# Texas Healthcare Transformation and Quality Improvement Program

# Section 1115 Quarterly Report

Texas Health and Human Services Commission

**Demonstration Reporting Period:**

2016 State Fiscal Quarter 3, March-May

Demonstration Year (DY) 5 April-June

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# I. INTRODUCTION

The Texas Healthcare Transformation and Quality Improvement Program Section 1115 waiver enabled the State to expand 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.

This report documents the State's progress in meeting these goals. It addresses the quarterly reporting requirements for the Delivery System Reform Incentive Payment (DSRIP) Regional Healthcare Partnerships (RHPs); the demonstration evaluation; budget neutrality; member months; operational, policy, systems, and fiscal issues; and action plans for addressing the identified issues. These requirements are found in the waiver's Special Terms and Conditions (STCs), items 50, 54, 66, 68, and 72. Information about the managed care Medicaid programs under the 1115 will be covered in a separate managed care quarterly report.

The State collects some data on a State Fiscal Quarter (SFQ) cycle; therefore, some of the quarterly information presented in this report is based on data compiled for 2016 SFQ3 (March-May) instead of Demonstration Year (DY) 5, Q3 ("2016 D3," covering April- June). Throughout the report, the State has identified whether the quarterly data relates to 2016 SFQ3 or 2016 D3.

## A. DEMONSTRATION FUNDING POOLS

The section 1115 demonstration establishes two funding pools, created by savings generated from managed care expansion and diverted supplemental payments, to reimburse providers for uncompensated care costs and to provide incentive payments to participating providers that implement and operate delivery system reforms.

Texas worked with private and public hospitals, local government entities, and other providers to create Regional Healthcare Partnerships that are anchored by public hospitals or other specific government entities. RHPs identified performance areas for improvement that may align with the following four broad categories to be eligible for incentive payments: (1) infrastructure development, (2) program innovation and redesign, (3) quality improvements, and (4) population focused improvements. The non-Federal share of funding for pool expenditures is largely financed by State and local intergovernmental transfers (IGTs).

Waiver activities are proceeding and detailed information on the status is included in the sections below.

## II. OPERATIONAL/POLICY/SYSTEMS/FISCAL DEVELOPMENTS/ISSUES

This section addresses STC 68, regarding operational issues identified during the quarter. It also addresses pending lawsuits that may potentially impact the Demonstration, and new issues identified during the reported quarter.

### A. UPDATE FROM PRIOR QUARTER

HHSC has not identified any ongoing issues in the relevant subject matter sections of this report.

### B. LITIGATION UPDATE

Below is a summary of pending litigation and the status. HHSC Legal is unaware of any threatened litigation affecting healthcare delivery.

Legacy Community Health Services, Inc., v. Janek (official capacity) and Texas Children's Health Plan. Filed on January 7, 2015, in the U.S. District Court for the Southern District of Texas. Plaintiff Legacy is a Federally Qualified Health Center (FQHC) and a Medicaid provider that was in Texas Children's Health Plan's (TCHP's) provider network. TCHP notified Legacy in December 2014 that Legacy was to be terminated as a provider in TCHP's plan. Legacy brought suit against both TCHP and HHSC's Executive Commissioner, alleging that HHSC's method of paying FQHCs is contrary to federal law. Legacy alleges first, that the State's process for providing reimbursement for services rendered to out-of-network patients allegedly violates the Medicaid Act, 42 U.S.C. § 1396b(m)(2)(A)(vii), and, second, that the State's delegation of its reimbursement responsibility to third-party Managed Care organizations allegedly violates the Act, id. § 1396a(bb)(5)(A). Plaintiff seeks injunctive relief under 42 U.S.C. § 1983 to remedy the alleged shortcomings in Texas's method for providing payments to Legacy for Medicaid services. FQHCs are guaranteed an encounter rate calculated under a methodology prescribed under 42 U.S.C. §1396a(bb). HHSC ensures compliance with this provision by requiring MCOs to pay FQHCs the full encounter rate, and includes funds for such payments in the capitated rate paid to MCOs. Legacy asserts that HHSC must make supplemental ("wrap") payments directly to FQHCs. District Judge Keith Ellison conducted a hearing on January 28, 2015, and denied Legacy's request for a preliminary injunction. Legacy non-suited TCHP, but continues to maintain its claims against HHSC.

