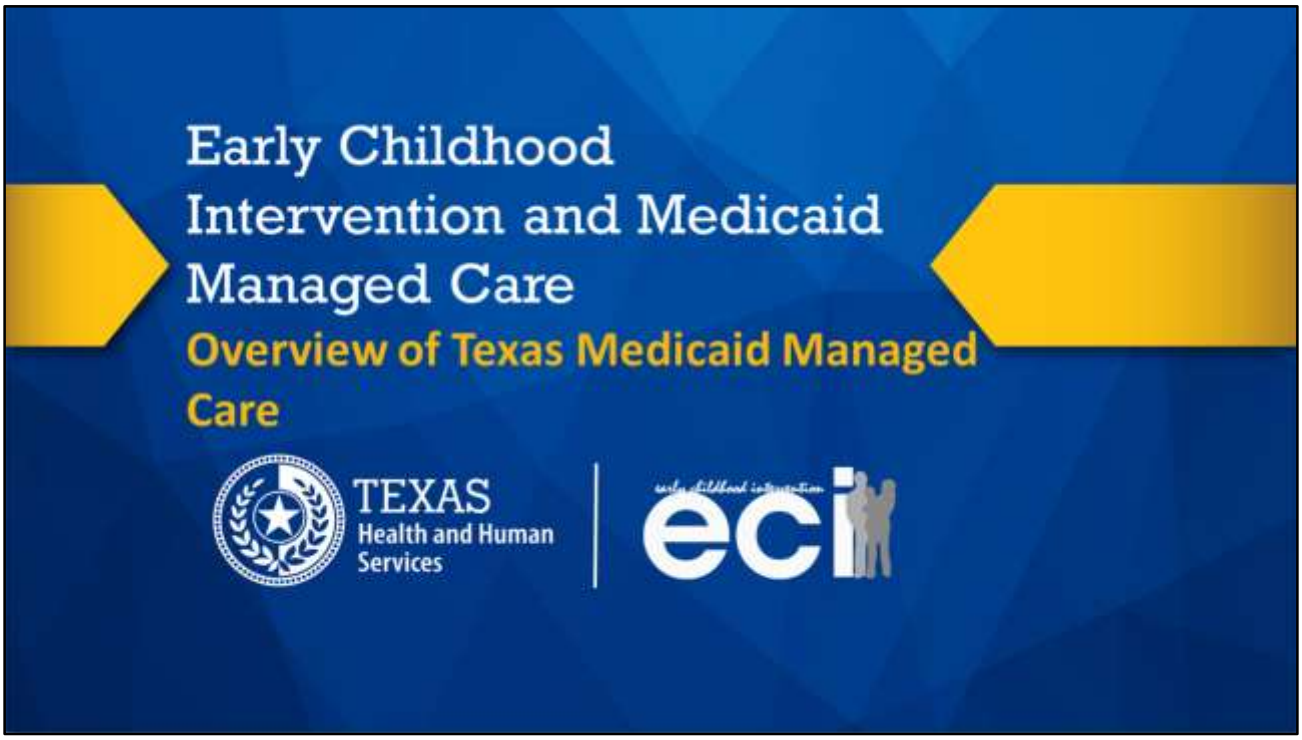
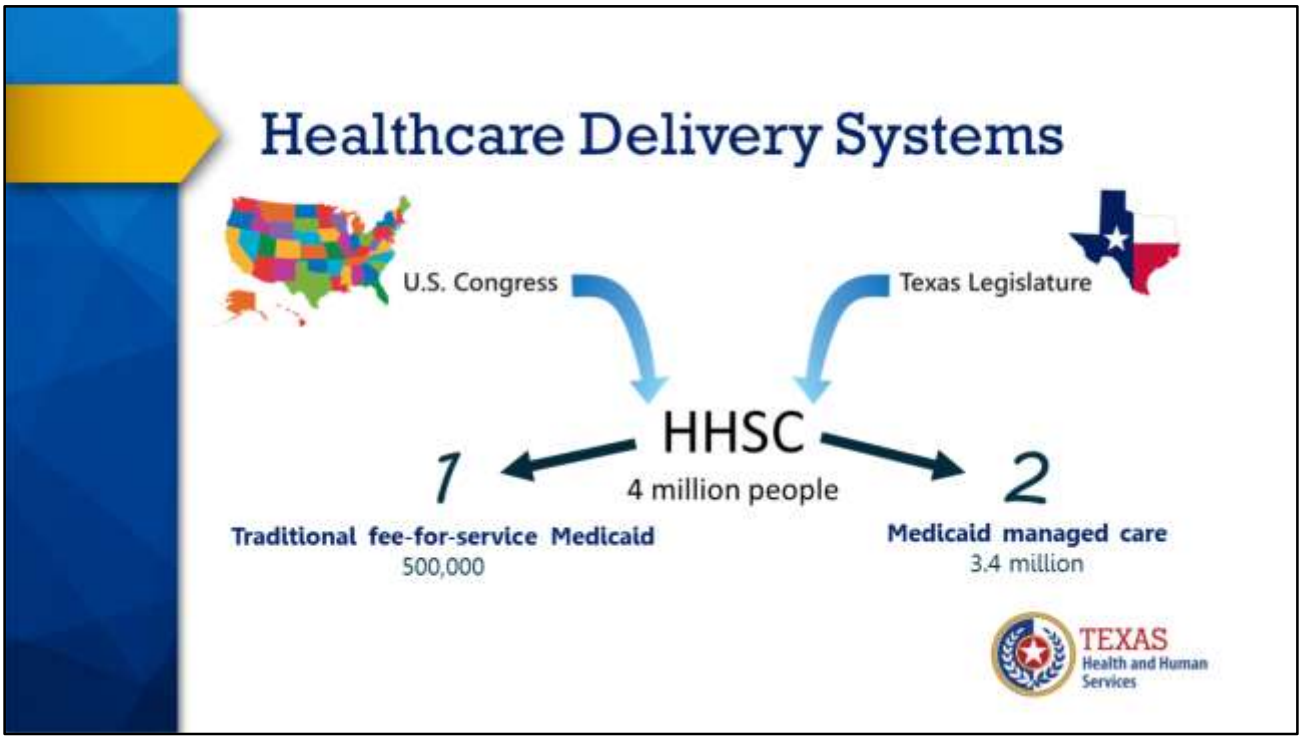


Welcome to the first of a four part series on Early Childhood Intervention and Medicaid managed care. Throughout the four parts, you will learn about Texas Medicaid Managed Care, Texas Early Childhood Intervention, and how these two service delivery systems connect to provide Medicaid covered services to children enrolled in Early Childhood Intervention or ECI. The purpose of this first webinar is to provide ECI contractor personnel with some basic information about Medicaid managed care as it relates to ECI. Please use the **Acronyms and Terms** document that accompanies this webinar to help with the different terms used by the ECI contractors and Medicaid managed care organizations or MMCOs. You will be able to submit any questions you have about the content of this presentation through a link that is located on the ECI Archived Webinars training website.

