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

Amendment 9 Request: 1) Community First Choice Program and 2) Technical Corrections
Demonstration Period: March 1, 2015 through September 30, 2016
Submitted: October 30, 2014

Introduction

Senate Bill 7, 83rd Legislature, Regular Session, 2013, requires the Health and Human Services Commission (HHSC) to implement a cost-effective option for attendant and habilitation services for people with disabilities who have STAR+PLUS Medicaid coverage. A federal option, called Community First Choice (CFC), allows states to provide home and community-based attendant services and supports to Medicaid recipients with disabilities. This option provides states with a 6 percent increase in federal matching funds for Medicaid for these services. To be eligible for Community First Choice services an individual must:

- Be eligible for Medicaid under the State Plan.
- Need an institutional level of care for an Intermediate Care Facility for Individuals with an Intellectual Disability or Related Conditions (ICF/IID), nursing facility (NF), or Institution for Mental Disease (IMD).

Community First Choice services include:

- Help with activities of daily living and health-related tasks through hands-on assistance, supervision or cueing.
- Services to help the individual learn how to care for themselves.
- Backup systems or ways to ensure continuity of services and supports.
- Training on how to select, manage and dismiss attendants.

Texas is planning to implement Community First Choice on March 1, 2015. This means:

- Individuals who meet the requirements will be eligible to be assessed for Community First Choice services beginning on March 1, 2015.
- Individuals already receiving services through a 1915(c) waiver will continue to receive those services as they do today from their existing providers.

Please see the following request for Amendment 9 to the 11-W-00278/6, Texas Healthcare Transformation and Quality Improvement Program STCs, to incorporate: 1) Community First Choice provisions, and 2) Technical Corrections to Attachment C, HCBS Service Definitions.

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 Community First Choice Program was published in the Texas Register on September 9, 2014, (see attachment named TX Reg Public Notice). Letters were sent on August 27, 2014, to Tribal Governments requesting comments, questions, or feedback on the Community First Choice Program by September 27, 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 Community First Choice Program will be implemented on March 1, 2015. The population impacted is current STAR+Plus members eligible for CFC services, caseloads above are existing clients and not new to BN. Total costs above are added to both the WW and WOW tabs for Aged & Medicare Related and Disabled and Blind in FY15 and 16. Current services that gain the 6% enhanced match rate represent attendant care services for individuals meeting ICF LOC in the following Department of Aging and Disability Services (DADS) programs: HCS, CLASS, DBMD, TXHML; and must meet NF, ICF, or IMD LOC in the following HHSC programs: STAR+PLUS HCBS for qualifying SSI individuals and Personal Care Services for individuals under 21 at HHSC. Rate Enhancement: The CFC rates are in place of current attendant rates for most CFC eligible population, with exception of STAR+PLUS HCBS assuming 30% of CFC eligible get CFC rates.

Evaluation Cost: Individuals under 21 receiving PCS who are not in the DADS MDCP program are assumed to be evaluated for medical necessity/LOC.

Newly Served IDD Population: SSI adults in STAR+PLUS not currently receiving LTSS services and on an IDD waiver interest list comprise the newly served IDD population. CFC benefits include personal assistance services, habilitation, emergency response services, and support consultation.

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) **Community First Choice Program**
   HHSC is proposing to implement the Community First Choice program under the Medicaid State Plan under section 1915(k) of the Social Security Act. CFC services would be provided to individuals who meet categorical coverage requirements for Medicaid or meet financial eligibility for Medicaid home and community-based services, and who meet an institutional level of care. The program is scheduled to begin March 1, 2015.
   HHSC is amending the 1115 waiver to reflect the provision of CFC services to STAR+PLUS members eligible for CFC services through the STAR+PLUS managed care organizations (MCOs). The benefits included in CFC are personal assistance services, habilitation, emergency response services, and support consultation. Members enrolled in STAR+PLUS for acute care only who are also enrolled in Community Living Assistance and Support Services, Texas Home Living, Deaf Blind Multiple Disabilities or other Home and Community-based Services 1915(c) waivers operated by the DADS will receive CFC services coordinated through the DADS, rather than the STAR+PLUS MCOs.

   The State has identified the waiver page changes shown in track changes to reflect the CFC program provisions (please see pages 4-9).

2) **Technical Corrections**
   CMS previously approved on May 21, 2014, the Texas Healthcare Transformation and Quality Improvement Program technical corrections, as well as changes to Attachments H, I, J, and K. The State has identified "cutting & pasting" errors in Attachment C, HCBS Service Definitions, on pages 83 and 88. The waiver page changes show in track changes the corrected information (please see attachment **Technical Corrections)**.

