DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, MD 21244-1850

State Demonstrations Group

October 20, 2026

Stephanie Stephens
State Medicaid Director
Texas Health and Human Services Commission
4900 Lamar Boulevard
MC:H100
P.O. Box 13247
Austin, Texas 78751

Dear Director Stephens:

The Centers for Medicare & Medicaid Services (CMS) is approving updates to the budget neutrality expenditure limits for the section 1115(a) demonstration entitled, "Texas Healthcare Transformation and Quality Improvement Program (THTQIP)" (Project Number 11-W-00278/6). These updates are required by the demonstration's special terms and conditions (STCs) and align with CMS's current approach to determining budget neutrality as described in CMS State Medicaid Director Letter (SMDL) #24-003.[1] CMS is also incorporating conforming changes into the demonstration STCs that align with recent changes to Medicaid statutes, CMS regulations, and policy. In addition, CMS is updating the STCs to reflect monitoring redesign expectations and to align the STCs with current standard STC language governing general financial requirements and budget neutrality monitoring.

Budget Neutrality Expenditure Limits

This demonstration project is being rebased using CMS's current approach to determining budget neutrality as described in CMS SMDL #24-003. However, CMS acknowledges that section 71118 of subchapter C of chapter 1 of subtitle B of title VII of Public Law 119-21 the Working Families Tax Cuts (WFTC) legislation adds a new subsection (g) to section 1115 of the Social Security Act (the Act) with budget neutrality requirements that will apply beginning January 1, 2027 to CMS approvals of section 1115 Medicaid demonstration project applications, renewals, or amendments.[2] CMS issued SMDL #26-003[3] on June 11, 2026 to provide states with early notice regarding the changes to budget neutrality that CMS intends to propose to implement subsection 1115(g) of the Act.

Under SMDL #24-003, as a condition of demonstration approval, demonstrations must be "budget neutral," meaning the federal costs of the state's Medicaid program with the demonstration cannot exceed what the federal government's Medicaid costs likely would have

[1] https://www.medicaid.gov/federal-policy-guidance/downloads/smd24003.pdf
[2] https://www.congress.gov/bill/119th-congress/house-bill/1/text
[3] https://www.medicaid.gov/federal-policy-guidance/downloads/smd26003.pdf

been in that state absent the demonstration.[4] In practice, budget neutrality generally means that the total computable (i.e., both state and federal) costs for approved demonstration expenditures are limited to a certain amount for the demonstration approval period. This limit is called the budget neutrality expenditure limit and is based on a projection of the Medicaid expenditures that could have occurred absent the demonstration (the "without waiver" [WOW] costs). The state will be held to the budget neutrality monitoring and general financial requirements as outlined in the STCs. Texas has agreed to accept CMS's current approach to determining budget neutrality as described in SMDL #24-003.

Rebasing Without Waiver Baselines
The STCs for the January 2021 extension of the THTQIP demonstration required that the demonstration's budget neutrality expenditure limits be rebased effective for demonstration year (DY) 12.

For rebasing under this demonstration, for existing Medicaid Expenditure Groups (MEGs) that were implemented and have per capita cost limits, CMS calculated the WOW baseline by using a weighted average of the state's historical WOW per-member-per-month (PMPM) baseline and its actual PMPM costs from DY 11. The projected demonstration expenditures associated with each MEG in the WOW baseline (except MEGs with aggregate cost limits) have been trended forward using the President's Budget trend rate to determine the maximum expenditure authority for DY 12 through DY 16. Using the President's Budget trend rate aligns the demonstration trend rate with federal budgeting principles and assumptions. Following rebasing, the THTQIP demonstration continues to be projected budget neutral to the federal government.

Budget Neutrality Adjustment
The STCs for the January 2021 extension of the THTQIP demonstration granted Texas a one-time adjustment to the budget neutrality expenditure limit to account for the impacts of the COVID-19 public health emergency on demonstration enrollment and expenditures. This adjustment is only applied to DY 13 through DY 16 of the current demonstration period.

General Financial Requirements and Monitoring Budget Neutrality STCs

CMS is updating the "General Financial Requirements" and "Monitoring Budget Neutrality" STC sections to be consistent with current standard STC language and to coincide with SMDL #24-003.

Mid-Course Correction STC
CMS has also updated its approach to mid-course corrections to budget neutrality calculations in this demonstration to provide flexibility and stability for the state over the life of a demonstration. CMS is updating the STCs in the "General Financial Requirements" section to include this approach. This update identifies, in the STCs, a list of circumstances under which a state's baseline may be adjusted based on actual expenditure data to accommodate circumstances that are either out of the state's control (for example, if expensive new drugs that the state is required to cover enter the market); and/or the effect is not a condition or consequence of the demonstration (for example, unexpected costs due to a public health emergency); and/or the new

[4] https://www.medicaid.gov/medicaid/section-1115-demonstrations/budget-neutrality

expenditure (while not a new demonstration-covered service or population that would require the state to propose an amendment to the demonstration) is likely to further strengthen access to care (for example, a legislated increase in provider rates). CMS also explains in the STCs what data and other information the state should submit to support a potentially approvable request for an adjustment. CMS considers this a more rational, transparent, and standardized approach to permitting budget neutrality modifications during the course of a demonstration.

STC Conforming Edits

CMS is approving edits to the demonstration STCs to reflect Texas' compliance with CMS's Calendar Year 2023 Medicare Advantage and Medicare Part D Final Rule.[5] Specifically, Texas was required to end its Dual-Eligibles Integrated Care Demonstration Project (i.e., the duals demonstration), and the state transitioned its Medicare-Medicaid plans to integrated dual eligible special needs plans (D-SNPs) by January 1, 2026. Approval of these conforming edits does not modify existing waiver or expenditure authorities or authorize new authorities.

WFTC Legislation Conforming Changes

The WFTC legislation made changes to the Medicaid and CHIP provisions of the Act, including eligibility and financing changes. This technical change action also incorporates the conforming changes that were applied to the demonstration through the WFTC legislation overlay letter and attachment, which was approved on September 25, 2026.[6] As a result of this action incorporating these conforming changes, CMS is removing Attachment Y from the demonstration.

Monitoring STCs

CMS is also updating the demonstration STCs to reflect CMS's Monitoring Redesign expectations, announced in CMS's June 25, 2025 letter to Texas.[7]

Program Integrity

As part of this action, CMS would like to remind the state about program integrity obligations. States are responsible for following all applicable federal law and regulations when they claim and use federal Medicaid funds and must fully comply with all applicable Medicaid statutes and regulations under a section 1115 demonstration, except where specific provisions have been expressly waived or identified as not applicable for that demonstration. This obligation includes all requirements in title XIX of the Act and implementing regulations governing provider screening and enrollment activities, pre- and post-payment review claiming, payment

[5] Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency, 87 FR 27704.

[6] https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/tx-hlth-trnsfrm-1115-overlay-09252026.pdf

[7] https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/tx-healthcare-trans-monitor-rdsgn-ovl-ltr.pdf

methodologies and rate-setting, utilization controls, and program integrity including processes to identify, investigate, and refer suspected fraud, and methods to receive complaints and identify questionable practices. States must maintain effective systems and safeguards to prevent, detect, and address any fraud, waste, or abuse (FWA) in the delivery of and payment for Medicaid services, including referrals to law enforcement when appropriate.

States should have heightened monitoring and oversight mechanisms in place featuring robust internal controls to identify and remediate all vulnerabilities (including, but not limited to, FWA and beneficiary access issues) inherent in service areas approved as part of a demonstration. At any time, CMS may request that the state provide a plan detailing the state's systems and safeguards to prevent, detect, and address any FWA relative to this demonstration. Failure to meet program integrity obligations under federal statutes and regulations or under the terms and conditions of this demonstration approval may result in compliance actions or other enforcement measures that could include requirements to develop and implement corrective action plans, withholdings, deferrals, disallowances, and termination of demonstration authority.

We look forward to our continued partnership on the THTQIP section 1115(a) demonstration. If you have any questions, please contact your CMS project officer, Ms. Jamie John, at Jamie.John@cms.hhs.gov.

Sincerely,

ANGELA D. GARNER -S5

Digitally signed by ANGELA D. GARNER -S5
Date: 2026.10.20 15:32:47 -04'00'

Angela D. Garner
Director
Division of System Reform Demonstrations

Enclosure

cc: Ford Blunt, State Lead, Medicaid and CHIP Operations Group

CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER LIST

NUMBER: 11-W-00278/6

TITLE: Texas Healthcare Transformation and Quality Improvement Program

AWARDEE: Texas Health and Human Services Commission

Title XIX Waivers

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived in this list, shall apply to the Demonstration project beginning *January 15, 2021,* through September 30, 2030. In addition, these waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs).

Under the authority of section 1115(a)(1) of the Social Security Act (the Act), the following waivers of State plan requirements contained in section 1902 of the Act are granted in order to enable Texas to carry out the Texas Healthcare Transformation and Quality Improvement Program section 1115 Demonstration.

1. Statewideness — Section 1902(a)

To enable the State to conduct a phased transition of Medicaid beneficiaries from fee-for-service to a managed care delivery system based on geographic service areas.

To the extent necessary, to enable the State to operate the STAR+PLUS program on a less than statewide basis.

2. Amount, Duration, and Scope of Services — Section 1902(a)(10)(B)

To the extent necessary, to enable the State to vary the amount, duration, and scope of services offered to individuals, regardless of eligibility category, by providing additional, or cost-effective alternative benefit packages to enrollees in certain managed care arrangements.

To the extent necessary, to enable the State to provide a greater duration of hospital services for individuals with severe and persistent mental illness.

3. Freedom of Choice — Section 1902(a)(23)(A)

To the extent necessary, to enable the State to restrict freedom of choice of provider through the use of mandatory enrollment in managed care plans for the receipt of covered services. No waiver of freedom of choice is authorized for family planning providers.

4. Self-Direction of Care for HCBS Members Section 1902(a)(32)

To permit section 1915(c)-like Home and Community Based Services (hereinafter HCBS) members to self-direct expenditures for HCBS long-term care and supports as specified in paragraph 28(n) of the STCs.

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITIES

NUMBER: 11-W-00278/6
TITLE: Texas Healthcare Transformation and Quality Improvement Program
AWARDEE: Texas Health and Human Services Commission

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the State for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act, shall, for the period of this demonstration extension, January 15, 2021, through September 30, 2030, be regarded as expenditures under the State's Medicaid title XIX State plan.

EXPENDITURES RELATED TO POPULATIONS COVERED UNDER THE DEMONSTRATION

1. Expenditures for the STAR+PLUS 217-Like HCBS Group

Expenditures for the provision of state plan benefits and HCBS like services to individuals age 65 and older, or age 21 and older with disabilities, not eligible for these benefits under the state plan, who would otherwise be Medicaid-eligible under section 1902(a)(10)(A)(ii)(VI) of the Act and 42 CFR § 435.217 in conjunction with section 1902(a)(10)(A)(ii)(V) of the Act, if the services they receive under STAR+PLUS were provided under a HCBS waiver granted to the State under section 1915(c) of the Act. This expenditure authority is subject to an enrollment cap. All Medicaid laws, regulations and policies apply to this expenditure authority except as expressly waived or listed as not applicable.

2. Expenditures Related to Managed Care Organization (MCO) Enrollment and Disenrollment

Expenditures made under contracts that do not meet the requirements in section 1903(m) of the Act specified below. Texas managed care plans will be required to meet all requirements of section 1903(m) of the Act except the following:

- Section 1903(m)(2)(H) of the Act, Federal regulations at 42 CFR 438.1, to the extent that the rules in section 1932(a)(4) are inconsistent with the enrollment and disenrollment rules contained in STC 21(c) of the Demonstration's Special Terms and Conditions (STCs), which permit the State to authorize automatic re-enrollment in the same managed care organization (MCO) if the beneficiary loses eligibility for less than six (6) months.

3. Expenditures for Inpatient Hospital Services and Prescription Drugs for STAR, STAR Kids, and STAR+PLUS Enrollees that Exceed State Plan Limits

Expenditures for all enrollees for inpatient hospital services that would not otherwise be covered under the State plan (as outlined in the STCs), and expenditures for prescription drugs for adults ages 21 and older enrolled in STAR or STAR+PLUS.

4. HCBS for SSI-Related State Plan Eligibles

Expenditures for the provision of HCBS waiver-like services as specified in Table 5 and Attachment A of the STCs that are not described in section 1905(a) of the Act, and not otherwise available under the approved State plan, but that could be provided under the authority of section 1915(c) waivers, that are furnished to STAR+PLUS enrollees who are ages 65 and older and ages 21 and older with disabilities, qualifying income and resources, and a nursing facility institutional level of care. All Medicaid laws, regulations and policies apply to the Demonstration Expenditure authority except as expressly waived or listed as not applicable.

5. EXPENDITURES RELATED TO THE UNCOMPENSATED CARE POOL

Subject to an overall cap on the Uncompensated Care (UC) Pool, the following expenditure authorities are granted for the period of the Demonstration:

Effective October 1, 2019, expenditures for furnishing medical services described in section 1905(a)(1) et seq. of the Act that are incurred by hospitals and other providers for uncompensated costs of medical services provided to uninsured individuals as charity care, and to the extent that those costs exceed the amounts paid to the hospitals pursuant to section 1923 of the Act. Such funds may be used by providers to offset the uncompensated costs of treating the uninsured, but this expenditure authority does not make uninsured patients eligible for any benefits under the demonstration.

6. EXPENDITURES RELATED TO THE DELIVERY SYSTEM REFORM INCENTIVE PAYMENT (DSRIP) PROGRAM

The following expenditure authorities are granted for the 9th, and 10th years of the Demonstration (FFY 2020 and FFY 2021):

Expenditures for incentive payments from DSRIP pool funds for the Delivery System Reform Incentive Payment Program. This expenditure authority does not make uninsured patients eligible for any benefits under the demonstration.

The following expenditure authorities are granted for the 11th and 12th years of the Demonstration (FFY 2022 and FFY 2023):

Incentive payments for prior periods of performance and administrative activities to close out the DSRIP program.

7. EXPENDITURES RELATED TO COVID-19 RESPONSE

Additional inpatient hospital care during COVID-19 Public Health Emergency:
The following are temporary expenditure authorities that will expire 60 days after the conclusion of the Secretary's Public Health Emergency, and are effective March 1, 2020:

Expenditure authority for inpatient hospital stays related to COVID-19 (i.e. a stay for which the COVID-19 diagnosis is listed anywhere on the claim but is not necessarily the primary diagnosis,

excluding presumptive positive cases), in order to extend the 30-day spell of illness limitation in STAR+PLUS for an additional 30 days, allowing an individual to stay up to 60 days in a hospital.

Expenditure authority for inpatient hospital stays related to COVID-19 to extend the 30-day spell of illness limitation described in the state plan for an additional 30 days to allow a Medicaid beneficiary to stay up to 60 days in a hospital.

Expenditure authority to allow Medicaid beneficiaries to exceed the $200,000 inpatient hospital benefit limitation for COVID-19 related stays.

8. EXPENDITURES RELATED TO THE PUBLIC HEALTH PROVIDERS CHARITY CARE POOL

Subject to an overall cap on the Public Health Providers Charity Care Pool (PHP-CCP), the following expenditure authorities are granted for the period of the Demonstration, effective October 1, 2021:

Through September 30, 2022, expenditures for furnishing services described in section 1905(a)(1) of the Act that are incurred by publicly-owned and operated Community Centers, Local Mental Health Authorities, or Local Behavioral Health Authorities providing behavioral health services under Chapter 533 or Chapter 534 of the Texas Health & Safety Code and publicly-owned and operated Local Health Departments (LHDs) and Public Health Districts (PHDs) that are established under the Texas Health and Safety Code, Title 2, Subtitle F, Chapter 121, not to exceed qualifying providers' uncompensated costs of furnishing services described in section 1905(a) of the Act to Medicaid eligible or uninsured individuals. Effective October 1, 2022, expenditures for services described in section 1905(a) of the Act that are incurred by publicly-owned and operated Community Centers, Local Mental Health Authorities, or Local Behavioral Health Authorities providing behavioral health services under Chapter 533 or Chapter 534 of the Texas Health & Safety Code and publicly-owned and operated Local Health Departments (LHDs) and Public Health Districts (PHDs) that are established under the Texas Health and Safety Code, Title 2, Subtitle F, Chapter 121, not to exceed qualifying providers' uncompensated costs of furnishing services described in section 1905(a) of the Act to uninsured individuals as charity care.

Such funds may be used by providers to offset the uncompensated costs of treating the uninsured, but this expenditure authority does not make uninsured patients eligible for any benefits under the demonstration.

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 EXTENSION PERIOD: January 15, 2021 through September 30, 2030

CENTERS FOR MEDICARE & MEDICAID SERVICES SPECIAL TERMS AND CONDITIONS

NUMBER:	**Title XIX No. 11-W-00278/6**
TITLE:	**Texas Healthcare Transformation and Quality Improvement Program**
AWARDEE:	**Texas Health and Human Services Commission**

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, 2030, unless otherwise specified.

The STCs have been arranged into the following subject areas:

I. Preface
II. Objectives
III. General Program Requirements
IV. Demonstration Delivery Systems
- A. Managed Care Delivery Systems
- B. Assurances Related to the Ongoing Operation of Managed Care
- C. Beneficiaries Served Through the Demonstration
- D. STAR, STAR+PLUS (non-HCBS), and STAR Kids Enrollment, Benefits and Reporting Requirements
- E. Children's Dental Program
- F. STAR+PLUS Home and Community Based Services (HCBS) Enrollment, Benefits and Reporting Requirements
- G. Delivery System and Provider Payment Initiatives in Managed Care Contracts

V. Funding Pools Under the Demonstration
VI. Health IT
VII. General Financial Requirements
VIII. Monitoring Budget Neutrality for the Demonstration
IX. Monitoring and Reporting Requirements
X. Evaluation of the Demonstration
XI. Schedule of State Deliverables for the Demonstration

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: HCBS Service Definitions
Attachment B: Evaluation Design
Attachment C: Reserved
Attachment D: HCBS Fair Hearing Procedures
Attachment E: HCBS Participant Safeguards
Attachment F: Reserved
Attachment G: Reserved
Attachment H: UC Claiming Protocol and Application
Attachment I: Regional Healthcare Partnership (RHP) Planning Protocol
Attachment J: Program and Funding Mechanics Protocol
Attachment K: Administrative Cost Claiming Protocol
Attachment L: Consumer Support System Plan
Attachment M: Historical Demonstration Information
Attachment N: Health IT Strategic Plan
Attachment O: Reserved
Attachment P: Reserved
Attachment Q: DSRIP Transition Plan
Attachment R: Measure Bundle Protocol
Attachment S: Reserved
Attachment T: PHP-CCP Payment Protocol
Attachment U: Emergency Preparedness and Response Attachment K (1)
Attachment V: Emergency Preparedness and Response Attachment K (2)

II. OBJECTIVES

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.

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 (ADA), Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and section 1557 of the Patient Protection and Affordable Care Act (Section 1557).

2) **Compliance with Medicaid and Children's Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid program and CHIP 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), apply to the demonstration.

3) **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in federal law, regulation, or written policy, come into compliance with any changes in law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes as needed without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the state 30 business days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.

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, a modified budget neutrality agreement as necessary to comply with such change, as well as a modified allotment neutrality worksheet as necessary to comply with such change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph. Further, the state may seek an amendment to the demonstration (as per STC 7 of this section) as a result of the change in FFP.
   b) If mandated changes in the federal law require state legislation, unless otherwise prescribed by the terms of the federal law, the changes must take effect on the earlier of the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law, whichever is sooner.

5) **State Plan Amendments.** The state will not be required to submit title XIX or XXI state plan amendments (SPAs) for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan is required, except as otherwise noted in these STCs. In all such cases, the Medicaid and CHIP state plans govern.

6) **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, beneficiary rights, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, 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 either through an approved amendment to the Medicaid or CHIP state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and no FFP of any kind, including for administrative or medical assistance expenditures, will be available under changes to the demonstration that have not been approved through the amendment process set forth in STC 7 below, except as provided in STC 3.

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 complete amendment request as described in this STCs, reports or other deliverables required in the approved

STCs in a timely fashion according to the deadlines specified herein. 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 STC 12. Such explanation must include a summary of any public feedback received and identification of how this feedback was addressed by the state in the final amendment request submitted to CMS;
b) A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation;
c) 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 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;
d) An up-to-date CHIP allotment worksheet, if necessary;
e) The state must provide updates to existing demonstration reporting and quality and evaluation plans. This includes a description of how the Evaluation Design and annual progress reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.

8) Extension of the Demonstration. States that intend to request an extension of the demonstration must submit an application to CMS from the Governor of the state in accordance with the requirements of 42 Code of Federal Regulations (CFR) 431.412(c). States that do not intend to request an extension of the demonstration beyond the period authorized in these STCs must submit a phase-out plan consistent with the requirements of STC 9.

9) Demonstration Transition and 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 transition and phase-out plan. The state must submit a notification letter and a draft transition and phase-out plan to CMS no less than six months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with STC 12, if applicable. Once the 30-day public comment period has ended, the state must provide a summary of the issues raised by the public during the comment period and how the state considered the comments received when developing the revised transition and phase-out plan.
b) Transition and 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 redetermine Medicaid or CHIP eligibility prior to the termination of the demonstration for the affected beneficiaries, and ensure ongoing coverage for eligible beneficiaries, as well as any community outreach activities the state will undertake to notify affected beneficiaries, including community resources that are available.

c) Transition and Phase-out Plan Approval. The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of transition and phase-out activities. Implementation of transition and phase-out activities must be no sooner than 14 calendar days after CMS approval of the transition and phase-out plan.

d) Transition and Phase-out Procedures. The state must comply with all applicable notice requirements found in 42 CFR, part 431 subpart E, including sections 431.206- 431.214. In addition, the state must assure all applicable appeal and hearing rights are afforded to beneficiaries in the demonstration as outlined in 42 CFR, part 431 subpart E, including sections 431.220 and 431.221. If a beneficiary in the demonstration 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 redetermine eligibility for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category prior to termination, as required under 42 CFR 435.916(f)(1). For individuals determined ineligible for Medicaid or CHIP, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e) and 457.350.

e) Exemption from Public Notice Procedures 42 CFR Section 431.416(g). CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR 431.416(g).

f) Enrollment Limitation during Demonstration Phase-Out. If the state elects to suspend, terminate, or not extend this demonstration, during the last six months of the demonstration, enrollment of new individuals into the demonstration must be suspended. The limitation of enrollment into the demonstration does not impact the state's obligation to determine Medicaid eligibility in accordance with the approved Medicaid state plan.

g) Federal Financial Participation (FFP). If the project is terminated or any relevant waivers are suspended by the state, FFP must be limited to normal closeout costs associated with the termination or expiration of the demonstration including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling beneficiaries.

10) **Withdrawal of Waiver or Expenditure Authority.** CMS reserves the right to withdraw waivers and/or expenditure authorities at any time it determines that continuing the waiver or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX and title 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, continued benefits as a result of beneficiary appeals, and administrative costs of disenrolling beneficiaries.

11) **Adequacy of Infrastructure.** The state will ensure the availability of adequate resources for 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.

12) **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the state notice procedures as required in 42 CFR section 431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request. The

state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

The state must also comply with tribal and Indian Health Program/Urban Indian Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR 431.408(b), State Medicaid Director Letter #01-024, or as contained in the state's approved Medicaid State Plan, when any program changes to the demonstration, either through amendment as set out in STC 7 or extension, are proposed by the state.

13) **Federal Financial Participation (FFP).** No federal matching funds for expenditures for this demonstration, including for administrative and medical assistance expenditures, will be available until the effective date identified in the demonstration approval letter, or if later, as expressly stated within these STCs.

14) **Administrative Authority.** When there are multiple entities involved in the administration of the demonstration, the Single State Medicaid Agency must maintain authority, accountability, and oversight of the program. The State Medicaid Agency must exercise oversight of all delegated functions to operating agencies, MCOs, and any other contracted entities. The Single State Medicaid Agency is responsible for the content and oversight of the quality strategies for the demonstration.

15) **Common Rule Exemption.** The state must ensure that the only involvement of human subjects in research activities that may be authorized and/or required by this demonstration is for projects which are conducted by or subject to the approval of CMS, and that are designed to study, evaluate, or otherwise examine the Medicaid or CHIP program – including public benefit or service programs, procedures for obtaining Medicaid or CHIP benefits or services, possible changes in or alternatives to Medicaid or CHIP programs and procedures, or possible changes in methods or levels of payment for Medicaid benefits or services. CMS has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.104(b)(5).

IV. DEMONSTRATION DELIVERY SYSTEMS

This section governs the state's exercise of the following: waivers of the requirements for Statewideness (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, as well as waivers of the requirements of the federal regulations implementing these statutory provisions.

A. MANAGED CARE DELIVERY SYSTEMS

16) **Description of Managed Care Program.** Under terms of this demonstration, the state provides managed medical assistance through the following programs.
   a) **STAR.** STAR is the primary managed care program providing acute care services to low-income families, children, and pregnant women.
   b) **STAR+PLUS.** STAR+PLUS provides acute and long-term service and supports to older adults and adults with disabilities.

c) **STAR Kids.** The STAR Kids Program provides acute and long-term service and supports to children with disabilities.

d) **Delivery of Medically Dependent Children Program (MDCP) Services.** The State will deliver services authorized under the MDCP section 1915(c) waiver through the STAR Kids managed care model for those individuals not in state conservatorship. Those children in state conservatorship who are eligible for the MDCP section 1915(c) waiver will receive those services through the STAR Health managed care program under the 1915(a) authority, rather than under the 1115 authority, and through contract with the STAR Health managed care organization.

The state contracts with managed care organizations on a geographical basis, and for this purpose, the state is divided into service areas. Table 1 provides the definitions of the service areas.

Table 1. Service Areas and Delivery Systems

Service Area	STAR, STAR+PLUS, and STAR Kids
Bexar	Atascosa, Bandera, Bexar, Comal, Guadalupe, Kendall, Medina, Wilson
Dallas	Collin, Dallas, Ellis, Hunt, Kaufman, Navarro, Rockwall
El Paso	El Paso, Hudspeth
Harris	Austin, Brazoria, Fort Bend, Galveston, Harris, Matagorda, Montgomery, Waller, Wharton
Hidalgo	Cameron, Duval, Hidalgo, Jim Hogg, Maverick, McMullen, Starr, Webb, Willacy, Zapata
Jefferson	Chambers, Hardin, Jasper, Jefferson, Liberty, Newton, Orange, Polk, San Jacinto, Tyler, Walker
Lubbock	Carson, Crosby, Deaf Smith, Floyd, Garza, Hale, Hockley, Hutchinson, Lamb, Lubbock, Lynn, Potter, Randall, Swisher, Terry
Nueces	Aransas, Bee, Brooks, Calhoun, Goliad, Jim Wells, Karnes, Kenedy, Kleberg, Live Oak, Nueces, Refugio, San Patricio, Victoria
Tarrant	Denton, Hood, Johnson, Parker, Tarrant, Wise
Travis	Bastrop, Burnet, Caldwell, Fayette, Hays, Lee, Travis, Williamson
Medicaid Rural Service Area: West Texas	Andrews, Archer, Armstrong, Bailey, Baylor, Borden, Brewster, Briscoe, Brown, Callahan, Castro, Childress, Clay, Cochran, Coke, Coleman, Collingsworth, Concho, Cottle, Crane, Crockett, Culberson, Dallam, Dawson, Dickens, Dimmit, Donley, Eastland, Ector, Edwards, Fisher, Foard, Frio, Gaines, Glasscock, Gray, Hall, Hansford, Hardeman, Hartley, Haskell, Hemphill, Howard, Irion, Jack, Jeff Davis, Jones, Kent, Kerr, Kimble, King, Kinney, Knox, La Salle, Lipscomb, Loving, Martin, Mason, McCulloch, Menard, Midland, Mitchell, Moore, Motley, Nolan, Ochiltree, Oldham, Palo Pinto, Parmer, Pecos, Presidio, Reagan, Real, Reeves, Roberts, Runnels, Schleicher, Scurry, Shackelford, Sherman, Stephens, Sterling, Stonewall, Sutton, Taylor, Terrell, Throckmorton, Tom Green, Upton, Uvalde, Val Verde, Ward, Wheeler, Wichita, Wilbarger, Winkler, Yoakum, Young, and Zavala
Medicaid Rural Service Area: Central Texas	Bell, Blanco, Bosque, Brazos, Burleson, Colorado, Comanche, Coryell, DeWitt, Erath, Falls, Freestone, Gillespie, Gonzales, Grimes, Hamilton, Hill, Jackson, Lampasas, Lavaca, Leon, Limestone, Llano, Madison, McLennan, Milam, Mills, Robertson, San Saba, Somervell, Washington
Medicaid Rural Service Area: Northeast Texas	Anderson, Angelina, Bowie, Camp, Cass, Cherokee, Cooke, Delta, Fannin, Franklin, Grayson, Gregg, Harrison, Henderson, Hopkins, Houston, Lamar, Marion, Montague, Morris, Nacogdoches, Panola, Rains, Red River, Rusk, Sabine, San Augustine, Shelby, Smith, Titus, Trinity, Upshur, Van Zandt, Wood

Texas uses Integrated Dual Eligible Special Needs Plans (D-SNPs) with Exclusively Aligned Enrollment (EAE). Table 1a lists the counties with integrated D-SNPs with EAE.

Table 1a. Counties with an Integrated D-SNP with EAE

Counties
Bexar, Dallas, El Paso, Harris, Hidalgo

B. ASSURANCES RELATED TO THE ONGOING OPERATION OF MANAGED CARE

17) Managed Care Requirements

a) General. The state must comply with the managed care regulations published at 42 CFR 438.

b) Medical Care Advisory Committee. The state will maintain a state Medical Care Advisory Committee, per CFR §431.12, which is comprised of Medicaid recipients, Managed Care Organizations, providers, community-based organizations and advocates serving or representing Medicaid recipients and other interested parties as set forth in Tex. Gov't Code sec. 533.041. The advisory committee will provide input and recommendations to the Health and Human Services Commission regarding the statewide implementation of Medicaid Managed Care, including input and recommendations regarding: 1) program design and benefits, 2) systematic concerns from consumers and providers, 3) the efficiency and quality of services delivered by Medicaid managed care organizations, 4) contract requirements for the Medicaid managed care organizations, 5) Medicaid managed care network adequacy, and 6) trends in claims processing. The advisory committee will also assist HHSC with issues relevant to Medicaid managed care to improve the polices established for and programs operating under Medicaid managed care, including early and periodic screening, diagnosis and treatment, provider and patient education issues, and patient eligibility issues. The state will maintain minutes from these meetings and use them in monitoring program operations and identifying necessary program changes. Copies of committee meeting minutes will be made available to CMS upon request and the outcomes of the meetings may be discussed on the demonstration monitoring calls.

c) MCO Participant Advisory Committees. The state shall require each MCO, through its contracts, to create and maintain participant advisory committees through which the MCO can share information and capture enrollee feedback. The MCOs will be required to support and facilitate participant involvement and submit meeting minutes to the State. Copies of meeting minutes will be made available to CMS upon request.

d) Independent Consumer Supports. To support the beneficiary's experience receiving medical assistance and long term services and supports in a managed care environment, the State shall create and maintain a system of consumer supports independent from the managed care plans to assist enrollees in understanding the coverage model and in the resolution of problems regarding services, coverage, access and rights.

e) Core Elements of the Independent Consumer Support System.

f) Organizational Structure. The Independent Consumer Supports System shall operate independently from any STAR+PLUS or STAR Kids MCO. The organizational structure of the support system shall facilitate transparent and collaborative operation with beneficiaries, MCOs, and state government.

g) Accessibility. The services of the Independent Consumer Supports System will be available to all Medicaid beneficiaries enrolled in STAR+PLUS or STAR Kids receiving Medicaid long-term services and supports (institutional, residential and community based). The Independent Consumer Supports system will be accessible through multiple entryways (e.g., phone, internet, office) and will have the capacity to reach out to beneficiaries and/or authorized representatives through various means (mail, phone, in person), as appropriate.

h) Functions. The Independent Consumer Supports system will be available to assist beneficiaries in navigating and accessing covered health care services and supports. Where an individual is enrolling in a new delivery system, the services of this system help individuals understand their choices and resolve problems and concerns that may arise between the individual and a provider/payer. The following list encompasses the system's scope of activity.

i) The system will offer beneficiaries support in the pre-enrollment stage, such as unbiased health plan choice counseling and general program- related information.

j) The system will serve as an access point for complaints and concerns about health plan enrollment, access to services, and other related matters.

k) The system will be available to help enrollees understand the hearing, grievance, and appeal rights and processes within the health plan as well as the fair hearing, grievance, and appeal rights and processes available at the state level and assist them through the process if needed/requested.

l) Staffing and training. The Independent Consumer Supports system will include individuals who are knowledgeable about the state's Medicaid programs; beneficiary protections and rights under Medicaid managed care arrangements; and the health and service needs of persons with complex needs, including those with a chronic condition, disability, and cognitive or behavioral needs. In addition, the Independent Consumer Supports System will ensure that its services are delivered in a culturally competent manner and are accessible to individuals with limited English proficiency. The system ultimately developed by the state may draw upon existing staff within the chosen organizational structure and provide substantive training to ensure core competencies and a consistent consumer experience.

m) Data Collection and Reporting. The Independent Consumer Supports System shall track the volume and nature of beneficiary complaints and the resolution of such complaints on a schedule and manner determined by the state, but no less frequently than quarterly. This information will inform the state of any provider or contractor issues and support the reporting requirements to CMS.

n) Reporting under the Demonstration. The state will report on the activities of the Independent Consumer Support System in the annual monitoring reports. The approved Independent Consumer Support System Plan is shown in Attachment L. Changes to Attachment L must be submitted to CMS for review and approval subject to STC 7. The state will monitor the impact of the Independent Consumer Support Program in the demonstration.

C. BENEFICIARIES SERVED THROUGH THE DEMONSTRATION

18) Eligibility Groups Affected by the Demonstration. 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 and as described in these STCs. Any Medicaid state plan amendments to the eligibility standards and methodologies for these eligibility groups will apply to this demonstration. These state plan eligible beneficiaries are required under the demonstration to enroll in managed care to receive benefits and may have access to additional benefits not described in the state plan.

Table 2 below describes the state plan eligibility groups that are mandatory and voluntary enrollees into managed care. A STAR+PLUS member who enters a nursing facility remains in STAR+PLUS and the nursing facility services are paid through managed care.

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; **F**= STAR January 2014; **G =** STAR+PLUS September 2014; * = Effective through August 31, 2014 (part of STAR+PLUS effective September 1, 2014 – see "G"); **H** = STAR Kids November 1, 2016, includes only individuals from birth through age 20; **I** = STAR+PLUS September 2017; **J**=STAR Kids September 2017; **K**= STAR September 2017.

Medicaid Eligibility Group	Description and Medicaid Eligibility Group (MEG)	Income Limit and Resource Standards	STAR		STAR+ (T)PLUS		STAR Kids (S)	
			Mandatory	Voluntary	Mandatory	Voluntary	Mandatory	Voluntary
Low Income Families §1931 low income families	Parents and other caretaker relatives; §1902(a)(10)(A)(i)(I); 42 CFR §435.110 MEG: THTQIP-Adults (parents and caretaker relatives)	14% FPL (uses MAGI converted AFDC limits); No resource test; member meets relationship requirement	A, C, D					
Earnings Transitional Twelve months TMA from increase in earnings, combined increase in earnings and Alimony/Spousal support	Individuals who lose eligibility under §1931 due to increased earnings or hours of work §1902(a)(52); §1902(e)(1); §1925; §1931(c)(2) MEG: THTQIP-Adults (parents and caretaker relatives) OR THTQIP-Children (dependent children)	185% FPL in second extension period; No resource test	A, C, D					
Alimony/ Spousal Support Transitional Four months post Medicaid resulting from Alimony/ Spousal support	Individuals who lose eligibility under §1931 due to Alimony/ Spousal support; §1902(a)(10)(A)(i)(I);); 42 CFR §435.115 MEG: THTQIP-Adults (parents and caretaker relatives) OR THTQIP-Children (dependent children)	N/A; No resource test	A, C D					
Pregnant Women	§1902(a)(10)(A)(i)(IV), §1902(l)(1)(A); 42 CFR §435.116 MEG: THTQIP-Adults	198% FPL; No resource test	A, C, D					
Children Under 1	Poverty level infants; §1902(a)(10)(A)(i)(IV), §1902(l)(1)(B); 42 CFR §435.118 MEG: THTQIP-Children	198% FPL	A, C, D					
Newborn Children 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: THTQIP-Children	N/A; No resource test	A, C, D					

Medicaid Eligibility Group	Description and Medicaid Eligibility Group (MEG)	Income Limit and Resource Standards	STAR		STAR+ (T)PLUS		STAR Kids (S)	
			Mandatory	Voluntary	Mandatory	Voluntary	Mandatory	Voluntary
Children Age 1-5	Poverty level children under 6; §1902(a)(10)(A)(i)(VI), §1902(l)(1)(C); 42 CFR §435.118 MEG: THTQIP-Children	144% FPL	A, C, D					
Children Age 6-18	Poverty level children under 19; §1902(a)(10)(A)(i)(VII), §1902(l)(1)(D); 42 CFR §435.118 Note: All children at or below 100 percent FPL in this eligibility group are funded through title XIX. Title XXI funding for children between 100-133% FPL shall be claimed as outlined in 42 CFR § 433.11 MEG: If title XIX: THTQIP-Children If title XXI: THTQIP-MCHIP Children	133% FPL	A, C, D, F					
Former Foster Care Children	Former foster care children §1902(a)(10)(A)(i)(IX); 42 CFR §435.150 Mandatory managed care for 18- 26. Ages 18 through 20: Choice between STAR Health or STAR. If receiving 1915(c) services: choice between STAR Health or STAR Kids. Ages 21 through 26: STAR-If receiving 1915(c) IDD waiver services (unless the individual is dually eligible): STAR+PLUS MEG: THTQIP-Children (if under age 21) OR THTQIP-Adults (parents and caretaker relatives, if age 21 or older)	N/A; No resource test	F		I		J	

Medicaid Eligibility Group	Description and Medicaid Eligibility Group (MEG)	Income Limit and Resource Standards	STAR		STAR+ (T)PLUS		STAR Kids (S)	
			Mandatory	Voluntary	Mandatory	Voluntary	Mandatory	Voluntary
SSI Recipient 21 and older with Medicare (Dual)	Individuals receiving SSI cash benefits; §1902(a)(10)(A)(i)(ll) §1902(a)(10)(A)(i)(ll)(cc) Covers gap month children within the waiver; however, retroactive payments, including payment for the gap month, are paid via FFS MEG: THTQIP-AMR	74% FPL (SSI Limit); $2,000 individual, $3,000 couple			B, E, G			
SSI Recipient under 21 with Medicare (Dual)	Individuals receiving SSI cash benefits; §1902(a)(10)(A)(i)(ll) §1902(a)(10)(A)(i)(ll)(cc). Covers gap month children within the waiver; however, retroactive payments, including payment for the gap month, are paid via FFS MEG: THTQIP-AMR	74% FPL (SSI Limit); $2,000 individual, $3,000 couple				B, E, G	H	
SSI Recipient without Medicare 21 and older	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: THTQIP-Disabled	74% FPL (SSI Limit); $2,000 individual, $3,000 couple	D*	A*	B, E, G			
SSI Recipient without Medicare under 21	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: THTQIP-Disabled	74% FPL (SSI Limit); $2,000 individual, $3,000 couple		A* D*		B, E, G	H	
Pickle Group 21 and older, with Medicare Includes pre-Pickle eligibility group	Would be eligible for SSI if title II COLAs deducted from income; 42 CFR §§435.134, 435.135 MEG: THTQIP-AMR	74% FPL (SSI Limit); $2,000 individual, $3,000 couple			B, E, G			
Pickle Group 21 and older without Medicare 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: THTQIP-Disabled	74% FPL (SSI Limit); $2,000 individual, $3,000 couple	D*	A*	B, E, G			
Pickle Group under 21 with Medicare	Would be eligible for SSI if title II COLAs deducted from income; 42 CFR §435.135 MEG: THTQIP-AMR	74% FPL (SSI Limit); $2,000 individual, $3,000 couple				B, E, G	H	

Medicaid Eligibility Group	Description and Medicaid Eligibility Group (MEG)	Income Limit and Resource Standards	STAR		STAR+ (T)PLUS		STAR Kids (S)	
			Mandatory	Voluntary	Mandatory	Voluntary	Mandatory	Voluntary
Pickle Group under 21 without Medicare	Would be eligible for SSI if title II COLAs deducted from income; 42 CFR §435.135 MEG: THTQIP-Disabled	74% FPL (SSI Limit); $2,000 individual, $3,000 couple		A* D*		B, E, G	H	
Disabled Adult Children (DAC) 21 or over with Medicare	§1635(c); §1935 MEG: THTQIP-AMR	74% FPL (SSI Limit); $2,000 individual, $3,000 couple			B, E, G			
Disabled Adult Children (DAC) 21 or over without Medicare	§1635(c); §1935 MEG: THTQIP-Disabled	74% FPL (SSI Limit); $2,000 individual, $3,000 couple	D*	A*	B, E, G			
DAC under 21 with Medicare	§1635(c); §1935 MEG: THTQIP-AMR	74% FPL (SSI Limit); $2,000 individual, $3,000 couple				B, E, G	H	
DAC under 21 without Medicare	1635(c); §1935 MEG: THTQIP-Disabled	74% FPL (SSI Limit); $2,000 individual, $3,000 couple		A* D*		B, E, G	H	
Disabled Widow(er)	Widows/Widowers, 1634(b); §1935 MEG: THTQIP-Disabled	74% FPL (SSI Limit); $2,000 individual, $3,000 couple	D*	A*	B, E, G			
Early Aged Widow(er)	Early Widows/ Widowers, 1634(d); §1935 MEG: THTQIP-Disabled	74% FPL (SSI Limit); $2,000 individual, $3,000 couple	D*	A*	B, E, G			
Medicaid Buy-In (MBI) with Medicare	BBA Work Incentives Group; §1902(a)(10)(ii)(XIII) MEG: THTQIP-AMR	250% FPL; $2,000			B, E, G		H	
Medicaid Buy-In (MBI) without Medicare	BBA Work Incentives Group; §1902(a)(10)(ii)(XIII) MEG: THTQIP-Disabled	250% FPL; $2,000	D*	A*		B, E, G	H	
Medicaid Buy-In for Children (under age 19) with Medicare	Family Opportunity Act (MBIC), §1902(a)(10)(A)(ii)(XIX) MEG: THTQIP-AMR	300% FPL; No resource standard				B, E, G	H	

Medicaid Eligibility Group	Description and Medicaid Eligibility Group (MEG)	Income Limit and Resource Standards	STAR		STAR+ (T)PLUS		STAR Kids (S)	
			Mandatory	Voluntary	Mandatory	Voluntary	Mandatory	Voluntary
Medicaid Buy-In for Children (under age 19) without Medicare	Family Opportunity Act (MBIC), §1902(a)(10)(A)(ii)(XIX) MEG: THTQIP-Disabled	300% FPL; No resource standard		A* D*		B, E, G	H	
Nursing Facility age 21 and older	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: THTQIP-AMR (with Medicare) OR THTQIP-Disabled (without Medicare)	300% SSI or Approx. 220% FPL; $2,000 individual/ $3,000 couple			B†, E†, G			
217 Group without Medicare under 21	Institutional eligibility and post- eligibility rules for individuals who are eligible as specified under 42 CFR 435.217, 435.236, and 435.726 and §1924 of the Act. MEG: THTQIP-Disabled (without Medicare)	300% SSI or Approx. 220% FPL; $2,000 individual/$3,000 couple. Use spousal impoverishment policy for eligibility, and for post-eligibility.		D*		G	H	
217 Group without Medicare 21and older	Institutional eligibility and post- eligibility rules for individuals who are eligible as specified under 42 CFR 435.217, 435.236, and 435.726 and §1924 of the Act. MEG: THTQIP-Disabled (without Medicare)	300% SSI or Approx. 220% FPL; $2,000 individual/$3,000 couple. Use spousal impoverishment policy for eligibility, and for post-eligibility.	D*		G			
Medicaid for Breast and Cervical Cancer (MBCC)	Individuals screened for breast and cervical cancer by the Centers for Disease Control and Prevention breast and cervical cancer early detection program and found to need treatment for breast or cervical cancer as specified in §1902 (aa) and 42 CFR 435.213. MEG: THTQIP-AMR	N/A; No resource test.			I			

Medicaid Eligibility Group	Description and Medicaid Eligibility Group (MEG)	Income Limit and Resource Standards	STAR		STAR+ (T)PLUS		STAR Kids (S)	
			Mandatory	Voluntary	Mandatory	Voluntary	Mandatory	Voluntary
Adoption Assistance and Permanency Care Assistance (AAPCA)	Children and young adults who are the subject of a IV-E adoption assistance agreement, as specified in SSA §1902(a)(10)(A)(i)(I), SSA §473(b)(3), and 42 CFR §435.145. Children and young adults who are the subject of a non-IV-E adoption assistance agreement, as specified in SSA §1902(a)(10)(A)(ii)(VII) and 42 CFR §435.227. Children and young adults for whom IV-E guardianship assistance payments are made, as specified in SSA §1902(a)(10)(A)(i)(I), SSA §473(b)(3), and 42 CFR §435.145. Children and young adults in AAPCA who meet any of the following criteria will have a choice between STAR Health and STAR Kids: receiving Supplemental Security Income (SSI),were receiving SSI before becoming eligible for AAPCA enrolled in Medicare enrolled in a 1915(c) Medicaid waiver Children and young adults in AAPCA who meet all of the following criteria are mandatory for STAR: not receiving SSI, not receiving SSI before becoming eligible for AAPCA not enrolled in Medicare not enrolled in a 1915(c) waiver Note: AAPCA clients who reside out-of-state will remain FFS. MEG: THTQIP Children (if under age 21) OR THTQIP-Adult (if age 21 or older)	N/A; No resource test.	K					J

(S): Note children and young adults who are members of federally-recognized tribes will still be able to opt to remain in traditional fee-for-service Medicaid.**(T):** Note individuals who are members of federally-recognized tribes, and have Medicaid through the Medicaid for Breast and Cervical Cancer

Program, Adoption Assistance Program, Permanency Care Assistance Program or Former Foster Care Group will be able to voluntarily enroll in managed care or opt to remain in traditional fee-for-service Medicaid.

19) **Demonstration Expansion Population – STAR+PLUS 217-Like Eligibility Group.** Table 3 below describes the demonstration expansion populations that are mandatory and voluntary enrollees into managed care. 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 3. Demonstration Expansion Populations Made Eligible 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; F = STAR January 2014; G = STAR+PLUS September 2014; *** = Effective through August 31, 2014 (part of STAR+PLUS effective September 1, 2014 – see "G")**						
Medicaid Eligibility Group	Description and Medicaid Eligibility Group (MEG)	Income Limit and Resource Standards	STAR		STAR+PLUS	
			Mandatory	Voluntary	Mandatory	Voluntary
<u>217-Like Group</u> Categorically needy individuals under the State plan receiving HCBS services (of the kind listed in Table 6) 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, 435.726, and §1924 of the Act, if the State had not eliminated its 1915(c) STAR+PLUS and CBA waivers. MEG: THTQIP-AMR (with Medicare) OR THTQIP-Disabled (without Medicare)	300% SSI or Approx. 220% FPL; $2,000 individual/$3,000 couple. Use spousal impoverishment policy for eligibility and for post-eligibility			B	

20) **Populations Not Affected by the Demonstration.** The following populations receive Medicaid services without regard to the demonstration.
   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.

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

21) **Enrollment.**
   a) **Time to Choose a Plan.** All beneficiaries who obtain Medicaid eligibility will have at least 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, and when applicable, the beneficiary's history with a managed care organization. If this is not possible the state will equitably distribute beneficiaries among qualified MCOs.
   c) **Re-Enrollment.** 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.
   d) **Exclusively Aligned Enrollment (EAE).** Per 42 CFR 422.107(e), the State uses state Medicaid agency contracts to require certain dual eligible special needs plans (D-SNPs) to be an applicable integrated plan (Integrated D-SNP), which requires EAE for beneficiary enrollment. EAE is only applicable to an individual with full benefit dual eligibility who is eligible for STAR+PLUS and voluntarily enrolls into an Integrated D-SNP. HHSC limits Integrated D-SNP enrollment to individuals with full benefit dual eligibility who receive their Medicaid benefits from the aligned Medicaid managed care plan offered by the same parent organization, or another entity controlled by the parent organization, as the Integrated D-SNP. Selection of the Integrated D-SNP for Medicare benefits initiates enrollment into the aligned STAR+PLUS MCO for Medicaid benefits, as well. To complete enrollment in the Integrated D-SNP, HHSC will automatically enroll the Dual Eligible Member to the aligned STAR+PLUS MCO for the purpose of receiving Medicaid benefits and services.

22) **Disenrollment or Transfer.** 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.
    a) **MCO Transfer at Request of Beneficiary.** Beneficiaries may request transfer to another managed care organization in the service area through the enrollment broker at any time.
    b) **Disenrollment at Request of Beneficiary.** Recipients that are voluntarily enrolled in a managed care program may request disenrollment and return to traditional Medicaid. Mandatory recipients must request disenrollment from managed care in writing to HHSC; however, HHSC considers disenrollment from managed care only in rare situations, when sufficient medical documentation establishes that the MCO cannot provide the needed services, or in any of the circumstances described in 42 CFR 438.56(c). 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.
    c) **Disenrollment 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 pursuant to 42 CFR 438.56(b).

23) **Benefits.** Table 4a specifies the scope of services that may be made available to STAR, STAR+PLUS, and STAR Kids enrollees through the STAR, STAR+PLUS and STAR Kids managed care plans. The schedule of services mirrors those provided in the Medicaid State plan, with the exception of 1915(b)(3)-like services as described in this waiver. 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. 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, STAR+PLUS, and STAR Kids MCOs.

Table 4a. State Plan Services[1] for STAR, STAR+PLUS, and STAR Kids Participants

Adult/Child	Service	Mandatory or Optional State Plan Services (*)
Adult/Child	Inpatient Hospital Services [1,2,3]	Mandatory §1905(a)(1), 42 CFR 440.10
Adult/Child	Outpatient Hospital Services	Mandatory §1905(a)(2), 42 CFR 440.20
Adult/Child	Rural Health Clinic Services	Mandatory §1905(a)(2), 42 CFR 440.20
Adult/Child	Federally Qualified Health Center (FQHC) Services	Mandatory §1905(a)(2)

[1] Services are provided as detailed in Texas' state plan.

Adult/Child	Service	Mandatory or Optional State Plan Services (*)
Adult/Child	Laboratory and x-ray services	Mandatory §1905(a)(3), 42 CFR 440.30
Adult/Child	Diagnostic Services	Optional §1905(a)(13), 42 CFR 440.130(a)
Child	EPSDT	Mandatory §1905(a)(4), 1902(a)(43), 1905(r)
Adult/Child	Family Planning	Mandatory §1905(a)(4)
Adult/Child	Tobacco cessation counseling services for pregnant women.	Mandatory §1905(a)(4)
Adult/Child	Physician's Services	Mandatory §1905(a)(5), 42 CFR 440.50(a)
Adult/Child	Medical and Surgical Services Furnished by a Dentist	Mandatory §1905(a)(5), 42 CFR 440.50(b)
Adult/Child	Podiatrists' Services	Optional §1905(a)(6), 42 CFR 440.60(a)
Adult/Child	Optometrists' Services	Optional §1905(a)(6), 42 CFR 440.60(a)
Adult/Child	Chiropractor services	Optional §1905(a)(6), 42 CFR 440.60(b)
Adult/Child	Other practitioner services: certified registered nurse anesthetists' services, other categories of advanced nurse practitioner services, licensed clinical social worker (LCSW) services, licensed professional counselor (LPC) services, licensed marriage and family therapist (LMFT) services, psychologists services, services provided by physician assistants, and licensed midwife services	Optional §1905(a)(6), 42 CFR 440.60
Adult/Child	Intermittent or part-time nursing services provided by a home health agency	Mandatory §1905(a)(7), 42 CFR 440.70
Adult/Child	Home health aide services provided by a home health agency	Mandatory §1905(a)(7), 42 CFR 440.70
Adult/Child	Medical supplies, equipment, and appliances	Mandatory §1905(a)(7), 42 CFR 440.70
Adult/Child	Physical therapy, occupational therapy, speech pathology, and audiology provided by a home health agency	Optional §1905(a)(7) 42 CFR 440.70

Adult/Child	Service	Mandatory or Optional State Plan Services (*)
Adult/Child	Clinic Services	Optional §1905(a)(9), 42 CFR 440.90
Child	Private Duty Nursing Services	Optional §1905(a)(8), 42 CFR 440.80
Adult/Child	Prescribed Drugs	Optional §1905(a)(12), §1902(a)(54)
Adult/Child	Physical Therapy and related services	Optional §1905(a)(11), 42 CFR 440.110(a)
Adult/Child	Speech Therapy services	Optional §1905(a)(11) , 42 CFR 440.110(c)
Adult/Child	Non-prescription drugs	Optional §1905(a)(12), §1902(a)(54)
Adult/Child	Prosthetic Devices	Optional §1905(a)(12), 42 CFR 440.120(c)
Adult/Child	Eyeglasses	Optional §1905(a)(12), 42 CFR 440.120(d)
Adult/Child	Preventive Services	Optional §1905(a)(13), 42 CFR 440.130(c)
Adult	Services for individuals over age 65 in IMDs – Inpatient, Not Nursing Facility	Optional §1905(a)(14), 42 CFR 440.140(a)
Adult	Nursing facility services (STAR+PLUS only)	Mandatory §1905(a)(4), 42 CFR 440.155(b)
Child	Inpatient psychiatric facility services for individuals under age 21	Optional §1905(a)(16), 42 CFR 440.160
Adult (STAR+PLUS/STAR Kids)	Rehabilitative Services – Day Activity & Health Services	Optional §1905(a)(13), , 42 CFR 440.130(d)
Adult/Child	Mental Health Rehabilitative Services	Optional, Rehabilitation Service, 1905(a)(13) and 42 CFR 440.130(d)
Adult/Child	Targeted Case Management for Individuals with Chronic Mental Illness	Optional 1915(a)(19), 1915(g), 42 CFR 440.169(b)
Adult/Child	Case Management for Children and Pregnant Women (CPW)[4]	Optional §1915(g), 42 CFR 440.169, 42 CFR 441.18
Adult/Child	Nurse-Midwife Services	Mandatory §1905(a)(17), 42 CFR 440.165

Adult/Child	Service	Mandatory or Optional State Plan Services (*)
Adult/Child	Extended services for pregnant women–Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls	Mandatory §1902(e)(5), 42 CFR 440.250(p)
Adult/Child	Extended services for pregnant women–Services for any other medical conditions that may complicate pregnancy.	Mandatory §1905(a)(1-5), (17), (21), (28), 42 CFR 440.250(p)
Adult/Child	Continuous postpartum coverage for the period beginning the first day after the end of the mandatory 60-day postpartum coverage period and ending the last day of the month in which the 12-month postpartum period (beginning on the last day of pregnancy) ends.[5]	Optional §1902(e)(16)
Adult/Child	Certified pediatric or family nurse practitioners' services	Mandatory §1905(a)(21), 42 CFR 440.166
Adult/Child	Personal care services in the home[6]	Optional §1905(a)(24) 42 CFR 440.167
Adult/Child	Community First Choice[6]	Optional §1915(k)
Adult/Child	Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by a eligible provider (in accordance with section 1920 of the Act).	Optional §1920
Adult/Child	Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).	Optional §1905(a)(20), 42 CFR 440.185
Adult/Child	Services provided in Religious Nonmedical Health Care Institutions.	Optional §1905(a)(31), 42 CFR 440.170(b), 440.170(c)
Adult/Child	Emergency hospital services.	Optional §1905(a)(31), 42 CFR 440.170(e)
Adult/Child	Ambulatory Surgical Center Services	Optional §1905(a)(31), 42 CFR 440.90
Adult/Child	Birthing Center Facility Services	Optional §1905(a)(28), (31)
Adult/Child	Transportation	Optional 1905(a)(31), 42 CFR 440.170(a)

[1]Substance use disorder treatment services are capitated services for STAR, STAR+PLUS, and STAR Kids, 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, STAR+PLUS, and STAR Kids capitation; however, the MCO is not restricted to only the delivery of State plan services when alternative services are a cost-effective and medically appropriate response to the needs of the member.

[2]The 30-day spell of illness limitation for hospital inpatient services described in the state plan does not apply to STAR enrollees, certain approved transplants, children age 20 and younger, or to individuals with severe and persistent mental illness. In addition, for inpatient hospital stays related to COVID-19 (i.e. a stay for which the COVID-19 diagnosis is listed anywhere on the claim but is not necessarily the primary diagnosis, excluding presumptive positive cases), Texas will extend the 30-day spell of illness limitation described in the state plan for an additional 30 days to allow an

individual to stay up to 60 days in a hospital for the period of the COVID19 Public Health Emergency (PHE).The state will also allow an individual to exceed the $200,000 inpatient hospital benefit limitation for COVID-19 related stays during the PHE.

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

[4]An MCO must offer and provide service coordination as required by the contract and must not delay offering service coordination on the basis the member is receiving CPW services from a provider. In accordance with 42 C.F.R. §441.18, an MCO must ensure reimbursement to providers for CPW covered services does not duplicate payments the MCO receives from HHSC for the same purpose.

[5] The extension of postpartum coverage was added to align with the approval of SPA 23-0028, which was effective 3/1/2024.

[6]For STAR, personal care services and Community First Choice services are delivered through a fee-for-service delivery model.

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

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

24) **Self-Referral.** Demonstration beneficiaries may self-refer for the following services:
    a) In-network behavioral 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, other than surgery, 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.

25) **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.

26) **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).

E. CHILDREN'S DENTAL PROGRAM

27) **Implementation of the Children's Dental Program.** Children's primary and preventive Medicaid dental services are delivered through a capitated statewide dental services program (the Children's Dental Program). Contracting dental maintenance organizations (DMOs) maintain networks of Main Dental Home providers, consisting of general dentists and pediatric dentists. The dental home framework under this statewide program is 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,STAR+PLUS, and STAR Kids 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 (a) 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 Individuals with an Intellectual Disability or Related Conditions (ICF/ID); and STAR Health Program recipients.
b) 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

28) 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 apply to the HCBS program authorized under section 1115, and provided through STAR+PLUS. HCBS, under the demonstration, operates in accordance with these STCs and associated attachments.
b) **Quality Improvement Strategy for 1915(c)-like HCBS Service.** For services that could have been authorized to individuals under a 1915(c) HCBS waiver, the state must develop and implement a Quality Improvement Strategy that encompass LTSS specific measures set forth in the federal managed care rule at 42 CFR 438.330 and in accordance with 42 CFR 441.301 and 441.302. The Quality Improvement Strategy must meet the requirements outlined in the March 12, 2014, CMS Informational Bulletin, Modifications to Quality Measures and Reporting in §1915(c) Home and Community–Based Waivers. Specifically, the state is required to develop performance measures to address the following assurances:

    (1) **Administrative Authority:** The state must have performance measures to demonstrate that the State Medicaid Agency (SMA) retains ultimate administrative authority and responsibility for the operation of the HCBS program by exercising oversight of the functions delegated to other state and local/regional non-state agencies (if appropriate) and contracted entities.
    (2) **Level of Care or Eligibility based on 1115 Requirements**: The state must have performance measures to demonstrate each of the following: a) that an evaluation for level of care is provided to all applicants for whom there is reasonable indication that 1915(c)-like HCBS services may be needed in the future, and b) that the process and instruments described in the approved demonstration are applied appropriately and according to the approved description to determine initial participant level of care. While the state is required to conduct annual re-evaluations for level of care, a performance measure is not required to demonstrate compliance with this sub-assurance.
    (3) **Qualified Providers:** The state must have performance measures to demonstrate each of the following: a) that the state verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other state standards prior to their furnishing 1915(c)-like HCBS services, b) that the state monitors non-licensed/non-certified providers to assure adherence to demonstration requirements, and c) that the state implements policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved demonstration.

(4) **Service Plan**: The state must have performance measures to demonstrate each of the following: a) service plans address all individuals' assessed needs (including health and safety risk factors) and personal goals, either by the provision of 1915(c)-like HCBS services or through other means, b) service plans are updated/revised at least annually or when warranted by changes in participant's needs, c) services are delivered in accordance with the service plan, including in the type, scope, amount, duration, and frequency specified in the service plan, and d) participants are afforded choice between/among 1915(c)-like HCBS services and providers.

(5) **Health and Welfare**: The state must have performance measures to demonstrate each of the following: a) that on an ongoing basis it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death, b) that it has an incident management system in place that effectively resolves incidents and prevents further similar incidents to the extent possible, c) that state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusions) are followed, and d) that the state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved demonstration. (See Attachment E).

(6) **Financial Accountability**: The state must demonstrate that it has designed and implemented an adequate system for insuring financial accountability of the 1915(c)-like HCBS program. The state must have performance measures to demonstrate that: a) claims are coded and paid for in accordance with the reimbursement methodology specified in the approved demonstration and only for services rendered, and b) it provides evidence that rates remain consistent with the approved rate methodology throughout the demonstration period. The state must demonstrate actuarial soundness on an annual basis pursuant to 42 CFR 438.

c) The state must submit the Quality Improvement Strategy (QIS) and performance measures to CMS for review and acceptance.

d) **Determination of Benefits by Designation into a STAR+PLUS HCBS Group.** The STAR+PLUS HCBS Program provides long-term services and supports as identified in Table 5 to two groups of people, as defined below:

i) **STAR+PLUS 217-Like HCBS Group.** This group consists of persons age 21 and older, 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. This group is subject to a numeric enrollment limitation, as described below.

(1) **Interest List for STAR+PLUS 217-LIKE HCBS Group.** The state operates an interest list for the STAR+PLUS 217-Like HCBS population in the demonstration who are not in the STAR+PLUS mandatory eligibility categories. An interest list is a 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 from the interest list, except that persons entering the demonstration through Money Follows the Person (MFP) are placed at the head of the interest list. These lists are managed on a statewide basis using a standardized assessment tool, and in accord with criteria established by the state. Interest list policies are based on objective criteria and applied consistently in all geographic areas served.

(2) **Unduplicated Participant Slots for the 217-Like HCBS Group.** Table 5(a) below specifies the unduplicated number of participants for the 217-Like Group.

(a) Column A reflects the following slots: (1) the number of unduplicated participant slots transferred from the STAR+PLUS 1915(c) waiver, TX 0862; (2) unduplicated participant slots transferred 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.

(b) Column B reflects the additional slots made available for the Nursing Facility Diversion Group, created June 1, 2013. The Nursing Facility Diversion Group was created as a subset of the STAR+PLUS 217- Like HCBS Group. This group consists of persons age 65 and older, and adults with physical disabilities age 21 and older, who meet the NF LOC as defined by the state, who qualify as members of the 217- Like HCBS Group, and who are at imminent risk of entering a nursing facility as a result of a catastrophic episode. Examples of a catastrophic episode include: (1) an individual is significantly dependent on a caregiver to remain in the community and the caregiver passes away or is suddenly no longer able to provide care; (2) an individual has a community support system but must suddenly move where there is no support system; (3) an individual has a sudden occurrence that would cause imminent placement in a nursing facility because he can no longer care for himself; or (4) an individual is identified by the Texas Department of Family and Protective Services as being at imminent risk of nursing facility placement. The number of nursing facility diversion group slots for each DY is listed in the chart below. Nursing Facility Diversion Group slots may be encumbered only by individuals identified as belonging to the Nursing Facility Diversion Group.

(c) Column C reflects the additional slots added September 1, 2015 and September 1, 2016 after the 84th Legislature (Regular Session) of Texas appropriated additional funds to increase the number of unduplicated participants for the STAR+PLUS 217-Like Group served by the STAR+PLUS HCBS Program.

Table 5(a). Unduplicated Number of Participants for the STAR+PLUS 217-Like HCBS group

Demonstration Year	Column A	Column B	Column C	Total
DY 7	23,001	100	1,235	24,336
DY 8	23,090	100	1,235	24,425
DY 9	23,407	100	1,235	24,742
DY 10	23,793	100	1,235	25,128
DY 11	24,239	100	1,235	25,574
DY 12	24,693	100	1,235	26,028
DY 13	25,156	100	1,235	26,491
DY 14	25,628	100	1,235	26,963

Demonstration Year	Column A	Column B	Column C	Total
DY 15	26,109	100	1,235	27,444
DY 16	26,598	100	1,235	27,933
DY 17	27,097	100	1,235	28,432
DY 18	27,605	100	1,235	28,940
DY 19	28,123	100	1,235	29,458

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. Table 5(b) below specifies the unduplicated number of participants for the SSI-Related Eligible HCBS Group.

(1) Column A reflects the following slots: (1) the number of unduplicated participants transferred from the STAR+PLUS 1915(c) waiver, TX 0325; (2) the number of unduplicated participants transferred from the CBA 1915(c) waiver; and (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.

Table 5b. Unduplicated Number of Participants for the SSI-Related Eligible Group

Demonstration Year	Column A
DY 7	44,249
DY 8	44,710
DY 9	45,562
DY 10	46,514
DY 11	47,563
DY 12	48,636
DY 13	49,734
DY 14	50,856
DY 15	52,003
DY 16	53,177
DY 17	54,376
DY 18	55,603
DY 19	56,858

e) **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.

i) 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.

ii) For an individual, other than a member of the medically fragile group, to be eligible for HCBS services under STAR+PLUS, the State must have determined that the cost to provide HCBS services to the individual is equal to or less than 202 percent of the average cost of care the State would pay for the individual's level of care in a nursing facility. This is the individual cost limit for the STAR+PLUS HCBS program.

iii) The medically fragile group consists of individuals age 21 or older who are determined by HHSC, pursuant to HHSC policy, to have a congenital or acquired physical impairment and/or a complex debilitating illness or disability, along with substantial skilled nursing medical care needs over a continuous 24-hour period that require the presence of a licensed nurse to provide frequent evaluation. Although these individuals are assessed to have high medical needs that exceed the individual cost limit for the STAR+PLUS HCBS program, they are not subject to the individual cost limit and are eligible for HCBS services under STAR+PLUS. There is a limit of 150 slots per demonstration year for the medically fragile group.

f) **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 choices 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.

g) The state, either directly or through its MCO contracts must ensure that participants' engagement and community participation is supported to the fullest extent desired by each participant.

h) Beneficiaries may change managed care plans if their residential or employment support provider is no longer available through their current plan.

i) **Conflict of Interest:** The state assures compliance with the HCBS conflict of interest protections set forth at 42 CFR 441.301(c)(1)(vi). Providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management or develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS. In these cases, the State must devise conflict of interest protections including separation of entity and provider functions within provider entities, which must be approved by CMS. Individuals must be provided with a clear and accessible alternative dispute resolution process.

j) **HCBS Settings Requirements:** The state must assure compliance with the characteristics of HCBS settings as described in 42 CFR 441.301(c)(4) in accordance with implementation/effective dates as published in the Federal Register.

k) **HCBS Electronic Visit Verification System**: The state will demonstrate initial compliance and ensures ongoing compliance with the Electronic Visit Verification System (EVV) requirements for personal care services (PCS) and home health services in accordance with section 12006 of the 21st Century CURES Act.

l) **Service Plan.** The state assures there is a person–centered service plan for each individual determined to be eligible for HCBS under this demonstration. The person–centered service plan must be developed using a person–centered service planning process in accordance with 42 CFR 441.301(c)(1) and the resulting written person–centered service plan must meet requirements set forth at 42 CFR 441.301(c)(2). The person–centered service plan must be reviewed and revised, as appropriate, based upon reassessment of functional need as required by 42 CFR 441.365(e), at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the beneficiary. 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. The State will use an electronic process for submission and approval of most individual service plans. Service plans for individuals turning 21, outside the cost ceiling, and the 217-Like Group will remain a manual process.

m) **Benefit Package under the STAR+PLUS HCBS Program.** The following Table 6 describes 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 A.

Table 6. 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	

Service	Provider Directed	Participant Directed
Cognitive Rehabilitation Therapy (Effective March 6, 2014)	X	X
Supported Employment Services (Effective September 1, 2014)	X	X
Employment Assistance Services (Effective September 1, 2014)	X	X

n) **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. Each beneficiary eligible for long term services and supports will have informed choice on their option to self-direct LTSS, have a designated representative direct LTSS on their behalf, or select traditional agency-based service delivery. Both level of care and person-centered service planning personnel will receive training on these options.

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.

(1) **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 Financial Management Services Agency (FMSA), 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 FMSA files required forms and reports to the Texas Workforce Commission.

(2) **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 HHSC.

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:

(1) 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 A for services that may be self-directed as specified in Table 5; 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.

(2) All participants, in conjunction with the FMSA, 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 FMSA, 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.

(3) 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.

o) **Fair Hearing.** For standard and expedited appeals, members must exhaust the MCO's internal standard or expedited appeals process before making a request for a standard or expedited state fair hearing. Procedures related to state fair hearings are described in Attachment D.

p) **Participant Safeguards**. The state must follow all member safeguard procedures as described in Attachment E of these STCs.

G. DELIVERY SYSTEM AND PROVIDER PAYMENT INITIATIVES IN MANAGED CARE CONTRACTS

29) State Directed Payment Programs. Pursuant to 42 CFR 438.6(c) and subject to prior CMS approval, as applicable, the state may direct expenditures for delivery system and provider payment initiatives (i.e., state directed payments) through its contracts with managed care plans. The state intends to submit requests for approval of state directed payments for the state's rating period from September 1, 2021-August 31, 2022, including the Comprehensive Hospital Increased Reimbursement Program (CHIRP), the Texas Incentives for Physician and Professional Services (TIPPS) Program, the Rural Access to Primary and Preventive Services (RAPPS) Program, and the Directed Payment Program for Behavioral Health Services. The state may also submit requests to continue the Quality Incentive Payment Program (QIPP) or to create new programs, including an Ambulance Services Directed Payment Program. Description of a particular state directed payment in these STCs does not qualify as CMS approval, nor does it negate the approval and other requirements of 42 CFR 438.6(c). Notwithstanding these STCs, all federal standards and requirements under 42 CFR 438.6(c), or successor regulations, will apply. All state directed payments must be based on the delivery and utilization of services to Medicaid beneficiaries covered under the contract delivered during the rating period and the services must be approved under an existing authority (e.g. Medicaid state plan, 1915(b) or 1915(c)). Payment cannot be conditioned upon historical data (services delivered or performance measured prior to the start of the rating period in question) nor can payment be conditioned upon completion or submission of a report. The state may require providers as a condition of participation in a program to complete an application, including submitting required financial data to assist the state in completing required elements of the form described in STC 31 and STC 36, and other reports related to quality improvements or data to assist the state in completing required elements of STC 35.

30) Requirements for State Submission of State Directed Payments. For programs that must obtain CMS approval and are proposed to begin on September 1, 2021, the state and CMS will work collaboratively towards consideration of approval of state requests and will adhere to the milestones outlined in the subsequent STCs. The state must submit to CMS on a form prescribed by CMS its requests for state directed payments.

31) CMS Initial Review of State Directed Payment Requests. CMS will furnish to Texas in writing within 30 calendar days following receipt of the complete request for approval, all requests for information needed to assist CMS in evaluating the request, including but not limited to documentation necessary to:

a. Determine compliance with 42 CFR 438.6(c) and all other applicable Federal requirements;
b. Determination that the state directed payment is reasonable, appropriate and attainable;

c. Determination, for any approved state directed payment prior to consideration for renewal, documentation of improvement in the quality measures identified in the state's approved evaluation plan; and
d. Determination that the quality measures and evaluation plan for the requested state directed payment documents commitment to year over year improvement based on nationally recognized measures (e.g. Adult or Child Core Set, NQF core measure, etc.), or other quantifiable measures as agreed to by the state and CMS.

32) **State Response to Requests for Additional Information**. When CMS requests additional information in an effort to consider a request for approval, Texas will provide responses in writing to such requests for information within 15 calendar days following receipt of the requests for additional information.

33) **CMS Review of the State's Response to Requests for Additional Information:** CMS will evaluate any information provided by the state by phone or in writing pursuant to the request for approval to determine whether CMS anticipates that the request may be considered approvable. If CMS determines that the request for approval is complete and complies with the requirements of 438.6(c), CMS will notify the state in writing within 20 calendar days of receipt of the state submitting complete responses to requests for information that CMS anticipates issuing a formal decision letter within 20 calendar days. If CMS identifies any outstanding matters that need technical or substantive modification in order for CMS to make a final decision, CMS will identify the matters and provide notification to the state in writing within 20 calendar days of receipt of the state submitting complete responses to requests for information.

34) **Additional Processing Requirements as needed**. If the state is notified by CMS that further modifications to the request are required, CMS and the state will work collaboratively to resolve any outstanding matters that need technical or substantive modification in order for CMS to make a final decision on the proposal. Within 5 business days of receipt of request for additional information by CMS, CMS and the state will meet by phone or other means to discuss the request. HHSC and CMS will meet by phone or other means at least every 5 business days, unless they mutually agree that there are no additional substantive or technical matters that either party wishes to clarify. HHSC will respond in writing within 20 calendar days of receipt of the written request for modifications.

35) **Approval Conditioned Upon Submission of Complete Evaluation Data**. Any approval of a one-year state directed payment proposal will be conditioned on the state submitting evaluation results within 18 months of the end of a rating period. For example, if a state directed payment was approved for SFY 2021 (September 1, 2020-August 31, 2021), the state must submit evaluation results specific to that SDP by March 1, 2023. Any approval of a multi-year state directed-payment proposal will be conditioned on the state submitting evaluation results within 18 months of the end of each annual rating period of the multi-year proposal. If the evaluation results are not received 18 months after the end of the applicable rating period(s), review of any future requests for the state directed payment will not begin until those evaluation results are received.
The state may also submit amendments to any approved state directed payment, as necessary, and CMS will review such amendment requests to determine whether they are approvable.

36) Monitoring State Directed Payments.

a. CMS will assess compliance with the regulatory requirements through ongoing monitoring with the state.

V. FUNDING POOLS UNDER THE DEMONSTRATION

The terms and conditions in Section V apply to the state's exercise of the following Expenditure Authorities: Expenditures Related to the Uncompensated Care Pool, Expenditures Related to the Public Health Providers Charity Care Pool, and Expenditures Related to the Delivery System Incentive Reform Payment (DSRIP) Pool.

37) 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. This report must identify the funding sources associated with each type of payment received by each provider.

c) 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.

38) Uncompensated Care (UC) Pool. Payments from this pool 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 uninsured individuals as charity care by hospitals, clinics, or by other provider types, as specified at subparagraph (c) below, including uninsured full or partial discounts, that provide all or a portion of services free of charge to patients who meet the provider's charity care policy and that adhere to the charity care principles of the Healthcare Financial Management Association.[2] Annual UC Pool payments are limited to the annual amounts identified in STC 41. Expenditures for UC payments must be claimed in accordance with CMS-approved claiming protocols for each provider type and application form in Attachment H. The methodology used by the state to determine UC payments will ensure that payments to hospitals, clinics, and other providers are distributed based on uncompensated cost, without any relationship to source of non-federal share, as specified in Attachment H. UC payments are not associated with particular individuals and are not a form of health coverage or any other benefit inuring to individuals.

a) **UC Application.** To qualify for a UC Payment, a provider 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 and non-hospital providers. The state must require hospitals to report data in a manner that is

[2] Available at http://www.hfma.org/WorkArea/DownloadAsset.aspx?id=14589.

consistent with the Medicare Form 2552-10 cost report, or for non-hospital providers, a CMS-approved cost report consistent with Medicare cost reporting principles.

i) Cost and payment data included on the application must be based on the Medicare 2552-10 cost report, or for non-hospital providers, a CMS-approved cost report consistent with Medicare cost reporting principles. For hospitals and physician groups, data on the application is for the 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 providers to finalize their cost reports from that data year and submit their application data to HHSC. (For example, FFY 2010 was 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. HHSC or its designee will reconcile estimates for prior years. If trending is used, the base year can be no older than 2 years old and must be tied to a generally recognized and widely published trending factor used for trending health care costs. For hospitals not required to report charity care uncompensated costs on their cost reports, the hospital must report the required data in the tool approved by CMS and included in Attachment H. 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, except that 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 accrued, the state may provide reimbursement for those actual documented unreimbursed UC costs through a prior period of adjustment. For ambulance and dental providers, data on the application is based on actual eligible costs incurred during the demonstration year for which the payments are made.

ii) 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:
   (1) Costs and revenue not reflected on the filed cost report, but which would be incurred for the program year, be included when calculating payment amounts; or
   (2) Costs and revenue reflected on the filed cost report, but which would not be incurred for the program year, be excluded when calculating payment amounts.
   Adjustments described in subparagraphs (1) and (2) above cannot be considered as part of the 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 ensure that providers actually incurred such eligible uncompensated costs.

iii) All applicable inpatient and outpatient hospital UC 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 for those services. 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 Form 2552-10 cost report or, for non-hospital providers, a CMS approved cost report consistent with Medicare cost reporting principles.

b) **UC Payment Protocol.** The state has completed this action and the protocol is in Attachment H. The UC Payment Protocol, also known as the funding and reimbursement protocol, establishes rules and guidelines for the State to claim FFP for UC Payments. The approved UC Payment Protocol is appended into these STCs as Attachment H. By March 30, 2018, the state must submit for CMS approval an addendum to the funding and reimbursement protocol that will establish rules and guidelines for the State to claim FFP for UC Payments beginning in DY 9 (October 1, 2019 through September 30, 2020). CMS and Texas will work collaboratively with the expectation of CMS approval of the protocol within 90 calendar days after it receives the addendum. The state cannot claim FFP for any UC Payments for DY 9 or later until a UC Protocol addendum has been submitted to and approved by CMS. The UC Payment 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). 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 charity care 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). The Protocol 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 addendum 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 for DY 9 or later until a cost-claiming protocol addendum consistent with the Medicare cost reporting principles is approved by CMS for the relevant non-hospital provider type.

c) **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, and government dental providers. UC Payments are considered to be Medicaid payments to providers and must be treated as Medicaid revenue when determining total title XIX funding received, in particular for any provider utilizing certified public expenditures as the non-Federal share of a Medicaid payment.

d) **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:
   i) By December 31st of each Demonstration Year, the State shall provide the following information to CMS:
      (1) The UC payment applications submitted by eligible providers; and
      (2) A chart of estimated UC Payments to each provider for a DY.
   ii) Within ninety (90) days after the end of each Demonstration year, the State shall provide the following information to CMS:
      (1) The UC Payment applications submitted by eligible providers; and
      (2) A chart of actual UC payments to each provider for the previous DY.

39) Public Health Providers Charity Care Pool (PHP-CCP). From October 1, 2021, through September 30, 2022, payments from the PHP-CCP may be used to defray the actual uncompensated cost of eligible or

uninsured individuals incurred by qualifying providers. For purposes of the PHP-CCP, qualifying providers are limited to publicly-owned and operated community mental health clinics (CMHCs), local behavioral health authorities (LBHAs), and local mental health authorities (LMHAs), local health departments (LHDs), and public health districts (PHDs), as agreed upon by CMS and the state and defined at subparagraph (c) of this STC. For DYs 11 and 12, publicly-owned and operated CMHCs, LBHAs, LMHAs, LHDs, and PHDs that are participating in the PHP-CCP may receive payments from the pool not to exceed $500 million per federal fiscal year. Starting October 1, 2022, payments from this pool may be used to defray the actual uncompensated cost discounts, that provide all or a portion of services free of charge to patients who meet the provider's charity care policy and that adhere to the charity care principles of the Healthcare Financial Management Association.[3] For DY 13 through 19, annual aggregate PHP-CCP Pool payments are limited to the annual amounts identified in STC 41. Expenditures for PHP-CCP payments must be claimed in accordance with CMS-approved claiming protocols for each provider type. The state will require an annual PHP-CCP Application that will collect cost and payment data on services eligible for reimbursement under the PHP-CCP. Data collected from the application will form the basis for PHP-CCP Payments made to CMHCs, LBHAs, LMHAs, LHDs, and PHDs. The methodology used by the state to determine PHP-CCP payments to individual providers must ensure that payments to CMHCs, LBHAs, LMHAs, LHDs, and PHDs are distributed based on the provider's actual uncompensated care costs, without any relationship to the provider's status as a source of non-federal share, as specified in Attachment T. Payments to providers must not exceed the provider's actual uncompensated care costs, except in the first year of the program's operations during which providers may also receive reimbursement not to exceed their actual Medicaid shortfall. PHP-CCP payments are not associated with particular individuals and are not a form of health coverage or any other benefit inuring to individuals.

a) **PHP-CCP Application.** To qualify for a PHP-CCP Payment, a provider must submit to the state an annual PHP-CCP Application that will collect cost and payment data on services eligible for reimbursement under the PHP-CCP. Data collected from the application will form the basis for PHP-CCP Payments made to CMHCs, LBHAs, LMHAs, LHDs, and PHDs. The state must require providers to report data in a manner that is consistent with a CMS-approved cost report consistent with Medicare cost reporting principles.
    i) For all demonstration years except DY11, cost and payment data included on the application must be based on the CMS-approved cost report consistent with Medicare cost reporting principles. For all provider groups, data on the application is based on actual eligible costs incurred during the demonstration year for which the payments are made.
    ii) For all demonstration years, any publicly-owned and operated provider that is able to certify public expenditures that fall under the provider types described in subpart (c) of this STC may submit a PHP-CCP Application to be eligible to receive a PHP-CCP Payment.
b) **PHP-CCP Payment Protocol.** The PHP-CCP Payment Protocol, also known as the funding and reimbursement protocol, establishes rules and guidelines for the State to claim FFP for PHP-CCP Payments and will be appended to these STCs as Attachment T, which will be approved subsequent to this extension reward. By June 30, 2021, HHSC must revise, test, and obtain CMS approval of the application tools used to collect the information needed to determine the eligibility of providers to participate in the PHP-CCP pool and their eligible uncompensated costs, as described in the protocol for DY 11. By August 31, 2021, the state must submit for CMS approval an addendum to the funding and

[3] Available at http://www.hfma.org/WorkArea/DownloadAsset.aspx?id=14589.

reimbursement protocol that will establish rules and guidelines for the State to claim FFP for PHP-CCP Payments beginning in DY 12 (October 1, 2022 through September 30, 2023). CMS and Texas will work collaboratively with the expectation of CMS approval of the protocol within 90 calendar days after it receives the Attachment T. The state cannot claim FFP for any PHP-CCP Payments for DY 12 or later until a PHP-CCP Protocol addendum has been submitted to and approved by CMS. The PHP-CCP Payment 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 PHP-CCP payments to unreimbursed charity care cost), which will apply to the protocol beginning in DY12 (October 1, 2022-September 30, 2023). 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 PHP-CCP Payments. The Protocol will contain allowable costs and revenues and indicate the twelve (12) month period for which the costs will apply.

c) **PHP-CCP Payments to Providers.** Publicly-owned and operated Community Centers, Local Mental Health Authorities, or Local Behavioral Health Authorities providing behavioral health services under Chapter 533 or Chapter 534 of the Texas Health & Safety Code and publicly-owned and -operated Local Health Departments (LHDs) and public health districts (PHDs) that are established under the Texas Health and Safety Code, Title 2, Subtitle F, Chapter 121 are eligible to participate in the PHP-CCP. To participate in the PHP-CCP, the governmental entity must be able to certify public expenditures**.** PHP-CCP Payments may be provided only to publicly-owned and operated CMHCs, LMHAs, LBHAs, LHDs, and PHDs. PHP-CCP Payments are considered to be Medicaid payments to providers and must be treated as Medicaid revenue when determining total title XIX funding received, in particular for any provider utilizing certified public expenditures as the non-Federal share of a Medicaid payment.

d) **Reporting Requirements for PHP-CCP Payments**. The state will submit to CMS, within ninety (90) days after the end of each Demonstration year:
   (1) The PHP-CCP Payment applications submitted by eligible providers; and
   (2) A chart of actual PHP-CCP payments to each provider for the previous DY.

e) **Required Milestones for PHP-CCP Pool Transition.** CMS expects Texas will work in good faith to implement all requirements specified in these STCs, and in particular this STC 39, within the necessary timeline. To help ensure the state is making adequate progress toward meeting these requirements on the required timetable, the state must satisfy the milestones specified in this sub-STC 39(e). If Texas fails to meet any one or more of them, the deferral process contemplated in STC 74 will apply to each deliverable (relating to solely the process and not the financial penalties invoked in that STC; the financial penalties below will apply).
   i) Submit and implement the revised Attachment T by DY12: Texas is required to submit the addendum to Attachment T (the PHP-CCP Payment Protocol) that is described in paragraph (b) of this STC for CMS review by August 31, 2021. The methodology described in the addendum must be implemented as part of the revised PHP-CCP distribution methodology for DY 12 (October 1, 2022-September 30, 2023).
      (1) CMS will permanently reduce Texas' PHP-CCP expenditure authority by 20 percent for DY 12 (October 1, 2022-September 30, 2023) and disallow funding that exceeds the reduced expenditure authority amount if Texas has not submitted a draft addendum to Attachment T to CMS by June 30, 2021.

(2) Texas may not claim FFP for PHP-CCP payments for DY 12 (October 1, 2022-September 30, 2023) until CMS has approved the addendum to Attachment T.
(3) Texas may claim FFP for DY 12 after it has received CMS approval and implemented the addendum to Attachment T, up to the annual limit (which is subject to reduction pursuant to sub-STC 39(e)(i)(4), below).
(4) If Texas has not demonstrated to CMS it has implemented the methodology described in the addendum to Attachment T by October 1, 2022 (DY12), CMS will permanently reduce Texas' PHP-CCP pool expenditure authority by 20 percent for DY 12 and disallow funding that exceeds the reduced expenditure authority amount.

ii) Revise PHP-CCP applications for PHP-CCP eligible providers: After HHSC receives CMS approval of the addendum to Attachment T (PHP-CCP Payment Protocol), and concurrent with the state administrative rule amendment timeframe (see sub- STC 39(e)(iii), below), HHSC must revise, test, and obtain CMS approval of the application tools used to collect the information needed to determine the eligibility of providers to participate in the UC pool and their eligible uncompensated costs, as described in the protocol.
(1) CMS will permanently reduce Texas' PHP-CCP expenditure authority by 20 percent for DY 12 and disallow funding that exceeds the reduced expenditure authority amount if Texas has not submitted draft revised PHP-CCP application tools for eligible providers to CMS by February 28, 2022, or if CMS has not approved revised PHP-CCP tools for all provider types by June 30, 2022.

iii) Amend the administrative rules that govern the program: Once HHSC has received CMS approval of the addendum to Attachment T (PHP-CCP Payment Protocol), and concurrent with its revision of the PHP-CCP applications for all provider types, HHSC must conduct the state administrative rulemaking process to amend the state's administrative rules governing the PHP-CCP pool with respect to each provider type to comport with the requirements of these STCs. The state has indicated that the rule development timeline is normally six-to- nine months, including the notice and comment periods required by state law.
(1) CMS will permanently reduce Texas' PHP-CCP expenditure authority by 20 percent for DY11 and disallow funding that exceeds the reduced expenditure authority amount unless Texas begins the necessary administrative rule amendment process required to implement the PHP-CCP pool distribution changes required by these STCs by no later than May 31, 2021. Texas must demonstrate to CMS that it is undertaking rulemaking to amend the Texas Administrative Code (TAC) to implement the required PHP-CCP pool distribution methodology changes; this will be demonstrated by publishing a notice of the proposed rulemaking in the Texas Register and notice of a public hearing related to that rulemaking.
(2) CMS will permanently reduce Texas' PHP-CCP expenditure authority by an additional 20 percent for DY12 and disallow funding that exceeds the reduced expenditure authority amount unless Texas has published the necessary final administrative rules to implement the required PHP-CCP pool distribution methodology by July 31, 2022. The amended rules must be effective no later than September 30, 2022. Texas must demonstrate this by sending CMS a copy of the final rule as published in the Texas Register.

iv) If Texas's PHP-CCP expenditure authority is reduced more than once for a DY, the reductions are applied cumulatively.[4]

40) Delivery System Reform Incentive Payment (DSRIP) Pool. The DSRIP program ends after September 30, 2021. Until it expires, the DSRIP Pool is available for the development of a program of activity that supports providers' 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 by a public hospital or a local governmental entity. 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 providers' DSRIP proposals must flow from the RHP plans, and be consistent with the providers' 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) (the Three Part Aim).

Starting with DY 7, DSRIP will be temporarily extended with the goal of identifying non- DSRIP funding to continue financing these activities, and an updated methodology, reflecting an evolution from project-level reporting to provider core activities supporting performing provider-level outcomes that measure continued transformation of the Texas healthcare system. Performing providers are named in RHP plans to be eligible to receive DSRIP payments. DSRIP in this extension will support performing providers to move further towards sustainability of their transformed systems outside of the DSRIP funding structure, which could include development of Alternative Payment Models (APMs) to continue services for Medicaid beneficiaries within managed care or FFS funding structures, and to low-income or uninsured individuals outside of the Medicaid program after the demonstration ends. Further operational details (such as the definitions of categories, terms and processes below) will be delineated in the protocols.

DSRIP payments are not associated with particular individuals and are not a form of health coverage or any other benefit inuring to individuals.

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. Activities will be identified within the following categories, and included in the full list of projects provided in the Measure Bundle Protocol (Attachment R)
   i) **Category A: Required reporting in order to be eligible for any amount of DSRIP payment** – Providers will describe transition from DY 2-6 to DY 7-8 activities, and specifically address the following.
      1. Core activities – Report on performance improvement projects designed to enhance achievement on Category C measure goals.

[4] For one reduction in a DY, multiply the original UC pool limit by (1 - 0.20). For two reductions in a DY, multiply the reduced UC pool limit again by (1 – 0.20), or equivalently, multiply the original UC pool limit by (1 - 0.20)×(1 - 0.20).

2. Alternative Payment Methodology (APM) – Report on provider's progress toward, or implementation of, APM arrangements.
3. Costs and savings – Performing providers with greater than $1M total valuation will submit costs and forecasted/generated savings for at least one core activity. Valuations are described in Attachment J.
4. Collaborative activities - Performing providers will attend at least one learning collaborative, stakeholder forum, or other stakeholder meeting annually.

ii) **Category B: Report on Medicaid and Low-income or Uninsured (MLIU) Patient Population by Provider (PPP)** – Performing providers must maintain or increase number of MLIU individuals served each DY, within allowable variation specified in the protocols.

iii) **Category C: Measure Bundles and Measures** – Providers will select and report on health care quality and system performance measures, selected from a menu of pre-determined Measure Bundles or measures, and be rewarded based on meeting targeted improvement goals.

iv) **Category D: Statewide Reporting Measure Bundle** – Providers will report on a statewide reporting Measure Bundle of population health measures for their provider type, to gain information on and understanding of the health status of key populations and to build the capacity for reporting on a comprehensive set of population health metrics.

b) **Regional Healthcare Partnerships.** Regional Healthcare Partnerships will be maintained throughout the state to coordinate regional planning, information sharing, and ongoing collaborative activities among DSRIP providers. Each RHP will include a variety of healthcare providers to adequately respond to the needs of the community, and the process of maintaining each RHP and developing RHP plans will evidence meaningful participation by all interested providers. Each RHP will be anchored (i.e. single point of contact for the RHP) by a public hospital (or in areas with no public hospital, anchored by a local governmental entity) that will be responsible for developing the RHP's DSRIP plan in coordination with other identified RHP providers.

c) **DSRIP Plans within the RHP.** RHP anchoring entities 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 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 DSRIP protocols (see STC 40(d)), a final RHP DSRIP Plan must include maximum payment amounts for DSRIP Payments. These amounts may be proportionally adjusted based on available non-Federal share.

d) **DSRIP Plans and Protocols.** The state may not claim DSRIP funding after January 1, 2018, for DSRIP DY 7-10, until the milestones discussed in this paragraph have been met.

i) Within one month of the approval of this second extension, CMS, the state and Texas providers will, through a collaborative process, finalize updates to the RHP Planning Protocol (Attachment I), Program Funding and Mechanics Protocol (Attachment J), or other protocol documents as the state may propose to implement the DSRIP program as described above.

ii) The updated protocols must include information on state and CMS review and approval processes for RHP Plan Updates, RHP and State reporting requirements, how potential DSRIP incentive payment amounts will be distributed to Performing Providers and to RHPs, mechanisms and payment methodologies.

iii) Texas may not claim FFP for DSRIP payments after January 1, 2018 for DSRIP DY 7-10, or later until after updated protocols for those DYs have been 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.

f) **DSRIP Expenditure Reporting**. Texas will submit total DSRIP expenditures, including payments to providers reflecting the basis for incentive payments, 6 months after the end of each demonstration year.

41) Limits on Pool Payments. Expenditures eligible for FFP for UC Pools and DSRIP Pool in each DY may not exceed the amounts shown in Table 7.

a) **Reassessment of Hospitals' Uncompensated Charity Care (UCC) in 2022.** CMS and Texas agree that UC Pool limits for DY 12-16 will be revised based on a reassessment of the amount of uncompensated charity care cost provided by Texas hospitals, to take place by September 1, 2022. The state and CMS will collaborate on the reassessment, which will be based on information reported by hospitals for periods beginning in federal fiscal year 2019 on schedule S-10 of the CMS 2552-10 hospital cost report, with adjustment to ensure that demonstration pool payments do not enter the calculation, following a methodology approved by CMS. For non-S-10 hospitals, costs will be based on the CMS-approved cost reports described in Attachment H for the most recent available year. The results of the reassessment will be used to revise the UC Pool limits for DY 12-*16*. CMS and Texas are using 2019 to avoid any impact to data caused by the public health emergency that was in effect in 2020 and after.

b) If the reassessment discussed in (a) is not completed to produce an updated UC Pool limit by October 1, 2022, all payments from the Hospital UCC pool will be unavailable until the reassessment is complete.

c) When 2019 S-10 data as specified in 41(a) becomes available, the state and CMS will collaborate to recalculate the UC pool limits for DY 12-*16* based on this updated information. The recalculated UC pool limits will become the final UC pool limits for DY 12-16. In addition to prospectively modifying the UC pool limits based on this recalculation, CMS and the state will perform a reconciliation of UC pool payments made on or after October 1, 2021. If UC pool payments for the reconciliation period have exceeded the final UC pool limit for that period, CMS will reclaim overpayments for these years. If the UC pool payments for the reconciliation period were less than the final UC pool limit, CMS will provide FFP for additional payments consistent with the final UC pool limits so that Texas may make additional payments to providers for UC costs.

d) **Reassessment of Hospitals' Uncompensated Charity Care in 2027.** CMS and Texas agree that UC Pool limits for DY 17-19 will be revised based on a reassessment of the amount of uncompensated charity care cost provided by Texas hospitals, to take place by September 1, 2027. The state and CMS will collaborate on the reassessment, which will be based on information reported by hospitals for periods beginning in federal fiscal year 2025 on schedule S-10 of the CMS 2552-10 hospital cost report, with adjustment to ensure that demonstration pool payments do not enter the calculation, following a

methodology approved by CMS.[5] For non-S-10 hospitals, costs will be based on the CMS-approved cost reports described in Attachment H for the most recent available year. The results of the reassessment will be used to revise the UC Pool limits for DY 17-19.

e) If the reassessment discussed in 41(d) is not completed to produce an updated UC Pool limit by September 1, 2027, all payments from the Hospital UCC pool will be unavailable until the reassessment is complete.

f) When 2025 S-10 data as specified in 41(d) becomes available, the state and CMS will collaborate to recalculate the UC pool limits for DY 17-19 based on this updated information. The recalculated UC pool limits will become the final UC pool limits for DY 17-19. In addition to prospectively modifying the UC pool limits based on this recalculation, CMS and the state will perform a reconciliation of UC pool payments made on or after October 1, 2027. If UC pool payments for the reconciliation period have exceeded the final UC pool limit for that period, CMS will reclaim overpayments for these years. If the UC pool payments for the reconciliation period were less than the final UC pool limit, CMS will provide FFP for additional payments consistent with the final UC pool limits so that Texas may make additional payments to providers for UC costs.

g) **Reassessment of PHP-CCP' Uncompensated Charity Care.** CMS and Texas agree that PHP-CCP Pool limits for DY 13-17 will be revised based on a reassessment of the amount of uncompensated charity care cost provided by Texas CMHCs, LBHAs, LMHAs, LHD, and PHDs to take place by March 1, 2024. The state and CMS will collaborate on the reassessment, which will be based on the CMS-approved cost reports described in Attachment T for the most recent available year. The results of the reassessment will be used to revise the PHP-CCP Pool limits for DY 13-*17*.

h) If the reassessment of PHP-CCP Pool limits discussed in 41(g) is not completed to produce an updated PHP-CCP Pool limit by March 1, 2024, all payments from the pool will be unavailable until the reassessment is completed.

i) When cost report data specified in 41(g) becomes available, the state and CMS will collaborate to recalculate the PHP-CCP pool limits for DY 13-*17* based on this updated information. The recalculated PHP-CCP pool limits will become the final PHP-CCP pool limits for DY 13-17.

j) CMS and Texas will perform another reassessment of PHP-CCP pool limits for DY 18-19 by September 1, 2027, following the same parameters. The recalculated PHP-CCP pool limits will become the final PHP-CCP pool limits for DY 18-19. If the reassessment of PHP-CCP Pool limits discussed herein is not completed to produce an updated PHP-CCP Pool limit by September 1, 2027, all payments from the pool will be unavailable until the reassessment is completed.

