IMPROVE OVERSIGHT OF MENTAL HEALTH TARGETED CASE MANAGEMENT AND REHABILITATIVE SERVICES IN THE TEXAS MEDICAID PROGRAM

Medicaid covers Mental Health Targeted Case Management and Mental Health Rehabilitative Services. These services are for clients with a serious mental illness or a serious emotional disturbance and provide assistance with gaining access to care and improving functioning. On September 1, 2014, these services were added into the capitation rate paid to managed care organizations that participate in the Texas Medicaid program. At that time, managed care organizations became responsible for the network development and payment for these services, but the organizations may subcontract part or all of this responsibility to a managed behavioral health organization.

Approximately 80 percent of Texas Medicaid program clients that have a mental health-related diagnosis indicative of a serious mental illness did not receive Mental Health Targeted Case Management or Mental Health Rehabilitative Services during fiscal year 2017. The Texas Health and Human Services Commission does not track data to determine why clients do not receive these services. Many of these clients are eligible for Mental Health Targeted Case Management and Mental Health Rehabilitative Services because they have schizophrenia or bipolar disorder. Clients with these diagnoses automatically are eligible for these services. Clients with major depressive disorder whose levels of functioning qualified them initially for Mental Health Targeted Case Management or Mental Health Rehabilitative Services are eligible automatically for continued services at reassessment.

Texas Medicaid program clients with a serious mental illness or serious emotional disturbance may experience negative outcomes if they fail to receive necessary services in a timely manner. Most individuals that have a serious mental illness or serious emotional disturbance can benefit from Mental Health Targeted Case Management and Mental Health Rehabilitative Services because these conditions typically are long-term and involve substantial functional impairment. These impairments can lead to an inability to work, poor social relations, substance abuse, repeated psychiatric hospitalizations, poor self-care, incarceration, homelessness, and suicide. Mental Health Targeted Case Management and Mental Health Rehabilitative Services are intended to improve or maintain a client's ability to remain fully functioning and integrated in the client's community.

To help ensure appropriate access to Mental Health Targeted Case Management and Mental Health Rehabilitative Services in the Texas Medicaid program, the Texas Health and Human Services Commission should monitor receipt of these services, improve prior authorization policies, strengthen agency oversight, and report feedback received regarding delivery of these services.

CONCERNS

- The percentage of Texas Medicaid clients that have a mental health-related diagnosis indicative of a serious mental illness who received Mental Health Targeted Case Management or Mental Health Rehabilitative Services during fiscal year 2017 was 18.6 percent. This rate means that a majority of clients are not receiving treatment for which they may be eligible. The Texas Health and Human Services Commission does not track data to determine why eligible clients do not receive these services.

- The process to authorize Mental Health Targeted Case Management and Mental Health Rehabilitative Services in the Texas Medicaid program results in unnecessary administrative cost for managed care organizations and providers due to duplication in effort among these entities. The state eventually incurs greater expense from an increase in these costs.

- State oversight of the delivery of Mental Health Targeted Case Management and Mental Health Rehabilitative Services in Texas Medicaid managed care does not include review of managed care organizations' activity specific to these services in several key areas. Some data is contained within broader behavioral health categories and is not reported separately for Mental Health Targeted Case Management or Mental Health Rehabilitative Services. As a result, it is not possible for the state to ensure that access to these services is adequate.

- Since the dissolution of the Behavioral Health Integration Advisory Committee, no formal reports have been submitted to the Texas Health and Human Services Commission by a collective group of consumers, providers, and managed care

organizations regarding integration of physical and behavioral health services into Texas Medicaid managed care. These services include Mental Health Targeted Case Management and Mental Health Rehabilitative Services. As a result, it is difficult for the Texas Legislature to monitor stakeholder feedback regarding the integration of these services.

OPTIONS

- **Option 1:** Include a rider in the introduced 2020–21 General Appropriations Bill to require the Texas Health and Human Services Commission to monitor regularly the extent to which Texas Medicaid clients are receiving Mental Health Targeted Case Management and Mental Health Rehabilitative Services for which they may be eligible. The rider also would require the agency to develop a strategy to ensure that clients receive the services for which they are eligible and desire, and to submit an annual report of the findings to the Legislative Budget Board and the Office of the Governor by December 1.

- **Option 2:** Amend statute to require the Texas Health and Human Services Commission to perform the following actions: (1) implement changes to prior authorization provisions for Mental Health Targeted Case Management and Mental Health Rehabilitative Services in the Texas Medicaid program to reduce any redundancy and unnecessary administrative cost for managed care organizations and providers; (2) modify managed care organization capitation payments to incorporate decreases in administrative costs; and (3) submit a report to the Legislative Budget Board and the Office of the Governor on actions taken by September 1, 2020.

- **Option 3:** Amend statute to require the Texas Health and Human Services Commission to ensure that its oversight of behavioral health service delivery in Texas Medicaid managed care includes the tracking and publishing of certain data. This data should include the areas of member complaints and appeals, provider complaints and appeals, network adequacy, claims processing, utilization management, customer satisfaction, and performance measures. The amended statute also would require the agency to ensure that data is reported separately for Mental Health Targeted Case Management and Mental Health Rehabilitative Services.

- **Option 4:** Include a rider in the introduced 2020–21 General Appropriations Bill to require the Texas Health and Human Services Commission to submit an annual report to the Legislative Budget Board and the Office of the Governor outlining feedback received from the Behavioral Health Advisory Committee regarding delivery of Mental Health Targeted Case Management and Mental Health Rehabilitative Services in the Texas Medicaid program by December 1.

DISCUSSION

Medicaid, financed with federal and state funds, is a healthcare program for low-income families, children, pregnant women, individuals age 65 and older, and individuals with disabilities. The Texas Health and Human Services Commission (HHSC) administers the Texas Medicaid program. Most Medicaid clients in Texas are enrolled in one of four comprehensive Medicaid managed care programs that operate statewide: the State of Texas Access Reform (STAR) program, STAR+PLUS, STAR Kids, and STAR Health. These programs serve distinct populations. As of fiscal year 2017, approximately 3.7 million of Texas' 4.1 million Medicaid clients are in managed care. **Figure 1** shows the types and numbers of members enrolled in each of these programs.

