Texas Healthcare Transformation and Quality Improvement Program

Section 1115 Demonstration Waiver

Extension Application

Texas Health and Human Services Commission

September 30, 2015

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EXECUTIVE SUMMARY

Based on direction from the Texas Legislature in 2011, the State sought a section 1115 Demonstration as the vehicle to transform healthcare in Texas by expanding the Medicaid managed care delivery system statewide, while operating funding pools, supported by managed care savings and diverted supplemental payments, to reimburse providers for uncompensated care costs and to provide incentive payments to providers that implement and operate delivery system reforms. The waiver was designed to build on existing Texas health care reforms and to redesign health care delivery in Texas consistent with CMS goals to improve the experience of care, improve population health, and reduce the cost of health care without compromising quality.

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

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

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

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

During the initial demonstration period, it took years to implement the programs within the waiver. Now that all three major components of the waiver have been implemented and are running smoothly, Texas proposes to focus the extension period on strengthening the waiver programs and the connections between them. Texas will further align the Medicaid managed care programs within the waiver with DSRIP projects to support systems of care for Medicaid enrollees and low income uninsured individuals and support sustainability of the innovative work underway in DSRIP. Texas will develop a quality roadmap that includes both managed care and DSRIP and actively engage health plans to coordinate with the DSRIP initiatives that benefit

their members. For DSRIP projects, Texas will be measuring outcome improvements over baseline this year and next. HHSC will partner with clinical and quality experts from around the state to identify best practices and lessons learned from DSRIP to help inform Medicaid benefits and value based purchasing arrangements in managed care. To further strengthen systems of care, HHSC will promote increased data sharing across providers and publish data to show whether Texas, the Regional Healthcare Partnerships, and the managed care service areas are making progress on key quality indicators. The UC pool will continue to be essential to ensure access to quality care for low-income Texans and enable hospitals and other providers to undertake initiatives to improve how care is delivered.

EXPAND RISK-BASED MANAGED CARE STATEWIDE

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

SUPPORT THE DEVELOPMENT AND MAINTENANCE OF A COORDINATED CARE DELIVERY SYSTEM

The 1115 Transformation Waiver's managed care programs together with the two funding pools help support the development and maintenance of a coordinated care delivery system. Managed care coordination includes a primary care provider/dental home, care management and service coordination, and value added services such as 24-hour nurse lines, cell phones for high risk clients, and weight loss programs. In addition to the managed care programs authorized under the 1115 Transformation Waiver, Texas implemented a Dual Eligible Integrated Care Demonstration project in six counties utilizing STAR+PLUS health plans to better coordinate Medicare and Medicaid acute and long term services and supports for individuals dually eligible for both programs. One of the early successes of the DSRIP program is that the establishment of 20 Regional Healthcare Partnerships (RHPs) covering the state has led to increased local and regional collaboration to identify and address priority community healthcare needs. Many of the active DSRIP projects by their nature involve coordinating care delivery, including projects

related to integrated physical and behavioral healthcare, patient-centered medical homes, chronic care management, and patient care navigation. In addition, Texas Medicaid MCOs are also required to have performance improvement projects (PIPs), some of which have goals in common with one or more DSRIP projects in a given geographic area. Activities are underway in many regions to further connect similar MCO and DSRIP projects so that they can better coordinate their efforts. The availability of UC pool funds to help offset uncompensated costs has provided hospitals and other providers the financial stability to try care improvement initiatives in the DSRIP program that they otherwise may not have undertaken.

IMPROVE OUTCOMES WHILE CONTAINING COST GROWTH

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

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

Regarding the outcomes of the pools, Texas successfully transitioned from its former upper payment limit (UPL) programs to the DSRIP and UC pools, which together support the Texas safety net for low income Texans while incentivizing providers to test initiatives to improve patient care and outcomes. DSRIP enabled groundbreaking work, including increased regional and cross-regional collaboration between diverse healthcare providers and stakeholders and investments in infrastructure and innovation to improve systems of care. After a necessary start-up period to develop the program protocols, conduct regional community needs assessments, and develop DSRIP projects based on priority community needs, DSRIP projects were approved from mid-2013 through mid-2014, and the baseline data for most outcome measures specific to each project was reported in October 2014. HHSC will collect data on improvements over baseline in 2015 and 2016. DSRIP also greatly increased access to care. In April 2015, providers reported achievement for over 10 percent of the outcome measures tied to projects, with many showing improvement related to emergency department utilization, hospital readmissions, flu vaccines, and controlling HbA1c and high blood pressure.

In demonstration year (DY) 3 (October 1, 2013-September 30, 2014), DSRIP projects collectively provided over 2 million additional encounters and served over 950,000 additional individuals compared to the service levels they had provided prior to implementing the projects.

Learning collaborative activities are underway throughout the state, and HHSC established an external Clinical Champions workgroup in early 2015 to help assess promising DSRIP projects for sharing of best practices and making improvements to the Medicaid program.

PROTECT AND LEVERAGE FINANCING TO IMPROVE TEXAS' HEALTH CARE INFRASTRUCTURE

As Texas expanded Medicaid managed care statewide through the 1115 Transformation Waiver, the UC pool enabled the State to support continued access to care for low-income Texans by converting historical upper payment limit (UPL) supplemental payments to hospitals and other providers into a new cost-based methodology that offsets their uncompensated costs for care. The UC pool is a key financing component for the healthcare safety net in Texas. UC funds are critical to Texas' health system, especially with potential decreases in the federal allocation of Medicaid DSH funds made to Texas, and with continued population growth in Texas at a rate more than double the national average.

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

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

TRANSITION TO QUALITY-BASED PAYMENT SYSTEMS ACROSS MANAGED CARE AND HOSPITALS

Texas has adopted a strategic direction to increase quality-based payment systems across managed care and hospitals. HHSC's Pay-for Quality program provides financial incentives and penalties to MCOs based on year-to-year incremental improvement on specified quality measures. The Pay-for-Quality program includes a risk/reward pool that places up to four percent of the MCO capitation rate at risk. The quality of care measures used in this initiative are a

combination of process and outcome measures which include select potentially preventable events (PPEs) as well as other measures specific to the program's enrolled populations. HHSC defined the PPEs for DSRIP Category 4 hospital reporting to mirror the PPE methodology used for MCO Pay-for-Quality. Some of the Texas Medicaid MCOs' PIPS have goals in common with one or more DSRIP projects in a given geographic area. HHSC also requires each MCO to have a program for targeting outreach, education and intervention for members who have high utilization patterns that indicate typical disease management approaches are not effective.

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

I. TEXAS HEALTHCARE TRANSFORMATION AND QUALITY IMPROVEMENT WAIVER OVERVIEW

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

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

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

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

A. MEDICAID MANAGED CARE OVERVIEW AND HISTORY

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

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

STATE OF TEXAS ACCESS REFORM (STAR) PROGRAM

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

STAR+PLUS PROGRAM

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

EXPANSION OF MANAGED CARE UNDER THE 1115 TRANSFORMATION WAIVER

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

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

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

GEOGRAPHIC EXPANSIONS

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

POPULATION EXPANSIONS

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

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

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

SERVICE CARVE-INS

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

- Effective March 2012:

    - Pharmacy services were carved into managed care. Providers must enroll with the Vendor Drug Program (VDP) before contracting with MCOs to provide pharmacy services for Medicaid clients.
    - Inpatient hospital services were carved into STAR+PLUS. Inpatient services were already a benefit delivered under STAR.
    - Texas implemented the Children's Medicaid Dental Services program (Dental Program). All Medicaid beneficiaries entitled to Early and Periodic Screening, Diagnostic, and Treatment benefits receive the full array of primary and preventive dental services required under the State Plan, through dental MCOs called dental maintenance organizations (DMOs).
- Effective March 2014, cognitive rehabilitation therapy services (CRT) were added to the State Plan and implemented in managed care for adults in the HCBS STAR+PLUS waiver program.
- Effective September 2014:
    - Mental health rehabilitation and targeted case management services were carved into managed care for members who have chronic mental illness.
        - Supported employment and employment assistance services were added to the State Plan and implemented in managed care for adults in the HCBS STAR+PLUS waiver program.
- Effective March 2015, nursing facility services were carved into managed care for adults in STAR+PLUS program.
- Effective June 2015, HHSC implemented Community First Choice benefits for certain individuals in STAR+PLUS.

B. MEDICAID MANAGED CARE SUCCESSES UNDER THE 1115 TRANSFORMATION WAIVER

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

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

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

STATEWIDENESS

The 1115 Transformation Waiver enabled HHSC to expand Medicaid managed care geographically making the STAR and STAR+PLUS programs available statewide. In addition, under the 1115 Transformation Waiver, Texas carved in Medicaid benefits and expanded to include additional populations. Figures 1 and 2 below depict the monthly number of persons enrolled in Medicaid managed care since the beginning of the demonstration. Between December 2011 and November 2014, the monthly number of persons enrolled in STAR increased by 68% (from 1,768,771 in December 2011 to 2,967,779 in November 2014); monthly enrollment in STAR+PLUS increased by 86% (from 280,654 in December 2011 to 520,928 in November 2014); and the monthly number of persons enrolled in the Dental Program increased by over 25% (from 2,335,571 in December 2011 to 2,939,555 in November 2014).

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

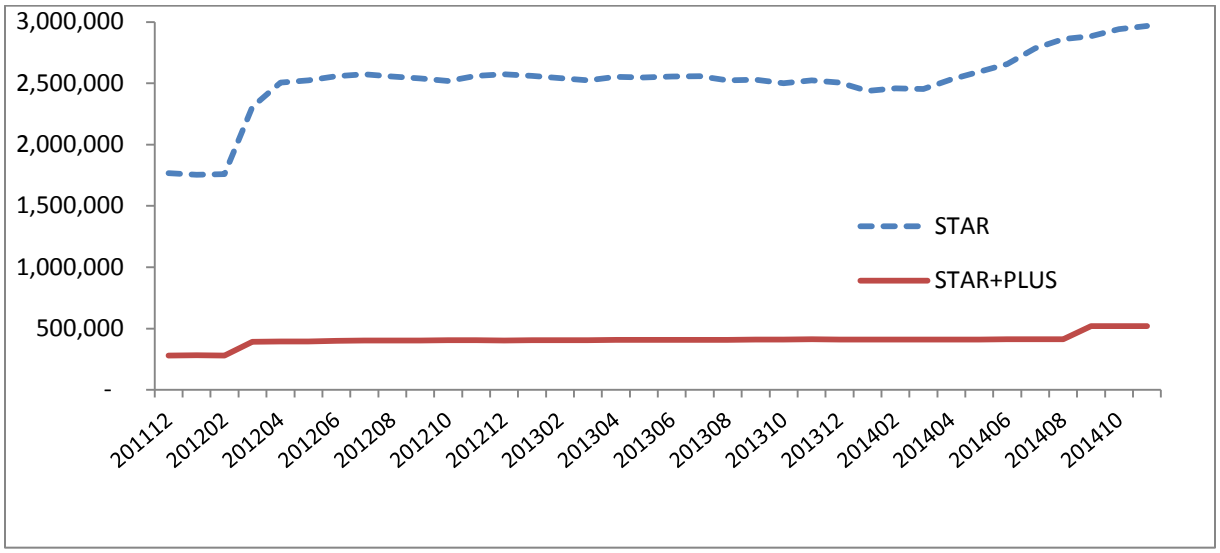
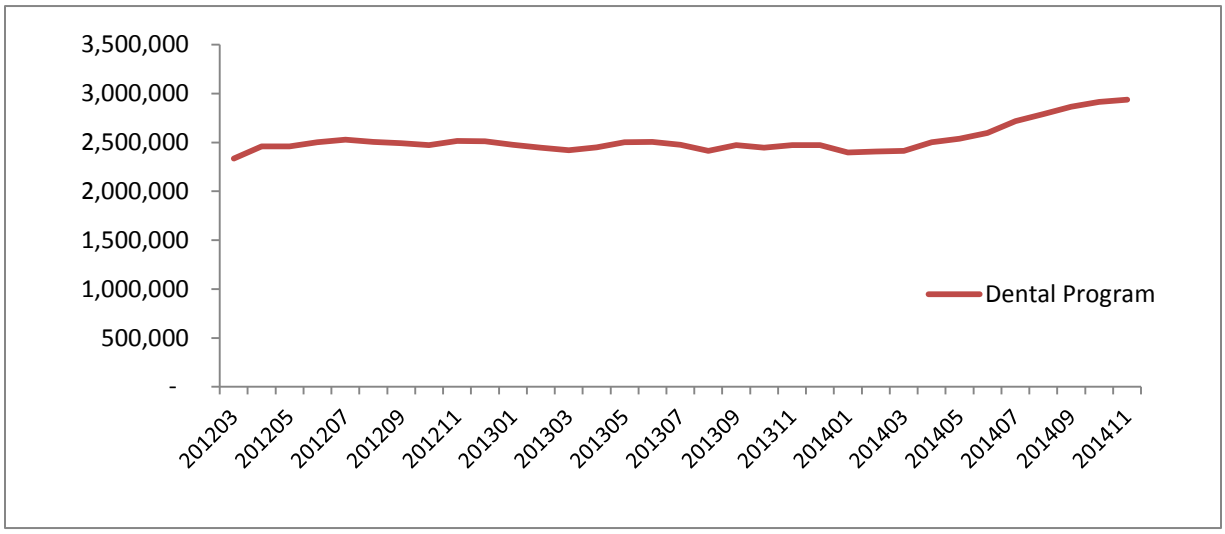


Figure 2: Monthly Enrollment in Dental Program, March 2012-November 2014



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

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

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

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

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

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

COORDINATED CARE

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

- Medical home through a primary care provider,
- Access to care management,
- Unlimited prescriptions,
- Unlimited necessary days in a hospital for STAR members, and
- Value-added services.

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

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

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

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

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

REQUEST FOR MANAGED CARE PROGRAMS IN THE EXTENSION PERIOD

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

In the near future, Texas plans to request a number of waiver amendments to be effective during the first year of the extension period to further expand managed care delivery in Texas. Notably, Texas is developing a comprehensive managed care model for children and youth with disabilities, called STAR Kids. This initiative is well underway and scheduled to implement early in the first year of the extension period. This population already is included in the 1115 waiver as they currently may be served through fee-for-service or opt into Medicaid managed care, so the amendment will be moving them from fee-for-service or optional managed care into a managed care model designed specifically for this group. The robust managed care program Texas has developed for STAR Kids complements well the care coordination and quality improvement activities underway through managed care and DSRIP in the 1115, and HHSC will work to further align DSRIP, STAR Kids and our existing managed care programs.

C. DELIVERY SYSTEM REFORM INCENTIVE PAYMENT POOL OVERVIEW AND HISTORY

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

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

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

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

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

1. Category 1 projects: Infrastructure Development lays the foundation for delivery system transformation through investments in technology, tools, and human resources that strengthen the ability of providers to serve populations and continuously improve services.
2. Category 2 projects: Program Innovation and Redesign includes the piloting, testing, and replicating of innovative care models, such as telemedicine, patient-centered medical home, and innovations in health promotion and disease prevention.
3. Category 3 outcomes: Quality Improvements assess the effectiveness of Category 1 and 2 interventions for improving outcomes in the Texas healthcare delivery system. Each project selected in Categories 1 and 2 has one or more associated outcome measures from Category 3.
4. Category 4 reporting: Population-focused Improvements include a series of reporting measures for a hospital to track the community-wide impact of delivery system reform investments. Required reporting includes data related to potentially preventable admissions,

readmissions, and complications, patient-centered health care and emergency department utilization, with optional reporting of core healthcare quality measures for children and adults.

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

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

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

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

D. DSRIP SUCCESSES AND CHALLENGES

The DSRIP program is showing great promise to improve healthcare delivery systems and quality of care**.** However, more time is needed for the projects to mature beyond their implementation phase and to evaluate which initiatives demonstrate the most promising practices. The collective effort from CMS, HHSC, and Texas stakeholders to develop and implement the DSRIP program has been remarkable. As of May 1, 2015, there are 1,458 active DSRIP projects performed by 298 providers. Those providers have earned over $4.5 billion (all funds) through September 30, 2014 (the end of DY 3) for achievement of over 11,800 milestones across DSRIP Categories 1-4.

A strength of the Texas DSRIP program is its regional approach; providers and other stakeholders in 20 regions throughout the state (encompassing 254 counties) formed RHPs, conducted needs assessments to identify priority healthcare needs in each region, and proposed a diverse array of projects to help address those needs. HHSC held a statewide learning collaborative summit in September 2014 with over 460 people in attendance and many others

participating via webinar. A key takeaway from the summit was that DSRIP and the RHP structure have encouraged collaboration across the continuum of care among providers who previously had not worked together as much. For example, the over 400 DSRIP projects that focus on behavioral healthcare have led to increased collaboration between community mental health centers, hospitals and other providers. This increased collaboration is also evident in the early results from the formal waiver evaluation, which show many new connections between RHP participants since the outset of the DSRIP program including through increased sharing of information, resources, and health data.

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

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

It took significant time to develop and implement the DSRIP program, and that delay makes it challenging at this time to determine the effectiveness of any one DSRIP project. CMS, HHSC, and Texas DSRIP participants worked diligently to implement the new program, but given the size and scope of Texas' DSRIP program, CMS did not approve projects until mid-2013 to mid-2014, more than halfway through demonstration years (DYs) 2 and 3. DSRIP projects are either

four-year projects or three-year projects, so those that required time to establish project infrastructure may still be fairly early in their implementation. In particular, there were some regions of the state, including South Texas (which has great needs), that due to lack of local funding to support projects during the initial RHP plan submission got a later start on many of their projects.

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

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

HHSC is beginning to collect data on Category 3 outcome improvements. Most projects will report their first year of improvement over baseline in October 2015. Roughly 210 outcomes (10% of all DSRIP Category 3 outcomes) reported achievement during the April 2015 reporting period. Of these early reported outcomes, 90% reported improvement over their baseline, and 76% reported fully achieving or exceeding their first year improvement goal. Many projects reported achieving their first goal related to risk-adjusted all-cause hospital readmissions, reducing emergency department visits for ambulatory care sensitive conditions, HbA1c control, controlling high blood pressure, influenza immunization, and adult emergency department utilization.

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

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

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

QPI information is heavily weighted to the final two years of the waiver–DYs 4 and 5 (federal fiscal years 2015 and 2016) –to allow for project development and ramp up, but many projects began to report patient impact in DY 3 as well. In DY 3, compared to pre-DSRIP service levels, DSRIP projects collectively provided over 2 million additional encounters and served over 950,000 additional individuals (summing up the number of individuals served by each DSRIP project), surpassing overall QPI goals by 171 percent for encounters and 136 percent for individuals. The two DSRIP target populations are Medicaid recipients and low income uninsured individuals, and the DY 3 DSRIP QPI figures demonstrate that the program already has done much to increase access to care and improve how care is delivered to these populations.

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

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

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

In Category 4, HHSC and CMS are collecting hospital-level data to show whether there are improvements in a number of broad population-based measures, including Medicaid potentially preventable events (hospitalizations, readmissions and complications), emergency department care, and patient-centered care. For DY 3, the Medicaid potentially preventable event (PPE) data was for calendar year 2012, and for DY 4, the PPE data is for calendar year 2013. As the waiver progresses, HHSC will have trend data for PPEs to show if improvements have been made during the demonstration. Category 4 PPE data by RHP for 2013 is posted at http://www.hhsc.state.tx.us/1115-RHP-Plans.shtml.

HHSC worked with an independent assessor to perform a mid-point assessment of projects in late 2014 through early 2015. The reporting data available to the independent assessor for its review was through the April 2014 DSRIP reporting period (reflecting project progress through March 31, 2014). The projects reviewed received initial CMS approval beginning in mid-2013, so the assessment reflected that many projects were still in early implementation. In spite of this timing, the independent assessor concluded: "On a statewide basis, with approximately 79

percent of the projects being low or moderate risk (meaning that they are on track for meeting their project outcome objectives), it appears that the State's Category 1 and 2 DSRIP projects are well on their way to achieving the intended project goals and those of the Triple Aim, which are to improve the health of the population, enhance the experience and outcomes of the patient, and reduce per capita cost of care for the benefit of communities." Between mid-2014 and the end of the mid-point review (May 1, 2015), 41 DSRIP projects withdrew for various reasons, including the inability to achieve project goals and in response to recommendations from the independent assessor's review.

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

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

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

Alignment with Medicaid Managed Care Quality Strategy

In the implementation of DSRIP, HHSC began to align DSRIP with Medicaid managed care. For example, HHSC defined the PPEs for DSRIP Category 4 reporting to mirror the PPE methodology used for the MCO Pay-for-Quality program. Texas Medicaid MCOs are also required to have PIPs, some of which have goals in common with one or more DSRIP projects in a given geographic area. Activities are underway in many regions to further connect similar MCO and DSRIP projects so that they can better coordinate their efforts. For example, to the extent that MCOs and DSRIP providers both have case managers to support targeted patients, they need to coordinate their efforts to provide the most efficient case management for those patients.

Value-based purchasing means a payment system that rewards managed care organizations, hospitals, doctors and other providers for delivering high quality, efficient clinical care. The Texas DSRIP program informs value based purchasing, as it enables providers to undertake

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

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

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

HHSC is actively moving toward an expanded definition of medical expenses for MCOs, and DSRIP experience is helping inform this process. MCO expenses fall into either medical services or administrative services. While certain services are excluded by federal rule from counting as MCO medical expenses, HHSC is reviewing opportunities in this area. Based on previous MCO feedback, there may be more expenses incurred by MCOs that could be counted towards medical expense, such as peer specialists and community health workers. These are some of the types of

services that are effectively being used in DSRIP projects. Since Texas Medicaid MCOs have a cap that limits the deductibility of administrative expenses, if HHSC allows MCOs to count additional services as medical expenses (when such services are recognized by CMS as medical), this will reduce any barriers that may exist for MCOs to use these types of services to best coordinate care for their members.

Coordination with National and State Quality and Value Based Purchasing Initiatives

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

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

At the State level, the Texas Institute of Health Care Quality and Efficiency was established by the 82nd Legislature in 2011 to improve health care quality, accountability, education and cost containment by encouraging health care provider collaboration, effective health care delivery models, and coordination of health care services. The Institute was administratively attached to HHSC and the Board was appointed by the Governor. The Strategic Plan of the Institute focuses on the Texas health care sector – both public and private – and recognizes the significant time, energy, and resources that Texas is directing into innovative approaches, such as the development of integrated service delivery models and regionalized system transformation that is the goal of DSRIP, to raise quality and contain costs. Investment in strategies that promote shared decision making between patients and providers, that increase care coordination, especially for individuals with complex medical, behavioral, and social support needs, and that

tackle emerging public and community health issues, including chronic disease prevention, can drive improvement across the entire health care system. The Institute issued its legislative recommendations in November 2014 related to expanded access to care, administrative simplification, health literacy, value-based care, serious and persistent mental illness, and data sharing. These issue recommendations align with DSRIP goals. HHSC has coordinated DSRIP efforts with the Institute and plans to continue to work with the Institute or its successor to support the ongoing work through the waiver to transform care in Texas.

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

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

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

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

DSRIP strives for all three SHIP goals--moving to patient-centered care, transitioning to quality based payment, and building capacity for continuous improvement throughout health care and public health. DSRIP incorporates elements of the five models from the SHIP. DSRIP encourages increased data sharing. Attachment A contains an example of increased data sharing in one of Texas' HIE "white spaces," in and around Wichita Falls in RHP 19. Many DSRIP projects, particularly in Category 2, relate to clinical care transformation, medical homes, and integrated physical and behavioral healthcare. Almost 10 percent of DSRIP projects focus on community-based public health, including health promotion and disease prevention, especially diabetes and related comorbidities, which are known issues and priorities in Texas. A goal of DSRIP, particularly in the extension period and with the assistance of the Clinical Champions workgroup, will be to increase the State's focus on spreading and sustaining innovations. As DSRIP supports healthcare delivery system transformation regardless of payer, the work being done through DSRIP also could be a springboard for further multi-payer engagement.

DSRIP REQUEST FOR THE EXTENSION PERIOD

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

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

- Further incentivizing transformation and strengthening healthcare systems across the state by continuing the RHP structure. The 20 RHPs already have demonstrated improved systems of care, and these systems will be strengthened over time by continuing the collaborative work facilitated by the RHPs and role of the anchoring entities to provide regional coordination and technical assistance.
- Continuing the majority of the current 1458 active DSRIP projects into the extension period in order to give projects more time to demonstrate outcomes. These projects may take a logical next step toward further transformation. Some projects will not be eligible to continue based on review of the independent assessor and HHSC.
- Reviewing the Category 3 outcome measure methodologies and how outcome measures align with projects. Texas may propose a structure to better align outcome measures with certain projects and to show meaningful improvement, including outcomes related to pediatrics and behavioral healthcare.
- Establishing a new shared performance bonus pool from unearned funds over the course of the extension period (either because projects withdraw or fail to achieve milestones). If a region improves its performance on key measures, all participating providers in the region would be eligible to earn funds from the bonus pool.
- Requesting for funds from the $3.1 billion annual pool not allocated to continuing projects: to allow alternate transformative projects from a narrower menu based on lessons learned (potentially including cross-regional projects and initiatives, including related to the unique needs of rural Texas); to bring smallest projects up to a minimum valuation level; and/or to add funds to the shared performance bonus pool for regions that make improvements on key measures.
- Streamlining the DSRIP program to lessen the administrative burden on providers while focusing on collecting the most important types of information.

- Standardize milestone language and reduce the number of milestones to be reported by requiring Category 1-2 milestones only for quantifiable patient impact (QPI), and allowing optional milestones only for specific milestones. Such optional milestones could relate to increased data exchange and project-level evaluation/sustainability planning (structured milestones with standard templates). Continuous quality improvement activities and other activities supporting the success of the project (such as hiring of staff, extending hours, achieving medical home certification) would be captured in semi-annual qualitative reporting.
- Allow certain projects to be combined into a single project to reduce reporting, such as cross-RHP projects by community mental health centers; smaller, related projects below a certain valuation threshold being done by smaller providers; similar projects by the same provider in the same region (same project, different populations); potentially the same system doing the same project across multiple hospitals (within a region).
- Consider reducing the period for allowable achievement carry forward (beyond the DY), but allow for partial achievement for QPI similar to what is allowed for Category 3 pay for performance now.
- Modify or eliminate the mid-point assessment review requirement, but continue with ongoing compliance monitoring.

