

Demonstration Extension Application Section 1115(a) Appendices A-E

Texas Healthcare Transformation and Quality Improvement Program

Project #11-W-00278/6

Texas

Health and Human
Services Commission

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Contents

Summary of Extension Application	4
Proposed Changes	6
Waiver Extension	6
Appendix A. Historical Summary	9
Waiver Approval: 2011 – Present	
Amendments	
Healthcare Delivery System, Eligibility Requirements,	
Benefit Coverage and Cost Sharing	14
Delivery System	14
Comprehensive Hospital Increase Reimbursement Program	15
Quality Incentive Payment Program	15
Texas Incentives for Physicians and Professional Services	16
Rural Access to Primary and Preventive Services	16
Directed Payment Program for Behavioral Health Services	16
Managed Care Eligibility and Enrollment Requirements	18
Benefit Coverage	20
Cost Sharing	21
Appendix B. Budget	
Cost Growth Containment	
Enrollment	23
Appendix C. Interim Evaluation	25
Evaluation Activities to Date	
Preliminary Evaluation Findings	25
Planned Evaluation Activities: THTQIP Extension	
MMC Component	
DPP Component	28
SPP Component	
Overall Demonstration Component	
Appendix D. Quality Assurance Monitoring	
External Quality Review	
Multi-Year Focus	
Quality Measures	
Initiatives	
Administrative Interviews	
Core Measure Reporting	
MCO Report Cards	
Network Adequacy	
Pay-for-Quality	
Medicaid Value-Based Enrollment	44

Alternative Payment Model (APM) Requirements	45
Performance Improvement Projects	
Performance Indicator Dashboards	
Quality Assessment and Performance Improvement Programs	
Hospital Quality-Based Payment Program	
Texas Healthcare Learning Collaborative Portal	
Resources	
Appendix E. Public Notice	52
Summary of Public Notice	52
Post-award Public Input Process Required by 42 CFR §431.420(c)	- 4
	54

Summary of Extension Application

Based on direction from the Texas Legislature in 2011, the State sought a section 1115 demonstration waiver as the vehicle to transform healthcare in Texas by expanding the Medicaid managed care delivery system statewide, while operating the Uncompensated Care and Delivery System Reform Incentive Payment (DSRIP) funding pools, supported by managed care savings. The waiver was designed to build on existing Texas healthcare reforms and to redesign healthcare delivery in Texas consistent with Centers for Medicare & Medicaid Services (CMS) goals to improve the experience of care, improve population health, and reduce the cost of healthcare.

CMS initially approved the Texas Healthcare Transformation and Quality Improvement Program 1115 waiver (the 1115 Transformation Waiver or the THTQIP Waiver) on December 12, 2011. CMS extended the waiver on May 2, 2016, and then again on January 1, 2018, when the waiver was approved through September 30, 2022.

On November 30, 2020, the Health and Human Services Commission (HHSC) requested that CMS extend the 1115 Transformation Waiver. After significant negotiation with the State, CMS approved an extension of the waiver for approximately ten years, with new terms and conditions effective January 15, 2021. Texas immediately began operating under the terms and conditions set forth in the January 15 waiver approval.

On April 16, 2021, CMS sent Texas a letter purporting to rescind the approval of the waiver extension. CMS stated in the letter that it erred in waiving certain state and federal notice requirements. CMS also stated that Texas could resubmit an extension application.

Texas hereby submits this application requesting approval of an extension on the same terms and conditions as CMS and Texas previously agreed and which CMS approved effective January 15, 2021. Texas requests that any amendments approved by CMS since January 15 be incorporated. Texas further requests that CMS approve the extension by September 30, 2021 in order to solidify the budget neutrality terms and commence DSRIP transition programs, both of which will secure and sustain the Medicaid managed care program.

Through the 1115 Transformation Waiver, the State expanded its use of Medicaid managed care to improve quality and achieve program savings, while also preserving locally funded supplemental payments to hospitals under two funding pools.

Through the 1115 Transformation Waiver, 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; and
- Transition to quality-based payment systems across managed care and hospitals.

Texas has made substantial progress toward achieving these four goals, but events surrounding the Public Health Emergency, as renewed by Secretary Xavier Becerra on April 15, 2021, have hampered the State's ability to fully achieve these goals. Responding to the emergency itself has put significant, additional pressures on HHSC, its managed care organizations, and their networks of providers. Moreover, the significant changes in demand for healthcare services have complicated efforts to collect the data that HHSC uses to assess the effectiveness of the Demonstration under the terms approved by CMS. Approval of this extension application will reduce uncertainty for our healthcare systems, ensure that the results reported to CMS accurately reflect the status of the Demonstration, and address the vital funding gaps currently facing Texas Medicaid.

The State updated this Demonstration Extension Application Section 1115(a) Appendices A-E to provide additional clarification based on stakeholder inquiries.

Proposed Changes

Waiver Extension

Texas Medicaid respectfully requests that CMS extend the 1115 Transformation Waiver under the terms and conditions approved by CMS on January 15, 2021 and incorporate amendments approved by CMS since then. (The Special Terms and Conditions (STCs) proposed in this application are the same STCs that were approved on January 15, 2021.)

The Public Health Emergency arising from COVID-19 has significantly impacted Texas' healthcare delivery system. In the fall of 2020, HHSC released an open survey to all healthcare providers in Texas, which concluded on November 13, 2020. The results indicate a dire emergency of another kind is unfolding: the long-term stability of healthcare infrastructure and Medicaid provider networks is in jeopardy. CMS and Texas must act immediately to ensure that Medicaid clients retain access to care through a stable Medicaid managed care program, and that providers are financially stabilized by assured continuation of the Uncompensated Care pool available under the 1115 waiver and a successful DSRIP transition. According to survey results:

- 76% of providers said they were very concerned or extremely concerned about the financial impacts of COVID-19;
- 42% of providers reported reduced hours of service;
- 20% of providers actively reduced services unrelated to COVID-19;
- 23% of providers closed locations or facilities; and
- 27% of providers reported that COVID-19 demand has exceeded provider capacity.

Overtasked providers are considering dropping out of Texas Medicaid because of the overwhelming financial pressure and reducing service availability and locations. These problems are exacerbated by uncertainty over the future of the State's 1115 waiver. The extension application seeks to mitigate that uncertainty.

The scope of the COVID-19 Public Health Emergency and its impacts on Texas Medicaid beneficiaries and providers continues to unfold, and its ultimate toll remains unknown. The State is acting expeditiously in response to the crisis to preserve and stabilize Medicaid program funding in order to protect the health, safety, and welfare of Medicaid beneficiaries and avoid further suffering for Texas families.

The proposed extension will allow the State to continue the goals of the 1115 Transformation Waiver. While the State has made significant progress toward the achievement of these goals, they remain ongoing priorities that will evolve and strengthen over time. Texas Medicaid also continues to advance value by expanding performance measurement and implementing new ways to incentivize quality and cost efficiency. Under the extension, DSRIP will fully transition as described below and Medicaid managed care will include directed payment programs to promote access to care and provide incentives that drive value.

The extension request specifies that the DSRIP pool is eliminated as of September 30, 2021, and describes the new directed payment programs that have been requested and the new approved charity care pool that Texas is in the process of implementing. The new directed payment programs include Comprehensive Hospital Increased Reimbursement Program (CHIRP); Texas Incentives for Physician and Professional Services (TIPPS) Program; Rural Access to Primary and Preventive Services (RAPPS) Program; and Directed Payment Program for Behavioral Health Services (DPP BHS). The objective of the new directed payment programs is to assist in the State's transition away from DSRIP. The desired outcomes of each program are described in the corresponding preprints that are pending CMS approval.

The Public Health Provider-Charity Care Program is planned to begin October 1, 2021, as a part of DSRIP transition contemplated in the January 2021 STCs. The program is designed to defray providers' costs associated with care, including behavioral health, immunizations, chronic disease prevention and other preventive services for the uninsured. The program is limited to publicly owned and operated community mental health center (CMHCs), local behavioral health authorities (LBHAs), local mental health authorities (LMHAs), local health departments (LHDs), and public health districts (PHDs).

The extension request includes a reassessment of the Uncompensated Care pool and PHP-CCP pool. Demonstration Year (DY) 2024 or Year 3 of the PHP-CCP will be resized based upon actual charity care cost data from Year 2. The Uncompensated Care pool will first be re-sized in DY11 to take effect in DY12 (FY2023). The second re-sizing will take place in DY16 to take effect in DY17 (FY2028). Re-sizing will allow for adjustments to the Uncompensated Care pool based on actual charity care.

The extension request includes new, standardized adjustments previously requested by CMS, new monitoring and reporting requirements for the Home and Community-Based Services program, updates to oversight and source of funds, an updated evaluation design, and additional monitoring reports. There are updates to charts, projections and tables throughout the document to reflect the extension request.

The extension request includes the rebasing approved on January 15, 2021. Without waiver expenditures will be rebased effective in FFY 2023 (Oct 2022-Sep 2023) using FFY 2022 (Oct 2021-Sep 2022) data to establish the rebased without-waiver per member per month (PMPM) costs. To calculate the new rebased amount, without waiver PMPMs will be adjusted to account for annualized amounts of approved state-directed payments (pending state legislative approval) made in FFY 2022. Texas is requesting that in response to the Public Health Emergency, CMS allow a one-time adjustment to budget neutrality to account for impacts of COVID-19 on enrollment and expenditures. A subsequent rebasing exercise to without waiver PMPMs is included effective FFY 2028 using FFY 2026 expenditures. These processes will ensure that budget neutrality will continue to support funding needs and flexibility moving forward.

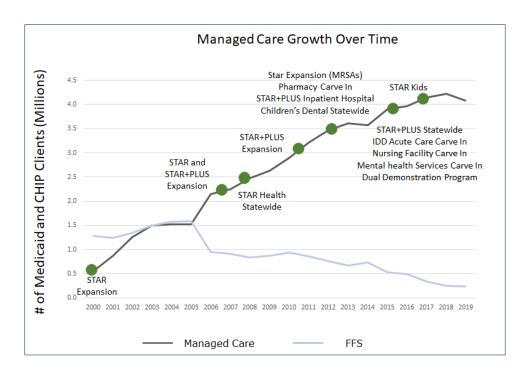
The extension request reflects the THTQIP Waiver changes previously agreed to by CMS and Texas. A central feature Texas sought was stability through budget certainty for our healthcare systems across Texas in the midst and throughout the ongoing Public Health Emergency. CMS and Texas collaborated to reach a waiver agreement that set into motion a successful DSRIP transition and increased accountability. Texas seeks to maintain this agreement and will work with CMS to reestablish the timelines, which have been paused or delayed by the rescission. Other changes, including recently approved provisions, technical corrections, and naming updates, are requested to be included (e.g. Non-Emergency Medical Transportation, renaming of Attachment T).

Appendix A. Historical Summary

Waiver Approval: 2011 - Present

Texas Medicaid has met its initial goal of expanding risk-based managed care statewide. Texas Medicaid has a mature 1115 Waiver inclusive of 17 Medicaid Managed Care Organizations (MCOs) and three Dental Maintenance Organizations. The State's managed care contracts require our health and dental plan contractors to meet goals related to quality improvement and alternative payment arrangements or value-based purchasing.

Texas significantly expanded risk-based managed care to additional populations over the last 10 years of the 1115 waiver. The STAR and STAR+PLUS managed care programs cover most beneficiaries statewide through three geographic expansions. The first expansion occurred on September 1, 2011, under existing section 1915(b) and section 1915(c) authorities; the second expansion occurred in March 2012, under section 1115 authority; and a third expansion of STAR+PLUS occurred on September 1, 2014 under section 1115 authority as a result of an amendment to the demonstration. In 2014, HHSC expanded STAR+PLUS to the rural service areas making STAR+PLUS a statewide program and added individuals in an intellectual or developmental disability (IDD) waiver program or in an intermediate care facility for individuals with intellectual disability to STAR+PLUS for their acute care services. In 2016, HHSC implemented a new managed care program for children with disabilities, STAR Kids. In 2017, HHSC moved individuals in Adoption Assistance, Permanency Care Assistance, and Medicaid for Breast and Cervical Cancer programs into the managed care model. This work supports a more coordinated care delivery system for these populations as they are able to benefit from service coordination offered by the MCO. HHSC implemented changes to support a coordinated care delivery system by more quickly moving children to another managed care program when they go from foster care Medicaid to Adoption Assistance or Permanency Care Assistance Medicaid. Thus, eliminating any time in fee-for-service and ensuring a more seamless transition under the 1115 waiver. MCOs are reimbursed through a risk-based capitation rate that helps ensure MCOs contain cost growth while still providing all medically necessary services that improve outcomes for individuals they serve.