Both Legacy and HHSC filed motions for summary judgment and on May 3, 2016, the court ruled in favor of Legacy on the "wrap payment" portion of the case, finding that HHSC improperly delegated to the managed care organizations (MCOs) the responsibility of ensuring

that the FQHCs receive their full encounter rate. The court also ruled that CMS approval of the State Plan Amendment authorizing this payment methodology was arbitrary and capricious and asked CMS to file an advisory with the court concerning the issues in the case. CMS filed a Statement of Interest with the court on July 25, 2016 asserting that the payment methodology used by HHSC comports with federal law. The court has not indicated when it will issue a final ruling on the case.

Texas Children's and Seattle Children's Hospital v. Burwell (official capacity), Tavenner (official capacity), and CMS. Filed on December 5, 2014, in the U.S. District Court for the District of Columbia. District Judge Emmet Sullivan granted a preliminary injunction request by Plaintiffs, and required CMS to discontinue enforcing its policy published as "FAQ Number 33" and involving the inclusion of revenues associated with patients having coverage under both Medicaid and private insurance. The court also expressly prohibited CMS from taking action to recoup past Disproportionate Share Hospital (DSH) program overpayments based on a state's compliance with FAQ No. 33.

HHSC notes that the same issue was litigated in state court. In 2013, Texas Children's Hospital (TCH) sued HHSC in state court alleging that by following CMS's FAQ 33, HHSC had improperly altered its method of calculating uncompensated care, adversely affecting TCH's disproportionate share and uncompensated care payments. That lawsuit was dismissed on March 29, 2014. However, TCH and co-plaintiff Seattle Children's now assert substantially the same theory against CMS in federal court litigation. Although HHSC is not a direct party to this federal litigation, HHSC recognizes that the outcome of this case could have a significant bearing on the hospital disproportionate share and uncompensated care payment programs. Until the issue is resolved with clarity, the litigation may result in delays and uncertainty concerning the appropriate method of making the uncompensated care calculations for future payments and for recouping past DSH and uncompensated-care overpayments.

Filed in 1993, *Frew, et al. v. Traylor, et al*. (commonly referred to as *Frew*), was brought on behalf of children birth through age 20 enrolled in Medicaid and eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefits. The class action lawsuit alleged that the Texas EPSDT program did not meet the requirements of the federal Medicaid Act. The Texas EPSDT program, known as Texas Health Steps (THSteps), provides comprehensive and preventive medical and dental services for children through age 20 enrolled in Medicaid. The parties resolved the *Frew* litigation by entering into an agreed consent decree, which the court approved in 1996. The decree sets out numerous state obligations relating to THSteps. It also provides that the federal district court will monitor compliance with the orders by the Texas Health and Human Services Commission (HHSC) and the Texas Department of State Health Services (DSHS) and that the federal district court will enforce the orders if necessary. In 2000, the court found the State defendants in violation of several of the decree's paragraphs. In 2007, the parties agreed to 11 corrective action orders to bring the state into compliance with the

consent decree and to increase access to THSteps services. The corrective action orders touch upon many program areas, and generally require the state to take actions intended to ensure access to or measure access to Medicaid services for children. The Texas Medicaid program must consider these obligations in many policy and program decisions for Medicaid services available for persons from birth through 20 years of age.

In 2013, the U.S. district court vacated two of the eleven corrective action orders: (1) Check Up Reports and Plans for Lagging Counties, and (2) Prescription and Non-Prescription Medications, Medical Equipment, and Supplies, and related paragraphs of the consent decree, after finding that the state defendants had complied with the required actions. The *Frew* Plaintiffs appealed the second order (regarding Prescription and Non-Prescription Medications, Medical Equipment, and Supplies) to the Fifth Circuit Court of Appeals. On March 5, 2015, the Fifth Circuit affirmed the district court's order vacating the corrective action order and related paragraphs of the consent decree, holding that the state had satisfied its obligations related to training Medicaid-enrolled pharmacists about EPSDT-covered pharmacy items. In February 2016, the U.S. Supreme Court denied the *Frew* Plaintiffs' petition for writ of certiorari seeking to have the Fifth Circuit's order reversed.