- Further integrating DSRIP efforts with Texas' Medicaid managed care quality strategy and other value based payment efforts.
  - Develop a Quality Alignment/Value Based Payment Roadmap by early 2017 to outline how HHSC plans to progress toward value based payment during the course of the extension.
  - Align DSRIP and managed care quality measures to the extent possible.
  - Analyze Medicaid data and available all-payer PPE data for managed care plans, MCO service delivery areas, and RHPs. HHSC will provide this global trend data to CMS from 2012 through the years of the extension period to show whether combined efforts are having an effect on these measures.
  - Require DSRIP projects to report Medicaid IDs of patients served by the project so that HHSC can analyze DSRIP and managed care data to increase alignment between DSRIP and Medicaid managed care and inform managed care value based purchasing opportunities
  - As part of DSRIP and UC requirements, require participating hospitals to provide emergency department admission, discharge, and transfer (ADT) information either to their regional HIE or the State. Medicaid ADT data will be available to MCOs to share with their providers for care coordination purposes.

Texas needs to continue the DSRIP pool to provide financial support for the innovative activities that have been initiated by local communities through DSRIP thus far. One of HHSC's primary

goals for the waiver extension period is to work with CMS and Texas DSRIP stakeholders to determine how to best evaluate which of the projects are "benchmark" projects to sustain and replicate in the healthcare delivery systems for Medicaid and the low income uninsured in order to further strengthen systems of care in Texas.

E. UC POOL OVERVIEW, HISTORY AND SUCCESSES

As Texas expanded Medicaid managed care statewide through the waiver, the UC pool enabled the State to support continued access to care for low-income Texans by converting historical upper payment limit (UPL) supplemental payments to hospitals and other providers to a new methodology that offsets their uncompensated costs for care. The UC pool is a key financing component for the healthcare safety net in Texas. UC funds are critical to Texas' health system, especially with potential reductions in Medicaid DSH funding under provisions of the Affordable Care Act (ACA), and with continued population growth in Texas more than double the national average.

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

In 2011 Texas submitted the waiver request to CMS to better coordinate care through Medicaid MCOs, including carving inpatient hospital care into the MCOs' capitation rates. Texas has successfully transitioned from the former UPL programs to the new UC program under the waiver, which uses a cost-based methodology to enable hospitals and certain other providers to partially offset the uncompensated care they provide to Medicaid and uninsured patients. During federal fiscal year (FFY) 2013 of the waiver, HHSC and CMS agreed to the protocols to govern the UC pool for each type of provider. HHSC then developed the applications for each provider type and conducted trainings for providers on how to fill out the UC tool applications. For hospitals, HHSC has moved to a combined application for DSH and UC since the allowable costs for the two programs are identical, except that per the STCs some additional costs for physician, clinic and pharmacy services are allowed to be reimbursed from the UC pool.

In DY 1, (October 2011 - September 2012), hospitals and physician groups had the option of either receiving transition payments based on their previous UPL payments, or submitting a UC

application. Beginning in DY 2, all hospitals and physician groups that sought to participate in the UC pool were required to submit to HHSC a UC application documenting their allowable uncompensated costs, which are subject to the DSH federal audit rule with respect to the computation of hospital specific limits and also to interim and final payment reconciliation processes.

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

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

The Texas UC pool methodology is transparent and outlined in administrative rule. In 2014 and 2015, HHSC proposed and adopted revisions to its administrative rules related to DSH and UC to provide distinct UC pools for different types of providers (including large public, small public, and private hospitals, with special protections for rural hospitals) to promote equity in the funding of UC.

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

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

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

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

UC REQUEST FOR THE EXTENSION PERIOD

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

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

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

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

II. PROGRAMMATIC DESCRIPTION OF WAIVERS & EXPENDITURE AUTHORITIES.

WAIVER AND EXPENDITURE AUTHORITIES REQUESTED FOR THE EXTENSION PERIOD

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

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

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

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

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

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

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

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

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

5. HCBS for SSI-Related State Plan Eligibles

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

EXPENDITURES RELATED TO THE UNCOMPENSATED CARE POOL

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

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

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

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

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

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

III. MONITORING QUALITY & ACCESS TO CARE

The Balanced Budget Act of 1997 requires state Medicaid agencies to provide an annual external independent review of quality outcomes, timeliness of services, and access to services provided

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

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

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

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

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

A. EVIDENCE-BASED CARE AND QUALITY MEASUREMENT

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

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

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

MCO-GENERATED DATA AND REPORTS

Quality Assessment and Performance Improvement

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

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

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

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

Performance Improvement Projects (PIPs)

The EQRO recommends topics for PIPs based on MCO performance results, data from member surveys, administrative and encounter files, medical records, and the immunization registry. HHSC selects two of these goals, which become projects that enable each MCO to target specific areas for improvement that will affect the greatest number of members. These projects are

specified and measurable, and reflect areas that present significant opportunities for performance improvement. When conducting PIPs, MCOs are required to follow the ten-step CMS protocol published in the CMS EQRO Protocols.

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

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

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

EQRO PROCESSES AND REPORTS

MCO Administrative Interviews

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

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

The MCOs complete the administrative interview tool online and are required to provide supporting documentation. For example, when describing disease management programs, the MCO must also provide copies of all evidenced-based guidelines used in providing care to

members. The EQRO analyzes all responses and documents and generates follow-up questions for each MCO as necessary. The follow-up questions are administered during in-person site visits and conference calls. The administrative interviews conducted between 2012 and 2014 are listed in Attachment B. Interviews for 2015 were held in the summer of 2015. This activity includes the determination of which MCOs will receive an on-site interview or a teleconference interview.

Data Certification Reports

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

Encounter Data Validation Report

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

Quarterly Topic Reports

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

Focus Studies

Focus studies are projects identified and defined by HHSC and conducted with a minimum amount of administrative burden on the Medicaid MCOs. Focus studies can be clinical,

financial, or administrative studies that relate to patterns of care or operational issues that influence quality of care, financial performance, or service delivery in managed care. In 2012, ICHP completed a study titled "STAR+PLUS Long-Term Care Focus Study – Baseline Report". In 2013, ICHP completed the "STAR+PLUS Home- and Community-Based Services Waiver Study Report".

Summary of Activities Report

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

Survey Reports

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

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

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

Quality of Care Reports

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

Potentially Preventable Events

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

FREW Report

The State's EQRO, ICHP, also reviews data related to Early and Periodic Screening, Diagnosis & Treatment (EPSDT), known in Texas as Texas Health Steps. The EQRO calculates rates by plan code for new and existing member preventive checkups based on the Medicaid Managed Care Texas Health Steps Medical Checkups Utilization Report instructions. The results are compiled and compared with MCO-submitted reports to determine if the MCO-submitted reports are within an eight percent threshold of EQRO calculated rates. A Medicaid Managed Care Texas Health Steps Medical Checkups Annual Report was completed for each year between 2012 and 2014. The 2015 draft report has been submitted to HHSC but is not yet final.

B. TEXAS QUALITY INITIATIVES

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

FINANCIAL INCENTIVE PROGRAMS

Performance Based At-Risk Capitation and Quality Challenge Award

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

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

Minimum achievement targets were developed based in part on:

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

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

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

2012 Quality Challenge Award and At-Risk Recoupment amounts

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

2013 Quality Challenge Award and At-Risk Recoupment amounts

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

Pay-for-Quality Program

To comply with legislative direction and to best identify quality of care measures that reflect the needs of the population served and areas of needed improvement, HHSC implemented the Pay-for-Quality Program, which replaced the At-Risk and Quality Challenge Program in 2014. The

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

Pay-for-Quality Program uses an incremental improvement approach that provides financial incentives and disincentives to MCOs based on year-to-year incremental improvement on pre-specified quality goals. The quality of care measures used in this initiative are a combination of process and outcome measures which include select potentially preventable events as well as other measures specific to the program's enrolled populations. The 2015 Pay-for-Quality Program measures are listed in Attachment C of this document.

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

DENTAL PAY-FOR-QUALITY PROGRAM

The 2014 Dental Pay-for-Quality Program includes an at-risk pool that is a two percent of the DMO capitation rate. In the Dental Pay-for-Quality Program, points are assigned to each plan based on its incremental performance on each quality measure, with positive points assigned for year-to-year improvements over the minimum baseline and negative points assigned for most year-to-year declines. The Dental Pay-for-Quality Program model sets minimum baseline performance levels for the measures so that low-performing DMOs would not be rewarded for substandard performance (see Attachment C for list of 2015 measures). Rewards and penalties are based on rates of improvement or decline over the baseline. Plans would earn back their own at-risk premium based on performance of quality of care measures. In no instance would funding be redistributed from one DMO to another; plans can only earn back their own two percent at-risk premium. Results for the 2014 program have been calculated, and recoupments and payments should be made in the fall of 2015.

PERFORMANCE COMPARISONS

Performance Indicator Dashboards

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

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

Long-Term Services and Supports Performance Measures. In the fall of 2013, HHSC convened a workgroup consisting of external stakeholders and representatives from the EQRO to develop a comprehensive set of performance measures that will provide data that allows the State to evaluate the quality of community-based long-term services and supports provided through Medicaid managed care. These measures were added to the Performance Indicators Dashboard in March 2015 (http://www.hhsc.state.tx.us/medicaid/managed-care/umcm/Chp10/10_1_7.pdf).

Development of managed care nursing facility performance measures. As part of the nursing facility carve-in that became effective September 1, 2014, HHSC developed a process for measuring quality of care provided to individuals residing in nursing facilities after the transition to managed care. In 2014, HHSC worked with the Department of Aging and Disability Services and stakeholders to develop a set of quality indicators that will incentivize MCOs to ensure a high level of quality of care. These measures were added to the Performance Indicators Dashboard in March 2015 (http://www.hhsc.state.tx.us/medicaid/managed-care/umcm/Chp10/10_1_7.pdf)..

MCO Report Cards

Texas Government Code §536.051 requires HHSC to provide information to Medicaid and CHIP members regarding MCO performance on outcome and process measures during the enrollment process. To comply with this requirement and other legislatively mandated transparency

initiatives, beginning in 2014 HHSC has developed annual MCO report cards for each program service area to allow members to compare the MCOs on specific quality measures. MCO report cards are posted on the HHSC website (STAR: http://www.hhsc.state.tx.us/QuickAnswers/report-cards/star.shtml, STAR+PLUS: http://www.hhsc.state.tx.us/quickanswers/report-cards/starplus.shtml) and included in Medicaid enrollment packets sent by the enrollment broker to potential members. They are updated annually. The 2014 report cards were posted on the HHSC website in March 2014, and included in member enrollment packets in April 2014. The 2015 report cards were posted on the HHSC website in February 2015, and included in enrollment packets in March 2015.

DATA SHARING AND TRANSPARENCY

Texas Healthcare Learning Collaborative

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

Through the Portal, HHSC and ICHP share monthly and quarterly reports with the MCOs about PPEs. The reports are interactive and the MCOs can query the data to create more customized summaries of the quality results. The Portal can be accessed at https://thlcportal.com. In 2014, a public access feature was added allowing anyone to view the quality of care data without a login. All-payer data from the Texas Department of State Health Services is expected to be added to the Portal by September 2015. This data includes hospital claims paid by fee-for-service Medicaid, Medicare, indigent care, commercial insurance, and others. The data will be used to calculate HEDIS measures and PPR and PPC rates, which will then be added to the Portal to fulfill a directive of the Texas Sunset Commission. Including data from other payers will allow HHSC and its stakeholders to perform more comprehensive analysis of potentially preventable hospital readmissions and complications, as well as all-payer HEDIS measure results.

Medicaid Quality Assurance and Improvement Website

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

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

OTHER QUALITY ACTIVITIES

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

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

Quality-Based MCO Enrollment Incentive Algorithm

There are members who qualify for Medicaid who do not choose a MCO at the time of enrollment, and are enrolled using HHSC's auto-enrollment process. HHSC is exploring potential algorithms that may be utilized to assign these members to high quality and high efficiency MCOs and DMOs. HHSC will first evaluate the effects of the MCO report cards initiative to determine if it shrinks the pool of members who do not actively choose a MCO. Based on that assessment, HHSC will determine whether to implement this initiative.

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

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

Alternative Provider Payment Structures

Texas Medicaid managed care contracts also require MCO and DMO provider payment structures to focus on quality, not volume. Managed care organizations and DMOs must submit to HHSC their plans for alternative provider payment structures, including the type of structure they plan to use the metrics used, the approximate dollar amount and number of members

impacted, and the evaluation process. This allows HHSC to better assess MCO and DMO progress in this area.

IV. INTERIM EVALUATION

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

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

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

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

The first four years of the 1115 Transformation Waiver have laid the framework for future success, but more time is needed to assess the effect of the Medicaid managed care expansion and the implementation of the DSRIP program. System transformation requires a sustained investment of both time and resources to bring positive change to Texas' health system. This summary provides an overview of the evaluation goals and presents preliminary findings during

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

the first three years of the 1115 Transformation Waiver. The complete interim evaluation report is also being submitted to CMS along with this extension application.

A. MANAGED CARE EXPANSION

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

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

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

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

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

PRELIMINARY FINDINGS

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

KEY ACHIEVEMENTS

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

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

Preliminary results:

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

ONGOING CHALLENGES

Results from the Program stakeholder surveys yield room for improvement:

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

B. HEALTHCARE DELIVERY SYSTEM TRANSFORMATION

EVALUATION GOALS

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

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

PRELIMINARY FINDINGS

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

KEY ACHIEVEMENTS

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

  Preliminary results:

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

ONGOING CHALLENGES

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

C. SUMMARY

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

V. FINANCIAL OVERVIEW

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

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

Outlook for Medicaid. These trends are very close to the presidential trends used in DY 01-05.

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

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

VI. PUBLIC NOTICE AND COMMENT PROCESS

PUBLIC NOTICE PROCESS FOR TEXAS' EXTENSION APPLICATION

Texas used a variety of methods to ensure that members of the public and interested stakeholders had ample opportunity to review the extension application and provide comments well in advance of submission of the application to CMS. HHSC informed the public through written and verbal communications with state tribal organizations, electronic notices in the State's administrative record and on the HHSC website, physical postings of the detailed public notice in Medicaid eligibility offices across the state, a webinar conducted by HHSC staff, and through a series of public meetings in eight different cities on seven different dates. The public comment period ran from Monday, July 6, 2015 through Wednesday, August 5, 2015, and by the end of this period, HHSC had received 196 comments covering a broad range of topics. The overall public notice process is described in detail below.

TRIBAL CONSULTATION

In accordance with 42 CFR § 431.408(b), Texas conducted consultation activities with tribes and sought advice from Indian health programs and urban Indian health organizations prior to

submission of the application. As outlined in the State's formal tribal consultation process, Texas provided notice of the extension application to tribal organizations at least 60 days in advance of the extension application. Staff provided written notification to the State's four tribal organizations (Alabama-Coushatta Tribe, Kickapoo Traditional Tribe, Urban Inter-Tribal Center of Texas and Yselta Del Sur Pueblo) on June 30th and asked the tribal representatives to submit comments or questions to HHSC by August 5th to allow time for consideration of comments. The notification included detailed information about the statewide public hearings as well as information on where the tribal representatives could find online postings of the abbreviated and full public notices and a copy of the complete extension application.

In addition to the June 30th written notification, staff informed the tribal representatives of the extension application and public meeting schedule during a standing monthly conference call held on July 2nd. Representatives of all four of the Texas tribal organizations participated on the call. Staff did not receive comments or questions from the tribal organizations during the public comment period. The tribal notification letters and the minutes from the July 2nd tribal meeting can be found in Attachment E.

PUBLIC NOTICE POSTINGS

As noted above, Texas established a 30-day comment period from July 6th through August 5th, during which members of the public and interested stakeholders could submit comments via email, regular mail or through oral or written testimony at public hearings. In compliance with 42 CFR § 431.408(a)(2)(ii), HHSC posted the abbreviated public notice of intent (PNI) in the *Texas Register* on July 3rd at Texas Register. The *Texas Register* is published weekly and is the journal of state agency rulemaking for Texas. In addition to activities related to rules, the *Texas Register* publishes various public notices including attorney general opinions, gubernatorial appointments, state agency requests for proposals and other documents, and it is used regularly by stakeholders. HHSC publishes all Medicaid waiver submissions in the *Texas Register* in addition to many other notices. The publication is available online and in hard copy at the Texas State Library and Archives Commission, the State Law Library, the Legislative Reference Library located in the State Capitol building, and the University of North Texas libraries. All of these sites are located in Austin, except for the University of North Texas, which is located in Denton. Printed copies of the *Texas Register* are also available through paid subscription; subscribers include cities, counties and public libraries throughout the state. The abbreviated PNI provided a summary description of the demonstration, the public meeting schedule with locations and times, and an active link to the HHSC 1115 waiver web page that had links to the 1115 waiver renewal web page where the full public notice document is posted. The abbreviated PNI also included contact information to request copies of the waiver extension application from HHSC via fax, email, mail, or telephone.

On June 30th HHSC's Office of Social Services directed their network of 290 local eligibility offices to physically post the abbreviated PNI from July 6th through August 5th. Local eligibility offices are accessible to the public and are predominantly used by persons seeking or receiving Medicaid and other public health and human services benefits. As noted above, the abbreviated PNI provided the public meeting schedule and contact information to request copies of the waiver extension application from HHSC via fax, email, mail or telephone and noted that copies are provided free of charge.

In accordance with 42 CFR § 431.408(a)(1), HHSC posted a detailed public notice of the extension application on July 2which comprehensively described the application, including links to financial and budget neutrality details and an interim evaluation summary of the goals of the demonstration, and provided physical and electronic addresses where written comments could be submitted or the public could obtain additional information or access and review the application in full. The detailed notice also included the public meeting schedule. In accordance with 42 CFR § 431.408(a)(2), HHSC posted the complete extension application on the agency website on July 2nd , and the application continues to be available on the website since that date.

Further, in accordance with 42 CFR 431.408(a)(2)(iii), HHSC utilized additional electronic mailing lists to notify interested parties of the extension application. HHSC notified stakeholders of the extension application and the opportunity to provide comment and attend public hearings through three separate electronic notices generated through the Gov Delivery system. The system allows members of the public to sign up for email notifications from HHSC on a variety of topics.

On July 3rd, HHSC generated a notice for public comment on the extension application through the Medicaid Transformation Waiver Gov Delivery list. The notice invited the public to comment on the application and included information on the public comment period, as well as how to provide comments at a meeting or webinar, or via email or mail. There were 7,033 recipients of this notice.

On July 10th, HHSC announced the eight extension application public meetings through the HHSC Public Meetings and Events Gov Delivery list. There were 11,790 recipients of this notice.

On July 13th, HHSC generated a notice about available DSRIP regional information and the extension application public comment period through the Medicaid Transformation Waiver list. The notice provided information on where stakeholders could find DSRIP regional plans and project information for each RHP to use in commenting on the extension application. There were 7,056 recipients of this notice.

PUBLIC MEETINGS

In accordance with 42 CFR § 431.408(3), Texas conducted public meetings on different dates and in different locations across the state well in advance of the extension application submission to CMS. Public meetings included a presentation on the extension application at the June 9th Medical Care Advisory Committee (MCAC) meeting in Austin. HHSC staff provided an overview of the submission process and key dates and explained that the application would focus on three key areas: DSRIP programs, the Uncompensated Care pool and Medicaid managed care. Staff also notified the committee members and public attendees about the stakeholder meetings that would be held across the state during the month of July. Members of the MCAC provided comments and questions related to DSRIP projects and allocation of funding, and metrics for mental health quality measures. No members of the public provided comment during the meeting.

During the public comment period, HHSC held the following public meetings:

- Houston - July 13
- Edinburg - July 15
- Tyler - July 16
- Austin - July 16
- San Antonio - July 20
- Dallas - July 21
- El Paso - July 22
- Amarillo - July 24

HHSC hired Health Management Associates (HMA) to attend each of the public meetings and provide a comprehensive summary of public testimony. The following section includes substantive portions from HMA's final report submitted to HHSC. Notes from the public meetings are available on HHSC's website at http://www.hhsc.state.tx.us/1115-docs/080715/WaiverExtension_PublicComments_2015.pdf.

A total of 786 people attended the public hearings. Attendees at the hearings were invited to submit oral testimony, written comments, or both. A total of 150 individuals completed registration forms at the eight in-person hearings indicating their intent to provide comments. Individuals also were asked on the registration form to indicate whether their comments reflected support, opposition, or were neutral on the waiver extension.

At the beginning of each meeting, HHSC staff presented a brief overview of the waiver extension application components and a description of the extension process. Registered attendees provided oral testimony following the staff presentation and some individuals submitted only written comments to HHSC staff. Once public testimony was completed, if additional time remained, HHSC and HMA staff stayed at the hearing until the time of the

meeting conclusion as published in the public hearing notice to accommodate any individuals who arrived within the posted timeframe.

As noted above, 150 individuals across the eight meetings submitted registration forms indicating their intent to submit testimony or simply indicating their position on the waiver application. Of the 150 registrants:

- 129 indicated they support the waiver renewal or support it with changes such as those mentioned in the summary of comments below.
- 12 individuals indicated they are neutral on the waiver renewal
- Eight individuals left the box blank
- One individual submitted two registration forms; in one form he checked “opposed” and in the other he checked “neutral."

In addition to the eight public meetings, HHSC hosted a webinar on July 23 and provided the same overview and opportunity to comment as provided in the face to face meetings. Approximately 200 individuals logged into the webinar and seven provided comments.

ONLINE SURVEY

HHSC solicited additional public feedback about the DSRIP and UC requests in the draft extension application via an online survey. The survey was posted on the Renewal Waiver webpage of the HHSC website during the comment period from July 6th through August 5th. HHSC provided notice about the survey during the monthly Regional Healthcare Partnership Anchor call on July 10th. A total of 17 comments were submitted to the online survey.

SUMMARY OF COMMENTS RECEIVED

The broad participation at the public meetings and the 196 comments submitted during the public comment period demonstrate the importance of the 1115 waiver to individuals and organizations across the state of Texas. HHSC staff documented, reviewed and carefully considered each comment, many of which were supportive of the waiver and contained ideas for program improvements. HHSC did not amend the extension application based on the comments, because most of the comments were relevant to details that will be handled through the program protocols rather than being applicable to the waiver Special Terms and Conditions. HHSC plans to consider the comments received about programmatic details when revising the program protocols this fall for submission to CMS in early 2016. Other comments were outside the scope of HHSC’s authority in submitting the extension request, including related to Medicaid coverage expansion and increasing Medicaid provider rates. Below is a summary of the comments submitted at the public hearings or directly to HHSC, as well as the State's response to that feedback.

SUPPORT FOR EXTENSION OF THE 1115 WAIVER WITH CONTINUATION OF DSRIP PROGRAM AND UC FUNDING

Public Comment

By far, the most predominant message included in the oral testimony was support for the current waiver program and its renewal. Most individuals mentioned specific support for DSRIP initiatives and/or Uncompensated Care (UC) pool funding. Only a few individuals specifically referenced Medicaid managed care programs. Dozens of individuals included specific examples of how the program has benefitted them at a personal level or at the community level. Specific examples provided by stakeholders include reductions in pre-term births; improved access to care through mobile clinics and expanded primary care services; behavioral health initiatives that have provided critical mental health services and diverted individuals from criminal incarceration; improved care coordination and outcomes for individuals with diabetes; and children who received intensive therapy for autism and who are now interacting with family and other children at a near-normal level. Nearly all hospital representatives who testified underscored the importance of increased UC funding. Stakeholders expressed serious concern that a reduction in UC funding would result in closures of hospitals or force a reduction of critical services.

Below are examples of the comments provided at hearings regarding support for DSRIP projects.

- Houston Hearing: The Therapy for Tots DSRIP program provides therapeutic intervention to kids who aren't eligible for DARS' Early Childhood Intervention (ECI) program. These children range in age from birth to 36 months…With this program, 1,118 unique kids have received developmental screening, evaluation, or intervention therapy. There have been 6,000 encounters and over 17,000 units of therapy services have been provided to date. Therapy is provided in both center and home/community settings and has a family-focused approach.
- Tyler hearing: Through the DSRIP, the Community Health Service Agency, Inc. (FQHC) focused on improving access to primary care. They have added after-hours appointments and weekend appointments. Individuals who went to the Emergency Department with non-emergency medical issues have been referred to their primary care providers' offices for one free, initial appointment, resulting in decreased inappropriate ER use reductions in cost of care. In 2014, provided care for 5,400 patients through this project.
- San Antonio: A person from the Health Science Center in San Antonio said that in DSRIP, we're working with Hispanic patients and primary care providers and have improved diabetes outcomes, reduced hypertension. Also putting into practice a process to test every baby boomer for hepatitis C.
- El Paso Hearing: A person from Hospice El Paso said that they participate in the 1115 waiver with the region's anchor, the University Medical Center of El Paso. They allow all individuals in the community, if terminal, to participate in our hospice waiver project regardless of insurance status. This hospice care access is an advantage for the community. Individuals have the care, comfort and needs – the total hospice experience – that others receive. Without the waiver, they wouldn't have access to these services. With it, we are able to take them earlier and provide

comprehensive care.

