The seal of the State of Texas is partially visible on the left side of the page, featuring a five-pointed star surrounded by a wreath and the words "THE STATE OF TEXAS".

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

**Texas Healthcare Transformation
and Quality Improvement
Program**

Project #11-W-00278/6

**Texas Health and Human
Services Commission**

May 2021



TEXAS
Health and Human
Services

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Appendix A. Historical Summary

Waiver 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 funding pools, including uncompensated care and delivery system reform incentives, supported by managed care savings. The waiver was designed to build on existing Texas health care reforms and to redesign health care 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 health care.

CMS initially approved the Texas Healthcare Transformation and Quality Improvement Program 1115 waiver (the 1115 Transformation Waiver or the THQIP 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, 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 rescinding the approval of the waiver extension. CMS stated in the letter that it erred in waiving certain state and federal notice requirements. The letter also offered the state the opportunity to resubmit an extension application.

Texas hereby re-submits to CMS an extension application with the same terms and conditions as agreed to between CMS and Texas and as approved by CMS effective January 15, 2021.

Through the 1115 Transformation Waiver, the State expanded its use of Medicaid managed care to achieve program savings, while also preserving locally funded

supplemental payments to hospitals under two funding pools. Through this Demonstration, the State has aimed to:

- Expand risk-based managed care statewide;
- Support the development and maintenance of a coordinated care delivery system;
- Improve outcomes while containing cost growth; 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 determined and renewed by Secretary Xavier Becerra on April 15, 2021, have been a shock to the system, making clear how essential extension of the project is. Responding to the emergency itself has put significant pressures on HHSC, its managed care organizations, and their networks of providers. Moreover, the significant changes in demand for healthcare services have complicated data collection to assess the effectiveness of the Demonstration under the terms approved by CMS. To reduce uncertainty for our health care systems and to ensure that the results reported to CMS accurately reflect the status of the Demonstration, HHSC requests an extension of the waiver.

Waiver Approval: 2011 – 2022

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 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 managed care organization. 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. 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 managed care organization. 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 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 health care services. Chief among these is the state's 1115 Healthcare Transformation and Quality Improvement Program Waiver, which includes incentive payments to hospitals and other providers for strategies to enhance access to health care, 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 (federal funds matched with intergovernmental transfer funds).

The DSRIP program structure, beginning in 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 health care 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 Models (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.

Waiver Extension

As CMS has offered the state the opportunity to resubmit an extension application, Texas Medicaid respectfully requests that CMS extend the Transformation waiver under the terms and conditions previously approved by CMS on January 15, 2021 (The January 15, 2021-approved STCs are the proposed STCs included in this application).

Texas would also like to call attention to the Public Health Emergency arising from the impact of COVID-19 which has significantly impacted Texas' health care 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 reduced 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 and Medicaid managed care expenditures will adjust to promote access to care and provide incentives that drive value.

The extension request notes that the DSRIP pool is eliminated and describes Texas's plans for new directed payment programs. 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 are described in the preprints corresponding to each program submitted to CMS for approval. The extension request includes a request to create a Public Health Provider-Charity Care Program. The program is proposed to begin on October 1, 2021, as a part of DSRIP transition. The program is designed to defray 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 clinics (CMHCs), local behavioral health authorities (LBHAs), and local mental health authorities (LMHAs), local health departments (LHDs), and public health districts (PHDs).

The extension request includes a reassessment of the charity care pools. Year 3 of the PHP-CCP will be resized based upon actual charity care cost data from Year 2. The Uncompensated Charity 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 uncompensated care pool based on actual charity care.

The extension request includes new, standardized adjustments previously noted 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 reflects the changes previously agreed to by CMS and Texas. A central feature Texas sought was stability through budget certainty for our health care systems across Texas in the midst and throughout the ongoing public health emergency. Through a collaborative process, a waiver agreement was reached between CMS and

Texas that set into motion a successful DSRIP transition and accountability. Texas seeks to maintain this agreement and will work with CMS to solidify the timelines, which have been paused or delayed. Other changes, including technical or naming updates, may be included in the negotiations.

Amendments

Texas Medicaid is on the precipice of including Nonemergency Medical Transportation (NEMT) in the array of services provided by MCOs to their members under the 1115 waiver. 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 no longer operating NEMT through managed transportation organizations under a state plan transportation broker model to MCOs under the 1115 waiver authority. This effort will improve outcomes and support a coordinated delivery system by making the same MCOs responsible for arranging health care services also responsible for arranging the NEMT some members require to access healthcare services.

HHSC is also 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.

Proposed Changes 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) for people with intellectual and developmental disabilities (IDD), traumatic brain injury that occurred after age 21, or people with similar functional needs as a person with IDD through a capitated managed care model.

The STAR+PLUS Pilot Program is expected to further goals and objectives of the demonstration to expand risk based managed care to new populations as it will be offering home and community-based services to individuals with traumatic brain injury that currently could not qualify for a home and community-based waiver program. Additionally, this new program will also create and support a more coordinated care delivery system by having MCOs who currently provide acute care services for people with intellectual and developmental disabilities to also provide the long-term services and supports 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 program. HHSC plans to submit an amendment to the 1115 Transformation waiver clarifying the coverage of certain early and periodic screening, diagnostic, and treatment (EPSDT) services for children and youth with a diagnosis of autism spectrum disorder (ASD).