[5] See methodology approved on October 18, 2023.

Table 7. Pool Allocations According to Demonstration Year (total computable)

Type of Pool	DY 6* (2016-2017)	DY 7* (2017-2018)	DY 8 (2018- 2019)	DY 9 (2019- 2020)	DY 10 (2020-2021)	DY 11 (2021-2022)
UC	3,100,000,000	3,101,776,278	3,101,776,278	3,873,206,193	3,873,206,193	3,873,206,193
PHP-CCP						$500,000,000
DSRIP	3,100,000,000	3,100,000,000	3,100,000,000	2,910,000,000	2,490,000,000	0^

Type of Pool	DY 12 (2022-2023)	DY 13 (2023-2024)	DY 14 (2024- 2025)	DY 15 (2025- 2026)	DY 16 (2026-2027)
UC	$4,512,075,400	$4,512,075,400	$4,512,075,400	$4,512,075,400	$4,512,075,400
PHP-CCP	$500,000,000	$499,193,023	$499,193,023	$499,193,023	$499,193,023
DSRIP	0^	0	0	0	0

Type of Pool	DY 17 (2027-2028)	DY 18 (2028-2029)	DY 19 (2029- 2030)
UC	TBD	TBD	TBD
PHP-CCP	$499,193,023	TBD	TBD
DSRIP	0	0	0

*Amounts shown for DY 6 are reduced by 20 percent from the amounts shown in the terms and conditions for the 15-month extension, to reflect redefinition of DY 6 to be 12 months instead of 15 months. Amounts for DY 7 include the 20 percent of adjustment formerly shown as part of DY 6.

^ Incentive payments may be made in DY 11 and DY 12 for prior periods of performance and administrative activities to close out the DSRIP program. Total DSRIP payments for the section 1115 demonstration may not exceed total authorized limits.

42) 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.

43) Transition Plan for DSRIP Pool.

a) Texas submitted a DSRIP transition plan to CMS on September 30, 2019 and it was approved by CMS on September 2, 2020, which describes how the state DSRIP program will hand off to other programs, such as Texas initiatives like the Value Based Purchasing (VBP) roadmap to further develop its delivery system reform efforts without DSRIP funding and/or phase out DSRIP funded activities. The final transition plan is Attachment Q of the STCs for this demonstration. As Texas' DSRIP is a time-limited federal investment that will conclude by October 2021, Texas will propose milestones by which it will be accountable for measuring sustainability of its delivery system reform efforts absent DSRIP funding. Milestones may relate to the use of alternative payment models, the state's adoption of managed care payment models, payment mechanisms that support providers' delivery system reform efforts, and other opportunities.

b) Portions of overall FFP for DSRIP will be at-risk for the state's achievement on achievement milestones, as specified below. If Texas fails to submit a complete sustainability plan by October 1, 2019, CMS will defer 10 percent of FFP for DSRIP funding starting in the next quarter, and an amount in all subsequent quarters indefinitely until the state comes into compliance. Accountability for performance on these milestones will be as follows: an additional 15 percent for FFP for DSRIP will be at risk in demonstration year 9, and additional 20 percent off FFP for DSRIP will be at risk in demonstration year 10.

c) This deliverable will not be subject to the deferral as described to STC 74; all accountability for the Transition Plan will be applied as per this STC.

VI. HEALTH IT

44) Health Information Technology. This STC is specifically related to the purposes of this demonstration. The plans envisioned in this section however should be aligned with the state's broader State Medicaid Health IT Plan (SMHP). The state will use Health Information Technology ("Health IT") to link services and core providers across the continuum of care to the greatest extent possible. The state is expected to achieve minimum standards in foundational areas of Health IT and to develop its own goals for the transformational areas of Health IT use. The state will discuss how it plans to meet the Health IT goals/milestones outlined below. Through Semi-Annual Reporting, the state will further enumerate how it has, or intends to, meet the stated goals. This STC is not subject to STC 74.

a) The state must have plan(s) with achievable milestones for Health IT adoption for Medicaid service providers both eligible and ineligible for the Medicaid Electronic Health Records (EHR) Incentive Programs and execute upon the plan(s).

b) The state shall create a pathway, or a plan, for the exchange of clinical health information related to Medicaid beneficiaries statewide to support the demonstration's program objectives.

c) The state shall advance the standards identified in the "Interoperability Standards Advisory—Best Available Standards and Implementation Specifications" (ISA) in developing and implementing state policies—and in all applicable state procurements (e.g. including managed care contracts).

i) Wherever it is appropriate, the state must require that contractors providing services paid for by funds authorized under this demonstration shall adopt the standards referenced in 45 CFR Part 170. ii. Wherever services paid for by funds authorized by this demonstration are not addressed by 45 CFR Part 170, but are addressed by the ISA, the state should require that contractors providing such services adopt the appropriate ISA standard.

ii) States should use the CMS 1115 Health IT resources available on "Medicaid Program Alignment with State Systems to Advance HIT, HIE, and Interoperability" at https://www.medicaid.gov/medicaid/data-and- systems/hie/index.html. Specifically, the state should utilize the "1115 Health IT Toolkit" for health IT considerations in conducting an assessment and developing their Health IT Strategic Plans.

d) Based on the assessment described above, the state will provide a Health IT Strategic Plan that details existing HIT capabilities. The Strategic Plan should also support the goals below -- and develop a mutually-agreed upon timeframe between CMS and the state for submitting the plan and any necessary enhancements. HHSC submitted the plan to CMS on March 31, 2020, and CMS approved the plan on May 11, 2020. The plan shall remain in effect during this extension period, and HHSC shall update it as necessary to reflect state changes in priorities and operations.

i) When multiple Medicaid providers provide coordinated care to a beneficiary, the state shall require the legally appropriate electronic exchange of clinical health information, using the Consolidated Clinical Document Architecture (C-CDA), among appropriate members of the individual patient's interdisciplinary care team.

ii) The state shall ensure legally appropriate access to a comprehensive Medicaid enterprise master patient index that supports the programmatic objectives of the demonstration.

iii) The state shall ensure a comprehensive Medicaid service provider directory strategy that supports the programmatic objectives of the demonstration.

iv) The state will pursue legally appropriate means of improved coordination and improved integration between Medicaid Behavioral Health, Physical Health, Home and Community Based Providers and community-level collaborators for Improved Care Coordination (as applicable) through the adoption of provider-level Health IT infrastructure and software—to facilitate and improve integration and coordination to support the programmatic objectives of the demonstration.

v) The State shall ensure a comprehensive Health IT-enabled quality measurement strategy that supports the legally appropriate collection of data necessary for the State to monitor and evaluate programmatic objectives of the demonstration, and the legally appropriate means of providing such data for demonstration monitoring and evaluation activities.

VII. GENERAL FINANCIAL REQUIREMENTS

45) Allowable Expenditures. This demonstration project is approved for authorized demonstration expenditures applicable to services rendered and for costs incurred during the demonstration approval period designated by CMS. CMS will provide FFP for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in these STCs.

46) Standard Medicaid and CHIP Funding Process. The standard Medicaid funding process will be used for this demonstration. The state will provide quarterly expenditure reports through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES) to report total expenditures under this Medicaid section 1115 demonstration following routine CMS-37 and CMS-64 reporting instructions as outlined in section 2500 of the State Medicaid Manual. The state will 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 shall submit form CMS-64 Quarterly Medicaid Expenditure Report, showing Medicaid expenditures made in the quarter just ended. If applicable, subject to the payment deferral process, CMS shall reconcile expenditures reported on 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.

a) The standard title XXI funding process will be used during the demonstration for M- CHIP children. The state must estimate matchable M-CHIP expenditures on the quarterly Form CMS-37. As a footnote to the CMS-37, the state shall provide updated estimates of expenditures for the M-CHIP children demonstration populations. CMS will 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-64.21 U-Waiver quarterly CHIP expenditure report. CMS will reconcile expenditures reported on the Form CMS-64.21U-waiver with Federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

47) Sources of Non-Federal Share. As a condition of demonstration approval, the state certifies that its funds that make up the non-federal share are obtained from permissible state and/or local funds that, unless permitted by law, are not other federal funds. The state further certifies that federal funds provided under this section 1115 demonstration must not be used as the non-federal share required under any other federal grant or contract, except as permitted by law. CMS approval of this demonstration does not constitute direct or indirect approval of any underlying source of non-federal share or associated funding mechanisms, and all sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable implementing regulations. CMS reserves the right to deny FFP in expenditures for which it determines that the sources of non-federal share are impermissible.

a) If requested, the state must submit for CMS review and approval documentation of any sources of non-federal share that would be used to support payments under the demonstration.
b) If CMS determines that any funding sources are not consistent with applicable federal statutes or regulations, the state must address CMS's concerns within the time frames allotted by CMS.
c) Without limitation, CMS may request information about the non-federal share sources for any amendments that CMS determines may financially impact the demonstration.

48) State Certification of Funding Conditions. As a condition of demonstration approval, the state certifies that the following conditions for non-federal share financing of demonstration expenditures have been met:

a) If units of state or local government, including health care providers that are units of state or local government, supply any funds used as non-federal share for expenditures under the demonstration, the

state must certify that state or local monies have been expended as the non-federal share of funds under the demonstration in accordance with section 1903(w) of the Act and applicable implementing regulations.

b) To the extent the state utilizes certified public expenditures (CPE) as the funding mechanism for the non-federal share of expenditures under the demonstration, the state must obtain CMS approval for a cost reimbursement methodology. This methodology must include a detailed explanation of the process, including any necessary cost reporting protocols, by which the state identifies those costs eligible for purposes of certifying public expenditures. The certifying unit of government that incurs costs authorized under the demonstration must certify to the state the amount of public funds allowable under 42 CFR 433.51 it has expended. The federal financial participation paid to match CPEs may not be used as the non-federal share to obtain additional federal funds, except as authorized by federal law, consistent with 42 CFR 433.51(c).

c) The state may use intergovernmental transfers (IGT) to the extent that the transferred funds are public funds within the meaning of 42 CFR 433.51 and are transferred by units of government within the state. Any transfers from units of government to support the non-federal share of expenditures under the demonstration must be made in an amount not to exceed the non-federal share of the expenditures under the demonstration.

d) The State Medicaid Director or his/her designee certifies that all state and/or local funds used as the state's share of the allowable expenditures reported on the CMS-64 for this demonstration were in accordance with all applicable federal requirements and did not lead to the duplication of any other federal funds.

49) Financial Integrity for Managed Care Delivery Systems. As a condition of demonstration approval, the state attests to the following, as applicable:

a) All risk-based managed care organization, prepaid inpatient health plan (PIHP), and prepaid ambulatory health plan (PAHP) payments, comply with the requirements on payments in 42 CFR 438.

b) For non-risk-based PIHPs and PAHPs, arrangements comply with the upper payment limits specified in 42 CFR 447.362, and if payments exceed the cost of services, the state will recoup the excess and return the federal share of the excess to CMS.

50) Requirements for Health Care-Related Taxes and Provider Donations. As a condition of demonstration approval, the state attests to the following, as applicable:

a) Except as provided in paragraph (c) of this STC, all health care-related taxes as defined by Section 1903(w)(3)(A) of the Act and 42 CFR 433.55 are broad-based as defined by Section 1903(w)(3)(B) of the Act and 42 CFR 433.68(c).

b) Except as provided in paragraph (c) of this STC, all health care-related taxes are uniform as defined by Section 1903(w)(3)(C) of the Act and 42 CFR 433.68(d).

c) If the health care-related tax is either not broad-based or not uniform, the state has applied for and received a waiver of the broad-based and/or uniformity requirements as specified by 1903(w)(3)(E)(i) of the Act and 42 CFR 433.72.

d) The tax does not contain a hold harmless arrangement as described by Section 1903(w)(4) of the Act and 42 CFR 433.68(f).

e) All provider-related donations as defined by 42 CFR 433.52 are bona fide as defined by Section 1903(w)(2)(B) of the Social Security Act, 42 CFR 433.66, and 42 CFR 433.54.

51) State Monitoring of Non-federal Share. If any payments under the demonstration are funded in whole or in part by a locality tax, then the state must provide a report to CMS regarding payments under the demonstration no later than 60 days after demonstration approval. This deliverable is subject to the deferral as described in STC 74. This report must include:

a) Number of providers in each locality of the taxing entities for each locality tax;
b) Whether or not all providers in the locality will be paying the assessment for each locality tax;
c) The assessment rate that the providers will be paying for each locality tax;
d) Whether any providers that pay the assessment will not be receiving payments funded by the assessment;
e) Number of providers that receive at least the total assessment back in the form of Medicaid payments for each locality tax;
f) The monitoring plan for the taxing arrangement to ensure that the tax complies with section 1903(w)(4) of the Act and 42 CFR 433.68(f); and
g) Information on whether the state will be reporting the assessment on the CMS form 64.11A as required under section 1903(w) of the Act.

52) Extent of Federal Financial Participation for the Demonstration. Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the following demonstration expenditures, subject to the budget neutrality expenditure limits described in the STCs in Section VIII:

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;
c) Medical assistance expenditures and prior period adjustments made under section 1115 demonstration authority with dates of service during the demonstration extension period; including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third-party liability; and
d) Net expenditures for Funding Pool payments.

53) Program Integrity. The state must have processes in place to ensure there is no duplication of federal funding for any aspect of the demonstration. The state must also ensure that the state and any of its contractors follow standard program integrity principles and practices including retention of data. All data, financial reporting, and sources of non-federal share are subject to audit.

54) Quarterly Expenditure Reports. The state must provide quarterly title XIX 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.

The state shall provide quarterly title XXI expenditure reports using the Form CMS64.21U/CMS64.21UP to report total title XXI expenditures for services provided to M- CHIP children under the section 1115 authority until its XXI allotment is spent and then using the 64.9/64.9P Waiver form with waiver name of "THTQIP-M-CHIP," and "64.21U & 64.21UP THTQIP-Qualified". CMS will provide Federal financial participation

(FFP) for allowable Texas title XXI demonstration expenditures that do not exceed the state's available title XXI funding and then Federal participation at the enhanced rate under Title XIX once the state's Title XXI funding is fully exhausted.

55) **Medicaid Expenditure Groups.** Medicaid Expenditure Groups (MEG) are defined for the purpose of identifying categories of Medicaid or demonstration expenditures subject to budget neutrality, components of budget neutrality expenditure limit calculations, and other purposes related to monitoring and tracking expenditures under the demonstration. The Master MEG Chart table provides a master list of MEGs defined for this demonstration.

Table 8: Master MEG Chart

MEG	Which BN Test Applies?	WOW Per Capita	WOW Aggregate	WW	Brief Description
THTQIP-Adults	Main test	X		X	Medical assistance expenditures for Adults
THTQIP-Children	Main test	X		X	Medical assistance expenditures for Children
THTQIP-AMR	Main test	X		X	Medical assistance expenditures for AMR
THTQIP-Disabled	Main test	X		X	Medical assistance expenditures for Disabled
THTQIP 217-like AMR	Hypo1	X		X	Medical assistance expenditures for 217-Like AMR
THTQIP 217-like Disabled	Hypo1	X		X	Medical assistance expenditures for 217-Like Disabled
THTQIP-UC	Main test			X	See Expenditure Authority 5
THTQIP – PHC-CCP	Main test			X	See Expenditure Authority 10
THTQIP-DSRIP	Main test			X	See Expenditure Authority 6, 7
64.21U & 64.21UP THTQIP-Qualified	Main Test			X	Medical assistance expenditures for M-CHIP Children
THTQIP-M-CHIP	Main Test			X	Medical assistance expenditures for M-CHIP Children
UPL for Excluded Population	Main test		X		UPL diversionary spending amount for Excluded Population inpatient hospital
UPL for Included Population	Main test		X		UPL diversionary spending amount for Included Population inpatient hospital
Physician UPL	Main test		X		UPL diversionary spending amount Physician
Outpatient UPL	Main test		X		UPL diversionary spending amount for outpatient hospital
One-time PHE Adjustment	Main Test	X			A one-time cost adjustment to account for impacts of the COVID-19 public health emergency (PHE) policy on enrollment and expenditures
THTQIP-Admin	N/A			X	Additional administrative costs that are directly attributable to the demonstration

BN – budget neutrality; MEG – Medicaid expenditure group; WOW – without waiver; WW – with waiver

56) Reporting Expenditures and Member Months. The state must report all demonstration expenditures claimed under the authority of title XIX of the Act and subject to budget neutrality each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (11-W-00278/6). Separate reports must be submitted by MEG (identified by Waiver Name) and Demonstration Year (identified by the two-digit project number extension). Unless specified otherwise, expenditures must be reported by DY according to the dates of service associated with the expenditure. All MEGs identified in the Master MEG Chart as WW must be reported for expenditures, as further detailed in the MEG Detail for Expenditure and Member Month Reporting table below. To enable calculation of the budget neutrality expenditure limits, the state also must report member months of eligibility for specified MEGs.

a) Cost Settlements. The state will report any cost settlements attributable to the demonstration on the appropriate prior period adjustment schedules (form CMS-64.9P WAIVER) for the summary sheet line 10b (in lieu of lines 9 or 10c), or line 7. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual. Cost settlements must be reported by DY consistent with how the original expenditures were reported.

b) Premiums and Cost Sharing Collected by the State. The state will report any premium contributions collected by the state from demonstration enrollees quarterly on the form CMS-64 Summary Sheet line 9D, columns A and B. To assure that these collections are properly credited to the demonstration, quarterly premium collections (both total computable and federal share) should also be reported separately by demonstration year on form CMS-64 Narrative, and on the Total Adjustments tab in the Budget Neutrality Monitoring Tool. In the annual calculation of expenditures subject to the budget neutrality expenditure limit, premiums collected in the demonstration year will be offset against expenditures incurred in the demonstration year for determination of the state's compliance with the budget neutrality limits.

c) Pharmacy Rebates. Because pharmacy rebates are not included in the base expenditures used to determine the budget neutrality expenditure limit, pharmacy rebates are not included for calculating net expenditures subject to budget neutrality. The state will report pharmacy rebates on form CMS-64.9 BASE, and not allocate them to any form 64.9 or 64.9P WAIVER.

d) Administrative Costs. The state will separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the forms CMS-64.10 WAIVER and/or 64.10P WAIVER. Unless indicated otherwise on the MEG Charts and in the STCs in Section VIII, administrative costs are not counted in the budget neutrality tests; however, these costs are subject to monitoring by CMS.

e) Member Months. Using the Budget Neutrality Monitoring Tool, the state must report the actual number of "eligible member months" for all demonstration enrollees for all MEGs identified as WOW Per Capita in the Master MEG Chart table above, and as also indicated in the MEG Detail for Expenditure and Member Month Reporting table below. The term "eligible member months" refers to the number of months in which persons enrolled in the demonstration are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months each contribute two eligible member months per person, for a total of four eligible member months. The state must submit a statement accompanying the annual report certifying the accuracy of this information.

f) Budget Neutrality Specifications Manual. The state will create and maintain a Budget Neutrality Specifications Manual that describes in detail how the state will compile data on actual expenditures

related to budget neutrality, including methods used to extract and compile data from the state's Medicaid Management Information System, eligibility system, and accounting systems for reporting on the CMS-64, consistent with the terms of the demonstration. The Budget Neutrality Specifications Manual will also describe how the state compiles counts of Medicaid member months. The Budget Neutrality Specifications Manual must be made available to CMS on request.

Table 9: MEG Detail for Expenditure and Member Month Reporting

MEG (Waiver Name)	Detailed Description	Exclusions	CMS-64.9 or 64.10 Line(s) To Use	How Expend. Are Assigned to DY	MAP or ADM	Report Member Months (Y/N)	MEG Start Date	MEG End Date
THTQIP-Adults	Medicaid assistance expenditures for all participating individuals whose MEG is defined as Adults;	None	Follow CMS-64.9 Base Category of Service Definitions	Date of service	MAP	Y	10/1/11	9/30/30
THTQIP-Children	Medicaid assistance expenditures for all participating individuals whose MEG is defined as Children;	None	Follow CMS-64.9 Base Category of Service Definitions	Date of service	MAP	Y	10/1/11	9/30/30
THTQIP-AMR	Medicaid assistance expenditures for all participating individuals who are aged, or who are disabled and have Medicare	None	Follow CMS-64.9 Base Category of Service Definitions	Date of service	MAP	Y	10/1/11	9/30/30
THTQIP-Disabled	Medicare assistance expenditures for all participating individuals who are disabled and do not have Medicare	None	Follow CMS-64.9 Base Category of Service Definitions	Date of service	MAP	Y	10/1/11	9/30/30
THTQIP 217-like AMR	Medical assistance expenditures for categorically needy individuals with Medicare receiving HCBS services (of the kind listed in Table 6) in the STAR+PLUS service areas, per Expenditure Authority 1.	None	Follow CMS-64.9 Base Category of Service Definitions	Date of service	MAP	Y	10/1/11	9/30/30

THTQIP 217-like Disabled	Medical assistance expenditures for categorically needy individuals without Medicare receiving HCBS services (of the kind listed in Table 6) in the STAR+PLUS service areas, per Expenditure Authority 1	None	Follow CMS-64.9 Base Category of Service Definitions	Date of service	MAP	Y	10/1/11	9/30/30
THTQIP-UC	All expenditures that count against UC Pool limits	None	Use Line 1C Inpatient Hospital - Sup. Payments, Line 5B Physician & Surgical Services - Sup. Payments, Line 8 Dental Services, or Line 49 Other Care Services	Date of payment	MAP	N	10/1/11	9/30/30
THTQIP – PHC-CCP	All expenditures that count against PHC-CCP Pool limits	None		Date of payment	MAP	N	10/1/20	9/30/30
THTQIP-DSRIP	All DSRIP Pool expenditures.	None	Use Line 49 Other Care Services	Date of payment	MAP	N	10/1/11	9/30/21
64.21U & 64.21UP THTQIP-Qualified	Medical assistance expenditures for all participating individuals whose MEG is defined as Qualified FFP-eligible non-citizens. Title XXI expenditures for this group are excluded from budget neutrality but are counted against the Title XXI allotment. If the state exhausts its title XXI allotment prior to the end of the federal fiscal year, the expenditures attributable to this group for which title XIX funds are available will count toward	None	Follow CMS-64.9 Base Category of Service Definitions	Date of service	MAP	Y	10/1/11	9/30/30

	the budget neutrality expenditure cap, as described in STC 61.							
THTQIP-M-CHIP	All medical assistance expenditures for children who are ages 6-18 and between 100-133% FPL, or children served in CHIP on December 31, 2013 due to assets in excess of Medicaid eligibility limits. These are children who meet the definition of "targeted low-income child" specified in section 2110 (b)(1) of the Social Security Act. Title XXI expenditures for this group are excluded from budget neutrality but are counted against the Title XXI allotment. If the state exhausts its title XXI allotment prior to the end of the federal fiscal year, the expenditures attributable to this group for which title XIX funds are available will count toward the budget neutrality expenditure cap, as described in STC 61.	None	Follow CMS-64.9 Base Category of Service Definitions	Date of service	MAP	Y	10/1/11	9/30/30
THTQIP-Admin	Additional administrative costs that are directly attributable to the demonstration	None	Follow CMS-64.10 Base Category Definitions	Date of payment	ADM	N	10/1/11	9/30/30

ADM – administration; DY – demonstration year; MAP – medical assistance payments; MEG – Medicaid expenditure group;

57) Demonstration Years. Demonstration Years (DY) for this demonstration are defined in the table below.

Table 10: Demonstration Years

Demonstration Year	Start Date	End Date
DY 1	December 12, 2011*	September 30, 2012
DY 2	October 1, 2012	September 30, 2013
DY 3	October 1, 2013	September 30, 2014
DY 4	October 1, 2014	September 30, 2015
DY 5	October 1, 2015	September 30, 2016
DY 6	October 1, 2016	September 30, 2017
DY 7	October 1, 2017	September 30, 2018
DY 8	October 1, 2018	September 30, 2019
DY 9	October 1, 2019	September 30, 2020
DY 10	October 1, 2020	September 30, 2021
DY 11	October 1, 2021	September 30, 2022 **
DY 12	October 1, 2022	September 30, 2023
DY 13	October 1, 2023	September 30, 2024
DY 14	October 1, 2024	September 30, 2025
DY 15	October 1, 2025	September 30, 2026
DY 16	October 1, 2026	September 30, 2027
DY 17	October 1, 2027	September 30, 2028
DY 18	October 1, 2028	September 30, 2029
DY 19	October 1, 2029	September 30, 2030

* For purpose of expenditure reporting and budget neutrality, DY 1 begins October 1, 2011.
**Original end date to the December 21, 2017 extension approval.

58) Claiming Period. The state will report all claims for expenditures subject to the budget neutrality agreement (including any cost settlements) within two years after the calendar quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the state will continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

59) Future Adjustments to Budget Neutrality. CMS reserves the right to adjust the budget neutrality expenditure limit:

a) To be consistent with enforcement of laws and policy statements, including regulations and guidance, regarding impermissible provider payments, health care related taxes, or other payments. CMS reserves the right to make adjustments to the budget neutrality limit if any health care related tax that was in effect during the base year, 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 Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

b) To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in FFP for expenditures made under this demonstration. In this circumstance, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this STC. The state agrees that if mandated changes in the federal law require state legislation, the changes shall 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 federal law.

c) The state certifies that the data it provided to establish the budget neutrality expenditure limit are accurate based on the state's accounting of recorded historical expenditures or the next best available data, that the data are allowable in accordance with applicable federal, state, and local statutes, regulations, and policies, and that the data are correct to the best of the state's knowledge and belief. The data supplied by the state to set the budget neutrality expenditure limit are subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit.

60) Budget Neutrality Mid-Course Correction Adjustment Request. No more than once per demonstration year, the state may request that CMS make an adjustment to its budget neutrality agreement based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

a) **Contents of Request and Process.** In its request, the state must provide a description of the expenditure changes that led to the request, together with applicable expenditure data demonstrating that due to these expenditures, the state's actual costs have exceeded the budget neutrality cost limits established at demonstration approval. The state must also submit the budget neutrality update described in STC 60.c. If approved, an adjustment could be applied retrospectively to when the state began incurring the relevant expenditures, if appropriate. After acknowledging receipt of the request, CMS will determine whether the state needs to submit an amendment pursuant to STC 7. CMS will evaluate each request based on its merit and will approve requests when the state establishes that an adjustment to its budget neutrality agreement is necessary due to changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside of the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

b) **Types of Allowable Changes.** Adjustments will be made only for actual costs as reported in expenditure data. CMS will not approve mid-demonstration adjustments for anticipated factors not yet reflected in such expenditure data. Examples of the types of mid-course adjustments that CMS might approve include the following:

i. Provider rate increases that are anticipated to further strengthen access to care;

ii. CMS or state technical errors in the original budget neutrality formulation applied retrospectively, including, but not limited to the following: mathematical errors, such as not aging data correctly; or unintended omission of certain applicable costs of services for individual MEGs;

iii. Changes in federal statute or regulations, not directly associated with Medicaid, which impact expenditures;

iv. State legislated or regulatory change to Medicaid that significantly affects the costs of medical assistance;

v. When not already accounted for under Emergency Medicaid 1115 demonstrations, cost impacts from public health emergencies;

vi. High-cost innovative medical treatments that states are required to cover; or,

vii. Corrections to coverage/service estimates where there is no prior state experience (e.g., SUD) or small populations where expenditures may vary widely.

c) **Budget Neutrality Update.** The state must submit an updated budget neutrality analysis with its adjustment request, which includes the following elements:

i. Projected without waiver and with waiver expenditures, estimated member months, and annual limits for each DY through the end of the approval period; and,

ii. Description of the rationale for the mid-course correction, including an explanation of why the request is based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or is due to a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

VIII. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

61) Limit on Title XIX and XXI Funding.

a) The state will be subject to limits on the amount of federal Medicaid funding the state may receive over the course of the demonstration approval. The budget neutrality expenditure limits are based on projections of the amount of FFP that the state would likely have received in the absence of the demonstration. The limit consists of a Main Budget Neutrality Test and one or more Hypothetical Budget Neutrality Tests, as described below. CMS's assessment of the state's compliance with these tests will be based on the Schedule C CMS-64 Waiver Expenditure Report, which summarizes the expenditures reported by the state on the CMS-64 that pertain to the demonstration.

b) The state will be subject to a limit on the amount of federal title XXI funding that the state may receive on demonstration expenditures for M-CHIP children during the demonstration period. Federal title XXI funding available for demonstration expenditures for M-CHIP children is limited to the state's available allotment, including currently available reallocated funds and contingency funds. Should the state expend its available title XXI Federal funds for the claiming period, no further enhanced title XXI Federal

matching funds will be available for costs of the approved title XXI child health program or demonstration until the next allotment becomes available.

i) Exhaustion of title XXI Funds. After the State has exhausted title XXI funds, expenditures for M-CHIP children, may be claimed as title XIX expenditures. The State shall report expenditures for these children as waiver expenditures on the Forms CMS 64.9 Waiver and/or CMS 64.9P Waiver in accordance with STC 42.

ii) Exhaustion of title XXI Funds Notification. The State must notify CMS in writing of any anticipated title XXI shortfall at least 120 days prior to an expected change in claiming of expenditures for the M-CHIP children. The State must follow Medicaid State plan criteria for these beneficiaries unless specific waiver and expenditure authorities are granted through this demonstration.

62) Risk. The budget neutrality expenditure limits are determined on either a per capita or aggregate basis as described in Table 8, Master MEG Chart and Table 9, MEG detail for Expenditure and Member Month Reporting. If a per capita method is used, the state is at risk for the per capita cost of state plan and hypothetical populations, but not for the number of participants in the demonstration population. By providing FFP without regard to enrollment in the demonstration for all demonstration populations, CMS will not place the state at risk for changing economic conditions; however, by placing the state at risk for the per capita costs of the demonstration populations, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration. If an aggregate method is used, the state accepts risk for both enrollment and per capita costs.

63) Calculation of the Budget Neutrality Limits and How They Are Applied. To calculate the budget neutrality limits for the demonstration, separate annual budget limits are determined for each DY on a total computable basis. Each annual budget limit is the sum of one or more components: per capita components, which are calculated as a projected without-waiver PMPM cost times the corresponding actual number of member months, and aggregate components, which project fixed total computable dollar expenditure amounts. The annual limits for all DYs are then added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality expenditure limit by the appropriate Composite Federal Share.

64) Main Budget Neutrality Test. The Main Budget Neutrality Test allows the state to show that approval of the demonstration has not resulted in Medicaid costs to the federal government that are greater than what the federal government's Medicaid costs would likely have been absent the demonstration, and that federal Medicaid "savings" have been achieved sufficient to offset the additional projected federal costs resulting from expenditure authority. The table below identifies the MEGs that are used for the Main Budget Neutrality Test. MEGs designated as "WOW Only" or "Both" are components used to calculate the budget neutrality expenditure limit. MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against the budget neutrality expenditure limit. In addition, any expenditures in excess of the limit from Hypothetical Budget Neutrality Tests count as expenditures under the Main Budget Neutrality Test. The Composite Federal Share for this test is calculated based on all MEGs indicated as "Both."

a) **Mechanics and Data for Rebasing the WOW PMPMs.** The budget neutrality limits for this demonstration were rebased, and the rebased without waiver (WOW) PMPMs are effective from DY 12

through DY 16. Due to the 10-year renewal, a second round of rebasing with actuals will occur for DY 17 (October 1, 2027 - September 30, 2028) using DY 15 (October 1, 2025 - September 30, 2026) as the base.

i) Once the new WOW PMPMs are calculated for DY 17 using DY 15 actual expenditures, table 11 will be updated to reflect those numbers.

Table 11 – Main Budget Neutrality Test

MEG	PC or Agg*	WOW Only, WW Only, or Both	Trend Rate	DY 10	DY 11
THTQIP-AMR	PC	Both	3.8%	$1,406.89	$1,470.31
THTQIP-Disabled	PC	Both	4.1%	1,946.81	$2,124.51
THTQIP-Adults	PC	Both	5.3%	$1,198.18	$1,560.53
THTQIP-Children	PC	Both	4.5%	$396.52	$450.00
THTQIP-UC	Agg	WW only	N/A	The state must have savings to offset these expenditures.	
THTQIP – PHP-CCP	Agg	WW only	N/A	The state must have savings to offset these expenditures.	
THTQIP-DSRIP	Agg	WW only	N/A	The state must have savings to offset these expenditures.	
UPL for Included Population	Agg	WOW only	0%	$2,346,880,705	$2,346,880,705
UPL for Excluded Population	Agg	WOW only	0%	$1,681,649,843	$1,681,649,843
Physician UPL	Agg	WOW only	0%	$84,237,473	$84,237,473
Outpatient UPL	Agg	WOW only	0%	$72,483,206	$72,483,206

*PC = Per Capita, Agg = Aggregate

Table 11 – Main Budget Neutrality Test (cont.)

MEG	PC or Agg*	WOW Only, WW Only, or Both	Trend Rate	DY 12	DY 13	DY 14	DY 15	DY 16
THTQIP-AMR	PC	Both	4.7%	$1,510.70	$1,581.70	$1,656.04	$1,733.87	$1,815.36
THTQIP-Disabled	PC	Both	5.4%	$2,314.88	$2,439.94	$2,571.69	$2,710.56	$2,856.94
THTQIP-Adults	PC	Both	4.9%	$1,108.28	$1,162.62	$1,219.59	$1,279.35	$1,342.04
THTQIP-Children	PC	Both	4.9%	$386.79	$405.78	$425.66	$446.52	$468.40
THTQIP-UC	Agg	WW only	N/A	The state must have savings to offset these expenditures.				
THTQIP – PHC-CCP	Agg	WW only	N/A	The state must have savings to offset these expenditures.				
THTQIP-DSRIP	Agg	WW only	N/A	The state must have savings to offset these expenditures.	N/A	N/A	N/A	N/A
UPL for Included Population	Agg	WOW only	0%	$2,346,880,705	$2,346,880,705	$2,346,880,705	$2,346,880,705	$2,346,880,705
UPL for Excluded Population	Agg	WOW only	0%	$1,681,649,843	$1,681,649,843	$1,681,649,843	$1,681,649,843	$1,681,649,843
Physician UPL	Agg	WOW only	0%	$84,237,473	$84,237,473	$84,237,473	$84,237,473	$84,237,473
Outpatient UPL	Agg	WOW only	0%	$72,483,206	$72,483,206	$72,483,206	$72,483,206	$72,483,206
One-time PHE Adjustment	PC	WOW only	N/A	N/A	$57.98	$61.30	$64.15	$67.16

*PC = Per Capita, Agg = Aggregate

Table 11 – Main Budget Neutrality Test (cont.)

MEG	PC or Agg*	WOW Only, WW Only, or Both	Trend Rate	DY 17	DY 18	DY 19
THTQIP-AMR	PC	Both	TBD	TBD	TBD	TBD
THTQIP-Disabled	PC	Both	TBD	TBD	TBD	TBD
THTQIP-Adults	PC	Both	TBD	TBD	TBD	TBD
THTQIP-Children	PC	Both	TBD	TBD	TBD	TBD
THTQIP-UC	Agg	WW only	N/A	The state must have savings to offset these expenditures		
THTQIP – PHC-CCP	Agg	WW only	N/A	The state must have savings to offset these expenditures		
THTQIP-DSRIP	Agg	WW only	N/A	The state must have savings to offset these expenditures		
UPL for Included Population	Agg	WOW only	0%	$2,346,880,705	$2,346,880,705	$2,346,880,705
UPL for Excluded Population	Agg	WOW only	0%	$1,681,649,843	$1,681,649,843	$1,681,649,843
Physician UPL	Agg	WOW only	0%	$84,237,473	$84,237,473	$84,237,473
Outpatient UPL	Agg	WOW only	0%	$72,483,206	$72,483,206	$72,483,206

65) **Hypothetical Budget Neutrality.** When expenditure authority is provided for coverage of populations or services that the state could have otherwise provided through its Medicaid state plan or other title XIX authority (such as a waiver under section 1915 of the Act), or when a WOW spending baseline for certain WW expenditures is difficult to estimate due to variable and volatile cost data resulting in anomalous trend rates, CMS considers these expenditures to be "hypothetical," such that the expenditures are treated as if the state could have received FFP for them absent the demonstration. For these hypothetical expenditures, CMS makes adjustments to the budget neutrality test which effectively treats these expenditures as if they were for approved Medicaid state plan services. Hypothetical expenditures, therefore, do not necessitate savings to offset the expenditures on those services. When evaluating budget neutrality, however, CMS does not offset non-hypothetical expenditures with projected or accrued savings from hypothetical expenditures; that is, savings are not generated from a hypothetical population or service. To allow for hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies separate, independent Hypothetical

Budget Neutrality Tests, which subject hypothetical expenditures to pre-determined limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If the state's WW hypothetical spending exceeds the Hypothetical Budget Neutrality Test's expenditure limit, the state agrees (as a condition of CMS approval) to offset that excess spending through savings elsewhere in the demonstration or to refund the FFP to CMS.

66) **Hypothetical Budget Neutrality Test 1**: **217-Like Groups**. The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 1. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 1 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 12 – Hypothetical Budget Neutrality Test 1

MEG	PC or Agg*	WOW Only, WW Only, or Both	TREND RATE	DY 10	DY 11
217-like AMR	PC	Both	3.8%	$3,077.87	$3,194.83
217-like Disabled	PC	Both	4.1%	$5,138.52	$5,349.20

MEG	PC or Agg*	WOW Only, WW Only, or Both	TREND RATE	DY 12	DY 13	DY 14	DY 15	DY 16
217-like AMR	PC	Both	4.7%	$2,775.90	$2,906.37	$3,042.97	$3,185.99	$3,335.73
217-like Disabled	PC	Both	5.4%	$5,667.58	$5,973.63	$6,296.21	$6,636.21	$6,994.57

MEG	PC or Agg*	WOW Only, WW Only, or Both	TREND RATE	DY 17	DY 18	DY 19
217-like AMR	PC	Both	TBD	TBD	TBD	TBD
217-like Disabled	PC	Both	TBD	TBD	TBD	TBD

67) **Composite Federal Share.** The Composite Federal Share is the ratio that will be used to convert the total computable budget neutrality limit to federal share. 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 by total computable demonstration expenditures for the same period, as reported through MBES/CBES and summarized on Schedule C. Since the actual final Composite Federal Share will not be known until the

end of the demonstration's approval period, for the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed to method. Each Budget Neutrality Test has its own Composite Federal Share, as defined in the paragraph pertaining to each particular test.

68) **Budget Neutrality Monitoring Tool and Reporting Requirements.** Per 42 CFR 431.428, the state must document the financial performance of the demonstration. The state must provide quarterly budget neutrality status updates that meet all reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements section of these STCs (including the submission of corrected budget neutrality data upon request), using the Budget Neutrality Monitoring Tool provided through the Demonstration Evaluation & Management Oversight System (DEMOS). The tool incorporates the "Schedule C Report" for comparing the demonstration's actual expenditures to the budget neutrality expenditure limits described in the Monitoring Budget Neutrality for the Demonstration section. The quarterly budget neutrality status updates are due no later than 60 calendar days following the end of each demonstration quarter, while the fourth-quarter information is due no later than 90 calendar days following the end of the DY. These monitoring reports are subject to the deferral as described in STC 74. CMS will provide technical assistance, upon request.[6]

69) **Exceeding Budget Neutrality**. CMS will enforce the budget neutrality agreement over the demonstration period, which extends from 1/15/2021 to 9/30/2030. The Main Budget Neutrality Test for this demonstration period may incorporate carry-forward savings, that is, net savings from up to 10 years of the immediately prior demonstration approval period(s) (1/12/2011 to 1/14/2021). If at the end of the demonstration approval period the Main Budget Neutrality Test has been exceeded, the excess federal funds will 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.

70) **Budget Neutrality Savings Cap.** The amount of savings available for use by the state during this demonstration period will be limited to the lower of these two amounts: 1) the savings amount the state has available in the current demonstration period, including carry-forward savings as described in STC 69, or 2) 15 percent of the state's projected total Medicaid expenditures in aggregate for this demonstration period. This projection will be determined by taking the state's total Medicaid spending amount in its most recent year with completed data and trending it forward by the President's Budget trend rate for this demonstration period. Fifteen percent of the state's total projected Medicaid expenditures for this demonstration period is $88,425,632,286.

71) **Corrective Action Plan**. If at any time during the demonstration approval period CMS determines that the demonstration is on course to exceed its budget neutrality expenditure limit, CMS will require the state to

[6] Per 42 CFR 431.420(a)(2), states must comply with the terms and conditions of the agreement between the Secretary (or designee) and the state to implement a demonstration project, and 431.420(b)(1) states that the terms and conditions will provide that the state will perform periodic reviews of the implementation of the demonstration. CMS's current approach is to include language in STCs requiring, as a condition of demonstration approval, that states provide, as part of their periodic reviews, regular reports of the actual costs which are subject to the budget neutrality limit. CMS has obtained Office of Management and Budget (OMB) approval of the monitoring tool under the Paperwork Reduction Act (OMB Control No. 0938 – 1148) and states agree to use the tool as a condition of demonstration approval.

submit a corrective action plan for CMS review and approval. CMS will use the threshold levels in the tables below as a guide for determining when corrective action is required.

Table 14: Budget Neutrality Test Corrective Action Plan Calculation

DY	Cumulative Target Definition	Percentage
DY 10	Cumulative budget neutrality cap plus:	1 percent
DY 11	Cumulative budget neutrality cap plus:	0.9 percent
DY 12	Cumulative budget neutrality cap plus:	0.8 percent
DY 13	Cumulative budget neutrality cap plus:	0.7 percent
DY 14	Cumulative budget neutrality cap plus:	0.6 percent
DY 15	Cumulative budget neutrality cap plus:	0.5 percent
DY 16	Cumulative budget neutrality cap plus:	0.4 percent
DY 17	Cumulative budget neutrality cap plus:	0.3 percent
DY 18	Cumulative budget neutrality cap plus:	0.2 percent
DY 19	Cumulative budget neutrality cap plus:	0.0 percent

* The percentage will be established at 0 percent upon rebasing in DY 17

72) 1115A Duals Demo Savings. When Texas' section 1115(a) demonstration is considered for an amendment, renewal, and at the end of the duals demonstration, CMS' Office of the Actuary (OACT) will estimate and certify actual title XIX savings to date under the duals demonstration attributable to populations and services provided under the 1115(a) demonstration. This amount will be subtracted from the 1115(a) budget neutrality savings approved for the renewal.

Specifically, OACT will estimate and certify actual title XIX savings attributable to populations and services provided under the 1115(a) demonstration following the methodology below.

The actual title XIX savings attributable to populations and services provided under the 1115(a) demonstration are equal to the savings percentage specified in the 1115A duals demonstration MOU multiplied by the 1115A demonstration capitation rate and the number of 1115A duals demonstration beneficiaries enrolled in the 1115(a) demonstration. 1115A Demonstration capitation rate is reviewed by CMS's Medicare and Medicaid Coordination Office (MPLAN), MPLAN's contracted actuaries and CMS' Office of the Actuary (OACT), and was certified by the state's actuaries. Per the 1115A duals demonstration MOU, the actual Medicaid rate paid for beneficiaries enrolled in the 1115A demonstration is equivalent to the state's 1115A Medicaid capitation rate minus an established savings percentage (as outlined in the chart below). The state must track the number of member months for every Medicare-Medicaid enrollee (MME) who participates in both the 1115(a) and 1115A demonstration.

The table below provides an illustrative example of how the savings attributable to populations and services provided under the 1115(a) demonstration is calculated.

Table 15: MME Savings Calculation					
A. 1115A Demonstration Year	**B. Medicaid Capitation Rate (hypothetical)**	**C. Medicaid Savings Percentage Applied Per MOU (average)**	**D. Savings Per Month (B*C)**	**E. Member Months of MMEs who participated in 1115A and 1115(a) Demos (estimated)**	**F. Amount subtracted from 1115(a) BN savings/ margin (D*E)**
DY 1	$1,000 PMPM	1%	$10 PMPM	1,000	1,000* $10 PMPM = $10,000
DY 2	$1,000 PMPM	2%	$20 PMPM	1,000	1,000 * $20 PMPM = $20,000
DY 3	$1,000 PMPM	4%	$40 PMPM	1,000	1,000 * 40 PMPM = $40,000

In each Quarterly Report, the state must provide the information in the above-named chart (replacing estimated figures with actual data). Should rates differ by geographic area and/or rating category within the 1115A demonstration, this table should be done for each geographic area and/or rating category. In addition, the state must show the "amount subtracted from the 1115(a) BN savings" in the updated budget neutrality Excel worksheets that are submitted in each Quarterly Report.

a) Finally, in each quarterly CMS-64 submission and in each Quarterly Report, the state must indicate in the notes section: "For purposes of 1115(a) demonstration budget neutrality reporting purposes, the state reports the following information:
b) Number of Medicare-Medicaid enrollees served under the 1115 duals demonstration = [Insert number]
c) Number of member months = [Insert number]
d) PMPM savings per dual beneficiary enrolled from the 1115A duals demonstration = [Insert number]

The State must make the necessary retroactive adjustments to the budget neutrality worksheets to reflect modifications to the rates paid in the 1115A demonstration. This must include any Medicaid payment triggered by the risk corridor, IGTs, or other retroactive adjustments. The State must add additional columns to the chart above in subsequent Quarterly Reporting to reflect those adjustments.

73) Withholding of Payment of Claims Under the Uncompensated Care Expenditure Authority Based on Failure to Submit Uncompensated Care Pool Reconciliations. Texas must submit to CMS final reconciliations of all uncompensated care pools payments across both the hospital uncompensated care pool as well as the one for public healthcare providers (e.g., identify all overpayments) for each period of the renewal by January 31, of the following year after the Demonstration year (DY) has expired. For example, if DYXX ends September 30, 20XX, the reconciliation is due to CMS no later than January 31 of the new DY. If the final reconciliation is not submitted by January 31, during the quarterly review of Medicaid expenditures, CMS will make a retroactive deferral adjustment to the State's DY expenditure authority for the current pool by one percent for non-compliance with the final reconciliation requirement for failure to adequately document uncompensated care pool claims through reconciliation of claimed payments with allowable payments. If the final reconciliation has not been submitted within six months of initiation of the withhold, CMS will further reduce the pool expenditure authority by one percent for and will offset any amount claimed in excess of the resulting expenditure authority from the grant award for the following quarter of calendar year.

Texas must also credit the federal government with a share of any provider overpayments that are found in the course of reconciliations in accordance with the requirements of 42 CFR Part 433, Subpart F, or redistribute them as authorized elsewhere in these STCs. Under those regulations, a refund of the Federal share of an overpayment must be made to CMS within one year after the date on which an overpayment is discovered or, if earlier, the date the provider refunded the overpayment. The date of discovery will be the earlier of the date that: the reconciliation is finalized; the provider was notified in writing of the overpayment or acknowledged the overpayment; or the state initiated a formal recoupment action.

For all claims, pool payments, etc. that are subject to recoupment, redistribution, and or settlement, and the reconciliation is due to CMS no later than January 31 of each year for the prior Demonstration year, all recoupments and redistributions must be finalized within the regulatory time frame for timely payments found at 45 C.F.R. 95, Subpart F. Any claims for prior demonstration years that exceed the requirement will not be accepted for federal funds participation unless the claim meets the requirement outlined in the regulation. Furthermore, when a claim for a prior DY is made, the claim must be made and attributed to the Federal Medical Assistance Percentage (FMAP) of the DY for all provider types, including private, public, and governmental.

Deliverables under this section will not be subject to the deferral indicated in STC 74, but solely the deferrals denoted in this STC.

IX. MONITORING AND REPORTING REQUIREMENTS

74) Deferral for Failure to Submit Timely Demonstration Deliverables. CMS may issue deferrals in accordance with 42 CFR part 430 subpart C, in the amount of $5,000,000 per deliverable (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs (hereafter singly or collectively referred to as "deliverable(s)") are not submitted timely to CMS or found to not be consistent with the requirements

approved by CMS. A deferral shall not exceed the value of the federal amount for the demonstration period. The state does not relinquish its rights provided under 42 CFR part 430 subpart C to challenge any CMS finding that the state materially failed to comply with the terms of this agreement.

The following process will be used: 1) 30 calendar days after the deliverable was due if the state has not submitted a written request to CMS for approval of an extension as described in subsection (b) below; or 2) 30 calendar days after CMS has notified the state in writing that the deliverable was not accepted for being inconsistent with the requirements of this agreement and the information needed to bring the deliverable into alignment with CMS requirements:

a) CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverable(s).

b) For each deliverable, the state may submit to CMS a written request for an extension to submit the required deliverable. The extension request must explain the reason why the required deliverable was not submitted, the steps the state has taken to address such issue, and the state's anticipated date of submission. Should CMS agree in writing to the state's request, a corresponding extension of the deferral process described below can be provided. CMS may agree to a corrective action plan as an interim step before applying the deferral, if corrective action is proposed in the state's written extension request.

c) If CMS agrees to an interim corrective process in accordance with subsection (b), and the state fails to comply with the corrective action plan or, despite the corrective action plan, still fails to submit the overdue deliverable(s) that meets the terms of this agreement, CMS may proceed with the issuance of a deferral against the next Quarterly Statement of Expenditures reported in Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) following a written deferral notification to the state.

d) If the CMS deferral process has been initiated for state non-compliance with the terms of this agreement for submitting deliverable(s), and the state submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the standards outlined in these STCs, the deferral(s) will be released.

As the purpose of a section 1115 demonstration is to test new methods of operation or service delivery, a state's failure to submit all required reports, evaluations, and other deliverables will be considered by CMS in reviewing any application for an extension, amendment, or for a new demonstration.

75) Submission of Post-approval Deliverables. The state must submit all deliverables as stipulated by CMS and within the timeframes outlined within these STCs, unless CMS and the state mutually agree to another timeline.

76) Compliance with Federal Systems Updates. As federal systems continue to evolve and incorporate additional 1115 demonstration reporting and analytics functions, the state will work with CMS to:

a) Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;

b) Ensure all 1115demonstration, T-MSIS, and other data elements that have been agreed to for reporting and analytics are provided by the state; and
c) Submit deliverables to the appropriate system as directed by CMS.

77) Monitoring Reports. The state must submit one Annual Monitoring Report each demonstration year (DY) that is due no later than 180 calendar days following the end of the DY. The state must submit a revised Annual Monitoring Report within 60 calendar days after receipt of CMS's comments, if any. CMS might increase the frequency of monitoring reporting if CMS determines that doing so would be appropriate. CMS will make on-going determinations about reporting frequency under the demonstration by assessing the risk that the state might materially fail to comply with the terms of the approved demonstration during its implementation and/or the risk that the state might implement the demonstration in a manner unlikely to achieve the statutory purposes of Medicaid. See 42 CFR 431.420(d)(1)-(2).

The Annual Monitoring Report will include all required elements as per 42 CFR 431.428, and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Annual Monitoring Report must follow the framework provided by CMS, which is subject to change as monitoring systems are developed/evolve and must be provided in a structured manner that supports federal tracking and analysis.

a) **Operational Updates.** Per 42 CFR 431.428, the Annual Monitoring Report must document any policy or administrative difficulties in operating the demonstration. The Annual Monitoring Report must provide sufficient information to document key operational and other challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion should also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. The Annual Monitoring Report should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.

b) **Performance Metrics**. The performance metrics will provide data to demonstrate the state's progress towards meeting the demonstration's goals, and any applicable milestones. Per 42 CFR 431.428, the Annual Monitoring Report must document the impact of the demonstration on beneficiaries' outcomes of care, quality and overall cost of care, and access to care, as applicable. This should also include the results of beneficiary satisfaction or experience of care surveys, if conducted, as well as grievances and appeals. The Annual Monitoring Report must provide detailed information about deviations from CMS's applicable metrics technical specifications, relevant methodology, plans for phasing in metrics, and data or reporting issues for applicable metrics, in alignment with CMS guidance and technical assistance.

The state and CMS will work collaboratively to finalize the list of metrics to be reported on in the Annual Monitoring Report. The demonstration's monitoring metrics must cover categories to include, but not be limited to, eligibility, utilization of services, quality of care and health outcomes, and grievances and appeals. The state must report these metrics for all demonstration populations. Demonstration monitoring reporting does not duplicate or replace reporting requirements for other authorities, such as Home and Community Based Services and Managed Care authorities.

In addition, per applicable CMS guidance, the state is expected to report monitoring metrics related to provider network and network adequacy to ensure MCO's meet service delivery area time/distance standards, and trends related to enrollment in STAR, STAR KIDS, STAR+PLUS, Dental Program, and Members with Special Health Care Needs), and Uncompensated Care (UC) (e.g., providers reporting UC costs). The reporting of these monitoring metrics may also be stratified by key demographic subpopulations of interest (e.g., by sex, age, race/ethnicity, or geography) and by demonstration component, as appropriate. Subpopulation reporting can support identifying any gaps in quality of care and health outcomes, and help track whether the demonstration's initiatives help improve outcomes for the state's Medicaid population.

c) **Evaluation Activities and Interim Findings.** Per 42 CFR 431.428, the Annual Monitoring Report must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.

78) 1915(c)-like HCBS Reporting Requirements:

a) The state must report annually to CMS on the deficiencies found during the monitoring and evaluation of the 1915(c)-like HCBS performance measures and assurances, an explanation of how these deficiencies have been or are being corrected, as well as the steps that have been taken to ensure that these deficiencies do not reoccur. The state must also report on the number of substantiated instances of abuse, neglect, exploitation and/or unexplained death in the 1915(c)-like HCBS demonstration, the actions taken regarding the incidents and how they were resolved. Submission to CMS is due no later than 6 months following the end of each Demonstration Year.

b) The state will submit a report to CMS following receipt of an Evidence Request letter and report template from CMS, no later than 21 months prior to the end of the demonstration period. The state's evidence report must include evidence on the status of the approved HCBS quality performance measures and assurances that adheres to the requirements outlined in the March 12, 2014, CMS Informational Bulletin, Modifications to Quality Measures and Reporting in §1915(c) Home and Community–Based Waivers. Following receipt of the state's evidence report, CMS will review the evidence to determine whether the performance measures and requirements have been met and will issue a draft report to the state. The state will have 90 days to respond to the draft report CMS will consider the state's response and will issue a final report of our findings to the state 60 days following receipt of the state's response to the draft report.

79) Corrective Action Plan Related to Monitoring. If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. A state corrective action plan could include a temporary suspension of implementation of demonstration programs in circumstances where monitoring data indicate substantial and sustained directional change inconsistent with state's demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 10. CMS might withdraw an authority, as described in STC 10, if metrics indicate substantial and sustained directional change inconsistent with state's demonstration goals and desired directionality, and the state has not implemented corrective action, and the circumstances described in STC 10 are met. CMS further has the ability to suspend

implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

80) Close-Out Report. Within 120 days after the expiration of the demonstration, the state must submit a draft Close-Out Report to CMS for comments.

i) The Close-Out Report must comply with the most current guidance from CMS.
ii) In consultation with CMS, and per guidance from CMS, the state will include an evaluation of the demonstration (or demonstration components) that are to phase out or expire without extension along with the Close-Out Report. Depending on the timeline of the phase-out during the demonstration approval period, in agreement with CMS, the evaluation requirement may be satisfied through the Interim or Summative Evaluation Reports stipulated in STC 89 and STC 90 respectively.
iii) The state will present to and participate in a discussion with CMS on the Close-Out Report.
iv) The state must take into consideration CMS' comments for incorporation into the final Close-Out Report.
v) A revised Close-Out Report is due to CMS no later than 30 calendar days after receipt of CMS' comments.
vi) A delay in submitting the draft or final version of the Close-Out Report may subject the state to penalties described in STC 74.

81) Monitoring Calls. CMS will convene no less frequently than quarterly, monitoring calls with the state.
i) The purpose of these calls is to discuss ongoing demonstration operations and implementation which align with the state's demonstration monitoring reports, including (but not limited to) any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, trends in reported data on metrics and associated mid-course adjustments, eligibility and access,, and progress on evaluation activities.
ii) These calls will follow the structure of and focus on the topics in the Annual Monitoring Report.
iii) CMS will provide updates on any pending actions, as well as federal policies and issues that may affect any aspect of the demonstration.
iv) The state and CMS will jointly develop the agenda for the calls.

82) Post Award Forum. Pursuant to 42 CFR 431.420(c), within six months of the demonstration's implementation, and annually thereafter, the state must afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 calendar days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state must also post the most recent Annual Monitoring Report on its website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the comments in the Annual Monitoring Report associated with the year in which the forum was held.

X. EVALUATION OF THE DEMONSTRATION

83) Cooperation with Federal Evaluators and Learning Collaborative. As required under 42 CFR 431.420(f), the state shall cooperate fully and timely with CMS and its contractors in any federal evaluation of the

demonstration or any component of the demonstration. This includes, but is not limited to, commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state shall include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they shall make such data available for the federal evaluation as is required under 42 CFR 431.420(f). This may also include the state's participation – including representation from the state's contractors, independent evaluators, and organizations associated with the demonstration operations, as applicable – in a federal learning collaborative aimed at cross-state technical assistance, and identification of lessons learned and best practices for demonstration measurement, data development, implementation, monitoring and evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 74.

84) Independent Evaluator. The state must use an independent entity (herein referred to as the Independent Evaluator) to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The Independent Evaluator must sign an agreement to conduct the demonstration evaluation in an independent manner in accordance with the CMS-approved Evaluation Design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

85) Evaluation Design. The state must submit, for CMS comment and approval, an Evaluation Design with implementation timeline no later than 180 calendar days after the approval of the demonstration. The Evaluation Design must be developed in accordance with the STCs and any applicable CMS evaluation guidance and technical assistance for the demonstration's policy components. The Evaluation Design must also be developed in alignment with CMS guidance on applying robust evaluation approaches, such as quasi-experimental methods like difference-in-differences and interrupted time series, as well as establishing valid comparison groups and assuring causal inferences in demonstration evaluations.

The state is strongly encouraged to use the expertise of the Independent Evaluator in the development of the Evaluation Design. The Evaluation Design also must include a timeline for key evaluation activities, including the deliverables outlined in STC 89 and STC 90.

For any amendment to the demonstration, the state will be required to update the approved Evaluation Design to accommodate the amendment component, unless otherwise agreed upon by the state and CMS. The amended Evaluation Design must be submitted to CMS for review no later than 180 calendar days after CMS's approval of the demonstration amendment.. The amendment components of the Evaluation Design must also be reflected in the state's Interim and Summative Evaluation Reports, described below.

86) Evaluation Design Approval and Updates. The state must submit a revised Evaluation Design within 60 calendar days after receipt of CMS' comments, if any. Upon CMS approval of the Evaluation Design, the document will be posted to Medicaid.gov. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design within 30 calendar days of CMS approval. The state must implement the Evaluation Design and submit a description of its evaluation progress in each Annual Monitoring Report. Once CMS

approves the Evaluation Design, if the state wishes to make changes, and the changes are substantial in scope, the state must submit a revised Evaluation Design to CMS for approval; otherwise, in consultation with CMS, the state may include updates to the Evaluation Design in an Annual Monitoring Report.

87) **Evaluation Questions and Hypotheses.** Consistent with the STCs and applicable CMS guidance, the evaluation deliverables must include a discussion of the evaluation questions and hypotheses that the state intends to test. In alignment with applicable CMS evaluation guidance and technical assistance, the evaluation must outline and address well-crafted hypotheses and research questions for all key demonstration policy components that support understanding of the demonstration's impact and its effectiveness in achieving the demonstration's goals.

The hypothesis testing should include, where possible, assessment of both process and outcome measures. The evaluation must study outcomes, such as eligibility and various measures of access, utilization, costs, and health outcomes, as appropriate and in alignment with applicable CMS evaluation guidance and technical assistance for the demonstration policy components. The evaluation is expected to use applicable demonstration monitoring and other data on the provision of and beneficiary utilization of demonstration and other applicable services. Proposed measures should be selected from nationally recognized sources and national measures sets, where possible. Measures sets could include the Consumer Assessment of Health Care Providers and Systems (CAHPS), the Medicaid and CHIP Core Sets of Health Care Quality measures, commonly referred to as the Child and Adult Core Sets, the Behavioral Risk Factor Surveillance System (BRFSS) survey, or measures endorsed by National Quality Forum (NQF).

As part of its evaluation efforts, the state must also conduct an overall demonstration cost assessment to include, but not be limited to, administrative costs of demonstration implementation and operation and Medicaid health services expenditures. In addition, the state must use findings from hypothesis tests aligned with other demonstration goals and cost analyses to assess the demonstration's effects on the fiscal sustainability of the state's Medicaid program.

CMS underscores the importance of the state undertaking a well-designed beneficiary survey or interviews to assess, for instance, beneficiary understanding of the demonstration policy components and beneficiary experiences with access to and quality of care. To better understand whether implementation of certain key demonstration policies happened as envisioned during the demonstration design process and whether specific factors acted as facilitators of—and barriers to—implementation, the state is strongly encouraged to undertake a robust process/implementation evaluation. The implementation evaluation can inform the state's crafting and selection of testable hypotheses and research questions for the demonstration's outcome and impact evaluations and provide context for interpreting the findings.

Finally, the state may collect data to support analyses stratified by key subpopulations of interest (e.g., by sex, age, race/ethnicity, or geography). Such stratified data analyses can provide a fuller understanding of gaps in access to and quality of care and health outcomes, as well as help inform how the demonstration's various policies support improving outcomes.

88) **Evaluation Budget.** A budget for the evaluation shall be provided with the Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative

data collection and cleaning, analyses and report generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the design is not sufficiently developed, or if the estimates appear to be excessive.

89) **Interim Evaluation Report(s).** The state must submit three Interim Evaluation Reports for the completed years of the demonstration, and for each subsequent extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). The state must provide a draft Interim Evaluation Report for the corresponding demonstration years described below, or—for specific demonstration components—for an evaluation period as determined most appropriate by the state and CMS during the development of the draft Evaluation Design to accommodate potential data lags or other reporting issues.

i. A draft Interim Evaluation Report for demonstration years 7-11 will be due no later than March 31, 2024

ii. A draft Interim Evaluation Report for demonstration years 10-14 will be due no later than March 31, 2027

iii. A draft Interim Evaluation Report for demonstration years 10-16 will be due no later than September 30, 2029

For policies and flexibilities carried forward from the previous demonstration approval period, this first Interim Evaluation report will include the period from October 1, 2017 through September 30, 2022. For any policy or flexibility not carried forward, the first Interim Evaluation Report will include the period from October 1, 2017 through September 30, 2020. This Interim Evaluation Report replaces the Summative Evaluation Report required per the STCs of the previous demonstration approval period and must include all data and analysis that would have been in that Summative Evaluation Report.

The draft Interim Evaluation Reports must be developed in alignment with the approved Evaluation Design, and in accordance with the requirements outlined in these STCs and applicable CMS guidance.

a) The Interim Evaluation Report will discuss evaluation progress and present findings to date as per the approved Evaluation Design.

b) For demonstration authority or any component within the demonstration that expires prior to the overall demonstration's expiration date, and depending on the timeline of the expiration/phase-out, the Interim Evaluation Report must include an evaluation of the authority, to be collaboratively determined by CMS and the state.

c) If the state is seeking to extend the demonstration, the last draft Interim Evaluation Report, representing demonstration years 10-16 is due when the application for extension is submitted, or one year prior to the end of the demonstration, whichever is sooner. When applying for an extension of the demonstration, the Interim Evaluation Report should be posted to the state's website with the application for public comment. If the state does not request an extension for the demonstration, the Interim Evaluation Report is due one year prior to the end of the demonstration. For demonstration phase-outs prior to the expiration of the approval period, the draft Interim Evaluation Report is due to CMS on the date that will be

specified in the notice of termination or suspension.

d) The state must submit a revised Interim Evaluation Report 60 calendar days after receiving CMS comments on the draft Interim Evaluation Report, if any.

e) Once approved by CMS, the state must post the final Interim Evaluation Report to the state's Medicaid website within 30 calendar days.

90) Summative Evaluation Report. The state must submit the draft Summative Evaluation Report for the demonstration's current approval period (demonstration years 10 –19) within 18 months of the end of the approval period represented by these STCs. The draft Summative Evaluation Report must be developed in alignment with the approved Evaluation Design, and in accordance with the requirements outlined in these STCs and applicable CMS guidance.

a) The state must submit a revised Summative Evaluation Report within 60 calendar days of receiving comments from CMS on the draft Summative Evaluation Report, if any.

b) Once approved by CMS, the state must post the final Summative Evaluation Report to the state's Medicaid website within 30 calendar days.

91) Corrective Action Plan Related to Evaluation. If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. These discussions may also occur as part of a extension process when associated with the state's Interim Evaluation Report, or as part of the review of the Summative Evaluation Report. A corrective action plan could include a temporary suspension of implementation of demonstration programs, in circumstances where evaluation findings indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services.. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 10. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

92) State Presentations for CMS. CMS reserves the right to request that the state present and participate in a discussion with CMS on the Evaluation Design, the Interim Evaluation, or the Summative Evaluation Report.

93) Public Access. The state shall post the final documents (e.g., Annual Monitoring Report, Close-Out Report, Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report) on the state's Medicaid website within 30 calendar days of approval by CMS.

94) Additional Publications and Presentations. For a period of 12 months following CMS approval of the final reports, CMS will be notified prior to presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration. Prior to release of these reports, articles or other publications, CMS will be provided a copy including any associated press materials. CMS will be given 30 calendar days to review and

comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews.

XI. SCHEDULE OF STATE DELIVERABLES FOR THE DEMONSTRATION

Deliverable	Timeline	STC Reference
CMS-64 Quarterly Medicaid Expenditure Report	30 calendar days after the end of each quarter	STC 46
Quarterly Budget Neutrality Monitoring Report	60 calendar days after the end of each demonstration quarter except the 4th quarter which is due 90 days after the end of each DY	STC 68
Estimated UC	December 31st of each DY	STC 38(d)(i)
Actual UC and PHP-CCP Payments	90 days following the end of DY	STC 38(d)(ii), 39(d)(2)
DSRIP Payments	6 months following end of DY	STC 40
Assurance of Budget Neutrality	October 1st of each year	STC 42(a)
HCBS Quality Improvement Strategy	February 27, 2026	STC 28(b)
HCBS Performance Measure Report	February 27, 2026	STC 28(b)
HCBS Deficiency, Remediation and A/N/E Incident Report	6 months following the end of each DY	STC 78(a)
HCBS Evidentiary Report	No later than 21 months prior to the end of the demonstration period, following receipt of Evidence Request Letter and sample report template from CMS	STC 78(b)
Evaluation Design	No later than 180 calendar days after approval of the demonstration. Revised no later than 60 days after receipt of CMS comments.	STC 85 and 86
Interim Evaluation Report	Demonstration years 7-11 due no later than March 31, 2024 Demonstration years 10-14 due no later than March 31, 2027	STC 89

Deliverable	Timeline	STC Reference
	Demonstration years 10-16 due no later than September 30, 2029 Revised no later than 60 calendar days after receipt of CMS comments.	
Summative Evaluation Report	No later than 18 months after the end of the demonstration period. Revised no later than 60 calendar days after receipt of CMS comments.	STC 90
Annual Monitoring Report	No later than 180 calendar days after the end of each demonstration year.	STC 77
PHP-CCP Provider Tools for DY11	No later than June 30, 2021	STC 39(b)
Revised PHP-CCP Protocol	No later than August 31, 2021	STC 39(e)
Revised PHP-CCP Provider Tools	No later than February 28, 2022	STC 39(e)
Reconciliations of all uncompensated care pools payments for DY 6 (October 1, 2016 – September 30, 2017) by January 31, 2021	No later than January 31, 2021	STC 73
Reconciliations of all uncompensated care pools payments for DY 7 (October 1, 2017 – September 30, 2018) by January 31, 2022	No later than January 31, 2022	STC 73
Reconciliations of all uncompensated care pools payments for DY 8 (October 1, 2018 – September 30, 2019) by January 31, 2023	No later than January 31, 2023	STC 73
Reconciliations of all uncompensated care pools payments for DY 9 (October 1, 2019 – September 30, 2020) by January 31, 2024	No later than January 31, 2024	STC 73
Reconciliations of all uncompensated care pools payments for DY 10 (October 1, 2020 – September 30, 2021) by January 31, 2025	No later than January 31, 2025	STC 73

Deliverable	Timeline	STC Reference
Reconciliations of all uncompensated care pools payments for DY 11 (October 1, 2021 – September 30, 2022) by January 31, 2026	No later than January 31, 2026	STC 73
Reconciliations of all uncompensated care pools payments for DY 12 (October 1, 2022 – September 30, 2023) by January 31, 2027	No later than January 31, 2027	STC 73
Reconciliations of all uncompensated care pools payments for DY 13 (October 1, 2023 – September 30, 2024) by January 31, 2028	No later than January 31, 2028	STC 73
Reconciliations of all uncompensated care pools payments for DY 14 (October 1, 2024 – September 30, 2025) by January 31, 2029	No later than January 31, 2029	STC 73
Reconciliations of all uncompensated care pools payments for DY 15 (October 1, 2025 – September 30, 2026) by January 31, 2030	No later than January 31, 2030	STC 73
Reconciliations of all uncompensated care pools payments for DY 16 (October 1, 2026 – September 30, 2027) by January 31, 2031	No later than January 31, 2031	STC 73
Reconciliations of all uncompensated care pools payments for DY 17 (October 1, 2027 – September 30, 2028) by January 31, 2032	No later than January 31, 2032	STC 73
Reconciliations of all uncompensated care pools payments for DY 18 (October 1, 2028 – September 30, 2029) by January 31, 2033	No later than January 31, 2033	STC 73
Reconciliations of all uncompensated care pools payments for DY 19 (October 1, 2029 – September 30, 2030) by January 31, 2034	No later than January 31, 2034	STC 73

Deliverable	Timeline	STC Reference
Request for Extension	12 months before expiration of Demonstration	STC 8
Notification letter and Draft Phase-Out Plan	6 months prior to the effective date of Demonstration's suspension or termination	STC 9
Draft Close Out Report to CMS for comments	Within 120 days prior to the expiration of the demonstration	STC 80
Revised Phase-Out Plan for incorporating public comment	Post 30-day public comment period	STC 9
Proposals for new programs	By December 31, 2020	STC 43
Analysis of DY 7-8 DSRIP quality data	By December 31, 2020	STC 43
Assessment of social factors	By March 31, 2021	STC 43
Updated VBP Roadmap	By March 31, 2021	STC 43
Assessment of financial incentives for MCOs and providers in managed care	By June 30, 2021	STC 43
Assessment of telemedicine and telehealth	By June 30, 2021	STC 43
Options for RHP Structure	By June 30, 2021	STC 43
Submission of analysis of options for new programs under 1115 or other authorities	By September 30, 2021	STC 43

Attachment A
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	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. 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. The annual cost limit of this service is $10,000 per waiver plan year, which is the 12-month period defined by the individual service plan. 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.
Adult Foster Care	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. The total number of individuals (including persons served in the waiver) living in the home cannot exceed three, without appropriate licensure. 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. 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. 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.
Assisted Living	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. 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,

Service	Service Definition
	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.
Cognitive Rehabilitation Therapy (effective March 6, 2014)	Cognitive rehabilitation therapy is a service that assists an individual in learning or relearning cognitive skills that have been lost or altered as a result of damage to brain cells/chemistry in order to enable the individual to compensate for the lost cognitive functions. Cognitive rehabilitation therapy is provided when determined to be medically necessary through an assessment conducted by an appropriate professional. Cognitive rehabilitation therapy is provided in accordance with the plan of care developed by the assessor, and includes reinforcing, strengthening, or reestablishing previously learned patterns of behavior, or establishing new patterns of cognitive activity or compensatory mechanisms for impaired neurological systems. Qualified providers • Psychologists licensed under Texas Occupations Code Chapter 501. • Speech and language pathologists licensed under Title 3 of the Texas Occupations Code, Subtitle G, Chapter 401. • Occupational therapists licensed under Title 3 of the Texas Occupations Code, Subtitle H, Chapter 454.
Dental Services	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: • 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, etc. 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. Payments for dental services are not made for cosmetic dentistry. The annual cost cap of this service is $5,000 per waiver plan year (which is the 12-month period defined by the individual service plan). 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.

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Emergency Response Services	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. 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.
Employment Assistance	Assistance provided to an individual to help the individual locate paid employment in the community. Employment assistance includes: • identifying an individual's employment preferences, job skills, and requirements for a work setting and work conditions; • locating prospective employers offering employment compatible with an individual's identified preferences, skills, and requirements; and • contacting a prospective employer on behalf of an individual and negotiating the individual's employment. In the state of Texas, this service is not available to individuals receiving waiver services under a program funded under section 110 of the Rehabilitation Act of 1973. Documentation is maintained in the individual's record that the service is not available to the individual under a program funded under the Individuals with Disabilities Education Act (20 U.S.C. §1401 et seq.). An employment assistance service provider must satisfy one of these options: Option 1: • a bachelor's degree in rehabilitation, business, marketing, or a related human services field; and • six months of documented experience providing services to people with disabilities in a professional or personal setting. Option 2: • an associate's degree in rehabilitation, business, marketing, or a related human services field; and • one years of documented experience providing services to people with disabilities in a professional or personal setting. Option 3: • a high school diploma or GED, and • two years of documented experience providing services to people with disabilities in a professional or personal setting. •
Financial Management Services	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: • Serves as the member's employer-agent;

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	• 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; and • Maintains a separate account for each member's budget. 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.
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	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. There is a lifetime limit of $7,500 per member for this service and $300 yearly for repairs. Once the $7,500 cap 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.
Nursing	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. 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

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	ongoing chronic conditions such as medication administration and supervising delegated tasks. This broadens the scope of these services beyond extended State plan services.
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. 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. 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.
Personal Assistance Services	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. 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. 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. 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

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	not be provided to members residing in adult foster care homes, assisted living facilities, or during the same designated hours or time period a member receives respite care.
Physical Therapy	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. 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.
Respite	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. 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.
Speech, Hearing, and Language Therapy	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.
Support Consultation	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 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.

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	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. 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.
Supported Employment Services	Assistance provided, in order to sustain competitive employment, to an individual who, because of a disability, requires intensive, ongoing support to be self-employed, work from home, or perform in a work setting at which individuals without disabilities are employed. Supported employment includes adaptations, supervision, training related to an individual's assessed needs, and earning at least minimum wage (if not self-employed). In the state of Texas, this service is not available to individuals receiving waiver services under a program funded under section 110 of the Rehabilitation Act of 1973. Documentation is maintained in the individual's record that the service is not available to the individual under a program funded under the Individuals with Disabilities Education Act (20 U.S.C. §1401 et seq.). A supported employment service provider must satisfy one of these options: Option 1: • a bachelor's degree in rehabilitation, business, marketing, or a related human services field; and • six months of documented experience providing services to people with disabilities in a professional or personal setting. Option 2: • an associate's degree in rehabilitation, business, marketing, or a related human services field; and • one year of documented experience providing services to people with disabilities in a professional or personal setting. Option 3: • a high school diploma or GED, and

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	• two years of documented experience providing services to people with disabilities in a professional or personal setting
Transition Assistance Services	Transition Assistance Services pay for non-recurring, set-up expenses for members transitioning from nursing homes to the STAR+PLUS HCBS program. 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.

Attachment B

Texas Healthcare Transformation and Quality Improvement Program Demonstration Waiver Evaluation Design Plan

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As Required by

Centers for Medicare and Medicaid Services

Texas Health and Human Services Commission

Office of Data, Analytics, and Performance

April 22, 2025

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1. Background and Introduction

Medicaid in Texas

Texas has the second largest population in the United States and operates the third largest Medicaid program in the country (Centers for Medicare and Medicaid Services, 2020). In State Fiscal Year (SFY) 2019, the Texas Health and Human Services Commission (HHSC) provided Medicaid benefits to approximately 4.3 million people (Texas Health and Human Services Commission, 2020). That same year, the Texas Medicaid program cost the state and federal governments a combined total of approximately $65 billion, accounting for 27 percent of the state budget (Texas Health and Human Services Commission, 2020).

One of the most significant issues facing the Texas Medicaid program is coordination of the healthcare system—specifically, how to provide coordinated, high quality services while containing costs. A lack of care coordination can lead to less effective use of care, resulting in increased costs for a program that already represents over one-quarter of the state's annual budget. Given the scope and importance of the Medicaid program in providing care to Texans, it is vital to maximize efficiency and stabilize system funding while supporting cost-effective access, coordination, and quality of care.

History of the Texas 1115 Demonstration

The 82nd Texas Legislature, 2011, directed HHSC to expand Medicaid managed care (MMC) statewide and preserve supplemental payments for hospitals (Texas Health and Human Services Commission, 2020). In response to these directives, HHSC applied for an 1115 demonstration waiver titled the "Texas Healthcare Transformation and Quality Improvement Program" (Demonstration) and received approval from the Centers for Medicare and Medicaid Services (CMS) for a five-year Demonstration in December 2011. The goals of the initial Demonstration were 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.
- Transition to quality-based payment systems across managed care and providers.

The Demonstration has been renewed and extended several times since its original approval. Table 1 shows the key dates of the Demonstration.

Table 1. Texas 1115 Demonstration Key Dates

Description	Approval Date	Demonstration Authorized Through
Initial Approval	December 12, 2011	September 30, 2016
15-Month Extension	May 1, 2016	December 31, 2017
Renewal	December 21, 2017	September 30, 2022
Ten-Year Extension	January 15, 2021	September 30, 2030

Focus of the Demonstration Extension

From 2011 to 2021, the Demonstration included three components: MMC expansion, the Delivery System Reform Incentive Payment (DSRIP) pool, and the Uncompensated Care (UC) pool. Together, these components played a critical role in transforming the state healthcare system over the life of the Demonstration. The three components improved care delivery and the efficient use of Medicaid funds through MMC expansion, created a broad-scale effort to drive quality improvement and incentivize provider innovation under the DSRIP program, and established critical financial supports for Medicaid providers through the UC pool.

While the state has made significant progress towards the goals set forth in the initial Demonstration, the objectives of the Demonstration remain ongoing priorities that continue to guide state efforts in the Medicaid program. The Demonstration Extension (Extension) approved on January 15, 2021 allows Texas continued flexibility to pursue these goals. Specific aims of the Extension include transitioning additional services to MMC while improving the overall quality of the MMC service delivery model, promoting access to care and value-based incentives achieved under DSRIP, and sustaining the financial stability of Medicaid providers.

To meet these aims, the Extension will make significant changes to previous Demonstration components, including:

- The expiration of the DSRIP program on September 30, 2021 and the implementation of four new Directed Payment Programs (DPPs).
- The implementation of a new supplemental payment program (SPP), titled the Public Health Provider Charity Care Pool (PHP-CCP) program, on October 1, 2021.

The Extension will facilitate MMC expansion for additional services and populations and will continue the UC pool. Figure 1 below depicts the key demonstration components over time.

MMC, DPPs, and two SPPs comprise the three main components of the Extension:

- Medicaid Managed Care
- Directed Payment Programs
  - Comprehensive Hospital Increased Reimbursement Program (CHIRP)

    - Directed Payment Program for Behavioral Health Services (DPP BHS)
    - Rural Access to Primary and Preventative Services (RAPPS)
    - Texas Incentives for Physician and Professional Services (TIPPS)
    - Quality Incentive Payment Program (QIPP)
- Supplemental Payment Programs
    - Uncompensated Care Program[1]
    - Public Health Provider Charity Care Pool Program

Additional details on components included in the Extension, as well as evaluation implications, are provided in subsequent sections.

[1] The UC Pool transitioned to charity care only in DY9.

Figure 1. Demonstration Overview

Demonstration Component	Initial Demonstration Period 5 Years: December 2011-September 2016					15-Month Extension	Demonstration Renewal Period 3 Years: January 2018-January 2021[1]			Demonstration Extension Period 10 Years: January 2021-September 2030										
	DY1	**DY2**	**DY3**	**DY4**	**DY5**	**DY6**	**DY7**	**DY8**	**DY9**	**DY10**	**DY11**	**DY12**	**DY13**	**DY14**	**DY15**	**DY16**	**DY17**	**DY18**	**DY19**
	FFY 2012	FFY 2013	FFY 2014	FFY 2015	FFY 2016	FFY 2017	FFY 2018	FFY 2019	FFY 2020	FFY 2021	FFY 2022	FFY 2023	FFY 2024	FFY 2025	FFY 2026	FFY 2027	FFY 2028	FFY 2029	FFY 2030
MMC[2]	PCCM ended STAR statewide expansion STAR+PLUS expansion to Hidalgo & Lubbock SDAs		STAR+PLUS statewide expansion STAR+PLUS HCBS program implemented			STAR Kids MMC program implemented													
	Additional populations and benefits carved into MMC from DY1 to DY10[3]																		
										NEMT carved into MMC, DRTS provided with less than 48-hours' notice for certain trips, and increased opportunities for TNCs									
	FFY 2012	FFY 2013	FFY 2014	FFY 2015	FFY 2016	FFY 2017	FFY 2018	FFY 2019	FFY 2020	FFY 2021	FFY 2022	FFY 2023	FFY 2024	FFY 2025	FFY 2026	FFY 2027	FFY 2028	FFY 2029	FFY 2030
DSRIP	Project development and planning																		
			Projects implemented																
									Funding decrease										
										Funding decrease									
											DSRIP ends								
	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025	SFY 2026	SFY 2027	SFY 2028	SFY 2029	SFY 2030
DPPs							QIPP implemented												
								UHRIP Implemented											
											CHIRP, DPP BHS, RAPPS, and TIPPS implemented								
	FFY 2012	FFY 2013	FFY 2014	FFY 2015	FFY 2016	FFY 2017	FFY 2018	FFY 2019	FFY 2020	FFY 2021	FFY 2022	FFY 2023	FFY 2024	FFY 2025	FFY 2026	FFY 2027	FFY 2028	FFY 2029	FFY 2030
UC	UPL program ended New UC reporting tool implemented: Focus shifted *from* claims for UC charges *to* UC costs																		
									Shift to reimbursement of UC costs for charity care provided to uninsured individuals only									
											UC Pool Resizing Establish amount for 2022-2026								
																UC Pool Resizing Establish amount for 2027-2030			
	FFY 2012	FFY 2013	FFY 2014	FFY 2015	FFY 2016	FFY 2017	FFY 2018	FFY 2019	FFY 2020	FFY 2021	FFY 2022	FFY 2023	FFY 2024	FFY 2025	FFY 2026	FFY 2027	FFY 2028	FFY 2029	FFY 2030
PHP-CCP											PHP-CCP Implementation								
													PHP-CCP Resizing Establish amount for 2024-2028						
																		PHP-CCP Resizing Establish amount for 2029-2030	

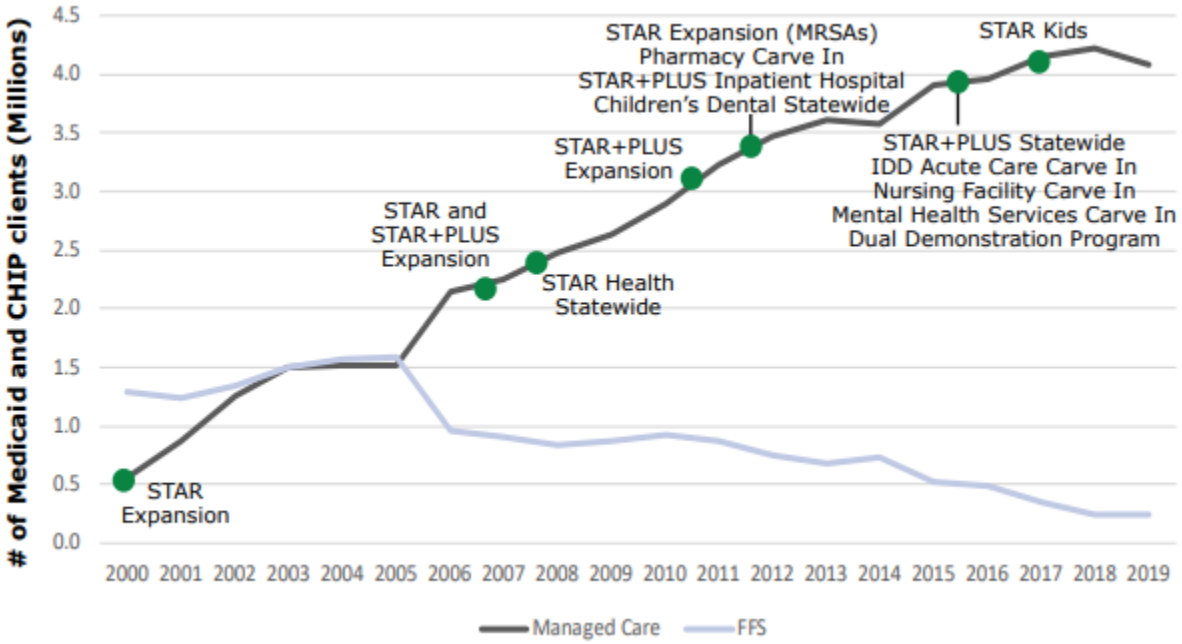
Notes. [1] The Demonstration Renewal Period was originally approved for five years through September 2022, however the Renewal Period ended upon approval of the Extension on January 15, 2021. [2] MMC section only includes expansion activities included in the evaluation at the time of writing. This figure will be updated, as necessary, to reflect future changes to MMC. [3] Additional populations and services Texas carved into MMC during the first 10 years of the Demonstration include pharmacy benefits, non-behavioral health inpatient hospital stays, children's dental services, nursing facility services, mental health targeted case management and rehabilitative services, acute care for individuals with intellectual and developmental disabilities, adoption assistance, permanency care assistance, and the Medicaid for Breast and Cervical Cancer program.

DY=Demonstration year, October 1-September 30; MMC=Medicaid managed care; FFY=Federal fiscal year, October 1-September 30; PCCM=Primary care case management; STAR=MMC program primarily serving children and pregnant women; STAR+PLUS=MMC program serving aged and disabled clients; SDA=Service delivery area; HCBS= Home and community-based services; STAR Kids=MMC program serving disabled individuals 20 years and younger; NEMT=Nonemergency medical transportation; DRTS=Demand response transportation services; TNC=Transportation network company; LTSS=Long-term services and supports; IDD=Intellectual or developmental disability; CMS=Centers for Medicare and Medicaid; DSRIP=Delivery System Reform Incentive Payment; DPP=Directed payment program; SFY=State fiscal year, September 1-August 31; QIPP=Quality Incentive Payment Program; UHRIP=Uniform Hospital Rate Increase Program; CHIRP=Comprehensive Hospital Increased Reimbursement Program; DPP BHS=Directed Payment Program for Behavioral Health Services; RAPPS=Rural Access to Primary and Preventive Services; TIPPS=Texas Incentives for Physician and Professional Services; UC=Uncompensated Care; UPL=Upper payment limit; PHP-CCP=Public Health Provider Charity Care Pool.

Medicaid Managed Care

Texas has operated various MMC programs since 1993, beginning with the implementation of STAR in Travis, Chambers, Jefferson, and Galveston counties. Since that time, Texas has vastly expanded its managed care delivery system, with the majority of these changes occurring under the Demonstration. Beginning in federal fiscal year (FFY) 2012, three changes to Texas Medicaid programs were implemented as part of the Demonstration: (1) the primary care case management health care delivery model ended; (2) the STAR MMC program, which provides coverage primarily to children and pregnant women, expanded statewide; and (3) the STAR+PLUS MMC program, which provides services to older adults and people with disabilities, expanded to two new service areas. As the Demonstration evolved, Texas expanded STAR+PLUS statewide and incorporated new services and populations into STAR+PLUS. Texas also implemented a new MMC program, STAR Kids, to provide services to children and young adults with disabilities. Additionally, Texas carved in new populations and services from traditional fee-for-service (FFS) into MMC programs over the course of the Demonstration. For example, pharmacy benefits, non-behavioral health inpatient hospital stays, children's dental services, nursing facility services, mental health targeted case management and rehabilitative services, acute care for individuals with intellectual and developmental disabilities, individuals receiving adoption assistance, individuals receiving permanency care assistance, and the Medicaid for Breast and Cervical Cancer program have all been carved into MMC under the Demonstration. HHSC has also been granted a series of amendments to make the MMC service delivery model easier for beneficiaries to navigate, such as allowing certain individuals to choose between MMC programs (e.g., Former Foster Care Children ages 18 to 20 years who meet STAR Kids criteria are allowed to choose between STAR Health and STAR Kids). Figure 2 depicts Texas's transition from FFS to MMC over the past 20 years. Collectively, Texas's efforts to transition populations and services into MMC have been successful; as of December 2020, 94 percent of Medicaid clients were enrolled in MMC (Texas Health and Human Services Commission, 2020).

Figure 2. Texas MMC Growth Over Time[1]



Source. [1] Medicaid caseloads experienced declines beginning in 2018 due to sustained positive economic conditions and record low unemployment rates. Texas Health and Human Services Commission (2020). Texas Medicaid and CHIP in Perspective: 13th Edition. Austin, TX: Texas Health and Human Services Commission.
MMC=Medicaid managed care; CHIP=Children's Health Insurance Program; STAR=MMC program primarily serving children and pregnant women; STAR+PLUS=MMC program serving aged and disabled clients; STAR Health=MMC program for individuals under or transferring out of conservatorship or foster care; STAR Kids=MMC program serving disabled individuals 20 years and younger; IDD=Intellectual or developmental disability; FFS=Fee-for-service.

Previous research has shown that MMC is designed to improve access to care, quality of care, and care coordination; increase Medicaid budget predictability; and reduce Medicaid spending (The Henry J. Kaiser Family Foundation, 2015). However, as Texas's MMC service delivery model matures, comparisons to historical FFS programs become less informative for driving ongoing program improvement processes. Since MMC is the primary service delivery model for Texas Medicaid beneficiaries, it is imperative to monitor and improve the MMC service delivery model. Throughout the Demonstration, HHSC has implemented new performance-based quality initiatives to help HHSC and MMC Managed Care Organizations (MCOs) identify areas for improvement in the MMC service delivery model. Taken together, these initiatives are designed to promote the expansion of quality-based payments and coordinated care delivery within the MMC delivery system. Appendix C summarizes MMC-related quality initiatives at the time of writing.

During the Extension, Texas will continue to transition additional services and populations into MMC and enhance the current MMC service delivery model to better meet the needs of beneficiaries. Texas will undergo five legislative sessions during the Extension,[2] which may significantly alter the MMC landscape. Some future legislative actions may substantially alter the service delivery model for MMC beneficiaries, warranting new evaluation questions and hypotheses, while others may not. This evaluation design is meant to span the entire Extension period; however, the MMC evaluation component presented here reflects MMC priorities at the time of writing. Should future MMC changes or initiatives necessitate adjustments to existing plans, or the development of new evaluation questions or hypotheses, this evaluation design will be revised accordingly.[3]

At the time of writing, there are three previously unevaluated changes to MMC which substantially altered, or would substantially alter, the service delivery model for MMC beneficiaries:[4]

- **STAR+PLUS Home and Community-Based Services (HCBS)**: On September 1, 2014, STAR+PLUS HCBS replaced a predecessor program operating under the Community Based Alternatives waiver.[5] STAR+PLUS HCBS provides LTSS in a community setting for individuals who meet a nursing facility level of care. LTSS provided through STAR+PLUS HCBS include but are not limited to nursing services, personal assistance services, adaptive aids, medical supplies, and minor home modifications.[6] Additionally, on November 16, 2023, CMS approved an amendment to the Demonstration allowing up to 150 medically fragile individuals enrolled in STAR+PLUS HCBS to receive services beyond the individual cost cap.
- **Nonemergency Medical Transportation (NEMT)**: On June 1, 2021, MCOs began providing all NEMT services for MMC beneficiaries. In addition, MCOs began providing demand response transportation services (DRTS) for certain

[2] At the time of writing, the 87th Texas Legislature, Regular Session, 2021, had recently concluded. Texas will also convene four additional regular legislative sessions during the Extension (88th session in 2023, 89th session in 2025, 90th session in 2027, and the 91st session in 2029); special sessions may also be convened at the direction of the governor.
[3] The 87th Texas Legislature passed multiple bills requiring changes to MMC. Some bills impacting MMC will require 1115 waiver amendments and state plan amendments. This evaluation design will be revised to include evaluation questions and hypotheses on pending bill implementations and forthcoming changes to MMC as a result of the 87th Texas Legislature, as necessary, at a later date.
[4] This is not a comprehensive list of Demonstration amendments requested by HHSC. A full list of Texas 1115 wavier amendments can be found at: https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/83231
[5] STAR+PLUS HCBS began during the Initial Demonstration Approval Period, but is included in the current evaluation because it was not evaluated in previous Demonstration approval periods and reflects CMS research interests.
[6] The full list of services provided through STAR+PLUS HCBS are accessible via: https://www.hhs.texas.gov/handbooks/starplus-program-support-unit-operational-procedures-handbook/8100-home-community-based-services

trips with less than 48-hours' notice and HHSC increased opportunities for transportation network companies (TNCs) to provide DRTS.[7] HHSC anticipates the expanded participation of TNCs will increase NEMT utilization and the shift to MCO coordination will improve the overall NEMT service delivery model.

- **Case Management for Children and Pregnant Women (CPW)**: On September 1, 2022,[8] MCOs began contracting with and reimbursing CPW providers for billable case management services. The transition of the CPW benefit from FFS to managed care encourages the maintenance of a coordinated care delivery system through coordination of case management services that are available to a beneficiary (through MCOs and CPW providers). A stand-alone evaluation of CPW services is being conducted by HHSC's Office of Data, Analytics, & Performance. The evaluation design for the CPW-specific assessment is provided in Appendix I. Findings from the stand-alone evaluation of CPW services will be included as an appendix to all evaluation deliverables.

