IMPROVE OPERATION OF THE STAR KIDS PROGRAM

The Eighty-third Legislature, Regular Session, 2013, directed the Health and Human Services Commission to establish a Medicaid managed-care program for children with disabilities intended to improve coordination and access to care while achieving cost containment. The new program, called STAR Kids, provided services to approximately 160,000 children during fiscal year 2018 at a cost of $3.3 billion in All Funds.

Through STAR Kids, the Health and Human Services Commission contracts with managed care organizations to provide medical services and coordinate care.

Before contracting with managed care organizations, the state contracted directly with providers and a third-party claims administrator that conducted prior authorizations on behalf of the state. In the current model, the Health and Human Services Commission monitors 10 managed care organizations that provide care throughout the state, each of which has different policies and procedures.

The Health and Human Services Commission is developing a methodology for monitoring and evaluating the performance of STAR Kids managed care organizations. The agency also has taken actions in response to several concerns. These concerns include appropriate access to care, uneven distributions of high-cost members among different managed care organizations, flaws identified in the agency's procurement process, and the adequacy of its oversight mechanisms and activities. However, the agency and the children enrolled in STAR Kids would benefit from legislative direction and resources to enable key oversight activities and changes to the program.

FACTS AND FINDINGS

- Studies conducted before fiscal year 2013 suggest that most Medicaid managed-care members in Texas were able to access routine primary care in a timely manner. Most members also were either satisfied or very satisfied with the health plans they chose in surveys conducted by the state's external quality review organization. Reviews of access to long-term services and supports such as those in STAR Kids, however, have generated concern.

CONCERNS

- The successful operation of STAR Kids depends on selecting high-performing vendors to promote competition based on quality and efficiency. However, according to a State Auditor's Office report published in July 2018, the agency made significant evaluation scoring errors in selecting vendors in the 2014 procurement. The agency also lacked appropriate documentation, and, as a result, the State Auditor's Office could not determine whether the evaluation scores supported the award recommendations. A number of the vendors selected had histories of performance issues.

- According to an external quality review organization for Texas Medicaid, differences in provider networks can result in some managed care organizations attracting higher-cost populations than others. When the Health and Human Services Commission set capitation rates for the first year of STAR Kids, it made no adjustments for differences in members' health status. During the first two years of the program, managed care organizations that attracted and retained children with more intensive needs spent more on medical expenses than the state provided in capitation payments. By contrast, plans with healthier children have spent less of their premiums on medical costs and have reported net profits. The uneven distribution of high-needs members continued to affect the financial performance and viability of health plans during the second year of the program.

- Service coordinators work directly for managed care organizations and are the primary source of information used to determine Medicaid eligibility for a number of the highest-need children in STAR Kids.

- Service coordinators in STAR Kids assess need and coordinate services, particularly long-term services and supports. The staff tasked with this responsibility may have large caseloads that limit the extent to which they can coordinate care.

- To date, the performance of some managed care organizations in STAR Kids regularly has not met contract standards. Service planning and

care coordination activities vary considerably among plans. Data show substantial variations in service denial rates by managed care organizations and decreases in utilization of critical services. Furthermore, the percentage of out-of-network claims for some plans exceeds the state's standards, indicating potentially inadequate networks. Despite recent efforts to improve oversight, gaps in the Health and Human Services Commission's oversight of the program remain. For example, the agency has not conducted utilization reviews for high-needs children to ensure appropriate service planning and access to care. Although the agency plans to add this utilization review for fiscal year 2020, it reports lacking the resources to conduct these reviews for each managed care organization.

- The Health and Human Services Commission has established a formal overall strategy for monitoring and improving quality in Medicaid consistent with state and federal requirements. However, as of September 2018, the agency was developing performance measures and monitoring for the STAR Kids program.

OPTIONS

- **Option 1:** Direct the Health and Human Services Commission to reprocure STAR Kids services as soon as possible to ensure that the state uses an effective and consistent process for awarding contracts to promote competition based on quality and efficiency.
- **Option 2:** Direct the Health and Human Services Commission to evaluate risk-adjustment methods used for STAR Kids to improve the relationship between capitation rates and distributions of high-cost members.
- **Option 3:** Amend statute to provide access to case management independent of the STAR Kids managed care organization at a member's family's request. This would provide members with an option to receive service coordination and case management services from an entity independent of their managed care organization.
- **Option 4:** Amend statute to require the Health and Human Services Commission to establish caseload guidelines for service coordinators with the goal of improving the ability of STAR Kids managed care organizations to meet assessment and service coordination requirements consistently.
- **Option 5:** Amend statute to require the Health and Human Services Commission to monitor access to care in the STAR Kids program through utilization reviews and service plan monitoring.
- **Option 6:** Amend statute to delay adding new populations with special healthcare needs into capitated managed care until outcomes from STAR Kids can be measured more fully.

DISCUSSION

The Eighty-third Legislature, Regular Session, 2013, passed legislation that required the Health and Human Services Commission (HHSC) to implement a capitated managed-care program for children with disabilities. HHSC transitioned children from Medicaid fee-for-service (FFS) into the new STAR Kids program statewide on November 1, 2016. During fiscal year 2018, STAR Kids provided services to approximately 160,000 children at a cost of $3.3 billion in All Funds.

Figure 1 shows the goals of STAR Kids, which are to improve health outcomes and achieve cost containment. Participation in the capitated managed-care program is mandatory for certain children and young adults age 20 and younger that have disabilities and receive Supplemental Security Income (SSI) and those eligible for services from a long-term care facility. However, the Texas Government Code, Section 533.0025(b), authorizes HHSC to implement alternative models, including a traditional FFS arrangement, if the agency determines that the alternative would be more cost-effective or efficient.

Children enrolled in STAR Kids have access to multiple Medicaid benefits. These benefits include acute care, such as primary care and other short-term medical care, pharmacy, behavioral health, and long-term services and supports (LTSS) through the managed care organization's (MCO) provider network. LTSS includes personal care services, private-duty nursing, and day activity health services. Some children enrolled in additional programs for children with intellectual or development disabilities access LTSS outside of the MCO network.

Children with the greatest healthcare needs may have access to additional services, subject to eligibility and resource availability. The Medically Dependent Children Program (MDCP) is a subprogram for the highest-need children within STAR Kids. Its goal is to support families caring for children and young adults age 20 and younger to prevent institutionalization of those who otherwise would reside in

FIGURE 1
STATUTORY GOALS FOR STAR KIDS PROGRAM, EFFECTIVE SEPTEMBER 2013

- provide benefits tailored to meet members' heathcare needs;
- better coordinate and improve access to care;
- improve health outcomes;
- achieve cost containment and cost efficiency;
- reduce administrative complexity of delivering care;
- reduce incidence of unnecessary institutionalization and potentially preventable events by ensuring availability of appropriate services and care management;
- require a health home; and
- improve coordination with long-term care providers, for members receiving long-term services and supports outside of the managed care organization

SOURCE: The Texas Government Code, Section 533.00253(b).

nursing facilities. For many families, enrollment in MDCP is critical for ensuring that they can afford to keep their children in the community. Enrollment is subject to a cap established by HHSC and the Legislature through the appropriation of slots. The primary additional service in this program used by members' families is respite care, which is care delivered temporarily to relieve the primary caregiver.