- Amarillo hearing: Amarillo Recovery from Drugs and Alcohol (ARAD) has served 304 clients since the program began. This program is an intensive 30 day recovery program for residents of local homeless shelters. The program provides transportation and meals for participants, which increases participation. They boast a 64% completion rate, which is unheard of in this field.
- Dallas hearing: The JPS Health Network's Care Transitions for Long-Term Care project has partnered with 7 local skilled nursing facilities. At the beginning of the partnerships, the overall readmission rate for their skilled nursing partners was at 21%. Since then the all-cause, all-condition readmission rate has gone down to 3.1%... These partnerships add incredible value not only for care at post-acute facilities but also for bringing to the forefront the important role that inpatient discharge process plays in successful transition in care for their patients.
- Austin hearing: The 11 projects of the Austin Travis County Integral Care focus on BH and integration of BH with primary care. Projects are beginning to show dramatic impact on costs. One project is a mobile crisis unit that works with civil justice, which diverts patients from ERs and has diverted more than 90% who would go into the criminal justice system. These projects improve lives and have led to the development of important community partnerships. Waiver supports sustainability and transformation in health care delivery.
- Edinburg hearing: The Doctor's Hospital at Renaissance said that DSRIP has supported our ability to improve access to primary care and develop integrated models of care through our projects. We've improved access by expanding specialty services. Hope Clinic project expanded care through provider recruitment. We've improved the quality of care through our Med Reconciliation and Chronic Disease Registry projects. Care Link Clinic has implemented medication therapy management to provide discharge care and eliminate medication errors.

State Response

The State appreciates the comments in support of the extension of the waiver and the requested DSRIP and UC pool funding levels. The testimonies about the benefits of DSRIP under the waiver underscore the importance of the work currently being done at the community level. HHSC appreciates those testimonies, as well as the comments about the critical nature of the Uncompensated Care pool. HHSC is seeking an increased UC pool in the waiver extension request based on the expected unmet need for UC compensation in the extension period, adjusted downward to maintain budget neutrality each year HHSC is committed to making the funding of the UC and DSRIP pools a priority.

SUPPORT FOR MEDICAID EXPANSION

Public Comment

The second most common message was from individuals advocating for Medicaid expansion as part of the waiver renewal, including using a market-based approach as some other states have done. Many of the commenters pointed out they expect CMS' recent decision to cut funding for Florida's uncompensated care program is likely to be repeated in Texas, which will result in significant underfunding of uncompensated care provided by Texas hospitals. Others pointed out the challenges uninsured individuals have accessing health care and the benefits of expanding Medicaid coverage under the Affordable Care Act. Some stakeholders also stated that while the DSRIP program provides significant benefits and has been a very successful program, it is not a substitute for health care coverage. One person recommended using waiver funds to expand Medicaid to 200% of the Federal Poverty Level. A number of the individuals advocating for expansion clarified that they understand the decision to expand is up to the Governor and/or Texas Legislature and not HHSC, but suggested HHSC initiate discussions with state leaders and include a discussion of expansion in the waiver renewal application rather than omitting it entirely from the application.

State Response

HHSC acknowledges the many comments in support of coverage expansion in the state. Texas has not opted to proceed with a Medicaid coverage expansion, so HHSC does not plan to include a request for coverage expansion in the extension request. Upon request, HHSC has and will continue to provide information to the Governor and legislators regarding the potential impacts of Medicaid expansion and the interaction of Medicaid expansion and waiver renewal.

DSRIP-SPECIFIC RECOMMENDATIONS

Public Comment

Strong support for DSRIP continuation and expansion of successful projects to ensure all communities benefit from the positive impact of the program.

Give current DSRIP projects more time to show results given that there was significant lead time to get the program developed and implemented.

The waiver extension is critical to help ensure the sustainability of successful projects by identifying and making needed statutory, funding and regulatory changed in the Texas Medicaid program.

Support for replacement project opportunities.

State Response

HHSC agrees that most current DSRIP projects should continue in order to give them sufficient time to demonstrate results and to allow time for sustainability planning. HHSC is proposing to continue most existing projects in the extension period, is considering replacement projects, and will work with stakeholders to flesh out programmatic details in the DSRIP protocols this fall for submission to CMS in early 2016.

Public Comment

Providers would like to see a reduction in administrative burdens/requirements associated with DSRIP projects.

State Response

The comments related to administrative simplification are consistent with concepts HHSC proposes in the extension request and plans to flesh out with Texas stakeholders this fall in the program protocols to be submitted to CMS in early 2016.

Public Comment

To address system fragmentation, incentivize formation of "systems of care" that provide better coordination of all care (inpatient, primary care, behavioral health, pharmacy, etc.).

- DSRIP needs retooling where the incentive system is modeled and bundled to encourage community partners and hospitals to address systems of care together.
- Development of new projects, including multi-provider collaborations and cross- regional projects, with a higher value placed on providers who collaborate.
- Support the consideration of cross-RHP projects to encourage collaborative projects within health

systems.
- Reward data exchange advances. Support increasing the role of Health Information Exchanges) and adoption of Electronic Medical Records.
- Wants more accountable, transparent model integrating all region's health care assets.

State Response

HHSC acknowledges the comments related to incentivizing systems of care and data sharing. These comments are consistent with concepts HHSC proposes in the extension request and plans to flesh out with Texas stakeholders this fall in the program protocols to be submitted to CMS in early 2016.

Public Comment

Extend more DSRIP to rural RHPs. Suggest adding increased funding to support rural projects, which received limited funding under initial round. Generally supportive of the bonus pool concept, but urge state to allocate funds to IGT-poor RHPs.

State Response

HHSC acknowledges the comments regarding allocating more funds to initiatives in rural counties and DSRIP administrative streamlining. HHSC will consider these issues as it works on the DSRIP program protocols with stakeholders this fall. HHSC intends to streamline the program, including for smaller providers, and is considering raising the minimum valuation of the smallest projects. All DSRIP projects will continue to need an IGT source to support the non-federal share of payments.

Public Comment

Expand education slots for healthcare workforce, and provide more money for rural mental health services.

State Response

Regarding using waiver funds for provider education at all levels and rural mental health care, a large portion of DSRIP dollars are dedicated to these areas and HHSC proposes to continue these programs in the extension period. The details of the DSRIP program in the extension period will be outlined in the revised DSRIP protocols, and HHSC will work with Texas stakeholders on revising the protocols this fall prior to submission to CMS in early 2016.

Public Comment

Comments regarding the lack of meaningful engagement of community-based physicians in DSRIP and concern that some DSRIP funding entities used the process to develop projects that simply

benefit the current hospital-centric environment rather than helping low-income individuals get access to needed care.

One commenter was critical of the implementation of the waiver in Region 9 for a number of reasons:

- some waiver projects are masking current operations as new initiatives;
- some new projects have limited community support or value and large start-up expenses;
- the waiver hasn't accomplished its goal of expanding access to primary and specialty care;
- the waiver encourages a fractured design with too many uncoordinated programs and projects, some that have reduced access to care.

State Response

Since the DSRIP program relies on local public funds as the non-federal share of funds, HHSC allowed local funding entities and DSRIP providers flexibility to propose projects to meet priority needs in each community within the allowable DSRIP menu of projects.

HHSC is working with an external Clinical Champions workgroup, including many physicians, to evaluate project best practices, narrow the extension menu, and encourage the most transformative projects. Texas plans to take additional steps to promote systems of care in the waiver extension period, including by working to further align DSRIP with Medicaid managed care and proposing region wide incentives for regional improvements. HHSC will work with stakeholders this fall to propose revised program details through the DSRIP protocols to submit to CMS in early 2016.

DSRIP projects must be new initiatives or expansions of current initiatives. If someone knows of projects that are not new or expansions, they can report that specific project to HHSC either for compliance monitoring or as a fraud allegation.

One of the goals of DSRIP is to increase access to care, and in no way is the program designed to reduce access to care. Of the 130 active projects in Region 9, 23 projects (over 17 percent) focus on primary and specialty care, as do many other projects throughout the state. Most of the Region 9 projects are being carried out by increasing capacity in hospital-owned clinics or through telemedicine.

Public Comment

Engage a broader range of stakeholders in DSRIP.

- Include community/individual physicians, community health centers, and other frontline providers as participants in DSRIP projects. Establish physician advisory councils and RHP-specific physician advisory committees.
- RHPs and anchor hospitals need to include community stakeholders.
- Include public health departments in input into design and structure of additional funds usage and add a group with expertise about non-clinical interventions.

State Response

Since DSRIP relies on local public funds as the non-federal share of funds, HHSC allowed local funding entities and DSRIP providers flexibility to propose projects to meet priority needs in each community. DSRIP requires broad stakeholder participation and HHSC has and will continue to encourage collaboration with community partners such as community physicians and health centers.

HHSC will continue to engage a broad range of stakeholders and to require RHPs to do the same. The details of the DSRIP program in the extension period will be outlined in the revised DSRIP protocols. HHSC will work with Texas stakeholders on revising the protocols this fall prior to submission to CMS in early 2016.

Public Comment

Numerous DSRIP performance measures and project assessment details such as support for (unless otherwise noted):

- Inclusion of providers and anchors in development of protocol documents
- Payment for partial completion of metrics
- Elimination of the midpoint assessment
- Better alignment of category 3 outcomes with projects
- Use other measures besides Quantifiable Patient Impact (QPI) to capture system transformation
- Allow projects to maintain or expand QPI as appropriate
- Recommend that HHSC carefully consider changes to Category 3 requirements; changing the requirements will cause problems for providers and delay improvements
- Redirection of Category 4 funds to support system-wide improvements
- Continuation of the carry-forward provisions
- Would like to see new DSRIP protocol requirements better aligned with what is actually occurring with projects and include more flexibility or ability to customize based on the type of provider
- Comments both for and against collection of unique Medicaid ID numbers from DSRIP projects and also requiring all DSRIP and UC hospitals to provide admit, discharge and transfer (ADT) data for emergency department care to improve timely care coordination.
- Suggest HHSC consider increasing the $5 million cap on projects due to significant investments some projects have required

State Response

HHSC acknowledges the many comments related to the details of the DSRIP program. HHSC will work with DSRIP stakeholders on these programmatic details as we work on the DSRIP protocols this fall for submission to CMS in early 2016.

Public Comment

Support continued Learning Collaboratives, which have been excellent for building local partnerships and sharing best practices.

State Response

HHSC appreciates the comments in support of the Learning Collaboratives. These comments are consistent with concepts HHSC proposes in the extension request and plans to flesh out with Texas stakeholders this fall in the program protocols to be submitted to CMS in early 2016.

Public Comment

NorthSTAR area needs larger share of DSRIP funding.

State Response

HHSC will continue to engage a broad range of community stakeholders and to require RHPs to do the same. HHSC worked with NorthSTAR stakeholders to work to find a way for greater inclusion of NorthSTAR in DSRIP early in the waiver, but no mutually agreeable path for this was identified given the program's requirements. HHSC will continue to work with RHP 9 and the other RHPs to encourage broad participation in the extension period.

Public Comment

Maximize private hospital participation in DSRIP, including increased participation requirements for private hospitals in Tier 1 and Tier 2 DSRIP regions.

State Response

The initial DSRIP protocols included minimum participation requirements for private hospitals in each RHP plan. The details of the DSRIP program in the extension period will be outlined in the revised DSRIP protocols. HHSC will work with Texas stakeholders on revising the protocols this fall prior to submission to CMS in early 2016.

Public Comment

Comments related to DSRIP payment structure:

- Support continued direct payments to DSRIP providers rather than moving the incentive program into managed care.
- DSRIP incentive payments should be bundled to encourage community partners and hospitals to address systems of care together.

Recommend that all DSRIP providers generate their own non-federal share for payments. For private

hospitals, the mechanism would be a hospital provider tax.

State Response

HHSC's proposal is to continue direct payments to each individual DSRIP provider rather than moving the incentive payments into managed care or bundling them to give the current program more time to demonstrate results.

HHSC cannot authorize a hospital provider tax; such a matter would need to be directed by Texas' elected leaders at their discretion during the next legislative session.

Public Comment

Suggestions for specific types of projects:

- Support continuation of behavioral health carve-out
- Support for including ABA (Applied Behavior Analysis) as a benefit under Medicaid and continued funding for DSRIP projects that provide ABA services based on long term cost savings it provides
- Outpatient palliative care programs
- Pediatric quality improvement projects that would be multi-site and multi-regional, including rapid cycle quality improvement projects at children's hospitals, testing these projects in community hospital and non-hospital settings, and disease registries for rare high cost pediatric conditions.
- Criminal justice/mental health officers training task force program
- Promote investments in ambulatory care through targeted DSRIP programming to promote prevention and population health activities
- Increased primary and specialty care access for vulnerable populations

State Response

HHSC acknowledges the comment regarding continuing behavioral health projects in the extension period, which is included in the HHSC proposal. Regarding additional funds for specific types of projects and collaborations, the details of the DSRIP program in the extension period will be outlined in the revised DSRIP protocols. HHSC will work with Texas stakeholders on revising the protocols this fall prior to submission to CMS in early 2016.

Public Comment

Support the public health carve-out

State Response

HHSC appreciates the comments in support of DSRIP under the waiver and local health department participation.

RECOMMENDATIONS FOR UNCOMPENSATED CARE (UC) POOL

Public Comment

Strong support for increased UC funding, which is critical to support hospitals' ability to provide care; significant concern that if CMS fails to increase UC funds, more hospitals will close, especially in rural communities.

State Response

Regarding the increases in UC Pool, HHSC is already seeking the highest possible UC pools in the waiver renewal request within budget neutrality based on historical unmet needs in the state trended forward for the new waiver period. The UC pool waiver renewal request is an increase from the current waiver. The current waiver provides for a total of $17.582 billion in UC funds over the five-year life of the waiver. The waiver renewal request seeks a total of $35.4 billion over a period of five years beginning in FFY 2017.

Public Comment

Several commenters pointed out that recent CMS guidance during the Florida UC pool negotiations indicates CMS prefers coverage expansion and higher provider payment rates to ongoing supplemental payments for uncompensated care.

State Response

HHSC understands these principles will factor into CMS negotiations with Texas regarding waiver extension in the coming year.

Public Comment

Target UC funds for alternative purposes:

- Allow mental health treatment centers to receive UC payments for treating uninsured individuals
- Consider providing UC funds for providers, other than hospitals, who provide uncompensated care to uninsured individuals
- If UC funds are reduced, at least part of available funds should be refocused on primary care to prevent hospitalizations, thus saving UC costs
- Some UC funds should be used to address the Medicaid burden and increase access for patients.
- Target UC payments for ambulatory care to better address persons in the coverage gap. Promote investments in ambulatory care through refocused UC payments to promote prevention and

population health activities.
- Target hospital UC payments to hospitals that serve a minimum percentage of Medicaid/uninsured and have vertical systems of care.
- Ensure that UC payments are proportional to each hospital's UC burden.
- Have a distinct UC pool for each type of provider

State Response

Current Texas administrative rules for distribution of UC funds are designed to ensure an equitable distribution of available funds across different spectrums of provider types, including: large public, small public and private hospitals; rural and urban hospitals; and hospitals, grandfathered physician groups, public ambulance providers and public dental providers.

Since UC funds are intended to continue the support of various provider types' unreimbursed costs for caring for Medicaid and low-income uninsured patients that existed under various upper payment limit (UPL) programs prior to the waiver effective date, HHSC does not envision opening the UC pool to provider types that did not have a UPL program in place prior to the implementation of the waiver.

Public Comment

Suggestion for the UC application:

- Need to streamline the UC application.

State Response

HHSC will consider the options for the UC pool in updating the UC application.

IMPROVE ACCESS TO MEDICAL HOME

Public Comment

Improve access to primary care/medical home in order to reduce hospital admissions and save on uncompensated care costs.

State Response

HHSC plans to promote in the extension period alternative payment models in managed care to help sustain successful DSRIP efforts going forward, including the many projects that support the medical home.

INCREASE MEDICAID PROVIDER PAYMENT RATES

Public Comment

Enhance physician participation though increased provider payment rates.

State Response

Regarding an increase in provider payment rates, HHSC sets Medicaid provider rates based upon appropriated funds and legislative direction. Based on that direction, HHSC does not plan to request in the September submission any changes in the extension period to increase provider rates. Many providers earn additional supplemental funds through both the UC and DSRIP pools in the waiver, but these payments aren't part of the base Medicaid provider rates.

SUPPORT FOR EQUITABLE AND SUSTAINABLE FUNDING

Public Comment

Equitable funding is crucial to the continuation and sustainability of DSRIP and UC. There is a need for more equitable IGT financing.

- Address financing inequities within IGT funding requirements so that hospitals that provide IGT funding for other hospitals are not disadvantaged, and to ensure sustainability of safety net providers
- To make IGT funding more equitable, suggest allowing any participating entity to put up IGT through a participation fee
- Need equitable and sustainable funding. Hospitals' with lower IGT expense have a higher percent of the project valuation to pay for DSRIP costs and overhead. To create equity in the incentive payment, each entity needs to provide its own State match.
- Unearned funds should not be redistributed to other providers due to IGT

State Response

HHSC acknowledges the comments regarding equitable and sustainable financing. HHSC will continue to work with stakeholders on program details in the protocols.

Regarding the use of unearned funds, HHSC does not plan to redistribute based on IGT previously submitted. HHSC would not request IGT until regional measures have been met and through the same IGT structure currently in place where an IGT Entity transfers IGT for a specific provider.

SUPPORT FOR FURTHER ALIGNMENT OF DSRIP WITH MANAGED CARE

Public Comment

Support further alignment of DSRIP with managed care quality strategy to support a coordinated care delivery system in Texas. Support value-based purchasing and allowing the providers to find the most effective and efficient ways to deliver care.

State Response

HHSC appreciates the comments in support of alignment of DSRIP and managed care quality strategies and the move toward value-based purchasing, which is expected to allow MCOs and providers to work together to find the most effective and efficient ways to deliver care.

Public Comment

Provide a structure for MCOs to participate. Require Managed Care Organizations (MCOs) to participate in projects relevant to the populations they serve.

Would like for HHSC to help forge relationships with MCOs.

State Response

HHSC plans to further encourage alignment of DSRIP with managed care in the extension period. The details of the DSRIP program, such as MCO participation, in the extension period will be outlined in the revised DSRIP protocols. HHSC will work with Texas stakeholders on revising the protocols this fall prior to submission to CMS in early 2016.

Public Comment

Need to be sure we can serve people's needs as we expand managed care.

State Response

HHSC acknowledges the comment about the need for parallel strategies for STAR Plus and DSRIP in terms of care coordination. HHSC is working and will continue to work to ensure greater collaboration between MCOs and DSRIP providers on care coordination.

Public Comment

Specific suggestions about how MCOs might contribute to the overall effort and help sustain

programs with more permanent payment arrangements, such as:

- Track population statistics
- Timely exchange of Health
- Care coordination and Case Management
- Medical homes, behavioral health and telemedicine
- Financial Sustainability
- Whole Person Projects
- Focused Quality Measures
- Value-based purchasing
- MCO Pilot Projects
- Collaborative Performance Improvement Project (PIP)

State Response

Regarding specific suggestions about how MCOs can contribute to the overall effort to sustain DSRIP projects, HHSC appreciates the thoughtful suggestions and will consider each of them as part of our ongoing effort to develop ways to sustain DSRIP projects, align DSRIP with managed care quality strategies, and further develop value-based purchasing in our managed care programs. As part of the consideration of the suggestions, HHSC will research the suggestions and explore the feasibility, cost effectiveness, and viability. HHSC will explore the best approach to implementation of the suggestions, such as amending contractual requirements with MCOs and/or requesting federal approval as needed.

IMPROVE ACCESS TO PROVIDERS

Public Comment

Texas received several comments, primarily from providers and MCOs, who noted concerns related to access to certain provider types. The comments focused on access to primary care providers, behavioral health providers, and specialty providers. Some of the comments related to the impact of DSRIP on improving access to care. These DSRIP-related comments largely were positive, indicating that DSRIP has helped to provide more access to care, but some comments were negative or said more needs to be done. Below are excerpts from some of these comments and the State's response:

- The aging population of providers in east Texas has complicated our efforts to grow the provider base so we are now finding the number of new recruits needed is double what we had anticipated just to provide the growth we established in the current waiver. Having to replace providers who are retiring clearly was not taken into account when we projected the number of providers needed and probably would not have been allowed under the current waiver. We are ready and want to

continue all of our provider projects and expand services as needed in the future, but without the waiver those efforts will simply be strained just to retain the current access due to factors like retirement and relocation of non-waiver funded positions. Improving the access to primary and specialty care outpatient clinics is the very best solution to slowing the current patient load at the emergency department and moving patients to a lower cost system.

- In 3 counties, they are only primary care provider in the entire county. These counties have an average of 30% uninsured individuals.
- First, the current waiver has NOT accomplished its goal of expanding patients' access to primary and specialty physician care. As the waiver is now structured, accomplishing that goal is unlikely. Despite the large influx of financial resources (>$1.0 Billion in the first 3 years) to Region 9 under the Waiver, physicians have seen only a minor expansion of primary and specialty physician care access. What was described in our 2013 Community Needs Assessment – a need for expansion of the safety net of primary care dedicated to vulnerable populations - has not been adequately addressed.
- Despite benefits of DSRIP, we're still in a crisis situation. We have significant behavioral health care needs. We've tried to improve access to psychiatric services through telemedicine and by coordinating with local mental health agencies. … We could improve payments under the waiver, perhaps offer alternative payment models to support medical homes through DSRIP population health management projects.
- Mental health funding has historically been insufficient. DSRIP has provided unprecedented influx of dollars and solutions for Behavioral Health system which has serious consequences in health care systems regarding wait lists for mental health care, fragmentation of services, criminalization of mental illness, mental health provider shortages.
- When looking at what DSRIP projects cover, we'd like to see improved access to care and particularly specialty providers. We need more providers in this region.
- One of our biggest needs is behavioral/mental health in our region. To meet this need as a part of the 1115 waiver we instituted telemedicine psychiatry services in the region and at our facilities. We are finding that we are surpassing our goals at an extremely fast rate.

State Response

Texas is a large state that includes rural counties where there are few primary care, specialty or behavioral health providers. Also, Texas and the nation are experiencing a shortage of mental health providers and the extent of the mental health shortage is expected to worsen as the workforce continues to age (Hogg Foundation for Mental Health, 2011). Some of the comments provided bring to light these facts.

To ensure access to Medicaid providers, Texas expects its contracted Medicaid MCOs and DMOs to ensure access to primary care, specialty, and behavioral health providers within a certain distance of a client's home, as defined by the state. However, MCOs and DMOs can only meet this standard when the provider base exists and the providers are also contracted with the state Medicaid program. MCOs and DMOs that do not meet these standards are subject to remedies, including liquidated

damages, and must maintain an adequate provider network as a condition of contract retention and renewal.

Texas is implementing other strategies to monitor and improve access to providers in its managed care programs. S.B. 760, 84th Legislative Session, 2015 requires, for example, that HHSC track and report the length of time between prior authorization and initiation of certain services; submit biannual reports to the Legislature on the results of network adequacy monitoring, and the provider-to-recipient ratios for PCPs and specialists; and develop access standards that distinguish between rural and urban settings and the number and geographic distribution of Medicaid providers. Texas is also conducting a study to learn how long clients are waiting for appointments as a way of measuring network adequacy. Texas recently shared with the MCOs the list of state Medicaid-enrolled psychiatrists not currently contracted with the MCOs to ensure MCOs are aware of and offering contracts to these psychiatrists throughout the state. Additionally, MCOs are contractually required to assign each member a primary care provider that serves as a medical home for that member and similarly, children are assigned a main dentist to serve as the main dental home in the dental program. Especially as Texas implements S.B. 760, we will continue to monitor and improve Medicaid clients' ability to access providers through its managed care programs.

One of the goals of DSRIP is to increase access to care, and in no way is the program designed to reduce access to care. In demonstration year (DY) 3 (October 1, 2013-September 30, 2014), DSRIP projects collectively provided over 2 million additional encounters and served over 950,000 additional individuals compared to the service levels they had provided prior to implementing the projects.

EXPAND CONSUMER ASSISTANCE

Public Comment

Recommend expanding consumer assistance through independent ombudsman and creating a risk group for individual with complex medical needs to improve health outcomes in the most integrated setting and maximize federal contributions.

State Response

A change to the extension application is not required to expand consumer assistance through the ombudsman or to explore options for improving health outcomes for individuals with complex medical needs and maximizing federal contributions.

As required by the Centers for Medicare and Medicaid Services (CMS), Texas already operates an independent consumer supports system that consists of HHSC's Medicaid/CHIP Division, the Office

of the Ombudsman, the State's managed care enrollment broker, and community support from the Aging and Disability Resource Centers (ADRCs) across the state. These entities operate independently of any Medicaid MCO and work with beneficiaries and MCOs to ensure beneficiaries working to enroll with a MCO understand their managed program, MCO options, and the process for resolving issues. As a result of SB 760, 84th Legislature, Regular Session 2015, HHSC will be working with its consumer support system, to additionally include the DADS Long Term Care Ombudsman and Area Agencies on Aging to coordinate a network of systems to educate and support Medicaid managed care members, which will expand on what is done to assist consumers today.

Regarding the comment to expand consumer assistance to individuals who could receive services under DSRIP, HHSC has relied on DSRIP providers to provide consumer outreach regarding their available services, as providers have incentives to meet their service goals in order to earn a portion of their DSRIP funds each year.

Regarding the request to add a new risk group of individuals with complex needs to the waiver to provide services in an integrated setting, HHSC continues to explore the feasibility and cost effectiveness of such an option per legislative direction. HHSC staff has been meeting internally to discuss systems, process, and policy changes, timelines and fiscal implications. While the State does not plan to amend the 1115 extension application at this time, HHSC will seek CMS guidance on the best approach for any proposed changes that develop from this research.

SYSTEMS OF CARE FOR THE UNINSURED

Public Comment

Failing a statewide approach to coverage, suggest offering an option for uninsured care within coordinated, integrated systems of care.

Reinvest the savings realized by the Texas Medicaid Waiver into development of systems of care that support low-income populations.

State Response

HHSC acknowledges the comments regarding an option for uninsured care within coordinated, integrated systems of care failing a statewide approach to coverage. HHSC would like to understand more details about this proposal.

Regarding using savings generated in the waiver to support systems of care for the uninsured, HHSC agrees that one very important goal of the waiver is to improve healthcare access and quality for low-

income uninsured Texans. The UC pool supports care for this population, and many DSRIP projects focus on serving the uninsured. The waiver is helping to support systems of care for the uninsured designed at the local level, and HHSC will be working to improve the waiver programs to further support in the extension period systems of care both for Medicaid and uninsured individuals.