In summary, previous MMC evaluation components of the Demonstration focused primarily on service changes among Medicaid clients whose benefits transitioned from FFS to MMC. However, as MMC has become the service delivery model for most Medicaid beneficiaries, inquiries into individuals transitioning from FFS to MMC are less frequent, increasingly population-specific, and less generalizable to the entire MMC population. In order to ensure findings from the MMC evaluation component are relevant, useful, and well-tailored to the overall goals of the Demonstration, HHSC expanded the scope of the MMC evaluation component during the Extension to assess the quality of Texas MMC in its entirety. This macro-level approach to the MMC evaluation will provide insight into the performance of MMC programs for the Demonstration as a whole, a perspective not explored in previous Demonstration evaluation plans.

[7] A transportation network company means a corporation, partnership, sole proprietorship, or other entity that, for compensation, enables a passenger to prearrange with a driver, exclusively through the entity's digital network, a digitally prearranged ride (e.g., Uber or Lyft; Texas Occupations Code, 2402.001).

[8] MCOs began overseeing CPW services on September 1, 2022, in accordance with House Bill 133, 87th Legislature, Regular Session, 2021, which mandated that HHSC implement a seamless transition of CPW services from FFS to managed care without any interruption in services. HHSC submitted an amendment to CMS to allow CPW services to be delivered via managed care under the THTQIP Demonstration on May 5, 2022, and CMS approved the amendment on November 16, 2023.

Directed Payment Programs

DSRIP provides incentive payments to providers who engage in innovations and reforms that improve access to care, quality of care, and population health outcomes. The DSRIP pool expired on September 30, 2021.[9] As a part of the DSRIP transition plan, Texas developed a series of DPPs to sustain key DSRIP initiative areas and support further delivery system reform after DSRIP expires.

Before the expiration of the DSRIP pool, Texas operated QIPP and the Uniform Hospital Rate Increase Program (UHRIP). QIPP will continue operating under the Extension; however, in accordance with the DSRIP transition plan, the state transitioned UHRIP to an expanded DPP called CHIRP, and developed three additional DPPs (DPP BHS, RAPPS, and TIPPS) to further support delivery system reform.

Supplemental Payment Programs

Uncompensated Care Pool

Uncompensated care refers to costs associated with hospital care for which no payment was received from the patient or insurer. These payment shortages fall into two categories: charity care and bad debt. Charity care is unreimbursed costs to hospitals for services provided to low-income individuals for free or at reduced prices; hospitals assume minimal payment on behalf of the patient. Bad debt refers to uncollectible inpatient and outpatient charges that result from the extension of credit to the patient after the facility expected payment for care. The possible fiscal impact of uncompensated care on hospitals that serve indigent persons and the entities who reimburse the facilities can be significant. Nationally, UC costs have more than doubled over the past two decades, from $17 billion in 1995 to $42 billion in 2019 (American Hospital Association, 2021).

On October 1, 2011, Texas replaced the previous Upper Payment Limit program with the UC program as part of an effort to facilitate the expansion of MMC while continuing to make supplemental payments to hospitals. Texas UC payments were used to reduce the actual uncompensated cost of medical services for both charity care and bad debt (Texas Health and Human Services Commission, 2021). The UC program payment methodology remained consistent from Demonstration Year (DY) 1 to DY8, but transitioned to a charity care only model at the beginning of DY9. The UC program now focuses exclusively on reimbursing costs associated with medical services provided under a provider's charity care policy; cost reimbursements associated with bad debt or Medicaid shortfall were retired. Prior to the transition to charity care only, HHSC implemented UHRIP, a directed payment program requiring MMC MCOs to pay increased reimbursement rates for certain hospital services

[9] The final DSRIP measurement period incorporates calendar year (CY) 2021. Final payments are scheduled for January 2023.

provided to STAR and STAR+PLUS members.[10] The expansion of UHRIP statewide roughly coincided with the termination of Medicaid shortfall, helping to offset potential financial losses for Texas hospitals.

To receive payments from the UC program, a Medicaid provider must complete an application listing its uncompensated costs for charity care services provided. A hospital may claim uncompensated costs for inpatient and outpatient services, as well as related costs for physician, and pharmacy services. This UC payment methodology based only on charity care will continue throughout the Extension. However, the UC program will undergo pool resizing for FFYs 2023-2027, and then again for FFYs 2028-2030, with the latter resizing based on the most recent charity care costs from eligible hospital providers.

Public Health Provider Charity Care Pool Program

In addition to the UC program, the Extension will provide new authority for the state to receive federal financial participation for payments made through the PHP-CCP program starting October 1, 2021. Texas developed the PHP-CCP program as part of the DSRIP transition plan to continue financial support for local public providers following the expiration of the DSRIP pool. The PHP-CCP program will provide supplemental payments to publicly-owned and operated community mental health clinics (CMHCs), local behavioral health authorities (LBHAs), local mental health authorities (LMHAs), local health departments (LHDs), and public health districts (PHDs). These payments are intended to help defray uncompensated care costs associated with furnishing medical services to Medicaid eligible or uninsured individuals incurred by qualifying providers following the expiration of the DSRIP pool on September 30, 2021.[11]

During the first year of the PHP-CCP program, payments may be used to defray actual uncompensated care costs, including Medicaid shortfall and bad debt. Starting October 1, 2022, PHP-CCP program payments may only be used to defray costs associated with services provided to patients under the provider's charity care policy. The PHP-CCP program will undergo pool resizing for FFYs 2024-2028, and then again for FFYs 2029-2030, based on a reassessment of providers' uncompensated charity care costs. Similar to the UC program, a provider must submit an annual application to the state containing cost and payment data on services eligible for reimbursement under the PHP-CCP program.

[10] UHRIP was piloted in two service areas on December 1, 2017 and implemented statewide beginning March 1, 2018 (DY7).

[11] PHP-CCP program providers may also participate in DPPs. However, since PHP-CCP eligible providers serve high rates of uninsured individuals, the payments available through DPPs may be lower than payments received under DSRIP. HHSC developed the PHP-CCP program to extend financial stability to PHP-CCP eligible providers following the expiration of DSRIP.

Focus of the Evaluation

The current evaluation, as outlined in this evaluation design plan, focuses primarily on the Extension period (FFY 2021 to FFY 2030). The evaluation builds on prior research conducted during the renewal period, where applicable, for policies and flexibilities carried forward from the previous demonstration approval period. The evaluation focuses on the MMC and SPP components of the extension; because the DPPs are independently evaluated as outlined in Special Terms and Conditions (STCs) 31 and 35, they will not be directly assessed as part of the current evaluation.[12]

The evaluation of MMC will focus on recent or ongoing changes to Medicaid service delivery (e.g., the carve-in of NEMT and LTSS for certain beneficiaries), as well as an assessment of the overall quality of the MMC service delivery model. The evaluation of SPPs will focus on the efficacy of these programs in delivering critical financial support to providers, as well as the impacts of key policy changes on cost and health outcomes (e.g., the transition to charity care only and the introduction of the PHP-CCP program). Finally, the Overall Demonstration evaluation component will investigate cost outcomes for the Demonstration as a whole.

Together, these lines of inquiry will provide insight into whether the state continued making progress towards the goals set forth in the initial Demonstration and met the specific aims of the Extension. Additionally, findings from the evaluation may guide future improvements to the state's healthcare system.

[12] Texas's evaluation of the DPPs will comply with requirements under 42 C.F.R §§ 438.6(c)(2)(ii)(D) and 438.340.

2. Evaluation Questions and Hypotheses

Texas developed a series of evaluation questions to assess state performance on the objectives of the Demonstration. The evaluation questions also promote the objectives of Title XIX by examining how quality-based payment systems and the expansion of MMC services support individuals in Texas Medicaid. Table 2 shows the alignment between Demonstration objectives, the main components of the Extension, and corresponding evaluation questions.

Table 2. Demonstration Alignment

Demonstration Objective	Demonstration Component	Evaluation Question(s)
Expand risk-based managed care to new populations and services.	MMC	Did programmatic changes associated with the carve-in of NEMT into MMC improve health care outcomes for MMC clients? Does STAR+PLUS HCBS improve health care outcomes for MMC clients?
Support the development and maintenance of a coordinated care delivery system.	MMC	Did the MMC service delivery model improve access to and quality of care over time?
Improve outcomes while containing cost growth.	MMC SPP	Do the SPPs financially support providers serving the Medicaid and charity care populations? Did the implementation of UHRIP support the hospital delivery system during the transition of the UC program to charity care only? What are the costs of providing health care services to Medicaid beneficiaries served under the Demonstration? What are the administrative costs of implementing and operating the Demonstration? How do directed and supplemental payment programs support providers and overall Medicaid program sustainability?

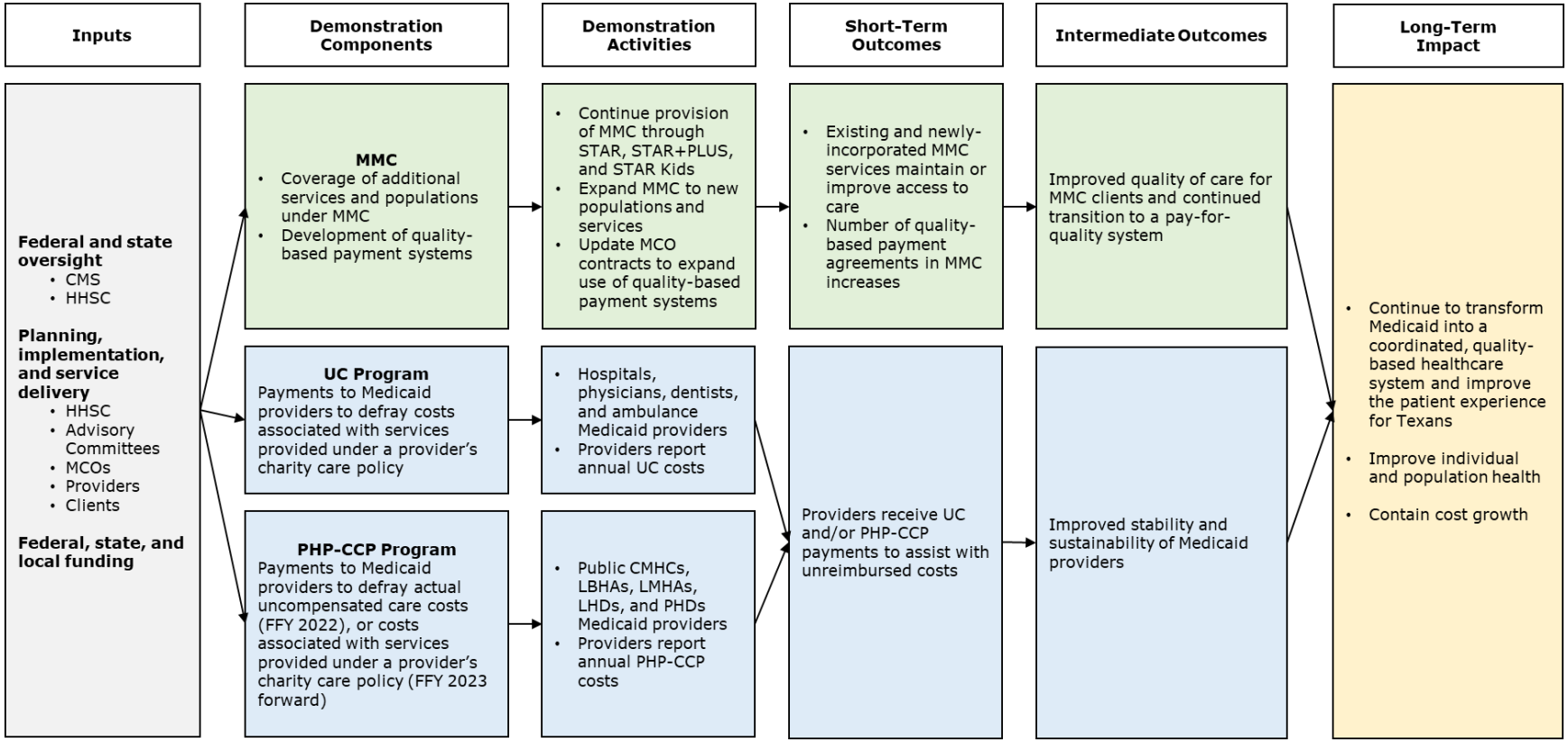
Demonstration Objective	Demonstration Component	Evaluation Question(s)
Transition to quality-based payment systems across managed care and providers.	MMC	Did Texas's quality initiatives impact the development and implementation of quality-based payment systems?

Notes. MMC=Medicaid managed care; DSRIP=Delivery System Reform Incentive Payment; SPP=Supplemental Payment Program; UHRIP=Uniform Hospital Rate Increase Program; UC=Uncompensated Care.

Logic Model

The logic model (Figure 3) illustrates the theory of change, or the pathways through which the Demonstration will work to achieve short-term, intermediate, and long-term outcomes during the Extension.

Figure 3. Demonstration Logic Model



Notes. CMS=Centers for Medicare and Medicaid Services; HHSC=Health and Human Services Commission; MCO=Managed care organization; MMC=Medicaid managed care; STAR=MMC program for children, newborns, and pregnant women; STAR+PLUS=MMC program for individuals age 21 and older with disabilities and individuals age 65 or older; STAR Kids=MMC program for children and adults age 20 and younger with a disability; UC=Uncompensated Care; PHP-CCP=Public Health Provider Charity Care Pool; FFY=Federal fiscal year, October 1-September 30; CMHC=Community Mental Health Clinic; LBHA=Local Behavioral Health Authority; LMHA=Local Mental Health Authority; LHD=Local Health Departments; PHD=Public Health District.

Evaluation Questions

The evaluation design plan for the Extension includes 9 evaluation questions and 23 hypotheses. The evaluation questions and hypotheses are grouped by the main components of the Extension. Each evaluation question is addressed through a minimum of one corresponding hypothesis and measure. Targets for improvement (e.g., improvement over baseline or pre-period) vary across evaluation measures. Additional details on measure-specific targets for improvement are provided in the Methodology section of this evaluation design plan, as well as Appendix E.

MMC Component

Evaluation Question 1. Did the programmatic changes associated with the carve-in of NEMT into MMC improve health care outcomes for MMC clients?

H1.1. Utilization of NEMT services will increase as a result of the programmatic changes associated with the carve-in of NEMT into MMC.

H1.2. Access to health care services will maintain or improve as a result of the programmatic changes associated with the carve-in of NEMT into MMC.

H1.3 Treatment of chronic, complex, and serious conditions will maintain or improve as a result of the programmatic changes associated with the carve-in of NEMT into MMC

H1.4. Preventable emergency department use will maintain or decrease as a result of the programmatic changes associated with the carve-in of NEMT into MMC.

H1.5. Experiences with transportation services will improve as a result of the programmatic changes associated with the carve-in of NEMT into MMC.

Evaluation Question 2: Does STAR+PLUS HCBS improve health care outcomes for MMC clients?

H2.1. STAR+PLUS HCBS serves a distinct population of MMC members.

H2.2. STAR+PLUS HCBS supports MMC members' treatment of chronic, complex, and serious conditions.

H2.3. STAR+PLUS HCBS supports MMC members' ability to make decisions about their everyday lives.

H2.4. STAR+PLUS HCBS supports MMC members' ability to self-direct their services.

H2.5. STAR+PLUS HCBS supports MMC members' satisfaction with their everyday lives.

Evaluation Question 3. Did the MMC service delivery model improve access to and quality of care over time?

H3.1. Access to preventive care will maintain or improve over time.

H3.2. Effective treatment of chronic, complex, and serious conditions will maintain or improve over time.

H3.3. Appropriate use of health care will maintain or improve over time.

H3.4. Poor care or care coordination which may result in unnecessary patient harm will maintain or reduce over time.

H3.5. MMC member experience will maintain or improve over time.

SPP Component

Evaluation Question 4. Do the SPPs financially support providers serving the Medicaid and charity care populations?

H4.1. The UC and PHP-CCP programs financially support Medicaid providers by reimbursing Medicaid or charity care costs in Texas.

H4.2. The UC and PHP-CCP programs support greater network adequacy and community health.

Evaluation Question 5. Did the implementation of UHRIP support the hospital delivery system during the transition of the UC program to charity care only?

H5.1. Hospital-based performance measures will maintain or improve following the transition to charity care only in DY9.

Overall Demonstration Component

Evaluation Question 6. What are the costs of providing health care services to Medicaid beneficiaries served under the Demonstration?

H6.1. The Demonstration results in overall savings in health care service expenditures.

Evaluation Question 7. What are the administrative costs of implementing and operating the Demonstration?

H7.1. Administrative costs required to implement and operate the Demonstration are relatively stable and reasonable over time.

Evaluation Question 8. How do directed and supplemental payment programs support providers and overall Medicaid program sustainability?

H8.1 The Demonstration leverages savings in health care service expenditures to administer directed and supplemental payment programs.

H8.2 The directed and supplemental payment programs support Medicaid provider operations and sustainability.

Evaluation Question 9. Did Texas's quality initiatives impact the development and implementation of quality-based payment systems?

H9.1. The implementation of alternative payment models (APMs) in Texas Medicaid will increase over time.

3. Methodology

Given the scope and breadth of the Demonstration, the evaluation design plan methodology is divided into three sections: one for each of the two main components of the Extension included in the evaluation (MMC and SPPs), as well as one Overall Demonstration component which investigates cost outcomes for the Demonstration as a whole. Each section includes information on the evaluation design, evaluation measures, study population(s), study period(s), data sources, analytic methods, and methodological limitations. Data, analytic methods, and reporting will meet traditional standards of scientific and academic rigor, as appropriate and feasible for each evaluation component.

Technical specifications for each evaluation measure are described in Appendix E. These specifications include the measure definition; study population; measure steward or source; technical specifications; exclusion criteria; data source or collection method; comparison group or subgroups, where applicable; analytic methods; interpretation; and benchmarks, where applicable.

The methodology described in this evaluation design plan may require changes to align with future innovations or modifications to the Medicaid landscape; in addition, changes may be required to execute the evaluation design plan after key data sources are assessed for completeness and proposed analytic methods are tested. Changes to the evaluation design plan will be documented in Appendix A.

MMC Evaluation Methods

The MMC evaluation component will utilize a mixed-method approach to address evaluation questions focused on specific changes to the MMC service delivery model and Texas MMC in its entirety. This evaluation will span the entire Extension.[13] At the time of writing, the MMC evaluation component was guided by three evaluation questions: two assessing expansion of the MMC service delivery model to specific populations or services, and a third assessing the MMC program in its entirety.

[13] This evaluation design will be revised, as necessary, in incorporate future changes to the MMC service delivery system.

MMC Evaluation Design

The MMC evaluation component will rely on two quasi-experimental designs: a one-group posttest only design and a one-group pretest-posttest design.

- **One-Group Posttest Only Design:** Measures assessing STAR+PLUS HCBS and Texas's entire MMC program will be evaluated with a one-group posttest only design. This design will use consecutive population-based observations to describe changes among STAR+PLUS HCBS members, as well as MMC operation and performance over time. Measures evaluated through a one-group posttest only design will use descriptive statistics and descriptive trend analysis (DTA).
- **One-Group Pretest-Posttest Design:** Measures assessing NEMT will be evaluated with a one-group pretest-posttest design. This design will use repeated observations of outcome measures to monitor changes before and after the MMC change. Measures evaluated through a one-group pretest-posttest design will use descriptive statistics, DTA, and interrupted time series (ITS).

Table 3, Table 4, and Table 5 provide an overview of all MMC-specific evaluation questions and hypotheses aligned with their respective measures. The measures selected to assess the entire MMC program reflect the most commonly incentivized performance measures across the state's various MMC quality initiatives. These measures reflect the state's priorities in ongoing MMC performance improvement.[14] Subsequent sections provide additional information on the study populations, study periods, data sources, and analytic methods. Additional details for each of the proposed measures can be found in Appendix E.

[14] Evaluation measures selected for assessing Texas's MMC program are dependent on continuity of measure stewards and EQRO reporting. Changes in measure specifications or the EQRO contract may disrupt availability of measures over the entire Extension. This evaluation design may be revised, where applicable, if evaluation measures identified in the MMC evaluation component are discontinued.

Table 3. Evaluation Design Overview, Evaluation Question 1: Did the programmatic changes associated with the carve-in of NEMT into MMC improve health care outcomes for MMC clients?

Evaluation Hypothesis	Measure(s)	Study Population	Data Source(s) or Data Collection Method(s)	Analytic Methods
H1.1. Utilization of NEMT services will increase as a result of the programmatic changes associated with the carve-in of NEMT into MMC.	1.1.1 MMC members utilizing NEMT services per month/quarter 1.1.2 NEMT services per month/quarter 1.1.3 Average NEMT services per member per month/ quarter	• MMC members utilizing NEMT services	• FFS claims and MMC encounter data • Member-level enrollment files • Provider-level enrollment data	• Descriptive statistics • ITS • Subgroup analysis[1]
H1.2. Access to health care services will maintain or improve as a result of the programmatic changes associated with the carve-in of NEMT into MMC.	1.2.1 Adults' access to preventive/ ambulatory health services (HEDIS®-like) 1.2.2 Child and adolescent well-care visits (HEDIS®) 1.2.3 Utilization of pharmacy benefits	• MMC members utilizing NEMT services	• FFS claims and MMC encounter data • Member-level enrollment files • Member-level pharmacy data • Provider-level enrollment data	• Descriptive statistics • DTA • ITS • Subgroup analysis[1]

Evaluation Hypothesis	Measure(s)	Study Population	Data Source(s) or Data Collection Method(s)	Analytic Methods
H1.3. Treatment of chronic, complex, and serious conditions will maintain or improve as a result of the programmatic changes associated with the carve-in of NEMT into MMC.	1.3.1 Diabetes medication adherence 1.3.2 Testing HbA1c levels 1.3.3 Asthma Medication Ratio (HEDIS®)	• MMC members utilizing NEMT services	• FFS claims and MMC encounter data • Member-level enrollment files • Member-level pharmacy data	• Descriptive statistics • DTA • ITS, if feasible • Subgroup analysis[1]
H1.4. Preventable emergency department use will maintain or decrease as a result of the programmatic changes associated with the carve-in of NEMT into MMC.	1.4.1 Prevention quality overall composite (PQI #90) 1.4.2 Pediatric quality overall composite (PDI #90) 1.4.3 Rate of potentially preventable emergency department use	• MMC members utilizing NEMT services	• FFS claims and MMC encounter data • Member-level enrollment files • Provider-level enrollment data	• Descriptive statistics • DTA • ITS, if feasible • Subgroup analysis[1]

Evaluation Hypothesis	Measure(s)	Study Population	Data Source(s) or Data Collection Method(s)	Analytic Methods
H1.5. Experiences with transportation services will improve as a result of the programmatic changes associated with the carve-in of NEMT into MMC.	1.5.1. Familiarity with transportation services 1.5.2. Transportation-related barriers to care 1.5.3. Satisfaction with transportation services	• MMC members utilizing NEMT services	• EQRO's Medical Transportation Program Client Satisfaction Survey	• Descriptive statistics • DTA

Notes. [1] Subgroup analysis will only be performed where applicable. NEMT=Nonemergency medical transportation; MMC=Medicaid managed care; FFS=Fee-for-service; ITS=Interrupted time series; HEDIS®=Healthcare Effectiveness Data and Information Set; DTA=Descriptive trend analysis; PQI=Prevention quality indicators; PDI=Pediatric quality indicators; EQRO=Texas's External Quality Review Organization.

Table 4. Evaluation Design Overview, Evaluation Question 2: Does STAR+PLUS HCBS improve health care outcomes for MMC clients?

Evaluation Hypothesis	Measure(s)	Study Population	Data Source(s) or Data Collection Method(s)	Analytic Methods
H2.1. STAR+PLUS HCBS serves a distinct population of MMC members.	2.1.1 MMC members enrolled in STAR+PLUS HCBS 2.1.2 Medically fragile individuals enrolled in STAR+PLUS HCBS	• STAR+PLUS HCBS members	• Member-level enrollment files • STAR+PLUS HCBS administrative data	• Descriptive statistics • DTA • Subgroup analysis[1]
H2.2. STAR+PLUS HCBS supports MMC members' treatment of chronic, complex, and serious conditions.	2.2.1 Diabetes care measures (HEDIS®) 2.2.2 Statin therapy for patients with cardiovascular disease (HEDIS®) 2.2.3 Antidepressant medication management (HEDIS®) 2.2.4 Follow-up after hospitalization for mental illness (HEDIS®) 2.2.5 Initiation and engagement of alcohol and other drug dependence treatment (HEDIS®)	• STAR+PLUS HCBS members	• EQRO-calculated MMC performance measures	• Descriptive statistics • DTA
H2.3. STAR+PLUS HCBS supports MMC members' ability to make decisions about their everyday lives.	2.3.1 Percentage of people who are able to get up and go to bed when they want to 2.3.2 Percentage of people who are able to eat their meals when they want to 2.3.3 Percentage of people who never feel in control of their lives	• STAR+PLUS HCBS members	• NCI-AD™	• Descriptive statistics • DTA

Evaluation Hypothesis	Measure(s)	Study Population	Data Source(s) or Data Collection Method(s)	Analytic Methods
H2.4. STAR+PLUS HCBS supports MMC members' ability to self-direct their services.	2.4.1 Percentage of people who can choose when they get services 2.4.2 Percentage of people who can choose their paid support staff	• STAR+PLUS HCBS members	• NCI-AD™	• Descriptive statistics • DTA
H2.5. STAR+PLUS HCBS supports MMC members' satisfaction with their everyday lives.	2.5.1 Percentage of people who like where they live 2.5.2 Percentage of people who like how they spend their time during the day 2.5.3 Percentage of people whose services help them live a better life	• STAR+PLUS HCBS members	• NCI-AD™	• Descriptive statistics • DTA

Notes. [1] Subgroup analysis will only be performed where applicable. STAR+PLUS=MMC program serving aged and disabled clients; HCBS= Home and community-based services; MMC=Medicaid managed care; DTA=Descriptive trend analysis; HEDIS®=Healthcare Effectiveness Data and Information Set; EQRO=Texas's External Quality Review Organization; NCI-AD™=National Core Indicators – Aging and Disabilities.

Table 5. Evaluation Design Overview, Evaluation Question 3: Did the MMC service delivery model improve access to and quality of care over time?

Evaluation Hypothesis	Measure(s)	Study Population	Data Source(s) or Data Collection Method(s)	Analytic Methods
H3.1. Access to preventive care will maintain or improve over time.	3.1.1 Childhood immunization status (HEDIS®) 3.1.2 Immunizations for adolescents (HEDIS®) 3.1.3 Prenatal and postpartum care (HEDIS®) 3.1.4 Cervical cancer screening (HEDIS®) 3.1.5 Breast cancer screening (HEDIS®)	• STAR • STAR+PLUS • STAR Kids	• EQRO-calculated MMC performance measures	• Descriptive statistics • DTA • Subgroup analysis[1]
H3.2. Effective treatment of chronic, complex, and serious conditions will maintain or improve over time.	3.2.1 Comprehensive diabetes care (HEDIS®) 3.2.2 Controlling high blood pressure (HEDIS®) 3.2.3 Follow-up care for children prescribed ADHD medication (HEDIS®) 3.2.4 Antidepressant medication management (HEDIS®) 3.2.5 Follow-up after hospitalization for mental illness (HEDIS®) 3.2.6 Initiation and engagement of alcohol and other drug dependence treatment (HEDIS®)	• STAR • STAR+PLUS • STAR Kids	• EQRO-calculated MMC performance measures	• Descriptive statistics • DTA • Subgroup analysis[1]
H3.3. Appropriate use of health care will maintain or improve over time.	3.3.1 Potentially preventable admissions (3M) 3.3.2 Potentially preventable emergency department visits (3M)	• STAR • STAR+PLUS • STAR Kids	• EQRO-calculated MMC performance measures	• Descriptive statistics • DTA • Subgroup analysis[1]

Evaluation Hypothesis	Measure(s)	Study Population	Data Source(s) or Data Collection Method(s)	Analytic Methods
H3.4. Poor care or care coordination which may result in unnecessary patient harm will maintain or reduce over time.	3.4.1 Potentially preventable complications (3M) 3.4.2 Potentially preventable readmissions (3M)	• STAR • STAR+PLUS • STAR Kids	• EQRO-calculated MMC performance measures	• Descriptive statistics • DTA • Subgroup analysis[1]
H3.5. MMC member experience will maintain or improve over time.	3.5.1 Getting care quickly composite (CAHPS®) 3.5.2 Getting needed care composite (CAHPS®) 3.5.3 Rating of personal doctor (CAHPS®) 3.5.4 Rating of health plan (CAHPS®)	• STAR • STAR+PLUS • STAR Kids	• EQRO-calculated MMC performance measures	• Descriptive statistics • DTA • Subgroup analysis[1]

Notes. [1] Subgroup analysis will only be performed where applicable. MMC=Medicaid managed care; HEDIS®=Healthcare Effectiveness Data and Information Set; STAR=MMC program primarily serving children and pregnant women; STAR+PLUS=MMC program serving aged and disabled clients; STAR Kids=MMC program serving disabled individuals 20 years or younger; EQRO=Texas's External Quality Review Organization; DTA=Descriptive trend analysis; CAHPS®=Consumer Assessment of Healthcare Providers and Systems.

MMC Study Populations

The MMC study population collectively refers to providers and members participating in the MMC delivery model. Evaluation questions focused on MMC service delivery changes will use eligibility and managed care enrollment criteria to identify study populations. Evaluation questions focused on the entire MMC program will center primarily on MMC program populations, but will also include a sample of MCOs and providers as part of primary data collection efforts. The units of analysis for the MMC evaluation component are MMC members, providers, and MCOs.

At the time of writing, the study population for MMC service delivery changes is:

- **MMC members utilizing NEMT services:** Prior to June 1, 2021, most MMC members received NEMT services through managed transportation organizations (MTOs) operating under the Medical Transportation Program.[15] On June 1, 2021, MCOs began providing all NEMT services for MMC beneficiaries. On this date, MCOs also began providing DRTS for certain trips with less than 48-hours' notice and increased opportunities for TNCs to provide DRTS. Evaluation measures assessing the impact of implementing NEMT through MMC will include all NEMT services (DRTS; non-DRTS rides, such as public transit; and non-ride services, such as meals, lodging, and air travel). If feasible, the external evaluator will create subgroups of members utilizing NEMT services to understand differing impacts of the NEMT carve-in on MMC members. Potential subgroups include:
  - *Pre- and Post-NEMT utilizers*: Members who utilized NEMT services prior to and after MMC implementation. This subgroup will provide insight into changes associated with the transition from FFS to MMC.
  - *Post-Only NEMT utilizers*: Members who began utilizing NEMT services only after MMC implementation. This subgroup will provide insight into impacts associated with receiving NEMT services through MMC.
- **STAR+PLUS HCBS members**: Starting September 1, 2014, STAR+PLUS HCBS fully replaced the Community Based Alternatives program. STAR+PLUS HCBS provides LTSS for qualifying members under the STAR+PLUS MMC program. To be eligible for STAR+PLUS HCBS, individuals must be 21 years or older, reside in Texas, be eligible for Medicaid, meet a nursing facility level of care, choose STAR+PLUS HCBS as an alternative to nursing facility services, and cannot be simultaneously enrolled in another HCBS waiver (e.g., Community Living Assistance and Support Services, Deaf-Blind with Multiple Disabilities, Home and Community-based Service, or Texas Home Living).
  - *Medically fragile individuals*: Medically fragile individuals are those ages 21 and older who qualify for nursing facility care, who are determined by a state assessment to have complex medical needs, and who have health

[15] MMC members in the Dallas/Fort Worth and Houston/Beaumont services areas received NEMT services through Full Risk Brokers. All other MMC members received NEMT services through MTOs.

care costs that exceed the individual cost limit of the STAR+PLUS HCBS program. HHSC submitted an amendment to allow services for medically fragile individuals to be delivered via managed care under on February 22, 2021. CMS approved the amendment on November 16, 2023.

The MMC study populations for the entire MMC program include members served through the following three MMC programs, as well as samples of MMC providers participating in a DPP and MCOs engaging in APMs:[16]

- **STAR:** STAR began in 1993 and is the primary managed care program providing acute care services to children, pregnant women, and some families. Sixty eight percent of Medicaid members are enrolled in STAR (Texas Health and Human Services Commission, 2020).
- **STAR+PLUS:** STAR+PLUS began in 1998 and provides acute care and LTSS to older adults, adults with disabilities, and women with breast or cervical cancer. Thirteen percent of Medicaid members are enrolled in STAR+PLUS (Texas Health and Human Services Commission, 2020).
- **STAR Kids:** STAR Kids began in 2016 and provides acute care and LTSS to children and adults age 20 and younger with disabilities. Four percent of Medicaid members are enrolled in STAR Kids (Texas Health and Human Services Commission, 2020).

Potential Comparison Groups

Although MMC eligibility has changed with the expansion of MMC into new service areas or populations, each point-in-time estimate in the evaluation includes all Medicaid members enrolled in MMC. Individuals not enrolled in MMC at a given point in time are systematically different from those enrolled in MMC; this form of selection bias is inherent to the eligibility criteria and presents significant problems for comparative analysis. As a result, no viable comparison group exists for the MMC program as a whole.

Analyses focused on MMC service delivery changes may allow for the use of a comparison group depending on the context of the change. At the time of writing, the MMC service delivery changes included in the MMC evaluation component (NEMT and STAR+PLUS HCBS) have been implemented statewide or among all eligible members, so equivalent comparison groups do not exist.[17] The evaluation of NEMT will use a historical cohort, however, to assess the transition from FFS to

[16] HHSC also administers MMC through STAR Health but this program is not included in the evaluation because it is outside the authority of the Extension.
[17] The state explored a comparison group of MMC members who did not utilize NEMT services, but individuals utilizing NEMT services differ from non-utilizers in observable demographic characteristics and, plausibly, non-observable non-medical drivers of health. This selection bias limits the utility of this potential comparison group in understanding the impacts of the carve-in of NEMT services.

MMC.[18] Potential comparison groups for future changes to the MMC landscape will be assessed as necessary. Should a future MMC service delivery change allow the use of a comparison group, this evaluation design will be updated accordingly.

State and national benchmarks will be leveraged, where feasible, to support interpretation of findings and to support understanding of changes in outcomes before and after service delivery changes to MMC amid key environmental confounds (e.g., the transition of NEMT services to MMC during the COVID-19 pandemic). Importantly, benchmarks at the state or national level may not be representative of MMC members and may not be available at the subgroup level (e.g. by race/ethnicity or age). As a result, direct comparisons between MMC members and state or national benchmarks should be interpreted with caution.

MMC Study Periods

Pre- and post-study periods for MMC service delivery changes will be anchored to the date when the change occurred. Pre- and post-study periods for the entire Texas MMC program reflect data points available for MMC programs prior to or after implementation of the Demonstration (2011). STAR Kids began in November 2016 so STAR Kids data are not available in the pre-Demonstration period (prior to 2011). Table 6 reflects the study periods for the MMC components at the time of writing.

Table 6. Study Periods for the MMC Evaluation Component

MMC Component	Study Population	Pre-Period[1]	Post-Period[1]
MMC Service Delivery Changes	MMC members utilizing NEMT services	September 1, 2017 – May 31, 2021	June 1, 2021 – May 31, 2026
	STAR+PLUS HCBS members	N/A	September 1, 2014 – December 31, 2029[2]
Texas MMC Program	STAR	September 1, 2006 – December 31, 2011[3]	January 1, 2012 - December 31, 2029[2]
	STAR+PLUS	September 1, 2006 – December 31, 2011[3]	January 1, 2012 - December 31, 2029[2]
	STAR Kids	N/A	January 1, 2017 – December 31, 2029[2]

Notes. [1] Measures may not all be available for the entire the pre- and post-periods. The external evaluator will use all data available for each measure. [2] The post-period ends on December 31, 2029, the last full calendar year before the Extension approval period ends. The external

[18] STAR+PLUS HCBS began September 1, 2014. Due to changes in medical coding, data reporting systems, and organizational oversight during the past eight years, it is not feasible to use a pre-2014 historical cohort for STAR+PLUS HCBS component of the evaluation.

evaluator may extend the post-period if additional data become available prior to the Summative Evaluation Report. [3] Prior to January 1, 2010, the EQRO calculated Texas MMC program measures each State Fiscal Year (September 1 – August 31). Starting January 1, 2010, the EQRO began calculating Texas MMC program measures each Calendar Year (January 1 – December 31). As a result, pre- and post-periods for Texas MMC program measures do not align with DYs. MMC=Medicaid managed care; NEMT=Nonemergency transportation; STAR+PLUS=MMC program serving aged and disabled clients; HCBS=Home and community-based services; STAR=MMC program primarily serving children and pregnant women; STAR Kids=MMC program serving disabled individuals 20 years or younger.

MMC Data Sources

The MMC evaluation component relies on a series of secondary data sources, including administrative data, survey data, and benchmark data, as outlined below.

- **Benchmark data:** The evaluation will leverage ongoing reporting of state and national benchmarks, where applicable, for contextual reference and to support understanding of MMC service delivery charges. The Texas Healthcare Learning Collaborative (THLC) online portal, aggregate HEDIS® results published by the National Committee for Quality Assurance and the Agency for Healthcare Research and Quality, and NCI-AD™ results published by ADvancing States and the Human Services Research Institute will be used to develop evaluation-specific benchmarks, where applicable.
- **EQRO-calculated MMC performance measures:** Texas's External Quality Review Organization (EQRO; The Institute for Child Health Policy (ICHP)) designed and operates the THLC Portal. The THLC portal is an online learning collaborative that includes a graphical user interface that allows the public, MCOs, and HHSC to visualize healthcare metrics. The THLC portal reports on MCO and Dental Maintenance Organization (DMO) performance across a variety of measures, including Healthcare Effectiveness Data and Information Set (HEDIS®), Consumer Assessment of Healthcare Providers and Systems (CAHPS®), and PPEs. The THLC Portal will be used to obtain MMC program-level outcome measures over time and subgroup estimates. ICHP will also calculate STAR+PLUS HCBS measures and additional subgroup estimates not already available on the THLC portal for the purpose of this evaluation.[19]
- **EQRO's Medical Transportation Program Client Satisfaction Survey:** Starting in SFY 2019, Texas's EQRO, in consultation with HHSC, developed and began administering a telephone survey to MMC members (children and adults) receiving NEMT services. The purpose of the survey is to evaluate MMC member experiences and satisfaction with transportation services. Survey results will include respondent demographic characteristics and item frequencies (both weighted and unweighted) by region and survey type (child and adult members).

[19] Additional information on MMC program-level outcome measures is presented in HHSC's Rider 61 Final Comprehensive Report: Evaluation of Medicaid and CHIP Managed Care, August 2018. This evaluation was conducted in partnership with Deloitte LLP and is accessible via: https://www.hhs.texas.gov/reports/2018/08/rider-61-evaluation-medicaid-chip-managed-care.

- **FFS claims and MMC encounter Data:** FFS claims and MMC encounter data have been processed by the Texas Medicaid and Healthcare Partnership (TMHP) since January 1, 2004. TMHP performs internal edits for data quality and completeness. The member-level claims/encounter data contain the Current Procedural Terminology (CPT) codes; the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) codes; place of service codes; and other information necessary to calculate outcome measures related to MMC service delivery changes. Claims and encounter data are adjudicated on an approximate eight-month time lag. Prior analyses with Texas data showed that, on average, over 96 percent of the claims and encounters are complete by that timeframe.
- **MCO APM reporting tool:** Starting September 1, 2018, HHSC required MCOs to report on their APM activities, both implemented and planned. Information from this tool will be used to learn about the types of APMs implemented throughout the Texas Medicaid program.
- **Member-level enrollment files:** The enrollment files contain information about the person's age, gender, race/ethnicity, county, health care service delivery model (i.e., FFS or MMC), MCO enrollment, and length of enrollment. The member-level enrollment files will be used to identify members and member-level subgroups for measures related to MMC service delivery changes. Member-level enrollment files are subject to an approximate eight-month time lag.
- **Member-level pharmacy data:** The member-level pharmacy data contain information about filled prescriptions, including the drug name, dose, date filled, number of days prescribed, and refill information. The member-level pharmacy will be used to calculate outcome measures related to MMC service delivery changes. Member-level pharmacy data are subject to an approximate one-month time lag.
- **National Core Indicators – Aging and Disabilities (NCI-AD™):** The NCI-AD™ is a survey that collects information about experiences with LTSS among individuals who are aging or who have a disability. The NCI-AD™ is a joint effort between ADvancing States (formerly the National Association of States United for Aging and Disabilities) and the Human Services Research Institute to provide states with reliable information on quality of life outcomes among LTSS recipients. Texas's EQRO began administering the NCI-AD™ biannually in 2015. The NCI-AD™ will be used to obtain STAR+PLUS HCBS measures over time.
- **Provider-level enrollment files:** Provider-level enrollment files contain information on National Provider Identifier (NPI), Texas Provider Identifier (TPI), provider location, provider type, and provider specialty. Provider data will be sourced from TMHP and an HHSC Structured Query Language (SQL) database, and are subject to a one-month lag. The provider-level enrollment files will be used to identify provider samples for the APM survey, and to develop provider-level subgroups for measures related to MMC service delivery changes.

- **STAR+PLUS HCBS administrative data:** HHSC will track the number of medically fragile individuals in STAR+PLUS HCBS, interest lists, if applicable, and Medicaid-paid services beyond the STAR+PLUS HCBS cost cap provided to medically fragile individuals. These data will be used to summarize medically fragile individuals enrolled in STAR+PLUS HCBS.

MMC Proposed Analytic Methods

Quantitative methods will be used for the MMC evaluation component. This section describes the proposed analytic strategies for examining the measures presented in Table 3, Table 4, and Table 5. Analytic methods will incorporate subgroup analyses (e.g., by age, race/ethnicity, region), and benchmarks where feasible, to strengthen the validity of observed outcomes. Additionally, the external evaluator should attempt to account for or provide context for historical programmatic factors such as amendments to the Demonstration (see Appendix H), the implementation or expiration of funding pools or payment programs which support the Medicaid system, and environmental and historical confounds (e.g., the Great Recession and the COVID pandemic), as applicable. Lastly, where feasible, the external evaluator should incorporate findings from previous evaluations of the Demonstration when there is overlap in measures to support an increased understanding of changes to the MMC program over time.

Descriptive Statistics

All MMC evaluation measures—except open-ended primary data collection questions—may be examined through a variety of descriptive and inferential statistics. Descriptive statistics include estimates of central tendency and dispersion. Potential inferential analyses include bivariate statistics, parametric tests (e.g., paired or unpaired t-tests), and non-parametric tests (e.g., McNemar's test, Wilcoxon signed-rank test). Importantly, some measures may not be suited to inferential statistics, such as those that rely on population-level data rather than a sample. The external evaluator will ensure the correct application of statistical testing depending on whether the data is population- or sample-based, whether the measure is categorical or continuous, and whether the data meet the assumptions of parametric tests (e.g., normality, independence).

Descriptive Trend Analysis

Texas has operated MMC in some capacity for over 25 years. Previous evaluation designs have conducted pre-post studies on the implementation of specific MMC programs or populations. Given the long-standing nature of MMC in the state of Texas, there is not a pre-period under the Demonstration that is free of MMC implementation, rendering preferred time-series designs such as ITS infeasible. DTA is an alternative approach to time-series analysis which plots and analyzes time-series data calculated at equally spaced intervals to explain patterns in selected measures over time. DTA typically focuses on identification and quantification of a trend through the use of correlation coefficients and ordinary

least squares regression. For outcome measures using DTA, the basic regression model is:

$$Y_t = \beta_0 + \beta_1 time + \beta_2 MMC\ transition + \beta_3 controls + \varepsilon_t$$

Where, $\beta_0$reflects the baseline level of the outcome at the beginning of the study period; $\beta_1 time$ estimates the trends in the outcome variable; when pre-period data is available, the external evaluator should add $\beta_2 MMC\ transition$, which reflects the impact of the MMC transition; and $\beta_3 controls$ reflects a vector of control variables the external evaluator may add to the DTA model. Potential control variables include client- or provider-level characteristics, or programmatic and historical factors, where feasible and necessary.

DTA will be used for all measures under Evaluation Questions 2 and 3, and measures under Evaluation Question 1 if the recommended minimum number of observations for ITS are not available (i.e., a minimum of eight pre- and eight post-MMC transition time points).

Interrupted Time Series

ITS analysis uses aggregate data collected over equally spaced intervals before and after a policy change to measure changes in outcomes over time. A key assumption of ITS is that data trends before the policy change can be extrapolated to predict trends had the policy change not occurred. If an MMC service delivery change has an impact on an outcome of interest, the post-transition trend will have a slope that is statistically different from the pre-transition trend. When properly executed, ITS is a valuable method to evaluate the success, failure, or unintended consequences of health care policy on outcomes (Lagarde, 2012). However, given the serial nature of ITS data, autocorrelation, nonstationarity, and seasonality need to be considered. Failing to assess and correct for these factors can lead to biased results (Wagner, Soumerai, Zhang, & Ross-Degnan, 2002). A key strength of ITS methodology is that a control site is not required, providing an alternate method of measuring the effect of an intervention "when randomization or identification of a comparison group are impractical" (Grimshaw, et al., 2003). The ITS method allows the target population to serve as its own comparison group in the pre-post analysis.

For outcome measures using ITS, the basic segmented regression model with one intervention or change point examines the outcome of interest (Y_t) over time, before and after the policy change:

$$Y_t = \beta_0 + \beta_1 time + \beta_2 MMC\ transition + \beta_3 postslope + \varepsilon_t$$

From the basic statistical model, β_0 reflects the baseline level of the outcome at the beginning of the pre-period; β_1 estimates the trend before the MMC transition; β_2 estimates the immediate impact of the MMC transition; and β_3 reflects the change in trend after the MMC transition. To ease interpretation, ITS results are presented as: baseline level, trend before MMC service delivery change, level change after MMC service delivery change, and trend after MMC service delivery change.

The external evaluator may add covariates to the ITS model to determine the effects of client- or provider-level characteristics, or programmatic and historical factors, where feasible and necessary. ITS will be attempted for all measures under Evaluation Question 1, but measures calculated annually may not have the required number of observations necessary for ITS (i.e., a minimum of eight pre- and eight post-MMC transition time points).

MMC Methodological Limitations

Most measures in the MMC evaluation component include the entire MMC population. As a result, observed changes in the evaluation measures reflect the population parameter rather than a sampling estimate. Parametric tests of hypotheses rely on sampling theory to produce estimates of sampling error, which make statistical testing, coefficient estimators, and standard errors meaningful. With population-level data, the application of sampling theory that undergirds inferential statistics (e.g., t-tests) is not meaningful in the traditional sense because there is no sample from which to make inferences about the population. Nevertheless, the external evaluator may apply statistical testing to observed population differences to better understand the magnitude of observed changes.

Measures using the entire MMC population are limited by the lack of a comparison group. Analyses focused on MMC service delivery changes will explore and develop comparison groups, if feasible. Analyses focused on MMC service delivery changes will also use pre-period data, rigorous quasi-experimental designs, subgroup analyses, and state and national benchmarks, where applicable. However, for MMC service delivery changes without a true comparison group, differences in outcomes may not imply causality.

Another limitation associated with the MMC evaluation component is the use of administrative data. These data have been designed and collected for billing purposes but are used in the evaluation to determine changes in access to and quality of care. Nevertheless, most measures derived from administrative sources in this section are validated and widely used for evaluation purposes. In addition, TMHP performs internal edits for data quality and completeness to help ensure data reliability.

Use of administrative data is also limited by data lags, which pose a challenge to measuring and reporting changes in a timely manner (Schoenberg, Heider, Rosenthal, Schwartz, & Kaye, 2015). Measures using FFS claims or MMC encounters require an approximate eight-month data lag for claims adjudication.

Lastly, study periods for the MMC evaluation component span the COVID-19 pandemic. Because the COVID-19 pandemic will impact all components of the evaluation, additional details regarding the implications of the pandemic are presented in the larger Methodological Limitations section on page 61.

Despite these limitations, the MMC evaluation component will provide insight into MMC service delivery changes, as well as the long-term performance of the MMC

program in its entirety. This evaluation component will inform whether Texas has continued making progress towards expanding risk-based managed care to new populations and services, and transforming Medicaid to a coordinated, quality-based healthcare system.

SPP Evaluation Methods

A quantitative approach will be used to evaluate two evaluation questions and three hypotheses specific to the UC and PHP-CCP programs. The evaluation questions and hypotheses examine whether SPPs financially support Medicaid providers and the impacts of key policy changes on cost and health outcomes. Two specific lines of inquiry will be pursued under this component:

- Do the UC and the PHP-CCP programs financially support Medicaid providers?
- Did the implementation of UHRIP prior to the transition of the UC program to charity care only mitigate possible hospital financial burden from the transition, resulting in maintenance or improvement in hospital-level performance measures?

SPP Evaluation Design

The SPP evaluation component will rely on two quasi-experimental designs: a one-group posttest only design and a one-group pretest-posttest design.

- **One-Group Posttest Only Design:** Most measures in the SPP evaluation component will rely on a one-group posttest only design. Measures assessing participating providers or uncompensated care costs (measures under Hypotheses 4.1 and 4.2) rely on application data, and therefore no pretest UC or PHP-CCP program data or comparison group data exist. This design will use consecutive population-based observations of SPP measures to describe changes in costs and payments over time. Measures evaluated through a one-group posttest only design will use descriptive statistics and DTA.
- **One-Group Pretest-Posttest Design:** Measures assessing hospital-based performance measures (measures under Hypothesis 5.1) will be evaluated with a one-group pretest-posttest design. This design will use repeated observations of outcome measures to monitor changes before and after the UC program transitioned to charity care only at the beginning of DY9. Measures evaluated through a one-group pretest-posttest design will use descriptive statistics, DTA, and ITS.

Table 7 and Table 8 provide an overview of all SPP-specific evaluation questions and hypotheses aligned with their respective measures. Subsequent sections provide additional information on the study population, study period, data sources, and analytic methods. Additional details for each of the proposed measures can be found in Appendix E.

Table 7. Evaluation Design Overview, Evaluation Question 4: Do the SPPs financially support providers serving the Medicaid and charity care populations?

Evaluation Hypothesis	Measure(s)	Study Population	Data Source(s) or Data Collection Method(s)	Analytic Methods
H4.1. The UC and PHP-CCP programs financially support Medicaid providers by reimbursing Medicaid or charity care costs in Texas.	4.1.1 Number of UC program providers 4.1.2 Number of PHP-CCP program providers 4.1.3 UC eligible costs and reimbursements 4.1.4 PHP-CCP eligible costs and reimbursements	• UC program providers • PHP-CCP program providers	• American Community Survey • DSH/UC application • PHP-CCP application • Provider-level eligibility files	• Descriptive statistics • DTA • Subgroup analysis[1]
H4.2. The UC and PHP-CCP programs support greater network adequacy and community health.	4.2.1 Network adequacy 4.2.2 Potentially preventable events (3M)	• MMC members • Individuals served by hospitals participating in Texas Medicaid	• American Community Survey • DSH/UC application • EQRO-calculated measures using 3M software • Network adequacy reports • PHP-CCP application	• Multiple linear regression • Subgroup analysis[1]

Notes. [1] Subgroup analysis will only be performed where applicable. SPP=Supplemental payment program; UC=Uncompensated Care; PHP-CCP=Public Health Provider-Charity Care Pool; DSH=Disproportionate share hospital; DTA=Descriptive trend analysis; EQRO=Texas's External Quality Review Organization.

Table 8. Evaluation Design Overview, Evaluation Question 5: Did the implementation of UHRIP support the hospital delivery system during the transition of the UC program to charity care only?

Evaluation Hypothesis	Measure(s)	Study Population	Data Source(s) or Data Collection Method(s)	Analytic Methods
H5.1. Hospital-based performance measures will maintain or improve following the transition to charity care only in DY9.	5.1.1 Average length of stay per Medicaid inpatient hospital admission 5.1.2 Average cost per Medicaid inpatient hospital admission 5.1.3 Patients' perceptions of hospital care 5.1.4 Potentially preventable complications (3M) 5.1.5 Potentially preventable readmissions (3M)	• Medicaid clients served by UC program providers in UHRIP • Patients served by UC program providers in UHRIP • UC program providers in UHRIP	• CMS HCAHPS® Surveys • DSH/UC application • EQRO-calculated measures using 3M software • FFS Claims and MMC Encounters • Member-level enrollment files • Provider-level eligibility files • UHRIP administrative data	• Descriptive statistics • DTA • ITS, if feasible • Subgroup analysis[1]

Notes. [1] Subgroup analysis will only be performed where applicable. UHRIP=Uniform Hospital Rate Increase Program; UC=Uncompensated Care; DY=Demonstration year, October 1-September 30; CMS=Centers for Medicare and Medicaid Services; HCAHPS®=Hospital Consumer Assessment of Healthcare Providers and Systems; DSH=Disproportionate share hospital; EQRO=Texas's External Quality Review Organization; FFS=Fee-for-service; MMC=Medicaid managed care; DTA=Descriptive trend analysis; ITS=Interrupted time series.

SPP Study Populations

The SPP evaluation component includes two primary study populations: UC program providers and PHP-CCP program providers.

- **UC program providers:** UC program providers include hospitals, clinics, and other providers who provide "medical assistance," as defined in section 1905(a) of the Social Security Act, to individuals who cannot pay for the services received. UC providers included in the evaluation are limited to those who submit an annual Disproportionate Share Hospital (DSH)/UC application. In DY9, there were 527 UC program providers, the majority of which were private hospitals (Table 9); however, the number and distribution of UC program providers may vary from year to year.

Table 9. UC Program Providers (DY9)

Provider Type	Count
Ambulance Providers	138
Dental Providers	1
Large Public Hospital	6
Physician Group Practice	16
Private Hospital	253
Small Public Hospital	96
State Hospital	17
Total	527

    - UC program providers for Hypothesis 5.1 are limited to those eligible for UHRIP. All hospitals except institutions for mental diseases are eligible for UHRIP. Therefore, Hypothesis 5.1 will be limited to UC large public hospitals, private hospitals, small public hospitals, and state hospitals that are not institutions for mental diseases.
- **PHP-CCP program providers:** PHP-CCP program providers are limited to publicly-owned and operated CMHCs, LBHAs, LMHAs, LHDs, and PHDs. Similar to UC program providers, PHP-CCP program providers included in the evaluation are limited to those who submit an annual PHP-CCP application. The final number of providers participating in the PHP-CCP program during the first year of implementation was not available at the time of writing, but HHSC anticipates the program to reimburse costs for up to 300 providers annually.

In addition to UC and PHP-CCP program providers, the SPP evaluation component will rely on population-level outcomes for Medicaid beneficiaries and individuals served by hospitals participating in Texas Medicaid to understand the impact of SPPs on community health measures.

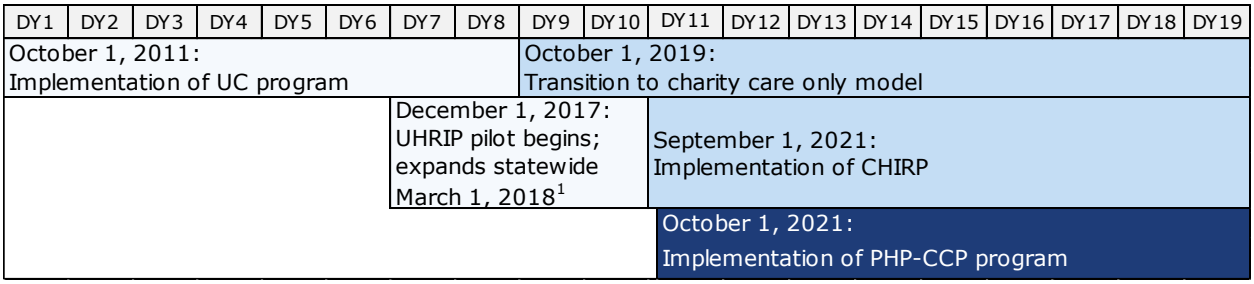
Potential Comparison Groups

Almost all eligible providers participate in the UC program. Since the final number of providers participating in the PHP-CCP program was not available at the time of writing, it is unclear whether there is a sufficient number of providers eligible for, but not participating in, the PHP-CCP program to constitute a comparison group. Moreover, the SPP evaluation component primarily relies on DSH/UC and PHP-CCP applications to obtain cost and payment data; this information is not available for providers not participating in UC or PHP-CCP programs. Thus, in the absence of application data, no viable comparison group exists for the UC or PHP-CCP programs. However, the external evaluator will leverage state and national benchmarks, where feasible, to support interpretation of findings amid key environmental confounds (e.g., the COVID-19 pandemic). Importantly, benchmarks at the state or national level may not be representative of all UC and PHP-CCP providers, and costs may differ definitionally from costs reported via DSH/UC and PHP-CCP applications. As a result, direct comparisons between UC and PHP-CCP measures and state or national benchmarks should be avoided.

SPP Study Periods

The UC program underwent significant changes at the beginning of DY9 when the program transitioned to a charity care only model (Figure 4). As a result, the focus of the Extension will be on the UC program in DY9 and later.[20] However, hospital-based performance outcomes for UC program providers dating back to DY1 will be used, where applicable, to examine whether the implementation of UHRIP supported hospitals before and after the transition to charity care only at the beginning of DY9. The PHP-CCP program study period will start in DY11 when the program is implemented. The study periods for both the UC and PHP-CCP programs will include payments made through the end of the Extension (DY19). Table 10 details key programmatic changes associated with study periods for the SPP evaluation component.

Figure 4. Study Periods for SPP Evaluation Component



Notes. [1] UHRIP expired on August 31, 2021 and transitioned to a component of CHIRP. DY=Demonstration year; UC=Uncompensated care; UHRIP=Uniform Hospital Rate Increase Program; CHIRP=Comprehensive Hospital Increased Reimbursement Program; PHP-CCP=Public Health Provider Charity Care Pool.

[20] The Draft Interim Evaluation Report covering DYs 7-11 due to CMS on March 31, 2024 includes an evaluation of the UC program prior to the transition to charity care only.

Table 10. Study Periods for SPP Evaluation Component

SPP Hypothesis	Pre-Period	Post-Period
H4.1. The UC and PHP-CCP programs financially support Medicaid providers by reimbursing Medicaid or charity care costs in Texas.	N/A	UC: DY9-DY19[1] PHP-CCP: DY11-DY19
H4.2. The UC and PHP-CCP programs support greater network adequacy and community health.	N/A	UC: DY9-DY19[1] PHP-CCP: DY11-DY19
H5.1. Hospital-based performance measures will maintain or improve following the transition to charity care only in DY9.	DY1-DY8[2,3]	DY9-DY19[3]

Notes. [1] Trends in UC costs and reimbursements should be explored before and after implementation of the DPPs and the PHP-CCP program. [2] Not all measures may be available as far back as DY1. The external evaluator will use the earliest data available for each measure. [3] The external evaluator may utilize multiple pre- or post-periods to capture implementation changes related to UHRIP, if feasible.
UC=Uncompensated Care; PHP-CCP= Public Health Provider Charity Care Pool; DY=Demonstration year.

SPP Data Sources

The SPP evaluation component relies on secondary data sources, as outlined below.

- **American Community Survey:** The evaluation will use estimates of regional characteristics, such as rural-urban continuum codes (RUCC) or uninsured rates, from the American Community Survey Samples for Texas.
- **Benchmark data:** The evaluation will leverage ongoing reporting of state and national benchmarks, where applicable, to support interpretation of findings amid key environmental confounds. The Hospital Cost Report Public Use File will be used to develop evaluation-specific benchmarks, where applicable.
- **CMS Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS®) Survey:** The HCAHPS® survey is a standardized national survey of clients' perceptions of hospital care. HCAHPS® assesses areas such as communication with hospital staff, cleanliness of hospital, the discharge process, and an overall rating of the hospital. CMS implemented the survey in 2006 and public reporting began in 2008. HCAHPS® data will be obtained through the CMS public data repository[21] to gather information on clients' experiences with hospitals participating in the UC program. Critical access hospitals and hospitals with less than 250 responses are exempted from the public use data file.

[21] CMS data repository can be accessed at: https://data.cms.gov/beta

- **DSH/UC application:** UC program providers complete an annual application to apply for reimbursement for costs incurred by providing services to uninsured individuals that are not otherwise reimbursed. Applications are submitted to HHSC annually, but are reimbursed on a two-year lag (e.g., UC payments during DY9 reflect charity care provided during DY7). The UC cost reimbursements are adjusted for inflation as an estimate of the UC costs for the year of payment.
- **EQRO-calculated measures using 3M software:** Texas's EQRO (ICHP) uses 3M software to calculate and publish potentially preventable events (PPEs) to the THLC portal. The THLC portal, or similar data obtained directly from ICHP, will be used to produce hospital-level estimates of potentially preventable complications (PPCs) and potentially preventable readmissions (PPRs).
- **FFS claims and MMC encounters:** FFS claims and MMC encounter data have been processed by TMHP since January 1, 2004. TMHP performs internal edits for data quality and completeness. The member-level claims/encounter data contain CPT codes, ICD-10-CM codes, place of service codes, and other information necessary to calculate duration and cost of hospital admissions. There is an approximate eight-month time lag for claims and encounter data adjudication. Prior analyses with Texas data showed that, on average, over 96 percent of the claims and encounters are complete by that timeframe.
- **Member-level enrollment files:** The enrollment files contain information about the person's age, gender, race/ethnicity, county, health care service delivery model (i.e., FFS or MMC), MCO enrollment, and length of enrollment. The member-level enrollment files will be used to identify member-level subgroups for measures related inpatient hospital admissions before and after the transition of UC to charity care only. Member-level enrollment files are subject to an approximate eight-month time lag.
- **Network adequacy reports**: HHSC developed a methodology for assessing network adequacy for each MMC program (STAR, STAR+PLUS, STAR Kids), per provider type and region. Specific information in network adequacy reports include member counts and the number/percentage of members meeting performance standards. Network adequacy reports include aggregate findings, and findings separated by each MMC program, provider type, and county classification (metro, micro, and rural).
- **PHP-CCP application:** PHP-CCP program providers complete an annual application to be reimbursed for certain costs incurred by providing services that are not otherwise reimbursed. During the first year of PHP-CCP implementation, providers may be reimbursed for charity care and Medicaid shortfall costs. For all other years, PHP-CCP is limited to costs incurred by providing services to uninsured individuals not otherwise reimbursed.

- **Provider-level enrollment files:** Provider-level enrollment files contain information on NPI, TPI, provider location, provider type, and provider specialty. Provider data will be sourced from TMHP and an HHSC SQL database, and are subject to an approximate one-month lag. The provider-level enrollment files will be used to support linking providers across multiple data sources and provide information necessary for any provider-level subgroups.
- **UHRIP administrative data:** HHSC maintains monitoring information for UHRIP to track participating providers and payment amounts over time. These data will be used identify UC program providers who participated in UHRIP.

SPP Proposed Analytic Methods

Quantitative methods will be used to evaluate the SPP evaluation component. This section describes the proposed analytic strategies for examining the measures presented in Table 7 and Table 8. The external evaluator should attempt to account for or provide context for historical programmatic factors such as amendments to the Demonstration (see Appendix H), the implementation or expiration of funding pools or payment programs which support the Medicaid system, and environmental and historical confounds (e.g., the COVID pandemic), as applicable.

Descriptive Statistics

All SPP evaluation measures—except open-ended primary data collection questions—may be examined through a variety of descriptive and inferential statistics. Descriptive statistics include estimates of central tendency and dispersion. Potential inferential analyses include bivariate statistics, parametric tests (e.g., paired or unpaired t-tests), and non-parametric tests (e.g., McNemar's test, Wilcoxon signed-rank test). Importantly, some measures may not be suited to inferential statistics, such as those that rely on population-level data rather than a sample. The external evaluator will ensure the correct application of statistical testing depending on whether the data is population- or sample-based, whether the measure is categorical or continuous, and whether the data meet the assumptions of parametric tests (e.g., normality, independence).

Descriptive Trend Analysis

DTA is an alternative approach to time-series analysis for measures that do not have enough pre-and post-period observations to conduct more rigorous time series analyses, such as ITS. DTA plots and analyzes time-series data calculated at equally spaced intervals to explain patterns in selected measures over time. DTA typically focuses on identification and quantification of a trend through the use of correlation coefficients and ordinary least squares regression. DTA will be used examine UC and PHP-CCP costs reimbursed over time (Measures 4.1.3 and 4.1.4). For outcome measures using DTA, the basic regression model is:

$$Y_t = \beta_0 + \beta_1 time + \beta_2 program\ transitions + \beta_3 controls + \varepsilon_t$$

Where, $\beta_0$reflects the baseline level of the outcome at the beginning of the study period; $\beta_1 time$ estimates the trends in the outcome variable; where applicable, the external evaluator should add $\beta_2 program\ transition$, which reflects the impact of the key program transitions (e.g., expiration of the DSRIP pool, implementation of new DPPs, introduction of PHP-CCP, and SPP pool resizing); and $\beta_3 controls$ reflects a vector of control variables the external evaluator may add to the DTA model. Potential control variables include client- or provider-level characteristics, or other programmatic and historical factors, where feasible and necessary.

DTA will also be used to examine hospital-based performance measures (5.1.1 to 5.1.5) before and after the UC program transitioned to charity care only in DY9 if the recommended minimum number of observations for ITS are not available (i.e., eight pre- and eight post-Demonstration time points).

Interrupted Time Series

ITS analysis uses aggregate data collected over equally spaced intervals before and after a policy change. A key assumption of ITS is that data trends before the policy change can be extrapolated to predict trends had the policy change not occurred. If a policy change has an impact on an outcome of interest, the trend of that outcome will have a slope that is significantly different from the slope before the policy change.

When properly executed, ITS is a valuable method to evaluate the success, failure, or unintended consequences of health care policy on outcomes (Lagarde, 2012). However, given the serial nature of ITS data, autocorrelation, nonstationarity, and seasonality need to be considered. Failing to assess and correct for these factors can lead to biased results (Wagner, Soumerai, Zhang, & Ross-Degnan, 2002). A key strength of ITS methodology is that a control site is not required, providing an alternate method of measuring the effect of an intervention "when randomization or identification of a comparison group are impractical" (Grimshaw, et al., 2003). The ITS method allows the target population to serve as its own comparison group.

An ITS model will be used to evaluate measures under Hypothesis 5.1. For Hypothesis 5.1, a basic segmented regression model will examine a series of hospital-based performance measures (5.1.1 to 5.1.5) before and after the UC program transitioned to charity care only in DY9. The proposed regression model for each outcome of interest (Y_t) over time is:

$$Y_t = \beta_0 + \beta_1 time + \beta_2 UC\ transition + \beta_3 post\ time + \varepsilon_t$$

In the above equation, β_0 represents the baseline level of the outcome measure at the beginning of the study period; $\beta_1$estimates trends in the outcome measure before the transition to charity care only; β_2 estimates the immediate impact of the transition to charity care only; and β_3 estimates the change in trend of the outcome measure after the transition to charity care only. To ease interpretation, ITS results are presented as: baseline level, trend before transition to charity care only, level change after transition to charity care only, and trend after transition to charity

care only. The external evaluator may add covariates to the ITS model to determine the effects of client- or provider-level characteristics, or programmatic and historical factors, where feasible and necessary.

The ITS model for Hypothesis 5.1 will incorporate subgroup analyses (e.g., by provider type or RUCC classification), where feasible, to strengthen the validity of observed outcomes.

Multiple Linear Regression

Multiple linear regression (MLR) will be used to examine how changes in network adequacy and PPE rates are associated with SPP funding over time (Hypothesis 4.2), while controlling for county or regional characteristics, such as county type (metro, micro, and rural) and the percentage of individuals who are uninsured per county. MLR is used to estimate the association between two or more independent variables and a single dependent variable. The goal of this analysis is to determine whether SPP payments support network adequacy and reduce the rate of avoidable healthcare events.

The proposed regression model for each outcome of interest (Y_{ct}) over time is:

$$Y_{ct} = \beta_{0i} + \beta_1 time_c + \beta_2 SPP\ payments_{ct} + \beta_3 county\ type_{ct} + \beta_4 uninsured_{ct} + \varepsilon_{ct}$$

Where the dependent variable is network adequacy or PPE rates for county *c* in DY *t*; *time* is a time trend variable; *SPP payments* represents the total amount of UC and PHP-CCP payments across all providers for county *c* in year *t*; *county type* delineates metro, micro, and rural counties; *uninsured* represents the percentage of individuals who are uninsured in county *c* in year *t*; and *e* is an error term.

The external evaluator may add additional county or regional characteristics to the proposed model, as deemed necessary. The external evaluator should aim to use county-level data for the regression model. However, PPE rates are calculated by the state's EQRO and are not currently available at the county level. HHSC and the external evaluator will examine the feasibility of obtaining county-level PPE rates; if county-level rates are not feasible for PPEs, or other model parameters, the external evaluator may use other regional breakouts for the model. The external evaluator may also choose to adjust the proposed model to account for the multicollinearity between model parameters, such as potential associations between county type and SPP funding. Lastly, because the dependent variables for network adequacy and PPE rates are bounded,[22] the external evaluator should use a Tobit regression, or a similar statistical approach, in the proposed model.

[22] Network adequacy rates are bounded between 0 and 1. PPE rates are bounded between 0 and 1,000 at-risk admissions (PPA, PPR, and PPCs) or between 0 and 1,000 at-risk ED visits (PPVs).

SPP Methodological Limitations

A major limitation of the SPP evaluation component is the use of application data. These data were designed for administrative payment purposes, not for research. As a result, the information is limited to what is required to be paid through the UC or PHP-CCP programs. These data do not include information on charity care costs prior to DY9, and do not include payer source or other subgroupings that would allow evaluators to determine the source of uncompensated care. Additionally, the use of application data means that uncompensated care cannot be estimated before the UC or PHP-CCP programs were implemented. This limitation is especially salient for the UC program, which transitioned to charity care only in DY9. DSH/UC applications prior to DY9 did not require providers to submit charity care costs like those submitted after DY9, limiting examinations into changes in charity care prior to DY9.

The use of application data also means the SPP evaluation component is limited by the lack of a comparison group. Subgroup analyses and rigorous one-group analytic methods will be utilized, where applicable. However, the lack of a comparison group makes it is difficult to draw causal inferences about the impact of these programs. A final limitation associated with the use of application data is data lags, which pose a challenge to measuring and reporting changes in a timely manner (Schoenberg, Heider, Rosenthal, Schwartz, & Kaye, 2015). The UC program is subject to a two-year data lag.

Analyses of some hospital-level outcome measures are limited by the use of all-payer data. Specifically, PPEs and patients' perceptions of hospital care are not restricted to individuals whose care was eventually reimbursed through the UC or PHP-CCP programs. Rather, these measures include both uninsured individuals and individuals with public or private insurance served at Medicaid-participating hospitals. Stronger hospital financial performance, including less uncompensated care or accounts receivable, has been associated with greater hospital quality, safety, and patient experience of care (Akinleye, McNutt, Lazariu, & McLaughlin, 2019). While the use of all-payer data will allow the evaluation to measure changes in hospital-level outcomes over the study period, it may be difficult to detect more nuanced impacts to specific payer groups resulting from the implementation of UHRIP or programmatic changes in the UC or PHP-CCP programs.

Lastly, the COVID-19 pandemic began in the middle of DY9 when UC transitioned to charity care only. Additionally, the PHP-CCP program is slated to be implemented amidst the ongoing COVID-19 pandemic. Impacts of these policy changes will be confounded by impacts to uncompensated care costs resulting from the COVID-19 pandemic. However, since the COVID-19 pandemic will impact all evaluation components, additional details regarding the implications of the pandemic are presented in the larger Methodological Limitations section on page 61.

Despite these limitations, the SPP evaluation component will provide insight into how UC and PHP-CCP programs support Medicaid providers, changes in

uncompensated care costs over time, and impacts to hospital-level outcomes following the transition to charity care only. This evaluation component will inform whether Texas has made progress towards improved outcomes while containing cost growth.

Overall Demonstration Evaluation Methods

The Overall Demonstration evaluation component will utilize a mixed-method approach to investigate four evaluation questions and five hypotheses related to cost outcomes for the Demonstration as a whole. The Overall Demonstration evaluation component explores Medicaid health service expenditures and the administrative costs associated with implementing and operating the Demonstration; in addition, this section considers how Demonstration costs align with other Demonstration components to support provider operations and sustainability.

Overall Demonstration Evaluation Design

The Overall Demonstration evaluation component will rely on one quasi-experimental design: a one-group posttest only design. This design will use repeated observations of cost measures across all Demonstration approval periods (DY1 to DY19). Measures will be evaluated using descriptive statistics and DTA.

Table 11, Table 12, Table 13, and Table 14 provide an overview of Overall Demonstration-specific hypotheses aligned with their respective measures. Subsequent sections provide additional information on the study populations, study periods, data sources, and analytic methods. Additional details for each of the proposed measures can be found in Appendix E.

Table 11. Evaluation Design Overview, Evaluation Question 6: What are the costs of providing health care services to Medicaid beneficiaries served under the Demonstration?

Evaluation Hypothesis	Measure(s)	Study Population	Data Source(s) or Data Collection Method(s)	Analytic Methods
H6.1. The Demonstration results in overall savings in health care service expenditures.	6.1.1 Actual Medicaid health service expenditures 6.1.2 Hypothetical WOW Medicaid health service expenditures	• Medicaid Eligibility Groups served under the Demonstration	• Budget neutrality worksheet	• Descriptive statistics • DTA

Notes. WOW=Without waiver; DTA=Descriptive trend analysis.

Table 12. Evaluation Design Overview, Evaluation Question 7: What are the administrative costs of implementing and operating the Demonstration?

Evaluation Hypothesis	Measure(s)	Study Population	Data Source(s) or Data Collection Method(s)	Analytic Methods
H7.1. Administrative costs required to implement and operate the Demonstration are relatively stable and reasonable over time.	7.1.1 HHSC administrative costs directly attributable to the Demonstration	• HHSC	• Form CMS-64	• Descriptive statistics • DTA
	7.1.2 MCO administrative costs	• MCOs	• MCO Financial Statistical Reports	• Descriptive statistics • DTA

Notes. HHSC=Health and Human Services Commission; CMS=Centers for Medicare and Medicaid Services; DTA=Descriptive trend analysis; MCO=Managed care organization.

Table 13. Evaluation Design Overview, Evaluation Question 8: How do directed and supplemental payment programs support providers and overall Medicaid program sustainability?

Evaluation Hypothesis	Measure(s)	Study Population	Data Source(s) or Data Collection Method(s)	Analytic Methods
H8.1. The Demonstration leverages savings in health care service expenditures to administer directed and supplemental payment programs.	8.1.1 Total expenditures for DSRIP, DPPs, and SPPs 8.1.2 Medicaid providers receiving payments through DSRIP, DPPs, and SPPs	• DPP providers • DSRIP providers • PHP-CCP program providers • UC program providers	• Budget neutrality worksheet • DSRIP and DPP administrative data • DSH/UC application • PHP-CCP application	• Descriptive statistics • DTA
H8.2. The directed and supplemental payment programs support Medicaid provider operations and sustainability.	8.2.1 Participation in directed and supplemental payment programs 8.2.2 Need for directed and supplemental payment programs 8.2.3 Perceived benefits and challenges of directed and supplemental payment programs 8.2.4 Provider perspectives on state priorities and policy development	• DPP providers • PHP-CCP program providers • UC program providers	• Provider survey and/or interviews	• Descriptive statistics • Thematic content analysis

Notes. DSRIP=Delivery System Reform Incentive Payment; DPP=Directed payment program; SPP=Supplemental payment program; PHP-CCP=Public Health Providers Charity Care Pool; UC=Uncompensated Care; DSH=Disproportionate share hospital.

Table 14. Evaluation Design Overview, Evaluation Question 9: Did Texas's quality initiatives impact the development and implementation of quality-based payment systems?

Evaluation Hypothesis	Measure(s)	Study Population	Data Source(s) or Data Collection Method(s)	Analytic Methods
H9.1. The implementation of APMs in Texas Medicaid will increase over time.	9.1.1 Percentage of providers implementing APMs 9.1.2 Percentage of MCOs and providers implementing risk-based APMs 9.1.3 Percentage of MCO payments made through APMs 9.1.4 Perceived benefits of implementing APMs 9.1.5 Perceived challenges with implementing APMs	• MCOs • DPP providers • PHP-CCP program providers • UC program providers	• MCO APM reporting tool • MCO survey • Provider survey	• Content analysis • Descriptive statistics • DTA • Subgroup analysis[1] • Thematic content analysis

Notes. [1] Subgroup analysis will only be performed where applicable. APM=Alternative payment model; MCO=Managed care organization; DPP=Directed payment program; DTA=Descriptive trend analysis.

Overall Demonstration Study Populations

The study population for the Overall Demonstration evaluation component collectively refers to all stakeholders, providers, members, and individuals contributing to and/or being served through the Demonstration. However, costs are presented for four study populations:

- **Medicaid Eligibility Groups (MEGs) served under the Demonstration:** The MEGs reflect state plan eligibility groups that are mandatory and voluntary enrollees in MMC (i.e., beneficiaries served through the Demonstration). MEGs are categorized into four groups for the purposes of budget neutrality limit calculations:[23]
  - **Adults:** Medicaid assistance expenditures for low-income parent and caretaker relatives, pregnant women, family members providing permanent homes for children who were in foster care, and individuals who aged out of foster care.
  - **Children:** Medicaid assistance expenditures for infants, children, and transitional youth in low-income families, and individuals who aged out of foster care.
  - **Aged and Medicare Related:** Medicaid assistance expenditures for children and adults receiving SSI benefits, Dual eligibles (Medicare and Medicaid), children with disabilities with Medicaid buy-in, individuals residing in a nursing facility, and individuals needing treatment for breast or cervical cancer.
  - **Disabled:** Medicaid assistance expenditures for children and adults receiving SSI benefits and/or with disabilities who are not receiving Medicare.
- **HHSC:** HHSC staff and contractors involved in the administration and operation of the Demonstration.
- **MCOs**: MCOs contracted to administer STAR, STAR+PLUS, and STAR Kids MMC Programs.

In addition to study populations associated with Demonstration costs, the Overall Demonstration evaluation component will rely on primary data collection with the following populations.

- **DPP Providers:** MMC providers participating in a DPP will be surveyed to gather provider perspectives on APMs. The provider survey will focus on MMC providers participating in DPPs because a wide range of provider types are eligible to participate in DPPs, and all DPP providers contract with MCOs, who administer APMs. Surveying Medicaid providers participating in DPPs may also allow the external evaluator to understand potential confounds or impacts to the MMC environment from DPPs, which are not a direct subject of this evaluation.

[23] STC 18 provides additional details on eligibility groups served through the Demonstration.

- **MCOs:** HHSC contracts with MCOs to manage and deliver quality health care services to MMC members statewide. At the time of writing, HHSC had contracts with 17 MCOs. MCOs vary in size, covered service areas, and MMC program offerings.[24] HHSC contractually requires MCOs to establish APMs with providers. By December 31, 2021, MCOs were expected to have at least 50 percent of total provider payments for medical and prescription expenses in APMs, and at least 25 percent in a risk-based model. MCOs contracted to provide MMC in Texas will be surveyed to gather MCO perspectives on APMs.
- **PHP-CCP program providers:** PHP-CCP program providers are limited to publicly-owned and operated CMHCs, LBHAs, LMHAs, LHDs, and PHDs. Similar to UC program providers, PHP-CCP program providers included in the evaluation are limited to those who submit an annual PHP-CCP application.
- **UC program providers:** UC program providers include hospitals, clinics, and other providers who provide "medical assistance," as defined in section 1905(a) of the Social Security Act, to individuals who cannot pay for the services received. UC providers included in the evaluation are limited to those who submit an annual Disproportionate Share Hospital (DSH)/UC application.

Potential Comparison Groups

The Demonstration operates statewide and encompasses almost all individuals served through MMC.[25] In addition, nearly all eligible providers have historically participated in the directed and supplemental payment programs administered through the Demonstration. Collectively, this means there is no characteristically similar group of individuals or providers not involved in Demonstration activities, and therefore, no available comparison group for the Demonstration as a whole.

However, the Overall Demonstration evaluation component relies on hypothetical health care service expenditures ('Without Waiver' [WOW] expenditures) to estimate costs for individuals served under the Demonstration if the Demonstration did not exist (i.e., a hypothetical comparison group). These WOW expenditures are created for budget neutrality purposes and reflect theoretical costs for MEGs served under the Demonstration if their services were provided through FFS instead of MMC. The WOW expenditures are available for each DY.

[24] Additional information on MCOs contracted to deliver MMC can be accessed at: https://www.hhs.texas.gov/services/health/medicaid-chip/provider-information/managed-care-organization-dental-maintenance-organization-provider-services-contact-information

[25] STAR Health is an MMC program that operates outside the Demonstration. STAR Health is limited to children in conservatorship, in the Adoption Assistance or Permanency Care Assistance program, extended foster care, or Former Foster Care Children.

Overall Demonstration Study Periods

The Overall Demonstration evaluation component will rely on costs (expenditures and payments) under the Demonstration (post-Demonstration) and will span all Demonstration approval periods (DY1 through DY19), as well as primary data collection focused on the Extension (DY10 through DY19).

Overall Demonstration Data Sources

The Overall Demonstration evaluation component will include both quantitative and qualitative data. These data include both primary and secondary data sources, as outlined below.

Overall Demonstration Primary Data Sources

- **MCO survey:** MCOs will be surveyed regarding their experiences planning and implementing APMs. This survey will be developed by the external evaluator but should include questions to address Evaluation Question 9 and related hypotheses. Additional details on the requirements for primary data collection, including possible methods, sampling strategy, data analysis, and timing of primary data collection activities, can be found in Appendix D.
- **Provider survey and/or interviews:** Provider perspectives offer valuable insight into the successes and challenges of various Demonstration activities, including funding pools and the development of APMs. The external evaluator will determine the most appropriate data collection approach and will develop corresponding instruments and/or guides. If feasible, the external evaluator should make efforts to assure primary data collection activities target providers of different types, sizes, and geographic regions to ensure a range of provider perspectives are included. The external evaluator may combine primary data collection activities across various evaluation questions (e.g., primary data collection on directed and supplemental payment programs in Evaluation Question 8 and APMs in Evaluation Question 9), as applicable. Additional details on the requirements for primary data collection, including possible methods, sampling strategy, data analysis, and timing of primary data collection activities, can be found in Appendix D.

Overall Demonstration Secondary Data Sources

- **Budget neutrality worksheet:** HHSC and CMS collaborate to determine the total cost of the Demonstration. "With waiver" (WW) costs are calculated for all years of the Demonstration, with past years based on actual costs and future years projected based on forecasted spending and enrollment trends. WOW costs are projections based on what the services provided would cost without the Demonstration. HHSC submits the budget neutrality worksheet to CMS quarterly, and also produces an annual budget neutrality summary. The quarterly budget neutrality worksheet relies exclusively on actual costs,

whereas the annual summary uses cost caps for SPPs and DPPs.[26] Quarterly budget neutrality worksheets and annual summaries will be provided to the external evaluator.

- **DSH/UC application:** UC program providers complete an annual application to apply for reimbursement for costs incurred by providing services to uninsured individuals that are not otherwise reimbursed. Applications are submitted to HHSC annually, but are reimbursed on a two-year lag (e.g., UC payments during DY9 reflect charity care provided during DY7). The UC cost reimbursements are adjusted for inflation as an estimate of the UC costs for the year of payment. These data will be used to examine Medicaid providers participating in funding pools administered through the Demonstration.
- **DSRIP and DPP administrative data:** HHSC maintains monitoring information for DSRIP and DPP providers to track program participation over time. These data will be used to examine Medicaid providers participating in payment incentive programs administered through the Demonstration.
- **Form CMS-64:** Form CMS-64 is part of the Medicaid Budget and Expenditure System, a web-based application used to obtain quarterly expenses to compute the Federal Financial Participation amount CMS provides to states. Form CMS-64 includes a variety of sections detailing different types of expenditures. The Overall Demonstration evaluation component will focus on 64.10 expenditures for state and local administration attributable to the Demonstration. These administrative expenditures include costs associated with the Medicaid Management Information System, preadmission screening costs, enrollment brokers, and all other costs necessary to administer the Demonstration, including staff time and contracts management.
- **MCO Financial Statistical Reports (FSRs):** All MCOs contracted to provide MMC in Texas are required to submit FSRs for each service area and MMC program they operate. FSRs include a variety of financial information from MCOs, including revenues and expenditures for MMC members in the service area. The Overall Demonstration evaluation component will focus on MCO administrative expenses such as staff time, office space, equipment, and supplies.
- **PHP-CCP application:** PHP-CCP program providers complete an annual application to be reimbursed for certain costs incurred by providing services that are not otherwise reimbursed. During the first year of PHP-CCP implementation, providers may be reimbursed for charity care and Medicaid shortfall costs. For all other years, PHP-CCP is limited to costs incurred by providing services to uninsured individuals not otherwise reimbursed. These data will be used examine Medicaid providers participating in funding pools administered through the Demonstration.

[26] The annual budget neutrality worksheet also relies on historical costs for DPPs.

Overall Demonstration Proposed Analytic Methods

Quantitative and qualitative methods will be used for the Overall Demonstration evaluation component. This section describes the proposed analytic strategies for examining the measures presented in Table 11, Table 12, Table 13, and Table 14. Analytic methods will incorporate subgroup analyses (e.g., by provider type or region), where feasible, to strengthen the validity of observed outcomes. Additionally, the external evaluator should attempt to account for or provide context for historical programmatic factors such as amendments to the Demonstration (see Appendix H), the implementation or expiration of funding pools or payment programs which support the Medicaid system, and environmental and historical confounds (e.g., the Great Recession and the COVID pandemic) which may impact cost outcomes over time, as applicable.

Quantitative Analysis

Descriptive Statistics

All Overall Demonstration evaluation measures—except open-ended primary data collection questions—may be examined through a variety of descriptive and inferential statistics. Descriptive statistics include estimates of central tendency and dispersion. Potential inferential analyses include bivariate statistics, parametric tests (e.g., paired or unpaired t-tests), and non-parametric tests (e.g., McNemar's test, Wilcoxon signed-rank test). Importantly, some measures may not be suited to inferential statistics, such as those that rely on population-level data rather than a sample. The external evaluator will ensure the correct application of statistical testing depending on whether the data is population- or sample-based, whether the measure is categorical or continuous, and whether the data meet the assumptions of parametric tests (e.g., normality, independence).

Descriptive Trend Analysis

The costs included in the Overall Demonstration evaluation component exist only under the Demonstration. As a result, preferred time-series designs such as ITS are infeasible. DTA is an alternative approach to time-series analysis for programs that do not have an intervention point in the time series. DTA plots and analyzes time-series data calculated at equally spaced intervals to explain patterns in selected measures over time. DTA typically focuses on identification and quantification of a trend through the use of correlation coefficients and ordinary least squares regression. DTA will be used for all Overall Demonstration evaluation measures—except open-ended primary data collection questions. For outcome measures using DTA, the basic regression model is:

$$Y_t = \beta_0 + \beta_1 time + \beta_2 controls + \varepsilon_t$$

Where, $\beta_0$reflects the baseline level of the outcome at the beginning of the study period; $\beta_1 time$ estimates the trends in the outcome variable; and $\beta_2 controls$ reflects a vector of control variables the external evaluator may add to the DTA model.

Potential control variables include client- or provider-level characteristics, or programmatic and historical factors, where feasible and necessary.

Qualitative Analysis

The appropriate methods for qualitative analysis will depend on the primary data collection tools adopted by the external evaluator. For measures relying on guided feedback through a limited number of open-ended survey questions, the external evaluator may utilize content analysis to supplement or expand upon quantitative survey results analyzed using descriptive statistics. Content analysis systematically examines documents to extract descriptive data that can be quantified in a structured dataset for statistical testing (Vaismoradi, Turunen, & Bondas, 2013). For less prescriptive approaches, such as provider interviews, more advanced qualitative techniques will be required, such as thematic content analysis. This qualitative method involves the identification of patterns and themes within survey or interview data, and is well-suited to analyzing the diverse and nuanced information collected from study participants (Vaismoradi, Turunen, & Bondas, 2013). As with quantitative approaches to data analysis, the external evaluator should incorporate subgroup analyses, where applicable.

Overall Demonstration Methodological Limitations

There are several limitations the Overall Demonstration evaluation component. First, given the long-standing, statewide nature of the Demonstration, no existing comparison groups are available for estimating a counterfactual condition without the Demonstration. Historical health care expenditures may be used as contextual reference, but due to differences in individuals included in historical health care expenditures and those served under the Demonstration, these historical costs cannot be used to determine costs which would have been incurred in the absence of the Demonstration.

Another limitation of the Overall Demonstration evaluation component is the reliance on application data and federally-and state-mandated reporting. These data were designed for administrative and oversight purposes, not for research. As a result, analyses are limited to what is available through these data sources. These data include health care service expenditures derived from FFS claims and MMC encounters data, administrative costs, and payments to providers necessary to investigate cost outcomes for the Demonstration as a whole; however, these data may not represent all possible costs associated with the Demonstration and may only be available at the aggregate level.

Conclusions derived from qualitative data analysis will be susceptible to common threats to validity, such as selection or sampling bias, recall bias, and social desirability bias. The number of survey waves may also be limited due to study timelines, survey logistics, and the level of effort required to conduct and analyze primary data collection.

Lastly, study periods for the Overall Demonstration evaluation component span the COVID-19 pandemic. Since the COVID-19 pandemic will impact all evaluation components, additional details regarding the implications of the pandemic are presented in the larger Methodological Limitations section on page 6161.

Despite these limitations, the Overall Demonstration evaluation component will provide insight into cost outcomes for the Demonstration as a whole, including health care service expenditures and administrative costs, how the Demonstration leverages cost savings into provider payment incentives and funding pools, and ultimately, how the Demonstration supports Medicaid provider operations and sustainability.

4. Special Methodological Considerations

The Demonstration aims to transform the Medicaid healthcare delivery system in Texas through the expansion of risk-based managed care and quality-based payment systems that target improved care coordination and health outcomes while containing overall cost growth. To meet these goals, the Demonstration contains multiple components. The complex, statewide nature of the Demonstration presents challenges for the evaluation of the Extension. Many demonstration components are pervasive in reach, including nearly all Medicaid clients or eligible providers that meet program criteria. Additionally, components of the Demonstration were implemented at different times, and each component comes with ongoing policy changes such as funding pool resizing, the initiation of new services, and the incorporation of new populations. Differences in timing and implementation of these components make it difficult to establish consistent definitions and isolate effects over time. Moreover, many providers and clients participate in multiple Demonstration components simultaneously; for example, many hospitals participate in the delivery of managed care, DPPs, and SPPs, effectively spanning the entire slate of Demonstration activities. Over time, the Demonstration has become increasingly intertwined with the broader operations of Texas Medicaid and its array of quality initiatives and satellite programs.

The Demonstration was in the tenth year of operation when CMS approved the Extension STCs. The long-standing nature of the Demonstration also poses unique challenges to the evaluation of the Extension because evaluation pre-periods are no longer free of relevant interventions. In the proposed evaluation design, new or modified Demonstration components are primarily compared to outcomes derived from prior Demonstration periods, not a historical cohort free from the Demonstration. Additionally, the statewide implementation of the Demonstration precludes the availability of a true comparison group. The implementation of new components or shifts in component operations apply to all eligible Medicaid members or providers. Members or providers who do not experience the change would either represent different eligibility groups or differences in motivation or engagement (i.e., selection bias). The lack of a true historical or contemporary comparison group is problematic for identifying a counterfactual condition that would allow the external evaluator to attribute changes in evaluation measures to specific Demonstration components. The evaluation design plan incorporates rigorous mixed-methods quasi-experimental evaluation designs to compensate for the absence of a true counterfactual. Results from the evaluation will provide insight into whether the state continued making progress towards the goals set forth in the initial Demonstration and met the specific aims of the Extension. However, evaluation results from specific Demonstration components may not imply direct causality; instead, evaluation results should be considered in aggregate when assessing the Demonstration performance.

The Demonstration evaluation will also coincide with programmatic changes to Texas Medicaid which may influence evaluation measures. Specifically, the state developed four new DPPs and one new SPP to sustain key DSRIP initiative areas and support further delivery system reform by incentivizing providers to maintain access and quality of care. The expiration of the DSRIP pool and the delayed approvals of the new DPPs may reduce incentives for system improvement and present additional financial burden for Medicaid providers, ultimately resulting in negative changes to access and quality of care measures for MMC programs and to cost-related measures for SPPs. The Overall Demonstration component includes measures of the new DPPs in the examination of how funding pools support providers and Medicaid program sustainability. However, since the DPPs are independently evaluated as outlined in STCs 31 and 35, the new DPPs are not directly assessed in the current evaluation. Additional programmatic changes include the state's other 1115 Demonstration Waiver for the Healthy Texas Women program, and updates to the Managed Care Quality Strategy, which Texas will revise no less than every three years. Texas will also undergo five legislative sessions during the Extension, which may significantly alter the Medicaid landscape operating both under and outside of the Demonstration. Collectively, the multiple ongoing state efforts to improve the administration of Texas Medicaid add further complexity to the interpretation of evaluation findings.

Finally, it should be noted that this evaluation design is being written during the ongoing COVID-19 pandemic. The outbreak has reordered priorities for both clients and providers in the state. One immediate consequence of the pandemic was to depress Medicaid utilization due to social distancing measures and shifting health care concerns. Medicaid enrollment was also impacted as the state implemented temporary eligibility changes to Medicaid programs in response to the pandemic. The COVID-19 pandemic is a confounding factor that may undermine casual inference of evaluation results across multiple domains. The external evaluator may use public use data files on COVID-19 confirmed cases and hospitalizations in Texas to better understand the impact of the pandemic on evaluation measures, where applicable. The external evaluator will take care to interpret and present pertinent findings within the appropriate context, carefully formulate primary data collection tools, and adjust the evaluation, where applicable and feasible, such that findings reflect the effects of 1115 Demonstration policies.

5. Communication, Dissemination, and Reporting

The Interim and Summative Evaluation Reports will be produced in alignment with the Attachment P of the Special Terms and Conditions (STCs), *Preparing the Evaluation Report,* and the schedule of deliverables listed in the timeline (Table 15 on the following page).

State Presentations for the CMS

As specified in STC 89, if requested by CMS, Texas will present and participate in discussions with CMS regarding the Evaluation Design, Interim Evaluation, and/or the Summative Evaluation Reports.

Public Access

As specified in STC 90, Texas shall post final documents (e.g., Monitoring Reports, Close Out Report, approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report) on the state's Medicaid website within 30 days of approval by CMS.

Additional Publications and Presentations

Attachment O to the STCs, *Developing the Evaluation Design,* endorses dissemination of 1115(a) Demonstration evaluation findings on "what is or is not working and why." As a result, presentation of evaluation reports or their findings are encouraged. However, as specified in STC 91, for a period of twelve (12) months following CMS approval of the final reports, CMS will be notified prior to presentation of these reports or their findings, including in related publications (e.g., journal articles), by the state, contractor, or any other third party directly connected to the demonstration, including any associated press materials. Additionally, all peer-reviewed and non-peer-reviewed publications and presentations will be listed as an appendix in the Interim and Summative Evaluation Reports.