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

Staff reviewed and analyzed the Texas Community First Choice, to identify evaluation design modifications. This narrative describes how the amendment of the 1115 waiver, reflecting the implementation of the Community First Choice (CFC) program under section 1915(k) of the Social Security Act to provide CFC services to individuals who have a

physical or intellectual disability and meet the coverage requirements, might affect the approved evaluation design.
No immediate changes are necessary to the approved evaluation design. The State previously identified the impact on the approved evaluation design of the inclusion of selected 1915(c) eligible clients in the 1115 waiver population. No additional changes to the current evaluation design are required due to this amendment.

Community First Choice Program provisions incorporated into the 1115 STCs using track changes:

II. PROGRAM DESCRIPTION AND OBJECTIVES

The Texas Legislature, through the 2012-2013 General Appropriations Act and Senate Bill 7, instructed the Texas Health and Human Services Commission (HHSC) to expand its use of pre-paid Medicaid managed care to achieve program savings, while also preserving locally funded supplemental payments to hospitals. 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. The State sought a section 1115 Demonstration as the vehicle to both expand the managed care delivery system, and to operate a funding pool, supported by managed care savings and diverted supplemental payments, to reimburse providers for uncompensated care costs and to provide incentive payments to participating hospitals that implement and operate delivery system reforms.

The STAR and STAR+PLUS managed care programs will cover most beneficiaries statewide through three geographic expansions. The first expansion occurred on September 1, 2011, under existing section 1915(b) and section 1915(c) authorities, and the second expansion occurred in March 2012, under section 1115 authority. A third expansion of STAR+PLUS ~~will~~ occurred September 1, 2014, under section 1115 authority as a result of an amendment to the demonstration.

STAR is the primary managed care program serving low-income families and children, and STAR+PLUS provides acute and long-term service and supports to the aged, disabled, and chronically ill. Medicaid-eligible adults who are not enrolled in Medicare, meet the level of care for Home and Community Based Services (HCBS), and reside in the MRSA, must enroll in a STAR managed care organization (MCO); children meeting these criteria can voluntarily enroll in STAR. STAR MCOs in the MRSA will provide acute care services, and will coordinate acute and long-term care services with section 1915(c) waivers, such as the Community Based Alternatives Program and the Community Living Assistance and Support Services Program, that exist outside of this section 1115 Demonstration.

STAR+PLUS, which serves beneficiaries meeting an institutional level of care (LOC) in the

home or community, did not operate in the MRSA during the March 2012 expansion, but effective September 1, 2014, Medicaid eligible adults over age 21 who meet STAR+PLUS eligibility criteria and reside in the MRSA must enroll in STAR+PLUS. Clients under 21 who meet the criteria ~~were~~are~~ill be~~ currently able to voluntarily enroll in STAR+PLUS ~~effective September 1, 2014, thus~~ but ~~will~~ not be required to enroll.

STAR and STAR+PLUS beneficiaries receive enhanced behavioral health services consistent with the requirements of the Mental Health Parity Act. As of March 2012, STAR+PLUS beneficiaries began receiving inpatient services through the contracted managed care organizations (MCOs). STAR+PLUS MCOs will also provide Medicaid wrap services for outpatient drugs and biological products to dual eligible beneficiaries for whom the State has financial payment obligations. Additionally, Medicaid beneficiaries under the age of 21 will receive the full array of primary and preventive dental services required under the State plan, through contracting pre-paid dental plans.

Effective March 6, 2014, cognitive rehabilitation therapy services (CRT) were~~ill be provided through~~ added to the STAR+PLUS HCBS program.

Effective September 1, 2014, the following additional benefits are~~will be~~ provided:

- acute care services for beneficiaries receiving services through an intermediate care facility for individuals with intellectual disabilities or a related condition (ICF/IID), or an ICF/IID waiver ~~will be~~are provided through STAR+PLUS; employment assistance and supported employment ~~will be~~are provided through the STAR+PLUS home and community based services (HCBS) program;
- mental health rehabilitation services ~~will be~~are provided via managed care; and
- mental health targeted case management for members who have chronic mental illness ~~will be~~are provided via managed care.
- Effective March 1, 2015, nursing facility services will be a covered benefit under STAR+PLUS managed care for adults over the age of 21,

Note: The NorthSTAR waiver in the Dallas service delivery area is not changing as a result of the September 1, 2014 and the March 1, 2015 STAR+PLUS expansions.

- Effective March 1, 2015, Community First Choice services will be a covered benefit of the State Plan.