TRANSITION FROM FEE-FOR-SERVICE PROGRAM TO STAR KIDS

HHSC transitioned all eligible children in the state from Medicaid fee-for-service into STAR Kids on November 1, 2016. In October 2016, the STAR Kids Managed Care Oversight Committee had recommended delaying implementation for children with complex medical conditions, such as those in MDCP and other waiver programs. The Committee was created by the program's enabling legislation and includes representatives from families, providers, and MCOs. Because children in MDCP would otherwise be eligible for admission to a nursing facility and experienced the largest change in how their services were delivered with the creation of STAR Kids, they are generally considered to be most at risk of harmful disruptions in care within STAR Kids. HHSC did not accept the committee's recommendation that the agency refine the program and make it fully operational before adding the highest-risk populations.

This approach to adding LTSS populations to managed care differs from that in five other states studied by Mathematica Policy Research. In a March 2016 study conducted for the U.S. Medicaid and CHIP Payment and Access Commission, they found that Arizona, Florida, Illinois, New York, and Wisconsin used gradual regional expansions to implement their new models of expanded managed LTSS.

VENDOR RESPONSES AND SELECTION

To implement STAR Kids successfully, selecting high-performing vendors is important to promoting competition in the provision of high-quality care. However, according to a July 2018 report from the State Auditor's Office (SAO), HHSC made significant evaluation scoring errors in selecting vendors during the 2014 STAR Kids procurement. The agency also lacked documentation of the evaluation process. As a result, SAO was unable to determine whether the evaluation scores supported the award recommendations. HHSC's criteria for selecting STAR Kids vendors included "the extent to which MCO's goods and services met the needs of HHSC and members" and "positive indicators of probable MCO performance." To assess probable performance, HHSC required each MCO to describe any actions, sanctions, or fines issued by a regulatory entity against the MCO or its affiliates from calendar years 2011 to 2014. Legislative Budget Board (LBB) staff reviewed portions of the evaluation tool and the MCOs' responses to understand how HHSC considered prior performance and how MCOs' corporate backgrounds relate to current performance.

Scoring for this criterion across HHSC reviewers was inconsistent. **Figure 2** shows the number of actions each MCO included in its response. Some companies with more sanctions received high scores from some reviewers. Among MCOs with relatively lower numbers of sanctions, some reviewers expressed concerns based on the nature of the sanctions.

MCOs did not include clear descriptions consistently for many sanctions. Some of the descriptions, for example, simply state that the MCO failed to meet a contract requirement. One MCO received a $2.4 million penalty that it described as "disincentives for seven measures."

MCOs described regulatory actions, sanctions, and fines that included issues pertaining to the following topics:

- inaccurate provider directories;
- failing to accurately describe benefits and coverage to members;
- failing to respond to member appeals of benefit denials in a timely manner;
- inadequate networks;
- failing to meet minimum standards for access to care;
- improper care management;
- failing to use appropriate criteria when making coverage determinations;
- failing to provide medically necessary services;
- deceptive marketing practices;
- failing to pay providers in a timely manner; and
- submitting inaccurate information to government agencies.

Many of the sanctions pertained to Medicaid contracts, including some within Texas, and were relevant to the types of complex care provided in STAR Kids. HHSC reviewers sometimes described the sanctions listed by MCOs as concerning and potentially disqualifying. With one exception, every company that provided a response was awarded a contract.

In addition to problems with HHSC's scoring methodology, the procurement process was affected by a limited number of vendors from which the agency had to choose. Federal rules require HHSC to provide at least two plans per region, unless granted an exception. In two of 13 STAR Kids regions, two health plans responded to the request for proposal. Both plans reported sanctions and regulatory actions taken against them during the three years before the STAR Kids procurement.

Current contracts are effective through August 31, 2019. The terms of the contracts give HHSC the option to renew the contracts for up to eight additional years. Option 1 would direct HHSC to reprocure STAR Kids services as soon as possible to ensure that HHSC uses an effective and consistent process for awarding contracts to promote competition based on quality and efficiency.

FIGURE 2
REGULATORY ACTIONS FROM CALENDAR YEARS 2011 TO 2014 REPORTED BY STAR KIDS MANAGED CARE ORGANIZATIONS IN REQUEST FOR PROPOSAL RESPONSE, 2014

ACTIONS (1)	MANAGED CARE ORGANIZATION
0	Children's Medical Center Dallas
Less than 100	Blue Cross Blue Shield, Community First, Cook Children's, Superior, Texas Children's
300 to 500	Aetna, Amerigroup, Molina (2)
More than 1,000	United

NOTES:
(1) Plans may have counted multiple regulation actions taken on the same day as a single action.
(2) Molina was not awarded a contract.
SOURCES: Legislative Budget Board; Health and Human Services Commission.

In reprocuring services for STAR Kids, HHSC should ensure that there are an adequate number of vendors with a history of consistently meeting contract standards to promote this type of competition. Statute authorizes HHSC to implement alternative models or arrangements, including a traditional FFS arrangement, if the agency determines that the alternative would be more cost-effective or efficient. If the agency is unable to attract an adequate number of qualified, high-performing vendors, it may be necessary for HHSC to use an alternative model in regions that lack adequate competition.

CAPITATION RATE-SETTING ASSUMPTIONS

MANAGED CARE EFFICIENCY ASSUMPTION

Statute requires HHSC to pay MCOs using a capitated rate in STAR Kids. Capitated rates are set for a group of people based on their expected health costs in a year. In STAR Kids, HHSC pays each MCO a certain amount per person enrolled with the company. If the total amount determined at the beginning of the year is not sufficient to pay for all the services needed by those people, the MCO experiences a financial loss.

Historically, HHSC actuaries have noted that the additional administrative cost of using MCOs requires offsetting decreases in medical expenditures to maintain cost neutrality. For STAR Kids, during fiscal year 2017, the actuaries decreased the base of FFS claims used to set managed care premiums by 3.9 percent based on a managed-care efficiency assumption. For fiscal year 2018, the decrease was 7.5 percent. According to HHSC, actuaries anticipate increasing this efficiency assumption to 8.4 percent in the future.

However, according to the actuaries, adequate utilization data relevant to these assumptions, such as inpatient days, outpatient visits, and office visits were not available in a credible format during the rate development process.

RISK ADJUSTMENT

Acuity describes the health status of members. Member acuity is not distributed equally across MCOs in STAR Kids, and according to the external quality review organization (EQRO) for the Texas Medicaid program, differences in provider networks among MCOs can predispose certain plans to attracting higher-cost populations. Additionally, some regions may include populations whose cost are higher than other regions. To account for these differences in managed care, actuaries typically adjust the capitation rates to account for differences in health status that are related to cost. The goal of these risk adjustments, according to the EQRO, is to ensure that premiums meet the following standards:

- equitably adjust capitation rates to account for differences in the average member health status at each MCO;
- minimize the incentive for health plans and providers to enroll healthy members selectively; and
- provide adequate reimbursement to MCOs whose providers treat sicker-than-average populations.

However, when HHSC set capitation rates for the first year of STAR Kids, from November 2016 to August 2017, it did not adjust for differences in members' health status between MCOs. One reason was because HHSC could not predict the enrollment choices of families. Members select a health plan when they enroll in STAR Kids. Some families choose plans for their children that contract with preferred specialty providers. If the family does not select a health plan, HHSC automatically assigns the member one based on the MCO with which its primary care physician contracts and other considerations, including market share by MCO.