QUESTIONS AND REQUESTS

Public Comment

- Request that HHSC explain recommendation to provide Medicaid IDs for reporting
- Request that HHSC clarify whether it intends to allow expansion of existing DSRIP projects during the next phase of the waiver
- Request that HHSC provide information on when the evaluation will be completed in order to allow providers to indicate that a project has met its purpose based on the evaluation, which should support continuation of the project under the renewal period
- Request that HHSC indicate when providers will know if new projects will be considered under the renewal

State Response

The details of the DSRIP program in the extension period will be outlined in the revised DSRIP protocols. HHSC will work with Texas stakeholders on revising the protocols this fall prior to submission to CMS in early 2016.

Public Comment

- Request that HHSC indicate whether they have any information on CMS' position regarding continuation of the current funding mechanism
- Request that HHSC indicate when the state will find out that CMS will look favorably on the renewal request

State Response

The current waiver expires on September 30, 2016 and there is no set deadline by which CMS must approve HHSC extension application request. HHSC anticipates negotiating modifications to the extension application with and receiving a decision from CMS during the 12 months following application submission.

Public Comment

- What becomes of funds contributed to I.G.T and not expanded due to lack of follow through?

State Response

HHSC only collects IGT based on DSRIP reported and HHSC approved achievement for processing DSRIP payments. There are not remaining IGT funds held by HHSC that are not used for payments.

Public Comment

- Section IV: What is a provider related donation? Specifically (b) in cash or in kind?

State Response

A provider-related donation is a voluntary donation from a non-governmentally operated health care provider or entity related to a private health care provider; in cash or in kind; made to a governmental entity, whether or not that entity provides for an IGT; and is directly or indirectly related to a Medicaid payment or other payment to providers.

Public Comment

- Will there be any change to allow counties to count any IGT toward their Indigent Care responsibility? Believe this has stopped many counties from supporting the waiver and limited the ability of many facilities to take care of the uninsured.

State Response

This is a state statutory issue rather than a waiver issue. Legislation was passed in 2013 (S.B. 872) during the 83rd Legislative Session to enable counties to count waiver IGT toward 4% of their 8% indigent care obligation if the County Commissioners determine this expenditure meets the county's indigent care obligation under Chapter 61 of the Texas Health and Safety Code.

POST-AWARD FORUMS

Since the original approval of the 1115 waiver, Texas has complied with STC 14 which requires the State, at least once a year, to afford the public an opportunity to provide meaningful comment on the progress of the demonstration and to post these public meetings at least 30 days in advance. STC 14 allows Texas to use the MCAC as a post-award forum and HHSC has done so on the following dates:

- February 9, 2012
- November 8, 2012
- June 12, 2013

- February 13, 2014
- August 14, 2014
- November 7, 2014
- June 9, 2015

HHSC has also provided information regarding the 1115 waiver at Health & Human Services Council meetings, at which the public is allowed to comment, on the following dates:

- June 14, 2012
- September 13, 2012
- November 29, 2012
- June 14, 2013
- August 28, 2013
- August 15, 2014

The 1115 waiver was also a topic at HHSC Stakeholder Forums held on July 14, 2014 and October 13, 2014. The forums were open to the public and HHSC staff presented an overview of progress to date on the demonstration waiver and took questions and feedback from those in attendance. Archived recordings of the forums are posted on the HHSC website.

VII. STC COMPLIANCE

Attachment F contains information on the State's compliance with the STCs as set forth in the current 1115 Transformation Waiver.

VIII. CONCLUSION

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

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

Texas has successfully implemented major managed care expansions and initiatives within a system that covers over 3.3 million Medicaid enrollees per month. The STAR, STAR+PLUS and Children's Medicaid Dental Services programs, together with DSRIP and UC funding pools, help support the development and maintenance of a coordinated care delivery system. Additionally, the combination of the DSRIP and UC pools provide critical safety net support for low income Texans while incentivizing providers to test initiatives to improve patient care and

outcomes. DSRIP has enabled groundbreaking work, including increased regional and cross-regional collaboration between diverse healthcare providers and stakeholders, and investments in infrastructure and innovation to improve systems of care.

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

ENCLOSURES/ATTACHMENTS

Attachment A - Examples of Texas DSRIP Projects

Attachment B - Quality Monitoring Reports and Deliverables

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

Attachment D - 1115 Waiver Extension Budget Neutrality Calculations

Attachment E - Documentation of Tribal Consultation

Attachment F - STC Compliance

Attachment A - Examples of Texas DSRIP Projects

Texas currently has 1,457 active DSRIP projects implemented by 298 providers in 20 Regional Healthcare Partnerships (RHPs) across the state. This attachment contains a few examples of projects underway in several RHPs, including some projects that have provided updates during the CMS Monthly Waiver Monitoring calls.

A complete list of active Category 1 and 2 DSRIP projects and associated Category 3 outcome measures is available at http://www.hhsc.state.tx.us/1115-RHP-Plans.shtml, along with a searchable database of projects, more detailed information on each project, and a link to the 20 RHP websites.

Regional Tools to Share Information about DSRIP Projects

Two examples of regional tools to share information about the projects underway:

- A project map for RHP 3 (Southeast Texas - Houston and surrounding) to find projects by topic area, provider, zip code, Congressional and Legislative Districts. http://www.setexasrhp.com/go/doc/6182/2421626/
- An interactive PowerPoint-based tool for RHP 6 (San Antonio and surrounding) to search for projects by provider, type of provider, project area, Category 3, etc. Download this interactive tool to help you navigate the most current RHP 6 DSRIP Projects. *Posted February 2015.*

Video Examples of DSRIP Projects and Collaboration

- RHP 7 (Austin and surrounding area) - A series of videos that show the impact of a number of DSRIP projects in the region, including related to Assertive Community Treatment for individuals with intellectual and developmental disabilities (IDD), mobile health teams, adult immunizations, mobile crisis outreach services, and veterans' peer support. http://texasregion7rhp.net/

- RHP 12 (Lubbock, Amarillo and surrounding) - A new partnership with other DSRIP providers (University Medical Center Lubbock and Texas Tech) to new offer local chemotherapy to patients at the 39-bed Childress Regional Medical Center. https://www.youtube.com/watch?v=sHp3jKX2GMY&feature=youtu.be

Example of Increased Data Exchange in RHP 19

In RHP 19, all 12 counties are in what we call “white space” in Texas. This means that there is no health information exchange (HIE) in place to cover these areas. This has been an ongoing issue as HIEs have worked to become self-sustainable, but most require an institution of higher education or other system to host them.

With the unique collaborations and regional projects initiated in RHP 19, the major tertiary hospital, United Regional Health Care System, and the RHP anchoring entity, Electra Memorial Hospital,

have forged a partnership creating an HIE. United is hosting an HIE powered by Cerner, and Electra is their first integrator. RHP 19 has a vision to create a single HIE for the entire region that would support data sharing, not only between hospitals and physicians, but also across the continuum of care including nursing homes, home health agencies, mental health agencies, and other providers.

To date, RHP 19 has identified the need to better coordinate care from the tertiary center back home to the primary care settings. They currently have a DSRIP project in place using United Regional's Community Partners group, which brings providers across the continuum of care together to discuss the major health issues, as well as quality. It also provides a dashboard measurement back to each type of provider related to their patients' disposition. These dashboards include patients that were readmitted, so that information can be reviewed and analyzed in hopes of preventing any future adverse results.

This is an environment of cooperation and transparency that could make a real difference in targeting and managing super utilizers. Being able to know what care a patient has received, who and where their primary care and mental health providers are located, and being able to provide real-time information to others, is extremely important in the continuum of care. RHP 19 would like to expand the HIE to include all providers in the region, but cost and technology remain a challenge. Our goal is that the next round of DSRIP will further incentivize these unique collaborative opportunities through regional projects and HIE integration.

Projects Reviewed on CMS Monthly Waiver Monitoring Calls

Below are the summaries of projects reviewed with CMS staff on recent waiver monthly monitoring calls. These are examples of the diversity of Texas DSRIP providers and projects and the early impact of the projects.

- **Bluebonnet Trails Community Center (RHP 6, Guadalupe County)** - In collaboration with the Guadalupe Regional Medical Center, implement a patient navigation project for persons who are frequent users of the Emergency Department due to behavioral health disorders to provide rapid triage, assessment and alternative services to frequent users of the ED. The Patient Navigator has a continuum of care to offer because of expanded Substance Use Disorder Services (supported by DSRIP), Extended Observation Unit (state funded) and the Integrated Health Clinic (HRSA funded). Over time, the goal is to move to a more value-based payment system with the Medicaid managed care plans in this area for this continuum of care, which would include payments and incentives for the Patient Navigation piece, which is critical to appropriate diversion from the ED.

    - Project update at the end of DY 3: 183 unique individuals have been served by 427 encounters in the Patient Navigator Program. Persons who have never used BTCS services have entered services after interaction with the Patient Navigation team, and the project has helped integrate services with other waiver projects (Crisis Respite, Child Crisis Respite, Transitional Housing, Seguin Extended Observation Unit, Georgetown Extended Observation Unit, and Expanded Access Program) and with existing BTCS services (Intellectual and Developmental Disabilities, Mental Health Services).

- Category 3 outcome measure - IT-3.14 Behavioral Health /Substance Abuse 30-day Readmission Rate

- **Texas Children's Hospital (RHP 3, Houston/Harris County)** - Establish a patient centered medical home for medically fragile children in order to provide proactive care coordination, chronic disease management, and a multi-disciplinary approach that educates patients and providers on appropriate transition processes from pediatric providers to a medical home with services provided by adult providers.
  - Project update at the end of DY 3: Our project met its goal of adding 123 new Medicaid patients in DY 3. Other major accomplishments include standardizing a referral process design to eliminate access barriers, successfully replacing several key staff members, educating community providers to care for complex patients and working with disease specific clinics to develop a defined transition plan.
  - Category 3 outcome measure - IT-10.1.a.i Assessment of Quality of Life (AQoL-4D).

- **Amarillo Public Health Department (RHP 12, Amarillo)** - Expand mobile clinics, which includes the development of an Immunization Program for low income adults 19 years and older, purchase vaccine to immunize targeted adult population ages 19 and older who are indigent or Medicaid, employ staff members to provide adult vaccines, and purchase mobile clinic vehicle to operationalize outreach for adult safety-net vaccination events.

  - Project update at the end of DY 3: The first mobile clinic was held on September 27, 2014 at the Amarillo Civic Center - 167 clients received 436 immunizations.
  - Category 3 outcome measures - IT-12.10 Adults (18+ years) Immunization status, IT-12.4 Pneumonia vaccination status for older adults, IT-12.6 Influenza Immunization -- Ambulatory.

- **Community Care Collaborative (RHP 7, Austin/Travis County)** - Expand the Community Health Paramedic (CHP) program currently operated by Austin Travis County Emergency Medical Services (ATCEMS) to provide short term care management and patient navigation services to low-income Travis County residents with multiple chronic conditions and have frequent recent Emergency Department (ED) utilization.

  - Project update at the end of DY 3: The program served 103 new patients due to the DSRIP effort (new staff, an additional vehicle and necessary equipment). These patients are all considered low-income uninsured, have two or more chronic diseases and have been to the ED 2 or more times within a 30 day period. Additionally, the team incorporated data from the patient's 30 day care plan into the CCC health information exchange (HIE), allowing all providers using the HIE to access this information.
  - Category 3 outcome measure - IT-9.2 Reduce ED visits for Ambulatory Care Sensitive Conditions (ACSC) per 100,000.

Attachment B - Quality Monitoring Reports and Deliverables

March 2012-December 2012

Performance Improvement Projects (PIPs) (additional information can be found at http://www.hhsc.state.tx.us/hhsc_projects/ECI/performance-improvements-projects-.shtml)

STAR	STAR+PLUS
• Improve treatment for ambulatory care sensitive conditions through reduction of emergency department visits • Improve access to specialty care	• Improve member understanding and utilization of service coordination • Reduce nursing facility admission rates

MCO Administrative Interviews

On-site Interviews	*Teleconference Interviews*
• BCBS • MCNA • Christus • Scott and White	• Amerigroup • Cook Children's • Community First Health Plan • Community Health Choice • DentaQuest • Driscoll • El Paso First • FirstCare • HealthSpring • Molina • Seton • Sendero • Superior • Texas Children's Health Plan • United Healthcare • Aetna • Parkland

Attachment B - Quality Monitoring Reports and Deliverables

EQRO Reports (Publically posted reports can be found at http://www.hhsc.state.tx.us/about_hhsc/reports/search/Search_Reports.asp)

Data Certification Reports (SFY 2012) • STAR Mid-year Data Certification Report, Measurement Period September 1, 2011 through August 31, 2012 • STAR Pharmacy Mid-year Data Certification Report, Measurement Period March 1, 2012 through February 28, 2013 • STAR+PLUS Mid-year Data Certification Report, Measurement Period September 1, 2011 through August 31, 2012 • STAR+PLUS Pharmacy Mid-year Data Certification Report, Measurement Period March 1, 2012 through February 28, 2013 • Medicaid Dental Mid-year Data Certification Report, Measurement Period March 1, 2012 through August 31, 2012
Encounter Data Validation Report • Texas Medicaid Managed Care and Children's Health Insurance Program Dental Encounter Data Validation Report, Measurement Period March 1, 2012 through October 31, 2012
Summary of Activities Report • Texas Medicaid Managed Care and Children's Health Insurance Program External Quality Review Organization Summary of Activities and Trends in Healthcare Quality, Measurement Period September 1, 2009 through December 31, 2011
Survey Reports • STAR Program Child Survey Report • STAR+PLUS Program Adult Member Survey Report, Measurement Period September 1, 2010 through August 31, 2011 • STAR+PLUS Program Adult Member Survey Addendum, Measurement Period June 2009 through March 2011
Quality of Care Reports • STAR Quality of Care Report, Measurement Period January 1, 2011 through December 31, 2011 • STAR+PLUS Quality of Care Report, Measurement Period January 1, 2011 through December 31, 2011
Potentially Preventable Events • Potentially preventable complications reports provided in 2012 were for fee-for-service and primary care case management. • Potentially Preventable Readmissions in the Texas Medicaid Population, State Fiscal Year 2011

Attachment B - Quality Monitoring Reports and Deliverables

January 2013-December 2013

Performance Improvement Projects (PIPs)

STAR	STAR+PLUS
• Reduce emergency department utilization due to ambulatory care sensitive conditions through improved treatment • Improve access to utilization of preventive care for physical and behavioral health	• Improve management of chronic disease • Reduce nursing facility admission rates

MCO Administrative Interviews

On-site Interviews	*Teleconference Interviews*
• Driscoll • HealthSpring • Molina • Superior • United Healthcare	• Aetna • Amerigroup • BCBSTX • Christus • Community First • Community Health Choice • Cook Children's • DentaQuest • El Paso First • FirstCare • MCNA Dental • Parkland • Scott & White • Sendero • Seton • Texas Children's

EQRO Reports

Data Certification Reports (SFY 2013)
• STAR Data Certification Report, Measurement Period September 1, 2012 through August 31, 2013 • STAR Pharmacy Data Certification Report, Measurement Period September 1, 2012 through August 31, 2013 • STAR+PLUS Data Certification Report, Measurement Period September 1, 2012 through August 31, 2013 • STAR+PLUS Pharmacy Data Certification Report, Measurement Period September 1, 2012 through August 31, 2013 • Medicaid Dental Data Certification Report, Measurement Period September 1, 2012 through August 31, 2013

Attachment B - Quality Monitoring Reports and Deliverables

Encounter Data Validation Report

- 2013 Encounter Data Validation Study Result Tables, including STAR and STAR+PLUS

Summary of Activities Report

- Texas Medicaid Managed Care and Children's Health Insurance Program External Quality Review Organization Summary of Activities and Trends in Healthcare Quality, Measurement Period September 1, 2009 through December 31, 2012

Survey Reports

- STAR Program Child Behavioral Health Survey Report, Measurement Period September 1, 2010 through August 31, 2011
- STAR+PLUS Behavioral Health Survey Report, Measurement Period September 1, 2010 through August 31, 2011
- STAR Adult Behavioral Health Survey Report, Measurement Period September 1, 2011 through August 31, 2012
- Medicaid and CHIP Dental Caregiver Survey Technical Appendix
- STAR+PLUS Program Member Survey Report, Measurement Period September 1, 2011 through August 31, 2012

Quality of Care Reports

- Medicaid and CHIP Physical and Behavioral Health Quality of Care Report, Measurement Period January 1, 2012 through December 31, 2012
- STAR+PLUS Quality of Care Report, Measurement Period January 1, 2012 through December 31, 2012
- Medicaid and CHIP Dental Quality of Care Report, Measurement Period February 1, 2012 through December 31, 2012

Potentially Preventable Events

- Potentially Preventable Complications in the Texas Medicaid Population State Fiscal Year 2012
- Potentially Preventable Readmissions in the Texas Medicaid Population, State Fiscal Year 2012

Attachment B - Quality Monitoring Reports and Deliverables

January 2014-December 2014

Performance Improvement Projects (Topics)

STAR	STAR+PLUS	Dental	Collaborative
• Adolescent Well-Care • Annual Dental Visit • Asthma • Cellulitis • Childhood Immunization Status • Comprehensive Diabetes Care • Controlling BP • Follow-up after Hospitalization for Mental Illness • Pneumonia • Potentially Preventable Admissions • Potentially Preventable ED Visits • Well-child Visits	• Adherence to Antipsychotic Medications • Asthma • Comprehensive Diabetes Care • Controlling Blood Pressure • Chronic obstructive pulmonary disease	• Sealants and Fluoride • Timeliness of Oral Evaluation • Annual Dental Visit • Preventive Care	• Asthma • Potentially preventable admission (cellulitis) • Comprehensive Diabetes Management

Attachment B - Quality Monitoring Reports and Deliverables

MCO Administrative Interviews

On-site Interviews	*Teleconference Interviews*
• Aetna • Amerigroup • Community Health Choice • Parkland • Seton • Texas Children's	• Blue Cross Blue Shield Texas • CHRISTUS • Cigna-HealthSpring • Community First • Cook Children's • DentaQuest • Driscoll • El Paso First • FirstCare • MCNA Dental • Molina • Scott & White • Sendero • Superior • UnitedHealthcare

EQRO Reports

Data Certification Reports (SFY 2014) • STAR Data Certification Report, Measurement Period September 1, 2013 through August 31, 2014 • STAR Pharmacy Data Certification Report, Measurement Period September 1, 2013 through August 31, 2014 • STAR+PLUS Data Certification Report, Measurement Period September 1, 2013 through August 31, 2014 • STAR+PLUS Pharmacy Data Certification Report, Measurement Period September 1, 2013 through August 31, 2014 • Medicaid Dental Data Certification Report, Measurement Period September 1, 2013 through August 31, 2014
Encounter Data Validation Report The 2014 report has not been received but will cover Medicaid dental services.
Summary of Activities Report • Texas Medicaid Managed Care and Children's Health Insurance Program External Quality Review Organization Summary of Activities and Trends in Healthcare Quality, Measurement Period September 1, 2008 through December 31, 2013 • Texas Medicaid Managed Care and Children's Health Insurance Program External Quality Review Organization Summary of Activities and Trends in Healthcare Quality Addendum: Performance Improvement Project and Encounter Data Validation, Measurement Period January 1, 2013 through December 31, 2013

Attachment B - Quality Monitoring Reports and Deliverables

Survey Reports

- STAR Child and STAR+PLUS Adult Behavioral Health Survey Report, Enrollment Period April 2012 through March 2013, Recall Period May 2012 to August 2013
- STAR Program Adult Member Survey Report, Measurement Period July 31, 2011 through August 1, 2012
- STAR Child Caregiver Survey Technical Appendix
- STAR Adult Technical Appendix
- STAR+PLUS Technical Appendix

Quality of Care Reports

- Quality of Care – In-depth Analysis Report: Antidepressant Medication Management, Preventable Admissions and Visits, and Dental Measures Report, STAR+PLUS
- Quality of Care – In-depth Analysis Report: Potentially Preventable Events in CHIP and STAR
- Quality of Care – In depth Analysis Report: Medicaid and CHIP Dental

Potentially Preventable Events

- Potentially Preventable Complications in Texas Medicaid and CHIP Programs, Measurement Period Fiscal Year 2013
- Potentially Preventable Readmissions in Texas Medicaid and CHIP Programs, Measurement Period Fiscal Year 2013

January 2015-December 2015

EQRO Reports

Encounter Data Validation Report

The 2015 report has not been received but will cover the STAR and STAR+PLUS programs.

Summary of Activities Report

Report is due to HHSC in December 2015 with an addendum due March 2016.

Survey Reports

Surveys will be conducted for the following programs:

- STAR Child – CAHPS and Behavioral Health
- STAR+PLUS Behavioral Health
- STAR Adult Behavioral Health
- Medicaid and CHIP Dental Caregiver Survey

Quality of Care Reports

- Quality of Care – In depth Analysis Report: Medicaid and CHIP Dental- due December 2015
- Quality of Care – In-depth Analysis Report: Physical and Behavioral Health- due February 2016

Potentially Preventable Events

- Potentially Preventable Admissions in Texas Medicaid and CHIP Programs, Measurement Period Calendar Year 2013
- Potentially Preventable Emergency Department Visits in Texas Medicaid and CHIP, Measurement Period Calendar Year 2013

Calendar Year 2015 MCO Quality Performance Dashboard Measures

I. POTENTIALLY PREVENTABLE EVENTS

STAR

Performance Indicator

Potentially Preventable Emergency Department Visits (PPV) - Ratio of Actual to Expected
Potentially Preventable Readmissions (PPR) - Ratio of Actual to Expected
Potentially Preventable Admissions (PPA) - Ratio of Actual to Expected
Potentially Preventable Complications (PPC) - Ratio of Actual to Expected
Potentially Preventable Ancillary Services (PPS)

STAR+PLUS

Performance Indicator

Potentially Preventable Emergency Department Visits (PPV) - Ratio of Actual to Expected
Potentially Preventable Readmissions (PPR) - Ratio of Actual to Expected
Potentially Preventable Admissions (PPA) - Ratio of Actual to Expected
Potentially Preventable Complications (PPC) - Ratio of Actual to Expected
Potentially Preventable Ancillary Services (PPS)

II. ACCESS TO CARE

Access/Availability of Care

STAR

Performance Indicator

Percent of Children w/Access to PCP (12 - 24 months) (CAP)
Percent of Children w/Access to PCP (25 mo - 6 years) (CAP)
Percent of Children w/Access to PCP (7 - 11 years) (CAP)
Percent of Children w/Access to PCP (12 - 19 years) (CAP)

STAR+PLUS

Performance Indicator

None

III. QUALITY OF CARE

Member Satisfaction – Adult

STAR

Performance Indicator

Percent good access to urgent care±
Percent good access to specialist appointments
Percent good access to routine care±
Percent good access to special therapies±
Percent good access to behavioral health treatment or counseling±
Percent rating personal doctor a "9" or "10"
Percent rating their health plan a "9" or "10"
Percent good experiences with doctors' communication±

STAR+PLUS

Performance Indicator

Percent good access to urgent care±
Percent good access to specialist appointments
Percent good access to routine care±
Percent good access to special therapies±
Percent STAR+PLUS members with good access to service coordination±
Percent good access to behavioral health treatment or counseling±
Percent rating personal doctor a "9" or "10"
Percent rating their health plan a "9" or "10"
Percent good experiences with doctors' communication±
Percent Members Utilizing Consumer Directed Services (CDS) that includes:1. Non-HCBS Program Primary Home Care 2. HCBS Personal Attendant Services

Member Satisfaction - Child (Parent/Caregiver)

STAR

Performance Indicator

Percent good access to urgent care±
Percent good access to specialist appointments
Percent good access to routine care±
Percent good access to behavioral health treatment or counseling±
Percent rating child's personal doctor a "9" or "10"
Percent rating their child's health plan a "9" or "10"
Percent good experiences with doctors' communication±

STAR+PLUS

Performance Indicator
None

Children's Preventive Health

STAR

Performance Indicator
Well-Child Visits – First 15 Months: 6+ Visits (W15)
Well-Child Visits – 3rd, 4th, 5th, and 6th Years (W34)
Well-Child Visits – Adolescents (AWC)
Childhood Immunization Status (CIS) - Combination 4

STAR+PLUS

Performance Indicator
Well-Child Visits – 3rd, 4th, 5th, and 6th Years (W34)
Well-Child Visits – Adolescents (AWC)

Women's Preventive Health

STAR

Performance Indicator
Cervical Cancer Screening (CCS)
Prenatal Care (PPC)
Postpartum Care (PPC)
Chlamydia Screening in Women (CHL)

STAR+PLUS

Performance Indicator
Cervical Cancer Screening (CCS)
Prenatal Care (PPC)
Postpartum Care (PPC)
Breast Cancer Screening (BCS)

Prevention and Screening

STAR

Performance Indicator
Child/Adolescent BMI Percentile Documented (WCC)
Counseling for Nutrition for Children/Adolescents (WCC)

Counseling for Physical Activity for Children/Adolescents (WCC)

STAR+PLUS

Performance Indicator

Adult BMI Assessment (ABA)

AHRQ Prevention Quality Indicators [PQI] (Adults ≥ 18 yrs)

STAR

Performance Indicator

Diabetes Short-Term Complications
Diabetes Long-Term Complications
Chronic Obstructive Pulmonary Disease or Asthma in Older Adults
Hypertension
Congestive Heart Failure
Low Birth Weight
Dehydration
Bacterial Pneumonia
Urinary Tract Infection
Angina w/o Procedure
Uncontrolled Diabetes
Asthma in Younger Adults
Lower Extremity Amputation among Patients with Diabetes

STAR+PLUS

Performance Indicator

Diabetes Short-Term Complications
Diabetes Long-Term Complications
Chronic Obstructive Pulmonary Disease or Asthma in Older Adults
Hypertension
Congestive Heart Failure
Dehydration Bacterial
Pneumonia Urinary Tract
Infection Angina w/o
Procedure Uncontrolled
Diabetes Asthma in
Younger Adults
Lower Extremity Amputation among Patients with Diabetes

AHRQ Pediatric Quality Indicators [PDI] (Children < 18 yrs)

