



MEDICAID MANAGED CARE FOR FOSTER CHILDREN: AN EARLY REPORT

After a series of high-profile serious child abuse cases, the Governor directed the Health and Human Services Commission (HHSC) to review the state's Child Protective Services (CPS) program in 2004. In its review of health care, HHSC found that children in foster care do not get optimal health care because of frequent changes in placements and health care providers, fragmented medical records, inconsistent access to appropriate care, and delays in Medicaid certification.¹ To address these systemic barriers, Senate Bill 6 in 2005 directed HHSC to create a new health care delivery model to provide foster children with comprehensive services, a "medical home," and coordinated access to care. HHSC worked with the Department of Family and Protective Services (DFPS) to develop STAR Health, a new Medicaid managed-care model for foster children, which was implemented on April 1, 2008. This report explores the initial implementation of the program and STAR Health's potential to improve health outcomes for foster children.

Health Care Needs of Foster Children

Children in the foster care system have unique and complex health care needs.² Children in state custody usually were victims of abuse or neglect at home. Removing children from these circumstances may be necessary to protect them; nevertheless, removal from the home, separation from parents and sometimes siblings, and movement between multiple placements traumatizes children.³

In addition, children entering foster care often were exposed to poverty, insufficient prenatal care, prenatal maternal substance abuse, parental mental illness, parental substance abuse, or family and community violence.⁴ As a result, children in foster care have a higher prevalence of physical health, behavioral health, and developmental problems than other children from the same socioeconomic backgrounds.⁵

Researchers estimate that 60 percent of foster children have a chronic medical condition, 25 percent have three or more chronic conditions, and between 54 and 80 percent of foster children have diagnosable behavioral health or psychiatric conditions.⁶

Due to their complex health care needs, foster children need access to and coordination of a range of health care services. Texas aims to meet this need through STAR Health, a managed-care model designed specifically for the foster care population.

Managed Care

Managed care refers to specific arrangements for organizing, delivering, and financing health care in a manner that encourages early access to preventive and primary care, appropriate use of services, and lower costs. Some common features of managed-care models include:

- **Provider Networks.** For most services in managed care, patients must seek care within a defined network of providers under contract with the managed care organization.
- **Primary Care Providers.** Patients in managed care must select an in-network primary care provider to provide preventive and primary care and coordinate referrals to specialty care.
- **Utilization Management.** Managed care organizations monitor care to ensure that it is

appropriate and medically necessary. For example, through prior authorization, a common utilization management tool, managed care organizations authorize or deny requests for certain expensive services in advance based on medical necessity.

- **Capitation.** Managed care organizations generally are paid a “capitated” rate, a fixed rate paid per person per month to cover health care services and program administration. Capitated arrangements place the managed care organization at risk for covering costs if they exceed the capitated rate and allow the managed care organization to profit if costs are less than the capitated rate. Capitation provides budget certainty for the health care purchaser (in this case Medicaid). Not all managed-care models are fully financed through capitation.

Managed care differs in several ways from the traditional “fee-for-service” method of delivering and financing health care. In fee-for-service systems, the health care purchaser directly pays providers for each health care service provided and bears the full risk of paying for covered health care services. Patients can generally see any willing provider, and providers are not obligated to coordinate care with other providers.

In fee-for-service systems, medical providers have a financial incentive to provide more care to increase their income. Managed care was designed to reverse this incentive and reward the provision of preventive care rather than expensive treatment procedures. Of course, managed care creates a financial incentive to provide less care, so capitated managed care systems must be carefully monitored to ensure they do not restrict access to medically necessary care in order to remain profitable.

But with proper oversight, managed care can effectively control health care costs. Providers contract with managed care organizations at specific reimbursement rates. Managed care organizations attempt to use their negotiating power to minimize provider reimbursement rates while providers seek to maximize rates. Managed care organizations also control costs by coordinating care. This

includes encouraging people to seek more cost-effective and appropriate care through primary care physicians than, for example, through hospital emergency rooms. It also involves denying requests for care that is not medically necessary. Finally, by providing access to preventive and primary care, managed care seeks to control costs by keeping its enrollees healthier.

Texas Medicaid Managed Care

As directed by the legislature, Texas implemented its first Medicaid managed care pilot program in 1993. Managed care expansions have since been implemented across the state. Today, more than 85 percent of the Texas Medicaid population is enrolled in managed care.⁷

In Texas, as in most other states, Medicaid programs increasingly turn to managed care to address two common issues with Medicaid: (1) rising medical costs and (2) difficulty finding providers willing to treat Medicaid clients. Capitated managed care offers a degree of budget certainty to the state, a clear benefit. The state pays a fixed, capitated rate per person to contracted managed care organizations that, in turn, must deliver coordinated care within the capitated budget or lose money. State oversight of managed care must ensure balanced incentives, so that managed care organizations do not under-serve Medicaid clients to remain profitable.⁸

Medicaid clients traditionally have relatively poor access to providers. Medicaid reimburses providers less than other payors like private health insurance and sometimes less than actual costs. Due to low reimbursement, many providers refuse to take Medicaid, thus limiting access to care for Medicaid clients. Medicaid managed care can increase access if its networks of providers are more willing to treat Medicaid clients. While increased access helps Medicaid clients, managed care also has trade-offs for clients. Managed care limits the freedom of Medicaid clients to choose providers, independently manage their own care, and access all services that they and their chosen doctors believe are medically necessary.

Texas Medicaid uses two forms of managed care.⁹

- **Primary Care Case Management (PCCM).** PCCM blends some elements of managed care with others from fee-for-service. Each Medicaid client in PCCM is assigned a primary care provider (PCP) who must approve most services and help coordinate care. The state contracts with a private administrator to build a network of PCPs. PCCM uses a non-capitated model. Through PCCM, the state directly pays providers a fee-for-service reimbursement. In addition, primary care providers are paid a monthly case management fee of about \$5 for each PCCM client they serve. Texas Medicaid provides managed care through PCCM in the non-urban counties and smaller cities outside of Medicaid HMO service areas.
- **Health Maintenance Organizations (HMOs).** HMOs use a fully capitated model. The state pays HMOs a monthly per person capitated rate set using a projection of the average cost to provide medically necessary care. The HMO in turn contracts with a network of providers to deliver and help coordinate care. Contracts may be with individual providers or groups, and HMOs may reimburse providers for services through either fee-for-service or capitated payments. HMOs bear the risk of potential losses if costs exceed capitation rates, and thus have incentive to control costs. The STAR Health model uses an HMO.

Texas Medicaid's largest HMO program is called STAR, for State of Texas Access Reform. The STAR and STAR Health programs differ through their names are similar.¹⁰ STAR, implemented in 1993, serves mainly non-disabled, low-income children and pregnant women through HMOs in urban and suburban areas around Austin, Corpus Christi, Dallas, El Paso, Fort Worth, Houston, Lubbock, and San Antonio. STAR Health, implemented in 2008, is the new managed-care model that serves only foster children across Texas.

HHSC's choice to use such similar names to denote two different programs causes confusion. Providers

participating in one program do not have to participate in the other. While researching this report we heard frequently that in the initial months of the program, the similar names led providers and caregivers to be confused about which providers participated in STAR Health. In fact, we commonly heard people mistakenly refer to STAR Health as just STAR, not realizing that STAR serves a different population under a separate contract.

HHSC could have prevented some of this confusion by selecting a name more distinct from STAR and signifying the program's foster child focus. HHSC should acknowledge this confusion and develop strategies to address it, which could include renaming STAR Health or emphasizing its association with foster children. Such strategies might help market the program to providers, who may be more willing to extend themselves to care for foster children than other Medicaid populations.

Implications for the State Not a Cost Cutting Measure

The state's rationale for moving foster children into managed care is to improve services, not to cut costs. The foster care population faces unique challenges accessing needed care that could conceivably be addressed in part through a managed care program designed specifically with the foster care population in mind. For example, managed care may increase needed access to specialized care. This would increase costs in the short term; however, if health outcomes improve over the long run, the state could possibly decrease the rate of growth of costs to care for foster children.

Improved Oversight of Medical Decision Making

For foster children, the state assumes the role of parent and acts through surrogates (e.g., foster families and caseworkers) to make medical decisions. A managed care system can provide the state with systematic information about medical decisions by surrogates and aggregate information on children's outcomes. For example, managed care can provide individual and aggregated data on health care usage by foster children, a review of

psychotropic medication use in near real-time, and data on which network providers have specialized training in the treatment of foster children.

