (ICF/IID). It is determined by evaluating the resident’s medical, nursing care and personal-care needs. See also Intermediate Care Facility for Individuals with an Intellectual Disability or Related Condition (ICF/IID) and Nursing Facility.

***Liquidated Damages (LDs)***

Liquidated damages (LDs) are compensation for contractual non-compliance. The Health and Human Services Commission (HHSC) assesses LDs quarterly to address any harm incurred due to managed care organization (MCO) contractual non-compliance.

***Local Intellectual and Developmental Disability Authority (LIDDA)***

Local intellectual and developmental disability authorities (LIDDAs) serve as the point of entry for publicly funded intellectual and developmental disability (IDD) programs, whether the program is provided by a public or private entity. LIDDAs provide or contract to provide an array of services and supports for persons with IDD and enroll eligible individuals into Medicaid programs, such as intermediate care facilities for individuals with an intellectual disability or related condition (ICFs/IID), Home and Community-based Services (HCS), and Texas Home Living (TxHmL). They are also responsible for Permanency Planning for eligible clients seeking to move from an institutional setting to a community-based setting.

***Local Mental Health Authority (LMHA)***

Local mental health authorities (LMHAs), along with local behavioral health authorities (LBHAs), evaluate the mental health needs of the communities in their areas and plan, develop policy, and coordinate services and resources to address those needs. LMHAs provide information, recommendations and referrals to individuals seeking mental health services.

### ***Long-acting Reversible Contraception (LARC)***

Through this Better Birth Outcome (BBO) initiative, Texas is working to increase access to this method of contraception to avert unintended pregnancies. Long-acting reversible contraception (LARC) devices are highly effective for preventing pregnancy, are easy to use, and last for several years. The Health and Human Services Commission (HHSC) has established an add-on reimbursement to incentivize utilization of immediate postpartum (IP) LARC for women enrolled in Medicaid for Pregnant Women. See also Better Birth Outcomes (BBO).

### ***Long-term Services and Supports (LTSS)***

Rather than treat or cure a disease or condition, long-term services and supports (LTSS) provide an individual support with ongoing, day-to-day activities. Clients typically eligible for LTSS include adults age 65 and older, and those with physical or intellectual disabilities. LTSS may be delivered through managed care or fee-for-service (FFS) and in conjunction with a waiver program.




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### ***Managed Care***

Managed care is a service delivery model where the Health and Human Services Commission (HHSC) contracts with managed care organizations (MCOs) to provide Medicaid and Children’s Health Insurance Program (CHIP) services to clients. Overall care of clients under managed care is coordinated by the MCOs to improve quality and control costs. In Texas, 97 percent of Medicaid clients are enrolled in managed care—where they select a health plan available in their service area and a primary care provider that coordinates their care. See also Health Plan, managed care organization (MCO), and Service Area and Primary Care Provider (PCP).

### ***Managed Care Long-term Services and Supports Utilization Review (MLTSS UR)***

The Managed Care Long-term Services and Supports Utilization Review (MLTSS UR) team conducts sampled reviews of STAR+PLUS Home and Community-based Services (HCBS) to determine how they, as managed care organizations (MCOs), conduct assessments and use procedures and related information to determine appropriateness of member enrollment. The review includes ensuring MCOs are providing services according to their assessment of service needs.

***Managed Care Organization (MCO)***

A managed care organization (MCO) delivers and manages health services under a risk-based arrangement. The Health and Human Services Commission (HHSC) contracts with MCOs and pays them a per member per month (PMPM) rate, or capitation payment. MCOs are required to provide all covered, medically necessary services to their members, and are incentivized to control costs. Medicaid clients generally have a choice between at least two MCOs, or health plans, operating in their service area. See also Capitation Rate and Per Member Per Month (PMPM).

***Managed Care Report Card***

A managed care report card evaluates the performance of a managed care organization (MCO) using a five-star rating system. Ratings are developed by surveying current members and analyzing claims data, and are updated yearly. Report cards are available on the Health and Human Services Commission (HHSC) website and are provided in all Medicaid and Children's Health Insurance Program (CHIP) enrollment packets.

***Mandatory Benefits***

The Social Security Act specifies a set of benefits state Medicaid programs must provide, or mandatory benefits. The state may also choose to provide some, all or no optional services specified under federal law. See also Appendix B, page 145, for a complete list of mandatory and optional benefits. See also Optional Benefits.

***Matching Funds***

Federal funds are a critical component of health care financing for the state of Texas. The amount of federal Medicaid funds that Texas receives is based primarily on the federal medical assistance percentage (FMAP), or Medicaid matching rate. The federal Children's Health Insurance Program (CHIP) funds that Texas receives are based on the enhanced federal medical assistance percentage (EFMAP).

***Maternal Opioid Misuse (MOM) Model***

The Maternal Opioid Misuse (MOM) model is a five-year project that seeks to facilitate better integration of prenatal care, addiction medicine and psychiatric care for pregnant women with an opioid use disorder (OUD) who are enrolled in Medicaid.

***Medicaid***

A joint federal-state entitlement program that pays for medical care on behalf of certain groups of low-income persons. The program was enacted federally in 1965 under Title XIX of the Social Security Act. Texas participation in Medicaid began September 1, 1967.

### ***Medicaid Breast and Cervical Cancer (MBCC) Program***

The Medicaid Breast and Cervical Cancer (MBCC) program provides Medicaid to eligible women diagnosed with breast or cervical cancer, including pre-cancerous conditions. To get MBCC, a woman must receive a screening at a Breast and Cervical Cancer Services (BCCS) clinic and apply for the program through the clinic. Women who have MBCC are enrolled into STAR+PLUS. Women remain eligible for MBCC if they are receiving active treatment, such as chemotherapy or radiation for breast or cervical cancer. See also Breast and Cervical Cancer Services (BCCS).

### ***Medicaid Buy-In for Children (MBIC)***

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. Children with family countable income at or below 300 percent of the federal poverty level (FPL) may qualify for the program, and households at or below 10 percent of the FPL will not pay a premium. MBIC families make monthly payments according to a sliding scale that is based on family income.

### ***Medicaid Buy-In (MBI) for Adults***

The Medicaid Buy-In (MBI) for Adults program offers low-cost Medicaid services to working adults with disabilities. Adults may qualify if they have a disability, are working and meet the income limits for the program, and are not living in an institution or nursing home continuously. The income limit for MBI is \$2,832 per month and countable assets must total no more than \$2,000.