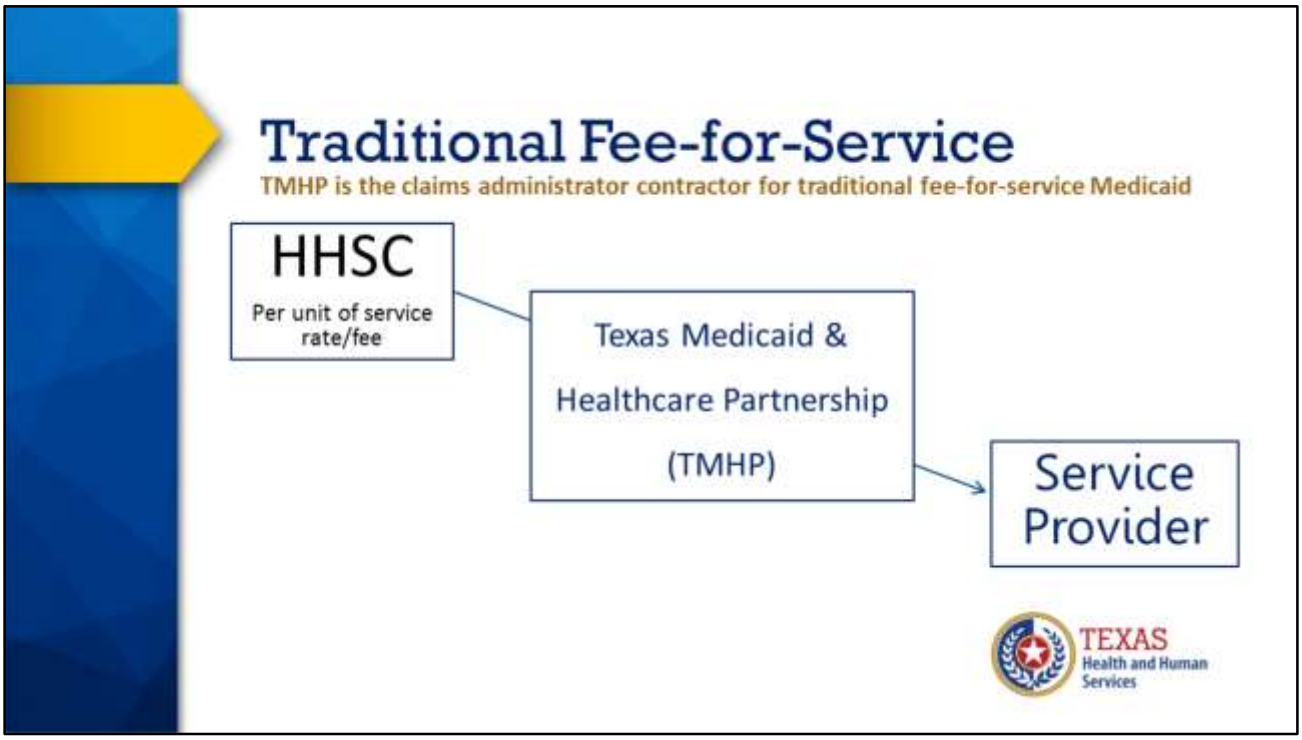
As a result of this presentation, you will be able to:

- compare the role of Medicaid managed care organizations (MMCOs) and the Texas Medicaid & Healthcare Partnership (TMHP);
- identify the responsibilities of MMCOs; and
- evaluate within your program which typical managed care mechanisms do not apply to ECI services.

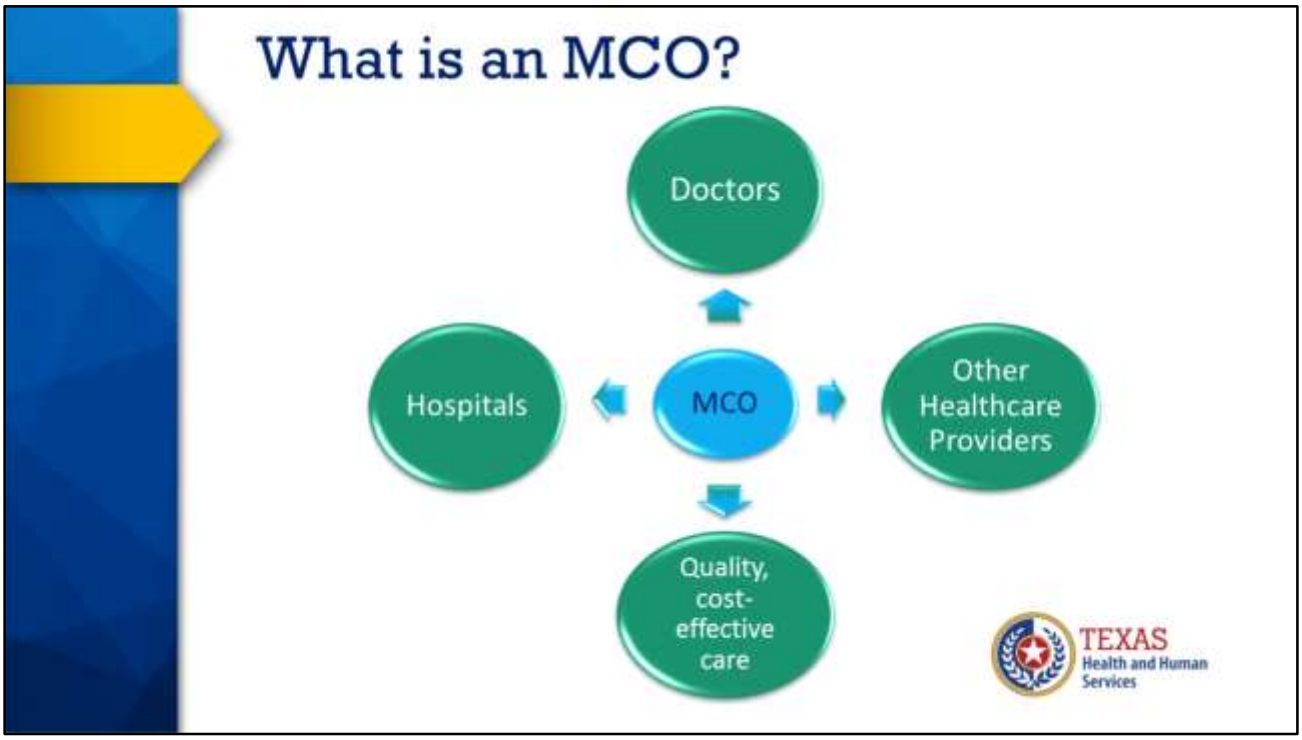


To be able to understand the differences between MMCOs and TMHP, we first need to explain Medicaid. Medicaid is health insurance that is jointly funded by the state and federal governments. Medicaid provides health coverage for some low-income people, families and children, pregnant women, the elderly, and people with disabilities. The Health and Human Services Commission (HHSC) is the single state agency for the State of Texas. HHSC has chosen to operate two health care delivery systems for Medicaid covered services. The first is the original system which is referred to as Traditional Fee-for-Service Medicaid. The second approach, Medicaid managed care, began in 1993 and now provides the majority of Medicaid services to the majority of Medicaid beneficiaries. Currently 3.4 million Medicaid beneficiaries are members of Medicaid managed care. 500,000 beneficiaries are not a member of a Medicaid managed care.