HHSC made the first risk adjustment to the STAR Kids capitation rates effective September 1, 2017. The categories used by HHSC to set risk adjustments for STAR Kids are based on Medicaid managed care spending on clients nationally. However, data used to develop these categories do not include significant amounts of LTSS commonly used by children in STAR Kids. These populations typically have not been enrolled in managed-care programs elsewhere. There is also typically a lag to incorporate new data. Therefore, LTSS costs may not be accounted for adequately in the model that HHSC uses to set risk adjustments. LTSS costs are a significant expense for health plans in STAR Kids. During fiscal year 2017, for example, 37.5 percent of medical expenses at STAR Kids MCOs were for LTSS.

According to federal rules for Medicaid managed care, states should seek to set capitation rates, including the risk adjustment, so that MCOs spend at least 85 percent of their premiums on medical expenses. The relationship between medical expenses and premiums is called the medical loss ratio (MLR). A ratio of at least 85 percent ensures that no more than 15 percent of premiums is expended on administrative costs and profits. Activities intended to improve quality, such as care coordination, are considered medical expenses.

Although CMS does not set a maximum MLR, the ratio should provide MCOs with a reasonable portion of the premium to pay administrative costs. The rate-setting process also should protect against an MLR that is too high. According to CMS, if an MLR is too high, "there is a possibility that the capitation rates were set too low, which raises concerns about enrollees' access to services, the quality of care, provider participation, and the continued viability of the Medicaid managed care plans in that market." CMS considers an MLR of greater than 100 percent to be extremely high. As shown in **Figure 3**, from November 2016 to April 2018, six of the 10 STAR Kids health plans had MLRs greater than 100 percent. MCOs collectively reported spending 95.4 percent of premiums on medical expenses during this period.

In addition to the risk adjustment, HHSC made other changes to the rates effective September 1, 2017, such as increasing the cost-savings assumption across MCOs. **Figure 4** shows the MLR for all STAR Kids MCOs combined before and after the rate changes.

Since this rate adjustment took effect, preliminary data indicate that MCOs collectively have spent 96.8 percent of their premium revenues for medical expenses through April 2018. Aetna reported an MLR of 81.4 percent, Amerigroup reported 83.4 percent. Superior reported an MLR of 89.9 percent, Cook reported 94.6 percent, and Texas Children's reported an MLR of 97.2 percent. The remaining five MCOs reported MLRs of greater than 100.0 percent.

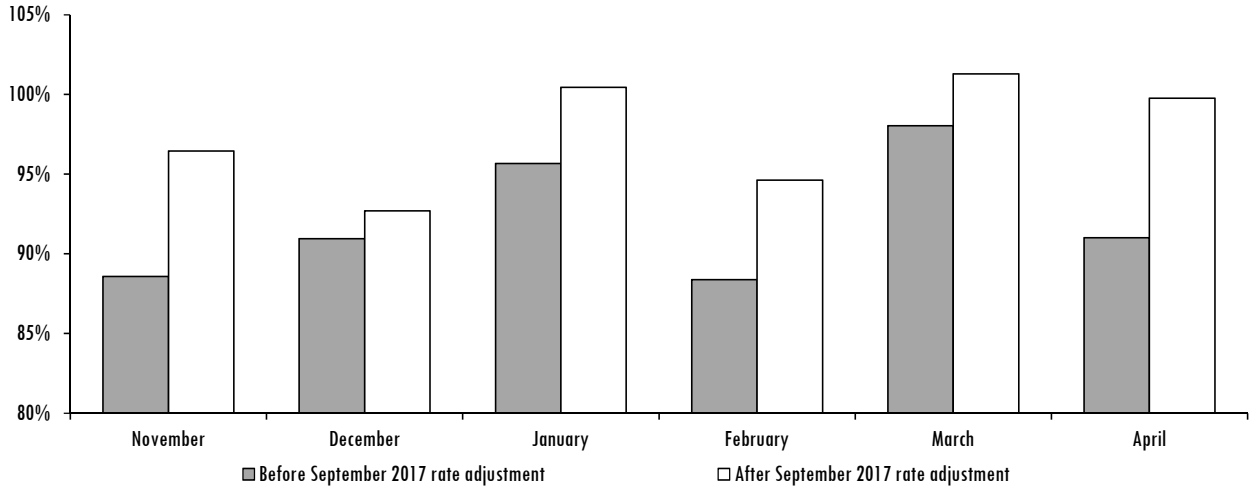
Figure 5 shows the MLR and acuity scores for every STAR Kids region and MCO. The acuity index is the sum of the acuity scores; plot points further to the right reflect health plans with higher-need children. Fiscal year 2017 shows a

FIGURE 3
STAR KIDS PROGRAM MANAGED CARE ORGANIZATIONS' REVENUES AND EXPENDITURES NOVEMBER 2016 TO APRIL 2018

($ IN MILLIONS) MANAGED CARE ORGANIZATION	ENROLLMENT (1)	PREMIUM REVENUES AFTER TAXES	MEDICAL EXPENSES	QUALITY IMPROVEMENT (2)	ADMINISTRATIVE COSTS	MEDICAL LOSS RATIO (3)	NET PRETAX INCOME (4)
United	30,946	$802.2	$804.6	$42.6	$47.2	100.3%	($49.5)
Superior	28,869	$782.7	$701.2	$43.4	$44.9	89.6%	$36.6
Amerigroup	27,638	$714.0	$560.6	$22.3	$35.9	78.5%	$117.5
Texas Children's	26,161	$806.1	$821.1	$40.8	$49.4	101.9%	($64.4)
Driscoll	10,427	$246.9	$221.4	$21.8	$15.8	89.7%	$9.7
Children's Medical Center Dallas	9,444	$363.8	$415.6	$17.3	$26.4	114.2%	($78.2)
Cook	9,365	$296.8	$298.6	$24.3	$17.6	100.6%	($19.4)
Community First	7,965	$261.3	$268.3	$9.1	$17.5	102.7%	($24.5)
Blue Cross Blue Shield	7,869	$216.8	$219.2	$6.3	$34.7	101.1%	($37.1)
Aetna (5)	4,911	$111.6	$80.9	$4.7	$7.8	72.5%	($23.0)
Total	**163,595**	**$4,602.3**	**$4,391.4**	**$232.7**	**$297.1**	**95.4%**	**($86.2)**

