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Healthy Texas Women

Section 1115 Demonstration Waiver

Application

Texas Health and Human Services Commission

Submitted June 30, 2017

Section I - Program Description

This section should contain information describing the goals and objectives of the Demonstration, as well as the hypotheses that the Demonstration will test. In accordance with 42 CFR 431.412(a)(i), (v) and (vii), the information identified in this section must be included in a state's application in order to be determined complete. Specifically, this section should:

1) *Provide a summary of the proposed Demonstration program, and how it will further the objectives of title XIX and/or title XXI of the Social Security Act (the Act).*
2) *Include the rationale for the Demonstration.*
3) *Describe the hypotheses that will be tested/evaluated during the Demonstration's approval period and the plan by which the State will use to test them.*
4) *Describe where the Demonstration will operate, i.e., statewide, or in specific regions within the State. If the Demonstration will not operate statewide, please indicate the geographic areas/regions of the State where the Demonstration will operate.*
5) *Include the proposed timeframe for the Demonstration.*
6) *Describe whether the Demonstration will affect and/or modify other components of the State's current Medicaid and CHIP programs outside of eligibility, benefits, cost sharing or delivery systems.*

Background

In 2014, the Texas Sunset Advisory Commission reviewed the State's health agencies and recommended consolidating Texas women's health care programs to improve service and efficiency for clients and providers. In response, the Texas Legislature directed the Texas Health and Human Services Commission (HHSC) to consolidate state women's health services, and on July 1, 2016, HHSC launched the Healthy Texas Women (HTW) program.

HHSC is requesting a new Section 1115 demonstration waiver for the HTW program. Through the Healthy Texas Women Section 1115 Demonstration Waiver (HTW demonstration), HHSC seeks to enhance women's health care services by increasing access to and participation in the HTW program. The proposed effective date is September 1, 2018, for a five-year period ending August 31, 2023.

Summary of Proposed Program

The HTW demonstration will provide women's health and family planning services at no cost to eligible, low-income Texas women. HTW demonstration services will be made available statewide.

The goals and objectives of the HTW demonstration are to:

- Increase access to women's health and family planning services to avert unintended pregnancies, positively affect the outcome of future pregnancies, and positively impact the health and well-being of women and their families
- Increase access to preventive health care, including screening and treatment for hypertension, diabetes, and high cholesterol, to positively impact maternal health and reduce maternal mortality
- Increase access to women's breast and cervical cancer services to promote early cancer detection
- Implement the state policy to favor childbirth and family planning services that do not include elective abortions or the promotion of elective abortions within the continuum of care or services and to avoid the direct or indirect use of state funds to promote or support elective abortions[1]
- Reduce the overall cost of publicly funded health care (including federally funded health care) by providing low-income Texans access to safe, effective services that are consistent with these goals

The HTW demonstration will be for women who meet all of the following qualifications pursuant to Title 1 of the Texas Administrative Code (TAC) Chapter 382:

- Age 15 through 44
  - A minor[2] age 15 through 17 must have a parent or legal guardian apply, renew, and report changes to her case on her behalf

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[1] Texas Human Resources Code §32.024(c-1) directs HHSC to ensure no money spent for the purpose of HTW is used to perform or promote elective abortions or to contract with entities that perform or promote elective abortions or affiliate with entities that perform or promote elective abortions.

[2] "Minor" as defined in 1 TAC §382.5(18).

- U.S. citizen or qualified immigrant
- Reside in Texas
- Not pregnant
- Does not currently receive benefits through a Medicaid program that provides full benefits, Children's Health Insurance Program (CHIP), or Medicare Part A or B, and does not have any other creditable health coverage[3]
- Net family income at or below 200 percent of the federal poverty level (FPL)

To provide continuity of care, women 18 through 44 years of age whose Medicaid for Pregnant Women[4] coverage period is ending will be automatically enrolled in the HTW demonstration if they are not otherwise eligible for full Medicaid benefits, Medicare Part A or B, or CHIP, and they do not have other creditable health coverage.

The HTW demonstration will provide family planning services as well as other women's health services that contribute to preconception care and better birth outcomes. The HTW demonstration will provide the following covered services[5] to eligible women:

- Pregnancy testing
- Pelvic examinations
- Sexually transmitted infection (STI) services
- Breast and cervical cancer screening and diagnostic services
- Clinical breast examinations
- Screening and treatment for hypertension, diabetes, and high cholesterol
- Human Immunodeficiency Virus (HIV) screenings

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[3] Applicants may not have creditable health coverage that covers the services HTW provides, except when an applicant affirms, in a manner satisfactory to HHSC, her belief that a party may retaliate against her or cause physical or emotional harm if she assists HHSC (by providing information or by any other means) in pursuing claims against that third party (1 TAC §382.7(a)(1)(7) and (c)).
[4] Refers to the Medicaid eligibility group identified under Section 1902(a)(10)(A)(i)(III) of the Social Security Act.
[5] "Covered service" is defined as a medical procedure for which the HTW demonstration will reimburse an enrolled health care provider (1 TAC §382.5(8)).

- Long-acting reversible contraceptives
- Oral contraceptive pills
- Permanent sterilizations
- Other contraceptive methods
- Screening and treatment for postpartum depression
- Immunizations

The HTW demonstration will use a fee-for-service delivery model. Any Medicaid provider will be able to provide HTW demonstration covered services to HTW demonstration clients on a fee-for-service basis if they meet all HTW demonstration provider eligibility requirements. Claims for covered services provided to HTW demonstration clients will be processed by the Texas claims administrator, Texas Medicaid & Healthcare Partnership (TMHP). To be enrolled as an HTW demonstration provider, all providers must be enrolled in Medicaid and be compliant with Texas Human Resources Code §32.024(c-1).

The HTW demonstration will not affect or modify other components of the State's current Medicaid program outside of eligibility, benefits, cost sharing or delivery systems.

The HTW demonstration will further the goals of Title XIX of the Social Security Act (Medicaid) by increasing and strengthening coverage for low-income women in Texas, through the provision of a unique benefit package to women who would not otherwise be eligible for family planning and preventive services under Medicaid. Additionally, the HTW demonstration is designed to improve health outcomes for the Medicaid population by providing preconception and interconception care to women who would be eligible for Medicaid coverage if they were pregnant, with the goal of improving birth outcomes and supporting women in achieving optimal birth spacing.

Program Standards

The delivery of HTW demonstration services will be in accordance with the following program standards.

Consent and Confidentiality

HHSC will require an HTW demonstration provider to maintain all health care information as confidential to the extent required by law, to verbally assure each client that her records are confidential, and to explain the meaning of confidentiality. Services will be provided with consent from a minor's parent, managing conservator, or guardian as authorized by Texas Family Code,

Chapter 32, or by federal law or regulations. Clients, or a parent or legal guardian if the client is 15 through 17 years of age, may elect to have HTW demonstration correspondence sent to a confidential mailing address.

Fair Hearings and Appeals

HHSC may deny, suspend, or terminate services to an applicant or client if HHSC determines the applicant or client is ineligible to participate in the HTW demonstration. Before HHSC denies, suspends, or terminates services, the applicant or client will be notified and provided an opportunity for a fair hearing in accordance with Medicaid fair hearing standards. An applicant or client may appeal HHSC's decision to deny, suspend, or terminate services in accordance with Medicaid standards.

Availability of Contraceptive Methods

All clients will be allowed freedom of choice in the selection of contraceptive methods as medically appropriate. All HTW demonstration covered methods of contraception will be made available to the client either directly or by referral.

Demonstration Rationale

Increasing access to women's health and family planning services is a priority in Texas. Texas has the fourth highest birth rate in the United States, with more than 400,000 births in 2015.[6] Of these, 210,215 births were Medicaid-paid births, accounting for 52.2 percent of all state births in state fiscal year 2015.[7] Texas Pregnancy Risk Assessment Monitoring System (PRAMS) data show 34.7 percent of women report their pregnancy was unintended, 53.5 percent report their pregnancy was intended, and 11.8 percent were unsure.[8] As of 2014, Texas was tied with New Mexico for the fourth highest teen birth rate in the United States.[9] The HTW demonstration

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[6] Kormondy, M. and Archer, N. (2016). *Healthy Texas Babies Data Book*. Austin, TX: Division for Family and Community Health Services, Texas Department of State Health Services, 2016. Retrieved from https://www.dshs.texas.gov/healthytexasbabies/data.aspx

[7] Department of State Health Services, Bureau of Vital Statistics and Texas Medicaid & Healthcare Partnership Claims and Health and Human Services Commission Delivery Supplemental Payment System. (2016). *Medicaid Paid Births*. Prepared by Texas Health and Human Services Commission.

[8] Texas Department of State Health Services. (2017). *Pregnancy Risk Assessment Monitoring System (PRAMS) 2014 Data Book Summary.* Retrieved from https://www.dshs.texas.gov/mch/PRAMS.aspx

[9] Kormondy, M. and Archer, N. (2016). *Healthy Texas Babies Data Book*. Austin, TX: Division for Family and Community Health Services, Texas Department of State Health

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seeks to increase access to family planning services to avert unintended pregnancies.

In addition to providing core family planning services, the HTW demonstration will offer preconception care and other related preventive services that positively impact the health and wellbeing of the enrolled women and contribute to better birth outcomes. Preventive services will include screening and treatment for hypertension, diabetes, and high cholesterol. Women with these chronic conditions are at increased risk for a variety of complications for both themselves and their babies. The rates of mothers in Texas with either hypertension or diabetes are rising, and the rates of preterm births and infants with a low birth weight are higher in Texas than nationally.[10] Additionally, research shows some of the most common causes of maternal deaths are cardiac events and hypertension/eclampsia.[11]

The HTW demonstration also will include breast and cervical cancer screening and diagnostic services to ensure women in Texas are receiving the care they need to detect cancer early. In state fiscal year 2013, 6,676 cervical cancer cases had a treatment cost to Medicaid of approximately $15,719,639.[12] The Centers for Disease Control and Prevention (CDC) estimates Texas has a female breast cancer incidence rate of 108.4 per 100,000[13] females and a cervical cancer incidence rate of 8.7 per 100,000 females based on 2013 data.[14] The Texas Cancer Registry estimates that from 2009 to 2013, Texas had a cancer mortality rate of 161.2 per 100,000 individuals.[15] Early detection of breast and cervical cancer is associated with

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Services, 2016. Retrieved from https://www.dshs.texas.gov/healthytexasbabies/data.aspx

[10] Ibid.