Within Texas Medicaid managed care, HHSC contracts with managed care organizations (MCO), also known as health plans, and pays them a monthly capitation payment for each enrolled member. This rate is based on an average projection of medical expenses for the typical patient. MCOs are responsible for providing a benefit package to members that includes all medically necessary services covered within the traditional fee-for-service Medicaid program, with one exception. Certain services are excluded from the MCO capitation rate and provided on another basis, such as a fee-for-service basis. Medicaid MCOs must cover services in the same amount, duration, and scope as traditional fee-for-service Medicaid.

DELIVERY OF MENTAL HEALTH TARGETED CASE MANAGEMENT AND MENTAL HEALTH REHABILITATIVE SERVICES IN THE TEXAS MEDICAID PROGRAM

The Texas Medicaid program covers behavioral health services to treat mental, emotional, alcohol, and substance use disorders. Within the broader category of behavioral health services, Medicaid covers mental health services, including Mental Health Targeted Case Management (MHTCM) and Mental Health Rehabilitative Services

FIGURE 1
TEXAS MEDICAID MANAGED CARE PROGRAMS, FISCAL YEAR 2017

PROGRAM	MEMBER	SERVICE CATEGORIES	MEMBERS ENROLLED
STAR	Low-income families, children, pregnant women, and some former foster care youth	Primary care, acute care, behavioral healthcare, pharmacy services	2,986,241
STAR+PLUS	Individuals who are age 65 or older and adults age 21 or older who have a disability	Primary care, acute care, behavioral healthcare, pharmacy services, certain long-term services and supports	527,331
STAR Kids	Children and youth younger than age 21 who have a disability	Primary care, acute care, behavioral healthcare, pharmacy services, certain long-term services and supports	136,033
STAR Health	Children in state conservatorship, young adults up to the month of turning age 22 who have voluntary foster care placement agreements, and some former foster care youth	Primary care, acute care, behavioral healthcare, dental, vision, pharmacy services, certain long-term services and supports	32,091
Dual Eligible Project	Certain individuals age 21 or older who are eligible for both Medicaid and Medicare	Primary care, acute care, behavioral healthcare, pharmacy services, certain long-term services and supports	39,950

NOTE: Data is based on average monthly enrollment during fiscal year 2017.
SOURCE: Texas Health and Human Services Commission.

FIGURE 2
TEXAS MEDICAID MENTAL HEALTH SERVICES, FISCAL YEAR 2018

Psychiatric diagnostic evaluation	Prescription medications
Psychotherapy	Medication management
Psychological and neuropsychological testing	Care and treatment of behavioral health conditions by a primary care physician
Inpatient psychiatric care in a general acute care hospital	Mental health targeted case management
Inpatient care in psychiatric hospitals	Mental health rehabilitative services

NOTE: Inpatient care in psychiatric hospitals is limited to individuals younger than age 21 and age 65 and older. Figure 4 shows the types of services provided within Mental Health Targeted Case Management and Mental Health Rehabilitative Services.
SOURCE: Texas Health and Human Services Commission.

(MHR). **Figure 2** shows the types of mental health services available to clients.

MHTCM and MHR are for adults that have serious mental illness (SMI) and children and youth that have a serious emotional disturbance (SED). These services provide assistance with gaining access to care and improving functioning. The definition of SMI in the mental health field includes one or more diagnoses of mental disorders combined with significant impairment in functioning. Schizophrenia, bipolar illness, and major depressive disorder are the diagnoses most commonly associated with SMI. However, people that have one or more other disorders also may fit the definition of SMI if those disorders result in functional impairment. The definition of SED is similar to SMI, but SED applies to children and youth, and some of the diagnoses that contribute to meeting criteria for SED are different from those meeting criteria for SMI. **Figure 3** shows the eligibility criteria for MHTCM and MHR, and **Figure 4** shows the types of services available.

On September 1, 2014, MHTCM and MHR were added into the capitation rate paid to MCOs, pursuant to Senate Bill 58, Eighty-third Legislature, Regular Session, 2013. MCOs already were responsible for other mental health services. Before this date, MHTCM and MHR were provided to managed care members within a fee-for-service payment arrangement among local mental health authorities (LMHA) and the Department of State Health Services. STAR and STAR+PLUS began offering MHTCM and MHR, and STAR Health, which already offered MHTCM, began offering MHR. STAR Kids, which was implemented in November 2016, also is responsible for providing mental health services to its members, including MHTCM and MHR. MCOs are responsible for the network development and payment for MHTCM and MHR, but they may

FIGURE 3
ELIGIBILITY CRITERIA FOR TEXAS MEDICAID MENTAL HEALTH TARGETED CASE MANAGEMENT AND MENTAL HEALTH REHABILITATIVE SERVICES, FISCAL YEAR 2018

ADULTS	CHILDREN AND YOUTH
Clients have a diagnosis or diagnoses of mental illness and have been determined via assessment process to have a serious functional impairment and are in need of Mental Health Targeted Case Management (MHTCM) or Mental Health Rehabilitative Services (MHR).	Clients have a diagnosis or diagnoses of mental illness or serious emotional disturbance and have been determined via assessment process to have a serious functional impairment and are in need of MHTCM or MHR, or are at risk of disruption of a preferred living or childcare environment due to psychiatric symptoms, or are enrolled in a school system's special education program because of a serious emotional disturbance.
Clients with schizophrenia or bipolar disorder automatically are eligible for services and service renewals.	
Clients with major depressive disorder whose levels of functioning qualified them initially are eligible automatically for continued services, regardless of whether their levels of functioning have improved.	

NOTE: The Texas Medicaid program defines an adult as an individual who is age 21 and older and defines children and youth as individuals who are younger than age 21.
SOURCE: Texas Health and Human Services Commission.

