# TEXAS HEALTH AND HUMAN SERVICES COMMISSION

KYLE L. JANEK, M.D.
EXECUTIVE COMMISSIONER

June 19, 2013

Rob Nelb, MHP
Centers for Medicare and Medicaid Services
Center for Medicaid, and CHIP Services
Division of State Demonstrations and Waivers
7500 Security Boulevard
Mail Stop S2-02-26
Baltimore, MD 21244-1850

Dear Mr. Nelb:

The Texas Health and Human Services Commission (HHSC) is requesting to amend the Texas Healthcare Transformation Quality Improvement Program (THTQIP-11-W-00278-6) waiver program, a Medicaid waiver program operating under the authority of the §1115 Social Security Act. The current waiver is approved for the five-year period beginning December 12, 2011, and ending September 30, 2016. The proposed effective date for the amendment is September 1, 2013.

Currently, the 1115 Demonstration waiver, known as the THTQIP allows for acute care facilities to be reimbursed utilizing waiver funding. Effective September 1, 2013, inpatient services for STAR+PLUS enrollees will be reimbursed for up to 30 days. After 30 days, reimbursement will not be considered until the enrollee has been out of the hospital for 60 consecutive days. The policy does not apply to certain approved transplants, nor to children age 20 and younger. There are exceptions to this policy for prior-approved solid organ transplants and for medically necessary inpatient services for early and periodic screening, diagnosis, and treatment beneficiaries age 20 and younger.

The Health and Human Services Commission is requesting that the Centers for Medicare & Medicaid Services approve the waiver amendment beginning September 1, 2013, and ending September 30, 2016. The amendment does not impact budget neutrality.

Please let me know if you have any questions or need additional information, Betsy Johnson, Policy Analyst in the Medicaid and CHIP Division, serves as the lead staff on this matter and can be reached at (512) 462-6286 or by email at betsy.johnson@hhsc.state.tx.us

Sincerely,

[redacted]

Kay Ghahremani
State Medicaid Director

cc: Bill Brooks, ARA, CMS Dallas Regional Office

**CENTERS FOR MEDICARE & MEDICAID SERVICES**
**EXPENDITURE AUTHORITIES**

**NUMBER:** **No. 11-W-00278/6**

**TITLE:** **Texas Healthcare Transformation and Quality Improvement Program**

**AWARDEE:** **Texas Health and Human Services Commission**

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the State for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act, shall, for the period of this Demonstration, December 12, 2011, through September 30, 2016, be regarded as expenditures under the State's Medicaid title XIX State plan.

## EXPENDITURES RELATED TO POPULATIONS COVERED UNDER THE DEMONSTRATION

### 1. 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 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.

### 2. Expenditures for section 1915(b)(3)-Like Services for STAR and STAR+PLUS Enrollees

Expenditures for STAR enrollees for the elimination of the 30-day spell-of-illness limitation and annual benefit limitations on inpatient hospital services that apply under the State plan. For the elimination of the 30-day spell-of-illness limit for inpatient services, the first 30 days' cost for this benefit is included in the capitation paid to MCOs, and the costs for services after 30 days are paid out of cost savings. For the elimination of the annual benefit limit for inpatient services, all costs of this benefit are included in the capitation paid to the MCOs. Like expenditures for STAR+PLUS enrollees are authorized as of the approval date of this Demonstration for behavioral health inpatient services, and, as of March 1, 2012 (or the implementation date of the managed care expansion planned for March 1, 2012, whichever is later), for non-behavioral health inpatient services (when these services are included in capitation rates). Effective September 1, 2013 acute care facilities are to be reimbursed utilizing waiver funding. Inpatient services for STAR+PLUS enrollees will be reimbursed for up to 30 days. After 30 days,

reimbursement will not be considered until the enrollee has been out of the hospital for 60 consecutive days. The policy does not apply to certain approved transplants, nor to children age 20 and younger. There are exceptions to this policy for prior-approved solid organ transplants and for medically necessary inpatient services for early and periodic screening, diagnosis, and treatment beneficiaries age 20 and younger.

Expenditures for unlimited prescriptions for adults ages 21 and older enrolled in STAR.

Expenditures for unlimited prescriptions for adults ages 21 and older enrolled in STAR+PLUS that are not recipients of Home and Community Based Services (HCBS).

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

Expenditures for the provision of HCBS like services that are not otherwise available under the State plan for STAR+PLUS enrollees who are ages 65 and older and adults ages 21 and older with disabilities and who would otherwise be Medicaid-eligible under section 1902(a)(10)(A)(ii)(VI) of the 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 includes the application of the spousal impoverishment eligibility rules. These expenditures are requested to provide the following:

a. Benefits as stipulated in the Medicaid State plan (except for nursing facility services); and

b. HCBS like services as specified in Table 4 and Attachment C of the STCs, net of beneficiary responsibility for the cost of care, and with post-eligibility treatment of income for individuals receiving short-term Nursing Facility care calculated upon admission as if they were in an institution.

**4. HCBS for SSI-Related State Plan Eligibles**

Expenditures (as of the initial approval date of the STAR+PLUS component of this Demonstration and subject to limits as described in the STCs), for the provision of HCBS waiver-like services as specified in Table 4 and Attachment C of the STCs that are not described in section 1905(a) of the 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 granted for the period of the Demonstration:

**5.** Expenditures for care and services that meet the definition of "medical assistance" contained in section 1905(a) of the 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.

**6.** Expenditures for transition year payments to hospitals and other providers as outlined in paragraph 44(b) (*Transition Payments*) of the 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:

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

**REQUIREMENTS NOT APPLICABLE TO EXPENDITURE AUTHORITY 3**

All title XIX requirements that are waived for Medicaid eligible groups are also not applicable to the STAR+PLUS 217-Like HCBS Group. In addition, the following Medicaid requirement is not applicable:

**Reasonable Promptness** **Section 1902(a)(8)**

To the extent necessary to enable the State to limit enrollment through an interest list for STAR+PLUS 217-Like HCBS Group individuals receiving Home and Community Based Services (HCBS) through STAR+PLUS to the enrollment target(s) established by the State, as authorized under paragraph 41(c)(i)(A) (*Interest List for STAR+PLUS 217-Like HCBS Group*) of the STCs.