[11] Texas Department of State Health Services. (2016). *Maternal Mortality and Morbidity Task Force and Department of State Health Services Joint Biennial Report.* Retrieved from https://www.dshs.texas.gov/mch/maternal_mortality_and_morbidity.shtm

[12] Texas Health and Human Services Commission and Texas Department of State Health Services. (2016). *Human Papillomavirus (HPV) Strategic Plan.* Retrieved from https://hhs.texas.gov/sites/hhs/files//human-papillomavirus-strategic-plan-accessible.pdf

[13] Centers for Disease Control and Prevention. (2013). *Female Breast Cancer Incidence Rates by State.* Retrieved from https://www.cdc.gov/cancer/breast/statistics/state.htm

[14] Centers for Disease Control and Prevention. (2013). *Cervical Cancer Incidence Rates*. Retrieved from https://www.cdc.gov/cancer/cervical/statistics/state.htm

[15] Texas Cancer Registry. (2017). *Age-Adjusted Invasive Cancer Incidence Rates in Texas*. Retrieved from http://www.cancer-rates.info/tx/

improved health outcomes and reduced mortality.[16,17] Further, cervical cancer screenings can identify abnormal cells, allowing for treatment before cancer develops.

The HTW demonstration will provide screenings and limited pharmaceutical treatment for postpartum depression. Based on 2014 data from Texas PRAMS, an estimated 13.5 percent of women who recently gave birth reported symptoms of postpartum depression.[18]

To prevent gaps in coverage and improve interconception health, eligible women whose Medicaid for Pregnant Women coverage period is ending will be automatically enrolled into the HTW demonstration. This continuity of care is especially important when considering postpartum depression may have an onset up to one year after a woman's pregnancy ends. Coverage under Medicaid for Pregnant Women ends the last day of the month in which the 60-day postpartum period ends. Automatic enrollment into the HTW demonstration allows women to continue to receive postpartum depression screening and treatment.

Demonstration Evaluation

In the 120 days following the date of waiver approval, HHSC Center for Analytics and Decision Support will submit an evaluation plan for CMS review and approval. Program performance evaluation parameters include provider activities, client service utilization, and estimated program savings and expenditures. Program success will be measured as the degree to which the HTW demonstration maintains or improves upon the performance of predecessor programs. HHSC hypothesizes the HTW demonstration will:

- Maintain or improve the access to and use of family planning services by women in the target population

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[16] American Cancer Society. (2017). *American Cancer Society Recommendations for the Early Detection of Breast Cancer*. Retrieved from https://www.cancer.org/cancer/breast-cancer/screening-tests-and-early-detection/american-cancer-society-recommendations-for-the-early-detection-of-breast-cancer.html

[17] American Cancer Society. (2017). *The American Cancer Society Guidelines for the Prevention and Early Detection of Cervical Cancer*. Retrieved from https://www.cancer.org/cancer/cervical-cancer/prevention-and-early-detection/cervical-cancer-screening-guidelines.html

[18] Texas Department of State Health Services. (2017). *Pregnancy Risk Assessment Monitoring System (PRAMS) 2014 Data Book Summary.* Retrieved from https://www.dshs.texas.gov/mch/PRAMS.aspx

- Maintain or improve the access to and use of other women's health services (e.g., screening and treatment for hypertension, diabetes, and high cholesterol and screening and diagnostic services for breast and cervical cancer) to women in the target population
- Maintain or reduce the number of unintended pregnancies among women enrolled in Medicaid
- Maintain or decrease the number of Medicaid and CHIP paid deliveries which will reduce annual expenditures for prenatal, delivery, and newborn and infant care
- Maintain or reduce the cost for the Medicaid for Breast and Cervical Cancer program

The proposed demonstration evaluation design will formulate the final evaluation plan and will meet the prevailing standards of scientific evaluation and academic rigor, as appropriate and feasible for each aspect of the evaluation, including standards for the evaluation design, conduct, interpretation, and reporting of findings. When developing the evaluation design, Texas will consider ways to structure the design that will facilitate the collection, dissemination, and comparison of valid quantitative data to support the research hypotheses. For each research hypothesis, Texas will identify a preferred quantitative and/or qualitative research methodology and provide a rationale for the selected methodology. To the extent applicable, the following items will be specified for each design option considered:

- Identification of independent evaluator
- Quantitative or qualitative outcome measures
- Identification of study design and population
- Proposed baseline and/or control comparisons
- Proposed process and improvement outcome measures and specifications
- Data sources, collection frequency, and proposed analyses
- Robust sampling designs (e.g., controlled before-and-after studies, interrupted time series design, and comparison group analyses)
- Timelines for deliverables

Section II – Demonstration Eligibility

This section should include information on the populations that will participate in the Demonstration, including income level. In accordance with 42 CFR 431.412(a)(ii), the information identified in this section must be included in a state's application in order to be determined complete. Specifically, this section should:

1) *Include a chart identifying any populations whose eligibility will be affected by the Demonstration.*

Demonstration Populations

Eligibility Group Name	Social Security Act and CFR Citations	Income Level
Healthy Texas Women demonstration group	Not applicable	At or below 200% of the FPL

2) *Describe the standards and methodologies the state will use to determine eligibility for any populations whose eligibility is changed under the Demonstration, to the extent those standards or methodologies differ from the State plan;*

To participate in the HTW demonstration, women must meet all of the following criteria:

- Age 15 through 44
  - A minor age 15 through 17 must have a parent or legal guardian apply, renew, and report changes to her case on her behalf
- U.S. citizen or qualified immigrant
- Reside in Texas
- Not pregnant
- Does not currently receive benefits through a Medicaid program providing full benefits, Children's Health Insurance Program (CHIP), or Medicare Part A or B, and does not have any other creditable health coverage
  - An applicant with creditable health coverage may be eligible to receive covered benefits if she affirms her belief a party may retaliate against her or cause physical or emotional harm if she assists HHSC in pursuing claims under that coverage
- Net family income at or below 200 percent of the FPL

Single Streamlined Application

The HTW demonstration will not use the single streamlined application used for Medicaid, CHIP, and other health insurance affordability programs as required by 42 CFR §435.907(b). HTW demonstration application procedures are detailed in Section V: Implementation of Demonstration.

Auto-Enrollment

To provide continuity of care, women 18 through 44 years of age whose Medicaid for Pregnant Women coverage period is ending will be automatically enrolled in the HTW demonstration if they are not otherwise eligible for full Medicaid benefits, CHIP, or Medicare, and they do not have other creditable health coverage. In the last benefit month for a woman receiving Medicaid for Pregnant Women benefits, HHSC will test if the woman is eligible for any other Medicaid program providing full benefits, if she is eligible for CHIP, if she has Medicare, and if she has any other creditable health coverage. If the woman is determined not eligible for full Medicaid benefits, Medicare, or CHIP, and she does not have any other creditable health coverage, she will be certified for the HTW demonstration. Income verification and other HTW non-financial rules (except Medicaid, CHIP, Medicare, or other creditable health coverage and age) will not be applied for individuals auto-enrolled into the HTW demonstration. All eligibility criteria will be addressed at renewal.

HTW demonstration coverage will begin the first day following the termination of a woman's Medicaid for Pregnant Women coverage. A woman auto-enrolled into the HTW demonstration may choose not to participate in the HTW demonstration. Additional details on how a client will be notified of HTW demonstration auto-enrollment are included in Section V: Implementation of Demonstration.

Transfer of Eligibility

A woman who is receiving services through the current HTW program will be automatically enrolled in the HTW demonstration and will be eligible to receive covered services for the remainder of her certification period. There will be no disruption in eligibility or services.

Financial Eligibility

The income calculation for the HTW demonstration will not follow Modified Adjusted Gross Income (MAGI) methodologies as described in 42 CFR §435.603. Differences between MAGI methodologies and the HTW demonstration income methodology include:

Household Composition

HTW demonstration eligibility determinations will not be based on the individual's intended tax filing status. Household composition for the HTW demonstration will include the applicant, applicant's children under age 19, applicant's spouse if she is 18 or older, and the applicant's parents if she is younger than 18.

Countable Income Types

HTW demonstration income calculations will be based on the income rules in place prior to the implementation of MAGI methodologies and will not be based on the Internal Revenue Service (IRS) tax filing methodology. Countable income types include wages, self-employment, and child support. Income is any type of payment that is of gain or benefit to a household. Earned income is related to employment. Unearned income is income received without performing work-related activities, and it includes benefits from other programs.

Allowable Deductions

HTW demonstration earned income deductions will be based on exceptions allowed prior to the implementation of MAGI methodologies. Allowable income deductions include work-related expense deductions and a dependent care deduction.

For additional information regarding HTW demonstration financial eligibility requirements, see Attachment A: Financial Eligibility.

Adjunctive Income Eligibility

A woman may be determined adjunctively eligible for the HTW demonstration through her eligibility for certain programs or a member of her household's eligibility for certain programs when she is included in the budget group. A budget group is defined as the members of a household whose income is considered in the financial eligibility determination.

An HTW demonstration applicant or client will be considered adjunctively eligible at an initial or renewal application, and therefore automatically financially eligible, if:

- She is a member of a certified Supplemental Nutrition Assistance Program (SNAP) household
- She is receiving Temporary Assistance for Needy Families (TANF) cash or is in the budget group of someone receiving TANF cash

- She is in the budget group of a child under 18 or a parent and other caretaker relative who is receiving Medicaid
- A member in her budget group receives benefits under the Women, Infants, and Children (WIC) supplemental nutrition program

Citizenship and Alien Status Verification (Reasonable Opportunity)

The HTW demonstration will not use the process described in 42 CFR §435.956(a)(5) to provide a period of reasonable opportunity for citizenship and alien status verification.[19]

For the HTW demonstration, HHSC will attempt to verify citizenship and alien status through available electronic data sources. If electronic data is not available, HHSC will request citizenship and alien status verification from the individual. The individual will have at least 30 days to provide verification at application and at least 10 days to provide verification at renewal. If the individual does not provide the required verification, new applications will be denied 45 days after the date of submission, and renewal applications will be denied the last day of the certification period. An individual who is denied for failure to provide verification of citizenship or alien status will be able to reapply for the HTW demonstration at any time.

Renewal

The HTW demonstration will not use the renewal process described in 42 CFR §435.916.[20]

HHSC will redetermine a woman's eligibility for the HTW demonstration every 12 months. HHSC will send the client, or her parent or legal guardian if she is 15 through 17 years of age, a renewal packet with a renewal application that must be completed and returned along with any required

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[19] 42 CFR §435.956(a)(5) requires state agencies to provide Medicaid and CHIP applicants or recipients who declare themselves to be U.S. citizens or declare to have an eligible alien status, but for whom verification of citizenship or alien status is unavailable a period of reasonable opportunity (90 days) to provide verification of citizenship or alien status. During a period of reasonable opportunity, the agency must provide Medicaid or CHIP benefits if the individual is otherwise eligible.