Texas also expanded risk-based managed care by adding new services to managed care programs under the 1115 waiver. The graph above shows over time the growth of our programs and services through managed care. In 2014, Community First Choice (CFC) services were added under the state plan and became available to individuals enrolled in managed care. CFC improves outcomes for people receiving the services because often these individuals are on an interest list for a waiver program and these services help them to remain in the community while they wait for their name to come to the top of the interest list. In 2015, HHSC added nursing facility services to the STAR+PLUS program. The addition of nursing facility services supports a more coordinated care delivery system as individuals in nursing facilities are able to benefit from service coordination offered by the MCO. Also, having nursing facility services as part of the array offered by the STAR+PLUS MCOs helps to contain cost growth as the MCO has the incentive to help individuals remain in or transition to less costly services in the community.

The Texas Medicaid program has been transitioning to a value-based model for some time now. For over 25 years, the State has gradually moved care delivered through Medicaid away from traditional fee-for-service reimbursement to a managed care system where private health plans are financially responsible for controlling costs and improving quality. The transition to managed care has been supported by system initiatives to improve quality and efficiency in state healthcare services. Chief among these is the State's 1115 Transformation Waiver, which includes incentive payments to hospitals and other providers for strategies to enhance access to healthcare, increase the quality and cost-

effectiveness of care, and improve the health of patients and families through the Delivery System Reform Incentive Payment (DSRIP) program. DSRIP has been an effective incubator allowing the State to establish consensus priorities for health system improvement and to test how flexible payment models can support patient centered care and clinical innovation. Since 2012, DSRIP providers have earned over \$19 billion all funds (intergovernmental transfer funds matched with federal funds).

The DSRIP program structure, beginning in federal fiscal year (FFY) 2018, evolved from a focus on projects and project-level reporting to system-level interventions to achieve selected measure bundles (or measures, depending on performing provider type). Among the allowable menu of measure bundles and measures, state priority measure bundle areas for hospitals and physicians include:

- Chronic Disease Management: diabetes and heart disease care, pediatric asthma management
- Primary care and prevention
- Pediatric primary care
- Improved maternal care
- Integrated behavioral health/primary care
- Chronic non-malignant pain management
- Behavioral health and appropriate utilization

Other significant initiatives for increasing value in state healthcare include: the MCO Pay for Quality Program (P4Q); Performance Improvement Projects (PIPs), which focus on improving quality across the managed care system; Hospital Quality Based Payment Program for Potentially Preventable Readmissions and Complications to incentivize quality and efficiency among hospitals; and Quality Incentive Payment Program (QIPP) to promote patient safety in nursing homes.

Finally, MCO Value-Based Contracting with Providers seeks to facilitate and encourage the development of alternative payment and flexible practice approaches between MCOs and their providers. Under this initiative, Texas Medicaid created contractual Alternative Payment Model (APM) targets for MCOs to connect provider payments to value starting in calendar year 2018. The APM percentage targets increase over time. If an MCO fails to meet the APM targets or certain allowed exceptions for high-performing plans, the MCO must submit an action plan and Texas may impose graduated contractual remedies, including liquidated damages.

The Uncompensated Care (UC) program exists to offset the costs of uncompensated care provided by hospitals and other providers. In 2019, as agreed to with CMS, the program transitioned from a broad definition of uncompensated care costs to unreimbursed charity care costs. UC payments are based on each provider's uncompensated care costs as reported to the State on a UC application. The non-federal share is provided by local governmental entities.

Amendments

Effective June 1, 2021 Texas Medicaid received federal approval to include Non-Emergency Medical Transportation (NEMT) in the array of services provided by MCOs to their members. In addition to providing the full array of NEMT services, House Bill 1576, 86th Legislature, Regular Session, 2019 (H.B.1576) requires MCOs to provide NEMT demand response transportation services for certain trips requested with less than 48-hours notice and increased opportunities for transportation network companies (TNCs) to provide demand response transportation services. This will expand risk-based managed care by transitioning from a state plan transportation broker model to MCOs operating under the 1115 waiver authority. This effort will improve outcomes and support a coordinated delivery system by making the same MCOs responsible for arranging healthcare services, also responsible for arranging the NEMT some members require to access healthcare services.

HHSC is seeking to remove the STAR+PLUS HCBS individual cost cap for individuals meeting specific medically fragile criteria and to remove the current state legislative requirement that the individual be deemed unable to safely be served in an institution. There will not be additional home and community-based services added to the program. Impacted individuals will continue to have access to services they are currently receiving in STAR+PLUS. While the population impacted by this change is not new to managed care and will not receive new services, the process for serving this very medically fragile population will improve the coordination of their care and improve health outcomes for them while containing cost growth. It is expected to result in a more cost-effective system, including better coordination of the person's care, benefiting the person, their family, and their MCO, all of which will lead to improved health outcomes for these particularly vulnerable individuals.

HHSC is working to implement Senate Bill 1096, 86th Legislature, Regular Session, 2019 (S.B. 1096) directing the pursuit of a waiver of comparability to exempt STAR Kids members from all preferred drug list (PDL) prior authorizations (PAs) to meet the requirements of Section 533.005, Government Code (a)(23)(L), as added by S.B. 1096.

Specifically, S.B. 1096 removes all the PDL PAs for all members of the STAR Kids program except those PAs based on evidence-based clinical criteria and nationally recognized peer-reviewed information and those PAs designed to minimize waste, fraud, or abuse. This amendment will not result in any changes to the formulary. This amendment will give a member the opportunity to be prescribed any drug whether the drug has preferred or non-preferred status, although a member will not have access to drugs not covered by Medicaid. HHSC is proposing to waive requirements in 42 C.F.R. §440.240, related to comparability of services for groups, because only members of the STAR Kids program will be allowed this option. 42 C.F.R. §440.240 requires the services available to any categorically needy beneficiary under the plan not be less in amount, duration, and scope than those services available to a medically needy beneficiary; and the services available to any individual in the following groups be equal in amount, duration, and scope for all beneficiaries within the group: (1) the categorically needy and (2) a covered medically needy group.

HHSC is also actively working to implement the legislatively-mandated STAR+PLUS Pilot Program under the 1115 waiver. The pilot must be implemented by September 1, 2023 and will operate for at least 24 months. The eligibility criteria for the program will include Medicaid-eligible adults age 21 and over who meet one of the following:

- Individuals with an IDD or cognitive disability, including:
 - individuals with autism; and
 - individuals with significant complex behavioral, medical, and physical needs who are receiving home and community-based services through the STAR+PLUS Medicaid managed care program.
- Individuals enrolled in the STAR+PLUS Medicaid managed care program who:
 - are on a Medicaid waiver program interest list;
 - meet criteria for an IDD; or
 - ▶ have a traumatic brain injury that occurred after the age of 21.
- Other individuals with disabilities who have similar functional needs without regard to the age of onset or diagnosis.

The STAR+PLUS Pilot Program will operate in one service area selected by HHSC with up to two STAR+PLUS Medicaid managed care plans. The pilot will test the delivery of long-term services and supports (LTSS) through a capitated managed care model for people with IDD, traumatic brain injury that occurred after age 21, or people with similar

functional needs as a person with IDD. Acute care services are already provided through a managed care model.

The STAR+PLUS Pilot Program is expected to further the demonstration goal of expanding risk-based managed care by offering home and community-based services to individuals with an IDD, traumatic brain injury, or similar functional need who currently do not receive these services through managed care. Additionally, this new program will create and support a more coordinated care delivery system by having MCOs who currently provide acute care services for people with IDD also provide LTSS through a waiver program. This is expected to improve outcomes while containing cost growth.

The 2020-21 Texas General Appropriations Act (Rider 32, Article II, House Bill (HB) 1) authorized the implementation of additional services for the treatment of eligible children with autism under the Texas Medicaid program¹. HHSC plans to submit an amendment to the 1115 Transformation waiver related to the coverage of certain early and periodic screening, diagnostic, and treatment (EPSDT) services for children and youth with a diagnosis of autism spectrum disorder.

Healthcare Delivery System, Eligibility Requirements, Benefit Coverage and Cost Sharing

Delivery System

Texas currently operates four of its Medicaid managed care programs under the demonstration: STAR, STAR+PLUS (including STAR+PLUS Home and Community Based Services (HCBS) waiver), STAR Kids, and the Children's Dental Program. Under these programs, individuals receive the full array of state plan services (including EPSDT). In STAR+PLUS, the HCBS waiver service array is offered. MCOs provide additional services on a case-by-case basis and through value-added services. MCOs also provide service management or service coordination to ensure individuals have their care coordinated according to the level of their need. Texas seeks to continue managed care and integrate the DSRIP transition plan into the capitated managed care model.

14

¹ Senate Bill 1, Article II, Rider 28, Applied Behavioral Analysis, 87th Legislature, Regular Session, 2021.

The State is not requesting changes to the existing healthcare delivery system, eligibility requirements or benefit coverage through this extension request. Additionally, there will continue to be no cost-sharing requirements related to premiums, co-payments, or deductibles as part of this extension request.

The State is not requesting changes to the DSRIP program; the funding and authorization still expire September 30, 2021. The State continues to adhere to the approved DSRIP Transition Plan by submitting all required deliverables.²

With approval of this application, Texas Medicaid and CMS would reestablish the DSRIP transition that was incorporated in the January 15, 2021 STCs. This provides continuity under the 1115 Transformation Waiver terms. The directed payment programs listed below were designed to improve the delivery system of Medicaid managed care and drive value.

Comprehensive Hospital Increase Reimbursement Program

The Comprehensive Hospital Increase Reimbursement Program (CHIRP) is a proposed directed payment program that provides increased Medicaid payments to hospitals for inpatient and outpatient services provided to persons with Medicaid enrolled in STAR and STAR+PLUS programs. CHIRP is the successor to the Uniform Hospital Rate Increase Program, which is currently in its fourth year of operation.

- Total Funding Requested for state fiscal year (SFY) 2022: \$5,020,000,000
- Eligible Providers: (1) children's hospitals, (2) rural hospitals, (3) state-owned hospitals that are not institutions for mental diseases (IMDs), (4) urban hospitals, (5) non-state-owned IMDs, and (6) state-owned IMDs.

Quality Incentive Payment Program

The Quality Incentive Payment Program (QIPP) is a value-based directed payment program that provides incentive payments to eligible nursing facilities participating in the Medicaid STAR+PLUS program. Through QIPP, MCOs are directed to make payments to

² In October 2020, HHSC separately requested an extension of the DSRIP program authorization and funding for the final demonstration year of the waiver in order to minimize disruptions to the healthcare system occurring as a result of COVID-19 and the timing of the DSRIP Transition. While CMS never responded to this request, the State continues to develop new proposals under the approved DSRIP Transition Plan and submit required deliverables.

eligible nursing facilities once the facilities demonstrate meeting the required goals. QIPP is currently in its fourth year of operation.

- Total Funding Requested for SFY 2022: \$1,100,000,000
- Eligible Providers: (1) non-state government-owned nursing facilities, and (2) private nursing facilities.

Texas Incentives for Physicians and Professional Services

The Texas Incentives for Physicians and Professional Services (TIPPS) is a proposed value-based directed payment program for certain physician groups providing healthcare services to persons with Medicaid enrolled in STAR, STAR+PLUS, and STAR Kids programs. TIPPS funds will be distributed to eligible physician groups based on each physician group's achievement of performance requirements collected twice per year.

- Total Funding Requested for SFY 2022: \$600,000,000
- Eligible Providers: (1) Health-Related Institution (HRI) physician groups, (2) Indirect Medical Education (IME) physician groups, and (3) other physician groups.