### ***Medicaid Estate Recovery Program (MERP)***

The Medicaid Estate Recovery Program (MERP) is required by federal and state law to recover—after time of death—certain long-term care and associated Medicaid costs of services provided to recipients age 55 and older.

### ***Medicaid for Former Foster Care Children (FFCC)***

Medicaid for Former Foster Care Children (FFCC) covers Medicaid clients who aged out of the foster care system in Texas at age 18 and who were receiving federally funded Medicaid when they aged out of foster care. FFCC clients are automatically enrolled in STAR Health through the month of their 21st birthday. Individuals may opt out of STAR Health for STAR, which allows for a choice of health plans. After an individual attains age 21, coverage will transfer to STAR. FFCC clients may continue to be eligible up to the month of their 26th birthday. See also Medicaid for Transitioning Foster Care Youth (MTFCY).

***Medicaid for Parents and Caretaker Relatives***

Medicaid for Parents and Caretaker Relatives is a program for adults who are a related caretaker for a child who already has Medicaid and who meet the program's income limits.

***Medicaid for Pregnant Women***

Medicaid for Pregnant Women provides health coverage to low-income pregnant women—including acute care services, like prenatal care, labor and delivery, and postpartum care. Texas elects to extend Medicaid eligibility to pregnant women with a household income at or below 198 percent of the federal poverty level (FPL)—well above the federal requirement of 133 percent of the FPL. Pregnant women who qualify receive services through the STAR program. Newborns, whose mothers qualified for Medicaid for Pregnant Women or Emergency Medicaid for their labor and delivery, are enrolled into Children's Medicaid and receive 12 months of continuous coverage from their date of birth.

***Medicaid for the Elderly and People with Disabilities (MEPD)***

Medicaid for the Elderly and People with Disabilities (MEPD) serves people age 65 and older and individuals with disabilities who do not receive Supplemental Security Income (SSI). Individuals may qualify for this program through a facility, such as a nursing facility or an intermediate care facility for individuals with an intellectual disability or related condition (ICF/IID). MEPD covers long-term services and supports (LTSS), including long-term care facilities and state plan home and community-based services. See also Long-term Services and Supports (LTSS).

***Medicaid for Transitioning Foster Care Youth (MTFCY)***

Medicaid for Transitioning Foster Care Youth (MTFCY) covers former foster care youth who were not receiving Medicaid when they aged out of foster care at age 18. Such individuals are eligible through the month of their 21st birthday to receive services through the fee-for-service or managed care models. See also Medicaid for Former Foster Care Children (FFCC).

***Medicaid Hospice Services***

Medicaid hospice services are palliative care consisting of medical, social and support services to terminally ill individuals and their loved ones—when curative treatment is no longer desired or possible and a physician has indicated the individual has six months or fewer to live.

***Medicaid Lock-in Program***

The Medicaid Lock-in Program is an Office of Inspector General (OIG) prescription drug program oversight that operates by limiting clients to receiving or purchasing their prescriptions to one provider or pharmacy to prevent the abuse or overuse of controlled substances. Enrolled individuals may only purchase prescriptions from the pharmacy to which they are “locked in.”

***Medicaid-Medicare Plan (MMP)***

Medicaid-Medicare Plans (MMPs) are designed to provide a fully integrated managed care model for individuals age 21 and older, who are dually eligible for Medicare and Medicaid. The model involves a three-party contract—between an MMP, the Health and Human Services Commission (HHSC), and the Centers for Medicare and Medicaid Services (CMS)—for the provision of the full array of Medicaid and Medicare services. All covered services, including acute care and long-term services and supports (LTSS), are provided by a single health plan. Participating individuals are required to be enrolled in STAR+PLUS. If eligible, individuals are passively enrolled into the program, but may choose to opt-out. MMPs operate in Bexar, Dallas, El Paso, Harris, Hidalgo and Tarrant counties.

***Medical Home***

A medical home consists of a patient’s primary care provider (PCP) who delivers comprehensive preventive and primary care and provides referrals for specialty care and other covered services. See also Primary Care Provider (PCP).

***Medical Necessity***

Medical necessity is a measure used to determine an individual’s eligibility for a program or service. Authorized providers assess whether a program or service is reasonable, appropriate and consistent with health care practice guidelines. The Health and Human Services Commission (HHSC) uses medical necessity to determine eligibility for programs and services delivered through fee-for-service (FFS). Managed care organizations (MCOs) also use medical necessity to make eligibility determinations for the programs and services they deliver. HHSC monitors the medical necessity determination for all MCOs through utilization reviews (URs). See also Acute Care Utilization Reviews (ACURs) Managed Care Long-term Services and Supports Utilization Review (MLTSS UR).

***Medical Transportation Program (MTP)***

The Medical Transportation Program (MTP) is responsible for ensuring consistent, appropriate, reasonably prompt and cost-effective nonemergency medical transportation

(NEMT) services to Medicaid fee-for-service (FFS) clients who need transportation to covered health care services. See also Nonemergency Medical Transportation (NEMT).

### ***Medically Dependent Children Program (MDCP)***

The Medically Dependent Children Program (MDCP) is a 1915(c) waiver program delivered through the STAR Kids managed care program. MDCP provides a cost-effective alternative to living in a nursing facility to children with disabilities. Eligibility determinations for MDCP are based on medical necessity criteria outlined in the Texas Administrative Code. Managed care organizations (MCOs) provide medical necessity assessments, which are used by the Health and Human Services Commission (HHSC) to help determine whether an individual qualifies for MDCP. MDCP has an interest list. See also Appendix B, page 149, for a full list of MDCP services. See also STAR Kids.

### ***Medically Needy with Spend Down Program***

Through the Medically Needy with Spend Down Program, Medicaid pays for unpaid medical expenses for medical services provided to children age 18 and younger, and pregnant women who meet the required Spend Down limits. Spend Down is the difference between an applicant's household income and the Medically Needy income limit. Applicants must have unpaid medical bills that exceed the Spend Down amount to receive benefits under the program. See also Medicaid for Pregnant Women.