Health Care Delivery System, Eligibility Requirements, Benefit Coverage and Cost Sharing

Texas currently operates four of its Medicaid managed care programs under the demonstration: STAR+PLUS (including STAR+PLUS Home and Community Based Services waiver), STAR, STAR Kids, and its children's dental services managed care 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, and MCOs provide services on a case-by-case and through value added services. MCOs also provide service management or service coordination to ensure individuals have their care coordinated to the level of their need.

The state is not requesting changes to the DSRIP program; the funding and authorization expire October 1, 2021. The state continues to develop new proposals under the approved DSRIP Transition Plan and submit required deliverables.¹

¹ In October 2020, HHSC separately requested an extension of the DSRIP program authorization and funding for the final demonstration year of the current waiver in order to minimize the disruption to the healthcare system occurring as a result of COVID-19 and the timing of the planned DSRIP Transition. While the requested extension is pending a response from CMS, the

Uncompensated Care (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 by 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. 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 Medicaid and CMS discussed DSRIP transition and contemplated the following directed payment programs in the approved January 15, 2021, STCs. These are designed to improve the delivery system of Medicaid managed care.

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 SFY 2022: \$5,020,000,000

state continues to develop new proposals under the approved DSRIP Transition Plan and submit required deliverables.

- 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 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 health care 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.

The extension will not change the array of benefits provided under the 1115 waiver authority. The extension does not make any changes to eligibility requirements. Extending the waiver will not have a significant impact on enrollment. Under the extension there will continue to be no beneficiary cost sharing.

The state is not requesting changes to the existing health care 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.

Managed Care Overview

Texas currently operates four of its Medicaid managed care programs under the demonstration: STAR+PLUS (including STAR+PLUS Home and Community Based Services waiver), STAR, STAR Kids, and its children's dental services managed care program. Under these programs individuals receive the full array of state plan services (including EPSDT for those under 21), in STAR+PLUS the HCBS waiver service array is offered, and MCOs provide services on a case-by-case and through value added services. MCOs also provide service management or service coordination to ensure individuals have their care coordinated to the level of their need, this includes coordination with non-capitated services that exist outside of this section 1115 demonstration. Individuals who are members of federally recognized tribes in Texas are voluntary to enroll in our managed care programs and can opt to remain in fee-for-service Medicaid. There is no cost sharing in any of these programs and that will remain the same through the demonstration extension period.

HHSC plans to continue these managed care programs and services through the demonstration extension period.

Managed Care Eligibility and Enrollment Requirements

STAR+PLUS.

STAR+PLUS provides acute and long-term service and supports to older adults and adults with disabilities, including individuals with breast and cervical cancer. Also, the STAR+PLUS program includes adults 21 and older who reside in an intermediate care facility for individuals with an intellectual or developmental disability (ICF/IID) or receiving 1915(c) waiver services (Home and Community-based Services (HCS), Texas Home Living (TxHmL), Community Living and Support Services (CLASS), or Deaf Blind with Multiple Disabilities (DBMD)) who do not have Medicare. 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.

STAR+PLUS provides acute and long-term service and supports to older adults and adults with disabilities. The STAR+PLUS HCBS Program provides long-term services and supports to two groups of people, as defined below:

- 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 LTC services.

- Medical and/or functional needs are assessed according to level of care (LOC) criteria published by the State 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

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

STAR Kids

The STAR Kids program provides a continuum of services, including acute care, behavioral health, state plan long-term services and supports, 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.

1. 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 long term services and supports (LTSS) through STAR Kids.
2. 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.
3. Children receiving HCBS through the following 1915(c) waivers -- CLASS, DBMD, HCS, TxHmL, and YES:
 - ▶ Children enrolled in CLASS, DBMD, HCS and TxHmL receive their 1915(c) LTSS and 1915(k) (Community First Choice) 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) services, as well as all acute care services through STAR Kids.

4. Children receiving SSI and disability-related (including SSI-related) Medicaid who reside in a community-based intermediate care facility for individuals with intellectual disabilities or a nursing facility: clients will continue to receive all long-term services and supports 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 dental maintenance organizations (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 Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions (ICF/ID); and STAR Health Program recipients.

Managed Care Benefits

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.

STAR+PLUS HCBS Program

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 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.

Appendix B. Budget

This request includes the rebasing previously approved by CMS in the January 15, 2021 version of the waiver. 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 Per member per month (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 FFY12-22, with waiver Per Member Per Month (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 in FFY 2022. These continue funding for current DPPs, launch new DPPs, and incorporate innovations from DSRIP into Medicaid managed care. Pending Applications include over \$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 directed-payment program 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 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 12% since the PHE began. Annual growth of 10% 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.

1115 MEG Total Member Months, DY06-DY19

	DY 06 (FFY 17)	DY 07 (FFY 18)	DY 08 (FFY 19)	DY 09 (FFY 20)	DY 10 (FFY 21)	DY 11 (FFY 22)
Aged and Medicare Related	4,260,091	4,260,293	4,254,228	4,295,619	4,316,342	4,348,666
Blind and Disabled	5,042,514	4,990,061	4,898,834	4,911,242	5,211,975	5,151,745
Adults	3,423,661	3,416,287	3,274,638	3,670,408	4,086,896	3,366,107
Children	31,460,800	31,614,307	30,691,208	32,018,364	35,249,138	32,945,528

	DY 12 (FFY 23)	DY 13 (FFY 24)	DY 14 (FFY 25)	DY 15 (FFY 26)	DY 16 (FFY 27)	
Aged and Medicare Related	4,421,112	4,507,470	4,616,355	4,698,756	4,782,628	
Blind and Disabled	5,114,843	5,130,933	5,220,264	5,304,033	5,389,146	
Adults	3,323,019	3,364,809	3,411,887	3,455,563	3,499,799	
Children	31,807,744	32,053,486	32,494,047	32,939,929	33,391,930	
	DY 17 (FFY 28)	DY 18 (FFY 29)	DY 19 (FFY 30)			
Aged and Medicare Related	4,867,996	4,954,889	5,043,332			
Blind and Disabled	5,475,625	5,563,492	5,652,768			
Adults	3,544,600	3,589,976	3,635,932			
Children	33,850,133	34,314,623	34,785,487			

Based on actual data through July 2020, projected member months thereafter.