Rural Access to Primary and Preventive Services

The Rural Access to Primary and Preventive Services (RAPPS) is a proposed directed payment program for rural health clinics (RHCs) that provide primary and preventive care to persons in rural areas of the State enrolled in Medicaid STAR, STAR+PLUS, and STAR Kids programs. RAPPS focuses on the management of chronic conditions. RAPPS funds will be distributed to enrolled RHCs who meet program requirements.

- Total Funding Requested for SFY 2022: \$19,814,345
- Eligible Providers: (1) hospital-based RHCs, which include non-state government-owned and private RHCs, and (2) free-standing RHCs.

Directed Payment Program for Behavioral Health Services

The Directed Payment Program for Behavioral Health Services (DPP BHS) is a proposed value-based payment program to incentivize Community Mental Health Centers (CMHCs) to continue providing services that are aligned with the Certified Community Behavioral Health Clinic (CCBHC) model of care to persons enrolled in Medicaid STAR, STAR+PLUS, and STAR Kids programs. DPP BHS funds will be distributed to enrolled CMHCs who meet program requirements.

- Total Funding Requested for SFY 2022: \$175,944,005
- Eligible Providers: (1) Community Mental Health Centers (CMHC) with CCBHC certification, and (2) CMHCs without CCBHC Certification.

Texas seeks to continue the Uncompensated Care (UC) program. UC payments are cost-based and help offset the costs of uncompensated care provided by hospitals and other providers. UC costs are federally defined as unreimbursed charity care costs. UC payments are based on each provider's uncompensated care costs as reported to the State on a UC application. The non-federal share is provided by local governmental entities.

Payments from this pool are used to defray the actual uncompensated cost of medical services that meet the definition of "medical assistance" contained in section 1905(a) of the Social Security Act, that are provided to uninsured individuals as charity care by hospitals, clinics, or other provider types, including uninsured full or partial discounts, that provide all or a portion of services free of charge to patients who meet the provider's charity care policy and that adhere to the charity care principles of the Healthcare Financial Management Association. Annual UC Pool payments are limited to annual amounts authorized. Expenditures for UC payments must be claimed in accordance with CMS-approved claiming protocols for each provider type and application form. The methodology used by the State to determine UC payments will ensure that payments to hospitals, clinics, and other providers are distributed based on uncompensated cost, without any relationship to source of non-federal share. HHSC will continue the UC pool through the demonstration extension period and is not requesting changes to the UC program. The UC program includes 529 providers, which provide charity care to patients who meet their charity care policy.

Texas requests to create a Public Health Provider-Charity Care Program, which CMS approved on January 15 following negotiations with HHSC. The program is proposed to begin on October 1, 2021, as a part of DSRIP transition. The program is designed to defray providers' costs associated with care, including behavioral health, immunizations, chronic disease prevention and other preventive services for the uninsured. The program is limited to publicly owned and operated community mental health centers (CMHCs), local behavioral health authorities (LBHAs), local mental health authorities (LMHAs), local health departments (LHDs), and public health districts (PHDs). The first two years have been limited to \$500 million with the third year of the program sized based on actual charity care.

Managed Care Eligibility and Enrollment Requirements

STAR

STAR is the primary managed care program providing acute care services to low-income families, children, pregnant women, recipients of adoption assistance and permanency care assistance, and former foster care children.

STAR+PLUS

STAR+PLUS provides acute and LTSS to older adults, adults with disabilities, and women with breast and cervical cancer. The STAR+PLUS program includes adults 21 and older who do not have Medicare and who reside in an intermediate care facility for individuals with an intellectual or developmental disability (ICF/IID) or receive services through the following 1915(c) waivers: Home and Community-based Services (HCS), Texas Home Living (TxHmL), Community Living and Support Services (CLASS), or Deaf Blind with Multiple Disabilities (DBMD). These individuals receive their state plan services through STAR+PLUS and receive their 1915(c) services through their respective waivers and waiver providers.

STAR+PLUS HCBS

The STAR+PLUS HCBS Program provides LTSS to two groups of people, as defined below, who also receive acute care services through STAR+PLUS:

- STAR+PLUS 217-Like HCBS Group. This group consists of persons age 21 and older, who meet the nursing facility level of care (LOC), who qualify as members of the 217-Like HCBS Group, and who need and are receiving HCBS as an alternative to nursing facility care. This includes persons who could have been eligible under 42 CFR 435.217 had the State continued its section 1915(c) HCBS waiver for persons who are elderly and/or physically disabled. This group is subject to a numeric enrollment limitation.
- SSI-Related Eligibles. Persons age 65 and older and adults age 21 and older with physical disabilities that qualify as SSI eligibles and meet the nursing facility LOC as defined by the State.

Individuals can be eligible for HCBS under STAR+PLUS depending upon their medical and/or functional needs, financial eligibility designation as a member of the 217-Like

STAR+PLUS HCBS Group or an SSI-related recipient, and the ability of the State to provide them with safe, appropriate, and cost-effective LTSS.

- Medical and/or functional needs are assessed according to level of care (LOC) criteria published in state rules. These LOC criteria will be used in assessing eligibility for STAR+PLUS HCBS benefits through the 217-Like or SSI-related eligibility pathways.
- For an individual to be eligible for HCBS services, the State must have determined that the individual's cost to provide services is equal to or less than 202 percent of the cost of the level of care in a nursing facility.

STAR Kids

The STAR Kids program provides a continuum of services, including acute care, behavioral health, state plan LTSS, and 1915(c) home and community-based waiver services to children with disabilities. The following groups of Medicaid clients from birth through age 20 are mandatory in the STAR Kids program.

- Children receiving SSI and disability-related (including SSI-related) Medicaid who do not participate in a 1915(c) waiver: these children will receive their state plan acute care services and their state plan LTSS through STAR Kids.
- Children receiving HCBS services through the Medically Dependent Children Program (MDCP) 1915(c) waiver: these children and young adults will receive the full range of state plan acute care services and state plan LTSS as well as MDCP 1915(c) HCBS waiver services through STAR Kids.
- Children receiving HCBS through the following 1915(c) waivers -- CLASS, DBMD,
 HCS, TxHmL, and Youth Empowerment Services (YES):
 - ▶ Children enrolled in CLASS, DBMD, HCS and TxHmL receive their 1915(c) LTSS and 1915(k) Community First Choice (CFC) services through their current 1915(c) waiver provider. These clients receive all other state plan LTSS and acute care services through STAR Kids.
 - ▶ Children enrolled in the YES waiver receive their 1915(c) LTSS through their current 1915(c) provider. These clients receive all state plan LTSS, including 1915(k) CFC services, as well as all acute care services through STAR Kids.
- Children receiving SSI and disability-related (including SSI-related) Medicaid who
 reside in a community-based ICF/IID or a nursing facility: clients will continue to
 receive all LTSS provided by the facility through the current delivery system. All
 non-facility related services will be provided through STAR Kids.

Children's Dental Program

Children's primary and preventive Medicaid dental services are delivered through a capitated statewide dental services program (the Children's Dental Program) to most children under 21. Contracting DMOs maintain networks of Main Dental Home providers, consisting of general dentists and pediatric dentists. The dental home framework under this statewide program is informed by the improved dental outcomes evidenced under the "First Dental Home Initiative" in the State. The Children's Dental Program must conform to all applicable regulations governing prepaid ambulatory health plans (PAHPs), as specified in 42 C.F.R. 438.

The following Medicaid recipients are excluded from the Children's Dental Program, and will continue to receive their Medicaid dental services outside of the Demonstration: Medicaid recipients age 21 and over; all Medicaid recipients, regardless of age, residing in Medicaid-paid facilities such as nursing homes, state-supported living centers, or ICFs/IID; and STAR Health³ recipients.

Benefit Coverage

STAR, STAR+PLUS, and STAR Kids enrollees are provided benefits in the same amount, duration, and scope as in the Medicaid state plan. Members under the age of 21 are also provided all EPDST benefits. Individuals in 1915(c) waivers receive all Texas state plan services based on medical necessity and delivered outside of managed care (e.g., dental, ICF/IID pursuant to their respective 1915(c) waivers), with the exception of MDCP which is provided by the STAR Kids MCOs. Services provided through the Children's Dental Program and DMOs are separate from the medical services provided by the STAR, STAR+PLUS, and STAR Kids MCOs, and are available to persons who are under age 21, with the exception of the groups listed above. DMOs are expected to provide all medically necessary dental services in the same amount, duration and scope as in the Medicaid state plan.

In addition to all state plan benefits, STAR+PLUS HCBS participants, whether in the 217-Like HCBS Group or the SSI-related group, that are provider-directed and, if the participant elects the option, self-directed, receive a number of other 217-Like HCBS Services including: Personal Assistance Services, Respite, Financial Management Services, Support Consultation, Adaptive Aids and Medical Supplies, Adult Foster Care, Assistive

³STAR Health provides Medicaid managed care to children who get Medicaid through the Department of Family and Protective Services.

20

Living, Dental Services, Emergency Response Services, Home Delivered Meals, Minor Home Modifications, Nursing, Occupational Therapy, Physical Therapy, Speech, Hearing, and Language Therapy, Transition Assistance Services, Cognitive Rehabilitation Therapy, Supported Employment Services, and Employment Assistance Services.

Cost Sharing

There will continue to be no cost-sharing requirements related to premiums, co-payments, or deductibles as part of this extension request.

Appendix B. Budget

This request includes the rebasing terms and conditions previously approved by CMS on January 15, 2021. Without waiver expenditures will be rebased effective in FFY 2023 (October 2022-September 2023) using FFY 2022 (October 2021-September 2022) data to establish the rebased without waiver per member per month (PMPM) costs. To calculate the new rebased amount, without waiver PMPMs will be adjusted to account for annualized amounts of approved state-directed payments (pending state legislative approval) made in FFY 2022. HHSC is requesting that in response to the Public Health Emergency, CMS allow for a one-time adjustment to budget neutrality to account for impacts of COVID-19 on enrollment and expenditures. A subsequent rebasing exercise to without waiver PMPMs will occur effective FFY 2028 using FFY 2026 expenditures. These processes will help ensure that budget neutrality not only complies with CMS policy but will also continue to support funding needs and flexibility moving forward.

Cost Growth Containment

Through initial managed care initiatives and continued expansions into the managed care delivery system, HHSC and the clients we serve have benefited from both increased coordination and quality of care. Over time, these same benefits and efficiencies have helped flatten the cost curve and maintain stable Medicaid client service cost trends year-over-year. For the demonstration period of FFY 2012-2022, with waiver PMPM annual cost growth trends are estimated to average 3.3%, a full 2% lower than without waiver PMPM cost growth for the same period (excluding UPL).

Based on previous negotiations, Texas and CMS estimated a collective savings of \$10 billion in taxpayer dollars due to the utilization of the managed care model through 2030, ensuring budget certainty for the next 10 years.

Aggregate expenditures under the 1115 extension are expected to increase consistent with historical state trends. Standard growth trends include population (caseload) growth and cost growth due to inflationary factors from case-mix changes, healthcare advancements and rate changes. Within the budget neutrality calculations, HHSC projects, subject to and pursuant to 42 CFR § 438.6, over \$7 billion will be included into the Medicaid Managed Care rates through directed payment programs (DPPs) in FFY 2022. These continue funding for current DPPs, launch new DPPs, and incorporate innovations from DSRIP into Medicaid managed care. Pending Applications include approximately \$5 billion directed to hospital services (CHIRP); \$600 million directed to physicians (TIPPS);

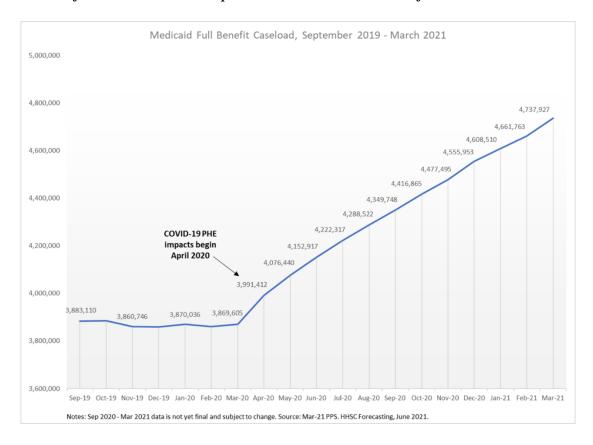
\$170 million directed to behavioral health services (BHS); \$20 million directed to Rural Health Clinics (RAPPS); and \$1.1 billion directed to nursing facilities services (QIPP). HHSC has submitted a state plan amendment to implement increased reimbursements for public ground ambulance services, which it intends to serve as a basis of a DPP in managed care; in managed care, the estimated annual payments could be \$150 million. HHSC also projects a pool size up to \$500 million in expenditures from the Public Health Provider Charity Care Program for FY 2022 and FY 2023. This is included in Attachment U.