### ***Medicare Advantage Dual Eligible Special Needs Plan (D-SNP)***

A Medicare Advantage Dual Eligible Special Needs Plan (D-SNP) is a managed care delivery model specifically designed to coordinate care between Medicare and Medicaid covered services for individuals who are dually eligible for both programs. D-SNPs can serve both full and partial benefit dual eligible members. 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.

### ***Medicare Savings Program***

Through the Medicare Savings Program, Medicaid provides limited assistance to certain Medicare beneficiaries, identified as partial dual eligible, who do not qualify for full Medicaid benefits. Individuals in this program receive assistance with all or a portion of Medicare premiums, deductibles and coinsurance payments through Medicaid.

***Medication Assisted Therapy (MAT)***

Medication Assisted Therapy (MAT) is the use of medications in combination with counseling and behavioral therapies for the treatment of substance use disorders (SUDs), which can help some people sustain recovery. An example is the use of methadone for opioid use disorder (OUD).

***Members with Special Health Care Needs (MSHCN)***

Members with special health care needs (MSHCN) refers to managed care clients who either (a) require regular, ongoing therapeutic intervention and evaluation by appropriately trained personnel, or (b) have a serious, ongoing illness; a chronic or complex condition; or a disability that has lasted or is anticipated to last for a significant period. MSHCN may include women with high-risk pregnancies, members with high-cost catastrophic cases, and individuals with mental illness and co-occurring substance abuse. All members in STAR+PLUS and STAR Kids are considered MSHCN.

***Modified Adjusted Gross Income (MAGI)***

Modified Adjusted Gross Income (MAGI) is a tool used for financial eligibility determinations. MAGI uses federal income tax rules for determining income and household composition. Federal law requires financial eligibility for programs like Medicaid be determined using MAGI, except for people age 65 and older, individuals with disability, and those receiving Supplemental Security Income (SSI).

***Mystery Shopper Method***

The state's external quality review organization (EQRO) uses the mystery shopper method to evaluate whether providers meet appointment availability standards and to quantify the extent of provider directory issues. Using contact information provided by managed care organizations (MCOs), mystery shoppers contact network providers to see how quickly they can get appointments across all Medicaid programs.



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### ***National Core Indicators-Aging and Disabilities (NCI-AD) Survey***

On a biennial basis, the Health and Human Services Commission (HHSC) participates in the National Core Indicators-Aging and Disabilities (NCI-AD) survey, which is similar to the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. This allows the state to assess outcomes of services provided to members who participate in STAR+PLUS Home and Community-based Services (HCBS), and the Program of All-Inclusive Care for the Elderly (PACE).

### ***Network Adequacy***

Network adequacy refers to access to care standards that the provider networks of managed care organizations (MCOs) must meet in to ensure clients are able to access all medically necessary covered services. Provider networks must establish minimum provider access standards—including minimum distance, travel time and appointment availability for member access to providers; expedited credentialing for certain provider types as specified by the Health and Human Services Commission (HHSC); and online publication of provider directories, with provider information updated at least weekly.

### ***Nonemergency Medical Transportation (NEMT)***

Nonemergency medical transportation (NEMT) services provide cost-effective medical transportation to a doctor or specialist, a pharmacy, or other providers for covered health care services. NEMT services are only for people enrolled in managed care or fee-for-service (FFS) Medicaid, Children with Special Health Care Needs, and qualified low-income cancer patients. NEMT services for managed care members are coordinated by their MCO. NEMT services for FFS clients are coordinated by the Medical Transportation Program (MTP). See also Medical Transportation Program (MTP).

### ***Non-financial Criteria***

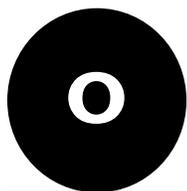
In addition to meeting financial eligibility criteria, applicants must meet non-financial criteria—including that they meet program-specific age limits, reside and intend to remain in Texas, provide a Social Security number (SSN) or apply for one, and meet citizenship or alien status program requirements. See also Qualified Aliens.

### ***Non-preferred Prior Authorization***

Non-preferred prior authorization may occur when prescribers choose medications listed on the Preferred Drug List (PDL) as “non-preferred” for their Medicaid patients. To prescribe the medication, the provider must obtain prior authorization from the Health and Human Services Commission (HHSC) or the patient’s managed care organization (MCO) before the drug is dispensed. See also Clinical Prior Authorization, Preferred Drug List (PDL) and Prior Authorization.

### ***Nursing Facility***

Nursing facilities are long-term care facilities that provide services to meet the medical, nursing and psychological needs of people who have a level of medical necessity requiring nursing care on a regular basis.



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### ***Office of Inspector General (OIG)***

The Office of Inspector General (OIG) is charged with safeguarding state health and human services by detecting and preventing fraud, waste and abuse and by ensuring the health and safety of Texans. The OIG engages in variety of activities related to Medicaid program integrity, including investigations, audits, inspections and reviews.

### ***Operational Review***

An operational review allows the Health and Human Services Commission (HHSC) to conduct an in-depth review of operational compliance and performance of a managed care organization (MCO) across several areas to ensure policies and practices align with performance standards. HHSC conducts on-site biennial operational reviews of MCOs—including review modules on claims processing, member and provider training, complaints/appeals, encounter data, utilization management, and website critical elements.

### ***Optional Benefits***

The Social Security Act specifies a set of benefits state Medicaid programs must provide and a set of optional benefits states may choose to provide. The state may choose to provide some, all, or no optional services specified under federal law. See also Mandatory Benefits.



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***Pay-for-Quality (P4Q)***

Pay-for-quality (P4Q) refers to programs that seek to reward the use of evidence-based practices and promote health care coordination and efficacy among managed care organizations (MCOs). The Health and Human Services Commission (HHSC) implements medical P4Q programs for STAR, STAR+PLUS, Children’s Health Insurance Program (CHIP), and a dental P4Q program. Strong P4Q programs incentivize MCOs to pursue quality-based alternative payment models (APMs) with providers to help them achieve higher performance on P4Q measures. P4Q programs were suspended for 2020 and 2021 in response to the federal public health emergency. See also Alternative Payment Model (APM).

***Pediatric Quality Indicator (PDI)***

Pediatric quality indicators (PDIs), which are similar to prevention quality indicators (PQIs), use hospital discharge data to measure quality of care for ambulatory care sensitive conditions—which are conditions where effective outpatient care or early intervention can prevent hospitalization, complications or more severe disease. PDIs specifically screen for problems that children and youth may experience. See also Prevention Quality Indicators (PQIs).