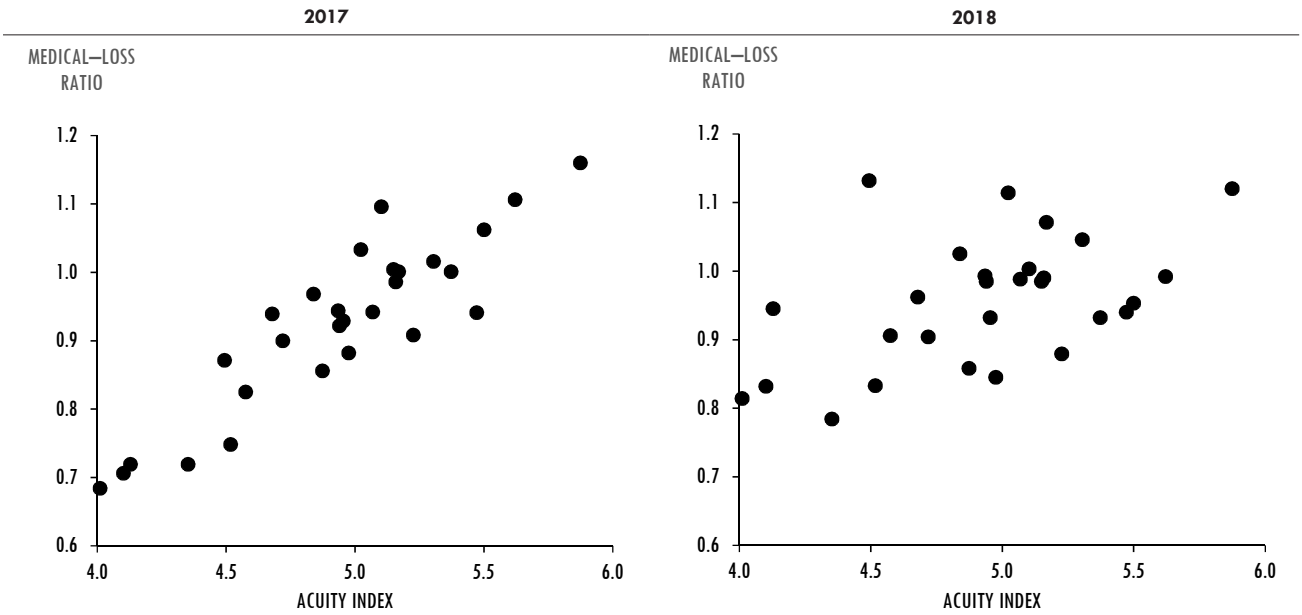
NOTES:
(1) Not reported in millions. Enrollment is based on managed care organization (MCO) reported enrollment in February 2018.
(2) Quality improvement is a subset of medical expenses.
(3) Medical loss ratio equals medical expenses divided into premium revenues after taxes. Consistent with federal guidance, medical expenses used for the medical loss ratio include quality improvement expenses at the MCO, including care coordination.
(4) Net income before taxes equals premium revenues after taxes minus medical and administrative expenses.
(5) March 2018 and April 2018 data were not available for Aetna.
(6) Financial data does not represent any experience rebate collections. MCOs with profits will share some of these profits with the Health and Human Services Commission.
SOURCES: Legislative Budget Board; Health and Human Services Commission.

FIGURE 4
MEDICAL LOSS RATIO FOR ALL MANAGED CARE ORGANIZATIONS IN STAR KIDS PROGRAM NOVEMBER 2016 TO APRIL 2017 AND NOVEMBER 2017 TO APRIL 2018



NOTE: March 2018 and April 2018 data were not available for Aetna. Aetna represented approximately 3.0 percent of program revenues during the previous period.
SOURCES: Legislative Budget Board; Health and Human Services Commission.

FIGURE 5
MEDICAL LOSS RATIO AND ACUITY SCORES BY REGION AND MANAGED CARE ORGANIZATIONS
FISCAL YEARS 2017 AND 2018 THROUGH APRIL 2018



NOTE: The acuity index is the sum of acuity scores for risk groups estimated by the external quality review organization for fiscal year 2017 for five categories. The five scores were summed to establish a proxy for the acuity of members at each health plan. This index is not weighted for the enrollment size of each group and is, therefore, an approximation. A higher acuity score indicates greater healthcare needs. Financial data for March 2018 and April 2018 data were not available for Aetna.
SOURCES: Legislative Budget Board; Health and Human Services Commission.

strong relationship between an MCO's financial performance and the acuity of its members.

After the first rate adjustments, there was still a relationship between the health status of a plan's members in the first year and their financial performance in the second year. This indicates that the uneven distribution of high-needs members continued to affect the financial performance and viability of health plans during the second year of the program.

According to the Texas Association of Health Plans, which represents the STAR Kids MCOs, the risk-score adjustment needs improvement. According to the CEO of a STAR Kids MCO, without improvements to the risk-score adjustment, health plans may need to discourage the enrollment of high-cost members to be financially viable.

Option 2 would direct HHSC to evaluate risk-adjustment methods for the STAR Kids program to improve the relationship between capitation rates and distributions of high-cost members. HHSC could consider multiple options to improve risk adjustment, such as adjusting the weights used for risk scoring to incorporate LTSS cost data. The agency also could consider establishing cost-sharing among MCOs for members whose costs exceed a certain threshold, to reduce the impact of unevenly distributed catastrophic cases.

MCO PERFORMANCE AND CONTRACT STANDARDS

Evidence suggests that some MCOs in STAR Kids have not regularly met performance standards established in the contracts. Service planning and care coordination outcomes vary considerably among MCOs. Data show substantial variations in service denial rates by MCOs and declines in utilization of services critical for STAR Kids clients. Furthermore, the percentage of out-of-network claims for some MCOs exceeds standards, which indicates networks that may be inadequate.

SERVICE PLANNING AND CARE COORDINATION

Historically, some caregivers for children reported difficulty accessing services when they were enrolled in FFS Medicaid, and some caregivers expressed interest in receiving help coordinating care. The EQRO for the Texas Medicaid program identified access to care coordination as an issue to monitor and improve in STAR Kids.

The Policy Council for Children and Families is an advisory committee tasked by the Legislature with making recommendations to HHSC about STAR Kids. More than 60.0 percent of the voting members are parents of children with disabilities. In March 2014, the council made the following statement in its recommendation against giving assessment and service coordination responsibilities to MCOs:

> Because managed care organizations receive flat, all-inclusive monthly payments for services rendered, they have an inherent incentive to limit the range and intensity of services to plan enrollees. For this reason, service coordination should be provided by an independent entity not affiliated with the MCO.

HHSC assigned responsibility for STAR Kids eligibility assessments and service coordination to MCOs. MCOs can delegate this responsibility to a provider-led health home. However, delegation is not common. As outlined in HHSC's contracts, assessments conducted by MCO service coordinators should identify the needs of STAR Kids members. MCOs also must ensure that members have service plans. Service plan development is intended to be a member-centered planning process directed by members and representing their goals.

Option 3 would amend statute to provide access to independent case management for families in STAR Kids. Stakeholders, including the Policy Council for Children and Families, have advocated for independent service coordination outside of MCOs. Authorizing members to choose independent service coordinators would decrease possible conflicts of interest that might influence needs assessments and eligibility determinations. To minimize complexity and ensure coverage in every STAR Kids region, a single state agency could perform this function. The Department of State Health Services could expand its current case management responsibilities for children and pregnant women to include assessments and coordination for STAR Kids families that select this option.

ASSESSMENTS AND SCREENINGS FREQUENCY

Evidence suggests that MCOs have not met standards consistently for the frequency of assessments and screenings of STAR Kids members. The EQRO has recognized high caseloads in other managed-care programs as a key barrier to effective care coordination. During vendor selection, some HHSC staff expressed uncertainty regarding the care coordinator caseloads that MCOs proposed as part of the contract proposals. Data subsequently provided by HHSC show that after program implementation, some service coordinators whose caseloads included MDCP children had caseloads in excess of 300 children. At another MCO, service coordinators had caseloads averaging more than 250 children, excluding MDCP and other high-needs children.

