Texas Medicaid and CHIP

Expansion of Medicaid Managed Care

http://www.hhsc.state.tx.us/medicaid/managed-care/mmc.shtml

Most people in Texas who have Medicaid get their services through managed care. In this system the member picks a health plan and gets Medicaid services through that health plan’s network of providers. Most health plans offer Medicaid members extra services not available through traditional Medicaid.

Right now, there are three Medicaid managed care programs in Texas: STAR, STAR+PLUS, and STAR Health. The 2013 Texas Legislature approved several expansions of Medicaid managed care and directed HHSC to develop a performance-based payment system that rewards outcomes and enhances efficiencies. Managed care expansion plans include:

**STAR+PLUS**

- Expands statewide on September 1, 2014.
- Services provided through the Community Based Alternatives (CBA) program will be provided through the STAR+PLUS Home and Community Based Services (HCBS) waiver on September 1, 2014.
- Day Activity Health Services (DAHS) and Primary Home Care (PHC) services will be provided through the STAR+PLUS health plans statewide on September 1, 2014.
- People with intellectual and developmental disabilities will get their basic health services (acute care) through a STAR+PLUS health plan on September 1, 2014.
- People living in nursing facilities will get full Medicaid coverage through a STAR+PLUS health plan on March 1, 2015.

**STAR Kids**

- Starts September 1, 2016.
- For children and youth age 20 and younger who have Medicaid through SSI or 1915(c) waiver programs.
- Provides full Medicaid services – both basic health services (acute care) and long-term services and supports – for people in Medically Dependent Children Program (MDCP).
- Provides basic health services (acute care) for children and youth in other 1915(c) waiver programs.
- Includes development of a service plan for each member and service coordination.

**Pilot programs and other initiatives**

- Addition of mental health rehabilitation and mental health targeted case management services in Medicaid managed care.
- Basic attendant care and habilitation services to increase or maintain the skills of a member and emergency response services (also referred to as community first choice).
- Redesign of the Medical Transportation Program.

Letters from HHSC

Many people with Medicaid will have new service options to think about due to the expansion of Medicaid managed care. All will get letters from HHSC. These letters will be written for specific situations and provide direction for action the person needs to take. Each of these letters is posted on this website.
Resources

- Common questions and answers about Medicaid managed care
- Maps of service areas for STAR and STAR+PLUS
  - STAR Service Areas (PDF)
  - STAR Rural Service Areas (PDF)
  - STAR+PLUS Service Areas (PDF)
  - STAR+PLUS Rural Service Areas (PDF)
- Medicaid Managed Care Initiatives presentation (changes to Medicaid managed care) – for consumers and stakeholders (PDF)
- Medicaid Managed Care Initiatives presentation (changes to Medicaid managed care) – for providers (PDF)
- House Committee on Human Services: Medicaid Managed Care Initiatives
- Provider Relations Contacts for Medicaid Health Plans (PDF)

Advisory Committees

Several committees are helping HHSC in the expansion of Medicaid managed care:

- Intellectual and Developmental Disability System Redesign Advisory Committee
- STAR Kids Advisory Committee
- STAR+PLUS Quality Council
- State Medicaid Managed Care Advisory Committee

Questions and answers about the expansion of Medicaid managed care

How Managed Care Works

- Who will be affected by these initiatives?

  New initiatives will change the way some services are provided to individuals included in nursing facilities, children with special needs, and individuals with intellectual and developmental disabilities (IDD).

- What is a managed care organization?

  HHSC contracts with managed care organizations, licensed by the Texas Department of Insurance, and pays them a monthly amount to coordinate health services for Medicaid clients enrolled in their health plan. The health plans contract directly with doctors and other health care providers to create provider networks their members can use. The health plans are required to provide all covered medically necessary services to their members.

- What is a provider network?

  Provider networks are organizations of health care providers that deliver services within managed care health plans. Managed care enrollees are expected to use network providers.

  In Texas, there are four types of Medicaid: STAR, STAR+PLUS, STAR Health, and traditional Medicaid. The type of Medicaid coverage a person gets depends on where the person lives and what kind of health issues the person has.
  - STAR
  - STAR+PLUS
• **STAR Health**
  Clients receive traditional Medicaid if they are not in a managed care network.

• **Do managed care members get to choose a health plan?**
  Yes, Medicaid managed care members get a packet in the mail with information about their plan choices. Members should check to see if the doctors and other providers they go to are in the packet's provider directory.

• **Can managed care members change their health plan?**
  Yes, members can request to change their health plan at any time. Changes take between 15 to 45 days to complete. Members can change plans by calling the Texas Enrollment Broker Helpline at 1-800-964-2777.

• **What happens if a member does not choose a health plan by the deadline?**
  If a member does not choose a health plan, one will be chosen for the member. This is known as an automatic assignment.

• **What if a member’s provider is not in the network?**
  A member can encourage their current provider to contract with the health plan. However, if the provider chooses not to contract with that health plan, the member must change to a provider who is on their health plan's provider list.