Enrollment

No impact to enrollment is expected as a result of the 1115 transformation waiver extension. There are no 1115 waiver policies that limit or impact Medicaid enrollment. While fiscal year trends during and following the COVID-19 Public Health Emergency period are impacted due to policies and economic recovery, overall member months under the 1115 are expected to experience long-term annual caseload growth trends of roughly 1% to 1.5% consistent with historical program growth.

Current enrollment growth during the PHE has been significant, with growth of over 20% since the PHE began. Annual growth of 18% over fiscal year 2021 is expected as the PHE continues and could increase depending on further PHE extensions and unemployment. While recovery is assumed over fiscal years 2022-2023, any number of factors can greatly influence the impact to Medicaid caseloads due to policy and economic conditions.

The chart below reflects enrollment and impacts on enrollment as a result of COVID-19.



Appendix C. Interim Evaluation

The overarching objectives of the THTQIP Waiver are to expand risk-based managed care to new populations and services, support the development and maintenance of a coordinated care delivery system, improve outcomes while containing cost growth, and transition to quality-based payment systems across managed care and providers. The June 2018 CMS-approved 1115 evaluation design examines these objectives through the three components of the THTQIP Waiver (DSRIP, UC Pool, Medicaid Managed Care (MMC) expansion), as well as the overall impact of the THTQIP Waiver (as measured by quality-based payment systems in Texas Medicaid and transformation of the healthcare system for the Medicaid/low-income population in Texas). The CMS-approved 1115 evaluation design includes five evaluation questions and 13 hypotheses.⁴ In December 2020, HHSC's external evaluator submitted preliminary interim evaluation findings to CMS.

Evaluation Activities to Date

During the past four years, HHSC developed the CMS-approved evaluation design, procured an external evaluator, provided the external evaluator with data sources outlined in the evaluation plan, provided data-related technical assistance as requested by the external evaluator, participated in quarterly and ad hoc meetings with the external evaluator, and submitted four revisions to the THTQIP evaluation design. HHSC also developed a new draft evaluation design for the extension period (see "Planned Evaluation Activities During THTQIP Extension" below).

Preliminary Evaluation Findings

The external evaluator completed preliminary findings of the interim report in December 2020. Key points from the preliminary findings are summarized below. Texas A&M University System's *Preliminary Evaluation Findings* (Supplement A-Preliminary Draft Results) provides the full summary of preliminary findings provided by the external evaluator.

⁴ The current CMS-approved evaluation design plan can be found at https://hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/1115-docs/tool-guidelines/1115-waiver-evaluation-design-plan.pdf.

Evaluation Question 1: Did the DSRIP program incentivize changes to transform the healthcare system for the Medicaid and low-income uninsured (MLIU) population in Texas?

Preliminary findings suggest the DSRIP program incentivized collaboration in tangible resource sharing and data sharing agreements, but less so in other areas of collaboration, such as joint service delivery. The DSRIP program has also supported improvements in Category C outcome measures such as heart disease management (DSRIP Category C measure A2-509) and primary care prevention (DSRIP Category C measure C1-502), but additional data is necessary to fully understand the impact of DSRIP on health outcomes.

Evaluation Question 2: Did the Demonstration impact unreimbursed costs associated with the provision of care to the MLIU population for UC providers?

Preliminary findings suggest the percentage of UC costs reimbursed decreased over time. Analysis of the overall UC cost growth rate is currently underway.

Evaluation Question 3: Did the expansion of the MMC healthcare delivery model to additional populations and services improve healthcare (including access to care, care coordination, quality of care, and health outcomes) for MMC clients?

Preliminary findings provide some support for the premise that the expansion of MMC improved access to care and quality of care for study populations included in the evaluation, but additional data are necessary to fully understand the impact of the MMC expansion.

Evaluation Question 4: Did the Demonstration impact the development and implementation of quality-based payment systems in Texas Medicaid?

Preliminary findings suggest providers' use of Alternate Payment Models (APMs) increased, but organizations were somewhat ambivalent about the benefits of APMs. Organizations reported financial efficiency as the most common perceived benefit of APMs, and lack of MCO engagement as the most common perceived barrier to APM participation.

Evaluation Question 5: Did the Demonstration transform the healthcare system for the MLIU population in Texas?

Preliminary findings suggest the THTQIP Waiver has resulted in overall cost savings and this trend is expected to continue.

Planned Evaluation Activities: THTQIP Extension

Texas developed a new evaluation design to guide evaluation activities during the extension period. The new evaluation design continues to assess whether Texas is achieving the goals and objectives of the THTQIP Waiver, and includes 10 revised evaluation questions, 20 hypotheses, and a selection of corresponding measures focused on recent or future changes to the THTQIP Waiver. These changes include recent or forthcoming transitions of new services or populations into MMC, the expiration of DSRIP, the addition of new directed payment programs (DPPs), and additions or revisions to supplemental payment programs (SPPs). The new evaluation design also includes additional evaluation questions assessing cost outcomes for the demonstration as a whole. The evaluation questions and hypotheses included in the new evaluation design for the extension period are provided below.

MMC Component

Evaluation Question 1. Did the expansion of the MMC service delivery model to additional populations or services improve healthcare outcomes for MMC clients?

- H1.1. Utilization of Demand Response Transportation Services (DRTS) will increase for MMC members.
- H1.2. Access to healthcare services will improve for MMC members whose DRTS were carved into MMC.
- H1.3. Preventable emergency department use will decrease among Medicaid members whose DRTS were carved into MMC.

Evaluation Question 2. Did the MMC service delivery model improve access to and quality of care over time?

- H2.1. Access to preventive care will maintain or improve over time.
- H2.2. Effective treatment of chronic, complex, and serious conditions will maintain or improve over time.
- H2.3. Appropriate use of healthcare will maintain or improve over time.
- H2.4. Poor care or care coordination which may result in unnecessary patient harm will maintain or reduce over time.
- H2.5. MMC member experience will maintain or improve over time.

Evaluation Question 3. Did Texas's quality initiatives impact the development and implementation of quality-based payment systems?

H3.1. The implementation of alternative payment models (APMs) in Texas Medicaid will increase over time.

DPP Component

Evaluation Question 4. Do DPPs continue or expand upon the successful innovations of DSRIP?

- H4.1. DPPs continue or expand upon DSRIP best practices.
- H4.2. DPPs support providers' transition from DSRIP.

Evaluation Question 5. Do DPPs advance at least one of the goals in the managed care quality strategy?

- H5.1. DPPs promote optimal health for Texans.
- H5.2. DPPs promote effective practices for people with chronic and serious conditions.
- H5.3. DPPs promote a safer delivery system that keeps patients free from harm.

SPP Component

Evaluation Question 6. Do the SPPs financially support providers serving the Medicaid and uninsured populations?

H6.1. The UC and PHP-CCP programs financially support Medicaid providers by reimbursing Medicaid or charity care costs in Texas.

Evaluation Question 7. Did the implementation of UHRIP support the hospital delivery system during the transition of the UC program to charity care only?

H7.1. Hospital-based performance measures will maintain or improve following the transition to charity care only in DY9.

Overall Demonstration Component

Evaluation Question 8. What are the costs of providing healthcare services to Medicaid beneficiaries served under the Demonstration?

H8.1. The Demonstration results in overall savings in healthcare service expenditures.

Evaluation Question 9. What are the administrative costs of implementing and operating the Demonstration?

H9.1. Administrative costs required to implement and operate the Demonstration are relatively stable and reasonable over time.

Evaluation Question 10. How do the funding pools administered through the Demonstration support providers and overall Medicaid program sustainability?

H10.1 The Demonstration leverages savings in healthcare service expenditures to administer quality-based payment systems and supplemental funding pools.

H10.2 The quality-based payment systems and supplemental funding pools administered through the Demonstration support Medicaid provider operations and sustainability.

HHSC will work with CMS to address any feedback or edits to the draft evaluation design for the extension period. In addition, HHSC will continue to fulfill federal evaluation monitoring and reporting requirements during the THTQIP extension and support the external evaluator in executing the new evaluation design.

Texas requests the following timeline for <u>future</u> interim reports during the extension period:

- 1. A Draft Interim Evaluation Report for demonstration years 7-11 will be due no later than March 31, 2024.
- 2. A Draft Interim Evaluation Report for demonstration years 10-14 will be due no later than March 31, 2027.
- 3. A Draft Interim Evaluation Report for demonstration years 10-16 will be due no later than September 30, 2029.

Appendix D. Quality Assurance Monitoring

Texas has a strong focus on quality of care in Medicaid and CHIP that includes initiatives based on state and federal requirements, including protocols published by the Centers for Medicare & Medicaid Services (CMS). HHSC strives to ensure high-value healthcare for Texans through its monitoring and oversight of Medicaid and CHIP managed care organizations (MCOs).

External Quality Review

Federal regulations require external quality review of Medicaid managed care programs to ensure States and their contracted MCOs are compliant with established standards. The external quality review organization (EQRO) performs four CMS required functions as mandated by the Balanced Budget Act of 1997 related to Medicaid managed care quality:

- Validation of MCOs' performance improvement projects (PIPs);
- Validation of performance measures;
- Determination of MCOs' compliance with certain federal Medicaid managed care regulations; and
- Validation of MCO and dental maintenance organization (DMO) network adequacy.

In addition, States may also contract with the EQRO to validate member-level data; conduct member surveys, provider surveys, or focus studies; and calculate performance measures. The Institute for Child Health Policy (ICHP) has been the EQRO for HHSC since 2002. HHSC's EQRO follows CMS protocols to assess access, utilization, and quality of care for members in Texas' CHIP and Medicaid programs.

The EQRO produces reports to support HHSC's efforts to ensure managed care clients have access to timely and quality care in each of the managed care programs. The results allow comparison of findings across MCOs in each program and are used to develop overarching goals and quality improvement activities for Medicaid and CHIP managed care programs. MCO findings are compared to HHSC standards and national percentiles, where applicable. A link to the annual EQRO Summary of Activities (SOA) Report can be found here.

The EQRO assesses care provided by MCOs participating in STAR, STAR+PLUS (including the STAR+PLUS home and community-based services waiver), STAR Health, CHIP, STAR Kids, and the Medicaid and CHIP dental managed care programs. The EQRO conducts ongoing evaluations of quality of care primarily using MCO administrative data, including

claims and encounter data. The EQRO also reviews MCO documents and provider medical records, conducts interviews with MCO administrators, and conducts surveys of Texas Medicaid and CHIP members, caregivers of members, and providers.

Multi-Year Focus

In summer 2016, the Texas Medicaid and CHIP EQRO began a multi-year focus study to evaluate the STAR Kids program and develop a set of quality measures for the STAR Kids population. The EQRO produced five reports for the study:

- 1. STAR Kids Program Focus Study Measures Background Report (February 10, 2017)
- 2. STAR Kids Program Focus Study Pre-Implementation Descriptive Report (May 26, 2017). https://hhs.texas.gov/sites/default/files//documents/about-hhs/process-improvement/quality-efficiency-improvement/STAR-Kids-Pre-Implementation-Report-052617.pdf
- 3. STAR Kids Post-Implementation Managed Care Organization (MCO) Interview Report (June 18, 2018). https://hhs.texas.gov/sites/default/files/documents/about-hhs/process-improvement/medicaid-chip-qei/star-kids-post-mco-interview-report-june-2018.pdf
- 4. Measures Feasibility Report (April 18, 2019)
- 5. Summary Report (November 13, 2019)

The final summary report contained a series of recommendations including the following:

- Conducting regular National Core Indicators (NCI) Child Family Surveys (NCI CFS) with STAR Kids caregivers;
- Conducting additional studies with the STAR Kids-Screening and Assessment Instrument (SK-SAI) and Individual Service Plan (ISP);
- Conducting Consumer Assessment of Healthcare Providers & Systems (CAHPS) surveys to assess member experiences;
- Creating quality-of-care measures specific to members enrolled in the Medically Dependent Children Program (MDCP); and
- Conducting focus groups with MDCP caregivers.