Appendix C. Interim Evaluation

The overarching objectives of the THTQIP demonstration 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 December 2017 CMS-approved 1115 evaluation design examines these objectives through the three components of the THTQIP demonstration (DSRIP, UC Pool, Medicaid Managed Care (MMC) expansion), as well as the overall impact of the THTQIP demonstration (as measured by quality-based payment systems in Texas Medicaid and transformation of the health care system for the Medicaid/low-income population in Texas). In December 2020, HHSC's external evaluator submitted preliminary interim evaluation findings to CMS. The official interim evaluation report is still on schedule to be submitted to CMS by September 30, 2021; the evaluation design² includes 5 evaluation questions and 13 hypotheses.

Texas will develop a new evaluation design for the extension period (see "Planned Evaluation Activities During THTQIP Extension" below). The new evaluation design will continue to assess whether Texas is achieving the goals and objectives of the THTQIP demonstration, and will adopt revised research questions, hypotheses, and measures focused on recent or future changes to the THTQIP demonstration waiver. These changes include the expiration of DSRIP; the addition of new directed payment programs (DPPs); additions or revisions to supplemental payment programs, and; recent or forthcoming changes in services or benefits provided to MMC populations.

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. The next

² 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>.

scheduled evaluation deliverable is the interim evaluation report, which is on schedule to be submitted to CMS by September 30, 2021.

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 Draft Results* (Supplement A) provides the full summary of preliminary findings provided by the external evaluator. Preliminary findings are still in draft form and are only provided for the purposes of this application.

Evaluation Question 1: Did the DSRIP program incentivize changes to transform the health care system for the 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 (A2-509) and primary care prevention (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 health care 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 renewal study populations, 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 health care system for the MLIU population in Texas?

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

Planned Evaluation Activities During THTQIP Extension

HHSC will continue to fulfill federal evaluation monitoring and reporting requirements during the THTQIP extension. HHSC will develop a new evaluation design for the approximate 10-year extension period. HHSC plans to incorporate the following updates into the evaluation design to reflect recent or future changes to the THTQIP demonstration waiver:

- Replace the DSRIP component of the evaluation with a component on the new Directed Payment Programs (DPPs), including evaluation questions assessing how the DPPs support providers' transition from DSRIP;
- Broaden the focus of the MMC component of the evaluation to incorporate evaluation questions on overall MMC performance over time;
- Incorporate evaluation questions on the new PHP-CCP, including questions assessing the intersection between the existing UC pool and PHP-CCP; and,
- Incorporate additional evaluation questions assessing cost outcomes for the demonstration as a whole.

Texas requests the following timeline for 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.

Resources

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>.

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,
- 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 external quality review organization (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-gei/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

- Conducting regular NCI-CFS surveys with STAR Kids caregivers;
- Conducting additional studies with the STAR Kids-Screening and Assessment Instrument (SK-SAI) and Individual Service Plan (ISP);
- Conducting 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 SB 1207, 86th Legislature, 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 health care; 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 performance improvement project (PIP) focused on members with complex behavioral health conditions. In 2020, PIPs focus on improving integration of behavioral health and physical health care, with the goal of reducing hospitalization.

To improve vaccination rates, HHSC has added immunizations for adolescents (IMA) 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/dental maintenance organization 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.³

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.⁴

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

Figure 1: STAR Adult Report Card, Bexar Service Area

³ <https://www.medicaid.gov/medicaid/quality-of-care/quality-of-care-performance-measurement/adult-and-child-health-care-quality-measures/index.html>

⁴ <https://hhs.texas.gov/services/health/medicaid-chip/programs/managed-care-report-cards>

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.

★★★★★ Highest Performance in STAR
★★★★
★★★
★★
★ Lowest Performance in STAR

	Aetna Better Health	Amerigroup	Community First Health Plans	Superior HealthPlan
Overall Health Plan Quality	★★	★	★★★★	★★★★★
Experience with Doctors and the Health Plan	★★	★	★★★★	★★★★★
People get the care they need without problems or long waits	★★★★	No rating [†]	★★★★	★★★★
Doctors listen carefully, explain clearly and spend enough time with people	★★★★	No rating [†]	★★★★	★★★★
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 constant low mood	★★★★★	No rating [†]	★★	★★★★
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

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.