Beginning January 1, 2014, children ages 6 - 18 with family incomes between 100 – 133 percent of the federal poverty level were transferred from the state's separate Children's Health Insurance Program (CHIP) to Medicaid in accordance with section 1902(a)(10)(A)(i)(VII) of the Act. Under the demonstration these targeted low-income children (M-CHIP) are required to enroll in managed care. For the purposes of eligibility and benefits, these children are considered a mandatory Medicaid group for poverty-level related children and title XIX eligibility and benefit requirements apply. The state may claim enhanced match from the state's title XXI allotment for these M-CHIP children in accordance with title XXI funding

requirements and regulations. All references to CHIP and title XXI in this document apply to these M-CHIP children only. Other requirements of title XXI (for separate CHIP programs) are not applicable to this demonstration.

Savings generated by the expansion of managed care and diverted supplemental payments will enable the State to maintain budget neutrality, while establishing two funding pools supported by Federal matching funds, to provide payments for uncompensated care costs and delivery system reforms undertaken by participating hospitals and providers. These payments are intended to help providers prepare for new coverage demands in 2014 scheduled to take place under current Federal law. The State proposes that the percentage of funding for uncompensated care will decrease as the coverage reforms of the Patient Protection and Affordable Care Act are implemented, and the percentage of funding for delivery system improvement will correspondingly increase.

Texas plans to continue to work with private and public hospitals to create Regional Healthcare Partnerships (RHPs) that are anchored financially by public hospitals and/or local government entities, that will collaborate with participating providers to identify performance areas for improvement that may align with the following four broad categories: (1) infrastructure development, (2) program innovation and redesign, (3) quality improvements, and (4) population focused improvements. The non-Federal share of funding pool expenditures will be largely financed by State and local intergovernmental transfers (IGTs). Texas will continue to work with CMS in engaging provider stakeholders and developing a sustainable framework for the RHPs. It is anticipated, if all deliverables identified in this Demonstration's STCs are satisfied, incentive payments for planning will begin in the second half of the first Demonstration Year (DY).
Through this Demonstration, the State aims 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 health care infrastructure to serve a newly insured population; and
- Transition to quality-based payment systems across managed care and hospitals.

B. ASSURANCES RELATED TO THE ONGOING OPERATION OF MANAGED CARE AND READINESS REVIEW REQUIREMENTS FOR SEPTEMBER 2014 EXPANSION

BENEFICIARIES SERVED THROUGH THE DEMONSTRATION

30. Populations Not Affected by the Demonstration. The following populations receive Medicaid services without regard to the Demonstration.
a) Medically Needy;
b) IV-E eligible adoption assistance individuals, STAR Health enrollees, transitioning foster care youth, non-IV-E Foster Care and State subsidized adoption children, independent foster care adolescents, and optional categorically needy children eligible under 42 CFR 435.222;

c) Women in the Medicaid Breast and Cervical Cancer Program;
d) Residents of State Supported Living Centers;
e) Undocumented or Ineligible (5-year bar) Aliens only eligible for emergency medical services;
f) Prior to September 1, 2014, individuals residing in a nursing facility, who entered the nursing facility while enrolled in STAR+PLUS, and who have been in the nursing facility for at least four months;
g) Individuals residing in a nursing facility who entered the nursing facility while enrolled in STAR, beginning with the month after the State receives notification that they entered the nursing facility; ~~and~~
h) Individuals enrolled in the Program for All Inclusive Care for the Elderly (PACE) program;
i) Individuals enrolled in the Medically Dependent Children Program (1915(c)); ~~and~~
j) Individuals residing in a facility in the pediatric care facility class of nursing facilities, or any Veterans Land Board (VLB) Texas State Veterans Homes~~.~~; and (pending CMS approval - 9/5/14)
k) Individuals in the 217-Like population group are not eligible for Community First Choice benefits.

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C. STAR AND STAR+PLUS (non-HCBS) ENROLLMENT, BENEFITS AND REPORTING REQUIREMENTS

33. Benefits. The following Table 3 specifies the scope of services that may be made available to STAR and STAR+PLUS enrollees through the STAR and STAR+PLUS managed care plans. The schedule of services mirrors those provided in the Medicaid State plan, with the exception of 1915(b)(3)-like services as described in this waiver.

Should the State amend its State plan to provide additional optional services not listed below, coverage for those services may also be provided through the STAR and STAR+PLUS MCOs. The State will include non-behavioral inpatient hospital services in STAR+PLUS capitation as of the March 2012 expansion.

