STAR+PLUS MEDICAID MANAGED CARE: THE BEST OPTION FOR TEXAS

March 2009

A *Role of Government* LIFT PERSPECTIVE

Recommendations:

In order to contain the growing cost of the state's Medicaid program, the HMO managed care model must be expanded statewide. The HMO model (STAR and STAR+PLUS) has proven to be a stronger approach to managed care than either the ICM or PCCM models. Specifically, the HMO model:

- Is significantly more cost-effective for the state;
- Provides a more comprehensive level of care to Medicaid clients; and,
- Is less vulnerable to fraud and abuse than other Medicaid delivery models.

Therefore, legislators should support continued expansion of the STAR and STAR+PLUS Medicaid managed care models as follows:

- Expand the STAR+PLUS Medicaid managed care model by ending county-specific exemptions.
- Expand STAR+PLUS into the Dallas and Tarrant service areas.
- Expand STAR+PLUS into the El Paso and Lubbock service areas.

Executive Summary

The Texas Legislature has a critical decision to make for the future of Medicaid. In a public opinion survey conducted for TCCRI in June 2008, 79 percent of respondents said that Texas' health care system has some problems or is broken, and that it should be reformed or radically changed.[i]

The public's perception that Texas' healthcare system is broken is extremely high, despite the fact that state healthcare expenditures are large and growing rapidly. Since 2001, the cost of the Texas Medicaid program has doubled, while enrollment has increased by more than 70 percent. Such increases demand that the state employ the most cost-effective method of Medicaid delivery on a statewide basis. There are many tools to control costs, but the focus of this paper is managed care.

Currently, there are three major Medicaid delivery models being utilized in Texas: the Health Maintenance Organization (HMO) managed care model, the Primary Care Case Management (PCCM) model, and the Integrated Care Management (ICM) model. At the end of 2007, the Texas Health and Human Services Commission (HHSC) reports, 1.9 million Texas Medicaid recipients were enrolled in one of these three models, while the remaining 911,000 Medicaid recipients were covered on a fee-for-service basis.[ii] The HMO model – which is delivered primarily through the STAR and STAR+PLUS programs – is the largest, accounting for 45 percent of Medicaid enrollment. The fee-for-service model accounts for 29 percent of Medicaid enrollment, and PCCM/ICM account for 26 percent of enrollment.[iii]

The STAR and STAR+PLUS programs are the only managed care approaches that work exclusively on a fee-per-member basis. Under STAR and STAR+PLUS, the state pays an HMO a fixed amount per Medicaid enrollee; the HMO then manages the health care of the Medicaid enrollee, placing them within a network of healthcare providers. HHSC estimates suggest that expansion of the STAR and STAR+PLUS programs to the exempted counties in South Texas could save the state $46 million in 2010-11 and $122 million in 2012-13.[iv] This expansion would also result in 7,280 Medicaid clients coming off waiting lists: this would represent a 23 percent waiting list reduction at no cost to the state, because STAR+PLUS automatically takes SSI eligible individuals off community-based alternative wait lists. According to HHSC, without STAR+PLUS, the cost of this waiting list reduction would total $82 million over each biennial budget cycle.[v]

Under the HMO model, the state has a greater degree of budget certainty and the Medicaid enrollee receives a higher quality of care. The incentives are aligned for HMOs to redirect care away from unnecessary and costly over-utilization of emergency room care and hospitalization and to invest funds into prevention, disease management, and long-term care support services. As a result, HHSC reports that Medicaid enrollees "receiving care coordination services in an integrated environment (e.g. STAR+PLUS beneficiaries) have lower rates of inpatient stays…[and] ER visits when compared to rates for SSI beneficiaries in nonintegrated environments without care coordination."[vi]

Aligning these incentives is good for patients, better for tax payers and creates cost containment for the state budget. The per-enrollee fee paid by the state is also significant in the HMO model, because it

limits the opportunity for fraud that exists when the state is billed on a per-procedure basis, which can be far more prevalent in other models of Medicaid delivery.

The ICM Medicaid delivery model, created by HB 1771 in the 79th Legislature and rolled out in the Dallas and Tarrant service areas (comprising 12 north Texas counties) in 2007 and 2008, is flawed and was recently criticized by HHSC. Testifying before the Senate Finance Committee on February 11, 2009, HHSC Commissioner Albert Hawkins described the problems that the state has experienced with the ICM model in north Texas:

> By April of '08 we documented some deficiencies and placed them on a corrective action plan…there have been subsequent corrective action plans; we've fined them…they have made some efforts to respond to deficiencies we identified in the corrective action plan, it has not resolved the problems and the problems do persist.