STAR

Performance Indicator

Asthma

Diabetes Short-Term Complications
Gastroenteritis
Perforated Appendix
Urinary Tract Infection

STAR+PLUS

Performance Indicator

Asthma
Diabetes Short-Term Complications
Gastroenteritis
Perforated Appendix
Urinary Tract Infection

IV. CARE FOR CHRONIC ILLNESS

Asthma

STAR

Performance Indicator

Use of Appropriate Medication for People with Asthma (all ages) (ASM)
Medication Management for People with Asthma - Medication Compliance 75Percent (MMA)
Asthma Medication Ratio > 50Percent (all ages)
Appropriate Treatment for Children with Upper Respiratory Infection (URI)
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)
Appropriate Treatment for Children with Pharyngitis (CWP)

STAR+PLUS

Performance Indicator

Use of Appropriate Medication for People with Asthma (all ages) (ASM)
Medication Management for People with Asthma - Medication Compliance 75Percent (MMA)
Asthma Medication Ratio > 50Percent (all ages)
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)

Behavioral Health†

STAR

Performance Indicator

7-day f/u After Hosp. for Mental Health (MH) (FUH)
30-day f/u After Hosp. for Mental Health (FUH)
Antidepressant Medication Management - Acute Phase (AMM)
Antidepressant Medication Management - Continuation Phase (AMM)
Follow-up Care for Children Prescribed ADHD Medication - Initiation (ADD)
Follow-up Care for Children Prescribed ADHD Medication - Maintenance (ADD)
Initiation of Alcohol and Other Drug Dependence Treatment (IET)

Engagement of Alcohol and Other Drug Dependence Treatment (IET)

STAR+PLUS

Performance Indicator

7-day f/u After Hosp. for Mental Health (MH) (FUH)
30-day f/u After Hosp. for Mental Health (FUH)
Antidepressant Medication Management - Acute Phase (AMM)
Antidepressant Medication Management - Continuation Phase (AMM)
Initiation of Alcohol and Other Drug Dependence Treatment (IET)
Engagement of Alcohol and Other Drug Dependence Treatment (IET)

Diabetes (Adults ≥ 18 yrs)

STAR

Performance Indicator

HbA1c Tested (CDC)
HbA1c Control < 8Percent (CDC)
Diabetic Eye Exam (CDC)
Medical Attention for Nephropathy (CDC)

STAR+PLUS

Performance Indicator

HbA1c Tested (CDC)
HbA1c Control < 8Percent (CDC)
Diabetic Eye Exam (CDC)
Medical Attention for Nephropathy (CDC)

High Blood Pressure

STAR

Performance Indicator

High Blood Pressure Controlled (CBP)

STAR+PLUS

Performance Indicator

High Blood Pressure Controlled (CBP)

Smoking Prevention

STAR

Performance Indicator

Percent advised to quit smoking

STAR+PLUS

Performance Indicator

Percent advised to quit smoking

V. LONG TERM SERVICES AND SUPPORTS

STAR

Performance Indicator

None

STAR+PLUS

Performance Indicator

Timeliness of face-to-face assessment for PAS services after member non-emergency request.
Timeliness of authorization of non-emergency PAS services after assessment determining need.
Timeliness of initiation of non-emergency PAS services after MCO authorization of services.
Timeliness of service coordinator assignment after a request for a service coordinator is made by a member not requiring and named service coordinator.
Rate of face-to-face service coordination encounters completed as required.
Quarterly turnover rate for field service coordinators.
Service Coordination Hotline Performance: Total Calls Answered
Service Coordination Hotline Performance: Calls Answered by 4th ring
Service Coordination Hotline Performance: Calls Answered by Live Person
Service Coordination Hotline Performance: Number of Calls Abandoned
Service Coordination Hotline Performance: Average Hold Time
Rate of admissions to nursing facility from community pre- vs post- carve-in^
Rate of admissions to nursing facility from hospital pre- vs post- carve-in^
Number of individuals who went from community to hospital to nursing facility and remained in nursing facility^
Potentially Preventable Admissions (PPA) - Ratio of Actual to Expected (Nursing Facility only)^
Potentially Preventable Readmissions (PPR) - Ratio of Actual to Expected (Nursing Facility only)^
Consumer Assessment of Healthcare Providers & Systems Nursing Home Long Stay Questionnaire*+
Number of individuals who transitioned from the nursing facility to the community who were readmitted to the nursing facility. +

* This measure is a placeholder to inform plans that this survey will be conducted. Specific survey questions to be added to the dashboard will be determined upon calculation of results.

^ Beginning March 2015.

+ Beginning June 2015.

± Specifications for reporting CAHPS HPS 5.0 items have changed to using the "top box" (Percent always), rather than the top two categories.

† The Behavioral Health Measures do not apply to STAR and STAR+PLUS MCOs in the Dallas Service Area as all Behavioral Health services are provided through NorthSTAR.

Calendar Year (CY) 2015 Medicaid Dental Quality Performance Indicator Dashboard

Quality of Care

Annual Dental Visit

- Percent of members (2 - 3 yrs) enrolled for at least 11 of the past 12 months who had at least one annual dental visit
- Percent of members (4 - 6 yrs) enrolled for at least 11 of the past 12 months who had at least one annual dental visit
- Percent of members (7 - 10 yrs) enrolled for at least 11 of the past 12 months who had at least one annual dental visit
- Percent of members (11 - 14 yrs) enrolled for at least 11 of the past 12 months who had at least one annual dental visit
- Percent of members (15 - 18 yrs) enrolled for at least 11 of the past 12 months who had at least one annual dental visit
- Percent of members (19 - 21 yrs) enrolled for at least 11 of the past 12 months who had at least one annual dental visit
- Percent of members (6 - 35 months) who had at least one First Dental Home Services visit

Preventive Dental Services

- Percent of members (1 - 20 yrs) enrolled for at least 11 of the past 12 months who had at least one preventive dental service during the measurement year
- THSteps Care Measures
    - Percent of members (6 months - 20 years) receiving exactly one THSteps Dental Checkup per year
    - Percent of members (1 year - 20 years) receiving exactly two THSteps Dental Checkup per year
- Percent of new members (6 mo - 20 yrs) receiving at least one THSteps Dental Checkup within 90 days of enrollment
- Percent of members (6 - 9 yrs) enrolled for at least 6 continuous months who had at least one sealant service on one of the permanent first molars during the measurement year
- Percent of members (10 - 14 yrs) enrolled for at least 6 continuous months who had at least one sealant service on one of the permanent second molars during the measurement year
- Dental Quality Alliance: Sealants in 6-9 Years. Percentage of enrolled children in the age category of 6-9 years at “elevated” risk (i.e., “moderate” or “high”) who received a sealant on a permanent first molar tooth within the reporting year.
- Dental Quality Alliance: Sealants in 10-14 Years. Percentage of enrolled children in the age category of 10-14 years at “elevated” risk (i.e., “moderate” or “high”) who received a sealant on a permanent second molar tooth within the reporting year.
- Dental Quality Alliance: Oral Evaluation - Percentage of enrolled children under age 21 who received a comprehensive or periodic oral evaluation within the reporting year

Treatment and Prevention of Caries

- Dental Quality Alliance : Topical Fluoride - Percentage of enrolled children aged 1-20 years who are at "elevated" risk (i.e. "moderate" or "high") who received at least 2 topical fluoride applications within the reporting year.

Continuity of Care

- Dental Quality Alliance: Care Continuity- Percent of members (1-20 yrs) enrolled in two consecutive years for at least 6 months in each year who received a comprehensive or periodic oral evaluation in both years*

Utilization for Dental Services

Patient Satisfaction

- Percent of members satisfied with dental services and providers

2015 Medical Pay-for-Quality

STAR

Measure

Well-Child Visits in the 3rd, 4th, 5th, and 6th years of Life (W34)
Adolescent Well-Care Visits (AWC)
Prenatal Care and Postpartum (PPC)
Potentially Preventable Admissions (PPAs)
Potential Preventable Readmissions (PPRs)
Potential Preventable ED Visits (PPVs)
Potentially Preventable Complications (PPCs)

STAR+PLUS

Measure

Potentially Preventable Admissions (PPAs)
Potential Preventable Readmissions (PPRs)
Potential Preventable ED Visits (PPVs)
Potentially Preventable Complications (PPCs)
Antidepressant Medication Management (AMM)- Effective Acute Phase Treatment and Effective Continuation Phase Treatment
HbA1c Control <8(CDC)

CHIP

Measure

None

2015 Medicaid Dental Pay-for-Quality

- Percent of members (1-20 years) enrolled for at least 11 of the past 12 months who had at least one preventive dental service during the measurement year.
- Percent of members (6 mo - 20 years) receiving exactly one THSteps Dental checkup per year (50% of weight of 2 checkups)
- Percent of members (1 year - 20 years) receiving exactly two THSteps Dental checkup per year
- Percent of new members (6 mo - 20 years) receiving at least one THSteps Dental checkup within 90 days of enrollment
    - % of members (6 - 9 yrs) enrolled for at least 6 continuous months who had at least one sealant services on one of the permanent first molars during the measurement year
    - % of members (10- 14 yrs) enrolled for at least 6 continuous months who had at least one sealant services on one of the permanent second molars during the measurement year

Managed Care Hospital Transition 1115 Waiver
Historic Data - High Level Summary

	SFY				
TIME PERIOD AND ELIGIBILITY GROUP SERVED:	**2007**	**2008**	**2009**	**2010**	**2007-2010**
Aged and Medicare Related					
EXPENDITURES AND UPL	$ 1,029,726,791	$ 1,194,691,949	$ 1,344,270,362	$ 1,476,426,137	**$ 5,045,115,238**
ELIGIBLE MEMBER MONTHS	2,925,756	2,968,538	3,020,974	3,095,763	**12,011,031**
PER MEMBER PER MONTH COSTS	$ 351.95	$ 402.45	$ 444.98	$ 476.92	**$ 420.04**
TREND RATES	**ANNUAL CHANGE**				**4-YEAR AVERAGE**
TOTAL EXPENDITURE		16.02%	12.52%	9.83%	**12.76%**
ELIGIBLE MEMBER MONTHS		1.46%	1.77%	2.48%	**1.90%**
PER MEMBER PER MONTH COSTS		14.35%	10.57%	7.18%	**10.66%**

	SFY				
TIME PERIOD AND ELIGIBILITY GROUP SERVED:	**2007**	**2008**	**2009**	**2010**	**2007-2010**
Blind and Disabled					
EXPENDITURES AND UPL	$ 3,640,483,850	$ 4,138,895,584	$ 4,682,497,276	$ 5,197,844,312	**$ 17,659,721,021**
ELIGIBLE MEMBER MONTHS	3,678,895	3,907,066	4,156,727	4,416,546	**16,159,234**
PER MEMBER PER MONTH COSTS	$ 989.56	$ 1,059.34	$ 1,126.49	$ 1,176.90	**$ 1,092.86**
TREND RATES	**ANNUAL CHANGE**				**4-YEAR AVERAGE**
TOTAL EXPENDITURE		13.69%	13.13%	11.01%	**12.60%**
ELIGIBLE MEMBER MONTHS		6.20%	6.39%	6.25%	**6.28%**
PER MEMBER PER MONTH COSTS		7.05%	6.34%	4.48%	**5.95%**

	SFY				
TIME PERIOD AND ELIGIBILITY GROUP SERVED:	**2007**	**2008**	**2009**	**2010**	**2007-2010**
Adults					
EXPENDITURES AND UPL	$ 1,641,765,439	$ 1,778,040,541	$ 1,920,575,071	$ 2,055,633,422	**$ 7,396,014,473**
ELIGIBLE MEMBER MONTHS	2,589,626	2,493,137	2,502,742	2,623,692	**10,209,197**
PER MEMBER PER MONTH COSTS	$ 633.98	$ 713.17	$ 767.39	$ 783.49	**$ 724.45**
TREND RATES	**ANNUAL CHANGE**				**4-YEAR AVERAGE**
TOTAL EXPENDITURE		8.30%	8.02%	7.03%	**7.78%**
ELIGIBLE MEMBER MONTHS		-3.73%	0.39%	4.83%	**0.44%**
PER MEMBER PER MONTH COSTS		12.49%	7.60%	2.10%	**7.31%**

	SFY				
TIME PERIOD AND ELIGIBILITY GROUP SERVED:	**2007**	**2008**	**2009**	**2010**	**2007-2010**
Children					
EXPENDITURES AND UPL	$ 4,860,573,211	$ 5,749,275,427	$ 6,363,770,393	$ 7,241,770,846	**$ 24,215,389,877**
ELIGIBLE MEMBER MONTHS	23,297,502	23,642,197	24,860,034	27,916,645	**99,716,378**
PER MEMBER PER MONTH COSTS	$ 208.63	$ 243.18	$ 255.98	$ 259.41	**$ 242.84**
TREND RATES	**ANNUAL CHANGE**				**4-YEAR AVERAGE**
TOTAL EXPENDITURE		18.28%	10.69%	13.80%	**14.21%**
ELIGIBLE MEMBER MONTHS		1.48%	5.15%	12.30%	**6.21%**
PER MEMBER PER MONTH COSTS		16.56%	5.27%	1.34%	**7.53%**

	SFY				
TIME PERIOD AND ELIGIBILITY GROUP SERVED:	**2007**	**2008**	**2009**	**2010**	**2007-2010**
Included Population Total Expenditures					
EXPENDITURES AND UPL	$ 11,172,549,290	$ 12,860,903,501	$ 14,311,113,102	$ 15,971,674,717	**$ 54,316,240,610**
ELIGIBLE MEMBER MONTHS	32,491,779	33,010,938	34,540,477	38,052,646	**138,095,840**
PER MEMBER PER MONTH COSTS	$ 343.86	$ 389.60	$ 414.33	$ 419.73	**$ 393.32**
TREND RATES	**ANNUAL CHANGE**				**4-YEAR AVERAGE**
TOTAL EXPENDITURE		15.11%	11.28%	11.60%	**12.65%**
ELIGIBLE MEMBER MONTHS		1.60%	4.63%	10.17%	**5.41%**
PER MEMBER PER MONTH COSTS		13.30%	6.35%	1.30%	**6.87%**

Attachment D - 1115 Waiver Extension BN Calculations

	SFY				
TIME PERIOD AND ELIGIBILITY GROUP SERVED:	**2007**	**2008**	**2009**	**2010**	**2007-2010**
Other UPL Programs					
UPL for Excluded Population	$ 1,014,666,359	$ 1,048,150,348	$ 1,085,883,761	$ 1,198,890,581	**$ 4,347,591,049**
Physician UPL	$ 97,548,654	$ 43,644,446	$ 40,205,270	$ 58,941,905	**$ 240,340,274**
Outpatient UPL	$ 15,275,700	$ 23,262,692	$ 16,821,148	$ 51,675,106	**$ 107,034,646**
TREND RATES	**ANNUAL CHANGE**				**4 YEAR AVERAGE**
UPL for Excluded Population		3.30%	3.60%	10.41%	5.72%
Physician UPL		-55.26%	-7.88%	46.60%	-15.46%
Outpatient UPL		52.29%	-27.69%	207.20%	50.12%

	SFY				
TIME PERIOD AND ELIGIBILITY GROUP SERVED:	**2007**	**2008**	**2009**	**2010**	**2007-2010**
Grand Total Expenditures					
EXPENDITURES AND UPL	$ 12,300,040,003	$ 13,975,960,987	$ 15,454,023,281	$ 17,281,182,308	**$ 59,011,206,578**
TREND RATES	**ANNUAL CHANGE**				**4-YEAR AVERAGE**
TOTAL EXPENDITURE		13.63%	10.58%	11.82%	12.00%

Managed Care Hospital Transition 1115 Waiver
Without Waiver (WOW) Budget Projection, May 2015 Update with 5 year extension

		DEMONSTRATION YEARS (DY)											2012-2021
TIME PERIOD AND ELIGIBILITY GROUP SERVED:	**Base Year (SFY 10)**	**DY 01 (FFY 12)**	**DY 02 (FFY 13)**	**DY 03 (FFY 14)**	**DY 04 (FFY 15)**	**DY 05 (FFY 16)**	**Total 5 yr WOW**	**DY 06 (FFY 17)**	**DY 07 (FFY 18)**	**DY 08 (FFY 19)**	**DY 09 (FFY 20)**	**DY 10 (FFY 21)**	**TOTAL WOW**
Aged and Medicare Related													
EXPENDITURES	$ 1,476,426,137	1,672,219,286	1,777,474,231	1,937,507,285	3,884,912,396	5,168,843,280	$ 14,440,956,478	5,469,998,124	5,837,750,514	6,260,007,262	6,730,580,549	7,236,527,473	**$ 45,975,820,401**
ELIGIBLE MEMBER MONTHS	3,095,763	3,282,530	3,335,662	3,475,599	4,335,027	4,430,601	18,859,419	4,495,440	4,599,877	4,729,239	4,875,112	5,025,485	
PER MEMBER PER MONTH COSTS	$ 476.92	$509.43	$ 532.87	$ 557.46	$ 896.17	$ 1,166.62	$ 765.72	$ 1,216.79	$ 1,269.11	$ 1,323.68	$ 1,380.60	$ 1,439.97	
TREND RATES	**ANNUAL CHANGE**						5-YEAR AVERAGE						**10-YEAR AVERAGE**
TOTAL EXPENDITURE		6.16%	6.29%	9.00%	100.51%	33.05%	32.59%	5.83%	6.72%	7.23%	7.52%	7.52%	**17.68%**
ELIGIBLE MEMBER MONTHS		2.85%	1.62%	4.20%	24.73%	2.20%	7.79%	1.46%	2.32%	2.81%	3.08%	3.08%	**4.85%**
PER MEMBER PER MONTH COSTS		3.22%	4.60%	4.61%	60.76%	30.18%	23.02%	4.30%	4.30%	4.30%	4.30%	4.30%	**12.24%**

		DEMONSTRATION YEARS (DY)											2012-2021
TIME PERIOD AND ELIGIBILITY GROUP SERVED:	**Base Year (SFY 10)**	**DY 01 (FFY 12)**	**DY 02 (FFY 13)**	**DY 03 (FFY 14)**	**DY 04 (FFY 15)**	**DY 05 (FFY 16)**	**Total 5 yr WOW**	**DY 06 (FFY 17)**	**DY 07 (FFY 18)**	**DY 08 (FFY 19)**	**DY 09 (FFY 20)**	**DY 10 (FFY 21)**	**TOTAL WOW**
Blind and Disabled													
EXPENDITURES	$ 5,197,844,312	6,626,928,709	7,156,659,413	7,622,401,527	8,323,876,295	9,069,075,616	$ 38,798,941,561	9,790,472,611	10,688,265,603	11,668,387,356	12,734,888,329	13,898,868,438	**$ 97,579,823,898**
ELIGIBLE MEMBER MONTHS	4,416,546	4,915,864	5,046,404	5,105,426	5,131,899	5,180,183	25,379,777	5,320,875	5,526,929	5,740,964	5,961,649	6,190,817	
PER MEMBER PER MONTH COSTS	$ 1,176.90	$1,348.07	$ 1,418.17	$ 1,493.00	$ 1,621.99	$ 1,750.72	$ 1,528.73	$ 1,840.01	$ 1,933.85	$ 2,032.48	$ 2,136.14	$ 2,245.08	
TREND RATES	**ANNUAL CHANGE**						5-YEAR AVERAGE						**10-YEAR AVERAGE**
TOTAL EXPENDITURE		12.37%	7.99%	6.51%	9.20%	8.95%	8.16%	7.95%	9.17%	9.17%	9.14%	9.14%	**8.58%**
ELIGIBLE MEMBER MONTHS		5.28%	2.66%	1.17%	0.52%	0.94%	1.32%	2.72%	3.87%	3.87%	3.84%	3.84%	**2.60%**
PER MEMBER PER MONTH COSTS		6.73%	5.20%	5.28%	8.64%	7.94%	6.75%	5.10%	5.10%	5.10%	5.10%	5.10%	**5.83%**

Attachment D - 1115 Waiver Extension BN Calculations

		DEMONSTRATION YEARS (DY)										2012-2021
TIME PERIOD AND ELIGIBILITY GROUP SERVED:	**Base Year (SFY 10) with STAR FFSE & UPL**	**DY 01 (FFY 12)**	**DY 02 (FFY 13)**	**DY 03 (FFY 14)**	**DY 04 (FFY 15)**	**DY 05 (FFY 16)**	**Total 5 yr WOW**	**DY 06 (FFY 17)**	**DY 07 (FFY 18)**	**DY 08 (FFY 19)**	**DY 09 (FFY 20)**	**DY 10 (FFY 21)**	**TOTAL WOW**
Adults													
EXPENDITURES	$ 2,456,431,483	3,095,202,596	3,358,275,145	3,493,476,936	3,843,247,715	3,980,701,763	$ 17,770,904,155	4,286,566,640	4,604,921,214	4,946,919,997	5,314,422,068	5,709,225,524	**$ 42,632,959,598**
ELIGIBLE MEMBER MONTHS	2,623,692	2,937,043	3,011,987	3,224,311	3,508,309	3,601,858	16,283,509	3,665,987	3,722,356	3,779,592	3,837,782	3,896,869	
PER MEMBER PER MONTH COSTS	$ 936.25	$1,053.85	$ 1,114.97	$ 1,083.48	$ 1,095.47	$ 1,105.18	$ 1,091.34	$ 1,169.28	$ 1,237.10	$ 1,308.85	$ 1,384.76	$ 1,465.08	
TREND RATES		**ANNUAL CHANGE**					5-YEAR AVERAGE						**10-YEAR AVERAGE**
TOTAL EXPENDITURE		11.73%	8.50%	4.03%	10.01%	3.58%	6.49%	7.68%	7.43%	7.43%	7.43%	7.43%	**7.04%**
ELIGIBLE MEMBER MONTHS		5.56%	2.55%	7.05%	8.81%	2.67%	5.23%	1.78%	1.54%	1.54%	1.54%	1.54%	**3.19%**
PER MEMBER PER MONTH COSTS		5.84%	5.80%	-2.82%	1.11%	0.89%	1.20%	5.80%	5.80%	5.80%	5.80%	5.80%	**3.73%**

		DEMONSTRATION YEARS (DY)										2012-2021
TIME PERIOD AND ELIGIBILITY GROUP SERVED:	**Base Year (SFY 10) with STAR FFSE & UPL**	**DY 01 (FFY 12)**	**DY 02 (FFY 13)**	**DY 03 (FFY 14)**	**DY 04 (FFY 15)**	**DY 05 (FFY 16)**	**Total 5 yr WOW**	**DY 06 (FFY 17)**	**DY 07 (FFY 18)**	**DY 08 (FFY 19)**	**DY 09 (FFY 20)**	**DY 10 (FFY 21)**	**TOTAL WOW**
Children													
EXPENDITURES	$ 7,800,549,385	9,253,764,671	9,643,302,903	9,859,011,181	10,624,037,233	11,092,696,358	$ 50,472,812,346	11,841,629,147	12,711,192,796	13,647,532,626	14,651,657,955	15,729,662,403	**$ 119,054,487,274**
ELIGIBLE MEMBER MONTHS	27,916,645	30,555,604	30,268,693	30,537,436	31,888,694	32,276,235	155,526,661	32,752,274	33,419,548	34,107,718	34,807,237	35,521,103	
PER MEMBER PER MONTH COSTS	$ 279.42	$302.85	$ 318.59	$ 322.85	$ 333.16	$ 343.68	$ 324.53	$ 361.55	$ 380.35	$ 400.13	$ 420.94	$ 442.83	
TREND RATES		**ANNUAL CHANGE**					5-YEAR AVERAGE						**10-YEAR AVERAGE**
TOTAL EXPENDITURE		8.55%	4.21%	2.24%	7.76%	4.41%	4.64%	6.75%	7.34%	7.37%	7.36%	7.36%	**6.07%**
ELIGIBLE MEMBER MONTHS		4.43%	-0.94%	0.89%	4.42%	1.22%	1.38%	1.47%	2.04%	2.06%	2.05%	2.05%	**1.69%**
PER MEMBER PER MONTH COSTS		3.94%	5.20%	1.34%	3.19%	3.16%	3.21%	5.20%	5.20%	5.20%	5.20%	5.20%	**4.31%**

Attachment D - 1115 Waiver Extension BN Calculations

		DEMONSTRATION YEARS (DY)											2012-2021
TIME PERIOD AND ELIGIBILITY GROUP SERVED:		**DY 01 (FFY 12)**	**DY 02 (FFY 13)**	**DY 03 (FFY 14)**	**DY 04 (FFY 15)**	**DY 05 (FFY 16)**	**Total 5 yr WOW**	**DY 06 (FFY 17)**	**DY 07 (FFY 18)**	**DY 08 (FFY 19)**	**DY 09 (FFY 20)**	**DY 10 (FFY 21)**	**TOTAL WOW**
Included Population Total Expenditures													
Total Expenditures and UPL		**$ 20,648,115,262**	**$ 21,935,711,693**	**$ 22,912,396,928**	**$ 26,676,073,639**	**$ 29,311,317,018**	**$ 121,483,614,540**	**$ 31,388,666,523**	**$ 33,842,130,127**	**$ 36,522,847,242**	**$ 39,431,548,901**	**$ 42,574,283,838**	**$ 305,243,091,170**
Total Eligible Member Months		**41,691,041**	**41,662,747**	**42,342,772**	**44,863,929**	**45,488,878**	**216,049,367**	**46,234,575**	**47,268,710**	**48,357,512**	**49,481,781**	**50,634,275**	**458,026,219**
Total Per Member Per Month Costs		**$ 495.27**	**$ 526.51**	**$ 541.12**	**$ 594.60**	**$ 644.36**	**$ 562.30**	**$ 678.90**	**$ 715.95**	**$ 755.27**	**$ 796.89**	**$ 840.82**	**$ 666.43**
Total Per Member Per Month Trend Rates			**6.31%**	**2.77%**	**9.88%**	**8.37%**	**6.80%**	**5.36%**	**5.46%**	**5.49%**	**5.51%**	**5.51%**	**6.06%**