★★★★★ Highest Performance in STAR Kids
★★★★
★★★
★★
★ Lowest Performance in STAR Kids

	Amerigroup	Texas Children's Health Plan	UnitedHealthcare Community Plan
Overall Health Plan Quality	★★	★★★★★	★★★★★
Getting Care	★★★★	★★★★★	★★★★★
People get the care they need without problems or long waits	★★★★	★★★★	★★★★
People get medical equipment, special therapy and behavioral counseling easily	★★★★	★★★★	★★★★★
People get regular checkups	★★	★★★★	★★
Services and Support	★★	★★★★★	★★★★★
Doctors understand how health conditions affect day-to-day life	★★★★	★★★★	★★★★
People get help arranging or coordinating care	★★★★	★★★★★	★★★★★
Doctors discuss eventual transition to adult care for adolescents	★★★★	★★★★★	★★★★
People give high ratings to the health plan	★	★★★★★	★★★★
Common Chronic Conditions	★★	★★	★★★★
Doctors follow up after urgent treatment for alcohol, opioid or other drug use	★★	★	★★★★★
Doctors follow up after urgent treatment for mental illness	★	★★	★
Prudent use of antipsychotics in managing mental illness	★★	★★★★	★★★★★

* 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.



Network Adequacy

SB 760, 84th Legislature, Regular Session, 2015 directed HHSC to establish and implement a process for direct monitoring of a 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 and accepted practice parameters.

Network adequacy initiatives 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, 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 health care 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.

Another key initiative to improve Medicaid and CHIP quality of care is the medical P4Q program. Under medical P4Q, 3 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 8 percent in CHIP. In addition, rates for six or more well child visits in the first 15 months increased by 4 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 is subject to recoupment. Table 1 shows the actual dollars earned or lost by each MCO. Figure 3 presents MCO performance against benchmarks and against self on STAR P4Q measures.

Table 1: STAR Capitation Earned/Recouped by MCOⁱ

MCO	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
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

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

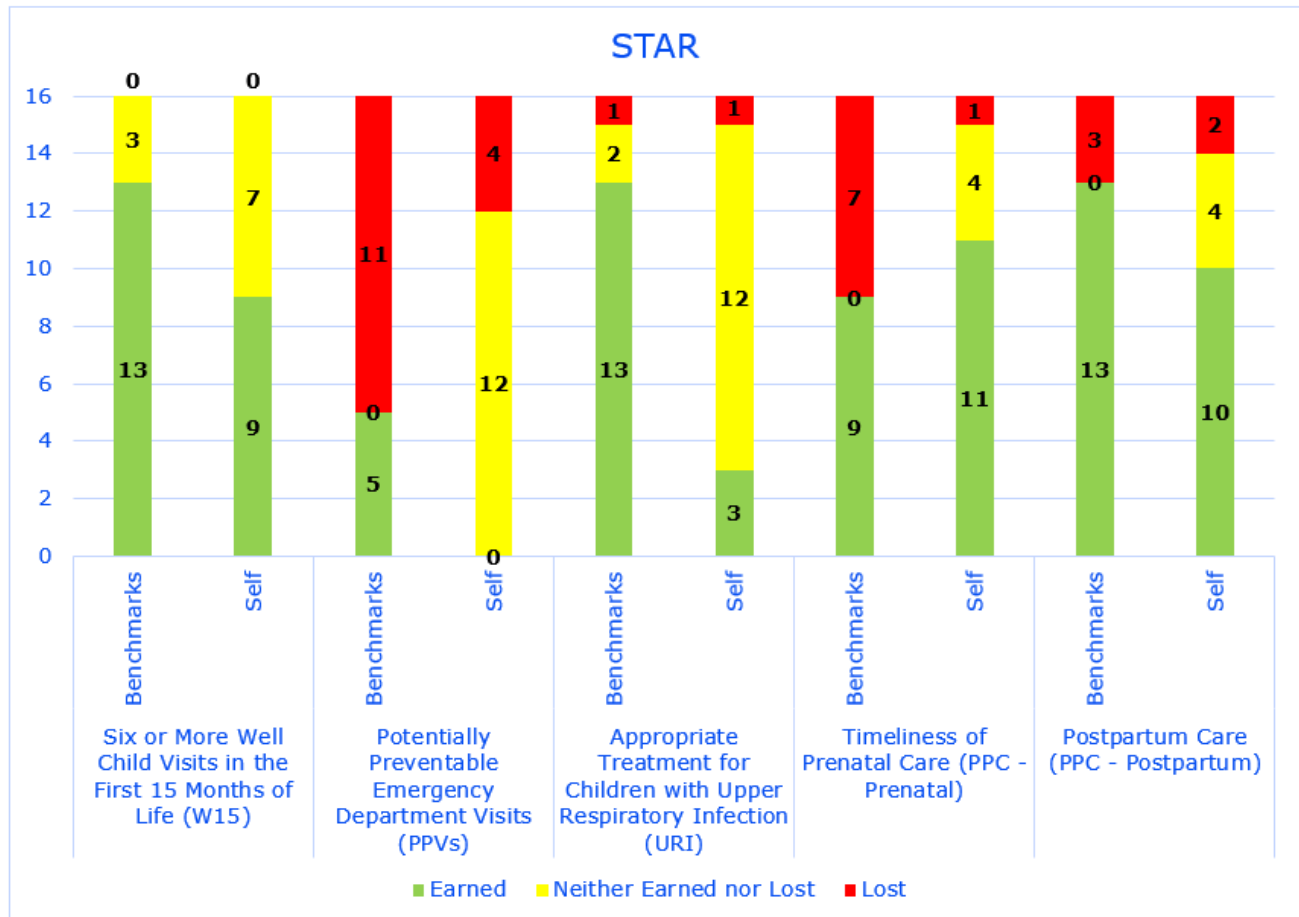
- *Well Child Visits in the First 15 Months of Life (W15)* - STAR MCOs generally performed well on ensuring infants receive the recommended number of well child visits, with more than half the MCOs earning money and no MCOs subject to

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.
- *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, FirstCare⁵, Molina, and United). No MCO achieved the five or more percent improvement required to earn capitation on performance against self.