Implications for Foster Children

Changes to Health Care Access

Clients and providers in most urban areas of the state are familiar with Medicaid HMOs through the STAR Program. But in the rest of the state where the PCCM Medicaid model is used, foster children will be the first Medicaid clients in an HMO. In PCCM, only primary care providers and hospitals must contract with the PCCM administrator. Before STAR Health, other providers in PCCM areas never had to sign a managed care contract or join a network to serve the Medicaid population. With STAR Health, however, providers serving foster children in PCCM areas of the state must now agree to deliver care and get reimbursed through Medicaid in a new way. The same is true for dentists across the state because children's dental services in regular Medicaid are provided on a fee-for-service basis, but with foster children, the STAR Health HMO provides them. Some providers may not be interested in signing up with a Medicaid HMO, especially providers in PCCM areas and dentists across the state who can continue to treat all non-foster care Medicaid clients without joining an HMO. This creates a potential barrier to the success of STAR Health.

Shift in Medical Decision Making

Moving foster children into managed care removes some control over medical decision-making from children's caretakers. In fee-for-service, caregivers have a greater ability to seek providers that will deliver desired treatment. This ability is diminished in managed care by limited provider networks and HMOs' ability to deny requests for certain services. The impact of these structural changes may be most apparent in changes in the provision of outpatient behavioral health care. Foster children have a pronounced need for individual and family counseling as well as other behavioral health services. Under STAR Health behavioral health providers must get periodic prior authorizations from the STAR Health HMO for outpatient therapy visits. The required authorizations

occur at more frequent intervals and may receive more scrutiny than under fee-for-service Medicaid, causing some stakeholders to fear that foster children will not get needed behavioral health care.

CPS Privatization Pilot

Texas is considering a pilot project to privatize some case management services now provided by CPS caseworkers.¹¹ The pilot would outsource this service through pay-for-performance contracts. Case management contractors could be evaluated using performance measures such as how many children reunite with their family, how many are adopted, how many are placed with relatives, school performance, etc. One of the most important tools to help children and families achieve good outcomes is effective behavioral health therapy; however, STAR Health rather than case management contractors will have control over behavioral health care authorization, thus creating a potential clash between two managed systems providing services to foster children.

Unknowns

It is unclear at this point how the structural changes put in place by managed care will play out. Diminishing providers' and caretakers' decision-making ability related to the provision of behavioral health care might reduce their ability to help children achieve desired outcomes. Or, with STAR Health, foster children might get more effective behavioral health (in part because behavioral health providers will be held more accountable for demonstrating progress through therapy) and have improved outcomes. An HMO could increase foster children's access to health care through active provider recruitment or offering reimbursement rates that encourage participation. Or, an HMO might lead to decreased access, especially in PCCM areas of the state where providers are unaccustomed to Medicaid HMOs and may be reluctant to participate.

Features of STAR Health

Before STAR Health, foster children were in traditional, fee-for-service Medicaid, which covered the same comprehensive health care services, but lacked unique

features of the STAR Health model discussed below that might deliver more coordinated care and produce better health outcomes for foster children.

- **Immediate Medicaid Eligibility.** Children qualify for STAR Health immediately upon entering conservatorship. When a court places a child in the custody of the state, DFPS generates form 2085, which lists the child’s DFPS ID number, medical consentor,¹² and backup medical consentor. This form is available when the child is placed in substitute care and can be used as proof of STAR Health coverage at providers’ offices and pharmacies. But we have heard several reports that not all providers understand this yet, delaying access to care in some cases. After HHSC processes Medicaid enrollment, the child receives a STAR Health ID card and a Medicaid ID form. Before STAR Health, children had no proof of coverage until their Medicaid ID arrived by mail, which could take a month or more.
- **Medical Home.** Each STAR Health member (children and young adults enrolled in STAR Health are referred to as “members” in this report) is assigned a primary care provider to act as a medical home. The PCP is a consistent source of primary care and makes referrals to specialists when needed.¹³ PCPs in STAR Health are required to manage and coordinate members’ care and receive support to do so through service coordination and service management, explained below.
- **Service Coordination.** Service coordination, a primary level of administrative care coordination, is available if requested by members, providers, caregivers, medical consentors, CPS caseworkers, or the court system. Service coordinators help members find providers, schedule appointments, and access services, and they help all involved in a child’s care to share information.
- **Service Management.** Service management, a secondary level of clinical care coordination, serves

members with ongoing and serious health care needs. Service managers identify members who could benefit from the service, conduct a needs assessment, prepare a health care services plan, and track members’ progress.

- **Health Passport.** Each STAR Health member has a Health Passport, a web-based, electronic health care record available to providers, medical consentors, DFPS staff and contractors, and service coordinators and managers. It is intended to facilitate the exchange of health-related information, which can prove challenging because foster children generally see multiple health care providers and may move frequently between placements.
- **Help Lines.** STAR Health members can call a nurse help line 24 hours a day, 7 days a week to get answers to health questions. Members also have access to a member services help line for general questions or to reach a service coordinator, and to a behavioral health help line (both of these lines are answered after hours by the 24-hour nurse line). When in fee-for-service Medicaid, foster children and their caretakers lacked similar services by phone.

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| <ul style="list-style-type: none">• 24-hour Nurse Line: 1-866-912-6283, option 7• Member Services Line: 1-866-912-6283• Behavioral Health Services Line: 1-866-218-8263 |
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The STAR Health model transfers financial risk to an HMO through a capitated system.¹⁴ Texas benefits by being assured of per-member costs in a year, but the state also takes a risk by transferring responsibility to an HMO. If the state does not pay enough to get the services it demands from an HMO, the HMO will not be able to do what is promised. HHSC must monitor STAR Health closely to ensure the state pays enough for the services required under the STAR Health contract and to ensure the contracted HMO effectively delivers the high-quality care the state expects.

Foster Connections to Success & Increasing Adoptions Act

The federal Foster Connections to Success & Increasing Adoptions Act of 2008, which the president signed into law on October 7, 2008, requires that states improve access to and coordination of health care for foster children as a condition of maintaining federal foster care and adoption funding.¹⁵ Specifically, states must ensure continuity of care, establish a medical home, oversee prescription medication, create a schedule for health screenings, and ensure that medical information is updated and appropriately shared through mechanisms which may include an electronic health record. With the implementation of STAR Health, Texas appears to already meet the act's provisions.

Covered Health Care Services

In general, STAR Health covers medically necessary physical health care, behavioral health care, dental and vision care, immunizations, hospital care, and prescription drugs. Specific covered services include:

- Texas Health Steps (THSteps) services. THSteps provides regular medical, dental, and vision check-ups and immunizations for children and young adults in Medicaid under age 21.
- General medical office visits
- Inpatient and outpatient behavioral health services including counseling, psychiatric care, and chemical dependency services
- Inpatient and outpatient hospital care and surgery
- Emergency care and ambulances
- Prescription medications
- Eyeglasses and contact lenses
- Hearing tests and hearing aids
- Lab tests and X-rays
- Physical therapy
- Organ transplants
- Home health care

- Family planning
- Telemedicine
- Durable medical equipment

Eligibility for STAR Health

As of September 1, 2008, STAR Health had 29,590 enrolled members.¹⁶ Children eligible for STAR Health include:

- **Children in DFPS conservatorship.**¹⁷ Children enter DFPS conservatorship (what other states may refer to as legal custody or legal guardianship) when the state removes them from their homes due to abuse and/or neglect. At the end of 2007, 27,458 children were in DFPS conservatorship in Texas.¹⁸ These children may be placed in foster homes, a relative's home, residential treatment centers, emergency shelters, or other forms of substitute care.
- **Young adults ages 18 to 22 who voluntarily agree to continue in their foster care placement.**¹⁹ When youth in foster care turn 18, they "age out" of the state's managing conservatorship but can choose to remain in a foster care placement while they work toward completing educational or vocational goals.
- **Young adults who age out of foster care and remain eligible for Medicaid.** Medicaid for Transitional Foster Care Youth is available through STAR Health for young adults who age out of foster care but are under age 21, meet an asset limit, and have incomes up to 400 percent of the federal poverty level (\$41,604 for a single person). DFPS helps young adults enroll in transitional Medicaid as they age out of foster care to ensure uninterrupted coverage. To maintain coverage, young adults must renew their Medicaid eligibility annually.²⁰

Foster children who are adopted maintain Medicaid eligibility, but once the adoption is completed, they move from STAR Health into regular Medicaid. If managing conservatorship is returned to a parent or given to a relative, children lose access to STAR Health, but may be eligible for regular Medicaid.

Implementation of STAR Health

HHSC awarded the STAR Health contract to Superior HealthPlan Network (Superior). Superior also contracts with HHSC to provide managed care services through other Medicaid and CHIP programs. Superior is a for-profit subsidiary of Centene Corporation, which operates Medicaid health plans in seven states and provides related managed care services. STAR Health was implemented on April 1, 2008.