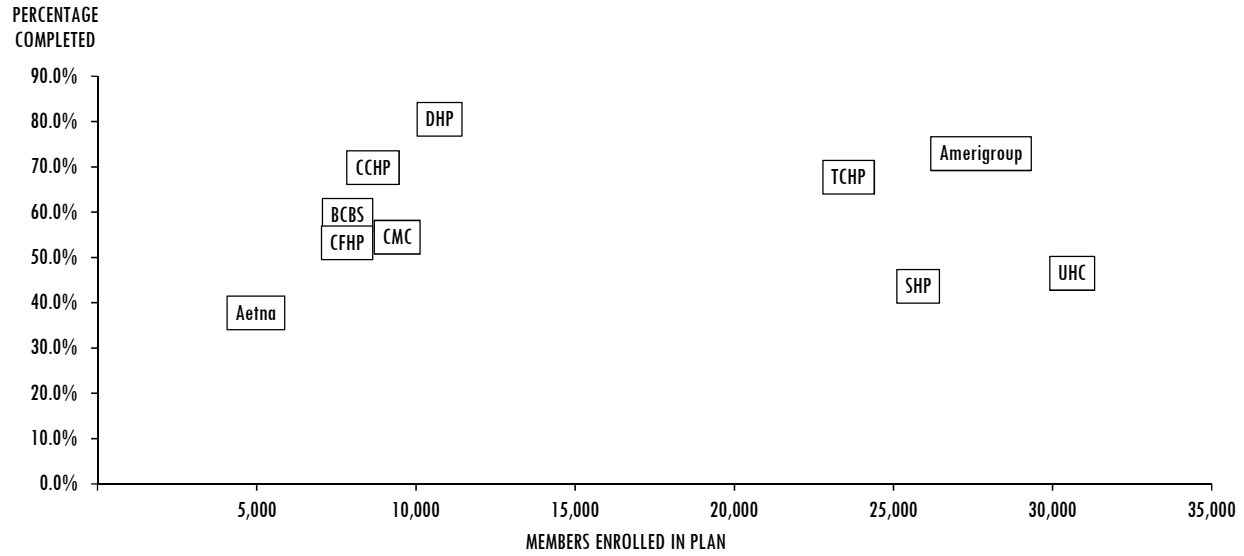
Federal rules and guidance require that MCOs must make "a best effort" to conduct an initial screening for all new members within 90 days to determine their healthcare needs. During the program launch, HHSC provided MCOs six months to conduct assessments. If a member requested immediate services, the deadline was seven business days. In either case, the MCO had to honor prior service plans until it conducted a new assessment.

Four months after implementation, HHSC reported to the STAR Kids Managed Care Advisory Committee that MCOs had completed 34.6 percent of the 77,209 assessments requested by families. In July 2018, HHSC reported that MCOs had completed 58.8 percent of members' comprehensive assessments, which falls short of contractual requirements. This percentage was based on MCO-provided information for assessments completed by February 2018 for members enrolled since at least November 2017. As shown in **Figure 6**, assessment completion percentages among MCOs differed greatly.

According to HHSC data, approximately 1.9 percent of members declined an assessment. MCOs reported the inability to locate or to schedule assessments with 24.9 percent of members. Another 14.4 percent of members did not have an assessment completed for other, unidentified reasons. As shown in **Figure 7**, the HHSC data indicates large variations in MCOs' reported inability to locate members.

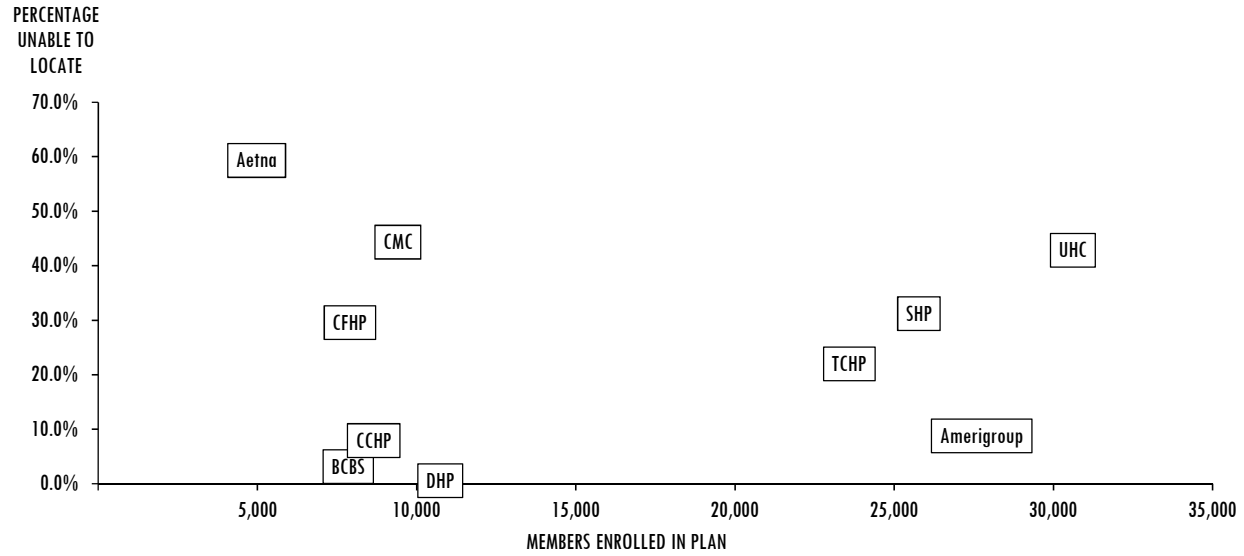
Data indicate that some MCOs are not meeting requirements for frequency of in-person or telephone contacts. HHSC requires MCOs to meet in person at least 4.0 times per year with each of its highest-needs children. This membership includes children enrolled in MDCP, children at risk of institutionalization, and others with complex medical needs. As shown in **Figure 8**, MCOs' average annual in-person contacts ranged from 0.60 at Aetna to 5.49 at Driscoll. The contract also requires at least 12 telephone contacts per year. United and Aetna spoke to members on the phone fewer than 3.0 times per year on average from February 2017 to May 2018, and Driscoll averaged 4.4 phone contacts during that period. All the other MCOs reported averages greater than 11.0, and Blue Cross Blue Shield reported the most at 25.9 contacts per person.

FIGURE 6
PERCENTAGE OF MEMBERS ENROLLED BY NOVEMBER 2017 WITH COMPLETED COMPREHENSIVE ASSESSMENTS BY MANAGED CARE ORGANIZATION, FEBRUARY 2018



Notes:
(1) Percentages represent assessments completed by February 28, 2018. Superior noted completing approximately 22.5 percent of assessments after this date, primarily for individuals enrolled in November 2017. Data was self-reported by managed care organizations and has not been audited by Legislative Budget Board staff.
(2) BCBS=Blue Cross Blue Shield; CMC=Children's Medical Center Dallas; CFHP=Community First Health Plan; CCHP=Cook Children's Health Plan; DHP=Driscoll Health Plan; TCHP=Texas Children's Health Plan; SHP=Superior Health Plan; UHC=United Health Care.
Sources: Legislative Budget Board; Health and Human Services Commission.

FIGURE 7
PERCENTAGE OF MEMBERS ENROLLED BY NOVEMBER 2017 THAT THE MANAGED CARE ORGANIZATION WAS UNABLE TO LOCATE, FEBRUARY 2018



Notes:
(1) Data were self-reported by managed care organizations and has not been audited by Legislative Budget Board staff.
(2) BCBS=Blue Cross Blue Shield; CMC=Children's Medical Center Dallas; CFHP=Community First Health Plan; CCHP=Cooks Children's Health Plan; DHP=Driscoll Health Plan; TCHP=Texas Children's Health Plan; SHP=Superior Health Plan; UHC=United Health Care.
Sources: Legislative Budget Board; Health and Human Services Commission.