FIGURE 4
SERVICES PROVIDED IN TEXAS MEDICAID MENTAL HEALTH TARGETED CASE MANAGEMENT AND MENTAL HEALTH REHABILITATIVE SERVICES, FISCAL YEAR 2018

CATEGORY	DEFINITION	SERVICES
Mental Health Targeted Case Management	Assists clients with gaining access to needed medical, social, behavioral, educational, and other services.	• comprehensive needs assessment and periodic reassessment; • development and periodic revision of a treatment plan; • making referrals and helping a client obtain needed services and supports; • monitoring and follow-up activities; and • coordination with institutions and inpatient facilities.
Mental Health Rehabilitative Services	Provides training and instructional guidance to restore a client's functional deficits. Services are intended to improve or maintain the client's ability to remain fully integrated and functioning in the client's community.	• crisis intervention services; • medication training and support services; • psychosocial rehabilitative services; • skills training and development services; and • day programs for acute needs.

SOURCE: Texas Health and Human Services Commission.

subcontract part or all of this responsibility to a managed behavioral health organization (BHO). Strategies used by BHOs to manage behavioral healthcare services include network development, performance measurement, utilization management, care coordination, and rate setting.

As of November 2018, 18 MCOs were participating in Medicaid managed care. Of these MCOs, 12 contract with a BHO, and the remaining 6 provide services within the MCO. MCOs vary by service area and managed care program. As of November 2018, one MCO is contracted to participate in the STAR Health Medicaid managed care program. The other programs (i.e., STAR, STAR+PLUS, and STAR Kids) have from two to five contracted MCOs participating, depending on the service area. Except for STAR Health, members of the managed care programs have at least two MCOs from which to choose in each service area.

The types of providers that may bill the Texas Medicaid program for MHTCM or MHR include private and public comprehensive provider agencies. These agencies provide or subcontract for the delivery of the full array of MHTCM and MHR, with the exception of day programs for acute needs. Comprehensive provider agencies include public local mental

FIGURE 5
UTILIZATION AND SPENDING ON MEDICAID MENTAL HEALTH TARGETED CASE MANAGEMENT AND MENTAL HEALTH REHABILITATIVE SERVICES, FISCAL YEAR 2017

SERVICE TYPE	CLIENTS	SPENDING (IN MILLIONS)	CLIENTS SERVED	AVERAGE ANNUAL SPENDING PER CLIENT
Mental Health Targeted Case Management	Children	$18.34	31,429	$583
	Adults	$5.20	28,764	$181
	Total	**$23.54**	**60,107**	**$392**
Mental Health Rehabilitative Services	Children	$31.29	35,712	$876
	Adults	$53.55	38,204	$1,402
	Total	**$84.84**	**73,747**	**$1,150**
Total		**$108.38**	**92,061**	**$1,177**

NOTE: Client counts are unduplicated. The unduplicated number of clients served across both categories (i.e., 92,061) is smaller than the sum of the total number of clients served within each service category because some clients receive both services. Data does not include services provided to NorthSTAR clients. Data was estimated at the time of collection due to a lag in claim data.
SOURCE: Legislative Budget Board.

health authorities, also referred to as community mental health centers, and private non-LMHA providers. As of November 2017, 38 LMHAs and 28 non-LMHA providers were contracted to provide MHTCM and MHR to Texas Medicaid clients. Multiple LMHA and non-LMHA providers contract to participate in each Medicaid managed care program within a service delivery area. However, Medicaid client access to a given provider depends on the provider's address within the service delivery area and whether the MCO has contracted capacity with a non-LMHA provider.

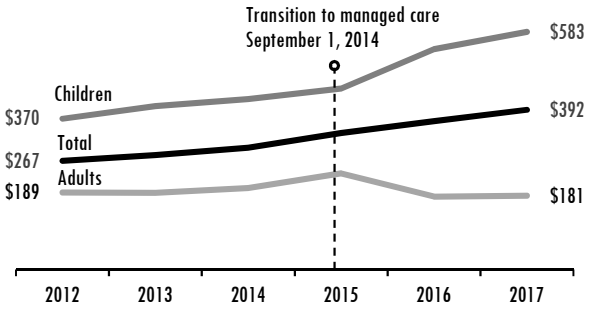
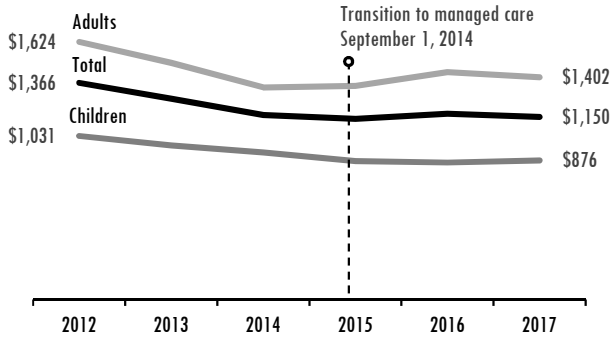
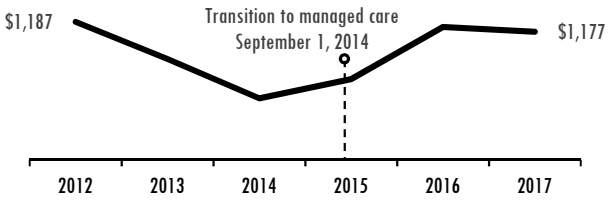
SPENDING AND UTILIZATION OF MENTAL HEALTH TARGETED CASE MANAGEMENT AND MENTAL HEALTH REHABILITATIVE SERVICES IN THE TEXAS MEDICAID PROGRAM

From fiscal years 2012 to 2017, Texas Medicaid spending on MHTCM and MHR increased by 32.2 percent, from $82.0 million in All Funds to $108.4 million in All Funds. **Figure 5** shows Texas Medicaid program utilization and spending on MHTCM and MHR by type of service for fiscal year 2017. Spending on MHR totaled $84.8 million, or 78.3 percent of total Medicaid spending on MHTCM and MHR for fiscal year 2017. Most spending on MHTCM, 77.9 percent, was for services provided to children, whereas almost two-thirds of spending on MHR, 63.1 percent, was for services provided to adults. Utilization and spending data does not include NorthSTAR. NorthSTAR was an integrated behavioral health delivery system in the Dallas service area that served people who were eligible for Medicaid or who met other eligibility criteria. When the state terminated NorthSTAR on December 31, 2016, clients began receiving all Medicaid services through other managed care programs, including STAR, STAR+PLUS, and STAR Kids.