We spoke with many different types of stakeholders to get their thoughts on the program and its implementation, including foster parents, child-placing agencies, residential treatment centers, children's advocacy organizations, physical health providers, behavioral health providers, provider associations, judges, court-appointed special advocates, HHSC and DFPS staff, and Superior staff. Though the feedback varied, the prevailing sentiment was that the program's implementation went relatively smoothly. Many stakeholders reported initial implementation issues, but noted that issues reported to HHSC or Superior management were generally resolved very quickly.

To better understand STAR Health's implementation, our discussion follows the seven priorities HHSC outlined in its request for proposals for the program: (1) network adequacy and access to care, (2) behavioral health services, (3) service management and service coordination, (4) medical home, (5) timeliness of initial Texas Health Steps visit, (6) Health Passport, and (7) timeliness of claims payment. The design and success of these key features will determine, in large part, the success of STAR Health. Below, we discuss each priority in detail.

Network Adequacy and Access to Care

HHSC contracted with Superior to provide one statewide STAR Health network to accommodate members and placements across the state. No other managed-care model in Texas Medicaid provides services statewide through a single HMO; other programs contract with a number of HMOs that serve specific regions of the state. Ensuring timely access to quality care tailored for a special

population across the state is challenging. Ensuring access to care in underserved areas is especially difficult.

Before STAR Health, foster children could see any willing Medicaid provider for services. Especially in medically underserved areas, veteran foster families cobbled together a network of providers willing to see foster children, even if the provider was not taking new patients or new Medicaid patients. Foster families and CPS caseworkers had to work hard to get specialized care needed by foster children, and even then they were not always successful.

With the implementation of STAR Health, the number of potential providers decreased from all Medicaid providers to those in the STAR Health network, but in exchange, Superior assumed the responsibility to ensure adequate access for covered services across the state. Although this change has the potential to relieve a burden for many caretakers and caseworkers, initially it has caused a disruption in traditional access to care in some places. In some cases, traditional providers of health care to foster care children have been unwilling to sign onto STAR Health, either because they are not interested in signing a managed care contract in general or in signing on with Superior in particular.

Contract Requirements

In its contract with Superior, HHSC seeks to ensure adequate network access by setting several standards, including allowable waiting times for appointments, required numbers of network providers within a geographical area, and allowable percentage of out-of-network claims.

Waiting Times

Superior must maintain a network with an adequate number of providers and sufficient capacity to provide all members with care within the timeframes specified in the table on the next page.²¹

Service	Allowable waiting time for appointment
Emergency services (including emergency behavioral health services)	Immediately
Urgent care	Within 24 hours
Routine primary care	Within 14 days of request
Initial and routine outpatient behavioral health visits	Within 14 days of request
Routine specialty care	Within 30 days of request
Routine pre-natal care	Within 14 days of request
High-risk pre-natal care or new members in the third trimester	Within 5 days of request
THSteps well baby visit for newborns	Within 14 days of enrollment
THSteps well child visit for newly enrolled children	Within 21 days of enrollment
THSteps dental visit for newly enrolled children (age 1 and older)	Within 60 days of enrollment

As a point of comparison, standards for allowable appointment waiting times in STAR Health are similar to those in STAR (i.e., for the general, non-foster care children’s Medicaid population in HMOs). The two differences are that STAR Health requires well child visits for newly enrolled children within 21 days while STAR allows 60 days, and STAR does not have a standard for THSteps dental visits because STAR HMOs do not provide dental benefits.²²

Distance to Providers

STAR Health also has specific access measures based on the availability of providers within a certain distance from members’ residences. The contract requires Superior to ensure all members can access in-network care from at least: (1) one PCP taking new patients within 30 miles, (2) one dentist within 75 miles, (3) one outpatient behavioral health provider within 30 miles in counties with more than 50,000 residents and within 75 miles in counties with fewer than 50,000 residents, (4) one OB/GYN within 75 miles (for female members), (5) one specialist within 75

miles for medical specialties including otolaryngology and orthopedics, and (6) one acute care hospital within 30 miles.²³ HHSC’s performance indicators for distance to providers set a 90-percent minimum standard for the percentage of members who can access providers within the distances listed above. STAR Health standards resemble standards in STAR contracts, with the exception that STAR Health has a higher standard for access to behavioral health providers in urban areas.²⁴

Out-of-network Claims

HHSC rules require that no more than 30 percent of claims costs for non-hospital services come from out-of-network providers.²⁵ This standard, which applies to STAR Health and other Medicaid managed care programs, encourages HMOs to maintain a network comprehensive enough to provide most services through in-network providers.

Current Status

Superior began building its STAR Health network for physical and behavioral health providers based on a list of providers who historically provided services to foster children. In a pre-operations readiness review, HHSC certified that the providers in Superior’s network provided 95 percent of services used by foster children in previous years.²⁶ While 95 percent sounds like a rigorous standard, it is important to remember that access in the previous fee-for-service system was also problematic.

Superior generally meets or exceeds network adequacy performance measures by ensuring that 90 percent of members can access providers within distance requirements. The one exception is that only 87 percent of members in rural counties can access a behavioral health provider within 75 miles (see *Initial Reporting on Performance Measures* on page 10).²⁷ Superior notes that it supplements its behavioral health provider network with telemedicine capacity, allowing rural members to use live video conferencing to receive services from psychologists and psychiatrists in other areas of the state. As of August 2008, Superior’s network included 5,700 PCPs, 2,800

behavioral health providers, 3,100 dental providers, and 1,100 vision service providers.²⁸

For the first five months of the program, Superior did not require prior authorizations for treatment by out-of-network providers. As of the beginning of September, Superior was receiving about 10 percent of physical and behavioral health claims from out-of-network providers.²⁹ This percentage is well below the 30-percent threshold required by HHSC, but indicates the level of needed services unobtainable within the network.³⁰

While researching this report, the concern heard most from an array of stakeholders was about the adequacy of Superior's network, especially for behavioral health and dental care in certain areas. Though stakeholders in some areas reported no disruption in services, others cited a reduction in providers who were available before STAR Health.

Laredo was one area of the state mentioned several times by stakeholders as having increased access challenges with STAR Health. At the end of 2007, about 670 children were in state conservatorship in Webb County (Laredo).³¹ As of October 2008, STAR Health had no network psychiatrists within 75 miles of Laredo, but the local MHMR center has begun facilitating telemedicine "visits" with a psychiatrist for foster children. Also, STAR Health has only four dentists within 75 miles: two in Laredo and the other two about 70 miles away in Cotulla and Carrizo Springs. Specialty medical services are limited in general in Laredo; however, as a point of comparison, children in non-STAR Health Medicaid have access to one child psychiatrist in Laredo as well as 16 dentists who treat children in Laredo.³²

Another concern heard while researching the report is that, especially at first, members were confused about which providers were in the STAR Health network. Stakeholders complained that when they called providers listed in Superior's STAR Health provider directory, they were told the provider did not participate. Some of this may be due

to providers' confusion between STAR and STAR Health discussed earlier, but Superior also released provider directories with incorrect information. HHSC sanctioned Superior in July 2008 for including incorrect information on participating providers in both print and online versions of its provider directory.³³ Caretakers can search for participating providers using Superior's online provider search function, but Superior's comprehensive provider directory manuals currently are not available online.³⁴

Superior claims to be meeting all contractual requirements related to network adequacy, but acknowledges that network access is limited in parts of the state and for certain provider types where access is limited in general, not just in managed care networks. Superior says it will continually work to build the network and has worked to recruit out-of-network providers that submit claims.³⁵

Remaining Questions

STAR Health access to psychiatrists and dentists in Laredo provides just a snapshot of access issues in one area, but it raises questions about why some traditional Medicaid providers are not participating in STAR Health. The Laredo example and Superior's first quarterly report showing that only 87 percent of rural STAR Health members have at least one behavioral health provider within 75 miles likely indicates that significant access issues remain.

Behavioral Health Services

In addition to access to adequate behavioral health care, HHSC envisions that children will have better integration of physical and behavioral health services through STAR Health.

Contract Requirements

Superior is required to contract with many different types of behavioral health providers to meet the needs of members, including providers who specialize in treating child victims of neglect and physical or sexual abuse. The STAR Health contract contains several (cont'd on p. 11)

Initial Reporting on Performance Indicators

HHSC tracks many performance indicators for HMOs and has a variety of different contract enforcement tools, from requiring corrective action plans to imposing financial penalties on HMOs. All STAR and CHIP HMO contracts leave 1 percent of the capitation rate “at risk,” dependent upon the HMO meeting expectations on a few specified performance measures. If HMOs meet all standards, they will receive the full capitation rate going forward. Otherwise, HHSC will reduce future capitation payments.