FIGURE 8
IN-PERSON ANNUAL CONTACT RATES FOR HIGH-NEEDS CHILDREN BY MANAGED CARE ORGANIZATION FEBRUARY 2017 TO MAY 2018

MANAGED CARE ORGANIZATION	MAY 2017 ENROLLMENT	MEMBERS ENROLLED IN LEVEL OF CARE 1 WITH A COMPLETED ASSESSMENT (1)	AVERAGE NUMBER OF ANNUAL IN-PERSON CONTACTS (1)	PERCENTAGE OF MEMBERS WHO RECEIVED AT LEAST 4.0 IN-PERSON CONTACTS (2)
Aetna	5,215	58	0.60	5.2%
United	30,331	1,291	0.86	13.8%
Superior	29,448	590	2.03	2.4%
Amerigroup	28,150	349	2.19	42.7%
Blue Cross Blue Shield	7,881	190	2.34	24.2%
Cook	8,909	504	3.48	49.0%
Texas Children's	25,583	1,674	3.87	53.7%
Community First	8,038	159	3.92	98.1%
Children's Medical Center Dallas	9,694	411	3.94	53.5%
Driscoll	10,670	99	5.49	85.9%

NOTES:
(1) Includes members whose comprehensive assessments were completed from February 2017 to May 2017 and still were enrolled on April 30, 2018. Contacts are reported through April 30, 2018, for these members.
(2) The contract between the Health and Human Services Commission and managed care organizations requires at least 4.0 contacts per year for members in Level of Care 1, the highest-need group of children enrolled in STAR Kids. Data was self-reported by managed care organizations and has not been audited by Legislative Budget Board staff.
SOURCES: Legislative Budget Board; Health and Human Services Commission.

State and federal guidelines require the assessment and planning processes to be collaborative between providers and driven by members' families. Evidence indicates gaps between these guidelines and actual practice. For example, members of the STAR Kids Managed Care Advisory Committee have reported instances of MCOs not contacting members and not providing members services for which they qualified. The Policy Council for Children and Families requested that HHSC ensure that MCOs are sending families and providers copies of their service plans, and recommended establishing an Internet portal for this purpose that is accessible by families and their providers. Stakeholders in focus groups conducted by Texas A&M University reported that lack of care coordination is a major concern.

Option 4 would amend statute to require HHSC to establish caseload guidelines for MCO service coordinators with the goal of improving the ability of MCOs to meet assessment and service coordination requirements consistently.

HHSC OVERSIGHT OF STAR KIDS MCOS

Since the implementation of managed care for state health programs in Texas, audits have documented problems with HHSC's oversight of managed-care programs similar to STAR Kids that use capitated rates and MCOs. In November 2003, the SAO found that HHSC had not monitored or enforced key MCO contract provisions effectively in Texas Medicaid and Children's Health Insurance Program. In December 2015, internal auditors at HHSC found that STAR Medicaid program and contract staff did not notify MCOs consistently regarding known performance problems. When notification occurred, the agency did not track implementation of corrective action plans consistently. Similarly, in an October 2016 report, SAO found that HHSC did not have a documented process to determine when a corrective action plan should be issued in response to a performance audit in the state's Medicaid managed-care program.

To ensure access to appropriate care, HHSC's monitoring of STAR Kids MCOs' adherence to contract standards should examine performance in the following areas: denials and appeals, utilization trends, network adequacy, and eligibility assessments.

DENIALS AND APPEALS

MCOs manage care through case management and utilization management, including prior authorization. Case management includes the assessment of needs, development of a service plan, and monitoring of the implementation of a care plan. Utilization management can include preadmission screenings and prior authorization of certain medical services,

FIGURE 9
PERCENTAGE OF SERVICE REQUESTS DENIED OR REDUCED BY SERVICE TYPE AND MANAGED CARE ORGANIZATION MARCH 2017 TO FEBRUARY 2018

MANAGED CARE ORGANIZATION	THERAPY SERVICES (1)	DURABLE MEDICAL EQUIPMENT	PRIVATE DUTY NURSING	PERSONAL CARE SERVICES	MDCP RESPITE (2)	COMMUNITY FIRST CHOICE	ALL SERVICES (3)
Superior (4)	23.3%	5.4%	23.6%	15.4%	0.5%	6.8%	**17.1%**
Driscoll	32.4%	4.8%	2.5%	2.7%	0.0%	0.0%	**15.8%**
Blue Cross Blue Shield	16.4%	6.6%	1.9%	1.8%	0.0%	0.5%	**9.5%**
Amerigroup (5)	7.6%	3.7%	19.3%	6.7%	2.0%	1.5%	**7.3%**
Texas Children's	5.8%	4.1%	9.6%	8.1%	2.6%	4.4%	**5.7%**
United	4.0%	12.8%	1.1%	0.0%	0.1%	0.2%	**4.7%**
Children's Medical Center Dallas	0.1%	1.9%	17.5%	1.6%	0.8%	0.2%	**3.1%**
Aetna	3.2%	1.8%	1.0%	0.0%	0.0%	0.0%	**2.4%**
Cook	4.3%	0.8%	3.4%	1.9%	0.0%	0.0%	**2.4%**
Community First	2.4%	2.9%	0.3%	0.3%	0.0%	0.0%	**1.8%**
All MCOs	**10.5%**	**5.1%**	**10.8%**	**6.3%**	**0.8%**	**1.7%**	**8.3%**

NOTES:
(1) Therapy services include occupational, speech, and physical therapy services.
(2) MDCP=Medically Dependent Children Program.
(3) The All Services category represents the total percentage of services denied or reduced for all of the services shown.
(4) A managed care organization (MCO) also may have taken adverse actions and categorized them as a terminated service. Including terminations would increase the percentage of service requests with an adverse determination for all services at Superior to 27.9 percent. This practice was an anomaly among MCOs for the impact of including terminations. According to Superior, this data includes some services authorizations that expired.
(5) Services are ordered based on the most commonly approved services across MCOs. MCOs counted only the final status of a request for service. If a service was requested, initially denied, and then later approved, this instance would count as one approval. Amerigroup counted both the initial denials and final approvals. United did not provide counts of service reductions.
(6) Data was self-reported by health plans and has not been audited by Legislative Budget Board staff.
SOURCES: Legislative Budget Board; Health and Human Services Commission.

retrospective reviews, and general monitoring to evaluate the appropriateness of services.

MCOs may establish their own procedures for reviewing and approving care. State and federal policies, however, require children to have access to similar levels of service across MCOs, each of which must provide at least the services specified in the state plan. Additionally, most children enrolled in Medicaid are entitled by federal law to all medically necessary services, regardless of whether the service is covered in the state plan.

Some STAR Kids families and other stakeholders have reported regular challenges in obtaining approval for services, which they say has affected families negatively and put members at risk. Stakeholders also reported inconsistent criteria and burdensome procedures for the authorization of services. Denials of requests for medical services can result in administrative burdens for families and may prevent children from accessing care prescribed by their physicians.

Broad variations in denial rates could indicate problematic differences in medical necessity criteria and access to care. **Figure 9** shows the percentage of service requests denied or reduced by MCO and service type.

Some variation may be expected based on reasonable differences of interpretation among medical personnel working with different populations at each MCO. In addition, other factors may affect denial rates, such as the percentage of members who also have commercial insurance that must be the primary payer. However, wide variation may indicate the use of problematic criteria to make authorization decisions. In response to concerns from stakeholders, HHSC has issued guidance several times to MCOs regarding authorization policies. Families, other stakeholders, and some providers have continued to raise concerns about access to care and MCO policies after receiving this guidance from HHSC.