In 2014, the parties jointly agreed to vacate a corrective action order related to Toll-Free Numbers, and the related paragraph of the consent decree, for several Medicaid-related toll-free lines operated by the state and its contractors. The district court granted the parties' joint motion and vacated the toll-free numbers orders for all but one remaining helpline: a medical transportation line operated by one of the state's full-risk broker transportation contractors.

On January 20, 2015, the district court vacated a corrective action order related to an Adequate Supply of Health Care Providers and several paragraphs of the consent decree relating to an adequate supply of healthcare providers. The Court found that the State had satisfied the terms of those orders by taking realistic and viable measures to enhance recipients' access to care through ensuring an adequate supply of healthcare providers (both primary care and specialists) by using targeted recruitment efforts, increasing reimbursement rates, and using best efforts to maintain updated lists of providers for recipients and other providers. In March 2016, the Fifth Circuit affirmed the district court's opinion vacating the decree paragraphs and most of the Adequate Supply of Health Care Providers corrective action order. The Fifth Circuit vacated and remanded to the district court for further proceedings the portion of the district court's order which held that the State had satisfied its obligation under the corrective action order to use provider assessments to identify provider "shortages" and implement corrective action based upon any shortages, because the parties and the district court did not define "shortages" correctly. Based upon the definition of "shortages" provided by the Fifth Circuit, the Fifth Circuit also vacated and remanded to the district court for further proceedings the portion of the district court's order which held that the State had satisfied its obligation under the corrective action order to have provider payment rates sufficient to attract enough providers to serve

Medicaid recipients under age 21. In May 2016, the State filed petitions for *en banc* and panel rehearing in the Fifth Circuit regarding the March 2016 panel opinion. The Fifth Circuit has not yet ruled on those petitions.

On September 28, 2015, the district court vacated two of the remaining corrective action orders: (1) Transportation Program, and (2) Health Care Provider Training, and related paragraphs of the consent decree, after finding that the state defendants had complied with the required actions. Plaintiffs did not appeal those two district court orders.

Diana D. as next friend of KD, a child, et al v. HHSC and Traylor (official capacity). Providers of home health speech, occupational and physical therapy services and children who receive those services brought suit in August 2015, in Travis County District court seeking declaratory and injunctive relief related to proposed rate reductions to those services. The Plaintiffs allege claims of ultra vires actions by the Commissioner in setting the new rates that the proposed rates were an invalid rule under section 2001.038 of the Government Code, and a constitutional due-course-of-law claim under article I, section 19 of the Texas Constitution. Plaintiffs were granted a temporary injunction enjoining HHSC from implementing the new rates pending resolution of their claims. On April 21, 2016, just prior to a trial on the merits, the 3rd Court of Appeals reversed the trial court and dismissed all the plaintiffs' claims for lack of jurisdiction and vacated the temporary injunction. The Plaintiffs appealed to the Texas Supreme Court and the rate implementation is delayed while the Supreme Court considers whether to accept the case for review.

### C. NEW ISSUES

HHSC has not identified any new issues in the relevant subject matter sections of this report, other than those already reported in previous sections. There were no issues outside of the general categories typically reported and HHSC does not anticipate any significant issues or activities in the near future that affect healthcare delivery.

## III. ACTION PLANS FOR ADDRESSING ANY ISSUES IDENTIFIED

This section describes the State's action plan for addressing issues identified in the quarterly report as required by STC 68.

1. Litigation

Plans for addressing pending litigation are considered confidential client information, but HHSC will keep CMS informed of any significant court orders or decisions.

2. Other

There were no fiscal or systems issues, or legislative activity that occurred in 2016 D3.

## IV. FINANCIAL/BUDGET NEUTRALITY DEVELOPMENT/ISSUES

This section addresses the quarterly reporting requirements in STC 66 and 68 regarding financial and budget neutrality development and issues.

There were no significant development issues or problems with financial accounting, budget neutrality and the CMS 64 and budget neutrality report for 2016 D3.

## V. MEMBER MONTH REPORTING

The tables below address the quarterly reporting requirements in STC regarding eligible member month participants in compliance with STC 54.