[20] 42 CFR §435.916 requires state agencies to make a redetermination of eligibility without requiring information from the individual if the agency is able to do so based on information in the individual's account and information available through electronic data sources. If the agency is not able to redetermine eligibility based on available information, the agency is also required to provide the individual with the pre-populated renewal form containing information needed to complete the renewal process.

verification. An individual may submit the renewal application over the phone, by fax, by mail, online, or in person at a local benefits office of HHSC.

Women who are determined adjunctively eligible at renewal will not need to submit a renewal application. HHSC will send the client a separate form for her to attest that she is not pregnant and does not have any other creditable health coverage. HHSC will not evaluate income at the time of renewal for women determined adjunctively eligible.

Eligibility Processes

The following eligibility processes are consistent with the Medicaid State Plan:

- Application channels
- Application and renewal processing timeframes
- Citizenship and alien status (with the exception of reasonable opportunity)
- Identity and Social Security Number requirements
- Residency

3) *Specify any enrollment limits that apply for expansion populations under the Demonstration.*

Enrollment limits will not apply to the HTW demonstration population.

4) *Provide the projected number of individuals who would be eligible for the Demonstration, and indicate if the projections are based on current state programs (i.e., Medicaid State plan, or populations covered using other waiver authority, such as 1915(c)). If applicable, please specify the size of the populations currently served in those programs.*

HHSC projects the following number of individuals would be eligible for the HTW demonstration:

Calendar Year	Projected Number
2017	676,000
2018	691,000
2019	707,000
2020	724,000
2021	740,000
2022	757,000

Calendar Year	Projected Number
2023	774,000

The projections are based on the following data sources:

- U.S. Census Bureau, 2015 American Community Survey for Texas Public Use Microdata Sample
- Texas Demographic Center, Office of the State Demographer at the University of Texas at San Antonio
- Texas Department of State Health Services Center for Health Statistics

5) *To the extent that long term services and supports are furnished (either in institutions or the community), describe how the Demonstration will address post-eligibility treatment of income, if applicable. In addition, indicate whether the Demonstration will utilize spousal impoverishment rules under section 1924, or will utilize regular post-eligibility rules under 42 CFR 435.726 (SSI State and section 1634) or under 42 CFR 435.735 (209b State).*

Not applicable.

6) *Describe any changes in eligibility procedures the state will use for populations under the Demonstration, including any eligibility simplifications that require 1115 authority (such as continuous eligibility or express lane eligibility for adults or express lane eligibility for children after 2013).*

HTW demonstration participants will receive 12 months of continuous eligibility.

7) *If applicable, describe any eligibility changes that the state is seeking to undertake for the purposes of transitioning Medicaid or CHIP eligibility standards to the methodologies or standards applicable in 2014 (such as financial methodologies for determining eligibility based on modified adjusted gross income), or in light of other changes in 2014.*

Not applicable.

Section III – Demonstration Benefits and Cost Sharing Requirements

This section should include information on the benefits provided under the Demonstration as well as any cost sharing requirements. In accordance with 42 CFR 431.412(a)(ii), the information identified in this section must be included in a state's application in order to be determined complete. Specifically, this section should:

1) *Indicate whether the benefits provided under the Demonstration differ from those provided under the Medicaid and/or CHIP State plan.*

■ Yes ☐ No

2) *Indicate whether the cost sharing requirements under the Demonstration differ from those provided under the Medicaid and/or CHIP State plan.*

The HTW demonstration will not impose cost-sharing requirements.

3) *If changes are proposed, or if different benefit packages will apply to different eligibility groups affected by the Demonstration, please include a chart specifying the benefit package that each eligibility group will receive under the Demonstration.*

Benefit Package Chart

Healthy Texas Women demonstration population	Demonstration-only benefit package

4) *If electing benchmark-equivalent coverage for a population, please indicate which standard is being used.*

Not applicable.

5) *In addition to the Benefit Specifications and Qualifications form: [http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By- Topics/Waivers/1115/Downloads/Interim1115-Benefit-Specifications-and-Provider- Qualifications.pdf](http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Interim1115-Benefit-Specifications-and-Provider-Qualifications.pdf), please complete the following chart if the Demonstration will provide benefits that differ from the Medicaid or CHIP State plan.*

Please refer to Attachment B for the Benefit Specifications and Qualifications form.

Benefit Chart

Benefit	Description of Amount, Duration and Scope	Reference
Outpatient Hospital Services	Limited to contraceptive services, pregnancy testing, STI services (including HIV/AIDS), breast and cervical cancer screening and diagnosis, and other family planning services.	Mandatory 1905(a)(2)
Rural Health Clinic Services (RHC)	RHCs are reimbursed for HTW demonstration services in accordance with the Medicaid State Plan.	Mandatory 1905(a)(2)
Federally Qualified Health Centers (FQHC) Services	FQHCs are reimbursed for HTW demonstration services in accordance with the Medicaid State Plan.	Mandatory 1905(a)(2)
Laboratory and X-Ray Services	Limited to family planning services, mammography, STI/HIV, hyperlipidemia, diabetes, and hypertension.	Mandatory 1905(a)(3)
Family Planning Services	Excludes diagnosis related to elective termination of pregnancy or emergency contraception. Other family planning services are provided by HTW demonstration providers in accordance with the Medicaid State Plan.	Mandatory 1905(a)(4)
Physicians' Services	Limited to HTW demonstration services as described on this chart.	Mandatory 1905(a)(5)
Clinic Services	Limited to HTW demonstration services as described on this chart.	Optional 1905(a)(9)

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Benefit	Description of Amount, Duration and Scope	Reference
Prescribed Drugs	Limited to oral contraceptives and medications for the treatment and management of hyperlipidemia, diabetes, hypertension, postpartum depression, and sexually transmitted diseases. There is no preferred drug list for the HTW demonstration.	Optional 1905(a)(12)
Diagnostic Services	Limited to STI services (including HIV/AIDS), screening for obesity, smoking, STI/HIV, lipid disorders, colorectal cancer, cervical cancer, and breast cancer.	Optional 1905(a)(13)
Screening Services	Limited to STI services (including HIV/AIDS), screening for obesity, smoking, STI/HIV, lipid disorders, colorectal cancer, cervical cancer, and breast cancer.	Optional 1905(a)(13)
Preventive Services	Limited to well-woman preventive care visits, contraception, STI/HIV screening, immunizations, mammograms, cervical cancer screening, screening for hyperlipidemia, diabetes, and hypertension, basic infertility services, counseling intervention related to smoking, nutrition, and mental health.	Optional 1905(a)(13)
Nurse-midwife services	Limited to gynecologic and preconception care, family planning services, and care during the postpartum period.	Mandatory 1905(a)(17)

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Benefits Not Provided

Benefit	Description of Amount, Duration and Scope	Reference
Inpatient Hospital Services	Not covered in the HTW demonstration	Mandatory 1905(a)(1)
Nursing Facility Services for Age 21 & Older	Not covered in the HTW demonstration	Mandatory 1905(a)(4)
EPSDT	Not covered in the HTW demonstration	Mandatory 1905(a)(4)
Tobacco Cessation for Pregnant Women	Not covered in the HTW demonstration	Mandatory 1905(a)(4)
Medical or Surgical Services by a Dentist	Not covered in the HTW demonstration	Mandatory 1905(a)(5)
Medical Care and any type of remedial care recognized under State Law - Podiatrists' Services	Not covered in the HTW demonstration	Optional 1905(a)(6)
Medical Care and any type of remedial care recognized under State Law - Optometrists' Services	Not covered in the HTW demonstration	Optional 1906(a)(6)
Medical Care and any type of remedial care recognized under State Law - Chiropractors' Services	Not covered in the HTW demonstration	Optional 1905(a)(6)
Medical Care and any type of remedial care recognized under State Law - Other Practitioners' Services	Not covered in the HTW demonstration	Optional 1905(a)(6)

Benefit	Description of Amount, Duration and Scope	Reference
Home Health Services - Intermittent or part-time nursing services provided by a home health agency	Not covered in the HTW demonstration	Mandatory for certain individuals - 1905(a)(7)
Home Health Services - Home health aide services provided by a home health agency	Not covered in the HTW demonstration	Mandatory for certain individuals - 1905(a)(7)
Home Health Services - Medical supplies, equipment and appliances	Not covered in the HTW demonstration	Mandatory for certain individuals- 1905(a)(7)
Home Health Services - Physical therapy, occupational therapy, speech pathology, audiology provided by a home health agency	Not covered in the HTW demonstration	Optional- 1905(a)(7), 1902(a)(10)(D), 42CFR 440.70
Private duty nursing services	Not covered in the HTW demonstration	Optional 1905(a)(8)
Dental Services	Not covered in the HTW demonstration	Optional 1905(a)(10)
Physical Therapy	Not covered in the HTW demonstration	Optional 1905(a)(11)
Occupational Therapy	Not covered in the HTW demonstration	Optional 1905(a)(11)
Services for individuals with speech, hearing and language disorders	Not covered in the HTW demonstration	Optional 1905(a)(11)
Dentures	Not covered in the HTW demonstration	Optional 1905(a)(12)
Prosthetic Devices	Not covered in the HTW demonstration	Optional 1905(a)(12)

Benefit	Description of Amount, Duration and Scope	Reference
Eyeglasses	Not covered in the HTW demonstration	Optional 1905(a)(12)
Rehabilitative Services	Not covered in the HTW demonstration	Optional 1905(a)(13)
Services for Individuals over 65 in Institutions for Mental Disease (IMDs) - Inpatient hospital services	Not covered in the HTW demonstration	Optional 1905(a)(14)
Services for Individuals over 65 in IMDs -Nursing facility services	Not covered in the HTW demonstration	Optional 1905(a)(14)
Intermediate Care Facility services for individuals in a public institution for individuals with intellectual disabilities or persons with related conditions	Not covered in the HTW demonstration	Optional 1905(a)(15)
Inpatient psychiatric services for under 22	Not covered in the HTW demonstration	Optional 1905(a)(16)
Hospice Care	Not covered in the HTW demonstration	Optional 1905(a)(18)
Case management services 1915(g)	Not covered in the HTW demonstration	Optional 1905(a)(19), 1915(g)
Special Tuberculosis (TB) related services	Not covered in the HTW demonstration	Optional 1905(a)(19), 1902(z)(2)
Respiratory care services under 1902(e)(9)(A) through (C)	Not covered in the HTW demonstration	Optional 1905(a)(20)