• **What if a member’s pharmacy is not in network?**
  Members should contact their health plan if their pharmacy is not in that network. The health plan will help members find another pharmacy that is in the network or try to enroll the member’s current pharmacy.

• **How does Medicare work with Medicaid managed care?**
  If someone is in both programs, the client will use Medicare for their health care needs, prescription drugs and medications. The client’s Medicaid health plan will provide Medicaid long-term services and supports needs and will cover certain medications not covered at all, or only partially, by Medicare.

• **What is service coordination?**
  Service coordination is a STAR+PLUS benefit that helps members identify and coordinate service and benefit needs and develop a plan to allow them to live in the most independent setting possible. A health plan service coordinator (such as a nurse, social worker, or other health plan staff member) will work directly with plan members, family members, doctors, and community supports to make sure all health care and long-term services and supports needs are met. Service coordination will also be a benefit in the STAR Kids program. A health plan service coordinator:
  • Makes home visits and assesses member needs.
  • Coordinates with Medicaid and Medicare providers.
  • Authorizes community long-term services and supports.
  • Arranges for other services such as medical transportation.
• Coordinates other community supports, such as housing.

• Will the managed care service coordinator be employed by the health plan?

STAR+PLUS health plans employ service coordinators. They also use contracted agencies or other staff to help identify members’ needs.

• How will HHSC verify individuals with complex conditions are getting the care they need in a managed care setting?

HHSC has a contract with all Texas Medicaid managed care health plans. The contract lists requirements the health plans must meet to get paid. For example, health plans must provide members with medically necessary services in a timely manner and appropriate setting. When a health plan does not meet its requirements, HHSC will address the issue and ensure the member’s needs are met.

Access to Care

• Will managed care change the types or amounts of services a member receives?

Members will continue to receive the types and amounts of services that most appropriately meet their medical needs. Needs are determined by the results of an assessment and development of an individual service plan, where appropriate. Medicaid health plans are required to provide all covered medically necessary services to members. Medically necessary means that services are:
  • Reasonably necessary to prevent illness or medical conditions, or provide early screening, interventions, and treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a handicap, cause illness or infirmity of a recipient, or endanger life.
  • Provided at appropriate locations and at the appropriate levels of care for the treatment of clients’ conditions.
  • Consistent with health care practice guidelines and standards that are issued by professionally-recognized health care organizations or governmental agencies.
  • Consistent with the diagnoses of the conditions.
  • No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency.

• How will HHSC provide consumer direction in a managed care model?

Medicaid managed care includes consumer-directed services that allow individuals who receive certain services to hire and manage the people who provide their services. The following services are available for self-direction:
  • Personal assistance services
  • Professional therapies (including, occupational, physical and speech/language therapy)
  • Respite
  • Nursing
  • Support consultation
  • Supported employment (September 1, 2014)
  • Employment assistance (September 1, 2014)
  • Cognitive rehabilitation therapy (March 1, 2014)
Consumer-directed services will continue to be an option in the STAR+PLUS model as it is in traditional Medicaid. In addition, the STAR+PLUS health plans are required to submit quarterly consumer directed services utilization reports to HHSC for review.

- **Will a member be able to keep their personal attendant or nurse?**

  Yes, if the provider agency contracts with the member’s chosen health plan. If the member’s current provider is not on the plan’s provider list, they will need to choose another provider. If a member must select a different provider, it is possible the attendant or nurse may be hired by the provider agency. They may also be able to continue to use their attendant through the health plan’s consumer-directed services option.

- **Will there be a limit on prescription drugs?**

  - If a member is enrolled in a Medicaid health plan and not Medicare, there is no limit on the medicines they can fill each month.
  - If an individual is enrolled in Medicaid (fee-for-service or managed care) and Medicare Part D, the individual’s Part D health plan will cover most medicines. Medicare Part B also covers certain medicines. Medicaid covers a limited number of medicines that are not covered by Medicare.
  - If an adult (age 21 and older) is transitioning from fee-for-service Medicaid, which currently has a limit on medicines, into managed care, they will receive unlimited prescriptions once they are enrolled in managed care.

- **Will transportation services still be available?**

  Yes, the [Medical Transportation Program](http://www.hhsc.texas.gov) is available to all Medicaid individuals including those enrolled in managed care.

- **How will members get medical supplies, equipment and adaptive aids?**

  Members will get medical supplies, equipment, and adaptive aids through their health plan provider network.

- **Will targeted case management and mental health rehabilitative services be covered under managed care in the future?**

  Yes, targeted case management for individuals with mental illness and mental health rehabilitative services will be available through managed care beginning September 1, 2014. Mental health targeted case management and mental health rehabilitative services are available to Medicaid recipients who are assessed and determined to have a severe and persistent mental illness such as schizophrenia, major depression, bipolar disorder and children and adolescents ages 3 through 17 years with a diagnosis of a mental illness who exhibit a serious emotional disturbance. Legislative direction was given to HHSC to make these services available in Medicaid managed care to provide better coordination of care by integrating physical and behavioral health care for these Medicaid recipients.