### Eligibility Groups Used in Budget Neutrality Calculations (2016 D3)

| Eligibility Group | Month 1 (April 2016) | Month 2 (May 2016) | Month 3 (June 2016) | Total for Quarter Ending June 2016 |
|---|---|---|---|---|
| **Adults** | 282,191 | 285,086 | 286,853 | 854,131 |
| **Children** | 2,604,603 | 2,614,538 | 2,626,543 | 7,845,684 |
| **AMR** | 363,711 | 363,397 | 362,768 | 1,089,876 |
| **Disabled** | 427,437 | 427,435 | 425,435 | 1,279,975 |

### Eligibility Groups Not Used in Budget Neutrality Calculations (2016 D3)

| Eligibility Group | Month 1 (April 2016) | Month 2 (May 2016) | Month 3 (June 2016) | Total for Quarter Ending June 2016 |
|---|---|---|---|---|
| **AMR in MRSA** | - | - | - | - |
| **Foster Care** | 33,443 | 33,540 | 33,798 | 100,781 |
| **Medically Needy** | 142 | 138 | 138 | 417 |
| **CHIP-Funded** | 273,275 | 274,084 | 274,893 | 822,253 |
| **Adoption Subsidy** | 47,246 | 47,452 | 47,660 | 142,358 |
| **STAR+PLUS 217-Like HCBS** | 10,853 | 10,871 | 10,917 | 32,642 |

# VI. DEMONSTRATION EVALUATION

This section addresses the quarterly reporting requirements in STC 68 and 72, regarding evaluation activities and issues.

## A. OVERVIEW OF EVALUATION

This quarterly report reflects evaluation activities from April 1, 2016 through June 30, 2016.

The Program includes two interventions:

> **Intervention I**: The expansion of the existing Medicaid managed care programs, STAR and STAR+PLUS, statewide; creating a new children's dental program, while carving-in prescription drug benefits; nursing facility services; and, the behavioral health services of targeted case management and rehabilitative services (Evaluation Goals 1-4).
>
> **Intervention II**: The establishment of two funding pools that will assist providers with uncompensated care costs and promote health system transformation (Evaluation Goals 5-11).

The Program evaluation will examine the implementation and impact of the Program through a set of annual performance measures through year four of the demonstration period. The principal focus of the demonstration evaluation will be on obtaining and monitoring data on performance measures for short-term (process measures) and intermediate (health outcomes) of the Program. The performance measures will be used to assess the extent to which the Program accomplishes its goals, track changes from year to year, and identify opportunities for improvement.

This report identifies:

- The current quarter's evaluation activities,
- Any challenges or issues encountered, and
- Planned evaluation activities in the next quarter.

## B. SUMMARY OF EVALUATION ACTIVITIES

**Joint Evaluation Activities (HHSC and Texas A&M): Interventions I & II**

1. HHSC's Office of Strategic Decision Support's evaluation team ("HHSC SDS") and the Texas A&M School of Public Health, including its subcontractors the University of Louisville School of Public Health and Information Sciences and The University of Texas School of Public Health (collectively referred to as "Texas A&M"), attended monthly

meetings and continued discussions regarding evaluation activities, including data collection, data requests, analysis, and preliminary results.
2. Texas A&M and HHSC SDS evaluation teams hosted the 4th annual Texas 1115 Healthcare Transformation Waiver Evaluation Expert Advisors Meeting on April 29, 2016. HHSC had representatives from program staff; Managed Care, Transformation Waiver Team, and Rate Analysis. External Advisors included evaluators from other states (i.e., New Jersey, Florida, Massachusetts, and California) currently conducting 1115 waivers, as well as from Mathematica, which is conducting a national evaluation of 1115 waivers for CMS.
3. CMS granted a 15-month extension to Texas' 1115(a) waiver, effective May 1, 2016 through December 31, 2017. The extension has no impact on the draft Final Evaluation Report due January 31, 2017 (STC 73(b)). During the 15-month extension, HHSC SDS will continue to work with CMS and HHSC program staff to collect data while developing new STC evaluation questions for waiver negotiations.
4. HHSC SDS and the University of Texas School of Public Health have submitted an Institutional Review Board (IRB) application to the Texas Department of State Health Services (DSHS) to link patient identifiers from two large intervention sites and two large comparison sites for the purpose of obtaining Medicaid utilization rates from HHSC and hospital discharge data from DSHS for additional analyses of patient-level data.