These recommendations were incorporated into Senate Bill 1207, 86th Legislature, Regular Session, 2019 (S.B. 1207), and HHSC has or is in the process of implementing them.

The annual Summary of Activities (SOA) reports to CMS all activities performed by the EQRO during the contract year. The SOA report presents findings by the Texas EQRO on activities for state fiscal year (SFY) 2018, which address quality of care in Texas Medicaid and CHIP. The report's recommendations include the following:

- Validate and update provider addresses to improve the return rate on records requested from providers;
- Identify members that most benefit from addressing social determinants of health (SDOH) and improve their access to care;
- Continue to improve access to behavioral healthcare; and
- Focus on improving key vaccination rates.

In response to these recommendations, MCOs are required to verify the provider address information prior to the EQRO requesting patient records for encounter data validation (EDV). In addition, MCOs and DMOs are subject to corrective action plans (CAPs) for data that does not meet minimum EDV quality standards.

HHSC, in conjunction with the EQRO, recently completed an analysis of state and national SDOH tools. HHSC plans to use this information to identify a recommended tool for Medicaid MCOs. In addition, the Medicaid/CHIP Services Department has formed an internal workgroup to further incorporate SDOH into quality initiatives.

In 2019, MCOs began a statewide, two-year PIP focused on members with complex behavioral health conditions. In 2020, PIPs focus on improving integration of behavioral health and physical healthcare, with the goal of reducing hospitalization.

To improve vaccination rates, HHSC has added immunizations for adolescents as a quality measure in the Medical Pay-for-Quality (P4Q) program for STAR, CHIP, and STAR Kids.

Quality Measures

A combination of established sets of national measures and state-developed measures validated by the EQRO are used to track and monitor program and health plan performance. Measures include:

• National Committee for Quality Assurance Healthcare Effectiveness Data and Information Set (HEDIS®): A nationally recognized and validated set of measures used to gauge quality of care provided to members.

- Agency for Healthcare Research and Quality (AHRQ) Pediatric Quality Indicators
 (PDIs)/Prevention Quality Indicators (PQIs): PDIs use hospital discharge data to
 measure the quality of care provided to children and youth. PQIs use hospital
 discharge data to measure quality of care for specific conditions known as "ambulatory
 care sensitive conditions" (ACSCs). ACSCs are conditions for which good outpatient
 care can potentially prevent the need for hospitalization, or for which early intervention
 can prevent complications or more severe disease.
- 3M® Potentially Preventable Events (PPEs): HHSC uses and collects data on Potentially Preventable Admissions (PPAs), Potentially Preventable Readmissions (PPRs), Potentially Preventable Emergency Department Visits (PPVs), Potentially Preventable Complications (PPCs), and Potentially Preventable Ancillary Services (PPSs).
- Consumer Assessment of Healthcare Providers & Systems (CAHPS®) Surveys: CAHPS
 Health Plan Surveys are nationally recognized and validated tools for collecting
 standardized information on members' experiences with health plans and services.

Initiatives

HHSC uses quality measures to evaluate health plan performance and develop initiatives to improve the quality of care provided to Medicaid and CHIP members in managed care.

Administrative Interviews

In accordance with 42 CFR 438.358, the EQRO conducts administrative interviews with each plan in Medicaid/CHIP, within a three-year period, to assess MCO/DMO compliance with state standards for access to care, structure and operations, and quality assessment and performance improvement (QAPI). The administrative interview process consists of four main deliverables, namely Administrative Interview (AI) tool, AI evaluations, onsite visits, and AI reports.

Core Measure Reporting

CMS has a Children's and an Adult Health Care Quality Core Set of measures which States voluntarily report on for children in Medicaid and CHIP and adults in Medicaid. The EQRO assists HHSC in reporting core measures to CMS each year.⁵

⁵ https://www.medicaid.gov/medicaid/quality-of-care/quality-of-care-performance-measurement/adult-and-child-health-care-quality-measures/index.html

MCO Report Cards

HHSC provides information on outcome and process measures to Medicaid and CHIP members regarding MCO performance during the enrollment process. To comply with this requirement and the quality rating system required by 42 CFR 438.334, HHSC develops report cards for each program service area to allow members to compare the MCOs on specific quality measures. These report cards are intended to assist potential enrollees in selecting an MCO based on quality metrics. Report cards are posted on the HHSC website and included in the Medicaid enrollment packets. Report cards are updated annually.⁶

Figures 1 and 2 show 2020 report cards for STAR adult members in the Bexar Service Area and STAR Kids members in the Harris Service Area.

⁶ <u>https://hhs.texas.gov/services/health/medicaid-chip/programs/managed-care-report-cards</u>

Figure 1: STAR Adult Report Card, Bexar Service Area

*** Highest Performance in STAR **HEALTH PLAN PERFORMANCE** Ratings are based on a scale of one to five stars. Fewer stars mean the plan has lower performance (but does not always mean bad performance) than other plans. **★ Lowest Performance in STAR Aetna Better Community First** Superior Health **Health Plans** HealthPlan Amerigroup ** *** **** **Overall Health Plan Quality** \star ** *** **** Experience with Doctors and the Health Plan * People get the care they need without *** No rating[†] *** *** problems or long waits Doctors listen carefully, explain clearly and *** No rating[†] *** *** spend enough time with people *** *** People give high ratings to their personal doctor *** *** *** **** People give high ratings to the health plan * *** *** ** *** **** Staying Healthy ** ** **** **** Women get checkups during pregnancy New mothers get checkups after giving birth **** *** **** **** People get regular yearly checkups ** ** *** **** **** **** Women get regular screenings for cervical cancer **** **** **Common Chronic Conditions** **** ** *** **** People get care for depression and **** ** *** No rating[†] constant low mood People get care for diabetes *** *** *** ****

if a plan shows "No rating": this is not a bad rating. At the time of the study, the plan either (1) was new to the area or (2) had too few members to rate.



Figure 2: STAR Kids Report Card, Harris Service Area



Network Adequacy

Senate Bill 760, 84th Legislature, Regular Session, 2015 (S.B. 760) directed HHSC to establish and implement a process for direct monitoring of an MCO's provider network, including the length of time a recipient must wait between scheduling an appointment with a provider and receiving treatment from the provider. To fulfill this direction, Section 8.1.3 of the Texas Uniform Managed Care Contract specifies that Medicaid and CHIP MCOs must assure that all members have access to all covered services on a timely basis, consistent with medically appropriate guidelines, accepted practice parameters and within the prescribed time or distance standards.

Network adequacy initiatives completed by the EQRO include the Appointment Availability (AA) Study and the Primary Care Provider (PCP) Referral Study. The AA Study is a series of sub-studies completed by the State's EQRO. The AA Study is comprised of four reports

in the areas of prenatal, primary care, vision, and behavioral health. MCO performance is assessed by determining provider compliance with contract standards for appointment availability and wait time for an appointment. The PCP Referral Study is conducted annually and examines PCP experiences when referring Medicaid managed care and CHIP beneficiaries for specialty care.

Pay-for-Quality

Senate Bill 7, 83rd Legislature, Regular Session, 2013, (S.B. 7) focused on the use of quality-based outcome and process measures in quality-based payment systems by measuring PPEs, rewarding use of evidence-based practices, and promoting healthcare coordination, collaboration, and efficacy. To comply with this legislative direction, HHSC implemented redesigned medical and dental Pay-for-Quality (P4Q) programs in January 2018. The P4Q programs create financial incentives and disincentives based on health plan performance on a set of quality measures. Contracted health plans are at-risk.

Under medical P4Q, three percent of the MCOs' capitation is at-risk based on their performance on a series of key quality metrics that focus on prevention, chronic disease management, behavioral health, and maternal and infant health. MCOs are evaluated on their own year-to-year performance and compared to their peers at the state and national level.

Medical P4Q has led to marked improvement in quality. In comparing 2017 to 2018 program rates, all at-risk measures in all programs (i.e., STAR, CHIP, and STAR+PLUS) showed improvement except for potentially preventable emergency room visits (PPVs) in STAR and CHIP. For example, rates for counseling for nutrition and physical activity increased by eight percent in CHIP. In addition, rates for six or more well child visits in the first 15 months increased by four percent in STAR. Additional detail regarding each program's results are provided below.

2018 Medical P4Q Results

Overall, MCOs performed well. FirstCare (CHIP, STAR) was the only MCO to have a net recoupment across all programs (\$3.7 million). While Molina had a recoupment for CHIP, gains in STAR more than offset the recoupment resulting in a net distribution overall. The sum of amounts recouped is apportioned to successful MCOs relative to the percentage they were eligible to earn. There are no amounts to be recouped in STAR+PLUS, so no dollars earned. No money is available for the bonus pool in any program.

In the tables that follow, the columns labeled "Potential" are based on each MCO's performance and reflect the maximum amount they could have earned or lost. The columns labeled "Actual" reflect the actual financial impact to each MCO, based on their performance and amounts available for payments. Attachment 2 presents each MCO's performance per measure and program, in summary and detail.

STAR

In STAR, only FirstCare out of 16 MCOs was subject to recoupment. Table 1 shows the actual dollars earned or lost by each MCO.

Table 1: STAR Capitation Earned/Recouped by MCO⁷

мсо	2018 Capitation	Potential Percent Earned/ Recouped	Potential Dollars Earned/ Recouped	Actual Percent Earned/ Recouped	Actual Dollars Earned/ Recouped
Aetna Better Health	\$208,462,504	1.03	\$2,149,770	0.047	\$97,683
Amerigroup	\$1,440,716,417	1.22	\$17,558,731	0.055	\$797,850
Blue Cross Blue Shield of Texas	\$77,513,430	0.75	\$581,351	0.034	\$26,416
Community First Health Plans	\$284,949,776	0.19	\$534,281	0.009	\$24,277
Community Health Choice	\$825,959,465	1.78	\$14,712,403	0.081	\$668,516
Cook Children's Health Plan	\$275,435,635	0.47	\$1,291,105	0.021	\$58,666

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⁷ Percentages have been rounded to fit this table.

мсо	2018 Capitation	Potential Percent Earned/ Recouped	Potential Dollars Earned/ Recouped	Actual Percent Earned/ Recouped	Actual Dollars Earned/ Recouped
Dell/Seton Health Plan	\$45,050,796	1.41	\$633,527	0.064	\$28,787
Driscoll Health Plan	\$463,063,325	1.88	\$8,682,437	0.085	\$394,520
El Paso First Health Plans, Inc	\$172,171,647	0.84	\$1,452,698	0.038	\$66,009
FirstCare Health Plans	\$245,963,022	-1.50	(\$3,689,445)	-1.500	(\$3,689,445)
Molina Healthcare of Texas, Inc.	\$252,846,368	1.22	\$3,081,565	0.055	\$140,023
Parkland Community Health Plan	\$495,034,885	0.94	\$4,640,952	0.043	\$210,880
RightCare from Scott & White Health Plan	\$127,242,677	0.75	\$954,320	0.034	\$43,363
Superior HealthPlan	\$2,061,684,117	0.66	\$13,529,802	0.030	\$614,779
Texas Children's Health Plan	\$865,191,531	0.84	\$7,300,054	0.038	\$331,706
UnitedHealthCare Community Plan	\$485,064,936	0.84	\$4,092,735	0.038	\$185,969

мсо	2018 Capitation	Potential Percent Earned/ Recouped	Potential Dollars Earned/ Recouped	Actual Percent Earned/ Recouped	Actual Dollars Earned/ Recouped
Total			\$77,506,285		\$0