The strengths of the fully capitated model contrast sharply with the fiduciary and qualitative deficiencies that are evident in the ICM model, and demand that the STAR and STAR+PLUS HMO managed care programs be expanded statewide. Specifically, the Legislature should:

- Expand the STAR+PLUS Medicaid managed care model by ending county-specific exemptions in parts of South Texas;
- Expand STAR+PLUS into the Dallas and Tarrant service areas as allowed under current statute; and,
- Expand STAR+PLUS into the El Paso and Lubbock service areas as allowed under current statute.

The STAR+PLUS managed care model is a necessary response to the imperfections and inherent short-comings of a mammoth government-sponsored health insurance program, like Medicaid. Without approaches such as STAR+PLUS, cost containment in Medicaid is virtually impossible, opportunities for fraud greatly enhanced, and clients receive a lower quality of care.

STAR+PLUS Managed Care: The Best Option for Texas

The STAR+PLUS managed care model of Medicaid delivery is far superior to other models in terms of both cost to the state and quality of service to clients, as well as reducing opportunities for fraud. While the STAR+PLUS HMO model has been operating successfully in Harris County since 1998, other approaches to Medicaid delivery have been less successful, generating fewer cost savings to the state and encountering service quality problems.

Most notably, the Integrated Care Management (ICM) model, which has been operating in the Dallas and Tarrant service areas since early 2008 has drawn the ire of the Health and Human Services Commission (HHSC). Testifying before the Senate Finance Committee on February 11, 2009, HHSC Commissioner Albert Hawkins described the problems that the state has experienced with the ICM model in north Texas. An HHSC document presented to the Committee highlighted the specific drawbacks of the ICM model[vii]:

- Incorrect/incomplete information submitted for service authorization.
- Delays in provider credentialing.
- Online provider information not reflecting the current network.
- Deficient provider education regarding network requirements and billing.
- Aggressive and inappropriate marketing of Evercare Medicare products to ICM members; confusing clients, physicians, and long-term services and supports providers.
- Lack of timely access to acute-care physicians.
- Lack of timely access to long-term services and supports.
- Failure to provide adequate service coordination.

Definitions

Managed Care *– An approach to Medicaid delivery that provides clients with a network of care providers.*

Capitated Managed Care *- A fully comprehensive managed care model that combines the financing and delivery of health care services under one entity.*

HMO *– Health Maintenance Organizations are licensed by the State and serve as single entity capitated managed care providers.*

STAR and STAR+PLUS *– Texas' largest managed care programs, providing managed care to more than one million Medicaid enrollees.*

ICM and PCCM *– Integrated Care Management and Primary Care Case Management are non-capitated, non comprehensive approaches to Medicaid delivery in which financing and delivery of health care are separated. Providers and hospitals contract directly with the State and are paid on a per service basis; the State pays separately for administrative services.*

Similarly, the *Dallas Morning News* reported (January 7, 2009) that:

> From February through early December 2008, the commission fielded more than 1,300 complaints about Evercare's [ICM] program, and experts believe that represents only some of those who've had problems. Complaints include difficulty locating a primary care physician and problems with "service coordination".[viii]

But the problem with ICM extends far beyond service delivery problems experienced by the contractor. There are also significant drawbacks associated with the less comprehensive approaches such as ICM. These drawbacks include:

- The ICM model has complexities that make it different from the STAR+PLUS program. For instance, the ICM model requires close coordination between multiple vendors, including the Fee-For-Service claims administrator, the Department of Aging and Disability Services (DADS), and Maximus (the enrollment broker). This multi-step, bureaucratic process can hinder the timely provision of services to members.
- The ICM model does not allow any flexibility in Medicaid benefits, which can result in more costly services being provided to members and higher levels of hospitalization than would be the case under other models.
- While implementation of electronic streamlining and access to databases are necessary to improve the performance of the ICM model, they are not a part of the piloted model currently in operation in the Dallas and Tarrant Service Areas.
- The ICM model is the most expensive model for long term care services and support.
- The root cause of many ICM complaints is the length of time involved to complete service authorizations through the Department of Aging and Disability Services (DADS).

Left unexplored in Commissioner Hawkins' February 11 testimony is whether the interest groups that actually lobbied for the integrated care management system made a policy error. If the system was flawed in its concept, the testimony omitted a thorough exploration of those flaws. Furthermore, the Legislature should begin to examine the culpability on the part of the state in the mismanagement of large outsourcing contracts, and the state's role in incomplete or inadequate implementation which contributes to delivery failures.