HHSC has identified some uses of inappropriate authorization criteria at MCOs. In a June 2018 written

FIGURE 10
STAR KIDS MEMBERS' COMPLAINTS AND APPEALS BY MANAGED CARE ORGANIZATION, MARCH 2017 TO MAY 2017 (1)

MANAGED CARE ORGANIZATION	MEMBER APPEALS	MEMBER COMPLAINTS	PROVIDER COMPLAINTS	SHARE OF MEMBER APPEALS	SHARE OF ENROLLMENT (2)
Superior	406	97	41	63.7%	18.0%
Texas Children's	70	58	18	11.0%	15.6%
United	41	44	14	6.4%	18.5%
Amerigroup	33	37	15	5.2%	17.2%
Driscoll	32	12	21	5.0%	6.5%
Aetna	19	18	11	3.0%	3.2%
Blue Cross Blue Shield	17	26	31	2.7%	4.8%
Children's Medical Center Dallas	14	19	13	2.2%	5.9%
Community First	4	11	3	0.6%	4.9%
Cook	1	18	3	0.2%	5.4%

NOTES:
(1) Complaints and appeals include those filed with either a managed care organization or the Health and Human Services Commission.
(2) The share of enrollment is based on May 2017 enrollment. In the Texas Medicaid program, member appeals typically involve the appeal of a denial or limitation of a benefit, dissatisfaction with plan administration, or untimely responses to authorization requests. Member complaints to plans commonly involve dissatisfaction with the quality of care provided by a treating physician or other provider, difficulties with accessibility or availability of services, and prior authorization denials. Providers also can file complaints related to utilization review; plan administration; and claims processing, billing, or denials.
SOURCES: Legislative Budget Board; Health and Human Services Commission.

statement, HHSC said that therapy policies at Driscoll were in conflict with contract requirements regarding utilization management. As shown in **Figure 9**, Driscoll denied or reduced the second-highest percentage of requests overall. This rate was driven by the MCO's denial or reduction of therapy requests.

Members that are denied services can appeal with the MCO within 10 days of notification. Members also can file complaints that may not be specific to a denial or other adverse action taken by the MCO. Finally, members can file complaints and appeals with HHSC, but only after appealing first to the MCO.

Similarly to denial rates, some variation may be expected in rates of appeals and complaints. However, variation or rates disproportionate with market share may indicate issues that need improvement and should be evaluated by HHSC.

According to some MCOs, many of the STAR Kids member complaints relate to issues with coordination of benefits for clients who have both commercial and Medicaid coverage. In these situations, MCOs report that they initially may issue a denial because they need documentation to show that the commercial plan will not cover the service. Without guidance from the state, however, MCOs are concerned about being sanctioned by the HHSC Office of Inspector General for not adequately enforcing primary coverage payment requirements.

Figure 10 shows complaints and appeals by MCO from March 2017 to May 2017.

UTILIZATION TRENDS

In addition to rates of denials and appeals, utilization of services before and after the implementation of STAR Kids may show how MCOs are interpreting and applying the state's medical necessity requirements compared to the vendor that previously conducted prior authorizations for members in FFS Medicaid.

According to HHSC, utilization of five services, including therapy personal care and private duty nursing, decreased for members after the transition to STAR Kids. After children moved to STAR Kids, their prior authorizations under the FFS model remained valid through late spring 2017. According to HHSC analysis, the percentage of STAR Kids members receiving speech therapy decreased by 12.0 percent from June 2017 to September 2017. Physical and occupational therapy utilization rates decreased 13.0 percent, where they have remained since. By contrast, the utilization rates for children enrolled in the STAR and STAR Health Medicaid programs remained stable during the same period. In December 2018, HHSC said that, based on the timing of

these decreases, the agency "is exploring the possibility of increased service denials correlating with the observed service trends." To examine this possibility further, HHSC has requested therapy prior authorization data from the MCOs.

NETWORK ADEQUACY

MCOs are required to maintain adequate networks to provide members with needed care. The Texas Medicaid program uses 13 service delivery areas. In STAR Kids, members typically are required to find in-network providers for certain services within these regions, unless granted exceptions. Regional networks can result in difficulties in accessing care because children with disabilities often see subspecialists at pediatric hospitals that may be located outside of their regions. The majority of MCOs in states with mandatory managed care for children in SSI operate statewide networks.

HHSC monitors network adequacy through measures that focus primarily on network breadth. These measures include mileage and time standards and caps on the volume of expenditures that can be made outside of the network. HHSC sets these caps, which limit out-of-network expenditures for inpatient admissions to 15.0 percent, emergency room visits to 20.0 percent, and other services to 20.0 percent.

From March 2017 to May 2017, every MCO except for Cook Children's and Community First exceeded at least one standard for out-of-network expenditures. For outpatient services, more than 74.0 percent of claims were out-of-network for Driscoll members. Amerigroup reported 31.0 percent of claims outside of the network in the Harris region, and Aetna and Blue Cross Blue Shield reported rates from 20.0 percent to 30.0 percent.

In January 2018, the Policy Council for Children and Families expressed concerns about the adequacy of networks for personal-care attendants, habilitation providers, and therapists. The group also expressed concern that plans were using inappropriate preferred provider agreements to restrict access to durable medical equipment. By July 2018, every MCO except Aetna was on a network adequacy-related corrective action plan with HHSC.

ELIGIBILITY ASSESSMENTS

In calendar year 2013, CMS issued the following guidance regarding best practices for managed LTSS programs: "MCOs may not be involved in any eligibility determination or functional assessment processes for a potential participant prior to that participant enrolling in the MCO." This guidance is intended to mitigate risks that an MCO would seek to enroll members with fewer medical needs selectively. According to the U.S. Governmental Accountability Office (GAO), CMS does not always require states to follow this guidance. CMS expects that when states do not follow its 2013 guidance, they will provide oversight related to conflicts of interest. However, GAO found that CMS does not require states to provide any evidence of oversight when plans are involved in eligibility determinations. As a result, GAO expressed concern that states may not develop adequate precautions or oversight. Even when MCOs are not involved in eligibility determinations, CMS has stated that Medicaid agencies "should monitor to ensure that identified participant needs and preferences are incorporated into service plans, and must provide enhanced monitoring of any service reductions (should there be any) during the transition to managed care."

For STAR Kids, MCOs collect the information used to make the determination using a standardized assessment tool, although a third party reviews the information to make the final eligibility determination. As part of this framework, HHSC reported to CMS that the agency's staff would conduct utilization reviews of this assessment process following the methodology that the Department of Aging and Disability Services staff used to conduct these reviews in FFS Medicaid. Using such a methodology, HHSC staff would have met with families, enabling the agency to compare members' needs to the corresponding MCO assessments and service plans to ensure the appropriateness of both and the receipt of services. However, when HHSC implemented STAR Kids in November 2016, the agency determined that it lacked adequate staff to conduct these reviews. As a result, the state stopped conducting the reviews after MCOs took responsibility for MDCP as part of STAR Kids.

In January 2018, the Office of the Governor expressed concerns about the adequacy of HHSC's oversight of MCOs in a letter to the HHSC Commissioner. In response, the agency said that it would consider establishing a utilization review process for STAR Kids. On June 1, 2018, HHSC received approval from the LBB and the Office of the Governor to reallocate funding for additional staff to conduct utilization reviews across managed-care programs, including STAR Kids. According to HHSC, utilization review staff will conduct a full program sample of reviews during fiscal year 2020.

