Improving Medicaid Efficiency and Cost-Effectiveness

Final Report

Texas Conservative Coalition Research Institute

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I. Executive Summary

At just over 28% of the entire state budget, and with a total FY 2020-2021 biennial appropriation of $66.4 billion all funds (AF), the Medicaid program is one of the single largest cost drivers for the State of Texas.[1] And, because the program is an entitlement with open-ended funding, and is largely ruled by federal laws and regulations, the state has limited control in curbing Medicaid population growth and costs. In Fiscal Year 2019, the Texas Medicaid program served about 3.9 million low-income, elderly, and disabled individuals.[2]

While the State has somewhat limited control of the program, this does not mean that state leaders are left with no options to improve Medicaid efficiency and contain costs. Because most Texans currently covered by Medicaid must be covered under the program in accordance with federal law, and because the state operates a mature and successful managed care program, there are no readily accessible high-impact cost savings to be easily gleaned. This, however, does not mean that improvements cannot, or should not, be made. The efficiencies to be gained now involve adjustments to existing practices that ensure quality service delivery and best value. So, while no one item in and of itself will provide a savings number that is significant relative to overall Medicaid spending or the state budget, it is important to examine these "smaller" items that can have a cumulatively important impact.

This Medicaid Study Group Report first provides background on the Texas Medicaid program and discusses the proven benefits of managed care. The "Maintaining the Infrastructure of the Managed Care Model" section of this report (Section V) discusses the importance of the concept of whole-person care coordination and why attempts to carve populations or services out of the model are regressive and should be rejected.

The "Maximizing the Managed Care Model" section (Section VI) examines ways in which the current model can be better utilized to drive efficiency, cost-effectiveness, and client outcomes. Policy recommendations in this area include examining additional services and populations that are served in a fee-for-service model but could be better served by managed care; leveraging the managed care program to drive quality and value with alternative-based payment models; increasing plan continuity among enrollees; and identifying opportunities to reduce duplicative administrative functions with the State and its contracted managed care organizations.

With respect to the "to Care Improvements" section (Section VII), this report recognizes the ongoing health care workforce shortages across much of the State, and considers how non-physician providers can be better utilized to provide quality appropriate care. Here, TCCRI recommends allowing the independent practice of advanced practice registered nurses (APRNs), aligning the personal care services (PCS) and private duty nursing (PDN) benefits, and providing the opportunity for ambulances to provide treatment in place services without the need for a costly emergency room visit when applicable.

In the "Strengthening the Medicaid Program's Administration" section (Section VIII), the report explores how the administrative side of the Medicaid program could be modernized and made more efficient.

Issues discussed here include monitoring managed care organization (MCO) deliverables to confirm that only requests for data and information that are still relevant are made; improving audit coordination between the Health and Human Services Commission (HHSC) and the Office of the Inspector General (OIG), ensuring that any audits are conducted in accordance with national auditing standards; developing a comprehensive dashboard that allows the public and HHSC to view key data points and to improve contract monitoring process; increasing transparency in the MCO rate setting process; capturing consent to communicate electronically with enrollees where appropriate, including through the use of online provider directories; maximizing the telehealth model to conduct virtual service coordination visits; and improving the Medicaid provider enrollment process.

The section entitled "Incorporating Best Practices in Managed Care Procurements" examines how "best value" criteria might be applied to managed care contracting, and the considerations that must be weighed heavily in the procurement of direct client services. Recommendations in this area include not looking to financial performance as the sole criterion for determining best value; clearly defining best value aligned with the State's policy goals; providing transparency scoring criteria to potential vendors; incentivizing a smaller number of well-trained and compensated procurement and contract professionals; and, finally, utilizing procurement and subject matter experts within the agency, as well as leveraging outside expertise when needed.

This report includes a number of administrative and legislative recommendations to improve the program. Some recommendations are small tweaks that result in increased efficiency and transparency while other recommendations have the potential for cost savings. Although these findings and recommendations are somewhat technical, and some are relatively minor in relation to the entire Medicaid program, they are all important, as each one individually lays the foundation for a stronger, more efficient, and more cost-effective program. This foundation is critical as Texas strives to operate a Medicaid program that improves patient outcomes and bends the cost curve, while serving the needs of a large and diverse state.

II. Background- The Texas Medicaid Program

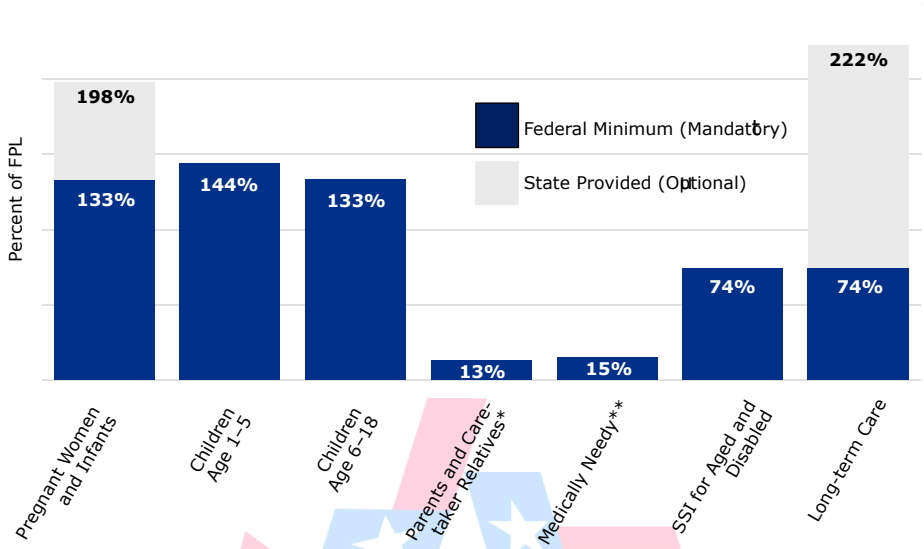
At just over 28% of the entire state budget, and with a total FY 2020-2021 biennial appropriation of $66.4 billion all funds (AF), the Medicaid program is one of the single largest cost drivers for the State of Texas.[3] And, because the program is an entitlement with open-ended funding, and is largely ruled by federal laws and regulations, the state has limited control in curbing Medicaid population growth and costs. In State Fiscal Year (SFY) 2019, Texas Medicaid served about 3.9 million low-income, elderly, and disabled individuals.[4] Although enrollment data had begun trending slightly downward, preliminary data as of October 2020 show Medicaid enrollment numbers at approximately 4.4 million[5]- undoubtedly a result of the economic effects of the COVID-19 pandemic and the maintenance of effort requirements for receiving public health emergency (PHE) enhanced federal match. The program covers about 53% of all births, about 43% of all children (along with the Children's Health Insurance Program), and 62% of all nursing facility residents in Texas.[6]

The Medicaid program is jointly funded by both the federal and state governments, with the state maintaining responsibility for the program's day-to-day operations. In Texas, about 60 percent of the program's funding comes from the federal government, while the state pays about 40 percent.[7] And, although states are given some flexibility within their Medicaid programs, the federal government sets policies that states must follow or obtain federal permission to alter. For instance, the federal government establishes mandatory populations that each state *must* cover (e.g., pregnant women and children at certain income levels) in order to participate in the Medicaid program, and it provides a list of optional populations states may *choose* to cover (e.g., traditional populations at higher income levels, childless adults at certain income levels). The same is true for program benefits. The state must seek approval from the federal government to make any substantive program changes, including populations covered, benefits provided, and even certification of premiums paid to managed care plans.

It should be noted that, even though our state has one of the nation's largest Medicaid programs,[8] Texas largely covers only mandatory populations required by the federal government. Figure 1, below, shows the population groups that are covered by Texas' program, and which are mandatory versus optional.

Although states can experience some degree of frustration with sclerotic federal regulations, this does not mean that state leaders are left with no options to improve Medicaid efficiencies and contain costs. One of the most effective means of providing high-quality affordable health care coverage is through managed care. Health plans are generally able to provide better care by helping coordinate care and direct enrollees to more preventive, lower-cost settings and by utilizing the providers within their networks. By only contracting with certain providers, health plans, just like those in the private sector, have the opportunity to negotiate lower prices and, most importantly, adopt standards that may restrict lower-quality providers from joining their networks. Texas has long embraced this concept as an early adopter of the Medicaid managed care model.

Figure 1. Texas Medicaid Eligibility Levels[i]



*For Parents and Caretaker Relatives, maximum monthly income limit in SFY20 was $230 for a family of three, or about 13 percent of the FPL.
**For Medically Needy pregnant women and children, the maximum monthly income limit in SFY20 was $275 for a family of three, or about 15 percent of the FPL.

Source: Texas Health & Human Services Commission[9]

This report delves further into how to draw upon the managed care model and maximize managed care to achieve greater efficiencies and to enable delivery of efficient, quality care in the most cost-effective way possible in Medicaid. Unlike the landscape in 2010, when statewide implementation of managed care and the ensuing efficiencies were planned, there are few if any readily accessible high-impact cost savings from utilization management or from emphasizing continuity of care within a medical home. Rather, there is now a new baseline to achieve savings. Because the managed care model has achieved success on those larger fronts, the efficiencies to be gained now involve adjustments to existing practices that ensure quality service delivery and best value. So, while no one item in and of itself will provide a savings number that is significant relative to overall Medicaid spending or the state budget, it is important to examine these "smaller" items that can have a cumulatively important impact. This report examines some issues on maximizing managed care within the services still under the fee-for-service (FFS) model, streamlining existing procedures and practices to gain even small efficiencies, and finally examining practices surrounding procurement of managed care services in a large and diverse state.

[i] *The Medically Needy with Spend Down program allows eligible low-income pregnant women, families, and children who would not normally qualify for regular Medicaid services to subtract health expenses from their incomes to make them eligible for the program, hence the program name, "Spend Down."*

III. Medicaid Managed Care

In March 2018, TCCRI published a paper entitled *Evaluating the Cost-Effectiveness of Medicaid Managed Care*. Building on information presented in a previous *Value of Managed Care* report, that 2018 report provided a history of managed care implementation in Texas and presented data corroborating the overall premise that managed care had ushered in savings and value to the Medicaid program.

Although these papers were released only a few years ago, the health care system is ever evolving and will undoubtedly be at the center of much discussion during the 87th Legislative Session. This paper revisits some of our prior findings, provides updated and new data, examines the increasing role of Medicaid managed care in the success of Texas' 1115 Transformation waiver, and recommends actions that can be taken in the current session to further strengthen and improve the Medicaid program.

History of Texas' Medicaid Managed Care Program

Prior to the 1990's, enrollees in Texas Medicaid received their services through a fee-for-service system, where providers are paid directly by the state for each claim. While enrollees can access any Medicaid provider in FFS, there is little or no coordination of care or benefits, often leading to unnecessary or duplicative services which results in an overall lack of successful management of, and poor health outcomes for, chronic conditions like asthma or diabetes, and for individuals who require both acute and long-term services and supports (LTSS).

With the passage of HB 7 (72S1) in 1991, the Texas Legislature established the state's first Medicaid managed care pilot program, and in the past 30 years managed care has grown to become the primary service delivery system, particularly with the statewide implementation of care beginning in 2012 under the 1115 Texas Transformation waiver.

In order to best examine opportunities to bring more innovation to Texas Medicaid, it is helpful to first explore a brief history of the various delivery models that have been utilized as the program has matured:

- Fee-for-Service (FFS)- The most basic form of Medicaid service delivery is an FFS system. Prior to the 1990s, all Texas Medicaid recipients received benefits under this model. In this environment, a Medicaid enrollee is responsible for locating and coordinating his or her own care. The state contracts directly with providers and pays claims, but there is generally little, if any, utilization review or prior authorization processes typically seen in a private sector insurance market.[10] Providers under this system also lack any incentives for helping to coordinate appropriate care to increase quality and health outcomes for enrollees. This also means that care can be fragmented, resulting in enrollees receiving duplicative and/or unnecessary services, as there is no major focus on care coordination or appropriate utilization.

- Primary Care Case Management (PCCM)- In 2006, Texas implemented a new Primary Care Case Management (PCCM) model.[11] The crux of this program was assigning enrollees to a primary care provider (PCP) to help "manage" the patient's care for a nominal monthly payment. While the model utilized some principles borrowed from a managed care approach, all payments to providers were still made on a volume-based claims system directly from the state and did not take any quality outcomes or metrics into account.

- Medicaid Managed Care - Texas began implementing pilot projects using a fully risk-based capitated managed care arrangement in the mid 1990s "in response to rising healthcare costs and national interest in ways to provide quality healthcare."[12] Over the years the Medicaid managed care program has grown to completely replace PCCM and has almost entirely phased out FFS due to its success in delivering higher quality health care outcomes and helping to control Medicaid costs.

  Texas, like other states at the time, originally turned to managed care as an innovative method for controlling skyrocketing Medicaid costs.[13] However, the managed care model also yielded myriad client benefits. Beginning in 1999, HHSC conducted a 15-month review of the state's current Medicaid managed care programs with the input of various stakeholders to assess the model's effectiveness and outcomes. The analysis concluded that "…implementation of managed care improved access to providers, produced program savings, and resulted in program accountability and quality improvement standards and measurement not found in the traditional fee-for-service (FFS) Medicaid program."[14]

Texas' move to managed care as its primary service delivery method has been mostly linear, with some variations over time to achieve the model in place today. The primary periods of expansion are noted below, followed by tables showing a timeline of various managed care expansions, as well as the percent of caseload served under managed care, and percent of Medicaid expenditures (non-supplemental) capitated through the years.[15] Key periods of Medicaid managed care roll outs include:

- Expansion of the STAR (State of Texas Access Reform) program serving non-disability-related adults and children into most large urban counties in the state, 1997-2000, and initial implementation of STAR+PLUS, serving aged and disability-related adults with acute care services and some long-term services and supports, in Harris county (Houston).

- Expansion of both STAR and STAR+PLUS models to other urban areas, and implementation of the non-capitated PCCM model in some rural areas, 2006-2008.

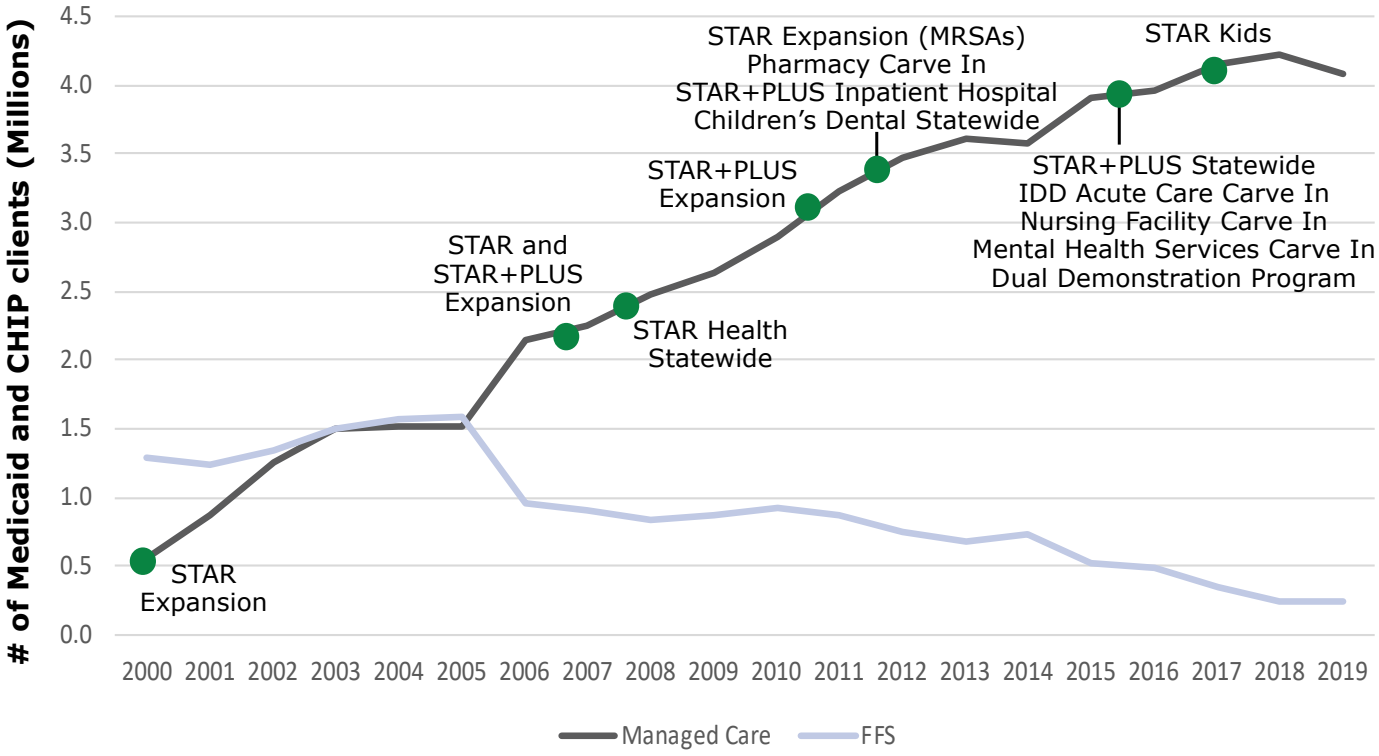
- Implementation of the 1115 Texas Transformation Waiver in 2012, aimed at delivering managed care statewide to most Medicaid recipients, including carve-in of services such as vendor drug services and in-patient hospital services for STAR+PLUS. PCCM was replaced by STAR.