The following 10 STAR Health performance indicators will be tracked by HHSC over fiscal year 2009 and used to determine Superior’s performance-based rate. Minimum standards that will apply starting in fiscal year 2009 are listed below along with Superior’s actual performance in the 3rd quarter of fiscal year 2008, which included the first two months of STAR Health operations.

Performance Indicator	1% at-risk standard, fiscal year 2009	Actual performance in 3 rd quarter fiscal year 2008
% of clean claims properly processed within 30 calendar days	≥ 98%	99.87% (physical health) 99.43% (behavioral health)
Member hotline call abandonment rate*	≤ 7%	7.71%
Provider hotline call abandonment rate*	≤ 7%	13.64%
Behavioral health hotline call abandonment rate*	≤ 7%	2.09%
% of members with access to at least one age-appropriate PCP accepting new patients within 30 miles	≥ 90%	100%
% of members with access to at least one outpatient behavioral health provider within 75 miles in a county with 50,000 or fewer residents	≥ 90%	87%
% of members with access to at least one outpatient behavioral health provider within 30 miles in a county with more than 50,000 residents	≥ 90%	99%
% of members who receive a Texas Health Steps visit within 21 days of enrollment	≥ 80%	not available
% of members who have a behavioral health screening conducted during a Texas Health Steps visit	≥ 90%	not available
% of members who have a dental examination within 60 days of enrollment	≥ 80%	not available

Sources: STAR Health Contract Document Version 1.2, Attachment B-1, Section 4.1.34.3; Superior HealthPlan Network, Star Health 3rd Quarter 2008 Report to HHSC; and STAR Health 4th Quarter GeoAccess data provided by HHSC.

* Call abandonment rate: percent of calls on hold in which caller hangs up before call is answered.

provisions to encourage the sharing of information related to behavioral health assessments and treatment between behavioral health providers, PCPs, DFPS staff, and other appropriate parties. Superior must require its behavioral health providers to periodically evaluate members' progress using a standardized measurement instrument and document outcome measures in the Health Passport. Behavioral health providers must also post a monthly narrative summary of visits and progress to the Health Passport.³⁶

Superior must require PCPs to use the Texas Health Steps behavioral health screening form to screen for behavioral health problems. PCPs must post the screening form to the Health Passport. Superior must also train network PCPs in the use of behavioral health assessment tools, and how to refer for and coordinate behavioral health services.

Current Status

Superior subcontracts with Integrated Mental Health Services (IMHS) to manage behavioral health services for STAR Health. Like Superior, IMHS is a for-profit subsidiary of Centene Corporation. As of August 2008, IMHS' Texas network included 2,223 licensed therapists, 345 psychologists, and 295 psychiatrists, and 40 acute psychiatric inpatient facilities.

Members do not need a referral for behavior health care and can seek care from any network behavioral health provider. Members do not need prior authorization for the first 10 behavioral health visits. As of September 1, 2008, after 10 visits the provider must get ongoing care authorized by submitting a two-page form with a summary of the diagnosis, treatment plan, and information on the member's progress.

Service Coordination and Service Management

Service *coordination* helps coordinate access to medical and non-clinical services to better meet members' needs. Service *management* ensures that members with serious needs receive integrated care according to an individualized health care service plan. Ideally, together they will provide a vital communication and coordination link in an otherwise disjointed system of members, caretakers,

physicians, behavioral health providers, CPS caseworkers, the court system, and community services.

Contract Requirements

Superior must provide service coordination at the request of members, caregivers, medical consenters, DFPS staff, and providers. Service *coordinators* help members locate providers and get appointments and also help members access public and community support services offered outside of STAR Health. Service coordinators must respond to requests for assistance by the next business day.

Service *managers* must proactively identify members with serious health care needs who could benefit from the program, assess their needs, and offer service management when appropriate. Caregivers, medical consenters, providers, and DFPS staff can also request service manager assistance. For members in service management, service managers must work with providers, caregivers, and DFPS staff to develop an individualized health care services plan. The plan will contain information on the child's medical needs and goals, services required to meet needs, the frequency of needed services, and information on who will provide the services.³⁷ Service managers must share the health care services plan with caregivers, medical consenters, providers, and DFPS staff and enter the plan into the Health Passport. Service managers must monitor a child's treatment progress and adherence to the plan to ensure the child gets needed services.

Current Status

Service coordinators and managers work in two-person teams with one member experienced in physical health and the other in behavioral health. Superior and IMHS have 14 service coordinator teams and 14 service manager teams based in 8 regions across the state and Austin-based specialty teams to assist the most medically fragile children.³⁸

About 27,400 children and young adults entered STAR Health on April 1, 2008. Most of these children had a prior claims history through traditional Medicaid. HHSC, DFPS, and Superior identified criteria in prior claims that would indicate that a particular child had complex needs

and might benefit from service management. Starting in mid-March 2008, Superior staff contacted caregivers of children identified in this manner to assess needs and offer service management to those who would benefit from it.

By August, Superior assessed all of the children identified for outreach (18,741 children or 68 percent of children who entered the program on April 1, 2008) and created health care service plans for 4,300 who entered service management (about 23 percent of the children assessed or 16 percent of children who entered the program on April 1, 2008).³⁹ A lower number of children enter service management mostly because not all children assessed qualify for service management. For example, a child may have been flagged for assessment due to a claim for a previous inpatient hospital admission, but the assessment may show that the child currently has minimal needs. Other reasons why children identified for assessment do not enter service management are because Superior could not reach all caregivers to conduct the assessment and some caregivers chose not to participate in service management.

As new children enter conservatorship and STAR Health, Superior assesses their need for service management. Health care service plans will be completed for new members who enter service management within 30 days.

One of the big potential benefits of service coordination is the assistance it can provide to CPS caseworkers, who have a high turnover rate and often manage large caseloads. Service coordinators assist CPS caseworkers in finding providers for children, expediting appointments for clinical assessments needed to determine appropriate residential placements, and providing medical information needed for case plans and court reports.

Medical Home

The American Academy of Pediatrics defines a medical home as an approach to delivering primary health care that is “accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective.”⁴⁰ In the medical home model, PCPs provide primary care, facilitate access to other services, and develop trusting

partnerships with families and caregivers. As a medical home provider, a PCP must work in partnership with medical consenters, other providers, Superior’s service coordinators and managers, and DFPS staff not only to meet children’s medical needs, but also to meet the need for services to address non-clinical issues that can affect health.

Contract Requirements

The STAR Health contract requires Superior to “promote, monitor, document, and make best efforts to ensure” that PCPs and other providers comply with a medical home model based on American Academy of Pediatrics’ approach.⁴¹ The contract lists provider types that can serve as a PCP and allows specialists to act as a PCP for members with special health care needs. HHSC also directs that Superior’s provider contracts require PCPs to assess the medical and behavioral health needs of members; provide referrals for specialty care; enroll as a THSteps provider or refer members to THSteps providers; submit THSteps forms to the Health Passport; and be accessible (calls returned with in 30 minutes) 24 hours a day, 7 days a week.

The STAR Health contract lists access to the medical home model as one of four performance improvement goals that will be evaluated starting in state fiscal year 2010. At this point, the specific goal is not defined. Before state fiscal year 2010, HHSC and Superior will negotiate a goal for the percentage of PCPs operating according to the medical home model as measured using the Center for Medical Home Improvement’s *Medical Home Index Tool* or another evaluation tool.⁴² Beginning in 2010, HHSC and Superior will meet semi-annually to evaluate progress toward the goals.

Current Status

At this point, it is too early to tell how the medical home model is being incorporated by providers, but Superior has developed some of the structures necessary for the model. The STAR Health medical home model is structured through both a requirement that members have a PCP who coordinates care and the development of medical

home support services for PCPs. Superior assigns a PCP to all members upon enrollment, and members may change their PCP at any time. PCP support services include facilitating the exchange of medical information through the Health Passport and care coordination functions performed by service coordinators and managers.

Remaining Questions

The medical home concept is central to STAR Health's potential to improve health outcomes for foster children. Compliance with the model will depend in part on providers' willingness and ability to incorporate the model into their practice. Compliance will also depend on Superior's ability to educate providers about the model; support medical homes through service coordination, service management, and the Health Passport; and provide incentives for providers to adopt the model.

Goals and evaluation criteria for the PCP medical home model remain unclear. Adoption of and compliance with the whole medical home model will be difficult to evaluate because the model extends well beyond the more easy-to-measure notions that every member has a PCP and PCPs return after-hours phone calls quickly. The full model also incorporates the quality of the relationships between providers, members, and caregivers and cultural sensitivity shown by providers, among other hard-to-quantify concepts.

