Texas Healthcare Transformation and Quality Improvement Program

Section 1115 Demonstration Waiver

Extension Application

Texas Health and Human Services Commission

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EXECUTIVE SUMMARY

The Texas Legislature, through the 2012-2013 General Appropriations Act (H.B. 1, 82nd Legislature, Regular Session, 2011) and Senate Bill (S.B.) 7, 82nd Legislature, First Called Session, 2011, instructed the Texas Health and Human Services Commission (HHSC) to expand its use of prepaid Medicaid managed care to achieve program savings, while also preserving locally funded supplemental payments to hospitals. The State of Texas submitted a section 1115 Demonstration proposal to CMS in July 2011 to implement a statewide expansion of risk-based managed care consistent with the existing STAR section 1915(b) and STAR+PLUS section 1915(b)/(c) waiver programs, and thereby replace existing Primary Care Case Management (PCCM) and fee-for-service (FFS) delivery systems.

The State sought a section 1115 Demonstration as the vehicle to both expand the managed care delivery system, and to operate funding pools, supported by managed care savings and diverted supplemental payments, to reimburse providers for uncompensated care costs and to provide incentive payments to providers that implement and operate delivery system reforms. The waiver was designed to build on existing Texas health care reforms and to redesign health care delivery in Texas consistent with CMS goals to improve the experience of care, improve population health, and reduce the cost of health care without compromising quality.

CMS approved the waiver on December 12, 2011. The Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver, commonly called the 1115 Transformation Waiver (or waiver in this document) is a five-year demonstration waiver running through September 2016.

Through the 1115 Transformation Waiver, the State expanded its use of Medicaid managed care to achieve program savings, while also preserving locally funded supplemental payments to hospitals under two new funding pools. Through this Demonstration, the State has aimed to:

- Expand risk-based managed care statewide;
- Support the development and maintenance of a coordinated care delivery system;
- Improve outcomes while containing cost growth;
- Protect and leverage financing to improve Texas' health care infrastructure; and
- Transition to quality-based payment systems across managed care and hospitals.

Texas has made substantial progress toward achieving these five goals, and requests a five-year waiver extension to build on the work accomplished thus far, continue to strengthen the waiver programs, and further demonstrate program outcomes. Texas requests to continue the DY 5 funding level for the Delivery System Reform Incentive Payment (DSRIP) program during each year of the extension ($3.1 billion annually) and an Uncompensated Care (UC) pool to address the unmet UC need in Texas within budget neutrality.

Expand Risk-based Managed Care Statewide

Texas Medicaid has exceeded its initial goal of expanding risk-based managed care statewide through the STAR, STAR+PLUS and Children's Medicaid Dental Services programs. All three of these capitated managed care programs were expanded statewide to cover all 254 Texas counties, including carving into managed care inpatient hospital services and pharmacy services. Together, these three programs cover over 3.3 million Medicaid enrollees per month. HHSC successfully implemented several other major managed care expansions and initiatives during the demonstration period, including adding eligible persons with intellectual and developmental disabilities (IDD) into STAR+PLUS for their acute care (September 2014), carving mental health targeted case management and rehabilitation services into managed care (September 2014), implementing the Texas Dual Eligible Integrated Care project (March 2015), carving nursing facility services into managed care (March 2015), and implementing the Community First Choice program (June 2015).

Support the Development and Maintenance of a Coordinated Care Delivery System

The 1115 Transformation Waiver's managed care programs together with the two funding pools help support the development and maintenance of a coordinated care delivery system. Managed care coordination includes a primary care provider/dental home, care management and service coordination, case-by-case services as needed, and value added services such as 24-hour nurse lines, cell phones for high risk clients, and weight loss programs. In addition to the managed care programs authorized under the 1115 Transformation Waiver, Texas implemented a Dual Eligible Integrated Care Demonstration project in six counties utilizing STAR+PLUS health plans to better coordinate Medicare and Medicaid acute and long term services and supports for individuals dually eligible for both programs. One of the early successes of the DSRIP program is that the establishment of 20 Regional Healthcare Partnerships (RHPs) covering the state has led to increased local and regional collaboration to identify and address priority community healthcare needs. Many of the active DSRIP projects by their nature involve coordinating care delivery, including projects related to integrated physical and behavioral healthcare, patient-centered medical homes, chronic care management, and patient care navigation. In addition, Texas Medicaid MCOs are also required to have performance improvement projects (PIPs), some of which have goals in common with one or more DSRIP projects in a given geographic area. Activities are underway in many regions to further connect similar MCO and DSRIP projects so that they can better coordinate their efforts. The availability of UC pool funds to help offset uncompensated costs has provided hospitals and other providers the financial stability to try care improvement initiatives in the DSRIP program that they otherwise may not have undertaken.

Improve Outcomes while Containing Cost Growth

Texas has demonstrated its ability to contain cost growth through the demonstration period. The statewide Medicaid managed care programs in the waiver, together with the two pools, stabilized Medicaid spending growth, as Texas is well under the five year budget neutrality cap for the demonstration.

HHSC has numerous ways to analyze and publicize Medicaid health plan performance and incentivize high quality care. For example, Texas' External Quality Review Organization (EQRO) produces a performance indicator dashboard with domains related to potentially preventable events, access to care, member satisfaction with care, population-specific preventive health, care for certain chronic conditions, and long-term services and supports. It also produces managed care organization (MCO) report cards to allow members to easily compare the MCOs on specific quality measures. Additionally, all MCOs are required to undertake PIPS, as mentioned above.

Regarding the outcomes of the pools, Texas successfully transitioned from its former upper payment limit (UPL) programs to the DSRIP and UC pools, which together support the Texas safety net for low income Texans while incentivizing providers to test initiatives to improve patient care and outcomes. DSRIP enabled groundbreaking work, including increased regional and cross-regional collaboration between diverse healthcare providers and stakeholders and investments in infrastructure and innovation to improve systems of care. DSRIP projects were approved from mid-2013 through mid-2014, and the baseline data for outcome measures specific to each project was reported in October 2014. HHSC will collect data on improvements over baseline in 2015 and 2016. DSRIP also greatly increased access to care. In April 2015, providers reported achievement for over 10 percent of the outcome measures tied to projects, with many showing improvement related to emergency department utilization, hospital readmissions, flu vaccines, and controlling HbA1c and high blood pressure. In demonstration year (DY) 3 (October 1, 2013-September 30, 2014), DSRIP projects collectively provided over 2 million additional encounters and served over 950,000 additional individuals compared to the service levels they had provided prior to implementing the projects. Learning collaborative activities are underway throughout the state, and HHSC established an external Clinical Champions workgroup in early 2015 to help assess promising DSRIP projects for sharing of best practices and making improvements to the Medicaid program.

Protect and Leverage Financing to Improve Texas' Health Care Infrastructure

As Texas expanded Medicaid managed care statewide through the 1115 Transformation Waiver, the UC pool enabled the State to support the healthcare delivery system by preserving historical upper payment limit (UPL) supplemental payments to hospitals and other providers under a new methodology that offsets their uncompensated costs for care. As a cost-based alternative to Texas' former UPL programs, the UC pool is a key financing component for the healthcare safety net in Texas. UC funds are critical to Texas' health system, especially as Medicare hospital

rates and Medicare Disproportionate Share Hospital (DSH) funds have been reduced, with potential decreases in the federal allocation of Medicaid DSH funds made to Texas, and with continued population growth in Texas at a rate more than double the national average.

Funding from the UC pool is a major contributor to the active participation of both public and private hospitals in Medicaid, giving Medicaid enrollees a choice of hospitals for their care. For DY 2 (October 2012 - September 2013), 334 hospitals and public physician groups earned UC pool funds. Of the almost $3.9 billion earned by these providers for DY 2, almost 59% went to private and not-for-profit hospitals, almost 38% went to public hospitals, and about 3.5% percent went to state-owned hospitals and physician groups.

To further improve Texas' wide healthcare safety net, the DSRIP program enabled hospitals, other healthcare providers, and community partners to improve Texas' health care infrastructure through innovative care delivery models and increased access to care. These improvements in care benefit not only Medicaid and low-income uninsured patients, but all Texans in need of care, including Medicare patients and those insured via their employers or the marketplace.

Transition to Quality-based Payment Systems across Managed Care and Hospitals

Texas has adopted a strategic direction to increase quality-based payment systems across managed care and hospitals. HHSC's Pay-for Quality program provides financial incentives and penalties to MCOs based on year-to-year incremental improvement on specified quality measures. The Pay-for-Quality program includes a risk/reward pool that places up to four percent of the MCO capitation rate at risk. The quality of care measures used in this initiative are a combination of process and outcome measures which include select potentially preventable events (PPEs) as well as other measures specific to the program’s enrolled populations. HHSC defined the PPEs for DSRIP Category 4 hospital reporting to mirror the PPE methodology used for MCO Pay-for-Quality. Some of the Texas Medicaid MCOs' PIPS have goals in common with one or more DSRIP projects in a given geographic area. HHSC also requires each MCO to have a program for targeting outreach, education and intervention for members who have high utilization patterns that indicate typical disease management approaches are not effective.

The Texas DSRIP program is a form of value based purchasing, as it enables providers to undertake initiatives to improve how care is delivered and to earn incentive funds based on achieving agreed upon project milestones and related outcomes. DSRIP is an incubator for value based purchasing in Medicaid managed care, as the findings from DSRIP will demonstrate which types of initiatives may be promising for value based reimbursement arrangements between managed care plans and providers in their networks. In 2014, HHSC began requiring MCOs to develop and submit a written plan for expansion of value-based provider payment structures that includes an inventory of different payment models being deployed, provider types involved,

performance metrics and evaluation methods used, etc., as well as payment models planned for the future.

I. TEXAS HEALTHCARE TRANSFORMATION AND QUALITY IMPROVEMENT WAIVER OVERVIEW

The State of Texas submitted a section 1115 Demonstration proposal to CMS in July 2011 to expand risk-based managed care statewide consistent with the existing STAR section 1915(b) and STAR+PLUS section 1915(b)/(c) waiver programs, and thereby replace existing Primary Care Case Management (PCCM) or fee-for-service (FFS) delivery systems. CMS approved the waiver on December 12, 2011. The Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver, known as the 1115 Transformation Waiver, is a five-year demonstration waiver running through September 2016.

Through the 1115 Transformation Waiver, the State expanded its use of Medicaid managed care to achieve program savings, while also preserving locally funded supplemental payments to hospitals. The goals of the demonstration are to:

- Expand risk-based managed care statewide
- Support the development and maintenance of a coordinated care delivery system
- Improve outcomes while containing cost growth
- Protect and leverage financing to improve and prepare the healthcare infrastructure to serve a newly insured population
- Transition to quality-based payment systems across managed care and hospitals

This section provides a historical narrative of Medicaid managed care in Texas and the Delivery System Reform Incentive Payment (DSRIP) and Uncompensated Care (UC) programs under the 1115 Transformation Waiver. Also covered in this section are the programmatic objectives of the waiver and the State' successes and challenges in achieving those objectives.

A. MEDICAID MANAGED CARE OVERVIEW AND HISTORY

Under the Medicaid managed care model, HHSC contracts with MCOs and pays a monthly capitation for each Medicaid member enrolled in that MCO. The MCO is responsible for the delivery of all medically-necessary covered Medicaid services in the same amount, duration and scope as the traditional Medicaid benefit package authorized under the State Plan. A full-risk, capitated approach like that used in the original State of Texas Access Reform (STAR) and STAR+PLUS programs is the most comprehensive solution to address the complex medical, behavioral, and social needs of Medicaid clients. The full-risk, capitated managed care approach also offers the maximum cost control benefit to the State. A full-risk model combines the responsibility for both the financing and delivery of health care services under one entity and drives a patient-centered management approach to addressing multiple and complex health care needs. Under the full-risk model, MCOs have incentives to coordinate care and services that

reduce the costs of inpatient care, over-utilization of prescription drugs, and other expensive categories of health care services.

STATE OF TEXAS ACCESS REFORM (STAR) PROGRAM

The State has used a managed care model to deliver Medicaid services since 1993. The first Medicaid managed care program in Texas was the STAR program authorized under a 1915(b) waiver. The STAR program provided acute care services to pregnant women and low-income children and families (and continues to do so under the section 1115 authority). At the time it was initiated, STAR was only available in the seven counties that make up the Travis service area. During the 1990s and 2000s, Texas expanded the STAR program to nine service areas and by September 2011, STAR operated in ten of the 13 service areas in the state.

STAR+PLUS PROGRAM

Implemented in 1998, STAR+PLUS provides acute and long-term services and supports to the aged and individuals with disabilities and chronic health conditions. STAR+PLUS was first implemented in the Harris service area under the authority of a combination of 1915(b) and (c) waivers. By September 2011, the STAR+PLUS program operated in seven of the 13 service areas and eventually became available statewide through amendments to the 1115 Transformation Waiver in 2012 and 2014. Included in STAR+PLUS are home and community based services (HCBS), which are community-based, long-term services and supports provided as a cost-effective alternative to living in a nursing facility.

