

TEXAS
SECTION 1115 DEMONSTRATION
FACT SHEET

Program Name: Texas Healthcare Transformation and Quality Improvement Program
Waiver Number: 11-W-00278/6

Date Initial Proposal Submitted: July 15, 2011
Date Initial Proposal Approved: December 12, 2011
Date of Implementation: December 12, 2011

Date Extension Proposal Submitted: September 30, 2015
Date Extension Proposal Approved: December 21, 2017
Date of Extension Implementation: January 1, 2018
Expiration Date: September 30, 2022

SUMMARY

On July 15, 2011, Texas submitted its formal proposal for the Texas Healthcare Transformation and Quality Improvement Program (THTQIP) section 1115(a) demonstration to CMS. THTQIP is designed to expand the existing Medicaid managed care programs (STAR and STAR+PLUS) statewide and to use savings from the expansion of managed care and the discontinuation of supplemental provider payments to finance a new safety net care pool to assist hospitals and other providers with uncompensated care costs and to promote health system transformation in preparation for new coverage demands that began in 2014. The demonstration was approved in December of 2011.

Through this demonstration, the state aims to:

- Expand risk-based managed care to new populations and services;
- Support the development and maintenance of a coordinated care delivery system;
- Improve outcomes while containing cost growth; and
- Transition to quality-based payment systems across managed care and providers.

The state will employ the following vehicles in achieving the above goals:

Managed Care Delivery System: The STAR program is the primary managed care program serving low-income families and children. STAR+PLUS provides acute care and long-term service and supports (including home and community based care) to the aged, disabled and chronically ill. STAR Kids provides services through managed care to disabled children.

Both the STAR and STAR+PLUS programs have been expanded to operate in all areas of the State. Enrollees in both STAR and STAR+PLUS receive unlimited monthly prescriptions, which provides a more comprehensive benefit than the monthly prescription limit imposed under the State plan. Additionally, STAR+PLUS includes non-behavioral health inpatient services, which have historically been carved out of the program.

- *Uncompensated Care:* The UC pool (\$6.2 billion total for demonstration years 7-8, see below for 9-11) will help defray the actual uncompensated care costs incurred by hospitals and other eligible providers for serving Medicaid eligible and uninsured individuals.
- *Delivery System Reform Incentive Program:* The \$14.7 billion DSRIP Pool is designed to incentivize programs that support efforts at the provider level to enhance access to care and the health of the patients and families they serve. The programs rewarded by the DSRIP will align with the following four broad categories: infrastructure development, program innovation and redesign, quality improvements, and population-focused improvement. Reform activities are conducted by Regional Healthcare Partnerships (RHPs) that are financially anchored by a public hospital or local governmental entity that will collaborate with a variety of healthcare providers to address identified challenges in the delivery system.

In June 2013, 67 slots were added to the STAR+PLUS 217-like group. In addition, the restriction for family members to serve as caregivers for adult foster care was removed.

In September 2013, a spell-of-illness limitation for STAR+PLUS was added to align the demonstration with the state plan and adjustments were made to conform with 2014 eligibility changes.

In March 2014, multiple managed care changes were approved, including expanding STAR+PLUS to the Medicaid Rural Service Area, carving nursing facility services into managed care, and adding additional mental health and home and community based services to managed care.

In February 2015, an amendment was approved to assist the state in implementing its Texas Dual Eligible Demonstration. Budget neutrality language was added to the Special Terms and Conditions (STCs) to address how the savings will be attributed to the demonstration.

In October 2015, an amendment was approved to remove the spell of illness limitation for beneficiaries with severe and persistent mental illness.

Texas submitted a five year extension request for the demonstration on September 30, 2016. The state and CMS agreed to a 15 month temporary extension to the demonstration, from October 1, 2016, until December 31, 2017, including an amendment to clarify the electronic statewide process used for reviewing managed care plans, and add program slots for home and community based service programs within the state.

In November 2016, an amendment was approved to implement the STAR Kids statewide mandatory managed care program for disabled children, and in December 2016, an amendment to transition the NorthSTAR behavioral health waiver program into STAR, STAR+PLUS, AND STAR Kids.