## HHSC Evaluation Activities: Interventions I & II

### General Evaluation Activities

1. HHSC SDS evaluation staff attended project meetings and scheduled monthly CMS calls.
2. HHSC SDS attended Regional Healthcare Partnership (RHP) anchor calls.
3. HHSC Research Specialist Charles Shumate left his position in May to pursue another opportunity.

### Intervention I

1. HHSC SDS Evaluator, Tenaya Sunbury, PhD presented on "Evaluating the longitudinal impact of Medicaid policy change on access to care for aged and disabled population" at the 4th annual Texas 1115 Healthcare Transformation Waiver Evaluation Expert Advisors Meeting on April 29, 2016.
2. HHSC SDS provided a description to Medicaid/CHIP staff on how the evaluation design will be modified with the inclusion of amendment 13: STAR KIDS, behavioral health carve-in for the Dallas SDA, and spell-of-illness limitation.
3. HHSC SDS is currently drafting a description to Medicaid/CHIP staff on how the evaluation design will be modified with the inclusion of amendment 14: Adoption Assistance, Permanency Care Assistance, and Medicaid Breast and Cervical Cancer Amendment.
4. HHSC SDS continued to identify and collect data for Final Report analyses to Program demonstration years (DYs) 2014-2015.

a. Fee-for-service claims and Managed Care encounters
b. Eligibility files

5. HHSC SDS continued to explore multivariate modelling methodologies to utilize for the Final Report.

**Intervention II**

***HHSC Evaluation Activities: Integrating Primary Care into Behavioral Health Settings for Adults with Severe and Persistent Mental Illnesses (SPMI)***

1. HHSC SDS continued to monitor progress in this project, which focused during the last quarter on preparations for procuring patient level data from participating community mental health centers.

## Texas A&M Evaluation Activities: Intervention II

**Evaluation Goal 5**

1. Hye-Chung Kum, PhD, presented on "Evaluation of the Texas Healthcare Transformation and Quality Improvement Program: Effects on Uncompensated Care" at the 4th annual Texas 1115 Healthcare Transformation Waiver Evaluation Expert Advisors Meeting.
2. Obtained, cleaned, and linked new sources of data (DSRIP payment data, Healthcare Cost Report Information System (HCRIS data), and American Hospital Association (AHA data)) for final Uncompensated Care (UC) analysis.
3. Initiated IRB application for new source of data, Blue Ribbon data. The Blue Ribbon data mart and extracts are used to report all paid episodes of care for Medicaid fee-for-service and MCO hospital inpatient claims. HHSC, State subcontractors, and the provider community use this file for statistical analysis and forecasting. This file is also used as the input for setting APR DRG rates for claim repayment.

**Evaluation Goals 6-8**

1. Rebecca Wells, PhD presented on "Comparative Case Study of Emergency Department-Related Care Navigation Projects" at the 4th annual Texas 1115 Healthcare Transformation Waiver Evaluation Expert Advisors Meeting.
2. The final site visit for the comparative case study of Emergency Department (ED)-related care navigation was completed in May.

3. The second round of telephone surveying of key partners about their interactions with the care navigation programs in the study was completed, and the data were prepared for analysis.

4. The team continued to populate and verify a table of site level attributes for both project and comparison sites (e.g., use of components of evidence-based disease management programs and presence of additional local resources that might affect ED use).

5. Qualitative coding of interviews continued, now using a finalized set of codes.

6. The UT School of Public Health IRB approved using Truven data to map average local ED charges for facility and physician services for four levels of ED care. This will be used to estimate cost implications of any differences in patient-reported ED use.
7. Data requests were submitted to two large intervention sites and one large comparison site for the purpose of obtaining Medicaid utilization rates and discharge data from HHSC and DSHS for additional analyses of patient-level data.

**Evaluation Goal 9**

1. Liza Creel, PhD presented on "Using Network Analysis to Measure Changes in Local Collaboration Resulting from Implementation of the Texas Healthcare Transformation and Quality Improvement Program" at the 4th annual Texas 1115 Healthcare Transformation Waiver Evaluation Expert Advisors Meeting.
2. Texas A&M continued the second wave of data collection.
3. Texas A&M continued qualitative analysis of T0 and T1 survey questions.
4. Texas A&M continued making revisions for the manuscript on evaluation goal (EG) 9 findings submitted for publication in *Public Administration Review* (revisions due July 2016).