Benefit	Description of Amount, Duration and Scope	Reference
Certified pediatric or family nurse practitioners' services	Not covered in the HTW demonstration	Mandatory 1905(a)(21)
Home and Community Care for Functionally Disabled Elderly Individuals	Not covered in the HTW demonstration	Optional 1905(a)(22)
Personal Care Services in the beneficiary's home	Not covered in the HTW demonstration	Optional 1905(a)(24), 42CFR 440.170
Primary care case management services	Not covered in the HTW demonstration	Optional 1905(a)(25)
Programs of All-Inclusive Care for the Elderly (PACE) Services	Not covered in the HTW demonstration	Optional 1905(a)(26)
Special Sickle-Cell Anemia-Related Services	Not covered in the HTW demonstration	Optional 1905(a)(27)
Licensed or Otherwise State-Approved Free-Standing Birthing Centers	Not covered in the HTW demonstration	Optional 1905(a)(28)
Transportation	Not covered in the HTW demonstration	Optional benefit – 1905(a)(29) – 42CFR 440.170, Required as an administrative function – 42CFR 431.53
Services provided in religious non-medical health care facilities	Not covered in the HTW demonstration	Optional 1905(a)(29), 42CFR 440.170(b)
Nursing facility services for patients under 21	Not covered in the HTW demonstration	Optional 1905(a)(29), 42CFR 440.170(d)

Benefit	Description of Amount, Duration and Scope	Reference
Emergency Hospital services	Not covered in the HTW demonstration	Optional 1905(a)(29), 42CFR 440.170(e)
Expanded Services for Pregnant Women - Additional Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends	Not covered in the HTW demonstration	Optional 1902(e)(5)
Expanded Services for Pregnant Women - Additional Services for any other medical conditions that may complicate pregnancy	Not covered in the HTW demonstration	Optional 1902(e)(5)
Emergency services for certain legalized aliens and undocumented aliens	Not covered in the HTW demonstration	Mandatory 1903(v)(2)(A)
Home and Community-Based Services for Elderly or Disabled Individuals	Not covered in the HTW demonstration	Optional 1915(i)
Self-Directed Personal Assistance Services	Not covered in the HTW demonstration	Optional 1915(j)
Community First Choice	Not covered in the HTW demonstration	Optional 1915(k)

6) *Indicate whether Long Term Services and Supports will be provided.*

☐ Yes

■ No

7) *Indicate whether premium assistance for employer sponsored coverage will be available through the Demonstration.*

☐ Yes

■ No

8) If different from the State plan, provide the premium amounts by eligibility group and income level.

Not applicable.

9) Include a table if the Demonstration will require copayments, coinsurance and/or deductibles that differ from the Medicaid State plan.

Not applicable.

10) Indicate if there are any exemptions from the proposed cost sharing.

Not applicable.

Section IV – Delivery System and Payment Rates for Services

This section should include information on the means by which benefits will be provided to Demonstration participants. In accordance with 42 CFR 431.412(a)(ii), a description of the proposed healthcare delivery system must be included in a state's application in order to be determined complete. Specifically, this section should:

1) *Indicate whether the delivery system used to provide benefits to Demonstration participants will differ from the Medicaid and/or CHIP State plan (if no, please skip questions 2-7 and the applicable payment rate questions).*

☐ Yes

■ No

HTW demonstration providers will be reimbursed for covered services provided to HTW demonstration clients on a fee-for-service basis. The HTW demonstration fee-for-service delivery system will be modeled after the Texas Medicaid fee-for-service delivery system and will use Medicaid reimbursement codes and rates. Any Medicaid provider will be able to provide HTW demonstration covered services to HTW demonstration clients on a fee-for-service basis if they meet all HTW demonstration provider eligibility requirements (provider eligibility requirements are described further in Section V: Implementation of Demonstration).

HHSC requests Federal Financial Participation (FFP) at an enhanced 90 percent for HTW demonstration family planning services and at the Federal Medical Assistance Percentage (FMAP) for all other HTW demonstration covered services.

2) *Describe the delivery system reforms that will occur as a result of the Demonstration, and if applicable, how they will support the broader goals for improving quality and value in the health care system. Specifically, include information on the proposed Demonstration's expected impact on quality, access, cost of care and potential to improve the health status of the populations covered by the Demonstration. Also include information on which populations and geographic areas will be affected by the reforms.*

Not applicable.

3) *Indicate the delivery system that will be used in the Demonstration by checking one or more of the following boxes.*

- ☐ Managed care
  - ☐ Managed Care Organization (MCO),
  - ☐ Prepaid Inpatient Health Plans (PIHP)
  - ☐ Prepaid Ambulatory Health Plans (PAHP)
- ■ Fee-for-service (including Integrated Care Models)
- ☐ Primary Care Case Management (PCCM)
- ☐ Health Homes
- ☐ Other (please describe):

4) *If multiple delivery systems will be used, please include a table that depicts the delivery system that will be utilized in the Demonstration for each eligibility group that participates in the Demonstration (an example is provided). Please also include the appropriate authority if the Demonstration will use a delivery system (or is currently seeking one) that is currently authorized under the State plan, section 1915(a) option, section 1915(b) or section 1932 option.*

Not applicable.

5) *If the Demonstration will utilize a managed care delivery system.*

The HTW demonstration will not utilize a managed care delivery system.

6) *Indicate whether any services will not be included under the proposed delivery system and the rationale for the exclusion.*

All HTW demonstration services will be provided under the proposed delivery system.

7) *If the Demonstration will provide personal care and/or long term services and supports, please indicate whether self-direction opportunities are available under the Demonstration. If yes,*

please describe the opportunities that will be available, and also provide additional information with respect to the person-centered services in the Demonstration and any financial management services that will be provided under the Demonstration.

☐ Yes ■ No

The HTW demonstration will not provide personal care services or long-term services and supports.

8) *If fee-for-service payment will be made for any services, specify any deviation from State plan provider payment rates. If the services are not otherwise covered under the State plan, please specify the rate methodology.*

All HTW demonstration covered services delivered to HTW demonstration clients will be reimbursed on a fee-for-service basis using the established Medicaid rates. FQHCs and RHCs will be reimbursed in accordance with the Medicaid state plan.

9) *If payment is being made through managed care entities on a capitated basis, specify the methodology for setting capitation rates, and any deviations from the payment and contracting requirements under 42 CFR Part 438.*

Not applicable.

10) *If quality-based supplemental payments are being made to any providers or class of providers, please describe the methodologies, including the quality markers that will be measured and the data that will be collected.*

Not applicable.

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Section V – Implementation of Demonstration

This section should include the anticipated implementation date, as well as the approach that the State will use to implement the Demonstration. Specifically, this section should:

1) *Describe the implementation schedule. If implementation is a phase-in approach, please specify the phases, including starting and completion dates by major component/milestone.*

2) *Describe how potential Demonstration participants will be notified/enrolled into the Demonstration.*

3) *If applicable, describe how the state will contract with managed care organizations to provide Demonstration benefits, including whether the state needs to conduct a procurement action.*

Implementation Schedule

The proposed effective date for the HTW demonstration is September 1, 2018, for a five-year period ending August 31, 2023. HHSC will not use a phased approach for implementing the HTW demonstration. HHSC anticipates a four month period for operational changes once CMS approval is received prior to the HTW demonstration effective date. Operational changes will include TMHP system technology modifications to update the funding mechanism, as well as updates to HTW administrative rules and policy.

HHSC anticipates a cost for operational changes prior to program implementation. HHSC requests FFP at the 50 percent rate for administrative expenditures resulting from the implementation of these changes, or at an increased FFP if available.

Client Application Process

A beneficiary within the current HTW program will not experience a gap in coverage as the program transitions to Medicaid and will be able to receive the same benefits previously provided under the HTW program.

A female, or parent or legal guardian acting on her behalf if she is 15 through 17 years of age, will be able to apply for HTW demonstration services by completing an application form and providing documentation as required by HHSC to verify citizenship and alien status, identity, and income. An applicant may obtain an application in any of the following ways:

- Online at HealthyTexasWomen.org or YourTexasBenefits.com
- In person at an HHSC local benefits office, an HTW provider's office, or any other location that makes HTW applications available

- By calling 2-1-1

HHSC accepts and processes every application received through all of the following means:

- In person at an HHSC local benefits office
- By fax
- By mail
- Electronically through HealthyTexasWomen.org or YourTexasBenefits.com

HHSC will process all HTW demonstration applications within 45 days of receipt. Program coverage will begin on the first day of the month in which HHSC receives a valid application. A client is deemed eligible to receive covered services for 12 continuous months. Providers and community-based organizations will be able to help women fill out and fax their applications to HHSC for processing.

To provide continuity of care in the postpartum period, women 18 through 44 years of age whose Medicaid for Pregnant Women coverage period is ending will be automatically enrolled in the HTW demonstration if they are not otherwise eligible for full Medicaid benefits, Medicare, or CHIP, and they do not have other creditable health coverage. If a woman is qualified for auto-enrollment she will be enrolled into the HTW demonstration on the first day of the month following her Medicaid for Pregnant Women coverage termination. At the time of auto-enrollment, a notification form will be sent to the woman to let her know she is able to receive HTW demonstration services. The woman can choose not to participate in the HTW demonstration by returning the form by mail, by fax, or by calling 2-1-1. The woman will be able to request on the form that all of her HTW demonstration correspondence be sent to a confidential mailing address. Once auto-enrolled into the HTW demonstration, the woman will be eligible to receive covered services for 12 continuous months.

Client Renewal Process

A client, or a parent or legal guardian acting on her behalf if she is 15 through 17 years of age, may renew HTW demonstration eligibility by completing a renewal application and providing any documentation as required by HHSC. An HTW demonstration client will be sent a renewal packet during month 10 of her 12-month HTW demonstration certification period. A client will be able to return the renewal application in person at a local HHSC benefits office, by fax, by calling 2-1-1, online, or through the mail.

HTW Outreach Efforts

Beginning in 2016, HHSC launched a statewide HTW outreach campaign targeting providers, clients and external stakeholders. The goals of the campaign include informing and educating eligible women in Texas about the HTW program, educating women on why it is important to see their health care provider, expanding access to women's health and family planning services, and increasing HTW program enrollment.