⁵ This may not reflect FirstCare's true performance due to their encounter data errors.

Figure 3: STAR MCO Performance by Measure



STAR+PLUS

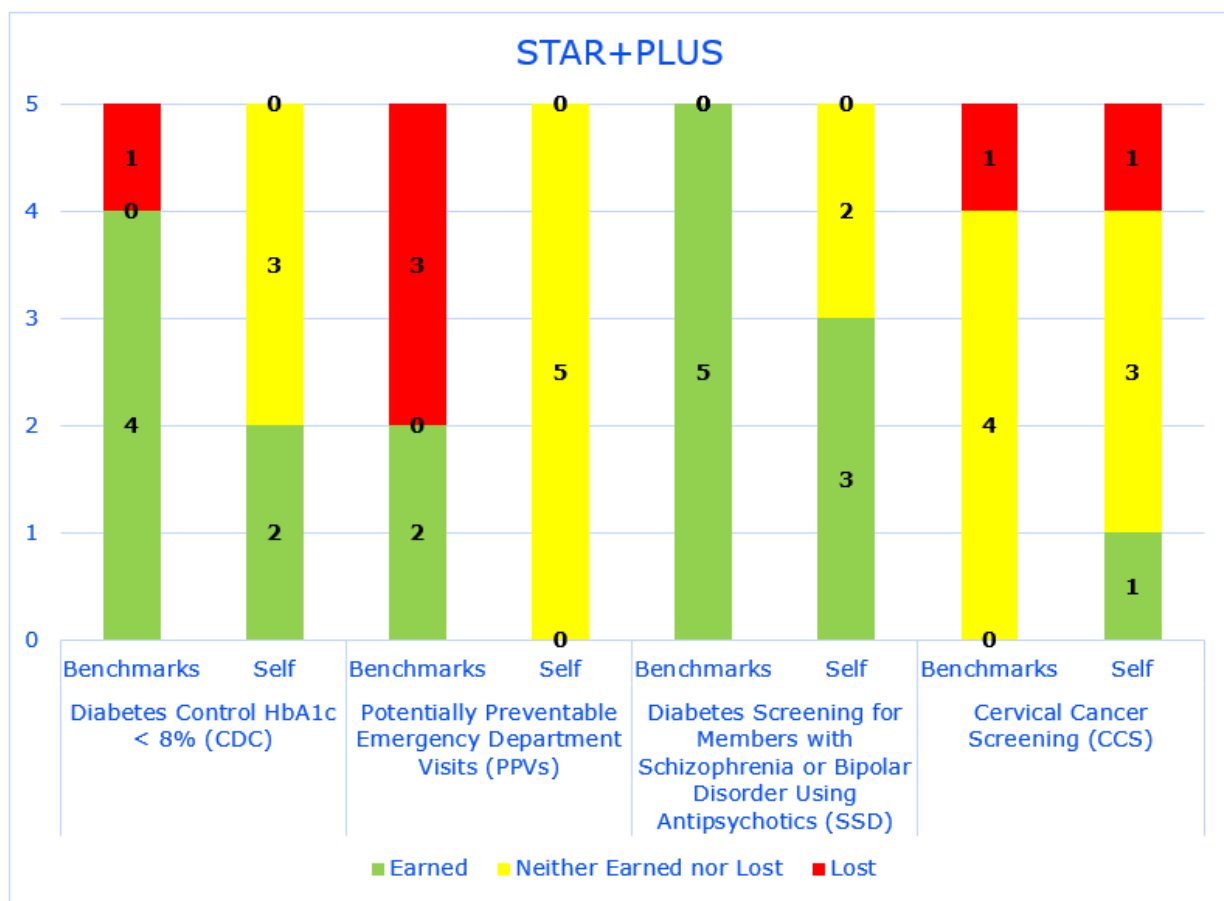
In STAR+PLUS, none of the five MCOs are subject to recoupment and no money is available to redistribute. Table 2 shows the actual dollars earned by each MCO. Figure 4 presents MCO performance against benchmarks and against self on STAR+PLUS P4Q measures. While MCOs may have lost capitation on one or 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 MCOⁱⁱ

MCO	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

- *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.

The medical P4Q program serves as a catalyst for MCOs to pursue value-based payment (VBP) arrangements with providers to achieve required P4Q outcomes. The state uses the [Healthcare Payment Learning and Action Network \(HCP LAN\)](#)

[Alternative Payment Model \(APM\) Framework](#)⁶ to guide this effort. APMs incentivize high-quality and cost-efficient care by linking healthcare payments to measures of value. The LAN provides a menu of payment models from which MCOs can choose to develop APM contracts with their providers.

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 autoenrollment method uses metrics aligned with the Triple Aim to promote value-based healthcare that achieves better care at lower costs.⁷

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 \(APM\) Framework](#)⁸ 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, HHS 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

⁶ LAN Framework available at: <http://hcp-lan.org/workproducts/apm-framework-onepager.pdf>

⁷ The [Triple Aim](#) 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' [value-based programs guidance](#).

⁸ LAN Framework available at: <http://hcp-lan.org/workproducts/apm-framework-onepager.pdf>

performing plans, the MCO must submit an action plan, and HHSC may impose graduated contractual remedies, including liquidated damages.