Table 15. Schedule of Evaluation Deliverables

Deliverable	Date
STCs approved for the 1115(a) the Extension	January 15, 2021
HHSC submits Draft Evaluation Design Plan to CMS for comments (within 180 calendar days of Extension approval)	July 14, 2021
HHSC receives comments from CMS	December 6, 2021
HHSC submits revised Evaluation Design (within 84 calendar days of receipt of CMS comments) and posts to the state's Demonstration website[1]	February 28, 2022
CMS approves Evaluation Design	May 26, 2022
HHSC obtains an independent evaluator	March 15, 2024
HHSC submits Draft Interim Evaluation Report for DYs 7-11 to CMS for comment	March 31, 2024
HHSC receives comments from CMS	March 21, 2025
HHSC submits Final Interim Evaluation Report for DYs 7-11 to CMS (within 60 calendar days of receipt of comments)[2]	May 20, 2025
HHSC submits Draft Interim Evaluation Report for DYs 10-14 to CMS for comment	March 31, 2027
HHSC receives comments from CMS (estimated within 90 business days)	*June 29, 2027*
HHSC submits Final Interim Evaluation Report for DYs 10-14 to CMS (within 60 calendar days of receipt of comments)[2]	August 28, 2027
HHSC submits Draft Interim Evaluation Report for DYs 10-16 to CMS for comment	September 30, 2029
HHSC receives comments from CMS (estimated within 90 business days)	*December 29, 2029*
HHSC submits Final Interim Evaluation Report for DYs 10-16 to CMS (within 60 calendar days of receipt of comments)[2]	February 27, 2030
HHSC submits Draft Summative Evaluation Report for DYs 10-19 to CMS for comment	March 30, 2032
HHSC receives comments from CMS (estimated within 90 business days)	*June 28, 2032*
HHSC submits Final Evaluation Report to CMS (within 60 calendar days of receipt of comments)[2]	August 27, 2032

Notes. [1] The Evaluation Design was originally due to CMS within 60 calendar days of receipt of CMS feedback (2/4/2022). CMS approved a 24-day extension on 12/15/2021, extending the deadline to 2/28/2022. [2] Evaluation deliverable date may require adjustments depending on when HHSC receives CMS comments on initial drafts. STC=Special Terms and Conditions; HHSC=Health and Human Services Commission; CMS=Centers for Medicare and Medicaid Services; DY=Demonstration year.

Appendix A. Document History Log

Table 16. Document History Log

Status[1]	Document Revision[2]	Effective Date	Description[3]
Baseline	n/a	July 14, 2021	Draft Evaluation Design for the Extension (STC 82)
Revision	2.1	February 28, 2022	Updated based on CMS feedback received December 6, 2020
Revision	3.1	August 13, 2024	Updated to incorporate amendments approved by CMS on November 16, 2023, necessary changes to STAR+PLUS HCBS measures (Evaluation Question 2), and other minor revisions
Revision	3.2	April 22, 2025	Updated based on CMS feedback received on March 18, 2025

Notes. [1] Status should be represented as "Baseline" for initial issuances, "Revision" for changes to the Baseline version, and "Cancellation" for withdrawn versions. [2] Revisions should be numbered according to the version of the issuance and sequential number of the revision – e.g., "1.2" refers to the first version of the document and the second revision. Brief description of the changes to the document made in the revision. STC=Special Terms and Conditions; CMS=Centers for Medicare and Medicaid Services.

Appendix B. Independent Evaluator

The STCs state the Demonstration evaluation must be conducted by an independent evaluator. To meet this requirement, HHSC will identify and contract with an independent external evaluator.

External Independent Evaluator

Required Qualifications

HHSC will select an independent evaluator with the expertise, experience, and impartiality to conduct a scientifically rigorous program evaluation meeting all requirements specified in the STCs, including the skills needed to examine measures in Appendix E, and meet deadlines in Table 15 (Schedule of Evaluation Deliverables). Required qualifications and experience include multi-disciplinary health services research skills and experience; an understanding of and experience with the Medicaid program; familiarity with HHSC programs and populations; experience conducting complex, multi-faced evaluations of large, multi-site health and/or social services programs; and proficiency producing accessible documents in line with CMS and HHSC requirements.

Potential external evaluators will be assessed on their relevant work experience, staff expertise, data management and analytic capacity, experience working with state agency program and research staff, proposed resource levels and availability of key staff, track record of related publications in peer-reviewed journals, and the overall quality of their proposal. Proposed deliverables must meet all standards of leading academic institutions and academic journal peer review. In the process of identifying, selecting, and contracting with an independent external evaluator, Texas will act appropriately to prevent a conflict of interest with the independent external evaluator, including the requirement to sign a declaration of "No Conflict of Interest."

HHSC will pursue a contract to secure independent evaluation services from a Texas university. The contracting process includes development of a project proposal and quote request specifying the Scope of Work, vendor qualifications, vendor requirements, timelines, milestones, and cost estimate template. The cost estimate template will include a breakdown of costs for staffing, fringe benefit, travel, equipment and supplies, data collection, and other administrative and indirect costs. The project proposal and quote request will be sent to the list of Texas universities allowing approximately 30 calendar days for response. A team of reviewers at HHSC will be identified prior to the submission deadline for proposals. Each proposal submitted in response to the request will be reviewed by the HHSC team of reviewers. Respondents with the best proposal and value are identified by the team. HHSC will make a final decision for contract award based on the strength of the overall proposal and the abilities of the external evaluator to satisfy the requirements of the project proposal and quote request and conduct the

independent evaluation in the timeframe required. The contracting process begins once a university is selected.

The timeframe for soliciting and contracting with an independent evaluator is 6-12 months from the date an Evaluation Design Plan is approved by CMS.

Evaluation Budget

As required by CMS in Attachment O of the STCs, Section F(2), the independent evaluator's budget for implementing the evaluation will include total estimated cost, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation. The total budget for the external independent evaluator is estimated to be approximately $12 million for 8.5 years (March 15, 2024 through September 30, 2032),[27] but the final budget will not be available until the external evaluator is selected. The estimated budget amount will cover all evaluation expenses, including salary, fringe, administrative costs, other direct costs such as travel for data collection, conference calls, as well as indirect costs and those related to quantitative and qualitative data collection and analysis, and report development. As part of the contracting process, potential contractors will populate the budget shell (Table 17).

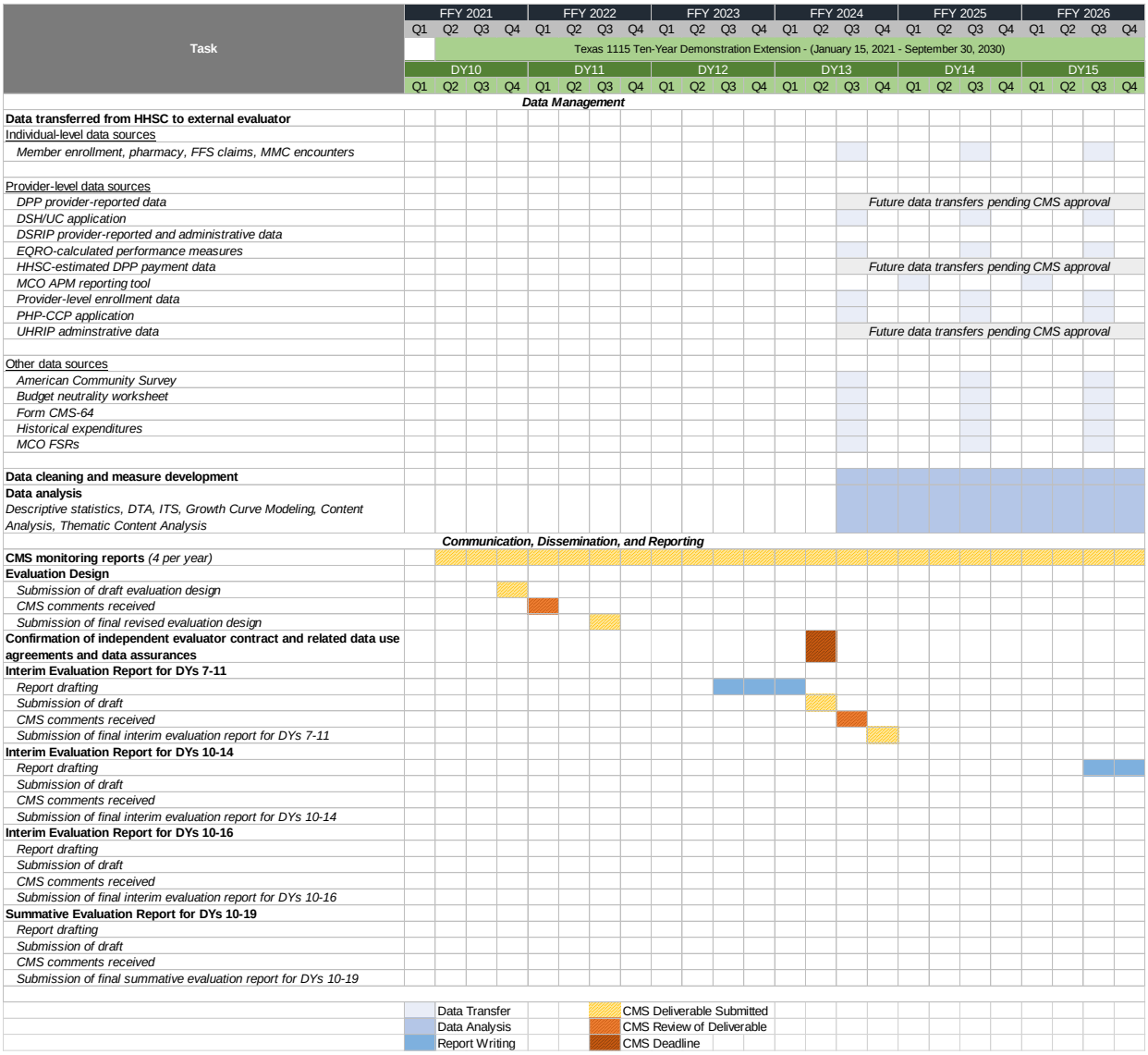
Table 17. Proposed Evaluation Budget

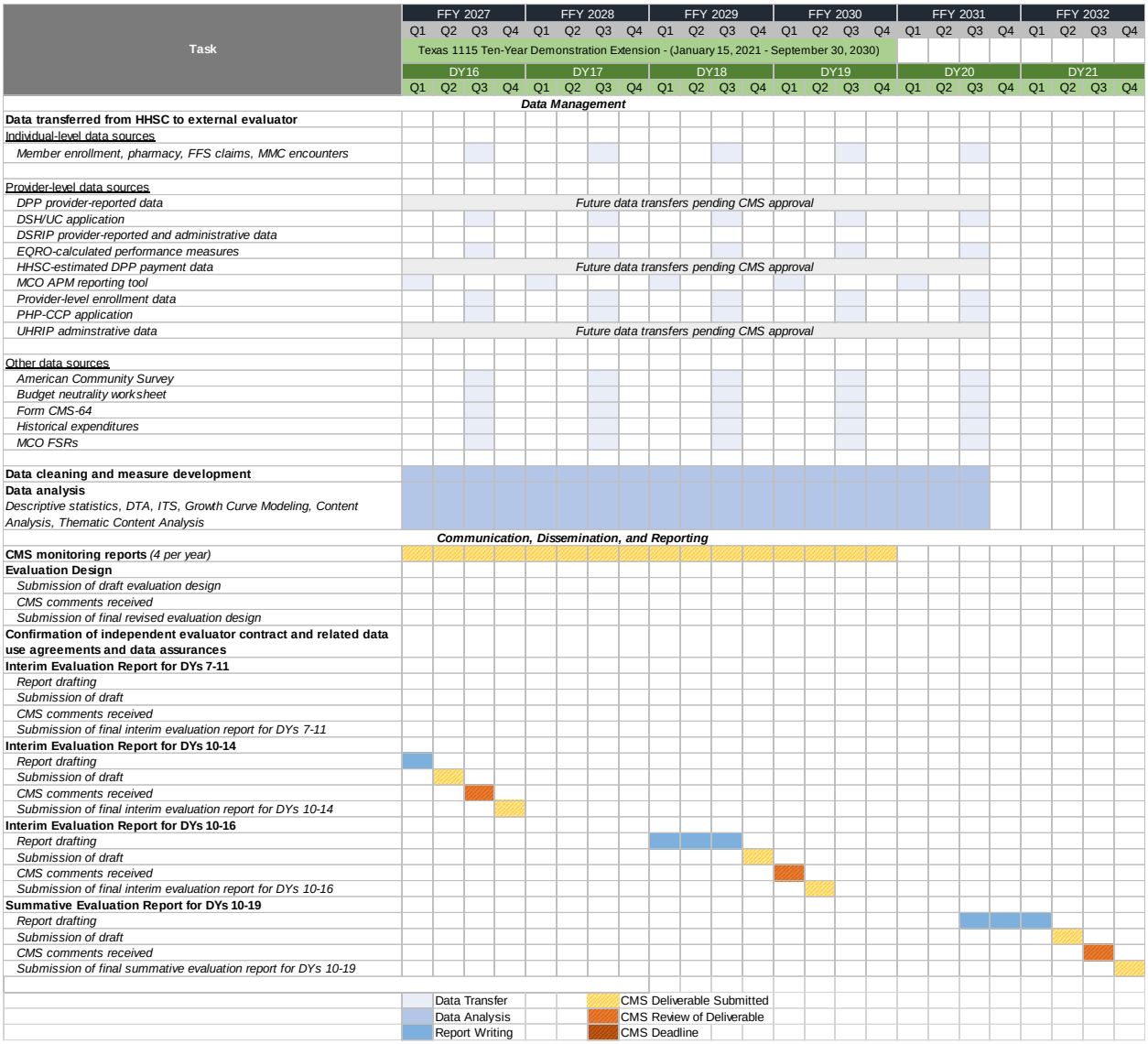
Category	Total Cost
Personnel	
Fringe	
Travel	
Indirect Costs	
Data Collection	
Equipment/Supplies	
Other Administrative Costs	
TOTAL EVALUATION COST	

[27] The external evaluator timeframe, March 15, 2024 through September 30, 2032, begins on the date HHSC executes the contract with an external evaluator and extends through CMS approval of the Summative Evaluation Report, allowing time for external evaluators to address any CMS comments/questions. The external evaluation contract end date may be extended based on when HHSC receives CMS comments on the Draft Summative Evaluation Report.

Evaluation Timeline and Major Milestones

Figure 5. Estimated Evaluation Timeline and Major Milestones





Notes. FFY=Federal fiscal year, October 1-September 30; Q1=October, November, and December; Q2=January, February, and March; Q3=April, May, and June; Q4=July, August, and September; DY=Demonstration year, October 1-September 30; FFS=Fee-for-service; MMC=Medicaid managed care; DPP=Directed payment program; DSH=Disproportionate share hospital; UC=Uncompensated Care; DSRIP=Delivery System reform Incentive Payment; EQRO=Texas's External Quality Review Organization; MCO=Managed care organization; APM=Alternative payment model; PHP-CCP=Public Health Provider Charity Care Pool; DTA=Descriptive trend analysis; ITS=Interrupted time series; CMS=Centers for Medicare and Medicaid Services.

Appendix C. HHSC Quality Initiative Descriptions

This appendix outlines the primary HHSC quality initiatives in place at the time of writing. HHSC quality initiatives are designed to incentivize and compare MCO, provider, and hospital performance across key process and outcome performance measures to improve the overall MMC service delivery model as specified in the state's managed care quality strategy.

Administrative Interviews: In accordance with 42 CFR 438.358, the EQRO conducts administrative interviews with each plan in Medicaid/CHIP, within a three-year period, to assess MCO/DMO compliance with state standards for access to care, structure and operations, and quality assessment and performance improvement (QAPI). The administrative interview process consists of four main deliverables, namely an Administrative Interview (AI) tool, AI evaluations, onsite visits, and AI reports.

Core Measure Reporting: Each year, CMS publishes Adult and Children Health Care Quality Core Set of measures to track quality of care and health care outcomes for Medicaid and CHIP beneficiaries. States voluntarily report on Adult and Children Health Care Quality Core Set measures to CMS. The EQRO assists HHSC in reporting core measures to CMS each year.[28]

Dental Pay-for-Quality (P4Q) Program: The Dental P4Q Program was implemented in 2014 and redesigned in 2018. The Dental P4Q program puts 1.5 percent of each dental plan's capitation at risk of recoupment based on performance measures. If dental plan performance declines beyond a set threshold for the Dental P4Q measures, HHSC will recoup 1.5 percent of the capitation. If dental plan performance falls within a "neutral zone" for Dental P4Q measures, they will not face recoupment or distribution of additional funds. If dental plan performance improves beyond a set threshold for the Dental P4Q measures, the plan will receive their full capitation rate and may be eligible for additional distribution of funds, contingent on funding availability.

Directed Payment Programs: HHSC has operated DPPs since the implementation of QIPP in 2018. Other DPPs include the state-wide implementation of UHRIP in 2018, and four new DPPs in 2021 (DPP BHS, CHIRP, RAPPS, and TIPPS). While the focus of each DPP may differ, the shared goal is to incentivize quality and innovation of services.

Hospital Quality-Based Payment Program: The Hospital Quality-Based Payment Program was implemented in SFY 2013. As part of this program, HHSC collects data on some PPEs and uses these data to improve quality and efficiency. MCOs and hospitals are fiscally accountable for PPCs and PPRs flagged by HHS. Based on

[28] CMS Core Set measure results are accessible via: https://thlcportal.com/measures/cmscoremeasuredashboard

performance on these measures, adjustments may be made to each MCO's capitation rates and to hospitals' FFS reimbursements.

MCO Report Cards: HHSC implemented MCO Report Cards in 2014. HHSC develops annual reports cards for each STAR, CHIP, STAR+PLUS, and STAR Kids MCO. The reports cards are provided at the service area level to allow Medicaid beneficiaries to compare MCOs on specific quality measures before enrolling in a plan. MCO report cards are posted on HHSC's website and included in Medicaid enrollment packets sent to potential members.

MCO Requirements for Value-Based Contracting: HHSC began assessing the payment methodologies MCOs use with their providers in 2012 and added a contract provision requiring MCOs to implement VBP models in 2014. HHSC established four-year targets for MCOs in 2018. The 2018 target required 25 percent of MCO payments to be associated with APMs, and 10 percent of MCO payments to be associated with APMs in which providers accept some level of risk. The 2021 target required 50 percent of MCO payments to be associated with APMs, and 25 percent of MCO payments to be associated with APMs in which providers accept some level of risk. MCOs failing to meet minimum APM targets are required to submit a corrective action plan and may be subject to additional contractual remedies, including liquidated damages.

Medical P4Q Program: The Medical P4Q Program was implemented in 2014 and redesigned in 2018. The Medical P4Q program creates incentives and disincentives for all MCOs based on their performance on certain quality measures. Health plans that excel at meeting the at-risk measures and bonus measures may be eligible for additional funds, while health plans that do not meet their at-risk measures can have up to three percent of their capitation payments for the measurement year recouped.

Medicaid Value-Based Enrollment: HHSC began using value scores in the auto-enrollment for MCOs participating in STAR, STAR+PLUS, and STAR Kids in 2020. The value score will automatically enroll a greater proportion of Medicaid beneficiaries who have not selected a health plan into MCOs with higher quality of care, efficiency, and effectiveness of service provision and performance.

Performance Improvement Projects: The Balanced Budget Act of 1997 requires all states with Medicaid managed care to ensure MCOs conduct Performance Improvement Projects (PIPs). 42 CFR 438.330 requires projects be designed to achieve, through ongoing measurements and interventions, significant improvement, sustained over time, in clinical care and nonclinical care areas that have a favorable effect on health outcomes and enrollee satisfaction. Health plans conduct PIPs to examine and improve areas of service or care identified by HHSC in consultation with Texas's EQRO as needing improvement. Topics are selected based on health plan performance on quality measures and member surveys. HHSC requires each health plan to conduct two PIPs per program. One PIP per health plan

must be a collaborative with another health plan or a DSRIP project, or a community-based organization.

Performance Indicator Dashboards: Texas's EQRO began producing Performance Indicator Dashboards in 2018. The dashboards include a series of measures that identify key aspects of MCO performance by MMC program to support transparency and accountability. MCOs whose performance falls below minimum standard thresholds for 33.33 percent or more of measures on the Performance Indicator Dashboard will be subject to remedies under the contract, including placement on a corrective action plan.

Appendix D. Primary Data Collection Protocol

The evaluation design relies on primary data collection to address two evaluation questions and hypotheses, and six corresponding measures, outlined in Table 18 on page 74. While the external evaluator is ultimately responsible for developing and executing the primary data collection protocol, this appendix outlines the expectations of HHSC and CMS related to primary data collection for the current evaluation. The external evaluator's ability to execute the primary data collection protocol outlined in this appendix is dependent on completion of prerequisite preparations for primary data collection (e.g., execution of the external evaluation contract, development of primary data collection tools, and IRB approval). Delays in these processes may alter this primary data collection protocol. Necessary adjustments or refinements to the plans outlined in this Appendix will be relayed to CMS in Quarterly Monitoring Reports for the Demonstration. CMS may provide feedback on proposed adjustments or refinements to the primary data collection protocol, when necessary.

Methods of Primary Data Collection

Primary data collection activities for the evaluation will include an MCO survey, a provider survey, and interviews with providers. Table 18 outlines possible primary data collection methods by evaluation question.

Table 18. Proposed Methods of Primary Data Collection

Evaluation Hypothesis	Purpose of Primary Data Collection	Corresponding Measures	Targeted Populations	Method(s) of Primary Data Collection
H8.2. The directed and supplemental payment programs support Medicaid provider operations and sustainability.	Gather perceptions on the benefits and challenges of directed and supplemental payment programs, including future priorities.	8.2.1 Participation in directed and supplemental payment programs 8.2.2 Need for directed and supplemental payment programs 8.2.3 Perceived benefits and challenges directed and supplemental payment programs 8.2.4 Provider perspectives on state priorities and policy development	• DPP providers • PHP-CCP program providers • UC program providers	• Print and/or online provider survey • Interviews
H9.1. The implementation of APMs in Texas Medicaid will increase over time.	Gather perceptions on the benefits and challenges of implementing APMs.	9.1.4 Perceived benefits of implementing APMs 9.1.5 Perceived challenges with implementing APMs	• MCOs • DPP providers • PHP-CCP program providers • UC program providers	• Print and/or online MCO survey • Print and/or online provider survey

Notes. DPP=Directed Payment Program; SPP=Supplemental Payment Program; PHP-CCP=Public Health Provider-Charity Care Pool; UC=Uncompensated Care; APM=Alternative Payment Model; MCO=Managed care organization.

Development of Primary Data Collection Tools

The external evaluator will develop corresponding surveys and interview guides to fully address evaluation questions, hypotheses, and measures relying on primary data collection. Appendix E provides required topics and example questions for measures relying on primary data collection to support development of primary data collection tools. To the extent possible, the external evaluator will model questions after existing and previously validated tools. The external evaluator should also incorporate Mathematica's best practices for designing and administering beneficiary surveys specific to 1115 demonstration evaluations (Matulewicz, Bradley, & Wagner, 2019). Additionally, the external evaluator should assess relevant external factors at the time of administration, in order to develop and frame corresponding surveys and/or guides carefully, and add contextual background, where necessary, to ensure feedback reflects the Demonstration, rather than external factors, such as unrelated changes to the Medicaid landscape or the COVID-19 pandemic, which may confound evaluation results. Lastly, the external evaluation should revisit surveys and interview guides through the Extension approval period to ensure tools are updated, as needed, to reflect new changes to APM or funding pool operations between DY10 and 19.

Sampling Strategy

The external evaluator will develop and execute a sampling strategy for each method of primary data collection (i.e., MCO survey, provider survey, and interviews with providers). Table 19 outlines the sampling technique for each method of primary data collection. The external evaluator may adjust the proposed sampling strategy outlined in Table 19 where necessary based on final MCO and provider demographic characteristics, however care should be taken to ensure the sample is representative at the statewide level (e.g., survey weights may be used to ensure demographic subgroups are appropriately represented in the statewide samples). The evaluator should detail the executed sampling strategy, including any modifications to Table 19, in Semi-Annual Monitoring Reports submitted to HHSC,[29] and subsequently through the Interim and Summative Evaluation Reports submitted to CMS.

[29] HHSC will document details on the executed sampling strategy to CMS via Quarterly Monitoring Reports for the Demonstration.

Table 19. Proposed Sampling Strategy for Primary Data Collection

Method of Primary Data Collection	Study Population	Sampling Technique	Target Analytic Sample[1]
Print and/or online MCO survey	• MCOs (17)[2]	At least one representative from each MCOs.	17
Print and/or online provider survey	• DPP providers (1,923)[3] • UC program providers (527)[4] • PHP-CCP program providers (300)[5,6]	Stratified random sample of providers based on DPP/SPP program participation and key demographic subgroups (e.g., region, provider type)	350[7]
Interviews	• Provider survey respondents (300)	Purposive sample of provider survey respondents with varying perspectives on funding pools (e.g., Maximum Variation Sampling) (Etikan, Musa, & Alkassin, 2015)	20

Notes. [1] The external evaluator will apply survey weights to ensure survey samples are representative of providers. [2] Reflects the number of Medicaid MCO contracts at the time of writing. [3] Reflects the estimated number of providers to be served by the four new DPPs in SFY 21 (CHIRP, DPP BHS, TIPPS, and RAPPS; N=709), plus the number nursing facilities eligible to participate in QIPP during SFY 21 (N=1,214). [4] Reflects the number of UC providers during DY 9. [5] Reflects the estimated number of providers to be served by the PHP-CCP at the time of writing. [6] Providers may participate in more than one funding pool (e.g., multiple DPPs and/or DPPs and UC). The external evaluator should de-duplicate providers before executing the proposed sampling technique. [7] Target analytic sample meets conventional criteria for statistical power (0.80) at $\alpha = 0.05$, based on largest possible sample (no overlap in providers across funding pools). The final analytic sample needed to meet conventional criteria for statistical power may vary due to overlap in providers across funding pools.

Primary Data Collection Analytic Methods

Descriptive Statistics

Closed-ended survey questions may be examined through a variety of descriptive statistics. The external evaluator will apply survey weights to close-ended survey items to ensure aggregate results are representative of the respective population. Descriptive statistics include estimates of central tendency and dispersion. For survey questions modeled from existing and previously validated tools, the external evaluator should use publicly available state or national benchmarks, where feasible, to support interpretation of findings.

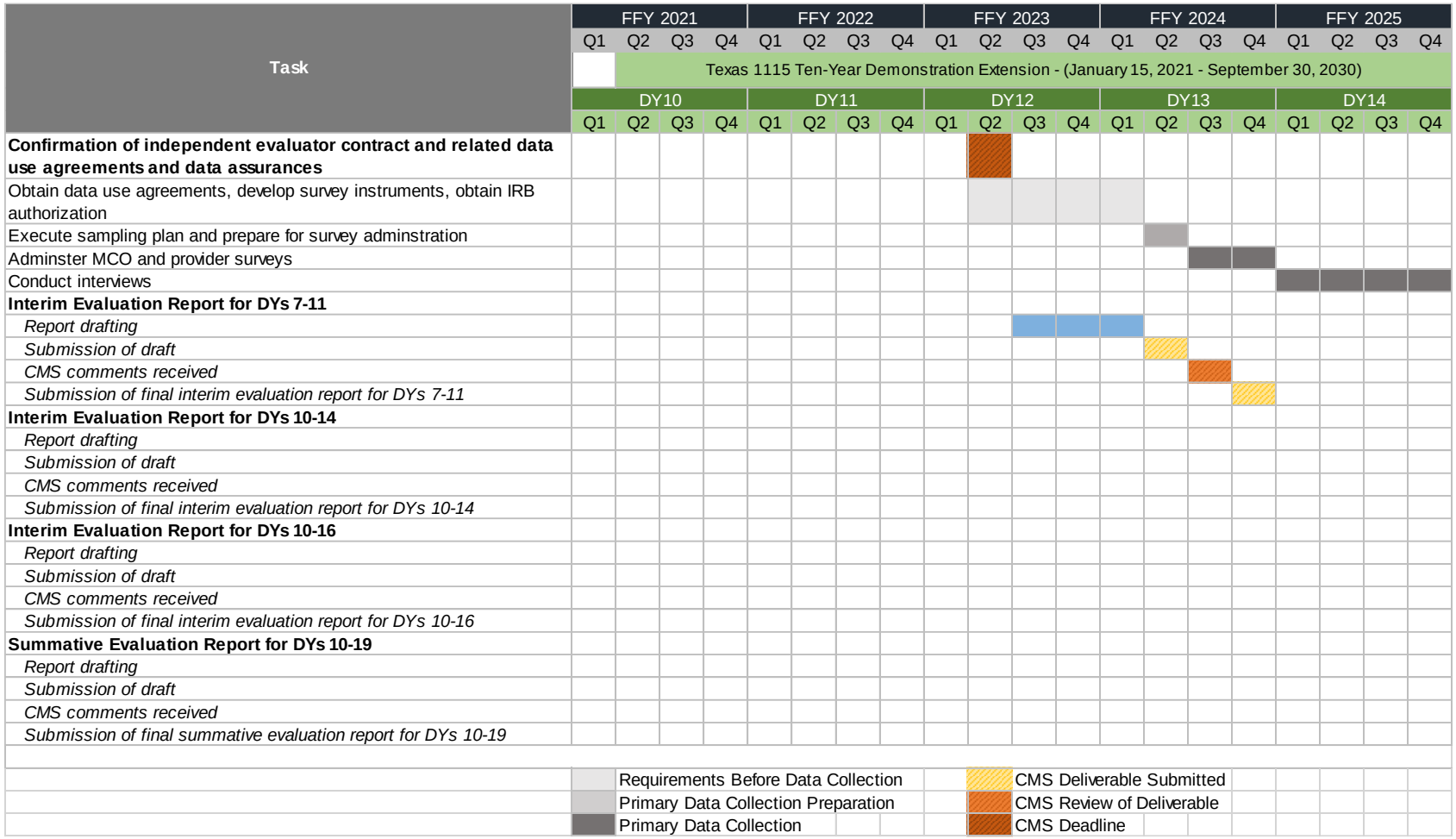
Qualitative Analysis

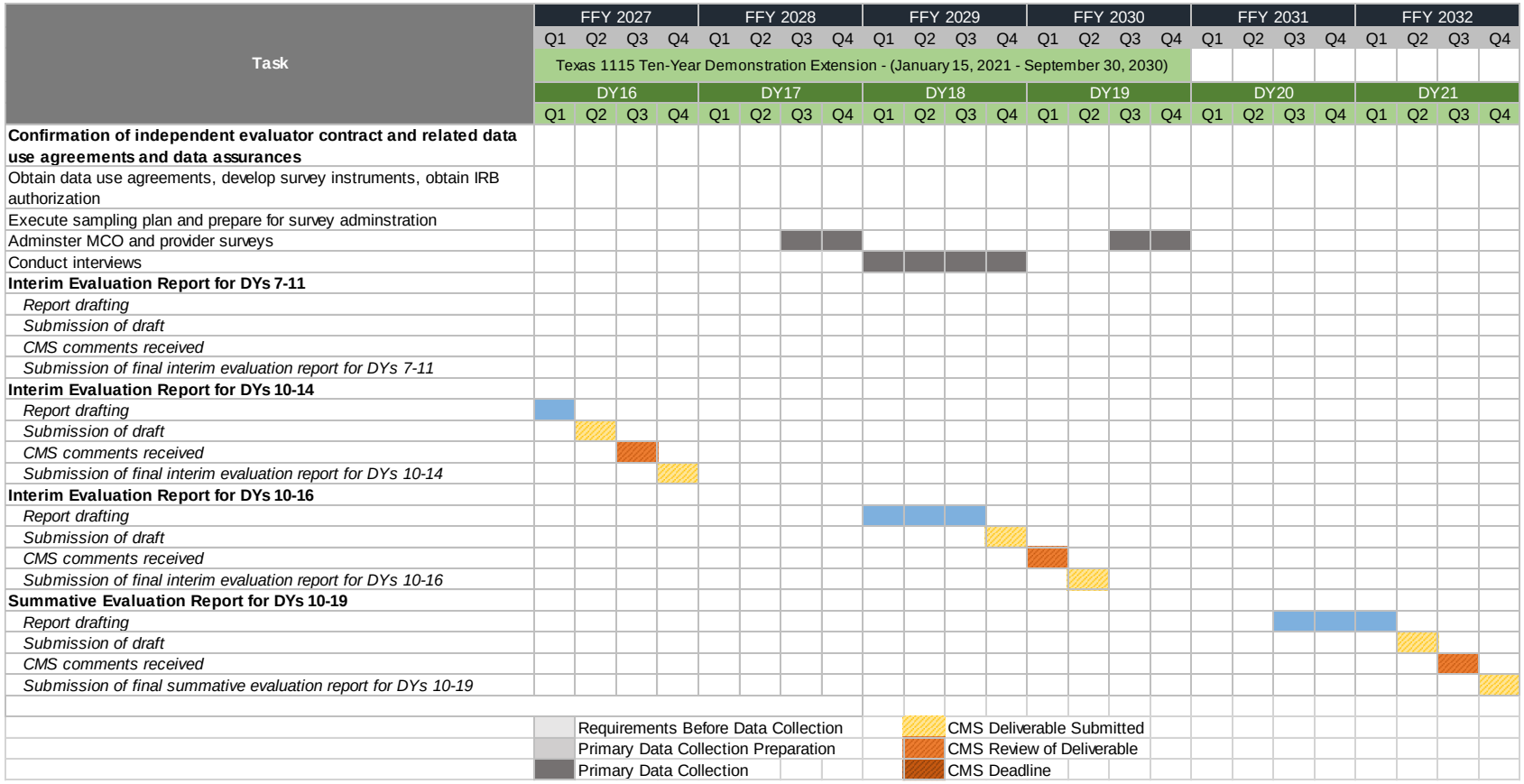
The appropriate methods for qualitative analysis will depend on the method of primary data collection and type of information gathered. The external evaluator may review open-ended survey responses using content analysis. Content analysis is used when the coding structure is based on previous theory and findings and/or a predefined set of hypotheses (Elo & Kyngas, 2008) which may be appropriate for some survey questions (e.g., focused or narrowly defined open-ended items). However, more advanced qualitative techniques will be required for stand-alone open-ended survey questions or interviews, such as thematic content analysis. Thematic content analysis is a qualitative analytic approach that identifies and codes patterns or themes in the data using inductive or deducting reasoning (Vaismoradi, Turunen, & Bondas, 2013). A strength of thematic content analysis is its ability to examine similarities and differences in the perspectives of study participants (Nowell, Norris, White, & Moules, 2017). As with quantitative approaches to data analysis, the external evaluator should incorporate subgroup analyses, where applicable.

Timing of Primary Data Collection Activities

After the external evaluation contract is executed, the external evaluator will begin obtaining data use agreements, developing survey instruments, and applying for IRB approval within their institution and with HHS, after which the external evaluator will execute the sampling plan, and prepare for primary data collection administration through survey printing and/or online survey development. HHSC estimates the MCO and provider surveys will be initially deployed approximately one year after the external evaluation contract is executed (Q3 of DY13), with additional waves occurring biannually, as deemed necessary and feasible by the external evaluator (4 possible waves). HHSC estimates interviews with providers will be conducted 3-6 months after the initial provider survey is deployed (Q1 of DY14). Due to the large labor investment required to conduct and analyze provider interviews, HHSC estimates the external evaluator will only conduct one additional round of interviews starting in Q1 of DY18, but the external evaluator may pursue additional rounds of interviews, as deemed necessary and feasible by the external evaluator. Preliminary findings from primary data collection will first be reported in the Interim Evaluation Report covering DYs 10-14 (due no later than March 31, 2027), with additional findings presented in subsequent reports. Figure 6 depicts the estimated timeline for primary data collection activities alongside major Demonstration deliverables.

Figure 6. Estimated Primary Data Collection Protocol





Notes. FFY=Federal fiscal year, October 1-September 30; Q1=October, November, and December; Q2=January, February, and March; Q3=April, May, and June; Q4=July, August, and September; DY=Demonstration year, October 1-September 30; MCO=Managed care organization; CMS=Centers for Medicare and Medicaid Services.

Appendix E. Detailed Tables

MMC Component

Evaluation Question 1: Did the programmatic changes associated with the carve-in of NEMT into MMC improve health care outcomes for MMC clients?

H1.1. Utilization of NEMT services will increase as a result of programmatic changes associated with the carve-in of NEMT into MMC.

Measure 1.1.1	**MMC members utilizing NEMT services per month/quarter**
Definition	The unique count of MMC members with a paid NEMT service.
Study Population	MMC members utilizing NEMT services
Measure Steward or Source	N/A
Technical Specifications	Unique PCN count of MMC members with a paid FFS claim or MMC encounter for any NEMT service. The unique PCN count can be calculated per month or quarter.
Exclusion Criteria	If calculated quarterly: MMC members with one or more gaps in MMC enrollment lasting more than 45 days (or more than one month if enrollment determined monthly) during quarter
Data Source(s)/Data Collection Methods	• FFS claims and MMC encounter data • Member-level enrollment files • Provider-level enrollment data
Comparison Group(s)/ Subgroup(s)	Pre-post comparison:[1] • Pre: 9/1/2017 – 5/31/2021 • Post: 6/1/2021 – 5/31/2026 Member demographic and geographic characteristics, where applicable Provider characteristics, where applicable NEMT service type (DRTS, non-DRTS ride, non-ride service, etc.), where applicable
Analytic Methods	• Descriptive statistics • ITS
Interpretation	This measure is a direct indicator of utilization of NEMT services for MMC members.

Measure 1.1.1	MMC members utilizing NEMT services per month/quarter
Benchmark	None

Notes. [1] The COVID-19 pandemic substantially suppressed NEMT utilization; the external evaluator will take care to interpret and present pre-post comparisons within the appropriate context. MMC=Medicaid managed care; NEMT=Nonemergency medical transportation; PCN=Patient Control Number; FFS=Fee-for-service; DRTS=Demand response transportation services; ITS=Interrupted time series.

Measure 1.1.2	NEMT services per month/quarter
Definition	The total number of NEMT services provided.
Study Population	MMC members utilizing NEMT services
Measure Steward or Source	N/A
Technical Specifications	Count of unique NEMT services from paid FFS claims or MMC encounters. MMC members may have multiple paid NEMT services in a single day (e.g., round trips or multiple stops). Each paid NEMT service should be counted separately. The count of NEMT services can be calculated per month or quarter.
Exclusion Criteria	If calculated quarterly: MMC members with one or more gaps in MMC enrollment lasting more than 45 days (or more than one month if enrollment determined monthly) during quarter
Data Source(s)/Data Collection Methods	• FFS claims and MMC encounter data • Member-level enrollment files • Provider-level enrollment data
Comparison Group(s)/ Subgroup(s)	Pre-post comparison:[1] • Pre: 9/1/2017 – 5/31/2021 • Post: 6/1/2021 – 5/31/2026 Member demographic and geographic characteristics, where applicable Provider characteristics, where applicable NEMT service type (DRTS, non-DRTS ride, non-ride service, etc.), where applicable
Analytic Methods	• Descriptive statistics • ITS
Interpretation	This measure is a direct indicator of utilization of NEMT services for MMC members.
Benchmark	None

Notes. [1] The COVID-19 pandemic substantially suppressed NEMT utilization; the external evaluator will take care to interpret and present pre-post comparisons within the appropriate

context. NEMT=Nonemergency medical transportation; MMC=Medicaid managed care; FFS=Fee-for-service; DRTS=Demand response transportation services; ITS=Interrupted time series.

Measure 1.1.3	**Average NEMT services per month/quarter**
Definition	The average number of NEMT services provided.
Study Population	MMC members utilizing NEMT services
Measure Steward or Source	N/A
Technical Specifications	**Numerator**: Count of unique NEMT services from paid FFS claims or MMC encounters **Denominator**: Unique PCN count of MMC members with a paid FFS claim or MMC encounter for any NEMT service **Rate**: Numerator / Denominator The rate can be calculated per month or quarter. MMC members may have multiple paid NEMT services in a single day (e.g., round trips or multiple stops). Each paid NEMT service should be counted separately.
Exclusion Criteria	If calculated quarterly: MMC members with one or more gaps in MMC enrollment lasting more than 45 days (or more than one month if enrollment determined monthly) during quarter
Data Source(s)/Data Collection Methods	• FFS claims and MMC encounter data • Member-level enrollment files • Provider-level enrollment data
Comparison Group(s)/ Subgroup(s)	Pre-post comparison:[1] • Pre: 9/1/2017 – 5/31/2021 • Post: 6/1/2021 – 5/31/2026 Member demographic and geographic characteristics, where applicable Provider characteristics, where applicable NEMT service type (DRTS, non-DRTS ride, non-ride service, etc.), where applicable
Analytic Methods	• Descriptive statistics • ITS
Interpretation	This measure is a direct indicator of utilization of NEMT services for MMC members.
Benchmark	None

Notes. [1] The COVID-19 pandemic substantially suppressed NEMT utilization; the external evaluator will take care to interpret and present pre-post comparisons within the appropriate context. NEMT=Nonemergency medical transportation; MMC=Medicaid managed care; FFS=Fee-for-service; PCN=Patient Control Number; DRTS=Demand response transportation services; ITS=Interrupted time series.

H1.2. Access to health care services will maintain or improve as a result of programmatic changes associated with the carve-in of NEMT into MMC.

Measure 1.2.1	Adults' access to preventive/ambulatory health services (HEDIS®-like)
Definition	The percentage of MMC members utilizing NEMT services who accessed preventive/ambulatory health care services.
Study Population	MMC members utilizing NEMT services
Measure Steward or Source	NCQA (HEDIS®)-like measure: Adults' access to preventive/ambulatory health services (AAP)
Technical Specifications	**Numerator**: Number of MMC members utilizing NEMT services who had an ambulatory or preventive care visit **Denominator**: Number of MMC members utilizing NEMT services **Rate**: (Numerator / Denominator) * 100 The rate can be calculated per quarter or measurement year.
Exclusion Criteria	MMC members with one or more gaps in MMC enrollment lasting more than 45 days (or more than one month if enrollment determined monthly) during quarter or measurement year.
Data Source(s)/Data Collection Methods	• FFS claims and MMC encounter data • Member-level enrollment files • Provider-level enrollment data
Comparison Group(s)/ Subgroup(s)	Pre-post comparison: • Pre: 9/1/2017 – 5/31/2021 • Post: 6/1/2021 – 5/31/2026 Member demographic and geographic characteristics, where applicable Provider characteristics, where applicable NEMT service type (DRTS, non-DRTS ride, non-ride service, etc.), where applicable
Analytic Methods	• Descriptive statistics • DTA • ITS, if feasible
Interpretation	An increase in this measure following the transition of NEMT into MMC would suggest programmatic changes associated with the transition improved access to primary health care services for adult MMC members.

Measure 1.2.1	Adults' access to preventive/ambulatory health services (HEDIS®-like)
Benchmark	None

Notes. HEDIS®=Healthcare Effectiveness Data and Information Set; MMC=Medicaid managed care; NEMT=Nonemergency medical transportation; NCQA=National Committee for Quality Assurance; FFS=Fee-for-service; DRTS=Demand response transportation services; NCQA=National Committee for Quality Assurance; DTA=Descriptive trend analysis; ITS=Interrupted time series.

Measure 1.2.2	Child and adolescent well-care visits (HEDIS®)
Definition	The percentage of MMC members utilizing NEMT services who had at least one comprehensive well-care visit with a primary care practitioner or an obstetrician/gynecologist in measurement year.
Study Population	MMC members utilizing NEMT services
Measure Steward or Source	NCQA (HEDIS®): Child and adolescent well-care visits (W15, W34, AWC) The codes used to calculate this measure are publicly available on the Medicaid website: • 2021 Medicaid and CHIP Child Core Set: https://www.medicaid.gov/medicaid/quality-of-care/downloads/medicaid-and-chip-child-core-set-manual.pdf The external evaluator should use the same HEDIS® technical specifications to calculate this measure across the entire study period.
Technical Specifications	**Numerator**: Total number of unduplicated MMC members meeting denominator criteria with one or more well-care visits (as specified in CMS Well-Care Value Set) in measurement year **Denominator**: Total number of unduplicated MMC members utilizing NEMT services who were ages 3 to 21 at end of measurement year **Rate**: (Numerator / Denominator) * 100
Exclusion Criteria	MMC members with one or more gaps in MMC enrollment lasting more than 45 days (or more than one month if enrollment determined monthly) during measurement year
Data Source(s)/Data Collection Methods	• FFS claims and MMC encounter data • Member-level enrollment files • Provider-level enrollment data

Measure 1.2.2	Child and adolescent well-care visits (HEDIS®)
Comparison Group(s)/ Subgroup(s)	Pre-post comparison: • Pre: 9/1/2017 – 5/31/2021 • Post: 6/1/2021 – 5/31/2026 Member demographic and geographic characteristics, where applicable Provider characteristics, where applicable NEMT service type (DRTS, non-DRTS ride, non-ride service, etc.), where applicable
Analytic Methods	• Descriptive statistics • DTA
Interpretation	An increase in this measure following the transition of NEMT into MMC would suggest programmatic changes associated with the transition improved access to primary health care services for children and young adult MMC members.
Benchmark	Texas CMS Core Measure, 2019 Medicaid State Rate:[1] • W15: 66.1 • W34: 79.8 • AWC: 70.1 NCQA Quality Compass 2020, 50th Percentile Benchmark: • W15: 67.9 • W34: 74.7 • AWC: 57.2

Notes. [1] Texas CMS Core Measure rates available via the Texas Healthcare Learning Collaborative Portal: https://thlcportal.com/measures/cmscoremeasuredashboard. HEDIS®=Healthcare Effectiveness Data and Information Set; MMC=Medicaid managed care; NEMT=Nonemergency medical transportation; NCQA=National Committee for Quality Assurance; CHIP=Children's Health Insurance Program; CMS=Centers for Medicare and Medicaid Services; FFS=Fee-for-service; DRTS=Demand response transportation services; DTA=Descriptive trend analysis.

Measure 1.2.3	Utilization of pharmacy benefits
Definition	MMC members utilizing NEMT services who received pharmacy benefits.
Study Population	MMC members utilizing NEMT services
Measure Steward or Source	N/A

Measure 1.2.3	Utilization of pharmacy benefits
Technical Specifications	Utilization of pharmacy benefits is calculated using two rates: 1) MMC members utilizing pharmacy benefits, and 2) Medications filled. **Numerator 1**: Unique PCN count of MMC members meeting denominator criteria with a paid pharmacy claim **Denominator 1**: Unique PCN count of MMC members with a paid FFS claim or MMC encounter for any NEMT service **Rate 1**: (Numerator / Denominator) * 100 **Numerator 2**: Count of paid medications filled for MMC members meeting denominator criteria **Denominator 2**: Unique PCN count of MMC members with a paid FFS claim or MMC encounter for any NEMT service **Rate 2**: Numerator / Denominator Both rates can be calculated per month or quarter.
Exclusion Criteria	If calculated quarterly: MMC members with one or more gaps in MMC enrollment lasting more than 45 days (or more than one month if enrollment determined monthly) during quarter
Data Source(s)/Data Collection Methods	• FFS claims and MMC encounter data • Member-level enrollment files • Member-level pharmacy data • Provider-level enrollment data
Comparison Group(s)/ Subgroup(s)	Pre-post comparison: • Pre: 9/1/2017 – 5/31/2021 • Post: 6/1/2021 – 5/31/2026 Member demographic and geographic characteristics, where applicable Provider characteristics, where applicable NEMT service type (DRTS, non-DRTS ride, non-ride service, etc.), where applicable
Analytic Methods	• Descriptive statistics • ITS
Interpretation	An increase in this measure following the transition of NEMT into MMC would suggest programmatic changes associated with the transition improved access to pharmacy-related health care services for MMC members.
Benchmark	None

Notes. MMC=Medicaid managed care; NEMT=Nonemergency medical transportation; FFS=Fee-for-service; PCN=Patient Control Number; FFS=Fee-for-service; DRTS=Demand response transportation services; ITS=Interrupted time series.

H1.3 Treatment of chronic, complex, and serious conditions will maintain or improve as a result of programmatic changes associated with the carve-in of NEMT into MMC.

Measure 1.3.1	**Diabetes medication adherence**
Definition	Overall proportion of days covered (PDC) for diabetes medications among MMC members utilizing NEMT services.
Study Population	MMC members utilizing NEMT services
Measure Steward or Source	PQA, as detailed in CMS' Quality Rating System[1]
Technical Specifications	PDC is the number of "covered" days by prescription claims divided by the number of days in the treatment period. PDC will be calculated for PQA's "Diabetes All Class" therapeutic category. The Index Prescription Start Date (IPSD) is the earliest date of service for a target medication (at least 91 days before start of measurement year). The treatment period begins on the IPSD and continues through the last day of the measurement year. **Numerator**: MMC members meeting denominator criteria who meet or exceed the 80% PDC threshold during the measurement year, for the "Diabetes All Class" therapeutic category **Denominator**: Unique PCN count of MMC members (18 years or older on first day of measurement year) with a paid FFS claim or MMC encounter for any NEMT service and at least two prescriptions filled for qualifying diabetes medications on different dates of service within the treatment period **Rate**: (Numerator / Denominator) * 100 The external evaluator should use the same PQA technical specifications to calculate this measure across the entire study period.
Exclusion Criteria	MMC members with any gaps in enrollment during treatment period Any MMC members with one or more of the following: • In hospice • A paid FFS claim or MMC encounter with an end stage renal disease (primary diagnosis or in any other diagnosis filed) during treatment period • A paid prescription claim for insulin during treatment period

Measure 1.3.1	Diabetes medication adherence
Data Source(s)/Data Collection Methods	• FFS claims and MMC encounter data • Member-level enrollment files • Member-level pharmacy data
Comparison Group(s)/ Subgroup(s)	Pre-post comparison: • Pre: 9/1/2017 – 5/31/2021 • Post: 6/1/2021 – 5/31/2026 Member demographic and geographic characteristics, where applicable NEMT service type (DRTS, non-DRTS ride, non-ride service, etc.), where applicable
Analytic Methods	• Descriptive statistics • DTA
Interpretation	An increase in this measure following the transition of NEMT into MMC would suggest programmatic changes associated with the transition improved treatment of diabetes for MMC members.
Benchmark	None

Notes. [1] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/ACA-MQI/Quality-Rating-System/About-the-QRS. PDC=Proportion of days covered; MMC=Medicaid managed care; NEMT=Nonemergency medical transportation; PQA=Pharmacy Quality Alliance; CMS=Centers for Medicare and Medicaid Services; IPSD=Index Prescription Start Date; PCN=Patient Control Number; FFS=Fee-for-service; DRTS=Demand response transportation services; DTA=Descriptive trend analysis.

Measure 1.3.2	Testing HbA1c levels
Definition	Individuals with HbA1c tests during the measurement period among MMC members utilizing NEMT services.
Study Population	MMC members utilizing NEMT services
Measure Steward or Source	N/A
Technical Specifications	**Numerator**: MMC members meeting denominator criteria with at least one HbA1c test (using CPT codes 83036, 83037, 83020, or 83021) **Denominator**: Unique PCN count of MMC members with a paid FFS claim or MMC encounter for any NEMT service and a paid FFS claim or MMC encounter with a diabetes diagnosis during measurement period **Rate**: (Numerator / Denominator) * 100 Rate can be calculated quarter or measurement year.
Exclusion Criteria	MMC members with one or more gaps in MMC enrollment lasting more than 45 days (or more than one month if enrollment determined monthly) during quarter or measurement year

Measure 1.3.2	Testing HbA1c levels
Data Source(s)/Data Collection Methods	• FFS claims and MMC encounter data • Member-level enrollment files
Comparison Group(s)/ Subgroup(s)	Pre-post comparison: • Pre: 9/1/2017 – 5/31/2021 • Post: 6/1/2021 – 5/31/2026 Member demographic and geographic characteristics, where applicable NEMT service type (DRTS, non-DRTS ride, non-ride service, etc.), where applicable
Analytic Methods	• Descriptive statistics • DTA • ITS, if feasible
Interpretation	An increase in this measure following the transition of NEMT into MMC would suggest programmatic changes associated with the transition improved treatment of diabetes for MMC members.
Benchmark	None

Notes. HbA1c=Glycosylated Hemoglobin, Type A1c; MMC=Medicaid managed care; NEMT=Nonemergency medical transportation; PCN=Patient Control Number; CPT=Current Procedural Terminology; FFS=Fee-for-service; DRTS=Demand response transportation services; DTA=Descriptive trend analysis; ITS=Interrupted time series.

Measure 1.3.3	Asthma Medication Ratio (HEDIS®)
Definition	The percentage of MMC members with a paid NEMT service between 5-64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year
Study Population	MMC members utilizing NEMT services

Measure 1.3.3	Asthma Medication Ratio (HEDIS®)
Measure Steward or Source	NCQA (HEDIS®): Asthma medication ratio (AMR) The codes used to calculate this measure are publicly available on the Medicaid website: • 2021 Medicaid and CHIP Adult Core Set: https://www.medicaid.gov/medicaid/quality-of-care/downloads/medicaid-adult-core-set-manual.pdf • 2021 Medicaid and CHIP Child Core Set: https://www.medicaid.gov/medicaid/quality-of-care/downloads/medicaid-and-chip-child-core-set-manual.pdf The external evaluator should use the same HEDIS® technical specifications to calculate this measure across the entire study period.
Technical Specifications	**Numerator:** MMC members meeting denominator criteria who have an asthma medication ratio of 0.50 or greater during the measurement year **Denominator:** Unique PCN count of MMC members with a paid FFS claim or MMC encounter for any NEMT service during the measurement year with persistent asthma in both the current and previous measurement years (as specified in CMS Value Sets) **Rate**: (Numerator / Denominator) * 100 Rates should be presented across the following age stratifications (based on age at end measurement year): 5-11 years; 12-18 years; 19-50 years; 51-64 years
Exclusion Criteria	MMC members with one or more gaps in MMC enrollment lasting more than 45 days (or more than one month if enrollment determined monthly) during the current and previous measurement years MMC members who have a diagnosis of: • Emphysema • Chronic obstructive pulmonary disease • Obstructive chronic bronchitis • Chronic respiratory conditions due to fumes/vapors • Cystic fibrosis • Acute respiratory failure (with no asthma controller or reliever medications dispensed)
Data Source(s)/Data Collection Methods	• FFS claims and MMC encounter data • Member-level enrollment files • Member-level pharmacy data

Measure 1.3.3	Asthma Medication Ratio (HEDIS®)
Comparison Group(s)/ Subgroup(s)	Pre-post comparison: • Pre: 9/1/2017 – 5/31/2021 • Post: 6/1/2021 – 5/31/2026 Member demographic and geographic characteristics, where applicable NEMT service type (DRTS, non-DRTS ride, non-ride service, etc.), where applicable
Analytic Methods	• Descriptive statistics • DTA
Interpretation	An increase in this measure following the transition of NEMT into MMC would suggest programmatic changes associated with the transition improved treatment of asthma for MMC members.
Benchmark	Texas CMS Core Measure, 2019 State Rate:[1] • Ages 5-11: 72.4 • Ages 12-18: 64.4 • Ages 19-50: 61.7 • Ages 51-64: 55.0 NCQA Quality Compass 2020, 50th Percentile Benchmark: • Ages 5-11: 73.9 • Ages 12-18: 65.5 • Ages 19-50: 53.3 • Ages 51-64: 56.3

Notes. [1] Texas CMS Core Measure rates available via the Texas Healthcare Learning Collaborative Portal: https://thlcportal.com/measures/cmscoremeasuredashboard. HEDIS®=Healthcare Effectiveness Data and Information Set; MMC=Medicaid managed care; NEMT=Nonemergency medical transportation; NCQA=National Committee for Quality Assurance; CHIP=Children's Health Insurance Program; PCN=Patient Control Number; FFS=Fee-for-service; CMS=Centers for Medicare and Medicaid Services; DRTS=Demand response transportation services; DTA=Descriptive trend analysis.

H1.4 Preventable emergency department use will maintain or decrease as a result of programmatic changes associated with the carve-in of NEMT into MMC.

Measure 1.4.1	Prevention quality overall composite (PQI #90)
Definition	Overall composite measure of hospital admissions for acute conditions per 100,000 adult population among MMC members with a paid NEMT service.
Study Population	MMC members utilizing NEMT services

Measure 1.4.1	Prevention quality overall composite (PQI #90)
Measure Steward or Source	AHRQ The codes used to calculate this measure are publicly available on the AHRQ website. At the time of writing, July 2021 PQI Technical Specifications were available at: • Prevention Quality Indicators Technical Specifications, Version v2021: https://qualityindicators.ahrq.gov/Modules/PQI_TechSpec_ICD10_v2021.aspx The external evaluator should use the same PQI technical specifications to calculate this measure across the entire study period.
Technical Specifications	The measure includes admissions with a principal diagnosis of one of the following conditions: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary, disease, asthma, hypertension, heart failure, angina without a cardiac procedure, dehydration, bacterial pneumonia, or urinary tract infection. **Numerator**: MMC members meeting denominator criteria who meet the inclusion and exclusion rules for the numerator in any of the PQIs included in the overall composite measure (PQI #s 1, 3, 5, 7, 8, 10, 11, 12, 13, 14, 15, and 16)[1] **Denominator**: Unique PCN count of MMC members ages 18 or older with a paid FFS claim or MMC encounter for any NEMT service during measurement period **Rate**: (Numerator / Denominator) * 100 The rate can be calculated per quarter or measurement year. However, quarterly rates should be interpreted with caution given seasonal differences for many conditions.
Exclusion Criteria	MMC members with one or more gaps in MMC enrollment lasting more than 45 days (or more than one month if enrollment determined monthly) during quarter or DY Numerator exclusion criteria defined for each PQI
Data Source(s)/Data Collection Methods	• FFS claims and MMC encounter data • Member-level enrollment files • Provider-level enrollment data

Measure 1.4.1	Prevention quality overall composite (PQI #90)
Comparison Group(s)/ Subgroup(s)	Pre-post comparison: • Pre: 9/1/2017 – 5/31/2021 • Post: 6/1/2021 – 5/31/2026 Member demographic and geographic characteristics, where applicable Provider characteristics, where applicable NEMT service type (DRTS, non-DRTS ride, non-ride service, etc.), where applicable
Analytic Methods	• Descriptive statistics • DTA • ITS, if feasible
Interpretation	A decrease in this measure following the transition of NEMT into MMC would suggest programmatic changes associated with the transition reduced avoidable hospital admissions for adult MMC members.
Benchmark	None

Notes. [1] MMC members who meet the inclusion and exclusion criteria rules for the numerator in more than one PQI are only counted once in the overall composite measure. PQI=Prevention quality indicators; MMC=Medicaid managed care; NEMT=Nonemergency medical transportation; AHRQ=Agency for Healthcare Research and Quality; FFS=Fee-for-service; DRTS=Demand response transportation services; DTA=Descriptive trend analysis; ITS=Interrupted time series.

Measure 1.4.2	Pediatric quality overall composite (PDI #90)
Definition	Overall composite measure of hospital admissions for acute conditions per 100,000 child population among MMC members with a paid NEMT service.
Study Population	MMC members utilizing NEMT services
Measure Steward or Source	AHRQ The codes used to calculate this measure are publicly available on the AHRQ website. At the time of writing, July 2021 PDI Technical Specifications were available at: • Pediatric Quality Indicators Technical Specifications, Version v2021: https://qualityindicators.ahrq.gov/Modules/PDI_TechSpec_ICD10_v2021.aspx The external evaluator should use the same PDI technical specifications to calculate this measure across the entire study period.

Measure 1.4.2	Pediatric quality overall composite (PDI #90)
Technical Specifications	The measure includes admissions with a principal diagnosis of one of the following conditions: asthma, diabetes with short-term complications, gastroenteritis, or urinary tract infection. **Numerator**: Number of hospital discharges for MMC members utilizing NEMT services, ages 6 to 17, that meet the inclusion and exclusion rules for the numerator in any of the PDIs included in the overall composite measure (PDI #s 14, 15, 16, and 18)[1] **Denominator**: Unique PCN count of MMC members ages 6 to 17 with a paid FFS claim or MMC encounter for any NEMT service during measurement period **Rate**: (Numerator / Denominator) * 100 The rate can be calculated per quarter or measurement year. However, quarterly rates should be interpreted with caution given seasonal differences for many conditions.
Exclusion Criteria	MMC members with one or more gaps in MMC enrollment lasting more than 45 days (or more than one month if enrollment determined monthly) during quarter or DY Numerator exclusion criteria defined for each PDI
Data Source(s)/Data Collection Methods	• FFS claims and MMC encounter data • Member-level enrollment files • Provider-level enrollment data
Comparison Group(s)/ Subgroup(s)	Pre-post comparison: • Pre: 9/1/2017 – 5/31/2021 • Post: 6/1/2021 – 5/31/2026 Member demographic and geographic characteristics, where applicable Provider characteristics, where applicable NEMT service type (DRTS, non-DRTS ride, non-ride service, etc.), where applicable
Analytic Methods	• Descriptive statistics • DTA • ITS, if feasible
Interpretation	A decrease in this measure following the transition of NEMT into MMC would suggest programmatic changes associated with the transition reduced avoidable hospital admissions for child MMC members.

Measure 1.4.2	Pediatric quality overall composite (PDI #90)
Benchmark	None

Notes. [1] MMC members who meet the inclusion and exclusion criteria rules for the numerator in more than one PDI are only counted once in the overall composite measure. PDI=Pediatric quality indicators; MMC=Medicaid managed care; NEMT=Nonemergency medical transportation; AHRQ=Agency for Healthcare Research and Quality; FFS=Fee-for-service; DRTS=Demand response transportation services; DTA=Descriptive trend analysis; ITS=Interrupted time series.

Measure 1.4.3	Rate of potentially preventable emergency department use
Definition	An emergency treatment for a condition that did not require immediate medical care; required immediate medical care but care could have been provided in a primary care setting; or, required immediate medical care but the nature of the condition was potentially preventable or avoidable if timely and effective primary care had been provided among MMC members with a paid NEMT service.
Study Population	MMC members utilizing NEMT services
Measure Steward or Source	NYU Wagner: https://wagner.nyu.edu/faculty/billings/nyued-articles
Technical Specifications	Using the NYU algorithm, potentially preventable ED use is defined as ED visits that are: • Non-emergent; • Emergent, but primary care treatable; or, • Emergent and ED care needed, but preventable/avoidable **Numerator**: Unique count of potentially preventable ED visits meeting denominator criteria **Denominator**: Unique count of ED visits during measurement period among of MMC members with a paid FFS claim or MMC encounter for any NEMT service **Rate**: (Numerator / Denominator) * 100 Rate can be calculated per month or quarter.
Exclusion Criteria	None
Data Source(s)/Data Collection Methods	• FFS claims and MMC encounter data • Member-level enrollment files

Measure 1.4.3	Rate of potentially preventable emergency department use
Comparison Group(s)/ Subgroup(s)	Pre-post comparison: • Pre: 9/1/2017 – 5/31/2021 • Post: 6/1/2021 – 5/31/2026 Member demographic and geographic characteristics, where applicable Provider characteristics, where applicable NEMT service type (DRTS, non-DRTS ride, non-ride service, etc.), where applicable
Analytic Methods	• Descriptive statistics • DTA • ITS, if feasible
Interpretation	A decrease in this measure following the transition of NEMT into MMC would suggest programmatic changes associated with the transition reduced preventable emergency department use for MMC members.
Benchmark	N/A

Notes. NYU=New York University; ED=Emergency department; PPV=Potentially preventable emergency department visit. NEMT=Nonemergency medical transportation; AHRQ=Agency for Healthcare Research and Quality; FFS=Fee-for-service; DRTS=Demand response transportation services; DTA=Descriptive trend analysis; ITS=Interrupted time series.

H1.5 Experiences with transportation services will improve as a result of programmatic changes associated with the carve-in of NEMT into MMC.

Measure 1.5.1	Familiarity with transportation services
Definition	Self-reported familiarity with transportation services
Study Population	MMC members utilizing NEMT services
Measure Steward or Source	N/A
Technical Specifications	Possible survey questions include: • Did you know the MTP/MCO offers help with [*transportation service type*]?
Exclusion Criteria	None
Data Source(s)/Data Collection Methods	EQRO's Medical Transportation Program Client Satisfaction Survey

Measure 1.5.1	Familiarity with transportation services
Comparison Group(s)/ Subgroup(s)	Pre-post comparison: • Pre: SFYs 2019 – 2020[1] • Post: SFYs 2021 – 2026[2] Member demographic and geographic characteristics, where applicable Transportation service type (mass transit, DRTS, mileage reimbursement, etc.), where applicable
Analytic Methods	• Descriptive statistics • DTA
Interpretation	Increases in this measure following the transition of NEMT into MMC would suggest the programmatic changes associated with the transition improved MMC members' awareness of NEMT services available.
Benchmark	N/A

Notes. [1] The pre-period reflects when the EQRO began administering the Medical Transportation Program Client Satisfaction Survey (SFY 2019). [2] Availability of this measure through SFY 2026 is contingent on continuity in the EQRO's administration of the Medical Transportation Program Client Satisfaction Survey. NEMT=Nonemergency medical transportation; MMC=Medicaid managed care; EQRO=Texas's External Quality Review Organization; SFY=State Fiscal Year, September 1-August 31; DTA=Descriptive trend analysis.

Measure 1.5.2	Transportation-related barriers to care
Definition	Self-reported transportation-related barriers to obtaining medical/dental care experienced in past 12 months
Study Population	MMC members utilizing NEMT services
Measure Steward or Source	N/A
Technical Specifications	Possible survey questions include: • In the past 12 months, how difficult was it for you/your child to find transportation to the doctor or dentist? • In the past 12 months, has a lack of transportation kept you/your child from medical appointments or getting medication? • In the past 12 months, how often have you/has your child missed a medical or dental appointment because of a lack of transportation? • In the past 12 months, how often was it easy to [*use specific transportation service type*]?
Exclusion Criteria	None
Data Source(s)/Data Collection Methods	EQRO's Medical Transportation Program Client Satisfaction Survey

Measure 1.5.2	Transportation-related barriers to care
Comparison Group(s)/ Subgroup(s)	Pre-post comparison: • Pre: SFYs 2019 – 2020[1] • Post: SFYs 2021 – 2026[2] Member demographic and geographic characteristics, where applicable Transportation service type (mass transit, DRTS, mileage reimbursement, etc.), where applicable
Analytic Methods	• Descriptive statistics • DTA
Interpretation	Decreases in transportation-related barriers following the transition of NEMT into MMC would suggest programmatic changes associated with the transition reduced MMC members' perceived barriers to care.
Benchmark	N/A

Notes. [1] The pre-period reflects when the EQRO began administering the Medical Transportation Program Client Satisfaction Survey (SFY 2019). [2] Availability of this measure through SFY 2026 is contingent on continuity in the EQRO's administration of the Medical Transportation Program Client Satisfaction Survey. NEMT=Nonemergency medical transportation; MMC=Medicaid managed care; EQRO=Texas's External Quality Review Organization; SFY=State Fiscal Year, September 1-August 31; DTA=Descriptive trend analysis.

Measure 1.5.3	Satisfaction with transportation services
Definition	Self-reported satisfaction with transportation services
Study Population	MMC members utilizing NEMT services
Measure Steward or Source	N/A
Technical Specifications	Possible survey questions include: • Overall, how satisfied were you on average with all the transportation services you/your child received from Medicaid in the past 12 months? • In the past 12 months, how satisfied were you overall with [*transportation service type*] you/your child received from Medicaid?
Exclusion Criteria	None
Data Source(s)/Data Collection Methods	EQRO's Medical Transportation Program Client Satisfaction Survey
Comparison Group(s)/ Subgroup(s)	Pre-post comparison: • Pre: SFYs 2019 – 2020[1] • Post: SFYs 2021 – 2026[2] Member demographic and geographic characteristics, where applicable Transportation service type (mass transit, DRTS, mileage reimbursement, etc.), where applicable

Measure 1.5.3	Satisfaction with transportation services
Analytic Methods	• Descriptive statistics • DTA
Interpretation	Increases in this measure following the transition of NEMT into MMC would suggest programmatic changes associated with the transition improved MMC members' satisfaction with NEMT services.
Benchmark	N/A

Notes. [1] The pre-period reflects when the EQRO began administering the Medical Transportation Program Client Satisfaction Survey (SFY 2019). [2] Availability of this measure through SFY 2026 is contingent on continuity in the EQRO's administration of the Medical Transportation Program Client Satisfaction Survey. NEMT=Nonemergency medical transportation; MMC=Medicaid managed care; EQRO=Texas's External Quality Review Organization; SFY=State Fiscal Year, September 1-August 31; DTA=Descriptive trend analysis.

Evaluation Question 2: Does STAR+PLUS HCBS improve health care outcomes for MMC clients?

H2.1. STAR+PLUS HCBS serves a distinct population of MMC members.

Measure 2.1.1	MMC members enrolled in STAR+PLUS HCBS
Definition	The unique count of MMC members enrolled in STAR+PLUS HCBS.
Study Population	STAR+PLUS HCBS members
Measure Steward or Source	N/A
Technical Specifications	**Numerator**: Unique PCN count of MMC members enrolled in STAR+PLUS HCBS. **Denominator**: Unique PCN count of MMC members enrolled in STAR+PLUS. **Rate**: (Numerator / Denominator) * 100 The external evaluator should present both the numerator and the rate as part of this measure. The numerator and rate can be calculated per month or quarter.
Exclusion Criteria	If calculated quarterly: MMC members with one or more gaps in MMC enrollment lasting more than 45 days (or more than one month if enrollment determined monthly) during quarter
Data Source(s)/Data Collection Methods	• Member-level enrollment files

Measure 2.1.1	MMC members enrolled in STAR+PLUS HCBS
Comparison Group(s)/ Subgroup(s)	Post Only: 9/1/2014 – 8/31/2029[1] Member demographic and geographic characteristics, where applicable
Analytic Methods	• Descriptive statistics • DTA
Interpretation	This measure is a direct indicator of MMC members served by STAR+PLUS HCBS.
Benchmark	None

Notes. [1] The post-period ends on August 31, 2029, approximately one year before the Ten-Year Demonstration Extension approval period ends. The external evaluator may extend the post-period if additional data become available prior to the Summative Evaluation Report. MMC=Medicaid managed care; STAR+PLUS=MMC program serving aged and disabled clients; HCBS= Home and community-based services; PCN=Patient Control Number; DTA=Descriptive trend analysis.

Measure 2.1.2	Medically fragile individuals enrolled in STAR+PLUS HCBS
Definition	A summary of medically fragile individuals enrolled in STAR+PLUS HCBS.
Study Population	STAR+PLUS HCBS members
Measure Steward or Source	N/A
Technical Specifications	Total number of medically fragile individuals receiving Medicaid-paid services beyond the STAR+PLUS HCBS cost cap, per SFY. Total number of medically fragile individuals on the interest list to receive Medicaid-paid services beyond the STAR+PLUS HCBS cost cap, per SFY. If no individuals are on the interest list, total number will be reported as zero. Total (sum) and average (per person) cost of Medicaid-paid HCBS services beyond the STAR+PLUS HCBS cost cap provided to medically fragile individuals, per SFY.
Exclusion Criteria	None
Data Source(s)/Data Collection Methods	• STAR+PLUS HCBS administrative data
Comparison Group(s)/ Subgroup(s)	Post Only: 11/16/2023[1] – 8/31/2029[2]
Analytic Methods	• Descriptive statistics • DTA

Measure 2.1.2	Medically fragile individuals enrolled in STAR+PLUS HCBS
Interpretation	This measure is a direct indicator of medically fragile individuals served by STAR+PLUS HCBS.
Benchmark	STAR+PLUS HCBS annual cost limits are 202% of the average nursing facility rate, based on the individual's resource utilization group value (approximately $70,000 to $250,000 per year).[3]

Notes. [1] HHSC submitted an amendment to allow services for medically fragile individuals to be delivered via managed care on February 22, 2021. CMS approved the amendment on November 16, 2023. Services beyond the STAR+PLUS HCBS cost cap transitioned to managed care on November 16, 2023, for medically fragile individuals with service plans renewed on or after July 1, 2024. [2] The post-period ends on August 31, 2029, approximately one year before the Ten-Year Demonstration Extension approval period ends. The external evaluator may extend the post-period if additional data become available prior to the Summative Evaluation Report. [3] STAR+PLUS HCBS annual cost limits are provided for contextual purposes only; costs for medically fragile individuals should not be directly compared to STAR+PLUS HCBS annual cost limits. Similarly, any direct or indirect comparisons between costs for medically fragile individuals and average nursing facility rates would also be inappropriate and misleading. The STAR+PLUS HCBS program, and additional services provided to medically fragile individuals, were designed to provide individuals requiring a nursing facility level of care the opportunity to receive comprehensive services in a community setting within the budget neutrality requirements of the 1115 Demonstration; the program was not designed to align with the average cost of care for clients served in a nursing facility. MMC=Medicaid managed care; STAR+PLUS=MMC program serving aged and disabled clients; HCBS= Home and community-based services; SFY=State Fiscal Year; DTA=Descriptive trend analysis.

H2.2. STAR+PLUS HCBS supports MMC members' treatment of chronic, complex, and serious conditions.

Measure 2.2.1	Diabetes care measures (HEDIS®)
Definition	The percentage of STAR+PLUS HCBS members with type 1 or type 2 diabetes who: • Had an eye exam (retinal) performed, • Received an annual kidney health evaluation, or • Received and adhered to statin therapy.
Study Population	STAR+PLUS HCBS members
Measure Steward or Source	EQRO-calculated NCQA (HEDIS®) measures: • Eye Exam for Patients With Diabetes (EED) • Kidney Health Evaluation for Patients With Diabetes (KED) • Statin Therapy for Patients With Diabetes (SPD)
Technical Specifications	**Eye Exam Numerator:** Patients with an eye screening for diabetic retinal disease during CY **Eye Exam Denominator:** Patients ages 18 to 75 with type 1 or type 2 diabetes **Eye Exam Rate:** (Numerator / Denominator) * 100

Measure 2.2.1	Diabetes care measures (HEDIS®)
	Kidney Health Numerator: Patients who received an annual kidney health evaluation, including a blood test for kidney function during CY **Kidney Health Denominator:** Patients ages 18 to 75 with type 1 or type 2 diabetes **Kidney Health Rate:** (Numerator / Denominator) * 100 **Statin Therapy Numerator 1:** Patients who received statin therapy during CY **Statin Therapy Numerator 2:** Patients who adhered with statin therapy at least 80% during CY **Statin Therapy Denominator:** Patients ages 40 to 75 with type 1 or type 2 diabetes, who do not have clinical atherosclerotic cardiovascular disease **Statin Therapy Rate 1 (received statin therapy):** (Numerator 1 / Denominator) * 100 **Statin Therapy Rate 2 (adhered to statin therapy):** (Numerator 2 / Denominator) * 100
Exclusion Criteria	STAR+PLUS HCBS members enrolled in Medicare (dual eligible) STAR+PLUS HCBS members with one or more gaps in MMC enrollment lasting more than 45 days (or more than one month if enrollment determined monthly) Additional exclusion criteria as specified for each measure in the HEDIS® technical specifications used by EQRO
Data Source(s)/Data Collection Methods	EQRO-calculated MMC performance measures
Comparison Group(s)/ Subgroup(s)	Post Only: 1/1/2015[1] - 12/31/2029[2]
Analytic Methods	• Descriptive statistics • DTA
Interpretation	Increases in these measures over time would suggest STAR+PLUS HCBS members experienced improvements in the effective treatment of diabetes.
Benchmark	NCQA Quality Compass 2020, 50th Percentile Benchmark: • Eye Exam (Retinal) Performed: 58.6 • Statin Therapy (Received): 65.9 • Statin Therapy (Adherence): 64.3

Notes. [1] Starting January 1, 2010, the EQRO began calculating Texas MMC program measures each calendar year (January 1 – December 31). As a result, measurement periods do not align with DYs. [2] The post-period ends on December 31, 2029, the last full calendar year before the Ten-Year Demonstration Extension approval period ends. Availability of this measure through December 31, 2029 is contingent on continuity in the EQRO's calculation and reporting of the measure. The external evaluator may extend the post-period if additional data become available

prior to the Summative Evaluation Report. HEDIS®=Healthcare Effectiveness Data and Information Set; STAR+PLUS=MMC program serving aged and disabled clients; HCBS=Home and community-based services; EQRO=Texas's External Quality Review Organization; NCQA=National Committee for Quality Assurance; CY=Calendar year, January 1-December 31; DTA=Descriptive trend analysis; DY=Demonstration year, October 1-September 30.

Measure 2.2.2	**Statin therapy for patients with cardiovascular disease (HEDIS®)**
Definition	Percentage of STAR+PLUS HCBS members ages 21 to 75 (males) or ages 40 to 75 (females) with clinical atherosclerotic cardiovascular disease who received and adhered to statin therapy.
Study Population	STAR+PLUS HCBS members
Measure Steward or Source	EQRO-calculated NCQA (HEDIS®) measure: Statin therapy for patients with cardiovascular disease (SPC)
Technical Specifications	**Numerator 1:** Patients who received statin therapy during CY **Numerator 2:** Patients who adhered with statin therapy at least 80% during CY **Denominator:** Patients ages 21 to 75 (males) or ages 40 to 75 (females) who have clinical atherosclerotic cardiovascular disease **Rate 1 (received statin therapy):** (Numerator 1 / Denominator) * 100 **Rate 2 (adhered to statin therapy):** (Numerator 2 / Denominator) * 100
Exclusion Criteria	STAR+PLUS HCBS members enrolled in Medicare (dual eligible) STAR+PLUS HCBS members with one or more gaps in MMC enrollment lasting more than 45 days (or more than one month if enrollment determined monthly) Additional exclusion criteria as specified in the HEDIS® technical specifications used by EQRO
Data Source(s)/Data Collection Methods	EQRO-calculated MMC performance measures
Comparison Group(s)/ Subgroup(s)	Post Only: 1/1/2015[1] - 12/31/2029[2]
Analytic Methods	• Descriptive statistics • DTA
Interpretation	An increase in this measure over time would suggest STAR+PLUS HCBS members with cardiovascular disease experienced improvements in the recommended use of statin treatment to treat their condition.

Measure 2.2.2	Statin therapy for patients with cardiovascular disease (HEDIS®)
Benchmark	NCQA Quality Compass 2020, 50th Percentile Benchmark: • Statin Therapy (Received): 80.0 • Statin Therapy (Adherence): 68.0

Notes. [1] Starting January 1, 2010, the EQRO began calculating Texas MMC program measures each calendar year (January 1 – December 31). As a result, measurement periods do not align with DYs. [2] The post-period ends on December 31, 2029, the last full calendar year before the Ten-Year Demonstration Extension approval period ends. Availability of this measure through December 31, 2029 is contingent on continuity in the EQRO's calculation and reporting of the measure. The external evaluator may extend the post-period if additional data become available prior to the Summative Evaluation Report. HEDIS®=Healthcare Effectiveness Data and Information Set; STAR+PLUS=MMC program serving aged and disabled clients; HCBS= Home and community-based services; EQRO=Texas's External Quality Review Organization; NCQA=National Committee for Quality Assurance; CY=Calendar year, January 1-December 31; MMC=Medicaid Managed Care; DTA=Descriptive trend analysis; DY=Demonstration year, October 1-September 30.

Measure 2.2.3	Antidepressant medication management (HEDIS®)
Definition	The percentage of STAR+PLUS HCBS members age 21 and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on antidepressant medication treatment.
Study Population	STAR+PLUS HCBS members
Measure Steward or Source	EQRO-calculated NCQA (HEDIS®) measure: Antidepressant medication management (AMM)
Technical Specifications	The HEDIS® measure includes two rates: 1) Effective acute phase treatment and 2) Effective continuation phase treatment. **Numerator 1:** Total number of unduplicated STAR+PLUS HCBS members age 21 and older with at least 84 days (12 weeks) of treatment with antidepressant medication beginning on the IPSD[1] through 114 days after the IPSD (115 total days). This allows gaps in medication treatment up to a total of 31 days during the 115-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication **Numerator 2:** Total number of unduplicated STAR+PLUS HCBS members age 21 and older with at least 180 days (6 months) of treatment with antidepressant medication beginning on the IPSD through 231 days after the IPSD (232 total days). This allows gaps in medication treatment up to a total of 52 days during the 232-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication **Denominator**: Total number of unduplicated STAR+PLUS HCBS members age 21 and older with any of the following:

Measure 2.2.3	Antidepressant medication management (HEDIS®)
	• An acute or nonacute inpatient stay with any diagnosis of major depression • An outpatient visit with any diagnosis of major depression • An intensive outpatient encounter or partial hospitalization with any diagnosis of major depression • A community mental health center visit with any diagnosis of major depression • Electroconvulsive therapy with any diagnosis of major depression • Transcranial magnetic stimulation visit with any diagnosis of major depression • A telehealth visit with any diagnosis of major depression • An observation visit with any diagnosis of major depression • An ED visit with any diagnosis of major depression • A telephone visit with any diagnosis of major depression **Rate 1 (Effective acute phase treatment)**: (Numerator 1 / Denominator) * 100 **Rate 2 (Effective continuation phase treatment)**: (Numerator 1 / Denominator) * 100
Exclusion Criteria	STAR+PLUS HCBS members enrolled in Medicare (dual eligible) STAR+PLUS HCBS members with one or more gaps in MMC enrollment lasting more than 45 days (or more than one month if enrollment determined monthly) 105 days prior to IPSD through 231 days after IPSD
Data Source(s)/Data Collection Methods	EQRO-calculated MMC performance measures
Comparison Group(s)/ Subgroup(s)	Post Only: 1/1/2015[2] - 12/31/2029[3]
Analytic Methods	• Descriptive statistics • DTA
Interpretation	Increases in the rates under this measure over time would suggest STAR+PLUS HCBS members experienced improvements in the effective treatment of mental health conditions.
Benchmark	Texas CMS Core Measure, 2019 Medicaid State Rate:[4] • Effective Acute Phase Treatment: 53.2 • Effective Continuation Phase Treatment: 37.5 NCQA Quality Compass 2020, 50th Percentile Benchmark:

Measure 2.2.3	Antidepressant medication management (HEDIS®)
	• Effective Acute Phase Treatment: 53.7 • Effective Continuation Phase Treatment: 38.4

Notes. [1] The IPSD is the earliest prescription dispensing event for an antidepressant medication during the period of 270 days prior to the start of the measurement period through 90 days after the start of the measurement period. [2] Starting January 1, 2010, the EQRO began calculating Texas MMC program measures each calendar year (January 1 – December 31). As a result, measurement periods do not align with DYs. [3] The post-period ends on December 31, 2029, the last full calendar year before the Ten-Year Demonstration Extension approval period ends. Availability of this measure through December 31, 2029 is contingent on continuity in the EQRO's calculation and reporting of the measure. The external evaluator may extend the post-period if additional data become available prior to the Summative Evaluation Report. [4] Texas CMS Core Measure rates available via the Texas Healthcare Learning Collaborative Portal: https://thlcportal.com/measures/cmscoremeasuredashboard. HEDIS®=Healthcare Effectiveness Data and Information Set; STAR+PLUS=MMC program serving aged and disabled clients; HCBS= Home and community-based services; EQRO=Texas's External Quality Review Organization; NCQA=National Committee for Quality Assurance; IPSD=Index Prescription Start Date; ED=Emergency department; MMC=Medicaid managed care; DTA=Descriptive trend analysis; CMS=Centers for Medicare and Medicaid Services; DY=Demonstration year, October 1-September 30.

Measure 2.2.4	Follow-up after hospitalization for mental illness (HEDIS®)
Definition	The percentage of discharges for STAR+PLUS HCBS members, 21 years of age and older, who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit within 7 or 30 days of discharge.
Study Population	STAR+PLUS HCBS members
Measure Steward or Source	EQRO-calculated NCQA (HEDIS®) measure: Follow-up after hospitalization for mental illness (FUH)
Technical Specifications	**7-Day Numerator**: STAR+PLUS HCBS members meeting the denominator criteria with a follow-up visit with a mental health provider within 7 days after acute inpatient discharge **30-Day Numerator**: STAR+PLUS HCBS members meeting the denominator criteria with a follow-up visit with a mental health provider within 30 days after acute inpatient discharge **Denominator**: STAR+PLUS HCBS members 21 years of age and older who were discharged from an acute inpatient setting (including acute care psychiatric facilities) with a principal diagnosis of mental illness or intentional self-harm in the measurement period **7-Day Rate**: (7-day Numerator / Denominator) * 100 **30-Day Rate**: (30-day Numerator / Denominator) * 100

Measure 2.2.4	Follow-up after hospitalization for mental illness (HEDIS®)
Exclusion Criteria	Discharges followed by readmission or direct transfer to a non-acute facility within the 7- or 30-day follow-up period, regardless of principal diagnosis for the readmission, or to an acute facility within the 7- or 30-day follow-up period if the principal diagnosis was not for mental health disorders or intentional self-harm Clinician-documented reason STAR+PLUS HCBS member was not able to complete 7- or 30-day follow-up from acute inpatient setting discharge (i.e., member death prior to follow-up visit, member non-compliance for follow-up) STAR+PLUS HCBS members enrolled in Medicare (dual eligible) STAR+PLUS HCBS members receiving hospice care Follow-up visits that occur on the date of discharge
Data Source(s)/Data Collection Methods	EQRO-calculated MMC performance measures
Comparison Group(s)/ Subgroup(s)	Post Only: 1/1/2015[1] - 12/31/2029[2]
Analytic Methods	• Descriptive statistics • DTA
Interpretation	Increases in the rates under this measure over time would suggest STAR+PLUS HCBS members experienced improvements in the effective treatment of mental health.
Benchmark	Texas CMS Core Measure, 2019 Medicaid State Rate:[3] • 7-Day Age 6-17 Rate: 35.0 • 7-Day Age 18+ Rate: 22.3 • 30-Day Age 6-17 Rate: 58.5 • 30-Day Age 18+ Rate: 40.9 NCQA Quality Compass 2020, 50th Percentile Benchmark: • 7-Day Rate: 36.8 • 30-Day Rate: 59.4

Notes. [1] Starting January 1, 2010, the EQRO began calculating Texas MMC program measures each calendar year (January 1 – December 31). As a result, measurement periods do not align with DYs. [2] The post-period ends on December 31, 2029, the last full calendar year before the Ten-Year Demonstration Extension approval period ends. Availability of this measure through December 31, 2029 is contingent on continuity in the EQRO's calculation and reporting of the measure. The external evaluator may extend the post-period if additional data become available prior to the Summative Evaluation Report. [3] Texas CMS Core Measure rates available via the Texas Healthcare Learning Collaborative Portal: https://thlcportal.com/measures/cmscoremeasuredashboard. HEDIS®=Healthcare Effectiveness Data and Information Set; STAR+PLUS=MMC program serving aged and disabled clients; HCBS=Home and community-

based services; EQRO=Texas's External Quality Review Organization; NCQA=National Committee for Quality Assurance; DTA=Descriptive trend analysis; CMS=Centers for Medicare and Medicaid Services; DY=Demonstration year, October 1-September 30.

Measure 2.2.5	**Initiation and engagement of alcohol and other drug dependence treatment (HEDIS®)**
Definition	The percentage of STAR+PLUS HCBS members age 21 and older with a new episode of alcohol or other drug (AOD) abuse or dependence who: • Initiated treatment within 14 days of the diagnosis, and • Initiated treatment and were engaged in ongoing treatment within 34 days of the initiation visit.
Study Population	STAR+PLUS HCBS members
Measure Steward or Source	EQRO-calculated NCQA (HEDIS®) measure: Initiation and engagement of alcohol and other drug abuse or dependence treatment (IET)
Technical Specifications	As of CY 2019, the EQRO calculated a rate for: • Alcohol abuse or dependence • Opioid abuse or dependence • Other drug abuse or dependence • Total alcohol/drug abuse or dependence For each rate: **Initiation of AOD Treatment Numerator**: STAR+PLUS HCBS members meeting the denominator criteria with initiation of AOD treatment within 14 days of the IESD[1] **Engagement of AOD Treatment Numerator**: STAR+PLUS HCBS members meeting the denominator criteria with one or more AOD-related medications filled or at least two treatment engagement visits with an AOD-related diagnosis within 34 days of the initiation visit **Denominator**: STAR+PLUS HCBS members age 21 or older as of December 31 with a claim/encounter with an AOD-related diagnosis between January 1 and November 14 (IESD),[1] and no claims/encounters with an AOD-related diagnosis for 60 days prior **Initiation of AOD Treatment Rate**: (Initiation of AOD Treatment Numerator / Denominator) * 100 **Engagement of AOD Treatment Rate**: (Engagement of AOD Treatment Numerator / Denominator) * 100

Measure 2.2.5	Initiation and engagement of alcohol and other drug dependence treatment (HEDIS®)
Exclusion Criteria	STAR+PLUS HCBS members enrolled in Medicare (dual eligible) STAR+PLUS HCBS members not continuously enrolled for 60 days prior to IESD through 47 days after IESD STAR+PLUS HCBS members if the initiation of treatment event is an inpatient stay with a discharge date after November 27 of CY STAR+PLUS HCBS members receiving hospice care
Data Source(s)/Data Collection Methods	EQRO-calculated MMC performance measures
Comparison Group(s)/ Subgroup(s)	Post Only: 1/1/2015[2] - 12/31/2029[3]
Analytic Methods	• Descriptive statistics • DTA
Interpretation	Increases in the rates under this measure over time would suggest STAR+PLUS HCBS members experienced improvements in the effective treatment of substance use disorders.
Benchmark	Texas CMS Core Measure, 2019 Medicaid State Rate:[4] • Total Initiation of AOD Treatment: 40.0 • Total Engagement of AOD Treatment: 7.8 NCQA Quality Compass 2020, 50th Percentile Benchmark: • Total Initiation of AOD Treatment: 43.6 • Total Engagement of AOD Treatment: 14.22

Notes. [1] The IESD is the earliest date of service for an eligible encounter during the Intake Period with a diagnosis of AOD abuse or dependence. [2] Starting January 1, 2010, the EQRO began calculating Texas MMC program measures each calendar year (January 1 – December 31). As a result, measurement periods do not align with DYs. [3] The post-period ends on December 31, 2029, the last full calendar year before the Ten-Year Demonstration Extension approval period ends. Availability of this measure through December 31, 2029 is contingent on continuity in the EQRO's calculation and reporting of the measure. The external evaluator may extend the post-period if additional data become available prior to the Summative Evaluation Report. [4] Texas CMS Core Measure rates available via the Texas Healthcare Learning Collaborative Portal: https://thlcportal.com/measures/cmscoremeasuredashboard. HEDIS®=Healthcare Effectiveness Data and Information Set; AOD=Alcohol or other drug; STAR+PLUS=MMC program serving aged and disabled clients; HCBS= Home and community-based services; EQRO=Texas's External Quality Review Organization; NCQA=National Committee for Quality Assurance; IESD=Index episode start date; CY=Calendar year, January 1-December 31; MMC=Medicaid managed care; DTA=Descriptive trend analysis; CMS=Centers for Medicare and Medicaid Services; DY=Demonstration year, October 1-September 30.

H2.3. STAR+PLUS HCBS supports MMC members' ability to make decisions about their everyday lives.

Measure 2.3.1	**Percentage of people who are able to get up and go to bed when they want to**
Definition	The percentage of STAR+PLUS HCBS survey respondents who reported they could get up and go to bed when they want to.
Study Population	STAR+PLUS HCBS members
Measure Steward or Source	NCI-AD™
Technical Specifications	Response options include: • No, never • Some days, sometimes • Yes, always/almost always • Don't know • Unclear/refused/no response Percentages may be presented for all response options, or for just for respondents indicating "Yes, always/almost always".
Exclusion Criteria	None
Data Source(s)/Data Collection Methods	• NCI-AD™
Comparison Group(s)/ Subgroup(s)	Post Only: 2015/16 biennium – 2027/28 biennium[1]
Analytic Methods	• Descriptive statistics • DTA
Interpretation	Responses will provide direct insight into STAR+PLUS HCBS members' perceptions about their ability to make decisions about their everyday lives.
Benchmark	NCI-AD™ 2018-2019 Overall HCBS Average: 94%

Notes. [1] The post-period extends through the 2027/2028 biennium, the final administration with results published before the Ten-Year Demonstration Extension approval period ends. The external evaluator may extend the post-period if additional data become available prior to the Summative Evaluation Report. Availability of this measure is contingent on continuity in the EQRO's administration of the NCI-AD™. STAR+PLUS=MMC program serving aged and disabled clients; HCBS= Home and community-based services; NCI-AD™=National Core Indicators – Aging and Disabilities; DTA=Descriptive trend analysis.

Measure 2.3.2	Percentage of people who are able to eat their meals when they want to
Definition	The percentage of STAR+PLUS HCBS survey respondents who reported they were able to eat their meals when they want to.
Study Population	STAR+PLUS HCBS members
Measure Steward or Source	NCI-AD™
Technical Specifications	Response options include: • No, never • Some days, sometimes • Yes, always/almost always • N/A – Unable to eat due to medical condition • Don't know • Unclear/refused/no response Percentages may be presented for all response options, or for just for respondents indicating "Yes, always/almost always".
Exclusion Criteria	None
Data Source(s)/Data Collection Methods	• NCI-AD™
Comparison Group(s)/ Subgroup(s)	Post Only: 2015/16 biennium – 2027/28 biennium[1]
Analytic Methods	• Descriptive statistics • DTA
Interpretation	Responses will provide direct insight into STAR+PLUS HCBS members' perceptions about their ability to make decisions about their everyday lives.
Benchmark	NCI-AD™ 2018-2019 Overall HCBS Average: 90%

Notes. [1] The post-period extends through the 2027/2028 biennium, the final administration with results published before the Ten-Year Demonstration Extension approval period ends. The external evaluator may extend the post-period if additional data become available prior to the Summative Evaluation Report. Availability of this measure is contingent on continuity in the EQRO's administration of the NCI-AD™. STAR+PLUS=MMC program serving aged and disabled clients; HCBS= Home and community-based services; NCI-AD™=National Core Indicators – Aging and Disabilities; DTA=Descriptive trend analysis.

Measure 2.3.3	Percentage of people who never feel in control of their lives
Definition	The percentage of STAR+PLUS HCBS survey respondents who reported they did not feel in control of their lives.
Study Population	STAR+PLUS HCBS members
Measure Steward or Source	NCI-AD™
Technical Specifications	Response options include: • No, rarely or never • In-between, sometimes • Yes, always/almost always • Don't know • Unclear/refused/no response Percentages may be presented for all response options, or for just for respondents indicating "No, rarely or never".
Exclusion Criteria	None
Data Source(s)/Data Collection Methods	• NCI-AD™
Comparison Group(s)/ Subgroup(s)	Post Only: 2015/16 biennium – 2027/28 biennium[1]
Analytic Methods	• Descriptive statistics • DTA
Interpretation	Responses will provide direct insight into STAR+PLUS HCBS members' perceptions about their ability to make decisions about their everyday lives.
Benchmark	N/A

Notes. [1] The post-period extends through the 2027/2028 biennium, the final administration with results published before the Ten-Year Demonstration Extension approval period ends. The external evaluator may extend the post-period if additional data become available prior to the Summative Evaluation Report. Availability of this measure is contingent on continuity in the EQRO's administration of the NCI-AD™. STAR+PLUS=MMC program serving aged and disabled clients; HCBS=Home and community-based services; NCI-AD™=National Core Indicators – Aging and Disabilities; DTA=Descriptive trend analysis.

H2.4. STAR+PLUS HCBS supports MMC members' ability to self-direct their services.