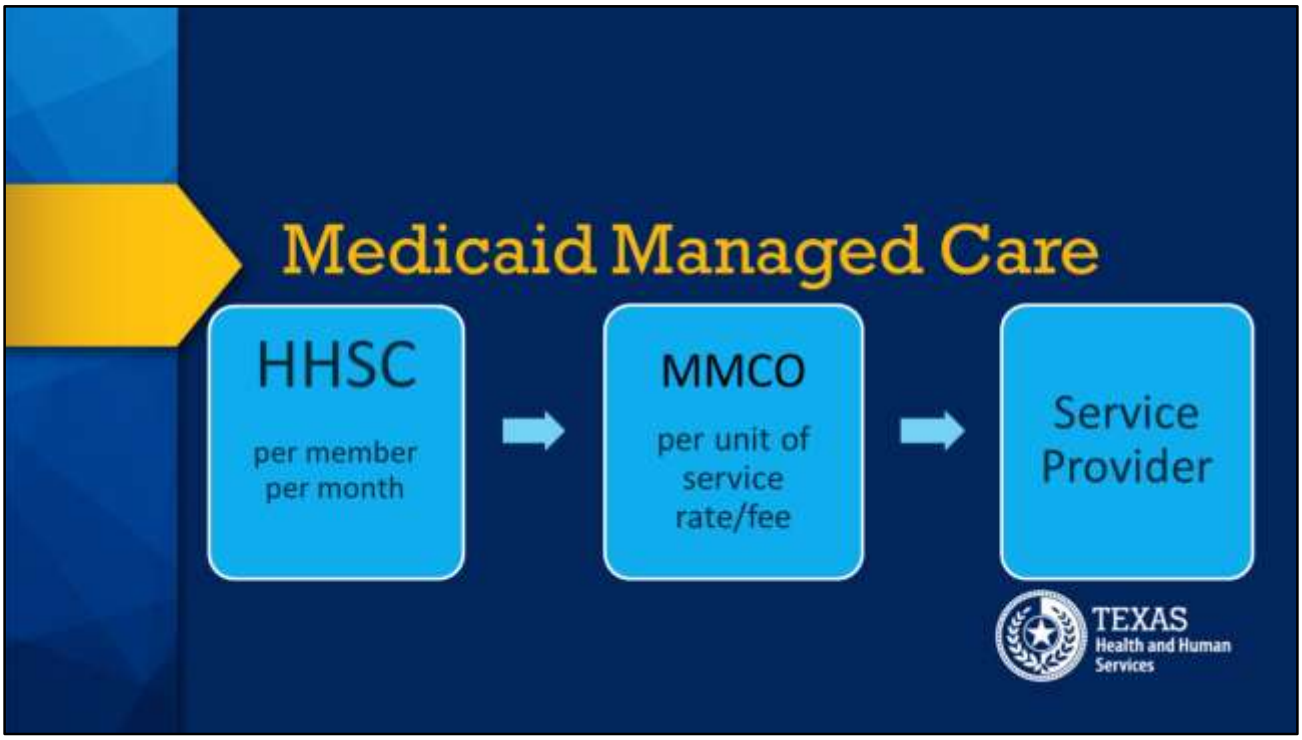
Let's take a few minutes to explore fee-for-service Medicaid.



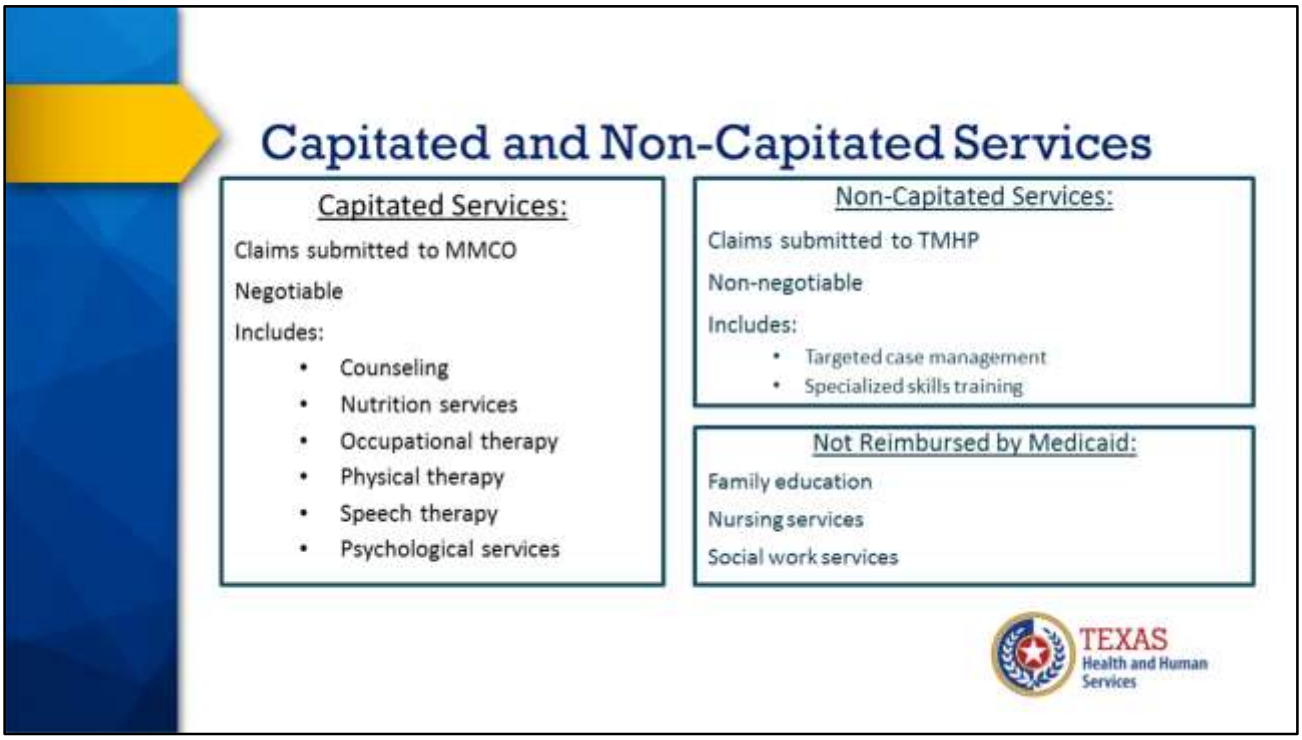
In traditional fee-for-service Medicaid, services are paid to the provider by HHSC. HHSC determines the service prior authorization processes and state's reimbursement rates or fee schedule. HHSC contracts with TMHP to perform a number of administrative functions for HHSC such as verifying service authorizations, processing claims, and performing audits, as directed by HHSC. So while the provider may be interacting with TMHP, they are really doing business with HHSC.



In Medicaid managed care, however, the provider is doing business with a managed care organization or MCO. In a managed care healthcare delivery system, the MCO uses techniques and concepts that reduce unnecessary health care costs through a variety of mechanisms. An MCO provides healthcare through a network of healthcare providers that satisfy the MCOs credentialing standards to ensure the delivery of quality cost-effective care. The MCO also uses prior authorization processes that reduce waste and ensure services are provided in the most appropriate setting. A single MCO may offer a number of different insurance products such as one product for Medicaid beneficiaries who are enrolled in STAR, a second product for Medicaid beneficiaries enrolled in STAR PLUS, a third product for CHIP beneficiaries, and a fourth commercial product that can be purchased by individuals or employers. This fourth option is also referred to as private insurance since it is not funded with public or governmental dollars. Even though all four of these products are available from one MCO, the covered services, provider network, prior authorization processes, reimbursement rates, and appeals process are going to differ across products.



