Texas Healthcare Transformation and Quality Improvement Program
Number: 11-W-00278/6
Demonstration Period: January 15, 2021 through September 30, 2030
Amendment Request: Medically Fragile Process
Submitted: First submitted on September 1, 2020-Resubmitted on February 16, 2021

III. General Program Requirements

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

a) An explanation of the public notice process used by the State, consistent with the requirements of STC 12, to reach a decision regarding the requested amendment.

Pursuant to STC. 12 Public Notice, Tribal Consultation, and Consultation with Interested Parties, the public notice for public comment about the changes requested in Amendment 18 was published in the Texas Register on July 31, 2020, (see attachment named TX Reg Public Notice). HHSC issued a revised notice on December 25, 2020 based on recent feedback from the Centers for Medicare and Medicaid Services (CMS) about 1115 waiver public notice requirements, applicable for all amendments. The revised PNI provides further clarification about the changes being requested in the amendment. The Texas Register is published weekly and is the journal of state agency rulemaking for Texas. In addition to activities related to rules, the Texas Register publishes various public notices including attorney general opinions, gubernatorial appointments, state agency requests for proposals and other documents, and it is used regularly by stakeholders. HHSC publishes all Medicaid waiver submissions in the Texas Register in addition to many other notices. The publication is available online and in hard copy at the Texas State Library and Archives Commission, the State Law Library, the Legislative Reference Library located in the State Capitol building, and the University of North Texas libraries. All of these sites are located in Austin, except for the University of North Texas, which is located in Denton. Printed copies of the Texas Register are also available through paid subscription; subscribers include cities, counties and public libraries throughout the state. In accordance with the requirements included in STC 12, letters were sent on July 30, 2020, to Tribal Governments requesting comments, questions, or feedback on the amendment by August 29, 2020, (see attached copy of one Tribal letters and read receipts for all Tribal letters sent). No comments, questions, or feedback on the project were received from Tribal Governments during the initial Tribal Consultation period. HHSC received one request for a copy of the draft amendment language from an external stakeholder during the initial Public Notice period. The stakeholder indicated support of the amendment and desire for the amendment to be effective before the requested effective date. HHSC issued a revised tribal notice on December 18, 2020 based on recent feedback from CMS about 1115 public notice requirements, applicable for all amendments. The revised tribal notice provides further clarification about the changes being

requested in the amendment and gave the Tribal Governments an opportunity to provide comments, questions or feedback on the amendment by January 15, 2021. No comments, questions, or feedback on the amendment were received.

b) A detailed description of the amendment, including what the state intends to demonstrate via the amendment as well as impact on beneficiaries with sufficient supporting documentation, the objective of the change and desired outcomes including a conforming Title XIX and/or Title XXI state plan amendment, if necessary.

HHSC aims to achieve the following demonstration objectives:

- Support the development and maintenance of a coordinated care delivery system; and
- Improve outcomes while containing cost growth.

While the population served by the amendment is not new to managed care and will not receive new services, the new process as outlined in this amendment for serving this very medically fragile population will improve the coordination of their care and improve health outcomes while containing cost growth.

The amendment also proposes to remove the individual cost cap for the eligible individuals. HHSC will dedicate staff to support the new process by reviewing assessment information from the MCOs and performing utilization review. This amendment will result in a more cost-effective system, including better coordination of the person's care, a more streamlined system benefiting the person, their family, and their MCO, all with the intent of improving health outcomes for these particularly vulnerable individuals.

These individuals will not receive new home and community-based services added to the program. These individuals will continue to have access to services they are currently receiving. This change only removes the cost cap for these individuals.

Additionally, there will continue to be no beneficiary cost sharing.

c) A list, along with a programmatic description, of the waivers and expenditure authorities that are being requested for the amendment.

The State is not requesting changes to existing waivers or expenditure authorities as part of this amendment.

d) A data analysis worksheet which identifies the specific "with waiver" impact of the proposed amendment on the current BN agreement. Such analysis shall include current total computable (TC) "With Waiver" and "Without Waiver" status on both a summary and detailed level through the current 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) the impact of the amendment.