***Performance Improvement Project (PIP)***

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. PIPs must use ongoing measurements and interventions to achieve significant improvement, over time, in health outcomes and enrollee satisfaction. Health plans conduct PIPs to improve areas of care identified by the Health and Human Services Commission (HHSC), in consultation with Texas’ external quality review organization (EQRO), as needing improvement. See also External Quality Review Organization (EQRO).

***Per Member Per Month (PMPM)***

Per member per month (PMPM) rates are calculated for each risk group within each of the service areas in Texas—based on encounter data—and form the basis for the capitation rates paid to managed care organizations (MCOs) for the delivery of contractually required

Medicaid and Children’s Health Insurance Program (CHIP) services. See also Capitation Rate and Encounter Data.

### ***Personal Assistance Services (PAS)***

Personal Assistance Services (PAS) are state plan, community-based, long-term services and supports (LTSS) benefits for children and adults. PAS includes assistance with activities of daily living (ADLs) or instrumental activities of daily living (IADLs). In managed care, PAS can be delivered as an entitlement service, through the STAR+PLUS home and community-based services component, or through Community First Choice (CFC).

### ***Personal Care Services (PCS)***

Personal Care Services (PCS) are state plan, community-based, long-term services and supports (LTSS) benefits for children that include assistance with activities of daily living (ADLs) or instrumental activities of daily living (IADLs).

### ***Pharmacy Benefits Manager***

Each Medicaid and Children’s Health Insurance Program (CHIP) managed care organization (MCO) contracts with a pharmacy benefits manager (PBM) to process prescription claims. The PBMs contract and work with pharmacies that dispense medications to Medicaid and CHIP managed care clients. MCOs must allow any pharmacy provider that is willing to accept the financial terms and conditions of the contract to enroll in the MCO’s network.

### ***Postpartum Depression***

Postpartum depression is a mental health disorder that women may experience after giving birth. Symptoms must meet the diagnostic criteria set forth in the latest edition of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (DSM). Given the far-reaching impacts of PPD on the health of women and their children, HHSC has launched several initiatives and has published a five-year PPD strategic plan to increase awareness, education and continuity of care for women with PPD.

### ***Potentially Preventable Admission (PPA)***

A potentially preventable admission (PPA) is a hospital admission or long-term care facility stay that might have been reasonably prevented with adequate access to ambulatory care or health care coordination. See also Potentially Preventable Event (PPE).

### ***Potentially Preventable Complication (PPC)***

A potentially preventable complication (PPC) is a harmful event or negative outcome,

such as an infection or surgical complication, which occurs after a hospital admission or a long-term care facility stay and that might have resulted from care, lack of care or treatment during the admission or stay. See also Potentially Preventable Event (PPE).

### ***Potentially Preventable Emergency Department Visit (PPV)***

A potentially preventable emergency department visit (PPV) is emergency treatment for a condition that could have been treated or prevented by a physician or other health care provider in a non-emergency setting. See also Potentially Preventable Event (PPE).

### ***Potentially Preventable Event (PPE)***

Potentially preventable events (PPEs) are encounters, which could be prevented, that lead to unnecessary services or contribute to poor quality of care. PPEs are used to measure care quality. See also Potentially Preventable Hospital Admission (PPA), Potentially Preventable Complication (PPC), Potentially Preventable Readmission (PPR), and Potentially Preventable Emergency Department Visit (PPV).

### ***Potentially Preventable Readmission (PPR)***

A potentially preventable readmission (PPR) is a return hospitalization, within a set time, which might have resulted from problems in care during a previous hospital stay or from deficiencies in a post-hospital discharge follow up. See also Potentially Preventable Event (PPE).

### ***Preadmission Screening and Resident Review (PASRR)***

A Preadmission Screening and Resident Review (PASRR) supports individuals with a mental illness, intellectual disability or developmental disability—who are at higher risk for moving into a nursing facility—to live independently in the community or most integrated setting of their choice. The PASRR process identifies the goals, wishes, and needed services and supports for these individuals to live a person-centered life—safely, and integrated within their community. If an individual is at risk of moving into a nursing facility and needs higher level supports and services to remain with their family or in the community, then these individuals are PASRR positive and are eligible for these enhanced levels of care.

### ***Preferred Drug List***

The Preferred Drug List (PDL) is a tool used to control growing Medicaid drug costs, while also ensuring program recipients can obtain medically necessary medicines. The PDL in Texas classifies drugs as preferred or non-preferred based on safety, efficacy and cost-effectiveness. Prescribers who choose non-preferred medications for their patients

must obtain prior authorization. The Vendor Drug Program (VDP) and its vendors perform supplemental rebate negotiation with manufacturers and manage the PDL centrally across all Medicaid programs. Participating MCOs must use the PDL in administering pharmacy benefits to their members. See also Texas Drug Utilization Review (DUR) Board and Vendor Drug Program (VDP).

### ***Prescription Drugs***

Prescription drugs are pharmaceuticals that require a medical prescription from a provider to be dispensed. Outpatient prescription drugs are a benefit of Children's Health Insurance Program (CHIP) and all managed care programs. For those enrolled in fee-for-service (FFS) Medicaid, Texas pays for all outpatient drug coverage through the Vendor Drug Program (VDP). See also Vendor Drug Program (VDP).

### ***Prevention Quality Indicator (PQI)***

Prevention quality indicators (PQIs) use hospital discharge data to measure quality of care for ambulatory care sensitive conditions—which are conditions where effective outpatient care or early intervention can prevent hospitalization, complications or more severe disease.

### ***Primary Care Provider (PCP)***

In managed care, primary care providers (PCPs) coordinate the care of Medicaid and CHIP clients and are responsible for providing initial and primary care to patients, maintaining continuity of care, and making referrals to specialists. PCPs tend to be general practitioners, family practice doctors, pediatricians, OB/GYNs, specialty trained nurses, or health clinics. Once enrolled in one of the managed care programs, clients pick a health plan, which includes a directory of PCPs contracting with that plan.

### ***Primary Home Care (PHC)***

Primary Home Care (PHC) services are state planned, community-based, long-term services and supports (LTSS) benefits for children and adults that include assistance with activities of daily living (ADLs) or instrumental activities of daily living (IADLs).