HHSC will continue and expand upon current outreach efforts already in place to educate women about the HTW demonstration and to help increase client and provider enrollment. Client outreach will include:

- Promotion of the newly redesigned women's health program website, HealthyTexasWomen.org, which enables clients to apply for program services online and locate a provider
- Television and radio public service announcements aimed at directing viewers to the program website
- Distribution of outreach materials to statewide community-based organizations, HHSC regional offices, and service providers
- Strategic advertising to targeted demographic using digital platforms and social media

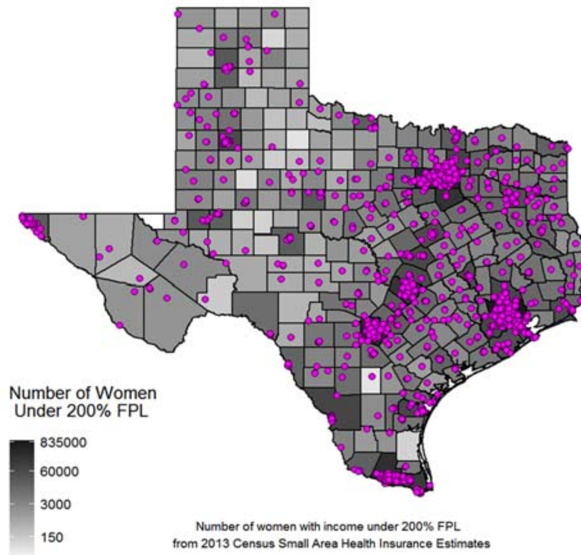
HHSC requests FFP at the 50 percent rate for administrative expenditures for HTW demonstration outreach efforts.

HTW Provider Eligibility

All HTW demonstration providers must be enrolled with TMHP as a Medicaid provider and be compliant with Texas Human Resources Code §32.024(c-1).

Figure 1 below shows the distribution of HTW fee-for-service providers across the state as of January 1, 2017.

Figure 1. HTW Fee-for-Service Provider Locations



As evidenced by Figure 1, the current HTW program has a large provider base to address the health and family planning needs of women across the state. While Texas has expanded its women's health provider base by 250 percent in the past five years, HHSC recognizes improvements can continue to be made to ensure women across the state are able to readily access high quality care. Through the HTW demonstration, HHSC anticipates further expansion of its provider network and increased access to services for women statewide, especially in rural and underserved regions of the state.

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Section VI – Demonstration Financing and Budget Neutrality

This section should include a narrative of how the Demonstration will be financed as well as the expenditure data that accompanies this application. The State must include 5 years of historical data, as well as projections on member month enrollment. In accordance with 42 CFR 431.412(a)(iii) and (iv), historical and projected expenditures as well as projected enrollment for the proposed demonstration project must be included in a state's application in order to be determined complete. The additional information requested will be needed before *the application can be acted upon.*

Please refer to Attachment C for the Demonstration Financing Form and Attachment D for the Budget Neutrality Spreadsheet.

Justification for With-Waiver Trend Rates, Per Member Per Month Costs and Member Months

The HTW demonstration trend rates are based on historical long-term trends experienced under predecessor women's health programs. The average annual trend rate for state fiscal years 2008 through 2016 for per member per month costs is 5.5 percent. The per member per month costs are based on actual fee-for-service claim expenditures for July 2016 through February 2017[21] and divided by corresponding actual monthly caseloads. Increase in utilization is assumed as program ramp-up continues through August 2017; long-term trends described above are applied thereafter.

For caseloads, the average annual trend from state fiscal years 2009 through 2016 is 2.8 percent. State fiscal year 2008 was excluded as an extreme outlier due to initial program ramp-up. Caseload estimates are based on actual program enrollment growth for July 2016 through March 2017[22]. Statistical software is used for baseline projections, and long-term trends are applied for future program growth.

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[21] July 2016 is the first month for which HTW program data are available, as the program launched on July 1, 2016. February 2017 is the latest month for which claims data are available.

[22] March 2017 is the latest month for which preliminary enrollment data are available.

The chart below lists all of the new populations in the HTW demonstration and explains their relationship to the eligibility groups listed in Section II.

Population Name	Brief Description	Cross-Walk to Section II
Healthy Texas Women demonstration group	Women enrolled in the HTW demonstration	Not otherwise eligible for Medicaid.

Explanation of Estimates, Methodology, and Data

This waiver application is unique in that the state is currently fully funding the HTW program. Though HHSC does not intend to end the program if this application is not approved, HHSC assumes CMS' intent is to evaluate the impact of the current HTW program, regardless of the method of finance. As such, the Without Waiver (WOW) tab of the budget neutrality worksheet (Attachment D) illustrates the anticipated impact if the HTW program were discontinued.

HHSC has determined that 42 CFR §431.412(a)(iii) is not applicable to this demonstration application. Thus, historical expenditures are not provided and a bridge period is not applicable.

HHSC's budget neutrality methodology assumes reductions in Medicaid-paid births, prenatal care, and newborn services due to increased access to family planning services. Additionally, the methodology assumes a reduction in Medicaid for Breast and Cervical Cancer enrollment due to increased access to screening for cervical cancer, as well as access to cervical dysplasia treatment, which can prevent the development of cervical cancer.

This budget neutrality analysis covers two categories directly and indirectly impacted by the demonstration: waiver eligibility group served and non-waiver eligibility group impacted. Five eligibility groups are considered and structured as:

- Waiver eligibility group served – Healthy Texas Women (HTW)
- Non-waiver eligibility group impacted – Medicaid for Pregnant Women, Medicaid Children Age 1 and Under, Medicaid for Breast and Cervical Cancer, and CHIP Perinatal

In addition to the five-year (FFY 2019 – FFY 2023) projections of expenditures, member months and cost per member per month, five-year total, and annual change are provided for each individual eligibility group.

The WOW tab shows the anticipated impact if the HTW program were discontinued. The direct impact is in the HTW eligibility group; cost/caseload is removed/zeroed out. Furthermore, without increased access to family planning to postpone or prevent pregnancy, cervical cancer screening, and cervical dysplasia treatment provided in HTW, HHSC's budget neutrality methodology assumes increases in Medicaid-paid births (reduced averted births), Medicaid for Pregnant Women caseloads, CHIP Perinatal caseloads, newborn caseloads, and cervical cancer treatment services under the Medicaid for Breast and Cervical Cancer program.

Pregnancy/birth related impacts are based on the estimated HTW population (unserved in WOW tab), a 2.5 percent fertility rate within 12 months, and another 4.5 percent from 12 to 18 months, based on Texas birth statistics for uninsured populations. Some attrition is also assumed due to other external factors (possible creditable health coverage, choice of family planning use, intended births, etc.). This would result in additional women and newborns being served under Medicaid for Pregnant Women and the Children Age 1 and Under eligibility groups. Due to the higher income limit (200 percent FPL) of the HTW demonstration, there is a small impact to the CHIP Perinatal program, which covers prenatal care for unborn children in households with incomes above the Medicaid for Pregnant Women eligibility threshold. Additionally, the analysis assumes a small increase in Medicaid for Breast and Cervical Cancer enrollment without the benefits of cervical cancer screening and cervical dysplasia treatment under the HTW program. This estimate is based on clients identified with moderate to severe cervical dysplasia under the predecessor women's health program in state fiscal year 2015. Based on cervical dysplasia statistics from the University of Maryland Medical Center, severe cervical dysplasia has a resulting cancer diagnosis in 30 percent to 50 percent of cases if left untreated. HHSC has assumed the lesser bound, such that 30 percent of these severe cases would result in cervical cancer treatment under Medicaid for Breast and Cervical Cancer due to lack of identification (without HTW).

The With Waiver (WW) tab in Attachment D shows the same eligibility groups under the Medicaid structure and HTW program as they exist today. Costs and caseloads on this tab are shown in the traditional format, and

projections are based on current historical enrollment through March 2017 and expenditure data through December 2016, except HTW which is through February 2017. No additional adjustments are made. The WOW tab uses this same underlying cost and caseload projection for each eligibility group but with adjustments on top for the impacts described above.

The Budget Neutrality Summary tab in Attachment D calculates the difference between WOW and WW and demonstrates budget neutrality for the HTW demonstration. Budget neutrality is not realized until the second year of the demonstration because of the methodology used for the WOW tab. As stated above, the WOW tab illustrates the anticipated impact if the HTW program were discontinued. In this scenario, most pregnancies not averted in the first year of the WOW tab do not show up as additional births until the second year.

Section VII – List of Proposed Waivers and Expenditure Authorities

This section should include a preliminary list of waivers and expenditures authorities related to title XIX and XXI authority that the State believes it will need to operate its Demonstration. In accordance with 42 CFR 431.412(a)(vi), this section must be included in a state's application in order to be determined complete. Specifically, this section should:

1) *Provide a list of proposed waivers and expenditure authorities.*
2) *Describe why the state is requesting the waiver or expenditure authority, and how it will be used.*

Expenditure Authority

Under the authority of Section 1115(a)(2) of the Social Security Act (the Act), expenditures made by Texas, which are not otherwise included as expenditures under Section 1903 of the Act shall, for the period of this demonstration, be regarded as expenditures under the State's Title XIX plan. All requirements of the Medicaid statute will be applicable to such expenditure authorities (including adherence to income and eligibility system verification requirements under Section 1137(d) of the Act), except those specified below as not applicable to these expenditure authorities. The expenditure authorities shall enable Texas to operate the Healthy Texas Women Section 1115 Demonstration Waiver.

Waiver Authorities

All Medicaid requirements apply, except the following:

1. Amount, Duration, and Scope of Services – Section 1902(a)(10)(B) of the Act

Rationale for Authority: The State will offer the HTW demonstration population a benefit package consisting only of approved HTW demonstration covered services.

2. Early and Periodic Screening, Diagnostic, and Treatment – Section 1902(a)(43)(A) of the Act (EPSDT)

Rationale for Authority: The State will not furnish or arrange for EPSDT services to the HTW demonstration population.

3. Comparability – Section 1902(a)(17) and Section 1902(e)(14) of the Act

Rationale for Authority: The State will not utilize MAGI methodologies for determining financial eligibility for the HTW demonstration.

4. Retroactive Coverage – Section 1902(a)(34) of the Act

Rationale for Authority: Individuals enrolled in the HTW demonstration will not be retroactively eligible.

5. Freedom of Choice – Section 1902(a)(23) of the Act

Rationale for Authority: To ensure qualified providers participate in the HTW demonstration in accordance with State law, HHSC includes this waiver authority to the extent CMS believes such a waiver is necessary.