In the face of the problems specific to ICM, it is critical that the state utilize its most successful Medicaid delivery model by expanding STAR+PLUS statewide. HHSC estimates suggest that expansion of the STAR+PLUS program could save the state $46 million in 2010-11 and $122 million in 2012-13.[ix] This expansion would also result in 7,280 Medicaid clients coming off waiting lists: this would represent a 23 percent waiting list reduction at no cost to the state. According to HHSC, without STAR+PLUS, the cost of this waiting list reduction would total $82 million over each biennial budget cycle.[x]

"It is critical that the state utilize its most successful Medicaid delivery model by expanding STAR+PLUS statewide."

Currently, statute prohibits expansion of STAR+PLUS into Cameron, Maverick and Hidalgo Counties, while state law allows significant scope for expansion into the Dallas, Tarrant, Lubbock, and El Paso service areas, though HHSC has not proceeded in those areas.

These projected budget savings will be particularly important as the state seeks to address the rising cost of its Medicaid program, which provides subsidized health care coverage to low income and needy Texas residents. The cost of the program is increasing dramatically: in 2009, state and federal spending on Texas Medicaid will total $24.5 billion, which represents a doubling of cost in just eight years since 2001 when the program cost $12.3 billion.[xi]

In 2001, there were 1.7 million people enrolled in the Texas Medicaid Program, by the end of 2007 (the last year for which data are available), there were 2.9 million enrollees. Disturbingly, the state population has only risen by 12 percent[xii] in the same period. In short, Texas Medicaid enrollment has increased by at least 70 percent over the past eight years, while state and federal spending on the program has increased by 100 percent over the same period.

In the face of such dramatic enrollment and cost increases, it is important that the Legislature continues to take steps to ensure that Medicaid services are delivered as cost-effectively as possible to all areas of the state, without compromising the quality of care or access.

TEXAS MEDICAID EXPENDITURES 1987 - 2009

Year	State Medicaid Spending ($ billion)	Total Medicaid Spending ($ billion; includes Federal funds)
2009	$14.531	$24.482
2008	$13.630	$22.523
2007	$12.813	$21.085
2006	$11.193	$18.444
2005	$10.928	$17.953
2004	$10.444	$16.804
2003	$ 9.995	$16.201
2002	$ 8.573	$14.270
2001	$ 7.434	$12.298
2000	$ 6.910	$11.291
1999	$ 6.918	$11.095
1998	$ 6.445	$10.382
1997	$ 6.245	$10.028
1996	$ 6.022	$ 9.691
1995	$ 5.734	$ 9.097
1994	$ 5.459	$ 8.528
1993	$ 4.721	$ 7.341
1992	$ 4.062	$ 6.382
1991	$ 2.699	$ 4.247
1990	$ 1.993	$ 3.256
1989	$ 1.421	$ 2.408
1988	$ 1.234	$ 2.153
1987	$ 1.142	$ 2.055

Source: Texas Health and Human Services Commission, Texas Medicaid & CHIP in Perspective, January 2009.

Started in 1993, Medicaid managed care forms the centerpiece of the Legislature's response to the rising cost of the Medicaid program:

> Managed care refers to the body of clinical, financial, and organizational activities designed to ensure better access to health care services; improve quality; promote more appropriate utilization of services; and contain costs.[xiii]

Medicaid managed care differs from traditional Medicaid in that clients typically receive primary and preventive care from an assigned primary care physician (the "medical home") and specialist care, when necessary, from a defined network of providers.

According to HHSC, managed care organizations "comprehensively monitor and evaluate the appropriateness, necessity, and efficacy of health care services delivered to clients (called members in managed care) on a prospective, concurrent, or retrospective basis."[xiv] In addition, the state requires that managed care organizations undertake continual quality assessment and performance improvement to ensure that clients are receiving a high quality of care and that the state's investment is being used as effectively as possible.[xv] Essentially, managed care works with clients to keep them healthy through preventive care and uses disease management to treat those with acute medical conditions.

Approaches to Medicaid Delivery

In the HMO (or "capitated") managed care model, the state pays a specific amount per person to the HMO, and the HMO assumes the financial risk of providing all medically necessary services.

Conversely, the ICM and PCCM (or "non-capitated") Medicaid delivery models assign a primary care physician to each client and use an administrator to set up physician networks and liaise with providers. Under the ICM and PCCM models, providers are reimbursed on a fee-for-service basis and primary care physicians receive a monthly "case management" fee based on the number of clients in their care.[xvi] These approaches can be summarized as follows:

- **Health Maintenance Organization (HMO) model:** Served 1,069,208 STAR and 115,004 STAR+PLUS enrollees in 2007.[xvii]

  Health Maintenance Organizations (HMOs), which are licensed by the Texas Department of Insurance, deliver and manage health services under risk-based arrangements. Each HMO contracts with providers and hospitals to form a network that serves Medicaid clients. The HMO receives a monthly capitation rate for each enrollee, which allows a fixed price and budget certainty for the State while the HMO assumes the risk for providing all eligible services.