### ***Prior Authorization***

A member's physician issues a prior authorization to document the medical necessity of a medication or medical service in certain situations before a managed care organization (MCO) can approve that medication or service. See also Clinical Prior Authorization and Non-clinical Prior Authorization.

***Profit Limit***

Managed care organizations (MCOs) are paid on a per member per month (PMPM) basis, also called a capitation rate. This rate includes a risk margin to account for fluctuations in predicted claims cost. This risk margin may result in profit for the plan. However, MCO profits are contractually limited, and any profits earned greater than three percent are considered excessive profit and recovered by the Health and Human Services Commission (HHSC) through a tiered-experience rebate system. See also Per Member Per Month (PMPM) and Risk Margin.

***Program of All-inclusive Care for the Elderly (PACE)***

Program of All-inclusive Care for the Elderly (PACE) is a comprehensive care approach providing an array of services for a capitated monthly fee that is below the cost of comparable institutional care. 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 at the time of enrollment. PACE participants receive all medical and social services needed through their PACE provider. PACE is available in Amarillo/Canyon, El Paso and Lubbock.

***Promoting Independence (PI) Initiative***

The Promoting Independence (PI) Initiative, also called Money Follows the Person (MFP) policy, provides the opportunity for individuals in need of long-term services and supports (LTSS) to move from facilities to community-based services. This better allows individuals to choose how and where they receive their LTSS. Other support services have since been developed to help identify individuals who want to leave an institutional setting and to assist them in relocating back to the community. PI is considered a reserve capacity group. See also Reserve Capacity Group.

***Prospective Drug Utilization Review (DUR)***

Prospective Drug Utilization Reviews (DURs) evaluate each client's drug history before medication is dispensed to ensure appropriate and medically necessary utilization. Therapeutic criteria for prospective DURs are determined by the Texas Drug Utilization Review (DUR) Board. See also Texas Drug Utilization Review (DUR) Board.

***Prospective Payment System (PPS)***

A prospective payment system (PPS) is a method of reimbursement in which payment is made based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system of that service. PPSs are used for inpatient and outpatient hospital reimbursement and rural health clinics (RHCs)

reimbursement. Federally Qualified Health Centers (FQHCs) may be reimbursed using a PPS system or an alternative prospective payment system (APPS). PPS rates are inflated annually using the Medicare Economic Index (MEI) for primary care. See also Alternative Prospective Payment System (APPS).

### ***Provider Agency***

Provider agencies are the employers of attendants or other direct service workers, who provide long-term services and supports (LTSS), and are responsible for all of the employment and business operations-related activities. Provider agencies are licensed or certified by the Health and Human Services Commission (HHSC) and must comply with HHSC licensure and program rules.

### ***Provider Credentialing***

The process through which managed care organizations (MCOs) ensure that each health care provider meets all professional standards, including licensure.

### ***Provider Enrollment Screening***

The Office of Inspector General (OIG), in close collaboration with the Health and Human Services Commission (HHSC), completes the required state and federal disclosure and screening activities for high-risk providers seeking to enroll, re-enroll or revalidate their enrollment in Medicaid and other HHSC programs. See Office of Inspector General (OIG).

### ***Psychiatric Hospital***

A psychiatric hospital is an institution primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally ill people. The provisions for certification apply only where the entire institution is primarily for the treatment of mental illness. A psychiatric wing of a general hospital may not be certified.

### ***Public Health Emergency***

The President of the United States or the United States Secretary of Health and Human Services may declare a public health emergency (PHE) when a disease or disorder presents a significant risk to public health, including outbreaks of infectious diseases or bioterrorist attacks. PHEs authorize the Secretary of Health and Human Services to take certain discretionary actions in response. If the president authorizes the PHE, these actions can include waiving or modifying certain requirements for Medicare, Medicaid and State Children's Health Insurance Programs (SCHIPs). Many elements of Texas Medicaid and CHIP, including enrollment, funding, services, and program oversight, have been impacted by the current federal PHE, which was originally declared in March 2020 in response to the COVID-19 pandemic. See also Continuous Medicaid Coverage and COVID-19.

### ***Public Health Provider-Charity Care Program***

Authorized under the current 1115 Transformation Waiver, the Public Health Provider—Charity Care Program (PHP-CCP) is designed to allow qualified providers to receive reimbursement for the cost of delivering uncompensated health care services, including behavioral health services, immunizations, and other preventative services. Eligible providers include Community Mental Health Clinics (CMHCs), Community Centers, Local Behavioral Health Authorities (LBHAs), Local Mental Health Authorities (LMHAs), Local Health Departments (LHDs) and Public Health Districts (PHDs). The PHP—CCP began operating on October 1, 2021.



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### ***Qualified Aliens***

Qualified aliens are non-citizen, Texas residents who are potentially eligible for certain programs like Medicaid. Qualified aliens may be subject to different requirements, such as waiting periods and time-based eligibility limitations. There are several categories, including but not limited to: Legal Permanent Residents (LPRs), asylees and refugees, and victims of human trafficking. See also Legal Permanent Resident (LPR).

### ***Qualified Disabled Working Individuals***

Qualified Disabled Working Individuals are dually eligible individuals who can receive partial, but not full, Medicaid benefits. Their income must be less than or equal to 200 percent of the federal poverty level (FPL). The Texas Medicaid program pays Medicare Part A premiums for disabled working individuals.

### ***Quality Assessment and Performance Improvement (QAPI) Projects***

Federal regulations require Medicaid health plans to develop, maintain and operate quality assessment and performance improvement (QAPI) programs. QAPI programs are ongoing, comprehensive quality assessment and performance improvement programs for all the services that the managed care organization (MCO) provides.

### ***Quality Incentive Payment Program (QIPP)***

The Quality Incentive Payment Program (QIPP) seeks to improve quality and innovation in the provision of nursing facility services. Both public and private nursing facilities can participate in the program. Payments are made quarterly by the STAR+PLUS managed

care organizations (MCOs) to the nursing facilities, based on their completion of required quality improvement activities and their performance on agreed-upon quality measures.