Timeliness of Initial Texas Health Steps Visit

The STAR Health contract makes Superior responsible for ensuring that new members get initial THSteps visits soon after entering the program. An initial THSteps exam must happen within 14 days of enrollment for newborns (under 12 months of age) and within 21 days of enrollment for other children. Also all new members age 1 and over must receive an initial THSteps dental check-up within 60 days. Superior requires its contracted providers to have office hours and appointments sufficient to accommodate timely initial THSteps exams.

Data on initial THSteps exam timeliness will be computed by an external quality review organization that contracts with HHSC.⁴³ No data have been released yet showing

performance on these standards, but this will be an important measure to watch. Initial THSteps exams provide an opportunity for children to establish the relationship with their medical home and for providers to assess both the physical and behavioral health needs of the child. In addition to the importance of what happens at the exam, the promptness of these initial exams is a measure of the strength of key pieces of program operations including:

- a sufficient network of PCPs and dentists across the state,
- the capacity of network providers to schedule prompt appointments,
- the capacity of network providers to take on new patients,
- the ability of service coordinators to help members coordinate check-ups, and
- the success of Superior's outreach and education efforts to foster parents and caretakers about THSteps exams.

Health Passport

All STAR Health members have a Health Passport, a web-based record containing health-related information on the child. The goal of the Health Passport is to improve health outcomes and care coordination for children by equipping parties involved in a child's care with consolidated medical information so they can better understand and meet the child's health care needs. Increased access to medical information may also help reduce provider errors caused by missing information, the delivery of duplicate immunizations, tests, and prescriptions, and costs associated with duplication of services. Funding for the development of the Health Passport came from a \$4 million Medicaid Transformation Grant from the Centers for Medicare and Medicaid Services (CMS).⁴⁴ Ongoing operations costs for the Health Passport are included in the capitated rate paid to Superior.

The Health Passport can be accessed by medical consenters, health care providers, CPS caseworkers, child-placing agencies, residential treatment centers, and authorized DFPS, HHSC, and Superior staff. The Health Passport is not a comprehensive medical record. Information available in the Health Passport includes:

- **Health care visit history.** Information submitted by providers on claims to Superior is available in the Health Passport. Claims data, updated daily in the Health Passport, include the name of the provider seen, dates of appointments, services provided at appointments, and diagnoses. Claims data are added to the Health Passport when Superior processes the claim, which can be a few weeks or even months after a medical visit (providers have 90 days after a visit to submit a claim, and Superior has 30 days in which to process claims once received). For foster children previously in Medicaid or CHIP, the Health Passport will also include Medicaid and CHIP claims data from the last two years, thus providing part of a health history.
- **Prescriptions filled.** The Health Passport contains a list of prescriptions filled at pharmacies with the prescribing provider, date filled, dosage, quantity, and instructions for use. This information is updated daily and is also available for the two years prior to the start of STAR Health for children previously in Medicaid and CHIP. Unlike medical claims, information on prescriptions filled is available in the Health Passport within a day because Texas Medicaid's pharmacy claims are processed immediately, before drugs are dispensed.
- **Demographic data including contact information for the child.** Updates to this information by DFPS staff post to the Health Passport daily.
- **Immunization history.** Information from ImmTrac, Texas' immunization registry, is updated monthly.
- **Lab results.** Results from lab tests processed by a contracted lab network are updated weekly.

- **Allergies.** Providers must manually enter allergy information in the Health Passport.
- **Vital signs.** Providers must manually enter vital signs like height, weight, blood pressure, and temperature in the Health Passport.
- **Forms.** Providers can add additional information to the Health Passport by completing forms associated with Texas Health Steps exams, behavioral health visits, and dental exams. If entered online (an option providers have) this information is available immediately. Providers can also fax forms to Superior for uploading into the Health Passport.

Plans for future improvements

HHSC plans two post-implementation improvements of the Health Passport. HHSC plans on making the Health Passport interoperable (able to electronically exchange data) with doctors' and hospitals' electronic medical record systems. Currently, providers with their own electronic medical record systems cannot import Health Passport information into their systems nor can they transmit data electronically from their systems to the Health Passport. Instead, providers with their own electronic systems must manually enter data into two systems.

HHSC also plans to create the capability for the Department of State Health Services state lab system to electronically send lab results to the Health Passport. Because the state labs process all lab tests associated with Texas Health Steps exams, enabling state lab test results to be posted will make the Health Passport more comprehensive.⁴⁵

How is the information protected?

The Health Passport is HIPAA-compliant. Superior and the state authenticate users before they can access the Health Passport. Files from Superior and DFPS listing appropriate users are updated daily. Once logged on, to access a child's record, users must enter the child's name and one of three identification numbers for the child: DFPS number, Medicaid ID number, or Social Security number. Before gaining access, users agree they will only

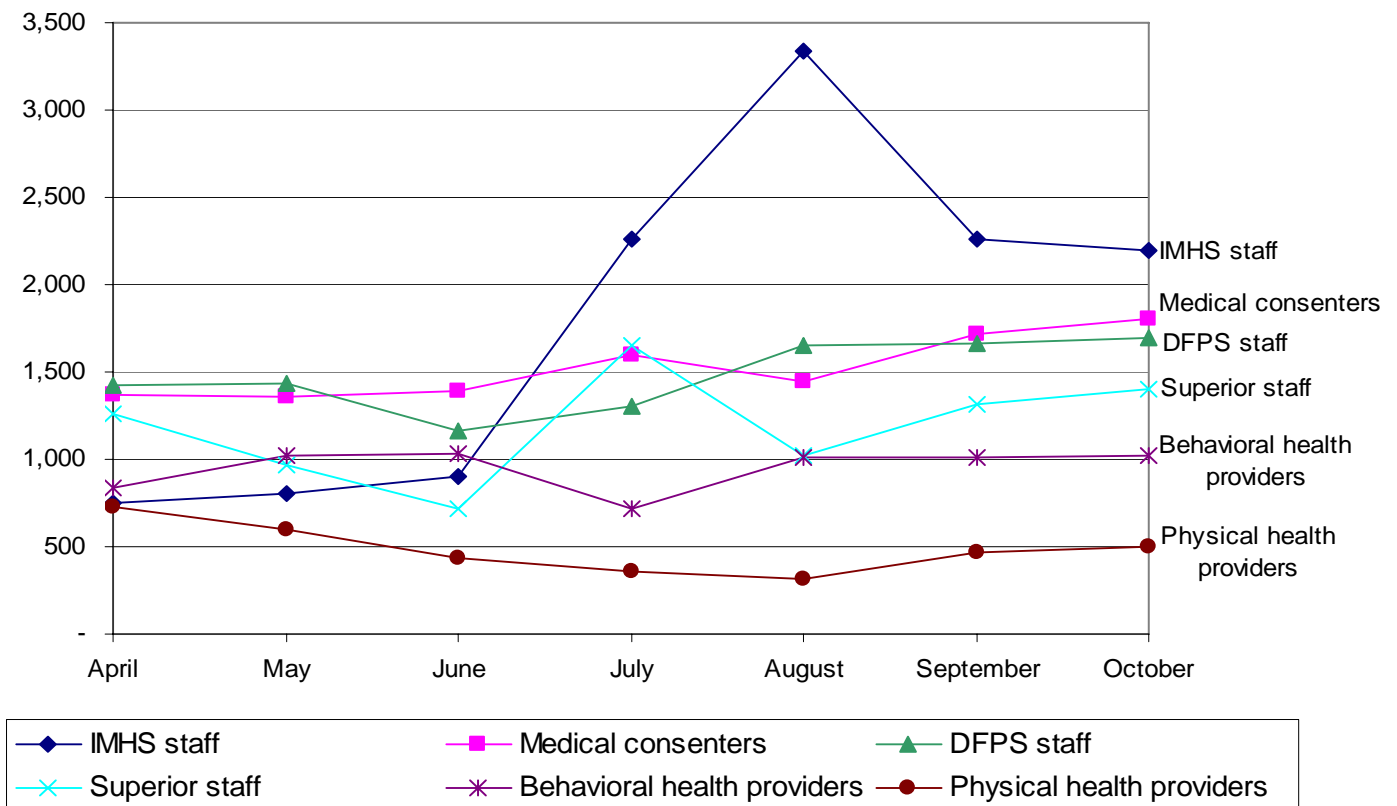
access records for children for whom they currently provide care.

In practice, however, a foster parent, health care provider, CPS caseworker, or other person with access to the system but no longer involved in the care of a particular child would have the information necessary to pull up the child's record. Superior electronically tracks all Health Passport activity by users and monitors records of use daily through several reports. Usage patterns that trigger suspicion (e.g., checking more records in one day than would be expected for a user logged in as a foster parent) are investigated. In addition to these audits based on usage patterns, Superior checks monthly on a sample of users to verify that all records accessed were for children with an appropriate relationship with the user.