In August 2017, an amendment was approved to move several populations into managed care from their current fee-for-service Medicaid, and allow Former Foster Care Children ages 18 through 20, also enrolled in 1915(c) waivers, to choose their program.

In December 2017, an extension was approved to modify Texas' UC pool so it reflects Administration policies, and relies upon an updated assessment of charity care within Texas. CMS and Texas have also reworked its DSRIP program to reflect Administration policies. Finally, CMS approved the extension of authorities for Texas' managed care and long term services and supports programs.

DELIVERY SYSTEM REFORM INCENTIVE PAYMENT PROGRAM

The state's DSRIP modifications within its 2017 extension will shift from a project-focused demonstration, to instead a systemic effort involving providers selecting measure bundles. Each bundle will contain a number of measures related to a specific domain (i.e. maternal health, diabetes management), and be weighted based on the state's prioritization of the domain. The state proposed a new framework of activities and reporting based on four new categories that replace the initial DSRIP project and measurement categories:

Category A—Core Activities: qualitative reporting that includes progress on selected core activities, alternative payment model arrangements, costs and savings, and collaborative activities.

Category B—Medicaid and low-income or uninsured (MLIU) patient population by provider (PPP): reporting the number of MLIU individuals and total number of individuals served by each performing provider's system.

Category C—Measure Bundles: measure bundles developed for hospitals and physician practices, and lists of measures for community mental health centers and local health departments.¹

Category D—Statewide Reporting Measure Bundle: expanded set of hospital Category 4 measures that are required of all performing providers. Only hospitals have to report values for Category D measures. Physician practices, community mental health centers (CMHCs), and local health departments (LHDs) have to provide qualitative information on efforts to impact ascribed measures, but they do not report the measure values themselves.

The focus of the program is on meeting the performance and reporting requirements of Category C measure bundles, as opposed to implementing specific projects evaluated by discrete measures. Instead of selecting projects, providers choose and describe "core activities" that are implemented by a performing provider to achieve Category C measure goals. Providers must select at least one core activity that directly supports the achievement of selected measure bundles. The protocol provides a menu of core activities in Category A, but providers can also propose activities from national quality initiatives like the Merit-based Incentive Payment System (MIPS) or create their own, unlisted core activity. Providers can revise their selection of Core Activities at any time without approval.

¹ Hospitals and physician practices select measure bundles, which include some measures the providers must report, and other optional measures. Community mental health centers and local health departments must select at least two measures from the associated lists of measures.

Providers then select measure bundles, which are composed of individual measures. Measures within bundles are a mix of both process and clinical outcomes, and are assigned a value of zero to three points. The points denote value with three points as the highest value, indicating high priority measures. To form bundles, measures are grouped by theme (for instance, diabetes care), target population, and whether they are impacted by similar activities. Providers must select measure bundles until the aggregate point values from the bundles are equal to or greater than a Minimum Point Threshold (MPT). An exception exists for Community Mental Health Centers and Local Health Departments, which select and report at least two individual measures instead of bundles. The majority of measures to be reported are Pay for Performance (P4P), a shift from predominantly Pay for Reporting (P4R) in the initial DSRIP.

In addition to the quantitative measures, qualitative reporting is required across Categories A through D. For example, in Category A, providers must report progress on alternative payment model (APM) arrangements with Medicaid managed care organizations (MCOs), submit costs and savings related to at least one core activity, and describe collaborative activities to the state.

UNCOMPENSATED CARE POOL

CMS will provide Texas five additional years of UC funding, with the level of funding subject to the STCs attached. CMS recognizes the critical role that safety net hospitals play in providing charity care to the uninsured and the associated fiscal burden that hospitals bear for that care. CMS has been working with states with UC pools to provide financial support, while applying consistent federal policy priorities to these pools. UC pool 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 incurred by hospitals, clinics, or other provider types, as agreed upon by CMS and the state in providing services to individuals as described in the STCs. These charity care costs may not include bad debt, Medicaid shortfall, or other costs.