Average annual spending per client on Medicaid MHTCM and MHR and the percentage of the population enrolled in the Texas Medicaid program who received these services have remained relatively flat since these services transitioned from fee-for-service to managed care during fiscal year 2015. **Figure 6** shows the average annual expenditure per client on Medicaid MHTCM and MHR in Texas from fiscal years 2012 to 2017. The average annual expenditure per client on Medicaid MHTCM and MHR increased from $1,111 during fiscal year 2014, the last fiscal year before MHTCM and MHR were added into the capitation rate paid to MCOs, to $1,177 during fiscal year 2017, a 5.9 percent increase. However, average annual per client spending on MHTCM increased by almost one-third for all clients during this period with a 39.8 percent increase for children and a 9.8 percent decrease for adults. Average annual per client spending on MHR decreased by 1.0 percent for all clients, with a 5.3 percent decrease for children and a 4.8 percent increase for adults.

Figure 7 shows the percentage of the Texas Medicaid enrolled population who received Medicaid MHTCM or MHR from fiscal years 2012 to 2017. These percentages were calculated by summing the number of Medicaid clients who received those services and dividing by the total Medicaid enrolled population for the given fiscal year. The percentage of the population enrolled in the Texas Medicaid program who received MHTCM or MHR increased from 1.8 percent during fiscal year 2014 to 2.3 percent during fiscal year 2017.

FIGURE 6
AVERAGE ANNUAL EXPENDITURE PER CLIENT ON MEDICAID MENTAL HEALTH TARGETED CASE MANAGEMENT AND MENTAL HEALTH REHABILITATIVE SERVICES IN TEXAS, FISCAL YEARS 2012 TO 2017

SERVICE TYPE		CLIENTS	2017
Mental Health Targeted Case Management		Children	$583
		Adults	$181
		Total	**$392**
Mental Health Rehabilitative Services		Children	$876
		Adults	$1,402
		Total	**$1,150**
Total			**$1,177**

NOTES:
(1) Data does not include services provided to NorthSTAR clients.
(2) Mental Health Targeted Case Management and Mental Health Rehabilitative Services transitioned from a fee-for-service payment arrangement to managed care September 1, 2014.
(3) Data for fiscal year 2017 was estimated at the time of collection due to a lag in claim data.
SOURCE: Legislative Budget Board.

FIGURE 7
UTILIZATION OF MENTAL HEALTH TARGETED CASE MANAGEMENT OR MENTAL HEALTH REHABILITATIVE SERVICES AMONG TEXAS MEDICAID ENROLLED POPULATION, FISCAL YEARS 2012 TO 2017

SERVICE TYPE	CLIENTS	2012	2013	2014	2015	2016	2017
Mental Health Targeted Case Management	Children	0.9%	0.9%	0.9%	1.0%	1.1%	1.2%
	Adults	3.2%	3.0%	3.0%	3.1%	3.0%	3.2%
	Total	**1.3%**	**1.2%**	**1.3%**	**1.3%**	**1.3%**	**1.5%**
Mental Health Rehabilitative Services	Children	1.0%	1.0%	1.0%	1.0%	1.2%	1.4%
	Adults	3.5%	3.4%	3.5%	3.7%	3.9%	4.3%
	Total	**1.4%**	**1.4%**	**1.4%**	**1.4%**	**1.6%**	**1.8%**
Total		**1.9%**	**1.8%**	**1.8%**	**1.8%**	**2.0%**	**2.3%**

NOTE: Percentages are based on unduplicated client counts. Percentages for each service category cannot be summed to obtain the total percentages because some clients receive both services. Data does not include services provided to NorthSTAR clients. Data for fiscal year 2017 was estimated at the time of collection due to a lag in claim data.
SOURCE: Legislative Budget Board.

IMPROVE OVERSIGHT OF MENTAL HEALTH TARGETED CASE MANAGEMENT AND REHABILITATIVE SERVICES IN THE TEXAS MEDICAID PROGRAM

Texas Medicaid program rules require that clients who meet eligibility criteria for MHTCM or MHR are entitled to receive these services. Clients with an SMI or SED may experience negative outcomes if they fail to receive necessary services in a timely manner. National studies show that adults with SMI are more likely than the general population to have multiple chronic conditions and general health issues, be unemployed, have incomes at less than the poverty level, experience homelessness, and be at high risk of death by suicide. National guidelines call for early intervention among children and youth with an SED to reduce the effects of mental disorders. State oversight can help ensure cost-efficiency while also ensuring appropriate access and quality of care. To ensure appropriate access to MHTCM and MHR in the Texas Medicaid program, HHSC should take steps in four areas: (1) monitoring receipt of MHTCM and MHR; (2) improving prior authorization policies for MHTCM and MHR; (3) strengthening agency oversight of behavioral health service delivery; and (4) reporting feedback received regarding delivery of MHTCM and MHR. Each of these steps is discussed in the following sections.

MONITOR RECEIPT OF MENTAL HEALTH TARGETED CASE MANAGEMENT AND MENTAL HEALTH REHABILITATIVE SERVICES

Most Texas Medicaid clients with a mental health-related diagnosis indicative of SMI did not receive MHTCM or MHR during fiscal year 2017. These clients are not receiving treatment for which they may be eligible. The definition for SMI used for this analysis includes mental illness diagnosis codes that align with the SMI definition found in the Texas Insurance Code, Chapter 1355, regarding benefits for certain mental disorders. The diagnosis codes used are indicators for SMI and include the following categories of disorders:

- schizophrenia and other psychotic disorders;
- schizotypal personality disorder;
- mood disorders, including, but not limited to, bipolar disorder and major depressive disorder;
- obsessive-compulsive disorder; and
- psychogenic skin disease.

Adult clients diagnosed with schizophrenia or bipolar disorder automatically are eligible for MHTCM and MHR. Clients that have major depressive disorder whose levels of functioning qualified them initially for MHTCM or MHR also automatically are eligible for continued services at reassessment. Clients with other mental health-related diagnoses indicative of SMI must be determined via assessment process to have serious functional impairments and to be in need of MHTCM or MHR to receive these services.