- Expansion of STAR+PLUS to all areas of the state, and continuation of carve-ins planned as part of the 1115 waiver, including Nursing Facilities in 2015, followed by other groups in 2018 (Adoption Assistance, Permanency Care Assistance, and Medicaid for Breast and Cervical Cancer).

- Development and implementation of the statewide STAR Kids program for disabled children in November 2017.

Figure 2 below depicts the growth of the Medicaid managed care program over time, while Figure 3 provides more detailed information on caseloads and services under capitation since the inception of the first managed care pilot in 1994.

Figure 2. Texas Medicaid Managed Care Growth Over Time



Source: Texas Health & Human Services Commission[16]

Figure 3. Historical Medicaid FFS and Managed Care Caseloads: FY 1994-2020

Texas Medicaid Managed Care: Timeline

Caseloads	FY 1994	FY 2004	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Fee-for-Service	1,975,244	1,571,728	934,267	865,137	762,595	675,706	733,859	532,121	490,153	345,734	245,590	238,571	226,737
% Total	*97%*	*59%*	*28%*	*24%*	*21%*	*18%*	*20%*	*13%*	*12%*	*9%*	*6%*	*6%*	*6%*
Managed Care	58,243	1,112,002	2,362,091	2,676,149	2,893,965	2,982,923	3,012,265	3,524,581	3,570,411	3,721,646	3,776,096	3,676,441	3,761,843
% Total	*3%*	*41%*	*72%*	*76%*	*79%*	*82%*	*80%*	*87%*	*88%*	*91%*	*94%*	*94%*	*94%*
Total Full-Benefit	2,033,487	2,683,730	3,296,358	3,541,286	3,656,560	3,658,629	3,746,124	4,056,702	4,060,564	4,067,380	4,021,686	3,915,011	3,988,580
% of Total Medicaid Client-Service Spend Capitation	**0%**	**15%**	**32%**	**48%**	**46%**	**46%**	**48%**	**56%**	**61%**	**69%**	**74%**	**74%**	**76%**

Source: Health & Human Services Commission, Caseload and Cost Forecasts, July 2020; CMS-37 Medicaid History Report
FY 2020 caseload data is not final, and will change; FY 2019 and 2020 expenditure data will change, and all expenditure data may change slightly with updated transactions

Current Texas Medicaid Managed Care Program

Today the program operates statewide and serves about 94% of the entire Texas Medicaid population through Medicaid managed care organizations (MCOs).[17] HHSC contracts with these plans and pays them a capitated per member per month (PMPM) premium to ensure that Medicaid recipients receive all necessary and appropriate services. Texas Medicaid managed care enrollees are served through the following programs:

- *STAR*- provides primary, acute, and behavioral care and prescription drug coverage for low-income pregnant women, children, and certain parents of children enrolled in Medicaid.

- *STAR+PLUS*- integrates primary care, behavioral health services, prescription drug benefits, and LTSS services for enrollees aged 65 or older or other adults with disabilities; a portion of this program also serves individuals in home or community-based settings as an alternative to institutional settings, such as nursing facilities.

- *STAR Kids*- similar to STAR+PLUS, this program integrates acute and LTSS services for children and young adults with disabilities.

- *STAR Health*- operates on a statewide basis to provide children and youth in foster care with comprehensive medical and behavioral health services.

- *Children's Medicaid Dental Services Program*- the state contracts separately with dental maintenance organizations to administer dental benefits for children who do not reside in a health care facility or are not in the STAR Health program (these clients receive dental services through their primary delivery models).

The state is divided into 13 geographic service areas (SA) through which the managed care model operates.[18] The state bids out the various managed care programs by SA, meaning that one plan might have multiple contracts with HHSC to serve clients in various programs and/or various SAs, depending

on the plan's offerings and geographic constraints. Federal law requires that Medicaid enrollees have a choice between at least two MCOs,[19] so each SA offers at least two plans for each program.[20] In addition, the state contracts with a neutral third-party enrollment broker to assist Medicaid clients in choosing and enrolling in the plan best suited to their needs.[21]

Health plans are at risk for facilitating the provision of all of an enrollee's services within the negotiated PMPM rate and have relatively wide latitude in implementing prior authorizations (PAs) for certain services, negotiating provider rates, and managing enrollee care. The exception to this rule, however, is the Medicaid prescription drug benefit. Although health plans are responsible for administering this benefit through their subcontracted pharmacy benefit managers (PBMs), MCOs are required to adhere to the state's drug formulary, clinical edits, and PA guidelines, although they do have some discretion to implement some care management in addition to the state's requirements.[22] Current statute requires that health plans adhere to the state formulary until August 31, 2023.[23] Plans are also required to accept any willing pharmacy provider.[24] This is unlike the commercial market, where each health plan develops and controls its own provider network, drug formulary, and clinical standards. However, despite this variation with the administration of prescription drug benefit, MCOs must still maintain provider networks that ensure their members' access to all types of care, including physician, hospital, pharmacy, and therapy services.[25]

IV. The Value of Managed Care

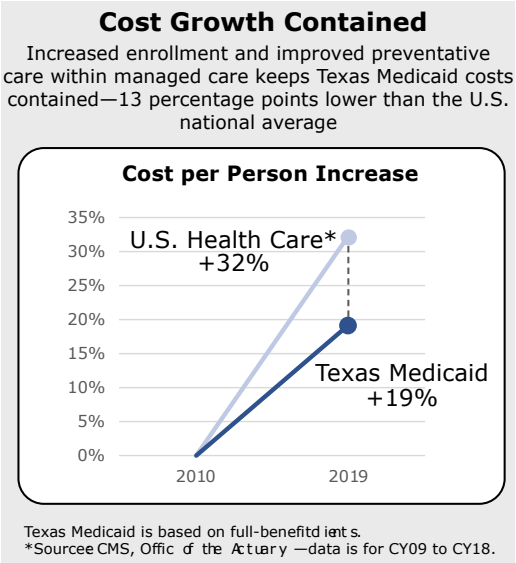
Over the past 30 years, managed care has unquestionably established itself as an essential component of the Texas Medicaid program, improving health outcomes, containing costs, and offering unique benefits to enrollees, state leaders, and taxpayers that would never have been possible under other service delivery models, such as FFS or PCCM.

A. Cost Savings in Texas Medicaid

A key takeaway from TCCRI's *Evaluating the Cost-Effectiveness of Medicaid Managed Care* paper presented in 2018 was that, as managed care has become the primary service delivery system in Texas, a significant component of the value is in the consistently generating of savings, preventing "cost creep," and continually managing utilization.

It is critical to point out that the longer the state is in the managed care model the more challenging it becomes to draw an apples-to-apples comparison of what costs would have run under a FFS system. In Texas, Medicaid managed care achieves cost savings by negotiating rates with a preferred network of providers, by ensuring that clients receive appropriate levels of care, by improving enrollees' health outcomes so they become less expensive over time (this is particularly true of the LTSS population), and by assuming financial risk. All of these variables have now been baked into the Medicaid program's cost and budget projections for several years. Thus, it becomes extremely difficult to attempt to determine what expenditures would have been without these cost and quality controls in place. Despite these challenges, there continues to be clear evidence that managed care provides far superior value than other service delivery models.

Figure 4. Per Person Health Care Costs: U.S. National Average vs. Texas Medicaid



Source: Texas Health & Human Services Commission[26] [Typographical errors contained in original chart]

That is borne out by a number of studies showing managed care savings in Texas,[27] the most recent of which shows a savings ranging from $5.3 billion on the low end to $13.9 billion on the high end over a period of nine years, from 2009 to 2017. In addition, HHSC's most recent Medicaid and CHIP Reference Guide found that "[i]ncreased enrollment and preventative care within managed care" has contained per person health care costs at a rate that is about 13 points below the national average, as shown in Figure 4.

B. Additional Benefits Provided by the Managed Care Model

In addition to tangible cost savings, the managed care model offers further benefits to the state, some of which were briefly noted above. These include:

- Budget Certainty- MCOs assume all financial risk under this model. Health plans must ensure that Medicaid recipients receive all necessary and appropriate services, and plans are at risk for facilitating the provision of an enrollee's acute, long-term services and supports, and pharmaceutical services within the PMPM rate (children's dental services are provided through three statewide DMO plans). If plans are able to provide appropriate care within that rate, or for less, they can make a profit, although they are capped and profits over a certain threshold are returned to the state. If there is a loss within the cost of care, that loss accrues to the plan, and not to the State of Texas.

- Improved Access to Care and Health Outcomes- MCOs must maintain provider networks that ensure their members' access to all types of care.[28] Unlike the FFS system, managed care plans must also meet specific access standards, such as how far members must travel to see a provider and how long it takes to get an appointment.[29] In addition, the state's independent External Quality Review Organization (EQRO) reports continue to show that the state's Medicaid managed care programs perform well in terms of patient satisfaction and meet or exceed national standards in enrollees' satisfaction both with their health plans, and with the care they receive.[30] A 2016 *Texas Medicaid Performance Study* by the University of Texas School of Public Health also found that under managed care, access to, and quality of, care for Medicaid enrollees is not only superior to the FFS system, but also on par with, and in some cases better than, private coverage.[31]

- Robust State Oversight- As part of its inclusive supervision, HHSC monitors all aspects of an MCO's business and operations, from the robustness and availability of provider panels, how long it takes enrollees to schedule appointments, and the quality of services provided, to the plan's fiscal soundness and staff turnover. HHSC also assesses contractual remedies, including corrective action plans and liquidated damages, when appropriate.[32] The state places a cap on the amount of money that MCOs may use towards administrative expenses, places a percentage of a health plan's premium at risk to ensure certain client quality metrics are met, and enforces a strict limit on the amount of profit these plans can make from Medicaid and CHIP business.[33]

Any profit that exceeds this threshold is recovered by the state through experience rebates - the process by which HHSC determines MCO profits and what, if any, amount must be shared back with the state.[34]

The combination of admin and profit caps, combined with quality measures, adds an additional layer of client protection by disincentivizing plans from taking any action that might adversely impact an enrollee's outcome in an attempt to increase profit margins. The aforementioned EQRO also assesses and reports on care provided by MCOs including patient access to providers, quality of care, and overall enrollee experience.

- Value-Added Benefits- Health plans are able to provide what are known as value-added benefits to Medicaid clients. These are services that could not be provided in a FFS system because they are not covered Medicaid benefits. The MCO uses its own money to provide such services with the understanding that it will improve the health care of its enrollees, and thereby ultimately reduce costs. Examples of value-added benefits include mold remediation or extermination services in a home with enrollees with severe asthma, assisting an enrollee in making a home wheelchair accessible in order to keep the enrollee out of a nursing facility, and diet/ weight-management programs for enrollees with obesity-related diabetes or other health complications.

C. Increasing Significance of Managed Care Within the Texas 1115 Waiver

The need for managed care is key to not only containing costs in Texas Medicaid, but also to ensuring continued program stability, cost containment, and distribution of funding from the Texas' Healthcare Transformation and Quality Improvement 1115 Demonstration Waiver (Transformation Waiver).

Figure 5, below, depicts the growth of all Medicaid funding, including Medicaid expenditures, shifting more and more into the managed care model since 2010, and the growth of supplemental funds used to support hospitals and other providers. Supplemental programs are funded from local tax or provider participation funds, matched by federal dollars. With the notable exception of the Disproportionate Share Hospital (DSH) program, most of these funds flow through the waiver and are capped by the pool of funds generated via the waiver budget neutrality.

The proportion of total client service Medicaid funds (i.e., not supplemental funds) that are managed care versus FFS is demonstrated in the bars on the graph.

Figure 5. Total Texas Medicaid Funding- FY 2010-2020

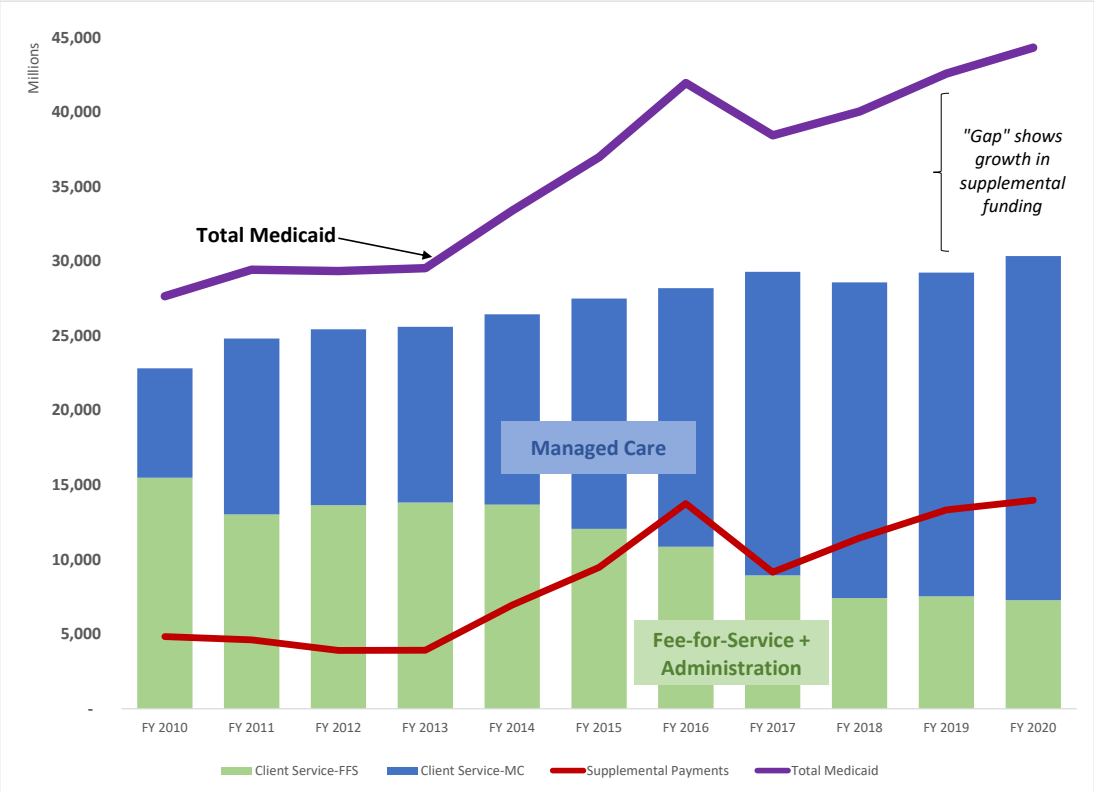


Figure 6 shows the numbers that drive the visual in Figure 5. Between 2014 and 2015, managed care grew to represent the majority of client-service funding (non-supplemental), and by 2020, 76 percent of Medicaid client-service expenditures were in managed care.

Figure 6. Total Medicaid Expenditures Including Supplemental Waiver Programs, FY 2010-20

	Caseload	Total Client Service+Admin *(millions)*	*Managed Care (Subset of Total CS)* *(millions)*	*Percent Managed Care*	Total Supplemental Payments *(millions)*	*Capitation Supplemental Payments (Subset)* *(millions)*	Total Medicaid: Client Service + Admin + Supplemental *(millions)*
FY 2010	3,296,358	$ 22,820.6	$ *7,331.2*	***32%***	$ 4,830.0	$ -	**$ 27,650.54**
FY 2011	3,541,286	$ 24,815.6	$ *11,789.5*	***48%***	$ 4,617.8	$ -	**$ 29,433.39**
FY 2012	3,656,560	$ 25,437.7	$ *11,789.5*	***46%***	$ 3,910.5	$ -	**$ 29,348.17**
FY 2013	3,658,629	$ 25,611.1	$ *11,789.5*	***46%***	$ 3,922.4	$ -	**$ 29,533.45**
FY 2014	3,746,124	$ 26,443.8	$ *12,761.2*	***48%***	$ 6,950.7	$ -	**$ 33,394.49**
FY 2015	4,056,702	$ 27,497.5	$ *15,441.0*	***56%***	$ 9,472.2	$ *301.5*	**$ 36,969.69**
FY 2016	4,060,564	$ 28,197.4	$ *17,332.4*	***61%***	$ 13,757.0	$ *773.8*	**$ 41,954.35**
FY 2017	4,067,380	$ 29,299.9	$ *20,363.4*	***69%***	$ 9,151.9	$ *419.9*	**$ 38,451.81**
FY 2018	4,021,686	$ 28,585.7	$ *21,170.7*	***74%***	$ 11,452.7	$ *1,350.7*	**$ 40,038.36**
FY 2019	3,915,011	$ 29,243.3	$ *21,702.9*	***74%***	$ 13,333.7	$ *2,018.9*	**$ 42,577.00**
FY 2020	3,988,580	$ 30,344.3	$ *23,072.7*	***76%***	$ 13,976.5	$ *2,762.8*	**$ 44,320.76**

Capitation/Managed Care numbers are a subset of the total.