		DEMONSTRATION YEARS (DY)											2012-2021
TIME PERIOD AND ELIGIBILITY GROUP SERVED:	**Base Year (SFY 10)**	**DY 01 (FFY 12)**	**DY 02 (FFY 13)**	**DY 03 (FFY 14)**	**DY 04 (FFY 15)**	**DY 05 (FFY 16)**	**Total 5 yr WOW**	**DY 06 (FFY 17)**	**DY 07 (FFY 18)**	**DY 08 (FFY 19)**	**DY 09 (FFY 20)**	**DY 10 (FFY 21)**	**TOTAL WOW**
Other UPL Programs (Not Included in Population)													
UPL for Excluded Population	$ 1,198,890,581	$ 1,346,191,839	$ 1,423,194,012	$ 1,504,600,709	$ 1,590,663,870	$ 1,681,649,843	$ 7,546,300,273	$ 1,777,840,214	$ 1,879,532,675	$ 1,987,041,944	$ 2,100,700,743	$ 2,220,860,825	**$ 17,512,276,673**
Physician UPL	$ 58,941,905	$ 74,843,903	$ 77,089,221	$ 79,401,897	$ 81,783,954	$ 84,237,473	$ 397,356,448	$ 86,764,597	$ 89,367,535	$ 92,048,561	$ 94,810,018	$ 97,654,318	**$ 858,001,476**
Outpatient UPL	$ 51,675,106	$ 58,024,149	$ 61,343,130	$ 64,851,957	$ 68,561,489	$ 72,483,206	$ 325,263,931	$ 76,629,246	$ 81,012,438	$ 85,646,350	$ 90,545,321	$ 95,724,514	**$ 754,821,800**
Total Other UPL	$ 1,309,507,592	$ 1,479,059,891	$ 1,561,626,362	$ 1,648,854,564	$ 1,741,009,313	$ 1,838,370,522	$ 8,268,920,652	$ 1,941,234,057	$ 2,049,912,648	$ 2,164,736,854	$ 2,286,056,081	$ 2,414,239,657	**$ 19,125,099,949**
TREND RATES		**ANNUAL CHANGE**											**10-YEAR AVERAGE**
UPL for Excluded Population		5.72%	5.72%	5.72%	5.72%	5.72%	5.72%	5.72%	5.72%	5.72%	5.72%	5.72%	**5.72%**
Physician UPL		12.15%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%	**3.00%**
Outpatient UPL		5.72%	5.72%	5.72%	5.72%	5.72%	5.72%	5.72%	5.72%	5.72%	5.72%	5.72%	**5.72%**

		DEMONSTRATION YEARS (DY)											2012-2021
TIME PERIOD AND ELIGIBILITY GROUP SERVED:		**DY 01 (FFY 12)**	**DY 02 (FFY 13)**	**DY 03 (FFY 14)**	**DY 04 (FFY 15)**	**DY 05 (FFY 16)**	**Total 5 yr WOW**	**DY 06 (FFY 17)**	**DY 07 (FFY 18)**	**DY 08 (FFY 19)**	**DY 09 (FFY 20)**	**DY 10 (FFY 21)**	**TOTAL WOW**
Grand Total Expenditures													
Total Expenditures and UPL		**$ 22,127,175,153**	**$ 23,497,338,055**	**$ 24,561,251,492**	**$ 28,417,082,952**	**$ 31,149,687,540**	**$ 129,752,535,192**	**$ 33,329,900,579**	**$ 35,892,042,775**	**$ 38,687,584,096**	**$ 41,717,604,983**	**$ 44,988,523,495**	**$ 324,368,191,120**

Managed Care Hospital Transition 1115 Waiver
With Waiver (WW) Budget Projection: May 2015 Update with 5 Year Extension

	DEMONSTRATION YEARS (DY)											2012-2021
TIME PERIOD AND ELIGIBILITY GROUP SERVED:	**DY 01 (FFY 12)**	**DY 02 (FFY 13)**	**DY 03 (FFY 14)**	**DY 04 (FFY 15)**	**DY 05 (FFY 16)**	**Total 5 yr WW**	**DY 06 (FFY 17)**	**DY 07 (FFY 18)**	**DY 08 (FFY 19)**	**DY 09 (FFY 20)**	**DY 10 (FFY 21)**	**TOTAL WW**
Aged and Medicare Related												
EXPENDITURES	$ 1,357,367,407	$ 1,460,144,507	$ 1,655,998,550	$ 3,121,887,773	$ 4,199,504,771	$ 11,794,903,008	$ 4,415,550,132	$ 4,677,484,282	$ 5,069,088,590	$ 5,433,566,877	$ 5,824,251,930	**$ 37,214,844,819**
ELIGIBLE MEMBER MONTHS	3,282,530	3,335,662	3,475,599	4,335,027	4,430,601	18,859,419	4,495,440	4,599,877	4,729,239	4,875,112	5,025,485	
PER MEMBER PER MONTH COSTS	$ 413.51	$ 437.74	$ 476.46	$ 720.15	$ 947.84	$ 625.41	$ 982.23	$ 1,016.87	$ 1,071.86	$ 1,114.55	$ 1,158.94	
TREND RATES	**ANNUAL CHANGE**					5-YEAR AVERAGE						**10-YEAR AVERAGE**
TOTAL EXPENDITURE		7.57%	13.41%	88.52%	34.52%	32.62%	5.14%	5.93%	8.37%	7.19%	7.19%	**17.57%**
ELIGIBLE MEMBER MONTHS		1.62%	4.20%	24.73%	2.20%	7.79%	1.46%	2.32%	2.81%	3.08%	3.08%	**4.85%**
PER MEMBER PER MONTH COSTS		5.86%	8.85%	51.15%	31.62%	23.04%	3.63%	3.53%	5.41%	3.98%	3.98%	**12.13%**

	DEMONSTRATION YEARS (DY)											2012-2021
TIME PERIOD AND ELIGIBILITY GROUP SERVED:	**DY 01 (FFY 12)**	**DY 02 (FFY 13)**	**DY 03 (FFY 14)**	**DY 04 (FFY 15)**	**DY 05 (FFY 16)**	**Total 5 yr WW**	**DY 06 (FFY 17)**	**DY 07 (FFY 18)**	**DY 08 (FFY 19)**	**DY 09 (FFY 20)**	**DY 10 (FFY 21)**	**TOTAL WW**
Blind and Disabled												
EXPENDITURES	$ 5,557,482,311	$ 6,015,692,998	$ 6,339,562,165	$ 6,902,477,386	$ 7,475,619,238	$ 32,290,834,099	$ 7,747,170,395	$ 8,307,554,183	$ 8,912,516,034	$ 9,534,940,140	$ 10,200,837,797	**$ 76,993,852,648**
ELIGIBLE MEMBER MONTHS	4,915,864	5,046,404	5,105,426	5,131,899	5,180,183	25,379,777	5,320,875	5,526,929	5,740,964	5,961,649	6,190,817	
PER MEMBER PER MONTH COSTS	$ 1,130.52	$ 1,192.08	$ 1,241.73	$ 1,345.01	$ 1,443.12	$ 1,272.31	$ 1,456.00	$ 1,503.10	$ 1,552.44	$ 1,599.38	$ 1,647.74	
TREND RATES	**ANNUAL CHANGE**					5-YEAR AVERAGE						**10-YEAR AVERAGE**
TOTAL EXPENDITURE		8.24%	5.38%	8.88%	8.30%	7.69%	3.63%	7.23%	7.28%	6.98%	6.98%	**6.98%**
ELIGIBLE MEMBER MONTHS		2.66%	1.17%	0.52%	0.94%	1.32%	2.72%	3.87%	3.87%	3.84%	3.84%	**2.60%**
PER MEMBER PER MONTH COSTS		5.44%	4.17%	8.32%	7.29%	6.29%	0.89%	3.24%	3.28%	3.02%	3.02%	**4.27%**

Attachment D - 1115 Waiver Extension BN Calculations

	DEMONSTRATION YEARS (DY)											2012-2021
TIME PERIOD AND ELIGIBILITY GROUP SERVED:	**DY 01 (FFY 12)**	**DY 02 (FFY 13)**	**DY 03 (FFY 14)**	**DY 04 (FFY 15)**	**DY 05 (FFY 16)**	**Total 5 yr WW**	**DY 06 (FFY 17)**	**DY 07 (FFY 18)**	**DY 08 (FFY 19)**	**DY 09 (FFY 20)**	**DY 10 (FFY 21)**	**TOTAL WW**
Adults												
EXPENDITURES	$ 1,695,575,084	$ 1,722,004,805	$ 1,767,539,879	$ 1,933,064,931	$ 2,064,545,965	$ 9,182,730,665	$ 2,177,076,674	$ 2,295,379,724	$ 2,420,331,346	$ 2,543,918,253	$ 2,673,815,752	**$ 21,293,252,414**
ELIGIBLE MEMBER MONTHS	2,937,043	3,011,987	3,224,311	3,508,309	3,601,858	16,283,509	3,665,987	3,722,356	3,779,592	3,837,782	3,896,869	
PER MEMBER PER MONTH COSTS	$ 577.31	$ 571.72	$ 548.19	$ 551.00	$ 573.19	$ 563.93	$ 593.86	$ 616.65	$ 640.37	$ 662.86	$ 686.14	
TREND RATES	**ANNUAL CHANGE**					5-YEAR AVERAGE						**10-YEAR AVERAGE**
TOTAL EXPENDITURE		1.56%	2.64%	9.36%	6.80%	5.05%	5.45%	5.43%	5.44%	5.11%	5.11%	**5.19%**
ELIGIBLE MEMBER MONTHS		2.55%	7.05%	8.81%	2.67%	5.23%	1.78%	1.54%	1.54%	1.54%	1.54%	**3.19%**
PER MEMBER PER MONTH COSTS		-0.97%	-4.11%	0.51%	4.03%	-0.18%	3.61%	3.84%	3.85%	3.51%	3.51%	**1.94%**

	DEMONSTRATION YEARS (DY)											2012-2021
TIME PERIOD AND ELIGIBILITY GROUP SERVED:	**DY 01 (FFY 12)**	**DY 02 (FFY 13)**	**DY 03 (FFY 14)**	**DY 04 (FFY 15)**	**DY 05 (FFY 16)**	**Total 5 yr WW**	**DY 06 (FFY 17)**	**DY 07 (FFY 18)**	**DY 08 (FFY 19)**	**DY 09 (FFY 20)**	**DY 10 (FFY 21)**	**TOTAL WW**
Children												
EXPENDITURES	$ 7,291,536,240	$ 7,135,331,891	$ 7,276,405,529	$ 7,554,661,235	$ 7,941,921,169	$ 37,199,856,064	$ 8,377,887,135	$ 8,876,842,370	$ 9,420,480,481	$ 9,967,797,480	$ 10,546,912,847	**$ 84,389,776,377**
ELIGIBLE MEMBER MONTHS	30,555,604	30,268,693	30,537,436	31,888,694	32,276,235	155,526,661	32,752,274	33,419,548	34,107,718	34,807,237	35,521,103	
PER MEMBER PER MONTH COSTS	$ 238.63	$ 235.73	$ 238.28	$ 236.91	$ 246.06	$ 239.19	$ 255.80	$ 265.62	$ 276.20	$ 286.37	$ 296.92	
TREND RATES	**ANNUAL CHANGE**					5-YEAR AVERAGE						**10-YEAR AVERAGE**
TOTAL EXPENDITURE		-2.14%	1.98%	3.82%	5.13%	2.16%	5.49%	5.96%	6.12%	5.81%	5.81%	**4.19%**
ELIGIBLE MEMBER MONTHS		-0.94%	0.89%	4.42%	1.22%	1.38%	1.47%	2.04%	2.06%	2.05%	2.05%	**1.69%**
PER MEMBER PER MONTH COSTS		-1.21%	1.08%	-0.58%	3.86%	0.77%	3.96%	3.84%	3.98%	3.68%	3.68%	**2.46%**

	DEMONSTRATION YEARS (DY)											2012-2021
TIME PERIOD AND ELIGIBILITY GROUP SERVED:	**DY 01 (FFY 12)**	**DY 02 (FFY 13)**	**DY 03 (FFY 14)**	**DY 04 (FFY 15)**	**DY 05 (FFY 16)**	**Total 5 yr WW**	**DY 06 (FFY 17)**	**DY 07 (FFY 18)**	**DY 08 (FFY 19)**	**DY 09 (FFY 20)**	**DY 10 (FFY 21)**	**TOTAL WW**
Included Population Total Expenditures												
Total Expenditures and UPL	**$ 15,901,961,042**	**$ 16,333,174,202**	**$ 17,039,506,124**	**$ 19,512,091,325**	**$ 21,681,591,144**	**$ 90,468,323,836**	**$ 22,717,684,336**	**$ 24,157,260,559**	**$ 25,822,416,451**	**$ 27,480,222,751**	**$ 29,245,818,326**	**$ 219,891,726,258**
Total Eligible Member Months	**41,691,041**	**41,662,747**	**42,342,772**	**44,863,929**	**45,488,878**	**216,049,367**	**46,234,575**	**47,268,710**	**48,357,512**	**49,481,781**	**50,634,275**	**458,026,219**
Total Per Member Per Month Costs	**$ 381.42**	**$ 392.03**	**$ 402.42**	**$ 434.92**	**$ 476.63**	**$ 418.74**	**$ 491.36**	**$ 511.06**	**$ 533.99**	**$ 555.36**	**$ 577.59**	**$ 480.09**
Total Per Member Per Month Trend Rates		**2.78%**	**2.65%**	**8.08%**	**9.59%**	**5.73%**	**3.09%**	**4.01%**	**4.49%**	**4.00%**	**4.00%**	**4.72%**

	DEMONSTRATION YEARS (DY)											2012-2021
TIME PERIOD AND ELIGIBILITY GROUP SERVED:	**DY 01 (FFY 12)**	**DY 02 (FFY 13)**	**DY 03 (FFY 14)**	**DY 04 (FFY 15)**	**DY 05 (FFY 16)**	**Total 5 yr WW**	**DY 06 (FFY 17)**	**DY 07 (FFY 18)**	**DY 08 (FFY 19)**	**DY 09 (FFY 20)**	**DY 10 (FFY 21)**	**TOTAL WW**
Other UPL Programs (Not Included in Population)												
UPL for Excluded Population	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Physician UPL	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Outpatient UPL	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
TREND RATES	**ANNUAL CHANGE**											**10-YEAR AVERAGE**
UPL for Excluded Population		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	**N/A**
Physician UPL		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	**N/A**
Outpatient UPL		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	**N/A**

	DEMONSTRATION YEARS (DY)											2012-2021
TIME PERIOD AND ELIGIBILITY GROUP SERVED:	**DY 01 (FFY 12)**	**DY 02 (FFY 13)**	**DY 03 (FFY 14)**	**DY 04 (FFY 15)**	**DY 05 (FFY 16)**	**Total 5 yr WW**	**DY 06 (FFY 17)**	**DY 07 (FFY 18)**	**DY 08 (FFY 19)**	**DY 09 (FFY 20)**	**DY 10 (FFY 21)**	**TOTAL WW**
Pool												
Uncompensated Care Pool Payments	$ 3,700,000,000	$ 3,900,000,000	$ 3,534,000,000	$ 3,348,000,000	$ 3,100,000,000	$ 17,582,000,000	$ 3,100,000,000	$ 3,100,000,000	$ 3,100,000,000	$ 3,100,000,000	$ 3,100,000,000	**$ 33,082,000,000**
DSRIP	$ 500,000,000	$ 2,300,000,000	$ 2,666,000,000	$ 2,852,000,000	$ 3,100,000,000	$ 11,418,000,000	$ 3,100,000,000	$ 3,100,000,000	$ 3,100,000,000	$ 3,100,000,000	$ 3,100,000,000	**$ 26,918,000,000**
TOTAL EXPENDITURE	**$ 4,200,000,000**	**$ 6,200,000,000**	**$ 6,200,000,000**	**$ 6,200,000,000**	**$ 6,200,000,000**	**$ 29,000,000,000**	**$ 6,200,000,000**	**$ 6,200,000,000**	**$ 6,200,000,000**	**$ 6,200,000,000**	**$ 6,200,000,000**	**$ 60,000,000,000**

Note: Pool payments for DY 01 include transition payments for hospitals shifting from the current UPL payment methodology to the waiver methodology as managed care is expanded statewide.

Attachment D - 1115 Waiver Extension BN Calculations

	DEMONSTRATION YEARS (DY)											2012-2021
TIME PERIOD AND ELIGIBILITY GROUP SERVED:	**DY 01 (FFY 12)**	**DY 02 (FFY 13)**	**DY 03 (FFY 14)**	**DY 04 (FFY 15)**	**DY 05 (FFY 16)**	**Total 5 yr WW**	**DY 06 (FFY 17)**	**DY 07 (FFY 18)**	**DY 08 (FFY 19)**	**DY 09 (FFY 20)**	**DY 10 (FFY 21)**	**TOTAL WW**
Network Access Improvement Project												
NAIP Expenditures	$ -	$ -	$ -	$ 126,558,753	$ 527,733,532	$ 654,292,285	$ 633,280,238	$ 696,608,262	$ 766,269,088	$ 842,895,997	$ 927,185,597	**$ 4,520,531,468**
Nursing Facility Directed Payments	$ -	$ -	$ -	$ 119,253,419	$ 535,269,291	$ 654,522,710	$ 642,323,150	$ 706,555,465	$ 777,211,011	$ 854,932,112	$ 940,425,323	**$ 4,575,969,771**
TOTAL EXPENDITURE	**$ -**	**$ -**	**$ -**	**$ 245,812,172**	**$ 1,063,002,823**	**$ 1,308,814,995**	**$ 1,275,603,388**	**$ 1,403,163,727**	**$ 1,543,480,100**	**$ 1,697,828,110**	**$ 1,867,610,920**	**$ 10,405,316,235**

	DEMONSTRATION YEARS (DY)											2012-2021
TIME PERIOD AND ELIGIBILITY GROUP SERVED:	**DY 01 (FFY 12)**	**DY 02 (FFY 13)**	**DY 03 (FFY 14)**	**DY 04 (FFY 15)**	**DY 05 (FFY 16)**	**Total 5 yr WW**	**DY 06 (FFY 17)**	**DY 07 (FFY 18)**	**DY 08 (FFY 19)**	**DY 09 (FFY 20)**	**DY 10 (FFY 21)**	**TOTAL WW**
Grand Total Expenditures												
Total Expenditures and Transition Pool	**$ 20,101,961,042**	**$ 22,533,174,202**	**$ 23,239,506,124**	**$ 25,957,903,497**	**$ 28,944,593,967**	**$ 120,777,138,831**	**$ 30,193,287,724**	**$ 31,760,424,285**	**$ 33,565,896,551**	**$ 35,378,050,860**	**$ 37,313,429,246**	**$ 288,988,227,497**

Managed Care Hospital Transition 1115 Waiver

Budget Neutrality Summary: May 2015 Update with 5 year extension

	DEMONSTRATION YEARS (DY)					2012-2016	DEMONSTRATION YEARS (DY)					2017-2021	2012-2021
WITHOUT WAIVER SUMMARY	**DY 01 (FFY 12)**	**DY 02 (FFY 13)**	**DY 03 (FFY 14)**	**DY 04 (FFY 15)**	**DY 05 (FFY 16)**	**Total 5 yr WOW**	**DY 06 (FFY 17)**	**DY 07 (FFY 18)**	**DY 08 (FFY 19)**	**DY 09 (FFY 20)**	**DY 10 (FFY 21)**	**Total 5 yr WOW extension**	**TOTAL 10 yr WOW**
Aged and Medicare Related	$ 1,672,219,286	$ 1,777,474,231	$ 1,937,507,285	$ 3,884,912,396	$ 5,168,843,280	$ 14,440,956,478	$ 5,469,998,124	$ 5,837,750,514	$ 6,260,007,262	$ 6,730,580,549	$ 7,236,527,473	$ 31,534,863,923	$ 45,975,820,401
Blind and Disabled	$ 6,626,928,709	$ 7,156,659,413	$ 7,622,401,527	$ 8,323,876,295	$ 9,069,075,616	$ 38,798,941,561	$ 9,790,472,611	$ 10,688,265,603	$ 11,668,387,356	$ 12,734,888,329	$ 13,898,868,438	$ 58,780,882,338	$ 97,579,823,898
Adults	$ 3,095,202,596	$ 3,358,275,145	$ 3,493,476,936	$ 3,843,247,715	$ 3,980,701,763	$ 17,770,904,155	$ 4,286,566,640	$ 4,604,921,214	$ 4,946,919,997	$ 5,314,422,068	$ 5,709,225,524	$ 24,862,055,443	$ 42,632,959,598
Children	$ 9,253,764,671	$ 9,643,302,903	$ 9,859,011,181	$ 10,624,037,233	$ 11,092,696,358	$ 50,472,812,346	$ 11,841,629,147	$ 12,711,192,796	$ 13,647,532,626	$ 14,651,657,955	$ 15,729,662,403	$ 68,581,674,928	$ 119,054,487,274
Other UPL Programs (Not Included in Population)	$ 1,421,035,742	$ 1,500,283,232	$ 1,584,002,606	$ 1,672,447,824	$ 1,765,887,316	$ 7,943,656,721	$ 1,864,604,811	$ 1,968,900,209	$ 2,079,090,504	$ 2,195,510,760	$ 2,318,515,143	$ 10,426,621,428	$ 18,370,278,149
Total WOW Expenditures	**$ 22,069,151,004**	**$ 23,435,994,925**	**$ 24,496,399,535**	**$ 28,348,521,463**	**$ 31,077,204,334**	**$ 129,427,271,260**	**$ 33,253,271,334**	**$ 35,811,030,337**	**$ 38,601,937,746**	**41,627,059,662**	**$ 44,892,798,981**	**$ 194,186,098,059**	**$ 323,613,369,320**
	DEMONSTRATION YEARS (DY)					2012-2016	**DEMONSTRATION YEARS (DY)**					2017-2021	2012-2021
WITH WAIVER SUMMARY	**DY 01 (FFY 12)**	**DY 02 (FFY 13)**	**DY 03 (FFY 14)**	**DY 04 (FFY 15)**	**DY 05 (FFY 16)**	**Total 5 yr WW**	**DY 06 (FFY 17)**	**DY 07 (FFY 18)**	**DY 08 (FFY 19)**	**DY 09 (FFY 20)**	**DY 10 (FFY 21)**	**Total 5 yr WW extension**	**TOTAL 10 yr WW**
Aged and Medicare Related	$ 1,357,367,407	$ 1,460,144,507	$ 1,655,998,550	$ 3,121,887,773	$ 4,199,504,771	$ 11,794,903,008	$ 4,415,550,132	$ 4,677,484,282	$ 5,069,088,590	$ 5,433,566,877	$ 5,824,251,930	$ 25,419,941,811	$ 37,214,844,819
Blind and Disabled	$ 5,557,482,311	$ 6,015,692,998	$ 6,339,562,165	$ 6,902,477,386	$ 7,475,619,238	$ 32,290,834,099	$ 7,747,170,395	$ 8,307,554,183	$ 8,912,516,034	$ 9,534,940,140	$ 10,200,837,797	$ 44,703,018,549	$ 76,993,852,648
Adults	$ 1,695,575,084	$ 1,722,004,805	$ 1,767,539,879	$ 1,933,064,931	$ 2,064,545,965	$ 9,182,730,665	$ 2,177,076,674	$ 2,295,379,724	$ 2,420,331,346	$ 2,543,918,253	$ 2,673,815,752	$ 12,110,521,749	$ 21,293,252,414
Children	$ 7,291,536,240	$ 7,135,331,891	$ 7,276,405,529	$ 7,554,661,235	$ 7,941,921,169	$ 37,199,856,064	$ 8,377,887,135	$ 8,876,842,370	$ 9,420,480,481	$ 9,967,797,480	$ 10,546,912,847	$ 47,189,920,313	$ 84,389,776,377
Other UPL Programs (Not Included in Population)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Non-Pool Expenditures	**$ 15,901,961,042**	**$ 16,333,174,202**	**17,039,506,124**	**19,512,091,325**	**21,681,591,144**	**90,468,323,836**	**22,717,684,336**	**24,157,260,559**	**$ 25,822,416,451**	**27,480,222,751**	**$ 29,245,818,326**	**$ 129,423,402,422**	**219,891,726,258**
Waiver Pool													
Uncompensated Care Pool Payments	$ 3,700,000,000	$ 3,900,000,000	$ 3,534,000,000	$ 3,348,000,000	$ 3,100,000,000	$ 17,582,000,000	$ 5,800,000,000	$ 6,600,000,000	$ 7,400,000,000	$ 7,400,000,000	$ 7,400,000,000	$ 34,600,000,000	**$ 52,182,000,000**
DSRIP	$ 500,000,000	$ 2,300,000,000	$ 2,666,000,000	$ 2,852,000,000	$ 3,100,000,000	$ 11,418,000,000	$ 3,100,000,000	$ 3,100,000,000	$ 3,100,000,000	$ 3,100,000,000	$ 3,100,000,000	$ 15,500,000,000	**$ 26,918,000,000**
Network Access Improvement Project													
NAIP Expenditures	$ -	$ -	$ -	$ 126,558,753	$ 527,733,532	$ 654,292,285	$ 633,280,238	$ 696,608,262	$ 766,269,088	$ 842,895,997	$ 927,185,597	$ 3,866,239,183	**$ 4,520,531,468**
Nursing Facility Directed Payments	$ -	$ -	$ -	$ 119,253,419	$ 535,269,291	$ 654,522,710	$ 642,323,150	$ 706,555,465	$ 777,211,011	$ 854,932,112	$ 940,425,323	$ 3,921,447,061	**$ 4,575,969,771**
Total WW Expenditures	**$ 20,101,961,042**	**$ 22,533,174,202**	**23,239,506,124**	**25,957,903,497**	**28,944,593,967**	**120,777,138,831**	**32,893,287,724**	**35,260,424,285**	**$ 37,865,896,551**	**39,678,050,860**	**$ 41,613,429,246**	**$ 187,311,088,666**	**308,088,227,497**
Expenditures (Over)/Under Cap	**$ 1,967,189,962**	**$ 902,820,723**	**$ 1,256,893,411**	**$ 2,390,617,966**	**$ 2,132,610,367**	**$ 8,650,132,430**	**$ 359,983,610**	**$ 550,606,051**	**$ 736,041,195**	**$ 1,949,008,802**	**$ 3,279,369,735**	**$ 6,875,009,393**	**$ 15,525,141,822**
Duals Demonstration Savings Adjustment (03/15-12/18)	$ -	$ -	$ -	$ 3,982,189	$ 35,021,152	$ 39,003,341	$ 54,708,732	$ 84,778,458	$ 24,401,335	$ -	$ -	$ 163,888,525	**$ 202,891,866**