Option 5 would amend statute to require HHSC to monitor access to care through service plan monitoring and utilization

reviews, which would compare authorized services to actual paid services to identify when members experience gaps in care. Fourteen states require this type of reporting. The STAR Kids Managed Care Advisory Committee has asked for similar information, and HHSC has identified that this request is an opportunity to improve oversight.

HHSC could leverage existing reporting requirements for electronic visit verification and claims data to identify when members do not receive services included in their service plans. This verification could help the agency practice more immediate monitoring, particularly for the highest-risk members, such as those enrolled in MDCP. HHSC also would be required to conduct utilization reviews on a statistically valid sample for each entity that conducts assessments to ensure that service coordinators conduct appropriate assessments and are ensuring access to medically necessary care. HHSC has been appropriated additional staff to conduct utilization reviews for STAR Kids. However, the agency has reported that more staff would be necessary to conduct statistically valid samples by MCO. Without such a sample, the agency is limited in taking action when it identifies problems.

QUALITY MEASURES FOR LTSS POPULATIONS

HHSC has established a formal overall strategy for monitoring and improving quality in Medicaid consistent with requirements in state and federal rules. CMS approves and periodically updates the strategy. Many of the initiatives rely on quantitative and systematic measures constructed from member surveys and medical claims. These measures are used for a performance indicator report, report cards sent to members selecting health plans, and a financial incentive program known as pay-for-quality.

As of September 2018, the performance measures for the STAR Kids program were being developed and none had been implemented. **Figure 11** shows HHSC's estimated implementation timeline.

Because STAR Kids includes LTSS, monitoring the performance of MCOs should include measures relevant to these services. According to the U.S. Medicaid and CHIP Payment and Access Commission:

> … quality measures focusing on beneficiary outcomes such as improvements in health status and function are not sufficient for monitoring LTSS programs. More appropriate LTSS quality measures include improvement in quality of life, community integration, avoidance or delay of institutionalization, and other outcomes that do not assume improvement in health and functional status.

FIGURE 11
ESTIMATED IMPLEMENTATION OF STAR KIDS QUALITY MONITORING ACTIVITIES, SEPTEMBER 2018

ACTIVITY	DATE
Measures Feasibility Study	October 2018
Pre/Post Implementation Member Survey Executive Summary	December 2018
Appointment Availability Study	Fall 2018
Managed Care Organization Report Cards	Early 2019
Administrative Measure Findings	February 2019
Performance Indicator Dashboard Standards	2019
Comprehensive Report on Survey Results and Administrative Measures	May 2019
Pay-for-Quality	January 2020

SOURCE: Health and Human Services Commission.

HHSC shared draft measures with the STAR Kids Managed Care Advisory Committee in a public meeting in September 2018. Of more than 50 proposed measures, one related to LTSS. The agency is working with the EQRO to refine the quality measures for STAR Kids and expected a feasibility report by October 2018. The agency will collect data for a year before establishing standards for performance in fiscal year 2019.

The EQRO also is comparing member experiences before and after implementation. During fiscal year 2016, the EQRO surveyed members before they transitioned into STAR Kids. During fiscal year 2018, the EQRO conducted a second set of surveys with the same families to compare their experiences. Topics included access to care, experiences with providers, care coordination, and overall satisfaction with care. According to HHSC, results from these surveys were available in December 2018.

Option 6 would amend statute to delay adding new populations into capitated managed care until outcomes from STAR Kids can be measured more fully. Starting on September 1, 2020, current law requires HHSC to transition additional individuals with intellectual and developmental disabilities (IDD) into managed care. When the Legislature established this timeline in statute, it also established the HHSC IDD System Redesign Advisory Committee to advise the agency regarding the development and implementation of these changes. The committee recommends delaying implementation

of these transitions due to concerns about whether HHSC has prepared adequately to transition these members into a capitated model. The committee indicated that "HHSC should evaluate lessons learned from the STAR Kids IDD acute care carve-in … to improve the system prior to carving in additional IDD waivers into Medicaid managed care."

FISCAL IMPACT OF THE OPTIONS

Option 1 would direct HHSC to reprocure STAR Kids services as soon as possible to ensure that contracts are awarded to the most qualified vendors. This option is not anticipated to have a significant fiscal impact because it could be implemented with existing resources. However, depending on other procurement needs, it is possible that HHSC would require additional full-time-equivalent (FTE) positions to conduct this reprocurement. MCOs historically have not provided bids with prices for this contract; however, changing the MCOs providing services could have impacts on capitation rates in the long term.

Option 2 would direct HHSC to evaluate risk-adjustment methods for STAR Kids and would have no significant fiscal impact.

Option 3 would require HHSC to provide an option for independent case management services. HHSC could use staff at the Department of State Health Services (DSHS) to provide these services, which are eligible for Medicaid funding. Approximately 667 service coordinators across MCOs provide services to 15,148 of the highest-need children enrolled in STAR Kids. Assuming that HHSC uses a gradual phase-in for these members first and that 20.0 percent of families elect for case management from DSHS rather than their health plans, the agency would need to hire approximately 121.0 FTE positions to provide services for 3,030 members. These positions would cost approximately $13.0 million per year, and 50.0 percent would be reimbursed through Federal Funds. If this option were expanded to include members in the second tier of need, HHSC would require 288.0 positions by fiscal year 2023 at a total cost of $30.8 million per fiscal year. The fiscal impact of this model is shown in **Figure 12**. The fiscal impact could decrease if HHSC actuaries decrease the amount of funding provided to MCOs for individuals receiving case management from DSHS.

However, other models could be used to provide independent case management services. Therefore, the net cost of this provision cannot be determined at this time.

Option 4 would amend statute to require HHSC to establish caseload guidelines for service coordinators. If the agency set standards that require substantial increases in MCO staff, the result likely would be an additional cost to the state, depending on how actuaries set the rates for MCOs. Subsequent decreased caseloads could require additional appropriations from the Legislature.

Option 5 would amend statute to require HHSC to monitor access to care through utilization reviews and service plan monitoring. HHSC lacks adequate staff to conduct utilization reviews by MCO. According to HHSC, the agency would require an additional 25.0 FTE positions at a cost of $2.5 million per year, and 50.0 percent would be reimbursed through Federal Funds. HHSC also may incur costs for information technology to develop gaps-in-access monitoring. **Figure 12** shows the fiscal impact of this option.

Option 6 would amend statute to delay implementation of moving additional populations with special healthcare needs into capitated managed care. The fiscal impact cannot be determined at this time.

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

FIGURE 12
FIVE-YEAR FISCAL IMPACT OF OPTIONS 3 AND 5, FISCAL YEARS 2020 TO 2024

YEAR	PROBABLE SAVINGS/(COST) IN GENERAL REVENUE FUNDS	PROBABLE REVENUE GAIN IN FEDERAL FUNDS	PROBABLE SAVINGS/(COST) IN FEDERAL FUNDS	PROBABLE ADDITION/(REDUCTION) OF FULL-TIME-EQUIVALENT POSITIONS
2020	($2,856,273)	$2,856,273	($2,856,273)	55.0
2021	($7,742,270)	$7,742,270	($7,742,270)	146.0
2022	($12,110,163)	$12,110,163	($12,110,163)	229.6
2023	($16,639,830)	$16,639,830	($16,639,830)	313.1
2024	($16,639,830)	$16,639,830	($16,639,830)	313.1

SOURCE: Legislative Budget Board.