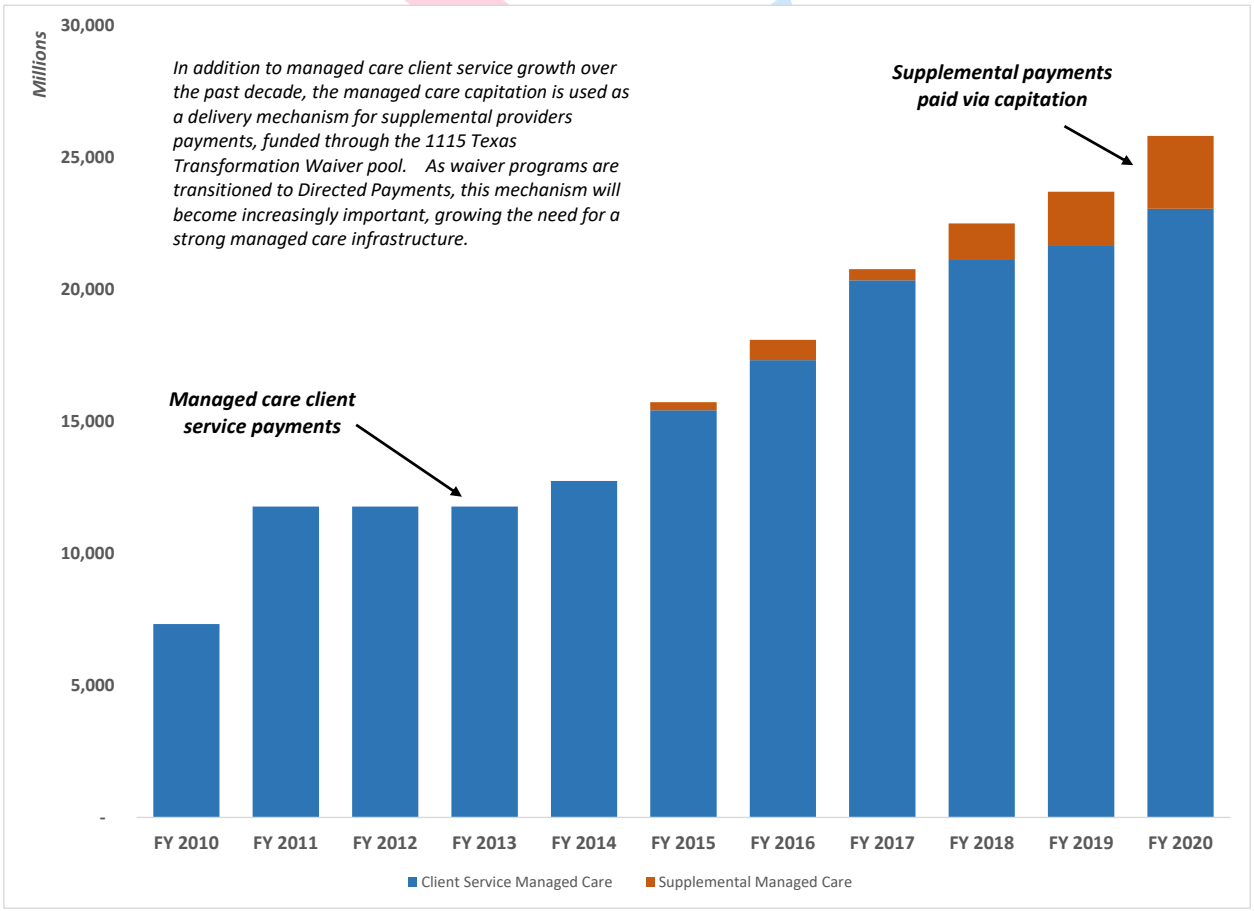
Sources: CMS-37 Medicaid History Report, November 2020; HHSC July 2020 LAR Caseload and Cost Forecasts

A factor not examined in TCCRI's 2018 paper which has become increasingly critical is the growth in the supplemental payments for providers, shown by the red line (and the "gap") in Figure 5. Overall, supplemental payments, which include the non-waiver Disproportionate Share Hospital (DSH), the Uncompensated Care program (UC), the Uniform Hospital Rate Increase Program (UHRIP), and the Delivery System Reform Incentive Program (DRSIP) have more than doubled in the past ten years.

Supplemental programs are constantly in flux – with DSRIP restructuring to include directed payments, based on and paid through managed care and tied to quality measures, and UHRIP restructuring to become the Comprehensive Hospital Increased Reimbursement Program (CHIRP).

Figure 7 provides a slightly different pictorial view of the data shown above, with only the managed care payment components shown. Note that the managed care client service amounts match those in Figure 5, clearly showing how Texas has chosen to utilize the Medicaid managed care model to deliver increasing amounts of supplemental payments to safety net providers. It is important to note that the increase of these dollars is not due to managed care or any increase in costs associated with this model; rather, it is the result of the state electing to direct supplemental payments- which are traditionally funded outside the General Appropriations Act and are less accountable to management via state appropriations- through managed care organizations.

Figure 7. Managed Care Medicaid Spending with Waiver Payments, FY 2010-2020



The purpose of this paper is not to examine supplemental payments in depth, but rather to note the increased use of supplemental funding and, specifically, of managed care as the delivery vehicle for payments. Managed care's ability to track quality metrics and drive budget neutrality pool savings underscores the growing value of the model. The Texas Transformation Waiver significantly changed the landscape not only of service delivery in Texas, but also of the financial environment in terms of how providers are paid – and who provides the funding. The two components are inexorably tied, and managed care is more and more the key component. As this paper is written, Texas has received an extension of the 1115 Transformation Waiver through September 2030 and, with that extension, directed payments distributed through managed care capitation will continue to grow over the next decade. Budget neutrality will be reassessed using fiscal years 2022 and 2027 as base years, making the savings that are sustained and generated through managed care fundamental to maintaining Medicaid stability in Texas.

V. Maintaining the Infrastructure of the Managed Care Model

The managed care program provides an optimal environment in which to test innovative payment and delivery models. But it is crucial to maintain the fundamental structure of the program to continue to achieve improved outcomes and cost containment strategies. Initiatives such as prior authorizations (PA), utilization review (UR), case management, and service coordination, when appropriately applied, are all key to the success of the model. While some may see these practices as arbitrary or punitive, that is not the case. Take for instance PAs, which require approval from a payer before an expensive or potentially complicated service or prescription drug will be reimbursed. These services or medications often require a PA, not to discourage the benefit from being provided, but to ensure the patient has not recently undergone the same test or been prescribed a drug with dangerous contraindications that was ordered by a different provider. Many clients, especially those with chronic or complex medical conditions, may see multiple providers and specialists who are not aware of what the others are ordering or prescribing. As the payer, MCOs are often the only entity able to see the entirety of an enrollee's medical history and, in that role, are uniquely positioned to identify costly redundancies and potentially unsafe interactions.

It is important that managed care companies retain flexibility around these key components of the model. The foundation and success of managed care lies in its ability to facilitate whole-person care. To effectively provide this level of coordination, plans must have access and ability to work across a member's needs including medical, pharmacy, therapy, home care, etc. Any attempts to remove or "carve out" services or populations from managed care will weaken the entire system, including the state's ability to maintain budget certainty.

A. Direct Primary Care

Over the past few years, the direct primary care, or DPC, delivery model has gained traction in the private health care sector. Under this model, patients directly pay their provider(s) a set agreed-to sum in exchange for a guaranteed set of services from that provider.[35] Texas has recognized the importance of the DPC model, first adopting HB 1945 (84R), which defined direct primary care in state statute and specifically established that this model does not constitute an insurance product.

This option can be attractive to providers who want to "cut out the middleman" and not go through a third-party payer system. Like some catastrophic plans, this option is likely most viable for individuals and families who are, for the most part, healthy and do not anticipate many ancillary medical costs.[36] It is important to note, though, that the very qualities that make direct care an important option in the private sector do not translate to the Medicaid system.

From the perspectives of the State and its Medicaid enrollees, direct primary care would closely resemble the FFS or PCCM models in which patients are responsible for facilitating care with little to no coordination or case management services. While this might be a reasonable option for generally "healthy" patients, care coordination can be crucial for individuals with chronic health conditions and

those who are medically fragile, many of whom are enrolled in Medicaid in Texas. MCOs also provide additional support services to individuals who may need assistance in navigating the complex health care system. By placing enrollees back into an FFS-like system the state would also lose its ability to ensure that services are not being duplicated and enrollees are not receiving unnecessary care.

Building on the challenges associated with a return to an FFS world, perhaps the most critical challenge to direct primary care in Medicaid revolves around the lack of ability to control utilization and costs- a shift that would ultimately erode the managed care program's ability to provide the state with budget certainty. While states have the authority to limit amount, duration, and scope of some mandatory benefits, they must cover those services required by the federal government. A "direct care" model only offers the services within the scope of that provider. Any ancillary services (i.e., labs, x-rays, prescription drugs, hospital stays) are not covered by this arrangement. So, while a Medicaid enrollee could theoretically enroll in a direct care practice (with the state paying the cost of that arrangement), that recipient is still entitled to any and all mandatory Medicaid services, which the state would also be required to provide as wrap-around benefits. It is doubtful that the Centers for Medicare & Medicaid Services (CMS) would have the willingness, or even the authority (short of Congressional action), to allow states to limit mandatory benefits or to create tailored benefit packages for "healthy" enrollees. This inability to limit services or benefits, coupled with federal constraints on cost-sharing policies,[37] would severely hinder any motivation for patients to self-regulate utilization and contain costs. Therefore, it is very likely that this model would result in a greater number of unnecessary services and increased costs that would be borne by the state and its taxpayers.

1. Policy Recommendation: Maintain the populations currently served in Medicaid managed care.

There is no question that direct care has a key role in the private sector, allowing consumers to enter into a direct agreement with the provider(s) of their choice. However, as an entitlement program, Medicaid is fundamentally different than the private sector and, as such, must rely on care coordination and other program controls to ensure that taxpayer dollars are being used astutely and that enrollees are receiving quality care.

B. Medicaid Prescription Drug Benefit

Background

Individuals enrolled in Medicaid and CHIP receive prescription, and some over the counter, drugs as part of their program benefits. Since the implementation of Texas' Medicaid managed care program, HHSC has continued to play a central role in the administration of prescription drug services. In March 2012, Texas successfully implemented one of the largest Medicaid managed care rollouts in history, extending care models statewide and carving in prescription drugs and nursing home care. Up until that point,

these services had continued to be paid through the FFS system, even though virtually all other aspects of enrollee care were under Medicaid managed care.

Although the state has been fully committed to the managed care model, state leaders made the decision to retain control of the Medicaid drug formulary, rather than ceding it to managed care plans. This was primarily due to the state's successful administration of its preferred drug list (PDL) and the negotiation and collection of supplemental rebates that prescription drug manufacturers must pay the state to be included on the PDL. While the *formulary* stipulates which drugs are covered by the state's Medicaid program, the *PDL* is a subset of the formulary and contains prescription drugs that are "preferred" and, therefore, covered without a prior authorization (PA).

Health plans are responsible for administering this benefit through their subcontracted pharmacy benefit managers (PBMs), but must adhere to the state's drug formulary, clinical edits, and PA guidelines, though they do have some discretion in employing additional state-approved care management strategies.[38] Current statute requires that health plans adhere to the state formulary until August 31, 2023.[39] It should be noted that, while plans are required to adhere to the state's formulary and guidelines, they remain responsible for all other aspects of the prescription drug benefit, including building and maintaining provider networks, claims adjudication, and taking on the financial risk of the benefit.

Health plans are also required to accept any willing pharmacy provider. This is unlike the commercial market, where each health plan develops and controls its own provider network, drug formulary, and clinical standards. The state's Drug Utilization Review (DUR) Board is responsible for reviewing various classes of drugs and recommending to HHSC which medications should be on the state's Medicaid preferred drug list (PDL).[40] Federal law requires that drug companies pay a rebate (shared between the federal and state governments) to have their drugs on the Medicaid PDL, and Texas negotiates an additional supplemental rebate on top of that.[41] In fiscal year (FY) 2016, Texas Medicaid spent about $3.7 billion for over 48 million prescriptions, with an average cost of about $75 per prescription.[42] According to HHSC's most recent *Medicaid and CHIP Reference Guide*, prescription drug spending is responsible for 14 percent of state's total Medicaid expenditures,[43] a percentage that has appeared to hold stable over the past several years.

Maintaining the Integrity of the Prescription Drug Benefit

During the last three sessions, there have been numerous attempts to alter the current Medicaid prescription drug program with efforts ranging from establishing prescriptive rate setting mandates in statute to even fully carving the prescription drug benefit out of managed care and back into FFS. Such attempts pose a significant risk to the success of the Medicaid managed care program, which focuses on whole-person coordination and care. Removing a critical piece of this equation jeopardizes not only the budget certainty that managed care affords Texas taxpayers, but also, more importantly, the care and health outcomes of some of Texas' most vulnerable populations.

Prescription Drug Carve-Out

After legislative discussion regarding a the Medicaid prescription drug benefit, the 2018-2019 General Appropriations Act (GAA) contained a rider (HHSC Rider 60) that directed the Commission to study the potential impact of carving the prescription drug program out of the managed care model and placing it within a single, statewide claims processor model.[44] HHSC engaged the services of Deloitte Consulting, and the initial report was released in August 2018. The analysis considered eight scenarios- four in which the federal Affordable Care Act (ACA) health insurer tax (HIT) had to be paid to the federal government, and four in which it did not.[45] The various scenarios attribute approximately $76.5 million in costs to the HIT if the program remains carved in to managed care (or conversely, in savings if the program were to be carved out of managed care) for the latest year studied (FY 2017).[46] In March 2019, Deloitte, via HHSC, released an updated addendum to their initial report showing the General Revenue impact of a carve out. However, since the release of these reports, Congress has permanently revoked thee HIT, so any costs associated with this tax as part of the carve-in scenarios (and savings in carve-out scenarios) are moot.[47]

While the Deloitte report and its numerous scenarios present a somewhat complicated analysis, the bottom line is quite clear. By carving the prescription drug benefit out of managed care and back into a FFS model, the state would forego the significant benefits it currently receives, both in terms of dollars and, more importantly, patient care. One of the key advantages that a managed care model provides to the state is budget certainty. As previously explained, all of a member's care, including the pharmacy benefit, are included in the PMPM paid to a managed care organization, and plans assume full financial risk on behalf of the state. While this does allow plans to retain a profit (that is contractually capped and shared back with the state) in some years, it also means that in years when the flu, or COVID-19 in today's climate, is particularly widespread, these plans take on the financial loss instead of Texas taxpayers. If the drug benefit were removed from this model, the state would lose that budget certainty.

While the aforementioned Deloitte report examined administering the prescription drug benefit via a statewide claims administrator model, it is more important to look at what the report did not include, namely any impact to members' overall healthcare, as well as the loss of any value-based purchasing agreements that would end if the benefit were back in a FFS model. It should also be noted that the Deloitte report does not project any future costs or savings. Instead, the reports look at fiscal years (FYs) 2015, 2016, and 2017 prescription drug information and apply their assumptions to that historical data. While supporters have touted the Rider 60 report as a case for carving drugs out of managed care, a closer examination at the report dispels that notion, and the March 2019 addendum further supports this position. Overall, the addendum found that, once HIT is removed from the equation, carving the drug benefit out of managed care would result in new annual state GR costs ranging from approximately $14.2 million to $86.4 million (based on FY 2017 data).[48]

A 2018 analysis, that was more comprehensive in scope that the Deloitte report, was commissioned to examine the possible impact of carving Louisiana's prescription drug benefit out of managed care. While the report found the state would incur a substantial cost by carving the benefit back into FFS, the report

included reference information that is of even greater significance to Texas. One particular section examined 13 states spanning 2011-2017. Nine of these states, including Texas, had prescriptions drugs in the FFS model in FY 2011, which they subsequently carved into managed care, while the "control group" remained in a FFS model the entire time. The "managed care" states saw an increase of 0.9% in per-prescription drug costs from FY 2011-2017, while the "control group" states experienced a 16% increase.[49]

While the cost savings provide clear and sufficient evidence of the need to maintain the current Medicaid prescription drug model, any discussion cannot omit the most important aspect of this equation, which is the patient. One of the key advantages of a managed care model is facilitation of patient care. The administration of the prescription drug benefit by MCOs allows these plans to have real-time access to prescription information, which is critical in coordinating and managing care for enrollees- particularly those with chronic disease that are managed pharmacologically (e.g., chronic obstructive pulmonary disease (COPD), asthma, heart disease). Access to this information also allows plans to flag patients who may be "doctor shopping" for controlled substances or filling multiple prescriptions with potentially dangerous counteractions, unaware of the potentially harmful consequences of mixing some drugs.