Current Status

On average, about 300 unique physical health providers and 300 behavioral health providers use the Health Passport in a week. Superior found that many of the providers using the Health Passport use it many times within a month. From April through October, providers completed 9,000 forms in the Health Passport and submitted another 7,200 hard copy forms for uploading. Also, providers entered vital signs for 413 children and allergies for 626 children. Vital signs and allergies are the two sections in the Health Passport where data are only available if entered manually by providers (i.e. there is no automatic feed for these data), but providers are under no contractual obligation to enter this information. More than half of STAR Health members have had their Health Passport viewed by at least one user since implementation. The graph below shows the number of unique log-ins to

Health Passport Unique Log-ins per Month, April-October 2008



Data provided by Superior HealthPlan Network

the Health Passport per month by user group.

Remaining Questions

Access

The Health Passport is the first project of its kind in Texas that facilitates the electronic sharing of protected and confidential health information for Medicaid clients between multiple caregivers. By expanding access to health information, the system could improve health outcome for foster children; however, due to the sensitive nature of health information, DFPS must allow reasonable access to caregivers without jeopardizing a child's right to privacy. This balance is not easily defined.

DFPS excludes certain parties, including attorneys ad litem, guardians ad litem, and court appointed special advocates, from accessing the Health Passport online; however, they can view hard copies of the Health Passport at DFPS offices. These parties must represent the child or the child's best interest in legal proceedings, and some argue that access to the Health Passport would help them to better fulfill their role. They also argue that they already have legal access to medical records and can obtain them by requesting them from providers' offices, so the policy to exclude their access does not make sense.

On the other hand, there are security issues raised by allowing so many people who are not state employees or contractors to access the system. Moreover, ad litem are appointed at the county level, which would make it difficult for DFPS and Superior to maintain up-to-date information on which ad litem represents a child so that access could be both granted and terminated appropriately. Ad litem typically represent multiple children, exacerbating the potential identity concerns discussed above.

When deciding on which parties would have access, DFPS deferred to the language of Senate Bill 6, which does not list ad litem in conjunction with the Health Passport.⁴⁶ SB 6 does not explicitly list parties that should have access to the Health Passport, but does list parties (foster parents and providers) that HHSC should train to use the Health Passport.

Expansion

Senate Bill 10 from the 2007 Texas Legislative Session charged HHSC with studying the feasibility of providing health passports to all children in Medicaid and CHIP.⁴⁷ The CHIP and general children's Medicaid populations on average have fewer barriers to accessing coordinated care and maintaining a complete medical record than the foster care population; however, the agency may eventually identify benefits of providing a health passport to all children in Medicaid.

Because HHSC is still developing ways to evaluate the Health Passport as part of its reporting to CMS, and because the Health Passport has been in use for less than a year, it is too early to declare that it is a success as part of STAR Health, much less decide that expanding the Health Passport to more than 2 million children in Medicaid and CHIP is worthwhile. Before making this determination, HHSC should evaluate the success of the Health Passport for the pilot population, including seeking feedback from users and non-users.

Timeliness of Claims Payments

The ability to pay claims fully and quickly helps managed care organizations attract providers necessary to build and maintain a comprehensive network.

Contract requirements

HHSC requires that Superior process all claims within standard Medicaid processing timelines. Ninety-eight percent of "clean claims" and appealed claims must be processed (paid or denied) within 30 days of receipt.⁴⁸

Current Status

Superior reports claims payment timeliness to HHSC through quarterly reports. Superior's first quarterly report covering April and May 2008 (the only one available when we were writing this report) shows Superior exceeded standards for timeliness with over 99 percent of clean claims and all appealed claims processed within 30 days.⁴⁹

Although STAR Health is new, Superior has provided managed care services through Texas Medicaid since 1999 and also provides CHIP managed care services.

Throughout fiscal year 2007, Superior was sanctioned for failing to meet claims payment timeliness standards in its other programs; however, performance improved in 2008. For its other programs, Superior met the standard for clean claims in the first two quarters of 2008 and for appealed claims in one of the first two quarters.⁵⁰ This pattern of improving performance on timeliness is reflected in most of HHSC's contracted health plans and is likely due to the transition in 2007 to stricter performance standards that have enhanced HHSC's ability to sanction all Medicaid and CHIP health plans for non-compliance.

Pediatric Centers of Excellence

Senate Bill 6 in 2005 reflected Texas' goal to better serve children who suffer abuse or neglect both within and outside of the child protective services system. In addition to the STAR Health initiative, the legislature also launched a separate initiative for pediatric centers of excellence. Pediatric centers of excellence are designated health care facilities with expertise in the assessment, diagnosis, and treatment of child abuse and neglect.

Texas has a shortage of providers who are trained and experienced in this area. SB 6 and its follow-up, Senate Bill 758 in 2007, lay the groundwork for Texas to create pediatric centers of excellence needed to increase access to high-quality child abuse services. An advisory committee comprised of state agencies and medical professionals has been meeting this year to develop recommendations for designating and financing centers of excellence and should release its findings before the next legislative session starts in January 2009.

Other Important Program Aspects

Outside of the priorities for STAR Health identified in the HHSC contract, a few more aspects of the program warrant discussion including use of psychotropic medications by foster children, STAR Health's prior authorization requirements, and STAR Health's interactions with the courts.

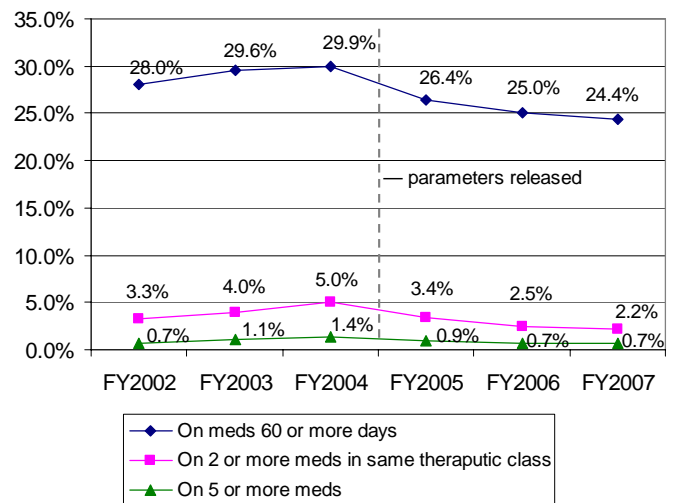
Appropriate Psychotropic Medication Usage

All STAR Health providers are required to comply with Texas Department of State Health Services' *Psychotropic*

Medication Utilization Parameters for Foster Children.

These guidelines are part of an ongoing effort in Texas to ensure appropriate use of psychotropic medications in the foster care population. The graph below shows that since the guidelines were released early in 2005, psychotropic medication usage by foster children has decreased. Decreases have been seen in the percentage of all Texas foster children on a psychotropic medication for 60 or more consecutive days, the percentage of foster children on two or more psychotropic medications within the same therapeutic class, and the percentage of foster children on five or more psychotropic medications.

Psychotropic Medication Usage by Texas Foster Children, Fiscal Years 2002-2007



HHSC, *Update on the Use of Psychoactive Medications in Texas Foster Children Fiscal Years 2005-2007*,

www.hhsc.state.tx.us/medicaid/OCC/Psychoactive_Medications.html.

Note: FY 2007 data include only 1st-3rd quarters, 2007.

The parameters helped the state reduce the use of psychotropic medication in foster children, and STAR Health may further improve outcomes. Through its network of contracted providers, Superior and IMHS can educate prescribers on the parameters, contractually require adherence with the parameters, and remove from the network any providers whose prescribing endangers children. Using claims data, Superior monitors psychotropic drug use in near real-time and will also track trends over time. Superior and the state have been working to ensure that data tracked before and during STAR

Health will be comparable so differences in outcomes can be measured over time.

To monitor prescriber compliance with the parameters, IMHS conducts psychotropic medication reviews (PMRs), which screen members' medication regimens against the guidelines. As of September 2008, 1,175 PMRs had been conducted through STAR Health. This group includes the highest-priority and most vulnerable members including children age 4 and under on psychotropic medication, children on five or more medications, and children on a psychotropic medication without a behavioral health diagnosis. PMRs on lower priority groups will follow.⁵¹

The PMRs identified cases where medication regimes are outside of the parameters and potentially causing harm, including two cases deemed as needing rapid intervention. These cases were referred to the DFPS medical director, and IMHS coordinated the transfer of these children to other psychiatric providers. When a PMR identifies usage outside of the parameters and opportunity for a reduction in the use of psychotropic medication, a psychiatrist affiliated with IMHS will consult with the prescribing physician to get a better understanding of the medication regime and discuss options to reduce medication, if appropriate.⁵²

IMHS and the state should release information when available showing how many PMRs have been conducted with aggregate information on the findings, including the percentage of foster children with regimens within and outside of the parameters; those outside of the parameters with the potential to reduce medication; those outside of the parameters with the potential to cause harm; and the outcomes when IMHS or the state intervene with prescribers.

