Texas Healthcare Transformation and Quality Improvement Program
Number: 11-W-00278/6
Demonstration Period: December 12, 2011 through September 30, 2016

Amendment 8 Request: 1) Texas Dual Eligibles Integrated Care Demonstration Project and 2) Clarifying Changes Regarding Nursing Facilities
Demonstration Period: March 1, 2015 through December 31, 2018
Submitted: September 5, 2014

Introduction

In July 2011, the federal Center for Medicare and Medicaid Innovation within the Centers for Medicare and Medicaid Services (CMS) presented states with an opportunity to develop demonstration projects to integrate care for fully dual eligible individuals. Fully dual eligibles are individuals who are eligible for Medicare and full Medicaid benefits. The goal of this demonstration project is to integrate and improve care management for Medicaid and Medicare services for dual eligibles while achieving savings and reducing costs. Participating states negotiated with CMS to retain a portion of the savings achieved through implementation of this initiative. The Texas Health and Human Services Commission (HHSC) submitted a proposal in May 2012.

On May 23, 2014, CMS and HHSC signed a Memorandum of Understanding (MOU). Through this partnership, HHSC and CMS will test a new model for providing Medicare-Medicaid enrollees with a more coordinated, person-centered care experience. The federal-state partnership, known as the Texas Dual Eligibles Integrated Care Demonstration, is intended to better serve individuals eligible for both Medicare and Medicaid. The federal-state partnership will include a three-way contract with managed care entities that will provide integrated benefits in targeted geographic areas. HHSC and CMS will contract with Medicare-Medicaid plans to coordinate the delivery of and be accountable for covered Medicare and Medicaid services for participating Medicare-Medicaid enrollees.

Under this initiative, these managed care plans, called STAR+PLUS (State of Texas Access Reform Plus) Medicare-Medicaid Plans (MMPs) in Texas, will be required to provide for, either directly or through subcontracts, Medicare and Medicaid-covered services, as well as additional items and services, under a capitated model of financing. CMS, the State, and the STAR+PLUS MMPs will ensure that beneficiaries have access to an adequate network of medical, behavioral health, long-term care, and supportive services.

Key objectives of the initiative are to improve the beneficiary experience in accessing services, deliver person-centered care, promote independence in the community, improve the quality of services, eliminate cost shifting between Medicare and Medicaid, and achieve cost savings for the state and federal government through improvements in care coordination.

CMS and the State will allow for certain flexibilities that will further the goal of providing a seamless experience for Medicare-Medicaid enrollees, utilizing a simplified and unified set of rules.

Flexibilities will be coupled with specific beneficiary safeguards and are included in the MOU and the three-way contract.

STAR+PLUS MMPs will have full accountability for managing the capitated payment to best meet the needs of enrollees according to plans of care developed by enrollees, their caregivers, and their service coordination teams. CMS and the State expect STAR+PLUS MMPs to achieve savings through better integrated and coordinated care.

Please see the following request for Amendment 8 to the 11-W-00278/6, Texas Healthcare Transformation and Quality Improvement Program STCs, to incorporate 1) Dual Demonstration 1115a budget neutrality language and 2) additional Nursing Facility changes for clarification.

III. General Program Requirements

STC. 7 Amendment Process. Requests to amend the Demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change, and may not be implemented until approved. CMS reserves the right to deny or delay approval of a Demonstration amendment based on non-compliance with these STCs, including, but not limited to, failure by the State to submit required reports and other deliverables in a timely fashion, according to the deadlines specified therein. Amendment requests must include, but are not limited to, the following:

a) An explanation of the public process used by the State, consistent with the requirements of paragraph 14, to reach a decision regarding the requested amendment.

Pursuant to **STC. 14 Post Award Forum**, the public notice for public comment on the Texas Dual Eligibles Integrated Care Demonstration Project was published in the Texas Register on July 25, 2014, (see attachment named TX Reg Public Notice). Letters were sent on July 7, 2014, to Tribal Governments requesting comments, questions, or feedback on the Texas Dual Eligibles Integrated Care Demonstration Project by August 7, 2014, (see attached copy of one Tribal letter and read receipts for all Tribal letters sent). HHSC received no comments, questions, or feedback on the project.

b) A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis must include current total computable "with waiver" and "without waiver" status, on both a summary and detailed level, through the current extension approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment which isolates (by Eligibility Group (EG)) the impact of the amendment.

The Texas Dual Eligibles Integrated Care Demonstration Project model will be budget neutral (BN). Title XIX cost savings attributable to populations and services provided under the 1115A demonstration will be subtracted from the 1115(a) budget neutrality savings and covered through the 1115A for individuals enrolled in the demonstration. The state will track the number of

member months for every Medicare-Medicaid enrollee who participates in both the 1115(a) and 1115A demonstration. Client participation in the project is optional. The State's reporting requirements related to the Dual Eligibles Integrated Care Demonstration project will follow the example in the table in the section below, labeled, Standard Duals Demo 1115a BN Language, once the program has been implemented.

c) A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation, including a conforming title XIX State plan amendment, if necessary.