While the state can contract with a claims administrator to process and pay these claims, health plans have the expertise and ability to flag potentially dangerous contraindications and to reach out to patients, working with their practitioners when appropriate, to reduce the chances of dangerous prescriptions interactions. In addition, health plans can also ensure that enrollees who need lifesaving medications are regularly filling their prescriptions. Although a third-party administrator could provide claims information to an enrollee's health plan after the fact, MCOs would lose the ability to intercede far sooner in the process by no longer having access to real-time pharmacy data. In addition to the increased costs and drug utilization, this could also result potentially life-threatening consequences for Medicaid recipients. Additionally, the 2020 HHSC *Medicaid and CHIP Reference Guide* explains that, "[a]dults enrolled in FFS are limited to three prescriptions per month," while children in FFS and anyone enrolled in managed care do not have a limit on the number of prescription drugs that Medicaid will cover.[50]

Much of the consternation in the discussion on whether to carve-out Medicaid prescription drug benefits has been around PBMs. However, Texas places specific requirements in its contract with health plans that prohibit some of the practices that PBMs may employ in the commercial market, such as spread pricing and negotiation of additional rebates.[51] The practice of spread pricing in general appears to be of particular concern to stakeholders and advocates. The HHSC contract and monitoring tools address this issue specifically, and these steps have proven effective. A 2019 audit of a major PBM conducted by HHSC's Office of Inspector General (OIG) confirmed no evidence of spread pricing in the Medicaid prescription drug benefit.[52] In February 2019 the Kentucky Cabinet for Health and Family Services issued a report entitled, "Medicaid Pharmacy Pricing: Opening the Black Box." As part of its analysis, the agency looked at initiatives in other state Medicaid programs and had the following to say about Texas:

> In 2014, Texas became one of the first states to closely regulate PBMs. Using a managed care system, all MCO-PBM contracts are uniform subcontracts to the state and MCOs are held responsible for all duties performed by the PBM. In order to keep costs low for the state, regulations

> prohibit PBMs from using spread pricing, receiving additional rebates from manufacturers, and using unauthorized clinical edits. Texas use of a Uniform Managed Care Contract dictates the role and operations of each of their 20 MCOs and 6 PBMs.[53]

While full carve-out is seen by many as a drastic and impractical policy proposal, some may view altering reimbursement methodologies as a more reasoned approach. To the contrary, dictating and cementing government pricing mandates in law is rarely, if ever, a prudent measure and, in the case of the Medicaid prescription drug benefit, could place the state at risk for significant cost increases.

Statutory Price Mandates

Prescription drug reimbursement is, in its simplest form, paid in two parts: the ingredient cost and a dispensing fee to pharmacists for filling and dispensing a prescription. In the prior two sessions there have been efforts to enact statutory-based pricing mandates for both components of this reimbursement formula. Though language has differed slightly, most of these attempts would have established new mandated pricing structures for Medicaid prescription drugs that would essentially be based off of what is known as the National Average Drug Acquisition Cost, or NADAC, for ingredient costs.

NADAC is developed based on ongoing surveys conducted by CMS. While this may sound like a promising data source on its face, a closer look into how NADAC is gathered and developed reveals valid concerns about using such a benchmark. First and foremost, the survey is voluntary and, to some degree, self-selecting. A 2018 report found that, of the nation's 67,000 pharmacies, CMS surveyed about 2,500 per month for NADAC, with about 450- 600 of those voluntarily responding.[54] While CMS does choose pharmacies to survey (no pharmacy can be surveyed more than one time in a four-month period), those pharmacies are not required to return survey information.[55] This could create a perverse incentive for pharmacies to forego survey participation in the event it could drive down NADAC ingredient costs. In addition, NADAC surveys do not capture any "off-invoice discounts, rebates, or price concessions,"[56] and they exclude specialty and mail-order pharmacies,[57] further skewing a comprehensive picture of true drug costs.

Moving to a mandatory NADAC benchmark will increase costs to the state, though it is difficult to pinpoint exactly what those costs will be. For example, the fiscal note for HB 1133 (85R) stated:

> **The fiscal implications of the bill cannot be determined at this time, but a significant cost is anticipated**. The bill is expected to result in an average increase to the per prescription cost of reimbursement under Medicaid and the Children's Health Insurance Program (CHIP), which is expected to result in a significant overall cost due to the large number of prescriptions reimbursed under those programs.

The engrossed version of HB 3388 (86R) would have established similar mandatory reimbursement. That fiscal note showed a relatively small cost of $8.2 million GR for the first biennium. However, the analysis

assumed that implementation of the new pricing structure would not begin until January 2021 (the second quarter in the last year of the biennium), with annual costs growing to $14.8 million GR by FY 2024.

1. Policy Recommendation: Maintain the Medicaid prescription drug benefit as part of the managed care program.

The cornerstone of the managed care model is coordination of whole person care. The prescription drug benefit is a critical component of this coordination, particularly for enrollees with expensive chronic health conditions who need drug therapy for adequate disease management. Carving this benefit out of managed care would be taking a step backwards, not only in retreating to an outdated FFS model, but also in terms of patient care. This carve-out is not worth the risk of Texas taxpayer dollars or the health and wellbeing of the 4 million plus individuals covered by Medicaid and CHIP.

2. Policy Recommendation: Reject the use of NADAC pricing benchmarks and any other attempts at government-mandated rate setting.

Texas has established a Medicaid prescription drug benefit that allows the state to retain control of its formulary and associated supplemental rebates, while placing health plans at full financial risk and benefiting from the care management that only MCOs can provide. Any attempts to prescribe pricing benchmarks or carve pieces out of the program will only serve to erode this highly successful model and result in costs to Texas taxpayers.

VI. Maximizing the Managed Care Model

As the managed care model has become the primary service delivery model in Texas, resulting in not only lower-than-national Medicaid cost growth trends but also in a significant pool of funds for supplemental provider payments, there remain components of the overall Medicaid program that inhibit managed care plans from providing cohesive care for their enrollees. Historically, as managed care was fully rolled out in Texas, the magnitude of the rural/urban geographic diversity and complexity of the programs and populations resulted in implementation that developed over a number of years and accelerated in the past decade. This is particularly true for populations such as nursing facility clients, clients with an intellectual or developmental disability (IDD, which is still not completely carved-in), disabled children receiving Social Security Insurance (SSI) benefits, and clients with breast or cervical cancer. There remain components of Medicaid that have not been carved-in, and managerial and administrative components that should be explored for possible managed care carve-in.

A. Outlying Services and Populations

Since beginning as a pilot program in 1994, managed care has continued to grow in Texas, accelerating to statewide rollout with the 1115 Texas Transformation Waiver implemented in FY 2012. However, there remain a small number of populations and services that are still part of the fee-for-service system, which can result in a confusing client experience, especially prior to enrolling in managed care. As of FY 2020, 94 percent of full-benefit clients receive services under managed care.

The full-benefit clients or services that remain fee-for-service include:

- "First month" clients, after Medicaid eligibility is determined but before a client is enrolled in a managed care plan. This is the largest component of full-benefit clients who receive services through FFS. While the term "first-month" is used, in some cases a client may be in FFS for up to 60 days, depending on how late in a given month an individual applies for Medicaid coverage. Because some clients may only spend a matter of months on Medicaid, this period of time when care plans and medical-home relationships could be established is critical;

- Hospice services in the STAR+PLUS program; and

- Wrap-services not paid by Medicare for dual-eligible Aged & Medicare Related clients.

Carving in services and populations not currently in managed care may or may not result in savings even when including premium tax revenue; however, the primary consideration is long-term management of client care, including the quality of care for each group and the service provided. It is part of the management of the lifespan of the whole client – from initial contact with the system through leaving Medicaid.

Figure 8 (below) outlines the cost of carve-in, and the related potential offsets and qualitative considerations. As is clear, there are significant costs for the fixed and variable administrative components of STAR+PLUS and STAR Kids which increase the overall cost to carve-in services.

Figure 8. Cost and Offset Assumptions of Additional Managed Care Carve-Ins

COST	*OFFSET*	*QUALITATIVE BENEFIT*
Carve-in Costs ** Fixed Admin Cost* *STAR* *$9.00* *STAR+Plus/Kids* *$20.00* ** Service Coord Cost* *STAR+Plus* *$38.00* *STAR+Kids* *$73.00* ** Variable Admin* *5.25%* ** Risk Margin* *STAR* *1.50%* *STAR+Plus/Kids* *1.75%* ** Premium Tax* *1.75%*	**Premium Tax** ** 1.75% Premium Tax with a return of approximately 74% based on weighted FMAP as state receives federal share* **Utilization Costs** ** Assumed decline or percentage decrease in utilization to offset increased costs of carve-in*	**Quality Metrics** ** MCO allows standardized tracking and reporting of quality metrics* **Improved Efficiencies & Access** ** Enhance coordination for client and MCO* ** Remove burdensome coordination among different networks* ** Enhance client experience and allow continued access to provider networks*

"First Month Eligibility"

Current-month" or "first-month" clients come on to the Medicaid rolls and spend their first month(s) in FFS prior to being enrolled in managed care. As of 2020, first month FFS clients make up more than 80 percent of the total full-benefit clients and costs for clients remaining in FFS, with an average of 200,000 monthly clients and an annual cost of $1.3 billion.

Overall, there may be more costs up-front for auto-enrolling clients into managed care, as the administrative, risk margin, and premium tax costs are added in, but any increases are offset with enhanced care delivery and quality components – such as first month visits and establishing a medical home - ultimately resulting in better quality care and down-the-line potential for savings. As noted above, this is particularly important for clients who have less than a year in their term of coverage. There will be some small amount of revenue from premium taxes, and potentially small savings in the claims processing system.

Hospice Services in the STAR+PLUS Program

Hospice services provide palliative care to Medicaid clients who are terminally ill and have a physician's prognosis of six months or less to live. Hospice services include physician and nursing care, counseling, prescription drugs, therapies, and respite and supportive care for caregivers.[58] Hospice services are currently carved out of STAR+PLUS managed care and paid via FFS, which can create confusion on how

and where to receive services for the client, and potentially result in duplicative or disjointed services – a particular concern at a time when coordination of care and continuity of provider network are critical. Hospice costs totaled $282 million for 7,711 clients in 2019.[59]

Wrap-Around Coverage for Dual-Eligible Clients

Dual-eligible clients are those who are financially eligible for both Medicare and Medicaid. Most acute care and hospital services, and Part D prescription drugs, are covered through Medicare. For clients who are fully dual-eligible, long-term services and supports (if need is met), co-pays, deductibles, and acute services not paid by Medicare are picked up by Medicaid. In 2019, acute care costs paid by Medicaid for Aged and Medicare-Related clients in STAR+PLUS totaled $306 million in 2019.[60]

MCOs are required by contract to coordinate benefits for dual-eligible clients in STAR+PLUS and are federally required to ensure Medicaid does not pay for services that Medicare should cover, and services must be denied by Medicare before an MCO can pay them. While MCOs go to extensive efforts to coordinate the delivery of these services, the process is complicated and often delayed as the majority of dual-eligible clients receive their Medicaid and Medicare services from different health plans or from Medicaid FFS. Medicaid MCOs are dependent on the cooperation of an external Medicare payer or provider (oftentimes not in network with the STAR+PLUS plan) to coordinate and provide ongoing status and supporting information to the MCO with no incentive. In the case of wrap-coverage, the Texas Medicaid & Healthcare Partnership (TMHP) — not the MCO — is responsible for paying for the service. Moving payment of wrap coverage for dual clients from TMHP to MCOs would further align accountability, enable better coordination of services for clients, and streamline processes and payment for providers. Having a single entity responsible for payment of all Medicaid services can simplify processes for providers while improving access to care for members.

In order to offset the cost of carve-in, there must be enough savings generated by the offsets to result in net savings to the state, or there must be a great enough need or reason to necessitate carve-in (e.g., to reduce an overwhelming administrative burden). In the case of carve-in for the services and clients discussed above, first-month clients, hospice services, and wrap services for dual-eligibles, savings are not easily demonstrable since only specific slices are being analyzed, but having these clients and services carved-in can reduce overall administrative burden and provide for better continuity of care to the client's Medicaid life cycle, furthering the ability to sustain savings in managed care as a whole.

Similar to opportunities to maximize the managed care model by carving in additional services, there is also an opportunity to maximize the technology that supports the Medicaid program. The Medicaid Management Information System (MMIS) has evolved piecemeal over time, from supporting the FFS system to also supporting managed care. For example, the state needs a centralized place where all MCO encounter data is stored and a process to validate that data. The state is currently in the process of redesigning and re-procuring this system which provides the opportunity to ensure that there is not duplication of effort and that the system works efficiently in the managed care environment.

1. Policy Recommendation: The Legislature should direct HHSC to study auto-enrolling clients into managed care at the time of eligibility determination and implement this policy change if found to be feasible and cost-effective.

While there will likely be one-time technology costs for such a change, and these costs could be significant, the suggested study must look at the longitudinal benefits to Medicaid enrollees and the savings that could accrue to Texas taxpayers once the policy is fully implemented. Specifically, this study should consider the benefits of enrollees having access to the full array of managed care services and provider networks at the earliest point in time, as well as quality metrics and potential savings for later improvement in benefits utilization. This study could be directed as a part of a budget rider.

2. Policy Recommendation: The Legislature should direct HHSC to study carving in hospice and STAR+PLUS wrap benefits into managed care and implement this policy if it is found to be feasible and cost-effective.

Like the prior recommendation, this study could be included in a budget rider, and should also consider the long-term impacts of such a carve-in. The study should examine the enhanced service delivery available to STAR+PLUS clients and reduced administrative burden to MCOs.

3. Policy Recommendation: The Legislature should direct HHSC to conduct a comprehensive review of the Medicaid Management Information System and identify any duplication of efforts with Medicaid managed care.

As the managed care model has grown to assume responsibility for the facilitation of care for the vast majority of the state's Medicaid population, it is incumbent upon the state the ensure that taxpayer dollars are not supporting any unnecessary duplication of efforts between state systems and private MCOs. The cadre of technology infrastructure that supports the state's side of the Medicaid program is known as the Medicaid Management Information System, or MMIS. HHSC describes MMIS as "a massive, fully integrated, highly complex ecosystem composed of applications, processes, call center, mainframe computers and datacenter infrastructure used in support of the Texas Medicaid delivery system."[61] This behemoth system supports functions ranging from provider enrollment to claims and data management. HHSC has announced its intent to re-procure this technology across four separate service components.[62] This re-procurement provides a prime opportunity for HHSC to conduct a comprehensive review of the system to ensure it is maximizing and supporting service delivery in managed care and is not duplicating functions that can and should be performed by MCOs.

B. Alternative Payment Models

Alternative payment models (APMs)- sometimes referred to as value-based payment arrangements- reward health care providers for the quality of care they provide, rather than paying based on the volume of services they provide. APMs are part of HHSC's quality strategy.

The agency's Value Based Purchasing (VBP) Roadmap, published in August 2017, stated that:

> "Through its managed care contracting model, HHSC is making progress on a multiyear transformation of provider reimbursement models that have been historically volume based (i.e., fee-for-service) toward models that are structured to reward patient access, care coordination and/or integration, and improved healthcare outcomes and efficiency. In concert with other policy levers, VBP has the strong potential to accelerate improvement in healthcare outcomes and increase efficiency." [63]

One type of APM that is utilized in commercial insurance, Medicare and Medicaid is a Preferred Provider Arrangements. The intent of these arrangements is to steer the majority of a managed care organization's members toward a provider with who the MCO has negotiated a value-based contract. Arrangements with durable medical equipment suppliers are a common type of preferred arrangement used in Medicaid and with commercial payers. While these arrangements are allowed in Texas, health plans have barriers in their ability to enter into effective arrangements. HHSC requires the MCOS to offer the option for enrollees to opt out of the preferred provider and pursue services with another network provider. The agency argues that the opt out requirement allows members to retain a level of choice and facilitates the state's compliance with federal regulations on member choice (42 C.F.R. §438.3(l)). The opt out language and process mandated by the state is very prescriptive and has led to some reported issues of providers inappropriately "coaching" enrollees regarding the opt-out process, in an effort to steer the enrollee back to them as the provider.

To promote the use of APMs, the agency adopted minimum thresholds for them in their managed care contracts with the measurement period beginning January 1, 2018. These targets stated that for 2018 25% of provider payments made by the managed care organization needed to be in APMs. These targets increase annually to 50% by 2021. For 2018, every plan met the APM target for STAR. The majority of the plans met the targets for STAR+PLUS and CHIP. Overall, across programs, 40% of payments were made through an APM.[64]

The contract further stipulated that 10% of the provider payments needed to be in Risk-Based APMs. These thresholds escalate to 25% by 2021. All of the health plans met the target for STAR in 2018, and the majority of them met it for STAR+PLUS and CHIP. Overall, across programs, 22% of payments in 2018 were made through risk-based APMs.[65]

While promoting the use of APMs to increase quality is a laudable goal, some providers aren't equipped to handle the complexity of these APM agreements, particularly the at-risk arrangements. As the agency noted in the Value Based Purchasing Roadmap, "HHSC must be mindful that there is a wide range of sophistication and administrative infrastructure among provider types, and explore workable solutions."[66] Furthermore, the report notes that "HHSC will evaluate the MCO VBP contract requirements and make adjustments as necessary to ensure forward progress."[67]

1. Policy Recommendation: Continue to support the use of APMs.

APMs provide unique opportunities to reward providers along the care continuum for contributing to truly improving patient health outcomes. The State should continue its support of this model.

2. Policy Recommendation: Leverage the managed care model to provide maximum flexibility in APMs.

One of the most fundamental benefits of the managed care model is that it provides an optimal framework in which to test innovative payment and care delivery models based on quality and cost controls. HHSC should amend managed care contracts to provide greater flexibility in the percentage of at-risk APM arrangements and to allow plans to design programs tailored to their network providers. Many providers, especially those smaller or solo practitioners in rural areas of the state, are not in a financial position to accept downside risk. Throughout the course of this Study Group, MCOs have expressed a need to "meet providers where they are" and to develop programs that benefit both the provider and the patient. HHSC should ensure that the Uniform Managed Care Contract allows for, and encourages, such flexibility.