Clients that would be eligible for the MF waiver today are already part of budget neutrality as their expenditures are part of managed care rate development. While well below 150 clients are at risk or exceed cost caps per year, the number of clients exceeding the cost cap has grown each year. The highest year to date has been FY19 which resulted in less than 50 clients exceeding the cap. The individuals eligible for this process are already part of the 1115 waiver population receiving STAR+PLUS services. The limit of 150 slots per year is an effort to maintain cost effectiveness given that these individuals will not be subject to service cost caps.

Refer to attached annual budget neutrality workbook.

e) **The state must provide an up-to-date CHIP allotment neutrality worksheet, if necessary.**

Not applicable.

f) **A description of how the evaluation design, and reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.**

Starting September 1, 2021, HHSC will incorporate a process under the THTQIP 1115 waiver for medically fragile individuals whose service needs exceed the cost limits of the STAR+PLUS Home and Community Based Services (HCBS) program. The process would ensure medically fragile individuals served under the THTQIP 1115 waiver have access to long-term nursing services at home through Medicaid managed care without a cost ceiling, thus avoiding the disruptions that accompany determining if individuals can be safely served in an institution due to STAR+PLUS HCBS costs caps.

The current CMS-approved evaluation design for the THTQIP 1115 waiver includes 5 evaluation questions and 13 hypotheses. There are no evaluation questions, hypotheses, or measures related to medically fragile individuals. As a result, the process will not directly impact the evaluation design and reports. In addition, evaluation measures in the CMS-approved evaluation design will not be indirectly impacted by the benefit because study populations do not include individuals receiving the benefit, study periods end prior to the September 1, 2021 implementation, and/or measures are unrelated to services provided under the benefit (see Table 1).

Table 1. Summary of Benefit Impact on Evaluation Measures

Measures	Study Population	Impact of Benefit	Explanation of Impact
Delivery System Reform Incentive Payment (DSRIP)			
1.1.1 to 1.1.6 (Social network analysis)	DSRIP performing providers	None	Study population does not include individuals receiving benefit.
1.1.7 to 1.1.8 (Health information exchange)	DSRIP performing providers	None	Study population does not include individuals receiving benefit.
1.2.1 to 1.2.4 (Improvements among clients with diabetes diagnosis)	DSRIP and non-DSRIP clients with diabetes diagnosis	None	Study period ends prior to implementation (ends 9/30/2020), and measures are unrelated to services provided under the benefit.
1.3.1 to 1.3.5 (Category C measures)	Medicaid and low-income uninsured	None	Study period ends prior to implementation (ends 9/30/2019), and measures are unrelated to services provided under the benefit.
1.4.1 to 1.4.5 (Category D measures)	DSRIP performing providers	None	Study population does not include individuals receiving benefit.
Uncompensated Care (UC)			
2.1.1 to 2.1.2 (UC costs)	Providers and hospitals reporting UC costs	None	Study period ends prior to implementation (ends 9/30/2020).
Medicaid Managed Care (MMC)			
3.1.1 to 3.5.2 (MMC populations)	Children's Medicaid Dental Services (CMDS) Nursing Facility (NF) Former Foster Care Children (FFCC) Adoption Assistance (AA) Permanency Care Assistance (PCA) Medicaid for Breast and Cancer (MBCC)	None	CMDS: Study period ends prior to implementation (ends 9/30/2020) and measures are unrelated to services provided under the benefit. NF: Study period ends prior to implementation (ends 9/30/2020). FFCC: Measures are unrelated to services provided under the benefit. AA/PCA: Study populations do not include individuals receiving the benefit (AA: under

Measures	Study Population	Impact of Benefit	Explanation of Impact
			18 years old; PCA: under 21 years old; neither include STAR+PLUS). MBCC: Measures are unrelated to services provided under the benefit.
Overall Evaluation			
4.1.1 to 4.1.3 (Alternative payment models)	Managed Care Organizations	None	HHSC does not anticipate the benefit will impact APMs.
5.1.1 (Preventable ED use)	Medicaid and low-income uninsured	None	Measures is unrelated to services provided under the benefit.
5.1.2 (Demonstration cost growth)	Medicaid and low-income uninsured	None	HHSC does not anticipate the benefit will impact overall 'With Waiver' or 'Without Waiver' costs since individuals receiving benefit are already included in 'With Waiver' estimates.