Expenditures (Over)/Under Cap w/out DD Savings	**$ 1,967,189,962**	**$ 902,820,723**	**$ 1,256,893,411**	**$ 2,386,635,777**	**$ 2,097,589,215**	**$ 8,611,129,089**	**$ 305,274,878**	**$ 465,827,594**	**$ 711,639,860**	**$ 1,949,008,802**	**$ 3,279,369,735**	**$ 6,711,120,868**	**$ 15,322,249,957**

NAIP and MPAP each assume 20% growth in FFY 17, followed by 10% growth in the following years

Annual 1115a Budget Neutrality Update and Impact of Texas Dual Eligible Integrated Care Demonstration Project ("Dual Demo")

										Savings Outside of BN (Add back)		
	DY	Dual Demo Avg Monthly Caseload	Dual Demo Total Recipient Months	Medicaid Capitation Rate (hypothetical, before savings)	% Savings Applied per MOU	PMPM Savings	Total DD Savings, Subtracted from 1115(a) BN Savings		Total DD Premium Cost (after savings)	Acute Savings	LTSS Savings	Total Savings
FFY 2015 (Mar-Sept)	DY 04	59,291	415,036	$ 767.58	1.25%	$ 9.59	3,982,189	FFY 2015 (Mar-Sept)	314,592,942	557,918	3,424,271	3,982,189
FFY 2016 (Oct-Dec)	DY 05	114,247	342,742	$ 1,053.62	1.25%	$ 13.17	4,514,009	FFY 2016 (Oct-Dec)	356,606,719	518,529	3,995,480	4,514,009
FFY 2016 (Jan-Sept)	DY 05	114,846	1,033,613	$ 1,073.27	2.75%	$ 29.52	30,507,143	FFY 2016 (Jan-Sept)	1,078,843,499	3,504,713	27,002,430	30,507,143
FFY 2016 Total	DY 05	114,696	1,376,356	$ 1,068.38			35,021,152	FFY 2016 Total	1,435,450,218	4,023,241	30,997,910	35,021,152
FFY 2017 (Oct-Dec)	DY 06	115,721	347,163	$ 1,109.66	2.75%	$ 30.52	10,593,877	FFY 2017 (Oct-Dec)	374,638,026	1,218,691	9,375,187	10,593,877
FFY 2017 (Jan-Sept)	DY 06	116,492	1,048,425	$ 1,122.06	3.75%	$ 42.08	44,114,855	FFY 2017 (Jan-Sept)	1,132,281,277	5,084,667	39,030,188	44,114,855
FFY 2017 Total	DY 06	116,299	1,395,588	$ 1,118.98			54,708,732	FFY 2017 Total	1,506,919,303	6,303,358	48,405,374	54,708,732
FFY 2018 (Oct-Dec)	DY 07	117,907	353,722	$ 1,154.70	3.75%	$ 43.30	15,316,561	FFY 2018 (Oct-Dec)	393,125,076	1,769,475	13,547,086	15,316,561
FFY 2018 (Jan-Sept)	DY 07	119,098	1,071,878	$ 1,178.25	5.50%	$ 64.80	69,461,896	FFY 2018 (Jan-Sept)	1,193,481,671	8,038,038	61,423,858	69,461,896
FFY 2018 Total	DY 07	118,800	1,425,600	$ 1,172.41			84,778,458	FFY 2018 Total	1,586,606,747	9,807,513	74,970,944	84,778,458
FFY 2019 (Oct-Dec)	DY 08	120,816	362,448	$ 1,224.07	5.50%	$ 67.32	24,401,335	FFY 2019 (Oct-Dec)	419,259,298	2,826,940	21,574,395	24,401,335

The dual demonstration is scheduled for implementation on March 1, 2015. The forecast used in our annual update of Budget Neutrality includes the impacts of this new program. Costs forecast for the new model is based on current STAR+PLUS premiums from the six SDAs where the demo will occur, minus the below savings assumptions. In order to remove these savings from the 1115a BN, we have subtracted cost savings attributed to the Duals Demonstration from the savings in the Budget Neutrality exhibit. The above chart details how this saving amount has been derived. Please note that the premiums above are based on STAR+PLUS costs and all include expenses for long term services and supports, making them higher than the overall AMR MEG pmpm.

Attachment E - Tribal Consultation

TEXAS HEALTH AND HUMAN SERVICES COMMISSION

KYLE L. JANEK, M.D.
EXECUTIVE COMMISSIONER

June 30, 2015

Nita Battise
Tribal Council Chairperson
Alabama-Coushatta Tribe of Texas
571 State Park Road, #56
Livingston, Texas 77351

Dear Ms. Battise:

The purpose of this letter is to notify members of the Alabama-Coushatta Tribe of Texas that the Texas Health and Human Services Commission (HHSC) is submitting a request to the Centers for Medicare & Medicaid Services (CMS) to extend the Texas Healthcare Transformation Quality Improvement Program under Section 1115 of the Social Security Act. CMS has approved this waiver through September 30, 2016. The proposed effective date for the extension is October 1, 2016 for a five-year period ending September 30, 2021.

Background of the 1115 Waiver

The State of Texas submitted an initial demonstration application to CMS in July 2011 to expand risk-based managed care statewide and to operate funding pools to reimburse providers for uncompensated care costs and to provide incentive payments for implementation and operation of delivery system reforms. CMS approved the application in December 2011. Through the 1115 waiver, the State has expanded its use of Medicaid managed care to achieve program savings, while also preserving locally funded supplemental payments to hospitals. The goals of the demonstration are to:

-expand risk-based managed care statewide,
-support the development and maintenance of a coordinated care delivery system,
-improve outcomes while containing cost growth,
-protect and leverage financing to improve and prepare the healthcare infrastructure to serve a newly insured population, and
-transition to quality-based payment systems across managed care and hospitals.

There are three major components within the 1115 waiver:

-HHSC has expanded the delivery of Medicaid managed care services statewide through the STAR, STAR+PLUS and Children's Medicaid Dental Services programs.

-The Delivery System Reform Incentive Payment (DSRIP) program has established 20 Regional Healthcare Partnerships across the state, overseeing multiple local projects focused on integrated physical and behavioral healthcare, patient-centered medical homes, chronic care management and patient care navigation.
-The Uncompensated Care (UC) pool helps offset uncompensated costs undertaken by hospitals and certain other providers serving Medicaid and other low-income populations.

Request for Extension of the 1115 Demonstration Waiver
HHSC is requesting a five-year extension to build on the work accomplished thus far, continue to strengthen programs operating under the waiver, and further demonstrate program outcomes. With the extension, HHSC is requesting that CMS continue the Demonstration Year 5 DSRIP funding level ($3.1 billion annually) and increase the UC pool to address the anticipated unmet UC need in Texas within current budget neutrality. HHSC is not seeking any changes to managed care program operations.

The general public is invited to submit comments on the waiver extension for a period of 30 days beginning Monday, July 6, 2015. The public comment period will end on Wednesday, August 5, 2015. HHSC will host a series of meetings to provide information about the extension application as well as an opportunity for the public to provide comments. Locations, dates and times are as follows:

- July 13, 2015 - 10AM to 12PM CDT
  Texas Department of Transportation, 7600 Washington, Houston, TX 77007
- July 15, 2015 - 1PM to 3PM CDT
  Edinburg Conference Center at Renaissance, 118 Paseo Del Prado, Edinburg, TX 78539
- July 16, 2015 - 10AM to 12PM CDT
  Tyler Junior College, West Campus, 1530 S SW Loop 323, Room 104, Tyler, TX 75701
- July 16, 2015 - 2PM to 4PM CDT
  Texas Health and Human Services Commission, Brown-Heatly Bldg., Public Hearing Room 1410, 4900 N. Lamar Blvd., Austin, TX 78751 (Webcast available at this meeting).
- July 20, 2015 - 9AM-11AM CDT
  Omni Colonnade, 9821 Colonnade Blvd., San Antonio, TX 78230
- July 21, 2015 - 10AM-12PM CDT
  Old Red Museum of Dallas County History and Culture, 100 S Houston St, Dallas, TX 75202
- July 22, 2015 - 1:30PM to 3:30 PM MDT
  El Paso First Health Plans Inc., 1145 Westmoreland Drive, El Paso, TX 79925
- July 24, 2015 - 1PM to 3PM CDT
  Region 16-Educational Services Center, Lecture Hall, 5800 Bell Street, Amarillo, TX 79109

HHSC will also host a webinar on July 23, 2015 from 9:30AM-11:30AM CDT. To join the online meeting please visit www.hhsc.state.tx.us/1115-waiver.shtml and follow the instructions provided.

The abbreviated public notice set forth in 42 CFR § 431.408(a)(2)(ii) will be published in the July 3, 2015 issue of the Texas Register. The full public notice and the complete extension application will be available online by July 3, 2015, at www.hhsc.state.tx.us/1115-waiver.shtml. The application includes a detailed description of the waiver programs, including current categories of eligibility for services under managed care; enrollment projections and financial information; a summary of the evaluation currently being conducted for the waiver programs; summaries of reports of quality of and access to care under the waiver; and additional information as required by CMS.

Feedback from Tribal Governments

The State is seeking advice from the tribal governments regarding changes to the State's waiver that are likely to have a direct effect on Indians, tribes, Indian health programs, or urban Indian health organizations. To allow sufficient time for consideration of the tribal governments' comments or questions, HHSC requests your feedback by August 5, 2015.

Please submit your comments regarding this amendment to:

Beren Dutra
Texas Health and Human Services Commission
P.O. Box 13247, Mail Code H-600
Austin, Texas 78711-3247

If you have questions or need additional information, Beren Dutra can be reached by phone at (512) 428-1932 or by email at TX_Medicaid_Waivers@hhsc.state.tx.us.

Sincerely,

Dana Williamson
Manager of Policy Development Support
Medicaid/CHIP Division, HHSC

TEXAS HEALTH AND HUMAN SERVICES COMMISSION

KYLE L. JANEK, M.D.
EXECUTIVE COMMISSIONER

June 30, 2015

Myra Sylestine
Health Director
Alabama-Coushatta Tribe of Texas
129 Daycare Rd.
Livingston, Texas 77351

Dear Ms. Sylestine:

The purpose of this letter is to notify members of the Alabama-Coushatta Tribe of Texas that the Texas Health and Human Services Commission (HHSC) is submitting a request to the Centers for Medicare & Medicaid Services (CMS) to extend the Texas Healthcare Transformation Quality Improvement Program under Section 1115 of the Social Security Act. CMS has approved this waiver through September 30, 2016. The proposed effective date for the extension is October 1, 2016 for a five-year period ending September 30, 2021.

Background of the 1115 Waiver

The State of Texas submitted an initial demonstration application to CMS in July 2011 to expand risk-based managed care statewide and to operate funding pools to reimburse providers for uncompensated care costs and to provide incentive payments for implementation and operation of delivery system reforms. CMS approved the application in December 2011. Through the 1115 waiver, the State has expanded its use of Medicaid managed care to achieve program savings, while also preserving locally funded supplemental payments to hospitals. The goals of the demonstration are to:

-expand risk-based managed care statewide,
-support the development and maintenance of a coordinated care delivery system,
-improve outcomes while containing cost growth,
-protect and leverage financing to improve and prepare the healthcare infrastructure to serve a newly insured population, and
-transition to quality-based payment systems across managed care and hospitals.

There are three major components within the 1115 waiver:

-HHSC has expanded the delivery of Medicaid managed care services statewide through the STAR, STAR+PLUS and Children's Medicaid Dental Services programs.

-The Delivery System Reform Incentive Payment (DSRIP) program has established 20 Regional Healthcare Partnerships across the state, overseeing multiple local projects focused on integrated physical and behavioral healthcare, patient-centered medical homes, chronic care management and patient care navigation.
-The Uncompensated Care (UC) pool helps offset uncompensated costs undertaken by hospitals and certain other providers serving Medicaid and other low-income populations.

Request for Extension of the 1115 Demonstration Waiver
HHSC is requesting a five-year extension to build on the work accomplished thus far, continue to strengthen programs operating under the waiver, and further demonstrate program outcomes. With the extension, HHSC is requesting that CMS continue the Demonstration Year 5 DSRIP funding level ($3.1 billion annually) and increase the UC pool to address the anticipated unmet UC need in Texas within current budget neutrality. HHSC is not seeking any changes to managed care program operations.

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Feedback from Tribal Governments

The State is seeking advice from the tribal governments regarding changes to the State's waiver that are likely to have a direct effect on Indians, tribes, Indian health programs, or urban Indian health organizations. To allow sufficient time for consideration of the tribal governments' comments or questions, HHSC requests your feedback by August 5, 2015.

Please submit your comments regarding this amendment to:

Beren Dutra
Texas Health and Human Services Commission
P.O. Box 13247, Mail Code H-600
Austin, Texas 78711-3247

If you have questions or need additional information, Beren Dutra can be reached by phone at (512) 428-1932 or by email at TX_Medicaid_Waivers@hhsc.state.tx.us.

Sincerely, ,

Dana Williamson
Manager of Policy Development Support
Medicaid/CHIP Division, HHSC

TEXAS HEALTH AND HUMAN SERVICES COMMISSION

KYLE L. JANEK, M.D.
EXECUTIVE COMMISSIONER

June 30, 2015

Nick Gonzalez
Health Director
Kickapoo Traditional Tribe of Texas
HCR 1, Box 9700
Eagle Pass, Texas 78852

Dear Mr. Gonzalez:

The purpose of this letter is to notify members of Kickapoo Traditional Tribe of Texas that the Texas Health and Human Services Commission (HHSC) is submitting a request to the Centers for Medicare & Medicaid Services (CMS) to extend the Texas Healthcare Transformation Quality Improvement Program under Section 1115 of the Social Security Act. CMS has approved this waiver through September 30, 2016. The proposed effective date for the extension is October 1, 2016 for a five-year period ending September 30, 2021.

Background of the 1115 Waiver

The State of Texas submitted an initial demonstration application to CMS in July 2011 to expand risk-based managed care statewide and to operate funding pools to reimburse providers for uncompensated care costs and to provide incentive payments for implementation and operation of delivery system reforms. CMS approved the application in December 2011. Through the 1115 waiver, the State has expanded its use of Medicaid managed care to achieve program savings, while also preserving locally funded supplemental payments to hospitals. The goals of the demonstration are to:

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-improve outcomes while containing cost growth,
-protect and leverage financing to improve and prepare the healthcare infrastructure to serve a newly insured population, and
-transition to quality-based payment systems across managed care and hospitals.

There are three major components within the 1115 waiver:

-HHSC has expanded the delivery of Medicaid managed care services statewide through the STAR, STAR+PLUS and Children's Medicaid Dental Services programs.

-The Delivery System Reform Incentive Payment (DSRIP) program has established 20 Regional Healthcare Partnerships across the state, overseeing multiple local projects focused on integrated physical and behavioral healthcare, patient-centered medical homes, chronic care management and patient care navigation.
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Request for Extension of the 1115 Demonstration Waiver

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Beren Dutra
Texas Health and Human Services Commission
P.O. Box 13247, Mail Code H-600
Austin, Texas 78711-3247

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Sincerely,

Dana Williamson
Manager of Policy Development Support
Medicaid/CHIP Division, HHSC

TEXAS HEALTH AND HUMAN SERVICES COMMISSION

KYLE L. JANEK, M.D.
EXECUTIVE COMMISSIONER

June 30, 2015

Don Spaulding
Tribal Administrator
Kickapoo Traditional Tribe of Texas
HCR 1, Box 9700
Eagle Pass, Texas 78852

Dear Mr. Spaulding:

The purpose of this letter is to notify members of the Kickapoo Traditional Tribe of Texas that the Texas Health and Human Services Commission (HHSC) is submitting a request to the Centers for Medicare & Medicaid Services (CMS) to extend the Texas Healthcare Transformation Quality Improvement Program under Section 1115 of the Social Security Act. CMS has approved this waiver through September 30, 2016. The proposed effective date for the extension is October 1, 2016 for a five-year period ending September 30, 2021.

Background of the 1115 Waiver

The State of Texas submitted an initial demonstration application to CMS in July 2011 to expand risk-based managed care statewide and to operate funding pools to reimburse providers for uncompensated care costs and to provide incentive payments for implementation and operation of delivery system reforms. CMS approved the application in December 2011. Through the 1115 waiver, the State has expanded its use of Medicaid managed care to achieve program savings, while also preserving locally funded supplemental payments to hospitals. The goals of the demonstration are to:

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There are three major components within the 1115 waiver:

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Sincerely,

Dana Williamson
Manager of Policy Development Support
Medicaid/CHIP Division, HHSC

TEXAS HEALTH AND HUMAN SERVICES COMMISSION

KYLE L. JANEK, M.D.
EXECUTIVE COMMISSIONER

June 30, 2015

Angela Young
Administrative Director
Urban Inter-Tribal Center of Texas
209 E. Jefferson Blvd.
Dallas, Texas 75203

Dear Ms. Young:

The purpose of this letter is to notify members of the Urban Inter-Tribal Center of Texas that the Health and Human Services Commission (HHSC) is submitting a request to the Centers for Medicare & Medicaid Services (CMS) to extend the Texas Healthcare Transformation Quality Improvement Program under Section 1115 of the Social Security Act. CMS has approved this waiver through September 30, 2016. The proposed effective date for the extension is October 1, 2016 for a five-year period ending September 30, 2021.

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Sincerely,

Dana Williamson
Manager of Policy Development Support
Medicaid/CHIP Division, HHSC

TEXAS HEALTH AND HUMAN SERVICES COMMISSION

KYLE L. JANEK, M.D.
EXECUTIVE COMMISSIONER

June 30, 2015

Gretchen P. Duffin
Administrative Director
Urban Inter-Tribal Center of Texas
1283 Record Crossing Rd.
Dallas, Texas 75235

Dear Ms. Duffin:

The purpose of this letter is to notify members of the Urban Inter-Tribal Center of Texas that the Texas Health and Human Services Commission (HHSC) is submitting a request to the Centers for Medicare & Medicaid Services (CMS) to extend the Texas Healthcare Transformation Quality Improvement Program under Section 1115 of the Social Security Act. CMS has approved this waiver through September 30, 2016. The proposed effective date for the extension is October 1, 2016 for a five-year period ending September 30, 2021.

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Dana Williamson
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Medicaid/CHIP Division, HHSC

TEXAS HEALTH AND HUMAN SERVICES COMMISSION

KYLE L. JANEK, M.D.
EXECUTIVE COMMISSIONER

June 30, 2015

Carlos Hisa
Governor
Ysleta Del Sur Pueblo
P.O.Box 17579 - Ysleta Station
El Paso, Texas 79907

Dear Governor Hisa:

The purpose of this letter is to notify members of Ysleta Del Sur Pueblo that the Texas Health and Human Services Commission (HHSC) is submitting a request to the Centers for Medicare & Medicaid Services (CMS) to extend the Texas Healthcare Transformation Quality Improvement Program under Section 1115 of the Social Security Act. CMS has approved this waiver through September 30, 2016. The proposed effective date for the extension is October 1, 2016 for a five-year period ending September 30, 2021.

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Dana Williamson
Manager of Policy Development Support
Medicaid/CHIP Division, HHSC

TEXAS HEALTH AND HUMAN SERVICES COMMISSION

KYLE L. JANEK, M.D.
EXECUTIVE COMMISSIONER

June 30, 2015

Martin Lopez
Health and Human Services Director
Ysleta Del Sur Pueblo
9314 Juanchido Lane
El Paso, Texas 79907

Dear Mr. Lopez:

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Austin, Texas 78711-3247

If you have questions or need additional information, Beren Dutra can be reached by phone at (512) 428-1932 or by email at TX_Medicaid_Waivers@hhsc.state.tx.us.

Sincerely,

Dana Williamson
Manager of Policy Development Support
Medicaid/CHIP Division, HHSC

Texas Medicaid and CHIP, Tribal Health Directors,
& Urban Indian Organization Monthly Conference Call
July 02, 2015 at 2:00 p.m. (CST)
MEETING SUMMARY

Conference Call Participants:

- Martin Lopez (Director of Health & Human Services of Ysleta Del Sur Pueblo)
- Norma Ramirez (Assistant Caseworker of the Kickapoo Traditional Tribe of Texas)
- Myra Sylestine (Health Director of Alabama-Coushatta Tribe of Texas)
- Gretchen P. Duffin (Accounting Director of the Urban Inter-Tribal Center of Texas)
- Angela Young (Administrative Director of the Urban Inter-Tribal Center of Texas)
- Becky Brownlee (Director of Policy Development Support, Medicaid/CHIP)
- Beren Dutra (Program Specialist &Tribal Liaison, State Plan, Policy Development Support, Medicaid/CHIP)
- J.R. Top (State Plan Coordinator, Policy Development Support, Medicaid/CHIP)
- Micah Erwin (Program Specialist, Waiver, Policy Development Support, Medicaid/CHIP)
- Natoshia Petsch (Program Specialist, Waiver, Policy Development Support, Medicaid/CHIP)
- Clare Seagraves (Waiver Team Lead, Policy Development Support, Medicaid/CHIP)
- Dana Williamson (SPA, Waiver and Rules Manager, Policy Development Support, Medicaid/CHIP)
- Dan Huggins (Director of Rate Analysis for Acute Care Services)
- Kym Oltrogge (Staff Counsel)

I. Welcome and Introductions:

Beren Dutra, from the Texas Health and Human Services Commission (HHSC), opened the meeting and welcomed the participants. The participants introduced themselves.

II. Review of the status of the most recent State Plan Amendments (SPAs):

J.R. Top (HHSC) gave the following updates:
The Centers for Medicare and Medicaid Services (CMS) approved the following five SPAs since the last conference call:

- 14-042: Disproportionate Share Hospital Methodology;
- 15-004: Same-sex marriage eligibility policy, which may change;
- 15-013: Durable Medical Equipment, Prosthetics, Orthotics, and Supplies fees;
- 15-014: Physician fees; and
- 15-015: Early and Periodic Screening, Diagnosis, and Treatment fees.

Martin Lopez, from Ysleta Del Sur Pueblo (YDSP), asked about the monthly updates on the physician's fees and wanted to know what the adjustments were.
Dan Huggins, from HHSC Rate Analysis Department (RAD), explained that these updates were part of the quarterly fee updates and were presented in the web site under the rate hearing information that was conducted last May. These fee updates vary every quarter. Mr. Huggins proposed to provide the link to the Tribal Health Directors and the Urban Indian Organization.

- Action Item: Ms. Dutra will send the RAD information which includes the website link, and the approved SPA packet on the physician fees.

III. <u>Review of the status of the most recent waivers</u>:

Clare Seagraves (HHSC) gave the most recent updates as follow:

1) The Community Living Assistance and Support Services (CLASS) waiver renewal documents were posted for public comment, mid-June. The Tribal designees received the tribal notices earlier in June. The renewal is half way through the process and will be closing on July 28, 2015.
2) The Youth Empowerment Services (YES) waiver amendments four, five and six were approved by CMS late last week.
3) The Home and Community-Based Services (HCS) waiver amendment five was submitted earlier in June. This amendment is still pending as HHSC is waiting for CMS response. The effective date is August 30, 2015. The monthly waiver updates document sent out has an incorrect effective date.
4) The Medically Dependent Children Program (MDCP) amendment three was submitted earlier in June with an effective date of August 1, 2015.
5) Under the 1915 (b) waivers, HHSC has some renewals regarding the Texas Medicaid Wellness Program (TMWP) and NorthSTAR. NorthSTAR renewal was just submitted yesterday and the tribal notices were sent out earlier this spring.

Becky Brownlee (HHSC) gave an update about the 1115 extension application:

The 1115 extension application has all of the Medicaid Managed Care programs operated under the 1115 demonstration as well as the local delivery system reform incentive payment (DSRIP) project, which received a lot of attention at regional and local levels. The application should be posted on the HHSC website by tomorrow.
Ms. Brownlee also mentioned that HHSC scheduled a series of public hearings across the state. On July 13 and July 14, 2015, HHSC will have public hearings in Houston, Edinburg, Tyler, Austin, San Antonio, Dallas/Fort Worth, El Paso, and Amarillo. HHSC Austin staff will be present to talk about the different components of the 1115 extension application, to answer questions and to take public comments. For any interested parties, those hearings are open to the public and the information will be posted tomorrow on the HHSC website along with the application.
Mr. Lopez thanked Ms. Brownlee for the information.
No one from the Indian Tribes designees had any questions.

Natoshia Petsch (HHSC) explained that HHSC received a question from Mr. Lopez on the HCS Amendment six on the tribal notices sent out last week.
In response to that question, a PowerPoint presentation regarding Medicaid/CHIP division was sent out prior to the conference call. Since Mr. Lopez previously worked in New Mexico, he wanted to know more about the Medicaid waiver in Texas, in general.

Ms. Petsch turned the floor over to Dana Williamson (HHSC). Ms. Williamson, who is a recent addition to HHSC, gave a presentation about the Texas waiver structure and gave a general overview of what waivers allow the state to do. She went over the PowerPoint presentation, which was more focused on the HCS waiver.
Ms. Williamson explained that the Department of Aging and Disability Service (DADS), where she worked previously, operates five 1915 (c) waivers.

The term waiver, in general, means that the federal government allows a state to waive off certain state plan requirements. A waiver can allow limitation on a targeted population, it can restrict the geographic coverage, and it can give some ability to offer different services than what is offered in the Medicaid State plan.
DADS has four waivers that waive off the institutional requirements for the intermediate care facility (ICF) for persons with intellectual and developmental disabilities (IDD). HCS, Texas Home Living (TxHmL), CLASS and DBMD waivers are all waiving off of ICF/IDD facilities. MDCP, under DADS, waives off nursing facilities level of care.

