

**CENTERS FOR MEDICARE AND MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS (STCs)**

NUMBER: 11-W-00278/6

TITLE: Texas Healthcare Transformation and Quality Improvement
Program

AWARDEE: Texas Health and Human Services Commission

DEMONSTRATION PERIOD: December 12, 2011 through September 30, 2016

**CENTERS FOR MEDICARE & MEDICAID SERVICES
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I. PREFACE

The following are the Special Terms and Conditions (STCs) for the Texas Healthcare Transformation and Quality Improvement Program section 1115(a) Medicaid demonstration (hereinafter “Demonstration”). The parties to this agreement are the Texas Health and Human Services Commission (HHSC/State) and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth, in detail, the nature, character, and extent of Federal involvement in the Demonstrations, and the State’s obligations to CMS during the life of the Demonstration. This Demonstration is effective the date of the approval letter through September 30, 2016, unless otherwise specified.

The STCs have been arranged into the following subject areas:

- I. Preface
- II. Program Description and Objectives
- III. General Program Requirements
- IV. Eligibility Derived from the Demonstration
- V. Demonstration Delivery Systems
 - A. Phased Expansion of Managed Care Delivery Systems
 - B. Assurances Related to the Ongoing Operation of Managed Care and Readiness Review Requirements for March 2012 Expansion
 - C. Eligibility
 - D. STAR AND STAR+PLUS (non-HCBS) Enrollment, Benefits and Reporting Requirements
 - E. Children’s Dental Program
 - F. STAR+PLUS HCBS Enrollment, Benefits and Reporting Requirements
- VI. Funding Pools Under the Demonstration
- VII. General Financial Requirements
- VIII. Monitoring Budget Neutrality for the Demonstration
- IX. General Reporting Requirements
- X. Evaluation of the Demonstration

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The following attachments have been included to provide supplemental information and guidance for specific STCs. The following attachments are incorporated as part of this agreement.

- Attachment A: Schedule of Deliverables
- Attachment B: Quarterly Report Template
- Attachment C: HCBS Service Definitions
- Attachment D: Quality Improvement Strategy for HCBS
- Attachment E: HCBS Quality Review Worksheet
- Attachment F: HCBS Fair Hearing Procedures
- Attachment G: HCBS Participant Safeguards
- Attachment H: UC Claiming Protocol and Application
- Attachment I: Regional Healthcare Partnership (RHP) Planning Protocol
- Attachment J: Delivery System Reform Incentive Payment (DSRIP) Plan
- Attachment K: Administrative Cost Claiming Protocol

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 beneficiaries statewide through two geographic expansions. The first expansion occurred on September 1, 2011, under existing section 1915(b) and section 1915(c) authorities, and the second expansion will occur in March 2012 (or later if the State notifies CMS of a need for a delay in implementation, and CMS approves such a change in the Demonstration, or if CMS otherwise determines that a delay in implementation is required). 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. STAR+PLUS, which serves beneficiaries meeting an institutional level of care (LOC) in the home or community, will not operate in the Medicaid Rural Service Area (MRSA). Medicaid eligibles meeting the level of care for Home and Community Based Services (HCBS), that reside in the MRSA, will be enrolled in a STAR managed care organization (MCO), which will provide acute care services and coordinate acute and long-term care services with other 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.

As an amendment effective 2/1/2013, Medicaid eligibles meeting the level of care for the Texas Home Living Waiver (TxHML), that reside in STAR+PLUS Service Areas, will be enrolled in the STAR+PLUS program. Those members will be enrolled in the TxHML waiver with the option of requesting disenrollment from the STAR+PLUS program. The individual will receive all State Plan and long term services and supports through the STAR+PLUS program and have access to those TxHML waiver services that are not available in the STAR+PLUS program. Existing STAR+PLUS members who meet the LOC for the TxHML waiver will have access to all TxHML waiver services that are not available in the STAR+PLUS program.

STAR and STAR+PLUS beneficiaries will also receive enhanced behavioral health services consistent with the requirements of the Mental Health Parity Act. As of March 2012, STAR+PLUS beneficiaries will begin receiving non-behavioral health inpatient services and Medicaid wrap services through the contracted managed care organizations (MCOs). 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.

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 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;

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- 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.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The State must comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.
2. **Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), must apply to the Demonstration.
3. **Changes in Medicaid Law, Regulation, and Policy.** The State must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in Federal law, regulation, or policy affecting the Medicaid program that occur during this Demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable.
4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy Statements.**
 - a. To the extent that a change in Federal law, regulation, or policy requires either a reduction or an increase in Federal financial participation (FFP) for expenditures made under this Demonstration, the State must adopt, subject to CMS approval, modified budget neutrality and allotment neutrality agreements for the Demonstration as necessary to comply with such change. The modified agreements will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under the subparagraph.
 - b. If mandated changes in the Federal law require State legislation, the changes must take effect on the day such State legislation becomes effective, or on the last day such legislation was required to be in effect under the law.
5. **State Plan Amendments.** The State will not be required to submit title XIX State plan amendments for changes affecting any populations made eligible solely through the Demonstration. If a population eligible through the Medicaid State Plan is affected by a change to the Demonstration, a conforming amendment to the appropriate State Plan may be required, except as otherwise noted in these STCs.
6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, cost sharing, sources of non-Federal share of funding, budget neutrality, spending limits for funding pools, methodologies for determining amounts paid from pools (to the extent specified in the STCs), deadlines for deliverables, and other comparable program elements must be submitted to CMS as amendments to the Demonstration. All amendment

requests are subject to approval at the discretion of the Secretary, in accordance with section 1115 of the Act. The State must not implement changes to these elements without prior approval by CMS. Amendments to the Demonstration are not retroactive, and FFP will not be available for changes to the Demonstration that have not been approved through the amendment process set forth in paragraph 7 below (*Amendment Process*).

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

8. Extension of the Demonstration. States that intend to request demonstration extensions under sections 1115(e) or 1115(f) are advised to observe the timelines contained in those statutes. Otherwise, no later than 12 months prior to the expiration date of the Demonstration, the chief executive officer of the State must submit to CMS either a Demonstration extension request or a phase-out plan, consistent with the requirements of paragraph 9.

As part of the Demonstration extension request, the state must provide documentation of compliance with the public notice requirements outlined in paragraph 15, as well as include the following supporting documentation:

- a. Demonstration Summary and Objectives: The State must provide a summary of the demonstration project, reiterate the objectives set forth at the time the demonstration was proposed, and provide evidence of how these objectives have been met. If changes are requested, a narrative of the changes being requested, along with the objective of the change, and desired outcomes must be included.
 - b. Special Terms and Conditions (STCs): The State must provide documentation of its compliance with each of the STCs. Where appropriate, a brief explanation may be accompanied by an attachment containing more detailed information. Where the STCs address any of the following areas, they need not be documented a second time.
 - c. Waiver and Expenditure Authorities: The State must provide a list along with a programmatic description of the waivers and expenditures authorities that are being requested in the extension.
 - d. Quality: The State must provide summaries of External Quality Review Organization (EQRO) reports, MCO and State quality assurance monitoring, and any other documentation of the quality of care provided under the demonstration.
 - e. Compliance with the Budget Neutrality Cap: The State must provide financial data (as set forth in the current STCs) demonstrating that the State has maintained, and will maintain, budget neutrality for the requested period of extension. CMS will work with the State to ensure that Federal expenditures under the extension of this project do not exceed the Federal expenditures that would otherwise have been made. In doing so, CMS will take into account the best estimate of current trend rates at the time of the extension.
 - f. Interim Evaluation Report: The State must provide an evaluation report reflecting the hypotheses being tested and any results available.
- 9. Demonstration Phase-Out.** The State may only suspend or terminate this Demonstration in whole, or in part, consistent with the following requirements.
- a. Notification of Suspension or Termination: The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a phase-out plan. The State must submit its notification letter and a draft phase-out plan to CMS no less than 5 months before the effective date of the Demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, the State must publish on its Web site, the draft phase-out plan for a 30-day public comment period. In addition, the State must conduct tribal consultation, in accordance with its approved tribal consultation State Plan Amendment. Once the 30-day public comment period has ended, the State must provide a summary of each public comment received, the State's response to the comment, and how the State incorporated the received comment into the revised phase-out plan.

The State must obtain CMS approval of the phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out activities must be no sooner than 14 days after CMS approval of the phase-out plan.

- b. **Phase-out Plan Requirements:** The State must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the State will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.
- c. **Phase-out Procedures:** The State must comply with all notice requirements found in 42 CFR §431.206, 431.210 and 431.213. In addition, the State must assure all appeal and hearing rights afforded to Demonstration participants as outlined in 42 CFR §431.220 and 431.221. If a Demonstration participant requests a hearing before the date of action, the State must maintain benefits, as required in 42 CFR §431.230. In addition, the State must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category, as discussed in the October 1, 2010, State Health Official Letter #10-008.
- d. **Federal Financial Participation (FFP):** If the project is terminated or any relevant waivers suspended by the State, FFP shall be limited to normal closeout costs associated with terminating the Demonstration including services and administrative costs of disenrolling participants.

10. CMS Right to Terminate or Suspend. CMS may suspend or terminate the Demonstration (in whole or in part) at any time before the date of expiration, whenever it determines, following a hearing, that the State has materially failed to comply with the terms of the project. CMS will promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date.

11. Finding of Non-Compliance. The State does not relinquish its rights to challenge the CMS finding that the State materially failed to comply.

12. Withdrawal of Waiver Authority. CMS reserves the right to withdraw waivers of expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX and/or XXI. CMS will promptly notify the State in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the State an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs or disenrolling participants.

13. Adequacy of Infrastructure. The State will ensure the availability of adequate resources for the implementation and monitoring of the Demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other Demonstration components.

14. Public Notice and Consultation with Interested Parties. The State must comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) and the tribal consultation requirements pursuant to section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act of 2009, when any program changes to the Demonstration, including (but not limited to) those referenced in paragraph 6, are proposed by the State. In States with Federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the State is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any amendment or extension of this Demonstration.

15. Federal Financial Participation (FFP). No Federal matching funds for expenditures authorized for this Demonstration will be available prior to the effective date identified in the Demonstration approval letter.

IV. ELIGIBILITY DERIVED FROM THE DEMONSTRATION

This section governs the State's exercise of Expenditure Authority 3.

16. STAR+PLUS 217-Like HCBS Eligibility Group. This section describes the eligibility requirements for the 217-Like group under the Demonstration.

- a. STAR+PLUS 217-Like HCBS Eligibility Group consists of persons age 65 and older or persons age 21 and older who are disabled and satisfy the following:
 - i. Meet the STAR+PLUS Nursing Facility (NF) level of care requirement;
 - ii. Will receive home and community based-services; and
 - iii. Would be eligible in the same manner as specified under 42 CFR 435.217, 435.236 and 435.726 of the Federal Regulations and eligibility rules specified in section 1924 of the Social Security Act, if the home and community based services of the kind listed in Table 4 were provided under a 1915(c) waiver. The State does not use spousal impoverishment post-eligibility rules.
- b. This demonstration eligibility group is active at the times and in the parts of the State as indicated below:
 - i. As of the implementation date of this Demonstration, in Column B counties (as defined in Table 1).

- ii. Starting March 1, 2012 (or the implementation date for the STAR+PLUS expansion, if a later date), in Column E counties (as defined in Table 1).
- c. The State retains the discretion to apply an interest list for the STAR+PLUS 217-Like Group as described in paragraph 41(c)(i)(A).

V. DEMONSTRATION DELIVERY SYSTEMS

This section governs the State's exercise of the following: waivers of the requirements for Statewide (section 1902(a)(1)), Amount, Duration, and Scope of Services (section 1902(a)(10)(B)), Freedom of Choice (section 1902(a)(23)(A)), and Self-Direction of Care for HCBS Participants (section 1902(a)(32)), and Expenditure Authorities 1 through 4.

A. PHASED EXPANSION OF MANAGED CARE DELIVERY SYSTEMS

- 17. Transition of Existing section 1915(b) and 1915(c) Waiver Programs into the Demonstration.** Prior to this Demonstration, the State operated managed care programs under the authority of section 1915(b) and 1915(c) waivers and provided HCBS through additional section 1915(c) waivers where managed care organizations did not operate. The following is a description of the 1915 (b) and (c) waivers that are affected by this Demonstration:
- a. STAR section 1915(b) waiver, TX 16 (ends with initial implementation of the Demonstration);
 - b. STAR+PLUS section 1915(b) waiver, TX 12 (ends with initial implementation of the Demonstration);
 - c. STAR+PLUS 1915 section (c) waiver, TX 0862 (Medical Assistance Only (MAO) eligibles) (ends with initial implementation of the Demonstration);
 - d. STAR+PLUS 1915 section (c) waiver, TX 0325 (SSI eligibles) (ends with initial implementation of the Demonstration);
 - e. Community Based Alternatives (CBA) section 1915(c) waiver, TX 0266 (ends in Column E counties that are not Column B counties, as defined in Table 1, when the March 2012 managed care expansion is implemented).

- 18. Description of Managed Care Expansion Plan.** The State shall conduct geographic expansion of the STAR and STAR+PLUS programs according to the Service Areas defined below. The Primary Care Case Management (PCCM) delivery system in place prior to the Demonstration will terminate and transition to a capitated managed care delivery system. The State shall implement the STAR and STAR+PLUS Expansions on March 1, 2012, or a later date approved by CMS, and determined as part of the Readiness Review, whichever is later. The State shall notify CMS of a need for a delay in implementation, or CMS may identify such a need. Table 1 below defines the Service Areas and delivery systems according to the managed care expansion plan. (Note: the MRSA is defined in paragraph 19 in Table 1, Column D).

Table 1. Service Areas and Delivery Systems as Defined by the Expansion Plan**Note:** Counties added to existing Service Areas are noted in italics.

| Service Area | STAR Start of Demo Column (A) | STAR+PLUS Start of Demo Column (B) | STAR March 2012 Column (C) | STAR March 2012 Column (D) (MRSA) | STAR+PLUS March 2012 Column (E) |
|--------------|---|---|--|--|--|
| Bexar | Atascosa, Bandera, Bexar, Comal, Guadalupe, Kendall, Medina, Wilson | Atascosa, Bandera, Bexar, Comal, Guadalupe, Kendall, Medina, Wilson | Atascosa, Bandera, Bexar, Comal, Guadalupe, Kendall, Medina, Wilson | N/A | Atascosa, Bandera, Bexar, Comal, Guadalupe, Kendall, Medina, Wilson |
| Dallas | Collin, Dallas, Ellis, Hunt, Kaufman, Navarro, Rockwall | Collin, Dallas, Ellis, Hunt, Kaufman, Navarro, Rockwall | Collin, Dallas, Ellis, Hunt, Kaufman, Navarro, Rockwall | N/A | Collin, Dallas, Ellis, Hunt, Kaufman, Navarro, Rockwall |
| El Paso | El Paso Hudspeth | N/A | El Paso, Hudspeth | N/A | <i>El Paso, Hudspeth</i> |
| Harris | Austin, Brazoria, Fort Bend, Galveston, Harris, Matagorda, Montgomery, Waller, Wharton | Austin, Brazoria, Fort Bend, Galveston, Harris, Matagorda, Montgomery, Waller, Wharton | Austin, Brazoria, Fort Bend, Galveston, Harris, Matagorda, Montgomery, Waller, Wharton | N/A | Austin, Brazoria, Fort Bend, Galveston, Harris, Matagorda, Montgomery, Waller, Wharton |
| Hidalgo | N/A | N/A | <i>Cameron, Duval, Hidalgo, Jim Hogg, Maverick, McMullen, Starr, Webb, Willacy, Zapata</i> | N/A | <i>Cameron, Duval, Hidalgo, Jim Hogg, Maverick, McMullen, Starr, Webb, Willacy, Zapata</i> |
| Jefferson | Chambers, Hardin, Jasper, Jefferson, Liberty, Newton, Orange, Polk, San Jacinto, Tyler, Walker | Chambers, Hardin, Jasper, Jefferson, Liberty, Newton, Orange, Polk, San Jacinto, Tyler, Walker | Chambers, Hardin, Jasper, Jefferson, Liberty, Newton, Orange, Polk, San Jacinto, Tyler, Walker | N/A | Chambers, Hardin, Jasper, Jefferson, Liberty, Newton, Orange, Polk, San Jacinto, Tyler, Walker |

| Service Area | STAR Start of Demo Column (A) | STAR+PLUS Start of Demo Column (B) | STAR March 2012 Column (C) | STAR March 2012 Column (D) (MRSA) | STAR+PLUS March 2012 Column (E) |
|--------------|--|--|--|-----------------------------------|--|
| Lubbock | Carson, Crosby, Deaf Smith, Floyd, Garza, Hale, Hockley, Hutchinson, Lamb, Lubbock, Lynn, Potter, Randall, Swisher, Terry | N/A | Carson, Crosby, Deaf Smith, Floyd, Garza, Hale, Hockley, Hutchinson, Lamb, Lubbock, Lynn, Potter, Randall, Swisher, Terry | N/A | <i>Carson, Crosby, Deaf Smith, Floyd, Garza, Hale, Hockley, Hutchinson, Lamb, Lubbock, Lynn, Potter, Randall, Swisher, Terry</i> |
| Nueces | Aransas, Bee, Brooks, Calhoun, Goliad, Jim Wells, Karnes, Kenedy, Kleberg, Live Oak, Nueces, Refugio, San Patricio, Victoria | Aransas, Bee, Brooks, Calhoun, Goliad, Jim Wells, Karnes, Kenedy, Kleberg, Live Oak, Nueces, Refugio, San Patricio, Victoria | Aransas, Bee, Brooks, Calhoun, Goliad, Jim Wells, Karnes, Kenedy, Kleberg, Live Oak, Nueces, Refugio, San Patricio, Victoria | N/A | Aransas, Bee, Brooks, Calhoun, Goliad, Jim Wells, Karnes, Kenedy, Kleberg, Live Oak, Nueces, Refugio, San Patricio, Victoria |
| Tarrant | Denton, Hood, Johnson, Parker, Tarrant, Wise | Denton, Hood, Johnson, Parker, Tarrant, Wise | Denton, Hood, Johnson, Parker, Tarrant, Wise | N/A | Denton, Hood, Johnson, Parker, Tarrant, Wise |
| Travis | Bastrop, Burnet, Caldwell, Fayette, Hays, Lee, Travis, Williamson | Bastrop, Burnet, Caldwell, Fayette, Hays, Lee, Travis, Williamson | Bastrop, Burnet, Caldwell, Fayette, Hays, Lee, Travis, Williamson | N/A | Bastrop, Burnet, Caldwell, Fayette, Hays, Lee, Travis, Williamson |
| Rural | N/A | N/A | N/A | See STC 19 | N/A |

19. Medicaid Rural Service Area (MRSA). The MRSA consists of 164 counties and, prior to this Demonstration, Medicaid beneficiaries residing in this service area received services through the non-capitated PCCM program under the State plan.

- a. The following counties comprise the Medicaid Rural Service Area: Anderson, Andrews, Angelina, Archer, Armstrong, Bailey, Baylor, Bell, Blanco, Borden, Bosque, Bowie, Brazos, Brewster, Briscoe, Brown, Burleson, Callahan, Camp, Cass, Castro, Cherokee, Childress, Clay, Cochran, Coke, Coleman, Collingsworth, Colorado, Comanche, Concho, Cooke, Coryell, Cottle, Crane, Crockett, Culberson, Dallam, Dawson, Delta, DeWitt, Dickens, Dimmit, Donley, Eastland, Ector, Edwards, Erath, Falls, Fannin, Fisher, Foard, Franklin, Freestone, Frio, Gaines, Gillespie, Glasscock, Gonzalez, Gray, Grayson, Gregg, Grimes, Hall, Hamilton, Hansford, Hardeman, Harrison, Hartley, Haskell, Hemphill, Henderson, Hill Hopkins, Houston, Howard, Irion, Jack, Jackson, Jeff Davis, Jones, Kent, Kerr, Kimble, King, Kinney, Knox, LaSalle, Lamar, Lampasas, Lavaca, Leon, Limestone, Lipscomb, Llano, Loving, Madison, Marion, Martin, Mason, McCulloch, McLennan, Menard, Midland, Milam, Mills, Mitchell, Montague, Moore, Morris, Motley, Nacogdoches, Nolan, Ochiltree, Oldham, Palo Pinto, Panola, Parmer, Pecos, Presidio, Rains, Reagan, Real, Red River, Reeves, Roberts, Robertson, Runnels, Rusk, Sabine, San Augustine, San Saba, Schleicher, Scurry, Shackelford, Shelby, Sherman, Smith, Somervell, Stephens, Sterling, Stonewall, Sutton, Taylor, Terrell, Throckmorton, Titus, Tom Green, Trinity, Upshur, Upton, Uvalde, Val Verde, Van Zandt, Ward, Washington, Wheeler, Wichita, Wilbarger, Winkler, Wood, Yoakum, Young, Zavala.
- b. STAR+PLUS will not operate in the Medicaid Rural Service Area (MRSA). Individuals in the MRSA who qualify for long-term services and supports may receive acute care services through STAR, and long-term services and supports through the Community Based Alternative 1915(c) waiver program.

B. ASSURANCES RELATED TO THE ONGOING OPERATION OF MANAGED CARE AND READINESS REVIEW REQUIREMENTS FOR MARCH 2012 EXPANSION

20. Managed Care Requirements. The State must comply with the managed care regulations published at 42 CFR 438, except as waived herein. Capitation rates shall be developed and certified as actuarially sound, in accordance with 42 CFR 438.6. The certification shall identify historical utilization of State Plan services used in the rate development process.

21. Managed Care Delivery Systems. The State has been granted the authority (subject to Readiness Review, as discussed below) to operate managed care programs in the areas described in paragraphs 18 and 19; therefore, a Demonstration amendment is not required to implement expansions in these service areas. However, any proposed changes in Demonstration authorities; implementation of managed care after June 1, 2012, in the service areas provided in Columns C, D, and E in Table 1; or changes in the populations included or excluded in the authorized service areas will require an amendment to the Demonstration as outlined in STC 7.

22. Readiness Review Requirements for STAR and STAR+PLUS Expansions. The State will submit to CMS, documentation regarding network adequacy and capacity for the STAR and STAR+PLUS Expansions, as described below:

- a. The Readiness Review for the STAR and STAR+PLUS Expansions will consist of the following elements:
 - i. Review and approval of managed care contract amendments; and
 - ii. Review of the State's plans for monitoring, overseeing, and ensuring compliance with MCO contract requirements, including network adequacy.
- b. Prior to the State's planned implementation date for the STAR and STAR+PLUS expansions, the State must submit the following to CMS review, according to the timelines specified below:
 - i. A list of deliverables and submissions the State will request from health plans to establish their readiness, with a description of the State's approach to analysis and verification (submitted by the State November 3, 2011);
 - ii. Plans for ongoing monitoring and oversight of MCO contract compliance (submitted by the State for STAR and STAR+PLUS MCOs and Children's Dental Program on November 3, 2011);
 - iii. A contingency plan for addressing insufficient network issues (submitted by the State for STAR and STAR+PLUS MCOs and Children's Dental Program on November 3, 2011);
 - iv. A plan for the transition from the section 1915(c) waiver program to the STAR+PLUS HCBS program as described in paragraph 46(d)(iii) (submitted by the State on November 28, 2011);
 - v. Demonstrations of network adequacy according to the list of deliverables provided in paragraph 24(e) (December 23, 2011); and
 - vi. Proposed managed care contracts or contract amendments, as needed, to implement the STAR and STAR+PLUS Expansions (December 23, 2011).
- c. CMS reserves the right to request additional documentation and impose additional milestones on the STAR and STAR+PLUS Expansions in light of findings from the September 2011 pre-Demonstration managed care expansion or readiness review activities.

- d. The State must postpone the March 2012 implementation of STAR and STAR+PLUS (in whole or in part) if requested to do so by CMS. CMS will provide the State its reasons, in writing, for requesting the postponement, which may be based on findings from the readiness review, and will modify the approved Demonstration as necessary to reflect the delay. CMS will endeavor to make any postponement request before January 1, 2012, but reserves the right to make a request later should new, material information become available that would give grounds for postponement.

23. Contracts. No FFP is available for activities covered under contracts and/or modifications to existing contracts that are subject to 42 CFR 438 requirements prior to CMS approval of such contracts and/or contract amendments. The State shall submit any supporting documentation deemed necessary by CMS. The State will provide CMS with a minimum of 45 days to review and approve changes. CMS reserves the right, as a corrective action, to withhold FFP (either partial or full) for the Demonstration, until the contract compliance requirement is met.

24. Network Requirements. The State must, through contract with MCOs, ensure the delivery of all covered benefits, including high quality care. Services must be delivered in a culturally competent manner, and the MCO network must be sufficient to provide access to covered services to the low-income population. In addition, the MCO must coordinate health care services for Demonstration populations. The following requirements must be met by the State through its MCOs for the duration of the Demonstration.