While the process may have practical implications for medically fragile individuals under the THTQIP 1115 waiver, HHSC does not anticipate statistically meaningful differences in evaluation measures since the benefit is an extension of services already provided through STAR+PLUS HCBS, utilization will be limited to very few individuals, and HHSC does not anticipate utilization to substantively change. Additionally, the process does not influence the goals of the evaluation; therefore, HHSC is not proposing changes to the evaluation design and reports. Likewise, HHSC is not adding a hypothesis to the existing THTQIP 1115 waiver evaluation since an evaluation of the process would be constrained by the limited number of individuals eligible for the benefit (150 individuals per demonstration year), and the amount of time between process implementation (September 1, 2021) and when the final report must be drafted (November 20, 2023). Due to data lags and the time required to pull, analyze, and produce the report, the final evaluation report would only include approximately six months of data after the process implementation change.

Ultimately, HHSC determined it was not practical to assess the impact of the benefit under the existing THTQIP 1115 waiver since the process is not expected to result in statistically meaningful changes and is being implemented during the final months of the evaluation study period. HHSC also does not intend to propose a comprehensive evaluation of the process's impact on medically fragile individuals in future renewals of the THTQIP 1115 waiver.

HHSC is not proposing changes to oversight, monitoring, and measurement of the provisions. HHSC Utilization Review (UR) will monitor and provide oversight of the new medically fragile process using existing tracking and reporting processes employed in the UR general revenue process.

TEXAS
Health and Human Services

Cecile Erwin Young
Executive Commissioner

February 22, 2021

Diona Kristian
Centers for Medicare and Medicaid Services
Center for Medicaid, and CHIP Services
Division of State Demonstrations and Waivers
7500 Security Boulevard
Mail Stop S2-02-26
Baltimore, MD 21244-1850

Dear Ms. Kristian,

The Health and Human Services Commission (HHSC) is submitting a request to the Centers for Medicare & Medicaid Services (CMS) for an amendment to the Texas Healthcare Transformation Quality Improvement Program (THTQIP) waiver under section 1115 of the Social Security Act, which is approved through September 30, 2030. HHSC submitted the initial amendment request on September 1, 2020.

HHSC is proposing an amendment in response to House Bill (H.B.) 4533, SECTION 32, 86th Legislature, Regular Session, 2019 which requires HHSC to pursue a benefit for medically fragile individuals.

SECTION 32 of H.B. 4533 provides: "[I]f the Health and Human Services Commission determines it would be cost effective, the executive commissioner of the Health and Human Services Commission shall seek a waiver or authorization from the appropriate federal agency to provide Medicaid benefits to medically fragile individuals:

(1) who are 21 years of age or older; and
(2) whose health care costs exceed cost limits under appropriate Medicaid waiver programs, as defined by Section 534.001, Government Code."

The medically fragile group will consist of adults who have high medical needs based on an assessment and whose needs exceed existing waiver program cost

limits. When it is determined an individual's service plan is at or near the STAR+PLUS Home and Community Based Services program cost limit, which usually occurs for these individuals prior to aging out of children's Medicaid or when leaving a nursing facility, the individual may be considered for the proposed process. If determined eligible, these members will be able to access home and community-based services through Texas' 1115 waiver, without an individual cost limit and are not subject to the cost cap. No new home and community-based services benefits are provided under this process. These individuals will continue to have access to services they are currently receiving. There will be a limit on the number of slots in this category to be determined based on cost effectiveness. HHSC is requesting an amendment effective date of September 1, 2021.

HHSC requests CMS approve this amendment package by June 22, 2021. Kathi Montalbano, Manager of Policy Development Support, is the lead staff on this matter and can be contacted by telephone at (512) 771-3503 or by e mail at kathi.montalbano@hhs.texas.gov.

Sincerely,

Stephanie Stephens

Digitally signed by Stephanie Stephens
Date: 2021.02.22 11:18:22 -06'00'

Stephanie Stephens
State Medicaid Director

TEXAS HEALTH AND HUMAN SERVICES COMMISSION

Public Notice

The Health and Human Services Commission (HHSC) plans to submit a request to the Centers for Medicare & Medicaid Services (CMS) for an amendment to the Texas Healthcare Transformation Quality Improvement Program (THTQIP) waiver under section 1115 of the Social Security Act. CMS has approved this waiver through September 30, 2022.