Measure 2.4.1	Percentage of people who can choose when they get services
Definition	The percentage of STAR+PLUS HCBS survey respondents who reported they can make decisions about when they get services.
Study Population	STAR+PLUS HCBS members
Measure Steward or Source	NCI-AD™
Technical Specifications	Response options include: • No • Sometimes, or some services • Yes, all services • Don't know • Unclear/refused/no response Percentages may be presented for all response options, or for just for respondents indicating "Yes, all services".
Exclusion Criteria	None
Data Source(s)/Data Collection Methods	• NCI-AD™
Comparison Group(s)/ Subgroup(s)	Post Only: 2015/16 biennium – 2027/28 biennium[1]
Analytic Methods	• Descriptive statistics • DTA
Interpretation	Responses will provide direct insight into STAR+PLUS HCBS members' perceptions about their ability to self-direct their services.
Benchmark	NCI-AD™ 2018-2019 Overall HCBS Average: 61%

Notes. [1] The post-period extends through the 2027/2028 biennium, the final administration with results published before the Ten-Year Demonstration Extension approval period ends. The external evaluator may extend the post-period if additional data become available prior to the Summative Evaluation Report. Availability of this measure is contingent on continuity in the EQRO's administration of the NCI-AD™. STAR+PLUS=MMC program serving aged and disabled clients; HCBS=Home and community-based services; NCI-AD™=National Core Indicators – Aging and Disabilities; DTA=Descriptive trend analysis.

Measure 2.4.2	Percentage of people who can choose their paid support staff
Definition	The percentage of STAR+PLUS HCBS survey respondents who reported they can choose or change their paid support staff.
Study Population	STAR+PLUS HCBS members
Measure Steward or Source	NCI-AD™
Technical Specifications	Response options include: • No • Sometimes, or some • Yes, all • Don't know • Unclear/refused/no response Percentages may be presented for all response options, or for just for respondents indicating "Yes, all".
Exclusion Criteria	None
Data Source(s)/Data Collection Methods	• NCI-AD™
Comparison Group(s)/ Subgroup(s)	Post Only: 2015/16 biennium – 2027/28 biennium[1]
Analytic Methods	• Descriptive statistics • DTA
Interpretation	Responses will provide direct insight into STAR+PLUS HCBS members' perceptions about their ability to self-direct their services.
Benchmark	NCI-AD™ 2018-2019 Overall HCBS Average: 75%

Notes. [1] The post-period extends through the 2027/2028 biennium, the final administration with results published before the Ten-Year Demonstration Extension approval period ends. The external evaluator may extend the post-period if additional data become available prior to the Summative Evaluation Report. Availability of this measure is contingent on continuity in the EQRO's administration of the NCI-AD™. STAR+PLUS=MMC program serving aged and disabled clients; HCBS=Home and community-based services; NCI-AD™=National Core Indicators – Aging and Disabilities; DTA=Descriptive trend analysis.

H2.5. STAR+PLUS HCBS supports MMC members' satisfaction with their everyday lives.

Measure 2.5.1	**Percentage of people who like where they live**
Definition	The percentage of STAR+PLUS HCBS survey respondents who reported they like where they are living.
Study Population	STAR+PLUS HCBS members
Measure Steward or Source	NCI-AD™
Technical Specifications	Response options include: • No • In-between, most of the time • Yes • Don't know • Unclear/refused/no response Percentages may be presented for all response options, or for just for respondents indicating "Yes".
Exclusion Criteria	None
Data Source(s)/Data Collection Methods	• NCI-AD™
Comparison Group(s)/ Subgroup(s)	Post Only: 2015/16 biennium – 2027/28 biennium[1]
Analytic Methods	• Descriptive statistics • DTA
Interpretation	Responses will provide direct insight into STAR+PLUS HCBS members' satisfaction with their everyday lives.
Benchmark	NCI-AD™ 2018-2019 Overall HCBS Average: 81%

Notes. [1] The post-period extends through the 2027/2028 biennium, the final administration with results published before the Ten-Year Demonstration Extension approval period ends. The external evaluator may extend the post-period if additional data become available prior to the Summative Evaluation Report. Availability of this measure is contingent on continuity in the EQRO's administration of the NCI-AD™. STAR+PLUS=MMC program serving aged and disabled clients; HCBS=Home and community-based services; NCI-AD™=National Core Indicators – Aging and Disabilities; DTA=Descriptive trend analysis.

Measure 2.5.2	Percentage of people who like how they spend their time during the day
Definition	The percentage of STAR+PLUS HCBS survey respondents who reported they like how they spend their time during the day.
Study Population	STAR+PLUS HCBS members
Measure Steward or Source	NCI-AD™
Technical Specifications	Response options include: • No, never • Some days, sometimes • Yes, always, or almost always • Don't know • Unclear/refused/no response Percentages may be presented for all response options, or for just for respondents indicating "Yes, always, or almost always".
Exclusion Criteria	None
Data Source(s)/Data Collection Methods	• NCI-AD™
Comparison Group(s)/ Subgroup(s)	Post Only: 2015/16 biennium – 2027/28 biennium[1]
Analytic Methods	• Descriptive statistics • DTA
Interpretation	Responses will provide direct insight into STAR+PLUS HCBS members' satisfaction with their everyday lives.
Benchmark	NCI-AD™ 2018-2019 Overall HCBS Average: 62%

Notes. [1] The post-period extends through the 2027/2028 biennium, the final administration with results published before the Ten-Year Demonstration Extension approval period ends. The external evaluator may extend the post-period if additional data become available prior to the Summative Evaluation Report. Availability of this measure is contingent on continuity in the EQRO's administration of the NCI-AD™. STAR+PLUS=MMC program serving aged and disabled clients; HCBS=Home and community-based services; NCI-AD™=National Core Indicators – Aging and Disabilities; DTA=Descriptive trend analysis.

Measure 2.5.3	Percentage of people whose services help them live a better life
Definition	The percentage of STAR+PLUS HCBS survey respondents who reported their services help them live a better life.
Study Population	STAR+PLUS HCBS members
Measure Steward or Source	NCI-AD™
Technical Specifications	Response options include: • No • Yes • Don't know • Unclear/refused/no response Percentages may be presented for all response options, or for just for respondents indicating "Yes".
Exclusion Criteria	None
Data Source(s)/Data Collection Methods	• NCI-AD™
Comparison Group(s)/ Subgroup(s)	Post Only: 2015/16 biennium – 2027/28 biennium[1]
Analytic Methods	• Descriptive statistics • DTA
Interpretation	Responses will provide direct insight into STAR+PLUS HCBS members' satisfaction with their everyday lives.
Benchmark	N/A

Notes. [1] The post-period extends through the 2027/2028 biennium, the final administration with results published before the Ten-Year Demonstration Extension approval period ends. The external evaluator may extend the post-period if additional data become available prior to the Summative Evaluation Report. Availability of this measure is contingent on continuity in the EQRO's administration of the NCI-AD™. STAR+PLUS=MMC program serving aged and disabled clients; HCBS=Home and community-based services; NCI-AD™=National Core Indicators – Aging and Disabilities; DTA=Descriptive trend analysis.

Evaluation Question 3: Did the MMC service delivery model improve access to and quality of care over time?

H3.1. Access to preventive care will maintain or improve over time.

Measure 3.1.1	Childhood immunization status (HEDIS®)
Definition	The percentage of children age 2 who received the following vaccines by their 2nd birthday: • Four diphtheria, tetanus and acellular pertussis (DtaP); • Three polio (IPV); • One measles, mumps and rubella (MMR); • Three haemophilus influenza type B (HiB); • Three hepatitis B (HepB); • One chicken pox (VZV); • Four pneumococcal conjugate (PCV); • One hepatitis A (HepA); • Two or three rotavirus (RV); and • Two influenza
Study Population	STAR; STAR+PLUS; STAR Kids
Measure Steward or Source	EQRO-calculated NCQA (HEDIS®) measure: Childhood immunization status (CIS)
Technical Specifications	As of CY 2019, the EQRO calculated a rate for each of the 10 vaccines, as well as three combination rates: • Combination 2: DtaP, IPV, HiB, HebP, and VZV • Combination 4: DtaP, IVP, MMR, HiB, HepB, VZV, PCV, HepA • Combination 10: DtaP, IPV, MMR, HiB, HepB, VZV, PCV, HepA, RV, and influenza For each rate: **Numerator**: Children meeting the denominator criteria with evidence that vaccine requirement was met **Denominator**: Children who turn age 2 during CY, who were enrolled in MMC for 12 months prior to 2nd birthday **Rate**: (Numerator / Denominator) * 100
Exclusion Criteria	MMC members with one or more gaps in MMC enrollment lasting more than 45 days (or more than one month if enrollment determined monthly) during CY
Data Source(s)/Data Collection Methods	EQRO-calculated MMC performance measures

Measure 3.1.1	Childhood immunization status (HEDIS®)
Comparison Group(s)/ Subgroup(s)	Pre-post comparison: • STAR Pre: 9/1/2006 – 12/31/2011[1] • STAR Post: 1/1/2012 – 12/31/2029[2] • STAR+PLUS Pre: 9/1/2006 – 12/31/2011 • STAR+PLUS Post: 1/1/2012 – 12/31/2029 • STAR Kids Post Only: 1/1/2017 – 12/31/2029 Member demographic and geographic characteristics, where applicable[3]
Analytic Methods	• Descriptive statistics • DTA
Interpretation	Increases in the rates under this measure over time would suggest MMC members experienced improvements in access to preventive care for children.
Benchmark	Texas CMS Core Measure, 2019 Medicaid State Rate:[4] • Combination 2: 72.4 • Combination 4: 69.7 • Combination 10: 32.0 NCQA Quality Compass 2020, 50th Percentile Benchmark: • Combination 2: 74.1 • Combination 4: 69.0 • Combination 10: 37.5

Notes. [1] Prior to January 1, 2010, the EQRO calculated Texas MMC program measures each State Fiscal Year (September 1 – August 31). Starting January 1, 2010, the EQRO began calculating Texas MMC program measures each calendar year (January 1 – December 31). As a result, pre- and post-periods for Texas MMC program measures do not align with DYs. [2] The post-period ends on December 31, 2029, the last full calendar year before the Ten-Year Demonstration Extension approval period ends. Availability of this measure through December 31, 2029 is contingent on continuity in the EQRO's calculation and reporting of the measure. The external evaluator may extend the post-period if additional data become available prior to the Summative Evaluation Report. [3] Member subgroups may not be available for all years. [4] Texas CMS Core Measure rates available via the Texas Healthcare Learning Collaborative Portal: https://thlcportal.com/measures/cmscoremeasuredashboard. HEDIS®=Healthcare Effectiveness Data and Information Set; Dtap=Diphtheria, tetanus and acellular pertussis; IPV=Inactivated polio vaccine; MMR=Measles, mumps, and rubella; HiB=Haemophilus influenza type B; HepB=Hepatitis B; VZV=Varicella-zoster virus; PCV=Pneumococcal conjugate virus; HepA=Hepatitis A; RV=Rotavirus; STAR=MMC program primarily serving children and pregnant women; STAR+PLUS=MMC program serving aged and disabled clients; STAR Kids=MMC program serving disabled individuals 20 years or younger; EQRO=Texas's External Quality Review Organization; NCQA=National Committee for Quality Assurance; CY=Calendar year, January 1-December 31; MMC=Medicaid managed care; DTA=Descriptive trend analysis; DY=Demonstration year, October 1-September 30.

Measure 3.1.2	Immunization for adolescents (HEDIS®)
Definition	The percentage of adolescents age 13 who received the following vaccines by their 13th birthday: • One meningococcal conjugate (MCV4) • One tetanus, diphtheria toxoids and acellular pertussis (Tdap) • Three human papillomavirus (HPV)
Study Population	STAR; STAR Kids
Measure Steward or Source	EQRO-calculated NCQA (HEDIS®) measure: Immunization for adolescents (IMA)
Technical Specifications	As of CY 2019, the EQRO calculated a rate for each of the 3 vaccines, as well as two combination rates: • Combination 1: MCV4, Tdap • Combination 2: MCV4, Tdap, HPV For each rate: **Numerator**: Adolescents meeting the denominator criteria with evidence that vaccine requirement was met **Denominator**: Adolescents who turn age 13 during CY, who were enrolled in MMC for 12 months prior to 13th birthday **Rate**: (Numerator / Denominator) * 100
Exclusion Criteria	MMC members with one or more gaps in MMC enrollment lasting more than 45 days (or more than one month if enrollment determined monthly) during CY
Data Source(s)/Data Collection Methods	EQRO-calculated MMC performance measures
Comparison Group(s)/ Subgroup(s)	Pre-post comparison: • STAR Pre: 9/1/2009 – 12/31/2011[1] • STAR Post: 1/1/2012 – 12/31/2029[2] • STAR Kids Post Only: 1/1/2017 – 12/31/2029 Member demographic and geographic characteristics, where applicable[3]
Analytic Methods	• Descriptive statistics • DTA
Interpretation	Increases in the rates under this measure over time would suggest MMC members experienced improvements in access to preventive care for adolescents.

Measure 3.1.2	Immunization for adolescents (HEDIS®)
Benchmark	Texas CMS Core Measure, 2019 Medicaid State Rate:[4] • Combination 1: 85.6 • Combination 2: 40.3 NCQA Quality Compass 2020, 50th Percentile Benchmark: • Combination 1: 82.3 • Combination 2: 36.7

Notes. [1] Prior to January 1, 2010, the EQRO calculated Texas MMC program measures each State Fiscal Year (September 1 – August 31). Starting January 1, 2010, the EQRO began calculating Texas MMC program measures each calendar year (January 1 – December 31). As a result, pre- and post-periods for Texas MMC program measures do not align with DYs. [2] The post-period ends on December 31, 2029, the last full calendar year before the Ten-Year Demonstration Extension approval period ends. Availability of this measure through December 31, 2029 is contingent on continuity in the EQRO's calculation and reporting of the measure. The external evaluator may extend the post-period if additional data become available prior to the Summative Evaluation Report. [3] Member subgroups may not be available for all years. [4] Texas CMS Core Measure rates available via the Texas Healthcare Learning Collaborative Portal: https://thlcportal.com/measures/cmscoremeasuredashboard. HEDIS®=Healthcare Effectiveness Data and Information Set; MCV4=Meningococcal conjugate vaccines; Tdap=Tetanus, diphtheria toxoids and acellular pertussis; HPV=Human papillomavirus; STAR=MMC program primarily serving children and pregnant women; STAR Kids=MMC program serving disabled individuals 20 years or younger; EQRO=Texas's External Quality Review Organization; NCQA=National Committee for Quality Assurance; CY=Calendar year, January 1-December 31; MMC=Medicaid managed care; DTA=Descriptive trend analysis; CMS=Centers for Medicare and Medicaid Services; DY=Demonstration year, October 1-September 30.

Measure 3.1.3	Prenatal and postpartum care (HEDIS®)
Definition	The percentage of women who received appropriate prenatal and postpartum care.
Study Population	STAR; STAR+PLUS; STAR Kids
Measure Steward or Source	EQRO-calculated NCQA (HEDIS®) measure: Prenatal and postpartum care (PPC)
Technical Specifications	The HEDIS® measure includes two rates: 1) Timeliness of prenatal care and 2) Postpartum care. **Numerator 1**: Women meeting the denominator criteria who received a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment in the MMC **Denominator 1**: Women who delivered a live birth between October 8 of prior CY and October 7 of current CY, who were enrolled in MMC 43 days prior to delivery through 60 days after delivery **Rate 1**: (Numerator 1 / Denominator 1) * 100 **Numerator 2**: Women meeting the denominator criteria who received a postpartum visit between 7 and 84 days after delivery **Denominator 2**: Women who delivered a live birth between October 8 of prior CY and October 7 of current CY, who were enrolled in MMC 43 days prior to delivery through 60 days after delivery **Rate 2**: (Numerator 2 / Denominator 2) * 100
Exclusion Criteria	Non-live births MMC members with any gaps in enrollment
Data Source(s)/Data Collection Methods	EQRO-calculated MMC performance measures
Comparison Group(s)/ Subgroup(s)	Pre-post comparison: • STAR Pre: 9/1/2006 – 12/31/2011[1] • STAR Post: 1/1/2012 – 12/31/2029[2] • STAR+PLUS Pre: 9/1/2006 – 12/31/2011 • STAR+PLUS Post: 1/1/2012 – 12/31/2029 • STAR Kids Post Only: 1/1/2017 – 12/31/2029 Member demographic and geographic characteristics, where applicable[3]
Analytic Methods	• Descriptive statistics • DTA
Interpretation	Increases in the rates under this measure over time would suggest MMC members experienced improvements in access to appropriate maternal care.

Measure 3.1.3	Prenatal and postpartum care (HEDIS®)
Benchmark	Texas CMS Core Measure, 2019 Medicaid State Rate, Postpartum care: 78.1[4] NCQA Quality Compass 2020, 50th Percentile Benchmark: • Timeliness of prenatal care: 89.1 • Postpartum care: 2: 76.4

Notes. [1] Prior to January 1, 2010, the EQRO calculated Texas MMC program measures each State Fiscal Year (September 1 – August 31). Starting January 1, 2010, the EQRO began calculating Texas MMC program measures each calendar year (January 1 – December 31). As a result, pre- and post-periods for Texas MMC program measures do not align with DYs. [2] The post-period ends on December 31, 2029, the last full calendar year before the Ten-Year Demonstration Extension approval period ends. Availability of this measure through December 31, 2029 is contingent on continuity in the EQRO's calculation and reporting of the measure. The external evaluator may extend the post-period if additional data become available prior to the Summative Evaluation Report. [3] Member subgroups may not be available for all years. [4] Texas CMS Core Measure rates available via the Texas Healthcare Learning Collaborative Portal: https://thlcportal.com/measures/cmscoremeasuredashboard. HEDIS®=Healthcare Effectiveness Data and Information Set; STAR=MMC program primarily serving children and pregnant women; STAR+PLUS=MMC program serving aged and disabled clients; STAR Kids=MMC program serving disabled individuals 20 years or younger; EQRO=Texas's External Quality Review Organization; NCQA=National Committee for Quality Assurance; MMC=Medicaid managed care; CY=Calendar year, January 1-December 31; DTA=Descriptive trend analysis; CMS=Centers for Medicare and Medicaid Services; DY=Demonstration year, October 1-September 30.

Measure 3.1.4	Cervical cancer screening (HEDIS®)
Definition	The percentage of women age 21 to 64 screened for cervical cancer in past 3 (cervical cytology) or 5 years (cervical cytology/human papillomavirus co-testing).
Study Population	STAR; STAR+PLUS
Measure Steward or Source	EQRO-calculated NCQA (HEDIS®) measure: Cervical cancer screening (CCS)
Technical Specifications	**Numerator 1:** Women meeting the denominator criteria who had cervical cytology during CY or in the previous two to Cys **Numerator 2:** Among women who do not meet criteria in Numerator 1, women meeting the denominator criteria who had cervical cytology and a human papillomavirus test with service dates four or fewer days apart during CY or in the previous four Cys (and who were age 30 or older on date of both tests) **Final Numerator:** Numerator 1 + Numerator 2 **Denominator:** Total number of women who are ages 24 to 64 as of December 31 **Rate:** (Final Numerator / Denominator) * 100

Measure 3.1.4	Cervical cancer screening (HEDIS®)
Exclusion Criteria	MMC members with one or more gaps in MMC enrollment lasting more than 45 days (or more than one month if enrollment determined monthly) during CY MMC members receiving hospice care Optional: MMC members with hysterectomy with no residual cervix, cervical agenesis, or acquired absence of cervix at any time in member's history through end of CY
Data Source(s)/Data Collection Methods	EQRO-calculated MMC performance measures
Comparison Group(s)/ Subgroup(s)	Pre-post comparison: • STAR Pre: 9/1/2006 – 12/31/2011[1] • STAR Post: 1/1/2012 – 12/31/2029[2] • STAR+PLUS Pre: 9/1/2006 – 12/31/2011 • STAR+PLUS Post: 1/1/2012 – 12/31/2029 Member demographic and geographic characteristics, where applicable[3]
Analytic Methods	• Descriptive statistics • DTA
Interpretation	An increase in this measure over time would suggest MMC members experienced improvements in access to preventive cancer screenings.
Benchmark	Texas CMS Core Measure, 2019 Medicaid State Rate: 53.4[4] NCQA Quality Compass 2020, 50th Percentile Benchmark: 61.3

Notes. [1] Prior to January 1, 2010, the EQRO calculated Texas MMC program measures each State Fiscal Year (September 1 – August 31). Starting January 1, 2010, the EQRO began calculating Texas MMC program measures each calendar year (January 1 – December 31). As a result, pre- and post-periods for Texas MMC program measures do not align with DYs. [2] The post-period ends on December 31, 2029, the last full calendar year before the Ten-Year Demonstration Extension approval period ends. Availability of this measure through December 31, 2029 is contingent on continuity in the EQRO's calculation and reporting of the measure. The external evaluator may extend the post-period if additional data become available prior to the Summative Evaluation Report. [3] Member subgroups may not be available for all years. [4] Texas CMS Core Measure rates available via the Texas Healthcare Learning Collaborative Portal: https://thlcportal.com/measures/cmscoremeasuredashboard. HEDIS®=Healthcare Effectiveness Data and Information Set; STAR=MMC program primarily serving children and pregnant women; STAR+PLUS=MMC program serving aged and disabled clients; EQRO=Texas's External Quality Review Organization; NCQA=National Committee for Quality Assurance; CY=Calendar year, January 1-December 31; MMC=Medicaid managed care; DTA=Descriptive trend analysis; CMS=Centers for Medicare and Medicaid Services; DY=Demonstration year, October 1-September 30.

Measure 3.1.5	Breast cancer screening (HEDIS®)
Definition	The percentage of women ages 50 to 74 who had a mammogram to screen for breast cancer.
Study Population	STAR; STAR+PLUS
Measure Steward or Source	EQRO-calculated NCQA (HEDIS®) measure: Breast cancer screening (BCS)
Technical Specifications	**Numerator:** Women meeting the denominator criteria with one or more mammograms any time on or before October 1 two years prior to the Cys and December 31 of CY **Denominator:** All women ages 52 to 74 as of December 31 of CY (to account for the look-back period) **Rate:** (Numerator / Denominator) * 100
Exclusion Criteria	MMC members with one or more gaps in MMC enrollment lasting more than 45 days (or more than one month if enrollment determined monthly) during CY MMC members receiving hospice or palliative care, or MMC members with frailty and advanced illness Optional: MMC members with bilateral mastectomy, or unilateral mastectomy with bilateral modifier at any time in member's history through end of CY
Data Source(s)/Data Collection Methods	EQRO-calculated MMC performance measures
Comparison Group(s)/ Subgroup(s)	Pre-post comparison: • STAR Pre: 9/1/2006 – 12/31/2011[1] • STAR Post: 1/1/2012 – 12/31/2029[2] • STAR+PLUS Pre: 9/1/2006 – 12/31/2011 • STAR+PLUS Post: 1/1/2012 – 12/31/2029 Member demographic and geographic characteristics, where applicable[3]
Analytic Methods	• Descriptive statistics • DTA
Interpretation	An increase in this measure over time would suggest MMC members experienced improvements in access to preventive cancer screenings.

Measure 3.1.5	Breast cancer screening (HEDIS®)
Benchmark	Texas CMS Core Measure, 2019 Medicaid State Rate: 50.4[4] NCQA Quality Compass 2020, 50th Percentile Benchmark: 58.8

Notes. [1] Prior to January 1, 2010, the EQRO calculated Texas MMC program measures each State Fiscal Year (September 1 – August 31). Starting January 1, 2010, the EQRO began calculating Texas MMC program measures each calendar year (January 1 – December 31). As a result, pre- and post-periods for Texas MMC program measures do not align with DYs. [2] The post-period ends on December 31, 2029, the last full calendar year before the Ten-Year Demonstration Extension approval period ends. Availability of this measure through December 31, 2029 is contingent on continuity in the EQRO's calculation and reporting of the measure. The external evaluator may extend the post-period if additional data become available prior to the Summative Evaluation Report. [3] Member subgroups may not be available for all years. [4] Texas CMS Core Measure rates available via the Texas Healthcare Learning Collaborative Portal: https://thlcportal.com/measures/cmscoremeasuredashboard. HEDIS®=Healthcare Effectiveness Data and Information Set; STAR=MMC program primarily serving children and pregnant women; STAR+PLUS=MMC program serving aged and disabled clients; EQRO=Texas's External Quality Review Organization; NCQA=National Committee for Quality Assurance; CY=Calendar year, January 1-December 31; MMC=Medicaid managed care; CMS=Centers for Medicare and Medicaid Services; DTA=Descriptive trend analysis; CMS=Centers for Medicare and Medicaid Services; DY=Demonstration year, October 1-September 30.

H3.2. Effective treatment of chronic, complex, and serious conditions will maintain or improve over time.

Measure 3.2.1	Comprehensive diabetes care (HEDIS®)
Definition	The percentage of MMC members ages 18 to 75 with type 1 or type 2 diabetes who had any of the following: • HbA1c testing • HbA1c poor control (>9.0%) • HbA1c control (<8.0% or <7.0% for select populations) • Eye exam (retinal) performed • Medical attention for nephropathy • BP control (<140/90 mm Hg)
Study Population	STAR; STAR+PLUS
Measure Steward or Source	EQRO-calculated NCQA (HEDIS®) measure: Comprehensive diabetes care (CDC)

Measure 3.2.1	Comprehensive diabetes care (HEDIS®)
Technical Specifications	As of CY 2019, the EQRO calculated five rates under this measure: • HbA1c testing • HbA1c control (<8.0%) • Eye exam (retinal) performed • Medical attention for nephropathy • BP control (<140/90 mm Hg) **Numerators**: MMC members meeting the denominator criteria specific to each rate: • *HbA1c testing*: Who had a HbA1c test performed in CY • *HbA1c control (<8.0%)*: Whose most recent HbA1c test result was <8.0% • *Eye exam (retinal) performed*: Who had an eyes screening for diabetic retinal disease • *Medical attention for nephropathy*: With a screening for nephropathy or evidence of nephropathy in CY • *BP control (<140/90 mm Hg)*: Whose most recent blood pressure level was <40/90mm Hg during CY **Denominator (applicable to all rates)**: MMC members ages 18 to 75 who with an inpatient discharge or two outpatient visits with a diagnosis of diabetes, or who were dispensed insulin or hypoglycemics/antihyperglycemics on an ambulatory basis in CY or previous CY **Rate**: (Numerator / Denominator) * 100
Exclusion Criteria	MMC members with one or more gaps in MMC enrollment lasting more than 45 days (or more than one month if enrollment determined monthly) during CY MMC members receiving hospice or palliative care, or MMC members with frailty and advanced illness MMC members aged 66 years of age or older as of December 31 of CY who were enrolled in an institutional special needs plan or living long-term in an institution at any point in CY
Data Source(s)/Data Collection Methods	EQRO-calculated MMC performance measures
Comparison Group(s)/ Subgroup(s)	Pre-post comparison: • STAR Pre: 9/1/2006 – 12/31/2011[1] • STAR Post: 1/1/2012 – 12/31/2029[2] • STAR+PLUS Pre: 9/1/2006 – 12/31/2011 • STAR+PLUS Post: 1/1/2012 – 12/31/2029 Member demographic and geographic characteristics, where applicable[3]

Measure 3.2.1	Comprehensive diabetes care (HEDIS®)
Analytic Methods	• Descriptive statistics • DTA
Interpretation	Increases in the rates under this measure over time would suggest MMC members experienced improvements in the effective treatment of diabetes.
Benchmark	NCQA Quality Compass 2020, 50th Percentile Benchmark: • HbA1c testing: 88.8 • HbA1c control (<8.0%): 51.8 • Eye exam (retinal) performed: 58.6 • Medical attention for nephropathy: 90.1 • BP control (<140/90 mm Hg): 64.0

Notes. [1] Prior to January 1, 2010, the EQRO calculated Texas MMC program measures each State Fiscal Year (September 1 – August 31). Starting January 1, 2010, the EQRO began calculating Texas MMC program measures each calendar year (January 1 – December 31). As a result, pre- and post-periods for Texas MMC program measures do not align with DYs. [2] The post-period ends on December 31, 2029, the last full calendar year before the Ten-Year Demonstration Extension approval period ends. Availability of this measure through December 31, 2029 is contingent on continuity in the EQRO's calculation and reporting of the measure. The external evaluator may extend the post-period if additional data become available prior to the Summative Evaluation Report. [3] Member subgroups may not be available for all years. HEDIS®=Healthcare Effectiveness Data and Information Set; MMC=Medicaid managed care; HbA1c=Hemoglobin A1c; BP=Blood pressure; STAR=MMC program primarily serving children and pregnant women; STAR+PLUS=MMC program serving aged and disabled clients; EQRO=Texas's External Quality Review Organization; NCQA=National Committee for Quality Assurance; CDC=Comprehensive Diabetes Care; CY=Calendar year, January 1-December 31; MMC=Medicaid managed care; DTA=Descriptive trend analysis; DY=Demonstration year, October 1-September 30.

Measure 3.2.2	Controlling high blood pressure (HEDIS®)
Definition	Percentage of beneficiaries ages 18 to 85 who had a diagnosis of hypertension and whose blood pressure was adequately controlled (< 140/90 mm Hg) during the measurement year.
Study Population	STAR; STAR+PLUS
Measure Steward or Source	EQRO-calculated NCQA (HEDIS®) measure: Controlling high blood pressure (CBP)
Technical Specifications	**Numerator:** MMC members meeting the denominator criteria whose most recent BP reading was taken on or after the date of the second diagnosis of hypertension where the BP reading was < 140/90 mm Hg. If there are multiple BPs on the same date of service, use the lowest systolic and lowest diastolic BP on that date as the representative BP **Denominator:** MMC members ages 18 to 85 as of December 31 of CY **Rate:** (Numerator / Denominator) * 100

Measure 3.2.2	Controlling high blood pressure (HEDIS®)
Exclusion Criteria	MMC members with one or more gaps in MMC enrollment lasting more than 45 days (or more than one month if enrollment determined monthly) during CY Beneficiaries receiving palliative care Optional: MMC members with frailty and advanced illness, MMC members with evidence of end stage renal disease, dialysis or renal transplant before or during the CY, MMC members who are pregnant during CY, and MMC members with nonacute inpatient admission during CY
Data Source(s)/Data Collection Methods	EQRO-calculated MMC performance measures
Comparison Group(s)/ Subgroup(s)	Pre-post comparison: • STAR Pre: 9/1/2006 – 12/31/2011[1] • STAR Post: 1/1/2012 – 12/31/2029[2] • STAR+PLUS Pre: 9/1/2006 – 12/31/2011 • STAR+PLUS Post: 1/1/2012 – 12/31/2029 Member demographic and geographic characteristics, where applicable[3]
Analytic Methods	• Descriptive statistics • DTA
Interpretation	An increase in this measure over time would suggest MMC members experienced improvements in the effective treatment of high blood pressure.
Benchmark	Texas CMS Core Measure, 2019 Medicaid State Rate: 49.6[4] NCQA Quality Compass 2020, 50th Percentile Benchmark: 61.8

Notes. [1] Prior to January 1, 2010, the EQRO calculated Texas MMC program measures each State Fiscal Year (September 1 – August 31). Starting January 1, 2010, the EQRO began calculating Texas MMC program measures each calendar year (January 1 – December 31). As a result, pre- and post-periods for Texas MMC program measures do not align with DYs. [2] The post-period ends on December 31, 2029, the last full calendar year before the Ten-Year Demonstration Extension approval period ends. Availability of this measure through December 31, 2029 is contingent on continuity in the EQRO's calculation and reporting of the measure. The external evaluator may extend the post-period if additional data become available prior to the Summative Evaluation Report. [3] Member subgroups may not be available for all years. [4] Texas CMS Core Measure rates available via the Texas Healthcare Learning Collaborative Portal: https://thlcportal.com/measures/cmscoremeasuredashboard. HEDIS®=Healthcare Effectiveness Data and Information Set; STAR=MMC program primarily serving children and pregnant women; STAR+PLUS=MMC program serving aged and disabled clients; EQRO=Texas's External Quality Review Organization; NCQA=National Committee for Quality Assurance; MMC=Medicaid Managed Care; BP=Blood pressure; CY=Calendar year, January 1-December 31; CMS=Centers for Medicare and Medicaid Services; DTA=Descriptive trend analysis; CMS=Centers for Medicare and Medicaid Services; DY=Demonstration year, October 1-September 30.

Measure 3.2.3	Follow-up care for children prescribed ADHD medication (HEDIS®)
Definition	The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed.
Study Population	STAR; STAR+PLUS; STAR Kids
Measure Steward or Source	EQRO-calculated NCQA (HEDIS®) measure: Follow-up care for children prescribed ADHD medication (ADD)
Technical Specifications	The HEDIS® measure includes two rates: 1) Initiation phase and 2) Continuation and maintenance phase. **Numerator 1:** Children meeting denominator criteria with a follow-up visit with a practitioner, within 30 days after the IPSD[1] **Numerator 2:** Among children who meet criteria in Numerator 1, children with at least two follow-up visits on different dates of service with any practitioner, from 31–300 days (9 months) after the IPSD. Only one of the two visits (during days 31–300) may be an e-visit or virtual check-in **Denominator:** Children age 6 as of March 1 of the year prior to the CY to age 12 as of the last calendar day of February of the CY **Rate 1 (Initiation phase):** (Numerator for Rate 1 / Denominator) * 100 **Rate 2 (Continuation and maintenance phase):** (Numerator for Rate 2 / Denominator) * 100
Exclusion Criteria	Children with narcolepsy MMC members receiving hospice care Rate 1 (Initiation phase): MMC members with gaps in MMC enrollment 120 days prior to IPSD through 300 days after IPSD Rate 2 (Continuation and maintenance phase): MMC members with one or more gaps in MMC enrollment lasting more than 45 days (or more than one month if enrollment determined monthly) 120 days prior to IPSD through 300 days after IPSD
Data Source(s)/Data Collection Methods	EQRO-calculated MMC performance measures

Measure 3.2.3	Follow-up care for children prescribed ADHD medication (HEDIS®)
Comparison Group(s)/ Subgroup(s)	Pre-post comparison: • STAR Pre: 9/1/2009- 12/31/2011[2] • STAR Post: 1/1/2012 – 12/31/2029[3] • STAR+PLUS Pre: 9/1/2009- 12/31/2011 • STAR+PLUS Post: 1/1/2012 – 12/31/2029 • STAR Kids Post Only: 1/1/2017 – 12/31/2029 Member demographic and geographic characteristics, where applicable[4]
Analytic Methods	• Descriptive statistics • DTA
Interpretation	Increases in the rates under this measure over time would suggest MMC members experienced improvements in the effective management of ADHD.
Benchmark	Texas CMS Core Measure, 2019 Medicaid State Rate:[5] • Initiation Phase: 41.7 • Continuation and Maintenance Phase: 56.7 NCQA Quality Compass 2020, 50th Percentile Benchmark: • Initiation Phase: 43.1 • Continuation and Maintenance Phase: 54.8

Notes. [1] The IPSD is the earliest prescription dispensing date for an ADHD medication where the date is in the Intake Period and there is a Negative Medication History. [2] Prior to January 1, 2010, the EQRO calculated Texas MMC program measures each State Fiscal Year (September 1 – August 31). Starting January 1, 2010, the EQRO began calculating Texas MMC program measures each calendar year (January 1 – December 31). As a result, pre- and post-periods for Texas MMC program measures do not align with DYs. [3] The post-period ends on December 31, 2029, the last full calendar year before the Ten-Year Demonstration Extension approval period ends. Availability of this measure through December 31, 2029 is contingent on continuity in the EQRO's calculation and reporting of the measure. The external evaluator may extend the post-period if additional data become available prior to the Summative Evaluation Report. [4] Member subgroups may not be available for all years. [5] Texas CMS Core Measure rates available via the Texas Healthcare Learning Collaborative Portal: https://thlcportal.com/measures/cmscoremeasuredashboard. HEDIS®=Healthcare Effectiveness Data and Information Set; ADHD=attention-deficit/hyperactivity disorder; STAR=MMC program primarily serving children and pregnant women; STAR+PLUS=MMC program serving aged and disabled clients; STAR Kids=MMC program serving disabled individuals 20 years or younger; EQRO=Texas's External Quality Review Organization; NCQA=National Committee for Quality Assurance; IPSD=Index Prescription Start Date; CY=Calendar year, January 1-December 31; MMC=Medicaid managed care; DTA=Descriptive trend analysis; CMS=Centers for Medicare and Medicaid Services; DY=Demonstration year, October 1-September 30.

Measure 3.2.4	Antidepressant medication management (HEDIS®)
Definition	The percentage of MMC members age 18 and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on antidepressant medication treatment.
Study Population	STAR; STAR+PLUS
Measure Steward or Source	EQRO-calculated NCQA (HEDIS®) measure: Antidepressant medication management (AMM)
Technical Specifications	The HEDIS® measure includes two rates: 1) Effective acute phase treatment and 2) Effective continuation phase treatment. **Numerator 1:** Total number of unduplicated MMC members age 18 and older with at least 84 days (12 weeks) of treatment with antidepressant medication beginning on the IPSD[1] through 114 days after the IPSD (115 total days). This allows gaps in medication treatment up to a total of 31 days during the 115-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication **Numerator 2:** Total number of unduplicated MMC members age 18 and older with at least 180 days (6 months) of treatment with antidepressant medication beginning on the IPSD through 231 days after the IPSD (232 total days). This allows gaps in medication treatment up to a total of 52 days during the 232-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication **Denominator**: Total number of unduplicated MMC members age 18 and older with any of the following: • An acute or nonacute inpatient stay with any diagnosis of major depression • An outpatient visit with any diagnosis of major depression • An intensive outpatient encounter or partial hospitalization with any diagnosis of major depression • A community mental health center visit with any diagnosis of major depression • Electroconvulsive therapy with any diagnosis of major depression • Transcranial magnetic stimulation visit with any diagnosis of major depression • A telehealth visit with any diagnosis of major depression • An observation visit with any diagnosis of major depression • An ED visit with any diagnosis of major depression

Measure 3.2.4	Antidepressant medication management (HEDIS®)
	• A telephone visit with any diagnosis of major depression **Rate 1 (Effective acute phase treatment)**: (Numerator 1 / Denominator) * 100 **Rate 2 (Effective continuation phase treatment)**: (Numerator 1 / Denominator) * 100
Exclusion Criteria	MMC members with one or more gaps in MMC enrollment lasting more than 45 days (or more than one month if enrollment determined monthly) 105 days prior to IPSD through 231 days after IPSD
Data Source(s)/Data Collection Methods	EQRO-calculated MMC performance measures
Comparison Group(s)/ Subgroup(s)	Pre-post comparison: • STAR Pre: 9/1/2009 – 12/31/2011[2] • STAR Post: 1/1/2012 – 12/31/2029[3] • STAR+PLUS Pre: 9/1/2009 – 12/31/2011 • STAR+PLUS Post: 1/1/2012 – 12/31/2029 Member demographic and geographic characteristics, where applicable[4]
Analytic Methods	• Descriptive statistics • DTA
Interpretation	Increases in the rates under this measure over time would suggest MMC members experienced improvements in the effective treatment of mental health conditions.

Measure 3.2.4	Antidepressant medication management (HEDIS®)
Benchmark	Texas CMS Core Measure, 2019 Medicaid State Rate:[5] • Effective Acute Phase Treatment: 53.2 • Effective Continuation Phase Treatment: 37.5 NCQA Quality Compass 2020, 50th Percentile Benchmark: • Effective Acute Phase Treatment: 53.7 • Effective Continuation Phase Treatment: 38.4

Notes. [1] The IPSD is the earliest prescription dispensing event for an antidepressant medication during the period of 270 days prior to the start of the measurement period through 90 days after the start of the measurement period. [2] Starting January 1, 2010, the EQRO began calculating Texas MMC program measures each calendar year (January 1 – December 31). As a result, pre- and post-periods do not align with DYs. [3] The post-period ends on December 31, 2029, the last full calendar year before the Ten-Year Demonstration Extension approval period ends. Availability of this measure through December 31, 2029 is contingent on continuity in the EQRO's calculation and reporting of the measure. The external evaluator may extend the post-period if additional data become available prior to the Summative Evaluation Report. [4] Member subgroups may not be available for all years. [5] Texas CMS Core Measure rates available via the Texas Healthcare Learning Collaborative Portal: https://thlcportal.com/measures/cmscoremeasuredashboard.
HEDIS®=Healthcare Effectiveness Data and Information Set; MMC=Medicaid Managed Care; STAR=MMC program primarily serving children and pregnant women; STAR+PLUS=MMC program serving aged and disabled clients; EQRO=Texas's External Quality Review Organization; NCQA=National Committee for Quality Assurance; IPSD=Index Prescription Start Date; ED=Emergency department; DTA=Descriptive trend analysis; CMS=Centers for Medicare and Medicaid Services; DY=Demonstration year, October 1-September 30.

Measure 3.2.5	Follow-up after hospitalization for mental illness (HEDIS®)
Definition	The percentage of discharges for MMC members, 6 years of age and older, who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit within 7- or 30-days of discharge.
Study Population	STAR; STAR+PLUS; STAR Kids
Measure Steward or Source	EQRO-calculated NCQA (HEDIS®) measure: Follow-up after hospitalization for mental illness (FUH)

Measure 3.2.5	Follow-up after hospitalization for mental illness (HEDIS®)
Technical Specifications	**7-Day Numerator**: MMC member meeting the denominator criteria with a follow-up visit with a mental health provider within 7 days after acute inpatient discharge **30-Day Numerator**: MMC member meeting the denominator criteria with a follow-up visit with a mental health provider within 30 days after acute inpatient discharge **Denominator**: MMC members 6 years of age and older who were discharged from an acute inpatient setting (including acute care psychiatric facilities) with a principal diagnosis of mental illness or intentional self-harm in measurement period **7-Day Rate**: (7-day Numerator / Denominator) * 100 **30-Day Rate**: (30-day Numerator / Denominator) * 100
Exclusion Criteria	Discharges followed by readmission or direct transfer to a non-acute facility within the 7- or 30-day follow-up period, regardless of principal diagnosis for the readmission, or to an acute facility within the 7- or 30-day follow-up period if the principal diagnosis was not for mental health disorders or intentional self-harm Clinician-document reason MMC member was not able to complete 7- or 30-day follow-up from acute inpatient setting discharge (i.e., member death prior to follow-up visit, member non-compliance for follow-up) MMC members receiving hospice care Follow-up visits that occur on the date of discharge
Data Source(s)/Data Collection Methods	EQRO-calculated MMC performance measures
Comparison Group(s)/ Subgroup(s)	Pre-post comparison: • STAR Pre: 9/1/2006- 12/31/2011[1] • STAR Post: 1/1/2012 – 12/31/2029[2] • STAR+PLUS Pre: 9/1/2006- 12/31/2011 • STAR+PLUS Post: 1/1/2012 – 12/31/2029 Member demographic and geographic characteristics, where applicable[3]
Analytic Methods	• Descriptive statistics • DTA
Interpretation	Increases in the rates under this measure over time would suggest MMC members experienced improvements in the effective treatment of mental health.

Measure 3.2.5	Follow-up after hospitalization for mental illness (HEDIS®)
Benchmark	Texas CMS Core Measure, 2019 Medicaid State Rate:[4] • 7-Day Age 6-17 Rate: 35.0 • 7-Day Age 18+ Rate: 22.3 • 30-Day Age 6-17 Rate: 58.5 • 30-Day Age 18+ Rate: 40.9 NCQA Quality Compass 2020, 50th Percentile Benchmark: • 7-Day Rate: 36.8 • 30-Day Rate: 59.4

Notes. [1] Starting January 1, 2010, the EQRO began calculating Texas MMC program measures each calendar year (January 1 – December 31). As a result, pre- and post-periods do not align with DYs. [2] The post-period ends on December 31, 2029, the last full calendar year before the Ten-Year Demonstration Extension approval period ends. Availability of this measure through December 31, 2029 is contingent on continuity in the EQRO's calculation and reporting of the measure. The external evaluator may extend the post-period if additional data become available prior to the Summative Evaluation Report. [3] Member subgroups may not be available for all years. [4] Texas CMS Core Measure rates available via the Texas Healthcare Learning Collaborative Portal: https://thlcportal.com/measures/cmscoremeasuredashboard. HEDIS®=Healthcare Effectiveness Data and Information Set; MMC=Medicaid managed care; STAR=MMC program primarily serving children and pregnant women; STAR+PLUS=MMC program serving aged and disabled clients; STAR Kids=MMC program serving disabled individuals 20 years or younger; EQRO=Texas's External Quality Review Organization; NCQA=National Committee for Quality Assurance; DTA=Descriptive trend analysis; CMS=Centers for Medicare and Medicaid Services; DY=Demonstration year, October 1-September 30.

Measure 3.2.6	Initiation and engagement of alcohol and other drug dependence treatment (HEDIS®)
Definition	The percentage of MMC members age 18 and older with a new episode of alcohol or other drug (AOD) abuse or dependence who: • Initiated treatment within 14 days of the diagnosis, and • Initiated treatment and were engaged in ongoing treatment within 34 days of the initiation visit.
Study Population	STAR; STAR+PLUS
Measure Steward or Source	EQRO-calculated NCQA (HEDIS®) measure: Initiation and engagement of alcohol and other drug abuse or dependence treatment (IET)

Measure 3.2.6	Initiation and engagement of alcohol and other drug dependence treatment (HEDIS®)
Technical Specifications	As of CY 2019, the EQRO calculated a rate for: • Alcohol abuse or dependence • Opioid abuse or dependence • Other drug abuse or dependence • Total alcohol/drug abuse or dependence For each rate: **Initiation of AOD Treatment Numerator**: MMC member meeting the denominator criteria with initiation of AOD treatment within 14 days of the IESD[1] **Engagement of AOD Treatment Numerator**: MMC members meeting the denominator criteria with one or more AOD-related medications filled or at least two treatment engagement visits with an AOD-related diagnosis within 34 days of the initiation visit **Denominator**: MMC members age 18 or older as of December 31 with a claim/encounter with an AOD-related diagnosis between January 1 and November 14 (IESD),[1] and no claims/encounters with an AOD-related diagnosis for 60 days prior **Initiation of AOD Treatment Rate**: (Initiation of AOD Treatment Numerator / Denominator) * 100 **Engagement of AOD Treatment Rate**: (Engagement of AOD Treatment Numerator / Denominator) * 100
Exclusion Criteria	MMC members not continuously enrolled for 60 days prior to IEDS through 47 days after IESD MMC members if the initiation of treatment event is an inpatient stay with a discharge date after November 27 of CY MMC members receiving hospice care
Data Source(s)/Data Collection Methods	EQRO-calculated MMC performance measures
Comparison Group(s)/ Subgroup(s)	Pre-post comparison: • STAR Pre: 9/1/2009- 12/31/2011[2] • STAR Post: 1/1/2012 – 12/31/2029[3] • STAR+PLUS Pre: 9/1/2009 – 12/31/2011 Member demographic and geographic characteristics, where applicable[4]
Analytic Methods	• Descriptive statistics • DTA

Measure 3.2.6	Initiation and engagement of alcohol and other drug dependence treatment (HEDIS®)
Interpretation	Increases in the rates under this measure over time would suggest MMC members experienced improvements in the effective treatment of substance use disorders.
Benchmark	Texas CMS Core Measure, 2019 Medicaid State Rate:[5] • Total Initiation of AOD Treatment: 40.0 • Total Engagement of AOD Treatment: 7.8 NCQA Quality Compass 2020, 50th Percentile Benchmark: • Total Initiation of AOD Treatment: 43.6 • Total Engagement of AOD Treatment: 14.22

Notes. [1] The IESD is the earliest date of service for an eligible encounter during the Intake Period with a diagnosis of AOD abuse or dependence. [2] Starting January 1, 2010, the EQRO began calculating Texas MMC program measures each calendar year (January 1 – December 31). As a result, pre- and post-periods do not align with DYs. [3] The post-period ends on December 31, 2029, the last full calendar year before the Ten-Year Demonstration Extension approval period ends. Availability of this measure through December 31, 2029 is contingent on continuity in the EQRO's calculation and reporting of the measure. The external evaluator may extend the post-period if additional data become available prior to the Summative Evaluation Report. [4] Member subgroups may not be available for all years. [5] Texas CMS Core Measure rates available via the Texas Healthcare Learning Collaborative Portal: https://thlcportal.com/measures/cmscoremeasuredashboard. HEDIS®=Healthcare Effectiveness Data and Information Set; MMC=Medicaid managed care; AOD=Alcohol or other drug; STAR=MMC program primarily serving children and pregnant women; STAR+PLUS=MMC program serving aged and disabled clients; EQRO=Texas's External Quality Review Organization; NCQA=National Committee for Quality Assurance; IESD=Index episode start date; CY=Calendar year, January 1-December 31; DTA=Descriptive trend analysis; CMS=Centers for Medicare and Medicaid Services; DY=Demonstration year, October 1-September 30.

H3.3. Appropriate use of health care will maintain or improve over time.

Measure 3.3.1	Potentially preventable admissions (3M)
Definition	A hospital admission or long-term care facility stay that might have been reasonably prevented with adequate access to ambulatory care or health care coordination.
Study Population	STAR; STAR+PLUS; STAR Kids
Measure Steward or Source	EQRO-calculated measure using 3M software

Measure 3.3.1	Potentially preventable admissions (3M)
Technical Specifications	Following the 3M protocol, the EQRO identifies inpatient admissions at-risk for being a potentially preventable admission (PPA), actual PPAs, assigns weights, risk-adjusts PPAs, and calculates expected-to-actual PPA rates. As of CY 2019, the EQRO published the following information on PPAs: • Total at-risk admissions • The number of PPAs • Total weight of all PPAs • Expected weight across all PPAs • Actual weight divided by expected weight • Total member months • Total PPA weight per 1,000 members • Total PPA weight per 1,000 at-risk admissions • Sum of the institutional expenditures across all PPAs
Exclusion Criteria	None besides exclusion criteria specified by 3M
Data Source(s)/Data Collection Methods	EQRO-calculated MMC performance measures
Comparison Group(s)/ Subgroup(s)	Pre-post comparison:[1] • STAR Post Only: 1/1/2012 – 12/31/2029[2,3] • STAR+PLUS Post Only: 1/1/2012 – 12/31/2029[3] • STAR Kids Post Only: 1/1/2017 – 12/31/2029[3] Member demographic and geographic characteristics, where applicable[4]
Analytic Methods	• Descriptive statistics • DTA
Interpretation	A decrease in this measure over time would suggest MMC members experienced improvements in the appropriate use of ambulatory health care and care coordination.
Benchmark	None

Notes. [1] Due to 3M software changes, PPA rates prior to January 1, 2012 are excluded. [2] Starting January 1, 2010, the EQRO began calculating Texas MMC program measures each calendar year (January 1 – December 31). As a result, pre- and post-periods do not align with DYs. [3] The post-period ends on December 31, 2029, the last full calendar year before the Ten-Year Demonstration Extension approval period ends. Availability of this measure through December 31, 2029 is contingent on continuity in the EQRO's calculation and reporting of the measure. The external evaluator may extend the post-period if additional data become available prior to the Summative Evaluation Report. [4] Member subgroups may not be available for all years. STAR=MMC program primarily serving children and pregnant women; STAR+PLUS=MMC program serving aged and disabled clients; STAR Kids=MMC program serving disabled individuals 20 years or younger; EQRO=Texas's External Quality Review Organization; PPA=Potentially preventable admission; CY=Calendar year, January 1-December 31; MMC=Medicaid managed care; DTA=Descriptive trend analysis; DY=Demonstration year, October 1-September 30.

Measure 3.3.2	Potentially preventable emergency department visits (3M)
Definition	Emergency treatment for a condition that could have been treated or prevented by a physician or other health care provider in a non-emergency setting.
Study Population	STAR; STAR+PLUS; STAR Kids
Measure Steward or Source	EQRO-calculated measure using 3M software
Technical Specifications	Following the 3M protocol, the EQRO identifies ED visits at-risk for being a potentially preventable emergency department visit (PPV), actual PPVs, assigns weights, risk-adjusts PPVs, and calculates expected-to-actual PPV rates. As of CY 2019, the EQRO published the following information on PPVs: • Total at-risk ED visits • The number of PPVs • Total weight of all PPVs • Expected weight across all PPVs • Actual weight divided by expected weight • Total member months • Total PPV weight per 1,000 members • Total PPV weight per 1,000 at-risk admissions • Sum of the institutional expenditures across all PPVs
Exclusion Criteria	None besides exclusion criteria specified by 3M
Data Source(s)/Data Collection Methods	EQRO-calculated MMC performance measures
Comparison Group(s)/ Subgroup(s)	Pre-post comparison:[1] • STAR Post Only: 1/1/2012 – 12/31/2029[2,3] • STAR+PLUS Post Only: 1/1/2012 – 12/31/2029[3] • STAR Kids Post Only: 1/1/2017 – 12/31/2029[3] Member demographic and geographic characteristics, where applicable[4]
Analytic Methods	• Descriptive statistics • DTA
Interpretation	A decrease in this measure over time would suggest MMC members experienced improvements in the appropriate use of non-emergency health care.

Measure 3.3.2	Potentially preventable emergency department visits (3M)
Benchmark	None

Notes. [1] Due to 3M software changes, PPV rates prior to January 1, 2012 are excluded. [2] Starting January 1, 2010, the EQRO began calculating Texas MMC program measures each calendar year (January 1 – December 31). As a result, pre- and post-periods do not align with DYs. [3] The post-period ends on December 31, 2029, the last full calendar year before the Ten-Year Demonstration Extension approval period ends. Availability of this measure through December 31, 2029 is contingent on continuity in the EQRO's calculation and reporting of the measure. The external evaluator may extend the post-period if additional data become available prior to the Summative Evaluation Report. [4] Member subgroups may not be available for all years. STAR=MMC program primarily serving children and pregnant women; STAR+PLUS=MMC program serving aged and disabled clients; STAR Kids=MMC program serving disabled individuals 20 years or younger; EQRO=Texas's External Quality Review Organization; ED=Emergency department; PPV=Potentially preventable emergency department visit; CY=Calendar year, January 1-December 31; MMC=Medicaid managed care; DTA=Descriptive trend analysis; DY=Demonstration year, October 1-September 30.

H3.4. Poor care or care coordination which may result in unnecessary patient harm will maintain or reduce over time.

Measure 3.4.1	Potentially preventable complications (3M)
Definition	A harmful event or negative outcome, such as an infection or surgical complication, that occurs during a hospital admission or a long-term care facility stay, which was not present on admission and might have resulted from poor care or treatment rather than from natural progression of the underlying disease.
Study Population	STAR; STAR+PLUS; STAR Kids
Measure Steward or Source	EQRO-calculated measure using 3M software
Technical Specifications	Following the 3M protocol, the EQRO identifies inpatient admissions at-risk for being a PPC, actual PPCs, assigns weights, risk-adjusts PPCs, and calculates expected-to-actual PPC rates. As of CY 2019, the EQRO published the following information on PPCs: • Total at-risk admissions • Number of admissions that had one or more PPC • Number of PPCs • Total weight of all PPCs • Expected weight across all PPCs • Actual weight divided by expected weight • Total PPC weight per 1,000 at-risk admissions
Exclusion Criteria	None besides exclusion criteria specified by 3M
Data Source(s)/Data Collection Methods	EQRO-calculated MMC performance measures

Measure 3.4.1	Potentially preventable complications (3M)
Comparison Group(s)/ Subgroup(s)	Pre-post comparison:[1] • STAR Post Only: 1/1/2016 – 12/31/2029[2,3] • STAR+PLUS Post Only: 1/1/2016 – 12/31/2029[3] • STAR Kids Post Only: 1/1/2017 – 12/31/2029[3] Member demographic and geographic characteristics, where applicable[4]
Analytic Methods	• Descriptive statistics • DTA
Interpretation	A decrease in this measure over time would suggest MMC members experienced reductions in harmful patient outcomes resulting from poor care or lack of care coordination.
Benchmark	None

Notes. [1] Due to 3M software changes, PPC rates prior to January 1, 2016 are excluded. [2] Starting January 1, 2010, the EQRO began calculating Texas MMC program measures each calendar year (January 1 – December 31). As a result, pre- and post-periods do not align with DYs. [3] The post-period ends on December 31, 2029, the last full calendar year before the Ten-Year Demonstration Extension approval period ends. Availability of this measure through December 31, 2029 is contingent on continuity in the EQRO's calculation and reporting of the measure. The external evaluator may extend the post-period if additional data become available prior to the Summative Evaluation Report. [4] Member subgroups may not be available for all years. STAR=MMC program primarily serving children and pregnant women; STAR+PLUS=MMC program serving aged and disabled clients; STAR Kids=MMC program serving disabled individuals 20 years or younger; EQRO=Texas's External Quality Review Organization; PPC=Potentially preventable complication; CY=Calendar year, January 1-December 31; MMC=Medicaid managed care; DTA=Descriptive trend analysis; DY=Demonstration year, October 1-September 30.

Measure 3.4.2	Potentially preventable readmissions (3M)
Definition	A return hospitalization within 30 days that might have resulted from problems in care during a previous hospital stay or from deficiencies in a post-hospital discharge follow-up.
Study Population	STAR; STAR+PLUS; STAR Kids
Measure Steward or Source	EQRO-calculated measure using 3M software

Measure 3.4.2	Potentially preventable readmissions (3M)
Technical Specifications	Following the 3M protocol, the EQRO identifies readmissions with a plausible clinical relationship to a prior admission, readmissions at-risk for being a PPR, actual PPRs, assigns weights, risk-adjusts PPRs, and calculates expected-to-actual PPR rates. As of CY 2019, the EQRO published the following information on PPRs: • Total at-risk admissions • The number of PPR chains • Number of PPRs • Total weight of all PPRs • Expected weight across all PPRs • Actual weight divided by expected weight • Total PPR weight per 1,000 at-risk admissions • Sum of the institutional expenditures across all PPRs
Exclusion Criteria	None besides exclusion criteria specified by 3M
Data Source(s)/Data Collection Methods	EQRO-calculated MMC performance measures
Comparison Group(s)/ Subgroup(s)	Pre-post comparison:[1] • STAR Post Only: 1/1/2012 – 12/31/2029[2,3] • STAR+PLUS Post Only: 1/1/2012 – 12/31/2029[3] • STAR Kids Post Only: 1/1/2017 – 12/31/2029[3] Member demographic and geographic characteristics, where applicable[4]
Analytic Methods	• Descriptive statistics • DTA
Interpretation	A decrease in this measure over time would suggest MMC members experienced reductions in unnecessary hospital readmissions resulting from poor care.
Benchmark	None

Notes. [1] Due to 3M software changes, PPR rates prior to January 1, 2012 are excluded. [2] Starting January 1, 2010, the EQRO began calculating Texas MMC program measures each calendar year (January 1 – December 31). As a result, pre- and post-periods do not align with DYs. [3] The post-period ends on December 31, 2029, the last full calendar year before the Ten-Year Demonstration Extension approval period ends. Availability of this measure through December 31, 2029 is contingent on continuity in the EQRO's calculation and reporting of the measure. The external evaluator may extend the post-period if additional data become available prior to the Summative Evaluation Report. [4] Member subgroups may not be available for all years. STAR=MMC program primarily serving children and pregnant women; STAR+PLUS=MMC program serving aged and disabled clients; STAR Kids=MMC program serving disabled individuals 20 years or younger; EQRO=Texas's External Quality Review Organization; PPR=Potentially preventable readmission; CY=Calendar year, January 1-December 31; MMC=Medicaid managed care; DTA=Descriptive trend analysis; DY=Demonstration year, October 1-September 30.

H3.5. MMC member experience will maintain or improve over time.

Measure 3.5.1	Getting care quickly composite (CAHPS®)
Definition	The percentage of members or caregivers who report "always" being able to get care quickly.
Study Population	STAR; STAR+PLUS; STAR Kids
Measure Steward or Source	AHRQ: Health Plan Survey 5.0H – Adult and Child Version (Medicaid) Including Medicaid and Children with Chronic Conditions Supplemental Items
Technical Specifications	**Members:** The percentage of member respondents who answered "Always" to the following questions: • In the last 6 months, when you needed care right away, how often did you get care as soon as you needed? • In the last 6 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed? **Caregiver**: Number of caregiver respondents who answered "Always" to the following questions: • In the last 6 months, when your child needed care right away, how often did your child get care as soon as he or she needed? • In the last 6 months, when you made an appointment for a check-up or routine care for your child at a doctor's office or clinic, how often did you get an appointment as soon as your child needed? Survey results are weighted to account for the probability of selection into the survey sample and potential response bias by members' race/ethnicity. The Getting Care Quickly composite score is the average percentage of member/caregiver respondents who answered "Always" across the two questions. The composite score is calculated using weighted counts.
Exclusion Criteria	Members or caregivers who do not answer getting care quickly questions
Data Source(s)/Data Collection Methods	EQRO-calculated MMC performance measures
Comparison Group(s)/ Subgroup(s)	Pre-post comparison: • STAR Post Only: 1/1/2012 – 12/31/2029[1,2] • STAR+PLUS Pre: 9/1/2008 – 12/31/2011 • STAR+PLUS Post: 1/1/2012 – 12/31/2029 • STAR Kids Post Only: 1/1/2018 – 12/31/2029 Member demographic and geographic characteristics, where applicable[3]

Measure 3.5.1	Getting care quickly composite (CAHPS®)
Analytic Methods	• Descriptive statistics • DTA
Interpretation	Increases in the rates under this measure over time would suggest MMC members experienced improvements in MMC members' experience getting care.
Benchmark	Texas CMS Core Measure, 2019 Medicaid State Rate:[4] • Adult: 54.8 • Child: 80.5 National Aggregate 2019 Percentiles:[5] • Adult: 60.0 • Child: 73.0

Notes. [1] Prior to January 1, 2010, the EQRO calculated Texas MMC program measures each SFY. Starting January 1, 2010, the EQRO began calculating Texas MMC program measures each calendar year (January 1-December 31). As a result, pre- and post-periods for Texas MMC program measures do not align with DYs. [2] The post-period ends on December 31, 2029, the last full calendar year before the Ten-Year Demonstration Extension approval period ends. Availability of this measure through December 31, 2029 is contingent on continuity in the EQRO's calculation and reporting of the measure. The external evaluator may extend the post-period if additional data become available prior to the Summative Evaluation Report. [3] Member subgroups may not be available for all years. [4] Texas CMS Core Measure rates available via the Texas Healthcare Learning Collaborative Portal: https://thlcportal.com/measures/cmscoremeasuredashboard. [5] National aggregate rates available via the CAHPS® Online Reporting System: https://cahpsdatabase.ahrq.gov/CAHPSIDB/HP/about.aspx. CAHPS®=Consumer Assessment of Healthcare Providers and Systems; STAR=MMC program for children, newborns, and pregnant women; STAR+PLUS=MMC program for individuals 21 and older with disabilities and individuals age 65 and older; STAR Kids=MMC program serving disabled individuals 20 years and younger; AHRQ=Agency for Healthcare Research and Quality; EQRO=External Quality Review Organization; MMC=Medicaid managed care; DTA=Descriptive trend analysis; CMS=Centers for Medicare and Medicaid Services; SFY=State Fiscal Year, September 1-August 31; DY=Demonstration year, October 1-September 30.

Measure 3.5.2	Getting needed care composite (CAHPS®)
Definition	The percentage of members or caregivers who report "always" being able to get needed care.
Study Population	STAR; STAR+PLUS; STAR Kids
Measure Steward or Source	AHRQ: Health Plan Survey 5.0H – Adult and Child Version (Medicaid) Including Medicaid and Children with Chronic Conditions Supplemental Items
Technical Specifications	**Members**: The percentage of member respondents who answered "Always" to the following questions: • In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed? • In the last 6 months, how often was it easy to get the care, tests, or treatment you needed? **Caregivers**: The percentage of caregiver respondents who answered "Always" to the following questions: • In the last 6 months, how often did you get an appointment for your child to see a specialist as soon as you needed? • In the last 6 months, how often was it easy to get the care, tests, or treatment your child needed? Survey results are weighted to account for the probability of selection into the survey sample and potential response bias by members' race/ethnicity. The Getting Needed Care composite score is the average percentage of member/caregiver respondents who answered "Always" across the two questions. The composite score is calculated using weighted counts.
Exclusion Criteria	Members or caregivers who do not answer getting needed care questions
Data Source(s)/Data Collection Methods	EQRO-calculated MMC performance measures
Comparison Group(s)/ Subgroup(s)	Pre-post comparison: • STAR Post Only: 1/1/2012 – 12/31/2029[1,2] • STAR+PLUS Pre: 9/1/2008 – 12/31/2011 • STAR+PLUS Post: 1/1/2012 – 12/31/2029 • STAR Kids Post Only: 1/1/2018 – 12/31/2029 Member demographic and geographic characteristics, where applicable[3]
Analytic Methods	• Descriptive statistics • DTA

Measure 3.5.2	Getting needed care composite (CAHPS®)
Interpretation	Increases in the rates under this measure over time would suggest MMC members experienced improvements in MMC members' experience getting care.
Benchmark	Texas CMS Core Measure, 2019 Medicaid State Rate:[4] • Adult: 54.4 • Child: 68.2 National Aggregate 2019 Percentiles:[5] • Adult: 56.0 • Child: 61.0

Notes. [1] Prior to January 1, 2010, the EQRO calculated Texas MMC program measures each SFY. Starting January 1, 2010, the EQRO began calculating Texas MMC program measures each calendar year (January 1-December 31). As a result, pre- and post-periods for Texas MMC program measures do not align with DYs. [2] The post-period ends on December 31, 2029, the last full calendar year before the Ten-Year Demonstration Extension approval period ends. Availability of this measure through December 31, 2029 is contingent on continuity in the EQRO's calculation and reporting of the measure. The external evaluator may extend the post-period if additional data become available prior to the Summative Evaluation Report. [3] Member subgroups may not be available for all years. [4] Texas CMS Core Measure rates available via the Texas Healthcare Learning Collaborative Portal: https://thlcportal.com/measures/cmscoremeasuredashboard. [5] National aggregate rates available via the CAHPS® Online Reporting System: https://cahpsdatabase.ahrq.gov/CAHPSIDB/HP/about.aspx. CAHPS®=Consumer Assessment of Healthcare Providers and Systems; STAR=MMC program for children, newborns, and pregnant women; STAR+PLUS=MMC program for individuals 21 and older with disabilities and individuals age 65 and older; STAR Kids=MMC program serving disabled individuals 20 years and younger; AHRQ=Agency for Healthcare Research and Quality; EQRO=External Quality Review Organization; MMC=Medicaid managed care; DTA=Descriptive trend analysis; CMS=Centers for Medicare and Medicaid Services; SFY=State Fiscal Year, September 1-August 31; DY=Demonstration year, October 1-September 30.

Measure 3.5.3	Rating of personal doctor (CAHPS®)
Definition	The rating members and caregivers provide of their personal doctor.
Study Population	STAR; STAR+PLUS; STAR Kids
Measure Steward or Source	AHRQ: Health Plan Survey 5.0H – Adult and Child Version (Medicaid) Including Medicaid and Children with Chronic Conditions Supplemental Items
Technical Specifications	**Members:** The percentage of member respondents who rate their personal doctor at a 9 or 10 on a scale of 0 to 10, with 0 being the worst and 10 being the best **Caregivers:** The percentage of caregiver respondents who rate their child's personal doctor at a 9 or 10 on a scale of 0 to 10, with 0 being the worst and 10 being the best Survey results are weighted to account for the probability of selection into the survey sample and potential response bias by members' race/ethnicity.
Exclusion Criteria	Members or caregivers who do not provide a rating
Data Source(s)/Data Collection Methods	EQRO-calculated MMC performance measures
Comparison Group(s)/ Subgroup(s)	Pre-post comparison: • STAR Post Only: 1/1/2012 – 12/31/2029[1,2] • STAR+PLUS Pre: 9/1/2008 – 12/31/2011 • STAR+PLUS Post: 1/1/2012 – 12/31/2029 • STAR Kids Post Only: 1/1/2018 – 12/31/2029 Member demographic and geographic characteristics, where applicable[3]
Analytic Methods	• Descriptive statistics • DTA
Interpretation	Increases in the rates under this measure over time would suggest MMC members experienced improvements in MMC members' perceptions of their personal doctor.

Measure 3.5.3	Rating of personal doctor (CAHPS®)
Benchmark	Texas CMS Core Measure, 2019 Medicaid State Rate:[4] • Adult: 67.7 • Child: 82.8 National Aggregate 2019 Percentiles:[5] • Adult: 67.0 • Child: 77.0

Notes. [1] Prior to January 1, 2010, the EQRO calculated Texas MMC program measures each SFY. Starting January 1, 2010, the EQRO began calculating Texas MMC program measures each calendar year (January 1-December 31). As a result, pre- and post-periods for Texas MMC program measures do not align with DYs. [2] The post-period ends on December 31, 2029, the last full calendar year before the Ten-Year Demonstration Extension approval period ends. Availability of this measure through December 31, 2029 is contingent on continuity in the EQRO's calculation and reporting of the measure. The external evaluator may extend the post-period if additional data become available prior to the Summative Evaluation Report. [3] Member subgroups may not be available for all years. [4] Texas CMS Core Measure rates available via the Texas Healthcare Learning Collaborative Portal: https://thlcportal.com/measures/cmscoremeasuredashboard. [5] National aggregate rates available via the CAHPS® Online Reporting System: https://cahpsdatabase.ahrq.gov/CAHPSIDB/HP/about.aspx. CAHPS®=Consumer Assessment of Healthcare Providers and Systems; STAR=MMC program for children, newborns, and pregnant women; STAR+PLUS=MMC program for individuals 21 and older with disabilities and individuals age 65 and older; STAR Kids=MMC program serving disabled individuals 20 years and younger; AHRQ=Agency for Healthcare Research and Quality; EQRO=External Quality Review Organization; MMC=Medicaid managed care; DTA=Descriptive trend analysis; CMS=Centers for Medicare and Medicaid Services; SFY=State Fiscal Year, September 1-August 31; DY=Demonstration year, October 1-September 30.

Measure 3.5.4	Rating of health plan (CAHPS®)
Definition	The rating members and caregivers provide of their health plan.
Study Population	STAR; STAR+PLUS; STAR Kids
Measure Steward or Source	AHRQ: Health Plan Survey 5.0H – Adult and Child Version (Medicaid) Including Medicaid and Children with Chronic Conditions Supplemental Items
Technical Specifications	**Members:** The percentage of member respondents who rate their health plan at a 9 or 10 on a scale of 0 to 10, with 0 being the worst and 10 being the best **Caregivers:** The percentage of caregiver respondents who rate their child's health plan at a 9 or 10 on a scale of 0 to 10, with 0 being the worst and 10 being the best Survey results are weighted to account for the probability of selection into the survey sample and potential response bias by members' race/ethnicity.
Exclusion Criteria	Members or caregivers who do not provide a rating

Measure 3.5.4	Rating of health plan (CAHPS®)
Data Source(s)/Data Collection Methods	EQRO-calculated MMC performance measures
Comparison Group(s)/ Subgroup(s)	Pre-post comparison: • STAR Post Only: 1/1/2012 – 12/31/2029[1,2] • STAR+PLUS Pre: 9/1/2008 – 12/31/2011 • STAR+PLUS Post: 1/1/2012 – 12/31/2029 • STAR Kids Post Only: 1/1/2018 – 12/31/2029 Member demographic and geographic characteristics, where applicable[3]
Analytic Methods	• Descriptive statistics • DTA
Interpretation	Increases in the rates under this measure over time would suggest MMC members experienced improvements in MMC members' perceptions of their health plan.
Benchmark	Texas CMS Core Measure, 2019 Medicaid State Rate:[4] • Adult: 56.9 • Child: 82.4 National Aggregate 2019 Percentiles:[5] • Adult: 60.0 • Child: 71.0

Notes. [1] Prior to January 1, 2010, the EQRO calculated Texas MMC program measures each SFY. Starting January 1, 2010, the EQRO began calculating Texas MMC program measures each calendar year (January 1-December 31). As a result, pre- and post-periods for Texas MMC program measures do not align with DYs. [2] The post-period ends on December 31, 2029, the last full calendar year before the Ten-Year Demonstration Extension approval period ends. Availability of this measure through December 31, 2029 is contingent on continuity in the EQRO's calculation and reporting of the measure. The external evaluator may extend the post-period if additional data become available prior to the Summative Evaluation Report. [3] Member subgroups may not be available for all years. [4] Texas CMS Core Measure rates available via the Texas Healthcare Learning Collaborative Portal: https://thlcportal.com/measures/cmscoremeasuredashboard. [5] National aggregate rates available via the CAHPS® Online Reporting System: https://cahpsdatabase.ahrq.gov/CAHPSIDB/HP/about.aspx. CAHPS®=Consumer Assessment of Healthcare Providers and Systems; STAR=MMC program for children, newborns, and pregnant women; STAR+PLUS=MMC program for individuals 21 and older with disabilities and individuals age 65 and older; STAR Kids=MMC program serving disabled individuals 20 years and younger; AHRQ=Agency for Healthcare Research and Quality; EQRO=External Quality Review Organization; MMC=Medicaid managed care; DTA=Descriptive trend analysis; CMS=Centers for Medicare and Medicaid Services; SFY=State Fiscal Year, September 1-August 31; DY=Demonstration year, October 1-September 30.

SPP Component

Evaluation Question 4: Do the SPPs financially support providers serving the Medicaid and charity care populations?

H4.1. The UC and PHP-CCP programs financially support Medicaid providers by reimbursing Medicaid or charity care costs in Texas.

Measure 4.1.1	Number of UC program providers
Definition	The unique count of providers participating in the UC program.
Study Population	UC program providers
Measure Steward or Source	N/A
Technical Specifications	Unique TPI count of UC providers who submitted DSH/UC application in DY
Exclusion Criteria	None
Data Source(s)/Data Collection Methods	• American Community Survey • DSH/UC application • Provider-level eligibility files
Comparison Group(s)/ Subgroup(s)	Provider characteristics, where applicable Regional characteristics (RUCC, uninsured rates, etc.), where applicable
Analytic Methods	• Descriptive statistics • DTA, including DY1-8 data, where applicable
Interpretation	This measure is a direct indicator of Medicaid providers that are financially supported by the UC program.
Benchmark	None

Notes. UC=Uncompensated Care; TPI=Texas provider identifier; DSH=Disproportionate Share Hospital; DY=Demonstration year, October 1-September 30; RUCC=Rural-Urban Continuum Codes; DTA=Descriptive trend analysis.

Measure 4.1.2	Number of PHP-CCP program providers
Definition	The unique count of providers participating in the PHP-CCP program.
Study Population	PHP-CCP program providers
Measure Steward or Source	N/A
Technical Specifications	Unique TPI count of PHP-CCP providers who submitted PHP-CCP application in DY
Exclusion Criteria	None

Measure 4.1.2	Number of PHP-CCP program providers
Data Source(s)/Data Collection Methods	• American Community Survey • PHP-CCP application • Provider-level eligibility files
Comparison Group(s)/ Subgroup(s)	Provider characteristics, where applicable Regional characteristics (RUCC, uninsured rates, etc.), where applicable
Analytic Methods	• Descriptive statistics • DTA
Interpretation	This measure is a direct indicator of Medicaid providers that are financially supported by the PHP-CCP program.
Benchmark	None

Notes. PHP-CCP=Public Health Provider-Charity Care Pool; TPI=Texas provider identifier; DY=Demonstration year, October 1-September 30; RUCC=Rural-Urban Continuum Codes; DTA=Descriptive trend analysis.

Measure 4.1.3	UC eligible costs and reimbursements
Definition	Total costs and reimbursements for costs associated with services provided under a provider's charity care policy.
Study Population	UC program providers
Measure Steward or Source	N/A
Technical Specifications	Total amount of UC eligible charity care costs in DY Total amount of UC eligible charity care costs reimbursed in DY.
Exclusion Criteria	None
Data Source(s)/Data Collection Methods	• American Community Survey • DSH/UC application • Provider-level eligibility files
Comparison Group(s)/ Subgroup(s)	Provider characteristics, where applicable Regional characteristics (metro, micro, rural; RUCC, uninsured rates, etc.), where applicable
Analytic Methods	• Descriptive statistics • DTA
Interpretation	This measure is a direct indicator of financial support delivered through the UC program to Medicaid providers.

Measure 4.1.3	UC eligible costs and reimbursements
Benchmark	The external evaluator should use the Hospital Cost Report Public Use File for benchmarks, where appropriate[1]

Notes. [1] Charity care definitions may vary across data sources, so direct comparisons between DSH/UC application data and the Hospital Cost Report Public Use File should be avoided. UC=Uncompensated Care; DY=Demonstration year, October 1-September 30; DSH=Disproportionate Share Hospital; RUCC=Rural-Urban Continuum Codes; DTA=Descriptive trend analysis.

Measure 4.1.4	PHP-CCP eligible costs and reimbursements
Definition	Total costs and reimbursements for costs associated used to defray actual uncompensated care (DY11), or costs associated with services provided under a provider's charity care policy (DY12 forward).
Study Population	PHP-CCP program providers
Measure Steward or Source	N/A
Technical Specifications	Total amount of PHP-CCP eligible costs in DY Total amount of PHP-CCP eligible costs reimbursed in DY.
Exclusion Criteria	None
Data Source(s)/Data Collection Methods	• American Community Survey • PHP-CCP application • Provider-level eligibility files
Comparison Group(s)/ Subgroup(s)	Provider characteristics, where applicable Regional characteristics (metro, micro, rural; RUCC, uninsured rates, etc.), where applicable
Analytic Methods	• Descriptive statistics • DTA
Interpretation	This measure is a direct indicator of financial support delivered through the PHP-CCP program to Medicaid providers.
Benchmark	None

Notes. PHP-CCP=Public Health Provider-Charity Care Pool; DY=Demonstration year, October 1-September 30; RUCC=Rural-Urban Continuum Codes; DTA=Descriptive trend analysis.

H4.2. The UC and PHP-CCP programs support greater network adequacy and community health.

Measure 4.2.1	Network adequacy
Definition	The percentage of MMC members meeting prescribed network adequacy distance standards.
Study Population	MMC members
Measure Steward or Source	N/A
Technical Specifications	HHSC creates robust and meaningful distance standards between enrolled MMC members' residence and service delivery addresses of providers. Network adequacy reports include: • Number MMC members • Number of MMC members within distance standard of two providers • Percentage of MMC members within distance standard of two providers Network adequacy reports present results by provider type, MMC program, county type, and MCO; not all variables or subgroups will be relevant to analysis conducted for this evaluation.
Exclusion Criteria	None
Data Source(s)/Data Collection Methods	• Network adequacy reports Additional data sources needed for MLR model: • American Community Survey • DSH/UC application • PHP-CCP application
Comparison Group(s)/ Subgroup(s)	Provider type (e.g., acute care hospital, behavioral health, primary care provider, specialty care provider, etc.) County/regional characteristics (SPP funding, county type, uninsured rates, etc.)
Analytic Methods	• Descriptive statistics • MLR
Interpretation	Results from the MLR model will inform whether county/regional concentration of UC and PHP-CCP funds are associated with access to care for Medicaid members, after controlling for other county/regional characteristics.
Benchmark	None

Notes. MMC=Medicaid managed care; MLR=Multiple linear regression; DSH=Disproportionate Share Hospital; UC=Uncompensated Care; PHP-CCP=Public Health Providers Charity Care Pool.

Measure 4.2.2	Potentially preventable events (3M)
Definition	A health care event, which could have been prevented, that led to unnecessary services or contributes to poor quality of care.
Study Population	Individuals served by hospitals participating in Texas Medicaid; MMC members
Measure Steward or Source	EQRO-calculated measures using 3M software
Technical Specifications	Following the 3M protocol, the EQRO calculates the following PPEs: • Potentially preventable admissions (PPA): A hospital admission or long-term care facility stay that might have been reasonably prevented with adequate access to ambulatory care or health care coordination. This measure only includes MMC members. • Potentially preventable complications (PPC): A harmful event or negative outcome, such as an infection or surgical complication, that occurs after a hospital admission or an long-term care facility stay and might have resulted from care, lack of care, or treatment during the admission or stay. This measure includes all individuals served by hospitals (e.g., all payer sources). • Potentially preventable emergency department visits (PPV): Emergency treatment for a condition that could have been treated or prevented by a physician or other health care provider in a non-emergency setting. This measure only includes MMC members. • Potentially preventable readmissions (PPR): A return hospitalization, within a set time, that might have resulted from problems in care during a previous hospital stay or from deficiencies in a post-hospital discharge follow-up. This measure includes all individuals served by hospitals (e.g., all payer sources). The EQRO calculates all PPEs as rates, which reflect the number of PPEs per 1,000 at risk admissions (PPA, PPR, and PPC) or per 1,000 at risk ED visits (PPV). The external evaluator may use all PPEs, or a subset of PPEs based on data availability at the county/regional level.
Exclusion Criteria	None

Measure 4.2.2	Potentially preventable events (3M)
Data Source(s)/Data Collection Methods	• EQRO-calculated measures using 3M software Additional data sources needed for MLR model: • American Community Survey • DSH/UC application • PHP-CCP application
Comparison Group(s)/ Subgroup(s)	County/regional characteristics (SPP funding, county type, uninsured rates, etc.)
Analytic Methods	• Descriptive statistics • MLR
Interpretation	Results from the MLR model will inform whether county/regional concentration of UC and PHP-CCP funds are associated with community health outcomes, after controlling for other county/regional characteristics.
Benchmark	None

Notes. MMC=Medicaid managed care; EQRO=Texas's External Quality Review Organization; PPC=Potentially preventable complication; PPR=Potentially preventable readmission; PPA=Potential preventable admission; PPV=Potentially preventable emergency department visit; DSH=Disproportionate Share Hospital; UC=Uncompensated Care; PHP-CCP=Public Health Providers Charity Care Pool; MLR=Multiple linear regression.

Evaluation Question 5: Did the implementation of UHRIP support the hospital delivery system during the transition of the UC program to charity care only?

H5.1. Hospital-based performance measures will maintain or improve following the transition to charity care only in DY9.

Measure 5.1.1	Average length of stay per Medicaid inpatient hospital admission
Definition	The average number of days of care per Medicaid inpatient hospital admission.
Study Population	Medicaid clients served by UC program providers in UHRIP
Measure Steward or Source	N/A
Technical Specifications	**Numerator**: Total number of days across all Medicaid inpatient hospital admissions **Denominator**: Unique count of Medicaid inpatient hospital admissions **Rate**: Numerator / Denominator The rate can be calculated per quarter or DY.

Measure 5.1.1	Average length of stay per Medicaid inpatient hospital admission
Exclusion Criteria	UC program providers not participating in UHRIP (non-hospital providers: ambulance providers, dental providers, and physician group practices)
Data Source(s)/Data Collection Methods	• DSH/UC application • FFS Claims and MMC Encounters • Member-level enrollment files • Provider-level eligibility files • UHRIP administrative data
Comparison Group(s)/ Subgroup(s)	Pre-post comparison:[1] • Pre: 10/1/2011- 9/30/2019 • Post: 10/1/2019- 9/30/2030 Member demographic and geographic characteristics, where applicable Provider characteristics, where applicable
Analytic Methods	• Descriptive statistics • ITS
Interpretation	No change or a decrease in this measure after DY9 would suggest UHRIP helped to maintain or improve hospital-based performance following the transition of the UC program to charity care only.
Benchmark	None

Notes. [1] Contingent of CMS approval, UHRIP will transition to a component of CHIRP on September 1, 2021. The external evaluator may utilize multiple pre- or post-periods to capture implementation changes related to UHRIP and the transition to CHIRP, if feasible.
UC=Uncompensated Care; UHRIP=Uniform Hospital Rate Increase Program; DY=Demonstration year, October 1-September 30; DSH=Disproportionate Share Hospital; FFS=Fee-for-service; MMC=Medicaid managed care; ITS=Interrupted time series.

Measure 5.1.2	Average cost per Medicaid inpatient hospital admission
Definition	The average cost per Medicaid inpatient hospital admission.
Study Population	Medicaid clients served by UC program providers in UHRIP
Measure Steward or Source	N/A
Technical Specifications	**Numerator**: Total cost across all Medicaid inpatient hospital admissions **Denominator**: Unique count of Medicaid inpatient hospital admissions **Rate**: Numerator / Denominator The rate can be calculated per quarter or DY.

Measure 5.1.2	Average cost per Medicaid inpatient hospital admission
Exclusion Criteria	UC program providers not participating in UHRIP (non-hospital providers: ambulance providers, dental providers, and physician group practices)
Data Source(s)/Data Collection Methods	• DSH/UC application • FFS Claims and MMC Encounters • Member-level enrollment files • Provider-level eligibility fil • UHRIP administrative data
Comparison Group(s)/ Subgroup(s)	Pre-post comparison:[1] • Pre: 10/1/2011- 9/30/2019 • Post: 10/1/2019- 9/30/2030 Member demographic and geographic characteristics, where applicable Provider characteristics, where applicable
Analytic Methods	• Descriptive statistics • ITS
Interpretation	No change or a decrease in this measure after DY9 would suggest UHRIP helped to maintain or improve hospital-based performance following the transition of the UC program to charity care only.
Benchmark	None

Notes. [1] Contingent of CMS approval, UHRIP will transition to a component of CHIRP on September 1, 2021. The external evaluator may utilize multiple pre- or post-periods to capture implementation changes related to UHRIP and the transition to CHIRP, if feasible.
UC=Uncompensated Care; UHRIP=Uniform Hospital Rate Increase Program; DY=Demonstration year, October 1-September 30; DSH=Disproportionate Share Hospital; FFS=Fee-for-service; MMC=Medicaid managed care; ITS=Interrupted time series.

Measure 5.1.3	Patients' perceptions of hospital care
Definition	Patients' experience with hospital care during a recent inpatient hospital stay.
Study Population	Patients served by UC program providers in UHRIP
Measure Steward or Source	Agency for Healthcare Research and Quality (AHRQ), administered by CMS State-level HCAHPS® results are publicly accessible via: • Patient survey (HCAHPS ®) - State: https://data.cms.gov/provider-data/dataset/84jm-wiui • HCAHPS ® Hospital Survey Website: https://hcahpsonline.org/en/summary-analyses/previous-summary-analyses-documents/ Provider-level HCAHPS® results are publicly available via: • Hospital comparison website: https://www.medicare.gov/care-compare/?providerType=Hospital&redirect=true#search
Technical Specifications	CMS administers the HCAHPS® survey to a random sample of adult patients who have been recently discharged. The HCAHPS® survey assesses patients' experience of communicating with nurses and doctors, patients' perception of hospital staff responsiveness, communication about medicines, hospital quietness and cleanliness, information about discharge, post-hospital care transition planning, and rating the hospital overall. HCAHPS® survey results are presented per CY.
Exclusion Criteria	UC program providers not participating in UHRIP (non-hospital providers: ambulance providers, dental providers, and physician group practices)
Data Source(s)/Data Collection Methods	• CMS HCAHPS® Surveys • DSH/UC application • Provider-level eligibility files • UHRIP administrative data
Comparison Group(s)/ Subgroup(s)	Pre-post comparison:[1,2] • Pre: 1/1/2012- 12/31/2019[3] • Post: 1/1/2020- 12/31/2029[4] Provider characteristics, where applicable
Analytic Methods	• Descriptive statistics • DTA • ITS, if feasible

Measure 5.1.3	Patients' perceptions of hospital care
Interpretation	No change or an increase in this measure after DY9 would suggest UHRIP helped to maintain or improve hospital-based performance following the transition of the UC program to charity care only.
Benchmark	HCAHPS® Percentile Tables 2018 Discharges, National Average "Top Box" Score:[5] • Communication with nurses: 81.0 • Communication with doctors: 81.0 • Responsiveness of hospital staff: 70.0 • Communication about medicines: 66.0 • Cleanliness of hospital environment:75.0 • Quietness of hospital environment: 62.0 • Discharge information: 87.0 • Care transition: 53.0 • Hospital rating: 73.0 • Would recommend hospital: 72.0

Notes. [1] Provider-level HCAHPS® survey results may not be available for the entire the pre- and post-periods. The external evaluator may use the all provider-level data available or may choose to use state-level estimates. [2] Contingent of CMS approval, UHRIP will transition to a component of CHIRP on September 1, 2021. The external evaluator may utilize multiple pre- or post-periods to capture implementation changes related to UHRIP and the transition to CHIRP, if feasible. [3] HCAHPS® survey results are published for calendar years (January 1 – December 31). As a result, pre- and post-periods for do not align with DYs. [4] The post-period ends on December 31, 2029, the last full calendar year before the Ten-Year Demonstration Extension approval period ends. The external evaluator may extend the post-period if additional data become available prior to the Summative Evaluation Report. [5] "Top Box" scores reflect how often respondents provided positive assessments of the hospital experience. HCAHPS® Percentile Tables are accessible via: https://hcahpsonline.org/en/summary-analyses/previous-summary-analyses-documents/. UC=Uncompensated Care; UHRIP=Uniform Hospital Rate Increase Program; AHRQ=Agency for Healthcare Research and Quality; CMS=Centers for Medicare and Medicaid Services; HCAHPS®=Hospital Consumer Assessment of Healthcare Providers and Systems; CY=Calendar year, January 1-December 31; DSH=Disproportionate Share Hospital; DTA=Descriptive trend analysis; ITS=Interrupted time series; DY=Demonstration year, October 1-September 30.

Measure 5.1.4	Potentially preventable complications (3M)
Definition	A harmful event or negative outcome, such as an infection or surgical complication, that occurs during a hospital admission or a long-term care facility stay, which was not present on admission and might have resulted from poor care or treatment rather than from natural progression of the underlying disease.
Study Population	UC program providers in UHRIP
Measure Steward or Source	EQRO-calculated measures using 3M software
Technical Specifications	Following the 3M protocol, the EQRO identifies inpatient admissions at-risk for being a PPC, actual PPCs, assigns weights, risk-adjusts PPCs, and calculates expected-to-actual PPC rates. As of CY 2019, the EQRO published the following information on PPCs: • Total at-risk admissions • Number of admissions that had one or more PPC • Number of PPCs • Total weight of all PPCs • Expected weight across all PPCs • Actual weight divided by expected weight • Total PPC weight per 1,000 at-risk admissions
Exclusion Criteria	UC program providers not participating in UHRIP (non-hospital providers: ambulance providers, dental providers, and physician group practices) Exclusion criteria specified by 3M
Data Source(s)/Data Collection Methods	• EQRO-calculated PPE performance measures • Provider-level eligibility files • UHRIP administrative data
Comparison Group(s)/ Subgroup(s)	Pre-post comparison:[1,2,3] • Pre: 1/1/2016- 12/31/2019 • Post: 1/1/2020- 12/31/2029[4] Provider characteristics, where applicable
Analytic Methods	• Descriptive statistics • DTA
Interpretation	No change or a decrease in this measure after DY9 would suggest UHRIP helped to maintain or improve hospital-based performance following the transition of the UC program to charity care only.

Measure 5.1.4	Potentially preventable complications (3M)
Benchmark	None

Notes. [1] Due to 3M software changes, PPC rates prior to January 1, 2016 are excluded. [2] Starting January 1, 2010, the EQRO began calculating Texas MMC program measures each calendar year (January 1 – December 31). As a result, pre- and post-periods do not align with DYs. [3] Contingent of CMS approval, UHRIP will transition to a component of CHIRP on September 1, 2021. The external evaluator may utilize multiple pre- or post-periods to capture implementation changes related to UHRIP and the transition to CHIRP, if feasible. [4] The post-period ends on December 31, 2029, the last full calendar year before the Ten-Year Demonstration Extension approval period ends. The external evaluator may extend the post-period if additional data become available prior to the Summative Evaluation Report. UC=Uncompensated Care; UHRIP=Uniform Hospital Rate Increase Program; EQRO=Texas's External Quality Review Organization; PPC=Potentially preventable complication; CY=Calendar year, January 1-December 31; PPE=Potentially preventable event; DTA=Descriptive trend analysis; DY=Demonstration year, October 1-September 30.

Measure 5.1.5	Potentially preventable readmissions (3M)
Definition	A return hospitalization within 30 days that might have resulted from problems in care during a previous hospital stay or from deficiencies in a post-hospital discharge follow-up.
Study Population	UC program providers in UHRIP
Measure Steward or Source	EQRO-calculated measures using 3M software
Technical Specifications	Following the 3M protocol, the EQRO identifies readmissions with a plausible clinical relationship to a prior admission, readmissions at-risk for being a PPR, actual PPRs, assigns weights, risk-adjusts PPRs, and calculates expected-to-actual PPR rates. As of CY 2019, the EQRO published the following information on PPRs: • Total at-risk admissions • The number of PPR chains • Number of PPRs • Total weight of all PPRs • Expected weight across all PPRs • Actual weight divided by expected weight • Total PPR weight per 1,000 at-risk admissions • Sum of the institutional expenditures across all PPRs
Exclusion Criteria	UC program providers not participating in UHRIP (non-hospital providers: ambulance providers, dental providers, and physician group practices) Exclusion criteria specified by 3M

Measure 5.1.5	Potentially preventable readmissions (3M)
Data Source(s)/Data Collection Methods	• EQRO-calculated PPE performance measures • Provider-level eligibility files • UHRIP administrative data
Comparison Group(s)/ Subgroup(s)	Pre-post comparison:[1,2,3] • Pre: 1/1/2012- 12/31/2019 • Post: 1/1/2020- 12/31/2029[4] Provider characteristics, where applicable
Analytic Methods	• Descriptive statistics • DTA
Interpretation	No change or a decrease in this measure after DY9 would suggest UHRIP helped to maintain or improve hospital-based performance following the transition of the UC program to charity care only.
Benchmark	None

Notes. [1] Due to 3M software changes, PPR rates prior to January 1, 2012 are excluded. [2] Starting January 1, 2010, the EQRO began calculating Texas MMC program measures each calendar year (January 1 – December 31). As a result, pre- and post-periods do not align with DYs. [3] Contingent of CMS approval, UHRIP will transition to a component of CHIRP on September 1, 2021. The external evaluator may utilize multiple pre- or post-periods to capture implementation changes related to UHRIP and the transition to CHIRP, if feasible. [4] The post-period ends on December 31, 2029, the last full calendar year before the Ten-Year Demonstration Extension approval period ends. The external evaluator may extend the post-period if additional data become available prior to the Summative Evaluation Report. UC=Uncompensated Care; UHRIP=Uniform Hospital Rate Increase Program; EQRO=Texas's External Quality Review Organization; PPR=Potentially preventable readmission; CY=Calendar year, January 1-December 31; PPE=Potentially preventable event; DTA=Descriptive trend analysis; DY=Demonstration year, October 1-September 30.

Overall Demonstration Component

Evaluation Question 6. What are the costs of providing health care services to Medicaid beneficiaries served under the Demonstration?

H6.1. The Demonstration results in overall savings in health care service expenditures.

Measure 6.1.1	Actual Medicaid health service expenditures
Definition	Actual Medicaid health care expenditures for Medicaid beneficiaries served prior to or under the Demonstration.
Study Population	Medicaid Eligibility Groups served under the Demonstration
Measure Steward or Source	N/A

Measure 6.1.1	Actual Medicaid health service expenditures
Technical Specifications	WW expenditures for MEGs served under the Demonstration per DY The external evaluator will calculate inflation adjustments as necessary. The external evaluator should present this measure alongside Measure 8.1.2 (Hypothetical WOW Medicaid health service expenditures).
Exclusion Criteria	Expenditures not associated with traditional reimbursement of Medicaid claims and encounters (e.g., SPPs or DPPs)
Data Source(s)/Data Collection Methods	• Budget neutrality worksheet
Comparison Group(s)/ Subgroup(s)	WW costs versus WOW costs MEGs served under the Demonstration
Analytic Methods	• Descriptive statistics • DTA
Interpretation	This measure is a direct indicator the costs of providing health care services to MMC members under the Demonstration.
Benchmark	None; Historical health care expenditures for Medicaid clients (FFS and MMC) prior to the Demonstration (October 2006 – September 2010) may be used as a contextual reference cohort[1]

Notes. [1] HHSC calculations of health care service expenditures prior to the Demonstration can be shared with the external evaluator upon request. Historical health care expenditures prior to the Demonstration include individuals receiving services through FFS and MMC. Most individuals who received services through FFS prior to the Demonstration transitioned into MMC and are included in WW expenditures for MEGs. However, at the time of writing, approximately 6% of all Medicaid beneficiaries received services through FFS, and therefore are not included in WW expenditures for MEGs. As a result, trends in historical health care expenditures are provided for contextual reference only and should not be used to make direct dollar amount comparisons. Additional information on historical expenditures prior to the Demonstration is presented in HHSC's Rider 61 Final Comprehensive Report: Evaluation of Medicaid and CHIP Managed Care, August 2018. This evaluation was conducted in partnership with Deloitte LLP and is accessible via: https://www.hhs.texas.gov/reports/2018/08/rider-61-evaluation-medicaid-chip-managed-care.
WW=With waiver; MEG=Medicaid Eligibility Group; DY=Demonstration year, October 1-September 30; FFS=Fee-for-service; SPP=Supplemental Payment Program; DPP=Directed Payment Program; DTA=Descriptive trend analysis; MMC=Medicaid managed care.