EXPANSION OF MANAGED CARE UNDER THE 1115 TRANSFORMATION WAIVER

Texas submitted a section 1115 Demonstration proposal to CMS in July 2011 with the intention of expanding risk-based managed care statewide during the life of the demonstration and received CMS approval on December 12, 2011. The STAR 1915(b) waiver program and the STAR+PLUS combination 1915(b)/1915(c) waiver program were transferred into the 1115 Transformation Waiver, maintaining the structure, design and operation of the programs. Texas utilized the 1115 Transformation Waiver as the vehicle to:

- expand managed care geographically throughout the state, and
- carve additional services into managed care from fee-for-service, including a new managed care program to deliver dental services for children enrolled in Medicaid.

Additional information on these expansions and carve-ins under the 1115 Transformation Waiver is provided in the following subsections.

Geographic Expansions

Under the 1115 Transformation Waiver, the STAR and STAR+PLUS managed care programs expanded statewide twice. The first expansion occurred in March 2012, when the STAR program expanded statewide to include the three Medicaid rural service areas, and STAR+PLUS expanded to three additional service areas, making STAR+PLUS available in ten of 13 service areas. The second major geographic expansion occurred in September 2014 when the STAR+PLUS program expanded to the remaining three Medicaid rural service areas making the program available statewide.

Population Expansions

Effective January 2014, children ages 6 to 18 with family incomes between 100 and 133 percent of the federal poverty level were transferred from the state's Children's Health Insurance Program (CHIP) to Medicaid in accordance with section 1902(a)(10)(A)(i)(VII) of the Social Security Act. Additionally, HHSC included former foster care youth up to the age of 26 in the Medicaid population.

Effective September 2014, acute care services for non-dually eligible adults receiving services through a community-based intermediate care facility for individuals with intellectual disabilities or a related condition (ICF/IID), or an ICF/IID 1915(c) waiver are provided through STAR+PLUS in accordance with a state legislative directive. Children in this population can choose to enroll in STAR+PLUS.

Effective March 2015, individuals who are dually eligible for both Medicaid and Medicare may choose to receive services through a Medicare-Medicaid plan that integrates acute care and long term services and supports. In order to participate in the program, members must be age 21 or older; receive Medicare Parts A, B, and D, and full Medicaid benefits; and be eligible for or enrolled in the Medicaid STAR+PLUS program.

Service Carve-ins

Under the authority of the 1115 Transformation Waiver, Texas carved several benefits into managed care, creating a more coordinated benefits package for enrollees under the MCO full-risk model:

- Effective March 2012:
  - Pharmacy services were carved into managed care. Providers must enroll with the Vendor Drug Program (VDP) before contracting with MCOs to provide pharmacy services for Medicaid clients.
  - Inpatient hospital services were carved into STAR+PLUS. Inpatient services were already a benefit delivered under STAR.
  - Texas implemented the Children's Medicaid Dental Services program (Dental Program). All Medicaid beneficiaries entitled to Early and Periodic Screening, Diagnostic, and

Treatment benefits receive the full array of primary and preventive dental services required under the State Plan, through dental MCOs called dental maintenance organizations (DMOs).

- Effective March 2014, cognitive rehabilitation therapy services (CRT) were added to the State Plan and implemented in managed care for adults in the HCBS STAR+PLUS waiver program.
- Effective September 2014:
  - Mental health rehabilitation and targeted case management services were carved into managed care for members who have chronic mental illness.
    - Supported employment and employment assistance services were added to the State Plan and implemented in managed care for adults in the HCBS STAR+PLUS waiver program.
- Effective March 2015, nursing facility services were carved into managed care for adults in STAR+PLUS program.
- Effective June 2015, HHSC implemented Community First Choice benefits for certain individuals in STAR+PLUS.

B. MEDICAID MANAGED CARE SUCCESSES UNDER THE 1115 TRANSFORMATION WAIVER

The State utilized the 1115 Transformation Waiver in order to achieve the following in Medicaid managed care:

- Expand risk-based managed care statewide; and
- Support the development and maintenance of a coordinated care delivery system.

Texas Medicaid exceeded its initial goal of expanding risk-based managed care statewide through the STAR, STAR+PLUS and Children's Medicaid Dental Services programs. All three of these capitated managed care programs were expanded statewide to cover all 254 Texas counties, including carving in managed care inpatient hospital services and pharmacy services. These program expansions cover over 3.3 million Medicaid enrollees per month with several additional services carved into managed care during the demonstration period.

STATEWIDENESS

The 1115 Transformation Waiver enabled HHSC to expand Medicaid managed care geographically making the STAR and STAR+PLUS programs available statewide. In addition, under the 1115 Transformation Waiver, Texas carved in Medicaid benefits and expanded to include additional populations. Figures 1 and 2 below depict the monthly number of persons enrolled in Medicaid managed care since the beginning of the demonstration. Between

December 2011 and November 2014, the monthly number of persons enrolled in STAR increased by 68% (1,199,008 monthly enrollees); monthly enrollment in STAR+PLUS increased by 86% (240,274 monthly enrollees); and the monthly number of persons enrolled in the Dental Program increased by over 25% (603,984 monthly enrollees).

Figure 1: Monthly Enrollment in STAR and STAR+PLUS, December 2011-November 2014

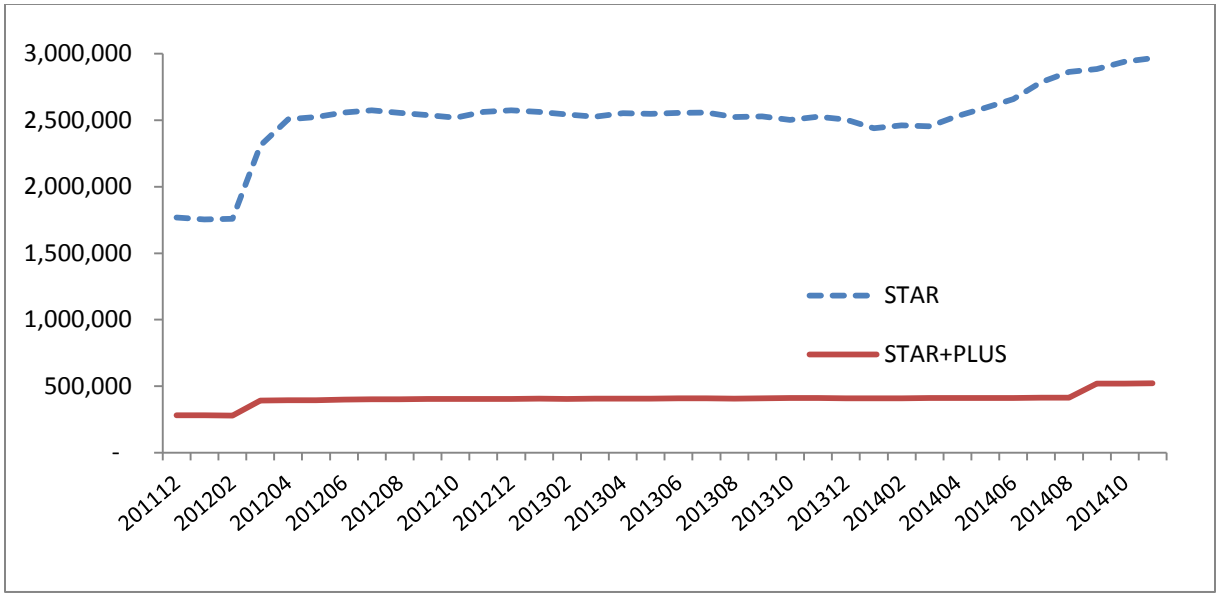
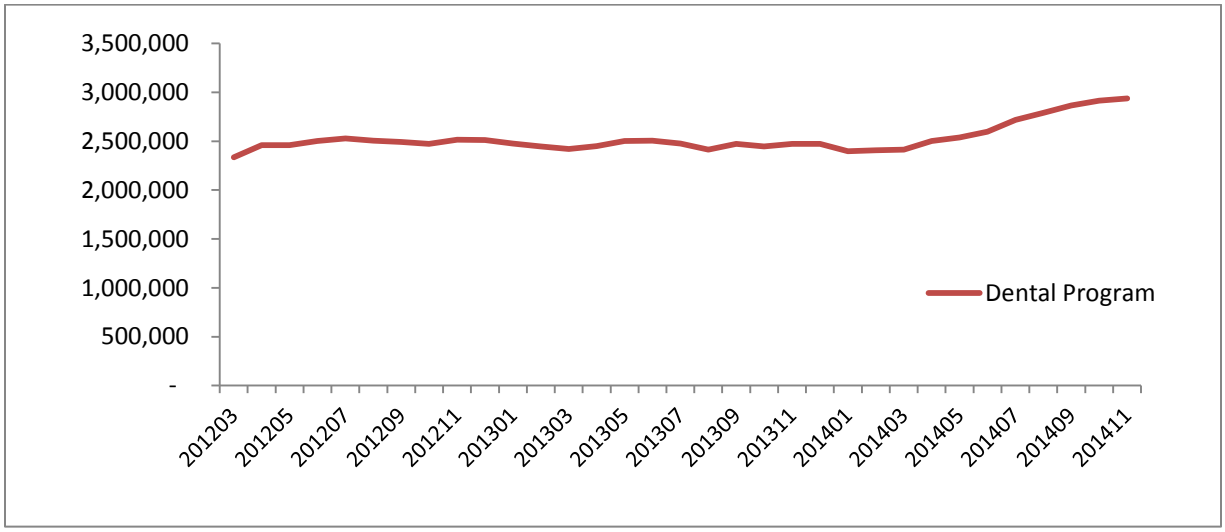


Figure 2: Monthly Enrollment in Dental Program, March 2012-November 2014



Note: Counts include clients receiving full or partial benefits.
Source: Texas Medicaid Premiums Payable System (PPS) 8 month eligibility files.
Prepared by: Data Analytics, Medicaid/CHIP Division, HHSC, May 20,2015

In order to ensure successful expansions and benefit carve-ins, HHSC coordinated various transition activities to educate members and train MCOs, DMOs, and providers.

HHSC traveled extensively around the state to educate the public and stakeholders, including members, providers, and advocacy groups. In addition, HHSC released information in written materials such as letters to members, newsletter articles, and more recently in YouTube informational videos.

HHSC worked very closely with the MCOs and DMOs in advance, during, and after all expansions and carve-ins. HHSC conducted weekly telephone calls with MCO executive and systems staff to discuss issues, provided technical assistance, and documented guidance in a question and answer format that was shared weekly with MCO, DMO, and HHSC staff. Additionally, HHSC conducted readiness reviews prior to the effective date of each expansion to assess the MCOs' and DMOs' ability, availability, and preparedness to fulfill its obligations. HHSC uses the readiness reviews to determine whether an MCO or DMO has implemented the necessary systems and operational processes to serve members. As part of the readiness review activities, HHSC conducts desk and onsite reviews of each MCO. In the desk review, HHSC evaluates the organizational, financial, systems, operations, and service coordination (as appropriate) policies and procedures. In an onsite review, MCOs and DMOs demonstrate functionality of systems, operations, and service coordination (as appropriate) for HHSC.

The post-transition period spanned three to six months after implementation. After the operational start date for the above expansions and carve-ins, HHSC worked with MCOs, DMOs, providers, and members to promptly identify and resolve issues and questions. HHSC enforces readiness review requirements and operational policies through managed care contracts and manuals.

HHSC is working on several initiatives related to reducing administrative burdens for providers, streamlining requirements, and standardizing policies in managed care. Additional requirements for improving managed care provider and member experience resulted from the recent legislative session. HHSC will continue working on these initiatives with stakeholders, including providers and the managed care organizations.

COORDINATED CARE

The State supports the development and maintenance of a coordinated care delivery system through managed care service delivery for Medicaid recipients. In addition to providing the traditional Medicaid benefits, managed care service delivery allows Medicaid recipients to receive the following additional benefits not ordinarily provided under the State Plan:

- Medical home through a primary care provider,
- Access to care management,

- Unlimited prescriptions,
- Unlimited necessary days in a hospital for STAR members, and
- Value-added services.

MCOs are required to assign each member a primary care provider (PCP) that serves as a medical home for that member and similarly, children are assigned a main dentist to serve as the main dental home in the Dental Program. PCPs must and main dentists may provide referrals for specialty care.

Managed care members may receive care management through the STAR and STAR+PLUS programs. The STAR MCOs offer service management to certain individuals they identify as a member with special health care needs (MSHCN). HHSC requires specific populations to be identified as MSHCN, such as high risk pregnant women , members with mental illness and co-occurring substance abuse diagnoses, and members with serious ongoing illness or a chronic complex condition. STAR MCOs develop individual service plans for each MSHCN and coordinate services with each member's PCP, specialty providers and non-medical providers. Service coordination for MSHCN ensures members have access to, and appropriately utilize, medically necessary covered services, non-capitated services, and other services and supports.