The targeted population for each of these waivers is slightly different, for instance it has different diagnostic criteria; all of these waivers actually serve children and adults, however, sometimes a waiver targets a specific age range.

HHSC operates the 1115 waiver, which is a demonstration waiver that provides even better flexibility than the 1915(c) waivers. Under the demonstration waiver, there are a number of different projects. It is a broader demonstration project that proposes a lot of different services, more than the 1915 (c) waivers at DADS offer. Also, there is one additional 1915(c) waiver that operates with the Department of State Health Services which is a waiver designed to service children with severe emotional disturbance.
The 1115 waiver is actually a managed care waiver; there are some special requirements that go along with the 1115 and also other waivers under the 1915(b) authority which allow for basically the design of a managed care waiver.

Mr. Lopez asked if there was another slide on the 1115 demonstration waiver. The PowerPoint received only mentioned the 1915 (c) waivers.
Ms. Williamson responded that since the question was directed at HCS, the information provided in the PowerPoint presentation was only about the (c) waivers. A different power point that would give a lot of information about the 1115 waiver could be send if desired.
Mr. Lopez replied that it was not necessary. He just wanted to make sure he was not missing a slide in the presentation he received.
Ms. Williamson proposed to provide the PowerPoint presentation with additional information on the 1115 waiver as it will be informative.
Ms. Brownlee mentioned that the document posted on line has a very detailed explanation of the extension application. If interested, anyone can go to the website and find the 1115 extension application information and by reading that detailed public notice, it will give a really good overview of what HHSC is able to provide under the 1115 demonstration. It is a very good summary overview for anybody who wants to know about the 1115 waiver in Texas.
Mr. Lopez thanked Ms. Williamson and Ms. Brownlee for the explanation.
Mr. Top reminded Mr. Lopez that HHSC also has available on line the Texas Medicaid and CHIP in Perspective book, named The Pink Book, which is a 300-page document about Medicaid.

- Action Item: Ms. Dutra will resend the link of the Pink Book as well as the link to the 1115 demonstration waiver.

IV. <u>Urban Inter-Tribal Center of Texas (UITCT) Presentation</u>:

Angela Young, Administrative Director for the Urban Inter-Tribal Center of Texas (UITCT), gave a presentation of UITCT. She explained that UITCT is an urban health program since 1971. Next year, in 2016, they will be celebrating 45 years of service. They are also planning their yearly exposition, in which several Oklahoma tribes participate. Once they have a location and a date, HHSC will be notified.

UITCT serves all American Indian & Alaska Natives (AI/AN) citizen with appropriate documentation, CDIB or Tribal membership. UITCT has a lot of Oklahoma tribal members who live on the Oklahoma and Texas border and who come over to receive services at the clinic. The primary counties served by UITCT are: Collin, Dallas, Denton, Ellis, Hood, Johnson, Kaufman, Parker, Rockwall, Tarrant, and Wise. It also serves AI/AN living outside these areas.

UITCT is a Federally Qualified Health Center (FQHC); they are currently doing Medicare billing and Part B labs; Medicaid FQHC and Medicaid Managed Care for their region since 2012. They are working on contracts, mainly based on the Indian Health Care Improvement Act (IHCIA) of 2011 in the Section 206.

The services that are offered at the center are primarily medical and include a dental program that operates three days a week (Wednesday, Thursday, and Friday). The dental services provided are preventive services (no

cosmetic type services, such as dentures or implants). They do not have any funding for dental; they have to take a little money from each one of their pots in order to have dental services at least three days a week.
They are moving forward to set up a third party billing for their dental program to be able to create more revenue; once they have the revenue built up they can increase the hours in their services.

UITCT also has a Class A pharmacy, which has a limited formulary but provides most of the diabetic medications. 500 diabetics are part of the diabetes's program and receive care at the clinic.

UITCT has a mental health and substance abuse program with a counselor on hand to provide services, and also has family and social services available to the AI/AN population.

In addition to the clinic services, UITCT offers an employment and training program that assists with job training.

Also WIC services are provided at the clinic to the AI/AN population. It is a partnership with Los Barrios Unidos Community Clinic which provides a staff person twice a month at no expense to UITCT.

One of the newest projects in UITCT is the community garden. They used some of the health promotion disease prevention money to be able to initiate that project. For the last two months
they have been working with the city to obtain a permit to have water in the garden, in the mean time they have been transporting water on a wagon.
Last week they added to the garden a traditional healing circle that is going to resemble to a medicine wheel which is composed of four quadrants with four different types of herbs. Each of these quadrants will also have a flower to represent the four colors of a medicine wheel: black, yellow, red and white. The healing circle has a walking path and around has rock benches build with the Oklahoma native stone. In the center of the circle there is a 600 pound rock as a sculpture. This fall they will be planting some trees along with gourdes and other plants that are traditional to Native American and Alaska Natives. Ms. Young welcomed everyone to visit and also mentioned that they are always looking for volunteers.

Ms. Oltrogge asked if they only had one facility.
Ms. Young confirmed they are the only Urban Indian Health facility in the state of Texas.

Mr. Huggins asked if that is why they were not qualifying for Indian health services.
Ms. Young replied that they do receive IHS funding. She explained that they receive grant funding and have IHS Contract.

In reference to Mr. Huggins question, patients receiving care at the clinic who are diagnosed with illnesses that's beyond our scope of care do not qualify for IHS Contract Health/Preferred Health funds. If these patients do not have insurance, UITCT tries to see if they can qualify for premium subsidies in the federally facilitated marketplace, Medicaid or Medicare. It is very difficult at times. For instance, patients with kidney failure or diagnosed with cancer, it can be a daunting task to find immediate care for patients with no insurance.

UITCT does not have X-ray services at the clinic. When someone, who is uninsured, comes in with a broken bone, that patient has to drive to Oklahoma. UITCT has a great working relationship with the Oklahoma Tribes which means anywhere where a tribal organization has X-ray all UITCT patients can get services. However, it is a burden if these patients do not have transportation to get to Oklahoma for these types of services.
For patients with no health insurance who need a colonoscopy or a CAT scan, UITCT has an arrangement with the Chickasaw Indian Hospital and the Talihina Indian Hospital to provide services to them.

Ms. Brownlee asked, out of the 3,000 patients, what was the percentage of patients eligible for Medicaid services.
Ms. Young responded that surprisingly not many of their patients qualify for Medicaid. With the Affordable Care

Act (ACA) they were hoping that Texas would expand as they were looking at creating more revenue where they could provide more services. The problem is that there is a big gap in services. Their middle-class people earn too much to qualify for Medicaid but cannot afford the insurance premiums. Fortunately, these people can use the waiver where they are not penalized by the Internal Revenue Services for not having health insurance.
UITCT is currently doing an analysis on how many of these patients are in that gap.
Ms. Young also explained that in the past, UITCT has not served many children in the facility because the chief physician was an internist who could not provide pediatric services under his license status.
UITCT hired a new doctor who is a family practice physician; she will be able to provide care to children.
This should increase the number of Medicaid patients, in the hope to get more children who are Medicaid certified or possibly could get certified.

Ms. Young mentioned that they have ongoing meetings to expand services that they do not currently offer, but nothing is finalized yet. For instance, they had a conversation with the children's hospital and are trying to work some kind of partnership with their pediatric services. They are also in negotiation with Baylor Pediatric Dental School where the School would actually place their students in the clinic in the dental department to help with pediatric services.

UITCT has a laboratory where it process lab work and has a contract with QUEST, which every evening picks up other lab work that cannot be processed in-house. They had negotiated some great rates with QUEST which are reviewed annually to make sure it continues to be affordable for their nonprofit agency. Patients from UITCT can also go to any Quest Laboratory to get their blood drawn and Quest will send the results electronically since the clinic has access to Electronic Health Records (EHR).

UITCT offers teleretinal eye screenings for the diabetic patients. UITCT collaborates with the Joslin Vision Network.

UITCT also has a shoe program available for diabetic patients. To qualify to receive free pair of native shoes twice a year, these patients have to continue with their follow-ups and maintain their health care. This program has been very successful.

UITCT is a contractor for the Breast and Cervical Cancer Service (BCCS) and has been a part of that program for five years. UITCT was able to obtain funding allocated just for AI/AN women, which took about a year. Because UITCT is designed as an Indian program under the BCCS, it can provide more mammograms, cervical cancer, screenings, and other tests. The clinic also assists with Medicaid enrollment process for continuity of care of their patients who are diagnosed with cancer.

Mr. Lopez asked if UITCT is a FQHC and a 330 grantee**. Ms. Young confirmed that UITCT is a FQHC Look-Alike* and gets all of the benefits of a FQHC and is not a 330 grantee. She explained that they could apply for the 330 grant but it would open them up to serving anyone who would come to the clinic. They want to stay true to their mission to serve the AI/AN population, which is part of the contract agreement they have with IHS.
Ms. Young reported that there are 36 other urban health programs throughout the United-States. Four or five facilities in California serve State recognized tribal members, which UITCT does not do in Texas. Some of the other urban programs have applied for the 330 funding and are serving other citizens other than AI/AN.

Per Ms. Young, the current facility of UITCT is near the medical district, close to the University of Texas (UT) Southwestern Medical Center, the Children's Hospital, and Parkland Hospital, which provide tremendous resources. It helps with the continuity of care for UITCT patients. Patients who live in Dallas County are referred to Parkland for services that the clinic cannot provide.

UITCT patients receiving care at their clinic do not pay for any service.

V. <u>Questions and Comments</u>:

Mr. Lopez and the other participants thanked Ms. Young for the great presentation.

Ms. Young is looking forward to meet again with all the other tribes in Texas. UITCT headquarter is located in Oklahoma City; Alabama Coushatta tribe is located in Nashville, and YDSP reports to Albuquerque, which is the reason the Tribal Health Directors and the Urban Indian Organization never see each other when they go to the IHS conferences.

Ms. Sylestine would like HHSC to share the contact information of each tribe.

Ms. Dutra thanked Ms. Young for her presentation and thanked everyone who participated. She wished everyone a nice holiday week-end and adjourned the meeting.

**FQHC Look-Alike (FQHC LA): Look-Alikes are health centers that have been certified by the federal government as meeting all the Health Center Program requirements, but do not receive funding under the Health Center Program.*

*** Section 330 of the Public Health Service (PHS) Act defines the Federal Health Center Program as the funding opportunity for organizations to provide care to underserved populations. Some of the benefits to health centers participating in this program include funding to help with the costs of uncompensated care and federal loan guarantees for facility improvement projects. These funds are dispersed from HRSA through the Bureau of Primary Health Care.*
Types of organizations that may apply are private non-profit outpatient clinics that meet the Section 330 Program Requirements. Once they receive the grants, they become community, migrant, homeless, or public housing health centers.

VI. <u>Conclusion</u>:

HHSC will send the following documents:

- RAD information which includes the website link
- Approval packet of SPA 15-014 (Physician Fees)
- Web link to the Pink Book
- Web link to the 1115 Demonstration Waiver
- Updated Tribal contacts information

Attachment F - STC Compliance

STC	Subject	Compliance Status
1	Non-discrimination statutes	Waiver operations are in compliance; no deliverable.
2	Medicaid & CHIP law, regulations and policy	Waiver operations are in compliance; no deliverable.
3	Changes in Medicaid & CHIP law, regulations and policy	The state complies with changes in law, regulation or policy related to the Demonstration. For example, effective January 1, 2014, the State amended this waiver to comply with the Affordable Care Act requirements including, conversion to the modified adjusted gross income (MAGI) standards related to considering income and resources, covering children from age 6 to age 18 from 100-133 percent FPL in the waiver, and providing Medicaid benefits for former foster care children until age 26. In December 2014, CMS provided guidance to the State as to HCBS requirements related to person-centered planning and self-direction. The State is in compliance with those requirements.
4	Impact of changes in federal law, regulation and policy	No changes in federal law, regulation or policy have made it necessary for the State to modify budget neutrality and allotment neutrality agreements during the demonstration period or to seek state legislative changes.

Attachment F - STC Compliance

STC	Subject	Compliance Status
5	State Plan Amendments	The State complies with this provision. The State has requested CMS guidance on Demonstration changes that may affect state plan eligibility groups, and the state has either followed CMS guidance that no state plan amendment is required, or the state has amended the state plan. For example, the state sought to remove the state plan limitation on providers of targeted case management to allow the state to utilize a broader range of providers in its managed care program authorized under this waiver. CMS determined that no state plan amendment was required. The State submitted and received approval on a number of SPAs related to the Affordable Care Act.
6	Changes subject to amendment process	Waiver operations are in compliance; no deliverable.
7	Amendment Process	Amendment submissions during the demonstration period have complied with these requirements.
8	Extension of Demonstration	The State is providing appropriate documentation through the extension application.
8.a)	Demonstration Summary and Objectives	
8.b)	Special Terms and Conditions (STCs)	
8.c)	Waiver and Expenditure Authorities	
8.d)	Quality	
8.e)	Compliance with the Budget Neutrality Cap:	
8.f)	Interim Evaluation Report	
8.g)	Demonstration of Public Notice 42 CFR §431.408	
9	Demonstration phase-out	Not applicable.
10	CMS Right to Terminate or Suspend	Not applicable.
11	Withdrawal of waiver authority	Not applicable.
12	Adequacy of infrastructure	Waiver operations are in compliance; no deliverable.
13	Public Notice, Tribal Consultation, and Consultation with Interested Parties	Waiver operations are in compliance; no deliverable.

Attachment F - STC Compliance

STC	Subject	Compliance Status
14	Post Award Forum	HHSC has provided the opportunity for public comment on updates to the demonstration at least annually, during HHSC Council meetings, HHSC stakeholder forums, or Medical Advisory committee Meetings. The State documented forums for the 2014 Q4 & Annual report and the 2015 Q1 report. The State will continue to include this documentation in future reports.
15	Federal Financial Participation	Not applicable.
16	STAR+PLUS 217-Like HCBS Eligibility Group	Waiver operations are in compliance; no deliverable.
17	Transition of existing 1915(b) and 1915(c) programs	Waiver operations are in compliance; no deliverable.
18	Description of managed care expansion	Geographic expansion completed March 1, 2012.
19	Medicaid Rural Service Area	Waiver operations are in compliance; no deliverable.
20	Managed Care Requirements	Waiver operations are in compliance; no deliverable.
	Data requirements	Fulfilled by the quarterly report; attachment B, template Part IV.
	State Advisory Committee	The Statewide Managed Care Advisory Committee has been in operation since 2013, 83rd legislature. The committee meets quarterly.
	MCO participant advisory committees	The contract states that the MCO must establish and conduct quarterly meetings with Members. MCO must maintain a record of Member Advisory Group meetings, including agendas and minutes, for at least three years.
	Independent Consumer Supports System (ICSS)	Plan submitted to CMS 5/1/14; updated February 6, 2015 and submitted to CMS February 9, 2015.

Attachment F - STC Compliance

STC	Subject	Compliance Status
	Reporting and evaluation of ICSS	The State has reported on the ICSS in subsequent quarterly reports. 2015 Quarter 2 was submitted May 29, 2015. This evaluation has not been incorporated into the overall evaluation since the plan is pending CMS approval as of the date of this report.
21	Managed care delivery systems	Waiver operations are in compliance; no deliverable.
22	Readiness Review for 9/1/14 and 3/1/15 expansions	
22.b) i.	Submit list of deliverables and submissions that will be requested from health plans to establish their readiness	Submitted on: 7/3/14; 12/18/2014; 5/01/2014.
22.b) ii.	Submit plans for ongoing monitoring and oversight of MCO contract compliance	Submitted on: 7/3/14; 12/18/2014.
22.b) iii.	Submit contingency plan for addressing insufficient network issues	Submittals 7/3/14; 12/18/2014.
22.b) iv.	Submit plan for the transition from the section 1915(c) waiver programs to the STAR+PLUS HCBS program	Submitted 1/10/2014. Revised and submitted responses to CMS questions on 5/29/2014.
22.b) v.	Submit documentation regarding network adequacy	Submitted 7/3/2014 for the September 1, 2014 expansion and 12/18/2014 for the March 1, 2015 Nursing Facility expansion.
22.b) vi.	Submit proposed managed care contracts or contract amendments, as needed to implement the STAR and STAR+PLUS	Submitted to CMS on July 17, 2014 for 9/1/14 STAR+PLUS MRSA (Version 1.2) expansion and for 3/1/15 nursing facility changes (UMCC Version 2.11.1).
22.b) vii.	Submit amendment to the Community Based Alternatives (CBA) section 1915(c) waiver (TX 0266) to allow beneficiaries to transition to STAR+PLUS	Submitted 1/10/2014.
22.c)	CMS reserves the right to request additional documentation and impose additional milestones on the September 1, 2014 and March 1, 2015, expansions in light of findings from the 2014 and 2015 readiness review activities.	Waiver operations are in compliance; no deliverable.

Attachment F - STC Compliance

STC	Subject	Compliance Status
22.d)	The state must postpone the September 1, 2014 or March 1, 2015, implementation of STAR+PLUS changes (in whole or in part) if requested to do so by CMS. CMS will provide the state its reasons, in writing, for requesting the postponement, which may be based on findings from the readiness review, and will modify the approved demonstration as necessary to reflect the delay. CMS will endeavor to make any postponement request before June 1, 2014 for the September 1, 2014, expansion and before December 1, 2014, for the March 1, 2015, expansion, but reserves the right to make a request later should new material information become available that would give grounds for postponement.	Waiver operations are in compliance; no deliverable.
22.e)	Attempts to Gain an Accurate Beneficiary Address.	The enrollment broker (MAXIMUS) sends address information reported back from the USPS from the Address Correction Service (ACS) or Notice of Change of Address (NCOA). During a program expansion, the MAXIMUS reports all of the USPS address data to MCD weekly as the letters are mailed and afterwards until advised. For ongoing mail, addresses reported with a forwarding address are provided to ES to update the client information system.
22.f)	Verification of Beneficiary's Enrollment.	MCOs, network and non-network providers, or the state can check an individual's Medicaid eligibility and managed care enrollment status on the Texas Medicaid Healthcare Partnership's (TMHP's) website using the Medicaid eligibility portal ("MESAVE") or the "Your Texas Benefits provider portal."
22.g)	Sample Notification Letters	Sample beneficiary notification letters are posted on the STAR+PLUS website.

Attachment F - STC Compliance

STC	Subject	Compliance Status
22.h) i-ii.	Educational Activities for Beneficiaries and Providers	STAR+PLUS MRSA and Nursing Facility expansion in-person information sessions were conducted across the state November 2013-April 2014 for beneficiaries and providers. STAR+PLUS MRSA in person provider trainings were held May 2014-July 2014 across the state and Nursing Facility in-person provider trainings were conducted January-February 2015 across the state. Webinars were also held during these dates. MCO staff were required to be present.
22.i)	State Operated Call Center	Waiver operations are in compliance; no deliverable.
22.j)	Call Center Response Statistics	Available for CMS upon request.
22.k)	Implementation Calls with the MCOs	After the STAR+PLUS expansion, the state provided the MCOs weekly conference call opportunities, which have continued through to at least September 1, 2015, to discuss MCO operations and determine plans for quickly addressing any issues related to changes in the STAR+PLUS program.
22.l)	State Review of Beneficiary Complaints, Grievances, and Appeals	Waiver operations are in compliance; no deliverable.
23	Contracts	Waiver operations are in compliance; no deliverable.
24	Network Requirements	
24.e)	Provide adequate assurances that it has sufficient capacity to serve the expected enrollment in its service area	
24.e) i.	State must provide supporting documentation to show that the MCO offers an adequate range of preventive, primary, pharmacy and specialty services care for the anticipated number of enrollees in the service area.	The State has documented compliance with these requirements through submission of the required quarterly, bi-monthly and annual progress reports
24.e) i.(A)	The MCO's Demonstration population enrollment	
24.e) i.(B)	Service utilization based on the Demonstration population's characteristics and health care needs	

Attachment F - STC Compliance

STC	Subject	Compliance Status
24.e) i.(C)	The number and types of primary care, pharmacy, and specialty providers available to provide covered services to the Demonstration population	The State has documented compliance with these requirements through submission of the required quarterly, bi-monthly and annual progress reports.
24.e) i.(D)	The number of network providers accepting the new Demonstration population	
24.e) i.(E)	The geographic location of providers and Demonstration populations, as shown through GeoAccess or similar software and identified according to the requirements contained in the State's MCO contract	
24.e) iii.	State must submit documentation any time a significant change occurs in the health plan's operations that would affect adequate capacity & services.	
25	Enrollment Broker Monitoring	Report received from MAXIMUS by the 15th calendar day following the report month. The State submits report to CMS within 10 days of receipt.
26	Notice of Change in Implementation Timeline	Waiver operations are in compliance; no deliverable.
27	Revision of the State Quality Strategy and required monitoring activity	Waiver operations are in compliance; last CMS approval was June 17, 2014; seeking approval of amendment to update attachment D.
28	Eligibility groups affected by demonstration	Waiver operations are in compliance; no deliverable.
29	Demonstration expansion population	
30	Populations not affected	
31	Enrollment	
32	Disenrollment or transfer	
33	Benefits	
34	Self-referral	
35	FQHCs and RHCs	
36	EPSDT	
37	Marketing and information	
38	Fair hearing procedures	
39	STAR and STAR+PLUS (non-HCBS) Reporting Requirements	The State met these requirements through submission of the required quarterly, bi-monthly and annual progress reports.

Attachment F - STC Compliance

STC	Subject	Compliance Status
40	Implementation of the Children's Dental Program	Waiver operations are in compliance, although quarterly dental stakeholder meetings have not occurred as the result of the absence of a dental director. Alternate communications activities with dental stakeholders have been noted in previous progress reports.
41	Operations of the STAR+PLUS HCBS Program	
41.a)	Compliance with specified HCBS requirements	Waiver operations are in compliance with all 1915(c) federal regulations that apply to the 1115 waiver.
41.b)	Regional roll-out and transition	Implementation occurred and notices provided as required. CBA transition plan submitted to CMS 01/10/2014.
41.c)	Determination of benefits by Designation into a STAR+PLUS HCBS Group	Waiver operations are in compliance; no deliverable.
41.d)	Eligibility for STAR+PLUS HCBS Benefits	
41.e)	Freedom of choice	
41.f)	Service plan	
41.g)	Benefit package under the STAR+PLUS HCBS Program	
41.h)	Self-direction of Home and Community Based Services	
41.i)	Fair hearing	
41.j)	Participant safeguards	Proposed amendment to update Attachment G submitted to CMS on 4/17/2015; pending CMS approval.
42	Quality Improvement Strategy	Proposed amendment to update Attachments D and E submitted to CMS on 4/17/2015; pending CMS approval.

Attachment F - STC Compliance

STC	Subject	Compliance Status
43	Terms and Conditions Applying to Pools Generally	In compliance: payment report submitted each quarter. Waiver operations are in compliance; State Plan Amendment approved on 02/08/2012.
44	Uncompensated Care Pool	Waiver operations are in compliance. STC 44(a)(i)(A) has not been delivered by September 30th of each year as there have been delays in the receipt/processing of the DY1, DY2 and DY3 UC Tools. CMS was made aware of these delays. The State will meet the September 30th deadline beginning in DY4 (September 2015).
45	DSRIP Pool	In compliance: RHP plans submitted 3/30/12, 9/21/12 and 10/31/12 according to requirements.
46	Limits on Pool Payments	In compliance.
47	Assurance of Budget Neutrality	In compliance: assessment of budget neutrality submitted to CMS each year: 10/02/2012, 10/03/2013, 10/17/2014.
48	Transition Plan for Funding Pool	Submitted to CMS on March 24, 2015.
49	1115A Duals Demonstration savings	Demonstration began in March 2015. Information submitted with quarterly report on 5/29/15.
50	Quarterly Expenditure Reports	The State has submitted the quarterly CMS 64 reports with expenditure information for the Demonstration via the CMS reporting system.
51	Expenditures subject to Title XIX BN expenditure limit	Waiver operations are in compliance; no deliverable.
52	Reporting Expenditures in the Demonstration	The State's processes for reporting information required under this STC are in compliance.
53	Reporting Member Months	The State met these requirements through submission of the required quarterly progress reports.
54	Standard Medicaid and CHIP Funding Process	The State's processes for reporting information required under this STC are in compliance.

Attachment F - STC Compliance

STC	Subject	Compliance Status
55	Extent of FFP for the demonstration	Waiver operations are in compliance; no deliverable.
56	Sources of Non-Federal Share	Waiver operations are in compliance.
57	Limit on Title XIX and XXI funding	Waiver operations are in compliance; no deliverable.
58	Risk	Waiver operations are in compliance; no deliverable.
59	BN expenditure limit	Waiver operations are in compliance; no deliverable.
60	Future adjustments to BN limit	Not applicable.
61	Enforcement of Budget Neutrality	
62	Exceeding BN	
63	Future Managed Care Rates	The State will submit the required reports by 12/31/15 and in September 2016.
64	General Financial Requirements	Waiver operations are in compliance; no deliverable.
65	Reporting Requirements Relating to Budget Neutrality State	Waiver operations are in compliance; no deliverable.
66	Monthly Monitoring Call	The State has participated in monthly conference calls with CMS over the course of the demonstration period.
67	Demonstration Quarterly Reports	The State has complied with quarterly reporting requirements over the course of the demonstration.
68	Demonstration Annual Report	Report submitted annually, 11/29/2012; 12/13/2013; 1/28/2015.
69	Transition Plan for Expansion of Medicaid Eligibility	Not applicable.
70	Submission of a Draft Evaluation Plan	Draft evaluation plan submitted to CMS on 04/03/2012.
71	Final Evaluation Design and Implementation.	The State submitted the final evaluation plan to CMS on 07/20/2012 and has provided updates in subsequent quarterly and annual reports.
72	Evaluation Reports	The State is submitting the interim evaluation report with the extension application on September 30, 2015.
73	Cooperation with Federal Evaluators	State will comply as required.