Table 3. State Plan Services for STAR and STAR+PLUS Participants

Adult/ Child	Service	Mandatory or Optional State Plan Services[2]
Adult/Child	Inpatient Hospital Services[1,2,3]	Mandatory §1905(a)(1)
Adult/Child	Outpatient Hospital Services	Mandatory §1905(a)(2)
Adult/Child	Rural Health Clinic Services	Mandatory §1905(a)(2)
Adult/Child	(Federally Qualified Health Center (FQHC) Services	Mandatory §1905(a)(2)
Adult/Child	Laboratory and x-ray services	Mandatory §1905(a)(3)
Adult/Child	Diagnostic Services	Optional §1905(a)(13)
Child	EPSDT	Mandatory §1905(a)(4)
Adult/Child	Family Planning	Mandatory §1905(a)(4)
Adult/Child	Physician's Services	Mandatory §1905(a)(5)
Adult/Child	Medical and Surgical Services Furnished by a Dentist	Mandatory §1905(a)(5)
Adult/Child	Podiatrists' Services	Optional §1905(a)(6)
Adult/Child	Optometrists' Services	Optional §1905(a)(6)

Adult/Child	Intermittent or part-time nursing services provided by a home health agency	Mandatory for individuals who, under the State plan, are entitled to nursing facility services, §1902(a)(10)(D)
Adult/Child	Home health aide services provided by a home health agency	Mandatory for individuals who, under the State plan, are entitled to nursing facility services, §1902(a)(10)(D)
Adult/Child	Medical supplies, equipment, and appliances	Mandatory for individuals who, under the State plan, are entitled to nursing facility services, §1902(a)(10)(D)
Adult/Child	Physical therapy, occupational therapy, speech pathology, and audiology provided by a home health agency	Optional §1902(a)(10)(D), 42 CFR 440.70
Adult/Child	Clinic Services	Optional §1905(a)(9)
Adult/Child	Prescribed Drugs (beginning March 1, 2012)[4]	Optional §1927(d)
Adult/Child	Non-prescription drugs (beginning	Optional §1927(d)

[2] This column describes whether a services is a required state plan service or if a state can elect to cover the service under the Social Security Act. All services listed here are covered in the Texas State plan.

Adult/ Child	Service	Mandatory or Optional State Plan Services[2]
	March 1, 2012	
Adult/Child	Prosthetic Devices	Optional §1905(a)(12)
Adult/Child	Eyeglasses	Optional §1905(a)(12)
Adult/Child	Preventive Services	Optional §1905(a)(13)
Adult	Services for individuals over age 65 in IMDs – Inpatient, Not Nursing Facility	Optional §1905(a)(14)
Adult	Effective through February 28, 2015: Nursing facility services for enrollees age 21 and older – 4 month service limitation. Effective March 1, 2015: Nursing facility services (STAR+PLUS only)	Mandatory §1905(a)(4)
Child	Inpatient psychiatric facility services for individuals under age 21	Optional §1905(a)(16)
Adult (STAR+PLUS)	Rehabilitative Services – Day Activity & Health Services	Optional, Rehabilitation Service, 42 CFR 440.130(d)
Adult/Child	Effective September 1, 2014: Mental Health Rehabilitative Services	Optional, Rehabilitation Service, 1905(a)(13) and 42 CFR 440.130(d)
Adult/Child	Effective September 1, 2014: Targeted Case Management for Individuals with Chronic Mental	Optional 1915(a)(19), 1915(g)
Adult/Child	Nurse-Midwife Services	Mandatory §1905(a)(17)
Adult/Child	Certified pediatric or family nurse practitioners' services	Mandatory §1905(a)(21)
Adult/Child	Personal care services in the home	Optional §1905(a)(24), 42 CFR 440.170
Adult/Child	Community First Choice: Personal Assistance Services, Habilitation, Emergency Response Services, and Support Consultation.	Optional, 42 CFR 441.

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[1]Substance use disorder treatment services are capitated services for STAR and STAR+PLUS, and MCOs may provide these services in a chemical dependency treatment facility in lieu of the acute care inpatient hospital setting. Similarly, the MCOs will be responsible for providing acute inpatient days for psychiatric conditions, and may provide these services in a free-standing psychiatric hospital in lieu of acute care inpatient hospital settings. The State does not include non-State plan services, such as room and board, in the STAR or STAR+PLUS capitation; however, the MCO is not restricted to only the delivery of State plan services when alternative services are a cost-effective and medically appropriate response to the needs of the member.

[2] The 30-day spell of illness limitation for hospital inpatient services that is described in the state plan does not apply to STAR enrollees. 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.

[3] The annual benefit limitation on inpatient hospital services that is described in the state plan does not apply to STAR or STAR+PLUS enrollees.

+ The state plan prescription drug limitations for adults aged 21 and older do not apply to STAR or STAR+PLUS enrollees.