Texas’s UC pool funding disbursement methodology will be revised as part of this extension, in alignment with nationally applied federal policies. Over the course of calendar year 2018, Texas will lay the groundwork to direct UC pool funding towards charity care. The state will not receive federal financial participation for any UC pool payments for DY 9 (October 1, 2019 through September 30, 2020) or later until a UC Protocol Addendum has been submitted to and approved by CMS. The UC Protocol Addendum must include precise definitions of eligible uncompensated provider charity care costs (consistent with the Medicare cost reporting principles) and revenues that must be included in the calculation of uncompensated charity care cost for purpose of reconciling UC payments to unreimbursed charity care cost. Once approved, Texas will begin distributing UC pool funds following this framework effective October 1, 2019.

CMS recognizes the need for Texas to conduct state-level rulemaking and other associated administrative work to reflect this change in methodology, and has included a provision that allows time for Texas to complete it. CMS anticipates Texas working in good faith to lay the necessary groundwork in order to comply with the UC pool distribution policy reflected in the approved STCs by October 1, 2019. However, CMS has included several separate benchmarks to ensure Texas implements its agreement by October 1, 2019.

For each of the first two years of the extension, Texas will receive approximately \$3.1 billion for the UC pool; for subsequent years, the UC pool amount will be determined as specified in STC 35. CMS has granted Texas an additional year of a transitional UC pool funding level, in light of the significant impact of Hurricane Harvey on Texas health care providers' operations and financial stability. During the first year of the extension, CMS expects Texas will work with its providers seeking to participate in the UC pool so that they accurately report the extent of their charity care in alignment with Medicare cost reporting principles, and have reported S-10 data documenting charity care provided in federal fiscal year 2017 by no later than September 2019. CMS will resize Texas' UC pool for the remaining years of this demonstration extension, beginning October 1, 2019, to reflect final UC amount based on the most recent available S-10 data reflecting provider charity care for 2017. In the event that Texas does not supply the necessary data, CMS will temporarily resize the state's UC pool to approximately \$2.3 billion based on CMS's current estimate, without further adjustment, of uncompensated care in the state.

Once 2017 S-10 data is used to determine the DY 9-11 UC pool amounts, CMS will assess whether total UC pool payments made during DY 9 through DY 11 exceed the final DY 9 through DY 11 pool sizes, and CMS will reclaim overpayments for these years. If the UC pool payments have not been sufficient to cover the final DY 9 through DY 11 UC pool sizes based on 2017 S-10 data, CMS will make additional payments consistent with the final pool sizes.

ELIGIBILITY

All individuals eligible under the Title XIX state plan are enrolled in the demonstration, except the following:

- a. Medically Needy;
- b. STAR Health enrollees, transitioning foster care youth, independent foster care adolescents, and optional categorically needy children eligible under 42 CFR 435.222;
- c. Adults 21 or older who have Medicare Part A or B and who are receiving 1915(c) IDD waiver services (HCS, TxHmL, CLASS and DBMD);
- d. Residents of State Supported Living Centers;
- e. Undocumented or Ineligible (5-year bar) Aliens only eligible for emergency medical services;
- f. Individuals residing in a nursing facility who entered the nursing facility while enrolled in STAR, beginning with the month after the State receives notification that they entered the nursing facility;

- g. Individuals enrolled in the Program for All Inclusive Care for the Elderly (PACE) program; and
- h. Individuals residing in a facility in the pediatric care facility class of nursing facilities (currently, the Truman W. Smith Children Care Center), or any Veterans Land Board (VLB) Texas State Veterans Homes.

DELIVERY SYSTEM

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BENEFITS

STAR, STAR Kids, and STAR+PLUS enrollees receive the full benefit package available under the Medicaid State plan. STAR+PLUS beneficiaries receive non-behavioral health inpatient services through their health plan, and beneficiaries in both programs have unlimited monthly access to medically necessary prescription drugs. Additionally, Medicaid beneficiaries under age 21 receive the full array of primary and preventative dental services through pre-paid dental health plans. The schedule of services mirrors those provided in the Medicaid State plan, with the exception of 1915(b)(3)-like services as described in this waiver. The individuals in these programs would still be able to receive all Texas state plan services based on medical necessity that are not listed in this chart and delivered outside of managed care; e.g. dental, ICF/IID.

COST SHARING

There are no cost-sharing obligations imposed on the populations covered by this demonstration.

STATE FUNDING SOURCE

The demonstration is funded by a combination of state general revenue funds and intergovernmental transfers (IGTs).