Measure 6.1.2	Hypothetical WOW Medicaid health service expenditures
Definition	Hypothetical Medicaid health care service expenditures for MMC members served under the Demonstration if the Demonstration did not exist (e.g., FFS).
Study Population	Medicaid Eligibility Groups served under the Demonstration
Measure Steward or Source	N/A
Technical Specifications	WOW expenditures for MEGs served under the Demonstration per DY The external evaluator will calculate inflation adjustments as necessary. The external evaluator should present this measure alongside Measure 6.1.1 (Actual Medicaid health service expenditures).
Exclusion Criteria	Expenditures not associated with traditional reimbursement of Medicaid claims and encounters (e.g., UPL program)
Data Source(s)/Data Collection Methods	• Budget neutrality worksheet
Comparison Group(s)/ Subgroup(s)	WW costs versus WOW costs MEGs served under the Demonstration
Analytic Methods	• Descriptive statistics • DTA
Interpretation	The difference between this measure and actual expenditure costs (Measure 6.1.1) is a direct indicator of overall cost savings in health care service expenditures.
Benchmark	None

Notes. WOW=Without waiver; MMC=Medicaid managed care; FFS=Fee-for-service; MEG=Medicaid Eligibility Group; DY=Demonstration year, October 1-September 30; UPL=Upper payment limit; DTA=Descriptive trend analysis.

Evaluation Question 7. What are the administrative costs of implementing and operating the Demonstration?

H7.1. Administrative costs required to implement and operate the Demonstration are relatively stable and reasonable over time.

Measure 7.1.1	HHSC administrative costs directly attributable to the Demonstration
Definition	HHSC-incurred administrative expenditures attributable to the Demonstration.
Study Population	HHSC
Measure Steward or Source	N/A
Technical Specifications	Form CMS-64 includes a variety of sections detailing different types of expenditures. This measure will focus on costs attributable to the Demonstration reported on 64.10, Expenditures for State and Local Administration, per DY. The external evaluator will calculate inflation adjustments as necessary.
Exclusion Criteria	None
Data Source(s)/Data Collection Methods	• Form CMS-64
Comparison Group(s)/ Subgroup(s)	Type of administrative expenditures, where applicable
Analytic Methods	• Descriptive statistics • DTA
Interpretation	This measure is a director indicator of the administrative costs of implementing and operating the Demonstration.
Benchmark	None

Notes. HHSC=Health and Human Services Commission; CMS=Centers for Medicare and Medicaid Services; DY=Demonstration year, October 1-September 30; DTA=Descriptive trend analysis.

Measure 7.1.2	MCO administrative costs
Definition	MCO-incurred administrative expenditures for implementing MMC.
Study Population	MCOs
Measure Steward or Source	N/A
Technical Specifications	MCO-reported administrative expenses directly or indirectly in support of MMC operations, per SFY.[1,2] Administrative expenses include salaries, wages and other benefits, payroll taxes, utilities and maintenance, auditing and other consulting expenses, etc. The external evaluator will calculate inflation adjustments as necessary.
Exclusion Criteria	None
Data Source(s)/Data Collection Methods	• MCO Financial Statistical Reports
Comparison Group(s)/ Subgroup(s)	Type of administrative expenditures, where applicable
Analytic Methods	• Descriptive statistics • DTA
Interpretation	This measure is a director indicator of the administrative costs of implementing MMC, which operates under the authority of the Demonstration.
Benchmark	None

Notes. [1] MCOs report administrative costs on State Fiscal Year (September 1 – August 31) cycles. As a result, post-period does not align with DYs. [2] Due to changes in MCO-required reporting over time, MCO administrative costs may not be comparable across all SFYs. MCO=Managed care organization; MMC=Medicaid managed care; SFY=State Fiscal Year, September 1-August 31; DTA=Descriptive trend analysis.

Evaluation Question 8. How do directed and supplemental payment programs support providers and overall Medicaid program sustainability?

H8.1. The Demonstration leverages savings in health care service expenditures to administer directed and supplemental payment programs.

Measure 8.1.1	Total expenditures for DSRIP, DPPs, and SPPs
Definition	Total expenditures per DY for the directed and supplemental payment programs administered through the Demonstration.
Study Population	DPP providers; DSRIP providers; PHP-CCP program providers; UC program providers
Measure Steward or Source	N/A
Technical Specifications	Total expenditures for DSRIP, DPPs, UC program, and PHP-CCP program per DY. Total expenditures should be presented for each program and summed across all programs. The external evaluator will calculate inflation adjustments as necessary.
Exclusion Criteria	Expenditures associated with payment systems not directly funded through the Demonstration (e.g., APMs)
Data Source(s)/Data Collection Methods	• Budget neutrality worksheet (quarterly version)
Comparison Group(s)/ Subgroup(s)	• Type of payment system or funding pool administered through the Demonstration
Analytic Methods	• Descriptive statistics • DTA
Interpretation	This measure is a director indicator of the directed and supplemental payment programs available through savings in health care service expenditures under the Demonstration.
Benchmark	None

Notes. DSRIP=Delivery System Reform Incentive Payment; DPP=Directed Payment Program; SPP=Supplemental Payment Program; DY=Demonstration year, October 1-September 30; PHP-CCP=Public Health Providers Charity Care Pool; UC=Uncompensated Care; APM=Alternative Payment Model; DTA=Descriptive trend analysis.

Measure 8.1.2	Medicaid providers receiving payments through DSRIP, DPPs, and SPPs
Definition	Total number of providers per DY enrolled in quality-payment systems and supplemental payment pools administered through the Demonstration.
Study Population	DPP providers; DSRIP providers; PHP-CCP program providers; UC program providers
Measure Steward or Source	N/A
Technical Specifications	Unique count of providers enrolled in DSRIP, any DPP program, UC program, or PHP-CCP program per DY/SFY.[1] Providers enrolled in multiple programs should only be counted once. Provider counts should be presented for each program and summed across all programs.
Exclusion Criteria	None
Data Source(s)/Data Collection Methods	• DSRIP and DPP administrative data • DSH/UC application • PHP-CCP application
Comparison Group(s)/ Subgroup(s)	• Type of payment system or funding pool administered through the Demonstration
Analytic Methods	• Descriptive statistics • DTA
Interpretation	This measure is a director indicator of participation in directed and supplemental payment programs available through savings in health care service expenditures under the Demonstration.
Benchmark	None

Notes. [1] DPPs operate on a State Fiscal Year (September 1-August 31) cycles. DSRIP=Delivery System Reform Incentive Payment; DPP=Directed Payment Program; SPP=Supplemental Payment Program; DY=Demonstration year, October 1-September 30; PHP-CCP=Public Health Providers Charity Care Pool; UC=Uncompensated Care; SFY=State fiscal year, September 1-August 31; DSH=Disproportionate Share Hospital; DTA=Descriptive trend analysis.

H8.2. The directed and supplemental payment programs support Medicaid provider operations and sustainability.

Measure 8.2.1	Participation in directed and supplemental payment programs
Definition	Self-reported participation in current directed and supplemental payment programs (e.g., DPPs, UC, PHP-CCP)
Study Population	DPP providers; PHP-CCP program providers; UC program providers
Measure Steward or Source	N/A – External evaluator will develop survey and/or interview guide
Technical Specifications	Providers will be asked to indicate which directed and supplemental payment programs they currently or previously participated in, as well as programs they plan to participate in.
Exclusion Criteria	None
Data Source(s)/Data Collection Methods	• Provider survey and/or interviews (to be developed by external evaluator)[1]
Comparison Group(s)/ Subgroup(s)	Respondent characteristics, where applicable Participating program (e.g., DPPs, UC, PHP-CCP)
Analytic Methods	• Descriptive statistics • Thematic content analysis
Interpretation	Responses will provide direct insight into how many Medicaid providers receive support directed and supplemental payment programs administered through the Demonstration.
Benchmark	None

Notes. [1] The external evaluator may supplement information gathered from the provider survey and/or interviews with administrative data (e.g., rosters of participating providers).
DPP=Directed Payment Program; SPP=Supplemental Payment Program; UC=Uncompensated Care; PHP-CCP=Public Health Provider-Charity Care Pool.

Measure 8.2.2	Need for directed and supplemental payment programs
Definition	Self-reported need for directed and supplemental payment programs (e.g., DPPs, UC, PHP-CCP).
Study Population	DPP providers; PHP-CCP program providers; UC program providers
Measure Steward or Source	N/A – External evaluator will develop survey and/or interview guide
Technical Specifications	Providers will be asked to describe how claims or costs eligible for rate enhancement or reimbursement under the directed and supplemental payment programs are incurred, and need for funds/payments received. Suggested questions include, but are not limited to: • What are typical sources of costs eligible for directed and supplemental payment programs (e.g., types of care and clients served)? • Has your organization experienced changes in costs eligible for directed and supplemental payment programs over time? If so, what were the changes? • What challenges do costs eligible for directed and supplemental payment programs present to your organization? • What impacts would your organization experience if directed and supplemental payment programs did not exist?
Exclusion Criteria	None
Data Source(s)/Data Collection Methods	• Provider survey and/or interviews (to be developed by external evaluator)
Comparison Group(s)/ Subgroup(s)	Respondent characteristics, where applicable Participating program (e.g., DPPs, UC, PHP-CCP)
Analytic Methods	• Descriptive statistics • Thematic content analysis
Interpretation	Respondent perspectives will provide direct insight into how directed and supplemental payment programs administered through the Demonstration support Medicaid providers in Texas.
Benchmark	None

Notes. SPP=Supplemental Payment Program; UC=Uncompensated Care; PHP-CCP=Public Health Provider-Charity Care Pool.

Measure 8.2.3	Perceived benefits and challenges of directed and supplemental payment programs
Definition	Perceived successes and challenges of directed and supplemental payment programs in supporting: • Provider operations • Provider sustainability
Study Population	DPP providers; PHP-CCP program providers; UC program providers
Measure Steward or Source	N/A – External evaluator will develop survey and/or interview guide
Technical Specifications	Providers will be asked to provide feedback on the successes and challenges of current and previous directed and supplemental payment programs (e.g., DSRIP, DPPs, UC, and PHP-CCP) in supporting provider operations and provider sustainability. Suggested questions include, but are not limited to: • How have directed and supplemental payment programs supported your organization? • Have directed and supplemental payment programs supported your organization's ability to serve different types of clients? If so, how? • Have directed and supplemental payment programs supported your organization's ability to deliver different services? If so, how? • Have directed and supplemental payment programs supported your organization's ability to continue serving Medicaid clients? If so, how? • What challenges remain despite payments your organization receives through directed and supplemental payment programs? • How could the directed and supplemental payment programs better support your organization?
Exclusion Criteria	None
Data Source(s)/Data Collection Methods	• Provider survey and/or interviews (to be developed by external evaluator)
Comparison Group(s)/ Subgroup(s)	Respondent characteristics, where applicable Participating program (e.g., DPPs, UC, PHP-CCP)
Analytic Methods	• Descriptive statistics • Thematic content analysis
Interpretation	Respondent perspectives will provide direct insight into successes and challenges of directed and supplemental payment programs in supporting Medicaid provider operations and sustainability.

Measure 8.2.3	Perceived benefits and challenges of directed and supplemental payment programs
Benchmark	None

Notes. DPP=Directed Payment Program; SPP=Supplemental Payment Program; UC=Uncompensated Care; PHP-CCP=Public Health Provider-Charity Care Pool.

Measure 8.2.4	Provider perspectives on state priorities and policy development
Definition	Provider perspectives on and recommendations for state priorities and policy development related to supporting to Medicaid providers in Texas.
Study Population	DPP providers; PHP-CCP program providers; UC program providers
Measure Steward or Source	N/A – External evaluator will develop survey and/or interview guide
Technical Specifications	Providers will be asked to share perspectives and recommendations for state priorities and policy development related to supporting Medicaid providers. Suggested questions include, but are not limited to: • How can HHSC better support your organization in serving Medicaid beneficiaries? • What successes from the directed and supplemental payment programs would you like to see HHSC continue or expand upon in the future? • What opportunities for improvement would you like to see HHSC incorporate in the future related to the directed and supplemental payment programs?
Exclusion Criteria	None
Data Source(s)/Data Collection Methods	• Provider survey and/or interviews (to be developed by external evaluator)
Comparison Group(s)/ Subgroup(s)	Respondent characteristics, where applicable Participating program (e.g., DPPs, UC, PHP-CCP)
Analytic Methods	• Descriptive statistics • Thematic content analysis
Interpretation	Respondent perspectives will provide direct insight into provider considerations for the directed and supplemental payment programs that support Medicaid providers in Texas.
Benchmark	None

Notes. DPP=Directed Payment Program; UC=Uncompensated Care; PHP-CCP=Public Health Provider-Charity Care Pool.

Evaluation Question 9: Did Texas's quality initiatives impact the development and implementation of quality-based payment systems?

H9.1. The implementation of APMs in Texas Medicaid will increase over time.

Measure 9.1.1	**Percentage of providers implementing APMs**
Definition	The percentage of providers implementing APMs.
Study Population	DPP Providers; PHP-CCP program providers; UC program providers
Measure Steward or Source	N/A
Technical Specifications	The percentage of providers self-reporting implementing at least one APM.
Exclusion Criteria	Providers not participating in MMC
Data Source(s)/Data Collection Methods	• Provider survey
Comparison Group(s)/ Subgroup(s)	Separated by the Health Care Payment Learning & Action Network APM categories and subcategories, if feasible. APM categories are accessible via: https://hcp-lan.org/apm-refresh-white-paper/ Provider characteristics, where applicable
Analytic Methods	• Descriptive statistics • DTA, including DY7-11 data, if feasible
Interpretation	This measure is a direct indicator of APM implementation among Medicaid providers.
Benchmark	None

Notes. APM=Alternative payment model; DPP=Directed Payment Program; PHP-CCP=Public Health Provider – Charity Care Program; UC=Uncompensated Care; MMC=Medicaid managed care; DTA=Descriptive trend analysis; DY=Demonstration year, October 1-September 30.

Measure 9.1.2	Percentage of MCOs and providers implementing risk-based APMs
Definition	The percentage of MCOs and providers implementing risk-based APMs.
Study Population	MCOs; DPP Providers; PHP-CCP program providers; UC program providers
Measure Steward or Source	N/A
Technical Specifications	The percentage of MCOs and providers self-reporting implementing at-risk APMs.
Exclusion Criteria	Providers not participating in MMC
Data Source(s)/Data Collection Methods	• MCO APM reporting tool • Provider survey
Comparison Group(s)/ Subgroup(s)	Separated by the Health Care Payment Learning & Action Network APM categories and subcategories, if feasible. APM categories are accessible via: https://hcp-lan.org/apm-refresh-white-paper/ MCO and provider characteristics, where applicable
Analytic Methods	• Descriptive statistics • DTA, including DY7-11 data, if feasible
Interpretation	This measure is a direct indicator of APM implementation.
Benchmark	None

Notes. MCO=Managed care organization; APM=Alternative payment model; DPP=Directed Payment Program; PHP-CCP=Public Health Provider – Charity Care Program; UC=Uncompensated Care; MMC=Medicaid managed care; DTA=Descriptive trend analysis; DY=Demonstration year, October 1-September 30.

Measure 9.1.3	Percentage of MCO payments made through APMs
Definition	The percentage of total MCO payments made to providers through APMs.
Study Population	MCOs
Measure Steward or Source	N/A
Technical Specifications	HHSC contractually requires MCOs to establish APMs with providers. By December 31, 2021, MCOs are expected to have at least 50 percent of total provider payments for medical and prescription expenses in APMs, and at least 25 percent in a risk-based model. MCOs are required to report on total provider payments in APMs and risk-based models by July 1, 2022. HHSC may establish new APM targets for MCOs after December 31, 2021.
Exclusion Criteria	None
Data Source(s)/Data Collection Methods	• MCO APM reporting tool
Comparison Group(s)/ Subgroup(s)	Separated by the Health Care Payment Learning & Action Network APM categories and subcategories, if feasible. APM categories are accessible via: https://hcp-lan.org/apm-refresh-white-paper/ MCO and provider characteristics, where applicable
Analytic Methods	• Descriptive statistics • DTA, including DY7-11 data, if feasible
Interpretation	This measure is a direct indicator of APM implementation.
Benchmark	None

Notes. MCO=Managed care organization; APM=Alternative payment model; HHSC=Health and Human Services Commission; MMC=Medicaid managed care; DTA=Descriptive trend analysis; DY=Demonstration year, October 1-September 30.

Measure 9.1.4	Perceived benefits of implementing APMs
Definition	MCO and provider-identified benefits, or perceived successes, of implementing APMs within the Texas MMC delivery model.
Study Population	MCOs; DPP Providers; PHP-CCP program providers; UC program providers
Measure Steward or Source	N/A
Technical Specifications	Open-ended responses on perceived benefits of implementing APMs.
Exclusion Criteria	Providers not participating in MMC
Data Source(s)/Data Collection Methods	• MCO survey • Provider survey
Comparison Group(s)/ Subgroup(s)	MCO and provider characteristics, where applicable
Analytic Methods	• Content analysis • Thematic content analysis
Interpretation	Respondent perspectives will provide direct insight into successes of implementing APMs in Texas.
Benchmark	None

Notes. APM=Alternative payment model; MCO=Managed care organization; DPP=Directed Payment Program; PHP-CCP=Public Health Provider – Charity Care Program; UC=Uncompensated Care; MMC=Medicaid managed care.

Measure 9.1.5	Perceived challenges with implementing APMs
Definition	MCOs and provider-identified challenges, or perceived drawbacks, of implementing APMs within Texas MMC delivery model.
Study Population	MCOs; DPP Providers; PHP-CCP program providers; UC program providers
Measure Steward or Source	N/A – External evaluator will develop survey
Technical Specifications	Open-ended responses on challenges or perceived drawbacks to the implementation of APMs.
Exclusion Criteria	Providers not participating in MMC
Data Source(s)/Data Collection Methods	• MCO survey • Provider survey
Comparison Group(s)/ Subgroup(s)	MCO and provider characteristics, where applicable
Analytic Methods	Content analysis Thematic content analysis
Interpretation	Respondent perspectives will provide direct insight into barriers or drawbacks associated with implementing APMs in Texas.
Benchmark	None

Notes. APM=Alternative payment model; MCO=Managed care organization; DPP=Directed Payment Program; PHP-CCP=Public Health Provider – Charity Care Program; UC=Uncompensated Care; MMC=Medicaid managed care.

Appendix F. List of Acronyms

Acronym	Full Name
ADHD	Attention-Deficit/Hyperactivity Disorder
AHRQ	Agency for Healthcare Research and Quality
AI	Administrative Interview
AOD	Alcohol or Other Drug
APM	Alternative Payment Model
BP	Blood Pressure
CAHPS®	Consumer Assessment of Healthcare Providers and Systems
CDC	Comprehensive Diabetes Care
CHIP	Children's Health Insurance Program
CHIRP	Comprehensive Hospital Increased Reimbursement Program
CMHC	Community Mental Health Clinic
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology Code
CPW	Case Management for Children and Pregnant Women
DAP	Office of Data, Analytics, and Performance
DMO	Dental Maintenance Organization
DPP	Directed Payment Program
DPP BHS	Directed Payment Program for Behavioral Health Services
DRTS	Demand Response Transportation Services
DSH	Disproportionate Share Hospital
DSRIP	Delivery System Reform Incentive Payment
DTA	Descriptive Trend Analysis
DY	Demonstration Year
ED	Emergency Department
EQRO	External Quality Review Organization
FFS	Fee-For-Service
FFY	Federal Fiscal Year
FSR	Financial Statistical Report
HbA1c	Hemoglobin A1c
HCAHPS®	Hospital Consumer Assessment of Healthcare Providers and Systems
HCBS	Home and Community-Based Services

Acronym	Full Name
HEDIS®	Healthcare Effectiveness Data and Information Set
HHSC	Texas Health and Human Services Commission
ICD-10-CM	International Classification of Diseases, 10th Revision, Clinical Modification Code
ICHP	Institute for Child Health Policy
IDD	Intellectual or Developmental Disability
IPSD	Index Prescription Start Date
ITS	Interrupted Time Series
LBHA	Local Behavioral Health Authority
LHD	Local Health Department
LMHA	Local Mental Health Authority
LTSS	Long-Term Services and Supports
MCO	Managed Care Organization
MEG	Medicaid Eligibility Group
MF	Medically Fragile
MLR	Multiple Linear Regression
MMC	Medicaid managed care
MTO	Managed Transportation Organization
NCI-AD™	National Core Indicators – Aging and Disabilities
NCQA	National Committee for Quality Assurance
NEMT	Nonemergency Medical Transportation
NPI	National Provider Identifier
P4Q	Pay-for-Quality
PIP	Performance Improvement Project
PCN	Patient Control Number
PDI	Pediatric Quality Indicator
PHD	Public Health District
PHP-CCP	Public Health Provider Charity Care Pool
PMPM	Per Member Per Month
PPA	Potentially Preventable Admission
PPC	Potentially Preventable Complication
PPE	Potentially Preventable Event
PPR	Potentially Preventable Readmission

Acronym	Full Name
PPV	Potentially Preventable Emergency Department Visit
PQI	Prevention Quality Indicator
QAPI	Quality Assurance and Performance Improvement
QIPP	Quality Incentive Payment Program
RAPPS	Rural Access to Primary and Preventive Services
RUCC	Rural-Urban Continuum Codes
SDA	Service Delivery Area
SFY	State Fiscal Year
SPP	Supplemental Payment Program
SQL	Structured Query Language
STC	Special Terms and Conditions
THLC	Texas Healthcare Learning Collaborative
THTQIP	Texas Healthcare Transformation and Quality Improvement Program
TIPPS	Texas Incentives for Physician and Professional Services
TMHP	Texas Medicaid and Healthcare Partnership
TNC	Transportation Network Companies
TPI	Texas Provider Identifier
UC	Uncompensated Care
UHRIP	Uniform Hospital Rate Increase Program
WOW	Without Waiver
WW	With Waiver

Appendix G. References

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Appendix H. CMS-Approved Demonstration Amendments

Table 20. Summary of CMS-Approved Demonstration Amendments Since January 2021

Amendment	Approval Date	Brief Description	Evaluation Components Impacted
NEMT Services	6/8/2021	Transitioned NEMT services to managed care and changed policies regarding demand response transportation services and transportation network companies.	HHSC included a NEMT component into the CMS-approved Evaluation Design (Evaluation Question 1).
Medically Fragile	11/16/2023	Allowed medically fragile individuals enrolled in STAR+PLUS HCBS to receive services beyond the individual cost limit through managed care.	A new measure (Measure 2.1.2) was added to the evaluation in response to this amendment. Existing measures under Evaluation Question 2 may also be impacted. This amendment may also impact existing measures under Evaluation Questions 3, 6, and 7, as medically fragile individuals are included in the populations for those measures. However, Evaluation Questions 3, 6, and 7 are focused on MMC programs or the THTQIP Demonstration at large, and only a small number of those individuals may receive additional services through the medically fragile amendment (no more than 150 at a time, which is less than 0.1% of the STAR+PLUS population). Therefore, any observed changes at the MMC program- or demonstration-level would not be attributable to the medically fragile amendment. Further, the sampling methodology for state-reported HEDIS and CAHPS measures prevents the state from isolating MMC program-level measures for the medically fragile population.

Amendment	Approval Date	Brief Description	Evaluation Components Impacted
CPW Services	11/16/2023[1]	Transitioned contracting and reimbursement for CPW providers delivering case management services to MCOs.	HHSC will execute a stand-alone evaluation of the CPW amendment, per CMS approval. The evaluation design for the CPW-specific assessment is provided in Appendix I. It is also possible this amendment may impact existing measures under Evaluation Questions 3, 6, and 7, but impacts, if any, would be limited given the relatively small number of individuals who receive CPW services (just under 10,000 per year, which is less than 0.5% of the STAR population[2]). Further, the sampling methodology for state-reported HEDIS and CAHPS measures prevents the state from isolating MMC program-level measures for individuals who receive CPW services.

Notes. [1] MCOs began overseeing CPW services on September 1, 2022, in accordance with House Bill 133, 87th Legislature, Regular Session, 2021, which mandated that HHSC implement a seamless transition of CPW services from FFS to managed care without any interruption in services. HHSC submitted an amendment to CMS to allow CPW services to be delivered via managed care under the THTQIP Demonstration on May 5, 2022, and CMS approved the amendment on November 16, 2023. [2] The overwhelming majority of individuals receiving CPW services are enrolled in the STAR MMC Program. STAR+PLUS=MMC program serving aged and disabled clients; HCBS= Home and community-based services; CPW=Case Management for Children and Pregnant Women; MCO=Managed care organization.

Appendix I. Evaluation Design for Case Management for Children and Pregnant Women Amendment

Introduction

Case Management for Children and Pregnant Women (CPW) provides case management services to assist certain individuals in gaining access to needed medical, social, educational, and other services. CPW is available for children ages 20 and younger with a health condition or health risk and high-risk pregnant women of any age. Services include: 1) a face-to-face comprehensive visit with the client and their family to perform a family needs assessment and develop a service plan to address the client's unmet needs; and 2) a face-to-face or telephone follow-up visits to assist the client and their family with obtaining the necessary services until their needs are met. At the time of writing, CPW services are delivered through CPW providers who must be a licensed registered nurse or licensed social worker[30].

CPW services were previously provided via Fee-for-service (FFS), including for clients enrolled in Medicaid managed care (MMC), until September 1, 2022, when Texas Medicaid managed care organizations (MCOs) began contracting with and reimbursing CPW providers for billable case management services, in accordance with House Bill 133, 87th Legislature, Regular Session, 2021. The transition of the CPW benefit under managed care encourages the maintenance of a coordinated care delivery system through coordination of case management services that are available to a client through MCOs and CPW providers.

Texas Health and Human Services (HHSC) submitted an amendment to CMS to allow CPW services to be delivered via managed care under the THTQIP 1115 Demonstration on May 5, 2022. CMS approved the amendment on November 16, 2023. As part of their approval, CMS outlined expectations for the state to accommodate this amendment within the evaluation design. Given the expansive scope of the CMS-approved Evaluation Design, paired with the focused nature of this amendment, HHSC elected to conduct a stand-alone evaluation on the transition of CPW to managed care, per CMS suggestion. HHSC's Office of Data, Analytics, and Performance (DAP) will execute the evaluation of the CPW services amendment. DAP is located under the Office of the Chief Policy and Regulatory Office, an organizational branch that is separate from the Medicaid program administration and oversight and has the necessary knowledge and experience to execute the evaluation. Additionally, DAP has experience evaluating Medicaid

[30]House Bill 1575, 88th Legislature, Regular Session, 2023, authorized doulas and community health workers to provide CPW services. HHSC submitted a state plan amendment to CMS on July 12, 2024, however, at the time of writing, CMS had not yet approved this change.

programs for both the state legislature and CMS, as CMS has previously approved DAP to conduct independent evaluations of 1915(b)(4) waivers.

Evaluation Questions and Hypotheses

To assess the transition of CPW services to MMC, Texas developed one evaluation question and two hypotheses.

- Evaluation Question 1: Did the carve-in of CPW services into MMC support care coordination for beneficiaries?
  - Hypothesis 1.1: Access to CPW-related case management will maintain or improve after the carve-in of CPW services into MMC.
  - Hypothesis 1.2: The carve-in of CPW services into MMC will support the development and maintenance of a coordinated care delivery system.

Evaluation Methods

This evaluation will rely on two study designs: a one-group pretest-posttest design, as well a one-group posttest only design. The one-group pretest-posttest study design will use consecutive population-based observations to describe changes in access to and utilization of CPW-related services before and after the transition to MMC. This portion of the evaluation will use a three-year pre-period (September 1, 2019 to August 31, 2022), and a three-year post-period (September 1, 2022 to August 31, 2025). The three year pre-and post-periods provide sufficient time to examine impacts of the transition of CPW-services to MMC, while ensuring aggregate results are not biased by noise (e.g., historical or environmental changes four or more years removed from the policy change which may influence aggregate pre- and post-period values).[31]

For the one-group posttest only design, MCOs will be surveyed to understand how CPW-related services connect individuals to necessary services, and the perceived benefits and challenges of transitioning CPW into MMC. The remaining sections provide additional details on the proposed measures, study populations, data sources, and analytic methods for the evaluation.

Evaluation Measures

Several measures have been identified to operationalize the two hypotheses. Table 21 on page 188 provides an overview of the proposed measures.

[31] DAP may extend the post period for no more than two additional years if unanticipated data challenges prevent DAP from executing the evaluation design as proposed while leveraging a three-year post-period.

Table 21. CPW Evaluation Hypotheses and Measures

Evaluation Hypothesis	Measure(s)	Study Population	Data Source(s) or Data Collection Method(s)	Analytic Methods
H1.1. Access to CPW-related case management will maintain or improve after the carve-in of CPW services into MMC.	1.1.1 Number of CPW requests submitted to MCOs 1.1.2 Number of CPW requests resulting in MCO-delivered service coordination 1.1.3 Number of MMC members receiving provider-delivered case management (CPW) 1.1.4 Average CPW sessions per person per year 1.1.5 Number of enrolled CPW providers 1.1.6 Number of active CPW providers	• MCOs • CPW recipients • CPW providers	• CPW MCO Frew Reporting • Client-level enrollment files • FFS claims and MMC encounters data • Provider-level enrollment files	• Descriptive statistics • Descriptive trend analysis • Interrupted time series • Subgroup analysis[1]
H1.2. The carve-in of CPW services into MMC will support the development and maintenance of a coordinated care delivery system.	1.2.1 Need for CPW, including services to which individuals are connected 1.2.2 Perceived benefits and challenges of CPW after the carve-in	• MCOs	• MCO survey	• Descriptive statistics • Content analysis

Notes. [1] Subgroup analysis will only be performed where applicable. CPW=Case Management for Children and Pregnant Women; MMC=Medicaid managed care; MCO=Managed care organization; FFS=Fee-for-service.

Study Populations

Populations of interest in this study will include MMC members receiving CPW services (children ages 20 and younger with a health condition or health risk, and high-risk pregnant women of any age), providers delivering CPW services, and MCOs offering CPW-related service coordination.

Data Sources

The evaluation will leverage administrative and primary data sources to evaluate the CPW amendment, as outlined below.

- **FFS claims and MMC encounters data.** FFS claims and MMC encounter data will be used to identify CPW services members received. These data are processed and housed by Texas Medicaid and Health Partnership (TMHP) and are finalized on an eight-month lag.
- **Client-level enrollment files.** The client enrollment files will be used to obtain information about a CPW client's age, sex, race/ethnicity, and county of residence. Enrollment data will be accessed using DAP's Data Repository that is finalized on an eight-month lag.
- **Provider-level enrollment files.** The provider enrollment files will be used to identify CPW providers who are authorized to provide CPW services, and to obtain information on providers who delivered CPW services.
- **CPW MCO Frew Reporting.** All contracted MCOs are required to report on CPW activities to HHSC. These reports will be used to tally the number of requests for CPW services MCOs received, the number of requests that resulted in MCO-delivered service coordination, and the number of requests that resulted in paid claims to a CPW provider.
- **MCO survey.** MCOs will be surveyed to understand how CPW-related services connect individuals to necessary services, and the perceived benefits and challenges of CPW services after the transition to MMC.

Analytic Methods

Quantitative and qualitative methods will be used for the evaluation of CPW services. This section describes the proposed analytic strategies for examining the measures presented in Table 21 on page 188. Analytic methods will incorporate subgroup analyses (e.g., by member or provider characteristics), where applicable, to strengthen the validity of observed outcomes. Additionally, DAP will attempt to account for or provide context for changes in CPW-related policies[32], historical programmatic factors, such as amendments to the Demonstration (see Appendix H), and environmental and historical confounds (e.g., the end of the COVID-19 pandemic), as applicable.

Descriptive and Inferential Statistics

All evaluation measures—except open-ended primary data collection questions—may be examined through a variety of descriptive statistics, including estimates of central tendency and dispersion. Potential inferential analyses include bivariate statistics, parametric tests (e.g., t-tests), and non-parametric tests (e.g., McNemar's test, Wilcoxon signed-rank test).

Descriptive Trend Analysis

For measures where there are insufficient observations to conduct more rigorous time series analyses, such as interrupted time series (e.g., annually calculated measures), DAP will implement descriptive trend analysis (DTA) to examine trends over time. DTA is an alternative approach to time-series analysis which plots and analyzes time-series data calculated at equally spaced intervals to explain patterns in selected measures over time. DTA typically focuses on identification and quantification of a trend through the use of correlation coefficients and ordinary least squares regression. For outcome measures using DTA, the basic regression model is:

$$Y_t = \beta_0 + \beta_1 time + \beta_2 MMC\ transition + \beta_3 controls + \varepsilon_t$$

Where, $\beta_0$reflects the baseline level of the outcome at the beginning of the study period; $\beta_1 time$ estimates the trends in the outcome variable; $\beta_2 MMC\ transition$ reflects the impact of the MMC transition; and $\beta_3 controls$ reflects potential control variables, such as client- or provider-level characteristics, or programmatic and historical factors.

[32] The state has made, or plans to make, changes to CPW-related policies during the study period. These changes include the termination of prior authorization requirements (effective July 1, 2024), the inclusion of two new CPW provider types (pending CMS approval), and a new rule that requires MCOs to assess all pregnant women for non-medical needs (effective September 1, 2024). Findings for this evaluation will be assessed prior to and after these policy changes which directly or indirectly impact CPW services.

Interrupted Time Series

Interrupted time series (ITS) analysis uses aggregate data collected over equally spaced intervals before and after a policy change to measure changes in outcomes over time. A key assumption of ITS is that data trends before the policy change can be extrapolated to predict trends had the policy change not occurred. If the transition of CPW services to MMC impacted an outcome of interest, the post-transition trend will have a slope that is statistically different from the pre-transition trend. When properly executed, ITS is a valuable method to evaluate the success, failure, or unintended consequences of health care policy on outcomes (Lagarde, 2012).

For outcome measures using ITS, the basic segmented regression model with one intervention or change point examines the outcome of interest (Y_t) over time, before and after the policy change:

$$Y_t = \beta_0 + \beta_1 time + \beta_2 MMC\ transition + \beta_3 postslope + \varepsilon_t$$

From the basic statistical model, β_0 reflects the baseline level of the outcome at the beginning of the pre-period; β_1 estimates the trend before the MMC transition; β_2 estimates the immediate impact of the MMC transition; and β_3 reflects the change in trend after the MMC transition. To ease interpretation, ITS results are presented as: baseline level, trend before MMC service delivery change, level change after MMC service delivery change, and trend after MMC service delivery change.

Content Analysis

DAP will utilize content analysis to supplement or expand upon MCO survey results analyzed using descriptive statistics. Content analysis systematically examines documents to extract descriptive data that can be quantified in a structured dataset for statistical testing (Vaismoradi, Turunen, & Bondas, 2013).

Methodological Limitations

The evaluation of CPW services will include the entire population of individuals receiving, or providers/MCOs delivering, these services. While there may be a group of individuals eligible for, but not receiving CPW services, this group is not actively monitored by HHSC. Furthermore, because there are a broad range of conditions which may qualify an individual to receive CPW services, it is not feasible to determine individuals who may qualify for, but opt out of, CPW services. As a result, there is no viable comparison group for the evaluation. The evaluation will leverage pre- and post-period data, rigorous quasi-experimental designs, and subgroup analyses, where applicable. However, without a true comparison group, differences in outcomes may not imply causality.

Another limitation associated with the evaluation is the use of administrative data. These data have been designed and collected for billing purposes but are used in the evaluation to determine changes in access to CPW services. Nevertheless, most

measures derived from administrative sources are validated and widely used for evaluation purposes. In addition, TMHP performs internal edits for data quality and completeness to help ensure data reliability. Use of administrative data is also limited by data lags, which pose a challenge to measuring and reporting changes in a timely manner (Schoenberg, Heider, Rosenthal, Schwartz, & Kaye, 2015). Measures using FFS claims or MMC encounters require an approximate eight-month data lag for claims adjudication.

Similarly, there are limitations associated with the reliance on MCO-reported data. MCOs provide an array of service coordination activities, of which only a subset are specific to CPW. Fortunately, HHSC required MCOs to report on CPW-related service coordination after the transition into MMC, but these data were designed for administrative and oversight purposes, not for research, and are only available in the post-period. While the currently available data sources provide valuable information about CPW utilization, they do not provide insight into MCO perspectives on the transition of CPW services to MMC. To help address some of these limitations, the evaluation will develop and administer a survey to better understand MCO perspectives on the transition of CPW services into MMC. However, survey responses will be susceptible to common threats to validity, such as selection or sampling bias, and recall bias (especially since the survey will not be administered until approximately two years after the service change).

Lastly, study periods for this evaluation component overlap with the COVID-19 pandemic. The COVID-19 pandemic substantially impacted Medicaid enrollment and service utilization, which may impact evaluation results. DAP will leverage public use data files on COVID-19 confirmed cases and hospitalizations in Texas to better understand the impact of the pandemic on evaluation measures, where applicable.

Despite these limitations, the evaluation will provide insight into changes in CPW services following the transition to MMC and inform whether Texas has continued making progress towards expanding managed care to new populations and services.

Evaluation Timeline

Table 22 details the timeline for submission of evaluation report deliverables.

Table 22. CPW Evaluation Timeline

Date	Deliverable
April 29, 2024	HHSC submits Initial Evaluation Proposal to CMS
August 13, 2024	HHSC submits Revised Evaluation Design to CMS
March 31, 2027[1]	HHSC attaches CPW Evaluation Report as supplement to Interim Evaluation Report #2
September 30, 2029[1]	HHSC attaches CPW Evaluation Report as supplement to Interim Evaluation Report #3
March 31, 2032[1]	HHSC attaches CPW Evaluation Report as supplement to Summative Evaluation Report

Notes. [1] HHSC will attach the CPW Evaluation Report alongside all Demonstration deliverables, but DAP expects the CPW evaluation to be completed by Interim Report #2. HHSC=Health and Human Services Commission; CMS=Centers for Medicare and Medicaid.

Detailed Tables

Evaluation Question 1: Did the carve-in of CPW services into MMC support care coordination for beneficiaries?

Hypothesis 1.1. Access to CPW-related case management will maintain or improve after the carve-in of CPW services into MMC.

Measure 1.1.1	**Number of CPW requests submitted to MCOs**
Definition	The total number of unique CPW requests received by the MCO.
Study Population	MCOs
Measure Steward or Source	N/A
Technical Specifications	Total number of unique CPW requests received by the MCOs. MCOs report on CPW requests quarterly.
Exclusion Criteria	None
Data Source(s)/Data Collection Methods	• CPW MCO Frew Reporting
Comparison Group(s)	Post Only: 9/1/2022 – 8/31/2025[1,2]
Subgroup(s)	The number of CPW requests received may be presented by MCO reported referral source (e.g., Maximus, DSHS, prior authorizations/approvals, or other referrals) and MMC program, if feasible.
Analytic Methods	• Descriptive statistics • DTA
Interpretation	This measure is a direct indicator of the number of CPW-related referrals MCOs received after the carve-in of CPW services into MMC.
Benchmark	None

Notes. [1] MCOs began contracting with and reimbursing CPW providers for billable case management services on September 1, 2022, in accordance with House Bill 133, 87th Legislature, Regular Session, 2021, which mandated that HHSC implement a seamless transition of CPW services from FFS to managed care without any interruption in services. CMS approved the amendment on November 16, 2023. Pre-and post-periods align with the service delivery change, rather than the CMS approval date. [2] The state has made, or plans to make, changes to CPW-related policies during the study period. Findings for this evaluation will be assessed prior to and after policy changes which directly or indirectly impact CPW services. CPW=Case Management for Children and Pregnant Women; MCO=Managed care organization; MMC=Medicaid managed care; DTA=Descriptive trend analysis.

Measure 1.1.2	Number of CPW requests resulting in MCO-delivered service coordination
Definition	Total CPW requests received by MCO that resulted in member being enrolled in MCO-delivered service coordination.
Study Population	MCOs
Measure Steward or Source	N/A
Technical Specifications	Total number of unique CPW requests received by the MCOs that resulted in: • The member receiving MCO-provided service coordination, or • The member receiving both MCO-provided service coordination and paid claims to a CPW provider. MCOs report on CPW requests quarterly.
Exclusion Criteria	None
Data Source(s)/Data Collection Methods	• CPW MCO Frew Reporting
Comparison Group(s)	• Post Only: 9/1/2022 – 8/31/2025[1,2]
Subgroup(s)	The number of CPW requests received may be presented by referral source (e.g., Maximus, DSHS, prior authorizations/approvals, or other referrals) and MMC program, if feasible.
Analytic Methods	• Descriptive statistics • DTA
Interpretation	This measure is a direct indicator of the number of CPW-related referrals that resulted in MCO-provided service coordination after the carve-in of CPW services into MMC.
Benchmark	None

Notes. [1] MCOs began contracting with and reimbursing CPW providers for billable case management services on September 1, 2022, in accordance with House Bill 133, 87th Legislature, Regular Session, 2021, which mandated that HHSC implement a seamless transition of CPW services from FFS to managed care without any interruption in services. CMS approved the amendment on November 16, 2023. Pre-and post-periods align with the service delivery change, rather than the CMS approval date. [2] The state has made, or plans to make, changes to CPW-related policies during the study period. Findings for this evaluation will be assessed prior to and after policy changes which directly or indirectly impact CPW services. CPW=Case Management for Children and Pregnant Women; MCO=Managed care organization; MMC=Medicaid managed care; DTA=Descriptive trend analysis.

Measure 1.1.3	Number of MMC members receiving provider-delivered case management (CPW)
Definition	Unduplicated count of MMC members who received at least one provider-delivered CPW service.
Study Population	MMC members
Measure Steward or Source	N/A
Technical Specifications	Unique count of MMC members (Medicaid IDs) with a Medicaid-paid FFS claim or MMC encounter for a CPW service. The unique count of MMC members will be calculated monthly.
Exclusion Criteria	None
Data Source(s)/Data Collection Methods	• FFS Claims Data • MMC Encounters Data
Comparison Group(s)	Pre-post comparison:[1,2] • Pre: 9/1/2019 – 8/31/2022 • Post: 9/1/2022 – 8/31/2025
Subgroup(s)	Member demographic and geographic characteristics, where applicable CPW service population (children with health risk, health condition, or high-risk pregnancy), and corresponding diagnoses, if feasible
Analytic Methods	• Descriptive statistics • ITS
Interpretation	This measure is a direct indicator of the number of members receiving provider-delivered CPW services prior to and after the carve-in of CPW services into MMC.
Benchmark	None

Notes. [1] MCOs began contracting with and reimbursing CPW providers for billable case management services on September 1, 2022, in accordance with House Bill 133, 87th Legislature, Regular Session, 2021, which mandated that HHSC implement a seamless transition of CPW services from FFS to managed care without any interruption in services. CMS approved the amendment on November 16, 2023. Pre-and post-periods align with the service delivery change, rather than the CMS approval date. [2] The state has made, or plans to make, changes to CPW-related policies during the study period. Findings for this evaluation will be assessed prior to and after policy changes which directly or indirectly impact CPW services. MMC=Medicaid managed care; CPW=Case Management for Children and Pregnant Women; FFS=Fee-for-service; ITS=Interrupted time series.

Measure 1.1.4	Average CPW sessions per person per year
Definition	Average number of unique CPW services per member per state fiscal year.
Study Population	CPW recipients
Measure Steward or Source	N/A
Technical Specifications	**Numerator**: Count of all paid CPW services (FFS claims or MMC encounters) **Denominator**: Unique PCN count of MMC members with a paid FFS claim or MMC encounter for any CPW service **Rate**: Numerator / Denominator The rate will be calculated per state fiscal year.[1]
Exclusion Criteria	None
Data Source(s)/Data Collection Methods	• FFS Claims Data • MMC Encounters Data
Comparison Group(s)	Pre-post comparison:[2,3] • Pre: 9/1/2019 – 8/31/2022 • Post: 9/1/2022 – 8/31/2025
Subgroup(s)	Member demographic and geographic characteristics, where applicable CPW service population (children with health condition, or high-risk pregnancy), if feasible
Analytic Methods	• Descriptive statistics • DTA
Interpretation	This measure is a direct indicator of the number of provider-delivered CPW services MMC members received of prior to and after the carve-in of CPW services into MMC.
Benchmark	None

Notes. [1] Prior to July 1 ,2024, CPW services were initially authorized for one year, and included one comprehensive visit and two follow-up visits. Additional services were provided as needed. The authorization requirement was removed on July 1, 2024. Average utilization per person will be calculated per year to reflect the standard authorization period of these services for the majority of the study period. [2] MCOs began contracting with and reimbursing CPW providers for billable case management services on September 1, 2022, in accordance with House Bill 133, 87th Legislature, Regular Session, 2021, which mandated that HHSC implement a seamless transition of CPW services from FFS to managed care without any interruption in services. CMS approved the amendment on November 16, 2023. Pre-and post-periods align with the service delivery change, rather than the CMS approval date. [3] The state has made, or plans to make, changes to CPW-related policies during the study period. Findings for this evaluation will be assessed prior to and after policy changes which directly or indirectly impact CPW services. CPW=Case Management for Children and Pregnant Women; FFS=Fee-for-service; MMC=Medicaid managed care; PCN=Patient Control Number; DTA=Descriptive trend analysis.

Measure 1.1.5	Number of enrolled CPW providers
Definition	Total number of CPW providers enrolled in Medicaid.
Study Population	CPW providers
Measure Steward or Source	N/A
Technical Specifications	Unique count of CPW providers enrolled in Medicaid. The unique providers count will be calculated monthly.
Exclusion Criteria	None
Data Source(s)/Data Collection Methods	• Provider-level enrollment files
Comparison Group(s)	Pre-post comparison:[1,2] • Pre: 9/1/2019 – 8/31/2022 • Post: 9/1/2022 – 8/31/2025
Subgroup(s)	Provider and geographic characteristics, where applicable
Analytic Methods	• Descriptive statistics • ITS
Interpretation	This measure is a direct indicator of the number of Medicaid providers eligible to provide CPW services prior to and after the carve-in of CPW services into MMC.
Benchmark	None

Notes. [1] MCOs began contracting with and reimbursing CPW providers for billable case management services on September 1, 2022, in accordance with House Bill 133, 87th Legislature, Regular Session, 2021, which mandated that HHSC implement a seamless transition of CPW services from FFS to managed care without any interruption in services. CMS did not approve the amendment until November 16, 2023. Pre-and post-periods align with the service delivery change, rather than the CMS approval date. [2] The state has made, or plans to make, changes to CPW-related policies during the study period. Findings for this evaluation will be assessed prior to and after policy changes which directly or indirectly impact CPW services. CPW=Case Management for Children and Pregnant Women; ITS=Interrupted time series; MMC=Medicaid managed care.

Measure 1.1.5	Number of active CPW providers
Definition	Total number unique Medicaid providers listed on paid claims or encounters for a CPW service.
Study Population	CPW providers
Measure Steward or Source	N/A
Technical Specifications	Unique count of CPW providers (NPIs and/or TPIs) listed as billing provider on a Medicaid-paid CPW service. Unique counts of performing or rending providers may also be reported, based availability of that information. The unique providers count will be calculated monthly.
Exclusion Criteria	None
Data Source(s)/Data Collection Methods	• FFS Claims Data • MMC Encounters Data • Provider-level enrollment files
Comparison Group(s)	Pre-post comparison:[1,2] • Pre: 9/1/2019 – 8/31/2022 • Post: 9/1/2022 – 8/31/2025
Subgroup(s)	Provider and geographic characteristics, where applicable CPW service population (children with health condition, or high-risk pregnancy), if feasible
Analytic Methods	• Descriptive statistics • DTA
Interpretation	This measure is a direct indicator of the number of Medicaid providers providing CPW services prior to and after the carve-in of CPW services into MMC.
Benchmark	None

Notes. [1] MCOs began contracting with and reimbursing CPW providers for billable case management services on September 1, 2022, in accordance with House Bill 133, 87th Legislature, Regular Session, 2021, which mandated that HHSC implement a seamless transition of CPW services from FFS to managed care without any interruption in services. CMS did not approve the amendment until November 16, 2023. Pre-and post-periods align with the service delivery change, rather than the CMS approval date. [2] The state has made, or plans to make, changes to CPW-related policies during the study period. Findings for this evaluation will be assessed prior to and after policy changes which directly or indirectly impact CPW services. CPW=Case Management for Children and Pregnant Women; NPI= National Provider Identifier; FFS=Fee-for-service; MMC=Medicaid managed care; DTA=Descriptive trend analysis.

Hypothesis 1.2. The carve-in of CPW services into MMC will support the development and maintenance of a coordinated care delivery system.

Measure 1.2.1.	Need for CPW, including services to which individuals are connected
Definition	MCO-identified need for and service connections provided through CPW-related services.
Study Population	MCOs
Measure Steward or Source	N/A

Technical Specifications	MCOs will be asked to describe the types of services individuals referred to CPW services are most in need of, and how MCO-provided service coordination helps address those needs.
	
	Suggested questions may include, but are not limited to:
	• What are the most common types of needs individuals referred to CPW services have?
	  ○ Did the needs of members receiving CPW-related service coordination change after the carve-in of CPW services into MMC?
	• What are the most common types of services or supports individuals receiving CPW-related service coordination are connected to?
	  ○ Did these services or supports change after the carve-in of CPW services into MMC?

Exclusion Criteria	None
Data Source(s)/Data Collection Methods	• MCO survey
Comparison Group(s)	None
Subgroup(s)	None
Analytic Methods	• Descriptive statistics • Content analysis
Interpretation	Respondent perspectives will provide direct insight into the perceived need for CPW services, and whether there were variations in need or provided connections after the carve-in of CPW services into MMC.
Benchmark	None

Notes. CPW=Case Management for Children and Pregnant Women; MCO=Managed care organization; MMC=Medicaid managed care.

Measure 1.2.2	Perceived benefits and challenges of CPW after the carve-in
Definition	MCO perceived benefits and challenges after the carve-in of CPW services into MMC.
Study Population	MCOs
Measure Steward or Source	N/A
Technical Specifications	MCOs will be asked to provide feedback on the successes and challenges of CPW services after the carve-in into MMC. Suggested questions include, but are not limited to: • How do CPW services help address members' needs? • Has the carve-in of CPW services into MMC improved your ability to address members' needs? If so, how? • Has the carve-in of CPW services into MMC introduced challenges to your ability to address members' needs? If so, how?
Exclusion Criteria	None
Data Source(s)/Data Collection Methods	• MCO survey
Comparison Group(s)	None
Subgroup(s)	None
Analytic Methods	• Descriptive statistics • Content analysis
Interpretation	Respondent perspectives will provide direct insight into the perceived benefits of CPW services, and benefits or challenges of the carve-in of CPW services into MMC.
Benchmark	None

Notes. CPW=Case Management for Children and Pregnant Women; MCO=Managed care organization; MMC=Medicaid managed care.

Attachment C

Reserved

Attachment D
HCBS Fair Hearing Procedures

The material presented in Attachment D 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 and have exhausted the managed care organization (MCO) internal appeal process. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing

The MCO must develop, implement and maintain an MCO internal Appeal process 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. Unless the Member or his or her authorized representative requests an MCO expedited internal appeal, the Member or his or her authorized representative are notified they must file a written MCO internal appeal. If the Member does not follow up on an oral request for appeal in writing, the MCO decision is upheld after 30 days from the notice and the Member may request a state fair hearing.

A Member must file a request for an MCO internal Appeal with the MCO within 60 days from receipt of the notice of reduction, denial or termination of services.

The MCO's internal Appeal process 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 MCO internal Appeal request. Except for the resolution of an Expedited MCO Appeal, the MCO must complete the entire standard MCO internal Appeal process within 30 calendar days after receipt of the initial written or oral request for an MCO internal Appeal. The timeframe for a standard MCO internal 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 MCO internal Appeal, if all of the following criteria are met:

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HCBS Fair Hearing Procedures

1. The Member or his or her representative files the MCO internal Appeal timely as defined in this Contract;
2. The MCO internal Appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
3. The services were ordered by an authorized provider;
4. The original period covered by the original authorization has not expired; and
5. The Member requests an extension of the benefits.

If the MCO fails to meet the timeliness requirement for notification or at the Member's request, the MCO continues or reinstates the Member's benefits while the MCO internal Appeal is pending, the benefits must be continued until one of the following occurs:

1. The Member withdraws the MCO internal Appeal;
2. Ten (10) days pass after the MCO mails the notice resolving the MCO internal Appeal against the Member, unless the MCO did not provide adequate notice or the Member, within the 10-day timeframe, has requested a state Fair Hearing with continuation of benefits until a state Fair Hearing decision can be reached; or
3. A state Fair Hearing officer issues a hearing decision adverse to the Member.

In accordance with 42 C.F.R.§ 438.420(d), if the final resolution of the MCO internal 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 only with written permission from the state.

If the MCO or state fair hearings officer reverses a decision to deny, limit, or delay services that were not furnished while the MCO internal Appeal was pending, the MCO must authorize or provide the disputed services promptly and as expeditiously as the Member's health condition requires but no more than 72 hours from the decision.

If the MCO or hearings officer reverses a decision to deny authorization of services and the Member received the disputed services while the MCO internal 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 MCO internal 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 MCO internal Appeal requirements for standard Member MCO internal Appeals except where differences are specifically noted. The MCO must accept oral or written requests for MCO Expedited internal Appeals.

Members must exhaust the MCO Expedited internal Appeal process before making a request for an expedited state Fair Hearing. After the MCO receives the request for an Expedited MCO internal Appeal, it must hear an approved request for a Member to have an MCO Expedited internal Appeal and notify the Member of the outcome of the MCO Expedited internal Appeal

within 72 hours, except that the MCO must complete investigation and resolution of an MCO internal 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 MCO Expedited internal Appeal is received.

The MCO is prohibited from discriminating or taking punitive action against a Member or his or her representative for requesting an MCO Expedited internal 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 state Fair Hearing process after exhausting the MCO internal 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 requesting an Expedited state Fair Hearing. The MCO must notify Members that they may be represented by an authorized representative in the MCO internal Appeal and state Fair Hearing process.

If a Member requests a Fair Hearing, the MCO will enter the request in the Texas Integrated Eligibility Redesign System (TIERS), within five (5) calendar days.

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

The hearings officer makes an administrative decision on state Fair Hearings. The hearings officers are employees of HHSC that are in a separate division with a separate reporting structure 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 organization 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, which HHSC refers to as complaints, concerning the provision of services.

A. Operational Responsibility

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

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HCBS Fair Hearing Procedures

The State Medicaid Agency operates and maintains an electronic complaint system that provides information to HHSC staff on any complaints 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.

The member is informed at enrollment that filing a complaint is not a pre-requisite or substitute for a state 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 MCO internal Appeal system that complies with the requirements in applicable federal and state laws and regulations.

The Complaint and MCO internal Appeal system must include a Complaint process, an MCO internal Appeal process, and access to HHSC's state 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 MCO internal 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.

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HCBS Fair Hearing Procedures

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

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.

Attachment E
HCBS Member Safeguards

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

Introduction

Managed long-term services and supports (MLTSS) refer to the delivery of long-term services and supports (LTSS) through managed care programs, including community-based and institutional LTSS under the State Plan and home and community-based services (HCBS) under the STAR+PLUS Waiver. Under the authority of the Texas Healthcare Transformation and Quality Improvement Program Demonstration, managed care organizations (MCOs) deliver MLTSS to members in Medicaid managed care programs in Texas.

Texas has well-established safeguards to ensure that member health and welfare are assured within the delivery of MLTSS. The state's critical incident system is comprised of three parts: HHSC, the Department of Family and Protective Services (DFPS), and local law enforcement. Depending upon the type of critical incident, individuals may report to one or both state agencies. Abuse, neglect and exploitation allegations are reported to DFPS; however, investigations are the responsibility of HHSC Provider investigations who must coordinate with local law enforcement. Critical incidents are tracked and monitored by HHSC. This document details these protections, such as statements of member rights and the critical incident management system, in order to protect members from abuse, neglect, and exploitation.

In 2015, the Texas Health and Human Services (HHS) system, comprised of five separate state agencies, began a reorganization to produce a more efficient, effective, and responsive system, by consolidating Medicaid functions and activities under HHSC. This streamlined approach will increase efficiencies and improve communication within the HHS system by removing barriers that existed when Medicaid functions were spread across multiple independent agencies. On September 1, 2017, the final phase of this process, referred to as the HHS "Transformation", began when the regulatory and investigatory bodies of two different agencies transitioned to HHSC, creating a new Regulatory Services Division within HHSC. In accordance with 42 Code of Federal Regulations (CFR) §431.10(e), HHSC is the single state Medicaid agency and retains oversight and full administrative authority over the waiver program.

Participant Rights and Responsibilities

In accordance and consistent with federal law under the CFR, HHSC established a statement of member rights that may be found in the Texas Administrative Code (TAC). These rights are reflected in the managed care contracts and the Uniform Managed Care Manual (UMCM) to ensure members are advised of their rights. Members are informed through MCO member handbooks and are provided with additional support, as needed, to understand their rights as well as their responsibilities. This support might come from the MCO service coordinator or through an independent entity such as the Office of the Long-term Care Ombudsman.

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Code of Federal Regulations: Enrollee Rights

In accordance with 42 CFR §438.100 (relating to Enrollee rights), Texas assures that each MCO has written policies regarding the enrollee rights specified in this section and each MCO complies with applicable federal and state laws pertaining to enrollee rights. HHSC ensures its staff and affiliated providers take these rights into account when delivering services to individuals.

HHSC requires that each managed care enrollee is guaranteed the following rights:

- Receive information in accordance with 42 CFR §438.10.
- Be treated with respect and with due consideration for his or her dignity and privacy.
- Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand.
- Participate in decisions regarding his or her health care, including the right to refuse treatment.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other federal regulations on the use of restraints and seclusion.
- Request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR §164.524 and 164.526 (if the privacy rule, as set forth in 45 CFR parts 160 and 164 subparts A and E, applies).
- Receive health care services in accordance with §§438.206 through 438.210.
- Be free to exercise his or her rights.

Finally, HHSC ensures that each MCO complies with all applicable federal and state laws.

Texas Administrative Code: Member Bill of Rights

Each MCO participating in the Texas Medicaid program must provide to each of its members an easy-to read, written document describing the member's rights, which must include the rights outlined in 1 TAC §353.202 (relating to Member Bill of Rights).

Managed Care Contracts: Member Rights and Responsibilities

In accordance with 42 CFR §438.100 (relating to Enrollee Rights), the managed care contracts require that MCOs maintain written policies and procedures for informing members of their rights and responsibilities, and notify members of their right to request a copy of these rights and responsibilities. An MCO's member handbook must include a notice regarding member rights and responsibilities, in compliance with the UMCM.

Definitions

Texas Human Resources Code, Chapter 48.251(b), directs HHSC to adopt definitions of abuse, neglect, and exploitation through rule. The following definitions of abuse, neglect, and exploitation (ANE) apply to investigations of alleged ANE in 1115 waiver programs:

- Texas Administrative Code, Chapter 711.11 (relating to How is physical abuse defined?);
- Texas Administrative Code, Chapter 711.13 (relating to How is sexual abuse defined?);
- Texas Administrative Code, Chapter 711.17 (relating to How is verbal/emotional abuse defined?);
- Texas Administrative Code, Chapter 711.19 (relating to How is neglect defined?); and
- Texas Administrative Code, Chapter 711.21 (relating to How is exploitation defined?)

HHSC defines critical events or incidents in the managed care contracts as those that may bring harm, or create the potential for harm, to an individual. Critical events or incidents include but are not limited to:

- abuse, neglect, or exploitation;
- the unauthorized use of restraint,
- the unauthorized use of seclusion
- serious injuries that resulted in medical intervention or hospitalization;
- criminal victimization;
- unexplained death;
- medication errors; and
- other incidents or events that involve harm or risk of harm to a member.

Critical Incident System

The state has a system to prevent, identify, report, investigate, and remediate critical incidents that occur within the delivery of MLTSS as well as to track and trend results in order to make system improvements. The obligation to report abuse, neglect, and exploitation is mandated by statute and HHSC clarifies roles, expectations, and responsibilities for providers and MCOs in the managed care contracts.

Prevention

Licensure Requirements

The state licenses the following MLTSS providers:

- Day activity and health services providers (TAC Title 40, Chapter 98);
- Adult foster care, serving four or more individuals (licensing as assisted living facilities: TAC Title 26, Chapter 553);
- Assisted living facilities (TAC Title 26, Chapter 553);
- Home and community support services agencies (TAC Title 26, Chapter 558); and
- Nursing facilities (TAC Title 40, Chapter 19).

- Prescribed Pediatric Extended Care Facilities (TAC Title 26, Part 1, Chapter 550) Additional

MLTSS providers licensed through other entities:

- Emergency response system providers (TAC Title 25, Part 1, Chapter 140, Subchapter B);
- Licensed durable medical equipment providers (TAC Title 25, Part 1, Chapter 229, Subchapter X);
- Providers of cognitive rehabilitation therapy services (TAC Title 16, Part 4; TAC Title 40, Part 12; TAC Title 22, Part 21)
- Registered Nurses (TAC Title 22, Part 11);
- Occupational therapists (TAC Title 40, Part 12);
- Physical therapists (TAC Title 22, Part 16); and
- Speech therapists (TAC Title 16, Part 4).

Prior to issuing licensure to the above healthcare providers, the state screens those facilities or persons for prior disciplinary or criminal history in Texas and in other states. In accordance with Section 1919(e)(2) of the Social Security Act, the state maintains a registry of all nurse aides who are certified to provide services in nursing facilities and skilled nursing facilities licensed by HHSC. These individuals may also be employed by assisted living facilities and home and community support services agencies. The Nurse Aide Registry (NAR) lists nurse aides who are unemployable because of confirmed instances of abuse, neglect, exploitation, misappropriation, or misconduct against a nursing facility resident. For those individual providers that do not require licensure, in accordance with state law, HHSC maintains an Employee Misconduct Registry (EMR) that includes the names of unlicensed persons who work at facilities licensed by HHSC, including intermediate care facilities for individuals with an intellectual disability or related conditions, adult foster care providers, home and community support services agencies, or prescribed pediatric extended care centers; or for individual employers, who have committed reportable conduct as defined in the Texas Health and Safety Code, Chapter 253.

HHSC-regulated facilities and agencies contracted with a MCO to provide MLTSS are required to check both the NAR and EMR before hiring an unlicensed individual and annually thereafter. In addition, all MCOs are required to check both the NAR and EMR prior to contracting with an unlicensed or uncertified MLTSS provider, and annually thereafter.

Credentialing Unlicensed or Uncertified Providers by MCOs

Through their credentialing process, the MCO ensures that the agencies they contract with have met all licensure requirements. According to the managed care contracts, before contracting with an unlicensed MLTSS provider or MLTSS provider not certified by a health and human services agency, such as minor home modification or home-delivered meals providers, the MCO must take steps to verify that the provider:

- has not been convicted of a crime listed in Texas Health and Safety Code, §250.006;

- is not listed as "unemployable" in the EMR or the NAR maintained by HHSC by searching or ensuring a search of such registries is conducted before hire and annually thereafter;
- is knowledgeable of acts that constitute abuse, neglect, or exploitation of a member;
- is instructed on and understands how to report suspected abuse, neglect, or exploitation;
- adheres to applicable state laws if providing transportation; and
- is not a spouse of, legally responsible person for, or employment supervisor of the member who receives the service, except as allowed in the Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver.

Training

The managed care contracts require MCOs to train and educate their staff, providers, and subcontractors to understand abuse, neglect, and exploitation and all prevention, detection, reporting, investigation, and remediation procedures and requirements. In addition, MCOs must educate members about abuse, neglect, and exploitation at enrollment with the MCO, 30 days prior to a change in covered services, and when requested by the Member. MCOs must ensure staff such as member services staff and service coordinators are knowledgeable about how to identify and report a critical event or incident such as abuse, neglect, and exploitation. MCOs must administer training for service coordination staff that includes identification and reporting of critical events or incidents.

In addition to the information provided to all members, a financial management services agency (FMSA), provides members who elect the consumer directed services option with training and written information related to reporting allegations of abuse, neglect, and exploitation.

Identification and Reporting

Obligation to Report

The failure to report suspected abuse, neglect, or exploitation of a child or of an individual who is elderly or who has a disability is considered a criminal offense. State agencies receiving reports of suspected ANE keep the reporter's identity confidential. Information on how to report suspected ANE can be found on HHS agency websites, member handbooks for various programs, and MCO provider manuals.

Reports to the Department of Family and Protective Services (DFPS)

A person having cause to believe that an individual who is elderly or who has a disability (including a child with a disability), or that an individual receiving services from a:

- facility;
- community center, local mental health authority, and local intellectual and developmental disability authority;
- person who contracts with a health and human services agency or MCO to provide home and community-based services;

- person who contracts with a Medicaid MCO to provide behavioral health services;
- MCO;
- contractor, subcontractor, officer, employee, or agent of a person or entity listed in (1)-(5); or
- fiscal agent, employee, case manager, or service coordinator of an individual employer participating in the consumer-directed service option, as defined by Section 531.051, Government Code is in a state of abuse, neglect or exploitation is required to report the information immediately to DFPS.

A person having cause to believe that a child's physical or mental health or welfare has been adversely affected by abuse or neglect by a person must report the information immediately to DFPS.

A professional who has cause to believe that a child has been abused or neglected or may be abused or neglected must make a report to DFPS within 48 hours after the professional first suspects abuse or neglect. All HCSSAs are required to self-report abuse, neglect, or exploitation to HHSC and DFPS within 24 hours of suspecting that an employee, volunteer, or contractor has committed ANE against an individual served by the HCSSA.

Reports to HHSC

If a person has cause to believe that an individual who is elderly or who has a disability, or an individual receiving services from a facility or a provider operated, licensed, certified, or registered by HHSC, has been abused, neglected, or exploited in a facility or by a provider operated, licensed, certified, or registered by HHSC, the person shall report the information to HHSC. This requirement is also addressed in Chapter 260A of the Health and Safety Code. A person, including an owner or employee of a facility, who has cause to believe that the physical or mental health or welfare of a resident has been or may be adversely affected by abuse, neglect, or exploitation caused by another person shall report the abuse, neglect, or exploitation to HHSC and law enforcement as appropriate under Chapter 260A of the Texas Health and Safety Code.

STAR+PLUS MCOs are required to report on a quarterly basis to HHSC the aggregated number of critical incidents outlined in the definitions section above. MCOs are required to report confirmed, unconfirmed, inconclusive, unfounded and any systems issues identified as a result of reported abuse, neglect or exploitation. When there are questions about the data provided in the quarterly reports, HHSC may follow up with the MCO to discuss the data further.

An updated version of this report has been developed and is being finalized for inclusion into the UMCM in 2021. The updated report will vary from previous versions in that MCOs will submit the report via TexConnect, an online submission portal, which will allow additional HHSC divisions access to the report and keep track of past submissions. MCOs currently use TexConnect to submit other reports.

The updated version of the report will include individual level detail on critical incident events and the remediation details for these critical incidents. Individual remediation will include the following:

- Termination of service provider (employee/contractor);

- Corrective action plan for contracted program provider (employee/contractor);
- Training for service provider (employee/contractor);
- Service planning meeting with victim;
- Program policy and procedure training for program provider (employee/contractor);
- Development of new program policies and procedures;
- Service provider (employee/contractor) suspended from providing pending appeal resolution;
- Employee (provider/contractor) disassociated from specific client.

The report will tie each case of reported ANE/CI to a remediation type so that HHSC can track and trend to determine how MCOs handle ANE/CI and the efficacy of the interventions they employ. Tracking and trending will take place through a Tableau dashboard dedicated to ANE/CI reporting.

HHSC is seeking a critical incident management system (CIMS) in 2021 that all 1915(c) and 1115 Medicaid Home and Community Based Service (HCBS) waiver providers will use to report all critical incidents as defined in state law and regulation. The CIMS solution will modernize, streamline, and advance the selected provider reporting and management activities defined by HHSC. This project constitutes a multi-year effort to provide a new CIMS solution to modernize and replace existing provider and some State agency critical incident reporting and management system functionality housed within various State provider systems. Through this project, the State seeks to maximize the current industry capabilities and trends. The proposed solution will enable the State to perform all functionality to operate, manage, control, and configure, as needed, a provider and State agency reporting and management application.

The new CIMS solution will include an online reporting portal for Texas Medicaid and Texas Medicaid-supported program providers. The solution will include a centralized data repository which will support online provider submissions, ad hoc query, and data retrieval processes through configurable business rules, workflow, and other features. Information will be analyzed, tracked, and trended to improve follow-up with MCOs and fee-for-service 1915(c) Medicaid waiver contracted providers. The system will provide a mechanism allowing HHSC to develop efficiencies in oversight and to comply with CMS guidance as outlined in Modifications to Quality Measures and Reporting in §1915(c) HCBS Waivers published by CMS on March 12, 2014.

Reports to Law Enforcement

Reports alleging that an individual's health or safety is in imminent danger; that an individual has died because of the alleged conduct; that an individual has been hospitalized or treated in an emergency room because of the alleged conduct; that the alleged conduct involves a criminal act; or that an individual has suffered bodily injury due to the alleged conduct shall be made to DFPS or HHSC and the appropriate law enforcement agency. All reports that allege abuse or neglect by a person responsible for a child's care, custody, or welfare received by a local or state law enforcement agency are referred immediately to DFPS or the designated agency. Reports of abuse, neglect or exploitation of an individual residing in a facility regulated by HHSC received by a law enforcement agency are referred to HHSC.

Attachment E
HCBS Member Safeguards

Investigation of Abuse, Neglect, or Exploitation (ANE)

HHSC's Long Term Care Regulation Division investigates reports of alleged ANE of individuals who are elderly or who have a disability, including a child with a disability, as well as individuals receiving services from a home and community support services agency (HCSSA) or a facility; community center, a local mental health authority, and local intellectual and developmental disability authority; person who contracts with a health and human services agency or MCO to provide home and community-based a services; person who contracts with a Medicaid MCO to provide behavioral health services; MCO; contractor, subcontractor, officer, employee, or agent of a person or entity listed in in this section; or fiscal agent, employee, case manager, or service coordinator of an individual employer participating in the consumer-directed service option, as defined by Section 531.051, Government Code.

HHSC also investigates reports of ANE of individuals who are elderly or have a disability that occur in a facility, or that are perpetrated by certain providers, which are operated, licensed, or certified by HHSC. These investigations are governed by Title 2 of the Texas Human Resources Code, Subtitle D, Chapter 48 (relating to Investigations and Protective Services for Elderly and Disabled Persons) and Title 4 of the Texas Health and Safety Code, Subtitle B, Chapter 260A (relating to Reports of Abuse, Neglect, and Exploitation of Residents of Certain Facilities).

When DFPS receives ANE reports concerning an individual in a facility licensed by a state agency that is explicitly responsible for investigating ANE in that facility, such as investigations of ANE in nursing facilities licensed by HHSC, DFPS forwards the report to that agency for investigation.

Joint Investigations with Law Enforcement

State law requires HHSC to notify the appropriate law enforcement agency of reports of abuse, neglect, or exploitation during certain investigations. Specifically, HHSC is required to immediately notify the appropriate law enforcement agency when a caseworker or supervisor has cause to believe that an individual who is elderly or who has a disability has been abused, neglected, or exploited by another person in a manner that constitutes a criminal offense under any law. This requirement does not apply when the law enforcement agency is the entity to report the alleged abuse, neglect, or exploitation to HHSC or DFPS.

Within 24 hours after the receipt of a report of abuse, neglect, or exploitation of a resident of an HHSC facility, HHSC must report the incident to the appropriate law enforcement agency when the complaint alleges: a resident's health or safety is in imminent danger; a resident has recently died because of conduct alleged in the report of abuse, neglect, exploitation, or other complaint; a resident has been hospitalized or treated in an emergency room because of conduct alleged in the report of abuse, neglect, exploitation, or other complaint; a resident has been a victim of any act or attempted act described by Section 21.02, 21.11, 22.011, or 22.021 of the Texas Penal Code; or a resident has suffered bodily injury, as that term is defined by Section 1.07 of the Texas Penal Code, because of conduct alleged in the report of abuse, neglect, exploitation, or other complaint.

HHSC must immediately notify the appropriate law enforcement agency of any report that concerns the suspected abuse, neglect, or exploitation of a child or the death of a child from abuse or neglect. If HHSC finds evidence indicating that a child may have been abused, neglected, or exploited, HHSC must report the evidence to the appropriate law enforcement agency. These requirements do not apply when the law enforcement agency is the entity to report the alleged abuse, neglect, or exploitation to HHSC or DFPS.

If a child has been or may be the victim of conduct that constitutes a criminal offense that poses an immediate risk of physical or sexual abuse of a child that could result in death or serious harm to the child, DFPS conducts a joint investigation with the appropriate law enforcement agency. Additionally, if DFPS initiates an investigation and determines that the abuse or neglect does not involve a person responsible for the child's care, custody, or welfare, DFPS refers the report to the appropriate law enforcement agency for further investigation.

Upon receipt of a report of alleged abuse, neglect, or exploitation of a person residing in a facility licensed, operated, certified or registered by HHSC, law enforcement must acknowledge the report and begin a joint investigation with HHSC within 24 hours after receipt of the report.

Monitoring

HHSC maintains overall responsibility for the operation of the critical incident system and engages in continuous process improvements. Protections against ANE are not limited to HHSC's jurisdiction; other state and local entities have related responsibilities as described elsewhere in this Attachment.

HHSC Utilization Review (UR) conducts annual MCO reviews of a statistically valid random sample of the MCO's members. Through the review, HHSC conducts interviews with STAR+PLUS HCBS members. HHSC UR provides updates to the MCO service coordinators after each member interview. If a critical incident is identified during the UR or through disclosure by the member during the interview, HHSC UR updates the MCO to intervene.

All access to care and health and safety issues are referred to HHSC Managed Care Compliance and Operations (MCCO) complaints team on behalf of the member so that the issue can be tracked and resolved. In addition, the HHSC UR team would refer to DFPS or HHSC Provider Investigations, if they identified any ANE. Referrals may also be made to other entities when appropriate, such as the board of nursing if a licensed nurse is involved, or HHSC Long Term Care Regulation for provider licensure issues.

If HHSC MCCO received an ANE report from DFPS or another agency, HHSC would send it to the MCO, to ensure that they were aware of the situation and are acting upon the referral. In the instances of ANE, the MCO has two hours upon receipt to respond to HHSC.

Through operational reviews, HHSC MCCO staff interview the MCOs about their process related to ANE calls and how to report and how to address calls. If HHSC identified a critical incident as part of the operational review process, the response would depend on the nature of the incident. Ensuring the safety of the member would be the first priority, and staff would make referrals to DFPS or other regulatory or legal entities if appropriate. HHSC MCCO would also determine whether or not the MCO

was non-compliant with contractual requirements (partially or wholly responsible for the incident) and if so, would review for potential contractual remedies.

Remediation

If an MCO fails to meet contractual requirements related to protection against or reporting of ANE, such as contracting with MLTSS providers that fail to meet standards outlined in Sections A and B, then HHSC has authority to use a variety of remedies, up to and including contract termination. HHSC has the authority to terminate or replace an MCO or its subcontractor(s), according to managed care contracts, if either are convicted of a criminal offense related to the neglect or abuse of members in connection with the delivery of an item or service.

Member Support

Texas maintains a consumer support system that is independent of the MCOs to assist members in understanding managed care and resolution of problems regarding services, benefits, access, and rights.

Texas' independent consumer supports system (ICSS) consists of HHSC's Medicaid/CHIP Division, Office of the Ombudsman (Ombudsman), the state's managed care Enrollment Broker (EB, "MAXIMUS"), and community support from the Aging and Disability Resource Centers (ADRCs). These entities operate independently of any Medicaid MCO and work with beneficiaries and MCOs to ensure beneficiaries seeking to enroll with a MCO understand the managed care program, MCO options, and the process for resolving issues.

Member complaints, including those that could involve critical incidents, are handled through the HHSC Office of Ombudsman. Response to complaints involving critical incidents include reaching out to the member/Authorized representative, for a detailed description of the issue; contacting the MCO for access to care cases; and if necessary contacting the MCO to perform a well-check.

If a consumer provides information that gives the Office of Ombudsman staff reason to suspect abuse, neglect, or exploitation, OO staff will:

- provide the consumer with contact information for the DFPS Texas Abuse Hotline;
- inform the consumer that the Office of Ombudsman staff must report it to DFPS;
- make a report to DFPS by:
    - phone (800-252-5400) if the situation is urgent and needs to be investigated within 24 hours; or
    - online submission if the situation is not urgent;
- document these actions in the system; and
- email their supervisor so they are aware of the report.

HHSC's Medicaid and CHIP Services Department provides guidance to the MCOs on Medicaid policy and managed care program requirements, reviews MCO materials, monitors the MCOs' contractual obligations, answers managed care inquiries, and resolves managed care complaints. HHSC's Medicaid

and CHIP Services Department also monitors implementation of MCO corrective action plans and assesses damages when necessary.

Restraints, Seclusions, and Medication Management

HHSC licenses adult foster care providers serving four or more individuals, assisted living facilities, nursing facilities, home and community support services agencies (HCSSAs), day activity and health services (DAHS) facilities, and prescribed pediatric extended care centers (PPECCs). HHSC is responsible for ensuring compliance with licensing requirements and inspects licensed providers for compliance with licensing requirements, such as medication management and authorized use of restraint and seclusion. HHSC licensing inspections include medication administration review that is based on a sample of individual and resident records. The state may seek enforcement action, such as administrative penalties and license revocation, when harmful medication management practices are detected. HHSC survey staff may conduct follow-up surveys and inspections to ensure the provider has effectively implemented plans of correction required due to cited state violations. HHSC tracks the number of substantiated instances of licensure violations.

Restraint

Pursuant to federal and state rules, a waiver recipient has the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. The state does permit the use of restraints in limited and appropriate circumstances, as detailed in this section. All allegations of improper restraints by providers licensed by HHSC are referred to HHSC for investigation.

STAR+PLUS HCBS services are provided in adult foster care (AFC) and assisted living facilities (ALFs)—both of which allow the use of restraints under certain circumstances. HHSC Long Term Care Regulation conducts licensing surveys of ALFs every two years and MCOs or a subcontractor of the MCO are responsible for annually ensuring AFC providers contracted with the MCO are following contracting standards for AFC providers. MCOs remain responsible for oversight of any contractors the MCOs use to recruit, enroll and oversee AFC providers. During licensing and contract reviews, documentation of unauthorized restraints identified, or restraints conducted outside of licensing or contract standards are addressed through contract actions or licensing citations.

HHSC maintains a Managed Long-term Services and Supports Ombudsman's Office responsible for documenting and resolving complaints received from individuals receiving STAR+PLUS services, including HCBS. The MLTSS Ombudsman may receive complaints about unauthorized restraints which would be referred to the MCO for resolution.

Adult Foster Care

All individuals receiving AFC have the right to be free from physical or chemical restraints not required to treat the resident's medical symptoms or imposed for purposes of discipline or convenience. A provider may use physical or chemical restraints 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 written authorization for the use of restraint must specify the circumstances under which the restraint may be used and the duration for which the restraint may be used. Except in a behavioral emergency, restraint may only be administered by qualified medical personnel. The AFC provider must inform the resident verbally and in writing, before or at the time of admission, of his rights and responsibilities, including those related to restraint and seclusion. HHSC applies and enforces these requirements for both licensed and unlicensed AFC facilities pursuant to the provisions in the STAR+PLUS Handbook. AFC providers who provide services to four or more unrelated individuals must be licensed as (ALFs and are also subject to the requirements discussed below.

In addition, AFCs licensed as Type A or B ALFs are also subject to ALF restraint rules that are specific to Type A or Type B facilities. These rules are found under TAC Title 26, Chapter 553, §553.41 (relating to Standards for Type A and Type B Assisted Living Facilities). Pursuant to these rules, all restraints for purposes of behavior management, staff convenience, or resident discipline are prohibited. A facility may use physical or chemical restraints only (1) if the use is authorized in writing by a physician and specifies: (a) the circumstances under which a restraint may be used; and (b) the duration for which the restraint may be used; or (2) if the use is necessary in an emergency to protect the resident or others from injury.

A restraint must 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 resident's ability to communicate; or places the resident in a prone or supine position. 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 restraint and document in the resident's record that the appointment was made. If the resident refuses to see the physician, staff must document the refusal in the resident's record. As soon as possible but no later than 24 hours after the use of restraint, the facility must notify the resident's legally authorized representative or an individual actively involved in the resident's care, if there is such a person, that the resident has been restrained, unless the release of this information would violate other law.

Staff at Type A or B ALFs must attend training which includes practices to decrease the frequency of the use of restraint and alternatives to restraints. Before or upon admission of a resident, a facility must notify the resident and, if applicable, the resident's legally authorized representative, of HHSC rules and the facility's policies related to restraint. In order to decrease the frequency of the use of restraint, facility staff must be aware of and adhere to the findings of the required resident assessment. A facility may adopt policies that allow less use of restraint than allowed by these rules.

Assisted Living Facilities

ALFs must comply with restraint rules found in TAC Title 26, Chapter 553, §92.125 (relating to Resident's Bill of Rights and Provider Bill of Rights). Pursuant to these rules, ALF residents have the right to be free from physical and chemical restraints that are administered for the purpose of discipline or convenience

and not required to treat the resident's medical symptoms. A provider may use physical or chemical restraints 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 written authorization for the use of restraint must specify the circumstances under which the restraint may be used and the duration for which the restraint may be used. Except in a behavioral emergency, restraint may only be administered by qualified medical personnel.

Furthermore, Type A and Type B ALFs must also comply with restraint rules in TAC Title 26, Chapter 553, §553.41 (relating to Standards for Type A and Type B Assisted Living Facilities). Pursuant to these rules, all restraints for purposes of behavior management, staff convenience, or resident discipline are prohibited. A facility may use physical or chemical restraints only (1) if the use is authorized in writing by a physician and specifies: (a) the circumstances under which a restraint may be used; and (b) the duration for which the restraint may be used; or (2) if the use is necessary in an emergency to protect the resident or others from injury.

A restraint must 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 resident's ability to communicate; or places the resident in a prone or supine position. 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 restraint and document in the resident's record that the appointment was made. If the resident refuses to see the physician, the facility must document the refusal in the resident's record. As soon as possible but no later than 24 hours after the use of restraint, the facility must notify the resident's legally authorized representative or an individual actively involved in the resident's care, if there is such a person, that the resident has been restrained, unless the release of this information would violate other law.

Staff at Type A or B ALFs must attend training which includes practices to decrease the frequency of the use of restraint and alternatives to restraints. Before or upon admission of a resident, a facility must notify the resident and, if applicable, the resident's legally authorized representative, of HHSC rules and the facility's policies related to restraint. In order to decrease the frequency of the use of restraint, facility staff must be aware of and adhere to the findings of the required resident assessment. A facility may adopt policies that allow less use of restraint than allowed by these rules.

Nursing Facilities

Nursing facilities must comply with restraint rules found in TAC Title 40, Chapter 19 (relating to Nursing Facility Requirements for Licensure and Medicaid Certification). Nursing facility providers may use restraints, of any kind, only with the orders of the attending physician. Residents must be informed in writing upon admission, and during their stay, of HHSC rules and the facility’s policies related to the use of restraint and involuntary seclusion. As part of orientation, and annually, each employee must receive instruction regarding restraint reduction. If restraints are used to treat a resident’s medical condition, the resident must be monitored hourly, and at a minimum, restraints must be released every two hours

for a minimum of ten minutes, and the resident must be repositioned. Restraints that obstruct the resident's airway, impair the resident's breathing, interfere with the resident's ability to communicate, or place the resident in a prone or supine position are prohibited. The use of restraints and their release must be documented in the clinical record.

Home and Community Support Services Agencies

Members receiving contracted services from home health agencies, licensed as HCSSAs, have the right to be free from restraint when it is used for someone else's convenience or is meant to force the member to do something, or to punish the member (TAC Title 1, Chapter 353, Subchapter C (relating to Member Bill of Rights and Responsibilities)).

Day Activity and Health Services

Providers of DAHS require a license issued by HHSC in accordance with TAC Title 40, Chapter 98 (relating to Day Activity and Health Services Requirements).

DAHS providers must comply with licensure and program rules found in TAC Title 40, Chapter 98, §98.61 (relating to General Requirements) and §98.62 (relating to Program Requirements). Pursuant to this section, DAHS providers must provide an individual with a written list of the individual's rights, as outlined under the Texas Human Resource Code, Chapter 102, §102.004 (relating to List of Rights). §102.003 (relating to Rights of the Elderly) sets forth the specific rights addressed by §102.004. Under this section, individuals receiving DAHS have the right to be free from physical or chemical restraints that are administered for the purpose of discipline or convenience and are not required to treat the individual's medical symptoms. A person providing services may use physical or chemical restraints only if the use is authorized in writing by a physician or the use is necessary in an emergency to protect the individual or others from injury. A physician's written authorization for the use of restraint must specify the circumstances under which the restraint may be used and the duration for which the restraint may be used. Except in an emergency, restraint may only be administered by qualified medical personnel.

Seclusion

The state does not permit the use of seclusion. The state does not permit the use of seclusion as it relates to services delivered through managed long term services and supports. All allegations of improper seclusion of individuals receiving managed long term services and supports by providers licensed by HHSC are referred to HHSC for investigation.

Because licensing regulation for home and community support services agencies allow for seclusion in narrow circumstances under the order of a physician, HHSC issues direction to MCOs making it clear that the use of seclusion in a person's own home is not permitted even if allowed by HCSSA licensure.

Adult Foster Care

The use of seclusion in any licensed or unlicensed AFC is prohibited. The state applies and enforces these requirements for licensed and unlicensed AFC facilities under provisions in the STAR+PLUS Handbook.

Assisted Living Facilities

Attachment E
HCBS Member Safeguards

The use of seclusion by Type A and Type B ALF providers is prohibited.

Nursing Facilities

Nursing facilities may not use involuntary seclusion on a resident. “Involuntary seclusion” is defined as the "separation of a resident from others or from the resident's room or confinement to the resident's room, against the resident's will or the will of a person who is legally authorized to act on behalf of the resident. Monitored separation from other residents is not involuntary seclusion if the separation is a therapeutic intervention that uses the least restrictive approach for the minimum amount of time, not to exceed 24 hours, until professional staff can develop a plan of care to meet the resident's needs."

Home and Community Support Services Agencies

Members receiving services from home health agencies, licensed as HCSSAs, have the right to be free from seclusion when it is for someone else’s convenience or is meant to force the member to do something, or to punish the member.

Day Activity and Health Services

Members receiving DAHS have the right to be free from seclusion when it is for someone else’s convenience or is meant to force the member to do something, or to punish the member.

Medication Management

AFC providers, ALFs, nursing facilities, HCSSAs, and DAHS providers must provide medication management in accordance with licensing standards. The State enforces the same requirements for unlicensed AFC facilities under provisions in the STAR+PLUS Handbook.

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 relevant law and rule. An RN that fails to properly supervise or delegate is subject to action by the Texas Board of Nursing.

HHSC conducts surveys of HCSSAs licensed providers who administer medications to ensure they have policies for maintaining a current medication list and a medication administration record. HHSC Long Term Care Regulation is a separate division within HHSC which serves as the Medicaid agency.

HHSC UR conducts annual MCO reviews of a statistically valid random sample of the MCO’s members. Through the review, HHSC conducts interviews with STAR+PLUS HCBS members. HHSC UR provides updates to the service coordinators after each member interview. If a critical incident, such as a medication error, is identified during the UR or through disclosure by the member during the interview, HHSC UR updates the MCO to intervene.

All access to care and health and safety issues are referred to HHSC MCCO complaints team on behalf of the member so that the issue can be tracked and resolved. Referrals may also be made to other entities when appropriate, such as the board of nursing if a licensed nurse is involved, or HHSC Long Term Care Regulation for provider licensure issues which would include problems with medication administration.

Attachment E
HCBS Member Safeguards

Adult Foster Care

All AFC providers must ensure that all medications are taken as prescribed and in a timely manner according to the instructions on the medication label or instructions from the resident's physician. The AFC provider may administer medications only as allowed by state law or regulation, and prescription medications must be kept in a locked container. Medications must be disposed of when the resident's medication regimen changes or when the medication is out of date. The AFC provider must ensure that a resident takes over-the-counter medications according to the package directions. Excessive use of these medications must be reported to the AFC caseworker. The AFC provider must inform the resident verbally and in writing, before or at the time of admission, of his rights and responsibilities. The State enforces the same requirements for unlicensed AFC facilities under provisions in the STAR+PLUS Handbook.

In addition, AFCs licensed as Type A or B ALFs, which are AFCs serving 5 or more residents and licensed prior to September 1, 2014, and AFCs with a current contract with HHSC, serving 4 or more residents and licensed after September 1, 2014, are also subject to ALF medication management rules that are specific to Type A or Type B facilities. These rules are found in TAC Title 40, Chapter 92, §92.41 (relating to Standards for Type A and Type B Assisted Living Facilities). Pursuant to these rules, medications must be administered according to physician's orders.

Residents who choose not to or who cannot self-administer their medications must have their medications administered by a person who: (i) holds a current license under state law that authorizes the licensee to administer medication; (ii) holds a current medication aide permit and functions under the direct supervision of a licensed nurse on duty or on call by the facility and that nurse authorizes the licensee to administer medication; or (iii) is an employee of the facility to whom the administration of medication has been delegated by a registered nurse, and must have been trained by the nurse to administer medications or have had the nurse verify the training of the employee. The delegation of the administration of medication is governed by TAC Title 22, Chapter 225 (relating to RN Delegation to Unlicensed Personnel and Tasks Not Requiring Delegation in Independent Living Environments for Clients with Stable and Predictable Conditions).

A resident's prescribed medication must be dispensed through a pharmacy or by the resident's treating physician or dentist. Each resident's medications must be listed on an individual resident's medication profile record. Supervision of a resident's medication regimen by facility staff may be provided to residents who are incapable of self-administering without assistance. Residents who self-administer their own medications and keep them locked in their room must be counseled at least once a month by facility staff to ascertain if the residents continue to be capable of self-administering their medications and if security of medications can continue to be maintained. The facility must keep a written record of counseling. Residents who choose to keep their medications locked in a central medication storage area may be permitted entrance or access to the area for the purpose of self-administering their own medication. A facility staff member must remain in or at the storage area the entire time any resident is present.

Attachment E
HCBS Member Safeguards

Facility staff immediately must report to the resident's physician and responsible party any unusual reactions to medications or treatments. When the facility supervises or administers the medications, a written record must be kept when the resident does not receive or take his/her medications or treatments as prescribed. The facility must provide a locked area for all medications. Medications no longer being used by the resident are to be kept separate from current medications and are to be disposed of according to state law.

Assisted Living Facilities

ALF providers must comply with medication management rules found in TAC Title 40, Chapter 92, Section 92.41 (relating to Standards for Type A and Type B Assisted Living Facilities). Pursuant to these rules, medications must be administered according to a physician's orders.

Residents who choose not to or who cannot self-administer their medications must have their medications administered by a person who: i) holds a current license under state law that authorizes the licensee to administer medication; (ii) holds a current medication aide permit and functions under the direct supervision of a licensed nurse on duty or on call by the facility and that nurse authorizes the licensee to administer medication; or (iii) is an employee of the facility to whom the administration of medication has been delegated by a registered nurse, and must have been trained by the nurse to administer medications or have had the nurse verify the training of the employee. The delegation of the administration of medication is governed by TAC Title 22, Chapter 225 (relating to RN Delegation to Unlicensed Personnel and Tasks Not Requiring Delegation in Independent Living Environments for Clients with Stable and Predictable Conditions).

A resident's prescribed medication must be dispensed through a pharmacy or by the resident's treating physician or dentist. Each resident's medications must be listed on an individual resident's medication profile record. Supervision of a resident's medication regimen by facility staff may be provided to a resident who is incapable of self-administering without assistance. Residents who self-administer their own medications and keep them locked in their room must be counseled at least once a month by facility staff to ascertain if the residents continue to be capable of self-administering their medications and if security of medications can continue to be maintained. The facility must keep a written record of counseling. Residents who choose to keep their medications locked in the central medication storage area may be permitted entrance or access to the area for the purpose of self-administering their own medication. A facility staff member must remain in or at the storage area the entire time any resident is present.

Facility staff immediately report to the resident's physician and responsible party any unusual reactions to medications or treatments. When the facility supervises or administers the medications, a written record must be kept when the resident does not receive or take his/her medications or treatments as prescribed. The facility must provide a locked area for all medications. Medications no longer being used by the resident are to be kept separate from current medications and are to be disposed of according to state law. Providers are required to record any type of medication error, regardless of severity, in the resident’s clinical record.

Attachment E
HCBS Member Safeguards

Nursing Facilities

Nursing facility providers must comply with medication management rules found in TAC Title 40, Chapter 19 (relating to Nursing Facility Requirements for Licensure and Medicaid Certification). A nursing facility provider must ensure that medications are administered pursuant to the ordering physician's directions. Each resident must have an individual medication record. An individual may self-administer medications if the interdisciplinary team has determined that this practice is safe. The facility nursing staff must report medication errors and adverse reactions to the resident's physician in a timely manner, as warranted by an assessment of the resident's condition, and record them in the resident's record. Medication errors include, but are not limited to, administering the wrong medication, administering at the wrong time, administering the wrong dosage, administering by the wrong route, omitting a medication, or administering to the wrong resident.

When not in use, a medication cart must be secured in a designated area. Self-administered medications may be kept in a locked cabinet in the resident's room. When medications are self-administered, the facility remains responsible for medication security, accurate information, and medication compliance. Medications of deceased residents, medications that have passed the expiration date, and medications that have been discontinued must be securely stored and reconciled. These medications must be disposed of according to federal and state laws or rules on a quarterly basis.

Home and Community Support Services Agencies

Home health agencies licensed as HCSSAs must comply with medication management rules found in TAC Title 26, Chapter 558, §558.300 (relating to Medication Administration). A HCSSA must adopt and enforce a written policy for maintaining a current medication list and a current medication administration record. An individual's healthcare provider must order administration of medication. Each individual must have an individual medication record. An individual delivering care must report any adverse reaction to a supervisor and document this in the individual's record on the day of occurrence. If the adverse reaction occurs after regular business hours, the individual delivering care must report the adverse reaction as soon as it is disclosed. Notification must also be made in the medication administration record or clinical notes of medications not given and the reason.

Day Activity and Health Services

DAHS require a license issued by HHSC in accordance with TAC Title 40, Chapter 98 (relating to Day Activity and Health Services Requirements).

DAHS providers must comply with medication management rules found in TAC Title 40, Chapter 98, §98.62 (relating to Program Requirements).