Clients with other mental health-related diagnoses that are not included in the definition of SMI used for this analysis might have an SMI if they have a significant impairment in functioning. However, they are not included in this analysis because it is difficult to estimate whether these clients would meet functional criteria and would be considered to have an SMI by looking at diagnosis alone. Similarly, due to data limitations, this analysis does not estimate the percentage of children and youth with conditions indicative of a serious emotional disturbance who received MHTCM or MHR.

As shown in **Figure 8**, during fiscal year 2017, the number of Texas Medicaid clients estimated to have an SMI totaled 389,107. This number includes Medicaid clients who had a mental health-related diagnosis indicative of SMI listed on any Medicaid claim or encounter. Of the number of clients enrolled in the Texas Medicaid program estimated to have an SMI, 72,182, or 18.6 percent, received MHTCM or MHR services during fiscal year 2017. This percentage, which is referred to as the penetration rate, is one measure of access to care.

HHSC does not track data to determine why eligible clients with a mental health-related diagnosis indicative of SMI do not receive MHTCM or MHR. Reasons that these clients may not receive treatment include inadequate screening and referral, client refusal, limited provider capacity, or not being found eligible for MHTCM or MHR during the assessment process. This analysis assumes that many of the adult clients with a mental health-related diagnosis indicative of SMI would be eligible for MHTCM and MHR because they have schizophrenia or bipolar disorder and are, therefore, automatically eligible for these services based on diagnosis. In addition, clients with major depressive disorder whose levels of functioning qualified them initially for MHTCM or MHR also are eligible automatically for continued services at reassessment. Furthermore, national studies show that, although the medical complexity and acuity of each individual varies, and symptoms can change, most individuals that have SMI can benefit from MHTCM and MHR because these conditions typically are long-term and involve substantial functional impairment. These impairments can lead to an inability to work, poor social relations, substance

FIGURE 8
TEXAS MEDICAID PENETRATION RATE FOR MENTAL HEALTH TARGETED CASE MANAGEMENT AND MENTAL HEALTH REHABILITATIVE SERVICES, FISCAL YEAR 2017

CLIENT DESCRIPTION	TOTAL
Number of clients who received MHTCM or MHR who have a mental health-related diagnosis indicative of SMI (A)	72,182
Number of clients who have a mental health-related diagnosis indicative of SMI (B)	389,107
Penetration Rate – Estimated percentage of clients who have a mental health-related diagnosis indicative of SMI who received MHTCM or MHR (C=A/B)	18.6%

NOTES:
(1) MHTCM=Mental Health Targeted Case Management; MHR=Mental Health Rehabilitative Services; SMI=serious mental illness.
(2) Some clients who received MHTCM or MHR have a mental health-related diagnosis that is not included in the definition of serious mental illness, such as children and youth with conditions indicative of a serious emotional disturbance. As a result, the number of clients who received MHTCM or MHR shown is less than the number who received these services shown in Figure 5.
SOURCE: Legislative Budget Board.

abuse, repeated psychiatric hospitalizations, poor self-care, incarceration, and homelessness.

MCOs that participate in the Texas Medicaid program are required to identify Members with Special Health Care Needs (MSHCN). MCOs are required to provide service management to MSHCN that may include development of service plans for members whose needs require care coordination to meet short-term and long-term needs and goals. Service plans are required in STAR+PLUS. SMI may be considered a Special Health Care Need; therefore, these requirements provide an opportunity for MCOs to locate members with an identified SMI and connect them to MHTCM and MHR. HHSC defines MSHCN as members who have the following factors: (1) have a serious ongoing illness, a chronic or complex condition, or a disability that has lasted or is anticipated to last for a significant period; and (2) require regular, ongoing therapeutic intervention and evaluation by appropriately trained healthcare personnel. HHSC requires that Medicaid MCOs designate certain groups of members as MSHCN. Two of these groups, which may include members with SMI or SED, are the following:

- members that have mental illness and co-occurring substance abuse diagnoses; and
- members identified by the MCO as having behavioral health issues that may affect their physical health and treatment compliance.

Option 1 would include a rider in the introduced 2020–21 General Appropriations Bill to require HHSC to monitor regularly the extent to which Texas Medicaid clients are receiving MHTCM and MHR for which they may be eligible. At a minimum, HHSC should determine the number of Medicaid clients who have a mental health-related diagnosis indicative of SMI based on claims or encounter data and calculate the following:

- percentage of Medicaid clients who have a mental health-related diagnosis indicative of SMI who were identified by the MCOs as a Member with Special Health Care Needs;
- percentage of Medicaid clients who have a mental health-related diagnosis indicative of SMI who have a service plan developed by the MCO; and
- percentage of Medicaid clients who have a mental health-related diagnosis indicative of SMI who received MHTCM or MHR.

HHSC also should determine the reasons why clients may not receive services and develop a strategy to ensure that clients receive the services for which they are eligible and desire. The rider also would require HHSC to submit an annual report of the findings to the Legislative Budget Board (LBB) and the Office of the Governor by December 1.

IMPROVE PRIOR AUTHORIZATION POLICIES FOR MENTAL HEALTH TARGETED CASE MANAGEMENT AND MENTAL HEALTH REHABILITATIVE SERVICES

Current prior authorization policies for MHTCM and MHR are inefficient. MHTCM and MHR require prior authorization before a client can receive services. MCOs may choose to waive this requirement. Providers use a uniform assessment process and utilization management guidelines to complete the authorization requests for MHTCM and MHR submitted to MCOs. As of fiscal year 2018, the uniform assessment includes, among other items, use of the Child and Adolescent Needs and Strengths and the Adult Needs and Strengths Assessment tools. These tools help assess a client's need for services. The utilization management guidelines

used are the Texas Resilience and Recovery Utilization Management Guidelines (TRRUMG). TRRUMG describes the type, amount, and duration of MHTCM and MHR that should be provided to each client. The following steps are in this process:

1. Providers enter information from the uniform assessment into the Clinical Management for Behavioral Health Services (CMBHS) web-based system;
2. CMBHS generates a recommended level of care (LOC-R) based on information entered by the provider using an algorithm;
3. The provider evaluates the client's clinical needs to determine if the type and amount of service for the LOC-R described in TRRUMG are sufficient to meet those needs. The provider may deviate from the LOC-R due to clinical need, client choice, or lack of resources when determining the requested level of care;
4. The provider uses a standard prior authorization request form to document the requested level of care, also known as the authorized level of care (LOC-A); and
5. The provider submits the prior authorization request form to the client's MCO.