- a. **Special Health Care Needs.** Enrollees with special health care needs must have direct access to a specialist, as appropriate for the individual's health care condition, as specified in 42 C.F.R. 438.208(c)(4).
- b. **Out of Network Requirements.** The State, through MCOs, must provide Demonstration populations with all Demonstration program benefits described within these STCs, and as specified in 42 CFR 438.206(b)(4), and must allow access to non-network providers, without extra charge, when services cannot be timely furnished through a geographically accessible preferred provider network.
- c. **Timeliness.** The State, through its MCOs, must comply with timely access requirements, and ensure their providers comply with these requirements. Providers must meet State standards for timely access to care and services, considering the urgency of the service needed. Network providers must offer office hours at least equal to those offered to the MCO's commercial line of business enrollees or Medicaid fee-for-service participants, if the provider accepts only Medicaid patients. Contracted services must be made available 24 hours per day, seven days per week, when medically necessary. The State, through the MCO contracts, must establish mechanisms to ensure and monitor provider compliance, and must take corrective action when noncompliance occurs.

- d. **Credentialing.** The State, through its MCOs, must demonstrate that the MCO providers are credentialed. The State must also require these MCOs to participate in efforts to promote culturally-competent service delivery.
- e. **Demonstrating Network Adequacy.** Annually, the State must provide adequate assurances that it has sufficient capacity to serve the expected enrollment in its service area.
 - i. The State must provide supporting documentation that must show that the MCO offers an adequate range of preventive, primary, pharmacy, and specialty service care for the anticipated number of enrollees in the service area. The network must contain providers who are sufficient in number, mix, and geographic distribution to meet the anticipated needs of enrollees. The supporting documentation for network adequacy by MCO includes the following:
 - (A) The MCO's Demonstration population enrollment;
 - (B) Service utilization based on the Demonstration population's characteristics and health care needs;
 - (C) The number and types of primary care, pharmacy, and specialty providers available to provide covered services to the Demonstration population;
 - (D) The number of network providers accepting the new Demonstration population;
 - (E) The geographic location of providers and Demonstration populations, as shown through GeoAccess or similar software and identified according to the requirements contained in the State's MCO contract.
 - ii. The State must submit the documentation required in subparagraphs (A), (C), (D), and (E) above to CMS in conjunction with the initial contract submission.
 - iii. The State must submit this documentation to CMS any time that a significant change occurs in the health plan's operations that would affect adequate capacity and services. Significant changes include changes in services, benefits, geographic service area, or payments or the entity's enrollment of a new population.

25. Enrollment Broker Monitoring. The State shall submit the enrollment broker's monthly reports to CMS upon receipt. The reports should include information on activities including, but not limited to, community outreach events, call center intake statistics, and other enrollment broker activities as needed.

26. Notice of Change in Implementation Timeline. The State must notify CMS of any potential changes in the implementation and deliverables timelines as specified in the STCs.

27. Revision of the State Quality Strategy. In accordance with Federal regulations at Subpart D 438.200 regarding Quality Assessment and Performance Improvement to ensure the delivery

of quality health care and establishment of standards, the State must update its Quality Strategy to reflect all managed care plans operating under the STAR and STAR+PLUS programs proposed through this Demonstration and submit to CMS for approval. The State must obtain the input of recipients and other stakeholders in the development of its revised comprehensive Quality Strategy and make the Strategy available for public comment. The comprehensive Quality Strategy must be submitted to CMS for final approval within nine (9) months from the approval date of the Demonstration. The State must revise the strategy whenever significant changes are made, including changes through this Demonstration. The State will also provide CMS with annual reports on the implementation and effectiveness of the updated comprehensive Quality Strategy as it impacts the Demonstration. Until the revised comprehensive Quality Strategy is approved by CMS and implemented by the State, the State must continue with its pre-demonstration Quality Strategy, which for HCBS is shown as Attachments D and E of these STCs.

C. ELIGIBILITY

28. Eligibility Groups. Mandatory and optional Medicaid State plan groups described below are subject to all applicable Medicaid laws and regulations except as expressly waived under authority granted by this Demonstration. Those groups made eligible by virtue of the expenditure authorities expressly granted in this Demonstration are subject to Medicaid laws, regulations and policies, except as expressly identified as not applicable under expenditure authority granted in this Demonstration. Table 2 below describes the eligibility groups that are mandatory and voluntary enrollees into managed care. Delivery system participation in the various Service Areas is subject to the implementation schedule and Readiness Review requirements described earlier in this Section. A STAR+PLUS member who enters a nursing facility remains in STAR+PLUS for four months, but the nursing facility services are paid through FFS.

Table 2. State Plan Populations Affected by the Demonstration

| Table 2: State Plan Populations Affected by the Demonstration | | | | | | |
|--|--|--|-------------|-----------|-----------|-----------|
| A=STAR Start of Demo; B = STAR+PLUS Start of Demo; C = STAR March 2012; D = STAR March 2012 (MRSA); E = STAR+PLUS March 2012 | | | | | | |
| Medicaid | Description and Medicaid | Income Limit and | STAR | | STAR+ | |
| | | | Mandatory | Voluntary | Mandatory | Voluntary |
| <u>Low Income Families</u> §1931 low income families | §1902(a)(10)(A)(i)(I) <u>MEG</u> : Adults (parents and caretaker relatives) OR Children (dependent children) | 14% FPL (uses AFDC limits); \$2,000/\$3,000 if an aged or disabled member meets relationship requirement | A C D | | | |

| Medicaid | Description and Medicaid | Income Limit and | STAR | | STAR+ | |
|--|---|--|-------------|-----------|-----------|-----------|
| | | | Mandatory | Voluntary | Mandatory | Voluntary |
| <u>Earnings Transitional</u> Twelve months TMA from increase in earnings, combined increase in earnings and child support, or loss of 90% earned income disregard | Individuals who lose eligibility under §1931 due to increase in income or new employment or loss of earned income disregards; §1902(a)(52) MEG: Adults (parents and caretaker relatives) OR Children (dependent children) | 185% FPL; No resource test | A C D | | | |
| <u>Child Support Transitional</u> Four months post Medicaid resulting from child support | Individuals who lose eligibility under §1931 due to child or spousal support; §1902(a)(10)(A)(i)(I) MEG: Adults (parents and caretaker relatives) OR Children (dependent children) | N/A; No resource test | A C D | | | |
| <u>Poverty Level Pregnant Women</u> | §1902(a)(10)(A)(i)(IV), §1902(l)(1)(A) MEG: Adults | 185% FPL; No resource test | A C D | | | |
| <u>Children Under 1</u> Poverty level infants | §1902(a)(10)(A)(i)(IV), §1902(l)(1)(B) MEG: Children | 185% FPL; \$2,000/\$3,000 if aged or disabled member meets relationship requirement | A C D | | | |
| <u>Newborn Children</u> Children to age one born to Medicaid eligible mother | Deemed Newborn – mother was eligible for and received Medicaid for the birth; §1902(e)(4), 42 CFR §435.117 MEG: Children | N/A; No resource test | A C D | | | |
| <u>Children Age 1-5</u> | Poverty level children under 6; §1902(a)(10)(A)(i)(VI), §1902(l)(1)(C) MEG: Children | 133% FPL; \$2,000/\$3,000 if aged or disabled member meets relationship requirement | A C D | | | |
| <u>Children Age 6-18</u> | Poverty level children under 19; §1902(a)(10)(A)(i)(VII), §1902(l)(1)(D) MEG: Children | 100% FPL; \$2,000/\$3,000 if aged or disabled member meets relationship requirement | A C D | | | |
| <u>SSI Recipient 21 and older with</u> | Individuals receiving SSI cash benefits; §1902(a)(10)(A)(i)(II) | 74% FPL (SSI Limit); \$2,000 individual, | | | B E | |

| A=STAR Start of Demo; B = STAR+PLUS Start of Demo; C = STAR March 2012; D = STAR March 2012 (MRSA); E = STAR+PLUS March 2012 | | | | | | |
|---|--|---|-----------|-----------|-----------|-----------|
| Medicaid Eligibility Group | Description and Medicaid Eligibility Group (MEG) | Income Limit and Resource Standards | STAR | | STAR+ | |
| | | | Mandatory | Voluntary | Mandatory | Voluntary |
| <u>Medicare (Dual)</u> | §1902(a)(10)(A)(i)(II)(cc) Covers gap month children within the waiver; however, retroactive payments, including payment for the gap month, are paid via FFS MEG: AMR | \$3,000 couple | | | | |
| <u>SSI Recipient under 21 with Medicare (Dual)</u> | Individuals receiving SSI cash benefits; §1902(a)(10)(A)(i)(II) §1902(a)(10)(A)(i)(II)(cc). Covers gap month children within the waiver; however, retroactive payments, including payment for the gap month, are paid via FFS MEG: AMR | 74% FPL (SSI Limit); \$2,000 individual, \$3,000 couple | | | | B E |
| <u>SSI Recipient without Medicare 21 and older</u> | Individuals receiving SSI cash benefits; §1902(a)(10)(A)(i)(II). §1902(a)(10)(A)(i)(II)(cc). Covers gap month children within the waiver; however, retroactive payments, including payment for the gap month, are paid via FFS MEG: Disabled | 74% FPL (SSI Limit); \$2,000 individual, \$3,000 couple | D | A | B E | |
| <u>SSI Recipient without Medicare under 21</u> | Individuals receiving SSI cash benefits; §1902(a)(10)(A)(i)(II) §1902(a)(10)(A)(i)(II)(cc) Covers gap month children within the waiver; however, retroactive payments, including payment for the gap month, are paid via FFS MEG: Disabled | 74% FPL (SSI Limit); \$2,000 individual, \$3,000 couple | | A D | | B E |
| <u>Pickle Group 21 and older, with Medicare</u> Includes pre-Pickle eligibility group | Would be eligible for SSI if Title II COLAs deducted from income; 42 CFR §§435.134, 435.135 MEG: AMR | 74% FPL (SSI Limit); \$2,000 individual, \$3,000 couple | | | B E | |
| <u>Pickle Group 21 and older without Medicare</u> Includes pre-Pickle eligibility group | Would be eligible for SSI if Title II COLAs were deducted from income; 42 CFR §435.134, 42 CFR §435.135 MEG: Disabled | 74% FPL (SSI Limit); \$2,000 individual, \$3,000 couple | D | A | B E | |

A=STAR Start of Demo; B = STAR+PLUS Start of Demo; C = STAR March 2012;

| Medicaid | Description and Medicaid | Income Limit and | STAR | | STAR+ | |
|--|--|---|-----------|-----------|-----------|-----------|
| | | | Mandatory | Voluntary | Mandatory | Voluntary |
| <u>Pickle Group under 21 with Medicare</u> | Would be eligible for SSI if Title II COLAs deducted from income; 42 CFR §435.135 MEG: AMR | 74% FPL (SSI Limit); \$2,000 individual, \$3,000 couple | | | | B E |
| <u>Pickle Group under 21 without Medicare</u> | Would be eligible for SSI if Title II COLAs deducted from income; 42 CFR §435.135 MEG: Disabled | 74% FPL (SSI Limit); \$2,000 individual, \$3,000 couple | | A D | | B E |
| <u>Disabled Adult Children (DAC) 21 or over with Medicare</u> | §1635(c); §1935 MEG: AMR | 74% FPL (SSI Limit); \$2,000 individual, \$3,000 couple | | | B E | |
| <u>Disabled Adult Children (DAC) 21 or over without Medicare</u> | §1635(c); §1935 MEG: Disabled | 74% FPL (SSI Limit); \$2,000 individual, \$3,000 couple | D | A | B E | |
| <u>DAC under 21 with Medicare</u> | §1635(c); §1935 MEG: AMR | 74% FPL (SSI Limit); \$2,000 individual, \$3,000 couple | | | | B E |
| <u>DAC under 21 without Medicare</u> | §1635(c); §1935 MEG: Disabled | 74% FPL (SSI Limit); \$2,000 individual, \$3,000 couple | | A D | | B E |
| <u>Disabled Widow(er)</u> | Widows/Widowers, 1634(b); §1935 MEG: Disabled | 74% FPL (SSI Limit); \$2,000 individual, \$3,000 couple | D | A | B E | |
| <u>Early Aged Widow(er)</u> | Early Widows/Widowers, 1634(d); §1935 MEG: Disabled | 74% FPL (SSI Limit); \$2,000 individual, \$3,000 couple | D | A | B E | |
| <u>SSI Denied Children with Medicare, under age 19</u> | Children no longer eligible for SSI because of change in definition of disability; §1902(a)(10)(A)(i)(II) MEG: AMR | 74% FPL (SSI Limit); \$2,000 individual, \$3,000 couple | | | | B E |
| <u>SSI Denied Children without Medicare, under age 19</u> | Children no longer eligible for SSI because of change in definition of disability; §1902(a)(10)(A)(i)(II) MEG: Disabled | 74% FPL (SSI Limit); \$2,000 individual, \$3,000 couple | | A D | | B E |
| <u>Medicaid Buy-In (MBI) with Medicare</u> | BBA Work Incentives Group; §1902(a)(10)(ii)(XIII) MEG: AMR | 250% FPL; \$2,000 | | | B E | |
| <u>Medicaid Buy-In</u> | BBA Work Incentives Group; | 250% FPL; \$2,000 | D | A | | B |

A=STAR Start of Demo; B = STAR+PLUS Start of Demo; C = STAR March 2012;

| Medicaid | Description and Medicaid | Income Limit and | STAR | | STAR+ | |
|---|---|---|-----------|-----------|-----------|-----------|
| | | | Mandatory | Voluntary | Mandatory | Voluntary |
| <u>(MBI) without Medicare</u> | §1902(a)(10)(ii)(XIII) MEG: Disabled | | | | | E |
| <u>Medicaid Buy-In for Children (under age 19) with Medicare</u> | Family Opportunity Act (MBIC), §1902(a)(10)(A)(ii)(XIX) MEG: AMR | 300% FPL; No resource standard | | | | B E |
| <u>Medicaid Buy-In for Children (under age 19) without Medicare</u> | Family Opportunity Act (MBIC), §1902(a)(10)(A)(ii)(XIX) MEG: Disabled | 300% FPL; No resource standard | | A D | | B E |
| <u>Nursing Facility</u> | Special income level group, in a medical institution for at least 30 consecutive days with gross income that does not exceed 300% of the SSI income standard; §1902(a)(10)(A)(ii)(V) MEG: AMR (with Medicare) OR Disabled (without Medicare) | 300% SSI or Approx. 220% FPL; \$2,000 individual/ \$3,000 couple | D | | B E | |
| <u>217-Like Group</u> Categorically needy individuals under the State plan receiving HCBS services (of the kind listed in Table 4) in the STAR+PLUS service areas. | Institutional eligibility and post-eligibility rules for individuals who would only be eligible in the same manner as specified under 42 CFR 435.217, 435.236, and 435.726 and §1924 of the Act, if the State had not eliminated its 1915(c) waivers. MEG: Disabled (without Medicare) | 300% SSI or Approx. 220% FPL; \$2,000 individual/\$3,000 couple. Use spousal impoverishment policy for eligibility, but not for post-eligibility. | D | | | |

29. Demonstration Expansion Population – STAR+PLUS 217-Like Eligibility Group

| Expansion | Description and MEG | Income Limit and | STAR | | STAR+ | |
|--|--|------------------------------|-----------|-----------|-----------|-----------|
| | | | Mandatory | Voluntary | Mandatory | Voluntary |
| <u>217-Like Group</u> Categorically needy individuals under the | Institutional eligibility and post-eligibility rules for individuals who would only be | 300% SSI or Approx. 220% FPL | | | B E | |

| Expansion Eligibility Group | Description and MEG | Income Limit and Resource Standards | STAR | | STAR+ | |
|--|---|-------------------------------------|-----------|-----------|-----------|-----------|
| | | | Mandatory | Voluntary | Mandatory | Voluntary |
| State plan receiving HCBS services (of the kind listed in Table 4) in the STAR+PLUS service areas. | eligible in the same manner as specified under 42 CFR 435.217, 435.236, and 435.726 and §1924 of the Act, if the State had not eliminated its 1915(c) STAR+PLUS waivers. <u>MEG:</u> AMR (with Medicare) OR Disabled (without Medicare) | | | | | |

30. Populations Excluded from the Demonstration. The following populations receive Medicaid services outside of 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's Health Program (women receiving a family planning benefit through a separate section 1115 demonstration);
- d. Women in the Breast and Cervical Cancer Program;
- e. Residents in Intermediate Care Facilities for Persons with Mental Retardation (ICF/MRs)
- f. Undocumented or Ineligible (5-year bar) Aliens only eligible for emergency medical services; and
- g. Persons who have resided in a nursing facility for more than four months.

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

31. Enrollment.

- a. **Time to Choose a Plan.** Prior to March 1, 2012, potential beneficiaries, excluding pregnant women, will have 30 days to choose a managed care organization. Pregnant women will have 16 days to choose a managed care organization. Beginning March 1, 2012, these timeframes will change. All beneficiaries will have 15 days to choose a managed care organization.
- b. **Auto-Assignment.** If a potential beneficiary does not choose a managed care organization within the time frames defined in (a), he or she may be auto-assigned to a managed care organization. When possible, the auto-assignment algorithm shall take into consideration the beneficiary's history with a primary care provider. If this is not possible the State will equitably distribute beneficiaries among qualified MCOs.
- c. The State may automatically re-enroll a beneficiary in the same managed care organization if there is a loss of Medicaid eligibility for six months or less.

32. Disenrollment. Individuals should be informed of opportunities no less than annually for disenrollment and ongoing plan choice opportunities, regularly and in a manner consistent with 42 CFR 438 and other requirements set forth in the Demonstration Special Terms and Conditions.

The State has a lock-in period (i.e. requires continuous enrollment with an MCO) of twelve (12) months. The State assures it meets the requirements of 42 CFR 438.56, and allows an enrollee to request disenrollment during the lock-in period under the circumstances described in 42 C.F.R. §438.56(c), and Texas Government Code § 533.0076.

- a. **Transfer at Request of Beneficiary.** Beneficiaries may request transfer to another managed care organization in the service area through the enrollment broker. Recipients that are voluntary for any of the Medicaid managed care programs may request disenrollment and return to traditional Medicaid. Mandatory recipients must request disenrollment from one MCO in writing to HHSC; however, HHSC considers disenrollment only in rare situations, when sufficient medical documentation establishes that the MCO cannot provide the needed services. An authorized HHSC representative reviews all disenrollment requests, and processes approved requests for disenrollment from an MCO. The Enrollment Broker provides disenrollment education and offers other options as appropriate.
- b. **Transfer at Request of MCO.** A managed care organization has a limited right to request a beneficiary be disenrolled from the managed care organization without the beneficiary's consent. HHSC must approve any managed care organization request for disenrollment of a beneficiary for cause. HHSC may permit disenrollment of a beneficiary under the following circumstances:
 - i. The beneficiary misuses or loans his or her managed care organization membership card to another person to obtain services; or

- ii. The beneficiary is disruptive, unruly, threatening or uncooperative to the extent that his or her membership seriously impairs the MCO's or provider's ability to provide services to the beneficiary, or to obtain new beneficiaries, and the beneficiary's behavior is not caused by a physical or behavioral health condition; or
- iii. The beneficiary consistently refuses to comply with managed care restrictions (e.g., repeatedly using the emergency room in combination with refusing to allow the managed care organization to treat the underlying medical condition);
- iv. For STAR+PLUS managed care organizations, under limited conditions, the managed care organization may request disenrollment of beneficiaries who are totally dependent on a ventilator or who have been diagnosed with End Stage Renal Disease. Services are provided to these beneficiaries through FFS.

The managed care organization must take reasonable measures to correct the beneficiary's behavior prior to requesting disenrollment. Reasonable measures may include providing education and counseling regarding the offensive acts or behaviors. HHSC must notify the beneficiary of HHSC's decision to disenroll the beneficiary, if all reasonable measures have failed to remedy the problem. If the beneficiary disagrees with the decision to disenroll the beneficiary from the managed care organization, HHSC must notify the beneficiary of the availability of the complaint procedure and HHSC's fair hearing process. The managed care organization cannot request a disenrollment based on adverse change in the member's health status or utilization of services that are medically necessary for treatment of a member's condition.

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. 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 | Description |
|-----------------|--|-----------------------|
| Adult/Child | Inpatient Hospital Services* | 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 | | Description |
|----------------------|--|---|
| Adult/Child | | 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) | Optional §1927(d) |
| Adult/Child | Non-prescription drugs (beginning March 1, 2012) | Optional §1927(d) |
| 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 | Nursing facility services for enrollees age 21 and older – 4 month service limitation | Mandatory §1905(a)(4) |
| Child | Inpatient psychiatric family services for individuals under age 22 | Optional §1905(a)(16) |
| Adult (STAR+PLUS) | Rehabilitative Services – Day Activity & Health Services | Optional, Rehabilitation Service, 42 CFR 440.130(d) |
| 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 |

*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.

34. Self-Referral. Demonstration beneficiaries may self-refer for the following services:

- a. In-network behavior health services;
- b. Obstetric and gynecological services, regardless of whether the provider is in the client's MCO network;
- c. In-network eye health care services, including optometry and ophthalmology;
- d. Family planning services, regardless of whether the provider is in the client's MCO network; and
- e. Services from a provider with the Early Childhood Intervention program for children ages 0-3 years with a developmental delay.

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.

36. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). The MCOs will fulfill the State's responsibilities for coverage, outreach, and assistance with respect to EPSDT services that are described in the requirements of sections 1905(a)(4)(b) (services), 1902(a)(43) (administrative requirements), and 1905(r) (definitions).

37. Marketing and Information. The State may permit indirect marketing by MCOs, including: radio, TV, billboard, bus signs, bench displays, newspaper, decals, and banners. Direct mail marketing is prohibited, with the exception of direct marketing conducted during HHSC-approved enrollment events. HHSC's managed care contracts and Uniform Managed Care Manual must include restrictions on offering gifts and other incentives to potential enrollees, and reporting and investigating alleged marketing violations.

- a. The State must require MCOs to translate marketing materials into languages of major population groups that comprise 10 percent or more of the population.
- b. All information provided to enrollees, inclusive of, and in addition to, educational materials, enrollment and disenrollment materials, benefit changes, and explanations and other communication, must fully comport with 42 CFR 438.10, and be accessible and understandable to individuals enrolled or potentially enrolled in the Demonstration.

38. Fair Hearing Procedures. For standard appeals, members have a right to access the fair hearing process at any time. For expedited appeals, members must exhaust the MCO's expedited appeals process before making a request for an expedited HHSC fair hearing.

39. STAR and STAR+PLUS (non-HCBS) Reporting Requirements. The State will be required to report to CMS the following topics within each report. Each report topic should include a brief description of the findings (if reported by MCOs as required under contract), any problems found, and any corrective action plans put in place either at the plan level or the State level to address the issues.

- a. Quarterly Progress Report – Provider termination rates (including primary care physicians and types of specialists) and reasons for termination; customer service reporting, including average speed of answer at the plans and call abandonment rates; Medicaid managed care helpline findings, MCO network adequacy reporting through Enrollment Broker reporting; and MCO compliance with access time/distance standards, including Geo Access mapping through HHSC Strategic Division Support.
- b. Bi-annual (Every Other Quarterly Progress Report) – Disenrollment requests by enrollees or the plans; summary of MCO appeals for the quarter; and outcomes of claims summary reporting including timeliness in processing claims, accuracy and any possible fraud and abuse detected, enrollment into managed care for people with special health care needs.
- c. Annual Report – CAHPS survey (for STAR or STAR+PLUS depending on the availability of the survey data), including report on provider wait times or appointment scheduling times; annual summary of network adequacy by plan, as specified in paragraph 27(e)(1), MCO compliance with provider 24/7 availability; summary of outcomes of any reviews or studies, including focused studies, External Quality Reviews, financial reviews, or other types of reviews or studies conducted by the State or a contractor of the State, as feasible and appropriate.

E. CHILDREN’S DENTAL PROGRAM

40. Implementation of the Children’s Dental Program. As of March 2012 (subject to the CMS readiness review, as discussed in STC 18), children’s primary and preventive Medicaid dental services shall be delivered through a capitated statewide dental services program (the Children’s Dental Program). Contracting dental maintenance organizations (DMOs) will develop networks of Main Dental Home providers, consisting of general dentists and pediatric dentists. The dental home framework under this statewide program shall be informed by the improved dental outcomes evidenced under the “First Dental Home Initiative” in the State. Services provided through the Children’s Dental Program are separate from the medical services provided by the STAR and STAR+PLUS managed care organizations, and are available to persons listed in Table 2 who are under age 21, with the exception of the groups listed in (b) below. The Children’s Dental Program must conform to all applicable regulations governing prepaid ambulatory health plans (PAHPs), as specified in 42 C.F.R. 438.

- a. The following Medicaid recipients are excluded from the Children’s Dental Program, and will continue to receive their Medicaid dental services outside of the Demonstration: Medicaid recipients age 21 and over; all Medicaid recipients, regardless of age, residing

in Medicaid-paid facilities such as nursing homes, state supported living centers, or Intermediate Care Facilities for Mentally Retarded Persons (ICF/MR); and STAR Health Program recipients.