  The full-risk model provides the most comprehensive managed care approach because it integrates both the financing of services and the accountability for delivery of services and improved outcomes under one umbrella organization. Thus, the twin incentives for the HMO are to control unnecessary utilization of services while also encouraging enrollees to seek primary and preventive health services.

- **Primary Care Case Management (PCCM) model:** Less comprehensive program model, served 737,439 Texans in 2007.[xviii]

  Under this model, each Medicaid client selects a primary care provider (PCP) who is responsible for the coordination of services for the client; however, providers and hospital networks contract directly with the State and are paid on a per-service basis. PCPs receive a monthly case management fee, in addition to payment for the services they render to clients. This model is non-capitated, and thus the alignment of the financing and delivery of health care are separated, potentially creating an avenue for duplication of effort and the emergence of unnecessary costs. Moreover, under the PCCM model, the level of coordination for complex

medical issues and accountability to the State for achieving health outcomes is lower than under a capitated program.

- **Integrated Care Management (ICM) model:** Provides a less comprehensive approach to the integration of financing and delivery of services. Like the PCCM model, the ICM model is a non-capitated model that pays for acute and long-term services and supports and provides service coordination. Providers and hospitals contract directly with the State and are paid on a per service basis. Separately, the State pays for a certain set of administrative services, such as prior authorization and utilization review.

The most successful model in achieving the comprehensive program goals of controlling costs, improving quality and access, and creating investment in innovation is the full-risk, capitated model delivered through the STAR and STAR+PLUS programs. The STAR program serves Medicaid clients who are eligible under the Temporary Assistance for Needy Families (TANF) program, and the STAR+PLUS program integrates acute and long-term care services and supports for clients who are eligible for Supplemental Security Income (SSI) and related services.

Benefits of the Full-Risk, Capitated Approach

A full-risk, capitated approach like that used in the STAR and STAR+ PLUS programs is the most comprehensive solution to address the complex medical, behavioral, and social needs of Medicaid clients. In Texas, enrollees in STAR+PLUS are generally those with the most complex health needs and most costly potential expenditures. However, through improved care coordination and management, STAR+PLUS has improved access to services, reduced duplication, and created a more effective delivery of health care services which benefits both the clients and the State. The STAR+PLUS programs have stemmed the costs for this population, while also establishing greater accountability for the services delivered to individuals under Medicaid.

"HMOs have incentives to coordinate care and services that reduce the costs of inpatient care, over-utilization of prescription drugs, and other expensive categories of health care services."

The full-risk, capitated managed care approach also offers the maximum cost control benefit to the State. A full-risk model combines the responsibility for both the financing and delivery of health care services under one entity and drives a patient-centered management approach to addressing multiple and complex health care needs. Under the full-risk model, HMOs have incentives to coordinate care and services that reduce the costs of inpatient care, over-utilization of prescription drugs, and other expensive categories of health care services. In one study, the rates of preventable hospitalization were reduced by 38 percent over the fee-for-service experience for individuals eligible for TANF, like those individuals enrolled in the STAR program.[xix] Another study of the STAR+PLUS program showed that the program achieved 17 percent program savings over what would have been spent absent the program.[xx]

In addition to the inherent strengths of the fully capitated, STAR+PLUS model, the fully comprehensive, capitated approach creates opportunities to deliver high quality services to clients and savings to the state through a number of mechanisms. A review of 22 Medicaid managed care studies conducted by the Lewin Group determined that these mechanisms include[xxi]:

- Improving access to preventive and primary health care by requiring participating doctors and hospitals to meet standards for hours of operation, availability of services, and acceptance of new patients;
- Investing in enrollee outreach and education initiatives designed to promote utilization of preventive services and healthy behaviors;
- Providing a "medical home" to an individual and utilizing a physician's expertise to refer patients to the appropriate place in the system, as opposed to relying on the patient's ability to self-refer appropriately;
- Providing individualized case management services and disease management services;
- Channeling care to providers who use clinical best practices;
- Using lower-cost services and products where such services and products are available and clinically appropriate, in lieu of higher-cost alternatives; and,
- Conducting provider profiling and enhancing provider accountability for quality and cost-effectiveness.

Access to Care

All health plans participating in the Texas Medicaid program must develop, maintain, and operate a quality assessment and performance improvement program to evaluate performance using objective quality standards. These measurable quality indicators show broad client satisfaction with the care they receive under the managed care model.