According to HHSC, the agency has instructed MCOs to accept the level of care requested by providers (i.e., LOC-A) when it does not deviate from the LOC-R. In cases where the provider wants to deviate from the LOC-R, MCOs can modify or deny requests using the same utilization management guidelines used by the providers –TRRUMG. A few MCOs have chosen to waive the prior authorization requirement for MHTCM and MHR. However, many MCOs continue to process prior authorization request forms despite the following requirements: (1) MCOs cannot modify requested levels of care that do not deviate from uniform assessment tool results (i.e., LOC-R); (2) MCOs must use the same utilization management guidelines used by providers when determining deviation requests; and (3) MCOs must approve requests for MHTCM and MHR for clients with schizophrenia or bipolar disorder because these clients are automatically eligible for these services. As a result, the process for authorizing MHTCM and MHR results in unnecessary administrative cost for MCOs and providers due to duplication in effort among these entities. The state eventually incurs greater expense from an increase in these costs through the administrative portion of capitation rates.

Option 2 would amend the Texas Government Code to require HHSC to implement changes to prior authorization provisions for MHTCM and MHR in the Texas Medicaid program to reduce any redundancy and unnecessary administrative cost for MCOs and providers. The amended statute also would require HHSC to modify MCO capitation payments to incorporate decreases in administrative costs. HHSC also would be required to submit a report to the LBB and the Office of the Governor regarding actions performed by September 1, 2020. HHSC should consider discontinuing prior authorization requirements for MHTCM and MHR, especially in cases where the services requested by the provider and determined by the uniform assessment tool do not differ (i.e., LOC-R). If prior authorization is discontinued, MCOs still would be able to perform retrospective utilization reviews to ensure provider adherence to TRRUMG.

STRENGTHEN AGENCY OVERSIGHT OF BEHAVIORAL HEALTH SERVICE DELIVERY

MCOs do not report data that would enable HHSC to monitor adequately the provision of MHTCM and MHR. According to the Institute of Medicine, the structure of the contract between a payer and MCO and the means for monitoring and enforcing the contract are among the most important ways to influence the quality of care. A purchaser of managed care can use a well-written contract to establish what standards it expects from an MCO and to specify how access and quality will be defined, monitored, and managed. Specifications in law, regulations, or contracts are needed to ensure access to care, to maintain the quality of care, and to establish and protect consumers' rights.

MCOs that participate in the Texas Medicaid program must adhere to federal regulations, state laws and rules, and contract requirements. First, Medicaid MCOs must adhere to federal regulations related to the operation of Medicaid managed care in accordance with Medicaid waiver authority pursuant to the U.S. Social Security Act, Section 1115. Federal regulations require MCOs to conduct, among other activities, quality assessment and performance improvement. Second, Texas statute and administrative rules include requirements related to the implementation of Medicaid managed care, including required contract provisions and contract compliance. Medicaid MCOs also must adhere to rules promulgated by the Texas Department of Insurance. Finally, the most detailed listing of Medicaid MCO requirements is in the Uniform Managed Care Contract (UMCC) and the Uniform Managed Care Manual (UMCM). The UMCM contains policies and procedures required of all MCOs participating in the Texas Medicaid program. The UMCM also includes the Consolidated

FIGURE 9
DATA USED BY THE TEXAS HEALTH AND HUMAN SERVICES COMMISSION TO MONITOR BEHAVIORAL HEALTH SERVICE DELIVERY IN TEXAS MEDICAID MANAGED CARE, FISCAL YEAR 2018

DATA COLLECTION AREAS	BEHAVIORAL HEALTH	MHTCM AND MHR
Prior authorization requests and determinations	No	No
Member complaints	Yes	No
Member appeals	Yes	No
Provider complaints	Yes	No
Network adequacy	Yes	Yes
Claims processing, including provider appeals	Yes	No
Performance measures	Yes	No
Quality Assessment and Performance Improvement Program reports	Yes	No
Behavioral Health Services Hotline Report	Yes	N/A
Customer satisfaction	Yes	No

NOTE: Within the broader category of behavioral health services, Medicaid funds mental health services, including Mental Health Targeted Case Management (MHTCM) and Mental Health Rehabilitative Services (MHR).
SOURCE: Legislative Budget Board.

Deliverables Matrix that lists all reports that MCOs are required to submit to HHSC. The UMCC includes requirements specifically related to the delivery of behavioral health services.

MHTCM and MHR are intended to improve or maintain a client's ability to remain fully integrated and functioning in the client's community. As a result, Texas Medicaid clients with an SMI or SED may experience negative outcomes if they fail to receive these services in a timely manner. As shown in **Figure 9**, HHSC collects data in several areas that are used to monitor MCO performance related to the delivery of behavioral health services. However, MCOs do not report most data separately for MHTCM or MHR, which are subsets of behavioral health services. As a result, it is not possible for the state to ensure that access to MHTCM and MHR for Medicaid managed care clients is adequate.

One key area where the state can monitor MCO performance is prior authorizations. For example, the state can use prior authorization data to identify MCOs with a greater-than-average number of adverse determinations for MHTCM or MHR and evaluate potential effects on clients and providers. HHSC reports that it does not review prior authorization documents specific to behavioral health services, but it has a long-term plan to perform this review. Furthermore, HHSC was unable to provide LBB staff with data regarding prior authorizations for MHTCM or MHR submitted by providers to MCOs, including the number of requests and determinations. The state's external quality review organization (EQRO) conducted biennial behavioral health surveys of Texas Medicaid managed care members in 2017. As shown in **Figure 10**, most members responding to the survey reported experiencing delays in counseling or treatment while waiting for approval from their MCOs or BHOs. In addition, some members reported that the MCOs denied the requests made by their behavioral health providers for additional treatment. These findings are similar to results of the American Medical Association's December 2017 survey of physicians practicing in the U.S. This survey found that 92.0 percent of physicians reported that prior authorization processes delay access to necessary care and can have negative effects on patients' clinical outcomes.