- b. Implementation of the Children's Dental Program is subject to the State demonstrating sufficient network adequacy, in accordance with the requirements and deliverables provided in paragraph 22(b) of these STCs, except that subparagraph 22(b)(iv) does not apply, and (to the extent that it cross-references requirements relating to primary care providers and pharmacy services in STC 24(e)) subparagraph 22(b)(v) does not apply. In addition, for purposes of this paragraph 40(b), references to the STAR and STAR+PLUS programs in paragraphs 22(b) and 24(e) are replaced with the Children's Dental Program. CMS acknowledges that the State already has submitted the readiness review deliverables due November 3, 2011.
- c. The State will continue to hold quarterly meetings with dental stakeholders, including dental care providers, as required under the *Frew* consent decree. The State will collect relevant data from each DMO to comply with CMS-416 reporting requirements.

**F. STAR+PLUS HOME AND COMMUNITY BASED SERVICES (HCBS)
ENROLLMENT, BENEFITS AND REPORTING REQUIREMENTS**

41. Operations of the STAR+PLUS HCBS Program

- a. **Compliance with Specified HCBS Requirements.** All Federal regulations that govern the provision of HCBS under section 1915(c) waivers shall apply to the HCBS program authorized under section 1115, and provided through STAR+PLUS. The State shall include a description of the steps taken to ensure compliance with these regulations as part of the Annual Report discussed in paragraph 67. HCBS, under the Demonstration, shall operate in accordance with these STCs and associated attachments. As of the initial approval of this Demonstration, these STCs define an HCBS program that operates in the same manner as under the approved section 1915(c) waiver authorities that were transferred to this Demonstration.
- b. **Regional Rollout and Transition of the Demonstration and Concurrent Ending of the section 1915(c) Waivers.**
 - i. The State must provide notice to STAR+PLUS HCBS participants residing in Column B counties (see Table 1) that the authority for such services is transferring from a section 1915(c) waiver authority to the Demonstration, that no action is required on behalf of the beneficiary, and that there is no disruption or changes to services. Such notice must be provided to said beneficiaries prior to the transfer of waiver authorities from section 1915(c) to the section 1115 Demonstration.
 - ii. The State may implement STAR+PLUS in Column E counties that are not Column B counties (see Table 1) no earlier than March 1, 2012.

- iii. The State must provide notice and any outreach and educational materials to all individuals currently enrolled in the section 1915(c) waiver known as Community Based Alternatives (control number 0266) that reside in Column E counties that are not Column B counties (see Table 1) where the Community Based Alternatives will terminate, and be replaced with the STAR+PLUS HCBS program. Such notice must be provided no later than 30 days prior to the transfer of waiver authorities from 1915(c) to the 1115 Demonstration. The transition plan for this population must be submitted to CMS as part of the Readiness Review specified in paragraph 22.
 - iv. The State must maintain the section 1915(c) waiver in those regions where the STAR+PLUS program has not been implemented.
 - v. Per an amendment and phase-out schedule for the section 1915(c) waiver, the State must simultaneously cease operation of the section 1915(c) waiver for persons who are elderly and/or disabled in the region in which the STAR+PLUS program is being implemented, in accordance with established requirements.
- c. **Determination of Benefits by Designation into a STAR+PLUS HCBS Group.** The STAR+PLUS HCBS Program provides long-term care services and supports as identified in Table 4 to two groups of people, as defined below:
- i. **STAR+PLUS 217-Like HCBS Group.** This group consists of persons age 65 and older, and adults age 21 and older, with physical disabilities who meet the NF level of care (LOC), who qualify as members of the 217-Like HCBS Group, and who need and are receiving HCBS as an alternative to NF care. The Demonstration population includes persons who could have been eligible under 42 CFR 435.217 had the State continued its section 1915(c) HCBS waiver for persons who are elderly and/or physically disabled.
- (A) **Interest List for STAR+PLUS 217-LIKE HCBS Group.** The State will operate an interest list for the STAR+PLUS 217-Like HCBS population in the Demonstration that follows the same protocol as the interest list used for the section 1915(c) waiver (TX 0862) that was subsumed under the Demonstration. An interest list is a waiting list that an individual is placed on when they express interest in enrollment, to the State or local agency that determines eligibility for STAR +PLUS. Individuals meeting all eligibility criteria are enrolled into this population on a “first-come, first-served” basis, except that persons entering the Demonstration through Money Follows the Person (MFP) are placed at the head of the interest list. These lists must be managed on a statewide basis using a standardized assessment tool, and in accord with criteria established by the State. Interest list policies must be based on objective criteria and applied consistently in all geographic areas served. Persons living in the service areas provided in Column B of Table 1 that are on an interest list for the CBA 1915(c) waiver

program at the time of transition to STAR+PLUS must be included in the STAR+PLUS interest list, and be offered enrollment in the same priority order as would have occurred if STAR+PLUS had been in place at the time of their initial application.

- (B) **Unduplicated Participant Slots for the 217-Like HCBS Group.** The following Table specifies the unduplicated number of participants for the 217-Like Group. The October 2011 – February 2012 column reflects the following: (1) the number of unduplicated participant slots transferred from the STAR+PLUS 1915(c) waiver, TX 0862; (2) the 515 unduplicated participant slots transferred from the from the Community Based Alternatives (CBA) 1915(c) waiver, TX 0266; (3) individuals released from the interest list; and (4) individuals discharged from institutional care who are in the Money Follows the Person (MFP) demonstration, in the areas of the State where the managed care expansion occurred on September 1, 2011. The March 2012 – September 2016 column reflects: (1) the 3,549 unduplicated participant slots transferred from the CBA 1915(c) waiver upon expansion of STAR+PLUS; (2) individuals released from the interest list; and (3) individuals discharged from institutional care who are in the MFP demonstration.

| Unduplicated Number of Participants for the STAR+PLUS 217-Like HCBS Group | | | |
|--|-------|-----------------------------|--------|
| October 2011-February 2012 | | March 2012 – September 2016 | |
| DY 1 | 8,794 | DY 1 | 12,592 |
| DY 2 | 9,064 | DY 2 | 13,079 |
| DY 3 | 9,347 | DY 3 | 13,602 |
| DY 4 | 9,644 | DY 4 | 14,146 |
| DY 5 | 9,957 | DY 5 | 14,712 |

- ii. **SSI-Related Eligibles.** Persons age 65 and older, and adults age 21 and older, with physical disabilities that qualify as SSI eligibles and meet the NF LOC as defined by the State. The October 2011 – February 2012 column reflects the following: (1) the number of unduplicated participant slots transferred from the STAR+PLUS 1915(c) waiver, TX 0325; (2) the 1,093 unduplicated participant slots transferred from the CBA 1915(c) waiver; and (3) individuals discharged from institutional care who are in the Money Follows the Person (MFP) demonstration, in the areas of the State where the managed care expansion occurred on September 1, 2011. The March 2012 – September 2016 column reflects the 7,348 unduplicated participant slots transferred from the CBA 1915(c) waiver upon expansion of STAR+PLUS, as well individuals discharged from institutional care in the MFP demonstration.

| |
|---|
| Unduplicated Number of Participants for the SSI-Related Eligible Group |
|---|

| October 2011-February 2012 | | March 2012 – September 2016 | |
|----------------------------|--------|-----------------------------|--------|
| DY 1 | 16,587 | DY 1 | 22,923 |
| DY 2 | 18,909 | DY 2 | 25,472 |
| DY 3 | 21,558 | DY 3 | 28,783 |
| DY 4 | 24,575 | DY 4 | 32,525 |
| DY 5 | 28,015 | DY 5 | 36,754 |

- d. **Eligibility for STAR+PLUS HCBS Benefits.** Individuals can be eligible for HCBS under STAR+PLUS depending upon their medical and / or functional needs, financial eligibility designation as a member of the 217-Like STAR+PLUS HCBS Group or an SSI-related recipient, and the ability of the State to provide them with safe, appropriate, and cost-effective LTC services.
- (A) Medical and / or functional needs are assessed according to LOC criteria published by the State in State rules. These LOC criteria will be used in assessing eligibility for STAR+PLUS HCBS benefits through the 217-Like or SSI-related eligibility pathways.
- (B) For an individual to be eligible for HCBS services, the State must have determined that the individual's cost to provide services is equal to or less than 202% of the cost of the level of care in a nursing facility.
- e. **Freedom of Choice.** The service coordinators employed by the managed care organizations must be required to inform each applicant or member of any alternatives available, including the choice of institutional care versus home and community based services, during the assessment process. The Freedom of Choice Form must be incorporated into the Service Plan. The applicant or member must sign this form to indicate that he or she freely chooses waiver services over institutional care. The managed care organization's service coordinator also addresses living arrangements, choice of providers, and available third party resources during the assessment.
- f. **Service Plan.** In accordance with 42 CFR § 441.301(b)(1)(i), a participant-centered service plan of care must be developed for each participant. All waiver services must be furnished pursuant to the service plan, according to the projected frequency and type of provider. The service plan must also describe the other services, regardless of the funding source, and the informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the HHSC. Federal financial participation (FFP) may not be claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.
- g. **Benefit Package under the STAR+PLUS HCBS Program.** The following Table 4.a describe the benefits available to HCBS participants, whether in the 217-Like HCBS

Group or the SSI-related group, that are provider-directed and, if the participant elects the option, self-directed. The services are further defined in Attachment C.

Table 4. a HCBS Services

| Service | Provider Directed | Participant Directed |
|---------------------------------------|-------------------|----------------------|
| Personal Assistance Service | X | X |
| Respite | X | X |
| Financial Management Services | X | |
| Support Consultation | X | X |
| Adaptive Aids and Medical Supplies | X | |
| Adult Foster Care | X | |
| Assisted Living | X | |
| Dental Services | X | |
| Emergency Response Services | X | |
| Home Delivered Meals | X | |
| Minor Home Modifications | X | |
| Nursing | X | X |
| Occupational Therapy | X | X |
| Physical Therapy | X | X |
| Speech, Hearing, and Language Therapy | X | X |
| Transition Assistance Services | X | |

The following Table 4.b describe the benefits available to HCBS participants in 217 like group only. This service will be for those individuals who are eligible for the HCBS STAR+PLUS Waiver and exceed the financial requirements for Day Activity and Health Services under the 1915(i) authority.

| Service | Provider Directed | Participant Directed |
|------------------------------------|-------------------|----------------------|
| Personal Assistance Service | X | X |
| Respite | X | X |
| Financial Management Services | X | |
| Support Consultation | X | X |
| Adaptive Aids and Medical Supplies | X | |
| Adult Foster Care | X | |
| Assisted Living | X | |
| Dental Services | X | |
| Emergency Response Services | X | |
| Home Delivered Meals | X | |
| Minor Home Modifications | X | |
| Nursing | X | X |
| Occupational Therapy | X | X |

| | | |
|---------------------------------------|---|---|
| Physical Therapy | X | X |
| Speech, Hearing, and Language Therapy | X | X |
| Transition Assistance Services | X | |
| Day Activity Health Services | X | |

- h. **Self-Direction of Home and Community Based Services.** STAR+PLUS participants who elect the self-direction opportunity will have the option to self-direct all or some of the long term services, as identified in Table 4, under the Demonstration. The services, goods, and supports that a participant self-directs will still be included in the calculations of the participant's budget. Participant's budget plans will reflect the plan for purchasing these needed services, goods, and supports.
- i. **Information and Assistance in Support of Participant Direction.** The State shall have a support system that provides participants with information, training, counseling, and assistance, as needed or desired by each participant, to assist the participant to effectively direct and manage their self-directed services and budgets. Participants shall be informed about self-directed care, including feasible alternatives, before electing the self-direction option. Participants shall also have access to the support system throughout the time that they are self-directing their care. Support activities must include, but are not limited to, financial management services and support consultation, defined as follows.
- (A) **Financial Management Services.** Financial management services provide assistance to members with managing funds associated with the services elected for self-direction. Financial management services include initial orientation and ongoing training related to responsibilities of being an employer, and adhering to legal requirements for employers. The financial management services providers, referred to as the Consumer Directed Services Agency (CDSA), serves as the member's employer-agent, which is the Internal Revenue Service's (IRS) designation of the entity responsible for making payables and withholding, and filing and depositing taxes on behalf of the members. As the employer-agent, the CDSA files required forms and reports to the Texas Workforce Commission.
- (B) **Support Consultation.** Support Consultation offers practical skills training and assistance to enable an individual to successfully direct those services the individual elects for participant-direction. This service is provided by a certified support advisor, and includes skills training related to recruiting, screening, and hiring workers, preparing job descriptions, verifying employment eligibility and qualifications, completion of documents required to employ an individual, management of workers, and development of effective back-up plans for services considered critical to the individual's health and welfare in the absence of the regular provider or an emergency situation. Support consultation is provided only

by a certified support advisor certified by the Department of Aging and Disability Services.

- ii. **Participant Direction by Representative.** The participant who self-directs one or more services may appoint a volunteer designated representative to assist with or perform employer responsibilities to the extent approved by the participant. The participant documents the employer responsibilities, and that only a non-legal representative freely chosen by the participant or legally authorized representative may serve as the designated representative to assist in performance of employer responsibilities, to the extent desired by the individual or legally authorized representative. The participant documents the employer responsibilities that the designated representative may and may not perform on the participant's behalf.
- iii. **Participant Budget Authority.** The participant's budget authority is operated and developed as follows:
 - (A) The participant has budget authority and decision-making authority over the budget to reallocate funds among services included in the budget; to determine the amount paid for services within the State's established limits; to substitute service providers and to schedule the provision of services; to specify additional service provider qualifications consistent with established criteria; to specify the provision of services consistent with service specifications in Attachment C for services that may be self-directed as specified in Table 4; to identify service providers and refer for provider enrollment; to authorize payment for waiver goods and services; and to review and approve provider invoices for services rendered.
 - (B) All participants, in conjunction with the CDSA, must develop a budget based on the service plan. The amount of funds included in the service plan is calculated by the service planning team based on the planned waiver services and the adopted reimbursement rate. The service plan is developed in the same manner for the participant who elects to have services delivered through the consumer directed services option as it is for the participant who elects to have services delivered through the traditional provider-managed option.

With approval of the CDSA, the participant may make revisions to a specific service budget that does not change the amount of funds available for the service in the approved service plan. Revisions to the service plan amount available for a particular service, or a request to shift funds from one self-directed waiver service component to another, must be justified by the participant's service planning team and authorized by the MCO.
 - (C) Modifications to the participant directed budget must be preceded by a change in the service plan.

iv. **Disenrollment from Self-Direction.** A participant may voluntarily disenroll from the self-directed option at any time and return to a traditional service delivery system. A participant may also be involuntarily disenrolled from the self-directed option for cause, if continued participation in the consumer directed services option would not permit the participant's health, safety, or welfare needs to be met, or the participant or the participant's representative, when provided with additional support from the CDSA, or through Support Consultation, has not carried out employer responsibilities in accordance with the requirements of this option. If a participant is terminated voluntarily or involuntarily from the self-directed service delivery option, the State will transition the participant to the traditional agency direction option and will have safeguards in place to ensure continuity of services.

i. **Fair Hearing.** For standard appeals, members have a right to access the fair hearing process at any time. For expedited appeals, members must exhaust the MCO's expedited appeals process before making a request for an expedited HHSC fair hearing. Procedures related to fair hearings are described in Attachment F.

j. **Participant Safeguards.** The State must follow all member safeguard procedures as described in Attachment G of these STCs.

42. Quality Improvement Strategy for the STAR+PLUS HCBS Program. The State will abide by the Quality Improvement Strategy that existed under the section 1915(c) waivers under the STAR+PLUS program prior to this Demonstration. The Quality Improvement Strategy is described in detail in Attachments D and E. This Quality Improvement Strategy will remain in full force until CMS approves the comprehensive quality strategy described in paragraph 27.

VI. FUNDING POOLS UNDER THE DEMONSTRATION

The terms and conditions in Section VI apply to the State's exercise of the following Expenditure Authorities: (5) Expenditures Related to the Uncompensated Care Pool, (6) Expenditures Related to Transition Payments, and (7) Expenditures Related to the Delivery System Incentive Reform Payment (DSRIP) Pool.

43. Terms and Conditions Applying to Pools Generally.

- a. The non-Federal share of pool payments to providers may be funded by state general revenue funds, transfers from units of local government, and certified public expenditures that are compliant with section 1903(w) of the Act. Any payments funded by intergovernmental transfers must remain with the provider, and may not be transferred back to any unit of government.
- b. The State must inform CMS of the funding of all payments from the pools to hospitals or other providers through a quarterly payment report to be submitted to CMS within 60

days after the end of each quarter, as required under paragraph 66 of the STCs. This report must identify the funding sources associated with each type of payment received by each provider.

- c. By December 31, 2011, the State must submit Medicaid State plan amendments to CMS to remove all supplemental payments for inpatient hospital, outpatient hospital, and physician services from its State plan, with an effective date of October 1, 2011.
- d. The State will ensure that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope or quality of services available under the State plan or this Demonstration. The preceding sentence is not intended to preclude the State from modifying the Medicaid benefit through the State Plan amendment process.

44. Uncompensated Care (UC) Pool. Payments from this pool will help defray uncompensated costs of care provided to Medicaid or Demonstration eligibles or to individuals who have no source of third party coverage, for the services provided by hospitals or other providers, as discussed below. Two types of payments can be made from the UC Pool: (1) UC Payments (described in subparagraph (a) below), and, (2) in DY 1 only, Transition Payments (described in (b) below). Annual UC payments are limited to the annual amounts identified in paragraph 46.

- a. **UC Payments.** Funds may be used to defray the actual uncompensated cost of medical services that meet the definition of “medical assistance” contained in section 1905(a) of the Act, that are provided to Medicaid eligible or uninsured individuals incurred by hospitals, clinics, or by other provider types, as agreed upon by CMS and the State and defined at subparagraph (iv) below. Expenditures must be claimed in accordance with CMS-approved claiming protocols for each provider type and application form in Attachment H. FFP is not available for any UC Payments other than Transition Payments in DY 1 prior to CMS approval of the claiming protocol and application for that particular provider type for which payments are sought. For any provider seeking to receive UC Payments in DY1, the total payment under the Medicaid State plan, Disproportionate Share Hospital (DSH) allotment, UC Payments, and Transition Payments cannot exceed the actual cost of providing services to Medicaid beneficiaries and the uninsured as defined in the cost claiming protocol.
- i. **UC Application.** To qualify for a UC Payment, a hospital must submit to the State an annual UC Application that will collect cost and payment data on services eligible for reimbursement under the UC Pool. Data collected from the application will form the basis for UC Payments made to individual hospitals. The State must require hospitals to report data in a manner that is consistent with the Medicare 2552-96 cost report, or for non-hospital providers, a CMS-approved cost report consistent with Medicare cost reporting principles.

- (A) After CMS has approved the applicable protocol, the State may begin accepting applications from providers for UC Payments in DY 1. Thereafter, hospitals are required to submit their UC Applications to the State by September 30 of each year, in order to qualify for a UC Pool payment for the DY that begins on October 1st.
- (B) Cost and payment data included on the application must be based on the Medicare 2552-96 cost report, or for non-hospital providers, a CMS-approved cost report consistent with Medicare cost reporting principles for a Federal fiscal year (FFY) that is two years prior to the DY in which UC Payments are to be made, in order to allow time for hospitals to finalize their cost reports from that data year and submit their application data to HHSC. (For example, FFY 2010 would be the data year for UC Payments under the UC pool in DY 1.) The State may trend the data to model costs incurred in the year in which payments are to be made. Subsequent DY applications will be used to reconcile estimates for prior years. For example, uncompensated care cost data from a DY 3 application will be used to determine the actual uncompensated care for DY 1 UC Payments for a qualifying hospital. Any overpayments identified in the reconciliation process that occurred in a prior year must be recouped from the provider, with the FFP returned to CMS. During the reconciliation process, if a provider demonstrates that it has allowable uncompensated costs consistent with the protocol that were not reimbursed through the initial UC Payment (based on application figures), and the State has available UC Pool funding for the year in which the costs were accrued, the State may provide reimbursement for those actual documented unreimbursed UC costs through a prior period of adjustment.
- (C) Any provider that meets the criteria below may submit a UC Application to be eligible to receive a UC Payment.
- (I) Private providers must have an executed indigent care affiliation agreement on file with HHSC.
 - (II) Only providers participating in a RHP are eligible to receive a UC Payment, although exceptions may be approved by CMS on a case by case basis.
- (D) When submitting the UC Application, providers may request that cost and payment data from the data year be adjusted to reflect increases or decreases in costs, resulting from changes in operations or circumstances. A provider may request that:
- (I) Costs not reflected on the filed cost report, but which would be incurred for the spending year, be included when calculating payment amounts; or

- (II) Costs reflected on the filed cost report, but which would not be incurred for the spending year, be excluded when calculating payment amounts.

Adjustments described in subparagraphs (I) and (II) above cannot be considered as part of the application for reconciliation of a prior year payment. Such costs must be properly documented by the provider, and are subject to review by the State. Such costs are subject to reconciliation to future year applications to ensure that providers actually incurred such eligible uncompensated costs.

- (E) All applicable inpatient and outpatient hospital UC payments, including Transition Payments, received by a hospital provider count as title XIX revenue, and must be included as offsetting revenue in the State's annual DSH audit reports. Providers receiving both DSH and UC Payments cannot receive total payments under the State plan and the UC Pool (related to inpatient and outpatient hospital services) that exceed the hospital's total eligible uncompensated costs. UC Payments for physicians, non-physician professionals, pharmacy, and clinic costs are not considered inpatient or outpatient Medicaid payments for the purpose of annual hospital specific DSH limits and the DSH audit rule. All reimbursements must be made in accordance with CMS approved cost-claiming protocols that are consistent with the Medicare 2552-96 cost report or, for non-hospital providers, a CMS approved cost report consistent with Medicare cost reporting principles.
- ii. **UC Payment Protocol.** The State must submit for CMS approval a funding and reimbursement protocol that will establish rules and guidelines for the State to claim FFP for UC Payments. The State may not claim FFP for any UC Payments until a draft UC Protocol is submitted to CMS by March 1, 2012, and such protocol is approved by CMS. The approved UC Payment Protocol will become Attachment H to these STCs. The UC Payment Protocol must include precise definitions of eligible uncompensated provider costs and revenues that must be included in the calculation of uncompensated cost. The Protocol will also identify the allowable source documents to support costs; it will include detailed instructions regarding the calculation and documentation of eligible costs, the tool used by the State and providers to apply for UC Payments, and a timetable and reconciliation of payments against actual cost documentation. This process will align the application process (based on prior cost periods) to the reconciliation process (using the application costs from subsequent years to reconcile earlier payments). Protocols will contain not only allowable costs and revenues, it will also indicate the twelve (12) month period for which the costs will apply.

The State must submit a UC Payment Protocol for each non-hospital provider type that may seek UC payments. FFP will not be available for UC Payments made to a non-hospital provider type until a cost-claiming protocol consistent with the Medicare

2552-96 cost report or, for non-hospital providers, a CMS-approved cost report consistent with Medicare cost reporting principles.

- iii. **UC Payments in DY 1.** The State will allow eligible hospitals to submit a CMS-approved UC Application in DY 1 to be eligible for UC Payments in DY 1. Eligible hospitals that do not submit a UC Application will only be eligible for Transition Payments in DY 1, as described in section (b) below. For hospitals that submit a UC Application, the State will reconcile the Transition Payments and UC Payments made to ensure the total pool payments paid in DY 1 do not exceed the total amount of actual UC costs in that year. Hospitals that are paid based on the UC Application will be subject to the reconciliation provisions described in subsection (a)(i)(B) above. All UC and Transition Payments made for DY 1 are subject to UC Pool annual limits for DY 1.
- iv. **UC Payments to Non-Hospital Providers.** UC Payments may be provided only to the following qualifying non-hospital providers: physician practice groups, government ambulance providers, government dental providers, and other providers in rural RHPs with no public hospitals. The State cannot claim FFP for UC Payments made to providers of the types listed here until CMS has approved a funding and reimbursement protocol, which will be incorporated into Attachment H. UC Payments are considered to be Medicaid payments to providers and must be treated as Medicaid revenue when determining total Title XIX funding received, particular for any provider utilizing certified public expenditures as the non-Federal share of a Medicaid payment.
- v. **Annual Reporting Requirements for UC Payments.** The State will submit to CMS two reports related to the amount of UC Payments made from the UC Pool per Demonstration year. The reporting requirements are as follows:
 - (A) By December 31st of each Demonstration year, starting with DY 2, the State shall provide the following information to CMS:
 - (I) The UC payment applications submitted by eligible providers; and
 - (II) A chart of estimated UC Payments to each provider for a DY.
 - (B) Within ninety (90) days after the end of each Demonstration year, beginning with the end of DY 2, the State shall provide the following information to CMS:
 - (I) The UC Payment applications submitted by eligible providers;
 - (II) A chart of actual UC payments to each provider for the previous DY;

- (III) For reconciliation payments to providers, the UC payments made to the provider in the prior Demonstration year and the reconciliation costs against the actual payments made to said provider.
- b. **Transition Payments.** During DY 1 only, the State will make Transition Payments to hospitals and physician groups that received supplemental payments under the Medicaid State plan for claims adjudicated during FFY 2011. This transition period ensures that these providers are eligible to secure historical Medicaid funding as the State develops the pool payment methodologies. These Transition Payments are available only during DY 1 subject to UC pool annual limits for DY 1. No protocol must be approved by CMS for the State to make Transition Payments; instead, Transition Payments are subject to the following requirements:
- i. A hospital or physician group is eligible to receive Transition Payments if it:
- (A) Is enrolled as a Texas Medicaid provider;
 - (B) Received a supplemental payment under the Medicaid State plan for claims adjudicated in one or more months between October 1, 2010, and September 30, 2011;
 - (C) Has a source of intergovernmental transfer (IGT) or State general revenue appropriated as the non-federal share of the Transition Payment consistent with section 1903(w) of the Act; and
 - (D) Submitted any documentation that would have been required to receive a supplemental payment under the State Plan to HHSC before September 30, 2011, and submits any other documentation requested by HHSC.
- ii. Transition Payments will be based on the following methodology:
- (A) Participating hospitals and physician groups will be eligible to receive total Transition Payments equal to the amount the provider received in supplemental payments for claims adjudicated during FFY 2011, annualized to cover the entire twelve (12) month period of DY 1.
 - (B) Participating providers are eligible to receive one-fourth of their total Transition Payment amount each quarter in DY 1, beginning October 1, 2011, through the quarter ending September 30, 2012.
 - (C) The State must provide CMS with a list of all hospitals and physician groups that will receive Transition Payments under this section, as well as the amounts of 2011 State plan supplemental payments and 2012 (DY 1) Transition Payments.

