SB 7 Details: Impetus, Facts vs Fiction, Strengths and Concerns Etc.

Impetus for Bill: What We Know or Have Heard

- According to Senator Nelson's January 18, 2013 *Capitol Digest*... SB 7 builds on previous efforts to improve outcomes in our Medicaid system with an emphasis on long term care services, which is one of the top cost drivers in the Medicaid program. "These are some of the most vulnerable people we serve. We need to make sure they get the best possible care-- and that we are delivering services in a way that ensures we can keep caring for them into the future."

- Some report that the purpose of SB 7 is to achieve *greater efficiencies* and *budget predictability* (defined by some as elimination of fee-for-service). To better understand the intent of the bill and the vision for the future, these terms need to be clearly defined. *See excerpt from the Kaiser Family Foundation on page 5.*

- A the January 30, 2013 SB 1 hearing, Senator Williams (Chair, Senate Finance Committee) indicated that healthcare and education spending are now equal - about $70 billion (GR and FMAP). He added "That's not to diminish the needs that we have in this area, but we cannot continue to fund 14% annual growth in [health spending] which is what we've had over roughly the last 10 years and build higher education facilities, highways and water infrastructure our state needs to continue growing. So there are going to be some tough choices we are going to make - those choices don't necessarily mean serving fewer people or reducing health services. It's not a choice about whether to serve a population or not. It's going to be how they are served." [Senator Nelson echoed his comments.]

Facts vs Fiction

- Other States are moving to this model. **FALSE...** No other State (based on our research) has moved its IDD population under a managed care model; i.e., handed full control of its IDD system over to for-profit insurance companies. Kansas is the only state that recently attempted to receive approval from its legislature to implement the Texas proposed model. Due to the outcry of families, persons receiving services, advocates, providers and other related stakeholders, however, the enabling legislation (and subsequent waiver application submitted to CMS) postponed implementation of the model for the IDD population until January 1, 2014. As stated in the December, 2012 CMS letter approving Kansas' request for a new section 1115 (a) Medicaid demonstration, Kansas will conduct a voluntary pilot project to test coordination of IDD care under an MCO for the first year of the demonstration waiver. More specifically, the letter states that... "This pilot project is voluntary and will allow providers and beneficiaries to become familiar with the benefits of managed care for their HCBS [services], and will help the MCOs to learn more about the unique needs of this population and program." **Note:** While Arizona, Michigan, Wisconsin and Vermont have included long term care services for persons with developmental disabilities in their managed care models, the approaches they used are vastly differently than the approach proposed in SB 7. Moreover, while many states are using some type managed care approach to Medicaid, such is to address acute care (medical needs) - not to apply managed care to long term care service needs.

- The Interest Lists will be eliminated. **FALSE...** Nothing in the current bill suggests that moving the system under an MCO will eliminate the Interest List.

- MCOs can manage the care for the IDD population more cost efficiently than providers. **FALSE...** There is no evidence to suggest such. In fact (and though not inclusive), according to the LBB Effectiveness and Efficiency Report:

  - A financial incentive exists for STAR+PLUS managed care organizations to recommend inappropriate placement of persons in STAR+PLUS home and community-based services and supports waiver services, given that the monthly premium payment methodology provides higher payments for persons receiving STAR+PLUS home and community based services and supports waiver services and the administrative payment methodology is linked to the total premiums received. This, coupled with the lack of sufficient controls of this process, places the state at risk for paying a greater level of premiums and administrative costs than are necessary. Expansion of the STAR+PLUS program magnifies this risk.

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- The capitated, per member per month premiums paid to STAR+PLUS managed care organizations for clients receiving STAR+PLUS home and community-based services and supports waiver services are significantly higher than the monthly premiums for other clients in the STAR+PLUS program.

- The Medicaid claims administrator, the entity responsible for determining STAR+PLUS home and community-based services and supports waiver eligibility, may not detect an inappropriate request for services because the managed care organization that stands to benefit from the decision supplies the information used to make the medical necessity/level of care determination.