In this webinar series the term Medicaid managed care organizations or MMCOs is used to differentiate the MCOs' Medicaid product from the MCOs' other non-Medicaid products. In Medicaid managed care HHSC does not pay the service provider. In Medicaid managed care, HHSC pays the MMCO a capitated rate for each Medicaid beneficiary enrolled with that MMCO. This rate is referred to as per member per month or PMPM. The contract between HHSC and the MMCO identifies the services for which the MMCO is financially responsible. These services are referred to as being carved-in to managed care or capitated services. Service providers must submit their claims for capitated services to the MMCO. On the other hand, Medicaid services that are not within the MMCO's capitation are referred to as carved-out of managed care or non-capitated services. Since HHSC is financially responsible for the non-capitated services, claims for these services must be submitted to TMHP. A single Medicaid managed care member may receive Medicaid services through both Traditional fee-for-service Medicaid and Medicaid managed care. Children enrolled in ECI are a good example of this.

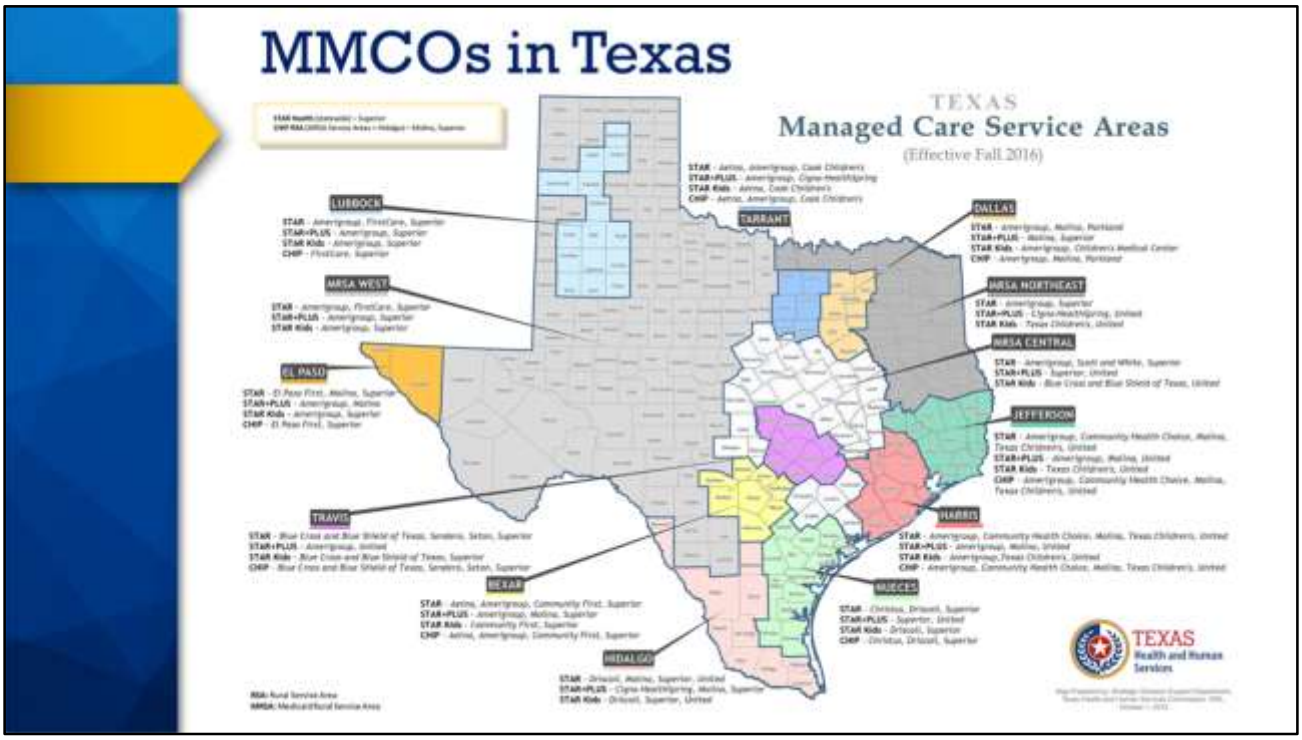


Some of the Medicaid covered services provided by ECI contractors are capitated, meaning the MMCOs are responsible for reimbursement, and claims are submitted to the MMCOs. The MMCOs and service providers are expected to negotiate the rate of reimbursement. The MMCOs can reimburse at a rate lower than HHSC's to control costs or higher than the state's rate to incentivize best practices. The capitated ECI services include: Counseling, nutrition services, occupational therapy, physical therapy, speech therapy, and psychological services.

Some of the Medicaid covered services provided by ECI contractors are non-capitated, meaning HHSC is responsible for reimbursement, and claims are submitted to TMHP, even if the child is enrolled in Medicaid managed care. HHSC sets the rate for non-capitated services and federal regulations require the rate to be the same across the state. The non-capitated ECI services are: Targeted case management and specialized skills training.

There is a third group of services provided by ECI contractors that are not covered by Medicaid. Examples are family education, nursing services, and social work services.

HHSC has set a number of goals for Medicaid managed care in the State of Texas. These goals include:
A service delivery system that establishes a medical home for Medicaid clients through a primary care physician or PCP. The PCP coordinates care and provides referrals to specialty services, when needed. The coordinated care provided through the managed care service delivery system: emphasizes preventive care and early intervention; improves access to care; ensures appropriate utilization of services; improves client and provider satisfaction; improves health outcomes; quality of care and cost effectiveness; and promotes care in the least restrictive and most appropriate setting.



The MMCO is required to manage the healthcare of Medicaid beneficiaries in the MMCO's designated service delivery area. Therefore the family will have to change MMCOs if they move out of the MMCO's service area. A single MMCO may offer a variety of Medicaid managed care products in a variety of service areas such as STAR in Dallas and Lubbock, and STAR Kids in San Antonio. The state requires a minimum of two MMCOs in each service area for STAR, STAR PLUS, and STAR Kids. While the Medicaid beneficiary may not be able to choose whether or not they are in managed care, the beneficiary does have the right to choose their MMCO.

HHSC's contract with the MMCOs is posted on HHSC's website. (https://hhs.texas.gov/services/health/medicaid-and-chip/provider-information/managed-care-contracts-and-manuals) Under this contract the MMCOs are financially responsible for and must pay for all medically necessary state plan services that are included in the managed care capitation. MMCOs are required to follow the benefit limits and exclusions as identified in the Texas Medicaid Provider Procedures Manual or TMPPM. For example, in the ECI section of the TMPPM it states that co-visits are allowed and speech therapy does not require a prescription.

The MMCOs may offer value-added services. Value-added services are usually services that improve health outcomes and motivate individuals to select that MMCO over other MMCOs. Examples of possible value-added services are respite, vision services in addition to what is required in the Medicaid state plan, and health and wellness services like weight reduction classes.