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### ***Readiness Reviews***

The Health and Human Services Commission (HHSC) conducts readiness reviews to determine if a managed care organization (MCO) can provide the services that it is being contracted to provide. Readiness reviews are completed at least 90 days prior to the operational start of a contract to provide enough time to identify and remedy operational issues prior to contract start date.

### ***Regional Healthcare Partnership (RHP)***

Under the 1115 Transformation waiver, eligibility to receive Uncompensated Care (UC) or Delivery System Reform Incentive Payment (DSRIP) payments requires participation in one of the 20 Regional Healthcare Partnerships (RHPs) across Texas. RHPs collaborate to develop meaningful delivery system reforms and improve patient care for low-income populations. RHP plans include projects outlined in the RHP planning protocols. See also Regional Healthcare Partnership (RHP) Planning Protocols.

### ***Regional Healthcare Partnership (RHP) Planning Protocols***

Regional Healthcare Partnerships (RHPs) are locally-developed confederations that fund the state share of all Texas Healthcare Transformation and Quality Improvement Program 1115 waiver payments in a partnership. RHPs provide waiver information, including requirements and opportunities for stakeholder involvement, and allow local communities to propose local partners and areas covered. RHPs seek to promote delivery system transformation, including improved access, quality, cost-effectiveness, and coordination of health care.

### ***Research and Demonstration 1115 Waivers***

Research and Demonstration 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.

***Reserved Capacity Group***

A portion of 1915(c) waiver program slots is set aside for individuals in reserve capacity groups. When a waiver program slot opens, an individual from a reserve capacity group bypasses the general interest list and is given an eligibility determination for the program. Examples of reserved capacity groups are Crisis Diversion and the Promoting Independence (PI) Initiative. See also Crisis Diversion.

***Resource-based Fee (RBF)***

Under the fee-for-service (FFS) delivery model, resource-based fees (RBFs) are a type of Medicaid rate used to pay physicians and other practitioners for services. Rates are uniform statewide and are categorized as either RBFs or access-based fees (ABFs). RBFs are calculated based on the actual resources required by an economically efficient provider to deliver a service. Reimbursement rates for services outlined above are evaluated at least once every two years as a part of a biennial fee review process. See also Access-based Fee (ABF) and Fee-for-Service (FFS) Rates.

***Retrospective Drug Utilization Review (DUR)***

Retrospective Drug Utilization Reviews (DURs) examine drug therapy after the person has received the medication. Retrospective DURs evaluate claims data to analyze prescribing practices, a person's medication use and pharmacy dispensing practices. The Health and Human Services Commission (HHSC) and managed care organizations (MCOs) conduct multiple reviews each calendar year on topics such as identifying patterns of drug misuse, medically unnecessary prescribing or inappropriate prescribing. Intervention letters are sent to physicians to help better manage a person's drug therapy. The Texas Drug Utilization Review (DUR) Board also reviews and approves the retrospective DURs for fee-for-service (FFS). See also Texas Drug Utilization Review (DUR).

***Risk Margin***

In capitation rate setting, a risk margin is added in case of possible fluctuations in predicted claims cost. This margin is calculated as a percentage of the initial capitation rate. To the extent that a managed care organization (MCO) successfully manages member care and keeps medical costs and administrative costs on target, the risk margin may result in profit for the health plan. The Health and Human Services Commission (HHSC) has reduced the risk margin for most programs, and this new lower risk margin could potentially translate to additional profit limits. See also Capitation Rates and Profit Limits.

### ***Rural Health Clinics (RHC)***

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.” To qualify as an RHC, the clinic must be located in a non-urbanized and medically underserved area, and have a nurse practitioner or physician assistant in the clinic 50 percent of the time. An RHC may not exist as a rehabilitation agency or serve primarily as a treatment facility for mental diseases.

### ***Rural Hospital***

A rural hospital is typically categorized by its location outside of a city or metropolitan area and by its size and caseload, which are usually considerably smaller than urban hospitals.



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### ***School Health and Related Services (SHARS)***

The School Health and Related Services (SHARS) program reimburses independent school districts, including public charter schools, for providing Medicaid services to children with disabilities. 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; counseling; physician and nursing services; physical, speech, and occupational therapies; personal care services; and psychological services.

### ***Service Area (SA)***

Service areas (SAs) are the geographic locations within the state where services are delivered by certain health plans and their providers. SAs may also be referred to as Service Delivery Areas (SDAs).

### ***Service Comparability***

In general, the state is required 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.

***Service Coordination***

Managed care organizations (MCOs) are required to provide service coordination to STAR Health, STAR Kids and STAR+PLUS members who meet the eligibility criteria. Service coordination, as well as eligibility for the service, may be defined differently by program. For example, children in STAR Kids are automatically eligible for this service, while adults in STAR+PLUS must have complex health needs to receive service coordination. See also Service Management. See also A Closer Look, page 47.

***Service Management***

Managed care organizations (MCOs) are required to provide service management for STAR, STAR Health, and Children's Health Insurance Program (CHIP) members who meet the eligibility criteria. Like service coordination, the definition and eligibility criteria for service management may be defined differently by program. See also Service Coordination. See also A Closer Look, page 47.

***Service Responsibility Option***

Service Responsibility Option (SRO) is available in Medicaid managed care programs, Community Attendant Services (CAS), and Primary Home Care (PHC). SRO is a hybrid of the agency option and Consumer Directed Services (CDS) option—in which an individual, the provider agency, and when applicable the managed care organization (MCO) work together to provide the individual with increased control over the delivery of their services. In Medicaid managed care, services with the CDS option also have SRO. See also Consumer Directed Services (CDS) Option.

***Single State Agency***

As required by federal law, a single agency must be designated by each state to administer and supervise the administration of the Medicaid state plan. In Texas, the Health and Human Services Commission (HHSC) fulfills this function. See also Health and Human Services Commission (HHSC).

***STAR***

STAR is a statewide managed care program primarily for pregnant women, low-income children and their caretakers. Most people in Texas Medicaid get their coverage through STAR.

***STAR Health***

STAR Health is a statewide managed care program that provides coordinated health services to children and youth in foster care and kinship care. STAR Health benefits include medical, dental and behavioral health services—as well as service coordination and a web-based electronic medical record, known as the Health Passport.

***STAR Kids***

STAR Kids is a statewide managed care program for children and youth age 20 and younger with disabilities, including children and youth receiving benefits under the Medically Dependent Children Program (MDCP) waiver.