3. Policy Recommendation: The Legislature should direct HHSC to allow for greater flexibility in the use of Preferred Provider Arrangements to improve quality and reduce costs.

While not every free-market principle can seamlessly translate into the Medicaid program, preferred provider arrangements offer such an opportunity. Frankly speaking, these arrangements can be somewhat controversial because, as members are driven *towards* a more exclusive network of high-quality providers for a better value, this inherently means they are being *driven* away from others. However, these models have been shown to be effective in the private market.

Researchers at the Washington Legal Foundation explain how health plans, and ultimately health care consumers, achieve greater cost savings and better services through exclusive pharmacy networks:

> Many networks are highly exclusive. The greater a network's exclusivity, the more customers a member pharmacy can expect. The prospect of a large number of customers creates intense competition for exclusive networks; this competition leads pharmacies bidding for network membership to offer higher discounts in order to join the network. It is well understood that cost savings resulting from this exclusivity are generally passed on to consumers in the form of lower premiums, lower out-of-pocket costs, and better services.[68]

A few years ago, Walmart made national news by announcing that it would start sending its employees to a small selected number of hospitals for complex, and expensive, spinal surgeries in order to "weed out unnecessary procedures and lower its healthcare spending."[69] Through this move, Walmart helped

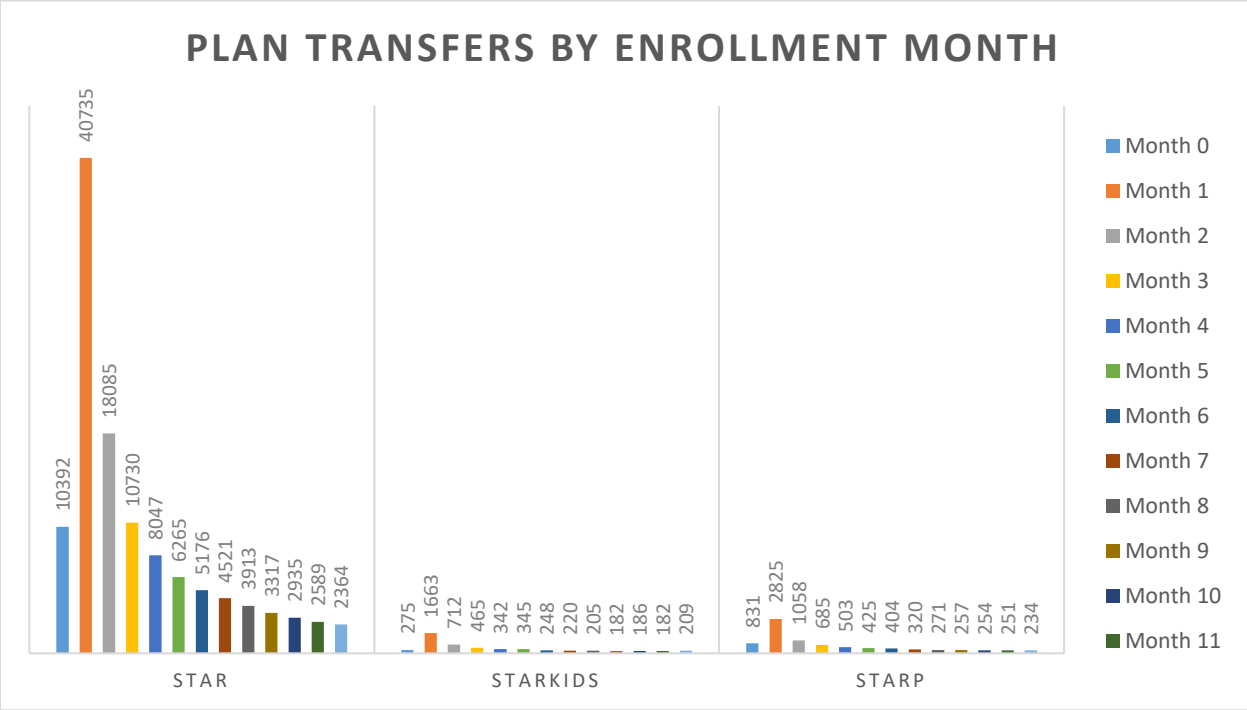
one employee avoid a painful, unnecessary surgery and saved $30,000 in the process.[70] Lowe's has since begun turning to these arrangements for certain services as well.[71]

Although premiums and out-of-pocket costs do not apply to Medicaid recipients, more cost-effective and efficient administration of the program does benefit the state and Texas taxpayers, and better services only stand to benefit Medicaid enrollees.

C. Managed Care Plan Continuity

Currently when a client is determined eligible for Medicaid, the enrollment broker sends an enrollment packet to the client to select a health plan. If the client does not select a plan, the State defaults him or her into a health plan using an algorithm that takes into account various factors including prior plan history, enrollment of other family members, cost, quality, and customer satisfaction.

Figure 9. MCO Transfers by Enrollment Month



In private health insurance and in the federal marketplace plan changes are generally limited to once a year unless a significant event occurs. The Code of Federal Regulations (42.438.56) allows Medicaid enrollees the flexibility to change plans, but it also authorizes Texas to be more restrictive regarding plan changes than the current practice and law in Texas.

Federal regulations allow one "without cause" change within the first 90 days of plan enrollment; allow at least one plan change every 12 months; and allow plan changes "with cause" at any time. Causes for

disenrollment outlined in the federal regulations include moving out of a service area, poor quality of care, and lack of access to services or providers. Section 533.0076 of the Texas Government Code is more flexible than federal law, allowing one additional "without cause" change each year. In reality, that state provision isn't strictly enforced since the majority of plan changes occur within the first 90 days.

According to 2018 enrollment data provided by the Health and Human Services Commission, the majority of plan changes occur within the first 90 days of enrollment with the highest number occurring in the first month. The chart below demonstrates that across managed care service lines, clients can initiate plan changes when they become aware of their plan assignment (month zero), prior to the actual start of managed care benefits.

According to this data, for STAR,67 percent of the plan transfers occur within the first 90 days; for STAR Kids, 60 percent occur within the first 90 days; and for STAR+PLUS, 65 percent occur within the first 90 days. The overall percentage of members with any plan transfers is 4 percent or less.

While the agency is likely to have some one-time costs to make the automation changes with the enrollment broker to enforce the lock-in, there are benefits that need to be taken into consideration that offset the costs. For example:

- The concept of changing plans once annually mirrors what occurs in the commercial marketplace.
- The health plans have more stability in membership helping them target members for preventive care. Those up-front investments that result in better health outcomes have a more long-term payout, so maintaining membership helps with that continuity of care management.
- In establishing value-based arrangements with providers, particularly at-risk arrangements, providers need the stability of membership to reach goals and produce better health outcomes.
- A lock-in Encourages investments by the health plans in providing services that are not reimbursable but improve health outcomes.
- From a member perspective, members retain the ability to change plans past the 90-day period if they do not have access to needed providers or if they are receiving poor quality care.
- There are some administrative savings to the State from reduced mailings generated from changes that are occurring today that don't meet an exception criterion and occur after the 90-day period. Furthermore, the plans achieve savings by reducing changes because they have contractually required onboarding activities such as printing and mailing welcome kits, providing member handbooks and ID cards, performing new member welcome calls, conducting health risk screenings, and initiating service coordination activities.

1. Policy Recommendation: Limit "without cause" changes in health plan selection after the initial 90-day enrollment period, to the fullest extent allowed by federal law.

Federal regulations (42 CFR § 438.56(d)(2)) specify causes for disenrollment, which include the enrollee moving to another service area; the plan not offering the service to which the enrollee is entitled; and "other reasons" such as poor quality of care, lack of access to covered services, and lack of access to providers experienced in dealing with the enrollee's care needs.

This policy change only applies to "without cause" changes." It would still allow a member to change health plans for any of the aforementioned reasons and would better mirror commercial market practices.

VII. Access to Care Improvements

(Note: The following section contains some crossover information that is also available in TCCRI's Healthcare & Human Services Task Force Report released in February 2021, which also examines ways in which policy reforms can increase access to care through improved utilization of non-physician providers)

A. Texas' Ongoing Physician Shortage

The onset and spread of the coronavirus over the past year has highlighted the heroic efforts of frontline healthcare workers who continue to selflessly put their own needs and fears aside to care not only for those with COVID-19, but also their regular patients with strep throat, appendicitis, broken limbs, cancer, and all of the other maladies they fight on a daily basis. However, the health care needs of the last ten months have also underscored a significant healthcare provider shortage- an issue that Texas has experienced for years and which is only exacerbated by current circumstances.

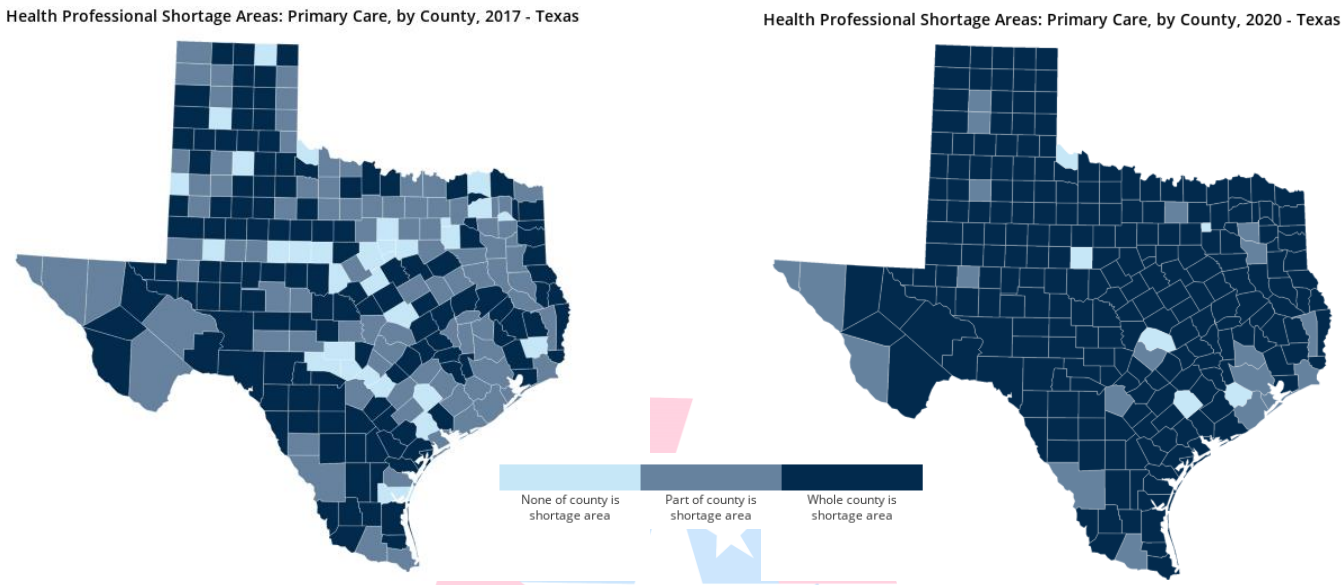
This state's physician shortage is well-documented and indisputable. A 2015 Merritt-Hawkins study focused on the physician workforce needs of Texas found that 35 of Texas' 254 counties had no practicing physician and 80 had five or fewer.[72] Fifty-seven percent of Texas's practicing physicians operate in the urban counties of Dallas, Tarrant, Travis, and Bexar,[73] and 2.2 million Texans live in small counties that are served by only 2.5 percent of the physician workforce.[74] While this study is worth examining because it is Texas-focused, it is also growing outdated. Unfortunately, more recent studies show this trend is headed in the wrong direction.[75] Later studies have found that Texas ranks near the bottom of the nation in having an adequate number of physicians to meet patient need, compounded by the fact that almost 30% of Texas physicians are nearing retirement age.[76] While the state has invested in new medical schools and residency slots, one academic, who is also a medical doctor, posited that even if every Texas medical school graduate stayed within the state to practice medicine, it still would not meet the state's demand.[77] State research seems to support this analysis; a 2018 study by the Texas Department of State Health Services (DSHS) found that by 2030, additional need for primary care physicians across the state will grow by 67 percent.[78] And these circumstances were present *before* the additional stressors placed on our already teeming system by the coronavirus.

The maps below, based on data from the federal Health Resources & Services Administration (HRSA), show the extent of primary care shortages in Texas. Counties may be designated by HRSA as a "whole" or "partial" health professional shortage area (HPSA), with either the entire county experiencing a shortage (show in dark blue) or only a portion of the county (show in medium blue). Counties meeting HRSA's defined primary care access needs are shown in light blue.

The map on the left reflects HRSA's 2017 designations for the State of Texas, while the map on the right presents the most up-to-date version of this data, released in October 2020. Although much of the state had some degree of access challenges in 2017, fewer than half of the counties were "whole" health professional shortage areas. In only three years, almost all of the "partial" designations have

transitioned to "whole county" shortage areas and only five counties now meet their residents' primary care needs. It is clear from this comparison that Texas is moving in the wrong direction on access to primary care, and immediate action is needed in the 87th Legislative Session.

Figure 10. Texas Primary Care Health Professional Shortage Areas: 2017 and 2020



Source: Rural Health Information Hub[79]

The strain on our current health care infrastructure is not likely to ease anytime soon. A Centers for Disease Control and Prevention (CDC) study found that, as of July 31, 2020, more than 40% of adults in the U.S. had delayed or foregone medical care due to the pandemic.[80] With statistics like these, our system will be playing catch-up for the foreseeable future, and our need for a growing health care workforce will only continue to increase. As state leaders navigate the 87th Legislative Session in the time of COVID-19, now is the time to comprehensively address Texas' health care provider shortage to support access needs both now and well into the future.

B. Allowing Advanced Practice Registered Nurses to Practice at the Top of Their Licenses

One key solution to address this issue that is fully within the state's purview is expanding the ability of certain qualified non-physician providers to practice at the top of their licenses- meaning to fully exercise the education, training, and scope conferred by their current licensure- thereby allowing these providers to expand access to healthcare. Research shows that voters broadly support this policy, with a November 2020 poll finding that almost 70% of voters across party lines support allowing practitioners to exercise a full scope of practice.[81]

While such policies have been pursued in past sessions, they have yet to be successful. This session, however, is a critical opportunity to embrace these reforms and entrust qualified providers to do the jobs for which they are trained and licensed.

Past Legislative Efforts

In past sessions multiple bills have been filed to permit Advanced Practice Registered Nurses (APRNs) to practice with independent authority, allowing these practitioners to fully exercise the medical licenses for which they are trained. Since their emergence in the 1960s to address access-to-care needs, ARPNs have become an integral part of the U.S. primary care system.[82] In 2017, there were about 230,000 APRNs across the country, an increase of more than 100,000 since 2009, with about 90% of these professionals trained in primary care.[83]

Currently, APRNs in Texas may practice and see patients, but must do so under the delegation of a licensed physician. Certified Registered Nurse Anesthetists (CRNAs), a type of APRN specializing in anesthesia, are not required to have supervision but must have a delegation requirement to access drugs and devices.[84] CRNAs determine drug, method, and dosage independently.

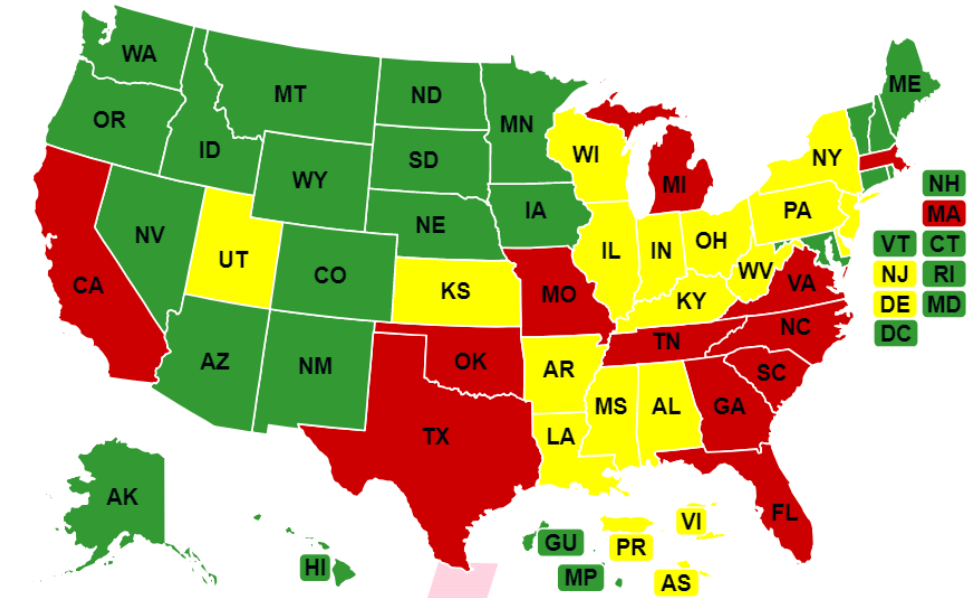
As such, APRNs generally may only contract with a health insurer if their delegating physician is also contracted with that plan. The Legislature did take an important step in helping Medicaid enrollees better access APRN care by passing SB 654 (85R) (Seliger/ SP: Smithee). While SB 654 does not grant an APRN any additional scope of practice authority, it does allow APRNs to contract directly with Medicaid managed care plans and see Medicaid patients, regardless of whether the delegating physician is in that plan's network. While this is a critical first step, more can be done to create increase health care access across the state. Some additional bills filed in the past would have taken further increased access to care. HB 1792 (Klick) and SB and SB 2438 (Rodríguez) in the 86th Legislative Session would have placed Texas on par with a significant number of other states, federal health care services, and all branches of the military[85] by allowing APRNs to practice without physician delegation authority.