The federal government requires HHSC to continually monitor the MMCOs to ensure the MMCOs are successful in creating a more efficient and effective service delivery system than traditional fee-for-service Medicaid.

The MMCOs' responsibilities are limited to a service delivery area based on their contract with HHSC. The MMCOs are required to have a customer service representative in each geographical area and provide a medical home or gatekeeper through a primary care physician (PCP). The PCP coordinates care and approves referrals for specialty providers, when needed .

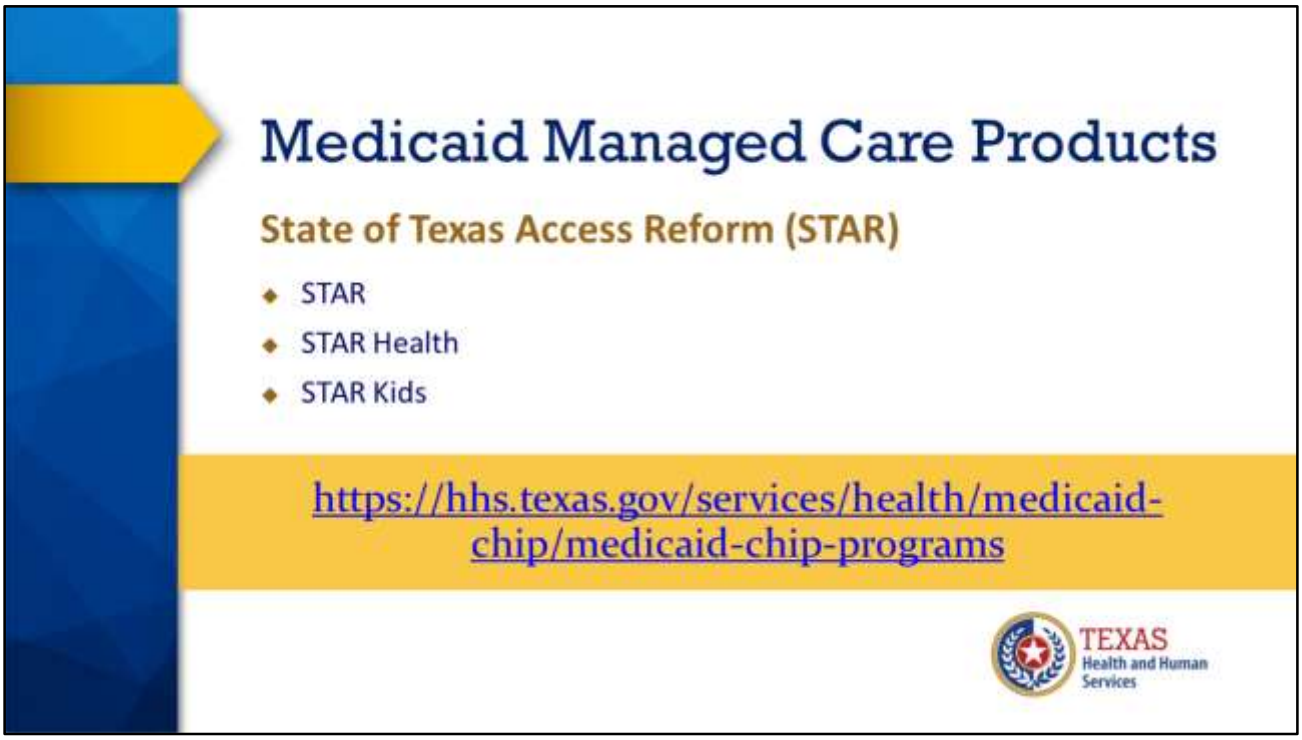
The MMCO's contract with the state requires the MMCO to have a provider service representative in each service delivery area to assist service providers. MMCOs must contract with and credential the service providers within their network. Since the MMCO is financially responsible for paying for all medically necessary capitated services while also obtaining the managed care goals listed previously, the MMCOs are allowed to implement the business processes that they have found are the most effective and efficient. These processes including forms, service provision contract content, provider credentialing, prior authorization, appeals, and rates. Therefore service providers will see variation across MMCOs and MMCO products. Since the MMCOs are allowed to set up their own processes, the MMCOs are required to train service provider claims staff as needed or requested.

The federal government requires HHSC to continually monitor the MMCOs to ensure the MMCOs are successful in creating a more efficient and effective service delivery system than the Traditional fee-for-service Medicaid. The managed care contracts posted on the HHSC website include the potential consequences the MMCO will face if the MMCO fails to meet the goals established by HHSC. Here are a few examples:

HHSC may assess up to $5,000 for the first quarter the MMCO falls below the performance standards. HHSC may assess up to $25,000 per quarter for each additional quarter.

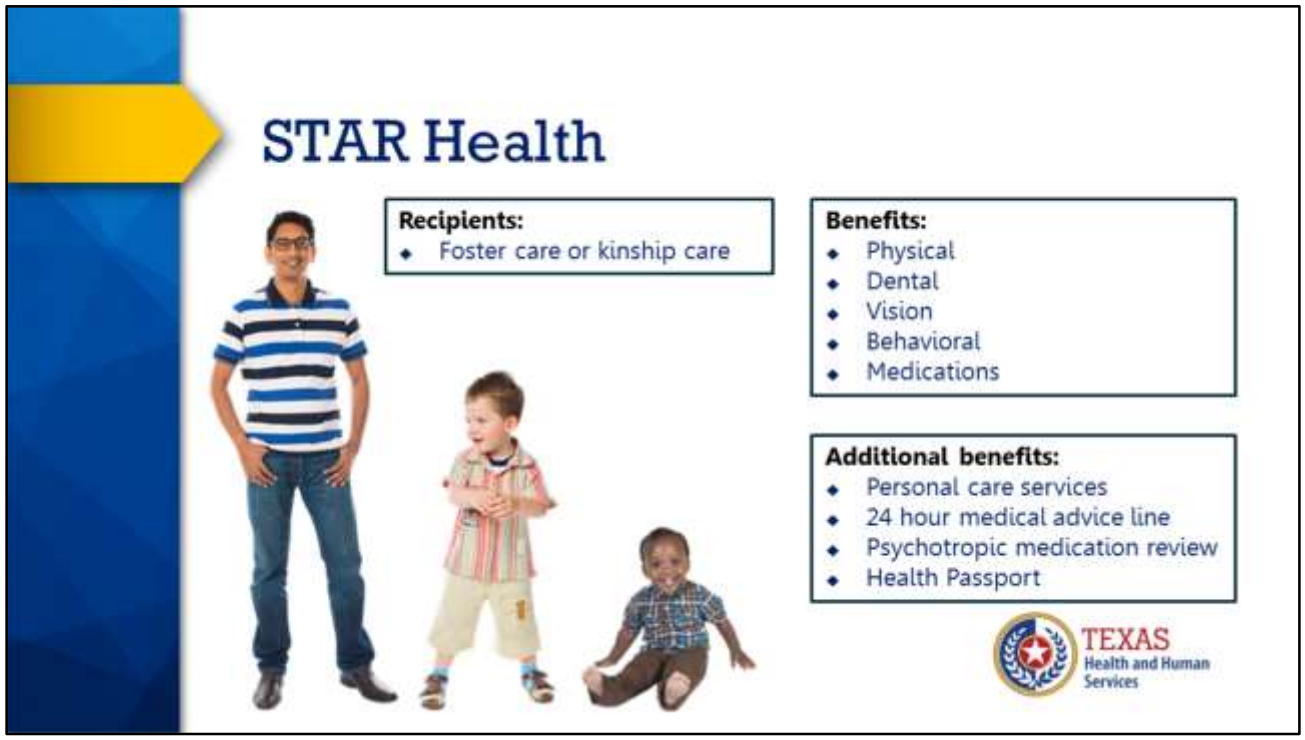
MMCOs are required to pay 98 percent of all clean claims received within 30 days, and 99 percent within 90 days. MMCOs are subject to liquidated damages if the MMCO does not pay providers interest of 18 percent for clean claims unadjudicated beyond the 30-day deadline. HHSC may assess up to $1,000 per claim if the MMCO fails to pay interest timely.