The State must identify the source of funding for each DY 1 Transition Payment as a part of this list.

(I) The State will provide a list of estimated maximum Transition Payments within forty-five (45) days of approval of the Demonstration; and

(II) The State will provide a list of actual Transition Payments made within ninety (90) days of the end of DY 1.

- iii. For hospitals qualifying for and receiving DSH payments for FFY 2012, Transition Payments are considered title XIX payments and must be treated as revenues when determining DSH eligible uncompensated costs as part of the annual DSH audits, except for transition payments related to hospital-based physician practice groups.
- iv. The supplemental provider payments to hospitals and physicians made in November and December 2011 under the Medicaid State plan in the amount of \$466,091,028 will be considered as if they were payments under this Demonstration, and will be included in the budget neutrality test, and the amount available as payment from the UC Pool. The State may count these payments under the UC Pool limit for any of the five years of the Demonstration.
- v. The State may not receive FFP for UC Payments, other than those described here in paragraph 44(b), until the UC Protocol is approved by CMS.

45. Delivery System Reform Incentive Payment (DSRIP) Pool. The DSRIP Pool is available for the development of a program of activity that supports hospitals' efforts to enhance access to health care, the quality of care, and the health of the patients and families they serve. The program of activity funded by the DSRIP shall be based in Regional Healthcare Partnerships (RHPs) that are directly responsive to the needs and characteristics of the populations and communities comprising the RHP. Each RHP will have geographic boundaries, and will be directed and financially supported by a public hospital or a local governmental entity with the authority to make intergovernmental transfers (IGTs). In collaboration with participating providers, the public hospital or local governmental entity will develop a delivery reform and incentive plan that is rooted in the intensive learning and sharing that will accelerate meaningful improvement within the providers participating in the RHP. Individual hospitals' DSRIP proposals must flow from the RHP plans, and be consistent with the hospitals' shared mission and quality goals within the RHP, as well as CMS's overarching approach for improving health care through the simultaneous pursuit of three aims: better care for individuals (including access to care, quality of care, and health outcomes; better health for the population; and lower cost through improvement (without any harm whatsoever to individuals, families or communities).

- a. **Focus Areas.** There are 4 areas for which funding is available under the DSRIP, each of which has explicit connection to the achievement of the Three Part Aim. Projects will be

identified within the following categories, and included in the full list of projects provided in the RHP Planning Protocol, and may include projects such as those identified below within each category.

- i. **Category 1: Infrastructure Development** – This category lays the foundation for delivery system transformation through investments in technology, tools, and human resources that will strengthen the ability of providers to serve populations and continuously improve services:
 - (A) Expand primary care capacity,
 - (B) Expand behavioral healthcare capacity,
 - (C) Expand specialty care capacity,
 - (D) Expand clinical and administrative reporting systems that support quality improvement,
 - (E) Increase training of primary care workforce, and
 - (F) Expand reporting and HIT systems and capabilities.
 - ii. **Category 2: Program Innovation and Redesign** – This category includes the piloting, testing, and replicating of innovative care models:
 - (A) Primary care redesign,
 - (B) Behavioral healthcare redesign,
 - (C) Increase specialty care access/redesign referral process,
 - (D) Adoption of medical homes,
 - (E) Expansion of chronic care management models,
 - (F) Implement /expand care transition programs, and
 - (G) Implement real-time Hospital acquired Infections (HAI) system.
 - iii. **Category 3: Quality Improvements** – This category involves the broad dissemination of up to four interventions from a list of 7 – 10 interventions to be identified in the RHP Planning Protocol, described in paragraph 45(d)(ii)(A), in which major improvements in care can be achieved within four years. These are hospital- specific initiatives and will be jointly developed by hospitals, the State, and CMS and need not be uniform across all of the hospitals.
 - iv. **Category 4: Population Focused Improvements** – This category includes reporting measures across several domains selected by a RHP based on community assessments that demonstrate the impact of delivery system reform investments made in previous years under the demonstration. The domains may include:
 - (A) Patient experience,
 - (B) Preventive health,
 - (C) Care coordination, and
 - (D) At-risk groups.
- b. **Regional Healthcare Partnerships.** Regional Healthcare Partnerships will be developed throughout the State to more effectively and efficiently, deliver care and provide

increased access to care for low-income Texans. Each RHP will include a variety of healthcare providers to adequately respond to the needs of the community, and the process of forming each RHP will evidence meaningful participation by all interested providers. Each RHP will be anchored financially (i.e. single point of contact for the RHP) by a public hospital (or in areas with no public hospital, anchored financially by the governmental entity providing IGTs to support funding pool payments) that will be responsible for developing the RHP's DSRIP plan in coordination with other identified RHP providers. To the extent that the public hospital is a government entity eligible to participate in the funding of the Medicaid program, they may be the source of the non-Federal share. The RHP DSRIP plan will identify the community needs, the projects, and investments under the DSRIP to address those needs, community healthcare partners, the healthcare challenges, and quality objectives within the RHP and the metrics described in State protocol associated with each project and quality objective. These plans must be submitted to the State and CMS for approval, and must delineate total DSRIP funding associated with the plan.

- c. **Hospital DSRIP Plans within the RHP.** RHP anchoring entities providing IGT for Uncompensated Care (UC) and DSRIP Payments within an RHP will develop RHP plans in good faith, to leverage public and non-public hospital and other community resources to best achieve delivery system transformation goals within RHP areas consistent with the Demonstration's requirements. RHP plans shall include estimated funding available by year to support UC and DSRIP payments; and specific allocation of funding to UC and to DSRIP projects proposed within the RHP plan. RHP anchoring entities shall provide opportunities for public input to the development of RHP plans, and shall provide opportunities for discussion and review of proposed RHP plans prior to plan submission to the State. In accordance with the guidelines specified in the RHP Protocol, a final RHP DSRIP Plan may include, not to exceed, payment amounts for UC and DSRIP Payments. These amounts may be proportionally adjusted based on available non-Federal share.
- d. **DSRIP Pool Plan and Funding Protocol.** The State may not claim DSRIP funding until the following milestones have been met:
 - i. By March 31, 2012, the State must submit to CMS for approval a document that describes the State's plan for and status on forming the RHPs, identifying the public hospitals directing each RHP, and the general projects and quality measures to be addressed in each RHP DSRIP, and potential provider partners that will comprise the RHP.
 - ii. No later than August 31, 2012, CMS, the State and Texas hospitals will, through a collaborative process, finalize the following two protocols to implement the DSRIP program.

(A) **RHP Planning Protocol:** This protocol will include a master list of potential project/interventions for each Category 1-4 and related milestones, and metrics which RHPs may select from, in developing their 5-year plans. When developing the RHP Planning Protocol, the State should consider ways to structure the different projects that will facilitate the collection, dissemination, and comparison of valid quantitative data to support the Evaluation Design required in Section X. From these, the State must select a preferred research plan for the applicable research question, and provide a rationale for its selection. To the extent possible, RHPs should use similar metrics for similar projects across RHPs to enhance the evaluation and learning experience between RHPs. To facilitate evaluation, the RHP Planning Protocol must identify a core set of Category 3 and Category 4 metrics that all participating hospitals must be required to report. This RHP Planning Protocol will become Attachment I.

(B) **Program Funding and Mechanics Protocol:** This protocol will include information on State and CMS review and approval processes for RHP plans, RHP and State reporting requirements, incentive payment mechanisms and payment methodologies, and penalties for missed milestones. This protocol will become Attachment J.

- iii. No later than October 31, 2012, urban and rural RHPs must submit their final RHP DSRIP Plans to the State and CMS for approval. Except for Category 3 for non-hospital RHPs, the final RHP DSRIP Plans must address all four focus areas described in paragraph 45(a). The final RHP DSRIP Plan must also identify the metrics that will be used by each provider selecting that project within the RHP, so that all providers selecting a particular project or quality measure will be held to the same standard reporting requirement. The final RHP DSRIP Plan will also include payment methodologies for each metric providing an annual maximum budget for each final RHP DSRIP Plan, and penalties for missed milestones.
- iv. Payments from the DSRIP Pool may begin during DY 1, based on approved final RHP DSRIP Plans, and based on successful completion of the metrics associated with DSRIP incentive payments. The State will not claim FFP for DSRIP Payments until the RHP Planning Protocol and DSRIP Plan are approved by CMS.

- e. **DSRIP Payments are Not Direct Reimbursement for Expenditures or Payments for Services.** Payments from the DSRIP pool are intended to support and reward hospital systems and other providers for improvements in their delivery systems that support the simultaneous pursuit of improving the experience of care, improving the health of populations, and reducing per capita costs of health care. Payments from the DSRIP Pool are not considered patient care revenue, and shall not be offset against disproportionate share hospital expenditures or other Medicaid expenditures that are related to the cost of patient care (including stepped down costs of administration of such care) as defined under these Special Terms and Conditions, and/or under the State Plan.

46. Limits on Pool Payments. The total amounts that the State can claim in FFP for UC Pool and DSRIP Pool in each DY are shown in Table 5. These amounts are subject to modification as described below.

Table 5. Pool Allocations According to Demonstration Year

| Type of Pool | DY 1 (2011-2012) | DY 2 (2012- 2013) | DY 3 (2013- 2014) | DY 4 (2014-2015) | DY 5 (2015-2016) | Totals |
|-----------------|---------------------|----------------------|----------------------|---------------------|---------------------|------------------|
| UC | 3,700,000,000 | 3,900,000,000 | 3,534,000,000 | 3,348,000,000 | 3,100,000,000 | \$17,582,000,000 |
| DSRIP | 500,000,000 | 2,300,000,000 | 2,666,000,000 | 2,852,000,000 | 3,100,000,000 | \$11,418,000,000 |
| Total/DY | 4,200,000,000 | 6,200,000,000 | 6,200,000,000 | 6,200,000,000 | 6,200,000,000 | \$29,000,000,000 |
| % UC | 88% | 63% | 57% | 54% | 50% | 60% |
| % DSRIP | 12% | 37% | 43% | 46% | 50% | 40% |

The State may adopt funding pool allocations within the range identified in Tables 5 and 6 if, within DY 1, the State determines that the final RHP DSRIP Plans and associated DSRIP Payments require increased funding for the DSRIP Pool. In order to implement the alternative pool allocations across Demonstration Years provided in Table 6, the State shall submit a letter of intent to CMS during DY 1, with final amounts within the range defined by Tables 5 and 6. Any further modifications to funding pool allocations will be subject to the amendment process.

Table 6. Alternative Pool Allocations According to Demonstration Year

| Type of Pool | DY 1 (2011-2012) | DY 2 (2012- 2013) | DY 3 (2013- 2014) | DY 4 (2014-2015) | DY 5 (2015-2016) | Totals |
|-----------------|---------------------|----------------------|----------------------|---------------------|---------------------|------------------|
| UC Pool | 3,700,000,000 | 2,900,000,000 | 2,534,000,000 | 2,348,000,000 | 2,100,000,000 | \$13,582,000,000 |
| DSRIP | 500,000,000 | 3,300,000,000 | 3,666,000,000 | 3,852,000,000 | 4,100,000,000 | \$15,418,000,000 |
| Total/DY | 4,200,000,000 | 6,200,000,000 | 6,200,000,000 | 6,200,000,000 | 6,200,000,000 | \$29,000,000,000 |
| % UC | 88% | 47% | 41% | 38% | 34% | 47% |
| % DSRIP | 12% | 53% | 59% | 62% | 66% | 53% |

47. Assurance of Budget Neutrality.

- a. By October 1 of each year, the State must submit an assessment of budget neutrality to CMS, including a summation of all expenditures and member months already reported to CMS, estimates of expenditures already incurred but not reported, and projections of future expenditures and member months to the end of the Demonstration, broken out by DY and Medicaid Eligibility Group (MEG) or other spending category.
- b. Should the report in (a) indicate that the budget neutrality Annual Target for any DY has been exceeded, or is projected to be exceeded, the State must propose adjustments to the limits on UC Pool and DSRIP Pool limits, such that the Demonstration will again be

budget neutral on an annual basis, and over the lifetime of the Demonstration. The new limits will be incorporated through an amendment to the Demonstration.

48. Transition Plan for Funding Pools. No later than March 31, 2015, the State shall submit a transition plan to CMS based on the experience with the DSRIP pool, actual uncompensated care trends in the State, and investment in value based purchasing or other payment reform options.

VII. GENERAL FINANCIAL REQUIREMENTS

49. Quarterly Expenditure Reports. The State must provide quarterly expenditure reports using Form CMS-64, to separately report total expenditures for services provided through this Demonstration under section 1115 authority that are subject to budget neutrality. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS shall provide FFP for allowable Demonstration expenditures, only as long as they do not exceed the pre-defined limits on the costs incurred, as specified in Section VIII.

50. Expenditures Subject to the Title XIX Budget Neutrality Expenditure Limit.

- a. All expenditures for Medicaid services for Demonstration participants (as defined in paragraphs 28 [Table 2], 29, 33 [Table 3], and 41 [Table 4]) are Demonstration expenditures subject to the budget neutrality expenditure limit, except expenditures for the services listed as follows:
 - i. Nursing facility services;
 - ii. Medical transportation;
 - iii. Medicare premiums;
 - iv. In Column D counties only, Community Based Alternatives 1915(c) waiver services, primary home care and day activity and health services, and
 - v. Other 1915(c) waiver programs as follows: Medically Dependent Children Program (TX 0181), Consolidated Waiver Program (TX 0373 and TX 0374), Deaf Blind with Multiple Disabilities (TX 0281), Home and Community-Based Services (TX 0110), Community Living Assistance and Support Services (TX 0221), Texas Home Living (TX 0403), and Youth Empowerment Services (TX 0657).
- b. All Funding Pool expenditures (as defined in Section VI) are Demonstration expenditures subject to the budget neutrality expenditure limit.

51. Reporting Expenditures in the Demonstration. The following describes the reporting of expenditures subject to the budget neutrality expenditure limit:

- a. **Use of Waiver Forms.** In order to track expenditures under this Demonstration, the State must report Demonstration expenditures through the Medicaid and Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual (SMM). All Demonstration expenditures claimed under the authority of title XIX of the Act, and subject to the budget neutrality expenditure limit, must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the Demonstration Project Number (11-W-00278/6) assigned by CMS.
- b. **Reporting By Date of Service.** In each quarter, Demonstration expenditures (including prior period adjustments) must be totaled and reported on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver by Demonstration Year (DY). The DY for which expenditures are reported is identified using the project number extension (a 2-digit number appended to the Demonstration Project Number). Expenditures must be assigned to DYs on the basis of date of service (except for pool payments, as discussed below). The date of service for premium payments is identified as the DY that includes the larger share of the month for which the payment is principally made. Pool payments must be reported by DY as follows: Transition payments must be reported for DY 1, UC payments must be reported in a manner consistent with the payment timeframes specified in the UC Pool Protocol, and DSRIP payments must be reported based on the payment methodologies and annual maximum budgets specified in the final master DSRIP plans. DY 1 will be the year beginning October 1, 2011, and ending September 30, 2012, and subsequent DYs will be defined accordingly.
- c. **Waiver Name.** Each quarter, the State must identify separate forms CMS-64.9 Waiver and/or 64.9P Waiver by Waiver Name to report expenditures that belong in the following categories:
- i. "Adults" – Medicaid service expenditures for all participating individuals whose MEG is defined as Adults;
 - ii. "Children" – Medicaid service expenditures for all participating individuals whose MEG is defined as Children;
 - iii. "AMR" – Medicaid service expenditures for all participating individuals who are aged, or who are disabled and have Medicare, except for 1915(c) waiver services described in (v) below;
 - iv. "Disabled" – Medicare service expenditures for all participating individuals who are disabled and do not have Medicare, except for 1915(c) waiver services described in (v) below;

- v. “CBA 1915(c)” – Expenditures for CBA 1915(c) waiver services for all individuals who reside in Column E counties that are not Column B counties (only used for expenditures with dates of service between the implementation of the Demonstration and the implementation date of the March 2012 STAR+PLUS expansion);
 - vi. “UC” – All expenditures that count against UC Pool limits, except those described in (vii);
 - vii. “UC UPL” – Medicaid State plan supplemental provider payments to hospitals or physician groups made between October 1 , 2011 and the approval date of the demonstration; and
 - viii. “DSRIP” – All DSRIP Pool expenditures.
- d. **Pharmacy Rebates.** Because pharmacy rebates are not reflected in the data used to determine the budget neutrality expenditure limit, all pharmacy rebates must be reported on Forms CMS-64.9 Base or Forms CMS-64.9P Base, and not on any waiver form associated with this Demonstration.
- e. **Cost Settlements.** For monitoring purposes, cost settlements related to the Demonstration must be recorded on Line 7 or 10.B, in lieu of Line 9. For any other cost settlements (i.e., those not attributable to this Demonstration), the adjustments should be reported, as instructed in the State Medicaid Manual. The amount of non-claim specific cost settlements will be allocated to each DY based on the larger share of the coverage period for which the cost settlement is made.
- f. **Premium and Cost Sharing Adjustments.** Premiums and other applicable cost-sharing contributions that are collected by the State from enrollees under the Demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet Line 9D, columns A and B. In order to assure that these collections are properly credited to the Demonstration, premium and cost-sharing collections (both total computable and Federal share) should also be reported separately by Demonstration Year on the Form CMS-64 Narrative. In the calculation of expenditures subject to the budget neutrality expenditure limit, premium collections applicable to Demonstration populations will be offset against expenditures. These section 1115 premium collections will be included as a manual adjustment (decrease) to the Demonstration’s actual expenditures on a quarterly basis.
- g. **Administrative Costs.** Administrative costs are not included in the budget neutrality expenditure limit, but the State must separately track and report additional administrative costs that are directly attributable to the Demonstration. All attributable administrative costs must be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver, using Waiver Name “TX Reform Admin.”

- h. **Administrative Cost Claiming Protocol.** The State must maintain a CMS-approved Administrative Cost Claiming Protocol, to be incorporated as Attachment K to these STCs, which explains the process the State will use to determine administrative costs incurred under the Demonstration. CMS will provide Federal financial participation (FFP) to the State at the regular 50 percent match rate for administrative costs incurred according to limitations set forth in the approved Administrative Cost Claiming protocol. No FFP is allowed until a claiming protocol is approved by CMS.
- i. **Claiming Period.** All claims for expenditures subject to the budget neutrality expenditure limit (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the Demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the Demonstration. During the latter 2-year period, the State must continue to identify separately on the CMS-64 waiver forms, the net expenditures related to dates of service during the operation of the section 1115 Demonstration, in order to account for these expenditures properly to determine budget neutrality.

52. Reporting Member Months. The following describes the reporting of member months for Demonstration participants.

- a. For the purpose of calculating the budget neutrality expenditure limit, the State must provide to CMS, as part of the quarterly report required under paragraph 65 of these STCs, the actual number of eligible member months for all Demonstration participants, according to the MEGs defined in paragraphs 28 (Table 2) and 29.
- b. To permit full recognition of “in-process” eligibility, reported member month totals may be revised subsequently, as needed. To document revisions to totals submitted in prior quarters, the State must report a new table with revised member month totals indicating the quarter for which the member month report is superseded.
- c. The term “eligible member months” refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes 3 eligible member months to the total. Two individuals, who are eligible for 2 months each, contribute 2 eligible member months to the total, for a total of 4 eligible member months.

53. Standard Medicaid Funding Process. The standard Medicaid funding process must be used during the Demonstration. The State must estimate matchable Demonstration expenditures (total computable and Federal share) subject to the budget neutrality expenditure limit, and separately report these expenditures by quarter for each Federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS shall make Federal funds available based upon

the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

54. Extent of Federal Financial Participation for the Demonstration. Subject to CMS approval of the source(s) of the non-Federal share of funding (see paragraph 55, *Sources of Non-Federal Share*), CMS shall provide FFP at the applicable Federal matching rates for the Demonstration as a whole as outlined below, subject to the budget neutrality limits described in section X of these STCs:

- a. Administrative costs, including those associated with the administration of the Demonstration;
- b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid State plan and waiver authorities;
- c. Net expenditures and prior period adjustments, made under approved Expenditure Authorities granted through section 1115(a)(2) of the Act, with dates of service during the operation of the Demonstration;
- d. Net expenditures for Funding Pool payments.

55. Sources of Non-Federal Share. The State certifies that the matching non-Federal share of funds for the Demonstration is State/local monies. The State further certifies that such funds shall not be used as the match for any other Federal grant or contract, except as permitted by law. All sources of non-Federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-Federal share of funding are subject to CMS approval.

- a. CMS may review, at any time, the sources of the non-Federal share of funding for the Demonstration. The State agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.
- b. Any amendments that impact the financial status of the program shall require the State to provide information to CMS regarding all sources of the non-Federal share of funding.
- c. Under all circumstances, health care providers must retain 100 percent of the STAR and STAR+PLUS reimbursement amounts claimed by the State as a Demonstration expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the State and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes (including health care

provider-related taxes), fees, and business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.

VIII. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

56. Limit on Title XIX Funding. The State shall be subject to a limit on the amount of Federal title XIX funding that the State may receive on selected Medicaid expenditures during the period of approval of the Demonstration. The limit is determined by using a per capita cost method, with an aggregate adjustment for projected supplemental provider payments. The budget neutrality expenditure targets are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire Demonstration. Actual expenditures subject to the budget neutrality expenditure limit shall be reported by the State using the procedures described in Section VII.

57. Risk. Under this budget neutrality agreement, Texas shall be at risk for the per capita cost of participating Medicaid and Demonstration eligibles, but not for the number of Demonstration eligibles. In this way, Texas will not be at risk for changing economic conditions that impact enrollment levels; however, by placing Texas at risk for the per capita costs for Medicaid and Demonstration eligibles, CMS assures that the Federal Demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no Demonstration.

58. Budget Neutrality Expenditure Limit. The following describes the method for calculating the budget neutrality expenditure limit:

- a. For each DY of the budget neutrality agreement, an Annual Target is calculated as the sum two components.
 - i. The Per Capita Component is the sum of six sub-components, calculated as the projected per member per month (PMPM) cost, times the actual number of member months (reported by the State in accordance with paragraph 53) for the MEGs identified in (b) below.
 - ii. The Aggregate Component is a projection of what certain supplemental payments to providers would have cost each year in the absence of the Demonstration, as shown in (c) below.
- b. The following tables give the projected PMPM costs to be used in the Per Capita Component calculation in each DY. PMPM costs for four of the six sub-components are shown in Table 7a, and for the remaining two sub-components are shown in Table 7b.
 - i. Table 7a gives the projected without-waiver costs of medical services for included populations. The Base Year PMPMs include fee-for-service claims and capitation payments for Medicaid State plan services and 1915(c) home and community based

services, and an attributed share of inpatient hospital supplemental payments, divided by base year member-months. FY 2012 President's Budget Medicaid Baseline trends are used to project without-waiver PMPM costs.

- ii. The PMPM amounts shown in Table 7b represent additional without-waiver costs that would have occurred for Adults and Children had the State carried out its plan to carve inpatient hospital services out from the capitated benefit for current STAR participants. These amounts follow the same President's Budget trends as the corresponding rows in Table 6a; however, per mutual agreement, these amounts will phase down to \$0, starting in DY 3.