The facility nurse is responsible for obtaining physician's orders for medication and treatments to be administered, and administering medication and treatments. Individuals who choose not to or cannot self-administer their medications must have their medications administered by a person who holds a current license under state law which authorizes the licensee to administer medications. All medication

prescribed to individuals must be dispensed through a pharmacy or by the individual's treating physician or dentist. Each individual's medications must be listed on his or her medication profile record.

Assistance with medication self-administration by licensed nursing staff may be provided to individuals who are incapable of self-administering without assistance. Individuals who self-administer their own medications must be counseled at least once a month by licensed nursing staff to ascertain if the individuals continue to be capable of self-administering their medications and/or treatments. A written record of counseling must be kept by the facility.

The facility director, the activities director, or a facility nurse must immediately report to the individual's physician and responsible party any unusual reactions to medications or treatments. When the facility supervises or administers the medications, a written record must be kept when the individual does not receive or take his medications and/or treatments as prescribed. The documentation must include the date and time the dose should have been taken, and the name and strength of medication missed. The facility must provide a locked area for all medications. Medications no longer in use must be disposed of according to state law.

Attachment H
UC Payment Protocol

OVERVIEW

This Uncompensated-Care (UC) Payment Protocol is submitted pursuant to the Special Terms and Conditions (STCs) of the Texas Healthcare Transformation and Quality Improvement Program, Section 1115 Waiver Demonstration No. 11-W-00278/6. This protocol establishes the rules and guidelines for the State to claim federal matching funds for UC payments.

STC 33 provides that payments from the UC pool will be used to defray the actual uncompensated cost of medical services provided to uninsured individuals as charity care (as defined below) by hospitals, clinics, or other provider types. Expenditures for UC payments must be claimed in accordance with CMS-approved claiming protocols for each provider type as described in this Attachment H.

STC 33 further provides that the UC Payment Protocol must include precise definitions of eligible uncompensated provider charity care costs. For all provider types, the following definition applies:

> *Charity care*: Healthcare services provided without expectation of reimbursement to uninsured individuals who meet the provider's charity-care policy. The charity care policy should adhere to the charity-care principles of the Healthcare Financial Management Association. In this protocol, the term charity care also includes full or partial discounts given to individuals who meet the provider's financial assistance policy. Charity care does not include bad debt, payment shortfall(s), insurance allowances, courtesy allowances, or discounts given to patients who do not meet the provider's charity care policy or financial assistance policy.

The term "payment shortfalls" refers to government program payment shortfalls, e.g. Medicaid payments to providers.

Insurance allowances refer to the negotiated rates between insurers and providers, e.g. BCBS paying 60% of a provider's charge list for a Medicaid patient's care. CMS would not recognize for purposes of the UC pool the remaining 40% of costs not reimbursed by an insurer, as it stems from an insurance allowance. The unmet amount left over after a discounted charge to a patient who meets the provider's financial assistance policy would be acceptable.

Additional provider-specific descriptions of eligible charity-care costs may be included in Parts 1 - 4 of this protocol.

STC 33 further provides that the protocol must:

- Identify the allowable source documents to support costs;
- Include detailed instructions regarding the calculation and documentation of eligible costs; and
- Include a timetable and reconciliation of payments against actual charity-care cost and documentation.

This Payment Protocol is organized to provide the required information by provider type as follows:

Part 1: Hospitals
Part 2: Physician Practice Groups
Part 3: Government Dental Providers
Part 4: Government Ambulance Providers

Part 5: Methodology for Ensuring Payments Are Based On Uncompensated Costs

STC 33 also requires that the protocol describe the methodology used by the state to determine UC payments to hospitals, clinics, and other providers are distributed based on uncompensated cost, without any relationship to the source of the non-federal share. This requirement is met in Part 5 of this protocol.

Attachment F

Reserved

Attachment G

Reserved

Attachment H
UC Payment Protocol

Part 1: Hospitals

Hospitals that submit the UC application described below and meet other qualification criteria are eligible to receive payments from the UC Pool to help defray the unreimbursed costs incurred by the hospitals for providing the following services to individuals as charity care:

- Inpatient hospital services;
- Outpatient hospital services;
- Physician and mid-level professional direct-patient-care services; and
- Pharmacy costs related to prescription drugs provided through the Texas Vendor Drug program.

Pursuant to STC 33, providers receiving both DSH and UC payments cannot receive total payments under the UC Pool (related to inpatient and outpatient hospital services provided to charity care individuals) and DSH payments that exceed the hospital's total eligible uncompensated costs. For purposes of this requirement, "total eligible uncompensated costs" means the hospital's DSH hospital-specific limit (HSL) plus the uncompensated costs of inpatient and outpatient services provided to uninsured charity-care patients not included in the HSL for the corresponding program year non-covered inpatient and outpatient services provided to charity-care patients. Therefore, before calculating interim UC payment amounts for a hospital in this group, HHSC will first calculate the DSH HSL and the amount of DSH payments the hospital is expected to receive for the program year. The hospital's UC payment associated with costs that are included in the DSH HSL calculation cannot exceed the remaining DSH HSL after the DSH payments have been calculated. Costs and payments attributable to physician and mid-level professional services, pharmacy, and clinic services are not included for purposes of calculating total eligible uncompensated costs in this context.

Additionally, for institutions of mental diseases (IMDs), expenditures for services to patients in an institution for mental diseases (IMD) who are under age 65, except inpatient psychiatric hospital services to individuals under age 21, while allowable for purposes of the DSH HSL calculation, are not allowable costs for reimbursement from the UC Pool. Therefore, for IMDs participating in both DSH and UC, the UC payment associated with costs in the DSH HSL cannot exceed the lesser of the IMD's cost for providing services to the age-restricted population and the remaining DSH HSL after the DSH payments have been calculated.

Instructions regarding the calculation and documentation of these eligible costs are included in the description below of the Texas Hospital Uncompensated Care Application (TXHUC).

The costs and other data included in the UC application should be representative of the fiscal period from October 1 through September 30 two years before the demonstration year for which payments are being calculated. The UC application should be submitted to the Texas Health and Human Services Commission (HHSC) by the deadline specified by HHSC. For hospitals, the source for these costs and other data will be the hospital's Medicare cost report that ends in the calendar year two years prior to the demonstration year for which UC payments are being determined, except that non-public hospitals required to make a mandatory payment (i.e., a provider tax or provider fee) to a local governmental entity may report on the UC application the amount of such payments that are proportionate to the hospital's charity care services, whether such payment is included in the cost report or not. The application provides instructions for determining the amount of such cost that may be claimed as charity care. It should be noted that when HHSC completes the reconciliation process described in this protocol, HHSC will utilize the hospital's actual data reported on the reconciliation surveys and best available cost reports to ensure that the hospital's payments did not exceed its eligible costs.

All costs and other data reported in the UC Application are subject to the Medicare regulations and

program instructions. The entity submitting the UC Application must maintain adequate supporting documentation for all information included in the UC Application in accordance with the Medicare program's data retention policies. The entity must submit the supporting documentation upon request from HHSC.

Texas Hospital Uncompensated Care Tool (TXHUC)

The TXHUC comprises a certification page, five primary schedules (a Summary Schedule and Schedules 1, 2, 3 & 4) and various other supporting schedules. Schedules 1, 2 and 3 determine the hospital's unreimbursed costs for services provided to patients related to physician and/or mid-level professional direct patient care costs, pharmacy costs, and allowable hospital costs for the UC programs. Schedule 4 identifies allowable hospital costs for DSH payments. The supporting schedules are the schedules hospitals are required to submit to HHSC when applying for the Medicaid DSH program and also to report allowable charity charges for UC payments. Each of these schedules along with instructions for the completion of the schedule is detailed below.

Certification

The certification page must be signed and dated by an officer or administrator of the provider. An officer is defined as a member of the provider's senior management such as the chief executive officer, chief financial officer, chief operating officer, etc. The certification must contain an original or acceptable electronic signature and not a copy. If the TXHUC is an initial submission, it should be so indicated in the appropriate box on the certification page.

Upon the termination of the 1115 Waiver, providers will be required to submit actual cost data in the prescribed format of the TXHUC for a minimum of two years for purposes of reconciling the UC Pool payments for the last two years of the Waiver with the provider's actual costs incurred for those fiscal periods

Summary Schedule

Column 1 - Summarizes the charity costs determined on Schedules 1, 2 & 3. These amounts will flow automatically from the respective schedules and no input is required.

Column 2 – The distribution of the Uncompensated Care Pool ("UC Pool") will be based on the charity costs incurred two years prior to the demonstration year. For example, distribution for the fiscal period 10/1/2019 - 9/30/2020 will be based on costs that are representative of the period from 10/1/2017 – 9/30/2018 as computed on Schedules 1, 2 & 3. If the provider knows these costs are not representative of their actual costs due to changes in their contractual arrangements or other operational or economic issues, the provider can enter adjustments to these costs in this column. The provider is required to maintain supporting documentation to support their adjustment amount and make this information available upon request from HHSC and/or CMS.

Column 3 – Represents the net charity costs after any adjustments and is determined by summing the amounts in Columns 1 & 2. The net cost amount will be utilized to determine the provider's distribution from the UC Pool.

Schedule 1
The schedule computes the costs related to direct patient care services provided by physicians and mid-level professionals to patients qualifying for charity care. To be included in the schedule, these costs must be recorded on the hospital's accounting records and reported on the hospital's Medicare cost report, Worksheet A, Columns 1 and/or 2.

Unless otherwise instructed, the source for these costs and other data will be the hospital's Medicare cost report for the period that ends in the calendar year two years prior to the demonstration year for which UC payments are being determined.

Column 1 - The direct patient care physician and/or mid-level professional costs are identified from the Medicare cost report. These professional costs are:

(1) Limited to allowable and auditable physician and/or mid-level professional compensations that has been incurred by the hospital;
(2) Physician's services to individual patients identified as professional component costs on Worksheet A-8-2, Column 4 of the cost report(s);
(3) Or, for contracted physicians and/or mid-level professionals only, Worksheet A-8, if the physician and/or mid-level professional compensation cost is not reported by the hospital on Worksheet A-8-2 because the physicians are contracted solely for direct patient care activities (i.e., no administrative, teaching, research, or any other provider component or non-patient care activities); and
(4) Removed from hospital costs on Worksheet A-8 / A-8-2

If the professional physicians' costs on Worksheet A-8-2, Column 4 include Medicare Part A costs (e.g. departmental administration, hospital committee activities, etc.) that were reported as professional component due to lack of a physicians' time study(s) to allocate the costs between professional and provider component and/or application of the Reasonable Compensation Equivalents (RCE) , these costs must be excluded from the physicians' costs related to direct patient care professional services and cannot be included for UC reimbursement purposes unless the following conditions are met:

(1) The costs must be allocated between direct patient care (Medicare Part B) and reimbursable Medicare Part A activities. The costs associated with Medicare Part A activities must be subjected to the Medicare RCEs.
(2) For a physician the hospital can elect to apply the RCE limit on an individual physician basis or in the aggregate.
(3) The hospital must allocate the physicians' costs based on the physicians' time study and apply the applicable RCE limits to the Medicare Part A non-teaching physicians' costs. The hospital must maintain auditable documentation of the determination of the allowable Part A non-teaching physician costs.
(4) The hospital is expected to obtain adequate and auditable time studies from each physician and time proxies from each mid-level professional employed by the hospital providing Medicare Part A services to the hospital for the proper application of the RCEs via the Medicare 2552 cost report. The physician and/or mid-level professional time study and time proxy forms to be used are located on the Texas Health and Human Services Commission website. Time studies should be completed for a two (2) week period once per quarter during the fiscal year. Ideally, the time study period will not be the same two weeks in any two given quarters. Medicare Part A physician and/or mid-level professional costs are not allowed to be included in the UC tool for cost reporting periods. In instances where a physician or mid-level professional is able to provide a contract that scopes out the specific direct patient

care being provided and that contains the same information provided by a time study or time proxy, that contract may be used for payment and reconciliation purposes. The time proxy must be signed by each midlevel professional employed by the hospital and the supervisor for cost reporting periods beginning on or after 10-1-2012.

Physician Part A costs cannot be included in Column 1. The physicians' costs should be reported in the cost center in which the expenses were reported on Worksheet A, Column 3 of the Medicare cost report.

Hospital costs for mid-level professional practitioner services that have been identified and removed from hospital costs on the Medicare cost report are to be included. Typically these costs comprise salaries and direct fringe benefits (payroll taxes, vacation and sick pay, health and life insurance, etc.), contract fees and professional liability insurance. The mid-level professional practitioner types to be included are:

(1) Certified Registered Nurse Anesthetists
(2) Nurse Practitioners
(3) Physician Assistants
(4) Dentists
(5) Certified Nurse Midwives
(6) Clinical Social Workers
(7) Clinical Psychologists
(8) Optometrists

To the extent these mid-level practitioners' professional compensation costs are not included in Worksheet A-8-2, Column 4, but are instead removed from hospital costs through an A-8 adjustment on the Medicare cost report, these costs may be recognized if the mid-level professional practitioners are Medicaid-qualified practitioners for whom the services are billable under Medicare separate from hospital services.

If the physician and/or mid-level practitioner costs are reported in a non-reimbursable cost center on the hospital's Medicare cost report, Worksheet A, these costs can be included in Column 1. The costs to be included would be the costs from Worksheet B Part I, the last column for the applicable line(s).

Hospitals may include physician and/or mid-level professional support staff compensation, data processing, and patient accounting costs as physician and/or mid-level professional-related costs to the extent that:

(1) These costs are removed from hospital inpatient and outpatient costs because they have been specifically identified as costs related to physician and/or mid-level professional services;
(2) They are directly identified on W/S A-8 as adjustments to hospital costs;
(3) They are otherwise allowable and auditable provider costs; and
(4) They are further adjusted for any non-patient-care activities such as research based on the physician and/or mid-level professional time studies.
(5) They are directly identified in a non-reimbursable cost center on the hospital's Medicare cost report, Worksheet A.
(6) For cost reporting periods beginning on or after 10-1-2013, physician and mid-level direct patient care costs incurred by the hospital that have been reported and removed from the hospital-based RHC cost center in the hospital's cost report through an adjustment in worksheets A-8 or A-8-2 (column 4) are allowable in

Schedule 1 of the application. Hospitals must provide adequate support documentation such as time studies for physicians and time proxies at a minimum for mid-level professionals to ensure only direct patient care is included in schedule 1. A copy of the contract between the hospital and physician(s) that includes a scope of service, remuneration, and term is required as the minimum supporting documentation for contracted physicians and/or mid-level professionals. Providers must also report all related revenues received for these costs. If the hospital does not report revenues on schedule 1 for these costs, adequate documentation from the provider to support how these services are billed for each payor group will be required or these costs will be disallowed.

If these costs are removed as A-8 adjustments to the hospital's general service cost centers, these costs should be reported on the General Services line (line 1) in Column 1.

If the hospital has costs for physicians and one or more types of mid-level professionals for a given cost center, the costs can be combined and the total reported in Column 1 provided the same allocation statistic will be utilized to apportion the costs to charity. If the hospital elects to utilize different allocation statistics to apportion the physician and/or any type of mid-level professional costs for a given cost center the cost center can be subscripted.

Column 1a – The recommended apportionment statistic for physician and/or mid-level professional costs is total billed professional charges by cost center. If a hospital does not maintain professional charges by payer type separately in its patient accounting system, then the professional costs can be apportioned based on total billed hospital departmental charges. Total billed hospital departmental charges by cost center are identified from the hospital's applicable Medicare cost report(s).

If professional charges related to the physician and/or mid-level professional services whose costs are reported in Column 1are utilized as the apportionment statistic, the professional charges must be from the same corresponding time period as the costs. The hospital must maintain adequate and auditable documentation to support the statistics reported in Column 1a.

If the hospital reports costs on the General Services line (Line 1) in Column 1, the recommended allocation statistic reported in Column 1a would be the aggregate total departmental charges (professional or hospital department, based on the apportionment statistic for the specific cost centers) for all cost centers.

Column 1b – The allocation basis the hospital elects to utilize to apportion the costs from Column 1 should be identified for each cost center. The approved allocation bases are total departmental professional charges if available. Otherwise departmental hospital charges may be utilized.

Column 2 - A cost to charge ratio (CCR) for each cost center is calculated by dividing the total costs for each cost center reported in Column 1 by the total allocation statistic for each cost center reported in Column 1a. If additional lines are added to Schedule 1, it will be necessary to copy the formula used to compute the CCR for the additional line(s). The CCR is carried out to six (6) decimal places.

Columns 2a & 2b - The applicable allocation statistics related to the physician and/or mid-level professional services provided to charity care patients are reported in Columns 2a and 2b based on the hospital's elected allocation basis reported in Column 1b. The allocation statistics applicable to charity care inpatient services are reported in Column 2a and allocation statistics applicable to charity care outpatient services are reported in Column 2b. The charity care inpatient and outpatient statistics should

be from the hospital's internal records and for the same fiscal period as the costs reported in Column 1 and total allocation statistics reported in Column 1a.

Columns 2c & 2d – The charity care inpatient and outpatient physician and/or mid-level professional costs are computed based on the CCR reported in Column 2 multiplied by the charity care inpatient and outpatient allocation statistics reported in Columns 2a and 2b, respectively. If additional lines are added to Schedule 1, it will be necessary to copy the formula used to compute the charity care inpatient and outpatient costs for the additional line(s).

All revenue received by the hospital related to physician and/or mid-level professional services provided inpatients and outpatients covered by charity care should be reported on Line 102 of the respective Columns 2c & 2d. The revenue will be subtracted from the respective costs to determine the net costs to be included in the hospital's UC Application.

Schedule 2

The schedule computes the pharmacy costs related to prescription drugs provided by hospitals participating in the Texas Vendor Drug program. These pharmacy costs are not related to services provided by the hospital's retail pharmacy or billed to a third party payer under revenue code 253. If the pharmacy costs were included in the hospital's Texas Medicaid DSH Application, they should not be included in the TXHUC application. If the pharmacy costs were included in the hospital's interim and/or final Hospital Specific Limit (HSL), they should not be included in Schedule 2 of the TXHUC application. Pharmacy costs should be related to drugs provided under either the hospital charity policy or the hospital pharmacy charity policy.

Column 1 - The total costs for the cost center that contains the drug costs related to the prescription drugs provided under the Texas Vendor Drug program are reported in Column 1, Line 1. These costs are from the hospital Medicare cost report(s) Worksheet B, Part I, last column for the applicable cost center.

Column 1a – The total hospital departmental charges for the cost center that contains the drug charges related to the prescription drugs provided under the Texas Vendor Drug program are reported in Column 1a, Line 1. These charges are from the hospital Medicare cost report(s) Worksheet C, Part I, Column 8 for the applicable cost center.

Column 1b – The allocation basis is hospital departmental charges. If the hospital wants to utilize an alternative allocation basis, they must submit a written request to Texas HHSC that identifies the alternative allocation basis and an explanation as to why the alternative allocation basis results in a more equitable apportionment of the pharmacy costs. HHSC will provide a written response to the hospital's request within 60 days of receiving the request and their decision is final.

Column 2 – The Cost-to-Charge ratio is computed by dividing the costs reported in Column 1 by the allocation statistic reported in Column 2. The CCR is carried out to six (6) decimal places.

Column 3a - The charges related to the prescription drugs provided to charity care patients under the Texas Vendor Drug program are reported in Column 3a, Line 1. These charges are obtained from the hospital's internal records. These charges should be for services provided during the period from October 1 through September 30 two years prior to the demonstration year for which UC payments are being

determined. The hospital must maintain the supporting documentation and submit it to HHSC upon request.

Column 3b – The costs related to the prescription drugs provided to Uninsured patients under the Texas Vendor Drug program are computed by multiplying the charges reported in Column 3a by the CCR computed in Column 2.

Line 2 - All revenue received by the hospital related to prescription drug services provided to charity care patients should be reported on Line 2 of the Columns 3b. This includes any rebates received from the Texas Vendor Drug program. The revenue will be subtracted from the cost to determine the net cost to be included in the hospital's UC Application.

Schedules 3 and 4

Schedule 3 determines the hospital charity care costs for the UC program for the applicable fiscal year (10/1/20XX – 9/30/20YY). HHSC will employ the same methodology used to compute the hospital-specific limit for the determination of the DSH Pool payments except that only charity care charges will be used to determine charity care costs for computing payments under UC. In addition, the Medicaid coverage limitations under Section 1905(a) of the Act, which exclude coverage for patients in an IMD who are under age 65, except for coverage of inpatient psychiatric hospital services for individuals under age 21, are applicable.

Hospitals must complete the Cost Report Collection Form worksheets in the TXHUC application to allow HHSC to compute their HSL. The source of charity charges for the calculation of allowable costs will be CMS 2552 Worksheet S-10 line 20 column 1 as reported on the Hospital Data 2 tab. Hospitals will be asked to report their associated charity care days that will be used to calculate per diem costs for charity care. Offsetting revenue for these costs will be obtained from CMS 2552 Worksheet S-10 line 22 column 1Non-S-10 hospitals will report their charity charges and charity care days on the Hospital Data 2 tab in accordance with the reporting requirements of the CMS 2552-10 S-10 instructions but will need to provide supporting schedules, including charity care days to HHSC.

Schedule 4 determines the hospital's Medicaid DSH costs (Medicaid shortfall and uninsured costs) and the Hospital-Specific Limit (HSL).

<u>Reconciliation of UC Payments to Hospitals</u>

As explained elsewhere in this protocol, UC payments to hospitals are determined utilizing the TXHUC, which is based on data for services furnished during the period two years before the demonstration year. In compliance with STC 33, HHSC reconciles the UC payments made in prior demonstration years to ensure that a hospital's payments did not exceed its actual eligible uncompensated costs incurred during that demonstration year. Payments in excess of actual eligible uncompensated costs are considered an overpayment to the hospital and will be recouped within one (1) year of the identified overpayment.

The reconciliation process utilizes a reconciliation survey that employs the same cost claiming methodology as the TXHUC to calculate uncompensated care costs (but which may have a format that is configured to interface with contractors' information technology systems), and the best available cost report or reports covering the demonstration year. If the hospital's cost report period does not coincide with the demonstration year being reconciled, it will be necessary to pro rate the data from the two cost

report periods that cover the demonstration year. HHSC will perform reconciliations for payments made during each year of the waiver.

At the beginning of the reconciliation process for each demonstration year, HHSC or its designee will notify each hospital that is subject to the reconciliation and will provide the hospital with a survey of costs and payments that is similar to the TXHUC described elsewhere in this protocol. The hospital is required to complete the reconciliation survey and cooperate with HHSC or its designee to complete the reconciliation. If a hospital fails to provide required information, HHSC will recoup any UC payment that is unsupported by the available data, up to the full amount of the UC payment made to the hospital during the demonstration year for which payments are being reconciled.

As part of the reconciliation process, HHSC or its designee will ensure that providers that received both DSH and UC payments in the period being reconciled did not receive total payments under the UC Pool (related to inpatient and outpatient hospital services provided to uninsured individuals as charity care) and under the DSH program that exceed the hospital's total actual eligible uncompensated costs for the demonstration year. For purposes of this requirement, "total eligible uncompensated costs" means the hospital's DSH hospital-specific limit (HSL) plus the uncompensated costs of non-covered inpatient and outpatient services provided to uninsured charity-care patients. UC payments attributable to physician and mid-level professional costs, pharmacy, and clinic costs are not considered inpatient or outpatient Medicaid payments for purposes of calculating total eligible uncompensated costs.

Before reconciling UC payments for hospitals that also participated in DSH, HHSC or its designee will calculate the final DSH HSL less the amount of DSH payments the hospital received in the same period. The hospital's UC payment associated with costs that are included in the DSH HSL calculation cannot exceed the remaining DSH HSL after the DSH payments have been calculated. In the event the UC payments related to costs in the DSH HSL and the DSH payments exceed the DSH HSL, the excess UC payment amount will be considered an overpayment and recouped. Costs and payments attributable to physician and mid-level professional services, pharmacy, and clinic services are not included for purposes of calculating total eligible uncompensated costs in this context.

Additionally, for IMDs that received payments in both DSH and UC, HHSC or its designee will calculate the total eligible uncompensated costs for services provided to the age-restricted population (under 21 and over 64). If the UC payments to the IMD exceed the lesser of the IMD's cost for providing services to the age-restricted population and the remaining DSH HSL after DSH payments, the excess UC payment amount will be considered an overpayment and recouped.

If, at the end of the reconciliation process, it is determined that a provider received an overpayment for any reason, the amount of the overpayment will be recouped from the provider and may be redistributed to hospitals that have UC room (in proportion to the amount of each hospital's UC room) or, alternatively, the federal share of the overpayment will be properly credited to the federal government through an adjustment shown on the CMS-64.

The reconciliation schedule is described in the section titled "Section 1115 Waiver UC Program Reconciliation Schedule" below.

Part 2: Physician Practice Groups

Texas Physician Uncompensated Care Application (TXPUC)

> The purpose of the TXPUC is to determine the physician professional costs related to services provided to charity care patients by physician organizations that may be reimbursable from the Uncompensated Care pool. Only professional organizations that previously participated in the Texas Medicaid Physician UPL ("Physician UPL") program or their successor organizations are eligible to submit a TXPUC and receive a distribution from the UC Pool. Under the Physician UPL, supplemental payments were made only for physician services performed by doctors of medicine and osteopathy licensed in Texas; furthermore, to remain eligible, all professionals, as defined below, must have a developed charity care policy that does not include bad debt, payment shortfall(s), insurance allowances, courtesy allowances, or discounts given to patients who do not meet the provider's charity care policy or financial assistance policy. Failure to have a written charity care policy will result in being ineligible for any UC payment.

All costs (direct and indirect) incurred by the physician organization related to services provided by mid-level professionals may also be reported on the physician organization's UC application.

For purposes of the TXPUC Application, a mid-level professional is defined as:

- Certified Registered Nurse Anesthetist (CRNA)
- Nurse Practitioner
- Physician Assistant
- Dentist
- Certified Nurse Midwife
- Clinical Social Worker
- Clinical Psychologist
- Optometrist

The TXPUC is based on established physician and/or mid-level cost finding methodologies developed by the Medicare program over the past 40 years. The schedules that follow use the same or similar methodology and worksheet identification process used by the Medicare hospital cost report.

For all the worksheets in the TXPUC, the cells requiring input are highlighted in green. All line numbers and descriptions are linked to Worksheet A. If lines are inserted, they must be inserted on all worksheets and in the same location.

The costs to be reported in the TXPUC are limited to identifiable and auditable compensation costs that have been incurred by the physician organization for services furnished by physicians and/or mid-level professionals in all applicable sites of service, including services provided in a hospital setting and non-hospital physician office sites for which the professional organization bills for and collects payment for the direct patient care services.

The basis for the total physicians' and/or mid-level professionals' compensation costs incurred by the professional organization will be the organization's general ledger. The costs should be representative of the services provided during the period from October 1 through September 30 two years prior to the demonstration year for which UC payments are being determined.

Total costs, reported by cost centers/departments, are then allocated between clinical and non-clinical activities using a CMS-approved time-study. The physician and/or mid-level professional time study forms to be used are located on the Texas Health and Human Service Commission website. Time studies

should be completed for a two (2) week period once per quarter during the fiscal year. Ideally, the time study period will not be the same two weeks in any 2 given quarters. The physician organization must utilize the CMS-approved time study to allocate physician and/or mid-level professional compensation costs between clinical and non-clinical activities. The result of the CMS-approved time study is the physicians' and mid-level professionals' compensation costs pertaining only to clinical, patient care activities. The physicians' and mid-level professionals' compensation costs are reduced by National Institute of Health (NIH) grants to the extent the research activities component is not removed via physician time studies.

The physician clinical and/or mid-level professional costs are subject to further adjustments and offsets, including any necessary adjustment to bring the costs in line with Medicare cost principles. There will be an offset of revenues received for services furnished to non-patients and other applicable non-patient care revenues that were not previously offset or accounted for by the application of the CMS-approved time study.

The above physicians' and/or mid-level professionals' compensation costs must not be duplicative of any costs claimed on a hospital's TXHUC.

Additional costs that can be recognized as professional direct costs are costs for non-capitalized medical supplies and equipment (as defined in the instructions for Worksheet A, Column 3 below) used in the furnishing of direct patient care.

Overhead costs will be recognized through the application of a rate for indirect costs to be determined by the actual costs incurred by the physician organization for the applicable reporting period(s) included in the UC application. The determination of the facility-specific indirect rate is defined in the instructions for Worksheet A, Column 8 below. Other than the direct costs defined above and the application of an approved indirect rate, no other costs are allowed.

Total billed professional charges by cost center related to physician and/or mid-level professional services are identified from provider records.

The total professional charges for each cost center related to Medicaid fee-for-service (FFS), Medicaid managed care (HMO), and charity care physician and/or mid-level professional services, billed directly by the professional organization, are identified using auditable financial records. Professional charges related to services provided to out-of-State Medicaid FFS and HMO patients should be included in the Medicaid charges reported on the TXPUC. The professional organization must map the claims to the respective cost centers using information from their billing systems. Each charge must be mapped to only one cost center to prevent duplicate mapping and claiming. These charges must be associated with services furnished during the period covered by the TXPUC (the period from October 1 through September 30 two years prior to the demonstration year for which UC payments are being determined). The professional organization must prepare a worksheet that identifies professional charges related to physician and/or mid-level professional services provided to patients covered by Medicaid FFS, Medicaid HMO, uninsured and all other payers for each cost center to be used to report the total charges on Worksheet B and the Program charges on Worksheet D. The worksheet total charges must be reconciled to the total charges per the professional organization's general ledger and/or financial statements for the applicable fiscal period(s).

Professional organizations are expected to obtain a time study from each physician and/or mid-level professional to be used in the allocation of the physicians' and/or mid-level professionals' compensation costs to direct patient care services and other activities. The physician and/or mid-level professional time study forms to be used are located on the Texas Health and Human Services website. Time studies should be completed for a two (2) week period once per quarter during the fiscal year. Ideally, the time study period will not be the same two weeks in any two given quarters.

If a professional organization incurs costs for services provided by another entity under a contractual arrangement, those costs can be included. The professional organization would be required to offset the revenue received on its UC Application to eliminate any duplicate payment for the costs related to these services.

Certification

The certification page must be signed and dated by an officer or administrator of the provider. An officer is defined as a member of the entity's senior management such as the chief executive officer, chief financial officer, chief operating officer, etc. The certification must contain an original signature and not a copy or electronic signature.

Upon the termination of the 1115 Waiver, entities will be required to submit actual cost data in the prescribed format of the TXPUC for a minimum of two years for purposes of reconciling the UC Pool payments for the last two years of the Waiver with the provider's actual charity costs incurred for those fiscal periods

Summary Schedule

Column 1 - Summarizes the charity costs determined on the applicable columns from Worksheet D. These amounts will flow automatically from the respective columns and no input is required.

Column 2 – The distribution of the Uncompensated Care Pool ("UC Pool") for a specific demonstration year will be based on the costs for the period from October 1 through September 30 two years prior to the demonstration year as computed on Worksheet D. If the entity knows these costs are not representative of their actual costs for the demonstration year, due to changes in their contractual arrangements or other operational or economic issues, the entity can make an adjustment to these costs. The entity is required to maintain supporting documentation to support their adjustment amount and make this information available upon request from HHSC and/or CMS.

Column 3 – Represents the net charity costs after any adjustments and is determined by summing the amounts in Columns 1 & 2. The net cost amount will be utilized to determine the entity's distribution from the UC Pool.

Worksheet A

This worksheet is a summary of the allowable direct patient care costs for physicians and mid-level professionals. The worksheet is segregated into 3 sections. Lines 1 – 29 contain the costs for physicians and mid-level professionals for patient care services provided in a hospital-based setting. Lines 31 – 55 contain the costs for physicians and mid-level professionals for patient care services provided in a non-hospital-based setting. Lines 56 – 79 contain costs for physicians and mid-level professionals for patient care services provided in settings other than those identified in Sections 1 and 2.

Cost center descriptions are input on this worksheet and will flow to the other worksheets. If lines are

added to this worksheet to accommodate the professional organization's unique cost centers, similar lines will need to be added to the other worksheets.

The professional organization's name, provider number, reporting period and indirect cost rate should be input on this worksheet and will flow to the other worksheets.

Column 1 – Physicians' costs determined on Worksheet A-1 will flow to this column.

Column 2 – Mid-level professionals' costs identified A-2 should be mapped to the respective cost centers on Worksheet A.

Column 3 – Non-capital equipment and supplies costs related to direct patient care are input in this column. Non-capital equipment would be items such as the purchase of reusable surgical trays, scalpels or other medical equipment whose costs are expensed upon acquisition since they are below the organization's threshold for capitalization. Supplies would be items such as disposable supplies utilized during the treatment of patients (sutures, gauze pads, tape, bandages, needles and syringes, splints, etc.). The source for these costs is the professional organization's accounting records. The source for these costs must be maintained by the professional organization and submitted to HHSC or CMS upon request.

Column 4 – This column is the sum of Columns 1, 2 and 3. If line(s) have been added to the worksheet, it will be necessary to copy the formula in this column from an existing line to the line(s) that were added.

Column 5 – Any reclassification of costs reported on Worksheet A-6 will flow to this column.

Column 6 – This column is the sum of Columns 4 and 5. If line(s) have been added to the worksheet, it will be necessary to copy the formula in this column from an existing line to the line(s) that were added.

Column 7 - Any adjustments of costs reported on Worksheet A-8 will flow to this column. For example, revenue received for National Institute of Health (NIH) grants, to the extent the research activities component is not removed via physician and/or mid-level professional time studies should be reported on this Worksheet.

Column 8 – The indirect costs in this column are computed based on the costs reported in Column 6 multiplied by the indirect cost rate for the professional organization. The indirect cost rate will be determined based on the professional organization's actual indirect costs to its total direct costs (allowable and nonallowable) for the applicable reporting period(s) covered by the UC application. The professional organization's costs per its general ledger for the applicable fiscal period(s) should be used to identify the allowable direct and indirect costs to be used to compute the indirect cost rate. The indirect cost rate should be rounded to two (2) decimal places (e.g. 22.58%). The professional organization must submit its calculation of its indirect cost rate with its UC application.

Allowable indirect costs are defined as costs incurred by the professional organization in support of the physicians' and mid-level professionals' direct patient care services, regardless of the location where these services are performed. Medicare cost finding principles should be used to determine allowable indirect costs. Allowable indirect costs would include, but are not limited to, nurse staff and other support personnel salaries and fringe benefits involved in direct patient care, billing and administrative personnel salaries and fringe benefits related to direct patient care, space costs (building and equipment depreciation or lease, interest, utilities, maintenance, etc.) related to the space utilized to provide care to patients.

Nonallowable indirect costs would include but are not limited to; advertising for the purpose of increasing patient utilization, bad debts related to accounts receivable, gain or loss on the sale of depreciable assets, fines or penalties imposed by local, state or federal government or their agencies. Any fringe benefits cost related to the physicians' and mid-level professionals' compensation costs should be included in Columns 1 and/or 2 of Worksheet A should not be included in the allowable indirect costs. The non-capital equipment and supply costs reported in Column 3 of Worksheet A above should also be excluded from allowable indirect costs.

Total costs would be determined based on the professional organization's total expenses per its general ledger. The following is an illustrative example of the calculation of an indirect cost rate for a professional organization.

UC application reporting period	**10/1/2009 - 9/30/2010**	
Fiscal year end of professional organization	12/31/2009	12/31/2010
Total expenses per the general ledger	25,000,000	28,600,800
Bad Debts	(800,000)	(923,000)
Loss on sale of depreciable assets	(200,000)	(123,000)
N/A Advertising Expenses	(111,000)	(133,000)
Physician and mid-level professional compensation (from Col. 1)	(11,500,700)	(13,600,200)
Non capital equipment and supplies (from Col. 3)	(765,000)	(842,000)
Allowable Direct Expenses	(12,265,700)	(14,442,200)
Allowable indirect costs	11,623,300	12,979,600
Total direct costs	13,376,700	15,621,200
Indirect cost ratio	86.89%	83.09%
Weighted indirect cost ratio	21.72%	62.32%
Allowable indirect cost ratio		84.04%

Column 9 – This column is the total physicians' and mid-level professionals' costs that flow to Worksheet B, Column 1. It is the sum of Columns 6, 7 and 8. If line(s) have been added to the worksheet, it will be necessary to copy the formula in this column from an existing line to the line(s) that were added.

Worksheet A-6

This reclassification worksheet is similar to the Worksheet A-6 in the Hospital 2552 Medicare cost report. It allows for the reclassification of costs between cost centers reported on Worksheet A. Any reclassifications reported on this worksheet will need to be input on Worksheet A, Column 5 in the applicable line.

Worksheet A-8

This adjustments worksheet is similar to the Worksheet A-8 in the Hospital 2552 Medicare cost report. It allows for any required adjustment(s) to the costs reported on Worksheet A (e.g. NIH grant revenue if

research costs are not identified via the time studies). All payments received for services provided to another entity's patients should be offset against the applicable costs. All payments received from another entity to subsidize the care provided to a patient who was referred by the entity should be offset against the applicable costs. Any adjustments reported on this worksheet will need to be input on Worksheet A, Column 7 in the applicable line**.**

Worksheet B

The worksheet calculates the cost-to-charge ratio (CCR) to be utilized in apportioning the physicians' and/or mid-level professionals' compensation costs for services provided to Medicaid and Uninsured patients that is the basis for the determination of the professional organization's distribution from the UC Physician Pool. The CCR is carried out to six (6) decimal places.

Column 1 – The net physicians' and mid-level professionals' costs from Worksheet A, Column 8 will flow to this column.

Column 2 – The physicians' and/or mid-level professionals' total billed charges are reported in this column. As an alternative, the professional organization can use the number of visits as the allocation basis to apportion the costs. If the professional organization does elect to utilize patient visits to apportion the costs, the allocation basis reported at the top of this column should be changed from Total Billed Charges to Patient Visits. For either allocation basis, the source for this data will be the professional organization's internal records and will be representative of costs incurred in the period October 1 to September 30 two years prior to the demonstration year for which UC payments are being determined.

For purposes of the UC Application, a visit is defined as a face-to-face encounter between a patient and a physician and/or mid-level professional. Multiple encounters with the same physician and/or mid-level professional that take place on the same day and at a single location for the same diagnosis constitute a single visit. More than one visit may be counted on the same day (which may be at a different location) in either of the following situations:

a) When the patient, after the first visit, suffers illness or injury requiring another diagnosis or treatment, two visits may be counted.
b) When the patient is seen by a dentist and sees a physician and/or mid-level professional, two visits may be counted.

Column 3 – The CCR is computed by dividing the costs reported in Column 1 of this worksheet by the total allocation basis reported in Column 2 of this worksheet. The CCR is carried out to six (6) decimal places.

Worksheet D

This worksheet computes the physicians' and/or mid-level professionals' costs for services provided to Medicaid FFS, Medicaid HMO and Uninsured patients. It utilizes the CCR determined on Worksheet B, Column 3 and the charges for physician and/or mid-level professional services. The source for the Medicaid FFS, Medicaid HMO and Uninsured data are the professional organization's internal records and will be representative of costs incurred in the period October 1 to September 30 two years prior to the demonstration year for which UC payments are being determined. The allocation basis reported on Worksheet B Column 2 must be the same as the apportionment basis reported on Worksheet D, Columns

2 – 3. If the professional organization elects to utilize patient visits to apportion the costs rather than billed charges, the apportionment basis at the top of Columns 2 – 3 should be changed from Billed Charges to Patient Visits.

Column 1 – The CCR from Worksheet B, Column 3 flows to this column.

Columns 2 – 3 – The physicians' and mid-level professionals' costs for inpatient and outpatient services provided to uninsured charity care patients are computed by multiplying the CCR reported in Column 1 multiplied by the apportionment statistics reported in Columns 2 – 3 for the respective columns.

The total costs for each column are determined at the bottom of the worksheet. All revenues received from any source related to the physician and/or mid-level professional services provided to uninsured charity care patients should be reported on the Less Payments line at the bottom of the worksheet in the respective column.

The Net Unreimbursed Cost for Columns 4 and 5 flows to the Cost Summary worksheet of the TXPUC tool. This cost will be utilized to determine the professional organization's distribution from the UC Physician Pool.

Reconciliation of UC Payments to Professional Organizations

As explained above, the professional organization's UC payments are determined using the TXPUC that captures data for the fiscal period October 1 through September 30 two years before the demonstration year. In compliance with STC 33, HHSC reconciles the UC payments made in prior demonstration years to ensure that the professional organization's payments did not exceed its actual eligible uncompensated costs incurred during that demonstration year. Payments in excess of actual eligible uncompensated costs are considered an overpayment to the hospital and will be recouped.

The UC payments are reconciled using data on the professional organization's TXPUC for the demonstration year two years after the year the payments were made. Once the TXPUC for the expenditure year has been finalized by the State, a reconciliation of the finalized costs to all UC payments made for the same period will be performed.

If, at the end of the reconciliation process, it is determined that a professional organization received an overpayment, the amount of the overpayment will be recouped from the provider and may be redistributed to professional organizations that were determined to be underpaid (in proportion to the amount of each professional organization's underpayment) or the federal portion of the overpayment will be properly credited to the federal government through an adjustment shown on the CMS-64.

The timelines for the submission of reconciliations are detailed in the "Section 1115 Waiver UCC Program Reconciliation Schedule" below.

Section 1115 Waiver UC Program Reconciliation Schedule

HHSC will complete the reconciliation process for hospitals and professional organizations no later than December 31 of the calendar year that is three years after the demonstration year. For example, for DY 9 (October 1, 2019, to September 30, 2020) the reconciliation process should be completed by December 31, 2023. (This is the same timeline required by CMS for completion of the federally-required DSH

audit.) HHSC will comply with federal requirements for completing the process of recouping and redistributing the overpaid amounts or crediting the federal share through an adjustment on the CMS 64.

Part 3: Government Dental Providers

General:

Governmentally owned dental providers are eligible to participate in the supplemental payment program if they are directly funded by a local government, hospital authority, hospital district, city, county or state as specified in 42 CFR § 433.50 (i) which describes a unit of government. This would include providers such as public health clinics and departments, dental schools, mobile dental units or other dental facilities that are owned by the government. Providers wanting to participate in the program should contact the Texas Health and Human Services Commission (HHSC), Rate Analysis Department at 512-730-7401.

The Dental Services Supplemental Payment Cost Report (cost report) must be prepared and completed on an annual basis. Cost reports are due to HHSC 180 days after the close of the applicable reporting period. An eligible provider who has been approved to submit a cost report for supplemental payment will prepare the cost report, attest to and certify the total actual and charity charges and costs/expenditures. The completed cost report will be sent to:

HHSC Provider Finance Department
North Austin Complex
4601 W Guadalupe St.
Mail Code H-400
Austin, Texas 78751

When using the Excel spreadsheet, many fields in the exhibits will automatically populate with information from another worksheet to avoid additional data entry and reduce errors. Therefore, only the **SHADED AREAS** of the cost report are to be completed. Please review and verify the accuracy of all information on the exhibits before completing the report.

For questions on completing the cost report, please contact the Health and Human Services Commission, Rate Analysis Department at 512-730-7401.

Definitions:

Charity Care - Charges or costs associated with provision of services to individuals under the provider's charity care policies that do not establish any amounts owed by the patient and do not include bad debt, payment shortfall(s), insurance allowances, courtesy allowances, or discounts given to patients who do not meet the provider's charity care policy or financial assistance policy

Cognizant agency - the agency responsible for reviewing, negotiating, and approving cost allocation plans or indirect cost proposals developed in accordance with the Office of Management and Budget Circular A-87.

Commercial Pay Insurance - health insurance that covers medical expenses and disability income for the insured. Commercial health insurance can be categorized according to its renewal provisions and type of medical benefits provided. Commercial policies can be sold individually or as part of a group plan.

Cost Allocation Plans - are the means by which costs are identified in a logical and systematic manner for reimbursement under federal grants and agreements.

Cost-to-charge-ratio (CCR) - a provider's reported costs are allocated to the Medicaid program based on

a cost-to-billed-charge ratio. Cost-to- billed charge ratio is calculated as total allowable cost reported for the service period divided by total billed charges for the service period. This ratio is then applied to total billed charges associated with charity claims to calculate total allowable billed costs for the cost report. The CCR is carried out to six (6) decimal places.

Direct Cost - means any cost which is identified specifically with a particular final cost objective. Direct costs are not limited to items which are incorporated in the end product as material or labor. Costs identified specifically with a contract are direct costs of that contract. All costs identified specifically with other final cost objectives of the contractor are direct costs of those cost objectives.

Federal Medical Assistance Percentage (FMAP) - the share of state Medicaid benefit costs paid for by the federal government.

Indirect Costs - cost incurred and identified with having two or more cost objectives but not specifically identified with any final cost objective.

Indirect Cost Rate - a device for determining in a reasonable manner the proportion of indirect costs each program should bear. It is the ratio, expressed as a percentage, of the indirect costs to the direct costs.

Intergovernmental Transfers (IGT) - State and local funds derived from taxes, assessments, levies, investments, and other public revenues within the sole and unrestricted control of a governmental entity and eligible for federal match under the 1115 Transformation Waiver. This does not include gifts, grants, trusts, or donations, the use of which is conditioned on supplying a benefit solely to the donor or grantor of the funds.

Medicare - a federal system of health insurance for those who are 65 and older, disabled or have permanent kidney failure.

Self-Pay - an individual who either does not have insurance or her/his insurance does not cover a particular procedure or provider and therefore, the individual is responsible for paying the provider.

Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver - the vehicle approved by HHSC and CMS for implementation of the waiver program under section 1115 of the Social Security Act.

Uninsured - an individual who has no health insurance or other source of third-party coverage for medical/health services.

Uninsured cost - the cost to provide dental services to uninsured patients as defined by the Centers for Medicare and Medicaid Services. An individual whose third-party coverage does not include the service provided is considered by HHSC to be uninsured for that service.

Unit of government - a state, city, county, special purpose district or other governmental unit in the State that: has taxing authority, has direct access to tax revenues, is a State university teaching hospital with

direct appropriations from the State treasury, or is an Indian tribe as defined in Section 4 of the Indian Self-Determination and Education Assistance Act, as amended (25 U.S.C. 450b).

Exhibit 1: Cover Page

Exhibit 1 is the cost report cover page. This form includes a provider's national and state provider identification numbers. Each governmental provider enters its legal name and the appropriate contact information for all parties listed on the form. This information will be used by HHSC to contact the provider during the cost reconciliation and settlement process.

DIRECTIONS TO COMPLETE EXHIBIT 1

Federal Fiscal Year: Enter the federal fiscal year for which the cost report will be completed (e.g., 2012). When this is entered on the cover page, this field will automatically transfer to subsequent exhibits.

Reporting Period: Enter the actual reporting period for which the cost report will be completed (e.g., 10/01/11 to 09/30/12). When this is entered on the cover page, this field will automatically transfer to subsequent exhibits.

Texas Provider Identification Number (TPI): Enter the 9-digit TPI number for the provider that is completing the cost report. When this is entered on the cover page, this field will automatically transfer to subsequent exhibits.

National Provider Identification Number (NPI): Enter the 10-digit NPI number for the provider that is completing the cost report. When this is entered on the cover page, this field will automatically transfer to subsequent exhibits.

Provider Information

Provider Name: Enter the provider's legal name (e.g., Laredo Health Department Dental Clinic)

Provider Contact Name: Enter the provider's contact

Street Address: Enter the street address and also include the city, state, and zip code in this field.

Mailing Address: Enter the mailing address and also include the city, state, and zip code in this field.

Phone Number: Enter the phone number of the provider's contact.

Fax Number: Enter the fax number of the provider's contact.

Email: Enter the email of the provider's contact.

Chief Financial Officer / Business Manager

Name: Enter the name of the chief financial officer or business manager.

Title: Enter the title of the chief financial officer or business manager.

Business Name: Enter the business name (e.g. UT Health Science Center at San Antonio Dental School).

Mailing Address: Enter the mailing address and also include the city, state, and zip code in this field.

Phone Number: Enter the phone number of the chief financial officer or business manager.

Fax Number: Enter the fax number of the chief financial officer or business manager.

Email: Enter the email of the chief financial officer or business manager.

Report Preparer Identification
Name: Enter the name of the person responsible for preparing the cost report (this is the person HHSC should contact if there are questions).

Title: Enter the title of the report preparer.
Business Name: Enter the business name (e.g. UT Health Science Center at San Antonio Dental School).

Mailing Address: Enter the mailing address and also include the city, state, and zip code in this field.

Phone Number: Enter the phone number of the report preparer.

Fax Number: Enter the fax number of the report preparer.

Email: Enter the email of the report preparer.

Location of Accounting Records that Support this Report. Enter the Physical Address of the location where the provider maintains the accounting records that support the cost report and include the city, state, and zip code in this field. When this is entered on the cover page, this field will automatically transfer to the subsequent exhibits.

Exhibit 2: General and Statistical Information

Directions To Complete Exhibit 2
Exhibit 2 is the General and Statistical Information page of the cost report. This exhibit includes general provider and statistical information used in the cost report.

General Provider Information
1.00-1.03: These fields will automatically transfer from the Exhibit 1.

1.04 : Enter either yes or no to indicate if the reporting period is less than a full federal fiscal year. If the cost report is being prepared for a partial fiscal quarter, enter a response that explains the reason why (e.g., no, Supplemental Payment Request Approval was effective beginning 3/1/20XX).

Cost Allocation Information
The purpose of this section is to obtain summary information regarding the cost allocation methodology the governmental entity utilized to allocate costs to various programs, grants, contracts and agreements. Additional information required to support an agency's methodology will be found on Exhibit 7 Worksheet C.

1.05 : Enter either yes or no to indicate whether your agency has an approved Cost Allocation Plan (CAP). Additional information must be provided on Exhibit 7 Worksheet C.

1.06 : If the answer to 1.05 is yes, enter the name of the Cognizant Agency.

1.07 : Enter yes or no to indicate whether your agency has an approved Indirect Cost Rate (IDCR).

1.08: If the answer to 1.07 is yes, enter the name of the Cognizant Agency.

1.09: Enter either yes or no to indicate whether your agency will be using an IDCR on this report.

1.10: If the answer to 1.09 is yes, enter the IDCR Statistical Information.

1.11 : Charity Care Charges Amount: Enter the total charges associated with charity care provided during the cost report period.

1.12 : Charity Care Reimbursement: Enter the total payments received associated with the charity care charges reported on line 1.11.

1.13 : Total Allowable Costs for Reporting Period: This field will automatically transfer from Exhibit 3 – Dental Cost Settlement, 2.40).

1.14 : Total Billed Charges: This field will automatically add the total charges for the cost report year.

Exhibit 3: Dental Cost Settlement

Directions To Complete EXHIBIT 3

Exhibit 3 identifies and summarizes all dental services costs. Much of the information contained within this exhibit is automatically populated from other exhibits; however, there are unique items of cost that must be entered in this exhibit.

Only allocable expenditures related to Uncompensated Charity Care as defined and approved in the Texas Healthcare Transformation and Quality Improvement 1115 Waiver Program will be included for supplemental payment.

Direct cost methods must be used whenever reasonably possible. Direct costing means that allowable costs, direct or indirect, incurred for the benefit of, or directly attributable to, a specific business component must be directly charged to that particular business component. Direct cost accounting may include:

1. Dedicated Cost Centers: Cost may be included for those cost centers that are solely dedicated to Uncompensated Charity Care.
2. Multiple Cost Centers: Cost may be included for those cost centers that are not solely dedicated to Uncompensated Charity Care. However, the provider must submit a detailed approved Cost Allocation Plan (CAP). If cost allocation is necessary for cost-reporting purposes, governmental providers must use reasonable methods of allocation and must be consistent in their use of allocation methods for cost-reporting purposes across all program areas and business entities. The allocation method should be a reasonable reflection of the actual business operations. Allocation methods that do not reasonably reflect the actual business operations and resources expended toward each unique business entity are not acceptable. Allocated costs are adjusted if HHSC considers the allocation method to be unreasonable. The provider must submit a detailed summary of their cost allocation methodology including a description of the components, the formula for calculating the percentage and any additional supporting documentation as required by HHSC. Supplemental schedules must also be attached to the cost report listing each

employee, job title, total salary and benefits, the applicable allocation percentage and the allocation amount that will be included in the cost report. The amounts from the supplemental schedule allocated to the Medicaid and Uncompensated Care programs should match the amounts entered on Exhibit 6 Worksheet B with additional detail entered on Exhibit 7 Worksheet C.

If Indirect Cost (IDC) is included, that amount should be listed in line 2.30 (Other) with the detail described in either the Explanation Box or as a separate attachment. Indirect cost is calculated by multiplying the **Total Allowable** costs by the provider's approved indirect cost rate. IDCR detail should include the methodology for determining the IDCR, the percentage and amount of the IDCR and if the dental provider is already using the IDCR to claim cost on another report. If IDCR costs are claimed in line 2.30, indirect or administrative costs cannot also be claimed as non-clinical cost in lines 2.26 a., 2.27 a. or in administrative salaries and compensation in Exhibit 6 (Worksheet B). IDCR costs may be disallowed if it is determined that the provider has already claimed those same IDCR costs on this or another report. Additional detail regarding an agency's IDCR must be provided on Exhibit 7 Worksheet C.

This exhibit sums the payroll expenses and adds other costs to calculate the total cost of dental services. Identified reductions, either from Exhibit 6 or entered manually with descriptions in the Explanation Box, are subtracted to calculate the adjusted amount of dental costs allowable as part of the cost report. The cost report identifies the portion of allowable costs that are related to Charity Care and applies the cost-to-charge-ratio applicable for the cost report period. This ratio is applied to billed charges associated with Uncompensated Charity Care billed charges resulting in the total computable amount for dental services. This amount is then reduced by any reimbursement received for Uncompensated Charity Care. The resulting amount is then multiplied by the applicable federal medical assistance percentage (FMAP) to calculate the Federal and non-federal share amounts. The exhibit is separated into the sections identifying:

Personnel/Payroll Expenses
2.00-2.21: If using hours as an allocation method enter the number of hours. Total paid hours include but are not limited to regular wage, sick and vacation hours. If personnel/payroll expenditure data is entered on Exhibit 6 – Worksheet B – Payroll and Benefits, those costs will automatically transfer to this exhibit.

2.22 : State Unemployment Payroll Taxes: Enter the total (if applicable).

2.23 : Federal Unemployment Payroll Taxes: Enter the total (if applicable).

2.24 : Unemployment Compensation (Reimbursing Employer): Enter the total (if applicable).

2.25 : Total Staff Costs: Will automatically calculate (sum of applicable items in 2.00-2.24).

Other Costs
2.26 : Supplies and Materials: Supplies and materials include but are not limited to dental and medical supplies, office supplies, and maintenance supplies. Supplies and materials must be separated according to whether they are non-clinical or clinical. The total for non-clinical supplies and materials would be entered on 2.26 a. and the total for clinical supplies and materials would be entered on 2.26 b. Detail describing the supplies and materials along with the amount and allocation methodology should be entered in the Explanation Box or attached as a separate sheet. If a cognizant-agency- approved indirect cost rate is used, additional administrative (non-clinical) cost will not be permitted.

2.27 : Equipment: Equipment costs include but are not limited to dental and medical equipment, computers and communication equipment. Equipment costs must be separated according to whether they

are non-clinical or clinical. The total for non-clinical equipment would be entered on 2.27 a. and the total for clinical equipment would be entered on 2.27 b. Details describing the equipment costs along with the amount and allocation methodology should be entered in the Explanation Box or attached as a separate sheet. If a cognizant-agency-approved indirect cost rate is used, additional administrative (non-clinical) cost will not be permitted. If equipment and depreciation costs are already claimed as indirect costs or through the cost allocation plan, such costs cannot be claimed again in this section.

2.28 : Support Services: Enter the total and provide detail in the Explanation Box. Support services expenditures may include personnel and non-personnel expenditures such as information technology salaries and benefits and operating expenditures.

2.29 : Depreciation: Depreciation information should first be entered on Exhibit 5 – Schedule A – Depreciation and those costs will automatically transfer to this line. If equipment and depreciation costs are already claimed as indirect costs or through the cost allocation plan, such costs cannot be claimed again in this section.

2.30 : Other: Enter the total and provide detail in the Explanation Box.

2.31 : Total Direct and Indirect Dental Other Costs: Will automatically calculate (sum of 2.26 through 2.30).

2.32 : Total Staff, Direct and Indirect Dental Other Costs: Will automatically calculate (sum of 2.25 and 2.31).

Reductions

2.33 : Other Federal Funds and Grants: If expenditure data is entered on Exhibit 6 – Worksheet B Payroll and Benefits, those costs will automatically transfer to this line.

2.34 : Other: Enter the total and provide detail in the Explanation Box.

2.35 : Total Reductions: Will automatically calculate (sum of 2.33 and 2.34).

Cost Settlement Calculation

2.40 : Total Allowable Costs: Will automatically calculate (2.32 less 2.35).

2.41 : Total Billed Charges: This field will automatically transfer from Exhibit 2 – General & Statistical, 1.19.

2.42 : Cost-to-Charge-Ratio (CCR) = Total Allowable Costs/Total Billed Charges: Will automatically calculate (2.40 divided by 2.41) The CCR is carried out to six (6) decimal places.

2.43 : Total Billed Charges Associated with Charity Care: This field will automatically transfer from Exhibit 2 – General & Statistical, (sum of 1.06 and1.08).

2.44 : Charity Care Cost = CCR * Total Billed Charges Associated with Uncompensated Charity Care: Will automatically calculate (2.42 multiplied by 2.43).

2.45 : 2.46: Charity Care Reimbursement: Any reimbursement received for providing services to individuals under Charity Care.

2.47 : Settlement Amount = Total Uncompensated Charity Care Charges minus payments associated with Uncompensated Charity Care: Will automatically calculate 2.45 minus 2.46

2.48 : FMAP (Federal Medical Assistance Percentage): HHSC will enter the correct FMAP.

2.49 : Federal Funds = Settlement Amount * FMAP: Will automatically calculate (2.47 multiplied by 2.48).

2.50 : Non- Federal Share Funds (IGT Amount): Will automatically calculate 2.47 less 2.49). Governmental entities are required to certify on Exhibit 4 Cost Report Certification that they have completed the appropriate documentation required by HHSC and the Texas Comptroller's Office regarding the Intergovernmental Transfer (IGT) process. Once the cost report has been reviewed and accepted by HHSC, the provider will be notified of the amount required for the IGT.

Exhibit 4 – Cost Report Certification

Directions To Complete EXHIBIT 4
Exhibit 4 is the certification of costs included in the cost report. This form attests to and certifies the accuracy of the financial information contained within the cost report and that the report was prepared in accordance with State and Federal audit and cost principle standards. The signer is also certifying that the expenditures included in this cost report have not been claimed on any other cost report.

Most of the information in Exhibit 4 will be updated automatically with information from previous exhibits. This exhibit must be signed and included **UPON COMPLETION OF ALL OTHER EXHIBITS**.

Upon completion of all other exhibits in the cost report, please have the appropriate person read and sign the form. **Scan and include the signed page from Exhibit 4** when sending the electronic version of the cost report to HHSC.

Signature Authority/Certifying Signature
Printed/Typed Name of Signer: Enter the name of the person that will be certifying the costs identified in the cost report.

Title of Signer: Enter the title of the signer.

Name of Provider: Enter the name of the Provider.

Address of Signer: Enter the address of the signer.

Phone Number: Enter the phone number of the signer.

Fax Number: Enter the fax number of the signer.

Email: Enter the email of the signer.

Signature of Signer and Date: The signer should sign and date the form.

Exhibit 5 – Schedule A - Depreciation

Directions To Complete EXHIBIT 5
Exhibit 5 identifies allowable depreciation expenses incurred by the provider. This exhibit will identify all depreciable assets for which there was a depreciation expense during the Cost Report period. Information on this exhibit must come from a depreciation schedule maintained by the provider in accordance with straight line depreciation guidelines.

Vehicles, Equipment, Building, Etc.

For depreciation expenses, the straight line method should be used.

Asset Description: Enter the name and description of the asset. If there is the need to add additional lines, please do so.

Month/Year Placed in Service: Enter the month/year placed in service as identified on the provider's depreciation schedule.

Years Useful Life: Enter the number of years of useful life of the asset.

Cost: Enter the amount of initial cost.

Prior Period Accumulated Depreciation: Enter the amount of prior period accumulated depreciation.

Depreciation for Reporting Period: Enter the amount of current period depreciation expense.

Years Useful Life: Enter the number of years of useful life of the asset as identified on the provider's depreciation schedule (e.g., 20 for twenty years of useful life).

Cost: Enter the amount of initial cost of the asset as identified on the provider's depreciation schedule.

Prior Period Accumulated Depreciation plus Depreciation for Reporting Period cannot exceed the total cost of an asset. In addition, assets that have been fully expensed should not be reported. For depreciation expense related to buildings where the provider's vehicles or staff is housed with other agencies or entities, **ONLY the portion related to the provider** may be reported. If this is the case, the provider must attach a supplemental page showing how the portion of the building related to the provider was calculated. If equipment and depreciation costs are already claimed as indirect costs or through the cost allocation plan, such costs cannot be claimed again in this section.

Exhibit 6 – Worksheet B – Payroll and Benefits

Directions To Complete EXHIBIT 6

Exhibit 6 includes the salary and benefits, and appropriate reductions for contract and employed staff related to the provision of dental services. Salary and compensation must be reported on a direct charge basis. This exhibit includes several pre-populated staffing classifications for which information will need to be completed. If these costs are already claimed as indirect costs or through the cost allocation plan, such costs cannot be claimed again in this section. These pre-populated classifications include:

Director: salary and benefit expenditures related to developing, administration, and overall operational effectiveness of the organization including strategic planning, leadership and oversight, including but not limited to:

- Director
- Director's Assistant

Dental Director: salary and benefit expenditures related to planning, developing, scheduling, and the implementation of dental program services and activities, including but not limited to:

- Dental Director
- Dental Director's Assistant

Dentists and Dental Assistants: salary and benefit expenditures related to dental care including but not limited to:

- Dentists
- Dental Assistants

Safety Officer:

- Safety Officer
- Safety Officer Assistants

Billing Account Representatives: salary and benefit expenditures related to verification of patients' insurance coverage, including Medicaid, collection of third party insurance submissions and payments, and patient service related tasks, including but not limited to:

- Billing Representatives
- Account Representatives
- Patient Account Representative

Quality Assurance Technicians: salary and benefit expenditures related to analyzing performance and quality improvement program including but not limited to:

- Quality Assurance Technicians

For each employee, the following information must be included:

Employee Information

Employee #: Enter the employee #.

Last Name: Enter the last name.

First Name: Enter the first name.

Job Title/ Credentials: Enter the job title/credentials.

Employee (E) /Contractor (C): Enter the appropriate designation, either an E or a C, for the employee.

Payroll and Benefits

Gross Salary: Enter the gross salary amount.

Contractor Payments: Enter the amount of contractor payments for the employee.

Employee Benefits: Enter the amount. This includes all benefits that are not discretely identified in Columns J-L of this exhibit.

Employer Retirement: Enter the amount.

FICA: Enter the amount of FICA.

Medicare Payroll Taxes: Enter the amount.

Federal Funding Reductions
This section of the exhibit is designed to identify the federal funding, or other payroll and benefit expenditure reduction necessary for the specific job classifications identified above. This section of the exhibit is also designed to discretely identify the payroll and benefit expenditures for any individual employee/contractor that must have a portion of their salary and/or benefits reduced from allowable expenditures on the Cost Report. For each of the job classifications identified above, the following information must be included:

Allocated Funded Positions Entry: Enter the appropriate designation, either yes or no, for the employee for which a portion of their salary and/or benefits must be reduced from the total allowable costs. A yes in this field designates an employee for which a portion or all of their salary and benefit expenditures are funded by federal funds or grants. A "no" in this field designates an employee whose entire salary or a portion of whose salary and benefit expenditures are not funded by federal funds or grants, but whose costs still need to be removed from allowable expenditures as reported on the Cost Report.

Federal Funding: If the answer to the field previously is yes, then enter the amount of federal funding related to the employee's salary and benefits that must be reduced from the total allowable costs.

Other Funds: Enter the other amount to be removed related to the employee's salary and benefits that must be reduced from the total allowable costs.

Total Reduction: Will automatically calculate (sum of federal funding and other funds).

Exhibit 7 – Worksheet C – Cost Allocation Methodologies

Directions To Complete EXHIBIT 7
Exhibit 7 details the cost allocation methodologies employed by the governmental entity.

a. If you entered "yes" on Exhibit 2, Line 1.05, please provide a copy of your agency's approved Cost Allocation Plan (CAP).
b. If you entered "yes" on Exhibit 2, Line 1.06 and 1.09, please provide a copy of your agency's approved Indirect Cost Rate (IDCR).
c. If you do not have an approved CAP or IDCR but are using another cost allocation methodology, please provide a copy of your methodology and the supporting documentation.
d. Please provide a list of personnel cost worksheets that support your CAP or IDCR.

Attachment H
UC Payment Protocol

Appendix A - List of Participating Providers

University of Texas at San Antonio Health Science Center (UTHSC-SA) Dental School: performs the patient billing activities for the dental school, the mobile dental unit, the Ricardo Salinas Dental Clinic and the Laredo Health Department Dental Clinic.

Houston Health Department Dental Clinic

Part 4: Government Ambulance Providers

General

Governmentally owned ambulance providers are eligible to participate in the supplemental payment program if they are directly funded by a local government, hospital authority, hospital district, city, county or state as specified in 42 CFR § 433.50 (i) which describes a unit of government, and must have a developed charity care policy that does not include bad debt, payment shortfall(s), insurance allowances, courtesy allowances, or discounts given to patients who do not meet the provider's charity care policy or financial assistance policy. Failure to have a formal charity care policy will result in being ineligible for any UC payment. This would include providers such as public health clinics and departments.

The cost report will include only allocable expenditures related to charity care as defined and approved in the Texas Healthcare Transformation and Quality Improvement 1115 Waiver Program.

The Ambulance Services Supplemental Payment Cost Report (cost report) must be prepared and completed by a governmental entity on an annual basis. Cost reports are due to HHSC 180 days after the close of the applicable reporting period. A provider who meets the definition of eligible governmental provider and who has been approved to submit a cost report for supplemental payment will prepare the cost report and will attest to, and certify through its cost report the total actual, incurred charity costs/expenditures, including the federal share and the non-federal share applicable to the cost report period. The completed cost report will be sent to the Texas HHSC at

HHSC Provider Finance Department
North Austin Complex
4601 W Guadalupe St
Mail Code H-400
Austin, TX 78751

When using the Excel spreadsheet, many fields in the pages will automatically populate with information from another worksheet to avoid additional data entry and reduce errors. For the cost report to be accurate, only the **SHADED AREAS** of the cost report are to be completed. Please review and verify the accuracy of all information on the pages before completing the report.
For questions on completing the cost report, please contact the Health and Human Services Commission, Provider Finance Department at 512-424-6930.

Definitions:

Ambulance Allocation Statistic – an allocation percentage that is calculated by taking total ambulance services time divided by total ambulance and fire and emergency department time during the data period to allocate ambulance specific costs in situations when there are joint ambulance and fire and emergency department costs.

Charity Care - charges or costs associated with provision of services to individuals under the provider's charity care policies that does not include bad debt, payment shortfall(s), insurance allowances, courtesy allowances, or discounts given to patients who do not meet the provider's charity care policy or financial assistance policy.

Cognizant agency – agency responsible for reviewing, negotiating, and approving cost allocation plans or indirect cost proposals developed in accordance with the Office of Management and Budget Circular A-87.

Cost Allocation Plans – are how costs are identified in a logical and systematic manner for reimbursement under federal grants and agreements. The purpose of the Cost Allocation Plan is to ensure costs benefiting multiple fund sources (including Federal, State, and Entity) are distributed fairly among each fund source based on the benefits received.

Cost-to-charge ratio – a provider's reported costs are allocated to the Medicaid program based on a cost-to-billed-charge ratio. Cost-to-billed-charge ratio is calculated as total allowable cost reported for the service period divided by total billed charges for the service period. This ratio is applied to total charity charges to calculate total computable charity costs for the cost report.

County/City Indigent Programs – programs that help low-income residents who do not qualify for other state or federal health care programs to get access to health care services.

Direct Cost – means any cost which is identified specifically with a particular final cost objective. Direct costs are not limited to items which are incorporated in the end product as material or labor. Costs identified specifically with a contract are direct costs of that contract. All costs identified specifically with other final cost objectives of the contractor are direct costs of those cost objectives.

Direct Medical Services-health care provided by a licensed or certified provider to a patient.

Direct Medical Utilization Percentage – an allocation percentage that is calculated by taking the sum of direct medical services time during the data period divided by total Ambulance time during the data period. The calculation must be supported by verifiable computer-aided dispatch (CAD) or time studies data.

Federal Medical Assistance Participation (FMAP) Rate – is the share of state Medicaid benefit costs paid for by the federal government.

Indirect Costs – costs incurred and identified with having two or more cost objectives but not specifically identified with any final cost objective. Examples of indirect costs are accounting and legal expenses, administrative salaries, office expenses, rent, security expenses, telephone expenses, and utilities.

Indirect Cost Rate – is a device for determining in a reasonable manner the proportion of indirect costs each program should bear. It is the ratio, expressed as a percentage, of the indirect costs to the direct costs.

Modified Total Direct Cost – means all direct salaries and wages, applicable fringe benefits, materials and supplies, services, travel, and subawards and subcontracts up to the first $25,000 of each subaward or subcontract (regardless of the period of performance of the subawards and subcontracts under the award). MTDC excludes equipment, capital expenditures, charges for patient care, rental costs, tuition remission, scholarships and fellowships, participant support costs and the portion of each subaward and subcontract in excess of $25,000. Other items may only be excluded when necessary to avoid a serious inequity in the distribution of indirect costs, and with the approval of the cognizant agency for indirect costs in accordance with CFR § 200.68 .

Uninsured – an individual who has no health insurance or other source of third-party coverage for medical/health services.

Uninsured cost – the cost to provide ambulance services to uninsured patients as defined by the Centers for Medicare and Medicaid Services (CMS). An individual whose third-party coverage does not include the service provided is considered by HHSC to be uninsured for that service. Ambulance providers treat costs of uninsured patients (less any payments received) as charity costs.

Medicare – A federal system of health insurance for people over 65 years of age and for certain younger people with disabilities.

Other third-party coverage

Commercial Pay Insurance – health insurance that reimburses medical expenses and disability income for the insured. Commercial health insurance can be categorized according to its renewal provisions and type of medical benefits provided. Commercial policies can be sold individually or as part of a group plan.

Self-Pay - patient pays in full at the time of visit for our services. Ambulance providers are not required to file claim or submit any documentation on his/her behalf to a third party.

Unit of Government - a state, city, county, special purpose district or other governmental unit in the State that: has taxing authority, has direct access to tax revenues, is a State university teaching hospital with direct appropriations from the State treasury, or is an Indian tribe as defined in Section 4 of the Indian Self-Determination and Education Assistance Act, as amended (25 U.S.C. 450b).

Exhibit A: Cost Report Cover Page

Exhibit A is the cost report cover page. This form includes a provider's National and State Provider Identification number. Each governmental provider must enter their entities legal name, name of person responsible for submitting the cost report, the cost preparers name and physical location, mailing address, phone number and fax number of all contacts listed. The information will be used by HHSC to contact the provider as necessary through the cost reconciliation and cost settlement process.

Fiscal Year:	Enter the federal fiscal year for which the cost report will be completed (e.g., 2010).

Reporting Period: Enter the actual reporting period for which the cost report will be completed (e.g., 10/01/10 to 09/30/11).

Texas Provider Identification Number (TPI): Enter the 9-digit TPI number for the provider that is completing the cost report (e.g., 1234567-89).

National Provider Identification Number (NPI): Enter the 10-digit NPI number for the provider that is completing the cost report (e.g., 1234567890).

Provider Information

Provider Legal Name Enter the provider's legal name (e.g., (Health and Human Services Commission EMS). This is the name of the provider completing the cost report.

Street Address: Enter provider street address (e.g., 11209 Metric Blvd., Bldg. H., Austin, TX 78758). Include the city, state, and zip code in this field.

Mailing Address: Enter provider mailing address (e.g., 11209 Metric Blvd., Building H., Austin, Texas 78758 or P.O. Box 85700, Mail Code H-360, Austin, Texas 78708-5200). Include the city, state, and zip code in this field.

Phone Number: Enter the phone number of the provider's contact (e.g., (512) 123-4567).

Fax Number: Enter the fax number of the provider's contact (e.g., (512) 987-6543).

Email Address: Enter the email address of the provider's contact (e.g., iampublic@xyzabc.com).

Business Manager / Financial Director

Business Manager/Financial Directors Name: Enter the name of the business manager or financial director of the provider (e.g., Jane Doe).

Title: Enter the title of the business manager or financial director of the provider identified in the field above (e.g., Director).

Email Address: Enter the email address of the provider's contact (e.g., jqpublic@xyzabc.com).

Report Preparer Identification

Report Preparer Name: Enter the name of the provider's contact or person responsible for preparing the cost report (e.g., Jane Doe). This is the name of the person that HHSC may contact if there are questions.

Title: Enter the title of the provider's contact identified in the field above (e.g., Director).

Location of Accounting Records that Support this Report

Records Location: Enter the physical address of the location where the provider maintains

the accounting records in support of the cost report (e.g., 11209 Metric Blvd., Bldg. H., Austin, Texas 78758). Include the city, state, and zip code in this field.

Exhibit 1: General and Statistical Information

Exhibit 1 is the General and Statistical Information page of the cost report. This exhibit includes general provider information and statistical information used in the cost report.

DIRECTIONS TO COMPLETE EXHIBIT 1

General Provider Information

Reporting Period: Begin Date: Enter the reporting period – beginning date or the beginning date of the cost report period (e.g., 10/1/2010).

Reporting Period: End Date: Enter the reporting period – ending date or the ending date of the cost report period (e.g., 9/30/2011).

Part Year Cost Report: Enter an answer to the question "Is reporting period less than a full year?" This question identifies if the cost report is being prepared for a period that is not an entire fiscal year. If the cost report is for an entire fiscal year (October 1 – September 30), then enter No in the field. If the cost report is being prepared for a partial fiscal year, enter a response that explains the reason why (e.g., Supplemental Payment Request Approval was effective beginning on 7/1/20XX).

Cost Allocation Information

The purpose of this section is to obtain summary information regarding the cost allocation methodology the governmental entity utilized to allocate costs to various programs, grants, contracts and agreements.

Cost Allocation Plan: Enter either Yes or No indicating whether your agency has an approved Cost Allocation Plan (CAP). If the answer is yes, enter the name of the Cognizant Agency that approved the agency CAP in accordance with 45 CFR part 75.

Approved Indirect Cost Rate: Enter either Yes or No indicating whether your agency has an approved Indirect Cost Rate.

Indirect Cost Rate: Enter either Yes or No indicating whether your agency will be utilizing an Indirect Cost Rate. If yes, enter the agency's approved Indirect Cost Rate.

Summary of Payments and Billed Charge Data (Applicable to Cost Report)

Total Uninsured Charity Charges: Enter the total customary/market/commercial charges for individuals that have been classified, meet the requirement and admitted to receive benefit of charity care for the applicable cost report period identified on the form. The ambulance charges for services entered should be for ambulance services approved as charity during the cost report period and must exclude all unfunded Medicaid and Medicare costs and does not include bad

debt, payment shortfall(s), insurance allowances, courtesy allowances, or discounts given to patients who do not meet the provider's charity care policy or financial assistance policy.

Direct Medical Uninsured Charity Charges: (if the amounts differ from the total charity): Enter the total Direct Medical Uninsured Charity Charges for services provided for the applicable cost report period identified on the form if that amount is different from the total charity charges. The ambulance charges for services entered should be for ambulance services approved as charity during the cost report period and must exclude all unfunded Medicaid and Medicare costs and does not include bad debt, payment shortfall(s), insurance allowances, courtesy allowances, or discounts given to patients who do not meet the provider's charity care policy or financial assistance policy.

Charity Reimbursements: Enter the reimbursements received associated with charity charges for the applicable cost report period identified on the form. The total reimbursements received associated with charity charges entered must only be for **dates of service** during the cost report period. In instances where recovery may be made after the cost report year, providers are required to inform HHSC of any uncompensated charity claims that are reimbursed after the cost report submission to determine necessary refund(s). Providers are obligated to make the necessary refunds as a result of recoveries and reimbursements.

Additional Cost Data: (for informational purposes only): In addition to the statistical information entered for cost reporting period, additional cost data is being requested.
Medicare Charges: Enter the total Medicare Charges for services provided for the applicable cost report period identified on the form. The ambulance Medicare costs for services entered should be for dates of service during the cost report period.

Other Third-Party Charges: Enter the total Other Third-Party coverage (Commercial Pay) costs for services provided for the applicable cost report period identified on the form. Third-Party charges should include all incidental charges covered by any outside sources not including indigent programs, Medicare and Medicaid charges. The ambulance "other" costs for services entered should be for dates of service during the cost report period.

Charges for Self-Pay, County/City Indigent Recipient Programs: Enter the amount of Self-Pay, County/City Indigent received by program as previously defined.

Exhibit 2: Direct Medical (Ambulance Services)

Exhibit 2 identifies and summarizes from other exhibits all ambulance services costs within the cost report. Much of the information contained within this exhibit is from either Exhibit 5 or Exhibit 6; however, there are unique items of cost that are identified in this exhibit. **Only allocable expenditures related to Charity Care as defined and approved in the Texas Healthcare Transformation and Quality Improvement 1115 Waiver Program will be included for supplemental payment.** This exhibit sums the personnel expenses and adds additional costs to calculate the total cost of Medical and Uncompensated Care Services.

Direct cost methods must be used whenever reasonably possible. Direct costing means that allowable costs, direct or indirect, incurred for the benefit of, or directly attributable to, a specific business component must be directly charged to that particular business component.

For example, the payroll costs of a direct service employee who works across cost areas within one contracted program would be directly charged to each cost area of that program based upon that employee's continuous daily time sheets and the costs of a direct care employee who works across more than one service delivery area would also be directly charged to each service delivery area based upon that employee's continuous daily time sheets. Health insurance premiums, life insurance premiums, and other employee benefits are applied as direct costs.

Direct costs are defined in accordance with 45 CFR 75.413 and only include Dedicated Direct Services Cost Centers, i.e. Ambulance cost center, which are comprised of a distinctly identifiable department or unit whose costs are associated with providing direct medical services.

Indirect costs are defined in accordance with 45 CFR 75.414 and may include costs benefitting more than one cost objective, and not readily assignable to the cost objectives specifically benefitted Cost Centers which included cost for those cost centers that are not solely dedicated to one activity but may be allocated to multiple activities.

Governmental providers must use reasonable methods of allocation and must be consistent in their use of allocation methods for cost-reporting purposes across all program areas and business entities. The allocation method should be a reasonable reflection of the actual business operations. Allocation methods that do not reasonably reflect the actual business operations and resources expended toward each unique business entity are not acceptable. Allocated costs are adjusted if HHSC considers the allocation method to be unreasonable. The provider must submit a detailed summary of their cost allocation methodology, including a description of the components, the formula for calculating the percentage and any additional supporting documentation as required by HHSC. Supplemental schedules must also be attached to the cost report listing each employee, job title, total salary and benefits, the applicable allocation percentage and the allocation amount that will be included in the cost report. The amounts from the supplemental schedule allocated to the Medicaid and Uncompensated Care programs should match the amounts entered on Exhibit 6 Schedule B with additional detail entered on Exhibit 7, Schedule C. Any change in cost-reporting allocation methods from one year to the next must be fully disclosed by the contracted provider on its cost report.

Indirect Costs Rate

If an Indirect Cost Rate (IDCR) is utilized, that rate must be applied to all appropriate cost objectives specifically identified in the cost report. Indirect cost is calculated by multiplying the Modified Total Direct Costs by the provider's approved indirect cost rate. These indirect rates are developed by the state cognizant agency and are updated annually. The methodology used by the respective cognizant agency to develop the Indirect Cost Rate (IDCR) has been approved by the cognizant federal agency. Indirect costs are included in the claim as reallocated costs. The provider is responsible to ensure that costs included in the cost report not included in the indirect cost rate, and no costs will be accounted for more than once.

All indirect cost calculations developed to arrive at the total allowable costs must be included in Exhibit 7 of the cost report. All scenarios utilized to calculate the indirect cost must be fully explained as well. The provider must verify that no duplicative costs are included in line 2.33

"Other Cost" of Exhibit 2. IDCR costs will be disallowed if it is determined that the provider has already claimed those same IDCR costs. All documents that support the indirect cost rate calculation must be maintained by the approved governmental entity and must be made immediately available upon request by HHSC.

Identified reductions, from Exhibit 6, are subtracted to calculate the adjusted amount of Direct Medical Costs allowable as part of the cost report. The cost report identifies the portion of allowable costs that are related to charity care and the cost to charge ratio applicable for the cost report period. The ratio is applied to billed charges associated with charity care charges resulting in the total computable amount for ambulance services. This amount is then reduced by the amount of any reimbursement received for charity care. The resulting amount is then multiplied by the applicable federal medical assistance percentage (FMAP) to calculate the amount of settlement due to, or owed by (if negative) the provider.

Exhibit 2 is separated into the sections identifying:

- Personnel / Payroll Expenses. This section of the exhibit includes, in part, expenditures from Exhibit 6. If these costs are already claimed as indirect costs or through the cost allocation plan, such costs cannot be claimed again in this section.
- Other Operating Costs. This section of the exhibit includes, in part, expenditures from Exhibit 5. If these costs are already claimed as indirect costs or through the cost allocation plan, such costs cannot be claimed again in this section.
- Reductions to Allowable Costs. This section of the exhibit includes reductions to expenditures identified in Exhibit 6.
- Cost Settlement Calculation. This section applies the cost to charge ratio calculation methodology to arrive at the final settlement due to or from the provider.

DIRECTIONS TO COMPLETE EXHIBIT 2

Personnel / Payroll Expenses

This section of the exhibit includes all personnel related expenditures and hours for the job classifications identified

Hours: The number of hours for each of the job classifications identified in this exhibit and for which costs are identified in Exhibit 6. Hours for this exhibit represent total paid hours that are reported by the provider on their payroll report as those hours relate to direct medical services. Total paid hours include, but are not limited to:

- Regular wage hours
- Sick hours
- Vacation hours

Payroll Taxes/Unemployment Compensation: the amount of the following payroll expenses:

- State Unemployment Payroll Taxes

- Federal Unemployment Payroll Taxes
- Unemployment Compensation (Reimbursing Employer)

Other Costs

This section of the exhibit identifies other operating costs not related to the job classifications identified above. Within this section, Support Services or Other may include personnel-related expenditures not identified in the job classifications in the section above.

All costs identified in the section of the exhibit are supported by supplemental schedules to the cost report and will be supplied at the time of cost report submittal.

Supplies and Materials Costs: Enter the amount of supplies and materials expenditures incurred by the provider during the cost report period, and for both non-medical and medical costs enter the amounts that are directly attributed to direct medical services.

- Medical supplies
- Office supplies
- Maintenance supplies
- Medical materials

Equipment Costs: Enter the total amount of equipment expenditures incurred by the provider during the cost report period. Reporting the total non-medical equipment costs as indirect amounts, and medical costs that are used in the reporting period as direct amounts. Equipment expenditures include, but are not limited to, the following non-depreciable items. If these costs are already claimed as indirect costs or through the cost allocation plan, such costs cannot be claimed again in this section.

- Medical equipment
- Computers
- Radios
- Communications equipment

Support Services Costs: Enter the total amount of Support Services expenditures incurred by the provider during the cost report period and enter the amounts that are directly attributed to direct medical services. Support Services expenditures may include personnel and non-personnel expenditures depending on if the personnel expenditures are represented in the job classification categories identified in this exhibit and detailed in Exhibit 6. Support Services expenditures include, but are not limited to, the following:

- Information technology salaries, benefits, and operating expenditures
- Telecommunications personnel and operating expenditures

Other Costs: Enter the total amount of other expenditures incurred by the provider during the cost report period and enter the amounts that are directly attributed to direct medical services. Other expenditures may include personnel and non-personnel expenditures depending on if the personnel expenditures are represented in the job classification categories identified in this exhibit and detailed in Exhibit 6. Other expenditures include, but are not limited to, the following:

- Depreciation expense (Exhibit 5)
- Parent organization allocated costs (discretely identified from prepared cost allocation plan (CAP))
- Other unit personnel and operating expenditures not otherwise identified (Indirect Cost)

Cost Settlement Calculation

Total Allowable Costs for Period of Service: The Total Allowable Costs entered into the cost report less any "other federal funding" received (No entry is required).

Total Allowable Direct Medical Costs for Period of Service: The Total Allowable Direct Medical Costs entered into the cost report less any "other federal funding" received (No entry is required).

Total Billed Charges for Period of Service: The Total Billed Charges for the applicable period of service (No entry is required).

Total Direct Medical Charges for Period of Service: The Total Direct Medical Charges for the applicable period of service only input if total charges included include non-medical charges.

Cost to Charge Ratio (CCR): The result of dividing a provider's Total Allowable Costs for the reporting period by the providers Total Billed Charges for the same period. The CCR is carried out to six (6) decimal places. The CCR will be monitored and additional support and explanation will be required if exceeding 100%. (No entry is required).

Total Charges Associated with Charity Care less any associated payments: The Total Billed Charges Associated with Charity services for the period applicable to the cost report less any associated payments received (No entry is required).

Total Billed Direct Medical Charges Associated with Charity Care: The Total Billed Direct Medical Charges Associated with Charity services for the period applicable to the cost report. (No entry is required).

Uninsured Charity Care Cost: The total direct medical costs associated with the direct medical charges. This is the result of the calculation of Direct Medical Cost to Charge Ratio multiplied with the allowable uninsured charity charges within the reporting period (No entry is required).

Charity Care Reimbursement: The amount of reimbursement received for charity care provided to patients within the reporting period that are received from any payer that reduce the unpaid balance of the amount entered on **Total Uninsured Charity Charges.** Include all subrogated awards or offsets (enter 0 if none).

Equals Settlement amount: The total Charity Allowable Costs for the period of service applicable to the cost report. This calculation is equal to the **Settlement Amount** for the reporting period (No entry is required).

Federal Medical Assistance Participation Rate (FMAP): The FMAP rate for the appropriate federal fiscal year of the cost report.

Non-Federal share Funds Certification of Public Expenditures (CPE amount): The amount of charges converted to cost associated with direct medical charity costs. This amount is the state share.

Amount due to the Provider: The net amount of the settlement due to or from a provider after the FMAP rate is applied.

Exhibit 3 – Cost Report Certification

Certification of Costs included in the cost report. This form attests to and certifies the accuracy of the financial information contained within the cost report.

DIRECTIONS TO COMPLETE EXHIBIT 3

Most of the information in Exhibit 3 will be updated automatically with information from previous exhibits. This exhibit must be signed and included **UPON COMPLETION OF ALL OTHER EXHIBITS**.

Upon completion of all other exhibits in the cost report, please **print this exhibit, sign the exhibit, have the form notarized, scan the exhibit, and include the signed exhibit** when sending the electronic version of the cost report to HHSC. Please have the appropriate person within the provider read and sign the form.

Signature Authority/Certifying Signature

Certifier Name:	Enter the name of the person that will be certifying the costs identified in the cost report (e.g., Jane Doe).
Title:	Enter the title of signer, or the title of the person that will be certifying the costs identified in the cost report (e.g., Director).
Print:	Please print this exhibit and have the appropriate person identified above sign the certification form.
Date:	Enter the date that the appropriate person identified above signs the certification form (e.g., 1/1/2011).

Signature Authority Check Box: Check the appropriate box that corresponds to the title of the person signing this Exhibit.

Notary: Upon printing and signing this Exhibit, please have this form notarized by a Notary Public.

Exhibit 4 – Certification of Funds

Certification of Public Expenditure that allows the state to use the computable Medicaid expenditures as the non-federal match of expenditures to draw the federal portion of Medicaid funding as identified in the settlement. This form attests to and certifies the accuracy of the provided financial information and that t the report was prepared in accordance with State and Federal audit and cost principal standards and that the costs have not been claimed on any other cost report for federal reimbursement purposes. This exhibit also identifies the amount of local provider expenditure that is allowable for use as the state match.

DIRECTIONS TO COMPLETE EXHIBIT 4

Most of the information in Exhibit 4 will be updated automatically with information from previous exhibits. This exhibit must be signed and included **UPON COMPLETION OF ALL OTHER EXHIBITS**.

Upon completion of all other exhibits in the cost report, please **print this exhibit, sign the exhibit, have the form notarized, scan the exhibit, and include the signed exhibit** when sending the electronic version of the cost report to HHSC. Please have the appropriate person within the provider read and sign the form.

Signature Authority/Certifying Signature

Print	Please print this exhibit and have the appropriate person sign the certification form.
Date:	Enter the date that the appropriate person identified above signs the certification form (e.g., 1/1/2011).
Certifier Name:	Enter the name of signer, or the person that will be certifying the public expenditures identified in the cost report (e.g., Jane Doe).
Title:	Enter the title of signer, or the title of the person that will be certifying the public expenditures identified in the cost report (e.g., Director).
Certifier Check Box	Check the appropriate box that corresponds to the title of the person signing this exhibit. If Other Agent/Representative is selected, please include the appropriate title in Column N, Line 40.
Notarized	Upon printing and signing this exhibit, please have this form notarized by a Notary Public.

Exhibit 5 – Schedule A (Depreciation Schedule)

Depreciation is only available to the assets in Direct Medical provision. Other assets of non-medical entities are not depreciable in consideration of this program. The depreciation schedule

identifies allowable depreciation expenses incurred by the provider related to. This exhibit will identify depreciable assets for which there was a depreciation expense during the cost report period. Information on this exhibit must come from a depreciation schedule maintained by the provider in accordance with appropriate accounting guidelines established by the provider and/or the parent organization of the provider. For depreciation expenses, the straight-line method should be used. Prior Period Accumulated Depreciation plus Depreciation for Reporting Period cannot exceed the total cost of an asset. In addition, assets that have been fully expensed should not be reported. If the asset or portion thereof has been funded by a separate federal agency, that amount must be reduce from the basis of the asset. If these costs are already claimed or through the cost allocation plan, such costs cannot be claimed again in this section.

Assets that serve more than one cost unit must be allocated by cost unit in accordance with 45 CFR 75.405(d) which states that if a cost benefits two or more projects or activities in proportions that can be determined without undue effort or cost, the cost must be allocated to the projects based on the proportional benefit. If a cost benefits two or more projects or activities in proportions that cannot be determined because of the interrelationship of the work involved, then, notwithstanding 45 CFR 75.405(c), the costs may be allocated or transferred to benefitted projects on any reasonable documented basis. Where the purchase of equipment or other capital asset is specifically authorized under a Federal award, the costs are assignable to the Federal award regardless of the use that may be made of the equipment or other capital asset involved when no longer needed for the purpose for which it was originally required.

DIRECTIONS TO COMPLETE EXHIBIT 5

Vehicles. Allowable vehicles are defined to include only vehicles that are used to provide Medicaid services. For depreciation expense related to vehicles, the provider must follow depreciable asset thresholds already in place at the provider and/or parent organization. The vehicle depreciation expense as reported on the cost report must come from the provider's depreciation schedule.

Asset Description:	Enter the description of the asset that will be included in this depreciation schedule. The name or account code, or both will suffice. If there is the need to add additional lines, please do so.
Month/Year Placed in Service:	Enter the month/year placed in service as identified on the provider's depreciation schedule (e.g., January 2000, or 1/2000). This is the month and the year that the depreciable asset was first put into service.
Years Useful Life:	Enter the number of years of useful life of the asset as identified on the provider's depreciation schedule (e.g., 20 for twenty years of useful life).
Cost:	Enter the amount of initial cost of the asset as identified on the provider's depreciation schedule.

Prior Period Accumulated Depreciation: Enter the amount of Prior Period Accumulated

Depreciation related to the asset as identified on the provider's depreciation schedule. This is the total amount of depreciable expenses to date related to the depreciable asset.

Depreciation for Reporting Period: Enter the amount of current period depreciation expense in the Depreciation for Reporting Period field related to the asset as identified on the provider's depreciation schedule. This is the total amount of depreciable expense incurred during the cost report period.

Direct Medical Allocation Statistic: Enter the allocation of ambulance services that the asset is used for direct medical services.

Equipment. For depreciation expense related to equipment, the provider must follow depreciable asset thresholds already in place at the provider and/or parent organization. The equipment depreciation expense as reported on the cost report must come from the provider's depreciation schedule.

Asset Description: Enter the description of the asset that will be included in this depreciation schedule. The name or account code, or both will suffice. If there is the need to add additional lines, please do so.

Month/Year Placed in Service: Enter the month/year placed in service as identified on the provider's depreciation schedule (e.g., January 2000, or 1/2000). This is the month and the year that the depreciable asset was first put into service.

Years Useful Life: Enter the number of years of useful life of the asset as identified on the provider's depreciation schedule (e.g., 20 for twenty years of useful life).

Cost: Enter the amount of initial cost of the asset as identified on the provider's depreciation schedule.

Prior Period Accumulated Depreciation: Enter the amount of Prior Period Accumulated Depreciation related to the asset as identified on the provider's depreciation schedule. This is the total amount of depreciable expenses to date related to the depreciable asset.

Depreciation for Reporting Period: Enter the amount of current period depreciation expense in the Depreciation for Reporting Period field related to the asset as identified on the provider's depreciation schedule. This is the total amount of depreciable expense incurred during the cost report period.

Direct Medical Allocation Statistic: Enter the allocation that the asset is used for direct medical

services.

Building. For depreciation expense related to buildings where the provider's vehicles or staff are housed with other agencies or entities, ONLY the portion related to the provider may be reported. If this is the case, the provider must attach a supplemental exhibit showing how the portion of the building related to the provider was calculated.

Asset Description: Enter the description of the asset that will be included in this depreciation schedule. The name or account code, or both will suffice. If there is the need to add additional lines, please do so.

Month/Year Placed in Service: Enter the month/year placed in service as identified on the provider's depreciation schedule (e.g., January 2000, or 1/2000). This is the month and the year that the depreciable asset was first put into service.

Years of Useful Life: Enter the number of years of useful life of the asset as identified on the provider's depreciation schedule that does not exceed Internal Revenue Service requirements (e.g., 20 for twenty years of useful life).

Cost: Enter the amount of initial cost of the asset as identified on the provider's depreciation schedule.

Prior Period Accumulated Depreciation: Enter the amount of Prior Period Accumulated Depreciation related to the asset as identified on the provider's depreciation schedule. This is the total amount of depreciable expenses to date related to the depreciable asset.

Depreciation for Reporting Period: Enter the amount of current period depreciation expense in the Depreciation for Reporting Period field related to the asset as identified on the provider's depreciation schedule. This is the total amount of depreciable expense incurred during the cost report period.

Ambulance Allocation Statistic: Enter the allocation that the asset is used for ambulance services.

Direct Medical Allocation Statistic: Enter the allocation that the asset is used for direct medical services.

Exhibit 6 – Worksheet B (Payroll and Benefits)

This exhibit includes the salary and benefits, and appropriate reductions related to contracted and employed staff of the provider. For this exhibit, all employed and contracted staff related to the provision of direct medical ambulance EMS services should be identified here. If these costs are already claimed as indirect costs or through the cost allocation plan, such costs cannot be claimed again in this section.