MMCOs are also limited to the amount of profit the MMCO can retain. The percent of profit the MMCO may retain or must give to the state is detailed in the MMCOs' contract with HHSC and is posted on the HHSC website. (https://hhs.texas.gov/services/health/medicaid-and-chip/provider-information/managed-care-contracts-and-manuals)



Now let's go into some of the state's Medicaid managed care products in a bit more detail. We'll limit our journey to the three Medicaid managed care delivery systems that reimburse services provided by ECI contractors. Those are STAR, STAR Health, and STAR Kids. Detailed information about all of the state's managed care products is available on the HHSC website. (https://hhs.texas.gov/services/health/medicaid-chip/medicaid-chip-programs)

STAR is a Medicaid managed care service delivery system for pregnant women, newborns, and children with limited income. STAR pays for primary care, acute care, and pharmacy services. Acute care services include doctor's visits, home health, medical equipment, lab, x-ray, and hospital services. STAR benefits include all of the benefits of traditional fee-for-service Medicaid plus the following: a primary care physician to provide a medical home and care coordination, unlimited prescriptions, unlimited medically necessary days in a hospital, and value-added services.



STAR Health is the managed care service delivery system for children and adolescents who are in foster care and kinship care and young adults who are in or were in foster care and kinship care. STAR Health provides reimbursement for physical, dental, vision, and behavioral healthcare, medications, and personal care services. HHSC contracts with a single MMCO to manage STAR Health across the entire state. Key to care coordination is the STAR Health Passport, a web-based electronic health information system that serves as a repository of medical information for each child in Texas' foster care system.

STAR Kids is for children and youth age 20 and younger who meet at least one of the following:
- Receive Supplemental Security Income
- Receive SSI and Medicare
- Receive services through the Medically Dependent Children Program waiver
- Receive services through the Youth Empowerment Services waiver
- Live in a community-based intermediate care facility for individuals with an intellectual disability or nursing facility
- Receive services through a Medicaid Buy-In program or
- Receive services through any of the following Medicaid waiver programs
    - Community Living Assistance and Support Services
    - Deaf Blind with Multiple Disabilities
    - Home and Community-based Services
    - Texas Home Living

STAR Kids

Benefits:

- Acute care
- Behavioral
- Medications
- Long-term services and supports
  - PDN
  - PCS
  - CFC

Additional benefits:

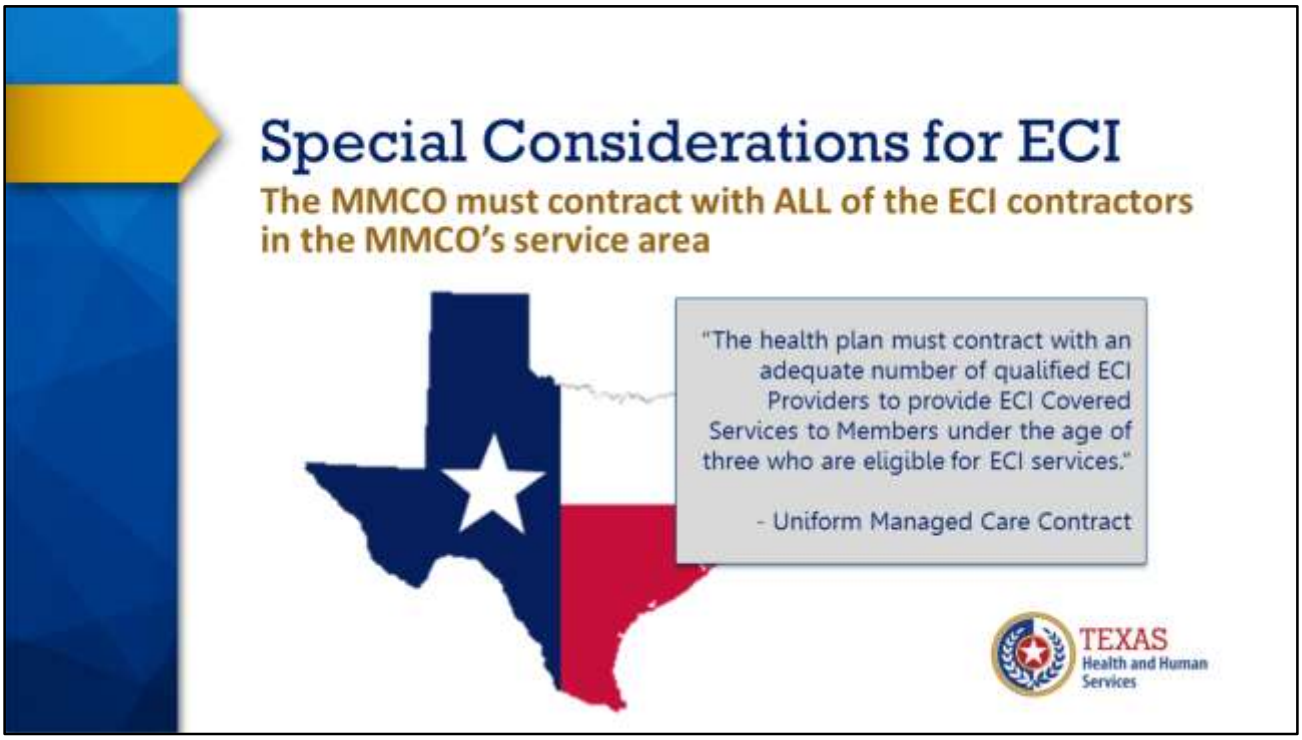
- Comprehensive needs assessment
- Service plan development
- MDCP
- Transition planning

TEXAS Health and Human Services

The STAR Kids service delivery system pays for state plan acute care and long-term services and supports such as private duty nursing, personal care services, and Community First Choice. Additional benefits include a comprehensive needs assessment, service plan development, Medically Dependent Children's Program waiver services, and transition planning.