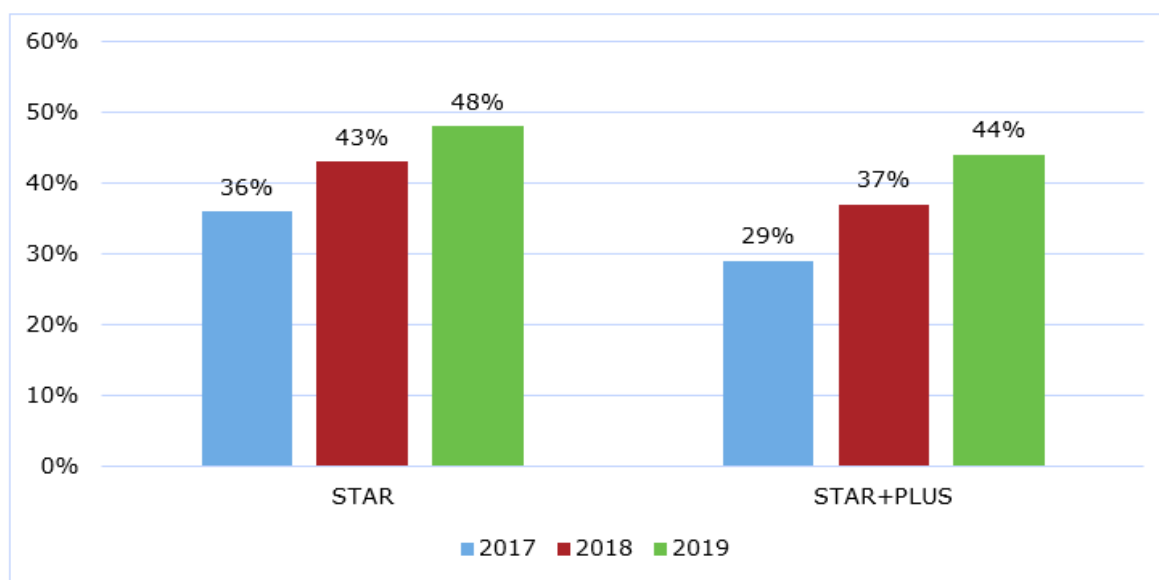
The full range of contractual requirements for MCOs to promote VBP include:

- 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.
- 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

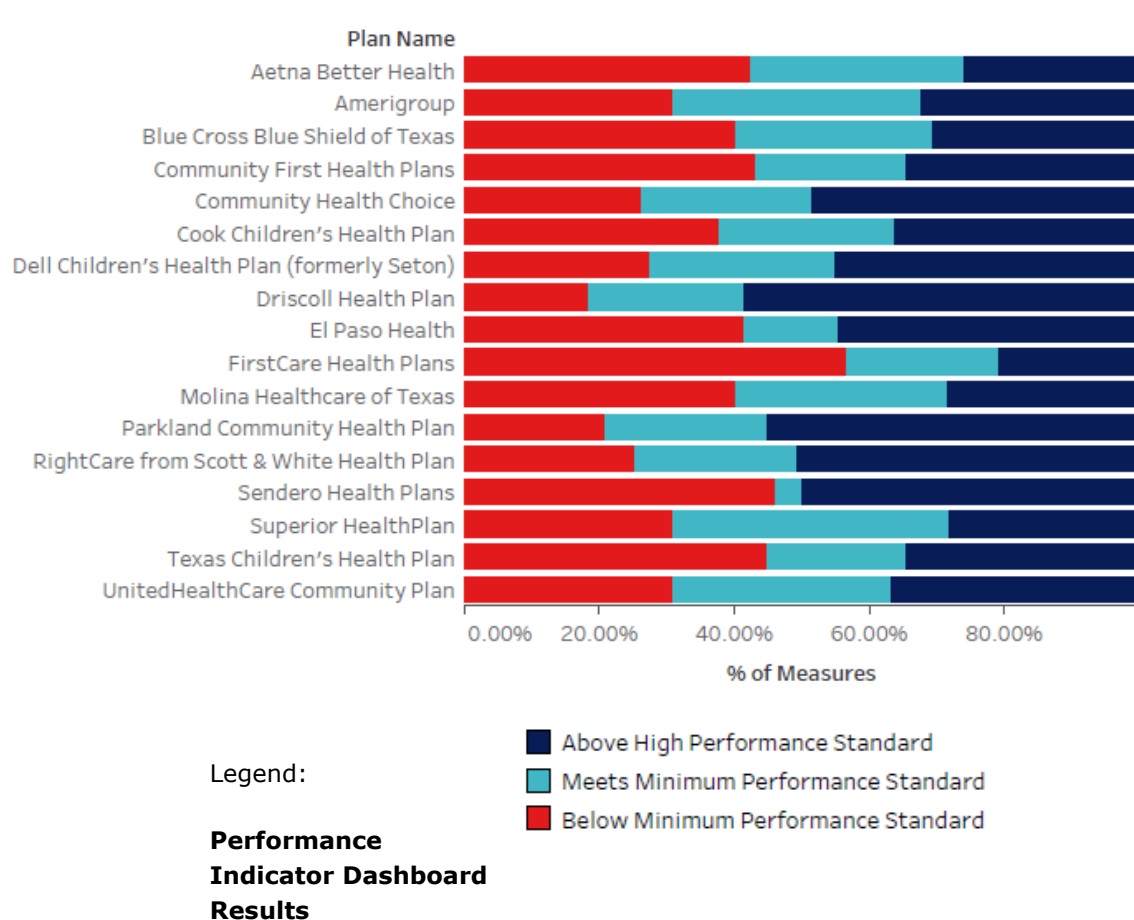
The Balanced Budget Act of 1997 requires all states with Medicaid managed care to ensure MCOs conduct performance improvement projects (PIPs). 42 CFR 438.330 requires projects be designed to achieve, through ongoing measurements and interventions, significant improvement, sustained over time, in clinical 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 or a Delivery System Reform Incentive Payment 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.