Service coordination is a cornerstone of the STAR+PLUS and Dual Demonstration programs. All STAR+PLUS members are eligible to receive comprehensive service coordination from qualified professionals. The service coordinator works with the member's PCP to coordinate all covered services and any applicable non-capitated services. The service coordinator actively involves the member's primary and specialty care providers, including Medicare Advantage plans for dually eligible members; behavioral health service providers; and providers of non-capitated services. The MCO may also train members or their families to coordinate their own care, when capable and willing. Additionally, the MCOs provide information about, and refer members to, community organizations that may improve the health and wellbeing of members, even if they do not provide Medicaid services.

Under the 1115 Transformation Waiver, adult Medicaid recipients may receive unlimited prescriptions and adults in STAR may receive unlimited necessary days in a hospital.

In addition, MCOs provide value-added services to managed care members. Value-added services are additional services beyond the scope of the traditional Medicaid package. Value-added services may be actual healthcare services, benefits, or positive incentives that will promote healthy lifestyles and improve health outcomes for Medicaid recipients. Examples of value-added services are extra dental and vision services for adults, nominal gift cards to promote well checks, and Weight Watchers program memberships.

REQUEST FOR MANAGED CARE PROGRAMS IN THE EXTENSION PERIOD

Texas requests to continue the STAR, STAR+PLUS and Children's Dental managed care programs in the extension period. HHSC does not request any changes to the waiver Special Terms and Conditions (STCs) related to these programs.

C. DELIVERY SYSTEM REFORM INCENTIVE PAYMENT POOL OVERVIEW AND HISTORY

DSRIP funding provides financial incentives that encourage hospitals and other providers to focus on achieving quality health outcomes. Participating providers develop and implement programs, strategies, and investments to enhance:

- Access to health care services
- Quality of health care and health systems
- Cost-effectiveness of services and health systems
- Health of the patients and families served

The DSRIP program is based in 20 Regional Healthcare Partnerships (RHPs) that are directly responsive to the needs and characteristics of the populations and communities comprising the RHP. Texas worked with private and public hospitals, local government entities, and other providers to create RHPs that are anchored by public hospitals or other government entities. The map of the 20 RHPs is located at http://www.hhsc.state.tx.us/1115-docs/Regions-Map-Aug12.pdf and the list of anchoring entities is at http://www.hhsc.state.tx.us/1115-docs/anchors.pdf.

Each anchoring entity collaborated with regional providers to develop an RHP plan rooted in the intensive learning and sharing that accelerates meaningful improvement within the providers participating in the RHP. RHP plans reflected broad inclusion of local stakeholders. Performing providers' DSRIP proposals flow from the RHP plans, and are consistent with the providers' shared mission and quality goals within the RHP, as well as CMS' overarching approach for improving health care through the simultaneous pursuit of three aims: better care for individuals (including access to care, quality of care, and health outcomes); better health for the population; and lower cost through improvement (without any harm whatsoever to individuals, families or communities).

To earn DSRIP funds, providers had to undertake projects from a menu agreed upon by CMS and HHSC in the RHP Planning Protocol.

1. Category 1 projects: Infrastructure Development lays the foundation for delivery system transformation through investments in technology, tools, and human resources that strengthen the ability of providers to serve populations and continuously improve services.

2. Category 2 projects: Program Innovation and Redesign includes the piloting, testing, and replicating of innovative care models, such as telemedicine, patient-centered medical home, and innovations in health promotion and disease prevention.
3. Category 3 outcomes: Quality Improvements assess the effectiveness of Category 1 and 2 interventions for improving outcomes in the Texas healthcare delivery system. Each project selected in Categories 1 and 2 has one or more associated outcome measures from Category 3.
4. Category 4 reporting: Population-focused Improvements include a series of reporting measures for a hospital to track the community-wide impact of delivery system reform investments. Required reporting includes data related to potentially preventable admissions, readmissions, and complications, patient-centered health care and emergency department utilization, with optional reporting of core healthcare quality measures for children and adults.

CMS initially approved the Texas DSRIP protocols--the RHP Planning Protocol and the Program Funding and Mechanics (PFM) Protocol--in August and September 2012. The RHP Planning Protocol, commonly referred to as the DSRIP menu, includes the project areas and options for Categories 1 through 4. The PFM Protocol contains the operational and financial requirements for the program, including requirements for each DSRIP performing provider, organization of the RHP Plan, funding allocations between and within RHPs, maximum project valuation, plan review process, required reporting, and plan modifications.

In December 2012, RHPs submitted five-year plans. The RHP plans outlined projects and proposed funding levels for HHSC and CMS approval. The plans described:

- the reasons for the selection of the projects, based on local data, gaps, community needs, and key challenges;
- how the projects included in the plan are related to each other and how, taken together, the projects support broad delivery system reform relevant to the patient population; and
- the progression of each project year-over-year, including the expected improvements that will occur in each demonstration year.

Both HHSC and CMS reviewed proposed projects in 2013, and approved the vast majority of them, with some approvals contingent on making changes to the project's content or valuation. With leftover funding, RHPs had the opportunity to propose additional three-year projects in late 2013, most of which were approved by mid-2014.

D. DSRIP SUCCESSES AND CHALLENGES

The DSRIP program is showing great promise to improve healthcare delivery systems and quality of care**.** However, more time is needed for the projects to mature beyond their implementation phase and to evaluate which initiatives demonstrate the most promising practices. The collective effort from CMS, HHSC, and Texas stakeholders to develop and implement the DSRIP program has been remarkable. As of May 1, 2015, there are 1,458 active

DSRIP projects performed by 298 providers that have earned over $4.5 billion (all funds) through September 30, 2014 (the end of DY 3) for achievement of over 11,800 milestones across DSRIP Categories 1-4.

Summary information on the active DSRIP Category 1 and 2 projects, along with the Category 3 outcomes associated with each project and regional Category 4 data, is located on HHSC's website at http://www.hhsc.state.tx.us/1115-RHP-Plans.shtml. A number of factors led to Texas' large volume of DSRIP projects and outcomes. First, the PFM Protocol sets valuation limits per project and requires that projects be RHP-specific, so that some providers such as community mental health centers with catchment areas across more than one RHP had to do between 2-4 of the same type of project (e.g., telemedicine) to cover all the counties they serve. Also, the PFM Protocol had minimum DSRIP participation requirements for private hospitals and major safety net hospitals for each RHP to be able to access its full regional allocation. Finally, Texas included many non-hospital providers in DSRIP, which broadened the scope of the program and helped to build and strengthen local and regional systems of care.

DSRIP providers include public and private hospitals, physician groups (largely affiliated with academic health science centers), community mental health centers, and local health departments. There is great variation in the 298 current DSRIP providers - urban and rural, large and small, public and private, nonprofit and for profit. These providers often are partnering with other entities in their communities, including federally qualified health centers, healthcare and social services non-profit organizations, and the criminal justice system, to carry out their projects. The projects focus on infrastructure (Category 1) and innovation (Category 2), both of which are very much needed to improve healthcare delivery in Texas. Texas DSRIP involves projects across the care continuum, with many projects focusing on primary and preventive care, behavioral healthcare, and better coordination of care for those with the most complex needs. Texas' DSRIP model recognizes that whole person health involves physical healthcare, behavioral healthcare, disease prevention and health promotion, and recognition of the social determinants of health.

A strength of the Texas DSRIP program is its regional approach; providers and other stakeholders in 20 regions throughout the state (encompassing 254 counties) formed RHPs, conducted needs assessments to identify priority healthcare needs in each region, and proposed a diverse array of projects to help address those needs. HHSC held a statewide learning collaborative summit in September 2014 with over 460 people in attendance and many others participating via webinar. A key takeaway from the summit was that DSRIP and the RHP structure have encouraged collaboration across the continuum of care among providers who previously had not worked together as much. For example, the over 400 DSRIP projects that focus on behavioral healthcare have led to increased collaboration between community mental health centers, hospitals and other providers. This increased collaboration is also evident in the

early results from the formal waiver evaluation, which show many new connections between RHP participants since the outset of the DSRIP program including through increased sharing of information, resources, and health data.

It took significant time to develop and implement the DSRIP program, and that delay makes it challenging at this time to determine the effectiveness of any one DSRIP project. CMS, HHSC, and Texas DSRIP participants worked diligently to implement the new program, but given the size and scope of Texas' DSRIP program, CMS did not approve projects until mid-2013 to mid-2014, more than halfway through demonstration years (DYs) 2 and 3. DSRIP projects are either four-year projects or three-year projects, so those that required time to establish project infrastructure may still be fairly early in their implementation. In particular, there were some regions of the state, including South Texas (which has great needs), that due to lack of local funding to support projects during the initial RHP plan submission got a later start on many of their projects.

There have been multiple revisions to the PFM Protocol and the RHP Planning Protocol. The latest substantive revisions to the protocols were completed in May 2014, more than halfway through the five-year waiver term. Program requirements changed for RHPs and their participating DSRIP providers numerous times. After the original RHP plans received initial CMS approval in mid-2013, HHSC worked with providers to strengthen and clarify projects as outlined in the PFM Protocol, including refining metric language for achievement, ensuring each project demonstrated quantifiable patient impact, and reviewing provider-proposed plan modifications to address changes that occurred from the time they initially submitted their projects in late 2012 to how projects were progressing one to two years later. While HHSC has set up a robust semi-annual qualitative and quantitative reporting system for all DSRIP projects, HHSC is frequently asked to stop changing the program requirements and allow providers to focus on carrying out their projects rather than having to keep up with the many administrative changes to this complex program.

Notably, in February 2014, the framework for Category 3 DSRIP outcomes, which are the outcome measure(s) associated with every Category 1 or 2 project, changed substantially at CMS' request. This change led to project outcome selections being finalized in August 2014 and outcomes baseline data reporting beginning in October 2014. HHSC staff has devoted considerable time to finalizing the outcomes menu and specifications and providing technical assistance to a diverse group of providers, including many non-hospital providers and smaller providers, to select appropriate Category 3 outcomes for each project and determine a baseline for each outcome. The most commonly selected Category 3 outcome measures relate to diabetes care, controlling high blood pressure, reducing preventable emergency department visits, and reducing hospital readmissions.

HHSC is beginning to collect data on outcome measure improvements over baseline in 2015. While most of the improvements will be reported in October 2015, during the April 2015 DSRIP reporting period, over 230 outcome measures (roughly 10 percent of all DSRIP outcome measures) reported achievement over baseline. For these measures, the average achievement toward the goal was 75 percent. For example, of the 23 projects that reported on risk-adjusted all-cause hospital readmissions, 22 met or exceeded their DY 4 goal and of the 9 projects that reported on reducing emergency department visits for ambulatory care sensitive conditions, 5 met or exceeded their DY 4 goal. Other commonly used measures with strong early results include HbA1c control (7 out of 8 met or exceeded their goal); controlling high blood pressure (all 6 that reported met or exceeded their goal); influenza immunization (8 of 9 met or exceeded their goal), and adult emergency department utilization (10 of 11 met or exceeded their goal).

More time is needed to assess the impact of projects on the chosen outcome measures since outcome selections were only finalized in August 2014 and measurement cannot be done prior to completion of project data collection. Additionally, while HHSC believes this information will be a key data point that can be used to evaluate projects' effectiveness, such information will only provide a partial picture of the direct impact of each project given that in most cases outcome measures were required to measure populations broader than those served by the project. Also, for many of the DSRIP projects, such as those that focus on chronic diseases, more time is needed to show even intermediate outcomes, as measurement of improvement takes place over a period of many years, not months.

Early DSRIP results show that the program is beginning to improve care for individuals as well as improve population health. A snapshot of the 20 RHPs, their priority community needs and the direct patient impact of some of their projects is demonstrated in a presentation from the September 2014 statewide summit: http://www.hhsc.state.tx.us/1115-docs/RHP-Snapshot-HHSC-SLC-2014.pdf. See Attachment A for additional information that demonstrates the variety of Texas DSRIP projects.

One component required for each Category 1 or 2 project is a "quantifiable patient impact" (QPI) –the number of additional individuals served or encounters provided as a result of the DSRIP project. Whether a project's QPI is individuals or encounters depends on the type of project. For example, a project to expand access to primary care would count additional encounters provided, while a project to provide chronic disease management would count individuals served. Each DSRIP project keeps track of its own individuals or encounters, so the cumulative QPI figures for the program for each year are not unduplicated. The same person may be served by more than one project, and may be served both in projects that count individuals and projects that count encounters.

QPI information is heavily weighted to the final two years of the waiver–DYs 4 and 5 (federal fiscal years 2015 and 2016) –to allow for project development and ramp up, but many projects

began to report patient impact in DY 3 as well. In DY 3, compared to pre-DSRIP service levels, DSRIP projects collectively provided over 2 million additional encounters and served over 950,000 additional individuals (summing up the number of individuals served by each DSRIP project), surpassing overall QPI goals by 171 percent for encounters and 136 percent for individuals. The two DSRIP target populations are Medicaid recipients and low income uninsured individuals, and the DY 3 DSRIP QPI figures demonstrate that the program already has done much to increase access to care and improve how care is delivered to these populations.