An independent evaluation of the quality of services delivered under STAR+PLUS showed benefits for both patient quality and program costs.[xxii] Overall, members reported satisfaction with the Care Coordinator's ability to solve problems with services, such as housing, meals, and transportation. 72 percent reported they were either "satisfied" or "very satisfied" with the Care Coordinator's ability to solve problems with their services, while 60 percent reported the Care Coordinator "usually" or "always" offered explanations that were understandable.

Almost 65 percent of STAR+PLUS enrollees had an outpatient follow-up within 30 days of an inpatient admission for mental illness, surpassing the national average of 57 percent.[xxiii] Ensuring continuity of care and providing follow-up in the community after inpatient stays for mental illness have been shown to reduce enrollees' health care costs and to improve their outcomes of care.

In a 2007 survey conducted by the Institute for Child Health Policy (ICHP), 82 percent of STAR+PLUS enrollees said they had a personal doctor or nurse to whom they had access. 96 percent ranked their satisfaction in the top half on a scale of one to ten, while 89 percent ranked their satisfaction in the top third. Satisfaction with specialty care was also high. Over 60 percent of STAR+PLUS enrollees stated that they usually or always could get appointments for care when they wanted it.[xxiv]

Preventing Fraud

The HMO managed care model is also less vulnerable to fraud than other methods of Medicaid delivery. Because the state contracts with HMOs on a flat monthly fee-per-client basis, there is no scope for the state to be fraudulently billed for health services. According to the Office of Attorney General's Medicaid Fraud Control Unit, there are many types of Medicaid fraud that it is frequently called to investigate. These include:

- billing Medicaid for X-rays, blood tests, and other procedures that were never performed, or falsifying a patient's diagnosis to justify unnecessary tests;
- giving a patient a generic drug and billing for the name-brand version of the medication;
- giving a patient over-the-counter drugs or goods and billing for the prescription drug;
- billing Medicaid for care not given, for care given to patients who have died or who are no longer eligible, or for care given to patients who have transferred to another facility;
- transporting Medicaid patients by ambulance when it is not medically necessary;
- requiring vendors to "kick back" part of the money they receive for rendering services to Medicaid patients (kickbacks may also include vacations, merchandise, etc.); and,
- billing patients for services already paid for by Medicaid.[xxv]

It is evident that these types of fraud are prevalent in areas of the state that are not subject to the STAR+PLUS managed care models. For instance, some South Texas counties, including Cameron, Hidalgo, and Maverick County are exempted from managed care and operate their Medicaid programs on a fee-for-service basis through the South Texas Health System. In 2007, it was reported that:

> Medicaid and Medicare fraud often occurs when health care providers bill for fake patients or charge the government for services they did not render. In several cases in the Rio Grande Valley, health-care providers have been accused of committing fraud without the knowledge of their bosses.[xxvi]

"In FY2007, $6.7 million of fraudulent payments were recovered from hospitals and county health systems in three South Texas counties…the Valley has the highest per-capita level of Medicaid fraud in Texas."

The Health and Human Services Commission' Office of Inspector General reported that in FY2007, $6.7 million of fraudulent payments were recovered from hospitals and county health systems in three South Texas counties. These figures confirm that the Valley has the highest per-capita level of Medicaid fraud in Texas.[xxvii] A sample of alleged Medicaid Fraud in South Texas is instructive:

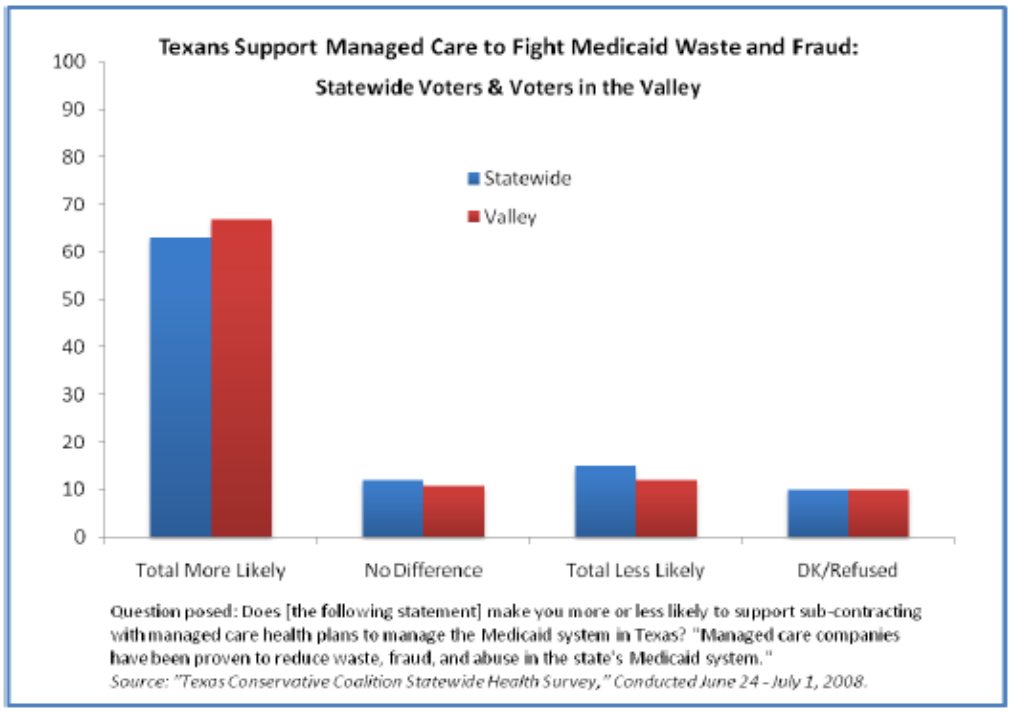
- In December 2006, the *Brownsville Herald* reported that two men in Cameron County were charged with embezzling up to $100,000 from the Medicaid program.[xxviii]

- In October 2007, it was reported that:

> [F]ederal officials are now looking into the details of physician contracting relationships within its South Texas Health System. The investigation seemingly focuses on whether South Texas made illegal payments to physicians and others. Earlier this year, South Texas was served with a criminal subpoena by federal officials, who were investigating potential False Claims Act violations.[xxix]

- On December 1, 2008, the U.S. Department of Justice confirmed that cardiologist Fabian Aurignac would be prosecuted for health care fraud in McAllen, Texas.[xxx]

Expanding STAR+PLUS statewide would eliminate many of the opportunities for fraud by removing the ability of health care providers to bill the state's Medicaid program for services. Instead, the state pays on a fixed monthly fee-per-client basis and the STAR+PLUS program assumes the full financial risk for providing all necessary care. According to a public opinion survey carried out for TCCRI, the fact that managed care programs have been proven to reduce Medicaid waste and fraud makes Texans more likely to support Medicaid managed care sub-contracting. Among Texans in the Valley, support for managed care is even stronger as a result of its success at reducing fraud and waste:



More broadly, waste and fraud in HHSC programs is a considerable problem in Texas: in its 2008 annual report, the HHSC Office of Inspector General reported that FY2008 recoveries totaled more than $270 million.[xxxi] These recoveries arise from OIG actions such as utilization reviews of hospitals and nursing homes, general investigation of Medicaid recipients, and recoupment of overpayments to providers.[xxxii]

Recommendations

The fully-capitated STAR+PLUS approach to managed care demonstrably provides the best quality care to Texans at the lowest cost to the state. Expanding STAR+PLUS is imperative. TCCRI has recommended expansion of STAR+PLUS since at least 2005. In its Health and Human Services Task Force report published in February 2005[xxxiii], TCCRI noted that:

> The STAR+PLUS program could be important tool in balancing the increasing cost and variable quality inherent to Texas' long-term care system. The STAR+PLUS program should be expanded to additional urban areas beyond Harris County, where it has been used since 1998, in an effort to further advance long term care integration.

The report went on to argue that:

> Expanding the STAR+PLUS program could result in enhanced cost savings to the state and improved access and quality of care for clients. Since 1998 the STAR+PLUS program has demonstrated positive outcomes with regards to access to health care services, quality of care, member satisfaction and cost effectiveness.
>
> The STAR+PLUS program has demonstrated the ability to maintain aged, blind and disabled individuals in their communities and produced significant cost savings for a high-risk population that traditionally accounts for a disproportionate share of Medicaid expenditures.

In line with these recommendations, continued expansion of STAR+PLUS must be pursued by the 81st Legislature in light of the budget crisis and the failure of the ICM model. To ensure that the state is able to achieve the maximum possible benefit from the fully comprehensive, capitated approach, the following expansions of that model are recommended:

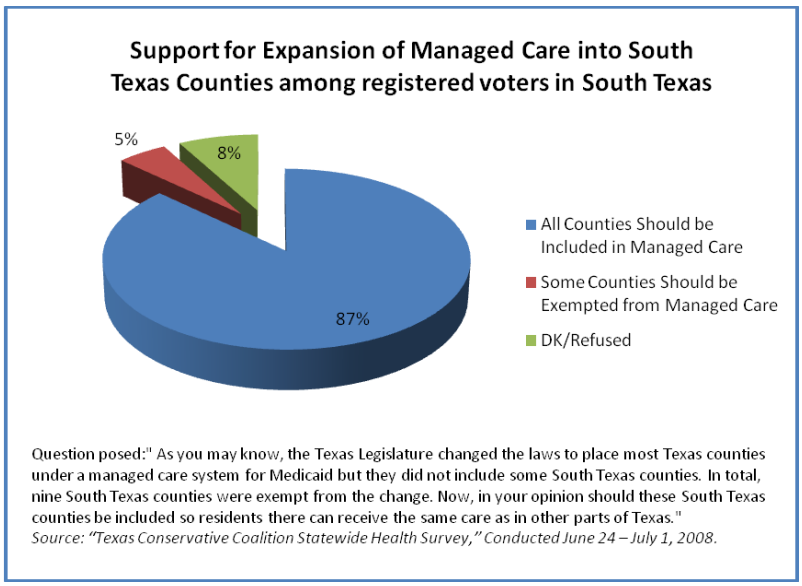
- **Expand the STAR+PLUS Medicaid managed care model by ending county-specific exemptions.**

Currently, the Texas Government Code (Section 533.0025) prohibits the Health and Human Services Commission from providing "medical assistance using a health maintenance organization in Cameron County, Hidalgo County, or Maverick County." This provision was added as a floor amendment (H92) to House Bill 2292 (78R) in 2003.

As of February 2009, according to HHSC monthly Medicaid enrollment statistics, Cameron County has 86,769 Medicaid recipients, Hidalgo County has 168,889 Medicaid recipients, and Maverick County has 13,323 recipients. With almost 270,000 Medicaid recipients between them, these three counties represent 10 percent of the state's Medicaid population. However, according to the U.S. Census Bureau, these three counties make up just 2.7 percent of the state's total population. Furthermore, in a public opinion survey conducted for TCCRI in June and July of 2008, 87 percent of

registered voters in the Valley agreed that all Texas counties should be included in Medicaid managed care.[xxxiv]

That Cameron, Hidalgo, and Maverick County have high rates of Medicaid enrollment makes their exemption from Medicaid Managed Care indefensible and costly. Other areas of the state, such as the Harris County service area, are using a more efficient model of Medicaid delivery that provides a higher quality of care to a larger number of clients at less cost to taxpayers. Every Medicaid service area should use the method of service delivery that is most efficient and that constitutes the most effective use of taxpayer dollars. STAR+PLUS has proven to be the most cost-effective model of service delivery and also to provide the highest quality of care to Medicaid recipients; it should therefore be expanded to the South Texas counties that are currently exempt from Medicaid managed care. Indeed, South Texas counties already operate another form of managed care through the Children's Health Insurance Program (CHIP).



If the state is to provide access to high-quality Medicaid services as efficiently as possible, all impediments to further expansion of Managed Care must be removed. There is no justification for expecting taxpayers to pay for a more costly Medicaid program with little or no accountability.

- **Replace ICM with STAR+PLUS in the Dallas and Tarrant Service Areas.**

House Bill 1771 (79R) directed the Health and Human Services Commission to "establish an Integrated Care Management (ICM) model pilot project for cash assistance and non-cash assistance, dual eligible, and Community Based Alternatives (CBA) waiver Medicaid recipients."[xxxv] In response to this legislative directive, HHSC created an ICM Advisory Committee to assist "in the development and implementation of the ICM model to serve the eligible ABD populations in the Dallas and Tarrant service areas."[xxxvi]

Since July 2007, the ICM model has been operational in the Dallas and Tarrant service areas, which comprise thirteen north Texas counties: Collin, Dallas, Denton, Ellis, Hood, Hunt, Johnson, Kaufman, Navarro, Parker, Rockwall, Tarrant, and Wise Counties. Since the implementation of ICM in the Dallas and Tarrant Service Areas, HHSC has had to intervene with corrective action plans to improve the quality of service being received by Medicaid ICM enrollees.

The strengths of the fully-capitated STAR+PLUS model contrast sharply with the fiduciary and qualitative deficiencies that are evident in the ICM model. Therefore, the Legislature should amend Chapter 533 of the Government Code to direct HHSC to expand the successful STAR+PLUS Medicaid managed care program into the Dallas and Tarrant service areas.