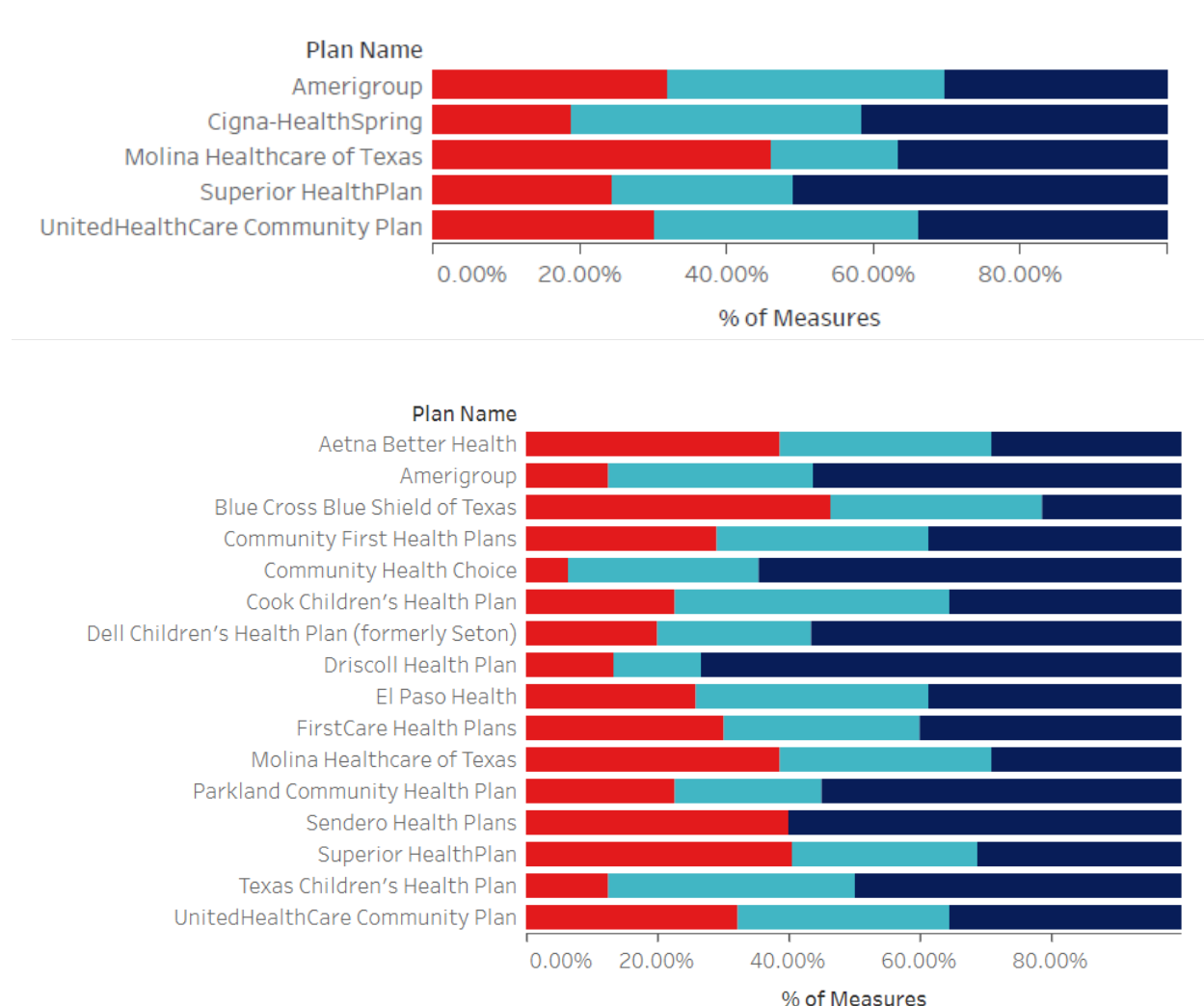
Beginning with the measurement year 2018, an MCO whose per program performance is below the minimum standard on more than 33 percent of the measures on the dashboard is subject to remedies under the contract, such as placement on a corrective action plan (CAP). For more information, please see Chapter 10.1.14 of the Uniform Managed Care Manual.⁹ Calendar year 2018 Performance Indicator Dashboard results for STAR and STAR+PLUS are presented in Figures 6, 5 and 7, below, and added detail for these and other programs is available on the THLC portal.

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



⁹ <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/handbooks/umcm/10-1-14.pdf>

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.