The cumulative QPI goals for DY 4 are approximately 4.7 million encounters and 1.3 million individuals. The current cumulative QPI goals for DY 5 are approximately 8 million encounters and 2.2 million individuals, but these goals will increase as HHSC works with providers who exceeded their DY 5 goals in DY 3 to increase their DY 5 QPI targets.

To further assess the impact of promising projects based on information from the initial years of project implementation, HHSC established the Clinical Champions Workgroup in January 2015. The workgroup is comprised of clinical, quality, and operational stakeholders representing DSRIP providers, state associations, and RHPs. The group met monthly from January through April, and will help HHSC identify strong projects to share promising practices with like projects around the state and establish a framework for more robust project evaluation in the future. The work of the Clinical Champions also will help improve the DSRIP project and outcome measures menus for the extension period and changes in Medicaid benefits and policy based on DSRIP lessons learned.

In addition to data from Categories 1, 2 and 3, there are learning collaborative activities across the state that are helping further the success of DSRIP through rapid, continuous quality improvement activities. Nine regional learning collaboratives are focusing on behavioral healthcare (including integrated care), and other common topics include decreasing preventable readmissions, improving care transitions/patient navigation, and increasing patient engagement. The learning collaboratives have encouraged data sharing and analysis. For example, an RHP 15 learning collaborative for diabetes care reviewed data regarding foot and eye examinations at various clinics, shared referral documentation and marketing materials to educate patients and clinicians about these important services, and months later confirmed a noticeable improvement in these examinations being conducted. Additionally, to support learning collaborative activities some regions are developing shared tools and resources (such as online searchable databases to assist patient navigation) and Plan-Do-Study-Act (PDSA) templates and trainings. See Attachment A for examples of tools developed by two of the regions to share information about their DSRIP projects.

In Category 4, HHSC and CMS are collecting hospital-level data to show whether there are improvements in a number of broad population-based measures, including Medicaid potentially preventable events (hospitalizations, readmissions and complications), emergency department

care, and patient-centered care. For DY 3, the Medicaid potentially preventable event (PPE) data was for calendar year 2012, and for DY 4, the PPE data is for calendar year 2013. As the waiver progresses, HHSC will have trend data for PPEs to show if improvements have been made during the demonstration. Category 4 PPE data by RHP for 2013 is posted at http://www.hhsc.state.tx.us/1115-RHP-Plans.shtml.

HHSC worked with an independent assessor to perform a mid-point assessment of projects in late 2014 through early 2015. The reporting data available to the independent assessor for its review was through the April 2014 DSRIP reporting period (reflecting project progress through March 31, 2014). The projects reviewed received initial CMS approval beginning in mid-2013, so the assessment reflected that many projects were still in early implementation. In spite of this timing, the independent assessor concluded: "On a statewide basis, with approximately 79 percent of the projects being low or moderate risk (meaning that they are on track for meeting their project outcome objectives), it appears that the State's Category 1 and 2 DSRIP projects are well on their way to achieving the intended project goals and those of the Triple Aim, which are to improve the health of the population, enhance the experience and outcomes of the patient, and reduce per capita cost of care for the benefit of communities." Between mid-2014 and the end of the mid-point review (May 1, 2015), 41 DSRIP projects withdrew for various reasons, including the inability to achieve project goals and in response to recommendations from the independent assessor's review.

HHSC proposes to use the results of the mid-point assessment as one of the factors to help inform which projects and project options continue in the extension period. HHSC reviewed continued project progress from the October 2014 DSRIP reporting period, and found the many projects that appeared at risk based on the April 2014 data now appear to be on track. HHSC will continue to review project progress to inform next steps for DSRIP.

ALIGNMENT OF THE DSRIP AND MANAGED CARE QUALITY STRATEGIES AND VALUE BASED PAYMENT EFFORTS

Texas has adopted a strategic direction to increase value based purchasing and payment reform to promote high-value, coordinated care. DSRIP is critical to this effort. While the initial years of DSRIP required concentrated efforts to establish and operationalize the program, HHSC is now focusing more on further alignment of DSRIP with Medicaid managed care and other quality improvement efforts in Texas. HHSC has an internal workgroup for quality coordination and is also engaging DSRIP participants, the Clinical Champions, Medicaid managed care organizations (MCOs), and other providers in this effort.

Alignment with Medicaid Managed Care Quality Strategy

In the implementation of DSRIP, HHSC began to align DSRIP with Medicaid managed care. For example, HHSC defined the PPEs for DSRIP Category 4 reporting to mirror the PPE

methodology used for the MCO Pay-for-Quality program. Texas Medicaid MCOs are also required to have PIPs, some of which have goals in common with one or more DSRIP projects in a given geographic area. Activities are underway in many regions to further connect similar MCO and DSRIP projects so that they can better coordinate their efforts. For example, to the extent that MCOs and DSRIP providers both have case managers to support targeted patients, they need to coordinate their efforts to provide the most efficient case management for those patients.

The Texas DSRIP program is a form of value based purchasing, as it enables providers to undertake initiatives to improve how care is delivered and to earn incentive funds based on achieving agreed upon project milestones and related outcomes. DSRIP is also an incubator for value based purchasing in Medicaid managed care, as the findings from DSRIP will demonstrate which types of initiatives may be promising for value based reimbursement arrangements between managed care plans and providers in their networks. HHSC is working with a DSRIP project in the Houston area that focuses on helping youths aged 18 to 21 with complex healthcare needs transition from the pediatric healthcare system to adult healthcare. HHSC is working with the provider on how to sustain this DSRIP project through value based purchasing arrangements with one or more STAR+PLUS health plans. HHSC plans to utilize this project as a model for the development of concrete steps for establishing value based purchasing arrangements and integrating DSRIP projects into Medicaid managed care.

If a DSRIP project in a geographic area is successful, this benefits the Medicaid MCOs whose enrollees are served through that DSRIP project. For instance, under its managed care contracts, HHSC requires each MCO to have a program for targeting outreach, education and intervention for members who have high utilization patterns that indicate typical disease management approaches are not effective. HHSC understands that some of the DSRIP projects with early results, such as reducing hospital readmissions for high utilizers, are beginning to approach MCOs to discuss alternate payment methodologies, which can help sustain DSRIP efforts.

HHSC recently underwent review by the Texas Sunset Advisory Commission, which made a number of recommendations to the Texas Legislature that are consistent with HHSC plans regarding the coordination of major quality initiatives. For example, based on the Sunset Commission's recommendations, S.B. 200, 84th Legislature, Regular Session, 2015, requires HHSC to develop a pilot project to promote increased use of incentive-based payments by MCOs. The work underway in DSRIP will highlight areas where MCOs should pursue incentive-based payments and HHSC is reviewing how to link DSRIP project success to MCO payment strategies. Texas Medicaid data shows that a high percentage of potentially preventable hospital admissions and readmissions are among individuals with serious mental health and/or substance use disorders, often with comorbidities. Over 25 percent of DSRIP projects have a behavioral healthcare focus, and if they are successful in keeping MCO members out of the

hospital, an MCO could pay a DSRIP provider to help coordinate health care and social supports for these high needs individuals.

HHSC is actively moving toward an expanded definition of medical expenses for MCOs, and DSRIP experience is helping inform this process. MCO expenses fall into either medical services or administrative services. While certain services are excluded by federal rule from counting as MCO medical expenses, HHSC is reviewing opportunities in this area. Based on previous MCO feedback, there may be more expenses incurred by MCOs that could be counted towards medical expense, such as peer specialists and community health workers. These are some of the types of services that are effectively being used in DSRIP projects. Since Texas Medicaid MCOs have a cap that limits the deductibility of administrative expenses, if HHSC allows MCOs to count additional services as medical expenses (when such services are recognized by CMS as medical), this will reduce any barriers that may exist for MCOs to use these types of services to best coordinate care for their members.

Coordination with National and State Quality and Value Based Purchasing Initiatives

DSRIP coordinates with a number of national and state initiatives in which Texas is participating. For example, Texas is participating in the CMS Substance Use Disorder (SUD) Learning Collaborative as part of the Medicaid Innovation Accelerator Program. Texas' main goal in this effort is to examine ways to optimize Medicaid SUD benefits. At the same time, HHSC is receiving input from SUD-focused DSRIP projects on their challenges with delivering SUD benefits through Medicaid MCOs, which will help inform the learning collaborative and Medicaid benefits changes. There may be opportunities through these efforts to pilot value based payment approaches with respect to this service (and/or behavioral healthcare services more broadly). Many DSRIP projects also align with the other areas being considered for the Medicaid Innovation Accelerator Program, including population health, integrated behavioral healthcare, perinatal care, and managing super utilizers.

Texas also is participating in SMINET with Rutgers University, which is an Agency for Healthcare Quality and Research (AHRQ)-supported initiative to increase the spread of evidence based practices in the care of adults with severe mental illness (SMI). This grant draws on AHRQ's proven method of using existing networks of providers and other key stakeholders to disseminate, translate, and implement delivery system evidence. The project focuses on transitions management and overall "person-centered" management of complex patients' healthcare needs as a whole (management of comorbid medical conditions and health risks, and care integration). Several DSRIP projects that focus on care transitions and management for adults with SMI are being invited to participate in this initiative along with Medicaid MCOs.

At the State level, the Texas Institute of Health Care Quality and Efficiency was established by the 82nd Legislature in 2011 to improve health care quality, accountability, education and cost

containment by encouraging health care provider collaboration, effective health care delivery models, and coordination of health care services. The Institute was administratively attached to HHSC and the Board was appointed by the Governor. The Strategic Plan of the Institute focuses on the Texas health care sector – both public and private – and recognizes the significant time, energy, and resources that Texas is directing into innovative approaches, such as the development of integrated service delivery models and regionalized system transformation that is the goal of DSRIP, to raise quality and contain costs. Investment in strategies that promote shared decision making between patients and providers, that increase care coordination, especially for individuals with complex medical, behavioral, and social support needs, and that tackle emerging public and community health issues, including chronic disease prevention, can drive improvement across the entire health care system. The Institute issued its legislative recommendations in November 2014 related to expanded access to care, administrative simplification, health literacy, value-based care, serious and persistent mental illness, and data sharing. These issue recommendations align with DSRIP goals. HHSC has coordinated DSRIP efforts with the Institute and plans to continue to work with the Institute or its successor to support the ongoing work through the waiver to transform care in Texas.

DSRIP supports the goals of the State Health Innovation Plan (SHIP) that Texas developed with the support of a State Innovation Model (SIM) development grant in 2013. The Texas SHIP articulated three long-term goals to achieve the Triple Aim (of better health outcomes, greater patient satisfaction, and containment of healthcare spending growth):

- transform the delivery system to models of patient-centered care;
- transition away from fee-for-service to quality-based payment; and
- build capacity for continuous, ongoing improvement and innovation throughout the health care and public health systems in Texas.

In the SHIP, Texas proposed five SIM innovation models to help achieve these goals:

- Electronic Health Record (EHR) and Health Information Exchange (HIE) expansion and sustainability initiatives;
- clinical care transformation programs, including support for medical home training and Bridges to Excellence;
- spreading and sustaining innovations;
- community-based public health programs, with a particular focus on diabetes and related comorbidities; and
- multi-payer engagement and alignment.

DSRIP strives for all three SHIP goals--moving to patient-centered care, transitioning to quality based payment, and building capacity for continuous improvement throughout health care and public health. DSRIP incorporates elements of the five models from the SHIP. DSRIP has encouraged increased data sharing. Attachment A contains an example of increased data sharing

in one of Texas' HIE "white spaces," in and around Wichita Falls in RHP 19. Many DSRIP projects, particularly in Category 2, relate to clinical care transformation, medical homes, and integrated physical and behavioral healthcare. Almost 10 percent of DSRIP projects focus on community-based public health, including health promotion and disease prevention, especially diabetes and related comorbidities, which are known issues and priorities in Texas. A goal of DSRIP, particularly in the extension period and with the assistance of the Clinical Champions workgroup, will be to increase the State's focus on spreading and sustaining innovations. As DSRIP supports healthcare delivery system transformation regardless of payer, the work being done through DSRIP also could be a springboard for further multi-payer engagement.

DSRIP REQUEST FOR THE EXTENSION PERIOD

Texas requests to continue the DSRIP program in the extension period to build on its early successes and to enable time to further evaluate program outcomes, best practices, and population health impacts. The only DSRIP-related STC change Texas requests for the extension period is to extend the DSRIP pool funds at the DY 5 level ($3.1 billion) for each year of the extension. In order to extend the DSRIP pool, STC 46, Limits on Pool Payments, will need to be modified to add to the table the pool amounts for the subsequent demonstration years approved by CMS.

