TEXAS HEALTH AND HUMAN SERVICES COMMISSION

KYLE L. JANEK, M.D.
EXECUTIVE COMMISSIONER

June 1, 2015

Brenda Blunt, MSN, RN
Centers for Medicare and Medicaid Services
Center for Medicaid and CHIP Services
Division of State Demonstrations and Waivers
7500 Security Boulevard
Mail Stop S2-01-16
Baltimore, MD 21244-1850

Dear Ms. Blunt:

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

Removal of Spell of Illness Limitation for Individuals with Severe and Persistent Mental Illness
HHSC currently has a spell of illness limitation which places a 30-day limit on inpatient hospital stays for adults in STAR+PLUS. More than one 30-day hospital visit can be paid for in a year if stays are separated by 60 or more consecutive days. This amendment proposes to remove the 30-day spell of illness limitation for STAR+PLUS members who have a diagnosis related to severe or persistent mental illness. These STAR+PLUS members will not be subject to a spell of illness limitation, which may result in some members having longer Medicaid inpatient hospital stays. The Medicaid costs associated with longer inpatient hospital stays may be partially offset, however, as inpatient psychiatric care required by these members that would otherwise be subject to the spell of illness limitations could avert more costly care. HHSC has provided the proposed language for your review and consideration as an attachment to this document.

FQHC Managed Care Payments Methodology Technical Correction
Texas is requesting a technical correction to the THTQIP waiver regarding managed care payments to federally qualified health centers (FQHCs) and rural health centers (RHCs).

Federal law establishes minimum reimbursement rates for FQHCs and RHCs for services provided to Medicaid and CHIP recipients (see Sections 1902(bb) and 2107(e)(1) of the Social

Security Act). Because these requirements apply in the managed care setting, Texas' managed care contracts have, for a number of years, required Medicaid and CHIP managed care organizations (MCOs) to pay FQHCs and RHCs at the full encounter rates, which are calculated using the prospective payment methodology described in the Social Security Act (see e.g., Attachment B, Section 8.1.22 of Joint Procurement Contract). This effectively eliminates the need for state supplemental payments, or "wrap payments" to FQHCs and RHCs. If the State determines, through periodic reviews or other sources, that an MCO is not paying an FQHC or RHC provider at the full encounter rate, it will require the noncompliant MCO to pay the provider the amount due, plus interest.

This methodology is included in Texas' CMS-approved MCO contracts, but is not specifically addressed in the THTQIP waiver. HHSC understands that a number of other states use this approach. To ratify the agreed-upon approach, Texas is requesting a technical correction to the waiver. HHSC has provided the proposed language for your review and consideration as an attachment to this document.

HHSC requests that CMS approve the Spell of Illness waiver amendment by October 1, 2015, and the FQHC technical correction as soon as possible. Becky Brownlee, Director of Policy Development Support, is the lead staff on this matter and can be contacted by telephone at 512-462-6281 or via email at becky.brownlee@hhsc.state.tx.us

Sincerely,

[redacted]

Kay Ghahremani
State Medicaid Director

III. General Program Requirements - Spell of Illness Amendment

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 Spell of Illness change was published in the Texas Register on 5/1/2015, (see attachment named TX Reg Public Notice). Letters were sent on 4/6/15 to Tribal Governments requesting comments, questions, or feedback on the Spell of Illness Change by 5/8/2015. HHSC sent an update to this Tribal letter on 4/16/2015 indicating that there would be budget neutrality changes with this amendment. HHSC requested feedback on this updated Tribal Letter by 5/22/2015, (see attached copies of the two Tribal letters and read receipts for all Tribal letters sent). HHSC received requests for review of the Spell of Illness amendment from external stakeholders. HHSC received one comment from a Tribal Government saying that the amendment will have no impact on them. No other comments, questions, or feedback on the project were received.

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.

Please see the attached budget neutrality projections document for the requested data analysis.

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.

Please refer to the first two pages of this document for a description of the requested change in this amendment and the requested technical correction.

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

This narrative describes how the amendment of the 1115 waiver, reflecting the removal of the 30-day spell of illness limitation for STAR+PLUS clients with a diagnosis related to severe and persistent mental illness, affects the evaluation design.

Understanding of the context for this amendment:

1. SB58 mandated that behavioral health services be carved into STAR and STAR+PLUS on September 1, 2014.

2. If approved, the proposed rule amendment to remove the 30-day spell of illness limitation for STAR+PLUS clients will go into effect on October 1, 2015, thirteen months after behavioral health services were carved into STAR+PLUS.

The evaluation question this could potentially influence:

- What is the impact of carving in behavioral health services to STAR and STAR+PLUS as compared to the carving out of behavioral health services in the service area of the NorthSTAR 1915(b) waiver on coordination and quality of care?

IMPACT ON THE EVALUATION:

While this rule amendment could possibly affect quality of care for SPMI clients who are hospitalized, the implementation date does not allow sufficient time to gather data to determine the impact of the rule amendment on the STAR+PLUS population during the waiver period. There will be 13 months (essentially DY4) during which behavioral health services are carved into the waiver – this would be the baseline from which we would measure change due to this rule amendment. There is not enough time to gather data for the post rule amendment period due to the data lag and waiver evaluation final reporting requirements. (First six months of rule amendment = October 2015 – March 2016; data available for first six months: September 2016; final report due to CMS January 31, 2017)

No immediate changes are necessary to the approved evaluation design.

Proposed Amendment Language for STC 33.

STC 33. Benefits. Note 2 under Table 3.

The 30-day spell of illness limitation for hospital inpatient services ~~that~~ is described in the state plan. The spell of illness limitation does not apply to STAR enrollees, certain approved transplants, children age 20 and younger, or to individuals with severe and persistent mental illness. ~~Effective September 6, 2013, the spell of illness limitation does apply to STAR+PLUS. As described in the state plan, the spell of illness limitation does not apply to certain approved transplants, nor to children age 20 and younger.~~

Proposed technical correction for STC 35.

STC 35. Federally Qualified Health Centers and Rural Health Centers. An enrollee is guaranteed the choice of at least one MCO which has at least one FQHC as a participating provider. If the enrollee elects not to select an MCO that includes a FQHC in the provider network, no FQHC services will be required to be furnished to the enrollee while the enrollee is enrolled with that MCO. The same requirements apply to Rural Health Centers.

The State requires Medicaid managed care organizations to pay full encounter rates to FQHCs and RHCs for medically necessary covered services, using the prospective payment methodology described in section 1902(bb) of the Social Security Act, and as further described and reflected in the CMS-approved managed care contracts and capitation rates. Because managed care organizations are responsible for the full payment amount in effect on the date of service, State cost settlements do not apply.