***STAR+PLUS***

STAR+PLUS is a statewide managed care program for adults with disabilities and those age 65 and older.

***STAR+PLUS Home and Community-based Services (HCBS) Program***

STAR+PLUS Home and Community-based Services (HCBS) is a waiver program delivered through managed care that provides a cost-effective alternative to living in a nursing facility for individuals who are elderly or have disabilities. STAR+PLUS HCBS is delivered through the Texas 1115 Healthcare Transformation Waiver. Eligibility determinations for STAR+PLUS HCBS are based on medical necessity criteria outlined in the Texas Administrative Code. Managed care organizations (MCOs) provide medical necessity assessments, which are used by the Health and Human Services Commission (HHSC) to help determine whether an individual qualifies for STAR+PLUS HCBS. STAR+PLUS HCBS has an interest list. See also Appendix B, page 149, for a full list of STAR+PLUS HCBS services. See also STAR+PLUS.

***State-owned Teaching Hospital***

Teaching hospitals provide medical education, including post-graduate residency training programs, which incur higher expenses than hospitals without these programs. The portion of these costs attributable to serving Medicaid patients may be covered by Graduate Medical Education (GME) payments. See also Graduate Medical Education (GME) payments.

***State Plan***

State plans describe the nature and scope of the Medicaid program, including administration, client eligibility, benefits and provider reimbursement. The Centers for Medicare and Medicaid Services (CMS) must approve all state plans. The state plan in

Texas gives the Health and Human Services Commission (HHSC), as the single state agency, the authority to administer the Medicaid program. See also Single State Agency.

### ***State Supported Living Center (SSLC)***

State Supported Living Centers (SSLCs) are certified intermediate care facilities for individuals with an intellectual disability or related condition (ICFs/IID) that serve individuals with an intellectual disability who have medical or behavioral health needs. SSLCs provide 24-hour residential services, comprehensive behavioral treatment, health care, and other services in a campus setting.

### ***Statewide Availability***

In general, a state must offer the same benefits to everyone throughout the state. Exceptions to this requirement are possible through Medicaid waiver programs and special contracting options.

### ***Substance Use Disorder (SUD)***

A substance use disorder (SUD) occurs when an individual's use of a substance, such as alcohol or opioids, leads to health issues or problems in everyday life/work, school or home. The pattern must meet the diagnostic criteria set forth in the latest edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM). The benefits of Medicaid SUD treatment include assessment, outpatient treatment, medication assisted therapy (MAT), and residential and ambulatory detoxification. Services must be provided by a chemical dependency treatment facility (CDTF). See also Medication Assisted Therapy (MAT).

### ***Sufficient Coverage***

Federal law allows states to determine what constitutes "reasonably sufficient" coverage in terms of the amount, duration and scope of services. Each state defines these parameters; thus, state Medicaid plans vary in what and how much they cover.

### ***Supplemental Hospital Funding***

The Health and Human Services Commission (HHSC) administers supplemental hospital payment programs that help cover the cost of uncompensated care, incentivize improvements to care quality and fund graduate medical education. Examples include the Uncompensated Care (UC) and Delivery System Reform Incentive Payment (DSRIP) pools created under the 1115 Transformation waiver. See also Delivery System Reform Incentive Payment (DSRIP) Pool, Uncompensated Care (UC) Pool, and 1115 Transformation Waiver.

### ***Supplemental Nutrition Assistance Program (SNAP)***

The Supplemental Nutrition Assistance Program (SNAP), also known as food stamps, helps people buy the food they need for good health.

### ***Supplemental Security Income (SSI)***

Supplemental Security Income (SSI) is a federal cash assistance program for low-income individuals with disabilities and those age 65 and older. In Texas, all people eligible for SSI are automatically eligible for Medicaid.

### ***Suspension of Default Enrollment***

Suspension of default enrollment is a contractual non-compliance remedy that temporarily stops a managed care organization (MCO) from receiving clients through the default enrollment process. See also Default Enrollment.



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### ***Targeted Review***

The Health and Human Services Commission (HHSC) conducts a targeted review of a managed care organization (MCO) when a significant or recurring problem occurs. The scope, entity and focus of targeted reviews vary based on the topics raised by complaints received and past instances of noncompliance.

### ***Teledentistry***

Teledentistry refers to dentistry services delivered by a dentist or dental hygienist using audio-visual telecommunications.

### ***Telehealth***

Non-medical, non-dental health services, like behavioral health services, delivered by a licensed professional using audio-visual or audio-only telecommunications.

### ***Telemedicine***

Health care delivered by a medical professional, such as a doctor, using audio-visual telecommunications.

***Temporary Assistance for Needy Families (TANF)***

The Temporary Assistance for Needy Families (TANF) program is a cash-assistance program that helps families pay for basic living needs.

***The Texas 1115 Transformation Waiver***

The expansion of managed care has resulted in the end of the Upper Payment Limit (UPL) program, as federal regulations prohibit supplemental payments to providers in a managed care context. To preserve federal hospital funding, the Health and Human Services Commission (HHSC) submitted—and the Centers for Medicare and Medicaid Services (CMS) approved—a proposal for a five-year Section 1115 Demonstration waiver. The Texas 1115 Transformation Waiver, also known the Texas Healthcare Transformation and Quality Improvement Program, provides the federal authority for operations of most of the state's Medicaid managed care programs, including STAR, STAR+PLUS, STAR Kids, and the Children's Dental Program, while preserving supplemental funding for providers. The waiver contains several supplemental funding pools including directed payment programs (DPPs), the Public Health Provider-Charity Care (PHP-CC) program, and Uncompensated Care (UC). See also Directed Payment Programs (DPPs), Public Health Provider-Charity Care (PHP-CC), and Uncompensated Care (UC).

***Texas Department of Family and Protective Services (DFPS)***

The Texas Department of Family and Protective Services (DFPS) is responsible for investigating charges of abuse, neglect or exploitation of children, elderly adults and adults with disabilities. DFPS also manages children in state conservatorship or foster care.

***Texas Department of Insurance (TDI)***

The Texas Department of Insurance (TDI) regulates both commercial and state-funded health insurance plans because managed care organizations (MCOs) are licensed as Health Maintenance Organizations (HMOs) in Texas. TDI requires MCOs to file a network adequacy report once a year. See also Network Adequacy.