- MCOs have not been subject to external (performed by an entity besides the MCO) utilization review. This limits the state's ability to detect inappropriate service provision and whether any MCOs are recommending individuals for enrollment in STAR+PLUS HCBS waiver services who do not require that level of care. Utilization review is a cost control mechanism used to review the appropriateness of service provision, given client needs. Utilization review could identify instances of over- and under-provision of services. **Note:** In contrast, many Texas Medicaid programs providing comparable services to a similar client base are subject to utilization review and cost recovery including hospitals, nursing facilities, and 1915(c) Medicaid waiver programs administered by DADS.

- Redesign of the IDD service system via a managed care or managed care model could offer Texas increased flexibility, better integration of care, and improved resource decisions. **YES and NO...** In fact (and though not inclusive), according to the LBB Effectiveness and Efficiency Report:

  - Although Texas has had ongoing discussions about reform options for many years, it was not until passage of SB 7 (82nd Legislature, First Called Session, 2011) that a definitive directive was given. The bill required HHSC to seek an 1115 demonstration waiver to redesign the state's Medicaid program which included a provision that the waiver "allow for the redesign of long-term care services and supports to increase access to patient-centered care in the most cost-effective manner." The legislation, however, did not prescribe what the redesign should involve. **Note:** Although DADS presented a one page outline of the redesign to the Legislative Oversight Committee (called for in the bill) in July, it was not until the fall of 2012 that DADS solicited public input. As the result, the LBB concludes in its report that while the reform options provide Texas with the opportunity to address some of the challenges confronting its continuum of services for persons with IDD, without information to vet the costs and benefits of these approaches, implementation may expose the state to differing degrees of financial risk.

  - Consolidation of some or all of Texas IDD waivers could eliminate remaining programmatic differences across waivers, provide consumers with access to needed services, and result in administrative savings or efficiencies. However, consolidation, absent any other changes in program design (such as providing residential services based on preference and not need) could also result in significant increased costs due to creation of a merged service array.

  - The 2010 Health Management Associates (HMA) report that evaluated different managed care pilot program options for Texas concluded there was "not enough evidence that capitation would create savings sufficient to justify the risks and effort involved with significantly restructuring the IDD service delivery system." The lack of standard information about current client and interest list client needs could complicate implementation of managed care if Texas moved forward with this option.

  - Setting of initial rates and ongoing validation of the appropriateness of rates overtime could be difficult without a thorough understanding of client needs. In addition, if populations served under multiple waivers were brought into managed care and offered the same service array, this option could be more costly than the current system.

  - Implementation of a Community First Choice program in Texas (attendant care/habilitation benefit added to state plan) would create an entitlement program that DADS estimated in its fiscal year 2014–15 Legislative Appropriations Request would serve 11,902 persons at a cost of $35.8 million in General Revenue Funds for fiscal year 2015. It is unknown what impact, if any, the program will have on the number of persons who would remain on the HCS interest list given the lack of information about the needs of the interest list population. Given that many persons who receive the benefit are

likely to remain on the interest list for HCS to gain access to residential services and other waiver services, creating this benefit may not significantly change demand for HCS services but would result in a long-term funding commitment through creation of a new entitlement program.

Bill Strengths

1. The bill appears to support increased flexibility in how services are delivered, but only on a short term basis.

2. Although evidence to support this premise is needed, if the true cost driver is the delivery of acute care services, then transferring ONLY the management and provision of acute care services under an MCO (whether via STAR +PLUS, STAR or some other like managed care model) could potentially serve as a strength.

3. Article 1 of the bill supports person-centered planning which assures that individuals have choice, direction, and control over their respective Medicaid benefits. [While a strength, the provision supports this process ONLY if persons choose consumer direction.]