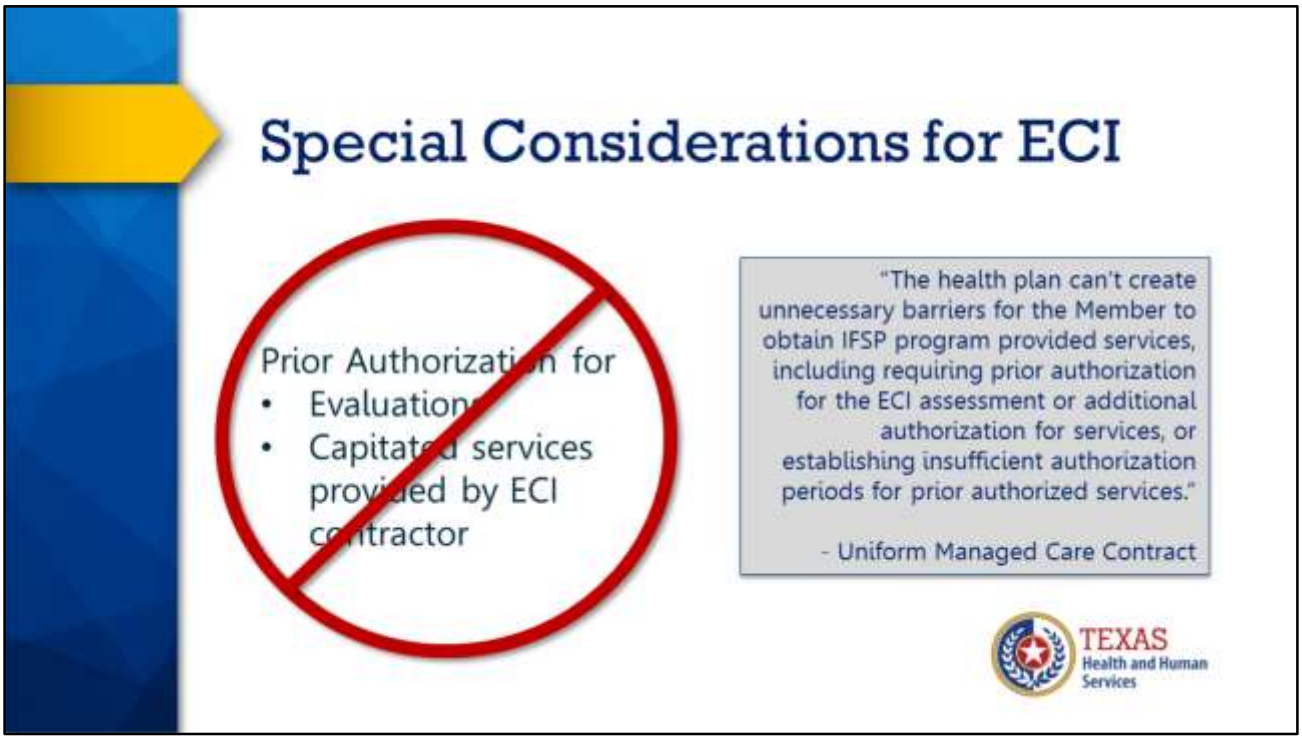
For all three of the managed care products, the MMCOs are required to designate children enrolled in ECI as a Member with Special Healthcare Needs. This designation requires the MMCOs to develop a seamless package of care in which primary, Acute Care, and specialty service needs are met. This includes:

- Provide the member with direct access to a specialty care provider
- Offer service management and develop a service plan to meet the member's short and long-term needs and goals
- Attempt to establish relationships with programs and community organizations including ECI contractors
- Enlist the involvement of community organizations that may be important to the health and wellbeing of members
- With the consent of the member's parent, include key information from the ECI Individualized Family Services Plan in the development of the service plan
- Include in the service plan information regarding non-covered services, such as non-capitated services, community resources, and how to access affordable, integrated housing
- Coordinate capitated services and authorizations to prevent duplication
- Implement a systematic process to coordinate non-capitated healthcare services
- Update the service plan at least annually or more frequently upon identifying changes in the member's health condition or at the parent's request.



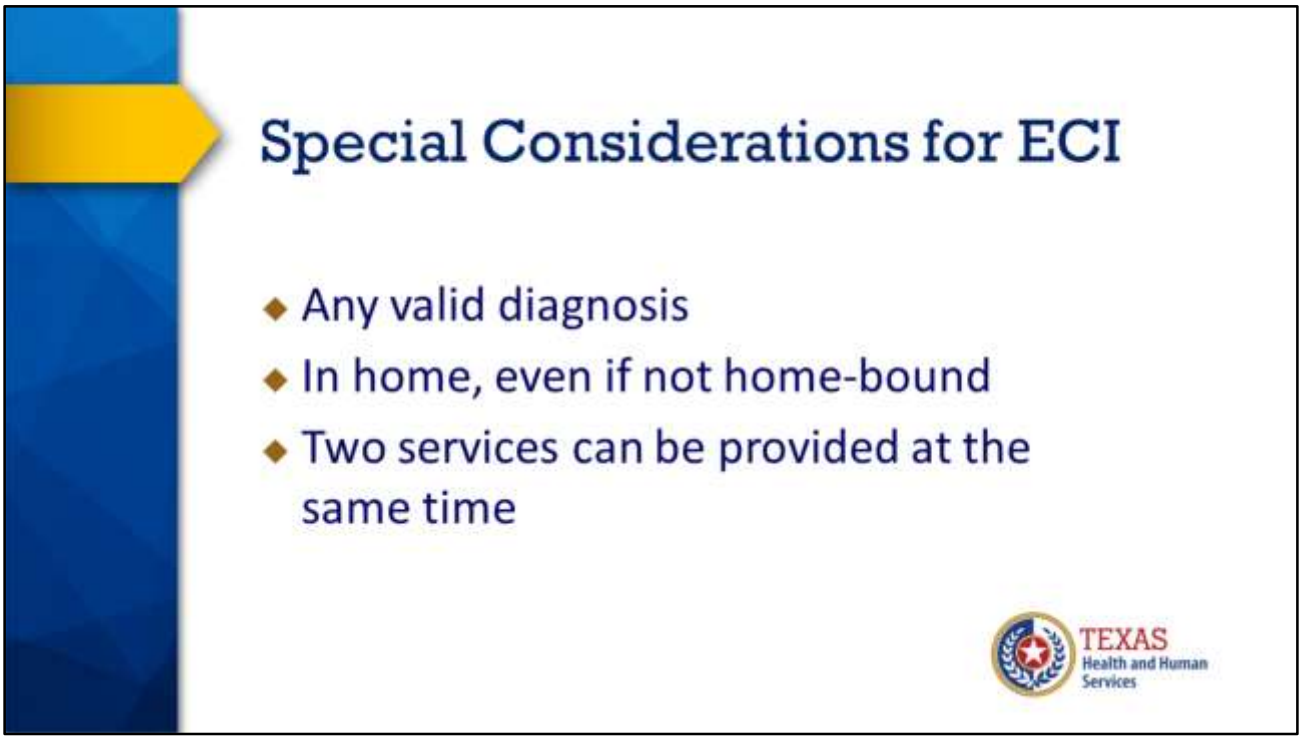
The MMCOs' contracts require a number of special considerations for ECI in addition to the designation of MSHCN. Let's take a moment to look at some of these special considerations.

One of the standard managed care mechanisms used is limiting the provider base. For ECI contractors the phrase, "sorry, our provider network is full" does not apply. Since the ECI contractors' service areas do not overlap, the MMCO must contract with all of the ECI contractors in the MMCO's service delivery area. Failure to contract with every ECI contractor would create a geographical gap in service provision.