Option 3 would amend the Texas Government Code to require HHSC to ensure that its oversight of behavioral health service delivery in Medicaid managed care includes the tracking and publishing of certain data. This data should include the areas of member complaints and appeals, provider complaints and appeals, network adequacy, claims processing, utilization management, customer satisfaction, and performance measures. HHSC would be required to ensure that data is reported separately for MHTCM and MHR. HHSC should consider performing the following actions:

1. Amend the UMCC and the UMCM, including the Consolidated Deliverables Matrix, to include additional requirements related to increased oversight of behavioral health services;
2. Require MCOs to file quarterly Behavioral Health Reports (with breakouts for MHTCM and MHR)

FIGURE 10
TEXAS MEDICAID STAR ADULT, STAR CHILD, AND STAR+PLUS BEHAVIORAL HEALTH SURVEY QUESTIONS REGARDING ACCESS TO CARE, CALENDAR YEAR 2017

	PERCENTAGE ACROSS MCOS		
QUESTION	STAR ADULT	STAR CHILD	STAR+PLUS
Never or sometimes got professional counseling needed on the phone.	62.0%	66.1%	53.8%
Never or sometimes saw someone for counseling or treatment as soon as wanted when needing care right away.	33.7%	26.0%	42.7%
Never or only sometimes got an appointment for counseling or treatment as soon as wanted when not needing care right away.	29.2%	25.8%	30.8%
Getting the counseling or treatment needed was a problem.	29.8%	18.4%	31.2%
Delays in counseling or treatment were a problem while waiting for approval.	56.2%	48.6%	58.2%
Health plan denied behavioral health provider request for additional treatment	10.8%	17.0%	17.3%

NOTE: MCO=managed care organization.
SOURCE: Texas External Quality Review Organization, University of Florida Survey Research Center.

that include key utilization and performance data, including the amount and type of services provided;
3. Modify processes to categorize and report provider and member complaint and appeal data, network adequacy, and claims processing reports to provide a breakout for MHTCM and MHR;
4. Monitor MCO utilization management functions by analyzing and reporting prior authorization and retrospective utilization review data. At a minimum, tracked data should include number of requests or reviews, initial and final determinations, and average wait time for determinations. If HHSC decides to discontinue prior authorization for MHTCM and MHR, agency review of utilization management functions still should include retrospective utilization review data;
5. Modify the biennial behavioral health surveys conducted by the state's EQRO to include a subset of questions specific to MHTCM and MHR;
6. Develop and implement a biennial behavioral health survey for STAR Health and STAR Kids; and
7. Establish a mechanism to obtain timely feedback from providers.

As shown in **Figure 11**, recent legislation requires HHSC to improve efforts to serve Medicaid clients that have SMI. HHSC could modify action performed on these efforts to include oversight mechanisms proposed in Option 3.

REPORT FEEDBACK RECEIVED REGARDING THE DELIVERY OF MENTAL HEALTH TARGETED CASE MANAGEMENT AND MENTAL HEALTH REHABILITATIVE SERVICES

HHSC lacks a formal mechanism to receive feedback regarding the provision of MHTCM and MHR. Senate Bill 58, Eighty-third Legislature, Regular Session, 2013, established the Behavioral Health Integration Advisory Committee (BHIAC). The membership of this committee included representation from consumers, managed care organizations, and public and private providers. The committee was required to meet at least quarterly and to issue formal recommendations to HHSC regarding the integration of behavioral health services, including MHTCM and MHR, and physical health services into Texas Medicaid managed care. The BHIAC was abolished January 2016 pursuant to Senate Bill 200, Eighty-fourth Legislature, 2015. In its final formal report issued in July 2015, the BHIAC wrote that its members were concerned that the elimination of the advisory committee would impede transformation of the system. The report included the following statement:

> This report recommends high-level policy changes but many decisions must be made as operational procedures are written. Without the BHIAC, or another committee with similar membership, HHSC will not have a stakeholder voice in the process of implementation. The BHIAC can provide continuity of feedback to HHSC from high-level policy to operational procedures if it is not eliminated.

Since the dissolution of the BHIAC, no formal reports have been submitted to HHSC by a collective group of consumers, providers, and managed care organizations, regarding

FIGURE 11
RECENT TEXAS LEGISLATION RELATED TO MEDICAID SERVICES FOR INDIVIDUALS THAT HAVE SERIOUS MENTAL ILLNESS FISCAL YEARS 2015 TO 2018