- **Expand STAR+PLUS into the El Paso and Lubbock service areas.**

The success of Managed Care in the Texas Medicaid program, and particularly the cost savings and quality improvements brought about by the STAR and STAR+PLUS programs support the conclusion that Legislators should encourage continued expansion of STAR and STAR+PLUS. The STAR+PLUS program should be expanded to the El Paso and Lubbock service areas. As of February 2009, there are 31,846 Medicaid recipients in the El Paso area and 11,806 Medicaid recipients in the Lubbock service area who are either aged, blind or disabled. [xxxvii]

These service areas were included in the initial expansion plan for STAR+PLUS beyond the Harris county pilot area but due to the modified payment structure for inpatient hospitals services to comply with Senate Bill 1, Article II, Special Provisions, Sec. 49 passed during the 79th Legislature, Regular Session, 2005, expansion to these counties were halted.

ENDNOTES

[i] "Texas Conservative Coalition Statewide Health Survey," Conducted June 24 – July 1, 2008. Question posed [Responses]: "Please tell me which of the following statements you agree with most: 1. Texas' health care system works well and should be kept basically the same as it is now [16%]; 2. Texas' health care system has some problems and should be reformed [60%]; 3. Texas' health care system is broken and should be radically changed [19%]; 4. DK/Refused [5%].

[ii] "Texas Medicaid and CHIP in Perspective," (7th Edition), Health and Human Services Commission, January 2009. HHSC, "Texas Medicaid in Perspective," January 2007.

[iii] Commissioner Albert Hawkins testimony to the Senate Committee on Health and Human Service, February 10, 2009.

[iv] HHSC document presented to the Article 2 Budget Workgroup.

[v] Commissioner Albert Hawkins testimony to the Senate Committee on Finance, January 11, 2009.

[vi] HHSC presentation "STAR+PLUS Medicaid Managed Care Program."

[vii] "Integrated Care Management," HHSC Presentation to the Senate Finance Committee, January 11, 2009.

[viii] "Critics say Texas' Evercare program is more like 'nevercare'," *Dallas Morning News,* January 7, 2009.

[ix] HHSC document presented to the Article 2 Budget Workgroup.

[x] Commissioner Albert Hawkins testimony to the Senate Committee on Finance, January 11, 2009.

[xi] "Texas Medicaid and CHIP in Perspective," (7th Edition), Health and Human Services Commission, January 2009.

[xii] United State and Texas Populations, 1850-2007, Texas State Library and Archives Commission.

[xiii] HHSC, "Texas Medicaid in Perspective," January 2007.

[xiv] *Ibid.*

[xv] *Ibid.*

[xvi] *Ibid.*

[xvii] "Texas Medicaid and CHIP in Perspective," (7th Edition), Health and Human Services Commission, January 2009.

[xviii] *Ibid*

xix Medicaid Managed Care Cost Savings – A Synthesis of 22 Studies, July 2004, Revised February 2008.

xx *Ibid*

[xxi] *Ibid.*

[xxii] The Texas STAR+PLUS Adult Enrollee CAHPS®, Health Plan Survey Report, Fiscal Year 2007

[xxiii] The Texas STAR+PLUS Adult Enrollee CAHPS®, Health Plan Survey Report, Fiscal Year 2007

[xxiv] *Ibid.*

[xxv] Medicaid Fraud Control Unit, Office of the Attorney General.

[xxvi] "Company Points to Fraud," *The Monitor, February 17, 2007.*

[xxvii] Health and Human Services Commission, Office of Inspector General, Semi-Annual Report, May 2007.

[xxviii] "Company Points to Fraud," *The Monitor, February 17, 2007.*

[xxix] "Universal Health Faces Wider Federal Investigation," *Fierce Healthcare,* October 31, 2007.

[xxx] "McAllen Cardiologist Indicted for Health Care Fraud," U.S. Department of Justice, News Release, December 1, 2008.

[xxxi] HHSC Office of Inspector General, Annual Report, 2008.

[xxxii] *Ibid.*

[xxxiii] "Improving Healthcare for All Texans," Final Report of the TCCRI Health and Human Services Task Force, February 2005.

[xxxiv] "Texas Conservative Coalition Statewide Health Survey," Conducted June 24 – July 1, 2008. Question posed: "As you may know, the Texas Legislature changed the laws to place most Texas counties under a managed care system for Medicaid but they did not include some South Texas counties. In total, nine South Texas counties were exempt from the change. Now, in your opinion should these South Texas counties be included so residents there

can receive the same care as in other parts of Texas." Respondents: All counties included, 87%; Some counties exempted, 5%, DK/Refused, 8%.

[xxxv] House Research Organization Analysis of HB1771(79R), April 26, 2005.

[xxxvi] Texas Health and Human Services Commission, Request for Proposals for Integrated Care Management Contractor, August 14, 2006.

[xxxvii] HHSC Medicaid Monthly Enrollment Statistics, February 2009.