Through refinements to the two DSRIP protocols, which HHSC plans to submit to CMS by early 2016, HHSC will propose to strengthen the DSRIP program in the extension period. Proposals under consideration include:

- Further incentivizing transformation and strengthening healthcare systems across the state by continuing the RHP structure. The 20 RHPs already have demonstrated improved systems of care, and these systems will be strengthened over time by continuing the collaborative work facilitated by the RHPs and role of the anchoring entities to provide regional coordination and technical assistance.
- Continuing the majority of the current 1458 active DSRIP projects into the extension period in order to give projects more time to demonstrate outcomes. These projects may take a logical next step toward further transformation. Some projects will not be eligible to continue based on review of the independent assessor and HHSC.
- Reviewing the Category 3 outcome measure methodologies and how outcome measures align with projects. Texas may propose a structure to better align outcome measures with certain projects and to show meaningful improvement, including outcomes related to pediatrics and behavioral healthcare.
- Establishing a new shared performance bonus pool from unearned funds over the course of the extension period (either because projects withdraw or fail to achieve milestones). If a region improves its performance on key measures, all participating providers in the region would be eligible to earn funds from the bonus pool.

- Requesting for funds from the $3.1 billion annual pool not allocated to continuing projects: to allow alternate transformative projects from a narrower menu based on lessons learned (potentially including cross-regional projects and initiatives, including related to the unique needs of rural Texas); to bring smallest projects up to a minimum valuation level; and/or to add funds to the shared performance bonus pool for regions that make improvements on key measures.
- Streamlining the DSRIP program to lessen the administrative burden on providers while focusing on collecting the most important types of information.
    - Standardize milestone language and reduce the number of milestones to be reported by requiring Category 1-2 milestones only for quantifiable patient impact (QPI), and allowing optional milestones only for specific milestones. Such optional milestones could relate to increased data exchange and project-level evaluation/sustainability planning (structured milestones with standard templates). Continuous quality improvement activities and other activities supporting the success of the project (such as hiring of staff, extending hours, achieving medical home certification) would be captured in semi-annual qualitative reporting.
    - Allow certain projects to be combined into a single project to reduce reporting, such as cross-RHP projects by community mental health centers; smaller, related projects below a certain valuation threshold being done by smaller providers; similar projects by the same provider in the same region (same project, different populations); potentially the same system doing the same project across multiple hospitals (within a region).
    - Consider reducing the period for allowable achievement carry forward (beyond the DY), but allow for partial achievement for QPI similar to what is allowed for Category 3 pay for performance now.
    - Modify or eliminate the mid-point assessment review requirement, but continue with ongoing compliance monitoring.

- Further integrating DSRIP efforts with Texas' Medicaid managed care quality strategy and other value based payment efforts.
    - Develop a Quality Alignment/Value Based Payment Roadmap by early 2017 to outline how HHSC plans to progress toward value based payment during the course of the extension.
    - Align DSRIP and managed care quality measures to the extent possible.
    - Analyze Medicaid data and available all-payer PPE data for managed care plans, MCO service delivery areas, and RHPs. HHSC will provide this global trend data to CMS from 2012 through the years of the extension period to show whether combined efforts are having an effect on these measures.
    - Require DSRIP projects to report Medicaid IDs of patients served by the project so that HHSC can analyze DSRIP and managed care data to increase alignment between DSRIP

and Medicaid managed care and inform managed care value based purchasing opportunities

- As part of DSRIP and UC requirements, require participating hospitals to provide emergency department admission, discharge, and transfer (ADT) information either to their regional HIE or the State. Medicaid ADT data will be available to MCOs to share with their providers for care coordination purposes.

Texas needs to continue the DSRIP pool to provide financial support for the innovative activities that have been initiated by local communities through DSRIP thus far. One of HHSC's primary goals for the waiver extension period is to work with CMS and Texas DSRIP stakeholders to determine how to best evaluate which of the projects are "benchmark" projects to sustain and replicate in the healthcare delivery systems for Medicaid and the low income uninsured in order to further strengthen systems of care in Texas.

E. UC POOL OVERVIEW, HISTORY AND SUCCESSES

As Texas expanded Medicaid managed care statewide through the waiver, the UC pool enabled the State to support the healthcare delivery system by preserving historical supplemental payments to hospitals and other providers to offset their uncompensated costs for care under a new methodology. As a cost-based alternative to Texas' former upper payment limit (UPL) programs, the UC pool is a key financing component for the healthcare safety net in Texas. UC funds are critical to Texas' health system, especially as Medicare hospital rates and Medicare Disproportionate Share Hospital (DSH) have been reduced, with potential reductions in Medicaid DSH funding under provisions of the Affordable Care Act (ACA), and with continued population growth in Texas more than double the national average.

Prior to the 1115 Transformation Waiver, Texas had Medicaid upper payment limit (UPL) supplemental payment programs for public and private hospitals as well as public physician groups, dental groups and ambulance providers. The UPL programs allowed hospitals and other providers to earn supplemental payments based on a variety of complex methodologies. For example, inpatient hospital UPL payments were based on charge room (the difference between a hospital's fee-for-service [FFS] billed charges for adjudicated Medicaid claims and all Medicaid and other payments for Medicaid inpatient services received during the calculation period for such claims). Inter-governmental transfers (IGT) from state-owned or local governmental entities financed the majority of the state share of UPL payments. In FY 2011, there were approximately $2.8 billion in UPL payments to Texas hospitals.

In 2011 Texas submitted the waiver request to CMS to better coordinate care through Medicaid MCOs, including carving inpatient hospital care into the MCOs' capitation rates. Due to federal restrictions on making UPL payments for managed care claims, in order to expand Medicaid managed care statewide and carve in inpatient hospital care, Texas agreed in the waiver to switch

from the UPL funding mechanism to the UC pool to continue to help Texas safety net providers offset a portion of their uncompensated care costs. The same types of providers that were eligible for UPL funds are eligible to earn UC pool funds under the waiver. Texas has successfully transitioned from the former UPL programs to the new UC program under the waiver, which uses a cost-based methodology to enable hospitals and certain other providers to partially offset the uncompensated care they provide to Medicaid and uninsured patients. During federal fiscal year (FFY) 2013 of the waiver, HHSC and CMS agreed to the protocols to govern the UC pool for each type of provider. HHSC then developed the applications for each provider type and conducted trainings for providers on how to fill out the UC tool applications. For hospitals, HHSC has moved to a combined application for DSH and UC since the allowable costs for the two programs are identical, except that per the STCs some additional costs for physician, clinic and pharmacy services are allowed to be reimbursed from the UC pool.

In DY 1, (October 2011 - September 2012), hospitals and physician groups had the option of either receiving transition payments based on their previous UPL payments, or submitting a UC application. Beginning in DY 2, all hospitals and physician groups that sought to participate in the UC pool were required to submit to HHSC a UC application documenting their allowable uncompensated costs, which are subject to the DSH federal audit rule with respect to the computation of hospital specific limits and also to interim and final payment reconciliation processes.

Once HHSC receives the UC tool applications for each year, it reviews them for completeness and does quality assurance (QA) edits. In the initial submissions, many UC tools were returned to providers for revisions, but the quality of the data submitted on the UC tools has improved over time as providers have become more familiar with the tools and instructions. HHSC then develops an initial UC database with costs for each provider, verifies that this database accurately reflects what providers submitted, and requests IGT commitments from public IGT entities in order to calculate each provider's possible UC payment. If all funded payments exceed the annual amount available in the UC pool, then all providers receive proportionately less than their allowable UC costs. For DY 1 - DY 3, HHSC made two UC payments each year; beginning with DY 4, UC payments will be made on a quarterly basis.

Many Texas hospitals earn and receive funds from the UC pool. For DY 3 (October 2013 - September 2014), 334 hospitals and public physician groups earned UC pool funds. Of the almost $3.5 billion earned by these providers for DY 3, almost 55% went to private and not-for-profit hospitals, almost 37% went to public hospitals, and about 5% percent went to state-owned hospitals and physician groups.

The Texas UC pool methodology is transparent and outlined in administrative rule. In 2014 and 2015, HHSC proposed and adopted revisions to its administrative rules related to DSH and UC to

provide distinct UC pools for different types of providers (including large public, small public, and private hospitals, with special protections for rural hospitals) to promote equity in the funding of UC.

As of June 2015, Texas has paid out a total of approximately $11.0 billion from the UC pool.

- Hospitals - $10.4 billion
  - Public - $4.1 billion
  - Private - $6.3 billion
- Physician groups - $294.3 million
- Ambulance and Dental groups - $263.0 million[1]

Funding from the UC pool is a major contributor to the active participation of both public and private hospitals in Medicaid and in the care of uninsured individuals, giving Medicaid enrollees and uninsured individuals a choice of hospitals for their care. Over 80 percent of Texas Medicaid hospital bed days were at private hospitals in 2013. In addition, among DSH hospitals, over half of the bed days for the low income uninsured were provided by private hospitals in DY 3. If UC in Texas grows without offsetting funding sources or if offsetting funding sources are reduced or eliminated, the safety net infrastructure in Texas will be seriously weakened and low-income patients either may have more limited choices for care or may not have access to care at all. UC funds also complement DSRIP in that they provide financial stability to hospitals and other providers to enable them to make investments to improve healthcare delivery that they otherwise may not have been able to make.

UC REQUEST FOR THE EXTENSION PERIOD

Texas requests to continue its current UC pool in the extension period at $5.8 billion for FFY 2017, $6.6 billion for FFY 2018 and $7.4 billion per year for FFY 2019-FFY 2021[2] adjusted as required to maintain budget neutrality, along with Attachment H to the STCs, UC Claiming Protocol and Application. In order to extend the UC pool, STC 46, Limits on Pool Payments, will need to be modified to add to the table the pool amounts for the subsequent demonstration years approved by CMS.

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[1] $118.7 million of the $263.0 million in UC payments for ambulance and dental are pending processing.

[2] These figures assume that the Medicaid DSH reductions mandated under the ACA are not delayed beyond their current expected implementation date of FFY 2017.

The requested UC pool size for the extension period is based on estimates of Texas' total UC burden as presented on Page 5 of Texas' STC 48 Transition Plan submitted to CMS in March 2015, [3] adjusted downward in FFY 2017 and FFY 2018 to remain within budget neutrality each year and to reflect $123 million per annum in additional general revenue funds appropriated by the 84th Texas Legislature for the purpose of reducing Texas' Medicaid inpatient and outpatient hospital shortfalls, and associated federal matching funds.

II. PROGRAMMATIC DESCRIPTION OF WAIVERS & EXPENDITURE AUTHORITIES.

WAIVER AND EXPENDITURE AUTHORITIES REQUESTED FOR THE EXTENSION PERIOD

Texas is requesting the same waiver and expenditure authorities as those approved in the current demonstration, including:

1. Texas requests waivers of the requirements of the following provisions of the Social Security Act: Statewideness (section 1902(a)(1)), Amount, Duration, and Scope of Services (section 1902(a)(10)(B)), Freedom of Choice (section 1902(a)(23)(A)), and Self-Direction of Care for HCBS Participants (section 1902(a)(32)).

2. Expenditures for the STAR+PLUS 217-Like HCBS Group

Expenditures for the provision of State Plan benefits and HCBS-like services to individuals age 65 and older, or age 21 and older with disabilities, who would otherwise be Medicaid-eligible under section 1902(a)(10)(A)(ii)(VI) of the Social Security Act and 42 CFR § 435.217 in conjunction with section 1902(a)(10)(A)(ii)(V) of the Act, if the services they receive under STAR+PLUS were provided under a HCBS waiver granted to the state under section 1915(c) of the Act. This expenditure authority is subject to an enrollment cap. All Medicaid laws, regulations and policies apply to this expenditure authority except as expressly waived or listed s not applicable.

3. Expenditures Related to Managed Care Organization (MCO) Enrollment and Disenrollment

[3] http://www.hhsc.state.tx.us/1115-docs/051215-waiver-updates/STC%2048%20Transition%20Plan%2020150323.pdf

Expenditures made under contracts that do not meet the requirements in section 1903(m) of the Act specified below. Texas managed care plans will be required to meet all requirements of section 1903(m) of the Act except the following:

• Section 1903(m)(2)(H) of the Act, federal regulations at 42 CFR 438.1, to the extent that the rules in section 1932(a)(4) are inconsistent with the enrollment and disenrollment rules contained in paragraph 31(c) of the current demonstration's Special Terms and Conditions (STCs), which permit the state to authorize automatic re-enrollment in the same managed care organization (MCO) if the beneficiary loses eligibility for less than six (6) months.

4. Expenditures for Inpatient Hospital Services and Prescription Drugs for STAR and STAR+PLUS Enrollees that Exceed State Plan Limits

Expenditures for STAR enrollees for inpatient hospital services that would not otherwise be covered under the State Plan, and expenditures for prescription drugs for adults ages 21 and older enrolled in STAR or STAR+PLUS.

5. HCBS for SSI-Related State Plan Eligibles

Expenditures for the provision of HCBS waiver-like services as specified in Table 4 and in Attachment C of the current STCs that are not described in section 1905(a) of the Social Security Act, and not otherwise available under the approved State Plan, but that could be provided under the authority of section 1915(c) waivers, that are furnished to STAR+PLUS enrollees who are ages 65 and older and ages 21 and older with disabilities, qualifying income and resources, and a nursing facility institutional level of care.