Section VIII – Public Notice

Public Notice and Comment Process

Documentation of compliance with the public notice process described in 42 CFR §431.408 will be completed after the public notice and comment period.

Section IX – Demonstration Administration

Please provide the contact information for the state's point of contact for the Demonstration application.

Name and Title: Jami Snyder, Associate Commissioner, Medicaid and CHIP Services

Telephone Number: 512-707-6096

Email Address: Jami.Snyder@hhsc.state.tx.us

Attachments

Attachment A - Title 1 Texas Administrative Code §382.11. Healthy Texas Women financial eligibility requirements.

Attachment B - Benefit Specifications and Provider Qualifications. The attachment provides a description of the amount, duration and scope of the services provided under the demonstration as well as the provider specifications and qualifications for the benefit or service.

Attachment C - Demonstration Financing Form. The attachment describes the financing for the demonstration.

Attachment D - Budget Neutrality Calculations.

Attachment E - Documentation of Tribal Consultation.

Attachment A

Title 1 Texas Administrative Code §382.11
Financial Eligibility Requirements

(a) Calculating countable income. Unless an applicant is adjunctively eligible as described in subsection (b) of this section, HHSC determines an applicant's financial eligibility by calculating the applicant's countable income. To determine countable income, HHSC adds the incomes listed in paragraph (1) of this subsection, less any deductions listed in paragraph (2) of this subsection, and exempting any amounts listed in paragraph (3) of this subsection.

(1) To determine income eligibility, HHSC counts the income of the following individuals if living together:

(A) the female age 18 through 44, inclusive, applying for HTW;

(i) the female's spouse; and

(ii) the female's children age 18 and younger; or

(B) the female age 15 through 17, inclusive, applying for HTW;

(i) the female's parent(s);

(ii) the female's siblings age 18 and younger; and

(iii) the female's children;

(2) In determining countable income, HHSC deducts the following items:

(A) work-related expense deductions of up to $120 of earned income;

(B) a dependent care deduction of $200 per month for each child under two years of age, and $175 per month for each dependent two years of age or older, including an earned income deduction for the actual costs of unreimbursed payments if the person incurs an expense for the care of a child or incapacitated adult or transportation of a child to and from day care or school;

(C) payments to dependents living outside the home;

(D) alimony;

(E) child support payments; and

(F) up to $75 per month in received regular child support payments, except HHSC counts all child support payments an applicant received if HHSC determines the applicant has violated an agreement to assign child support to the State.

(3) HHSC exempts from the determination of countable income the following types of income:

(A) any income that federal law excludes;

(B) the earnings of a child:

(i) who is 18 years of age and is a full-time student, including a home-schooled student, or a part-time student employed less than 30 hours a week; or

(ii) who is under 18 years of age and is:

(I) a full-time student, including a home-schooled student; or

(II) a part-time student employment less than 30 hours a week;

(C) up to $300 per federal fiscal quarter in cash gifts and contributions that are from private, nonprofit organizations and are based on need;

(D) proceeds from claims on insurance policies to compensate for a loss or that are used to pay medical expenses;

(E) payments from federal volunteer programs for volunteer service, such as payments:

(i) for volunteer service in a senior citizen volunteer program, under the Domestic Volunteer Service Act (42 U.S.C. §§5000 et seq.);

(ii) for volunteer service to Volunteers in Service to America (VISTA), (42 U.S.C. §§4951 - 4960); and

(iii) for volunteer service under the National and Community Service Act (42 U.S.C. §§12511 - 12657);

(F) payments under the Workforce Innovation and Opportunity Act (29 U.S.C. §§3101, et seq.);

(G) the value of any benefits received under a government nutrition assistance program that is based on need, including benefits under the Supplemental Nutrition Assistance Program (SNAP) (formerly the Food Stamp Program) (7 U.S.C. §§2011-2036), the Child Nutrition Act of 1966 (42 U.S.C. §§1771-1793), the National School Lunch Act (42 U.S.C. §§1751-1769), and the Older Americans Act of 1965 (42 U.S.C. §§3056, et seq.);

(H) foster care payments;

(I) payments made under a government housing assistance program based on need;

(J) energy assistance payments;

(K) job training payments that:

(i) are earmarked as reimbursement for training-related expenses; and

(ii) do not duplicate payment for an item that is covered by budgetary needs;

(L) a lump sum provided and used to pay burial, legal, or medical bills, or to replace damaged or lost possessions, except HHSC does not exclude amounts from lump sums used for another purpose;

(M) reimbursements for monies spent on items not covered by budgetary needs;

(N) amounts deducted from royalties for production expenses and severance taxes;

(O) all income of Supplemental Security Income recipients;

(P) third-party funds received and used for a third-party beneficiary who is not a household member;

(Q) vendor payments made from funds not legally obligated to the household;

(R) veterans benefits for special needs that are not items covered by budgetary needs;

(S) workers' compensation payments legally obligated to the recipient that are earmarked and used for medical expenses;

(T) the amount of any nonfarm self-employment income offsetting a tax deduction taken that year for a farm loss, for households with farms generating income of at least $1,000 annually;

(U) up to $2,000 of gifts annually from tax-exempt organizations provided to children with life-threatening conditions;

(V) independent living payments to youths who are leaving foster care, as provided by the Social Security Act, Title IV-E (42 U.S.C. §§670 et seq.);

(W) funds from payments of up to $2,000 to Native Americans made under the federal Old Age Assistance Claims Settlement Act (25 U.S.C. §§2301-2307) or the federal Alaska Native Claims Settlement Act (43 U.S.C. §§1601-1629);

(X) funds from payments made to volunteers under Title I of the Domestic Volunteer Services Act of 1973 (42 U.S.C. §§4950, et seq.);

(Y) funds from adoption subsidy payments made under Title IV-A (42 U.S.C. §§601, et seq.) and Title IV-E (42 U.S.C. §§670, et seq.) of the Social Security Act;

(Z) funds from insurance policy dividends;

(AA) funds from veterans payments earmarked as a housebound allowance or as an aid and attendance allowance;

(BB) earned income tax credit payments;

(CC) federal, state, or local government payments provided to rebuild a home or replace personal possessions damaged in a disaster, including payments under the Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. §§5121 et seq.), if the recipient is subject to legal sanction if the payment is not used as intended;

(DD) funds from educational assistance payments (but only during the quarter, semester, or applicable period that the payment is intended to cover);

(EE) loans, if the circumstances satisfy HHSC that there exists an understanding that the money will be repaid, and the applicant or client reasonably explains to HHSC how the money will be repaid; and

(FF) crime victim's compensation payments.

(b) Adjunctive eligibility. An applicant or client is considered adjunctively eligible at an initial or renewal application, and therefore automatically financially eligible, if:

(1) a member in her budget group receives benefits under the Women, Infants, and Children (WIC) supplemental nutrition program;

(2) she is a member of a certified Supplemental Nutrition Assistance Program (SNAP) household;

(3) she is in a Children's Medicaid budget group for someone receiving Medicaid; or

(4) she is receiving Temporary Assistance for Needy Families (TANF) cash or is in a TANF budget group for someone receiving TANF cash.

Attachment B

Benefit Specifications and Provider Qualifications

Name of Benefit or Service:

Family Planning Services

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:

Family planning services are limited such that any HTW demonstration claim submitted which includes a diagnosis related to elective termination of pregnancy or emergency contraception will be denied.

Amount of Benefit/Service – Describe any limitations on the amount of service provided under the Demonstration:

Services for counseling for or the provision of emergency contraception are not a covered benefit.

Authorization Requirements-describe any prior, concurrent or post-authorization requirements, if any:

Not applicable.

Provider Category(s):

All HTW demonstration providers may provide HTW family planning services.

Description of allowable providers:

The Texas Medicaid State Plan allows family planning services to be provided by physicians, advanced practice registered nurses, nurse-midwives, and family planning clinics. The HTW demonstration will not impose the same limitations.

HTW demonstration family planning providers will include: physician assistant, nurse practitioner, clinical nurse specialist, physician, physician group, registered nurse, nurse midwife, federally qualified health centers, ambulatory surgical centers, maternity service clinics, family planning clinics, and rural health clinics.

Each HTW provider must be enrolled as a Texas Medicaid provider, comply with all applicable state licensure and certification requirements, and comply with Texas Human Resources Code §32.024(c-1).

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Name of Benefit or Service:

All HTW demonstration services

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:

Except as otherwise noted in this application all HTW demonstration services are provided in the same amount, duration, and scope as described in the Medicaid State Plan.

Duration of Benefit/Service-describe any limitations on the duration of the service under the demonstration:

Except as otherwise noted in this application all HTW demonstration services are provided in the same amount, duration, and scope as described in the Medicaid State Plan.

Authorization Requirements-describe any prior, concurrent or post-authorization requirements, if any:

Not applicable.

Provider Category(s):

All HTW demonstration providers

Description of allowable providers:

All HTW services must be provided by a qualified HTW demonstration provider who is a Medicaid provider and compliant with Texas Human Resources Code §32.024(c-1).

These providers may include physician assistant, nurse practitioner, clinical nurse specialist, physician, physician group, registered nurse, nurse midwife, federally qualified health centers, ambulatory surgical centers, maternity service clinics, family planning clinics, and rural health clinics.

Attachment C

Demonstration Financing Form

The State proposes to finance the non-federal share of expenditures under the Demonstration using the following (please check all that are applicable):

- ■ State General Funds
- ☐ Voluntary intergovernmental transfers from governmental entities.
- ☐ Voluntary certified public expenditures from governmental entities.
- ☐ Provider taxes.
- ☐ Other

Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State Plan. To ensure that program dollars are used only to pay for Medicaid services, we are asking States to confirm to CMS that providers retain 100 per cent of the payments for services rendered or coverage provided.

Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, DRG, DSH, fee schedule, global payments, supplemental payments, enhanced payments, capitation payments, other), including the Federal and non-Federal share (NFS)?

■ Yes ☐ No

If no, provide an explanation of the provider payment arrangement.

Do any providers (including managed care organizations [MCOs], prepaid inpatient health plans [PIHPs] and prepaid ambulatory health plans [PAHPs]) participate in such activities as intergovernmental transfers (IGTs) or certified public expenditure (CPE) payments, or is any portion of payments are returned to the State, local governmental entity, or other intermediary organizations?

☐ Yes ■ No

If providers are required to return any portion of any payment, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount of percentage of payments that are returned, and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.). Please indicate the period that the following data is from.

Not applicable.

DRAFT

Section 1902(a) (2) provides that the lack of adequate funds from other sources will not result in the lowering of the amount, duration, scope, or quality of care and services available under the plan.