BILL OR RIDER	PROVISIONS RELATED TO SMI POPULATION	ACTION REPORTED BY HHSC
Senate Bill 200, Eighty-fourth Legislature, 2015	Requires the Health and Human Services Commission (HHSC) to monitor compliance with behavioral health integration, including: (1) ensure that managed care organizations (MCO) fully integrate behavioral health services into a client's primary care coordination; (2) use performance audits and other oversight tools to improve monitoring of the provision and coordination of behavioral health services; and (3) establish performance measures that may be used to determine the effectiveness of the integration of behavioral health services. Requires HHSC to give particular attention to MCOs that provide behavioral health services through a contract with a third party.	HHSC reviewed related contract provisions and identified additional monitoring mechanisms, including reporting of incorporating integration into quality improvement plans and provider contract provisions to ensure that MCOs are requiring primary care providers and behavioral health providers to coordinate. HHSC is tracking performance measures related to integration. HHSC analyzed potentially preventable events among members that have behavioral and physical health conditions and plans to work with MCOs to improve outcomes. HHSC surveyed MCOs to measure integration and is using the information to inform contract changes.
Eighty-fourth Legislature, General Appropriations Act (GAA), 2016–17 Biennium, HHSC, Rider 29, Monitor the Integration of Behavioral Health Services, and Eighty-fifth Legislature, GAA, 2018–19 Biennium, HHSC, Rider 29, Monitor the Integration of Behavioral Health Services	Requires HHSC to monitor the integration of behavioral health services into Medicaid managed care and to prioritize monitoring MCOs that provide behavioral health services through a contract with a third party.	Same action as Senate Bill 200, 2015. HHSC also added an MCO contract requirement specific to network adequacy for Mental Health Targeted Case Management (MHTCM) and Mental Health Rehabilitative Services (MHR) providers effective September 1, 2018.
Senate Bill 74, Eighty-fifth Legislature, Regular Session, 2017	Clarifies that a provider that is not a local mental health authority (LMHA) may contract with an MCO to provide MHTCM, and MHR to children, adolescents, and their families. Streamlines credentialing requirements and restricts application of certain rules and guidelines in an attempt to increase the number of these providers. Establishes requirements for MCOs that provide behavioral health services through contracts with third parties or arrangements with subsidiaries of the MCO related to data sharing, colocation of physical and behavioral healthcare coordination staff, certain call transfers, sharing of clinical information (joint rounds), and a seamless provider portal.	HHSC met with stakeholders in January 2018 and made changes to administrative rules effective October 17, 2018, and MCO contracts effective September 1, 2018.
2018–19 GAA, HHSC, Rider 45, Managed Care Organization Services for Individuals with Serious Mental Illness	Requires HHSC to improve efforts to serve individuals with serious mental illness better, including developing performance metrics to hold MCOs accountable for care provided to this population. The agency must submit a report to the Legislative Budget Board and the Office of the Governor by November 1, 2018. Authorizes HHSC, if cost-effective, to develop and procure an alternative model of managed care in at least one service delivery area of the state to serve individuals with serious mental illness in Medicaid and CHIP. HHSC must submit a report before any relevant procurement regarding why it did not develop and procure an alternative model, including an explanation of how HHSC and MCOs will serve better those with severe mental illness in existing managed care service models.	HHSC worked to increase the number of performance measures used to monitor outcomes for clients that have serious mental illness (SMI) and submitted the report due November 1, 2018. HHSC also submitted an initial report regarding MCO services for individuals with SMI in November 2017 that documented its decision to not pursue an alternative model for SMI as part of the STAR+PLUS reprocurement. HHSC continues to evaluate the feasibility and cost-effectiveness of procuring an alternative model of managed care for members that have SMI. HHSC plans to issue a Request for Information regarding how MCOs might operationalize an alternative model in the existing market.

FIGURE 11 (CONTINUED)
RECENT TEXAS LEGISLATION RELATED TO MEDICAID SERVICES FOR INDIVIDUALS THAT HAVE SERIOUS MENTAL ILLNESS FISCAL YEARS 2015 TO 2018

BILL OR RIDER	PROVISIONS RELATED TO SMI POPULATION	ACTION REPORTED BY HHSC
2018–19 GAA, HHSC, Rider 77, Medicaid Services Capacity for High-needs Children in the Foster Care System	Allocates $2.0 million in General Revenue Funds for fiscal year 2018 to establish a statewide grant program to increase access to Targeted Case Management and Rehabilitation for high-needs children in the foster care system. The onetime grant program may provide funds to LMHAs and other nonprofit entities. HHSC is required to enter into a no-cost agreement with a nonprofit third party that will act as administrator of the initiative. HHSC is required to provide monthly updates regarding the number of entities that have been credentialed or have expanded services and the number of children in the foster care system that receive services from newly credentialed or expanded entities.	As of October 2018, HHSC plans to execute contracts during the first quarter of fiscal year 2019 with the entities who will receive grant funds.

SOURCE: Legislative Budget Board.

integration of physical and behavioral health services, including MHTCM and MHR, into Texas Medicaid managed care. As a result, it is difficult for the Texas Legislature to monitor stakeholder feedback regarding the integration of these services.

HHSC established the Behavioral Health Advisory Committee (BHAC) in July 2016 in response to federal law that requires states that receive certain federal grant funds to establish and maintain a state mental health planning council. The membership of this committee includes representation from consumers, managed care organizations, and public and private providers. The purpose of the committee is to provide stakeholder feedback to the state Health and Human Services system in the form of recommendations regarding the allocation and adequacy of behavioral health services and programs within Texas. Option 4 would include a rider in the introduced 2020–21 General Appropriations Bill to require HHSC to submit an annual report to the LBB and the Office of the Governor outlining feedback received from the BHAC regarding delivery of MHTCM and MHR in the Texas Medicaid program by December 1. One stated task of the BHAC is to issue recommendations regarding the integration of behavioral health services and supports with physical health service delivery. HHSC should include any BHAC recommendations related to this task that are specific to MHTCM or MHR in its report to implement Option 4.

FISCAL IMPACT OF THE OPTIONS

The options in this report would direct HHSC to take steps to help ensure that Medicaid clients with SMI or SED receive adequate care. These options would direct HHSC to monitor receipt of MHTCM and MHR among clients, improve prior authorization policies, strengthen agency oversight of behavioral health service delivery, and report feedback received regarding delivery of these services.

It is assumed that Options 1, 3, and 4 would have no significant fiscal impact and could be implemented using existing resources. These options may result in Medicaid clients' increased access to MHTCM and MHR, improved client functioning, and reduced hospitalizations. If the options increase use of MHTCM or MHR, then MCOs and, ultimately, the state could incur a cost. However, if increased utilization of MHTCM or MHR results in reduced hospitalizations because client functioning has improved, the increased cost from expanding access to these services may be offset by reduced hospital spending. Modifications to costs and savings would accrue to MCOs unless the capitation amounts paid by HHSC to MCOs are adjusted to include these changes.

In accordance with Option 2, if HHSC discontinues prior authorization requirements for Medicaid MHTCM and MHR, there could be savings during the 2020–21 biennium due to reduced administrative costs currently incurred by MCOs to process prior authorization requests submitted by providers. The savings would be achieved by requiring HHSC to reduce the portion of the capitation rates paid to

MCOs for fixed administrative costs. These amounts cannot be estimated at this time.

The introduced 2020–21 General Appropriations Bill does not include any adjustments as a result of these options.