4. Article 3 of the bill supports establishment of a comprehensive assessment and resource allocation process, permits flexible, low-cost residential options and calls for increased behavioral supports for persons at risk of institutionalization via increased training and establishment of intervention teams - all critical needs within the current system . [Conversely, the bill states that the department may satisfy the requirement to implement the comprehensive assessment instrument and the resource allocation process by implementing the instrument and process only for purposes of the pilot programs. The bill further states that use of the assessment tool expires when the pilots expire which raises many questions not the least of which is why expend time, efforts and money on developing the assessment tool if long term use is not intended. This limitation does not apply to the behavioral intervention teams or prior authorization for enrollment in a residential setting. Lastly, while many support more flexibility in housing options, many equally question allowing development of congregate settings.]

5. Article 4 of the bill supports a quality-based long-term care payment system. [While a strength, it is not clear who or what entities fall under the system. In other words, does it include IDD providers?]

Bill Concerns (the list below is not inclusive)

1. There is not sufficient detail about the pilots to assess their intent, particularly to determine whether the goals and outcomes will provide any reliable data to compare their success to the 'perceived' success the bill contemplates will be achieved under STAR +PLUS. **Note:** To date information as to how the pilots would be structured has not been clearly articulated, and, as currently proposed in SB 7, appear to be testing an undefined model that will not yield any sound data to determine whether moving the IDD system of care (both acute care and long term care services and supports) will achieve the intended goal of SB 7.

2. The pilot provisions do not specify whether the individuals currently being served by a pilot provider will be required to participate or whether they will have the option to continue receiving the services to which they are accustomed. **Note:** DADS indicated in recent past forums that consumer participation in a pilot would not be mandatory.

3. The pilots, including the 'default to STAR +PLUS or STAR, exclude a critical component of the IDD system; i.e., persons residing in the SSLCs. Data from other states evidences that all IDD resources must be accessed to achieve any level of success. Exclusion of the SSLC resources is critical since Texas severely underfunds community-based services for this population when compared to other states. Without access to all IDD resources, moving to a managed care model will reduce the resources available

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to ensure persons needs are met and that their quality of life and health and safety are not compromised. *See item #7 below related to the community-based ICF/IID program.*

4. The bill excludes a local safety net to prevent and intervene early in behavioral and other crises (such as a direct service provider who relinquishes its contract with little to no notice). Heretofore, MCOs have not had to be responsible for these events and it is assumed adjustments to their current premiums to provide this added level of service will be necessary ((hence increasing costs).

5. The bill does not support the value of the existing provider network (both large and small) and their expertise and longstanding relationships with families and persons whom they serve.

6. While there are mixed opinions about the current structure of the IDD case management (CM) system, (both CLASS and HCS) the bill appears to transfer this role to the MCOs. If so, currently, MCOs are required to only contact a person once a year and are not required to be based locally. The result is no oversight of consumer satisfaction or care provision. As the responsibility for reporting complaints lies with the individual - not the provider - and given that many consumers do not have the capacity to communicate their concerns, if SB 7 is passed, it will be critical for HHSC and/or DADS to ensure that either the MCOs assume an enhanced role in providing CM or that another entity assumes this role. See below for more information related to the current roles and responsibilities of MCOs under STAR +PLUS.

7. Application of the bill to the ICF/IID community-based program is not clear. While the program is included in the pilots, there are questions as to whether the program will be transitioned into STAR +PLUS on September 1, 2018. On the other hand, Sec. 534.202 of the bill does call for the transition of persons in community-based ICFs/IID and in certain other Medicaid waiver programs to a managed care program.

8. While the bill calls for stakeholder input through the various stages of transition to a managed care model, the time for input and in depth discussion with stakeholders should have occurred prior to the filing of SB 57, and now its replacement, SB 7. Only one legislative committee hearing on the redesign concept occurred. At this July 31, 2012 hearing DADS laid out its redesign concept - a redesign concept (described on one page) that offered no information other than DADS would test multiple IID service models including capitated and non-capitated model. Prior to this presentation, DADS sought little input into the design and offered no specifics related to such when queried. In the fall of 2012 DADS conducted a meeting to receive stakeholder input, yet again, offered no specifics to assist stakeholders in providing any meaningful or relevant suggestions.