Please describe how the NFS of each type of Medicaid payment (normal per diem, DRG, fee schedule, global, supplemental, enhanced payments, capitation payments, other) is funded.

Legislative appropriations to the Texas Health and Human Services Commission.

Please describe whether the NFS comes from appropriations from the legislature to the Medicaid agency, through IGT agreements, CPEs, provider taxes, or any other mechanism used by the State to provide NFS. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated.

Legislative appropriations to the Texas Health and Human Services Commission.

Please provide an estimate of total expenditures and NFS amounts for each type of Medicaid payment. Please indicate the period that the following data is from:

FFY 2019 October 1, 2018 - September 30, 2019		
Medicaid Payments	Expenditures	NFS
Family Planning (90/10)	$32,444,898	$3,244,490
Family Planning Pharmacy (90/10)	$13,802,049	$1,380,205
Non-family-planning Medical Regular FMAP	$21,071,046	$9,098,478
Non-family-planning Pharmacy Regular FMAP	$1,178,461	$508,859
Outreach (50/50)	$2,500,000	$1,250,000

FFY 2020 October 1, 2019 - September 30, 2020		
Medicaid Payments	Expenditures	NFS
Family Planning (90/10)	$35,213,071	$3,521,307
Family Planning Pharmacy (90/10)	$14,893,443	$1,489,344
Non-family-planning Medical Regular FMAP	$22,868,811	$9,874,753
Non-family-planning Pharmacy Regular FMAP	$1,271,647	$549,097

Outreach (50/50)	$2,500,000	$1,250,000

FFY 2021 October 1, 2020 - September 30, 2021		
Medicaid Payments	Expenditures	NFS
Family Planning (90/10)	$38,217,421	$3,821,742
Family Planning Pharmacy (90/10)	$16,071,139	$1,607,114
Non-family-planning Medical Regular FMAP	$24,819,959	$10,717,258
Non-family-planning Pharmacy Regular FMAP	$1,372,203	$592,517
Outreach (50/50)	$2,500,000	$1,250,000

FFY 2022 October 1, 2021 - September 30, 2022		
Medicaid Payments	Expenditures	NFS
Family Planning (90/10)	$41,478,101	$4,147,810
Family Planning Pharmacy (90/10)	$17,341,961	$1,734,196
Non-family-planning Medical Regular FMAP	$26,937,578	$11,631,646
Non-family-planning Pharmacy Regular FMAP	$1,480,709	$639,370
Outreach (50/50)	$2,500,000	$1,250,000

FFY 2023 October 1, 2022 - September 30, 2023		
Medicaid Payments	Expenditures	NFS
Family Planning (90/10)	$45,016,979	$4,501,698
Family Planning Pharmacy (90/10)	$18,713,272	$1,871,327
Non-family-planning Medical Regular FMAP	$29,235,870	$12,624,049
Non-family-planning Pharmacy Regular FMAP	$1,597,796	$689,928
Outreach (50/50)	$2,500,000	$1,250,000

If any of the NFS is being provided using IGTs or CPEs, please fully describe the matching arrangement, including when the state agency receives the transferred amounts from the local governmental entity transferring the funds.

Not applicable.

If CPEs are used, please describe the methodology used by the State to

verify that the total expenditures being certified are eligible for Federal matching funds is in accordance with 42 CFR 433.51(b).

Not applicable.

For any payment funded by CPEs or IGTs, please provide the following, and indicate the period that the data is from:

Not applicable.

Section 1902(a) (30)(A) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a) (1) and 2105(a)(1) provide for Federal financial participation to States for expenditures for services under an approved State Plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type, and indicate the time period that that the data is from.

Not applicable.

Please provide a detailed description of the methodology used by the State to estimate the upper payment limit for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated).

Not applicable.

Does any governmental provider or contractor receive payments (normal per diem, DRG, fee schedule, global, supplemental, enhanced, and other) that, in the aggregate, exceed its reasonable costs of providing services?

☐ Yes ☒ No

If yes, provide an explanation.

In the case of MCOs, PIHPs, PAHPs, are there any actual or potential payments which supplement or otherwise exceed the amount certified as actuarially sound as required under 42 CFR 438.6(c)?

☐ Yes ☐ No ☒ Not Applicable

If so, how do these arrangements comply with the limits on payments in §438.6(c)(5) and §438.60 of the regulations?

Not applicable.

If payments exceed the cost of services (as defined above), does the State recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

DRAFT

☐ Yes ■ No

This is not a cost-settlement program. The Texas HHSC Rate Analysis Department reviews all rates once every 2 years and sets those based on factors explained and approved by CMS as part of the state plan amendment process.

Use of other Federal Funds

Are other federal funds, from CMS or another federal agency, being used for the Demonstration program?

☐ Yes ■ No

If yes, provide a list below of grants the State is receiving from CMS or other federal agencies. CMS must ensure these funds are not being used as a source of the non-federal share, unless such use is permitted under federal law. In addition, this will help to identify potential areas of duplicative efforts and highlight that this demonstration is building off of an existing grant or program.

Healthy Texas Women 1115 waiver
WITHOUT WAIVER (WOW) BUDGET PROJECTION: FFY19 - FFY 23

WAIVER ELIGIBILITY GROUP SERVED:	DY 01 (FFY 19)	DY 02 (FFY 20)	DY 03 (FFY 21)	DY 04 (FFY 22)	DY 05 (FFY 23)	Total 5 yr WOW
Healthy Texas Women						
EXPENDITURES	$ -	$ -	$ -	$ -	$ -	$ -
ELIGIBLE MEMBER MONTHS	-	-	-	-	-	-
PER MEMBER PER MONTH COSTS	$ -	$ -	$ -	$ -	$ -	$ -

TREND RATES		ANNUAL CHANGE				5-YEAR AVERAGE
TOTAL EXPENDITURE		0.00%	0.00%	0.00%	0.00%	0.00%
ELIGIBLE MEMBER MONTHS		0.00%	0.00%	0.00%	0.00%	0.00%
PER MEMBER PER MONTH COSTS		0.00%	0.00%	0.00%	0.00%	0.00%

NON-WAIVER ELIGIBILITY GROUP IMPACTED:	DY 01 (FFY 19)	DY 02 (FFY 20)	DY 03 (FFY 21)	DY 04 (FFY 22)	DY 05 (FFY 23)	Total 5 yr WOW
Pregnant Women						
EXPENDITURES	$ 1,393,276,760	$ 1,537,583,417	$ 1,615,193,812	$ 1,684,376,103	$ 1,757,255,586	$ 7,987,685,677
ELIGIBLE MEMBER MONTHS	1,743,721	1,859,461	1,900,356	1,935,135	1,970,524	9,409,198
PER MEMBER PER MONTH COSTS	$ 799.03	$ 826.90	$ 849.94	$ 870.42	$ 891.77	$ 848.92

TREND RATES		ANNUAL CHANGE				5-YEAR AVERAGE
TOTAL EXPENDITURE		10.36%	5.05%	4.28%	4.33%	5.97%
ELIGIBLE MEMBER MONTHS		6.64%	2.20%	1.83%	1.83%	3.10%
PER MEMBER PER MONTH COSTS		3.49%	2.79%	2.41%	2.45%	2.78%

NON-WAIVER ELIGIBILITY GROUP IMPACTED:	DY 01 (FFY 19)	DY 02 (FFY 20)	DY 03 (FFY 21)	DY 04 (FFY 22)	DY 05 (FFY 23)	Total 5 yr WOW
Children Age 1 and Under						
EXPENDITURES	$ 2,377,760,873	$ 2,544,565,441	$ 2,730,180,414	$ 2,847,563,779	$ 2,969,946,979	$ 13,470,017,486
ELIGIBLE MEMBER MONTHS	3,213,996	3,328,606	3,456,658	3,489,315	3,522,123	17,010,699
PER MEMBER PER MONTH COSTS	$ 739.81	$ 764.45	$ 789.83	$ 816.08	$ 843.23	$ 791.86

TREND RATES		ANNUAL CHANGE				5-YEAR AVERAGE
TOTAL EXPENDITURE		7.02%	7.29%	4.30%	4.30%	5.72%
ELIGIBLE MEMBER MONTHS		3.57%	3.85%	0.94%	0.94%	2.32%
PER MEMBER PER MONTH COSTS		3.33%	3.32%	3.32%	3.33%	3.32%

NON-WAIVER ELIGIBILITY GROUP IMPACTED:	DY 01 (FFY 19)	DY 02 (FFY 20)	DY 03 (FFY 21)	DY 04 (FFY 22)	DY 05 (FFY 23)	Total 5 yr WOW
Medicaid Breast & Cervical Cancer						
EXPENDITURES	$ 129,843,970	$ 136,822,530	$ 144,178,177	$ 151,931,296	$ 160,103,317	$ 722,879,290
ELIGIBLE MEMBER MONTHS	58,716	58,970	59,225	59,482	59,739	296,132
PER MEMBER PER MONTH COSTS	$ 2,211.40	$ 2,320.21	$ 2,434.40	$ 2,554.25	$ 2,680.03	$ 2,441.07

TREND RATES		ANNUAL CHANGE				5-YEAR AVERAGE
TOTAL EXPENDITURE		5.37%	5.38%	5.38%	5.38%	5.38%
ELIGIBLE MEMBER MONTHS		0.43%	0.43%	0.43%	0.43%	0.43%
PER MEMBER PER MONTH COSTS		4.92%	4.92%	4.92%	4.92%	4.92%

NON-WAIVER ELIGIBILITY GROUP IMPACTED:	DY 01 (FFY 19)	DY 02 (FFY 20)	DY 03 (FFY 21)	DY 04 (FFY 22)	DY 05 (FFY 23)	Total 5 yr WOW
CHIP Perinates						
EXPENDITURES	$ 1,182,302	$ 1,583,878	$ 1,671,639	$ 1,724,109	$ 1,776,875	$ 7,938,802
ELIGIBLE MEMBER MONTHS	4,146	5,441	5,625	5,682	5,735	26,629
PER MEMBER PER MONTH COSTS	$ 285.17	$ 291.10	$ 297.20	$ 303.44	$ 309.81	$ 298.13

TREND RATES		ANNUAL CHANGE				5-YEAR AVERAGE
TOTAL EXPENDITURE		33.97%	5.54%	3.14%	3.06%	10.72%
ELIGIBLE MEMBER MONTHS		31.24%	3.37%	1.02%	0.94%	8.45%
PER MEMBER PER MONTH COSTS		2.08%	2.10%	2.10%	2.10%	2.09%