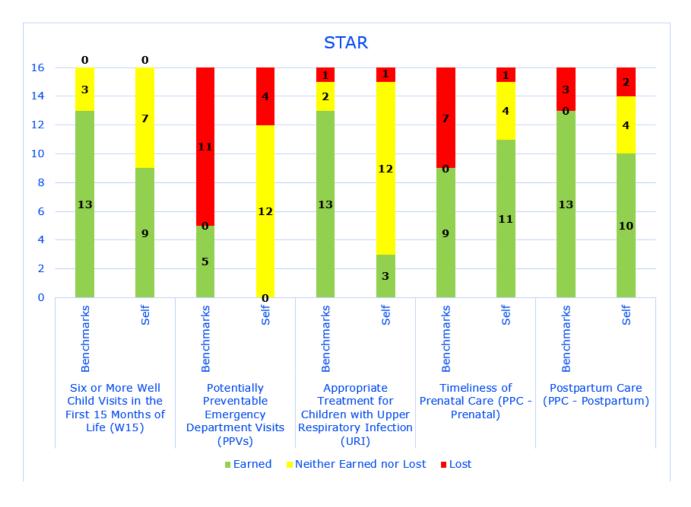
Following are observations regarding STAR MCOs' performance by measure:

- Well Child Visits in the First 15 Months of Life (W15): STAR MCOs generally
 performed well on ensuring infants receive the recommended number of well child
 visits, with more than half the MCOs earning money and no MCOs subject to
 recoupment for both performance against self and performance against
 benchmarks.
- Prenatal and Postpartum Care (PPC): More than half the MCOs earned money for both performance against self and benchmarks on timeliness of prenatal care and postpartum care. Some MCOs lost capitation on these measures for performance against benchmarks, including seven MCOs on prenatal care and three on postpartum care. For performance against self, one MCO lost capitation on prenatal care (Texas Children's) and two MCOs (FirstCare and Scott & White) lost capitation on postpartum care.
- *Upper Respiratory Infection (URI):* MCOs generally performed well on the URI measure, with 13 MCOs earning capitation and only FirstCare losing capitation on performance against self and benchmarks.
- PPVs: STAR MCOs were most challenged by PPVs, with 11 MCOs losing capitation on performance against benchmarks and four MCOs losing capitation on performance against self (El Paso, FirstCare⁸, Molina, and United). No MCO achieved the five or more percent improvement required to earn capitation on performance against self.

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⁸ This may not reflect FirstCare's true performance due to their encounter data errors.





STAR+PLUS

In STAR+PLUS, none of the five MCOs were subject to recoupment and no money was available to redistribute. Table 2 shows the actual dollars earned by each MCO. Figure 4 presents MCO performance against benchmarks and against self on STAR+PLUS P4Q measures. While MCOs may have lost capitation on one or more measures, it was offset by capitation earned on other measures resulting in net overall capitation earned.

Table 2: STAR+PLUS Capitation Earned/Recouped by MCO9

мсо	2018 Capitation	Potential Percent Earned/ Recouped	Potential Dollars Earned/ Recouped	Actual Percent Earned/ Recouped	Actual Dollars Earned/ Recouped
Amerigroup	\$1,296,905,712	0.30	\$3,890,717	0.0	\$0
Cigna-HealthSpring	\$426,826,409	0.30	\$1,280,479	0.0	\$0
Molina Healthcare of Texas, Inc.	\$856,235,158	0.75	\$6,421,764	0.0	\$0
Superior HealthPlan	\$1,493,042,737	0.90	\$13,437,385	0.0	\$0
UnitedHealthCare Community Plan	\$1,287,229,942	0.45	\$5,792,535	0.0	\$0

42

⁹ Percentages have been rounded to fit this table.

- Cervical Cancer Screening (CCS): For performance against self, STAR+PLUS
 MCOs did not lose capitation on any of the measures except CCS, with one
 MCO's rate (United) declining more than the five percent threshold for
 recoupment. One MCO also lost capitation for performance against
 benchmark for this measure.
- Diabetes Screening for Members Using Antipsychotics (SSD): All MCOs earned capitation on performance against benchmarks for the measure SSD. Three MCOs also earned capitation on performance against self for this measure.
- PPVs: Similar to STAR and CHIP, STAR+PLUS MCOs were most challenged by PPVs: three MCOs (Amerigroup, Cigna, and Molina) lost capitation on performance against benchmarks and no MCO achieved the five or more percent improvement required to earn capitation on performance against self.
- Diabetes Control (CDC): Only one MCO lost capitation on performance against benchmarks for the CDC measure (Superior). Two MCOs earned capitation on performance against self for this measure (Molina and Superior).



Figure 4: STAR+PLUS Performance by Measure

HHSC's focus on maternal and infant health through P4Q, PIPs, and other initiatives have resulted in significant improvement in infant and maternal health outcomes. From 2008 to 2018, there was a 24 percent rate of improvement in children receiving six or more well child visits in the first 15 months of life, a 26 percent rate of improvement for adolescents receiving an annual well child visit, and a 14 percent rate of improvement in timeliness of prenatal care.

Medicaid Value-Based Enrollment

Pursuant to Texas Government Code §533.00511, HHS implemented an incentive program that automatically enrolls a greater percentage of Medicaid recipients who have not selected a managed care plan into a plan based on quality of care, efficiency and effectiveness of service provision, and performance. The State's new

auto-enrollment method uses metrics aligned with the Triple Aim to promote value-based healthcare that achieves better care at lower costs.¹⁰

Alternative Payment Model (APM) Requirements

The P4Q and value-based enrollment programs serve as catalysts for managed care to pursue value-based payment arrangements with providers to achieve improved outcomes. APMs are payment arrangements in which some portion of an MCO's reimbursement to a provider is linked to measures of quality and outcomes. HHSC uses the Healthcare Payment Learning and Action Network (HCP LAN) Alternative Payment Model (APM) Framework¹¹ to help guide this effort. This framework provides a menu of payment models from which MCOs could choose to develop alternative payment contracts with their providers. Moving from one category to the next adds a level of risk to the payment model.

Under this initiative, HHSC created contractual targets for MCOs to connect provider payments to value using APMs. The APM percentage targets increase over time. If an MCO fails to meet the APM targets or certain allowed exceptions for high performing plans, the MCO must submit an action plan, and HHSC may impose graduated contractual remedies, including liquidated damages.

The full range of contractual requirements for MCOs to promote VBP include:

- The establishment of MCO APM targets: Overall and risk-based APM contractual targets were established for MCO expenditures on VBP contracts with providers relative to all medical and pharmacy expenses. The targets start at 25 percent of provider payments in any type of APM and 10 percent of provider payments in risk-based APMs for calendar year 2018. These targets increase over four years up to 50 percent overall and 25 percent risk-based by calendar year 2021.
- Requirements for MCOs to establish and maintain data sharing processes with providers.

¹⁰ The <u>Triple Aim</u> is a framework developed by the Institute for Healthcare Improvement that describes an approach to optimizing health system performance by improving the patient experience, improving population health, and reducing costs. These dimensions are also reflected in the Centers for Medicare and Medicaid Services' <u>value-based programs</u> <u>quidance</u>.

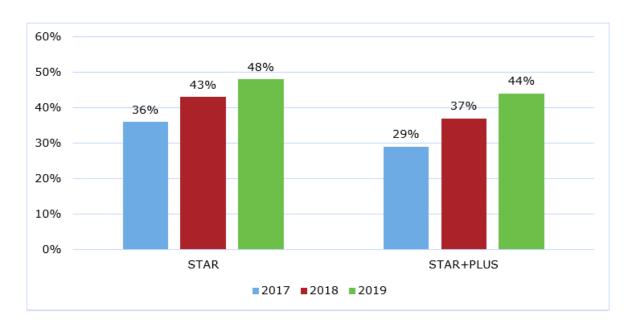
¹¹ LAN Framework available at: http://hcp-lan.org/workproducts/apm-framework-onepager.pdf

- Requirements for MCOs to adequately resource this activity: MCOs and DMOs must dedicate sufficient resources for provider outreach and negotiation, provide assistance with data and/or report interpretation, and initiate collaborative activities to support VBP and provider improvement.
- Requirements for MCOs to have a process in place to evaluate APM models:
 MCOs are required to evaluate the impact of APM models on utilization,
 quality, cost and return on investment.

HHSC collects reports on their APM initiatives on an annual basis. In general, most of the reported APM initiatives involve primary care providers, but MCOs also have reported APMs with specialists (including obstetricians/gynecologists), behavioral health providers, hospitals, nursing facilities, and long-term services and supports providers.

In 2018, the first target year for HHSC's Medicaid MCO APM targets, MCOs reported that 40 percent of their payments to providers were in an APM, with about 22 percent in a risk-based APM. For 2019, MCOs reported even higher achievement. As a whole, the Texas Medicaid programs performed at or above contractually required thresholds and national goals in 2018 and 2019 (Figure 5).

Figure 5. Overall APM Achievement by Program, CY 2017 - 2019



Performance Improvement Projects

The Balanced Budget Act of 1997 requires all States with Medicaid managed care to ensure MCOs conduct performance improvement projects (PIPs). 42 CFR 438.330 requires projects be designed to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical care and nonclinical care areas that have a favorable effect on health outcomes and enrollee satisfaction. Health plans conduct PIPs to examine and improve areas of service or care identified by HHSC in consultation with Texas's EQRO as needing improvement. Topics are selected based on health plan performance on quality measures and member surveys. HHSC requires each health plan to conduct two PIPs per program. One PIP per health plan must be a collaborative with another health plan, a DSRIP project, or a community-based organization.

Performance Indicator Dashboards

The Performance Indicator Dashboards include sets of measures per program that identify key aspects of performance to support MCO accountability. HHSC expects Medicaid and CHIP MCOs to meet or surpass the HHSC-defined minimum standard on more than two-thirds of the measures on the Performance Indicator Dashboard. The minimum standard is the program rate or the national average, whichever is lower, from two years prior to the measurement year.

Beginning with the measurement year 2018, an MCO whose per program performance is below the minimum standard on more than 33 percent of the measures on the dashboard is subject to remedies under the contract, such as placement on a corrective action plan (CAP). For more information, please see Chapter 10.1.14 of the Uniform Managed Care Manual. Calendar year 2018 Performance Indicator Dashboard results for STAR and STAR+PLUS are presented in Figures 6 and 7, below, and added detail for these and other programs is available on the Texas Healthcare Learning Collaborative (THLC) portal, which is discussed further below.

47

¹² https://hhs.texas.gov/sites/default/files/documents/laws-regulations/handbooks/umcm/10-1-14.pdf

Figure 6. STAR Performance Indicator Dashboard Results by MCO, CY 2018

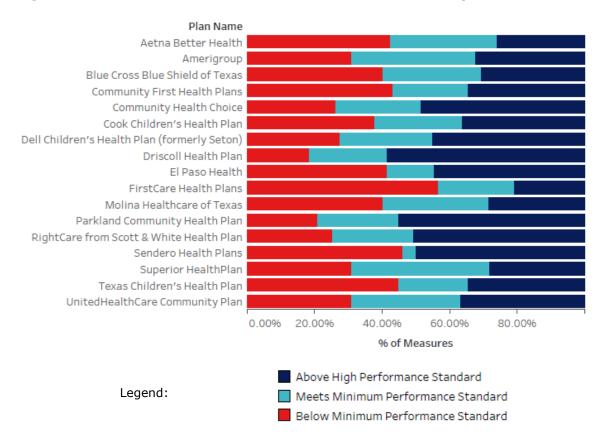
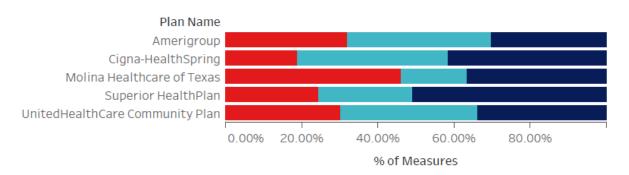


Figure 7. STAR+PLUS Performance Indicator Dashboard Results by MCO, CY 2018



The Performance Indicator Dashboard measure sets are comprised of HEDIS and CAHPS survey measures and vary per program. The Dashboard for STAR has over 60, and STAR+PLUS has over 50. For example, Figure 8, below, presents the performance for one STAR+PLUS MCO (Cigna HealthSpring) on each measure and sub-measure.