This amendment is in response to House Bill (H.B.) 4533, SECTION 32, 86th Legislature, Regular Session, 2019 which requires HHSC to pursue a benefit for medically fragile individuals.

SECTION 32 of HB 4533 provides: "[I]f the Health and Human Services Commission determines it would be cost effective, the executive commissioner of the Health and Human Services Commission shall seek a waiver or authorization from the appropriate federal agency to provide Medicaid benefits to medically fragile individuals:

(1) who are 21 years of age or older; and

(2) whose health care costs exceed cost limits under appropriate Medicaid waiver programs, as defined by Section 534.001, Government Code."

The medically fragile group will consist of individuals who have high medical needs based on an assessment and whose needs exceed existing program cost limits. When it is determined an individual's service plan is at or near the STAR+PLUS Home and Community-Based Services (HCBS) program cost limit (usually prior to aging out of children's Medicaid or when leaving a nursing facility), the individual may be considered for the proposed program. If determined eligible for the program, these members will be able to access home and community-based services through Texas' 1115 waiver, without an individual cost limit. There will be a limit on the number of slots in this category, to be determined based on cost effectiveness.

HHSC first provided notice of its intent to request an amendment to the THTQIP 1115 waiver on July 31, 2020 in the Texas Register. HHSC is updating its notice to provide the following clarifying information:

HHSC aims to achieve the following demonstration objectives:

Support the development and maintenance of a coordinated care delivery system;

Improve outcomes while containing cost growth; and

While the population served by the amendment is not new to managed care and will not receive new services, the new process as outlined in this amendment for serving this very medically fragile population will improve the coordination of their care and improve health outcomes for them while containing cost growth.

The amendment also proposes to remove the individual cost cap for the eligible individuals. HHSC will dedicate a staff person to support the new process by reviewing assessment information from the MCOs and performing utilization review. This amendment will result in a more cost-effective system, including better coordination of the person's care, a more streamlined system benefiting the person, their family, and their MCO, all of which will lead to improved health outcomes for these particularly vulnerable individuals.

Individuals that would be eligible under this amendment are already part of the THTQIP budget neutrality as their expenditures are part of managed care rate development. While well below 150 clients are at risk of exceeding cost caps per year, the number of clients exceeding the cost cap has grown each year. The highest year to date has been FY19 which resulted in less than 50 clients exceeding the cap. The individuals eligible for this benefit are already part of the 1115 waiver population receiving STAR+PLUS services. The limit of 150 slots per year is in an effort to maintain cost effectiveness given that these individuals will not be subject to service cost caps.

These individuals will not receive additional home and community-based services benefits as a result of this amendment. These individuals will continue to have access to services they are currently receiving. This change removes the cost cap for these individuals.

The CMS-approved 1115 evaluation design does not include any evaluation questions, hypotheses, or measures directly related to medically fragile individuals. Additionally, evaluation measures in the CMS-approved evaluation design will not be indirectly impacted by the benefit because study populations do not include individuals receiving the benefit, study periods end prior to the September 1, 2021 implementation, and/or measures are unrelated to services provided under the benefit.

HHSC is not planning to add evaluation questions or hypotheses related to the benefit for medically fragile individuals due to the limited number of individuals eligible for the benefit and constraints imposed by the implementation timelines, data lags, and time required to pull, analyze, and produce the final report.

Additionally, there will continue to be no beneficiary cost sharing.

If determined cost effective and approved by CMS, the waiver amendment proposed by HHSC will provide Medicaid HCBS to a limited number of medically fragile adults whose health care costs exceed current cost limits with an effective date of September 1, 2021.

An individual may obtain a free copy of the proposed waiver amendment, ask questions, obtain additional information, or submit comments regarding this amendment by contacting Amanda Sablan by U.S. mail, telephone, or email. The addresses are as follows:

U.S. Mail
Texas Health and Human Services Commission
Attention: Amanda Sablan, Waiver Coordinator, Policy Development Support
PO Box 13247
Mail Code H-600
Austin, Texas 78711-3247

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512-487-3446
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