**Evaluation Goal 10-11**

1. Texas A&M continued comparative analyses on EG 10-11 results in preparation for the final report.
2. Texas A&M continued learning collaborative analyses for inclusion in the final report.

***Texas A&M Evaluation Activities: Integrating Primary Care into Behavioral Health Settings for Adults with Severe and Persistent Mental Illnesses (SPMI)***

1. The research team finished coding qualitative data from site visits and follow-up interviews with all participating community centers.
2. The research team applied to the DSHS IRB for approval to obtain hospital discharge data, using patient identifiers provided by participating community mental health centers for all patients who have received integrated primary/behavioral care in site projects.
3. Construction of patient measures and analyses were further refined in collaboration with participating community mental health centers. Dr. Kite worked with a pilot site to pull and format patient-level data for analyses of patient outcomes before and after receiving

integrated primary/behavioral health care. Using the lessons learned from working with the pilot site, Dr. Kite requested patient-level data from the other nine sites and received data from three of those sites by the end of this reporting period.
4. Dr. Kite began cleaning data received from community centers, in preparation for requesting Medicaid data from HHSC and hospital discharge data from DSHS.

**Challenges or Issues Encountered**

1. There is a scarcity of cost-related data for EG 8, examining the effect of DSRIP on cost outcomes. As noted above, the research team is going to map average local ED costs onto patient survey responses about likelihood of returning to the ED. HHSC is also working to share discharge and potentially Medicaid claims data to measure the impact of DSRIP care navigation on inpatient and outpatient service use.
2. One of the DSRIP ED care navigation sites was unresponsive to repeated requests to schedule a site visit. HHSC reminded this site's administrator that participation in the evaluation is required for selected sites. The site then promptly scheduled the site visit, which became the last one of the study (as reported above, occurring in May).

## C. ACTIVITIES PLANNED IN NEXT QUARTER

**(July 1, 2016 through September 30, 2016)**

1. HHSC SDS will attend project meetings and monthly CMS calls, as well as RHP anchor calls.
2. HHSC SDS and Texas A&M will continue to meet monthly to collaborate and provide feedback on each other's evaluations.
3. HHSC SDS and Texas A&M representatives will attend the Statewide Learning Collaborate on August 30 - 31, 2016 in Austin, Texas.
4. Texas A&M will explore use of other data sources (e.g. HCRIS, Texas hospital discharge data, and Blue Ribbon data) and draft the final report for EG 5
5. HHSC SDS and Texas A&M will iterate the final evaluation report and begin HHSC review by October 2016.

**Intervention I**

1. HHSC SDS is finalizing analyses for Intervention I for the Final Report. DY4 (the last year reported in the Final Report became available in April 2016).

2. HHSC SDS will continue to draft Intervention I evaluation sections for the Final Report, which includes longitudinal methodology to examine the impact of Medicaid Managed care expansion.

**Intervention II**

1. The EG 5 team will incorporate all descriptive and statistical analysis into the draft final report describing the pattern of UC in Texas.
2. The EG 6-8 team will submit a data request to one additional comparison site for the purpose of obtaining Medicaid utilization data from HHSC and hospital discharge data from DSHS for additional cost-related analyses.
3. The EG 6-8 team will complete analyses of data from site visits, the patient phone survey, and surveying of care navigation program's key partners to determine how DSRIP ED care navigation projects affected quality, health, and cost-related outcomes.
4. The EG 6-8 team will use Truven data on average local ED charges by 3 digit zip codes to estimate the cost implications of ED use reported by phone survey participants.
5. The EG 9-11 team will complete the learning collaborative analysis.
6. The research teams will prepare the first draft of the final report to submit to HHSC.
7. Based on input from a range of HHSC stakeholders within and beyond SDS, the research teams will submit a final report to HHSC.
8. Manuscript preparation will continue.