Figure 8. Example: STAR+PLUS MCO Performance, Cigna HealthSpring, CY 2018

2018 Performance Summary: HealthSpring

STAR+PLUS Program



Performance	Measure Description	Minimum Standard	High Standard	Plan Rate	Numerator	Denominator
Above High	CDC - HbA1c Control (<8%)	46.00	50.00	50.36	207	411
Performance	PQI - Diabetes Short-term Complications Admission Rate (PQI 1)	37.00	34.00	28.24	67	237240
Standard	PQI - Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI 5	166.00	157.00	134.58	3 206	153074
	PQI - Congestive Heart Failure (CHF) Admission Rate (PQI 8)	127.00	120.00	117.60	279	237240
	PQI - Bacterial Pneumonia Admission Rate (PQI 11)	50.00	47.00	46.79	111	237240
	PQI - Urinary Tract Infection Admission Rate (PQI 12)	40.00	37.00	29.51	. 70	237240
	PQI - Uncontrolled Diabetes Admission Rate (PQI 14)	20.00	18.00	14.75	35	237240
	PQI - Asthma in Younger Adults Admission Rate (PQI 15)	15.00	14.00	3.56	3	84166
	 PQI - Rate of Lower-extremity Amputation among Patients with Diabetes (PQI 16) 	15.00	14.00	13.49	32	237240
	PCE - Systemic Corticosteroids	68.00	72.00	73.50	513	698
	SPC - Total Adherence	56.00	61.00	63.48	372	586
	SPD - Received Statin Therapy	62.00	63.00	66.27	1377	2078
	PPE - Potentially Preventable Readmissions (PPR)	1.00	0.90	0.85	1024.8	1206.39
	SVY-Adult - % Good Access to Urgent Care	62.00	65.00	65.95		
	SVY-Adult - % Good Access to Specialist Appointment	54.00	55.00	60.96	3	
	SVY-Adult - % Good Access to Routine Care	56.00	61.00	61.91		
	SVY-Adult - % Good Access to Special Therapies	33.00	35.00	52.06		
	SVY-Adult - % Good Access to Behavioral Health Treatment or Counseling	52.00	54.00	56.85		
	SVY-Smoke - % Advised to Quit Smoking	39.00	48.00	49.41		
	PQI - Chronic PQI Composite Rate (PQI 92)	345.00	327.00	312.70	5 742	237240
	HVL-All Ages	67.00	70.00	71.10	155	218
	CDS - Non-HCBS Program Primary Home Care	2.50	2.60	4.31	28	650
Meets Minimum	AAB - Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	24.00	29.00	26.10	113	433
Performance	ABA - Adult BMI Assessment	80.00	86.00	85.40	351	411
Standard	AMM - Effective Acute Phase Treatment	47.00	52.00	50.54	375	742
	AMM - Effective Continuation Phase Treatment	33.00	36.00	33.42	248	742
	CCS - Cervical Cancer Screening	42.00	62.00	44.77	184	411
	CDC - Eye Exam	46.00	55.00	51.50	2059	3998
	MMA - Total Age 5 to 64 75% Covered	33.00	50.00	47.23	128	271
	PQI - Hypertension Admission Rate (PQI 7)	13.00	12.00	12.22	29	237240
	PCE - Bronchodilators	83.00	86.00	83.95	586	698
	SAA - 80% Coverage	57.00	61.00	60.02	764	1273
	SMD - Diabetes Monitoring for People with Diabetes and Schizophrenia	70.00	73.00	70.84		391
	SSD - Diabetes Screening	80.00	83.00	82.03		1853
	SPC - Total Statin Therapy	73.00	76.00	75.42		777
	SPD - Statin Adherence	53.00	60.00	59.40		1377
	PPE - Potentially Preventable Admissions (PPA)	1.00	0.95	0.96	1820.5	
	PPE - Potentially Preventable Emergency Department Visits (PPV)	1.00	0.90	1.00	4743.4	
	SVY-Adult - % Good Access to Service Coordination	52.00	54.00	52.74		47 23.43
	SVY-Adult - "% Rating Personal Doctor a "9" or "10""	66.00	69.00	67.79		
	SVY-Adult - % Rating Personal boctor a 9 or 10 " SVY-Adult - % Rating Their Health Plan a "9" or "10""	57.00	61.00	60.09		
	PQI - Diabetes PQI Composite Rate (PQI 93)	96.00	91.00	94.84		237240
		75.00	79.00	78.58		23/240
Relow Minimum	SVY-Adult - How Well Doctors Communicate Composite	90.00	92.00	89.92		3998
Below Minimum Performance Standard	- to the state of	87.00	87.00			411
	CDC - HbA1c Testing	44.00	57.00	86.37 39.77		176
	CHL-Total		84.00			
	PPC - Timeliness of Prenatal Care	63.00		55.05		109
	PPC - Postpartum Care	40.00	64.00	33.03		109
	AMR - Total 5 to 64 Ratios >= 50%	57.00	62.00	52.71		406
	PQI - Diabetes Long-term Complications Admission Rate (PQI 3)	44.00	42.00	45.95		237240
		78.00	82.00	69.77		43
	PPE - Potentially Preventable Complications (PPC)	1.00	0.90	1.04	145.16	
	CDS - HCBS Personal Attendant Services	6.40	6.70	3.25	1400	43057

Quality Assessment and Performance Improvement Programs

42 CFR 438.330 requires Medicaid MCOs to operate QAPI programs. These programs evaluate performance using objective quality standards, foster data-driven decision-making, and support programmatic improvements. MCOs report on their QAPI programs each year and these reports are evaluated by Texas's EQRO.

Hospital Quality-Based Payment Program

HHSC administers a Hospital Quality-Based Payment Program for all hospitals in Medicaid and CHIP in both the managed care and FFS delivery systems. Hospitals are measured on their performance for risk-adjusted rates of potentially preventable hospital readmissions within 15 days of discharge (PPR) and potentially preventable inpatient hospital complications (PPC) across all Medicaid and CHIP programs, as these measures have been determined to be reasonably within hospitals' ability to improve. Under the program, hospitals can experience reductions to their payments for inpatient stays of up to 2 percent for high rates of PPRs and 2.5 percent for PPCs. Measurement, reporting, and application of payment adjustments occur on an annual cycle.

Texas Healthcare Learning Collaborative Portal

The Texas Healthcare Learning Collaborative (THLC) portal is a secure web portal developed for use by HHSC and their Medicaid contractors to track performance data on key quality-of-care measures, including potentially preventable events (PPEs), Healthcare Effectiveness Data and Information Set (HEDIS) data, and other quality-of-care information. The data is interactive and can be queried to create more customized summaries of the quality results. Most of the data is available to the public with some additional information available to HHSC and MCO staff with a login.

Resources

- HHSC quality webpage:
 - https://hhs.texas.gov/about-hhs/process-improvement/medicaid-and-chipquality-and-efficiency-improvement
- Texas Healthcare Learning Collaborative Portal:
 - https://thlcportal.com

Appendix E. Public Notice

Texas Medicaid has sought to be timely in this reapplication request as our providers across Texas continue to face challenges daily. Federal approval of this extension of approximately ten years will stabilize our Medicaid delivery system during this Public Health Emergency and allow HHSC to collect data to accurately evaluate the waiver. Texas Medicaid remains committed to achieving the goals set forward and agreed to with the Centers for Medicare and Medicaid Services under our current Special Terms and Conditions (STCs).

Summary of Public Notice

Before submitting this extension application, Texas complied with the requirements in 42 C.F.R. § 431.408 for public notice and comment, including applicable tribal consultation requirements. On May 14, 2021, Texas Medicaid notified the federally-recognized tribes in Texas of the intent to submit an extension application and invited them to a call to discuss the extension. On May 18, 2021, a notice was issued through GovDelivery to more than 100,000 stakeholders, notifying them that Texas Medicaid would be again filing an extension application and holding public hearings to receive comments. On May 28, 2021, notice of the intent to file an extension application was published in the Texas Register, beginning the 30-day public comment period. The notice included a link to the application, which was posted that same day on the Texas HHSC website at https://hhs.texas.gov/laws-regulations/policies-rules/waivers/waiver-renewal. Also on May 28, 2021, an additional notice was issued through GovDelivery informing stakeholders that the documents were posted and available online. The documents were posted and available online.

The public notice included a comprehensive description of the 1115 Transformation Waiver and the extension. It included locations where the extension could be requested and reviewed by the public, the address where written comments could be submitted, and the locations, both physical and virtual, of the four public hearings where the State would be seeking public input on the extension application.

Given the current concerns regarding in-person meetings during the Public Health Emergency, two of the public hearings were held both in-person and virtually. The Medical Care Advisory Committee (MCAC) and Post Award Forum were held virtually only. The public was able to provide oral comments in all meetings and

submit written comments through June 28, 2021. Comments have been summarized to identify the issues raised during the public comment period and how the State considered the comments when developing the demonstration extension application for submission to CMS. (see Summary of Public Comment)

Location and times of Public Hearings

(1) 1115 Transformation Waiver: Extension Application Public Hearing In Person and Virtual Meeting June 2, 2021

10 a.m.

UT Southwestern Medical Center

T. Boone Pickens Building

6001 Forest Park Road, Dallas, TX 75235

(Located between Inwood Road and Mockingbird Lane, and between Maple Avenue and Harry Hines Boulevard)

(2) Medical Care Advisory Committee Virtual Only June 10, 2021 9 a.m.

(3) 1115 Transformation Waiver: Extension Application Public Hearing In Person and Virtual Meeting June 15 10 a.m.

Texas Health and Human Services Commission Brown-Heatly Building Public Hearing Room 4900 North Lamar Blvd., Austin Texas, 78751

(4) Post Award Forum for the 1115 Texas Healthcare Transformation Quality Improvement Program Waiver (THTQIP Waiver); Post Award Forum for the Healthy Texas Women 1115 Waiver (HTW); and Public Hearing on the THTQIP Waiver Extension Virtual Only June 21, 2021 1:00 p.m.

In addition to the hearings above, the extension was an agenda item and discussed at the following public meetings:

- State Medicaid Managed Care Advisory Committee on May 27, 2021
- Hospital Payment Advisory Committee on June 3, 2021
- The Health and Human Services Commission Executive Council on June 24, 2021

Texas Medicaid met with the federally-recognized tribes on June 16, 2021 and provided an overview of the extension. Comments have been summarized to identify the issues raised during the call and how the State considered the comments when developing the demonstration extension application for submission to CMS. (see Summary of Public Comment)

Post-award Public Input Process Required by 42 CFR §431.420(c)

Texas hosted a public forum via webinar on June 21, 2021 to provide updates on the THTQIP Waiver. The date, time, and location of the public forum was published on HHSC's website 30 days in advance of the meeting. During this public forum, an update was provided on the following Transformation waiver topics: Medicaid Managed Care, Health Information Technology (HIT) Strategic Plan, Delivery System Reform Incentive Payment program (DSRIP), Uncompensated Care, Evaluation, Waiver Amendments, the Annual Report, and the Extension Application. Links to the 1115 THTQIP DY9 annual report and COVID-19 resource pages were also provided. Public comment was received and documented at this meeting. A report of the issues raised by the public during the comment period and how the State considered the comments when developing the demonstration extension application are set forth below in the Summary of Public Comment section.

Summary of Public Comment

HHSC received oral public comments through the aforementioned public hearings, as well as over 1,000 written public comments through email and letter submissions; and comments were received from individuals as well as organizations and associations with signatory membership endorsing the comment submission. A summary of public comment and responses follows.

General Comments

<u>Comment:</u> Several commenters also noted the importance of the waiver to support health care providers in rural communities.

<u>Response:</u> HHSC agrees that the waiver is very important in supporting health care providers in rural communities. In recognition of this, HHSC has created the Rural Access to Primary and Preventive Services program, which is proposed to operate within the waiver. In addition, HHSC has made specific payment allocations under the Uncompensated Care program protocol for rural hospitals. HHSC continues to look for additional opportunities to support providers in rural communities.

<u>Comment:</u> Several commenters expressed urgency and support that the waiver be extended beyond September 30, 2022 and for Delivery System Reform Incentive Payment (DSRIP) program transition beyond September 30, 2021 to avoid the loss of significant dollars in healthcare and mental health support funding. One commenter acknowledged the importance of the public input process but expressed concerns with Centers for Medicare and Medicaid Services (CMS)' decision to rescind the January 15 extension approval; the commenter urges resolution of all issues raised by CMS because the "waiver's reversal may have detrimental impact on the Medicaid population."