Current Role and Responsibilities of MCOs under STAR +PLUS

The information below is based on conversations with DADS, HHSC, providers that currently operate under STAR +PLUS and those who experienced the recent STAR/MRSA carve-in and comments made by individuals receiving services under STAR +PLUS and STAR/MRSA. As the result, **not all of the information should be assumed to be based on verifiable facts**. Although the fate of SB 7 is not known at this time, assuring that it includes provisions related to improving MCO accountability and processes/practices that do not penalize providers, etc. will be critical.

Note: While HHSC is in the process of making some changes to the current rules that govern the contracts it has with MCOs, stakeholders report that the changes being contemplated will not adequately resolve current stakeholder concerns and will not even begin to address concerns now being raised by IDD stakeholders resultant of the advent of SB 7.

1. DADS continues to conduct licensing surveys and complaint investigations of the providers under STAR +PLUS.

2. The contracts between the MCO and a provider are not without compliance requirements and, in many cases, almost parallel the contracts current IDD providers have with DADS.

3. The MCO is responsible for monitoring service authorization and claims and assessing client satisfaction.

4. Under the current STAR +PLUS (MCO) model, the individuals receiving services are responsible for selecting the plan (MCO) from which they receive services. Depending on the number of available plans in a given region, providers will not only have to maintain separate contracts with each MCO, but also bill each MCO separately for services provided. In short, providers will have to interface with more than one entity in coordinating care for the persons they serve.

5. MCOs have up to 30 days to pay claims (and several are known to go beyond the 30 days with no negative consequence applied by HHSC.

6. For the first 3 years of an MCO's operation they must contract with all eligible providers (referred to as Significant Traditional Providers) after which the MCOs can select the providers with whom they wish to contract.

7. Under the current system STP providers must accept MCO conditions for contracting and pass credentialing. Additionally, they must be licensed under HCSSA (medically-oriented requirements).

8. MCOs do have the authority to cancel contracts with providers that are not in compliance with their contract. DADS/HHSC also maintains the authority to revoke a provider's license.

9. Although HHSC provides a fee schedule to MCOs, they are not obligated to adhere to this schedule and may set whatever reimbursement rate they want. Some MCOs negotiate the rates they pay to certain providers.

10. The ability of MCOs to manage care for persons with significant behavioral health issues is untested.

People with Disabilities and Medicaid Managed Care: Key Issues to Consider
Issued February, 2012 by Henry J. Kaiser Family Foundation (excerpts)

Savings from managed care are uncertain... Short-term savings from managed care for persons with disabilities are likely to be elusive. Although risk-based managed care offers states increased budget predictability, managed care for persons with disabilities has not produced short-term Medicaid savings for states. Medicaid FFS payment rates, on which capitation rates may be based, are already so low in many states that there is effectively no "room" to extract cost savings by reducing price. That leaves utilization as the remaining source of potential savings. However, there is no evidence of over-utilization by beneficiaries with disabilities. On the contrary, large unmet needs for specialized care, high initial utilization due to pent-up demand and improved care coordination, and up-front administrative costs may help to explain why near-term savings, at least, have not materialized. In addition, effective care coordination for disabled beneficiaries requires a more intense and likely more expensive, multidisciplinary, team-based approach that spans health and social services, organizes and disseminates case information across providers, and includes face-to-face case management with active and regular beneficiary outreach efforts.

Sound efforts to reduce Medicaid spending associated with individuals with disabilities will focus on improving access and care management for these beneficiaries. Research examining the experience of four states that adopted managed care for adult Medicaid beneficiaries with disabilities suggests that managed care initiatives for this population that are driven by short-term budget imperatives are ill-advised. The potential for savings, the study concludes, lies in more appropriate patterns of care over time, especially reduced hospital utilization, that may result from better management of prescription drug use and more advanced clinical management and care coordination for people with disabilities.

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