Deadline for Prior Authorization

A few STAR Health services must receive prior authorization from Superior before they are provided. These services include out-of-network services and inpatient hospitalizations (except emergencies), certain rehabilitative therapies, visits to certain specialists, and ongoing outpatient behavioral health care visits. Members

do not need prior authorization for the first 10 behavioral health visits, but ongoing visits after the first 10 must be authorized. Superior's provider handbook notes that it will respond to providers' requests for prior authorization within 48 hours.⁵³

To ease the transition into STAR Health, HHSC required Superior to suspend prior authorization requirements for the first three months of the program. When this deadline was reached, HHSC directed Superior to extend the transition period for another two months, through August 31, 2008, for all services needing prior authorization except non-emergency inpatient hospitalizations. HHSC extended the deadline because Superior was still working to complete service management assessments for children who entered the program on April 1, 2008.⁵⁴

To limit the number of service requests that are denied or reduced, HHSC and Superior created a pre-appeals process for services requested through prior authorization, the first such program in Texas Medicaid. If Superior does not receive sufficient clinical or other information to authorize a request, before it is denied, a service manager will try to contact the provider or medical consentor to get the needed additional information. If Superior still cannot determine medical necessity with the information provided, Superior's medical director or a consulting physician will make at least two attempts to conduct a peer-to-peer review with the member's provider to get any additional clinical information or discuss alternative treatment options.

Because the prior authorization requirements in STAR Health did not go into effect until September, this report cannot evaluate their effects. Superior anticipates that the effects of the prior authorization requirements will be felt most by behavioral health providers who must seek more frequent authorizations to provide ongoing outpatient treatment.⁵⁵ Members who continued to receive care from out-of-network providers before September may now be required to switch to in-network providers. Treatment for some members may be delayed in the weeks and months

following September 1, 2008 while providers adjust to the newly applied requirements.

Interaction with the Courts

Because the court system plays a central role in the child welfare system, STAR Health must be responsive to the needs of the courts. By contract, Superior must authorize and reimburse all court-ordered care that is a benefit of Texas Medicaid. This includes instances when a judge orders care from a specific provider not in Superior's network as long as the provider accepts Medicaid. Superior cannot authorize or reimburse services that are not Medicaid benefits under federal law (such as services considered experimental or investigational) or care from providers who do not accept Medicaid. If a judge orders such services, DFPS must either find another way to provide and pay for them or appeal the judge's order. DFPS reports that judges only infrequently order care that Medicaid will not cover, and the agency addresses each instance on a case-by-case basis.⁵⁶

As required under its contract with HHSC, Superior's contracts with providers require that they testify in court when needed. Before STAR Health, DFPS reimbursed some behavioral health providers for their time performing court-related activities in child protection cases, but testimony has never been directly reimbursed as a benefit through Medicaid. With the implementation of STAR Health, DFPS is updating this process to reimburse behavioral health providers for participation in court-related services such as testimony, depositions, and mediation. DFPS expects it will release details on this process before the end of 2008.

Before STAR Health, DFPS directly reimbursed behavioral health providers for court-related services when legally necessary for children in kinship care and DFPS foster home placements. Other types of placements are paid through DFPS residential care contracts, and those contracts require that the residential care providers reimburse subcontracted behavioral health providers for court-related services.⁵⁷

DFPS has not released information on whether physical health providers will be able to access reimbursement for court-related services even though their STAR Health contracts require them to provide testimony. It is also unclear at this point how behavioral health providers can be reimbursed for court-related services if they are in the Superior/IMHS network and treat a child in DFPS-contracted residential care, but do not have a subcontract with the residential care provider. At this point, it appears that some STAR Health providers are contractually required to provide testimony, but the state has no process to reimburse them for that service.

As one would expect, providers may be reluctant to sign up for a program that mandates participation in court hearings but does not reimburse for it. To remedy this, DFPS needs to reimburse all STAR Health providers for court-related responsibilities and ensure that all STAR Health providers and prospective providers understand how they will be reimbursed for this service. HHSC may also want to remove its requirement that Superior contractually require providers to testify in court. Courts have sufficient tools to compel providers to testify when needed. An additional requirement in an HMO contract is unnecessary and may discourage provider participation in STAR Health. It emphasizes a negative side of serving foster children without letting providers know that having to testify in court is not common.

Superior employs a staff of six regionally based judicial liaisons. Judges may contact STAR Health liaisons by calling (512) 466-4102 or sending email to SHPNFC@centene.com.

Recommendations and Remaining Questions

Just a few months into STAR Health operations, it is too early to evaluate the program. We can, however, make a few recommendations and point out a few significant lingering questions.

Recommendations

- HHSC should acknowledge the confusion over the names of STAR and STAR Health and develop

strategies to address it, which could include renaming STAR Health or some how emphasizing its association with foster children.

- HHSC should wait until it can thoroughly evaluate the Health Passport in STAR Health before the agency recommends expanding the use of Health Passports to all children in Medicaid and CHIP.
- DFPS should ensure that all STAR Health providers are reimbursed for required court-related services, and HHSC should consider removing the contractual requirement for providers to testify.
- HHSC should review the performance measures in the STAR Health and other managed care contracts to ensure that they measure the most appropriate outcomes. For example, hotline call abandonment rates and hold times are important measures, but whether the caller was given correct and useful information is also important but not currently evaluated.

Remaining Questions

- Children who transition out of foster care through adoption or family reunification lose access to STAR Health once they leave state conservatorship, which may reduce their access to services and providers. These types of transitions in foster children's lives make accessing continuous health care challenging—one of the challenges STAR Health was designed to address. Would foster children's access to continuous care and comprehensive behavioral health services improve if those transitioning back home or into adoptive homes were allowed to maintain STAR Health instead of transitioning to regular Medicaid? If so, the state should consider extending STAR Health eligibility to them.
- How can HHSC and Superior work together to address remaining network adequacy issues, especially as they relate to behavioral health services?

- Do some children in regular Medicaid have better access to care than STAR Health members? If so, why are some traditional Medicaid providers not participating in STAR Health?
- How will HHSC evaluate Superior's effort to "promote, monitor, document, and make best efforts to ensure" that STAR Health providers comply with the medical home model?
- How did the prior authorization requirement that went into affect on September 1, 2008, affect STAR Health providers and members? Did providers understand and respond to the requirement, or has treatment been delayed as a result?
- The most important remaining question will not have an immediate answer: Will STAR Health improve foster children's access to health care and health care outcomes? Features of the model could create improved outcomes, but only time will tell.

Need More Information?

Superior's STAR Health website: www.fostercaretx.com.

DFPS' STAR Health website:

www.dfps.state.tx.us/About/Renewal/CPS/medical.asp.

STAR Health contract:

www.hhsc.state.tx.us/medicaid/STAR_Health.pdf.



This policy page was underwritten in part through funding by Casey Family Programs, whose mission is to provide and improve—and ultimately to prevent the need for—foster care. Established by UPS Founder Jim Casey in 1966, the foundation provides direct services and promotes advances in child welfare practice and policy. To learn more, visit www.casey.org. The opinions expressed in this policy brief, however, are those of the Center for Public Policy Priorities and do not necessarily reflect the views of Casey Family Programs.

¹ HHSC, *Protecting Texas Children: Final Report in Response to Governor Rick Perry's Executive Order to Reform Child Protective Services Program*, January 6, 2005, http://www.hhs.state.tx.us/news/reports/010605_CPS_FinalReport.shtml.

² General references to children in foster care are intended to include all children in CPS conservatorship including those placed in settings other than foster homes, and young adults who remain in the foster care system.

³ Child Welfare League of America, *Standards of Excellence for Health Care Services of Children in Out-of-Home Care*, p. 14, 2007, www.cwla.org/programs/standards/standardsintrohealthcare.pdf.

⁴ Mark D. Simms, Howard Dubowitz, and Moira A. Szilagyi, "Health Care Needs of Children in the Foster Care System," *Pediatrics*, 2000, 106: 909-918; and Child Welfare League of America, *Standards of Excellence for Health Care Services of Children in Out-of-Home Care*.

⁵ Simms, Dubowitz, and Szilagyi, "Health Care Needs of Children in the Foster Care System;" and American Academy of Pediatrics, Committee on Early Childhood, Adoption, and Dependent Care, "Health Care of Young Children in Foster Care," *Pediatrics*, 2002, 109:536-541.