The Case for Independent Practice

Proponents of expanded APRN practice authority argue that the current system of regulations really amounts to a requirement that APRNs sign expensive delegation agreements with physicians, up to $120,000 per year in some cases, in order to see their patients and write prescriptions.[86] Proponents of independent practice argue that these expensive delegation requirements put Texas at a distinct disadvantage to neighboring states that don't require delegating physicians, such as New Mexico.[87]

The following map, produced by the American Academy of Nurse Practitioners in October 2020,[88] provides an overview of how APRNs are able to practice across the nation, and clearly shows how Texas could lose to some surrounding states in recruiting these providers; only one adjacent state, Oklahoma, restricts the practice of APRNs to the same degree as Texas.

Figure 12. 2021 Nurse Practitioner State Practice Environment



Full Practice: State practice and licensure laws permit all NPs to evaluate patients; diagnose, order and interpret diagnostic tests; and initiate and manage treatments, including prescribing medications and controlled substances, under the exclusive licensure authority of the state board of nursing. This is the model recommended by the National Academy of Medicine, formerly called the Institute of Medicine, and the National Council of State Boards of Nursing.

Reduced Practice: State practice and licensure laws reduce the ability of NPs to engage in at least one element of NP practice. State law requires a career-long regulated collaborative agreement with another health provider in order for the NP to provide patient care, or it limits the setting of one or more elements of NP practice.

Restricted Practice: State practice and licensure laws restrict the ability of NPs to engage in at least one element of NP practice. State law requires career-long supervision, delegation or team management by another health provider in order for the NP to provide patient care.

Source: American Association of Nurse Practitioners

While the Texas Medical Association (TMA) has historically favored what it calls a "team approach" with physicians and APRNs, under current regulations APRNs are not required to be located in the same city as their delegating physicians, nor are the physicians required to see any patients treated by an APRN. So, although some opponents might argue that allowing independent practice could place patient safety at risk because there is no physician oversight, this policy change would alter little in the actual way APRNs care for their patients. Rather, this policy change would remove a cumbersome and costly hurdle to practice and increase access to care in certain areas of the state.

In terms of delivery of anesthesia, CRNAs have slightly different scope of practice, requiring delegation, but not supervision, in Texas. This means that there must be an order for anesthesia from a physician, but the CRNA determines the dosage, technique, and medication used in the procedure.

Potential for Cost Savings

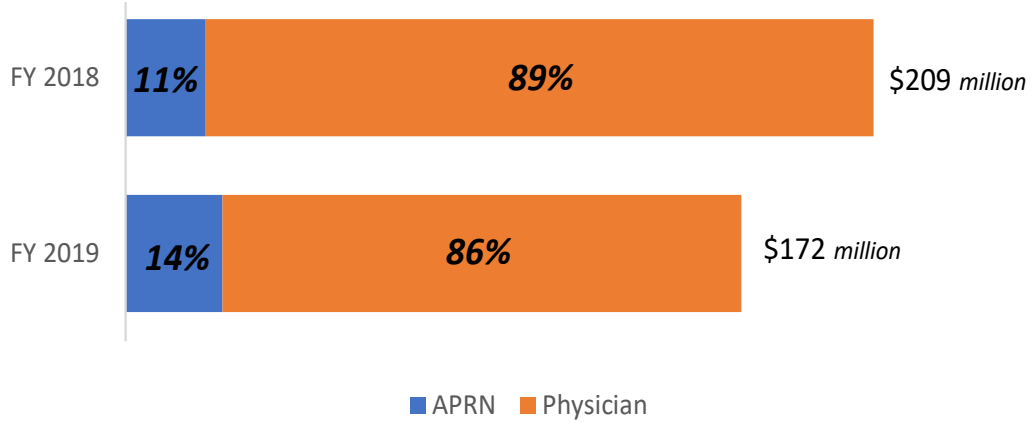
Because APRNs are reimbursed at a percentage of the cost of a regular physician visit, there is potential for cost savings if utilization shifts to greater use of APRNs. Comparing only cost for primary care services for evaluation and management (E&M) procedures between APRNs and physicians will result in cost savings as utilization shifts from physicians reimbursed at relatively higher rates to APRNs. For Texas Medicaid, that reimbursement is 92 percent of the regular physician rate. However, there are other considerations when it comes to cost and utilization, including whether APRNs tend to order more services (lab, x-ray) or to provide more referrals, potentially negating these savings. Analysis of longitudinal data patterns has shown that not to be the case, leading to conclusions that there are minimal differences in referral patterns and use of ancillary services,[89] and specific to Medicaid no increase in overall utilization (claims, days of care) when patients are treated by APRNs.[90]

Overall, multiple studies and simulations show overall cost-effectiveness and sometimes significant savings with no restrictions on APRN practice,[91] with net savings ranging from more than $700 million in Alabama over a 10-year period[92] to billions of dollars in Pennsylvania and California over a 10-year timeframe, considering the overall healthcare system.[93, 94]

Cost and Utilization Data: Texas Medicaid

Fiscal year 2018 and 2019 data for all primary care evaluation and management procedures for each risk group has been analyzed (Figure 12 below) to provide some insight into current utilization and potential Medicaid savings for a market shift to APRNs. It should be noted that the current Texas Medicaid program has CRNAs in solo practices. In group and team practice structures with CRNAs and physicians, Medicaid reimbursement is 50 percent to the physician and 50 percent to CRNA, but the physician may oversee up to four procedures at one time.

Figure 13. Primary Care Expenditures for Advanced Practice Nurses and Physicians, FY 2018-2019



A market shift in practice and utilization would naturally yield savings, based on the 92 percent of rate reimbursement for APRNs. Also important to this shift in use of APRNs is an understanding of the current utilization. Expenditure data for 2018 and 2019 by client and provider (APRN and Physician) for primary care evaluation and management codes shows that the overall cost per client is lower for APRNs compared to physicians, as expected. As this is aggregate data, it could also mean that APRNs are seeing patients for the lower cost services. However, the number of visits per client is also lower for APRNs. Research shows that APRNs and physicians' assistants (PAs) spend more time with patients and have higher satisfaction surveys.[95] While these data are supportive of that finding, there is not enough detail-level data to be conclusive based on the current utilization patterns.

Looking only at data for primary care evaluation and management codes (E&M) for APRNs compared with physicians[96] shows the following overall expenditures for fiscal years 2018 and 2019, and potential savings with a shift of 25 or 47.5 percent visits to APRNs (Figure 13). While this will include most of the services provided by APRNs, it is not exhaustive, and there are additional areas where shifts in Medicaid costs can occur. Overall, using the approximate mid-point of the potential shift to APRNs where 47.5 percent of primary care visits are moved to APRNs, the two-year savings is approximately $12.6 million.

Figure 14. Potential Savings (Cost) for Primary Care Evaluation & Management Shift to APRN

	25% Shift	***47.5% Shift***
FY 2018	$ 3,724,000	$ 7,076,000
FY 2019	$ 2,893,000	$ 5,496,000
2-Year Total	**$ 6,617,000**	**$ 12,572,000**

Additional savings opportunities are available from a shift to CRNA utilization. As with APRNs, there will be savings when more utilization is driven to CRNA use in anesthesia.

Fiscal year 2019 data shows that 35 percent of all anesthesia reimbursement is for a physician-performed service (only), with 41 percent for anesthesiologist-directed service, of which 50 percent of the rate is for the anesthesiologist and 50 percent for the CRNA. An anesthesiologist can direct up to four CRNAs. This area is where the shift can take place, depending on the practices of the hospital; a CRNA would receive 92 percent of the rate, with the remaining 8 percent "saved". More than 20 percent of the expenditures were made with a CRNA operating as an independent practitioner under the direction of a physician other than anesthesiologist.

A 75 percent shift would show savings of $9 million over a two-year period using the data for 2018-19, and a 50 percent of these procedures shift would show $6 million.

Figure 15. Potential Savings for Shift from Anesthesiologist-Directed CRNA Procedures to CRNA-Only

	75% Shift	*50% Shift*
FY 2018	$ 3,641,121	$ 2,427,414
FY 2019	$ 5,396,498	$ 3,597,665
2-Year Total	**$ 9,037,619**	**$ 6,025,079**

These utilization shifts may look different when all advanced practice nurses' practice at the top of their licenses, particularly as/if the patterns of utilization change for use of APRNs as the primary drivers of primary care and maintenance of stable health "homes" for clients with increased access to preventative care. The figures above are low-end estimates for evaluation and management primary care in Medicaid only – and based on current utilization patterns and costs. There will also be small offsets which reduce the savings due to lower managed care premium tax revenue.

1. Policy Recommendation: Allow the Independent Practice of Advanced Practice Registered Nurses Non-Physician Providers to Practice at the Top of Their Licensees

While the passage of SB 654 in the 85th Legislative Session was a positive start in better utilizing APRNs, the time has come to place Texas on par with other neighboring states. The 87th Legislature should pass legislation allowing the independent practice of advance practice registered nurses, as set forth in last session's HB 1792 (Klick) and SB 2438 (Rodríguez).

These bills would have made various changes to laws governing APRNs, most significantly allowing them to practice as independent practitioners. The legislation does not alter the scope of practice of these providers, meaning that an APRN would still have had to operate under current requirements regarding education, training, and certification standards, and to adhere to the Texas Nursing Practice Act and Board of Nursing (BON) rules.[97] However, the legislation would have removed the requirement that APRNs practice under a delegation agreement with a licensed physician and would have centralized the regulation of APRNs at the BON (APRNs are currently regulated by both the BON and Texas Medical Board).

While the Texas Medical Association (TMA) has historically favored of what it calls a "team approach" with physicians and APRNs, it should be noted that under current regulations APRNs are not required to be located in the same city as their delegating physicians, nor are the physicians required to see any patients treated by an APRN.[98] In addition, research supports the safety and efficacy of APRN care. An in-depth study looking at the role of APRNs in helping to fill primary care needs examined multiple studies on APRN safety and patient satisfaction, finding the following:

> Several studies consider the quality of care or clinical outcomes provided by NPs and the existing literature suggests that NPs provide a quality of care almost on par with physicians. A meta-analysis of NPs in primary care found that in studies, controlling for patient risk in a non- randomized way, patient satisfaction and resolution of pathological conditions were greater for NP patients and NPs were equal to physicians in the majority of variables in controlled studies.[99]

Although some opponents might argue that allowing this independent practice could place patient safety at risk because there is no physician oversight, this policy change would alter little in the actual manner in which APRNs care for their patients. Rather, this legislation removes a cumbersome and costly hurdle to practice and is a critical step towards safely increasing access to care in areas of the state where that care might not be otherwise available. It also offers the opportunity for cost efficiencies within the Medicaid program, as well as freeing up physician time to focus on more complex patient needs.

C. Aligning Private Duty Nursing and Personal Care Services

Private Duty Nursing (PDN) is a Medicaid Texas Health Steps benefit for people under age 21 who require continuous skilled individualized care in the home. PDN is the next step in the level of care beyond a home health aide visit for personal care services (PCS) or a skilled nursing visit. PDN services must be ordered by a physician or an advanced practice nurse, require prior authorization, and must be provided by a registered nurse (RN) or a licensed vocational nurse (LVN) working with an agency or working independently and enrolled with Texas Medicaid.[100] Personal care services are a Medicaid benefit for the same population that receives help with activities of daily living, such as bathing, eating, toileting, and/or walking. PCS may be offered in place of PDN when the client does not meet the level of need for PDN. However, there are barriers to utilization of PCS instead of PDN, resulting in the potential for continued use of PDN in cases where PCS/attendant services are appropriate. PDN is a large cost driver in Medicaid, and one way to lower costs is to ensure that the level of care and service is not more than necessary to meet the needs of the client.

The state's Nursing Practice Act[101] sets forth the guidelines for nursing practice, supervision, and delegation, and can only be amended by legislation. Licensing requirements for PCS services would need modification through the Nursing Practices Act to require a nurse on staff with authority to delegate and supervise attendees. Without this change, care often defaults to PDN as families and medical providers may not be comfortable with the care provided through PCS without nurse oversight.

The potential utilization shift from PDN to PCS as the most appropriate level of care is unknown, but the potential is significant. As a whole, PDN services are some of the costliest in the Medicaid program with services totaling $804 million (all funds) in FY 2019. Almost all of those services were provided through managed care. If PDN and PCS services are aligned and allowed to operate as parallel services, with the

client receiving the most appropriate level of services, utilization savings are possible. Texas lawmakers should examine the possibility of changing the Nursing Practices Act to authorize nurses to delegate and supervise attendees, and direct HHSC to estimate the potential savings from the utilization shift of joining PDN and PCS services.

1. Policy Recommendation: The Legislature should direct HHSC to study the feasibility of aligning Personal Care Services (PCS) and Private Duty Nursing (PDN).

Lawmakers should direct HHSC to study the feasibility and potential cost savings of joining PDN and PCS, including overall utilization of both services to ensure that the most appropriate level of care is being provided to clients. The study should also include recommendations to the Legislature on licensing changes to the Nursing Practices Act, if needed, to allow nurses the authority to delegate and supervise PCS attendees to achieve this goal.

D. Ambulance Treatment in Place

Under current state Medicaid regulations, emergency transportation is reimbursed only for transport to an emergency department (ED). Last year CMS announced a new initiative known as the Emergency Triage, Treatment, and Transport- or ET3- model to allow flexibility at the point of service and enable emergency medical personnel to determine the best course of action for the patient. Triage and in-place treatment may include a telemedicine visit, or an on-the-spot assessment and treatment. Avoiding an unnecessary and costly ED visit serves several functions – lowers costs, results in the most timely and appropriate treatment, and frees up valuable ED space for other patients. The purpose of this model is to enable the most appropriate – and cost-effective – treatment for the patient.

A CMS pilot program beginning January 2021 will implement an ET3 payment model in Medicare. Although this program is in its infancy, a prior study on such a model offers encouraging findings. The Regional Emergency Services Authority (REMSA) in Reno, Nevada ran a four-year study of Ambulance Transport Alternative (ATA) funded by CMS to test the efficacy of transporting patients to alternative locations when warranted, such as mental health centers or detoxification units. Allowing paramedics to function at the top of their licenses by performing advanced triage/assessment, and using nurse-lines for 9-1-1 calls and additional assessment and treatment-in-place yielded positive results. Although there were fewer reductions of ED visits than initially expected, the report offered recommendations for improvement, and showed almost $10 million in avoided emergency room visit costs during the four years.[102] Low-end estimates from Medicare data suggest 12 to 16 percent of clients could be treated in place,[103] thereby avoiding unnecessary and costly emergency room visits.

Currently, Medicaid reimbursement is only allowed for emergency medical services (EMS) transport if the patient is taken to an ED. CMS has provided guidance in the form of a letter to state Medicaid Directors on August 8, 2019 outlining the potential for ET3

implementation in Medicaid, noting that "…Medicare-enrolled ambulance suppliers or hospital-based ambulance providers that participate in the model and implement the model interventions across multiple payers, including Medicaid, will be in the best position to achieve ET3's cost and quality goals."[104]

CMS offered targeted learning opportunities for state Medicaid programs including training on multi-payer model options, peer-to-peer learning among states, and ways to promote implementation and scaling of the model.

Implementation of ET3 will likely require legislative direction, and HHSC must work with CMS to ensure appropriate rules and payment structure for reimbursement.

1. Policy Recommendation: The Legislature should direct HHSC to review and modify Medicaid reimbursement rules to enable ambulance treatment in place.

Based on early findings from Medicare's pilot program, this innovation is worth testing in the Medicaid program, and should allow the use of telehealth and transport to locations other than an emergency department when warranted. In its directions to HHSC, lawmakers should specify that this treatment modality should be allowed, but not required, as MCOs deem appropriate.