Table 7a – Projected PMPM Costs, Base Medical and Included UPL

| MEG | Base Year PMPM (SFY 2010) | Trend | DY 1 | DY 2 | DY 3 | DY 4 | DY 5 |
|----------|---------------------------|-------|------------|------------|------------|------------|------------|
| AMR | \$463.87 | 4.6% | \$509.43 | \$532.87 | \$557.38 | \$583.02 | \$609.84 |
| Disabled | \$1,212.96 | 5.2% | \$1,348.07 | \$1,418.17 | \$1,491.91 | \$1,569.49 | \$1,651.11 |
| Adults | \$784.30 | 5.8% | \$882.05 | \$933.21 | \$987.33 | \$1,044.60 | \$1,105.18 |
| Children | \$252.48 | 5.2% | \$280.60 | \$295.19 | \$310.54 | \$326.69 | \$343.68 |

Table 7b – Projected PMPM Costs, STAR FFSE and STAR UPL

| MEG | Base Year PMPM (SFY 2010) | Trend | DY 1 | DY 2 | DY 3 | DY 4 | DY 5 |
|----------|---------------------------|-------|----------|----------|---------|---------|------|
| Adults | \$152.76 | 5.8% | \$171.80 | \$181.76 | \$96.15 | \$50.87 | \$0 |
| Children | \$20.02 | 5.2% | \$22.25 | \$23.40 | \$12.31 | \$6.47 | \$0 |

- c. The following table shows the calculation of the Aggregate Component for each DY. These projections were developed by the State and accepted by CMS, and are based on historical trends in supplemental payment amounts and UPLs. They represent what the State would have paid in supplemental provider payments in the absence of the Demonstration.

Table 8-7 – Aggregate Component

| Payment Stream | DY 1 | DY 2 | DY 3 | DY 4 | DY 5 |
|--|-----------------|-----------------|-----------------|-----------------|-----------------|
| Inpatient Hospital UPL for Excluded Population | \$1,346,191,839 | \$1,423,194,012 | \$1,504,600,709 | \$1,590,663,870 | \$1,681,649,843 |

| Payment Stream | DY 1 | DY 2 | DY 3 | DY 4 | DY 5 |
|-------------------------|------------------------|------------------------|------------------------|------------------------|------------------------|
| Outpatient Hospital UPL | \$58,024,149 | \$61,343,130 | \$64,851,957 | \$68,561,489 | \$72,483,206 |
| Physician UPL | \$74,843,903 | \$77,089,221 | \$79,401,897 | \$81,783,954 | \$84,237,473 |
| TOTAL | \$1,479,059,891 | \$1,561,626,363 | \$1,648,854,563 | \$1,741,009,313 | \$1,838,370,522 |

- d. The budget neutrality expenditure limit is the Federal share of the combined total of the Annual Targets for all DYs, and is calculated as the sum of the Annual Targets times the Composite Federal Share (defined in (e) below). This limit represents the maximum amount of FFP that the State may receive for title XIX expenditures during the Demonstration period.
- e. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the State on actual demonstration expenditures during the approval period (as reported through the MBES/CBES and summarized on Schedule C) by total computable Demonstration expenditures for the same period as reported on the same forms.

59. Future Adjustments to the Budget Neutrality Expenditure Limit. CMS reserves the right to adjust the budget neutrality expenditure limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new Federal statutes, or policy interpretations implemented through letters, memoranda, or regulations with respect to the provision of services covered under this Demonstration. CMS reserves the right to make adjustments to the budget neutrality expenditure limit if any health care-related tax that was in effect during the base year with respect to the provision of services covered under this Demonstration, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care-related tax provisions of section 1903(w) of the Social Security Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

60. Enforcement of Budget Neutrality. CMS shall enforce budget neutrality over the life of the Demonstration rather than on an annual basis. However, if the State exceeds the calculated cumulative target limit by the percentage identified below for any of the DYs, the State shall submit a corrective action plan to CMS for approval.

| DY | Cumulative Target Definition | Percentage |
|------|--|-------------|
| DY 1 | Cumulative budget neutrality cap plus: | 3 percent |
| DY 2 | Cumulative budget neutrality cap plus: | 1 percent |
| DY 3 | Cumulative budget neutrality cap plus: | 0.5 percent |
| DY 4 | Cumulative budget neutrality cap plus: | 0 percent |
| DY 5 | Cumulative budget neutrality cap plus: | 0 percent |

61. Exceeding Budget Neutrality. If the budget neutrality expenditure limit has been exceeded at the end of this Demonstration period, the excess Federal funds shall be returned to CMS. If the Demonstration is terminated prior to the end of the budget neutrality agreement, the budget neutrality test shall be based on the time elapsed through the termination date.

IX. GENERAL REPORTING REQUIREMENTS

62. General Financial Requirements. The State will comply with all general financial requirements under title XIX set forth in these STCs.

63. Reporting Requirements Relating to Budget Neutrality. The State will comply with all reporting requirements for monitoring budget neutrality set forth in these STCs. The State must submit any corrected budget neutrality data upon request.

64. Monthly Calls. CMS shall schedule monthly conference calls with the State. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the Demonstration. Areas to be addressed include, but are not limited to:

- a. The health care delivery system;
- b. Enrollment, quality of care, and access to care;
- c. The benefit package;
- d. Performance of hospitals according receiving incentive payments as described in the STCs;
- e. Audits, lawsuits;
- f. Financial reporting and budget neutrality issues;
- g. Progress on evaluations;
- h. State legislative developments; and
- i. Any Demonstration amendments, concept papers or State plan amendments under consideration by the State.

CMS shall update the State on any amendments or concept papers under review as well as Federal policies and issues that may affect any aspect of the Demonstration. The State and CMS (both the Project Officer and Regional Office) shall jointly develop the agenda for the calls.

65. Demonstration Quarterly Reports. The State will submit progress reports 60 days following the end of each quarter (Attachment B). Information required for the first quarter of DY 1 (October 2011 – December 2011) will be included in the second quarter report for DY 2 (January 2012 – March 2012). The intent of these reports is to present the State's analysis and the status of the various operational areas. These quarterly reports will include, but are not limited to:

- a. A discussion of the events occurring during the quarter or the anticipated to occur in the near future that affect health care delivery, enrollment, quality of care, access, the benefit package, and other operational issues;

- b. Action plans for addressing any policy, operations, and administrative issues identified;
- c. Monthly enrollment data during the quarter and Demonstration Year to Date by eligibility group;
- d. Budget neutrality monitoring tables;
- e. Grievance and appeals filed during the quarter by beneficiaries in STAR and STAR+PLUS

66. Demonstration Annual Report. The State will submit a draft annual report documenting accomplishments, project status, quantitative, and case study findings, utilization data, and policy and administrative difficulties in the operation of the Demonstration. The State will submit the draft annual report no later than 120 days after the end of each operational year. Within 60 days of receipt of comments from CMS, a final annual report will be submitted for the Demonstration Year to CMS.

67. Transition Plan for the Expansion of Medicaid Eligibility in 2014. On or before November 1, 2012, the State is required to submit a draft a transition plan describing how the State plans to coordinate the transition of any individuals enrolled in the Demonstration who may become eligible for a coverage option available under the Affordable Care Act without interruption in coverage to the extent possible. The plan must also describe the steps the State will take to support adequate provider networks for Medicaid State plan populations in 2014. The Plan will include a proposed schedule of activities that the State may use to implement the Transition Plan. After submitting the initial Transition Plan for CMS approval, the State must include progress updates in each quarterly and annual report. The Transition Plan shall be revised as needed.

X. EVALUATION OF THE DEMONSTRATION

68. Submission of a Draft Evaluation Plan. The State shall submit to CMS for approval a draft evaluation design for an overall evaluation of the Demonstration no later than 120 days after CMS approval of the Demonstration. The draft evaluation design must discuss the outcome measures that shall be used in evaluating the impact of the Demonstration during the period of approval. It shall discuss the data sources, including the use of Medicaid encounter data, and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the Demonstration shall be isolated from other initiatives occurring in the State. The draft design shall identify whether the State will conduct the evaluation, or select an outside contractor for the evaluation.

- a. Domains of Focus. The Evaluation Design must, at a minimum, address the research questions listed below. For questions that cover broad subject areas, the State may propose a more narrow focus for the evaluation.

- i. What is the impact of the managed care expansion on access to care, the quality, efficiency, and coordination of care, and the cost of care? This impact should be measured for health care services in general, as well as specifically evaluating the following:
 - (A) What is the impact of including pharmacy benefits in the capitated managed care benefit on access to prescription drugs? Does the effect vary by service area?
 - (B) What is the impact of managed dental care on the likelihood that children receive recommended dental services? For example, have the dental managed care organizations been successful in meeting the target utilization measures set in the State's dental performance dashboard?
 - (C) What are the consequences of automatically re-enrolling individuals into the same managed care plan after a period of ineligibility of three months or more? How often do individuals in such circumstances request reassignment to another plan, and for what reasons? How does the frequency of reassignment requests for this group differ from those of comparable groups, such as persons who were re-enrolled after an eligibility gap of two months or less, or those auto-assigned following their initial enrollment? Does enrollee satisfaction for this group differ from that of other comparable enrollee groups?
 - (D) How does the State's Experience Rebate provision compare to Medical Loss Ratio regulation as a strategy for ensuring that managed care plans spend an appropriate amount of their premium revenue on medical expenses? How can an Experience Rebate be structured to address this goal? Would the same plans return approximately the same amounts to the State under a Medical Loss Ratio requirement as under the Experience Rebate, or would the results differ? Are there changes that could be made to either model to improve upon the intended purpose of such mechanisms?
 - (E) What is the impact of including the non-behavioral health inpatient services in the STAR+PLUS program in terms of access to and quality of care and program financing?
- ii. What percentage of providers' uncompensated care cost was made up by payments from the UC Pool? What was the distribution of percentage of UC Pool funds and DSRIP funds among types of providers (hospitals v. community providers, public hospitals vs. other hospitals)?
- iii. Were the Regional Health Partnerships able to show quantifiable improvements on measures related to the goals of:
 - (A) Better Care for Individuals (including access to care, quality of care, health outcomes),
 - (B) Better Health for the Population, and
 - (C) Lower Cost Through Improvement, especially with respect to per capita costs for Medicaid, uninsured, and underinsured populations, and the cost-effectiveness of care?

(D) To what degree can improvements be attributed to the activities undertaken under DSRIP?

- iv. How effective were the Regional Health Partnerships as a governing structure to coordinate, oversee, and finance payments for uncompensated care costs and incentives for delivery system reform? If issues were encountered, how were they addressed? What was the cost-effectiveness of DSRIP as a program to incentivize change? How did the amount paid in incentives compare with the amount of improvement achieved?
- v. What do key stakeholders (covered individuals and families, advocacy groups, providers, health plans) perceive to be the strengths and weaknesses, successes and challenges of the expanded managed care program, and of the UC and DSRIP pools? What changes would these stakeholders recommend to improve program operations and outcomes?
- b. Evaluation Design Process: Addressing the research questions listed above will require a mix of quantitative and qualitative research methodologies. When developing the RHP Planning Protocol, the State should consider ways to structure the different projects that will facilitate the collection, dissemination, and comparison of valid quantitative data to support the Evaluation Design required in Section X. From these, the State must select a preferred research plan for the applicable research question, and provide a rationale for its selection. To the extent applicable, the following items must be specified for each design option considered:
 - i. Quantitative or qualitative outcome measures;
 - ii. Proposed baseline and/or control comparisons;
 - iii. Proposed process and improvement outcome measures and specifications;
 - iv. Data sources and collection frequency;
 - v. Robust sampling designs (e.g., controlled before-and-after studies, interrupted time series design, and comparison group analyses);
 - vi. Cost estimates;
 - vii. Timelines for deliverables.
- c. Levels of Analysis: The evaluation designs proposed for each question may include analysis at the beneficiary, provider, and aggregate program level, as appropriate, and include population stratifications to the extent feasible, for further depth.

69. Final Evaluation Design and Implementation. CMS shall provide comments on the draft evaluation plan described in paragraph 68 within 60 days of receipt, and the State shall submit a final design within 60 days after receipt of CMS comments. The State shall implement the evaluation plan and submit its progress in each of the quarterly and annual reports.

70. Evaluation Reports.

- a. **Interim Evaluation Report.** The state must submit an Interim Evaluation Report by October 1, 2015, or in conjunction with the State's application for renewal of the Demonstration, whichever is earlier. The purpose of the Interim Evaluation Report is to present preliminary evaluation finds, plans for completing the evaluation design, and submitting a Final Evaluation Report according to the schedule outlined in subparagraph (b). The State shall submit the final Interim Evaluation Report within 60 days after receipt of CMS comments.
- b. **Final Evaluation Report.** The State shall submit to CMS a draft of the Final Evaluation Report by January 31, 2017. The State shall submit the Final Evaluation Report within 60 days after receipt of CMS comments.

71. Cooperation with Federal Evaluators. Should CMS undertake an independent evaluation of any component of the Demonstration, the State shall cooperate fully with CMS or the independent evaluator selected by CMS. The State shall submit the required data to CMS or the contractor.

**Attachment A
Schedule of Deliverables**

| Monthly Deliverables | | |
|--|--|--------------------------|
| Monthly | Monitoring Call | 64 |
| Monthly, upon receipt | Enrollment Broker Reports | 25 |
| Quarterly Deliverables | | |
| 60 days after end of each quarter | Quarterly Progress Reports (The first quarterly report due in DY 1 will encompass Oct. 2011 – March 2012) | 39(a) and (b), 65 |
| | Quarterly expenditure, budget neutrality, member month reports | 49, Section VIII, and 52 |
| 60 days after end of each quarter | Quarterly Payment Reports | 43(b) |
| Dec. 31, 2011 | Medicaid State Plan Amendments to remove all supplemental payments for inpatient hospital, outpatient hospital, and physician services from the State plan | 43(c) |
| Annual Deliverables | | |
| Beginning DY 2, December 31st of each DY | Estimated UC Payments | 44(a)(v)(A) |
| Beginning DY 2, 90 days following end of DY | Actual UC Payments and any Reconciliation | 44(a)(v)(B) |
| 120 days after end of each Demonstration year | Draft Annual Report | 66, 39(c) |
| Within 60 days of receipt of comments from CMS, annually | Final Annual Report | 66 |
| | | |
| Oct. 1 st of each year | Assessment of Budget Neutrality | 47(a) |
| Annually; anytime significant changes occur | Adequate assurances of sufficient capacity to serve the expected enrollment in service area | 24 |
| Annually | Annual Reports on Implementation and Effectiveness of Quality Strategy | 27 |
| Other Deliverables | | |

Comment [linda1]: Unsure if these edited ones are correct

Comment [NLK2]: To reference managed care reporting requirements

Comment [NLK3]: Duplicative, delete

Comment [linda4]: STC 70 didn't reference the Quality Strategy

**Attachment A
Schedule of Deliverables**

| | | |
|---|---|------------------|
| 45 days following approval of the Demonstration | Report on estimated maximum Transition Payment Amounts | 44(b)(ii)(C)(I) |
| December 31, 2012 | Report on actual amounts of Transition Payments | 44(b)(ii)(C)(II) |
| 12 months before expiration of Demonstration | Request For Extension | 8 |
| 5 months prior to the effective date of Demonstration's suspension or termination | Notification letter and Draft Phase-Out Plan | 9 |
| Post 30-day public comment period | Revised Phase-Out Plan incorporating public comment | 9 |
| The earlier of the date of Application for Renewal or October 1, 2015 | Interim Evaluation Report | 8 and 70(a) |
| Within 120 days after CMS approval of Demonstration | Draft Evaluation Design/Plan | 69 |
| Within 60 days of receipt of CMS comments on Draft Evaluation Design | Final Evaluation Design | 69 |
| 120 days after expiration of Demonstration (January 31, 2017) | Draft Evaluation Report | 70(b) |
| Within 60 days of receipt of CMS comments on Draft Evaluation Report | Final Evaluation Report | 70(b) |
| No later than 120 days prior to | Demonstration amendments, including requests for changes subject to the | 6 and 7 |

**Attachment A
Schedule of Deliverables**

| | | |
|--|---|-----------------|
| planned implementation and may not be implemented until approved | amendment process | |
| Within 9 months from approval date of Demonstration | Comprehensive Quality Strategy, revision upon any significant changes | 27 |
| Submitted Nov. 3, 2011 | List of deliverables and submissions | 22(b)(i) |
| Submitted Nov. 3, 2011 | Plans for ongoing monitoring and oversight of MCO contract compliance | 22(b)(ii) |
| Submitted Nov. 3, 2011 | Contingency Plan for addressing insufficient network issues | 22(b)(iii) |
| Submitted Nov. 28, 2011 | Transition plan from the 1915(c) waiver | 22(b)(iv), |
| Dec. 23, 2011 | Demonstrations of Network Adequacy | 22(b)(v), 24(e) |
| Dec. 23, 2011 | Proposed managed care contracts or contract amendments | 22(b)(vi) |
| March 31, 2012 | State's plan for formation of RHPs | 45(d)(i) |
| August 31, 2012 | Program Funding and Mechanics Protocol | 45(d)(ii)(A) |
| August 31, 2012 | RHP Planning Protocol | 45(d)(ii)(B) |
| March 1, 2012 | Draft UC Protocol | 44(a)(ii) |
| October 31, 2012 | Final master DSRIP plans from RHPs | 45(d)(iii) |
| November 12, 2012 | Transition Plan for the Expansion of Medicaid Eligibility in 2014 | 67 |
| March 31, 2015 | Transition Plan for Funding Pools | 48 |

Comment [linda5]: Both urban and rural RHP plans are due

Attachment B
Quarterly Report Template

Under Section IX, paragraph 65 (*Demonstration Quarterly Report*) of these STCs, the State is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the State. A complete quarterly progress report must include an updated budget neutrality monitoring workbook. An electronic copy of the report narrative, as well as the Microsoft Excel workbook must be provided.

NARRATIVE REPORT FORMAT:

Title Line One – Texas Healthcare Transformation and Quality Improvement Program

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:

Example: Demonstration Year: 1 (12/12/2011 – 9/30/2016)

Federal Fiscal Quarter: 1/2012 (10/011 - 12/11)

Footer: December 12, 2011 – September 30, 2016

I. Introduction

Present information describing the goal of the demonstration, what it does, and the status of key dates of approval/operation.

II. Enrollment and Benefits Information

Discuss the following:

- Trends and any issues related to STAR and STAR+PLUS eligibility, enrollment, disenrollment, access, and delivery network.
- Any changes or anticipated changes in populations served and benefits. Progress on implementing any Demonstration amendments related to eligibility or benefits.

Please complete the following table that outlines all enrollment activity under the demonstration. The State should indicate “N/A” where appropriate. If there was no activity under a particular enrollment category, the State should indicate that by “0”.

Enrollment Counts for Quarter

Note: Enrollment counts should be person counts, not member months

| Demonstration Populations | Total No. |
|---------------------------|-----------|
|---------------------------|-----------|

Attachment B
Quarterly Report Template

| | |
|-----------------|--|
| Adults | |
| Children | |
| AMR | |
| Disabled | |

III. Outreach/Innovative Activities to Assure Access

Summarize marketing, outreach, or advocacy activities to potential eligibles and/or promising practices for the current quarter to assure access for STAR and STAR+PLUS enrollees or potential eligibles.

IV. Collection and Verification of Encounter Data and Enrollment Data

Summarize any issues, activities, or findings related to the collection and verification of encounter data and enrollment data.

V. Operational/Policy/Systems/Fiscal Developments/Issues

Identify all other significant program developments/issues/problems that have occurred in the current quarter or are anticipated to occur in the near future that affect health care delivery, including, but not limited to, program development, quality of care, approval and contracting with new plans, health plan contract compliance and financial performance relevant to the Demonstration, fiscal issues, systems issues, and pertinent legislative or litigation activity.

VI. Action Plans for Addressing Any Issues Identified

Summarize the development, implementation, and administration of any action plans for addressing issues related to the Demonstration.

VII. Financial/Budget Neutrality Development/Issues

Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS 64 and budget neutrality reporting for the current quarter. Identify the State's actions to address these issues.

VIII. Member Month Reporting

Enter the member months for each of the EGs for the quarter.

A. For Use in Budget Neutrality Calculations

| Eligibility Group | Month 1 | Month 2 | Month 3 | Total for Quarter Ending XX/XX |
|--------------------------|----------------|----------------|----------------|---|
| Adults | | | | |
| Children | | | | |
| AMR | | | | |
| Disabled | | | | |

Attachment B
Quarterly Report Template

B. Not Used in Budget Neutrality Calculations

| Eligibility Group | Month 1 | Month 2 | Month 3 | Total for Quarter Ending XX/XX |
|-------------------|---------|---------|---------|-----------------------------------|
| | | | | |
| | | | | |
| | | | | |

IX. Consumer Issues

A summary of the types of complaints or problems consumers identified about the program or grievances in the current quarter. Include any trends discovered, the resolution of complaints or grievances, and any actions taken or to be taken to prevent other occurrences.

X. Quality Assurance/Monitoring Activity

Identify any quality assurance/monitoring activity or any other quality of care findings and issues in current quarter.

XI. Demonstration Evaluation

Discuss progress of evaluation plan and planning, evaluation activities, and interim findings.

XII. Regional Healthcare Partnership Participating Hospitals

Enclosures/Attachments

Identify by title the budget neutrality monitoring tables and any other attachments along with a brief description of what information the document contains.

State Contact(s)

Identify the individual(s) by name, title, phone, fax, and address that CMS may contact should any questions arise.

Date Submitted to CMS

Attachment C
HCBS Service Definitions

The following are the provider guidelines and service definitions for HCBS provided to individuals requiring a nursing facility level of care under STAR+PLUS.

| Service | Service Definition |
|---|---|
| Adaptive Aids and Medical Supplies | <p>Adaptive aids and medical supplies are specialized medical equipment and supplies which include devices, controls, or appliances that enable members to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.</p> <p>This service also includes items necessary for life support, ancillary supplies, and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Texas State Plan, such as: vehicle modifications, service animals and supplies, environmental adaptations, aids for daily living, reachers, adapted utensils, and certain types of lifts.</p> <p>The annual cost limit of this service is \$10,000 per waiver plan year. The \$10,000 cost limit may be waived by the HHSC upon request of the managed care organization.</p> <p>The State allows a member to select a relative or legal guardian, other than a legally responsible individual, to be his/her provider for this service if the relative or legal guardian meets the requirements for this type of service.</p> |
| Adult Foster Care | <p>Adult foster care services are personal care services, homemaker, chore, and companion services, and medication oversight provided in a licensed (where applicable) private home by an adult foster care provider who lives in the home. Adult foster care services are furnished to adults who receive these services in conjunction with residing in the home.</p> <p>The total number of individuals (including persons served in the waiver) living in the home who are unrelated to the principal care provider cannot exceed four. Separate payment will not be made for personal assistance services furnished to a member receiving adult foster care services, since these services are integral to and inherent in the provision of adult foster care services.</p> <p>Payments for adult foster care services are not made for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep, and improvement. Payment for adult foster care services does not include payments made, directly or indirectly, to anyone in the member's immediate family.</p> |
| Assisted Living | <p>Assisted living services are personal care, homemaker, and chore services; medication oversight; and therapeutic, social and recreational programming provided in a homelike environment in a licensed community facility in conjunction with residing in the facility. This service includes 24-hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety, and security. Other individuals or agencies may also furnish care directly, or under arrangement with the community facility, but the services provided by these other entities supplement that provided by the community facility and do not supplant those of the community facility.</p> |

Attachment C
HCBS Service Definitions

| Service | Service Definition |
|-------------------------------------|---|
| | <p>The individual has a right to privacy. Living units may be locked at the discretion of the individuals, except when a physician or mental health professional has certified in writing that the individual is sufficiently cognitively impaired as to be a danger to self or others if given the opportunity to lock the door. The facility must have a central dining room, living room or parlor, and common activity center(s) (which may also serve as living rooms or dining rooms. The individual retains the right to assume risk, tempered only by the individual's ability to assume responsibility for that risk. The State allows an individual to select a relative or legal guardian, other than a spouse, to be his/her provider for this service if the relative or legal guardian meets the requirements to provide this service. Nursing and skilled therapy services (except periodic nursing evaluations if specified above) are incidental, rather than integral to the provision of assisted living services. Payment will not be made for 24-hour skilled care or supervision. Federal financial participation is not available in the cost of room and board furnished in conjunction with residing in an assisted living facility.</p> |
| Day Activity Health Services | <p>Day Activity and Health Services Licensed Day Activity and Health Services facilities provide daytime services, up to 10 hours per day, Monday through Friday, to people residing in the community. Services address physical, mental, medical and social needs. Individuals may attend up to five days per week, depending on their eligibility. Services include:</p> <ul style="list-style-type: none"> • Nursing and personal care • Physical rehabilitation • Noon meal and snacks • Social, educational and recreational activities • Transportation <p>This service will be for those individuals who are eligible for the HCBS STAR+PLUS Waiver and exceed the financial requirements for Day Activity and Health Services under the 1915(i) authority.</p> |
| Dental Services | <p>Dental services which exceed the dental benefit under the State plan are provided under this waiver when no other financial resource for such services is available or when other available resources have been used. Dental services are those services provided by a dentist to preserve teeth and meet the medical need of the member. Allowable services include:</p> <ul style="list-style-type: none"> • Emergency dental treatment procedures that are necessary to control bleeding, relieve pain, and eliminate acute infection; • Operative procedures that are required to prevent the imminent loss of teeth; • Routine dental procedures necessary to maintain good oral health; • Treatment of injuries to the teeth or supporting structures; and • Dentures and cost of fitting and preparation for dentures, including extractions, molds, |