EXPENDITURES RELATED TO THE UNCOMPENSATED CARE POOL

Subject to an overall cap on the Uncompensated Care (UC) Pool, the following expenditure authorities are requested for the extension period:

7. Expenditures for care and services that meet the definition of "medical assistance" contained in section 1905(a) of the Social Security Act that are incurred by hospitals and other providers for uncompensated costs of medical services provided to Medicaid eligible or uninsured individuals, and to the extent that those costs exceed the amounts paid to the hospitals pursuant to section 1923 of the Act.

8. Expenditures for transition year payments to hospitals and other providers as outlined in paragraph 44(b) (Transition Payments) of the current STCs.

EXPENDITURES RELATED TO THE DELIVERY SYSTEM REFORM INCENTIVE PAYMENT (DSRIP) PROGRAM

Subject to CMS' timely receipt and approval of all deliverables specified in STC paragraph 45 (Delivery System Reform Incentive Payment (DSRIP) Pool) relating to the creation, operation, and funding of the Regional Healthcare Partnerships (RHPs), the following expenditure authorities are granted for the period of the demonstration:

9. Expenditures for incentive payments from pool funds for the Delivery System Reform Incentive Payment (DSRIP) Program.

III. MONITORING QUALITY & ACCESS TO CARE

The Balanced Budget Act of 1997 requires state Medicaid agencies to provide an annual external independent review of quality outcomes, timeliness of services, and access to services provided by Medicaid MCOs and prepaid inpatient health plans. To comply with this requirement, and to provide HHSC with data analysis and information to effectively manage its Medicaid managed care programs, HHSC contracts with an external quality review organization (EQRO) for Medicaid managed care and CHIP. In collaboration with the EQRO, HHSC evaluates, assesses, monitors, guides, and directs the Medicaid managed care programs and organizations for the state. Since 2002, Texas has contracted with the University of Florida's Institute for Child Health Policy (ICHP) to conduct EQRO activities.

The Institute of Child Health Policy performs the following three CMS-required functions:

- Validation of performance improvement projects
- Validation of performance measures
- Determination of MCO compliance with certain federal Medicaid managed care regulations

In addition, ICHP conducts focused quality of care studies, performs encounter data validation and certification, conducts surveys to assess member experiences and satisfaction, provides assistance with rate setting activities, and completes other reports and data analysis as requested by HHSC. Through the development of studies, surveys, or other analytical approaches the EQRO assesses enrollees' quality and outcomes of care and identifies opportunities for MCO operational improvement. To facilitate these activities, HHSC ensures that the ICHP has access to data related to enrollment, health care claims and encounters, pharmacy claims, and the state immunization registry. The MCOs collaborate with ICHP to ensure medical records are available for focused clinical reviews. In addition to these activities, ICHP collects and analyzes data on potentially preventable events for DSRIP projects.

This summary includes the quality-related activities conducted for STAR, STAR+PLUS and the Dental Program during the current waiver cycle. Some of the activities summarized here are required of the EQRO, while others are either optional or not specifically mentioned in federal guidance.

A. EVIDENCE-BASED CARE AND QUALITY MEASUREMENT

Texas relies on a combination of established sets of measures and state-developed measures that are validated by the EQRO. This approach allows the State to collect data comparable to nationally recognized benchmarks and ensure validity and reliability in collection and analysis of data that is of particular interest to Texas. Resources used include:

- National Committee for Quality Assurance Healthcare Effectiveness Data and Information Set (HEDIS®)
- AHRQ Pediatric Quality Indicators /Prevention Quality Indicators
- 3M Software for PPEs
- Consumer Assessment of Healthcare Providers & Systems (CAHPS®) Surveys

The analysis and dissemination of quality data is primarily conducted using MCO-generated data and reports and EQRO data analysis and summary reports. It is important to note that in general, quality activities are conducted based on the calendar year.

MCO-GENERATED DATA AND REPORTS

Quality Assessment and Performance Improvement

Each MCO must develop, maintain, and operate a Quality Assessment and Performance Improvement Program that meets state and federal requirements. The MCO must approach all clinical and nonclinical aspects of quality assessment and performance improvement based on principles of Continuous Quality Improvement/Total Quality Management and must:

- Evaluate performance using objective quality indicators,
- foster data-driven decision-making,
- recognize that opportunities for improvement are unlimited,
- solicit member and provider input on performance and Quality Assessment and Performance Improvement activities,
- support continuous ongoing measurement of clinical and non-clinical effectiveness and member satisfaction,
- support programmatic improvements of clinical and non-clinical processes based on findings from ongoing measurements, and
- support re-measurement of effectiveness and member satisfaction, and continued development and implementation of improvement interventions as appropriate.

The MCO must adopt at least two evidence-based clinical practice guidelines per program (e.g., STAR, STAR+PLUS). Practice guidelines must be based on valid and reliable clinical evidence, consider the needs of the MCO's members, be adopted in consultation with network providers, and be reviewed and updated periodically, as appropriate. The MCO must adopt practice guidelines based on members' health needs and opportunities for improvement identified as part of the Quality Assessment and Performance Improvement Program.

These activities are conducted annually. The MCOs submit self-reports to the EQRO. These reports are reviewed and the EQRO develops reports summarizing the results of their review. These activities have been completed for each year of the 1115 Transformation Waiver as specified in Attachment B of this document.

Performance Improvement Projects (PIPs)

The EQRO recommends topics for PIPs based on MCO performance results, data from member surveys, administrative and encounter files, medical records, and the immunization registry. HHSC selects two of these goals, which become projects that enable each MCO to target specific areas for improvement that will affect the greatest number of members. These projects are specified and measurable, and reflect areas that present significant opportunities for performance improvement. When conducting PIPs, MCOs are required to follow the ten-step CMS protocol published in the CMS EQRO Protocols.

During the 2012 and 2013 PIP cycles, HHSC selected the overarching goals from which the plans were able to choose. The 2012 and 2013 goals are listed in Attachment B. Beginning in 2014, HHSC, with input from ICHP, directed each MCO to develop performance improvement projects based on specific topics selected for each MCO based on their HEDIS performance. Also beginning in 2014, MCOs had the option of engaging in collaborative performance improvement projects. The topics with at least one PIP are also listed in Attachment B.

Beginning in 2015, MCOs are conducting PIPs for a minimum of two years in order to allow sufficient time for the interventions to influence health care outcomes. For 2015, each MCO is continuing its 2014 PIPs, will retire one 2014 PIP per program on December 31, 2015, and begin a new PIP. The remaining 2014 PIP will be continued for one additional year, to be retired December 31, 2016. Following this schedule, PIPs will be implemented and retired on alternate years. HHSC and the EQRO reserve the right to require a MCO to develop a new PIP rather than continue an ineffective project.

Beginning in 2015, MCOs are required to collaborate with an outside entity on at least one PIP. This outside entity can be another MCO, a dental contractor, a participant in one of the DSRIP projects, or the NorthSTAR behavioral health organization.

EQRO PROCESSES AND REPORTS

MCO Administrative Interviews

To ensure Medicaid MCOs are meeting all state and federal requirements related to providing care to Medicaid members, the EQRO conducts MCO administrative interviews using an online portal, teleconferences, and on-site visits to assess the following domains:

- organizational structure,

- children's programs,
- care coordination and disease management programs,
- utilization and referral management,
- provider network and contractual relationships,
- provider reimbursement and incentives,
- member enrollment and enrollee rights and grievance procedures, and
- data acquisition and health information management.

The MCOs complete the administrative interview tool online and are required to provide supporting documentation. For example, when describing disease management programs, the MCO must also provide copies of all evidenced-based guidelines used in providing care to members. The EQRO analyzes all responses and documents and generates follow-up questions for each MCO as necessary. The follow-up questions are administered during in-person site visits and conference calls. The administrative interviews conducted between 2012 and 2014 are listed in Attachment B. Interviews for 2015 are being held in the summer of 2015. This activity includes the determination of which MCOs will receive an on-site interview or a teleconference interview.

Data Certification Reports

The information contained in these data certification reports is used for actuarial analysis and rate setting, and meets the requirements of Texas Government Code §533.0131, Use of Encounter Data in Determining Premium Payment Rates. Analyses include volume analysis based on service category, data validity and completeness, consistency analysis between encounter data and MCO financial summary reports, and validity and completeness of provider information (not performed for pharmacy data). Annual and mid-year reports are completed. Data certification is done on a state fiscal year cycle. A list of completed reports can be found in Attachment B of this document.

Encounter Data Validation Report

Encounter data validation ensures the data used for rate setting and calculating quality of care measures is valid. Encounter data validation is an optional EQRO activity per CMS but is highly recommended. Encounter data validation is the strongest approach to ensure that high quality data are available for analysis and reporting. Reports summarize the results of the EQRO's assessment of the accuracy of the information found in the MCOs' claims and encounter data compared to corresponding medical records. Due to the consistent high quality of the MCO's encounter data, validation is performed on a biannual basis, with dental data validated in even years and medical data validated in odd years.

Quarterly Topic Reports

These reports provide additional information on issues of importance to HHSC. Historically, Texas HHSC has requested special topic reports to obtain in-depth analyses and information on legislative topics. No reports were completed during 2012 or 2013; however, a webinar on potentially preventable admissions in STAR was conducted on January 15, 2013. HHSC and ICHP are currently discussing a quarterly topic report examining the September 2014 STAR+PLUS expansion to individuals with intellectual and developmental disabilities.

Focus Studies

Focus studies are projects identified and defined by HHSC and conducted with a minimum amount of administrative burden on the Medicaid MCOs. Focus studies can be clinical, financial, or administrative studies that relate to patterns of care or operational issues that influence quality of care, financial performance, or service delivery in managed care. In 2012, ICHP completed a study titled "STAR+PLUS Long-Term Care Focus Study – Baseline Report". In 2013, ICHP completed the "STAR+PLUS Home- and Community-Based Services Waiver Study Report".

Summary of Activities Report

Texas provides the Summary of Activities report to CMS annually as evidence of EQRO activities. The report includes an annual summary of all quality of care activities, PIP information, MCO structure and processes, and a description of all findings and quality improvement activities. A list of completed reports can be found in Attachment B of this document.

Survey Reports

ICHP conducts member surveys using validated and nationally accepted instruments, including the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys. These surveys are typically conducted in alternating years, and include the following:

- STAR Adult Behavioral Health Survey Report
- STAR Adult CAHPS® Report
- STAR+PLUS CAHPS® Report
- STAR Health CAHPS® Report
- STAR Child CAHPS Report
- STAR Child Behavioral Health Survey Report
- Medicaid and CHIP Dental Survey Report

A list of completed surveys can be found in Attachment B of this document.

Quality of Care Reports

CMS requires the EQRO to validate performance measures. This is done through analysis of data used to develop quality of care reports. Additionally, the EQRO calculates the quality of care measures that rely on administrative data (i.e., enrollment, health care claims and encounter data). This provides the state with a comprehensive set of measures calculated using National Committee for Quality Assurance-certified software and audited by a National Committee for Quality Assurance-certified auditor. Historically, this data has been used to develop program-specific quality of care reports. Beginning in 2014, these reports have been consolidated into a single behavioral and physical health report and a single dental report, and are focused on specific aspects of care. Program-specific data tables are still developed and shared with stakeholders. A list of completed reports can be found in Attachment B of this document.

Potentially Preventable Events

As noted previously in this application, PPEs include inpatient stays, hospital readmissions, potentially preventable complications, and emergency department visits that may have been avoidable had the patient received high quality primary and preventive care prior to or after the event in question. High potentially preventable event rates may reflect inadequacies in the health care provided to the patient in multiple settings, including inpatient and outpatient facilities and clinics. A better understanding of the factors that contribute to PPEs in STAR and STAR+PLUS can assist HHSC and MCOs in developing intervention strategies to reduce their occurrence and to estimate the potential cost savings associated with implementing these interventions. Until 2013, HHSC contracted with its fee-for-service claims administrator to calculate statewide and hospital-level reports on Potentially Preventable Readmissions (PPRs) and Potentially Preventable Complications (PPCs). Since 2014, HHSC has contracted with its EQRO to develop PPE reports. A list of completed reports can be found in Attachment B of this document.

FREW Report

The State's EQRO, ICHP, also reviews data related to Early and Periodic Screening, Diagnosis & Treatment (EPSDT), known in Texas as Texas Health Steps. The EQRO calculates rates by plan code for new and existing member preventive checkups based on the Medicaid Managed Care Texas Health Steps Medical Checkups Utilization Report instructions. The results are compiled and compared with MCO-submitted reports to determine if the MCO-submitted reports are within an eight percent threshold of EQRO calculated rates. A Medicaid Managed Care Texas Health Steps Medical Checkups Annual Report was completed for each year between 2012 and 2014. The 2015 report is due in June 2015.

B. TEXAS QUALITY INITIATIVES

HHSC and ICHP have developed multiple quality initiatives that are in various stages of implementation.