***Integrating Primary Care into Behavioral Health Settings for Adults with SPMI***

1. The research team will secure and analyze patient-level data from the remaining community mental health centers.
2. HHSC will use patient identifiers provided by community health centers to request discharge data from the Texas Department of State Health Services in order to measure patients' hospital use and, potentially, outpatient (Medicaid-billed) use before and after beginning integrated care.
3. Descriptive profiles of the integrated projects will be shared as a poster at the 23rd NIMH Conference on Mental Health Services Research (August 1 – 3, 2016, Bethesda, MD).

April 2016 was the first opportunity for providers to report achievement of DY5 metrics along with reporting metrics carried forward from DY4. Provider reports were due April 30, and HHSC began the reporting review in May and completed it in early June. Providers were sent reporting feedback in June and given until July 6 to respond to requests for additional information to support achievement of 53 metrics.

During the April reporting period DSRIP providers reported achievement of 21.3 percent of the 9,003 DY4-DY5 Category 1-4 milestones and metrics. HHSC approved 97.2 percent of the

reported milestones/metrics. Based on available intergovernmental transfer funds (IGT), $4.9 million was collected in Monitoring IGT and $722,433,038 was paid for DSRIP in July 2016. The total DY1 - DY5 DSRIP payments to date is about $7.9 billion. HHSC approved 98 percent of the milestones/metrics that required additional information to substantiate achievement, and those will be included for payment in January 2017.

Anchors were able to report administrative costs during Q3 on May 16, 2016 using the HHSC and CMS approved cost template spreadsheet. HHSC reviewed the administrative cost reports during Q3. Anchor administrative cost payments will be made on August 12 during Q4.

During Q3, Myers & Stauffer continued Component 2 of their monitoring work, which is compliance monitoring for validation of data submitted by performing providers as the basis for their milestone/metric achievement and subsequent DSRIP payments. This validation began with a review of Category 3 baselines and continued with metrics from Category 1 and 2 reporting. Myers & Stauffer reviews Category 1 and 2 metrics in several steps: review of the existing reported information submitted by the provider for a specific metric; review of the additional information requested by Myers & Stauffer; and requesting support for the sample selected by Myers & Stauffer to assess accuracy of the data. All projects that have reported metrics are eligible for review. Once HHSC reviews Myers & Stauffer's findings and recommendations, HHSC may request recoupment of the metric payment for which a provider could not substantiate reporting.

On April 7, 2016, HHSC submitted a request to CMS for an initial 15-month waiver extension to facilitate a transition to the overall requested five-year extension. Texas requested to maintain DY5 funding levels for both Uncompensated Care (UC) and DSRIP, which is $3.1 billion (all funds) for twelve months for each pool, and a prorated amount for the additional three months. Texas would also continue the delivery of Medicaid services through the managed care delivery model statewide. On May 2, 2016, HHSC received approval of the 15-month waiver extension at the existing funding levels for DSRIP and UC. During the fifteen months, Texas and CMS will continue negotiations on a longer term agreement.

In Q3, HHSC continued work on processes for Demonstration Year 6, which is the initial extension year. Staff worked on two sets of administrative rules for DY6: those that will be effective June 1, 2016 for actions in preparation for DY6 and another set effective September 1 for requirements during DY6. HHSC staff also developed a proposed Program Mechanics and Funding Protocol (PFM) specific to DY6, which sets the guidelines for the 15 month DSRIP program extension, and submitted it to CMS; CMS approved the PFM (Attachment J to the waiver's standard terms and conditions) on June 23, 2016.

Also during Q3 and related to laying the groundwork for DY6, HHSC developed a DY6 DSRIP Participation Template to prepare DSRIP providers for DY6 requirements included in the updated PFM protocol. The template allowed providers to indicate projects that will be continued or discontinued in DY6; view and confirm their DY6 Quantifiable Patient Impact (QPI) and Medicaid and low-income and/or uninsured (MLIU) milestones; request some changes to QPI or MLIU with strong justification; increase total DY6 provider valuation up to $250,000; and update IGT information, among some additional items. Projects that had been under review for continuation by HHSC also used the template to update their required next steps and give project updates. HHSC

held a webinar for providers on June 29, 2016 for technical assistance on how to complete the template, which was due to HHSC by July 22, 2016.