Attachment C
HCBS Service Definitions

| Service | Service Definition |
|--------------------------------------|---|
| | <p>etc.</p> <p>The State allows a member to select a relative or legal guardian, other than a spouse, to be his/her provider for this service if the relative or legal guardian meets the requirements to provide this service.</p> <p>Payments for dental services are not made for cosmetic dentistry. The annual cost cap of this service is \$5,000 per waiver plan year. The \$5,000 cap may be waived by the managed care organization upon request of the member only when the services of an oral surgeon are required. Exceptions to the \$5,000 cap may be made up to an additional \$5,000 per waiver plan year when the services of an oral surgeon are required.</p> |
| Emergency Response Services | <p>Emergency response services provide members with an electronic device that enables certain members at high risk of institutionalization to secure help in an emergency. The member may also wear a portable “help” button to allow for mobility. The system is connected to the person’s phone and programmed to signal a response center once a “help” button is activated. Trained professionals staff the response center. Emergency response services are limited to those members who live alone, who are alone for significant parts of the day, or who have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.</p> <p>The State allows a member to select a relative or legal guardian, other than a spouse, to be his/her provider for this service if the relative or legal guardian meets the requirements to provide this service.</p> |
| Financial Management Services | <p>Financial management services provide assistance to members with managing funds associated with the services elected for self-direction. The service includes initial orientation and ongoing training related to responsibilities of being an employer and adhering to legal requirements for employers. The financial management services provider, referred to as the Consumer Directed Services Agency, also:</p> <ul style="list-style-type: none"> • Serves as the member’s employer-agent; • Provides assistance in the development, monitoring, and revision of the member’s budget; • Provides information about recruiting, hiring, and firing staff, including identifying the need for special skills and determining staff duties and schedule; • Provides guidance on supervision and evaluation of staff performance; • Provides assistance in determining staff wages and benefits; • Provides assistance in hiring by verifying employee’s citizenship status and qualifications, and conducting required criminal background checks in the Nurse Aide Registry and Employee Misconduct Registry; • Verifies and maintains documentation of employee qualifications, including citizenship status, and documentation of services delivered; • Collects timesheets, processes timesheets of employees, processes payroll and payables, and makes withholdings for, and payment of, applicable Federal, State, and local employment-related taxes; • Tracks disbursement of funds and provides quarterly written reports to the member of all expenditures and the status of the member’s Consumer Directed Services budget; |

**Attachment C
HCBS Service Definitions**

| Service | Service Definition |
|---------------------------------|---|
| | <p>and</p> <ul style="list-style-type: none"> • Maintains a separate account for each member's budget. <p>The State allows a relative or legal guardian, other than a legally responsible member, to be the member's provider for this service if the relative or legal guardian meets the requirements for this type of provider.</p> |
| Home Delivered Meals | Home delivered meals services provide a nutritionally sound meal to members. The meal provides a minimum of one-third of the current recommended dietary allowance for the member as adopted by the United States Department of Agriculture. |
| Minor Home Modifications | <p>Minor home modifications are those physical adaptations to a member's home, required by the service plan, that are necessary to ensure the member's health, welfare, and safety, or that enable the member to function with greater independence in the home. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the member's welfare. Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the member, such as carpeting, roof repair, central air conditioning, etc. Adaptations that add to the total square footage of the home are excluded from this benefit. All services are provided in accordance with applicable State or local building codes. Modifications are not made to settings that are leased, owned, or controlled by waiver providers. The State allows a member to select a relative or legal guardian, other than a spouse, to be the member's provider for this service if the relative or legal guardian meets the requirements to provide this service.</p> <p>There is a lifetime limit of \$7,500 per member for this service and \$300 yearly for repairs. To request approval to exceed the service cost cap for minor home modifications, the managed care organization must send a written request to HHSC along with appropriate documentation which must include the cost estimate and an assurance that the Plan of Care is within the member's overall cost ceiling and adequate to meet the needs of the member. Once the \$7,500 cap or a higher amount approved by HHSC is reached, only \$300 per year per member, excluding the fees, will be allowed for repairs, replacement, or additional modifications. The home and community support services provider is responsible for obtaining cost-effective modifications authorized on the member's ISP by the managed care organization.</p> |
| Nursing | <p>Nursing services are those services that are within the scope of the Texas Nurse Practice Act and are provided by a registered nurse (or licensed vocational nurse under the supervision of a registered nurse), licensed to practice in the State.</p> <p>In the Texas State Plan, nursing services are provided only for acute conditions or exacerbations of chronic conditions lasting less than 60 days. Nursing services provided in the waiver cover ongoing chronic conditions such as medication administration and supervising delegated tasks. This broadens the scope of these services beyond extended State plan services.</p> |
| Occupational Therapy | Occupational therapy consists of interventions and procedures to promote or enhance safety and performance in activities of daily living, instrumental activities of daily living, education, work, play, leisure, and social participation. |

**Attachment C
HCBS Service Definitions**

| Service | Service Definition |
|-------------------------------------|--|
| | <p>Occupational therapy services consist of the full range of activities provided by a licensed occupational therapist, or a licensed occupational therapy assistant under the direction of a licensed occupational therapist, acting within the scope of his/her state licensure. Texas assures that occupational therapy is cost-effective and necessary to avoid institutionalization.</p> <p>The State allows a member to select a relative or legal guardian, other than a spouse, to be the member's provider for this service if the relative or legal guardian meets the requirements to provide this service.</p> |
| Personal Assistance Services | <p>Personal assistance services provide assistance to members in performing the activities of daily living based on their service plan. Personal assistance services include assistance with the performance of the activities of daily living and household chores necessary to maintain the home in a clean, sanitary, and safe environment. Personal assistance services also include the following services: protective supervision provided solely to ensure the health and safety of a member with cognitive/memory impairment and/or physical weakness; tasks delegated by a registered nurse under the rules of the Texas Board of Nursing; escort services consist of accompanying, but not transporting, and assisting a member to access services or activities in the community; and extension of therapy services. The attendant may perform certain tasks if delegated and supervised by a registered nurse in accordance with Board of Nursing rules found in 22 Texas Administrative Code, Part 11, Chapter 224. The home and community support services agency registered nurse is responsible for delegating any task to the attendant, and the home and community support services agency must maintain a copy of the delegation requirements in the member's case record.</p> <p>Health Maintenance Activities are limited to tasks that enable a member to remain in an independent living environment and go beyond activities of daily living because of the higher skill level required. A registered nurse may determine that performance of a health maintenance activity for a particular member does not constitute the practice of professional nursing. An unlicensed person may perform health maintenance activities without delegation. (See Board of Nursing rules at 22 Texas Administrative Code, Part 11, Chapter 225.) Licensed therapists may choose to instruct the attendants in the proper way to assist the member in follow-up on therapy sessions. This assistance and support provides reinforcement of instruction and aids in the rehabilitative process. In addition, a registered nurse may instruct an attendant to perform basic interventions with members that would increase and optimize functional abilities for maximum independence in performing activities of daily living such as range of motion exercises.</p> <p>The following contingencies apply to providers: Texas does not allow service breaks of personal assistance services for health and safety reasons; therefore, providers are required to have back-up attendants if the regular attendant is not available. The provider nurse may provide personal assistance services if the regular and back-up attendants are not available and nurse delegation is authorized.</p> <p>The State allows, but does not require, a member to select a relative or legal guardian, other than a spouse, to be the member's provider for this service if the relative or legal guardian meets the requirements to provide this service. Personal assistance services will not be provided to members residing in adult foster care homes, assisted living facilities,</p> |

Attachment C
HCBS Service Definitions

| Service | Service Definition |
|--|---|
| | or during the same designated hours or time period a member receives respite care. |
| Physical Therapy | <p>Physical therapy is defined as specialized techniques for evaluation and treatment related to functions of the neuro-musculo-skeletal systems provided by a licensed physical therapist or a licensed physical therapy assistant, directly supervised by a licensed physical therapist. Physical therapy is the evaluation, examination, and utilization of exercises, rehabilitative procedures, massage, manipulations, and physical agents (such as mechanical devices, heat, cold, air, light, water, electricity, and sound) in the aid of diagnosis or treatment.</p> <p>Physical therapy services consist of the full range of activities provided by a licensed physical therapist, or a licensed physical therapy assistant under the direction of a licensed physical therapist, acting within the scope of state licensure. Physical therapy services are available through this waiver program only after benefits available through Medicare, Medicaid, or other third party resources have been exhausted. The State allows a member to select a relative or legal guardian, other than a spouse, to be the member's provider for this service if the relative or legal guardian meets the requirements to provide this service.</p> |
| Respite | <p>Respite care services are provided to individuals unable to care for themselves, and are furnished on a short-term basis because of the absence of or need for relief for those persons normally providing unpaid services. Respite care may be provided in the following locations: member's home or place of residence; adult foster care home; Medicaid certified NF; and an assisted living facility. Respite care services are authorized by a member's PCP as part of the member's care plan. Respite services may be self-directed. Limited to 30 days per year.</p> <p>There is a process to grant exceptions to the annual limit. The managed care organization reviews all requests for exceptions, and consults with the service coordinator, providers, and other resources as appropriate, to make a professional judgment to approve or deny the request on a case-by-case basis. Members residing in adult foster care homes and assisted living facilities are not eligible to receive respite services. Other waiver services, such as Personal Assistance Services, may be provided on the same day as respite services, but the two services cannot be provided at the exact same time.</p> |
| Speech, Hearing, and Language Therapy | <p>Speech therapy is defined as evaluation and treatment of impairments, disorders, or deficiencies related to an individual's speech and language. The scope of Speech, Hearing, and Language therapy services offered to HCBS participants exceeds the State plan as the service in this context is available to adults. Speech, hearing, and language therapy services are available through the waiver program only after benefits available through Medicare, Medicaid, or other third party resources have been exhausted. The State allows a member to select a relative or legal guardian, other than a spouse, to be the member's provider for this service if the relative or legal guardian meets the requirements to provide this service.</p> |
| Support Consultation | <p>Support consultation is an optional service component that offers practical skills training and assistance to enable a member or his legally authorized representative to successfully direct those services the member or the legally authorized representative chooses for consumer-direction. This service is provided by a certified support advisor, and includes skills training related to recruiting, screening, and hiring workers, preparing job descriptions, verifying employment eligibility and qualifications, completion of documents required to employ an individual, managing workers, and development of</p> |

Attachment C
HCBS Service Definitions

| Service | Service Definition |
|---------------------------------------|---|
| | <p>effective back-up plans for services considered critical to the member's health and welfare in the absence of the regular provider or an emergency situation.</p> <p>Skills training involves such activities as training and coaching the employer regarding how to write an advertisement, how to interview potential job candidates, and role-play in preparation for interviewing potential employees. In addition, the support advisor assists the member or his or her legally authorized representative to determine staff duties, to orient and instruct staff in duties and to schedule staff. Support advisors also assist the member or his or her legally authorized representative with activities related to the supervision of staff, the evaluation of the job performance of staff, and the discharge of staff when necessary.</p> <p>This service provides sufficient information and assistance to ensure that members and their representatives understand the responsibilities involved with consumer direction. Support consultation does not address budget, tax, or workforce policy issues. The State defines support consultation activities as the types of support provided beyond that provided by the financial management services provider. The scope and duration of support consultation will vary depending on a member's need for support consultation. Support consultation may be provided by a certified support advisor associated with a consumer directed services agency selected by the member or by an independent certified support advisor hired by the member. Support consultation has a specific reimbursement rate and is a component of the member's service budget. In conjunction with the service planning team, members or legally authorized representatives determine the level of support consultation necessary for inclusion in each member's service plan.</p> |
| Transition Assistance Services | <p>Transition Assistance Services pay for non-recurring, set-up expenses for members transitioning from nursing homes to the STAR+PLUS HCBS program.</p> <p>Allowable expenses are those necessary to enable members to establish basic households and may include: security deposits for leases on apartments or homes; essential household furnishings and moving expenses required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed and bath linens; set-up fees or deposits for utility or service access, including telephone, electricity, gas, and water; services necessary for the member's health and safety, such as pest eradication and one-time cleaning prior to occupancy; and activities to assess need, arrange for, and procure needed resources (limited to up to 180 consecutive days prior to discharge from the nursing facility). Services do not include room and board, monthly rental or mortgage expenses, food, regular utility charges, or household appliances or items that are intended for purely recreational purposes. There is a \$2,500 limit per member.</p> |

Attachment D
Interim Quality Improvement Strategy For STAR+PLUS HCBS Program

The following is the current approved strategy as found in the section 1915(c) STAR+PLUS waivers, and which the State has been given permission to use until such time as a comprehensive quality improvement strategy for the section 1115 waiver has been developed.

a. System Improvements.

The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application.

Health Plan Operations, a unit of Managed Care Operations, manages the External Quality Review Organization contract, the Managed Care Organization contracts, the Uniform Managed Care Manual, and the STAR+PLUS handbook. Health Plan Management staff work directly with the health plans to look at various administrative measures and manage complaints that are submitted to HHSC. Additionally, Long Term Services and Supports Policy staff, within the Medicaid and Children's Health Insurance Program (CHIP) Division, manages waiver activities. The Department of Aging and Disability Services carries out delegated functions related to operations of STAR+PLUS.

Health Plan Operations holds quarterly meetings with all parties listed above to examine data, discuss trends, and look for opportunities to address program issues and development improvement strategies. Health Plan Operations documents decisions and tracks them through minutes. Developing and implementing improvement strategies are accomplished through various methods, such as focusing the plans on particular quality measures through the performance at-risk capitation and Quality Challenge Pool. Other opportunities include directing the health plans to particular goals when they are developing their Performance Improvement Projects; making changes to the Managed Care Contracts, Uniform Managed Care Manual, or the STAR+PLUS handbook to address specific operational issues; and taking strategic initiatives forward for executive management review. Additionally, Health Plan Operations, in conjunction with the External Quality Review Organization, holds a quality forum twice per year to further develop the expertise of the health plans on initiatives that are important to the program.

Health Plan Operations is responsible for coordinating and organizing all of the above activities. As new initiatives or projects are developed, Health Plan Operations, working with the above parties, will track whether or not changes to the program have the intended effect and will recommend interventions or revisions when needed. These will be reported to the Deputy Director for Managed Care Operations.

The State of Texas contracts the Institute for Child Health Policy from the University of Florida to serve as the independent External Quality Review Organization to support many of the State's managed care quality and performance goals and objectives. In collaboration with the Institute for Child Health Policy, the Texas Health and Human Services Commission (HHSC) evaluates, assesses, monitors, guides, and directs the Medicaid managed care programs, as well as the contracted managed care organizations. The Institute for Child Health Policy incorporates experience and proven methodologies to evaluate program effectiveness and managed care organizations performance by using the Health Plan Employer Data and Information Set (HEDIS®), non-Health Plan Employer Data and Information Set, and Consumer Assessment of Health Plans Survey (CAHPS®) performance measure benchmarking. The Institute for Child Health Policy develops annual Quality of Care reports, which give information on a number of performance measures for the program. Additionally, data is collected on various quality measures on a quarterly basis. Complaints are also monitored and tracked through the HHS Enterprise Administrative Report and Tracking System. Finally, HHSC is working with the Institute for Child Health Policy to

Attachment D
Interim Quality Improvement Strategy For STAR+PLUS HCBS Program

develop a Long Term Services and Supports report that will include vital measures for indicating how successfully the program is operating.

The State Medicaid Agency is developing data collection methodologies for each performance measure. These methodologies will be completed by February 28, 2012. Data collection will begin in two service delivery areas later this year. Data collection for each performance measure across all service delivery areas will begin in February 2013. Preliminary analyses of the data and remediation data aggregation and analysis will begin during the in calendar year 2012 and full analyses will occur in calendar year 2013.

Processes for developing trending, prioritizing and implementing system improvements will begin in 2011. Field testing of processes will begin in 2011. Actual implementation of the processes will begin in calendar year 2012. The State will use the data analysis in looking at trends in the performance measures. The State will prioritize those areas that are of most importance to the health and welfare of the waiver member. If design changes are needed to the processes that the State uses to administrate and deliver waiver services, these will be developed and implemented in calendar year 2013. The quality improvement system should be fully operational and functional by calendar year 2013.

The contract between the State of Texas and the managed care organizations includes HHSC quality improvement components, such as enhanced value-based purchasing approaches, annual negotiated quality improvement goals, and semi-annual meetings with each managed care organization to assess the status of quality improvement activity. HHSC will incorporate the data and analysis from the performance measures into the overall performance evaluation of the managed care organizations.

Health Plan Operations will continue to develop procedures that will assess the quality of care for Medicaid managed care enrollees consistent with federal regulations and the Protocols for External Quality Review of Medicaid managed care organizations and Prepaid Health Plans, as adopted by Centers for Medicare and Medicaid Services (CMS). These procedures will include the use of surveys, data analysis, evaluation of performance improvement projects, evaluation of performance measures data analysis, and HEDIS®, non-HEDIS®, and CAHPS® benchmarking. From the reported results, HHSC will identify areas of improvement for the managed care organizations. HHSC will also utilize national performance indicators identified or developed by CMS in consultation with States and other relevant stakeholders.

b. System Design Changes

Health Plan Operations is responsible for coordinating and organizing all of the above activities. As new initiatives or projects are developed, Health Plan Operations will use data and analysis from evaluations conducted during the quarterly interims to track whether or not changes to the program have the intended effect and will recommend interventions or revisions as needed. These will be reported to the Deputy Director for Managed Care Operations as well as the members of the various forums that Health Plan Operations will conduct on a quarterly basis. Reports and recommendations for system and program changes produced by Managed Care Operations will be reviewed by executive management for approval. If design changes are needed to the processes that the State is using to administrate and deliver waiver services, these will be developed and implemented by the third year of the waiver renewal. The quality improvement system should be fully operational and functional by calendar year 2013.

Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

Texas Healthcare Transformation and Quality Improvement Program
Demonstration Approval Period: December 12, 2011 through September 30, 2016

Attachment D
Interim Quality Improvement Strategy For STAR+PLUS HCBS Program

Executive management will be provided quarterly reports that will include an evaluation of the overall Quality Improvement Strategy with recommended changes that will result in program improvement. The State will develop processes for evaluation the Quality Improvement Strategy by calendar year 2013.

Attachment E HCBS Quality Review Worksheet

The following worksheet provides the sub-assurances and performance measures for level of care determinations, service plan development and maintenance, qualified providers, health and welfare, administrative authority, and financial accountability. This information was transferred from the state's 1915(c) STAR+PLUS waivers, and these measures will remain in effect under the Demonstration until such time as a comprehensive quality strategy has been developed and approved by CMS.

Where applicable, the State shall consider using the follow types of evidence to verify adherence to the sub-assurances for Level of Care Determinations, Service Plans, Qualified Providers, Health and Welfare, Administrative Authority, and Financial Accountability: Summary reports based on a significant sample of any single or combined method or source of evidence, such as On-site record reviews; Off-site record reviews; Training: record verification; On-site observations, interviews, monitoring; Analyzed collected data (including surveys, focus group, interviews, etc.); Trends, remediation actions proposed/taken; Provider performance monitoring, Operating agency performance monitoring; Staff observation or opinion; Participant/family observation/opinion; Critical events and incident reports; Mortality reviews; Program logs; Medication administration data reports, logs; Financial records (including expenditures); Financial audits; Meeting minutes; Presentation of policies; and Reports to HHSC on delegated administrative functions.

I. Level of Care (LOC) Determination

The State demonstrates that it implements the processes and instrument(s) specified in its 1915(c) waiver for the STAR+PLUS program, which was subsumed by this Demonstration, for evaluating/reevaluating an applicant's/Demonstration participant's level of care consistent with care provided in a nursing facility. The State, through the Health and Human Services Commission, will collect the data indicated below based on a representative sample on a continuous, ongoing basis.

| Sub-Assurances | CMS Expectations | Performance Measures |
|---|---|---|
| An evaluation for level of care is provided to all applicants for whom there is a reasonable indication that services may be needed in the future. | State submits evidence that it has reviewed applicant files to verify that individual level of care evaluations are conducted. | Number and percent of applicants who had a LOC evaluation prior to the receipt of services. |
| The level of care of enrolled participants is reevaluated at least annually. | State submits evidence that it reviews participant files to verify that reevaluations of level of care are conducted at least annually. | Number and percent of members' who received an annual determination of eligibility within 12 months from premium LOC evaluation |
| The process and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care. | State submits that it regularly reviews participant files to verify that the approved instrument is used appropriately in all LOC redeterminations and the person(s) who implement LOC determinations are those specified under this Demonstration. | Number and percent of members' initial LOC determinations that were made using the instrument required by the State. Number and percent of members' annual LOC determinations that were made by a qualified evaluator. |
| Methods for Remediation/Fixing Individual Problems Related to Level of Care Determinations | | |
| The State's Medicaid Management Information System (MMIS) prevents entry of Medical Necessity/LOC determinations that are not completed by a qualified person or are not completed using an approved instrument. If the system rejects the Medical Necessity/LOC, the managed care organization (MCO) must submit a Medical Necessity/LOC completed by a qualified person using an approved instrument. | | |
| The system does not allow payment for services delivered to a person without a Medical Necessity/LOC determination. If a person receives services prior to the completion of the Medical Necessity/LOC determination, the MCO receives a reduced capitation payment. The State would require the MCO to complete the Medical Necessity/LOC determination within forty-five (45) days. If not completed within forty-five (45) days, the MCO is contacted directly for resolution and, if necessary, a corrective action plan will be issued. The State collects data and completed corrective action plans, which are retained in the State's database. If the redetermination is not completed timely, the MCO is paid a reduced capitation payment and must | | |

Attachment E HCBS Quality Review Worksheet

complete the Medical Necessity/LOC within 10 business days of notification by the State. If not completed within 10 business days, the MCO is contacted directly for resolution and, if necessary, a corrective action plan will be issued.

II. Service Plans

The State demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for Demonstration participants receiving HCBS services. The State, through an independent external vendor that contracts with the Health and Human Services Commission, will collect and analyze the data indicated below annually using a proportional sampling approach at less than 100% review.

| Sub-Assurances | CMS Expectations | Performance Measures |
|---|---|--|
| Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of Demonstration HCBS services or through other means. | The State demonstrates that service plans are reviewed periodically to assure that all participant needs are addressed and preferences considered. | <p>Number and percent of members who had service plans that addressed members' needs (including health care needs) as indicated in the assessment(s);</p> <p>Number and percent of members' service plans that address members' goals as indicated in the assessment(s).</p> <p>Number and percent of members reporting that service coordinators asked about their preferences.</p> |
| The State monitors service plan development in accordance with its policies and procedures. | The State submits evidence of its monitoring process for service plan development and any corrective action taken when service plans were not developed according to policies and procedures. | Number and percent of members' service plans that were developed in accordance with the State's policies and procedures. |
| Service plans are updated/revised at least annually or when warranted by changes in the Demonstration participant's needs. | The State submits evidence of its monitoring process for service plan update/revision including service plan updates when a participant's needs changed and corrective actions taken when service plans were not updated/revised according to policies and procedures | <p>Number and percent of members' service plans that are renewed annually prior to service plan expiration date.</p> <p>Number and percent of members' service plans that addressed member needs including revisions when appropriate.</p> <p>Number and percent of members' service plan changes that occur within State required time frames when members' needs change.</p> |
| Services are delivered in accordance with the service plan, including in the type, scope, amount, and frequency specified in the service plan. | The State submits evidence of the results of its monitoring process for ensuring the services identified in the service plan are implemented. | Number and percent of members whose services were delivered according to the service plan; |
| Participants are afforded choice: 1) Between Demonstration services and institutional care; 2) Between/among Demonstration services and providers. | The State submits evidence of the results of its monitoring process for ensuring services identified in the service plan are implemented. | <p>Number and percent of members who were afforded choice between waiver services and institutional care.</p> <p>Number and percent of members who</p> |

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HCBS Quality Review Worksheet

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| | | signed that they understand their right to change MCOs and who to contact. |
| Methods for Remediation/Fixing Individual Problems Related to Service Plans | | |
| <p>If a member's service plan is discovered not to meet the member's needs, goals, preferences, or risks, the State requires the MCO to revise the service plan based on the assessment, correcting any deficiencies within the State established timeframes. If a member's service plan is discovered not to have been developed according to standards set by the State, the State requires the MCO to revise the service plan according to State policies and procedures within State established timeframes.</p> <p>The system does not allow payment for services delivered to a person without a service plan. If a person receives services prior to the completion of the services plan, the CMO receives a reduced capitation payment. The State would require the MCO to complete the services plan within forty-five (45) days. If not completed within forty-five (45) days, the MCO is contacted directly for resolution, and if necessary, a corrective action plan will be issued. If the redetermination is not completed timely, the MCO is paid a reduced payment and must complete the service plan within ten (10) business days of notification by the State. If not completed within ten (10) business days, the MCO is contacted directly for resolution and, if necessary a corrective action plan will be issued. The State collects data and completed corrective action plans, which are retained in the State's database.</p> <p>If a member's service plan is not updated to address changes in need within State required timeframes, the State requires the MCO to revise the service plan correcting any deficiencies within State established timeframes. If a member is discovered to not have received services according to his or her service plan, the MCO will either be required to deliver the services according to the service plan, or to revise the service plan if the member's circumstances have changed and deliver services in accordance with the revised plan. If a member's service plan does not indicate that the member was provided choice of waiver services—the choice between waiver services and institutional care—and was not informed of the right to change MCOs, the MCO is required to meet with the member, within state established timeframes, to revise the member's service plan to indicate that the member If the member's choices are different than what is already being provided, the member's choices will be honored within established timeframes.</p> | | |

III. Qualified Providers

The State demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers. The State, through the Health and Human Services Commission, will collect the data indicated below based on a representative sample on a continuous, ongoing basis.

| Sub-Assurances | CMS Expectations | Performance Measures |
|---|---|---|
| The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing services. | The State provides documentation of periodic review by licensing or certification entity. | <p>Number and percent of new program providers that are licensed/certified as required, prior to the provision of services;</p> <p>Number and percent of program providers recertified by the MCOs which retain licensure/certification</p> <p>Number and percent of program providers that assure that personnel who provide services to members are qualified by licensing, certification, and State regulations;</p> |
| The State monitors non-licensed/non-certified providers to assure adherence to waiver | The State provides documentation that non-licensed/non-certified providers are monitored on a | Number and percent of new non-licensed providers of waiver services that meet background and training |

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HCBS Quality Review Worksheet

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| requirements. | periodic basis sufficient to provide protections to Demonstration participants. | qualifications prior to the provision of services; Number and percent of non-licensed providers of waiver services that meet background and training qualifications prior to the provision of services; |
| The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved Demonstration. | The State provides documentation of monitoring of training and actions it has taken when providers have not met requirements (e.g., technical assistance, training). | Number and percent of providers who receive state required training; |

Methods for Remediation/Fixing Individual Problems Related to Qualified Providers

Individual problems may be discovered during monitoring activities by the State or any of the entities that have been delegated certain functions within the performance measures of this appendix. Those responsible for conducting the monitoring and frequency are described in each performance measure of this appendix. The options for remediation are as follows: For all performance measures related to provider qualifications, the State initiates remediation if an unqualified provider is discovered delivering services by requiring the MCO or the employing agency to terminate the provider's contract, recoup payment, transition members to qualified providers, and ref to the HHSC Office of Inspector General and the Department of Aging and Disability Service Regulatory if appropriate.