Financial Incentive Programs

Performance Based At-Risk Capitation and Quality Challenge Award

At the outset of the waiver, the managed care contract stipulated that up to five percent of a MCO's capitation could be recouped based on performance based measures. This initiative, called the At-Risk and Quality Challenge Program, gave HHSC an opportunity to focus MCO performance on specific measures that foster achievement of HHSC program goals and objectives.

Each MCO had the opportunity to achieve performance levels that enable it to receive the full at-risk amount. However, should a MCO not achieve those performance levels, HHSC had the option to recoup a portion of the five percent at-risk amount. Some of the performance indicators were standard across the managed care programs while others applied to a specific program.

Minimum achievement targets were developed based in part on:

- HHSC MCO program objectives of ensuring access to care and quality of care.
- Past performance of the HHSC MCOs.
- National performance of Medicaid MCOs on HEDIS® and CAHPS® survey measures.

HHSC reallocated any unearned funds from the performance-based, at-risk portion of a MCO's capitation rate to the MCO program's Quality Challenge Award. HHSC used these funds to reward MCOs that demonstrated superior clinical quality, service delivery, access to care, or member satisfaction. HHSC determined the number of MCOs that received Quality Challenge Award funds annually based on the amount of the funds available for reallocation. Separate Quality Challenge Award payments were made to each MCO program.

The At-Risk and Quality Challenge Program ended in 2013, replaced by the Pay-for-Quality Program. The following amounts were awarded or recouped through the At-Risk and Quality Challenge Program[4]:

2012 Quality Challenge Award and At-Risk Recoupment amounts

[4] No At-Risk and Quality Challenge Program funds were awarded or recouped in 2012.

- STAR: Total Recouped and redistributed: $7,173,328
- STAR+PLUS: Total Recouped and redistributed: $3,984,871

2013 Quality Challenge Award and At-Risk Recoupment amounts

- STAR: Total Recouped and redistributed: $7,364,092
- STAR+PLUS: Total Recouped and redistributed: $31,939,063

Pay-for-Quality Program

To comply with legislative direction and to best identify quality of care measures that reflect the needs of the population served and areas of needed improvement, HHSC implemented the Pay-for-Quality Program, which replaced the At-Risk and Quality Challenge Program in 2014. The Pay-for-Quality Program uses an incremental improvement approach that provides financial incentives and disincentives to MCOs based on year-to-year incremental improvement on pre-specified quality goals. The quality of care measures used in this initiative are a combination of process and outcome measures which include select potentially preventable events as well as other measures specific to the program's enrolled populations. The 2015 Pay-for-Quality Program measures are listed in Attachment C.

The Pay-for-Quality Program includes an at-risk pool that is four percent of the MCO capitation rate. In the Pay-for-Quality Program, points are assigned to each plan based on incremental performance on each quality measure, with positive points assigned for year-to-year improvements over a minimum baseline. Negative points are assigned for most year-to-year declines, with the exception of modest decreases of plans whose performance is already performing within a specified range of the attainment goal rate. The Pay-for-Quality Program model sets minimum baseline performance levels for the measures so that low performing MCOs would not be rewarded for substandard performance. Rewards and penalties are based on rates of improvement or decline over the baseline. All funds recouped from MCOs through the assignment of negative points are redistributed to MCOs through the rewarding of positive points. Each MCO pays in proportion to its total negative points and receives funds in proportion to its total positive points. No funds are returned to the State. Participation in this program is required for all Texas MCOs. Results for the 2014 program are still being calculated. Recoupments and payments will be made in the fall of 2015.

Dental Pay-for-Quality Program

The 2014 Dental Pay-for-Quality Program includes an at-risk pool that is a two percent of the DMO capitation rate. In the Dental Pay-for-Quality Program, points are assigned to each plan based on its incremental performance on each quality measure, with positive points assigned for year-to-year improvements over the minimum baseline and negative points assigned for most year-to-year declines. The Dental Pay-for-Quality Program model sets minimum baseline

performance levels for the measures so that low-performing DMOs would not be rewarded for substandard performance (see Attachment C for list of 2015 measures). Rewards and penalties are based on rates of improvement or decline over the baseline. Plans would earn back their own at-risk premium based on performance of quality of care measures. In no instance would funding be redistributed from one DMO to another; plans can only earn back their own two percent at-risk premium. Results for the 2014 program are being calculated. Recoupments and payments will be made in the fall of 2015.

Performance Comparisons

Performance Indicator Dashboards

The Performance Indicator Dashboard includes a series of measures related to key aspects of performance, supporting transparency and MCO accountability. It is not an all-inclusive set of performance measures; HHSC measures other aspects of the MCO's performance as well. Rather, the Performance Indicator Dashboard assembles performance indicators that assess many of the most important dimensions of MCO performance and includes measures that incentivize excellence. The Dashboard is posted on the HHSC website and includes minimum threshold standards as a means to gauge performance. Additionally, HHSC plans to begin including state-level performance data on these measures and sharing this information on the HHSC website. The medical Performance Indicator Dashboard can be found here: http://www.hhsc.state.tx.us/medicaid/managed-care/umcm/Chp10/10_1_7.pdf. The Medicaid Dental Performance Indicator Dashboard can be found here: http://www.hhsc.state.tx.us/medicaid/managed-care/umcm/Chp10/10-1-10.pdf. The 2015 measures in both dashboards are listed in Attachment C.

The Performance Indicator Dashboards are updated annually, and were posted for each year of the waiver cycle.

Long-Term Services and Supports Performance Measures. In the fall of 2013, HHSC convened a workgroup consisting of external stakeholders and representatives from the EQRO to develop a comprehensive set of performance measures that will provide data that allows the State to evaluate the quality home and community-based services long-term services and supports provided through Medicaid managed care. These measures were added to the Performance Indicators Dashboard in March 2015.

Development of managed care nursing facility performance measures. As part of the nursing facility carve-in that became effective September 1, 2014, HHSC developed a process for measuring quality of care provided to individuals residing in nursing facilities after the transition to managed care. In 2014, HHSC worked with the Department of Aging and Disability Services and stakeholders to develop a set of quality indicators that will incentivize MCOs to ensure a

high level of quality of care. These measures were added to the Performance Indicators Dashboard in March 2015.

MCO Report Cards

Texas Government Code §536.051 requires HHSC to provide information to Medicaid and CHIP members regarding MCO performance on outcome and process measures during the enrollment process. To comply with this requirement and other legislatively mandated transparency initiatives, beginning in 2014 HHSC has developed annual MCO report cards for each program service area to allow members to compare the MCOs on specific quality measures. MCO report cards are posted on the HHSC website (STAR: http://www.hhsc.state.tx.us/QuickAnswers/report-cards/star.shtml, STAR+PLUS: http://www.hhsc.state.tx.us/quickanswers/report-cards/starplus.shtml) and included in Medicaid enrollment packets sent by the enrollment broker to potential members. They are updated annually. The 2014 report cards were posted on the HHSC website in March 2014, and included in member enrollment packets in April 2014. The 2015 report cards were posted on the HHSC website in February 2015, and included in enrollment packets in March 2015.

Data Sharing and Transparency

Texas Healthcare Learning Collaborative

The Texas Healthcare Learning Collaborative is a secure web portal designed and run by ICHP. The Portal is an online learning collaborative that includes a graphical user interface that allows MCOs, HHSC, and ICHP to visualize healthcare metrics. Managed care organizations, HHSC staff, and Texas legislative staff are able to log in to the portal and generate graphical reports of plan and program specific performance.

Through the Portal, HHSC and ICHP share monthly and quarterly reports with the MCOs about PPEs. The reports are interactive and the MCOs can query the data to create more customized summaries of the quality results. The Portal can be accessed at https://thlcportal.com. In 2014, a public access feature was added allowing anyone to view the quality of care data without a login. All-payer data from the Texas Department of State Health Services is expected to be added to the Portal by September 2015.

Medicaid Quality Assurance and Improvement Website

In June 2014, HHSC launched a dedicated quality website (http://www.hhsc.state.tx.us/hhsc_projects/ECI/index.shtml) to consolidate information related to different quality and efficiency related initiatives in one place, and promote better information dissemination. The website promotes transparency, public reporting related to quality of care, and efficiency of services provided to Medicaid beneficiaries, and provides a centralized location

for stakeholders to access information such as MCO data, presentations, specialized reports, and committee information.

Other Quality Activities

National Core Indicators- Aging and Disabilities (NCI-AD)

The National Association of States United for Aging and Disabilities (NASUAD), in collaboration with the Human Services Research Institute (HSRI) and the National Association of State Directors of Developmental Disabilities Services (NASDDDS), has developed the NCI-AD survey, which is intended to obtain feedback from individuals receiving long-term services and supports on their experience receiving those services. Data for the project is gathered through yearly in-person consumer surveys administered by state agencies to a sample of at least 400 participants, which includes older adults and individuals with physical disabilities accessing publicly funded services through skilled nursing facilities, Medicaid waivers, Medicaid state plans, and/or state-funded programs, as well as older adults served by Older Americans Act programs. Texas is one of at least 19 states participating in the initiative. Surveys are expected to begin in July 2015.

Quality-Based MCO Enrollment Incentive Algorithm

There are significant numbers of members who qualify for Medicaid who do not choose a MCO at the time of enrollment, and are enrolled using HHSC's auto-enrollment process. In 2014, the monthly percent of STAR enrollees who were enrolled in a MCO using the HHSC default process ranged from 3.86% to 36.7%. In STAR+PLUS the percent ranged from .08% to 42.8% for that same year. HHSC is exploring potential algorithms that may be utilized to assign these members to high quality and high efficiency MCOs and DMOs. HHSC will first evaluate the effects of the MCO report cards initiative to determine if it shrinks the pool of members who do not actively choose a MCO. Based on that assessment, HHSC will determine whether to implement this initiative.

Focused analysis and quality improvement efforts with MCOs on "superutilizers"

Texas Medicaid managed care contracts require MCOs to focus on the unique needs of high cost, high utilizing populations (called "superutilizers"). MCOs must submit to HHSC their plans for targeting this group, including intervention strategies, and resources dedicated to care management of this group. HHSC hosts regular conference calls with MCOs to discuss their efforts and encountered successes and barriers, allowing HHSC to better assess MCO progress in this area.

Alternative Provider Payment Structures

Texas Medicaid managed care contracts also require MCO and DMO provider payment structures to focus on quality, not volume. Managed care organizations and DMOs must submit to HHSC their plans for alternative provider payment structures, including the type of structure they plan to use they are, the metrics used, the approximate dollar amount and number of members impacted, and the evaluation process. This allows HHSC to better assess MCO and DMO progress in this area.

IV. INTERIM EVALUATION

The overarching goal of the 1115 Transformation Waiver is to support the development and maintenance of a coordinated healthcare delivery system, thereby maintaining or improving health outcomes while containing cost growth. This goal is consistent, as noted previously, with CMS' "triple aim" approach to improve the experience of care, improve the health of populations, and to reduce the cost of healthcare without compromising quality.[5]

Specifically, the 1115 Transformation Waiver used two integrated interventions aimed to improve access to healthcare, increase quality of care, and reduce costs of care: expand Medicaid managed care, and revise the upper payment limit (UPL) supplemental payment program by creating two new pools to fund healthcare system improvement.

1. **Medicaid managed care expansion** – Texas leveraged the existing Medicaid managed care delivery system to operationalize reforms by expanding Medicaid managed care throughout the state. Specifically, the 1115 Transformation Waiver expanded the existing Medicaid managed care programs, STAR and STAR+PLUS, statewide, carved-in prescription drug benefits and non-behavioral health inpatient hospitalizations, and transformed the children's dental program from fee-for-service to a managed care model.

2. **Healthcare Delivery System Transformation** – In order to preserve UPL supplemental payments to hospitals, given federal limitations related to the carve-in of non-behavioral health inpatient hospitalizations under the Medicaid managed care expansion, Texas established two new funding pools: the uncompensated care (UC) pool to assist providers with uncompensated care costs and the Delivery System Reform Incentive Payment (DSRIP) pool to promote health system transformation.

The first four years of the 1115 Transformation Waiver have laid the framework for future success, but more time is needed to assess the effect of the Medicaid managed care expansion

[5] Berwick, D.M., Nolan, T.W., & Whittington, J. (2008). The Triple Aim: Care, Health, and Cost. Health Affairs, 27(3), 759-769.

and the implementation of the DSRIP program. System transformation requires a sustained investment of both time and resources to bring positive change to Texas' health system. This summary provides an overview of the evaluation goals and presents preliminary findings during the first three years of the 1115 Transformation Waiver.

A. MANAGED CARE EXPANSION

The evaluation goals examining the impact of managed care expansion relate to access to, coordination, quality, efficiency, and cost of care. The evaluation has four primary goals.

- **Evaluation Goal 1:** Evaluate the extent to which *access to care* improved through managed care expansion to new STAR and STAR+PLUS service delivery areas (SDAs), dental services, and pharmacy services.
  - Waiver focus goals include access to prescription drugs, dental care for children, non-behavioral inpatient care, and adult access to preventative/ambulatory health service.