HTW WAIVER AND NON-WAIVER ELIGIBILITY GROUPS IMPACTED:	DY 01 (FFY 19)	DY 02 (FFY 20)	DY 03 (FFY 21)	DY 04 (FFY 22)	DY 05 (FFY 23)	Total 5 yr WOW
Included Population Total Expenditures						
Total Expenditures	**$ 3,902,063,904**	**$ 4,220,555,266**	**$ 4,491,224,042**	**$ 4,685,595,286**	**$ 4,889,082,756**	**$ 22,188,521,255**
Total Member Months	**5,020,579**	**5,252,478**	**5,421,864**	**5,489,614**	**5,558,122**	**26,742,657**
Total Per Member Per Month Costs	**$ 777.21**	**$ 803.54**	**$ 828.35**	**$ 853.54**	**$ 879.63**	**$ 829.71**
Total Per Member Per Month Trend Rates		**3.39%**	**3.09%**	**3.04%**	**3.06%**	**3.14%**

Healthy Texas Women 1115 waiver
WITH WAIVER (WW) BUDGET PROJECTION: FFY19 - FFY 23

WAIVER ELIGIBILITY GROUP SERVED:	DY 01 (FFY 19)	DY 02 (FFY 20)	DY 03 (FFY 21)	DY 04 (FFY 22)	DY 05 (FFY 23)	Total 5 yr WW
Healthy Texas Women						
EXPENDITURES	$ 68,496,454	$ 74,246,972	$ 80,480,722	$ 87,238,348	$ 94,563,917	$ 405,026,414
ELIGIBLE MEMBER MONTHS	2,483,902	2,552,682	2,623,367	2,696,009	2,770,662	13,126,622
PER MEMBER PER MONTH COSTS	$ 27.58	$ 29.09	$ 30.68	$ 32.36	$ 34.13	$ 30.86
TREND RATES		ANNUAL CHANGE				5-YEAR AVERAGE
TOTAL EXPENDITURE		8.40%	8.40%	8.40%	8.40%	8.40%
ELIGIBLE MEMBER MONTHS		2.77%	2.77%	2.77%	2.77%	2.77%
PER MEMBER PER MONTH COSTS		5.47%	5.48%	5.48%	5.48%	5.48%

NON-WAIVER ELIGIBILITY GROUP IMPACTED:	DY 01 (FFY 19)	DY 02 (FFY 20)	DY 03 (FFY 21)	DY 04 (FFY 22)	DY 05 (FFY 23)	Total 5 yr WW
Pregnant Women						
EXPENDITURES	$ 1,378,534,763	$ 1,436,796,207	$ 1,498,215,561	$ 1,562,536,549	$ 1,630,053,013	$ 7,506,136,093
ELIGIBLE MEMBER MONTHS	1,724,465	1,755,423	1,786,932	1,819,114	1,851,875	8,937,808
PER MEMBER PER MONTH COSTS	$ 799.40	$ 818.49	$ 838.43	$ 858.95	$ 880.22	$ 839.82
TREND RATES		ANNUAL CHANGE				5-YEAR AVERAGE
TOTAL EXPENDITURE		4.23%	4.27%	4.29%	4.32%	4.28%
ELIGIBLE MEMBER MONTHS		1.80%	1.79%	1.80%	1.80%	1.80%
PER MEMBER PER MONTH COSTS		2.39%	2.44%	2.45%	2.48%	2.44%

NON-WAIVER ELIGIBILITY GROUP IMPACTED:	DY 01 (FFY 19)	DY 02 (FFY 20)	DY 03 (FFY 21)	DY 04 (FFY 22)	DY 05 (FFY 23)	Total 5 yr WW
Children Age 1 and Under						
EXPENDITURES	$ 2,375,632,489	$ 2,475,402,004	$ 2,579,374,086	$ 2,687,694,234	$ 2,800,614,649	$ 12,918,717,463
ELIGIBLE MEMBER MONTHS	3,211,138	3,238,333	3,265,760	3,293,419	3,321,313	16,329,963
PER MEMBER PER MONTH COSTS	$ 739.81	$ 764.41	$ 789.82	$ 816.08	$ 843.23	$ 791.11
TREND RATES		ANNUAL CHANGE				5-YEAR AVERAGE
TOTAL EXPENDITURE		4.20%	4.20%	4.20%	4.20%	4.20%
ELIGIBLE MEMBER MONTHS		0.85%	0.85%	0.85%	0.85%	0.85%
PER MEMBER PER MONTH COSTS		3.32%	3.33%	3.32%	3.33%	3.33%

NON-WAIVER ELIGIBILITY GROUP IMPACTED:	DY 01 (FFY 19)	DY 02 (FFY 20)	DY 03 (FFY 21)	DY 04 (FFY 22)	DY 05 (FFY 23)	Total 5 yr WW
Medicaid Breast & Cervical Cancer						
EXPENDITURES	$ 129,297,372	$ 136,275,932	$ 143,631,580	$ 151,384,698	$ 159,556,720	$ 720,146,303
ELIGIBLE MEMBER MONTHS	58,526	58,780	59,036	59,292	59,550	295,183
PER MEMBER PER MONTH COSTS	$ 2,209.23	$ 2,318.40	$ 2,432.97	$ 2,553.21	$ 2,679.39	$ 2,439.66
TREND RATES		ANNUAL CHANGE				5-YEAR AVERAGE
TOTAL EXPENDITURE		5.40%	5.40%	5.40%	5.40%	5.40%
ELIGIBLE MEMBER MONTHS		0.43%	0.43%	0.43%	0.43%	0.43%
PER MEMBER PER MONTH COSTS		4.94%	4.94%	4.94%	4.94%	4.94%

NON-WAIVER ELIGIBILITY GROUP IMPACTED:	DY 01 (FFY 19)	DY 02 (FFY 20)	DY 03 (FFY 21)	DY 04 (FFY 22)	DY 05 (FFY 23)	Total 5 yr WW
CHIP Perinates						
EXPENDITURES	$ 1,099,292	$ 1,124,388	$ 1,150,593	$ 1,177,302	$ 1,204,632	$ 5,756,207
ELIGIBLE MEMBER MONTHS	3,856	3,863	3,871	3,880	3,888	19,358
PER MEMBER PER MONTH COSTS	$ 285.10	$ 291.09	$ 297.20	$ 303.44	$ 309.81	$ 297.35
TREND RATES		ANNUAL CHANGE				5-YEAR AVERAGE
TOTAL EXPENDITURE		2.28%	2.33%	2.32%	2.32%	2.31%
ELIGIBLE MEMBER MONTHS		0.18%	0.23%	0.22%	0.22%	0.21%
PER MEMBER PER MONTH COSTS		2.10%	2.10%	2.10%	2.10%	2.10%

HTW WAIVER AND NON-WAIVER ELIGIBILITY GROUPS IMPACTED:	DY 01 (FFY 19)	DY 02 (FFY 20)	DY 03 (FFY 21)	DY 04 (FFY 22)	DY 05 (FFY 23)	Total 5 yr WW
Included Population Total Expenditures						
Total Expenditures	**$ 3,953,060,371**	**$ 4,123,845,503**	**$ 4,302,852,542**	**$ 4,490,031,131**	**$ 4,685,992,931**	**$ 21,555,782,479**
Total Member Months	**7,481,887**	**7,609,081**	**7,738,966**	**7,871,713**	**8,007,287**	**38,708,934**
Total Per Member Per Month Costs	**$ 528.35**	**$ 541.96**	**$ 556.00**	**$ 570.40**	**$ 585.22**	**$ 556.87**
Total Per Member Per Month Trend Rates		**2.58%**	**2.59%**	**2.59%**	**2.60%**	**2.59%**

Healthy Texas Women 1115 waiver
BUDGET NEUTRALITY SUMMARY: FFY19 - FFY 23

WITHOUT WAIVER SUMMARY	DEMONSTRATION YEARS (DY) DY 01 (FFY 19)	DY 02 (FFY 20)	DY 03 (FFY 21)	DY 04 (FFY 22)	DY 05 (FFY 23)	Total 5 yrs
Healthy Texas Women	$ -	$ -	$ -	$ -	$ -	$ -
Pregnant Women	$ 1,393,276,760	$ 1,537,583,417	$ 1,615,193,812	$ 1,684,376,103	$ 1,757,255,586	$ 7,987,685,677
Children Age 1 and Under	$ 2,377,760,873	$ 2,544,565,441	$ 2,730,180,414	$ 2,847,563,779	$ 2,969,946,979	$ 13,470,017,486
Medicaid Breast & Cervical Cancer	$ 129,843,970	$ 136,822,530	$ 144,178,177	$ 151,931,296	$ 160,103,317	$ 722,879,290
CHIP Perinates	$ 1,182,302	$ 1,583,878	$ 1,671,639	$ 1,724,109	$ 1,776,875	$ 7,938,802
Total WOW Expenditures	**$ 3,902,063,904**	**$ 4,220,555,266**	**$ 4,491,224,042**	**$ 4,685,595,286**	**$ 4,889,082,756**	**$ 22,188,521,255**

WITH WAIVER SUMMARY	DEMONSTRATION YEARS (DY) DY 01 (FFY 19)	DY 02 (FFY 20)	DY 03 (FFY 21)	DY 04 (FFY 22)	DY 05 (FFY 23)	Total 5 yrs
Healthy Texas Women	$ 68,496,454	$ 74,246,972	$ 80,480,722	$ 87,238,348	$ 94,563,917	$ 405,026,414
Pregnant Women	$ 1,378,534,763	$ 1,436,796,207	$ 1,498,215,561	$ 1,562,536,549	$ 1,630,053,013	$ 7,506,136,093
Children Age 1 and Under	$ 2,375,632,489	$ 2,475,402,004	$ 2,579,374,086	$ 2,687,694,234	$ 2,800,614,649	$ 12,918,717,463
Medicaid Breast & Cervical Cancer	$ 129,297,372	$ 136,275,932	$ 143,631,580	$ 151,384,698	$ 159,556,720	$ 720,146,303
CHIP Perinates	$ 1,099,292	$ 1,124,388	$ 1,150,593	$ 1,177,302	$ 1,204,632	$ 5,756,207
Total WW Expenditures	**$ 3,953,060,371**	**$ 4,123,845,503**	**$ 4,302,852,542**	**$ 4,490,031,131**	**$ 4,685,992,931**	**$ 21,555,782,479**

Expenditures (Over)/Under Cap	$ (50,996,466)	$ 96,709,763	$ 188,371,500	$ 195,564,155	$ 203,089,825	$ 632,738,776