<u>Response:</u> HHSC is cognizant of the urgent situation cited by the commenters. The September 30, 2021 requested approval date reflects this urgency. Several of the programs proposed in this waiver extension are intended to provide funding for providers previously supported by DSRIP. Additionally, HHSC is currently in discussions with CMS for approval of a Directed Payment Program for Behavioral Health Services, a program that seeks to continue behavioral health innovation, maintain access to services provided under DSRIP, and sustain funding.

<u>Comment:</u> Several commenters identified a concern that the extension application request is for a 10-year extension period, given the complexity of the method of finance, proposed DSRIP transition to the Public Health Provider Charity Care Pool (PHP-CCP) program, and the "urgent need for coverage expansion." While expressing general support for the extension application, these commenters did not support the request for a 10-year extension period.

<u>Response:</u> HHSC considered these comments but is requesting an extension of approximately 10 years in order to secure stability and funding for Texas safety net systems. Terms previously negotiated included resizing activities in order to take into account the longer approval period.

Behavioral Health Comments

<u>Comment:</u> Several commenters expressed that urgent action is needed to preserve access to safety net behavioral health services (i.e., mental health and substance use services), necessitating approval of the extension by October 1, 2021. The current waiver is set to expire on September 30, 2021; the resulting loss of hundreds of millions of dollars to local health departments and local mental health authorities for critical behavioral health services puts Texas' behavioral health safety net in jeopardy. Commenters strongly urged having the extension application effective starting on October 1, 2021 to ensure access to behavioral health services.

A commenter cited that almost one third of community center (including local mental health authorities) funds supporting mental health expenditures are federal funds accessed through Texas' 1115 waiver, which is a critical funding mechanism for the community behavioral health system in Texas, especially as providers anticipate an increased behavioral health need resulting from the COVID-19 pandemic.

<u>Response:</u> HHSC maintains a commitment to behavioral health services in the proposed extension application through its request for approval by September 30, 2021 and the creation of the PHP-CCP program and the Directed Payment Program for Behavioral Health Services.

Comprehensive Healthcare Coverage Comments

<u>Comment:</u> Several commenters that generally supported the extension application also raised concerns about Medicaid eligibility, the numbers of underinsured and uninsured Texans, and how to address the uninsured. These commenters stated that the extension application does not seem primarily focused on improving health or access to care and recommended an expansion of current Texas Medicaid eligibility across various populations.

These commenters supported comprehensive coverage for low wage working Texans and their families stating, "uncompensated care funding is not a substitute for healthcare coverage and comprehensive healthcare for low-age Texans" to include preventive, primary, specialty care, prescription drug, dental, and chronic disease management services. In addition, several commenters pointed out that uninsured Texans may also be working as part of the healthcare workforce (i.e., community attendants).

Several commenters also noted that Texas is one of several States that excludes certain "lawfully present" immigrants and "qualified alien" adults from Medicaid.

<u>Response:</u> Decisions related to Medicaid eligibility expansion are statutorily confined to the Texas Legislature, and HHSC has included in this extension application all statutorily permissible populations.

HHSC recognizes that providers serving the uninsured, in addition to Medicaid clients, are critical to the safety-net and sustained access to services for Medicaid clients that are included under this waiver. HHSC seeks with this application to continue the existing Uncompensated Care program and to create the PHP-CCP program.

Budget Neutrality Comments

Comment: Several commenters acknowledged that an inadequate budget neutrality determination may significantly reduce the overall available funding for Texas' proposed waiver extension period therefore hindering the ability to maintain current Medicaid programs and services for the uninsured as well as payment programs to offset costs providers incur for treating underinsured and uninsured individuals. Commenters supported the proposed budget neutrality "room" submitted by HHSC in January 2021 as a "floor" of base funding to avoid the fiscal cliff for providers should an extension not be provided. One commenter expressed that anything short of the previously determined budget neutrality room could hinder the State's ability to transition the Delivery System Reform Incentive Payment program, scheduled to terminate September 30, 2021.

Response: HHSC agrees with the commenters that the waiver extension must provide adequate budget neutrality room, and in its extension application, HHSC is requesting appropriate funding for approximately 10 years. The extension application request maintains the January 2021 budget neutrality "floor" to maintain funding for services and providers for the waiver extension period. The terms previously negotiated took into consideration an approximately 10-year approval and included two rebasing exercises, resizing activities, and specified roll-over years in order to provide guidance and stability for the Texas Medicaid program.

PHP-CCP Comments

<u>Comment:</u> Several commenters supported the proposed extension application to transition the DSRIP program into the new PHP-CCP program designed to help local

health departments and mental health authorities pay for free care to the uninsured. In addition, commenters expressed support for expedited approval of the waiver extension so that the PHP-CCP program can begin operating on October 1, 2021, as requested by HHSC.

<u>Response:</u> HHSC appreciates these comments and acknowledges that the extension application will transition a portion of waiver funding from the DSRIP Program into the new PHP-CCP program.

Directed Payment Program Comments

<u>Comment:</u> A commenter supported the transition of the DSRIP program into the DPPs and recommended continuation of the DSRIP best practices into the DPPs in development to ensure that interests of children are included through pediatric innovation. Another commenter stated that the DSRIP transition to DPPs allows for maintaining predictable, sustainable funding and access to federal funding which is important to the planning and continuation of healthcare programs and access to care in Texas. One commenter noted that the proposed rate enhancements through DPPs do not benefit uninsured Texans, but the proposed funding will help Texas to mitigate the abrupt loss of DSRIP funding in fiscal year 2022.

<u>Response</u>: HHSC appreciates these comments and acknowledges that the extension application includes the proposed DPPs. HHSC is currently in discussions with CMS regarding approval of the proposed DPPs with the goal of continuing lessons learned from DSRIP.

<u>Comment:</u> A commenter expressed concern about the distribution of funding across the healthcare safety net resulting from the programs included in the extension application and recommended rebalancing the investment in DPPs to equitably support the continuum of Medicaid healthcare providers.

<u>Response</u>: HHSC is currently in discussions with CMS regarding the approval of the proposed DPPs for state fiscal year 2022. The proposed DPPs benefit a range of provider types and services.

Uncompensated Care Pool Comments

<u>Comment:</u> Several commenters expressed the continued need for funding for the existing hospital uncompensated care (UC) pool because Texas providers continue to incur UC costs. These commenters pointed out that even under an option for Medicaid expansion which is not considered in this extension application, a

significant number of Texans would still rely on indigent care services for which UC funding offsets part of the cost. A consideration to limit or eliminate UC pool would reduce patient's access to care and the safety net providers required by the Emergency Medical Treatment and Labor Act to provider emergency care for anyone seeking it, regardless of their ability to pay. The UC pool is just one critical funding component for safety net providers. One commenter stated the UC pool is critical to maintaining Texas' healthcare system. These commenters supported the ongoing request for the UC pool in the extension application.

A commenter expressed through the COVID-19 pandemic Texas hospitals rose to meet challenging circumstances, ensuring hundreds of thousands of seriously ill Texans received the hospital care regardless of insurance status or ability to pay. Without the stability afforded by the waiver, hospitals might not have been able to withstand the financial impact of the pandemic. The waiver is critical to ensure the strength of Texas' healthcare safety net for all 29 million Texans.

<u>Response:</u> HHSC recognizes the need for continuation of the uncompensated care pool to reimburse for charity care costs in hospital and other settings as a mechanism to maintain the safety net system. Therefore, no changes to the UC pool have been made to this extension application. HHSC is also proposing the PHP-CCP to reimburse for charity care mental health and public health service costs.

Health Disparities Comments

<u>Comment:</u> A commenter recommended addressing social determinants of health (SDOH) in the extension application through defining a statewide SDOH approach as recommended by the Center for Health Care Strategies; incentivizing managed care organizations to address SDOH including food insecurity; and exploring quality measures for the DPPs that encourage addressing social factors to support a statewide approach.

Response: SDOH is a focus area of the DSRIP Transition Plan. HHSC incorporated one SDOH measure into the Texas Incentives for Physician and Professional Services (TIPPS) program, the DPP for physician groups. HHSC does not see a need to amend the extension application at this time but continues to explore options for policies and programmatic changes that could address SDOH and improve health outcomes for individuals affected by SDOH.

<u>Comment:</u> Several commenters cited concerns regarding health disparities to include: "three in four Texans in the coverage gap are people of color"; "healthcare coverage is essential for improving racial equity;" that without access to high

quality affordable healthcare "kids don't learn, mothers die following childbirth & workers are absent from their jobs;" and issues facing the uninsured "disproportionality affect immigrants."

Another commenter noted that "the pandemic has laid bare the health inequities that exist in our State. A person's chance at a long, healthy life should not depend on their occupation, their zip code, or their income."

Response: HHSC works to ensure all Texans who are eligible have equal access to the services and programs we provide. HHSC recently contracted with researchers to assess social factors impacting healthcare quality in Texas Medicaid. The assessment was required as part of the DSRIP program Transition Plan. The report, as well as the original study and study addendum were submitted to the Centers for Medicare and Medicaid Services in March 2021. Overall, the assessment results show that to better understand outcomes on key Medicaid healthcare quality measures, it's important to consider the social context in which Texas Medicaid managed care members live. HHSC is evaluating next steps to address social determinants of health in the Medicaid program.

Other Comments

<u>Comment:</u> Several commenters recommended the extension application focus on a more functional Home and Community Base Services (HCBS)/Long Term Services and Supports (LTSS) system through recruitment and retention of HCBS/Community Attendants; increasing Community Attendant wages; a project to ensure network adequacy HCBS/Community services; a project to increase selection of the existing Consumer Directed Services (CDS) option; and projects focusing on ongoing diversion/relocation to HCBS/Community services. Commenters expressed concerns that individuals in need of HCBS receive those services without being placed on waiting lists.

In addition, several commenters requested utilizing the proposed budget neutrality to fund a community care quality incentive payment program for HCBS providers.

<u>Response</u>: In response to this comment, HHSC will begin reporting timeliness for community attendant care services in the quarterly waiver report for the proposed extension time period once data is available for the corresponding reporting period.

Currently, HHSC tracks use of CDS in certain programs and reports rates on the Texas Healthcare Learning Collaborative Portal (thlcportal.com). In addition to monitoring network adequacy performance of the MCOs related to primary and

specialty care, HHSC continues to enhance efforts to monitor long-term services and supports, in particular, community attendant care. As part of the implementation of the Community Attendant Workforce Development Strategic Plan required by the 2020-21 General Appropriations Act, House Bill 1, 86th Legislature, Regular Session, 2019 (Article II, Health and Human Services Commission [HHSC], Rider 157)[1], HHSC is enhancing provider network adequacy standards for Medicaid MCOs to ensure members have sufficient access to community care attendants. Managed care contracts have been updated to clarify that MCOs must ensure timely access to community attendant care services upon authorization of services.

HHSC believes additional changes to the waiver application are not needed because HHSC is monitoring the attendant workforce through the Community Attendant Workforce Development Strategic Plan and implementing state legislation to improve the interest list process.

These initiatives combined will help further HHSC's stated objectives related to ensuring people are allowed to live in the community, in the least restrictive setting possible.

<u>Comment:</u> A commenter urges CMS approval no later than September 1, 2021 of the amendment to the THTQIP waiver that HHSC submitted to CMS on February 22, 2021. This amendment would provide benefits to medically fragile adults whose needs exceed existing cost limits.

<u>Response</u>: HHSC appreciates the comment and looks forward to working with CMS regarding approval of the proposed amendment.

<u>Comment</u>: A commenter recommended adding a quality measure for HIV Viral Load Suppression as it signifies that a patient has reached the goal of HIV treatment, which is viral suppression. Since Medicaid uses quality measures to assess care quality, assign provider accountability, and support performance improvement, add a measure would allow tracking and reporting on HIV.

Response: HHSC does track and report the viral load suppression core measure. Data on this measure can be found on the Texas Healthcare Learning Collaborative Portal (thlcportal.com) and in our "Annual Report on Quality Measures and Value Based Payments" https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2020/hb-1629-quality-measures-value-based-payments-dec-2020.pdf. Given the foregoing, HHSC does not believe that a change to the waiver application is needed.