***Texas Drug Utilization Review (DUR) Board***

The Texas Drug Utilization Review (DUR) Board is a Health and Human Services Commission (HHSC) advisory board whose members are appointed by the HHSC Executive Commissioner. The duties of the Texas DUR Board include developing and submitting recommendations to HHSC for the Preferred Drug List (PDL), suggesting restrictions or prior authorizations for certain prescription drugs, developing and reviewing

educational interventions for Medicaid providers, and reviewing drug utilization across the Medicaid program. See also Clinical Prior Authorization and Preferred Drug List (PDL).

### ***Texas Formulary***

The Texas Formulary is a list of all the drugs covered by Texas Medicaid and the Children's Health Insurance Program (CHIP).

### ***Texas Healthcare Learning Collaborative (THLC)***

Texas Healthcare Learning Collaborative (THLC) is a website that serves as a public reporting platform, contract oversight tool, and a tool for managed care organization (MCO) quality improvement efforts. It was developed for use by the Health and Human Services Commission (HHSC), MCOs, providers, and the general public to obtain up-to-date MCO and hospital performance data on key quality-of-care measures—including potentially preventable events (PPEs), Healthcare Effectiveness Data and Information Set (HEDIS) data, and other quality-of-care information.

### ***Texas Health Steps***

Texas Health Steps is a required program, known in federal law as the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. Texas Health Steps provides medical and dental prevention and treatment services for children of low-income families, who are age 20 and younger and are enrolled in Medicaid. The program offers comprehensive and periodic evaluation of a child's health—including growth and development; nutritional status; and vision, dental and hearing care. See also Comprehensive Care Program (CCP).

### ***Texas Home Living (TxHmL)***

Texas Home Living (TxHmL) is a 1915(c) waiver program that provides community-based services to current Medicaid recipients with intellectual disabilities or related conditions, as an alternative to an intermediate care facility for individuals with an intellectual disability or related condition (ICF/IID). Eligibility determinations for TxHmL are based on level of care (LOC) criteria outlined in the Texas Administrative Code. TxHmL has an interest list. See also Appendix B, page 149, for a full list of TxHmL services.

### ***Third Party Liability (TPL)***

Third-party liability (TPL) is a requirement of federal law for Medicaid to be the payer of last resort. This means that other sources of coverage a client or Medicaid-eligible patient may have, such as private health insurance, may be required to pay claims before

Medicaid. Medicaid is also required to take reasonable measures to identify liable third parties and process claims accordingly.

### ***Time and Distance Standards***

Time and distance standards are metrics used to ensure managed care organization (MCO) provider networks can and are sufficiently capable of providing their members access to medically necessary services.



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### ***Uncompensated Care (UC) Pool***

The Uncompensated Care (UC) pool is a hospital funding pool under the 1115 Transformation waiver. UC payments are cost based and help offset the costs of uncompensated care provided by hospitals and other health care providers. Though previously defined as either unreimbursed costs for Medicaid or uninsured patients incurred by hospitals, uncompensated care costs are currently defined as unreimbursed charity care costs. The pool has historically been smaller than the reported total uncompensated care costs. See also 1115 Transformation Waiver.

### ***Uniform Hospital Rate Increase Program (UHRIP)***

The Uniform Hospital Rate Increase Program (UHRIP) is designed to reduce hospitals' uncompensated care costs through enhanced payments to hospitals for medically necessary covered services provided to Medicaid managed care members.

### ***Uniform Managed Care Contract***

The uniform managed care contract is a legal document that establishes the requirements that all managed care organizations (MCOs) must follow.

### ***Urban Hospital***

An urban hospital is typically categorized by its location within a city or metropolitan area and its size and caseload, which are usually considerably larger than rural hospitals.



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### ***Value-based Enrollment***

Value-based enrollment is the mechanism the Health and Human Services Commission (HHSC) uses for determining which managed care organization (MCOs) a new member will enroll with if they do not choose their MCO. New members who do not select an MCO are default enrolled. Value-based enrollment scores MCOs to determine each MCO's monthly auto-enrollment allocation. HHSC has created a single value score based on key performance metrics. Scores are calculated by service area and used, along with member choice data, to determine an MCO's monthly target auto-enrollment allocation. See also Default Enrollment.

### ***Vendor Drug Program***

The Vendor Drug Program (VDP) provides outpatient drug coverage for individuals enrolled in fee-for-service (FFS). In addition, the VDP maintains control of certain aspects of the pharmacy administration for both FFS and managed care—including managing federal and supplemental drug rebates, the Preferred Drug List (PDL), and clinical prior authorizations. See also Clinical Prior Authorization, Fee-for-Service (FFS) and Preferred Drug List (PDL).



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### ***Waivers***

Federal law allows states to apply to the Centers for Medicare and Medicaid Services (CMS) for permission to depart from certain Medicaid requirements. Federal law allows three types of waivers: Research and Demonstration 1115 waivers, Freedom of Choice 1915(b) waivers, and Home and Community-based Services (HCBS) 1915(c) waivers.

### ***Waste***

Waste refers to any practice that a reasonably prudent person would deem careless or that would allow inefficient use of resources, items or services.



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### ***Your Texas Benefits Website***

A self-service website ([YourTexasBenefits.com](https://www.yourtexasbenefits.com)) where individuals can apply for Medicaid and other Texas Health and Human Services Commission (HHSC) programs. Clients can also accomplish the following online: view benefit information, edit and manage personal information, select their health plan, print temporary Medicaid cards or order replacement cards, set up and view their Texas Health Steps alerts, and view services provided by Medicaid.

### ***Youth Empowerment Services (YES)***

The Youth Empowerment Services (YES) is a 1915(c) waiver program that provides community-based services to children and adolescents age 3 through age 18 who have severe mental, emotional or behavioral disturbances, and their families.

# Acknowledgments

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- All MCS units
- HHSC Financial Services
- Access and Eligibility Services
- Office of Data Analytics and Policy
- Health, Developmental and Independence Services
- Health and Specialty Care System
- Behavioral Health Services
- Community Services
- Office of the Inspector General
- Department of State Health Services (DSHS) Vital Statistics

Every attempt has been made to ensure the accuracy of the material reported in this book at the time of publication in December 2022.