Another standard managed care mechanism used is to require the service provider to obtain prior authorization from the MMCO before services can be provided. MMCOs cannot require prior authorization for evaluations or capitated services provided by an ECI contractor.

For Medicaid reimbursement, the IFSP Services Pages are the authorization for services provided by the ECI contractor. While the MMCO may require the ECI contractor (with parental consent) to send the IFSP Services Pages to the MMCO, the MMCO may not require additional authorization nor modify the frequency or intensity indicated on the IFSP.



Most medical services are restricted to certain diagnoses for obvious reasons. Special consideration is given to ECI services in that ECI services are not restricted to a limited set of diagnoses. For example, some third party payers will not pay for services for a child with a diagnosis of development delay. The Medicaid ECI policy, on the other hand, accepts the diagnosis of development delay and the MMCOs must follow this policy. Please remember that the diagnosis code used on the claim must be a valid code that is appropriate for the service being provided.

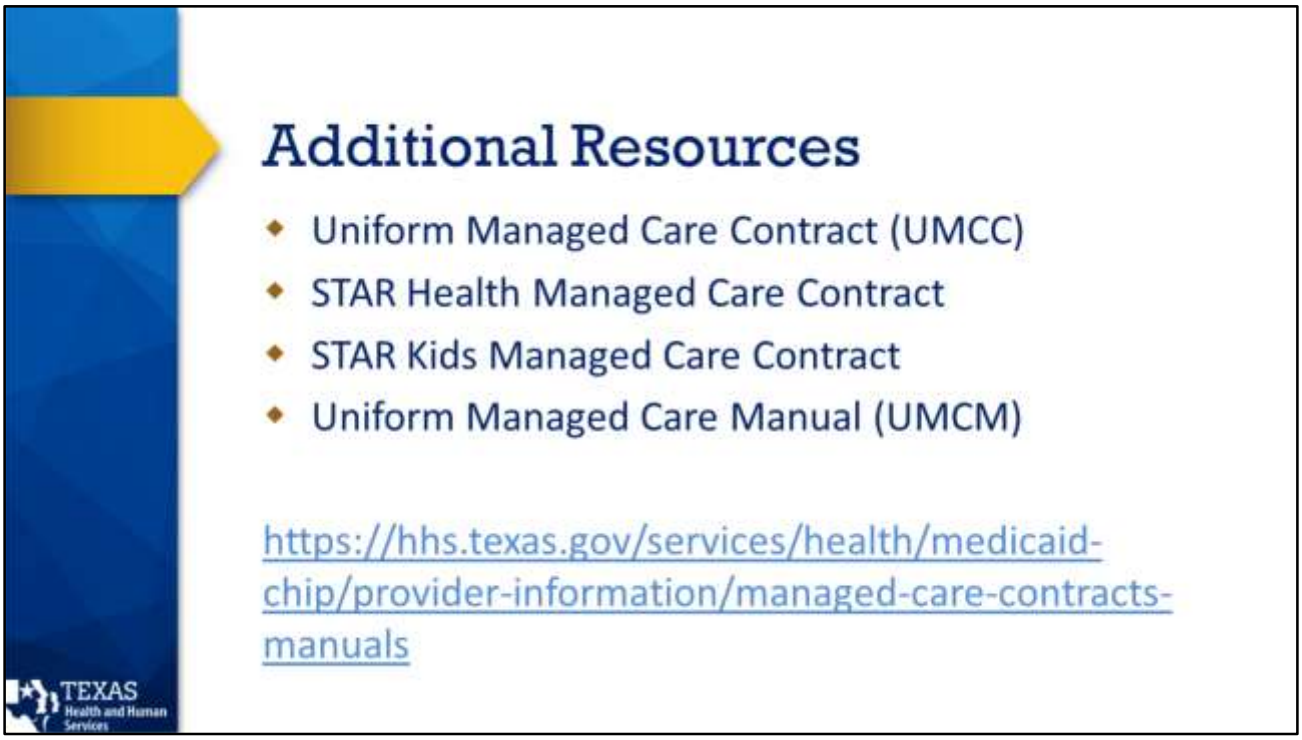
Another common area of restriction across third party payers is to provide services in the home only when the individual is homebound. Once again special consideration is given to ECI. MMCOs cannot deny payment for services provided in the child's home because the child is not homebound. The Medicaid ECI policy allows reimbursement for ECI services provided in the child's home, the service provider's office or clinic, and other locations such as playgrounds, stores, restaurants, and daycares. The MMCOs are required to follow this policy.

Some third party payers build their automated billing systems to deny payment for more than one service on the same day. The Medicaid ECI policy, however, allows the provision of a combination of PT, OT, ST, or SST when the IFSP indicates necessity for two services to be provided at the same time and the parent(s) have agreed on the two services being provided at the same time. The MMCOs are required to follow this policy as well.

An area of frequent confusion occurs when the ECI-enrolled child also receives OT, PT, or ST from non-ECI providers. The MMCOs cannot limit ECI services because the child is or will be receiving services from a non-ECI provider. Conversely, the child cannot be denied access to medically necessary Medicaid covered services because the child is or will be receiving ECI services. The state expects the MMCO, ECI Contractor, non-ECI provider, and parent to collaborate to determine the services that are best for the child and family. The MMCO is responsible for determining the medical necessity of the services to be provided by the non-ECI provider. The best citation for the child's entitlement to the services provided by the ECI contractors is US Dept. of Ed. letter dated Sept. 4, 2007. The citation for the child's entitlement to Medicaid funded services is the Social Security Act §1905(r)(5).

As an ECI contractor, take the opportunity to form relationships with MMCOs to negotiate contracts, rates, and to give input regarding expected procedures and processes that may impact you, the ECI contractor.

When working with the MMCOs it is important to remember that ECI contractors have a number of special considerations that require the MMCOs to deviate from their normal processes when doing business with ECI contractors. Given that the MMCOs do business with thousands of providers across most of the Medicaid services and provider types, the MMCO personnel may not have immediate recall of all of ECI's special considerations. Therefore it is advantageous for the ECI contractors to be aware of these special considerations so the ECI contractors can effectively negotiate and advocate for their agencies, families, and children. ECI contractors are encouraged to cite the applicable section of the Uniform Managed Care Contract (UMCC) when educating their MMCO partners.



Being knowledgeable about the MMCO contract is crucial to forming and maintaining a functional relationship with the MMCOs. There are contractual requirements specific to STAR Health and STAR Kids, so each of those contracts go into the requirements that are specific to those managed care products. Another document that can provide guidance is the Uniform Managed Care Manual which defines procedures that the MMCOs must follow to meet their contractual requirements. The manual also provides interpretation and clarification on contractual requirements.

Website: https://hhs.texas.gov/services/health/medicaid-chip/provider-information/managed-care-contracts-manuals

This concludes part 1 of the Early Childhood Intervention and Medicaid managed care series. Please return to the ECI Archived Webinars training website and select the survey link that is included with the materials for this presentation. A copy of the PowerPoint presentation is also included with the materials and you can access the referenced links from the PowerPoint. You can submit any questions you have through the survey or you can send them to Beatrice at the phone and email address above. The questions you submit will be answered and posted with this webinar on the ECI training site.

Email: Beatrice.Sager@hhsc.state.tx.us