- **Evaluation Goal 2:** Evaluate the extent to which *coordination of care* improved through managed care expansion to new STAR and STAR+PLUS SDAs.
  - Waiver focus goals include coordination of care among providers and service coordination.

- **Evaluation Goal 3:** Evaluate the extent to which *quality of care* improved through managed care expansion to new STAR and STAR+PLUS SDAs, dental services, and pharmacy services.
  - Waiver focus goals include quality of dental care for children and quality of adult preventive and emergent care.

- **Evaluation Goal 4:** Evaluate the extent to which *efficiency improved and cost decreased* through managed care expansion to new STAR and STAR+PLUS SDAs, and dental services.
  - Waiver focus goals include reduction of member costs, increased utilization rates, and an analysis of the experience rebate provision.

PRELIMINARY FINDINGS

Medicaid managed care expansion supports 1115 Transformation Waiver goals by building a foundation for an integrated healthcare delivery system that incentivizes quality and efficiency and improves healthcare quality and outcomes for the Texas Medicaid population. Although Medicaid managed care expansion statewide has been successful, the benefits offered continue to change, suggesting that further evaluation, especially for clients utilizing long-term care services and supports (LTSS), is warranted.

KEY ACHIEVEMENTS

- Texas completed statewide expansion of Medicaid managed care delivery system for STAR in March 2012 and STAR+PLUS in September 2014.

- Considerable policy changes have been made to consolidate 1915(c) and 1915(b) waivers into the 1115 Transformation Waiver. These changes have eradicated multiple layers of regulation and reporting requirements, thereby reducing administrative burden and streamlining processes.
- Texas added behavioral health benefits to Medicaid managed care in September 2014 and nursing facility benefits in March 2015.
- Through changes in policy with a shift towards home- and community-based care, there has been increased utilization of services. [Evaluation Goal 1]

Preliminary results:

  - An increased focus on coordinated care across physical and behavioral health services, and long-term care. However, there is potential to improve quality and value within the delivery system but sufficient data are not yet available to adequately evaluate. [Evaluation Goal 2]
  - A decrease in costly restorative and orthodontic dental services under managed care compared to fee-for-service. [Evaluation Goals 3 and 4]
  - More money was returned to Texas under the Experience Rebate provision of the 1115 Transformation Waiver compared to what would have been returned under the Medical Loss Ratio regulations. [Evaluation Goal 4]

ONGOING CHALLENGES

Results from the Program stakeholder surveys yield room for improvement:

- Stakeholders expressed dissatisfaction with MCO administration/staff levels, inefficient MCO credentialing process, and processing time for claims and payment (especially for clients needing urgent behavioral health services or primary care).
- Recommendations include streamlining Medicaid:
  - provider regulations,
  - enrollment procedures,
  - prior authorization policies,
  - credentialing, and
  - claims processing rules.
- Providers recommended standardizing policies and processes across MCOs.
- Stakeholders recommend creating a formal system to increase communication across all stakeholders.
- An unintended consequence of the policy allowing clients to change MCOs every 30 days has led to provider frustration related to increased administrative burden for service payment.
-

B. HEALTHCARE DELIVERY SYSTEM TRANSFORMATION

EVALUATION GOALS

The evaluation goals for the new UC and DSRIP pools relate to the 1115 Transformation Waiver's ability to show quantifiable improvements in the quality of care, lowering cost, and health of the population; the amount of funds disbursed through the UC pool; and stakeholder perceptions of Medicaid managed care expansion, the Regional Healthcare Partnerships (RHPs), and the UC and DSRIP pools. The evaluation has seven goals.

- **Evaluation Goal 5:**
    - Evaluate whether uncompensated costs, based on service type, remain stable or decrease over time for hospitals participating in the 1115 Transformation Waiver.
- **Evaluation Goal 6, 7, & 8:**
    - Evaluate the extent to which, through the implementation of DSRIP projects, RHPs impacted the *quality of care*.
    - Evaluate the extent to which, through the implementation of DSRIP projects, RHPs impacted the *health of the population served*.
    - Evaluate the extent to which, through the implementation of DSRIP projects, RHPs impacted the *cost of care*.
- **Evaluation Goal 9:**
    - Evaluate the extent to which the establishment of RHPs increased collaboration among healthcare organizations and stakeholders in each region.
- **Evaluation Goals 10 &11:**
    - Assess stakeholder-perceived *strengths and weaknesses*, and *successes and challenges* of the expanded managed care program, the UC pool, and the DSRIP pool to improve operations and outcomes.
    - Assess stakeholder-recommended *changes* to the expanded managed care program, the UC pool, and the DSRIP pool to improve operations and outcomes.

PRELIMINARY FINDINGS

The UC and DSRIP programs support waiver goals by building a foundation for an integrated healthcare delivery system that incentivizes quality and efficiency through a pay-for-performance or pay-for-reporting model. However, while DSRIP implementation has been successful, more time is necessary to demonstrate which projects demonstrate impact in terms of outcomes and whether it is feasible to replicate any of the innovative models at a statewide level or in a Medicaid managed care environment. In addition, more time is necessary to better examine the impact of the DSRIP projects or Medicaid managed care on rates of UC.

KEY ACHIEVEMENTS

- Texas successfully developed the UC and DSRIP pools and created the 20 RHPs.
- The Texas DSRIP program is the largest implementation of DSRIP projects in the nation with 1,458 active projects administered by 298 participating providers (as of May 2015).
- While comprehensive DSRIP evaluations are not feasible for each of the 1,458 active projects, the required reporting of metrics include multiple examples of quality improvements in these innovative care delivery redesign projects. Unfortunately, not all improvements are captured by DSRIP metrics.
- Texas Medicaid providers report the ability, via DSRIP, to provide services currently not reimbursable by Texas' Medicaid program and note the care improvements made as a result of these investments.

Preliminary results:

  - The formation of the 20 RHPs led to a:
    - 25 percent increase in the number of collaborative inter-organizational relationships,
    - 24 percent increase in the centralization of collaborations (a measurement of the restructuring of collaborations in favor of a central organization acting as a hub for resources and information dissemination), and
    - on average, each organization in the RHP increased the number of relationships by 22 percent with a 6 percent increase in the strength of those relationships. [Evaluation Goal 9].
  - Across all RHPs results show an increase in collaboration and integration of healthcare providers through increased sharing of information, resources, and health data. [Evaluation Goal 9]
  - Stakeholders report that DSRIP waiver activities are benefitting many residents of the community due to the increased collaboration among organizations and subsequent increased access to health services. [Evaluation Goal 10]
  - Stakeholders are satisfied with the RHP's progress toward addressing community needs and with Texas HHSC administration of the DSRIP program. [Evaluation Goal 10]
  - Due to incomparability between projects, select project area options were chosen for detailed evaluation analyses.
    - A comparative case study analysis of project area option 2.9.1 projects is ongoing. The purpose of this project area option is to establish/expand patient navigation designed to reduce inappropriate emergency department (ED) use.
    - Preliminary results show that, in general, large urban sites had the resources necessary to implement a more comprehensive patient care navigation program compared to the programs the small rural facilities were able to provide.
    - Patient care navigation projects are reaching a wider range of patients than initially intended and projects continue to modify services to provide more education and additional outreach to better serve clients.
    - Overall, clients surveyed who reported having patient care navigation services were satisfied with their care navigators. [Evaluation Goals 6-8]

ONGOING CHALLENGES

- The administrative resources required for implementation were intensive at the State and local levels and continue to be an ongoing concern.
- The DSRIP program was intended to offer providers flexibility to redesign and pilot test delivery system transformation within the context of state/local needs and goals. While project diversity is a major characteristic of Texas DSRIP, the growing national trend toward standardization is reflected in the abbreviated three-year DSRIP project menu and revised Category 3 outcome menu that may ultimately limit the ability to address unique local needs. There is also an on-going challenge to balance standardized reporting metrics while providing flexibility to sufficiently capture overall project benefits and lessons learned. Stakeholders recognize areas for improvement: DSRIP implementation process; the need for more clarification regarding outcome expectations; and sensitivity to contextual differences among organizations, communities, and regions, e.g., urban-rural/hospital differences.
- Stakeholders report that political and administrative issues were a challenge for RHP formation and administration. These issues included:
  - Differing of opinions among RHP members on which organization would function as the anchor institution.
  - The unclear and changing guidance from state and federal government entities,
  - The limiting the menu of project options and outcomes, and
  - The frequently modified standardized reporting measures used for project monitoring. [Evaluation Goal 10]

C. SUMMARY

Preliminary evaluation results highlight challenges related to the implementation of the waiver and recommendations to address those issues. While it is premature to report on waiver health outcomes, the increased organizational collaboration and coordination of services suggest the initiation of active system transformation efforts. Overall, additional time is necessary to further examine the impact of waiver interventions (DSRIP projects or Medicaid managed care) on client health outcomes and uncompensated care.

V. FINANCIAL OVERVIEW

Texas is requesting to continue using the budget neutrality methodology set forth in the current STCs. Below is a summary of that methodology.

- Caseload forecasts for both WW and WOW sides are a continuation of the caseload forecast for years 4 and 5, based on time series models using data through March 2015. All populations currently excluded from the waiver are assumed to be excluded in years 6-10.
- Cost forecasts on the WOW side of the budget neutrality exhibit utilize DY 5 PMPMs, trended with cost trends from page 32-36 the 2013 Actuarial Report on the Financial Outlook for Medicaid. These trends are very close to the presidential trends used in DY 01-05.

- Costs for other UPL program amounts in the WOW side of the BN are assumed to grow at the same rate assumed in DY 02-05. Annual trends were applied to the previous year's costs (starting with DY 05) for each year of the proposed extension period.
- The cost forecasts on the WW side of budget neutrality are a continuation of the cost forecast for years 4 and 5, based on time series models using data through March 2015. All costs (medical transportation, LTSS programs paid in FFS) that are currently excluded from the waiver are assumed to be excluded in years 6-10.
- NAIP and Nursing Facility Directed payments have been added to total WW expenditures starting in DY 04. Final amounts for FFY 15 are shown, preliminary amounts for FFY 16 (DY 05) are assumed. The FFY 16 costs are trended forward at 20% in FFY 17, and 10% in all following years.
- Uncompensated Care Pool Payments are assumed at $5.8 billion in DY 06, $6.6 billion in DY 07 and $7.4 billion in DY 08 and forward.
- DSRIP amounts are assumed to continue each year at $3.1 billion.
- Dual Demonstration (1115A) savings has been extended through December 2019 (the end date for the demonstration) and removed from overall budget neutrality savings.

Please see Attachment D for detailed calculations illustrating the budget neutrality methodology and impact, enrollment data and projections, and historical and projected expenditures. Those calculations demonstrate that Texas has maintained, and will maintain, budget neutrality for the five year extension.

VII. PUBLIC NOTICE AND COMMENT PROCESS

Public Notice and Comment Process *(transparency requirements)*. Documentation of compliance with the public notice process described in 42 CFR 431.408, including the post-award public input process described in 42 CFR 431.420(c), with a report of the issues raised by the public during the comment period and how the State considered the comments when developing the application - *This section will be completed after the Public Notice and Comment Period.*

VIII. STC COMPLIANCE

Attachment E contains information on the State's compliance with the STCs as set forth in the current 11115 Transformation Waiver.

IX. CONCLUSION

Since receiving approval for the 1115 demonstration waiver in 2011, Texas has made substantial progress toward achieving the five goals and objectives of the demonstration:

- Expand risk-based managed care statewide;
- Support the development and maintenance of a coordinated care delivery system;
- Improve outcomes while containing cost growth;

- Protect and leverage financing to improve Texas' health care infrastructure; and
- Transition to quality-based payment systems across managed care and hospitals.

Texas has successfully implemented major managed care expansions and initiatives within a system that covers over 3.3 million Medicaid enrollees per month. The STAR, STAR+PLUS and Children's Medicaid Dental Services programs, together with DSRIP and UC funding pools, help support the development and maintenance of a coordinated care delivery system. Additionally, the combination of the DSRIP and UC pools provide critical safety net support for low income Texans while incentivizing providers to test initiatives to improve patient care and outcomes. DSRIP has enabled groundbreaking work, including increased regional and cross-regional collaboration between diverse healthcare providers and stakeholders, and investments in infrastructure and innovation to improve systems of care.

Texas' request for a five-year waiver extension will provide the State with a continuing opportunity to align DSRIP with Medicaid managed care and other quality improvement efforts. Furthermore, the waiver extension will build on the work accomplished thus far, continue to strengthen the waiver programs, and further demonstrate program outcomes. Texas appreciates the consideration of this request by our federal partners and looks forward to continued success under the demonstration.

ENCLOSURES/ATTACHMENTS

Attachment A - Texas DSRIP Projects

Attachment B - Quality Monitoring Reports and Deliverables

Attachment C - Performance Indicator Dashboards and Pay-for-Quality Measures

Attachment D - 1115 Waiver Extension Budget Neutrality Calculations

Attachment E - STC Compliance