VIII. Strengthen the Medicaid Program's Administration

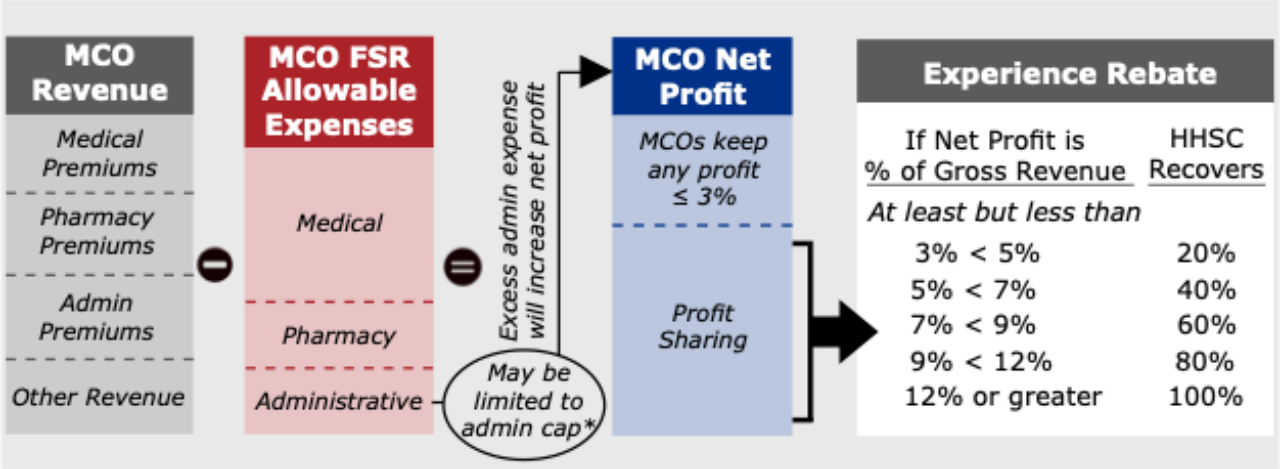
As the Texas Medicaid program evolved from a fee-for-service to a managed care model, the administration of the program also had to evolve. In an effective managed care regulatory environment, the State must resist the urge to over-regulate managed care organizations by forcing them to do things in a particular way. The goal is to foster a regulatory environment that holds health plans accountable to outcomes while allowing them flexibility in achieving the objectives of the program.

A. Managed Care Program Oversight and Streamlined Operations

As Texas has transitioned the vast majority of its Medicaid population to managed care, the state's regulatory framework has developed into a robust oversight environment that includes oversight of the MCOs' financial practices, operations, access to services, service delivery, and quality of services. The state employs various strategies to oversee plan performance, including but not limited to annual independent financial and performance audits, utilization reviews, and quality studies, the latter of which includes member surveys and secret shopper studies to assess access and appointment availability. Failure to meet contractual requirements result in remedies. The primary remedies that are applied include corrective action plans and payment of liquidated damages.

The managed care contracts limit allowable administrative expenses and limit profits through an experience rebate structure that requires MCOs with net income greater than 3 percent of total revenues to share a portion of that income with the state. Figure 16 below depicts the caps on administrative costs and the profit-sharing provisions in the managed care contracts. An evaluation of Texas' 1115 waiver found that Texas' experience rebate structure generates larger cost savings for taxpayers than Medical Loss Ratio regulations employed by other states.[105] In addition, the administrative caps are effective. On a per member per month basis, Texas spent $4 less than the national mean in SFY2017 on administrative expenses.[106]

Figure 16. MCO Net Profit and Experience Rebate Structure



Source: Texas Health and Human Services Commission[107]

In addition to contractual requirements, the state has a strong quality strategy. One of the primary mechanisms for advancing value-based care in Medicaid managed care is the Pay-for-Quality program (P4Q) The P4Q program evaluates each MCOs on a defined set of quality measures and uses financial risks and rewards to improve performance. For the medical program, up to three percent of an MCO's capitation is at-risk of recoupment for failing to meet target performance thresholds. Dollars recouped from MCOs failing to meet the targets are redistributed to award high-performing MCOs. The quality measures include disease management and disease prevention. In addition, Managed Care Report Cards are produced annually and publicized to members making a plan selection and posted on the HHSC website. These report cards rate MCOs performance against each other on a five-star rating system. The report cards are produced by individual product line (STAR, STAR+PLUS, STAR Kids) and by service delivery area.

In Senate Bill 1, Rider 61 of the General Appropriations Act for the 2018-19 Biennium, the 85th Legislature directed HHSC to contract with an independent entity to conduct a review of contract management and oversight for Medicaid and CHIP. In 2018, an independent evaluation of managed care oversight was published. The evaluation used two frameworks to assess the State's managed care oversight: 1) the Medicaid and CHIP Managed Care Final Rule issued by the CMS in May 2016 and 2) Contract Maturity Model, introduced by the National Contract Management Association to help organizations measure the maturity of their contract management process. While the report identified opportunities for improvement, overall, it demonstrated that HHSC has built a strong foundation for its oversight of Medicaid and CHIP managed care.

One of the recommendations from the report was that the agency should continue its ongoing effort to streamline MCO deliverables. Prioritizing and reducing the number of deliverables could free up the managed care organizations from unnecessary administrative burdens, but more importantly it could better enable the state to target resources by analyzing key data points and trends. Rider 26 of the 2016-2017 General Appropriations Act, 84th Regular Session required an annual review of deliverables to assess their value. The agency completed the first review in 2017-2018 and yielded the following:

# Deliverables Merged	40
# Deliverables Deleted	23
# Deliverables Replaced	57
# Deliverables Unchanged	34

In February 2019, HHSC sent a survey to all managed care organizations requesting feedback on existing deliverables and soliciting recommendations for improvement. Simultaneously the agency conducted an internal review to determine if the deliverables being requested were being utilized and evaluating their efficacy. Two additional deliverables were eliminated through this process and information technology checklists were streamlined into a single deliverable.

Rider 61 also requires the agency to develop a dashboard of Medicaid indicators. The agency developed an internal dashboard to oversee plan performance related to contract terms. This was an important step in increasing oversight, but this dashboard should continue to mature. For the Medicaid program there are a variety of ways to measure health plan performance and there is an overwhelming amount of data available such as quality measures, report cards, and compliance to contract terms.

As the regulatory environment has been strengthened over the years, the State needs to ensure there is not duplication of effort or inefficiencies in the process. MCOs are audited and reviewed by many state and federal agencies. In Texas, much of those reviews are directed by HHSC and the Office of the Inspector General (OIG). There are times where audits and reviews are conducted by multiple entities on the same topic, but different data sets are being examined. This can lead to conflicting recommendations and inefficiencies in producing the recommendations.

1. Policy Recommendation: HHSC should continue annual reviews of contractual deliverables to ensure that information collected remains relevant.

HHSC should continue to conduct an annual collection and assessment of deliverables that managed care plans are contractually required to provide to the State to ensure that information being serves a meaningful purpose. As part of this effort, the agency should provide feedback on the status of deliverables that are managed, deleted, and replaced, and should also report new deliverables added each year.

2. Policy Recommendation: HHSC and OIG should identify and eliminate audit overlap or redundancies.

While steps have been taken in this area, HHSC and the Office of Inspector General should continue to coordinate audits and reviews and eliminate duplicative audits. The State should ensure that any audits should comply with Generally Accepted Auditing Principles (GAAP), and health plans should have the right to review and dispute any findings before they are finalized.

3. Policy Recommendation: HHSC should develop a comprehensive dashboard of MCO plan performance.

To improve its ongoing health plan management and oversight activities, HHSC should develop a dashboard that shows a comprehensive view of plan performance focused on key measures, rather than the segmented views that exist today. This dashboard should be public-facing as well as an agency oversight tool for measuring health plan performance. Creating this type of dashboard will require prioritizing what measures are most important to the state; the indicators on the dashboard should provide an overall picture of health plan performance by measuring multiple factors including quality, access to services, client and provider satisfaction, cost-effectiveness, and operational excellence. In

developing this tool, the agency should have a transparent process through which health plans and interested stakeholders can provide input in the determination of key measures.

B. Managed Care Rate Setting Process

Managed care rate setting in Texas has become a year-round process, with capitation rates set for multiple programs, including STAR, STAR+PLUS, STAR Kids, STAR Health, Dental, Transportation, Pharmacy, Dual-Demonstration, Nursing Facility, PACE, and CHIP. As of December 2020, more than 4 million clients received Medicaid through a managed care program. The process of gathering, validating, certifying, and analyzing the necessary data and claims (encounters) for this number of clients in such a large and diverse state with multiple regions and managed care plans make rate setting a significant undertaking requiring extensive time and personnel. The enormity of the task makes its transparency all the more necessary.

Managed care rate setting is a function of the Actuarial Analysis department in the financial services area of HHSC, reporting through the Chief Financial Officer. HHSC has a number of actuaries on staff, as well as a Chief Actuary, licensed through the Society of Actuaries. The rates are developed using an outside firm of consulting actuaries, who have extensive knowledge of the Medicaid program in Texas. The consulting actuaries use data provided by the MCOs and HHSC for a period of several years, as well as data certified through the External Quality Review Organization (EQRO) that HHSC contracts with for review and certification of encounter data. The EQRO is the Institute for Child Health Policy (ICHP).

Currently the data, methods, trends, and recommended rates are provided in a report given to HHSC by the consulting actuaries for each program for which rates are set. While this report contains valuable information, the information needed for any comparative analyses or for MCOs to be able to calculate their own rates is unavailable to them. MCOs wish to have the ability to see and calculate, as closely as possible, their rates and rate changes within service areas as shifts in utilization, acuity, and caseload risk group distribution occur. In fact, the 2015 Sunset Advisory Report[108] made this recommendation to provide health plans with more transparency into their rates, ultimately serving to better track progress (or regress) in their health care delivery business models. The recommendation (Issue 2.7 in the Sunset Advisory Report)[109] is to "Improve transparency in setting capitated rates. . . .HHSC should consider providing additional information and time to managed care organizations so that these entities can independently calculate various factors making up their capitated rates."[110]

1. Policy Recommendation: The Legislature should direct HHSC to improve transparency within the rate development process.

The Legislature should instruct HHSC, potentially via a rider, to work with MCOs to develop a way of providing the information that allows MCOs the needed transparency into rate development. The best possible product would be borne of a collaborative process, allowing both parties to contribute to what information and level of detail is available, appropriate, and achievable.

Given the growth of managed care, its demonstrated value to the Texas Medicaid program, and increasing involvement of managed care plans as the mechanism to drive and ensure quality in both regular and supplemental programs, the need for MCOs to have transparency in the capitated managed care rate setting process is imperative. A number of data reporting requirements already exist for both the MCOs and HHSC, and a significant amount of data is collected and used for rate setting – the objective is to use these data points, and any other relevant information, to form a cohesive, transparent, guide that shows all components that drive the capitation. One example of reform pertains to how FFS rate changes for procedures fit into the managed care rate setting process. In this scenario, when FFS rate changes occur at the state level, the timing of FFS rates and managed care rates is offset. This requires MCOs to retroactively adjust payments already made to providers, creating administrative burdens for the MCOs and increasing provider abrasion.

C. Consent for Electronic Communications

Roughly seven in ten adults with household incomes below $30,000 a year (29%) own a smartphone. And many lower-income Americans rely on smartphones to access the internet.[111] As of early 2019, 26% of adults living in households earning less than $30,000 a year are "smartphone-dependent" internet users – meaning they own a smartphone but do not have broadband internet at home.[112] This adoption of smartphone technology by the population that is relatively likely be enrolled in Medicaid, opens up new channels of communication for both the State and managed care organizations.

The State has been promoting the use of technology to improve the efficiency of the eligibility application process and to reduce costs. Benefit recipients may opt out of receiving paper notices and communication from the state and instead receive electronic communications through their online account with text or email notifications. While recipients opt into this preference with the State, that consent to receive electronic correspondence does not pass along to the managed care organization. The MCO must also ask a recipient their preference for communication. This bifurcated process is confusing to members, is inefficient, and does not allow either the State or the MCO to maximize the adoption of email or texting for communications with members.

For an applicant who is pregnant, Human Resources Code, Section32.025(g) directs the agency to include in the application for benefits a question regarding the applicant's preference for being contacted. The statute prescribed language for the application to use to capture consent. The agency determined that that language reflected in statute is not adequate to document consent to receive electronic communication, and that the MCO must go through additional steps before communicating through text or email.

1. Policy Recommendation: Allow consent for electronic communications to be captured at the time of application.

The Legislature should direct the agency to allow Medicaid recipients to opt into receiving text or email communications from the State and/or managed care organizations on the application for benefits. The

consent should be constructed in a way that does not require the MCO to implement a separate and duplicative process. Data regarding individuals that opt into text or email communications should be shared with the managed care organization upon enrollment to further streamline administrative processes and reduce the need for unnecessary paper notifications.

D. Maximize Opportunities to Use Tele-visits for Service Coordination

During COVID-19 lockdowns, managed care plans began providing service coordination visits via tele-health technology in an effort to protect medically fragile enrollees and reduce the number of people unnecessarily visiting member homes. These "tele-assessments" have proven to be a success, both for helping to insulate Medicaid enrollees with complex health conditions, and for allowing service coordinators to reduce travel time, streamline visits with their members, and obtain real-time access to their members with needs. Although tele-assessments are not appropriate for every health plan enrollee or every service coordination visit, there should be a process by which MCOs can utilize this technology when appropriate in the regular course of business outside of the current pandemic.

The ongoing pandemic has unquestionably increased the use of, and comfort level with, telehealth platforms to facilitate health care visits with an array of provider types. Over the past year, telehealth and telemedicine platforms have become a critical tool in maintaining access to care across the country. U.S. News and World Report has been tracking the increase in telehealth utilization during the pandemic and found that, between March 2019 and March 2020, telehealth claims increased by an astounding 4,374% nationally, with about 4.5 million Texans utilizing telehealth over the past several months. While Texas Medicaid has historically embraced the use of telehealth, and even home tele-monitoring for those with certain health conditions, the use of tele-assessments to provide service coordination to STAR+PLUS and STAR Kids members has only come about during the COVID-19 emergency declaration.

A tele-assessment visit works much like a telehealth visit, with the difference being that service coordination, rather than a medical service, is being provided. Health plans employ service coordinators- nurses, social workers, and other specialists- to help enrollees with complex needs coordinate their care. Service coordination is a cornerstone of the managed care model, helping to facilitate medical care, social, and/or long-term services and supports for members with complex conditions. In addition to ensuring that members receive the care they need, this coordination is critical in better managing finite federal and state resources by increasing member outcomes and eliminating unnecessary costs.

To qualify for certain Medicaid programs and services, individuals must meet both income and functional eligibility criteria. Part of a service coordinator's responsibility is to conduct an annual assessment where functional eligibility is assessed, and a plan of care is developed for the member during the coming year. This plan helps determine the level of services a member will receive, such as the number of therapy or home health hours per day or week. Service coordinators then conduct follow-up visits throughout the year as appropriate.

When COVID-19 lock downs started in mid-March 2020, MCOs began providing service coordination visits virtually in order to help protect medically fragile members. While visual contact is always optimal, it should be noted that some of these visits had to be conducted telephonically when members did not have access to the technology needed (i.e., device or broadband access) to conduct a visual assessment. Health plans report that in anticipation of restrictions beginning to ease, many members and caregivers have specifically requested that service coordinators continue to not visit their homes in person. Tele-assessments will certainly still be used under the current emergency declaration. But MCOs are exploring ways to continue the use of tele-assessments, particularly for the aforementioned follow-up visits, to increase operational efficiencies post-pandemic.

Members for whom service coordination is provided are medically fragile and some of the Medicaid program's most vulnerable populations. There is undoubtedly a benefit to protecting these individuals from outside illnesses, be it COVID-19 or the common cold, whenever possible. In addition, the travel required to conduct these visits in certain parts of the state can be burdensome. Opportunities to reduce the number of health plan personnel unnecessarily visiting these members' homes should be explored. However, these opportunities must be balanced with ensuring that member choice is honored; that members are receiving the care they need; and that the Medicaid program is operating in a way that maximizes efficiencies and cost-effectiveness.

There are lessons to be learned by the COVID-19 response that should be incorporated into ongoing practices. HHSC is likely to consider tele-assessments for STAR+PLUS and STAR Kids members, with certain guidelines in place. First and foremost, it is important to understand the difference in consequences between the initial annual assessment and the follow-up visits. These initial visits should be conducted in person, as that is when functional Medicaid eligibility is established for many of these members and when appropriate services levels are determined for the year. It is crucial that the integrity of the functional eligibility process be maintained, to ensure both that members are receiving appropriate services and that the program is serving as a thoughtful steward of taxpayer resources.

Some additional considerations that should be taken into account when determining how and when tele-assessments should be used include:

- Member choice must take preference.
- Telephonic-only communication is not an acceptable choice. It is important that these visits allow for synchronous communication. In the event that connectivity is unavailable, telephonic assessments could be considered with the approval of HHSC.
- Follow-up assessment visits could be carried out using expanded tele-assessment technology, but these types of visits will not be appropriate for all members. Plans should develop a process by which they can distinguish members with whom they have an established relationship and feel comfortable conducting a "virtual" visit (considerations may include whether: the member's condition makes a change in level of need or services unlikely; the member has been with the current plan; the specific service coordinator has an established relationship with the member and applicable caregivers; the member and/or caregiver has any history of instability in condition, social supports, etc.).

- In instances where tele-assessments are used, plans must mitigate opportunities for fraud, waste, and abuse.

1. Policy Recommendation: The Legislature should direct HHSC to allow for the use of service coordination tele-assessments with appropriate parameters.

Providing some service coordination visits via tele-assessment provides the opportunity to reduce administrative processes, increase efficiencies, and limit exposure of medically fragile Medicaid enrollees. This is a process that will serve the Medicaid program well throughout the remainder of the coronavirus pandemic and well beyond.