1) HHSC is proposing a new way to serve people who are eligible for both Medicare and Medicaid, known as dual eligibles. One health plan will be responsible for the provision of both Medicare and Medicaid services. Individuals will continue to receive all the Medicaid and Medicare services to which they are entitled. Texas' goal for the project is to make it easier for members who are dual eligible to receive care, improve the quality of care received, and promote independence in the community. The demonstration will be optional for individuals eligible to participate. The project is scheduled to begin March 1, 2015.

   To participate, an individual must be:
   - Receiving Medicare Part A, B and D,
   - receiving full Medicaid benefits through the STAR+PLUS program, including individuals who receive STAR+PLUS Home and Community Based Services (HCBS) waiver services,
   - age 21 or older, and
   - residing in one of the following six Texas counties: Bexar, Dallas, El Paso, Harris, Hidalgo, or Tarrant.

2) CMS previously approved on May 21, 2014, the delay of the effective date for the nursing facility carve-in from September 1, 2014 to March 1, 2015. The State has identified an additional clarifying modification to STC: 30. Populations Not Affected by the Demonstration. The waiver page changes show in track changes the modifications the State has made (please see attachment, Clarifying Changes for Nursing Facilities).

d) A description of how the evaluation design will be modified to incorporate the amendment provisions.

Staff reviewed and analyzed the Texas Dual Eligibles Integrated Care Demonstration Project MOU signed by CMS and Texas HHSC on May 23, 2014, to identify evaluation design modifications. There will be no change in the program evaluation for the 1115 Texas Healthcare Transformation and Quality Improvement Program, as a result of this amendment.

The following language will serve as the format for calculation of the reporting requirements when the program is implemented:

Standard Duals Demo 1115a BN Language

1115A Duals Demo Savings. When Texas section 1115(a) demonstration is considered for an amendment, renewal, and at the end of the duals demonstration, CMS' Office of the Actuary (OACT) will estimate and certify actual title XIX savings to date under the duals demonstration attributable to populations and services provided under the 1115A demonstration. This amount will be subtracted from the 1115(a) budget neutrality savings approved for the renewal.

Specifically, OACT will estimate and certify actual title XIX savings attributable to populations and services provided under the 1115A demonstration following the methodology below.

The actual title XIX savings attributable to populations and services provided under the 1115A demonstration are equal to the savings percentage specified in the 1115A duals demonstration MOU multiplied by the 1115A demonstration capitation rate and the number of 1115A duals demonstration beneficiaries enrolled in the 1115(a) demonstration. 1115A Demonstration capitation rate is reviewed by CMS's Medicare and Medicaid Coordination Office (MPLAN), MPLAN's contracted actuaries and CMS' Office of the Actuary (OACT), and was certified by the state's actuaries. Per the 1115A duals demonstration MOU, the actual Medicaid rate paid for beneficiaries enrolled in the 1115A demonstration is equivalent to the state's 1115A Medicaid capitation rate minus an established savings percentage (as outlined in the chart below). The state must track the number of member months for every Medicare-Medicaid enrollee (MME) who participates in both the 1115(a) and 1115A demonstration.

The table below provides an illustrative example of how the savings attributable to populations and services provided under the 1115A demonstration is calculated.

A. 1115A Demonstration Year	**B. Medicaid Capitation Rate (hypothetical)**	**C. Medicaid Savings Percentage Applied Per MOU (average)**	**D. Savings Per Month (B*C)**	**E. Member Months of MMEs who participated in 1115A and 1115(a) Demos (estimated)**	**F. Amount subtracted from 1115(a) BN savings/ margin (D*E)**
DY 1	$1,000 PMPM	1%	$10 PMPM	1,000	1,000* $10 PMPM = $10,000
DY 2	$1,000 PMPM	2%	$20 PMPM	1,000	1,000 * $20 PMPM = $20,000
DY 3	$1,000 PMPM	4%	$40 PMPM	1,000	1,000 * 40 PMPM = $40,000

In each quarterly report, the State must provide the information in the above-named chart (replacing estimated figures with actual data). Should rates differ by geographic area and/or rating category within the 1115A demonstration, this table should be done for each geographic area and/or rating category. In addition, the State must show the "amount subtracted from the 1115(a) BN savings" in the updated budget neutrality Excel worksheets that are submitted in each quarterly report.

Finally, in each quarterly CMS-64 submission and in each quarterly report, the state must indicate in the notes section: "For purposes of 1115(a) demonstration budget neutrality reporting purposes, the state reports the following information:

- Number of Medicare-Medicaid enrollees served under the 1115 duals demonstration = *[Insert number]*
- Number of member months = *[Insert number*]
- PMPM savings per dual beneficiary enrolled from the 1115A duals demonstration = *[Insert number]*

The State must make the necessary retroactive adjustments to the budget neutrality worksheets to reflect modifications to the rates paid in the 1115A demonstration. This must include any Medicaid payment triggered by the risk corridor, IGTs, or other retroactive adjustments. The State must add additional columns to the chart above in subsequent quarterly reporting to reflect those adjustments.