2018 Performance Summary: HealthSpring

STAR+PLUS Program



- Above High Performance Standard (41.51%)
- Meets Minimum Performance Standard (39.62%)
- Below Minimum Performance Standard (18.87%)

Performance	Measure Description	Minimum Standard	High Standard	Plan Rate	Numerator	Denominator
Above High Performance Standard	CDC - HbA1c Control (<8%)	46.00	50.00	50.36	207	411
	PQI - Diabetes Short-term Complications Admission Rate (PQI 1)	37.00	34.00	28.24	67	237240
	PQI - Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI 5)	166.00	157.00	134.58	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	1024.84	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		
	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	312.76	742	237240
Meets Minimum Performance Standard	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
	AAB - Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	24.00	29.00	26.10	113	433
	ABA - Adult BMI Assessment	80.00	86.00	85.40	351	411
	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	277	391
	SSD - Diabetes Screening	80.00	83.00	82.03	1520	1853
	SPC - Total Statin Therapy	73.00	76.00	75.42	586	777
	SPD - Statin Adherence	53.00	60.00	59.40	818	1377
	PPE - Potentially Preventable Admissions (PPA)	1.00	0.95	0.96	1820.55	1900.82
	PPE - Potentially Preventable Emergency Department Visits (PPV)	1.00	0.90	1.00	4743.48	4729.45
	SVY-Adult - % Good Access to Service Coordination	52.00	54.00	52.74		
	SVY-Adult - % Rating Personal Doctor a "9" or "10"	66.00	69.00	67.79		
	SVY-Adult - % Rating Their Health Plan a "9" or "10"	57.00	61.00	60.09		
Below Minimum Performance Standard	PQI - Diabetes PQI Composite Rate (PQI 93)	96.00	91.00	94.84	225	237240
	SVY-Adult - How Well Doctors Communicate Composite	75.00	79.00	78.58		
	CDC - Monitoring for Nephropathy	90.00	92.00	89.92	3595	3998
	CDC - HbA1c Testing	87.00	87.00	86.37	355	411
	CHL - Total	44.00	57.00	39.77	70	176
	PPC - Timeliness of Prenatal Care	63.00	84.00	55.05	60	109
	PPC - Postpartum Care	40.00	64.00	33.03	36	109
	AMR - Total 5 to 64 Ratios >= 50%	57.00	62.00	52.71	214	406
	PQI - Diabetes Long-term Complications Admission Rate (PQI 3)	44.00	42.00	45.95	109	237240
	SMC - Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	78.00	82.00	69.77	30	43
	PPE - Potentially Preventable Complications (PPC)	1.00	0.90	1.04	145.16	139.13
	CDS - HCBS Personal Attendant Services	6.40	6.70	3.25	1400	43057

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

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: 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-chip-quality-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 ten years will stabilize our Medicaid delivery system during this Public Health Emergency. 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).

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

Texas hosted a public forum via webinar on June 22, 2020 and will again host a public forum June 21, 2021, to provide the public with updates on the Texas Healthcare Transformation and Quality Improvement Program (THTQIP) 1115 waiver. The last public in person forum was held on June 24, 2019. The date, time, and location of the public forums were published on HHSC's website 30 days in advance of the meetings.

During the June 2020 public forum, the public was provided with an update on the following Transformation waiver topics: Health Information Technology (HIT) Strategic Plan, Delivery System Reform Incentive Payment program (DSRIP), Uncompensated Care, and Nursing Home Quality Incentive Payment Program. Links to the 1115 DY8 annual report and COVID-19 resource pages was also provided to the public. Public comment was also received and documented at this meeting. Comments received related to identifying external entities involved in the Health IT strategies, the process for creating new Medicaid benefits or programs, DSRIP operations and extension of DSRIP program, Value Based Purchasing, Uncompensated Care pool payments, and the potential to request an extension in light of COVID-19 as some other states are also doing. Requests for the PowerPoint presentation were received from some stakeholders and the slide deck was provided to those individuals electronically. During the forum, HHSC responded to comments and clarifying questions received.

Texas seeks the same Special Terms and Conditions (STCs) previously negotiated, approved, and agreed to by CMS and Texas on January 15, 2021; however, HHSC anticipates revisions to dates and naming conventions in the STCs and related attachments as needed.

Summary of Public Notice

In accordance with federal public notice requirements for an 1115 extension, Texas will hold three public hearings on the following dates and separate locations:

(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, Auditorium

6001 Forest Park Road, Dallas, TX 75235.

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

Virtual attendees register here:

http://texashhsmeetings.org/1115Waiver_June22021.

(2) Medical Care Advisory Committee

June 10, 2021

9 a.m.

Virtual attendees register here:

http://texashhsmeetings.org/MCAC_PCReg_June2021.

(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

Virtual attendees register here:

http://texashhsmeetings.org/1115Waiver_June152021.

Given the current concerns regarding in-person meetings during the public health emergency, two public hearings will be held both in-person and virtually. The Medical Care Advisory Committee (MCAC) will be held virtually only. The public will be able to provide public comment in both meetings and submit written comments by June 28, 2021. Comments will be summarized to identify the issues raised during the public during the comment period and how the State considered the

comments when developing the demonstration extension application for submission to CMS.

Texas will allow for a 30-day public comment period and notice of the extension will be published in the Texas Register on May 28, 2021. Texas will invite the federally-recognized tribes in Texas to a call to discuss the extension and provided them with written notice on May 14, 2021. The application packet is posting May 28, 2021, on the Texas Health and Human Services Commission website at <https://hhs.texas.gov/laws-regulations/policies-rules/waivers/waiver-renewal>. The documents were made accessible and requests for copies should be sent to [TX Medicaid Waivers@hhsc.state.tx.us](mailto:TX_Medicaid_Waivers@hhsc.state.tx.us).

ⁱ Percentages have been rounded to fit this table.

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