If the State discovers that provider training was not received according to State requirements, the State will require that the MCO take action within State established timeframes, including, but not limited to, completion of training within specified timeframes, corrective action plans, and contract suspension or termination.

IV. Health and Welfare

The State demonstrates, on an ongoing basis that it identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation.

| Sub-Assurances | CMS Expectations | Performance Measures |
|---|--|---|
| The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation. | The State demonstrates that, on an ongoing basis, abuse, neglect, and exploitation are identified, appropriate actions have been taken when the health or welfare of a participant has not been safeguarded, and an analysis is conducted of abuse, neglect, and exploitation trends and strategies it has implemented for prevention. | Number and percent of member complaints that received follow-up within the required timeframe. Number and percent of newly enrolled members who received educational materials upon enrollment on reporting abuse, neglect and exploitation. |

Methods for Remediation/Fixing Individual Problems Related to Member Health and Welfare

Individual problems may be discovered during monitoring activities by the State or any of the entities that have been delegated certain functions within the performance measures of this appendix. Those responsible for conducting the monitoring and frequency are described in each performance measure of this appendix.

If the State discovers that a complaint has not been followed up on within the timeframe required by the

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HCBS Quality Review Worksheet

State, the managed care organization is subject to various remedies which may include communicating with the managed care organization directly, requiring corrective actions to be completed when appropriate, assessing liquidated damages, freezing enrollment into the managed care organization, and termination of the MCO's contract. All remedies are accompanied by the assumption that the MCO will resolve the complaint. If the State discovers that upon enrollment a member was not provided educational material on reporting abuse, neglect, and exploitation, the managed care organization is required to provide the member with that material within State established timeframes.

V. Administrative Authority

The State demonstrate that it retains ultimate administrative authority over the Demonstration HCBS program and that its administration of the program is consistent with the approved Demonstration Terms and Conditions

| Sub-Assurances | CMS Expectations | Performance Measures |
|--|---|---|
| The Medicaid agency retains ultimate administration authority and responsibility for the operation of the Demonstration's HCBS program by exercising oversight of the performance of Demonstration functions by other State and local/regional non-State agencies (if appropriate) and contracted entities. | State submits evidence of its monitoring of all delegated functions, and implementation of policies/procedures related to its administration authority over the Demonstration's HCBS program, including: memoranda of agreements, description of roles and responsibilities relative to program operations, monitoring, and remediation or system improvements instituted when programs are identified in the operation of the program. | <p>Number and percent of enrollments completed by the Department of Aging and Disability Services within five days of posting service plan to a secure File Transfer Protocol server by the managed care organization.</p> <p>Number and percent of level of care evaluation determinations completed by Texas Medicaid Healthcare Partnership within required time frames.</p> <p>Number and percent of initial level of care evaluation determinations verified by the Department of Aging and Disability Services prior to service delivery.</p> <p>Number and percent of level of care redeterminations verified by the Department of Aging and Disability Services that were completed within required time frames.</p> <p>Number and percent of member service plans verified as meeting waiver requirements by the Department of Aging and Disability Services prior to service delivery.</p> <p>Number and percent of members' service plans authorized by the managed care organization prior to service delivery.</p> <p>Number and percent of managed care organizations that follow an agreed upon utilization process as outlined in their</p> |

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HCBS Quality Review Worksheet

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| | | <p>contracts.</p> <p>Number and percent of managed care organizations that contracted with only qualified Medicaid providers as outlined in their contracts.</p> <p>Number and percent of managed care organizations that demonstrate their credentialing process meets the State's criteria as outlined in their contracts.</p> |
| Methods for Remediation/Fixing Individual Problems Related to Administrative Authority | | |
| <p>In reference to the execution of Medicaid provider agreements, the process varies somewhat in STAR+PLUS program. The managed care organizations contracted with the State of Texas to manage and operate the STAR+PLUS program contract only with providers that are Medicaid certified. The managed care organizations have a credentialing process to ascertain and confirm that the provider has a Medicaid provider agreement with the State along with meeting all applicable licensure and/or certification requirements prior to contracting with the managed care organization.</p> <p>Individual problems may be discovered during monitoring activities by the State or by any of the entities that have been delegated certain functions within the performance measures of this appendix. Those responsible for conducting the monitoring and frequency are described in each performance measure of this appendix. The options for remediation are listed below:</p> <p>If the State discovers the Texas Medicaid Healthcare Partnership has not completed a level of care within required timeframes, the Texas Medicaid Healthcare Partnership will be required to complete the level of care within State established timeframes. The State monitors the timeliness requirement monthly using an automated contract management/monitoring system. If the requirement is identified as not being met in one month, a performance memo is sent to TMHP documenting the deficiency and corrective measures are requested. If a second "Not Met" is identified, the issues are referred to the Performance Group for an evaluation of a formal remedy under the Contract which include: oral notice of deficiency; written notice of deficiency; request for a corrective action plan; assessment of a performance remedy (i.e. liquidated damages, actual damages, etc.).</p> <p>If the State discovers that the Department of Aging and Disability Services has not, within State established timeframes, completed an enrollment, verified a level of care appropriately, or verified a service plan, the State will, within five business days of the discovery, notify the Department of Aging and Disability Services of its finding and request that the Department of Aging and Disability Services respond with the reasons for the deficiency and its proposed corrective action. HHSC will notify the Department of Aging and Disability Services in writing of specific areas of the Department of Aging and Disability Services' performance that fail to meet performance expectations, standards, or schedules set forth in the operating agreement between the Department of Aging and Disability Services and HHSC or the STAR+PLUS waiver documents. The Department of Aging and Disability Services will, within ten business days (or another date approved by HHSC) of receipt of written notice, provide HHSC with a written response that explains the reasons for the deficiency, outlines the Department of Aging and Disability Services' plan to address or cure the deficiency, and states the date by which the deficiency will be cured. If the Department of Aging and Disability Services disagrees with HHSC's findings, this written response will state the reasons for disagreement with HHSC's findings. The Department of Aging and Disability Services' proposed cure of a deficiency is subject to approval of HHSC.</p> <p>At its option, HHSC may require the Department of Aging and Disability Services to submit to HHSC a written plan to correct or resolve any noncompliance with the operating agreement between the two</p> | | |

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agencies. The corrective action plan must provide a detailed explanation of the reasons for the cited deficiency; the Department of Aging and Disability Services' assessment or diagnosis of the cause; and a specific proposal to cure or resolve the deficiency (including the date by which the deficiency will be cured). The corrective action plan must be submitted by the deadline set forth in HHSC's request for a corrective action plan. The corrective action plan is subject to approval by HHSC.

If the State discovers that a managed care organization has not, within State established timeframes, authorized a service plan, followed an agreed upon utilization process, contracted with qualified Medicaid providers, or demonstrated a credentialing process, the State will require the managed care organization to take corrective action within State established timeframes.

VI. Financial Accountability

The State demonstrates that it has designed and implemented an adequate system for assuring financial accountability of the Demonstration's HCBS program.

| Sub-Assurances | CMS Expectations | Performance Measures |
|--|--|---|
| State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved Demonstration. | <p>The State submits results of its financial monitoring process for verifying maintenance of appropriate financial records as specified in the approved Demonstration.</p> <p>The State submits results of its review of Demonstration participant claims to verify that they are coded and paid in accordance with the Demonstration's reimbursement methodology.</p> <p>The State demonstrates that interviews with State staff and providers are periodically conducted to verify that any identified financial irregularities are addressed.</p> <p>The State demonstrates that site visits are conducted with providers to verify that they maintain financial records according to provider agreements/contracts.</p> | Number and percent of per member per month capitated payments paid to the managed care organization only for eligible Medicaid members. |
| Methods for Remediation/Fixing Individual Problems Related to Financial Accountability | | |
| <p>Individual problems may be discovered during monitoring activities by the State or any of the entities that have been delegated certain functions within the performance measures of this appendix. Those responsible for conducting the monitoring and frequency are described in each performance measure of this appendix. The options for remediation are as follows: If the State discovers that a capitated payment was made to a managed care organization for a non-eligible member, the State recoups the funds from the managed care organization. At the end of the month in which the member became ineligible, the member is disenrolled from the program.</p> | | |

Attachment F
HCBS Fair Hearing Procedures

The material presented in Attachment F corresponds to the contents of Appendix F of the Application for a §1915(c) Home and Community-Based Services Waiver, Version 3.5.

I. Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing

The managed care organization (MCO) must develop, implement and maintain an Appeal procedure that complies with state and federal laws and regulations. When a Member or his or her authorized representative expresses orally or in writing any dissatisfaction or disagreement with an Action, the MCO must regard the expression of dissatisfaction as a request to Appeal an Action.

A Member must file a request for an Appeal with the MCO within 30 days from receipt of the notice of reduction, denial or termination of services.

The MCO's Appeal procedures must be provided to Members in writing and through oral interpretive services.

The MCO must send a letter to the Member within five (5) business days acknowledging receipt of the Appeal request. Except for the resolution of an Expedited Appeal, the MCO must complete the entire standard Appeal process within 30 calendar days after receipt of the initial written or oral request for Appeal. The timeframe for a standard Appeal may be extended up to 14 calendar days if the Member or his or her representative requests an extension; or the MCO shows that there is a need for additional information and how the delay is in the Member's interest. If the timeframe is extended and the Member had not requested the delay, the MCO must give the Member written notice of the reason for delay. The MCO must designate an officer who has primary responsibility for ensuring that Appeals are resolved within these timeframes and in accordance with the MCO's written policies.

In accordance with 42 C.F.R. § 438.420, the MCO must continue the Member's benefits currently being received by the Member, including the benefit that is the subject of the Appeal, if all of the following criteria are met:

1. The Member or his or her representative files the Appeal timely as defined in this Contract;
2. The Appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
3. The services were ordered by an authorized provider;

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4. The original period covered by the original authorization has not expired; and
5. The Member requests an extension of the benefits.

If, at the Member's request, the MCO continues or reinstates the Member's benefits while the Appeal is pending, the benefits must be continued until one of the following occurs:

1. The Member withdraws the Appeal;
2. Ten (10) days pass after the MCO mails the notice resolving the Appeal against the Member, unless the Member, within the 10-day timeframe, has requested a Fair Hearing with continuation of benefits until a Fair Hearing decision can be reached; or
3. A state Fair Hearing officer issues a hearing decision adverse to the Member or the time period or service limits of a previously authorized service has been met.

In accordance with 42 C.F.R. § 438.420(d), if the final resolution of the Appeal is adverse to the Member and upholds the MCO's Action, then to the extent that the services were furnished to comply with the Contract, the MCO may recover such costs from the Member.

If the MCO or State Fair Hearing Officer reverses a decision to deny, limit, or delay services that were not furnished while the Appeal was pending, the MCO must authorize or provide the disputed services promptly and as expeditiously as the Member's health condition requires.

If the MCO or State Fair Hearing Officer reverses a decision to deny authorization of services and the Member received the disputed services while the Appeal was pending, the MCO is responsible for the payment of services.

The MCO is prohibited from discriminating or taking punitive action against a Member or his or her representative for making an Appeal.

In accordance with 42 C.F.R. § 438.410, the MCO must establish and maintain an expedited review process for Appeals, when the MCO determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the Member's life or health. The MCO must follow all Appeal requirements for standard Member Appeals except where differences are specifically noted. The MCO must accept oral or written requests for Expedited Appeals.

Members must exhaust the MCO's Expedited Appeal process before making a request for an expedited Fair Hearing. After the MCO receives the request for an Expedited Appeal, it must hear an approved request for a Member to have an Expedited Appeal and notify the Member of the outcome of the Expedited Appeal within 3 business days, except that the MCO must complete investigation and resolution of an Appeal relating to an ongoing emergency or denial of continued hospitalization:

1. In accordance with the medical or dental immediacy of the case; and
2. not later than one business day after receiving the Member's request for Expedited Appeal is received.

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The MCO is prohibited from discriminating or taking punitive action against a Member or his or her representative for requesting an Expedited Appeal. The MCO must ensure that punitive action is neither taken against a provider who requests an expedited resolution or supports a Member's request.

If the MCO denies a request for expedited resolution of an Appeal, it must:

1. Transfer the Appeal to the timeframe for standard resolution, and
2. Make a reasonable effort to give the Member prompt oral notice of the denial, and follow up within two (2) calendar days with a written notice.

The MCO must inform Members that they have the right to access the Fair Hearing process at any time during the Appeal system provided by the MCO. In the case of an expedited Fair Hearing process, the MCO must inform the Member that the Member must exhaust the MCO's internal Expedited Appeal process prior to filing an Expedited Fair Hearing. The MCO must notify Members that they may be represented by an authorized representative in the Fair Hearing process.

If a Member requests a Fair Hearing, the MCO will submit to the request to the appropriate Fair Hearings office, within five (5) calendar days.

Within five (5) calendar days of notification that the Fair Hearing is set, the MCO will prepare an evidence packet for submission to the HHSC Fair Hearings staff and send a copy of the packet to the Member. The evidence packet must comply with HHSC's Fair Hearings requirements.

The Fair Hearings Officer makes the final decision on appeals submitted to Fair Hearings. The Fair Hearings Officers are employees of HHSC that are separate from the State Medicaid Agency. This provides for an independent review and disposition for the member. The MCO sends a letter to the member informing the member that if an appeal is filed timely the member's benefits/services will continue. The member may also contact a member advocate or service coordinator for assistance or clarification. All documentation related to the adverse action and/or requests are maintained by the managed care operation in the member's case file.

II. State Grievance/Complaint System

The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services.

A. Operational Responsibility

HHSC, the State Medicaid agency, and the MCO operate the grievance/complaint system.

The State Medicaid Agency operates and maintains an electronic complaint/grievance system that provides information to HHSC staff on any complaints/grievances related to members of the MCOs. The MCO is required by contract to develop, implement and maintain a member complaint and appeal system specific to their members.

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The member is informed at enrollment that filing a grievance or making a complaint is not a pre-requisite or substitute for Fair Hearing. The member is also informed that they can contact a Member Advocate or their service coordinator if they need assistance for issues related to making complaints or filing a grievance.

B. Description of System

The MCO must develop, implement, and maintain a Member Complaint and Appeal system that complies with the requirements in applicable federal and state laws and regulations.

The Complaint and Appeal system must include a Complaint process, an Appeal process, and access to HHSC's Fair Hearing System. The procedures must be the same for all Members and must be reviewed and approved in writing by HHSC or its designee. Modifications and amendments to the Member Complaint and Appeal system must be submitted for HHSC's approval at least 30 days prior to the implementation.

The MCO must have written policies and procedures for receiving, tracking, responding to, reviewing, reporting and resolving Complaints by Members or their authorized representatives. The MCO must resolve Complaints within 30 days from the date the Complaint is received. The Complaint procedure must be the same for all Members under the Contract. The Member or Member's authorized representative may file a Complaint either orally or in writing. The MCO must also inform Members how to file a Complaint directly with HHSC, once the Member has exhausted the MCO's complaint process.

The MCO's Complaint procedures must be provided to Members in writing and through oral interpretive services. The MCO must include a written description of the Complaint process in the Member Handbook. The MCO must maintain and publish in the Member Handbook, at least one local and one toll-free telephone number with Teletypewriter/Telecommunications Device for the Deaf (TTY/TDD) and interpreter capabilities for making Complaints.

The MCO's process must require that every Complaint received in person, by telephone, or in writing must be acknowledged and recorded in a written record and logged with the following details:

1. Date;
2. Identification of the individual filing the Complaint;
3. Identification of the individual recording the Complaint;
4. Nature of the Complaint;
5. Disposition of the Complaint (i.e., how the managed care organization resolved the Complaint);
6. Corrective action required; and
7. Date resolved.

The MCO is prohibited from discriminating or taking punitive action against a Member or his or her representative for making a Complaint.

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If the Member makes a request for disenrollment, the MCO must give the Member information on the disenrollment process and direct the Member to the HHSC Administrative Services Contractor. If the request for disenrollment includes a Complaint by the Member, the Complaint will be processed separately from the disenrollment request, through the Complaint process.

The MCO will cooperate with the HHSC's Administrative Services Contractor and HHSC or its designee to resolve all Member Complaints. Such cooperation may include, but is not limited to, providing information or assistance to internal Complaint committees. The MCO must provide a designated Member Advocate to assist the Member in understanding and using the MCO's Complaint system until the issue is resolved.

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The material presented in Attachment G corresponds to the contents of Appendix G of the Application for a §1915(c) Home and Community-Based Services Waiver, Version 3.5.

I. RESPONSE TO CRITICAL EVENTS OR INCIDENTS

The State operates a Critical Event or Incident Reporting and Management Process.

A. State Critical Event or Incident Reporting Requirements: The State has in place the reporting and investigation of abuse, neglect, and exploitation to ensure health and safety of waiver members.

- 1. The State definition of abuse, neglect and exploitation of adults, incident reporting requirements and reporting mechanism is found in Chapter 48 of the Human Resource Code (Investigations And Protective Services For Elderly And Disabled Persons):**

Sec. 48.002. DEFINITIONS.

a) Except as otherwise provided under Section 48.251, in this chapter:

1. "Elderly person" means a person 65 years of age or older.
2. "Abuse" means:
 - A. the negligent or willful infliction of injury, unreasonable confinement, intimidation, or cruel punishment with resulting physical or emotional harm or pain to an elderly or disabled person by the person's caretaker, family member, or other individual who has an ongoing relationship with the person; or
 - B. sexual abuse of an elderly or disabled person, including any involuntary or nonconsensual sexual conduct that would constitute an offense under Section 21.08, Penal Code (indecent exposure) or Chapter 22, Penal Code (assaultive offenses), committed by the person's caretaker, family member, or other individual who has an ongoing relationship with the person.
3. "Exploitation" means the illegal or improper act or process of a caretaker, family member, or other individual who has an ongoing relationship with the elderly or disabled person using the resources of an elderly or disabled person for monetary or personal benefit, profit, or gain without the informed consent of the elderly or disabled person.
4. "Neglect" means the failure to provide for one's self the goods or services, including medical services, which are necessary to avoid physical or emotional harm or pain or the failure of a caretaker to provide such goods or services.

Sec. 48.002(a)(8).

"Disabled person" means a person with a mental, physical, or developmental disability that substantially impairs the person's ability to provide adequately for the person's care or protection and who is:

- (A) 18 years of age or older; or
- (B) under 18 years of age and who has had the disabilities of minority removed.

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2. DADS licensing and contracting rules contain requirements related to reporting incidents and complaints. DADS regularly monitors a provider's compliance with these requirements.

All facilities and agencies providing services to waiver members are required to comply with the following requirements:

- All facilities and agencies providing services to waiver members must comply with the provisions of Chapter 250 of the Health and Safety Code (relating to Nurse Aide Registry and Criminal History Checks of Employees And Applicants For Employment In Certain Facilities Serving The Elderly, Persons With Disabilities, or Persons With Terminal Illnesses).
- Before a facility or agency hires an employee, the facility or agency must search the employee misconduct registry (EMR) established under §253.007, Health and Safety Code, and DADS' nurse aide registry (NAR) to determine if the individual is designated in either registry as unemployable. Both registries can be accessed on the DADS Internet website.
- A facility or agency is prohibited from hiring or continuing to employ a person who is listed in the employee misconduct registry or nurse aide registry as unemployable.
- A facility or agency must provide information about the employee misconduct registry to all employees in accordance with 40 Texas Administrative Code §93.3 (relating to Employee Misconduct Registry).
- In addition to the initial verification of employability, a facility or agency must:
 - conduct a search of the nurse aide registry and the employee misconduct registry annually during the month of each employee's employment anniversary date to determine if the employee is listed in either registry as unemployable; and
 - keep a copy of the results of the initial and annual searches of the nurse aide registry and employee misconduct registry in the employee's personnel file.

3. 40 Texas Administrative Code §92.102 (relating to Abuse, Neglect, or Exploitation Reportable to the State by Facilities and Agencies) also provides a process for reporting abuse, neglect, or exploitation to the State:

(a) Any facility or agency staff who has reasonable cause to believe that a resident is in a state of abuse, neglect, or exploitation must report the abuse, neglect, or exploitation to DADS' state office at 1-800-458-9858 and must follow the facility's internal policies regarding abuse, neglect, or exploitation.

(b) The following information must be reported to the department:

- (1) name, age, and address of the member;
- (2) name and address of the person responsible for the care of the member, if available;
- (3) nature and extent of the elderly or disabled person's condition;
- (4) basis of the reporter's knowledge; and
- (5) any other relevant information.

(c) The facility agency must investigate the alleged abuse or neglect and send a written report of the investigation to DADS' state office no later than the fifth calendar day after the oral report.

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(d) A facility or agency may not retaliate against a person for filing a complaint, presenting a grievance, or providing in good faith information relating to personal care services provided by the facility.

4. Pursuant to Human Resource Code Sec. 48.151 (relating to Action On Report), the State is required to take the following actions:

Not later than 24 hours after the department receives a report of an allegation of abuse, neglect, or exploitation under Section 48.051, the department shall initiate a prompt and thorough investigation as needed to evaluate the accuracy of the report and to assess the need for protective services, unless the department determines that the report:

- a. is frivolous or patently without a factual basis; or
- b. does not concern abuse, neglect, or exploitation, as those terms are defined by Section 48.002.

5. DADS investigatory requirements are described in Human Resources Code Sec. 48.152 (relating to Investigation):

An investigation by the department or a state agency shall include an interview with the elderly or disabled person, if appropriate, and with persons thought to have knowledge of the circumstances. The investigation may include an interview with an alleged juvenile perpetrator of the alleged abuse, neglect, or exploitation. The department or state agency may conduct an interview under this section in private or may include any person the department or agency determines is necessary.

6. Licensure Requirements

DADS licenses the following providers: Home and Community Support Services Agencies (40 Texas Administrative Code, Chapter 97); assisted living facilities (40 Texas Administrative Code, Chapter 92); adult foster care, serving four individuals (40 Texas Administrative Code, Chapter 92); intermediate care facilities for persons with mental retardation (40 Texas Administrative Code, Chapter 90); and nursing facilities providing out-of-home respite (VTCA Human Resources Code Chapter 145 40 Texas Administrative Code 48.6034).

DADS does not license or certify home-delivered meals providers; however, the home-delivered meals providers are required to comply with DADS contracting rules at 40 Texas Administrative Code, Chapter 49, and DADS program rules at 40 Texas Administrative Code, Chapter 55. Adult foster care providers who serve three or fewer individuals are not licensed, but are reviewed annually for compliance with adult foster care home requirements. The requirements for adult foster care are found in 40 Texas Administrative Code, Chapter 98.

Emergency response services providers are licensed by the Department of State Health Services (25 Texas Administrative Code, Chapter 140, Subchapter B).