During Q3 HHSC worked on logistics and the agenda for the annual two-day Statewide Learning Collaborative Summit to be held in Austin on August 30-31, 2016. HHSC expects to have about 500 people attend in person, with livestreaming webinar capability for other interested parties. The primary goals of the Summit are to share outcome data and best practices from projects and discuss next steps as we look to the future of the 1115 Healthcare Transformation Waiver.

HHSC continued stakeholder communications in Q3 through biweekly Anchor calls, Clinical Champions and Executive Waiver Committee meetings. On May 12, 2016, HHSC presented to the Executive Waiver Committee updates on DSRIP and Uncompensated Care, and led a discussion on the 15-month waiver extension, including the Uncompensated Care study. The Clinical Champions workgroup met May 16th to discuss potential agenda items for the Statewide Learning Collaborative summit. On April 6th, HHSC conducted webinars to provide technical assistance for DY5 reporting (DY5 General Reporting Guidance, Quantifiable Patient Impact, and Category 3 & 4 Reporting Guidance). HHSC will continue to inform stakeholders of waiver developments through multiple approaches in FFY2016 Q4.

## ENCLOSURES/ATTACHMENTS

**Attachment P – Budget Neutrality**. The attachment includes actual expenditure and member-month data as available to track budget neutrality. This document is updated with additional information in each quarterly report submission.

**Attachment Y-Remaining DY4-DY5 Possible DSRIP Payments.**

**Attachment X-DSRIP Project Summary April DY5**

## STATE CONTACTS

For questions regarding the RHPs, UC, and DSRIP, please contact:

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**Date Submitted to CMS: 8/29/16**

## ACRONYM LIST

| | |
|---|---|
| AAA | area agency on aging |
| ADRC | Aging and Disability Resource Centers |
| APHA | American Public Health Association |
| BIP | Balancing Incentive Program |
| CAHPS | Consumer Assessment of Health Providers and Systems |
| CAP | corrective action plan |
| CFC | Community First Choice |
| CMS | Centers for Medicare & Medicaid Services |
| DADS | Department of Aging and Disability Services |
| DMO | dental managed care organization |
| DSH | Disproportionate Share Hospital |
| DSHS | Department of State Health Services |
| DSRIP | Delivery System Reform Incentive Payment |
| DY | demonstration year |
| EB | enrollment broker |
| EG | evaluation goal |
| ENT | otolaryngologist |
| EPSDT | Early and Periodic Screening, Diagnostic, and Treatment |
| EQRO | External Quality Review Organization |
| ER | emergency room |
| ERS | emergency response services |
| FQHC | Federally Qualified Health Center |
| HEDIS | Healthcare Effectiveness Data and Information Set |
| HHSC | Health and Human Services Commission |
| HPM | Health Plan Management |
| HSRI | Human Services Research Institute |
| ICF-IID | intermediate care facility for individuals with intellectual disabilities or a related condition |
| ICHP | Institute for Child Health Policy |
| ICSS | Independent Consumer Supports System |
| IGT | intergovernmental transfer |
| IMD | institution for mental disease |
| LD | liquidated damages |
| LTCO | long-term care ombudsman |
| MACPAC | Medicaid and CHIP payment and Access Commission |
| MAGI | modified adjusted gross income |
| MCO | managed care organization |
| MMCH | Medicaid Managed Care Helpline |
| MRSA | Medicaid Rural Service Areas |
| NASDDDS | National Association of State Directors of Developmental Disabilities Services |
| NASHP | National Academy for State Health Policy |

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| NASUAD | National Association of States United for Aging and Disabilities |
| NCI-AD | National Core Indicators-Aging and Disabilities |
| OON | out-of-network |
| P4Q | Pay-For-Quality |
| PBM | Pharmacy Benefits Manager |
| PIP | performance improvement project |
| PCP | primary care provider |
| PFM | Program Funding and Mechanics |
| RHP | Regional Healthcare Partnerships |
| SDA | service delivery area |
| SDS | HHSC Strategic Decision Support |
| SFQ | State Fiscal Quarterly |
| SMMC | State Medicaid Managed Care Advisory Committee |
| SPMI | severe and persistent mental illness |
| STCs | Special Terms and Conditions |
| TCH | Texas Children's Hospital |
| TCHP | Texas Children's Health Plan |
| THSteps | Texas Health Steps |
| UC | uncompensated care |