The Legislature should direct HHSC to allow for the use of tele-assessments with the following guidelines:

- Continue to conduct initial annual visits, in which functional eligibility and level of need is determined, in face-to-face visits.
- Direct HHSC to develop a process by which MCOs may provide follow-up services coordination visits via tele-assessment technology.
- This process must ensure that member choice is given preference and that MCOs mitigate opportunities for fraud, waste, or abuse of services authorized by tele-assessment visits.

E. Provider Enrollment

Having a robust network of providers willing to participate in Medicaid is essential to the quality of the program. Participation in Medicaid comes with additional administrative burdens for providers, including a lengthy and complex enrollment and credentialing process. To ensure that isn't a barrier to participation, Texas should ensure that the process for providers to participate in Medicaid is as streamlined and efficient as possible.

Federal regulations set minimum requirements for screening and enrollment of any provider seeking to participate in Medicaid.[113] Provider enrollment and credentialing for Texas Medicaid is currently a three-step process that can take up to a year before a provider is eligible to contract with a Managed Care Organization (MCO).

First, many providers must enroll with Medicare, then they enroll with Medicaid, then they must be credentialed through the MCO's Credentialing Verification Organization (CVO). The MCO credentialing process in Texas includes many of the same federal requirements as the TMHP enrollment process (background check, licensure check, etc.).

Some states have attempted to leverage the Medicare enrollment process to reduce state Medicaid enrollment requirements, but CMS has not authorized the use of Medicare enrollment data by the states.

For providers participating in Medicaid Managed Care, credentialing is also a component of participating in Texas Medicaid. The Texas Department of Insurance (TDI) requires MCOs to verify that a physician's license and certifications are valid at the time of credentialing and recredentialing, a process that must meet National Committee for Quality Assurance (NCQA) standards.[114]

In response to a recommendation of the 84th Legislature, the MCOs began using a CVO (Aperture) for Medicaid credentialing, so that providers who participate in more than one MCO network do not have to go through credentialing multiple times before contracting. At that time, HHSC was directed to share enrollment information with the CVO and was also authorized to contract with a third-party to develop a single, consolidated Medicaid provider enrollment and credentialing process.[115]

Once centralized credentialing was implemented in 2017, the vision was to share common data elements to streamline the process for providers. The State of Texas, the MCOs, the CVO and health care providers all agree on the need for an integrated data system to a) simplify and shorten the process for clearing providers to serve Medicaid members, and b) ensure a single source of truth for provider data. In that regard, the State has been working with the MCOs and the CVO to identify opportunities to share data and streamline the process, but it will take time.

Integration of enrollment and credentialing data is a shared goal for many state Medicaid programs and while many states are actively exploring the concept, including Texas, New York and Tennessee, few states have implemented such a system. New York has successfully leveraged an all-payer claims database to verify and maintain accurate provider directory information, but has not integrated enrollment and credentialing systems. California instituted a centralized Symphony Provider Directory for all providers in the state, but there is no state requirement that providers participate, so implementation has been difficult.

HHSC is currently implementing a more user-friendly streamlined Provider Enrollment Management System (PEMS) with a go-live date of August 31, 2021. Stakeholder meetings are happening now to discuss system improvements.

PEMS changes scheduled for Fiscal Year 2021 include:

- Improving the provider experience by promoting online applications. Paper applications will only be accepted with a qualified exception. Online enrollment speeds the enrollment process, compared to paper enrollment, because built-in system edits reduce errors that delay the process.
- Centralizing enrollment of all provider types through PEMS. Previously, providers for the Kidney Health program, long-term care, long-term services and supports, and the Vendor Drug Program (VDP) were all enrolled through different systems. HHSC plans a soft roll-out of centralized VDP enrollment starting in February 2021 with full roll-out scheduled for August of that year. This improvement will streamline enrollment for providers that work across multiple systems. For

example, pharmacies that also provide durable medical equipment have to currently navigate through two separate and siloed processes.

- Improving provider data integrity through either (a) a single sign-on option to ensure that all provider efforts to update information with the MCOs go back to the master provider file, or (b) a flag in the PEMS system when provider information changes at the MCO level, so that the most current information is always available.
- Eliminating the Texas Provider Identification (TPI) per SB 1991 (86R) and basing all credentialing and recredentialing on a single national provider ID (NPI).

Future improvements to PEMS are also planned but will require more time.

- Completing a comprehensive review to compare elements required by the enrollment and credentialing processes, to identify efficiencies and ensure that TMHP can transfer proof that providers have met shared requirements to the CVO. Some limitations will apply to this effort; for example, HHSC can share proof of licensure, but cannot share fingerprinting.
- The CVO currently receives a weekly transfer of the Medicaid Master Provider File from TMHP, but more frequent data sharing should be explored, with the availability of real time data.

1. Policy Recommendation: HHSC should continue to streamline the provider enrollment process.

The Commission should continue to streamline the existing provider enrollment process and work with the MCO credentialing verification organization and the Texas Department of Insurance (TDI) to reduce duplicative Medicaid enrollment and credentialing requirements wherever possible. Additionally, HHSC should explore any additional data sharing opportunities to further improve this process to reduce provider abrasion and the time it takes a provider to complete the entire enrollment process. For instance, should data sharing with Medicaid provider enrollment become an option, the state should attempt to leverage that data.

2. Policy Recommendation: Establish a "single source of truth" for provider data.

The concept of a "single source for truth" is generally defined as "[a] data storage principle to always source a particular piece of information from one place."[116] This model has enjoyed some success in one healthcare model. Orlando Health, a nonprofit health system in Florida implemented a single source of truth protocol to help data challenges, including the provider credentialing process and patient change of address information.[117] Since adoption of the system, the health system has realized improvements in timeliness, ease of access, improved analytics and reduced queue time.[118]

HHSC should work with MCOs and the CVO to establish this source for accurate provider data by facilitating system changes to ensure enhanced data sharing capabilities among entities.

F. Provider Directories

Maintaining the accuracy of provider directories is a well-known challenge throughout the insurance industry. Because of changes in network status of providers, printed directories are out-of-date as soon as they are printed. The cost of printing, storing and mailing these paper directories is an unnecessary expense that does not reflect consumer preferences. Recognizing that electronic versions of directories are more reliable than printed directories, CMS has amended federal regulations to allow MCOs to provide provider directories electronically, unless otherwise requested by the client. Additionally, CMS is encouraging MCOs to offer a mobile-enabled directory. A 2018 survey of health care consumers reveals that most Medicaid beneficiaries own mobile technologies. The survey conducted by Deloitte, found that 86 percent of adult Medicaid beneficiaries own smartphones and 69 percent own tablets.[119] The report further notes that for about 20 percent of Americans a mobile device is the only means for connecting to the Internet, and that this figure is even greater among people with lower incomes.

Federal requirements specify that provider directories must be updated regularly and, if printed, must include certain information, but there is no requirement to provide a paper directory unless it is requested. Texas law (Government Code, Section 533.0063) requires paper provider directories be provided for individuals enrolled in STAR Kids and STAR+PLUS unless the individual opts out of receiving it. Enrollees have the option to opt out of receiving paper directories, but by default they will receive one. STAR recipients receive a paper directory only if requested.

Senator Schwertner has filed SB 205 (87R) to remove the requirement that paper copies be provided to STAR+PLUS and STAR Kids enrollees. The bill defaults enrollees to electronic directories and makes paper copies available on request.

1. Policy Recommendation: Pass SB 205 (Schwertner) or similar legislation to remove the requirement for paper directories in the STAR+PLUS and STAR Kids programs.

This legislation ensures that any STAR+PLUS or STAR Kids enrollee who wishes to receive a paper provider directory may still do so. It simply removes the administratively cumbersome requirement that MCOs print out and provide a directory for members who do not wish to receive them.

IX. Incorporating Best Practices in Managed Care Procurements

In January 2013, the Texas Conservative Coalition Research Institute published a policy white paper on Texas government contracting with recommendations for improvement. In looking at managed care procurements, those same principles hold true.

"Best value" can be defined in many different ways depending on the eye of the beholder, but generally, it speaks to guaranteeing the state gets the best service it can for a fair price, considering both short- and long-term impact, the quality of goods and services purchased, the ability of a provider to deliver on time and under the terms of a contract, and many other factors. As noted in 2013, taking a low bid sometimes ensures best value. But sometimes, to quote the old axiom, the state gets what it pays for—and may end up with a contract that is lacking in terms of quality and dependability.

Competitive Rate Setting

Medicaid managed care contracts are different than many other state contracts for goods or services in that rates are not bid or negotiated. In Texas the state establishes the capitation rate based primarily upon health plan financial experience. The managed care plan may accept or reject the offered capitation rate, but there is no negotiation. The Center for Medicaid and Medicare Services must review and approve rates as actuarially sound. A handful of states competitively bid Medicaid managed care rates. With this contracting approach, a state's actuary establishes an actuarially sound range, and the managed care plans bid within this range.

The General Appropriations Act for the 2018-19 Biennium, Article II, Health and Human Services Commission, Rider 61, Subsection (c), directed HHSC to conduct a study of Medicaid Managed Care rate setting processes and methodologies in other states and to consider the advantages and disadvantages of competitively bidding managed care rates. The analysis, conducted by Deloitte, noted several key considerations for states when looking at whether to use a state established rate or a competitively bid rate. Most importantly, while cost savings are often cited as a reason to engage in competitive bidding, there are no studies that support this conclusion.[120] Another briefing paper on this topic by Milliman notes that while cost and budget certainty is often a consideration for Medicaid programs, "The competitive bid rate scenario provides a greater unknown until the capitation rates are submitted and evaluated through the bid process."[121] In addition, often in procurements utilizing competitive bidding with a cost component, the submitted MCO bids may require an adjustment after submission due to program changes or other emerging experience that occurred prior to the effective date of the contract, but after the bids were accepted.[122] This can further erode any cost certainty. It is also important to note that the introduction of competitively bid rates increases procurement complexity and timelines.[123]

While both reports admittedly point to both positives and negatives with the competitive rate bidding process, Milliman noted that states must carefully weigh their individual circumstances to determine the best approach for their objectives and circumstances. While free market principles are implemented in Medicaid to the greatest extent possible, it is imperative to keep in mind that Medicaid is not a free

market. Rather, it is a highly regulated and manipulated environment because it has to be to contain costs. When considering Texas' circumstances, competitively bid rates has no clear advantages; rather, it would likely introduce additional risks. Texas has a mature rate setting process and sets actuarially sound rates at the low-end creating a downward pressure on costs. The effectiveness of the rate setting process is demonstrated by the aforementioned low-cost growth in the Texas Medicaid program. In addition, it is important to note that Texas is one of the few states which requires MCOs to assume all the financial risk of downside losses and return upside gains to the states. Most of the states with competitive bidding on rates do not place the managed care organizations fully at-risk. There are risk corridors that limit their losses. The Texas approach of a full-risk model with profit sharing provisions has produced a stable market with low rates of cost growth.

Managed Care Procurement Process

Although rates are not competitively bid in Texas Medicaid contracts, the procurement itself is competitive and is based on a number of other factors that determine how managed care contracts are ultimately awarded. While HHSC relies on a number of important metrics (e.g., provider networks, historical performance, operational ability), it is important to note that the State should not rely solely on a health plans' historical profits or losses in determining best value. Low cost can be confused with value and higher costs can be confused with poor care management. But low cost can also be impacted by factors that create barriers to accessing services and can lead to lower quality of care such as narrow provider networks or additional administrative hassle through aggressive prior authorization practices.

As a result, the total cost of delivering care through an individual managed care plan should not be the sole factor in determining best value. Other factors, such as a proven record in delivering quality, customer satisfaction, provider adequacy and satisfaction, and innovative solutions focused on addressing the State's priorities should carry equal weight.

HHSC recently encountered challenges in managed care procurements resulting in the cancellation of seven recent managed care Requests for Proposals (RFP) at various stages in the award process. Such high-profile examples often lead to conclusions that procurement reform in the form of more prescriptive requirements and rules are the panacea that will ensure the state is contracting for best value. As a result, over time, implementation of the state's procurement and contracting practices have become more compliance and process driven based on the erroneous assumption that, if all of the rules and processes are followed, citizens will receive the best value.

HHSC has taken steps to strengthen the procurement process. In 2018 the agency published the *Health and Human Services Procurement and Contracting Improvement Plan* laying out a comprehensive and long-term approach to advance the maturity of procurement and contracting opportunities.[124] Furthermore, specific to managed care procurements, the agency contracted with Mercer to conduct a *Medicaid Managed Care Procurements Assessment*. This comprehensive report includes recommendations to strengthen the procurement process and to ensure that the state obtains the best value from the process. Recommendations include:

- Beginning the procurement process by creating a clear vision that includes key design features for the procurement including such things as best value criteria, number of MCOs by service area, etc.;
- Providing more specificity around best value criteria descriptions; and
- Strengthening the evaluation process by reducing the number of evaluation questions and revising the questions to be concise, measurable, and clear.

The agency proactively secured Mercer's assistance in improving the procurement process and has indicated it is incorporating recommendations to improve further procurements.

Improving the Procurement Process

It is important to allow the agency the flexibility to make improvements to the procurement design and process without being overly prescriptive. Prescriptive regulation tends to limit the ability to achieve best value, and implicit in the push for such regulation is the assumption that, if public employees merely follow the rules, the same result will be achieved each time. However, the success of the procurement is more dependent upon the skills and abilities of the state employees who implement the statutes and the quality of the contractor, not necessarily the rules and processes themselves, which have tended to take precedence.

A sound procurement process that results in the selection of health plans aligned with state goals is the foundation for maximizing the managed care model. An effective procurement process, combined with a strong regulatory environment, produces innovation and improved outcomes for the State and for Medicaid members.

1. Policy Recommendation: Financial performance should not be the primary or sole criterion for determining best value.

The "best value" definition for HHSC currently contemplates that there are other factors the agency should consider. Texas Government Code Sec. 2155.144 gives health and human services agencies broad authority to determine best value for the agency. Given that actuarially sound managed care rates are set by the agency at least annually and that the managed care plans are fully at-risk, financial performance alone is not an adequate measure for managed care contracts. HHSC has never used financial performance as the sole or primary criterion for determining best value and it should continue to look at the broad array of impacts of managed care including quality, access to services, client and provider satisfaction and operational performance.

2. Policy Recommendation: HHSC should clearly define best value with transparent scoring criteria to guide the procurement process.

The agency should clearly define best value and the scoring criteria should be as transparent as possible. Clearly establishing a strong vision and goals for the Medicaid program will improve the quality of responses. This will enable HHSC to determine how respondents should be measured and how past performance would be considered, and ultimately will result in the selection of managed care organizations aligned with State goals. The agency should also ensure that the development of measures and processes should be as transparent as possible.

3. Policy Recommendation: The State should attempt to incentivize agencies to pursue a smaller number of well-trained and compensated procurement and contract professionals.

As reported in TCCRI's 2014 broader paper on this topic, Texas contract professionals are relatively low-paid compared to industry standards, which limits the state's ability to attract employees with the necessary skills for these positions. The state might benefit from a smaller total number of more highly skilled contract professionals that a higher compensation level would attract. It is important to keep in mind that Medicaid managed care contracts govern the provision of care for some of our state's most vulnerable citizens and are funded with billions of taxpayer dollars. Hence, it is imperative to ensure that these procurements are facilitated by an appropriately skilled workforce.

4. Policy Recommendation: Procurement teams should be composed of a combination of procurement professionals and subject matter expertise, augmented by external resources as appropriate.

HHSC, like all state agencies, has limited resources. It should augment those resources with outside consultants to support the complex procurement process. However, defining the vision and evaluating best value in the proposals are a core function of the State, and therefore must not be delegated to external entities.

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TCCRI extends its sincere thanks to Stephanie Muth and Lisa Carruth for their work on this report:

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Stephanie Muth specializes in health and human services policy, design and operations. Prior to establishing her consulting practice in June 2020, she had over twenty years of experience in Texas state government. She began her state career at the Texas Legislature and held senior executive level positions in health and human services for more than fifteen years, including director of external relations, chief of staff, deputy over social services eligibility, and State Medicaid Director. Stephanie's accomplishments include modernizing the Texas eligibility system and reducing the processing costs per case while increasing speed and accuracy. She oversaw a large-scale reorganization of health and human services programs that led to the transition of over 4,000 staff and more than 120 programs. As State Medicaid Director, she was responsible for the operational and policy aspects of a health care delivery system that provides services to more than four million Texans. She overhauled managed care oversight and increased accountability.

Stephanie has a Bachelor of Arts in Political Science from the University of Florida and a Master of Public Affairs from the LBJ School of Public Affairs at the University of Texas.

Lisa Carruth

Lisa Carruth specializes in financial and policy analysis in the health care sector, with an emphasis on Medicaid, hospital reimbursement, and managed care. Lisa's 30-year public-sector career doing research, forecasts, and fiscal impacts to inform policy and program decisions - first in the field of criminal justice, then in health care - provide her with a strong foundation to understand the complexities of health care finance.

Lisa ended her public-sector career as Chief Financial Officer of the Texas Health and Human Services Commission (HHSC), leading the request for a biennial appropriation nearing $80 billion dollars while concurrently overseeing the financial transformation of HHSC as it became one of the largest state agencies in the country via a merger with other HHS agencies and programs.

Lisa holds a Bachelor's degree from Texas A&M University, and a Master's degree from Louisiana State University.

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