⁶ Child Welfare League of America, *Standards of Excellence for Health Care Services of Children in Out-of-Home Care*, pp. 13-14.

⁷ Texas Health and Human Services System, *Strategic Plan 2009-13*, p. 125. www.hhs.state.tx.us/StrategicPlans/HHS09-13/HHS_StPlan.shtml.

⁸ HHSC's managed care contracts contain provisions that require managed care organizations to return a portion of profits to the state if they exceed a 3 percent profit margin. However, the contracts do not require the state to share in any financial losses with managed care organizations.

⁹ Texas Health and Human Services Commission, *Texas Medicaid in Perspective*, Sixth Edition, January 2007, p. 6-2.

¹⁰ Many Texas Medicaid managed-care models other than the STAR program incorporate the word STAR including, STAR+PLUS, North STAR, and STAR Health.

¹¹ For more information on the child welfare privatization debate in Texas see CPPP, *Drawing the Line between Public and Private Responsibility in Child Welfare: The Texas Debate*, www.cppp.org/research.php?aid=780&cid=4.

¹² A medical consenter is the party or parties authorized by the court to consent to medical care when a child is taken into state custody. The medical consenter is often a foster parent, but can also be a parent or other relative, a CPS caseworker, or a foster child who is at least age 16 and deemed able to make medical decisions.

¹³ PCP referrals are not required for behavioral health care, THSteps check-ups, regular dental care, regular vision care, emergency care, family planning, annual well woman exams, and obstetrical care.

¹⁴ Most but not all Medicaid benefits are included within the STAR Health capitated rate. The state still bears the risk for services that are provided on a fee-for-service basis, outside of the capitated rate, such as prescription drugs, transportation to medical appointments through the Medicaid Transportation Program, and targeted case management

¹⁵ For more information on the Foster Connections to Success & Increasing Adoptions Act of 2008 see CPPP, *New Federal Foster Care Legislation: What It Means for Texas*, www.cppp.org/research.php?aid=790.

¹⁶ HHSC STAR Health monthly enrollment report.

¹⁷ Depending on their placements, certain children in state conservatorship are in traditional, fee-for-service Medicaid instead of STAR Health, including children in the following placement types: Intermediate Care Facilities for Persons with Mental Retardation (ICF-MRs), nursing homes, state schools, state centers, Texas Youth Commission facilities, and placements in other states or counties.

¹⁸ HHS 2009-2013 Strategic Plan, Ch 8. p. 237.

¹⁹ Young adults age 18 and over in STAR Health may choose to opt out of STAR Health into fee-for-service Medicaid.

²⁰ DFPS, Child Protective Services Handbook sec. 1544.1

²¹ STAR Health Contract Document Version 1.2 Attachment B-1, Section 4.1.3.1, www.hhsc.state.tx.us/medicaid/STAR_Health.pdf.

²² Dental benefits are "carved out" of the managed-care model in STAR and instead delivered through fee-for-service. Thus, the STAR contract does not have an equivalent standard for waiting time for a THSteps dental appointment or for proximity to a dentist.

²³ STAR Health Contract Document Version 1.2, Attachment B-1, Section 4.1.4.1.

²⁴ STAR Health requires access to a network behavioral health provider within 30 miles in urban counties (population above 50,000 people) and within 75 miles in rural counties. STAR requires one behavioral health care provider within 75 miles of members regardless of the population of the county in which they live.

²⁵ Texas Administrative Code, Title 1, part 15, rule 353.4(e)(2)(C).

²⁶ HHSC and Superior, STAR Health update presentation to the Partners in CPS Reform meeting, June 4, 2008, Austin, TX.

²⁷ STAR Health 4th Quarter GeoAccess files data provided by HHSC.

²⁸ HHSC and Superior, STAR Health update presentation given at the CPS Judicial Conference, August 26, 2008, Austin, TX.

²⁹ Phone call with Holly Munin, CEO of the Texas foster care program at Superior HealthPlan Network, September 4, 2008.

³⁰ It is too early to say for sure that out-of-network claims represent care that cannot be obtained within the network. The requirement to have out-of-network care authorized was just implemented on September 1, 2008. Some of the out-of-network claims before and around the cut-off may be for services that could have been obtained within the network, but weren't required to be before September 1.

³¹ DFPS, *Data Book 2007*, CPS Children in Care During FY07, www.dfps.state.tx.us/Documents/about/Data_Books_and_Annual_Reports/2007/databook/Statistics_FY07.pdf.

³² Comparison of available providers in PCCM Medicaid and STAR Health within 75 miles of zip code 78040 (Laredo, TX) using online provider locators on October 13, 2008. STAR Health provider locator at www.fostercaretx.com, under "Find a Provider." PCCM Medicaid provider locator at www.tmhp.com/OPL/providerManager/AdvSearch.aspx. All psychiatrists and dentist that came up in the PCCM Medicaid provider searches were called to verify that they take Medicaid and treat children. PCCM providers not accepting new Medicaid patients were not counted. In addition to the 16 private practice dentists counted in Laredo that provide services to children in PCCM Medicaid, these children also have access to dental services at the Federally Qualified Health Center in Laredo, which is not listed in the STAR Health network.

³³ HHSC, Managed Care Organization Sanctions, Sanctions for Superior HealthPlan Network – STAR Health, www.hhsc.state.tx.us/medicaid/ContractorSanctions/MCO/SuperiorSTARHealth.pdf.

³⁴ Superior's comprehensive provider directory manuals were previously available online at www.fostercaretx.com/portal/public/fc/fostercare/provider_directory_manuals, but were not available when checked occasionally through October and the first half of November. Superior's online provider search function can be accessed by choosing "Find a Provider" at www.fostercaretx.com.

³⁵ Call with Holly Munin and Dr. David Harmon of Superior HealthPlan Network, September 4, 2008; and email from Holly Munin, September 19, 2008.

³⁶ STAR Health Contract Document Version 1.2, Attachment B-1, Section 4.1.18 – 4.1.18.2.

³⁷ STAR Health Contract Document, Version 1.2, Attachment A, Article 2, definition of "health care service plan."

³⁸ STAR Health Contract Document Version 1.2, Attachment C-2, pp. 16-17.

³⁹ Call with Holly Munin and Dr. David Harmon of Superior HealthPlan Network, September 4, 2008; and email from Holly Munin, October 22, 2008.

⁴⁰ American Academy of Pediatrics, Medical Home Initiatives for Children with Special Needs Project Advisory Committee, "The Medical Home," *Pediatrics*, July 2002, 110: 184-186.

⁴¹ STAR Health Contract Document Version 1.2, Attachment B-1, Section 4.1.4.5.

⁴² STAR Health Contract Document Version 1.2, Attachment B-1, Section 4.1.1. The Center for Medical Home Improvement's *Medical Home Index* is located at www.medicalhomeimprovement.org/assets/pdf/MHI-FullV_2006CMHI.pdf.

⁴³ HHSC Uniform Managed Care Manual, STAR Health Performance Indicator Dashboard Version 1.0, www.hhsc.state.tx.us/medicaid/UMCM/Chp10/10_1_3.pdf

⁴⁴ HHSC, *Medicaid Transformation Grant: Foster Care Health Passport 2nd Progress Report*, April 30, 2008.

⁴⁵ Ibid.

⁴⁶ Meeting with Sue Milam, DFPS Deputy Commissioner, and DFPS staff, September 5, 2008, Austin, TX.

⁴⁷ Senate Bill 10, section 29, 80th Texas Legislature, regular session.

⁴⁸ Clean claims are those submitted in an approved claim format with complete and accurate data in all required fields.

⁴⁹ Superior HealthPlan Network, Star Health 3rd Quarter 2008 Report to HHSC.

⁵⁰ HHSC, Managed Care Organization Sanctions, Sanctions for Superior HealthPlan Network, www.hhsc.state.tx.us/medicaid/ContractorSanctions/MCO/Superior.pdf.

⁵¹ Superior HealthPlan Network, The Judicial System and STAR Health, presentation given at the CPS Judicial Conference, August 26, 2008, Austin, TX.

⁵² Ibid.

⁵³ Superior HealthPlan Network, STAR Health Provider Manual, https://www.superiorhealthplan.com/superior/FC_Provider_Manual_021308.pdf

⁵⁴ HHSC and Superior, STAR Health update presentation to the Partners in CPS Reform meeting, June 4, 2008, Austin, TX.

⁵⁵ Call with Holly Munin and Dr. David Harmon of Superior HealthPlan Network, September 4, 2008.

⁵⁶ Phone call with Sue Milam, DFPS Deputy Commissioner, August 22, 2008.

⁵⁷ DFPS, CPS Handbook, sec. 8250, and DFPS FY2009 Residential Child Care Contract, sec. 20.