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All providers, whether licensed by DADS or not, are required to report any instances of abuse, neglect, or exploitation of an individual to the Department of Family and Protective Services (DFPS) immediately upon suspicion of such activities. DFPS investigates assigned reports and makes a determination as to whether abuse, neglect, or exploitation occurred. In some instances, DFPS may offer services, if appropriate. Providers subject to DADS licensure are further required to report allegations of abuse, neglect, and exploitation directly to DADS immediately upon suspicion of such activities.

Providers make the reports of suspected abuse, neglect, or exploitation by telephone to either the State abuse hotline or the licensing complaint hotline. Individuals may report suspected instances of abuse, neglect, or exploitation using either telephone number 24 hours a day.

DADS requires licensed providers to have a disaster preparedness plan in place.

B. Participant Training and Education

At the time an applicant is enrolled in the LTSS STAR+PLUS waiver program, the managed care organization and contracted providers must ensure that the member is informed orally and in writing of the processes for reporting allegations of abuse, neglect, or exploitation. The toll-free numbers for HHSC, DADS and DFPS must be provided. Facilities must post the information in a conspicuous place. Home and community support services agencies must provide the information to the member at the time of admission. Evidence supporting compliance with these requirements is reviewed during DADS' on-site licensure surveys and managed care organization contract monitoring reviews of the program provider.

The service coordinators play a role in ensuring that waiver member receives training and education regarding protections from abuse, neglect, and exploitation. Service coordinators provide information regarding protections from abuse, neglect, and exploitation at the time the members are enrolled in the LTSS STAR+PLUS waiver program. Service providers advise waiver member of their rights to freedom from abuse, neglect, and exploitation by ensuring that the member read and sign the Consumer Rights and Responsibilities form. Training occurs at the time of the member's enrollment. Additional Training is provided upon the member's request.

In addition to the information provided to all members in the waiver, a CDSA provides members who elect the consumer directed services option with training and written information related to reporting allegations of abuse, neglect, and exploitation.

C. Responsibility for Review of and Response to Critical Events or Incidents

The Texas Department of Family and Protective Services (DFPS) is responsible for receiving and investigating reports of abuse, neglect, and exploitation for all adults. DFPS assigns a

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priority level to a complaint at the time of intake based on the perceived threat level to the member. DFPS must initiate a case by contacting a person with current and reliable information within 24 hours of intake, and must conclude the investigation within 30 days. The investigator may change the priority level based on information from the contact. DFPS must make the initial face-to-face contact with the alleged victim based on the priority level. The results of the investigation are reported to the complainant and other pertinent parties within 30 days by generating a letter from their automated system.

Texas Human Resources Code Chapter 48 requires that DFPS investigate persons thought to have knowledge of the circumstances regarding abuse, neglect, and exploitation. Texas Human Resources Code also provides certain laws to assist with investigations including access to records and a prohibition against interference with investigation or services.

All abuse, neglect and exploitation reported to the DFPS as required by licensure regulations are investigated. Investigation of some self-reported incidents may be completed without an on-site investigation. If further investigation is warranted to ensure compliance with federal, state, or local laws, an on-site investigation is scheduled.

The State's code on health and safety for waiver members addresses abuse, neglect and exploitation.

The State's regulatory agency publishes an online Employee Misconduct Registry that includes non licensed individuals that were investigated and found in violation of the health and safety of waiver members. As part of their licensure requirements, facilities and agencies are required to check the Registry prior to offering employment to anyone that will be providing direct service to a waiver member. Through their credentialing process, the managed care organizations ensure the agencies they contract with have met all licensure requirements.

D. Responsibility for Oversight of Critical Incidents and Events

In accordance with 42 Code of Federal Regulations, §431.10(e), HHSC is the Single State Medicaid Agency and retains oversight and full administrative authority over the waiver program.

The Texas Department of Family and Protective Services (DFPS) is also involved in administrative and operation activities. HHSC and DFPS are part of the Texas Health and Human Services Enterprise. DFPS is responsible for handling all reports of abuse, neglect, and exploitation related to adults receiving services in the community, including adults served by a Home and Community Support Services Agency licensed under Health and Safety Code, Chapter 142, except for those occurring in a facility subject to licensure by DADS.

As required by Texas Human Resources Code, §48.103, upon completion of an investigation in which abuse, neglect, or exploitation is validated against an employee of a Home and

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Community Support Services Agency or against an adult foster care provider, after the DFPS due process procedure has been completed, the DFPS Adult Protective Services caseworker releases the investigation findings to HHSC. HHSC reviews all investigation reports provided by DFPS. Based on the content of the report, HHSC may conduct an on-site survey of the provider or require the provider to submit evidence of follow-up action on the incident. The investigative findings and HHSC's follow-up on those findings is entered into the abuse, neglect, or exploitation database by HHSC staff. HHSC also records deaths in a database. Reports of critical incidents are compiled on a monthly basis for each program provider.

In preparation for annual and some intermittent reviews of providers, HHSC staff compiles data related to all critical incidents reported by or involving the program provider. HHSC may use this information in selecting the sample of individuals whose records will be reviewed and who may be interviewed to ensure appropriate follow-up was conducted by the provider.

All abuse, neglect and exploitation reported to the DFPS as required by licensure regulations are investigated. Investigation of some self-reported incidents may be completed without an on-site investigation. If further investigation is warranted to ensure compliance with federal, state, or local laws, an on-site investigation is scheduled.

Oversight activities occur on an ongoing basis. Information regarding validated instances of abuse, neglect or exploitation is monitored, tracked and trended for purposes of training HHSC staff and to prevent recurrence.

Providers are responsible for training their staff about reporting critical incidents and events.

II. SAFEGUARDS CONCERNING RESTRAINTS AND RESTRICTIVE INTERVENTIONS

The use of restraints or seclusion is permitted during the course of the delivery of waiver services.

A. Use of Restraints or Seclusion

1. Safeguards Concerning the Use of Restraints or Seclusion.

HHSC does not allow restraints in community-based settings except in an assisted living facility. The assisted living facility must have a policy about restraints and seclusion. The facility must notify the resident and, if applicable, their legal representative about HHSC's rules and the facility's policies about restraint and seclusion.

Licensing requirements for assisted living facilities prohibit the use of restraints unless it is a behavioral emergency and ordered by a physician. A provider may use physical or chemical restraints (seclusion is not permitted) only if the use is authorized in writing by a physician or if the use is necessary in an emergency to protect the resident or others from injury. A physician's

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written authorization for the use of restraints must specify the circumstances under which the restraints may be used and the duration for which the restraints may be used. The provider must make every attempt to use behavior management and de-escalation techniques prior to considering physical or chemical restraints. Assisted living facilities that choose to accept and retain residents with written physician's authorization must maintain this document in the resident files. Any use of restraints must be documented by the provider in the resident's record.

A restraint may not be administered under any circumstance if it obstructs the resident's airway, including a procedure that places anything in, on, or over the resident's mouth or nose, impairs the resident's breathing by putting pressure on the resident's torso, interferes with the residents ability to communicate, or places the resident in a prone or supine position.

If the facility uses a restraint hold, they must use an acceptable restraint hold. The assisted living facility rules explain what qualifies as an unacceptable and acceptable restraint hold. After the use of restraint the facility must, with the resident's consent, make an appointment with the resident's physician no later than the end of the first working day after the use of the restraint and document in the resident's record that the appointment was made. If the resident refuses to see the physician, they must document the refusal.

The State does not prescribe specific elements with respect to the documentation for instances in which an approved restraint is utilized on a waiver participant. The facility must develop these criteria based on the individual.

As soon as possible, but no later than 24 hours after the use of restraint, the facility must notify the participant's legally authorized representative or an individual actively involved in the resident's care, unless the release of this information would violate other law.

Attendants must complete 16 hours of on the job supervision and training within the first 16 hours of employment following orientation. The training must include seven specified topics. One of the topics is behavior management practices, such as prevention of aggressive behavior and de-escalation techniques, to decrease the frequency of the use of restraints.

Direct care staff must complete one hour of training annually in behavior management practices, such as prevention of aggressive behavior and de-escalation techniques, fall prevention, and alternatives to restraints. Facilities that employ licensed nurses, certified nurse aides, or certified medication aides must provide annual in-service training, appropriate to their job responsibilities from one of six topics. One of the topics is restraint use.

A facility may adopt policies that allow less use of restraint than allowed by the State's rules. See 40 Texas Administrative Code §92.41(p)(7). All actions and measures related to restraints or seclusion are state specific.

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DADS monitors improper use of restraints through on-site surveys and complaint investigations. As per the State's licensure requirements, the facility must demonstrate during on-site surveys and/or during a complaint investigation that a restraint policy is in place and the protocol used by the facility staff meets licensure parameters.

The State Uniform Managed Care Contract: Attachment B-1, Section 8.2.6, requires the managed care organizations to maintain written policies and procedures for informing members of their rights, consistent with 42 C.F.R. §438.100. Attachment B-1, Sections 8.1.5.1 and 8.1.5.3 establishes the general requirements for the managed care organizations member materials, including the Member Handbook. HHSC's Uniform Managed Care Manual (UMCM), which is incorporated by reference into the contract, provides the managed care organizations further guidance on the critical elements that need to be included in the member materials. Uniform Managed Care Manual Chapter 3.4 includes the critical elements for the Member Handbook, and Attachment L to this chapter provides the managed care organizations with template language regarding "Member Rights and Responsibilities."

UMCC Attachment B-1, 8.2.7 Medicaid Member Complaint and Appeal System

The managed care organization must develop, implement, and maintain a Member Complaint and Appeal system that complies with the requirements in applicable federal and state laws and regulations, including 42 Code of Federal Regulations §431.200, 42 Code of Federal Regulations Part 438, Subpart F, "Grievance System," and the provisions of 1 Texas Administrative Code Chapter 357 relating to Medicaid managed care organizations.

The Complaint and Appeal system must include a Complaint process, an Appeal process, and access to HHSC's Fair Hearing System. The procedures must be the same for all members and must be reviewed and approved in writing by HHSC or its designee. Modifications and amendments to the Member Complaint and Appeal system must be submitted for HHSC's approval at least 30 days prior to the implementation.

2. State Oversight Responsibility

Agencies and providers are monitored by the DADS, the regulatory agency that licenses these types of facilities. The managed care organizations monitor contract performance on a biannual basis. DADS uses a State approved protocol when conducting on-site visits and surveys that includes appropriate use of restraints as per licensure requirements. Any evidence of licensure violations is investigated and sanctions are applied as per state law and rules.

DADS is the State agency responsible for overseeing the use of restraints. Inspection and survey staff perform inspections and surveys, follow-up visits, complaint investigations, investigations of abuse or neglect, and other contact visits from time to time as they deem appropriate or as required for carrying out the responsibilities of licensing or in response to complaints. An inspection may be conducted by an individual surveyor or a team, depending on the purpose of the inspection or survey, size of facility, and service provided by the facility, and other factors.

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To determine standard compliance which cannot be verified during regular working hours, night or weekend inspections may be conducted to cover specific segments of operation and will be completed with the least possible interference to staff and residents. Generally, all inspections, surveys, complaint investigations and other visits, whether routine or non-routine, made for the purpose of determining the appropriateness of resident care and day-to-day operations of a facility will be unannounced. Exceptions must be justified. Certain visits may be announced, including, but not limited to, visits to determine conditions when certain emergencies arise, such as fire, windstorm, or malfunctioning or nonfunctioning electrical or mechanical systems. The facility must make all books, records, and other documents maintained by or on behalf of a facility accessible to DADS upon request. These facility inspections provide information regarding the use of restraints in an assisted living facility. DADS also investigates incidents and complaints related to use of restraints to ensure the assisted living facility is complying with state requirements.

DADS is able to collect data on specific complaints or licensing survey deficiencies for assisted living facilities. DADS Data Management and Analysis monitors, tracks and trends data regarding validated instances of abuse, neglect or exploitation for purposes of training DADS staff and to prevent recurrence. Management and Analysis also reports the number of validated instances of abuse, neglect, or exploitation in assisted living facilities, including restraint use. The incidence of inappropriate restraint use has been so low that occurrences are addressed on a case-by-case basis; however, if the incidence were to increase, trends and patterns could be analyzed to prevent reoccurrences.

DADS will determine if a facility meets licensing rules, including both physical plant and facility operation requirements. Violations of regulations will be listed on an inspection checklist designed for the purpose of the inspection and will include specific reference to the Assisted Living Standards for the violations cited. At the conclusion of an inspection, the inspector will perform an exit conference, advising the assisted living facility of the findings resulting from the inspection. At the exit conference, the inspector will provide a copy of the inspection checklist to the assisted living facility and lists each violation discovered during the inspection, with specific reference to the standard violated. If, after the initial exit conference, additional violations are cited, the inspector will conduct an additional exit conference regarding the newly identified violations, with specific reference to the standard violated. The facility must submit an acceptable plan of correction to the regional director not later than 10 calendar days after receiving notice that the final exit conference has been completed. An acceptable plan of correction must address the following areas:

- (1) how corrective action will be accomplished for those residents affected by the violation(s);
- (2) how the facility will identify other residents with the potential to be affected by the same violation(s);
- (3) the measures that will be put into place or systemic changes made to ensure the violation(s) will not recur;

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- (4) how the facility will monitor its corrective actions to ensure that the violation(s) are being corrected and will not recur; and
- (5) dates when corrective action will be completed.

A clear and concise summary in nontechnical language of each licensure inspection, inspection of care, or complaint investigation will be provided by DADS. That summary will outline significant violations noted at the time of the visit, but will not include names of residents, staff, or any other statement that would identify individual residents or other prohibited information under general rules of public disclosure. The summary will be provided to the facility at the time the report of contact or similar document is provided. If the provider and the inspector cannot resolve a dispute regarding a violation of regulations, the provider is entitled to a regional level informal dispute resolution (IDR) for all violations. For a violation determined to be valid, the provider is entitled to an IDR at either the regional or state office level. A written request and all supporting documentation must be submitted to the Regional Director, Long Term Care-Regulatory, for a regional IDR, or to Long Term Care-Regulatory, Texas DADS, P.O. Box 149030 (E-343), Austin, TX 78714-9030, for a central office IDR, no later than the tenth calendar day after receipt of the official statement of violations. DADS will complete the IDR process no later than the 30th calendar day after receipt of a request from a facility. Violations deemed invalid in an IDR will be so noted in DADS records.

If the provider's license is either suspended or revoked, the managed care organization will terminate the provider's existing contract. Steps to transition all members who are using the provider as an assistive living facility will be taken by the managed care organization to ensure the health and safety of the members.

In an effort to provide consistent policy and process, the State incorporates the DADS Quality Assurance and Improvement (QAI) vision for restraint reduction in Texas Long Term Care (LTC) as methodology of assuring the health and welfare of waiver members residing in assistive living and adult foster care facilities where restraints are permitted on a limited basis. The DADS Quality Assurance and Improvement vision for restraint reduction in Texas LTC is a resident-centered evaluation and care planning for restraint-free environments. In this framework, the term restraints focuses exclusively on devices applied to a resident's wrists, trunk or waist that limit the resident's normal access to the environment or self and that the resident cannot remove at will without assistance. While the use of other devices that achieve these same ends is also discouraged, the findings described below apply only to these three general classes of devices. The DADS Quality Monitoring Program uses this structured resident assessment to evaluate the appropriateness of resident assessment, care planning and care for residents who are restrained.

The Restraint Reductions Program includes the following elements and structure: unequivocal support from facility owners and administrators; restraint reduction education for all levels of direct care staff on every shift; restraint reduction education for medical staff and family members; use of a multidisciplinary restraint reduction team (a restraint Review Committee that

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includes a physician, nurse, Certified Nurses Aide staff, Administrator, housekeeping, others); use of a consultative, resident-centered, problem-solving approach; allocation of staff time specifically for restraint reduction; implementation of restraint reduction one unit or floor at a time; restraint reduction in the easiest residents first; use of restraint-free intervals to gradually reduce restraints in the most difficult residents; use of multiple interventions to solve individual clinical problems (average of three interventions per resident); long-term commitment to achieving a restraint-free environment (6-12 months to succeed); and on-going, scheduled re-evaluation of all residents who remain restrained.

The Program incorporates the following components: Identify any staff and family concerns or misconceptions about restraint use and restraint reduction; develop and distribute a restraint reduction education handout for family and staff to address concerns and false beliefs; use DADS Joint Trainings, handouts and Quality Matters Web presentations and resources to provide in-service and family education on restraint reduction; develop a plan for methodical restraint reduction and present it to staff, family and resident council; work with DADS Quality Monitors to test, evaluate and refine the restraint reduction program; create a Restraint Review Committee to evaluate all residents in restraints and all new orders for restraints; review and analyze data resulting from evaluations done by the Restraint Review Committee; begin with the Minimum Data Set Resident-Level QI Report to identify residents who are in restraints; visually identify additional residents not identified as being restrained by the Minimum Data Set report; evaluate each of these residents for appropriateness of restraints using the accompanying structured assessment instrument or a comparable instrument to evaluate each resident. Leave the completed assessment on the chart for future reference; use the results of structured assessment to identify residents who are not candidates for restraint reduction. Note the reasons in the resident's care plan. Ensure that in every instance there is a specific physician order for restraints and that the care plan addresses how the use of restraints will be monitored as well as when and how restraint reduction will be attempted; in each instance that restraint use is medically justifiable, schedule each such resident for periodic restraint use reevaluation. Evaluate the need for restraints justified as a temporary intervention for behavioral symptoms within a short time such as 24-48 hours that allows time for evaluation of causes and alternative interventions without permitting temporary restraint use to become on-going restraint use; for each remaining resident, identify the clinical problems for which restraints are currently being used; require the use of structured assessment for restraint use before restraints can be ordered; create a Restraint Review Committee that includes the facility Medical Director, an RN, physical therapist, other direct care staff and housekeeping; engage physical therapy/occupational therapy in the evaluation of the resident for restraint alternatives; require the Restraint Review Committee to approve all orders for restraints within 24 hours of the order; and use the Restraint Review Committee to develop care plan alternatives when structured assessment shows that there is no valid indication for the use of restraints. Reports of increased cases or unusual trends and patterns would be forwarded to the Regulatory Agency. The Texas Administrative Code requires the Regulatory Agency to perform inspections and surveys, follow-up visits, complaint investigations, investigations of abuse or neglect, and other contact visits from time to time as

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they deem appropriate or as required for carrying out the responsibilities of licensing (40 T.A.C. §92.81).

Inspection and survey personnel as well as the managed care organizations have access to data and information collected by the Restraint Review Committee when conducting site visits, desk reviews or as a result of a complaint investigation.

Recommendations for improvement are included in an overall Quality Improvement Plan and are shared with the managed care organizations contracted with the providers.

B. Use of Restrictive Interventions

The State does not permit or prohibits the use of restrictive interventions. HHSC does not allow restrictive interventions in any setting. DADS Regulatory Services licenses home and community support services agencies and assisted living facilities. DADS monitors unauthorized use of restrictive interventions through on-site surveys and complaint investigations. All surveys and inspections are unannounced. Contracted home and community support services agencies are surveyed during their first year of operation, approximately 18 months after the initial survey, and at least every 36 months thereafter. Assisted living facilities are inspected annually. Licenses are valid for one year. The inspection includes observation of the care of residents.

III. MEDICATION MANAGEMENT AND ADMINISTRATION

A. Medication Management and Follow-Up

1. Responsibility

Home and community support services agencies, assisted living facilities, adult foster care providers, and nursing facilities must provide medication management as required by their license. Other providers do not provide medication management.

Home and community support services agencies are required to monitor all aspects of a participant's medication that the agencies administer. Medication management is monitored at annual and quarterly reevaluations.

Assisted living facilities and nursing facility providers are required to monitor all aspects of a participant's medication. Provider registered nurses review the participant's medications annually and upon significant change in the participant's condition.

DADS oversees medication management provided by its contractors through licensure surveys and complaint investigations. HCSSAs are surveyed within 18 months of their initial licensure and every three years thereafter. Assisted Living facilities are surveyed annually. The

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state imposes penalties such as requiring corrective action plans, administrative penalties and license revocation when harmful medication management practices are detected. DADS survey staff follow up to ensure corrective action plans are properly implemented.

The adult foster care providers are monitored by the regulatory agency that licenses these types of facilities. The managed care organizations monitor contract performance on a biannual basis. The appropriate regulatory agency uses a State-approved protocol when conducting on-site visits and surveys that includes appropriate medication management as per licensure requirements. Any evidence of licensure violations is investigated and sanctions are applied as per state law or rules. DADS Data Management and Analysis reports the number of validated instances of licensure violations, which includes medication administration errors. DADS Data Management and Analysis also publishes an annual list of the top 10 deficiencies and violations. DADS will produce a semi-annual report with all the data and associated analysis to the Single State Agency. This will enable the State to identify trends and patterns that will be analyzed to prevent reoccurrences of medication administration errors.

2. Methods of State Oversight and Follow-Up

Pursuant to 42 CFR Section 431.10(c), HHSC is the state Medicaid agency and retains full administrative authority over the LTSS STAR+PLUS waiver program.

DADS Regulatory Services licenses and monitors home and community support services agencies, assisted living providers, and nursing facilities. Medication management is part of the license requirements for these providers. DADS staff conduct follow-up surveys and inspections to ensure the provider has effectively implemented any corrective action plan required due to cited State violations.

DADS surveys home and community support services agencies during their first year of operation, approximately 18 months after the initial survey, and at least every 36 months thereafter. DADS surveys assisted living facilities annually and nursing facilities every nine to fifteen months. DADS may inspect licensed facilities or the home and community support services agencies more frequently if appropriate.

DADS enforces licensing requirements through on-site surveys and contract monitoring visits. The frequency of licensing surveys varies with each type of license. The State imposes penalties such as requiring corrective actions plans, administrative penalties and license revocation when harmful medication management practices are detected. DADS Contract and Regulatory staff follows-up to ensure corrective action plans are properly implemented.

The adult foster care providers are monitored by the regulatory agency that licenses these types of facilities. The managed care organizations monitor contract performance on a biannual basis. The appropriate regulatory agency uses a State-approved protocol when conducting on-site visits and surveys that includes appropriate medication management as per licensure requirements.

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Any evidence of licensure violations is investigated and sanctions are applied as per state law and rules.

B. Medication Administration by Waiver Providers: Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.

1. State Policy

Home and community support services agencies, assisted living facilities, and nursing facilities must administer medications as required by licensure. Licensure only allows licensed nurses, certified medication aides (under the direct supervision of a licensed nurse), or persons who administer medication as a registered nurse-delegated task to administer medications. The same requirements for assisted living facilities apply to adult foster care under the Texas Administrative Code, 40 TAC RULE §48.8907.

A registered nurse who supervises a medication aide or delegates medication administration must provide ongoing supervision and any necessary training to the unlicensed person. Registered nurses must follow procedures for delegation in accordance with the Nurse Practice Act.

Home and community support services agencies are responsible for monitoring medications but may not have any additional responsibilities. Assisted living facilities, and nursing facilities are required to monitor all aspects of a member's medication, regardless of whether the provider administers the medication or the member self-medicates. Home and community support services agency registered nurses review the member's medications annually and upon significant change in the member's condition.

Licensing requirements for assisted living facilities require the facility to provide monthly counseling to a member who self-medicates. The assisted living facility must report any unusual reactions to the member's physician. The assisted living facility must also document any time a member fails to take medication.

2. Medication Error Reporting

Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies). Errors are reported to the DADS. Providers are required to record any type of medication error, regardless of severity, in the member's clinical record. Any type of medication error, regardless of severity, must be reported to the State.

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3. State Oversight Responsibility

DADS is responsible for monitoring compliance with licensing requirements, and the agency surveys licensed providers for compliance with licensing requirements on a regular basis. Licensing surveys include medication administration review.

DADS Data Management and Analysis reports the number of validated instances of licensure violations, which includes medication administration errors. DADS Data Management and Analysis also publishes an annual list of the top 10 deficiencies and violations. DADS will produce a semi-annual report with all the data and associated analysis to the Single State Agency. This will enable the State to identify trends and patterns that will be analyzed to prevent reoccurrences of medication administration errors.

IV. REMEDIATION

Individual problems may be discovered during monitoring activities by the State or any of the entities that have been delegated certain functions within the performance measures of this appendix. Those responsible for conducting the monitoring and frequency are described in each performance measure of this appendix.

The options for remediation are listed below:

If the State discovers that a complaint has not been followed up on within the timeframe required by the State, the managed care organization is subject to various remedies which may include communicating with the managed care organization directly, requiring corrective actions to be completed when appropriate, assessing liquidated damages, freezing enrollment into the managed care organization, and termination of the managed care organization's contract. All remedies are accompanied by the assumption that the managed care organization will resolve the complaint.

If the State discovers that upon enrollment a member was not provided educational material on reporting abuse, neglect, and exploitation, the managed care organization is required to provide the member with that material within State established timeframes.

Attachment H
UC Claiming Protocol and Application
PLACEHOLDER

Attachment I
Regional Healthcare Partnership (RHP) Planning Protocol
PLACEHOLDER

Attachment J
Program Funding and Mechanics Protocol
PLACEHOLDER

Attachment K
Administrative Cost Claiming Protocol
PLACEHOLDER