Attachment H
UC Payment Protocol

This exhibit includes several pre-populated staffing classifications for which information will need to be completed. The pre-populated staffing classifications include:

For Direct Costs in the provision of Direct Medical Services:

- **Paramedics:** This cost classification includes all personnel salary and benefit expenditures related to performing basic and advanced medical rescue procedures to access, stabilize, evacuate, and transport a patient to an appropriate medical facility's emergency department, including, but not limited to:
  - Paramedics
  - EMTs
  - …

- **CPR Technicians:** This cost classification includes all personnel salary and benefit expenditures related to the coordination of all EMS activities related to community education of CPR and First Aid skills and techniques, including, but not limited to:
  - CPR Techs
  -

- **Contracted EMT/Paramedics:** This cost classification includes all contracted expenditures related to performing basic and advanced medical rescue procedures to access, stabilize, evacuate, and transport a patient to an appropriate medical facility's emergency department, including, but not limited to:
  - Contracted Paramedics
  - Contracted EMTs
  - …

For Indirect Costs that support the provision of Direct Medical Services:

- **9-1-1 Call Technicians:** This cost classification includes all personnel salary and benefit expenditures related to operation of emergency communications equipment used in receiving, sending, and relaying medical self-help in response to emergency calls, including, but not limited to:
  - 9-1-1 Call Technicians
  - 9-1-1 Call Technician Assistants
  - …
- **Training Coordinators:** This cost classification includes all personnel salary and benefit expenditures related to providing training, quality, operational, and support of specific ambulance service training and organizational programs, including local pre-paramedic institutions, internal paramedic/communications medic instruction, training activities within Field Operations and Communications, and analysis of performance and quality improvement programs, including, but not limited to:
  - Training Coordinators
  - …

- **Quality Assurance Technicians:** Quality Assurance Technicians have the same job

description as training coordinators above. This cost classification includes all personnel salary and benefit expenditures related to providing training, quality, operational, and support of specific ambulance service training and organizational programs, including local pre-paramedic institutions, internal paramedic/communications medic instruction, training activities within Field Operations and Communications, and analysis of performance and quality improvement programs, including, but not limited to:

- Quality Assurance Techs
- …

- **Safety Officer:** This cost classification includes all personnel salary and benefit expenditures related to developing, administering, implementing, and evaluating departmental occupational safety program and activities, including, but not limited to:
  - Safety Officer
  - Safety office assistant
  - …

- **Billing / Account Representatives:** This cost classification includes all personnel salary and benefit expenditures related to verification of patients' insurance coverage, including Medicaid, collection of third-party insurance submissions and payments, and patient customer service-related tasks, including, but not limited to:
  - Billing representative
  - Account representative
  - Patient account representative
  - …

- **Medical Director:** This cost classification includes all personnel salary and benefit expenditures related to the clinical oversight of pre-hospital treatment rendered by EMS personnel. The Medical Director costs shall only include those costs as identified to be related to including, but not limited to:
  - Medical Director
  - Medical Director Assistant
  - …

- **Director:** This cost classification includes all personnel salary and benefit expenditures related to developing, administration, and overall operational effectiveness of the organization including strategic planning, leadership, and oversight of all operational aspects of the EMS Department, including, but not limited to:
  - Director
  - Director's Assistant
  - …

- **Public Information Officer:** This cost classification includes all personnel salary and benefit expenditures related to planning and directing public information, public

relations, media relations, or public involvement programs and developing, maintaining, and improving public awareness initiatives, including, but not limited to:

- Public Information Officer
- PIO Assistant
- …

DIRECTIONS TO COMPLETE EXHIBIT 6

Employee Information

This section of the exhibit is designed to identify employee information for the specific job classifications identified above. This section of the exhibit is also designed to discretely identify the employee information for any individual employee/contractor that must have a portion of their salary and/or benefits reduced from allowable expenditures on the cost report.

For each of the job classifications identified above, the following information must be included:

Employee #: Enter the Employee # for the employee for which a portion of their salary and/or benefits must be reduced from the total allowable costs.

Last Name: Enter the last name of the employee for which a portion of their salary and/or benefits must be reduced from the total allowable costs.

First Name: Enter the first name of the employee for which a portion of their salary and/or benefits must be reduced from the total allowable costs.

Job Title/ Credentials: Enter the job title / credentials of the employee for which a portion of their salary and/or benefits must be reduced from the total allowable costs.

Employee (E) /Contractor (C): Enter the appropriate designation, **either an E or a C,** of the employee for which a portion of their salary and/or benefits must be reduced from the total allowable costs. E designates an employee of EMS. C designates a contractor for EMS.

Payroll and Benefits

This section of the exhibit is designed to identify payroll and benefit expenditures for the specific job classifications identified above. This section of the exhibit is also designed to discretely identify the payroll and benefit expenditures for any individual employee/contractor that must have a portion of their salary and/or benefits reduced from allowable expenditures on the cost report.

For each of the job classifications identified above, the following information must be included:

Gross Salary: Enter the gross salary amount for the employee for which a portion of their salary and/or benefits must be reduced from the total allowable costs.

Contractor Payments: Enter the amount of contractor payments for the employee for which a portion of their salary and/or benefits must be reduced from the total allowable costs.

Employee Benefits: Enter the amount of employee benefits for the employee for which a portion of their salary and/or benefits must be reduced from the total allowable costs. This includes all benefits that are not discretely identified in Columns J-L of this exhibit.

Employer Retirement: Enter the amount of employer retirement expenditure for the employee for which a portion of their salary and/or benefits must be reduced from the total allowable costs.

FICA: Enter the amount of FICA expenditure for the employee for which a portion of their salary and/or benefits must be reduced from the total allowable costs.

Payroll Taxes: Enter the amount of payroll taxes expenditure for the employee for which a portion of their salary and/or benefits must be reduced from the total allowable costs.

Federal Funding Reductions

This section of the exhibit is designed to identify the federal funding, or other payroll and benefit expenditure reduction necessary for the specific job classifications identified above. This section of the exhibit is designed to discretely identify the payroll and benefit expenditures for any individual employee/contractor that must have a portion of their salary and/or benefits reduced from allowable expenditures on the cost report.

For each of the job classifications identified above, the following information must be included:

Allocated Funded Positions Entry: Enter the appropriate designation, either a Y or an N, for the employee for which a portion of their salary and/or benefits must be reduced from the total allowable costs. A "Y" in this field designates an employee for which a portion, or all of their salary and benefit expenditures are funded by federal funds or grants. An "N" in this field designates an employee for which a portion, or all of their salary and benefit expenditures are not funded by federal funds or grants, but still need to be removed from allowable expenditures as reported on the cost report.

Federal Funding: If the answer to the field previously is "Y", then enter the amount of federal funding related to the employee's salary and benefits that must be reduced from the total allowable costs as reported on the cost report.

Other Funds: Enter the amount of Other Amount to be Removed related to the employee's salary and benefits that must be reduced from the total allowable costs as reported on the cost report.

Payroll and Benefits Entry: Enter the amount of salary and appropriate benefits for all other personnel and staff related to the job classifications identified above, for which no salary or benefit expenditures must be reduced from the total allowable costs.

Exhibit 7-Schedule C – Cost Allocation Methodologies

This exhibit details the cost allocation methodologies employed by the governmental entity.

a. If you entered "yes" on Exhibit 1, Line 1.06, please provide a copy of your agency's approved Cost Allocation Plan (CAP).
b. If you entered "yes" on Exhibit 1, Lines 1.08 and 1.09, please provide a copy of your agency's approved Indirect Cost Rate (IDCR).
c. Provide a list of personnel cost worksheets that support your CAP or IDCR

Part 5: Methodology for Ensuring Payments are based on Uncompensated Charity Costs

STC 33 requires that the methodology used by the state to determine UC payments will ensure that payments are distributed based on uncompensated cost, unrelated to the source of the non-federal share. Eligible uncompensated costs must be for services provided to uninsured individuals who meet the provider's charity-care policy or financial assistance policy where all or a portion of the services are free of charge and where the provider's charity-care policy adheres to the charity-care principles of the Healthcare Financial Management Association (HFMA). This Part 5 describes the methodology used by the state to fulfill this requirement.

Each provider that qualifies for a payment from the UC Pool will be reimbursed a percentage of its total eligible uncompensated charity-care costs calculated as described in this Attachment H.

Providers may be categorized in four groups: hospitals, physician practice groups, government dental providers, and government ambulance providers. Within the hospital group, providers may be further subdivided based on existing classifications that have been approved by CMS for payments under Texas State Plan or 1115 waiver programs, or by directed payment models.

Attachment I
Regional Healthcare Partnership (RHP) Planning Protocol

I. PREFACE

A. Delivery System Reform Incentive Payment Program

Special Terms and Conditions (STC) 45 of the Demonstration authorizes Texas to establish a Delivery System Reform Incentive Payment (DSRIP) program. Initiatives under the DSRIP program are designed to provide incentive payments to hospitals and other providers for investments in delivery system reforms that increase access to health care, improve the quality of care, and enhance the health of patients and families they serve.

The program of activity funded by the DSRIP shall be based on Regional Healthcare Partnerships (RHPs). Each RHP shall have geographic boundaries and will be coordinated by a public hospital or local governmental entity with the authority to make intergovernmental transfers. The public hospital or local governmental entity shall collaborate with hospitals and other potential providers to develop an RHP Plan that will accelerate meaningful delivery system reforms that improve patient care for low-income populations. The RHP Plans must be consistent with regional shared mission and quality goals of the RHP and CMS's triple aims to improve care for individuals (including access to care, quality of care, and health outcomes); improve health for the population; and lower costs through improvements (without any harm whatsoever to individuals, families, or communities).

B. RHP Planning Protocol and Program Funding and Mechanics Protocol

In accordance with STC 45(a) and 45(d)(ii)(A) & (B), the RHP Planning Protocol (Attachment I) defines the specific initiatives that will align with the following four categories: (1) Infrastructure Development; (2) Program Innovation and Redesign; (3) Quality Improvements; and (4) Population-focused Improvements. The Program Funding and Mechanics Protocol (Attachment J) describes the State and CMS review process for RHP Plans, incentive payment methodologies, RHP and State reporting requirements, and penalties for missed milestones.

Each RHP must submit an RHP Plan that identifies the projects, outcomes, population-focused objectives, and specific milestones and metrics in accordance with these attachments and STCs.

C. Organization of "Attachment I: RHP Planning Protocol"

Attachment I has been organized into the following sections:

I. Preface
II. Key Principles
III. Required RHP Plan Elements
IV. Format of this Document
V. Category 1 Infrastructure Development
VI. Category 2 Program Innovation and Redesign
VII. Category 3 Quality Improvements
VIII. Category 4 Population Focused Improvements
Appendix: CMS-Provided Key Elements for Learning Collaboratives and Continuous Quality Improvement

Attachment I
Regional Healthcare Partnership (RHP) Planning Protocol

This document is supplemented by a ***metric specification guide*** developed by the state in consultation with CMS that provides more detail on the Category 1, 2, 3, and 4 metrics, including the data source for each measure, the measure steward, and the high performance level or other target setting methodology that will be used to determine targets for Category 3 metrics. The metric specification guide will be made available on the state's website.

II. Key Principles

A. Responding to the Needs and Challenges of the Texas Health Care Delivery System

Texas faces many unique health challenges. For example, rates of obesity and chronic diseases are some of the highest in the nation, and many Texans do not have a regular source of care to help manage and prevent these diseases. Many Texans do not receive regular treatment for mental health issues, and as a result, mental health problems account for a large percentage of admissions to hospitals that could have been avoided. These challenges and many more disproportionately affect safety net providers who serve Medicaid beneficiaries and the uninsured.

DSRIP provides an unprecedented opportunity to improve patient care for low-income populations by incentivizing delivery system reforms that increase access to health care, improve the quality of care, and enhance the health of patients and families they serve. These investments not only contribute to the triple aim, but they can also help position safety net providers for the emerging healthcare market, in which data-based quality performance and cost-efficiency drive competition.

This protocol presents a "menu" of evidence-based projects that can be incentivized through DSRIP. These projects were selected by HHSC and CMS to have the maximum impact on the health system challenges facing Texas.

Since health system reform requires regional collaboration, providers must select projects that relate to the community needs identified by the RHP, and RHPs must engage stakeholders in the development of RHP plans. The requirements for the community needs assessment and stakeholder engagement are described in section 10 of the Program Funding and Mechanics Protocol (Attachment J).

B. Interconnection and Shared Orientation of Projects

DSRIP activities are divided into four categories, which are interrelated and complementary:

- Category 1 Infrastructure Development 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.
- Category 2 Program Innovation and Redesign includes the piloting, testing, and replicating of innovative care models.

- Category 3 Quality Improvements includes outcome reporting and improvements in care that can be achieved within four years.
- Category 4 Population-focused Improvements is the reporting of measures that demonstrate the impact of delivery system reform investments under the waiver.

Multiple, complementary initiatives will be occurring in the same RHP simultaneously, reinforcing each other in the transformation of care delivery. The selected projects for the RHP plan should possess the following qualities:

- While they are highly related projects, each improvement project is distinct;
- All of the proposed projects are oriented to creating more effective and coordinated care provision; and
- There is a coordinated approach to supporting improved patient experience, population health, quality improvement, and cost control.

In order to achieve meaningful change by the end of the demonstration, every performing provider must link each of its Category 1 and 2 projects to a related Category 3 outcome. The outcomes shall assess the results of care experienced by patients, including patients' clinical events, patients' recovery and health status, patients' experiences in the health system, and efficiency/cost. Additional information about category 3 outcomes and the setting of outcome targets is provided in section 11.d of the Program Funding and Mechanics Protocol (Attachment J).

C. Fostering Continuous Quality Improvement

In order to achieve and sustain success at responding to community needs, providers and communities will need to apply best practices in continuous quality improvement. Most notably, learning collaboratives are essential to the success of high quality health systems that have achieved the highest level of performance. Performing providers are strongly encouraged to form learning collaboratives to promote sharing of challenges and testing of new ideas and solutions by providers implementing similar projects in each RHP. These regionally-focused learning collaboratives also can inform the learning collaborative conducted annually during DYs 3-5 to share learning, experiences, and best practices acquired from the DSRIP program across the State. For the Key Elements for Learning Collaboratives provided by CMS, please see Attachment 1.

RHPs can be a natural hub for this type of shared learning by connecting providers who are working together on common challenges in the community, but providers and RHPs are also encouraged to connect with others across Texas to form a "community of communities" that can connect on an ongoing basis to share best practices, breakthrough ideas, challenges and solutions. This will allow regions to learn from each other's challenges and develop shared solutions that can accelerate the spread of breakthrough ideas across Texas.

III. Required Plan Elements

Based on the projects and measures listed in this Protocol and the requirements for plan development defined in the *Program Funding and Mechanics Protocol* (Attachment J) , RHPs

will submit five-year RHP plans that describe: (1) the reasons for the selection of the projects, based on local data, gaps, community needs, and key challenges; (2) how the projects included in the plan are related to each other and how, taken together, the projects support broad delivery system reform relevant to the patient population; and (3) the progression of each project year-over-year, including the specifics and exact data source needed per project per milestone per metric per year.

Each RHP must submit an RHP Plan using a State-approved template that identifies the projects, objectives, and specific milestones, metrics, measures, and associated DSRIP values. The plan must meet all requirements pursuant to Standard Terms and Conditions (STCs) 45 and 46 and follow the format outlined in the *Program Funding and Mechanics Protocol* (Section III, Key Elements of Proposed RHP Plans).

Attachment I
Regional Healthcare Partnership (RHP) Planning Protocol

Organization of Projects and Measures
The RHP five-year plan will include sections on each of the four categories included in this Protocol.

Categories 1-2 Requirements: For each project selected from Category 1 and 2, RHP Plans must include a narrative that has the following subsections:

- Identifying Information: Identification of the DSRIP Category, name of the project, project element, and RHP Performing Provider name and Texas Provider Identifier (TPI) involved with the project. Each project shall be implemented by one Performing Provider only.
- Project Goal: The goal(s) for the project, which describes the challenges or issues of the Performing Provider and brief description of the major delivery system solution identified to address those challenges by implementing the particular project; the starting point of the Performing Provider related to the project and based on that, the 5-year expected outcome for the Performing Provider and the patients.
- Rationale: As part of this subsection, each Performing Provider will provide the reasons for selecting the project, milestones, and metrics based on relevancy to the RHP's population and circumstances, community need, and RHP priority and starting point with available baseline data, as well as a description of how the project represents a new initiative for the Performing Provider or significantly enhances an existing initiative, including any initiatives that may have related activities that are funded by the U.S. Department of Health and Human Services. These projects should be data-driven and based on community needs and local data that demonstrate the project is addressing an area of poor performance and/or disparity that is important to the population (i.e. a provider selecting a project to implement a chronic care model for diabetes should discuss local data such as prevalence of diabetes in the community and rates of preventable admissions for diabetes and describe why diabetes is an important health challenge for the community).
- Related Category 3 Outcome Measure(s): The Performing Provider will indicate the Category 3 Outcome Measure(s) and reasons/rationale for selecting the outcome measure(s). The rationale should be data-driven, including:
    - Data supporting why these outcomes are a priority for the RHP;
    - Validated, evidence-based rationale describing how the related Category 1 or 2 project will help achieve the Category 3 outcome measure selected; and/or
    - Explanation of how focusing on the outcomes will help improve the health of low-income populations.
- Relationship to Other Projects and Measures: A description of how this project supports, reinforces, enables, and is related to other Category 1 and 2 projects and Category 4 population-focused improvement measures within the RHP Plan
- Milestones and Metrics Table: For each project, RHP Plans shall include milestones and metrics adopted in accordance with this Protocol. In a table format, the RHP Plan will indicate by demonstration year when project milestones will be achieved and indicate the data source that will be used to document and verify achievement.
    - For each project from Category 1 and 2, the Performing Provider must include at least one milestone based on a Process Milestone and at least one milestone based on an Improvement Milestone over the 4-year period.

  - Since Quality Improvement (QI) activities are essential to the provider's success implementing Category 1 and 2 projects and achieving Category 3 outcome measures, Quality Improvement (QI) is a core project component for all project options for most Category 1 and 2 projects (except 1.1 Expand Primary Care Capacity, 1.2 Increase Training of Primary Care Workforce, 1.9 Expand Specialty Care Capacity, 1.12 Enhance Service Availability, and 1.14 Develop Workforce Enhancement). Category 1 and 2 project areas contain recommended process milestones designed to support providers that are engaging in meaningful quality improvement work to improve performance and achieve outcomes. Performing Providers are strongly encouraged to include process milestones reflecting their Quality Improvement activities for all 4 years of the DSRIP.
  - For each milestone, the estimated DSRIP funding must be identified as the maximum amount that can be received for achieving the milestone. For each year, the estimated available non-federal share must be included and the source (Intergovernmental Transfer (IGT) Entity) of non-federal share identified.
- Relationship to Other Providers' Projects in the RHP: If applicable, a list of other providers in the RHP that are proposing similar projects and will be members of a learning collaborative to support this project and share best practices, new ideas, and solutions across the RHP.
- Plan for Learning Collaborative: If applicable, describe plans for participating in a RHP-wide learning collaborative with other providers with similar projects. Describe how the learning collaborative will promote sharing of challenges and testing of new ideas and solutions between providers implementing similar projects.

Category 3 Requirements: Category 3 involves outcomes associated with Category 1 and 2 projects. All Performing Providers (both hospital and non-hospital providers) shall select outcomes and establish improvement targets that tie to their projects in Categories 1 and 2. RHP Plans must include:

- Identifying Information: Identification of the Category 3 outcomes and RHP Performing Provider name and Texas Provider Identifier that is reporting the measure.
- Narrative Description: Each Performing Provider shall provide a narrative describing the Category 3 outcomes.
- Outcomes Table: In a table format, the RHP Plan shall include the outcomes selected by each Performing Provider.
  - For each outcome, the RHP Plan may include process milestones described in 11.d.ii of the *Program Funding and Mechanics Protocol* in DY 2-3 only that support the development of the outcomes.
  - For each outcome, the RHP Plan shall include improvement targets beginning no later than DY 4. In DY 4 and 5, incentive payments will only be received for achieving improvement targets (pay-for-performance) in Category 3.
  - For each milestone or outcome improvement target, the estimated DSRIP funding must be identified as the maximum amount for achieving the milestone or outcome target. For each year, the estimated non-federal share must be included and the source (IGT Entity) of non-federal share identified.

Category 4 Requirements: Category 4 involves population-focused improvements associated with Category 1 and 2 projects and Category 3 outcomes. Each hospital-based Performing Provider shall report on all Category 4 measures, unless the hospital-based performing provider either is exempt from all measures or from certain measures in accordance with *Program Funding and Mechanics Protocol*, Sections 11.e. and 11.f. For Category 4, RHP Plans must include:

- Identifying information: Identification of the DSRIP Category 4 measures and the name and Texas Provider Identifier of the RHP Performing Provider that is reporting the measure.
- Narrative description: A narrative description of the Category 4 measures.
- Table Presentation: In a table format, the RHP Plan will include, starting in DY 3:
    - List of Category 4 measures the Performing Provider will report on by domain;
    - For each measure, the estimated DSRIP funding must be identified as the maximum amount that can be received for reporting on the measure. For each year, the estimated available non-federal share must be included and the source of non-federal share identified.

IV. Explanation of the Format of this Document

Each RHP will follow the guidelines in this document and provide specificity in its plan. The Categories 1 and 2 projects that follow include the following components, which guide the RHPs in what to include in the plan:

- **Project Area:** The overarching subject matter the project addresses.
- **Project Goal:** This component describes the purpose of performing a project in the project area.
- **Project Option:** This component describes a comprehensive intervention a Performing Provider may undertake to accomplish the project goal.
- **"Other" Project Options:** Each Category 1 and 2 project area includes an "other" project option. Providers that wish to implement an innovative, evidence-based project that is not included on the list of project options for a project area may choose the "other" project option. Providers implementing an innovative, evidence-based project using the "Other" project option may design their project using the process and improvement milestones specified in the project area or may include one or more customizable process milstones P-X and/or improvement milestones I-X, as appropriate for their project. "Other" project options will be subject to additional scrutiny during the plan review and approval process.
- **Project Component:** Activities that may occur in conjunction with one another to carry out a project option. Project components may be required core components or optional components. Required core components are listed with the project options with which they must be completed. Providers either must incorporate all required core components in their plan narrative or they must provide justification for why they are not including a core component (e.g., the provider was at a more advanced stage with the project and had already completed one or more core components).

The metric specification guide, which is a compendium to this protocol, provides the following additional information:

- **Milestone:** An objective for DSRIP performance comprised of one or more metrics.

  - **Process Milestones:** Objectives for completing a process that is intended to assist in achieving an outcome. These include objectives for continuous quality improvement, rapid-cycle testing, and collaborative learning that are intended to help providers share best practices, spread breakthrough ideas, and test new solutions with the goal of performing at a higher level and achieving outcomes within the 5 years.
  - **Improvement Milestones:** Objectives, such as outputs, to assist in achieving an outcome.
- **Metric:** Quantitative or qualitative indicator of progress toward achieving a milestone from a baseline. There are one or more metrics associated with each milestone. The RHP participants may tailor the targets in the metric, as appropriate.
- **Data Source:** The data source often lists multiple options that could be used for the data being measured by the metric. Please note that these options identify appropriate sources of information, but as allowed, Performing Providers may identify alternative sources that are more appropriate to their individual systems and that provide comparable or better information. The RHP plans will specify the exact data source being used for the metric each year.
- **Rationale:** This component describes why the metric is appropriate, including academic citations, descriptions of how widely used the metric is in the industry, and other reasons why the metric is seen as the appropriate data to meaningfully measure progress toward achieving the milestone.

Additional Process Milestones

In an effort to avoid repetition, it is permissable for each project to include any one of the following as process milestones, in addition to or in lieu of the other process milestones listed. Each is in the spirit of continuous improvement and applying and sharing learning. If a Performing Provider elects to use one or more of these process milestones, the RHP plan would describe the related specifics for the milestone, such as the metric and data source, using customizable process milestone P-X, which is included in each project area:

- Participate in a learning collaborative (e.g., in DY 2, join the Hospital Engagement Network, as documented by the appropriate participation document)Conduct a needs/gap analysis, in order to inform the establishment or expansion of services/programs (e.g., in DY2, conduct a gap analysis of high-impact specialty services to identify those in most demand by the local community in order to expand specialty care capacity targeted to those specialties most needed by patients)
- Pilot a new process and/or program
- Assess efficacy of processes in place and recommend process improvements to implement, if any (e.g., in DY 4, evaluate whether the primary care redesign methodology was as effective as it could be, by: (1) performing at least two team-based Plan-Do-Study-Act workshops in the primary care clinics; (2) documenting whether the anticipated metric improvements were met; (3) identifying opportunities, if any, to improve on the redesign methodology, as documented by the assessment document capturing each of these items)
- Redesign the process in order to be more effective, incorporating learnings (e.g., in DY 4, incorporate at least one new element into the process based on the assessment, using the

process modification process to include the specificity needed as new learnings are discovered in DY 3)

- Implement a new, improved practice piloted in one or more Performing Providers within an RHP (e.g., in DY 5, implement improved practices across the Performing Provider's ambulatory care setting)
- Establish a baseline, in order to measure improvement over self
- Complete a planning process/submit a plan, in order to do appropriate planning for the implementation of major infrastructure development or program/process redesign (e.g., in DY 2, complete a planning process for a care navigation program to provide support to patient populations who are most at risk of receiving disconnected and fragmented care)
- Designate/hire personnel or teams to support and/or manage the project/intervention
- Implement, adopt, upgrade, or improve technology to support the project
- Develop a new methodology, or refine an existing one, based on learnings
- Incorporate patient experience surveying

Attachment I
Regional Healthcare Partnership (RHP) Planning Protocol

Category 1 Infrastructure Development

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Category 1

1.1 Expand Primary Care Capacity

Project Goal:
Expand the capacity of primary care to better accommodate the needs of the regional patient population and community, as identified by the RHP needs assessment, so that patients have enhanced access to services, allowing them to receive the right care at the right time in the right setting. Projects plans related to access to primary care services should address current challenges to the primary care system and patients seeking primary care services, including: expanded and/or enhanced system access points, barriers to transportation, and expanded or enhanced primary care services to include urgent care.

Project Options:

a) Establish more primary care clinics
b) Expand existing primary care capacity
   Required core project components:
   a) Expand primary care clinic space
   b) Expand primary care clinic hours
   c) Expand primary care clinic staffing
c) Expand mobile clinics
d) "Other" project option: Implement other evidence-based project to expand primary care capacity in an innovative manner not described in the project options above. Providers implementing an innovative, evidence-based project using the "Other" project option may select among the process and improvement milestones specified in this project area or may include one or more customizable process milestone(s) P-X and/or improvement milestone(s) I-X, as appropriate for their project. Milestone I-15 includes suggestions for improvement metrics to use with this innovative project option.

Rationale:
In our current system, more often than not, patients receive services in urgent and emergent care settings for conditions that could be managed in a more coordinated manner if provided in the primary care setting. This often results in more costly, less coordinated care and a lack of appropriate follow-up care. Patients may experience barriers in accessing primary care services secondary to transportation, cost, lack of assigned provider, physical disability, inability to receive appointments in a timely manner and a lack of knowledge about what types of services can be provided in the primary care setting. By enhancing access points, available appointment times, patient awareness of available services and overall primary care capacity, patients and their families will align themselves with the primary care system resulting in better health outcomes, patient satisfaction, appropriate utilization and reduced cost of services.

1.2 Increase Training of Primary Care Workforce

Project Goal:
Texas has a growing shortage of primary care doctors and nurses due to the needs of an aging population, a decline in the number of medical students choosing primary care, and thousands of aging baby boomers who are doctors and nurses looking towards retirement. The shortage of primary care workforce personnel in Texas is a critical problem that we have the opportunity to begin addressing under this waiver. It is difficult to recruit and hire primary care physicians. The shortage of primary care providers has contributed to increased wait times in hospitals, community clinics, and other care settings. Expanding the primary care workforce will increase access and capacity and help create an organized structure of primary care providers, clinicians, and staff. Moreover, this expansion will strengthen an integrated health care system and play a key role in implementing disease management programs. The extended primary care workforce will also be trained to operate in patient-centered medical homes. A greater focus on primary care will be crucial to the success of an integrated health care system. Furthermore, in order to effectively operate in a medical home model, there is a need for residency and training programs to expand the capabilities of primary care providers and other staff to effectively provide team-based care and manage population health. Therefore, the need to expand the responsibilities of primary care workforce members will be even more important. In summary, the goal for this project is to train more workforce members to serve as primary care providers, clinicians, and staff to help address the substantial primary care workforce shortage and to update training programs to include more organized care delivery models. This project may apply to primary care physicians (including residents in training), nurse practitioners, physician assistants, and other clinicians/staff (e.g., health coaches, community health workers/promotoras) in the following service areas: family medicine, internal medicine, obstetrics and gynecology, geriatrics, and pediatrics.

In 2010, Texas had 176 patient care physicians per 100,000 population and 70 primary care physicians per 100,000 population with a state ranking of 46 and 47, respectively. (Comparable ratios for US Total are 219.5 and 90.5, respectively.) From 2001 to 2011, the Texas physician workforce grew 32.3%, exceeding the population growth of 25.1%. Primary care physician workforce grew only 25% in the same period. From 2002 to 2011, Texas increased medical school enrollment 31% from 1,342 to 1,762 in line with the national call by the Association of American Medical Colleges to increase medical school enrollments by 30%. In 2011, there were 1,445 medical school graduates. Coincidentally, there were 1,445 allopathic entry-level GME positions offered in the annual National Resident Matching program. (There were 31 osteopathic slots.) The Texas Higher Education Coordinating Board recommends a ratio of 1.1 entry-level GME positions for each Texas medical school graduate. The number of Texas medical school graduates is expected to peak at over 1,700 in 2015. This implies a need for 400 additional GME positions by 2015. The shortage of GME positions or residency slots may be

the single most problematic bottleneck in Texas' efforts to alleviate the state's physician shortage.[1]

The rate of Primary Care Physicians per 100,000 Population varies by region from 43 (South Texas) to 78 (Central Texas). Resident physicians provide low-cost care to needy populations and tend to remain in the state in which they complete their residency training.

Project Options:

a) Update primary care training programs to include training on the medical home and chronic care models, disease registry use for population health management, patient panel management, oral health, and other identified training needs and/or quality/performance improvement

b) Increase the number of primary care providers (i.e., physicians, residents, nurse practitioners, physician assistants) and other clinicians/staff (such as health coaches and community health workers/promotoras).

c) Increase the number of residency/training program for faculty/staff to support an expanded, more updated program

d) Establish/expand primary care training programs, with emphasis in communities designated as health care provider shortage areas (HPSAs)

e) "Other" project option: Implement other evidence-based project to increase training of the primary care workforce in an innovative manner not described in the project options above. Providers implementing an innovative, evidence-based project using the "Other" project option may select among the process and improvement milestones specified in this project area or may include one or more customizable process milestone(s) P-X and/or improvement milestone(s) I-X, as appropriate for their project.

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[1] 2010 physician supply extracted from "Physician Characteristics and Distribution in the U.S., " 20122012 Edition, published by American Medical Association. U.S. and Texas population estimates, 2010, extracted from U.S. Census Bureau American Fact Finder Website. Prepared by: Medical Education Dept., Texas Medical Association, 2/2012.

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Regional Healthcare Partnership (RHP) Planning Protocol

Category 1

1.3 Implement a Chronic Disease Management Registry

Project Goal:
Implement a disease management registry for one or more patient populations diagnosed with a selected chronic disease(s) or with Multiple Chronic Conditions (MCCs). By tracking key patient information, a disease registry can help physicians and other members of a patient's care team identify and reach out to patients who may have gaps in their care in order to prevent complications, which often lead to more costly care interventions. A disease registry can assist physicians in one or more key processes for managing patients with a chronic disease, including:

- Prompt physicians and their teams to conduct appropriate assessments and deliver condition-specific recommended care;
- Identify patients who have missed appointments, are overdue for care, or are not meeting care management goals;
- Provide reports about how well individual care teams and overall provider organizations are doing in delivering recommended care to specific patient populations;
- Stratify patients into risk categories in order to target interventions toward patients with highest needs.

Project Options:

a) Implement/enhance and use chronic disease management registry functionalities
Required core project components:
   a) Enter patient data into unique chronic disease registry
   b) Use registry data to proactively contact, educate, and track patients by disease status, risk status, self-management status, community and family need.
   c) Use registry reports to develop and implement targeted QI plan
   d) Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.

b) "Other" project option: Implement other evidence-based project to implement a chronic disease management registry in an innovative manner not described in the project options above. Providers implementing an innovative, evidence-based project using the "Other" project option may select among the process and improvement milestones specified in this project area or may include one or more customizable process milestone(s) P-X and/or improvement milestone(s) I-X, as appropriate for their project. Milestone I-23 includes suggestions for improvement metrics to use with this innovative project option.

Category 1

Note: All of the project options in project area 1.3 should include a component to conduct quality improvement for the project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, "lessons learned," opportunities to scale all or part of the project to a broader patient population, and key challenges associated with expansion of the project, including special considerations for safety-net populations.

Rationale:
Utilization of registry functionalities helps care teams to actively manage patients with targeted chronic conditions because the disease management registry will include clinician prompts and reminders, which should improve rates of preventive care.

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Regional Healthcare Partnership (RHP) Planning Protocol

Category 1

1.4 Enhance Interpretation Services and Culturally Competent Care

Project Goal:
Patients have access to timely, qualified health care interpreter services in their primary language, thereby increasing the likelihood of safe and effective care, open communication, adherence to treatment protocols, and better health outcomes. This Project Area applies to both written and oral interpretation services.

Cultural competence in health care describes the ability of systems to provide care to patients' with diverse values, beliefs and behaviors, including tailoring care delivery to meet patients' social, cultural, and linguistic needs. Cultural competence can be described both as a vehicle to increase access to quality care for all patient populations and as a business strategy to attract new patients and market share.

To achieve **organizational cultural competence** within the health care leadership and workforce, it is important to maximize diversity.

To achieve **systemic cultural competence** (e.g., in the structures of the health care system) it is essential to address such initiatives as conducting community assessments, developing mechanisms for community and patient feedback, implementing systems for patient racial/ethnic and language preference data collection, developing quality measures for diverse patient populations, and ensuring culturally and linguistically appropriate health education materials and health promotion and disease prevention interventions.

To attain **clinical cultural competence**, health care providers must: (1) be made aware of the impact of social and cultural factors on health beliefs and behaviors; (2) be equipped with the tools and skills to manage these factors appropriately through training and education; and (3) empower their patients to be more of an active partner in the medical management.

Project Options:

a) Expand access to written and oral interpretation services
   Required core project components:
   a) Identify and address language access needs and/or gaps in language access
   b) Implement language access policies and procedures (in coordination with statewide and federal policies to ensure consistency across the state)
   c) Increase training to patients and providers at all levels of the organization (and organization-wide) related to language access and/or cultural competency/sensitivity
   d) Increase interpretation staff

b) Enhance Organizational Cultural Competence
   Required core project components:
   a) Hire, promote, and retain minorities at all levels of the organization to increase diversity in the health care workforce.

b) Develop a program that actively involves community representatives in the health care organization's planning and quality improvement meetings, whether as part of the board or as part of focus groups.

c) Enhance Systemic Cultural Competence

Required core project components:

a) Develop policies and procedures to measure systemic culture competence, or use existing evidence-based culturally competency assessment tool (e.g., CAHPS Cultural Competency Supplement).
b) Adopt and implement all 14 CLAS standards, including those that are not federal mandates.2Conduct CLAS Standards trainings at facilities
c) Identify federal and state reimbursement strategies for interpreter services and identify community resources and partnerships to develop the needed workforce.
d) Provide staff training around Title VI requirements mandating the provision of interpreter services in health care settings.
e) Identify and use tools to detect medical errors that result from lack of systemic cultural competence, including those stemming from language barriers (e.g., taking a prescribed medication incorrectly); misunderstanding health education materials, instructions, or signage (e.g., inappropriately preparing for a diagnostic or therapeutic procedure, resulting in postponement or delay); and misunderstanding the benefits and risks of procedures requiring informed consent.
f) Implement projects to address medical errors resulting from systemic cultural competency.

d) Clinical Cultural Competence: Develop cross-cultural training program that is a required, integrated component of the training and professional development of health care providers at all levels. The curricula should:

- increase awareness of racial and ethnic disparities in health and the importance of socio-cultural factors on health beliefs and behaviors;
- address the impact of race, ethnicity, culture, and class on clinical decision making;
- develop tools to assess the community members' health beliefs and behaviors
- Develop human resource skills for cross-cultural assessment, communication, and negotiation.

e) Implement Quality improvement efforts that include culturally and linguistically appropriate patient survey methods as well as process and outcome measures that reflect the needs of multicultural and minority populations.

f) Clinical Cultural Competence: Develop programs to help patients navigate the health care system and become a more active partner in the clinical encounter.

g) "Other" project option: Implement other evidence-based project to enhance interpretation services and culturally competent care in an innovative manner not

[2] http://minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf

described in the project options above. Providers implementing an innovative, evidence-based project using the "Other" project option may select among the process and improvement milestones specified in this project area or may include one or more customizable process milestone(s) P-X and/or improvement milestone(s) I-X, as appropriate for their project. Milestone I-18 includes suggestions for improvement metrics to use with this innovative project option.

Note: All of the project options in project area 1.4 should include a component to conduct quality improvement for the project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, "lessons learned," opportunities to scale all or part of the project to a broader patient population, and key challenges associated with expansion of the project, including special considerations for safety-net populations.

Rationale:

The 2010 United States Census confirmed that our nation's population has become more diverse than ever before, and this trend is expected to continue over this century. As we become a more ethnically and racially diverse nation, health care systems and providers need to reflect on and respond to patients' varied perspectives, values, beliefs, and behaviors about health and well-being. Failure to understand and manage socio-cultural differences may have significant health consequences for minority groups in particular.

Various systemic issues have been identified in the literature and by the health care experts. While this was more obvious in poorly constructed and complicated systems that are not responsive to the needs of diverse patient populations, the issue of language discordance between provider and patient was of foremost importance. Systems lacking interpreter services or culturally and linguistically appropriate health education materials lead to patient dissatisfaction, poor comprehension and adherence, and lower-quality care. According to various studies, care experts in government, managed care, academia, and community health care make a clear connection between cultural competence, quality improvement, and the elimination of racial/ethnic disparities.

Category 1

1.5 Collect Valid and Reliable Race, Ethnicity, and Language (REAL) Data to Reduce Disparities

In 2002, the Institute of Medicine report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*[3]*, signified a new era of national attention to racial and ethnic disparities in the American health care system. Corroborating that report, many research studies have established that Americans* do not all have equal access to health care, or experience similar health care quality and outcomes. Low-income, racial and ethnic minority, limited-English proficient, and other underserved populations often have higher rates of disease, fewer treatment options, reduced access to care, and lower satisfaction with care. A key prerequisite for measuring equity of care and addressing disparities is to collect valid and reliable patient demographic data on race, ethnicity, and preferred language (REAL data). These data elements must be effectively linked to data systems used in health care service delivery (to tailor care to patient needs), as well as data systems used in quality improvement (to identify disparities). Creating organizational systems for capturing REAL data is a long and resource-intensive process. Currently, the processes for analyzing equity of care are mostly piecemeal and limited in scope, taxing organizational resources. However, in the state of Texas there are significant barriers to effective collection and utilization of these patient demographic data for public hospitals. To address these barriers, key next steps for public hospitals systems include developing tools, HIT protocols and training curricula to improve the collection and utilization of REAL data elements, which is the foundation for achieving significantly greater efficiency and cost-effectiveness in measuring equity of care, thus enabling the designs of more successful efforts to eliminate health care disparities.

Project Goal:
To improve the collection of valid and reliable self-reported data on the demographics of patients receiving care, the quality of care delivered, and implementing stratification capabilities to stratify clinical/quality data, and analyzing data by relevant demographic categories: race, ethnicity, sex, primary language and disability status.[4] Recently finalized data collection standards for surveys of demographic categories were released by HHS and will be used in the process of developing standards for administrative data collection for the same 5 categories. RHPs will work to implement initiatives, promote training, and accelerate capacity building, community engagement and empowerment. The project focuses on efforts to reduce health and mental health disparities, disparities among racial/ethnic groups, women, seniors, children, rural populations, and those with disabilities and their families.

Project Options:

a) Train patients and staff on the importance of collecting REAL data (For project option 1.5.1, the provider must do both subpart (i) and subpart (ii), If the provider is not using existing curriculum. If the provider is using existing curriculum, only subpart (ii) is required.):

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3 http://www.iom.edu/Reports/2002/Unequal-Treatment-Confronting-Racial-and-Ethnic-Disparities-in-Health-Care.aspx
4 http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208

i. Develop curriculum that includes effective strategies to explain relevance of collecting REAL data to patients and staff. Education about the value of the information for patient care, with clear examples of the benefits of data collection is central to an effective training.
ii. Train patients and staff on the importance of collecting REAL data using developed or existing curricula.

b) Implement intervention that involves collaborating/partnering/ instituting data sharing agreements with Medicaid agencies, public health departments, academic research centers, other agencies, etc. to better assess patient populations and aid in the evaluation of health disparities

c) Implement project to enhance collection, interpretation, and / or use of REAL data.

Required core project components:

a) Redesign care pathways to collect valid and reliable data on race, ethnicity, and language at the point of care

b) Implement system to stratify patient outcomes and quality measures by patient REAL demographic information in order to identify, analyze, and report on potential health disparities and develop strategies to address goals for equitable health outcomes. NOTE: Providers are encouraged to stratify outcomes and measures using both two-way and three-way interactions (race and quality; gender, race, and quality)

c) Develop improvement plans, which include a continuous quality improvement plan, to address key root causes of disparities within the selected population.

d) Use data to undertake interventions aimed at reducing health and health care disparities (tackling "the gap") for target patient populations through improvements in areas such as f preventive care, patient experience, and/or health outcomes.

d) "Other" project option: Implement other evidence-based project to implement and use REAL data in an innovative manner not described in the project options above. Providers implementing an innovative, evidence-based project using the "Other" project option may select among the process and improvement milestones specified in this project area or may include one or more customizable process milestone(s) P-X and/or improvement milestone(s) I-X, as appropriate for their project. Milestone I-12 includes suggestions for improvement metrics to use with this innovative project option.

Note: All of the project options in project area 1.5 should include a component to conduct quality improvement for the project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, "lessons learned," opportunities to scale all or part of the project to a broader patient population, and key challenges associated with expansion of the project, including special considerations for safety-net populations.

Rationale:
Several RHPs within Texas focus on health disparities in communities through research, education, and community relations. To build upon the existing infrastructure to address health

disparities in Texas, RHPs will select projects appropriate to specific populations based on relevancy to the RHP needs assessment. Some populations experience disparities in health, quality of care, health outcomes, and incidence as related to conditions such as: tuberculosis, congestive heart failure, stroke, COPD, Chlamydia, cervical cancer, liver cancer, stomach cancer, gallbladder cancer, child and adolescent leukemia, neural tube defects, other birth defects, obesity, diabetes, and pesticide poisoning. Disparities can been seen among groups based on race and ethnicity, language, economic factors, education, insurance status, geographic location (rural vs. urban, zip code) , gender, sexual orientation and many other social determinants of health. The collection of REAL data helps providers to delineate potential categories of differences in observed health status.

Category 1

1.6 Enhance Urgent Medical Advice

Project Goal:
Provide urgent medical advice so that patients who need it can access it telephonically, and an appropriate appointment can be scheduled so that access to urgent medical care is increased and avoidable utilization of urgent care and the ED can be reduced. The advice line provides callers with direct access to a registered nurse who can address their specific health needs with an on-demand service.

Project Options:

a) Expand urgent care services

b) Establish/expand access to medical advice and direction to the appropriate level of care to reduce Emergency Department use for non-emergent conditions and increase patient access to health care.
Required core project components:
   a) Develop a process (including a call center) that in a timely manner triages patients seeking primary care services in an ED to an alternate primary care site. Survey patients who use the nurse advice line to ensure patient satisfaction with the services received.
   b) Enhance linkages between primary care, urgent care, and Emergency Departments in order to increase communication and improve care transitions for patients.
   c) Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.

c) "Other" project option: Implement other evidence-based project to implement and use urgent medical advice in an innovative manner not described in the project options above. Providers implementing an innovative, evidence-based project using the "Other" project option may select among the process and improvement milestones specified in this project area or may include one or more customizable process milestone(s) P-X and/or improvement milestone(s) I-X, as appropriate for their project. Milestone I-17 includes suggestions for improvement metrics to use with this innovative project option.

Note: All of the project options in project area 1.6 should include a component to conduct quality improvement for the project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, "lessons learned," opportunities to scale all or part of the project to a broader patient population, and key challenges associated with expansion of the project, including special considerations for safety-net populations.

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Rationale:
Several RHPs within Texas implemented an urgent medical advice line to serve patients within selected populations. To facilitate the diffusion of practices among RHPs, RHPs will have the opportunity to implement an urgent medical advice line to underserved and under privileged areas.
Implementation across Texas for an urgent medical advice line is not consistent between RHPs. As such, Texas will promote the implementation of an **urgent medical advice line** for underserved and underprivileged populations (i.e. rural areas with limited access to healthcare, or areas where cultural differences may disincentivize the use of automated telephone services).

Category 1

1.7 Introduce, Expand, or Enhance Telemedicine/Telehealth

Project Goal:
Provide electronic health care services to increase patient access to health care. Telemedicine is the use of medical information exchanged from one site to another via electronic communications to improve patients' health status. Closely associated with telemedicine is the term "telehealth," which is often used to encompass a broader definition of remote healthcare that does not always involve clinical services. Videoconferencing, transmission of still images, remote monitoring of vital signs with a focus on the specialty care access challenges in rural communities, and continuing medical education are all considered part of telemedicine and telehealth.[5]

Telehealth is the use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health and health administration. Technologies include videoconferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications.[6]

Telemedicine is viewed as a cost-effective alternative to the more traditional face-to-face way of providing medical care (e.g., face-to-face consultations or examinations between provider and patient) that states can choose to cover under Medicaid. This definition is modeled on Medicare's definition of telehealth services (42 CFR 410.78). Note that the federal Medicaid statute does not recognize telemedicine as a distinct service.[7]

Telemedicine is not a separate medical specialty. Products and services related to telemedicine are often part of a larger investment by health care institutions in either information technology or the delivery of clinical care. Even in the reimbursement fee structure, there is usually no distinction made between services provided on site and those provided through telemedicine and often no separate coding required for billing of remote services. Telemedicine encompasses different types of programs and services provided for the patient. Each component involves different providers and consumers.[8]

Telemedicine Services:

Specialist referral services typically involves of a specialist assisting a general practitioner in rendering a diagnosis. This may involve a patient "seeing" a specialist over a live, remote consult or the transmission of diagnostic images and/or video along with patient data to a specialist for viewing later. Recent surveys have shown a rapid increase in the number of specialty and subspecialty areas that have successfully used telemedicine. Radiology continues to make the greatest use of telemedicine with thousands of images "read" by remote providers each year. Other major specialty areas include: dermatology, ophthalmology, mental health, cardiology and

[5] http://www.americantelemed.org/i4a/pages/index.cfm?pageid=3333
[6] http://www.hrsa.gov/ruralhealth/about/telehealth/
[7] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Telemedicine.html
[8] http://www.americantelemed.org/i4a/pages/index.cfm?pageid=3333

pathology. According to reports and studies, almost 50 different medical subspecialties have successfully used telemedicine.

Patient consultations using telecommunications to provide medical data, which may include audio, still or live images, between a patient and a health professional for use in rendering a diagnosis and treatment plan. This might originate from a remote clinic to a physician's office using a direct transmission link or may include communicating over the Web.

Remote patient monitoring uses devices to remotely collect and send data to a monitoring station for interpretation. Such "home telehealth" applications might include a specific vital sign, such as blood glucose or heart ECG or a variety of indicators for homebound patients. Such services can be used to supplement the use of visiting nurses.

Medical education provides continuing medical education credits for health professionals and special medical education seminars for targeted groups in remote locations.

Consumer medical and health information includes the use of the Internet for consumers to obtain specialized health information and on-line discussion groups to provide peer-to-peer support.

Delivery Mechanisms:

Networked programs link tertiary care hospitals and clinics with outlying clinics and community health centers in rural or suburban areas. The links may use dedicated high-speed lines or the Internet for telecommunication links between sites. Studies by the several agencies within the U.S. Department of Health and Human Services, private vendors and assessments by ATA of its membership place the number of existing telemedicine networks in the United States at roughly 200. These programs involve close to 2,000 medical institutions throughout the country. Of these programs, it is estimated that about half (100) are actively providing patient care services on a daily basis. The others are only occasionally used for patient care and are primarily for administrative or educational use.

Point-to-point connections using private networks are used by hospitals and clinics that deliver services directly or contract out specialty services to independent medical service providers at ambulatory care sites. Radiology, mental health and even intensive care services are being provided under contract using telemedicine to deliver the services.

Primary or specialty care to the home connections involves connecting primary care providers, specialists and home health nurses with patients over single line phone-video systems for interactive clinical consultations.

Home to monitoring center links are used for cardiac, pulmonary or fetal monitoring, home care and related services that provide care to patients in the home. Often normal phone lines are used

to communicate directly between the patient and the center although some systems use the Internet.

Web-based e-health patient service sites provide direct consumer outreach and services over the Internet. Under telemedicine, these include those sites that provide direct patient care.

Project Options:

a) Implement telemedicine program to provide or expand specialist referral services in an area identified as needed to the region.
Required core project components:
   a) Provide patient consultations by medical and surgical specialists as well as other types of health professional using telecommunications
   b) Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.

b) Implement remote patient monitoring programs for diagnosis and/or management of care. Providers should demonstrate that they are exceeding the requirements of the EHR incentive program.

c) Use telehealth to deliver specialty, psychosocial, and community-based nursing services

d) Develop a teledentistry infrastructure and use telehealth to provide dental and oral health services.

e) Use telehealth services to provide medical education and specialized training for targeted professionals in remote locations.

f) Implement an electronic consult or electronic referral processing system to increase efficiency of specialty referral process by enabling specialists to provide advice and guidance to primary care physicians that will address their questions without the need for face-to-face visits when medically appropriate.

g) "Other" project option: Implement other evidence-based project to expand/establish telemedicine/telehealth program to help fill significant gaps in services in an innovative manner not described in the project options above. Providers implementing an innovative, evidence-based project using the "Other" project option may select among the process and improvement milestones specified in this project area or may include one or more customizable process milestone(s) P-X and/or improvement milestone(s) I-X, as appropriate for their project. Milestone I-18 includes suggestions for improvement metrics to use with this innovative project option.

Note: All of the project options in project area 1.7 should include a component to conduct quality improvement for the project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts,

"lessons learned," opportunities to scale all or part of the project to a broader patient population, and key challenges associated with expansion of the project, including special considerations for safety-net populations.

Rationale[9]:

One of the greatest challenges facing the U.S. healthcare system is to provide quality care to the large segment of the population, which does not have access to specialty physicians because of factors such as geographic limitations or socioeconomic conditions. The use of technology to deliver health care from a distance, or telemedicine, has been demonstrated as an effective way of overcoming certain barriers to care, particularly for communities located in rural and remote areas. In addition, telemedicine can ease the gaps in providing crucial care for those who are underserved, principally because of a shortage of sub-specialty providers.

The use of telecommunications technologies and connectivity has impacted real-world patients, particularly for those in remote communities. This work has translated into observable outcomes such as:

- improved access to specialists
- increased patient satisfaction with care
- improved clinical outcomes
- reduction in emergency room utilization
- cost savings

Nowhere are these benefits more evident than in Texas. With a land mass area of 268,820 square miles and a growing population of 25.1 million, Texas is the second largest US state by area and population.1 Its population growth rose more than 18.8 percent between 2000 to 2009, reflecting an increase that is more than double the national growth in this period.2 This rapid growth is attributed to a diversity of sources such as natural increases from the total of all births minus all deaths and to a high rate of net in-migration from other states and countries. Along with the increase in population, an ever-growing aging population (the state's older population, 65+, is expected to double that of the previous 8 years) has significantly affected the demand on the healthcare workforce as demands for quality care increased.

In its Statewide Health Plan 2011-2016 report[10], the Texas Statewide Health Council concluded: "Texas faces particular challenges with respect to physician and other healthcare workforces not primarily because of an overall shortage, but because of sharp disparities in the allocation of healthcare resources to different parts of the state. In the metropolitan areas outside the border, there is one physician in direct patient care for each 573 county residents. In the 32-county border region and in non-metropolitan Texas, the ratios are 2 to 3 times as high."

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[9] http://telehealth.utmb.edu/presentations/Benefits_Of_Telemedicine.pdf

[10] Texas Statewide Health Coordinating Council. 2011-2016 Texas State Health Plan Update. Texas Department of State Health Services. http://www.dshs.state.tx.us/chs/shcc/. Retrieved February 28, 2011

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Category 1

Although the overall supply of physicians has increased in Texas since 2000 from in-migration, the vast majority of these healthcare professionals resides and practices within four primary areas of Texas: Dallas, Houston, Austin, and San Antonio. Moreover, Texas has consistently lagged behind the US average in the ratio of physician supply per 100,000 of population, and the gap between the two appears to be increasing. In 2009, there were 25 counties with no physicians, and the counties with lowest ratios of providers to populations were by and large in West Texas, South Texas and the Panhandle.

Theoretically, resources such as healthcare would be distributed across the state in accordance with population density and needs. Realistically, however, geographical and economic barriers create significant disparities across the state, with rural and underserved communities enduring significantly greater barriers to accessing the care continuum. The supply ratios for a number of health professionals, including primary care physicians and mental health professionals, are lowest in rural, border and other health professional shortage areas. Data for 2009 indicated that out of the 254 counties in Texas, 118 counties are designated as whole county primary care Health Professional Shortage Areas (HPSAs) due to primary care doctor to patient ratios of 1:3500 or less, and 173 counties (68 percent of the state) are designated as whole county mental health HPSAs[2]

In Texas, communities are struggling to care for an increasing number of underserved, disadvantaged, and at-risk populations. In most communities, especially in rural areas, care is not organized to promote prevention and early intervention, coordinate services, or monitor access to and quality of care. Moreover, public and private funding to subsidize care remains inadequate, despite growing community needs associated with increases in the uninsured and aging populations. Consequently, many people are left to seek care in emergency rooms, often as a last resort, in an unmanaged and episodic manner. The costs of such care are borne by care-giving institutions, local governments, and, ultimately, taxpayers, many of whom are already burdened with the costs of meeting health-related costs of their own.

Given the various benefits observed through the provision of health care via telemedicine, there is a tremendous amount of momentum toward increasing access to care through the use of health information technologies, thereby creating an exciting and central role for innovation and implementation of new and advanced platforms for service delivery. Two such platforms include the use of wireless and telemonitoring technologies. It is our belief that healthcare delivery is about to make a significant leap forward. The development and installation of high-speed wireless telecommunications networks coupled with large-scale search engines and mobile devices will change healthcare delivery as well as the scope of healthcare services. It will allow for real-time monitoring and interactions with patients without bringing them into a hospital or a specialty care center. This real/near-time monitoring and interacting could enable a healthcare team to address patient problems before they require major interventions, creating a potentially patient-centered approach that could undoubtedly change our expectations of our healthcare system.

In conclusion, the overall goal of the proposed telehealth projects is to reduce disparities in access, outcome, cost and satisfaction that are created by geographic barriers. Specifically, we hope to achieve the following goals for the state's Medicaid population:

1.) increase the knowledge and capacity of rural primary care physicians to manage complex chronic conditions
2.) increase patients' timely access to specialty care and reduce geographic barriers;
3.) create the ability for specialists to provide direct patient consults to patients based at rural clinics
4.) improve efficiency in the referral process by letting specialists divert unnecessary referrals and decreasing the wait time for urgent referrals
5.) provide services in HPSAs
6.) enhance access to other health care services (case management, education, etc.)

Category 1

1.8 Increase, Expand, and Enhance Oral Health Services

Project Goal:
Dental health is a key component of overall health. Oral disease can lead to poor nutrition; serious systemic illnesses and conditions such as poor birth outcomes, diabetes, and cardiovascular disease; and a diminished quality of life and life expectancy.[11] Inadequate access to oral health services compounds other health issues. It can result in untreated dental disease that not only affects the mouth, but can also have physical, mental, economic, and social consequences.[12] Fortunately, many of the adverse effects associated with poor oral health can be prevented with quality regular dental care, both at home and professionally. Increasing, expanding, and enhancing oral health services will improve health outcomes.

Barriers to Oral Health Care:

- Distribution of dental providers/lack of dental providers in underserved areas
- Inconvenient hours and location of dental clinic/services
- Transportation issues
- Low oral health literacy within the community
- Cultural and language competency of dental providers
- Cost of services/health insurance coverage
- Providers' limited experience treating special groups (medically compromised, elderly, special needs, pregnant women, young children)

Specific Project Goals:

- Close gaps/disparities in access to dental care services
- Enhance the quality of dental care
- Increase and enhance the dental workforce
- Redistribute and retain the dental workforce to/in underserved areas

Project Options:
Increase dental provider training, education, recruitment and/or retention, as well as expand workforce capacity through one of the following project options:

a) The development of academic linkages with the three Texas dental schools, to establish a multi-week externship program for fourth year dental students to provide exposure and experience in providing dental services within a rural setting during their professional academic preparation.

b) The establishment of a clinical rotation, continuing education within various community settings for dental residents to increase their exposure and experience providing dental services to special populations such as the elderly, pregnant women, young children, medically compromised, and/or special needs patients.

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[11] http://www.perio.org/consumer/media/releases.htm#pregnancy

[12] Building Better Oral Health: A Dental Home for All Texans. A Report Commissioned by the Texas Dental Association. Fall 2008

c) The establishment of a loan repayment program or scholarships for advanced training/education in a dental specialty with written commitments to practice in underserved markets after graduation for fourth year dental students, new dental and dental hygiene graduates, and dental residents.

Increase interdisciplinary training and education opportunities for dentists and other health care providers to promote an interdisciplinary team approach to addressing oral health through one of the following project options:

d) Grand rounds, in-service trainings, and other continuing education events that integrate information on oral health issues and implications as related to chronic diseases, such as diabetes and cardiovascular disease, and the importance of good oral health during pregnancy and perinatal period.

e) Establishing a referral system/network that provides medically complex patients with coordinated care between dental and medical providers such as cardiologists, pediatricians, OB/GYNs, endocrinologists, oncologists, etc.

Increase and expand services by increasing clinics, clinic hours, using satellite mobile clinics with an affiliated fixed-site dental clinic location, school-based/school-linked health centers or other approaches to increase oral health services to underserved populations through one of the following project options:

f) The expansion of existing dental clinics, the establishment of additional dental clinics, or the expansion of dental clinic hours.

g) The expansion or establishment of satellite mobile dental clinics with an affiliated fixed-site dental clinic location.

h) The development of a tele-dentistry infrastructure including Medicaid reimbursement to expand access to dental specialty consultation services in rural and other limited access areas.

i) The implementation or expansion of school-based sealant and/or fluoride varnish programs that provide sealant placement and/or fluoride varnish applications to otherwise unserved school-aged children by enhancing dental workforce capacity through collaborations and partnerships with dental and dental hygiene schools, local health departments (LHDs), federally qualified health centers (FQHCs), and/or local dental providers.

j) The addition or establishment of school-based health centers that provide dental services for otherwise unserved children by enhancing dental workforce capacity through collaborations and partnerships with dental and dental hygiene schools, LDHs, FQHCs, and/or local dental providers.

k) The implementation of dental services for individuals in long-term care facilities, intermediate care facilities, and nursing homes, and for the elderly, and/or those with special needs by enhancing dental workforce capacity through collaborations and partnerships with dental and dental hygiene schools, LHDs, FQHCs, and/or local dental providers.

l) "Other" project option: Implement other evidence-based project to enhance oral health services in an innovative manner not described in the project options

above. Providers implementing an innovative, evidence-based project using the "Other" project option may select among the process and improvement milestones specified in this project area or may include one or more customizable process milestone(s) P-X and/or improvement milestone(s) I-X, as appropriate for their project.

Note 1: All of the project options in project area 1.8 should include a component to conduct quality improvement for the project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, "lessons learned," opportunities to scale all or part of the project to a broader patient population, and key challenges associated with expansion of the project, including special considerations for safety-net populations.

Note 2: The following project components to implement or enhance efforts to improve quality of care and quality assurance in the delivery of dental care may be included as a part of the above project options:

- Integrating oral health information with electronic medical record.
- Establishing dental care coordination collaboratives where dental case studies are reviewed by dental and medical healthcare providers in an effort to identify best practices and to evaluate health outcomes as a result of the dental interventions and services provided.

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1.9 Expand Specialty Care Capacity

Project Goal:
To increase the capacity to provide specialty care services and the availability of targeted specialty providers to better accommodate the high demand for specialty care services so that patients have increased access to specialty services. With regard to specialty areas of greatest need, the recent report of the Committee on Physician Distribution and Health Care Access cites psychiatry, general/preventive medicine, and child/adolescent psychiatry where the ratios per 100,000 population are 56.7%, 60.2%, and 67% of the US ratios, respectively. Federal funding (Medicare Direct Graduate Medical Education or DGME) for residency training is capped at 1996 levels for the direct support of graduate medical education. The cap only supports a third of the costs of 4,056 of the 4,598 actual positions in Texas, leaving the residency programs to cover the cost of two-thirds of the 4,056 positions and the full cost of 542 positions. Texas is currently over its Medicare cap by 13%.

Residency programs require 3 to 8 years of training, depending on the specialty. Medicare funding only covers years 1 through 3. In 2011, Texas had more than 550 residency programs, offering a total of 6,788 positions. Only 22% (1,494) of theses were first-year residency positions. According to the Coordinating Board, conservative estimates indicate that the cost to educate a resident physician for one year is $150,000.

Hence, a great need for extended residency programs in Texas and increase in the number of specialists.

Project Options:

a) Expand high impact specialty care capacity in most impacted medical specialties

Required core project components:

a) Identify high impact/most impacted specialty services and gaps in care and coordination
b) Increase the number of residents/trainees choosing targeted shortage specialties
c) Design workforce enhancement initiatives to support access to specialty providers in underserved markets and areas (recruitment and retention)
d) Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.

b) Improve access to specialty care

Required core project components:

a) Increase service availability with extended hours
b) Increase number of specialty clinic locations
c) Implement transparent, standardized referrals across the system.

d) Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.

c) "Other" project option: Implement other evidence-based project to expand specialty care capacity in an innovative manner not described in the project options above. Providers implementing an innovative, evidence-based project using the "Other" project option may select among the process and improvement milestones specified in this project area or may include one or more customizable process milestone(s) P-X and/or improvement milestone(s) I-X, as appropriate for their project. Milestone I-33 includes suggestions for improvement metrics to use with this innovative project option.

Rationale:
Inadequate access to specialty care has contributed to the limited scope and size of safety net health systems. To achieve success as an integrated network, gaps must be thoroughly assessed and addressed.

Category 1

1.10 Enhance Performance Improvement and Reporting Capacity

Project Goal: To expand quality improvement capacity through people, processes and technology so that the resources are in place to conduct, report, drive and measure quality improvement.

The goal of this project is to implement process improvement methodologies to improve safety, quality, and efficiency. Providers may design customized initiatives based on various process improvement methodologies such as Lean, Six Sigma, Care Logistics, and Nurses Improving Care for Health system Elders (NICHE) among others.

The Lean methodology as applied to medicine evaluates the use of resources, measures the value to the patient, considers the use of resources in terms of their value to the patient, and eliminates those that are wasteful. Focus on Lean is especially valuable to safety net providers because of its emphasis on waste reduction. Denver Health a safety net hospital in Denver, Colorado has identified more than $124 million in cost savings that the health system has achieved due to Lean Rapid Improvement Events since implementing Lean in 2005[13]. Using methodologies such as Lean that are proven to eliminate waste and redundancies and optimize patient flow, providers may customize a project that will develop and implement a program of continuous improvement that will increase communication, integrate system workflows, provide actionable data to providers and patients, and identify and improve models of patient-centered care that address issues of safety, quality, and efficiency. Implementation frequently requires a new "operational mindset" using tools such as Lean to identify and progressively eliminate inefficiencies while at the same time linking human performance, process performance and system performance into transformational performance in the delivery system.[14] The process improvement, as a further example, may include elements such as identifying the value to the patient, managing the patient's journey, facilitating the smooth flow of patients and information, introducing "pull" in the patient's journey (e.g. advanced access), and/or continuously reducing waste by developing and amending processes awhile at the same time smoothing flow and enhancing quality and driving down cost.[15]

Rationale:
Performance improvement and reporting is a very large component of success of all of the project areas across the categories. The necessity for quality and safety improvement initiatives permeates health care.[2,3] Quality health care is defined as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge"[3] (p. 1161). According to the Institute of Medicine (IOM)

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[13] http://denverhealth.org/LEANAcademy.aspx
[14] Oujiri J, Ferrara C. "The Phoenix Project – Integrating Effective Disease Management Into Primary Care Using Lean Six-Sigma Tools." *Duluth Clinic Presentation*. 2010.
[15] Bibby J. "Lean in Primary Care: The Basics – Sustaining Transformation." *Asian Hospital and Healthcare Management* (2011) 18.

report, To Err Is Human,[16] the majority of medical errors result from faulty systems and processes, not individuals.

Processes that are inefficient and variable, changing case mix of patients, health insurance, differences in provider education and experience, and numerous other factors contribute to the complexity of health care. With this in mind, the IOM also asserted that today's health care industry functions at a lower level than it can and should, and it put forth the following six aims of health care: effective, safe, patient-centered, timely, efficient, and equitable.[3] The aims of effectiveness and safety are targeted through process-of-care measures, assessing whether providers of health care perform processes that have been demonstrated to achieve the desired aims and avoid those processes that are predisposed toward harm. The goals of measuring health care quality are to determine the effects of health care on desired outcomes and to assess the degree to which health care adheres to processes based on scientific evidence or agreed to by professional consensus and is consistent with patient preferences.

Because errors are caused by system or process failures, it is important to adopt various process-improvement techniques to identify inefficiencies, ineffective care, and preventable errors to then influence changes associated with systems. Each of these techniques involves assessing performance and using findings to inform change. This chapter will discuss strategies and tools for quality improvement—including failure modes and effects analysis, Plan-Do-Study-Act, Six Sigma, Lean, and root-cause analysis—that have been used to improve the quality and safety of health care.[17]

Whatever the acronym of the method (e.g., TQM, CQI) or tool used (e.g., FMEA or Six Sigma), the important component of quality improvement is a dynamic process that often employs more than one quality improvement tool. Quality improvement requires five essential elements for success: fostering and sustaining a culture of change and safety, developing and clarifying an understanding of the problem, involving key stakeholders, testing change strategies, and continuous monitoring of performance and reporting of findings to sustain the change.

Project Options:

a) Enhance improvement capacity within people
   Required core project components
   a) Provide training and education to clinical and administrative staff on process improvement strategies, methodologies, and culture.
   b) Develop an employee suggestion system that allows for the identification of issues that impact the work environment, patient care

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[16] Hughes RG. Tools and Strategies for Quality Improvement and Patient Safety. In: Hughes RG, editor. Patient Safety and Quality: An Evidence-Based Handbook for Nurses. Rockville (MD): Agency for Healthcare Research and Quality (US); 2008 Apr. Chapter 44. Available from: http://www.ncbi.nlm.nih.gov/books/NBK2682/

[17] Hughes RG. Tools and Strategies for Quality Improvement and Patient Safety. In: Hughes RG, editor. Patient Safety and Quality: An Evidence-Based Handbook for Nurses. Rockville (MD): Agency for Healthcare Research and Quality (US); 2008 Apr. Chapter 44. Available from: http://www.ncbi.nlm.nih.gov/books/NBK2682/

and satisfaction, efficiency and other issues aligned with continuous process improvement.

b) Enhance improvement capacity through technology
Required core project components
   a) Provide training and education to clinical and administrative staff on process improvement strategies, methodologies, and culture.
   b) Develop an employee suggestion system that allows for the identification of issues that impact the work environment, patient care and satisfaction, efficiency and other issues aligned with continuous process improvement.
   c) Design data collection systems to collect real-time data that is used to drive continuous quality improvement (possible examples include weekly run charts or monthly dashboards)

c) Enhance improvement capacity within systems
Required core project components
   d) Provide training and education to clinical and administrative staff on process improvement strategies, methodologies, and culture.
   e) Develop an employee suggestion system that allows for the identification of issues that impact the work environment, patient care and satisfaction, efficiency and other issues aligned with continuous process improvement.

f) "Other" project option: Implement other evidence-based project to enhance performance improvement and reporting capacity in an innovative manner not described in the project options above. Providers implementing an innovative, evidence-based project using the "Other" project option may select among the process and improvement milestones specified in this project area or may include one or more customizable process milestone(s) P-X and/or improvement milestone(s) I-X, as appropriate for their project.

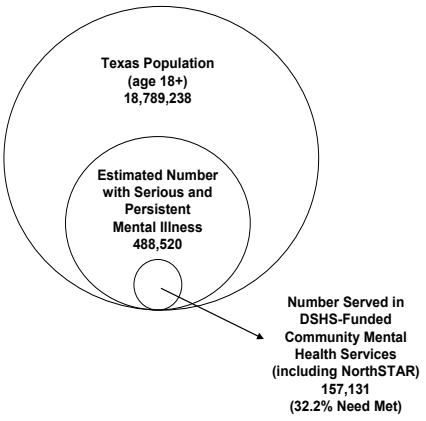
Note: All of the project options in project area1.10 should include a component to conduct quality improvement for the project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, "lessons learned," opportunities to scale all or part of the project to a broader patient population, and key challenges associated with expansion of the project, including special considerations for safety-net populations.

CATEGORY 1: BEHAVIORAL HEALTH INFRASTRUCTURE PROJECTS

GOAL: Improve the infrastructure for delivery of mental health and substance use disorder (AKA behavioral health) services.

The goals of infrastructure-related mental health and substance use disorder (behavioral health) projects are to improve the access to appropriate behavioral health interventions and specialists throughout Texas. This is an especially critical need in Texas for several reasons:

- State funding for behavioral health indigent care is limited. Texas ranks 50th in per capita funding for state mental health authority (DSHS) services and supports for people with serious and persistent mental illness and substance use disorders. Medically indigent individuals who are not eligible for Medicaid have no guarantee of access to needed services and may face extended waiting periods.
- Texas ranks highest among states in the number of uninsured individuals per capita. One in four Texans lack health insurance. People with behavioral health disorders are disproportionately affected. For example, 60 percent of seriously mentally ill adults served in the public mental health system are uninsured.[18]
- The supply of behavioral health care providers is inadequate in most of the State. In April of 2011, 195 (77%) of Texas' 254 counties held federal designations as whole county Health Provider Shortage Areas (HPSAs). This is an increase from the 183 counties designated in 2002.[19]



Projects / project elements under this heading are designed to increase the supply of behavioral health professionals practicing in the State, extend the capacity of behavioral health providers to offer expertise to other health care providers, such as primary care physicians and enhance the capacity of behavioral health and other providers to effectively serve patients with behavioral health conditions. Examples of such projects could include training and residency programs for behavioral health providers, programs which expand access to certified peer support services, telehealth consultation programs in which behavioral health providers offer timely expertise to primary care providers and extended clinic hours / mobile clinics.

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[18] DSHS Decision Support, 2012

[19] **"Highlights: The Supply of Mental Health Professionals in Texas -2010", Texas Department of State Health Services Center for Health Statistics, E-Publication No. E25-12347. Accessed at:** **http://www.dshs.state.tx.us/chs/hprc/publicat.shtm**

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1.11 Implement technology-assisted services (telehealth, telemonitoring, telementoring, or telemedicine) to support, coordinate, or deliver behavioral health services

Project Goal:
Texas faces several access barriers that make the deployment of workable integrated health care models a challenge. Specifically, Texas is composed of 254 counties, the majority of which can be classified as either "rural" or "frontier". The availability of health care providers is severely limited in many of these sparsely populated areas. While these shortages make access to physical healthcare difficult for those who reside in these rural areas, the impact on individuals with behavioral health needs is even more severe. For example, in 2009, 171 Texas counties did not have a psychiatrist, 102 counties did not have a psychologist, 40 counties did not have a social worker and 48 counties did not have a licensed professional counselor.

There are 195 Texas counties (77% of all Texas counties) that have been designated by the Health Resources and Services Administration (HRSA) as Health Professional Shortage Areas (HPSAs) in relation to behavioral health. Furthermore, certain specialties (such as Child Psychiatrists) are virtually non-existent in the vast majority of the rural and frontier areas of the state.

Additionally, the size of the state makes travel from these underserved areas to larger urban settings difficult. For individuals who lack reliable transportation or have disabilities that restrict driving, the challenge of accessing health care may be virtually insurmountable.

Furthermore, there are many non-rural areas of the state where the availability of health care professionals is greatly limited. For example, in Bexar country, which has one of the largest urban populations in Texas, there are 123 areas within the county that have been designated as HPSAs by HRSA. Similar shortages can be found in most Texas urban counties.

Modern communications technology holds the greatest promise of bridging the gap between medical need in underserved areas and the provision of needed services. The developments in internet-based communications that began with voice messaging have been extended to video in the form of widely available video compression technologies that allow for high quality, real time, face-to-face communications and consultations over relatively inexpensive telecommunications equipment. With this new technology, in any area of the state where high speed broadband internet access is available, access to many forms of health care can become a reality. To leverage the promise of this new technology, Texas would like to expand the use of telemedicine, telehealth, and telemonitoring to thereby increase access to, and coordination of, physical and behavioral healthcare.

Televideo technology can be used to provide a variety of what have been referred to as "Telemental Health" services. These services may include mental health assessments, treatment, education, monitoring, mentoring and collaboration. These services may be used in a variety of locations (schools, nursing facilities, and even in homes) in any geographical location where traditional service providers are in short supply. Providers can include psychiatrists, nurse

practitioners, physician assistants, social workers, pharmacists, psychologists, counselors, PCPs, and nurses. For example, telemental health could be used to provide follow-up outpatient consults with a psychiatrist or other mental health professional within 7 or 30 days of discharge from the inpatient hospital. These virtual follow-up visits could focus on monitoring for remission of symptoms, adjusting psychotropic medications, and developing a treatment plan to prevent readmissions in partnership with the primary care provider. Telemental services could also be used to provide medication management services to community mental health patients with severe mental illness to ensure appropriate medication treatment and compliance, preventing psychiatric crises which would require psychiatric hospitalization.

The use of telemedicine could provide direct video access to a psychiatrist while the use of telementoring would provide a General Practitioner with access to consultation with psychiatrists with expertise in managing complex medication regimens. Additionally, telehealth could provide direct access to Cognitive Behavioral Therapy and other evidence-based counseling protocols that have proven to be effective in addressing major depression, trauma, and even schizophrenia in some populations.

Telecommunications technology can also be used to foster peer support and mentoring efforts among providers and among consumers (e.g., support groups, peer mentors).

For example, The University of New Mexico has successfully utilized a telementoring program (Project ECHO) to successfully train and provide ongoing support to Primary Care Physicians (PCPs) who provide care to persons with addiction. This initiative provides weekly didactic sessions as well as case presentations to address challenging clinical cases and get feedback from specialists based at the University and from colleagues around the state.[20]

Project Options:

a) Procure and build the infrastructure needed to pilot or bring to scale a successful pilot of the selected forms of service in underserved areas of the state (this must be combined with one of the two interventions below). Required core project components:
   a) Identify existing infrastructure for high speed broadband communications technology (such as T-3 lines, T-1 lines) in rural, frontier, and other underserved areas of the state;
   b) Assess the local availability of and need for video communications equipment in areas of the state that already have (or will have) access to high speed broadband technology.
   c) Assess applicable models for deployment of telemedicine, telehealth, and telemonitoring equipment.

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[20] **Project ECHO: a model for expanding access to addiction treatment in a rural state**
Miriam Komaromy, MD, 2010.

b) Implement technology-assisted behavioral health services from psychologists, psychiatrists, substance abuse counselors, peers and other qualified providers). Required core project components:

- a) Develop or adapt administrative and clinical protocols that will serve as a manual of technology-assisted operations.
- b) Determine if a pilot of the telehealth, telemonitoring, telementoring, or telemedicine operations is needed. Engage in rapid cycle improvement to evaluate the processes and procedures and make any necessary modifications.
- c) Identify and train qualified behavioral health providers and peers that will connect to provide telemedicine, telehealth, telementoring or telemonitoring to primary care providers, specialty health providers (e.g., cardiologists, endocrinologists, etc.), peers or behavioral health providers. Connections could be provider to provider, provider to patient, or peer to peer.
- d) Identify modifiers needed to track encounters performed via telehealth technology
- e) Develop and implement data collection and reporting standards for electronically delivered services
- f) Review the intervention(s) impact on access to specialty care and identify "lessons learned," opportunities to scale all or part of the intervention(s) to a broader patient population, and identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations.
- g) Scale up the program, if needed, to serve a larger patient population, consolidating the lessons learned from the pilot into a fully-functional telehealth, telemonitoring, telementoring, or telemedicine program. Continue to engage in rapid cycle improvement to guide continuous quality improvement of the administrative and clinical processes and procedures as well as actual operations.
- h) Assess impact on patient experience outcomes (e.g. preventable inpatient readmissions)

c) "Other" project option: Implement other evidence-based project to implement technology-assisted services to support, coordinate, or deliver behavioral health services in an innovative manner not described in the project options above. Providers implementing an innovative, evidence-based project using the "Other" project option may select among the process and improvement milestones specified in this project area or may include one or more customizable process milestone(s) P-X and/or improvement milestone(s) I-X, as appropriate for their project.

Note: All of the project options in project area 1.11 should include a component to conduct quality improvement for the project using methods such as rapid cycle

improvement. Activities may include, but are not limited to, identifying project impacts, "lessons learned," opportunities to scale all or part of the project to a broader patient population, and key challenges associated with expansion of the project, including special considerations for safety-net populations.

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1.12 Enhance service availability (i.e., hours, locations, transportation, mobile clinics) of appropriate levels of behavioral health care

Project Goal

Positive healthcare outcomes are contingent on the ability of the patient to obtain both routine examinations and healthcare services as soon as possible after a specific need for care has been identified. However, many Texans are unable to access either routine services or needed care in a timely manner either because they lack transportation or because they are unable to schedule an appointment due to work scheduling conflicts (or school scheduling conflicts in the case of children) or because they have obligations to provide care for children or elderly relatives during normal work hours. While such barriers to access can compromise anyone's ability to make or keep scheduled appointments, individuals with behavioral health needs may be especially negatively affected. Many individual with behavioral health needs are reticent to seek treatment in the first place and such barriers may be sufficient to prevent access entirely. Others may be easily discouraged by such barriers and may drop out of treatment. Any such delay in accessing services or any break or disruption in services may result in functional loss and the worsening of symptoms. These negative health outcomes come at great personal cost to the individual and also result in increased costs to payers when care is finally obtained.

In order to mitigate the effects of these barriers to accessing care, Texas proposes to take specific steps to broaden access to care that will include an expansion of operating hours in a select number of clinics, an expansion of community-based service options (including the development of mobile clinics), and an expanded transportation program that will support appointments that are scheduled outside of normal business hours.

Project Options:

a) Establish extended operating hours at a select number of Local Mental Health Center clinics or other community-based settings in areas of the State where access to care is likely to be limited.
   Required core project component:
   a) Evaluate existing transportation programs and ensure that transportation to and from medical appointments is made available outside of normal operating hours. If transportation is a significant issue in care access, develop and implement improvements as part of larger project.
   b) Review the intervention(s) impact on access to behavioral health services and identify "lessons learned," opportunities to scale all or part of the intervention(s) to a broader patient population, and identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations.

b) Expand the number of community based settings where behavioral health services may be delivered in underserved areas

c) Develop and staff a number of mobile clinics that can provide access to care in very remote, inaccessible, or impoverished areas of Texas.

d) "Other" project option: Implement other evidence-based project to enhance service availability of appropriate levels of behavioral health care in an innovative manner not described in the project options above. Providers implementing an innovative, evidence-based project using the "Other" project option may select among the process and improvement milestones specified in this project area or may include one or more customizable process milestone(s) P-X and/or improvement milestone(s) I-X, as appropriate for their project.

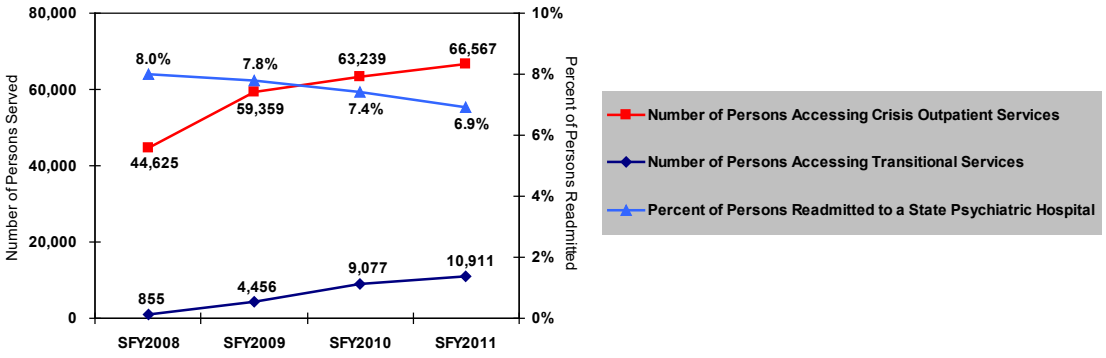
Category 1

1.13 Development of behavioral health crisis stabilization services as alternatives to hospitalization.

Project Goal

When a consumer lacks appropriate behavioral health crisis resolution mechanisms, first responders are often limited in their options to resolve the situation. Sometimes the choice comes down to the ER, jail or an inpatient hospital bed. Crisis stabilization services can be developed that create alternatives to these less desirable settings. Building on existing systems, communities can develop crisis alternatives such as sobering units, crisis residential settings and crisis respite programs with varying degrees of clinical services based on the needs of clients. While hospitalization provides a high degree of safety for the person in crisis, it is very expensive and is often more than what is needed to address the crisis. Community-base crisis alternatives can effectively reduce expensive and undesirable outcomes, such as preventable inpatient stays. For example, state psychiatric hospital recidivism trended downward coincident with implementation of crisis outpatient services in some Texas communities. The percent of persons readmitted to a Texas state psychiatric hospital within 30 days decreased from 8.0% in SFY2008 (before implementation of alternatives) to 6.9% in SFY2011.[21]

Figure 2. **Number of persons accessing crisis outpatient services and transitional services at DSHS-funded community mental health centers compared to percent of persons readmitted to a state psychiatric hospital within 30 days, SFY2008-2011.**



Project Options

a) Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system

Required core project components:

a) Convene community stakeholders who can support the development of crisis stabilization services to conduct a gap analysis of the current community crisis system and develop a specific action plan that identifies specific crisis stabilization services to address identified

[21] **Behavioral Health NEWS BRIEF Vol. 7 Issue 3 -** May 25, 2012 , http://www.dshs.state.tx.us/sa/_BHNB/

gaps (e.g. for example, one community with high rates of incarceration and/or ED visits for intoxicated patients may need a sobering unit while another community with high rates of hospitalizations for mild exacerbations mental illness that could be treated in community setting may need crisis residential programs).

b) Analyze the current system of crisis stabilization services available in the community including capacity of each service, current utilization patterns, eligibility criteria and discharge criteria for each service.

c) Assess the behavioral health needs of patients currently receiving crisis services in the jails, EDs, or psychiatric hospitals. Determine the types and volume of services needed to resolve crises in community-based settings. Then conduct a gap analysis that will result in a data-driven plan to develop specific community-based crisis stabilization alternatives that will meet the behavioral health needs of the patients (e.g. a minor emergency stabilization site for first responders to utilize as an alternative to costly and time consuming Emergency Department settings)

d) Explore potential crisis alternative service models and determine acceptable and feasible models for implementation.

e) Review the intervention(s) impact on access to and quality of behavioral health crisis stabilization services and identify "lessons learned," opportunities to scale all or part of the intervention(s) to a broader patient population, and identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations

b) "Other" project option: Implement other evidence-based project to develop behavioral health crisis stabilization services in an innovative manner not described in the project options above. Providers implementing an innovative, evidence-based project using the "Other" project option may select among the process and improvement milestones specified in this project area or may include one or more customizable process milestone(s) P-X and/or improvement milestone(s) I-X, as appropriate for their project.

Note: All of the project options in project area 1.13 should include a component to conduct quality improvement for the project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, "lessons learned," opportunities to scale all or part of the project to a broader patient population, and key challenges associated with expansion of the project, including special considerations for safety-net populations.

Category 1

1.14 Develop Workforce enhancement initiatives to support access to behavioral health providers in underserved markets and areas (e.g., psychiatrists, psychologists, LMSWs, LPCs and LMFTs.)

Project Goal:
The goal of this project is to enhance access and reduce shortages in specialty behavioral health care to improve local integration of behavioral health care into the overall health delivery system; improve consumer choice and increase availability of effective, lower-cost alternatives to inpatient care, prevent inpatient admissions when possible and promote recovery from behavioral health disorders. The supply of behavioral health care providers is inadequate in most of the State. In 2011, 195 (77%) of Texas' 254 counties held federal designations as whole county Health Provider Shortage Areas (HPSAs) in relation to behavioral health.[22] Indeed, Texas ranks far below the national average in the number of mental health professionals per 100,000 residents. These shortages are even greater in rural, poor and Texas – Mexico border communities.

Project Options:

a) Implement strategies defined in the plan to encourage behavioral health practitioners to serve medically indigent public health consumers in HPSA areas or in localities within non-HPSA counties which do not have access equal to the rest of the county. Examples of strategies could include marketing campaigns to attract providers, enhanced residency programs or structured financial and non-financial incentive programs to attract and retain providers, identifying and engaging individual health care workers early in their studies/careers and providing training in identification and management of behavioral health conditions to other non-behavioral health disciplines (e.g., ANPs, PAs).

Required core project components:

a) Conduct a qualitative and quantitative gap analysis to identify needed behavioral health specialty vocations lacking in the health care region and the issues contributing to the gaps.

b) Develop plan to remediate gaps identified and data reporting mechanism to assess progress toward goal. This plan will specifically identify:

- The severity of shortages of behavioral health specialists in a region by type (psychiatrists, licensed psychologists, nurse practitioners, physicians assistants, nurses, social workers, licensed professional counselors, licensed marriage and family therapists, licensed chemical dependency counselors, peer support specialists, community health workers etc.)
- Recruitment targets by specialty over a specified time period.

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[22] "Highlights: The Supply of Mental Health Professionals in Texas -2010", Texas Department of State Health Services Center for Health Statistics, E-Publication No. E25-12347. Accessed at:
http://www.dshs.state.tx.us/chs/hprc/publicat.shtm

- Strategies for recruiting healthcare specialists
- Strategies for developing training for primary care providers to enhance their understanding of and competency in the delivery of behavioral health services and thereby expand their scope of practice.

c) Assess and refine strategies implemented using quantitative and qualitative data. Review the intervention(s) impact on behavioral health workforce in HPSA areas and identify "lessons learned," opportunities to scale all or part of the intervention(s) to a broader patient population, and identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations

b) "Other" project option: Implement other evidence-based project to develop workforce enhancement initiatives to support access to behavioral health providers in underserved markets in an innovative manner not described in the project options above. Providers implementing an innovative, evidence-based project using the "Other" project option may select among the process and improvement milestones specified in this project area or may include one or more customizable process milestone(s) P-X and/or improvement milestone(s) I-X, as appropriate for their project.

Category 2 Innovation and Redesign

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Category 2

2.1 Enhance/Expand Medical Homes

Project Goal:
The goal of projects under this heading is to expand or enhance the delivery of care provided through the Patient-Centered Medical Home (PCMH) model[23]. The PCMH provides a primary care "home base" for patients. Under this model, patients are assigned a health care team who tailors services to a patient's unique health care needs, effectively coordinates the patient's care across inpatient and outpatient settings, and proactively provides preventive, primary, routine and chronic care.

Project Options:

a) Develop, implement, and evaluate action plans to enhance/eliminate gaps in the development of various aspects of PCMH standards.
Required core project components:
- **a)** Utilize a gap analysis to assess and/or measure hospital-affiliated and/or PCPs' NCQA PCMH readiness.
- **b)** Conduct feasibility studies to determine necessary steps to achieve NCQA PCMH status
- **c)** Conduct educational sessions for primary care physician practice offices, hospital boards of directors, medical staff and senior leadership on the elements of PCMH, its rationale and vision.
- **d)** Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.

b) Collaborate with an affiliated Patient-Centered Medical Home to integrate care management and coordination for shared, high-risk patients.
Required core project components:
- **a)** Improve data exchange between hospitals and affiliated medical home sites.
- **b)** Develop best practices plan to eliminate gaps in the readiness assessment.
- **c)** Hire and train team members to create multidisciplinary teams including social workers, health coaches, care managers, and nurses with a diverse skill set that can meet the needs of the shared, high-risk patients
- **d)** Implement a comprehensive, multidisciplinary intervention to address the needs of the shared, high-risk patients

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23 http://www.aafp.org/online/etc/medialib/aafp_org/documents/about/pcmh.Par.0001.File.dat/PCMH.pdf

e) Evaluate the success of the intervention at decreasing ED and inpatient hospitalization by shared, high-risk patients and use this data in rapid-cycle improvement to improve the intervention.

f) Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.

c) Implement medical homes in HPSA and other rural and impoverished areas using evidence-approached change concepts for practice transformation developed by the Commonwealth Fund's Safety Net Medical Home Initiative: Required core project components:

a) Empanelment: Assign all patients to a primary care provider within the medical home. Understand practice supply and demand, and balance patient load accordingly.

b) Restructure staffing into multidisciplinary care teams that manage a panel of patients where providers and staff operate at the top of their license. Define roles and distribute tasks among care team members to reflect the skills, abilities, and credentials of team members.

c) Link patients to a provider and care team so both patients and provider/care team recognizes each other as partners in care.

d) Assure that patients are able to see their provider or care team whenever possible.

e) Promote and expand access to the medical home by ensuring that established patients have 24/7 continuous access to their care teams via phone, e-mail, or in-person visits.

f) Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.

d) "Other" project option: Implement other evidence-based project to enhance/expand medical home in an innovative manner not described in the project options above. Providers implementing an innovative, evidence-based project using the "Other" project option may select among the process and improvement milestones specified in this project area or may include one or more customizable process milestone(s) P-X and/or improvement milestone(s) I-X, as appropriate for their project. Milestone I-19 includes suggestions for improvement metrics to use with this innovative project option.

Category 2

Note: All of the project options in project area 2.1 should include a component to conduct quality improvement for the project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, "lessons learned," opportunities to scale all or part of the project to a broader patient population, and key challenges associated with expansion of the project, including special considerations for safety-net populations.

Note: PCMH models include investments in projects that are the foundation of delivery system change and a complete package of change. Therefore, it is preferable to pursue a full continuum of projects (PCMH readiness preparations, the establishment or expansion of medical homes which may include gap analyses and eventual application for PCMH recognition[24] to a nationally recognized organization such as NCQA, as well as educating various constituent groups within hospitals and primary care practices about the essential elements of the NCQA medical home standards). [25,26,27,28,29,30,31]

Rationale:
Federal, state, and health care providers share goals to promote more patient-centered care focused on wellness and coordinated care. In addition, the PCMH model is viewed as a foundation for the ability to accept alternative payment models under payment reform. PCMH development is a multi-year transformational effort and is viewed as a foundational way to deliver care aligned with payment reform models and the Triple Aim goals of better health, better patient experience of care, and ultimately better cost-effectiveness. By providing the right care at the right time and in the right setting, over time, patients may see their health improve, rely less on costly ED visits, incur fewer avoidable hospital stays, and report greater patient satisfaction. These projects all are focused on the concepts of the PCMH model; yet, they take different shapes for different providers.[32]

This initiative aims to eliminate fragmented and uncoordinated care, which can lead to emergency department and hospital over-utilization. The projects associated with Medical Homes establish a foundation for transforming the primary care landscape in Texas by emphasizing enhanced chronic disease management through team-based care.

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24 http://www.medicalhomeinfo.org/national/recognition_programs.aspx
25 http://www.commonwealthfund.org/Topics/Patient-Centered-Care.aspx
26 http://www.qhmedicalhome.org/pcmh-qualis-health/change-concepts
27 http://www.pcmh.ahrq.gov/portal/server.pt/community/pcmh__home/1483
28 http://www.medicalhomeforall.com/
29 http://www.acponline.org/running_practice/pcmh/
30 http://www.pediatricmedhome.org/
31 Transformed: http://www.transformed.com/index.cfm
32 http://www.pcpcc.net/content/pcmh-vision-reality

Attachment I
Regional Healthcare Partnership (RHP) Planning Protocol

Category 2

2.2 Expand Chronic Care Management Models[33]

Project Goal:
The goal of this project is to develop and implement chronic disease management interventions that are geared toward improving effective management of chronic conditions and ultimately improving patient clinical indicators, health outcomes and quality, and reducing unnecessary acute and emergency care utilization. Chronic disease management initiatives use population-based approaches to create practical, supportive, evidence-based interactions between patients and providers to improve the management of chronic conditions and identify symptoms earlier, with the goal of preventing complications and managing utilization of acute and emergency care. Program elements may include the ability to identify one or more chronic health conditions or co-occurring chronic health conditions that merit intervention across a patient population, based on a an assessment of patients' risk of developing complications, co-morbidities or utilizing acute or emergency services. These chronic health conditions may include diabetes, congestive heart failure, chronic obstructive pulmonary disease, among others, all of which are prone to co-occurring health conditions and risks.

Project Options:

a) Redesign the outpatient delivery system to coordinate care for patients with chronic diseases
   Required core project components:
   a) Design and implement care teams that are tailored to the patient's health care needs, including non-physician health professionals, such as pharmacists doing medication management; case managers providing care outside of the clinic setting via phone, email, and home visits; nutritionists offering culturally and linguistically appropriate education; and health coaches helping patients to navigate the health care system
   b) Ensure that patients can access their care teams in person or by phone or email
   c) Increase patient engagement, such as through patient education, group visits, self-management support, improved patient-provider communication techniques, and coordination with community resources
   d) Implement projects to empower patients to make lifestyle changes to stay healthy and self-manage their chronic conditions
   e) Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion

33 Some chronic diseases addressed by chronic care management models in RHP plans may include diabetes, hypertension, heart failure, asthma, post-secondary stroke, community-acquired pneumonia (CAP), HIV/AIDS, and chronic pain.

of the project, including special considerations for safety-net populations.

b) Apply evidence-based care management model to patients identified as having high-risk health care needs

c) Redesign rehabilitation delivery models for persons with disabilities

d) Develop a continuum of care in the community for persons with serious and persistent mental illness and co-occurring disorders

e) Develop care management functions that integrate the primary and behavioral health needs of individuals

f) "Other" project option: Implement other evidence-based project to expand chronic care management models in an innovative manner not described in the project options above. Providers implementing an innovative, evidence-based project using the "Other" project option may select among the process and improvement milestones specified in this project area or may include one or more customizable process milestone(s) P-X and/or improvement milestone(s) I-X, as appropriate for their project. Milestone I-21 includes suggestions for improvement metrics to use with this innovative project option.

Note: All of the project options in project area 2.2 should include a component to conduct quality improvement for the project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, "lessons learned," opportunities to scale all or part of the project to a broader patient population, and key challenges associated with expansion of the project, including special considerations for safety-net populations.

Rationale:

Promoting effective change in provider groups to support evidence-based clinical and quality improvement across a wide variety of health care settings. There are many definitions of "chronic condition", some more expansive than others. We characterize it as any condition that requires ongoing adjustments by the affected person and interactions with the health care system. The most recent data show that more than 145 million people, or almost half of all Americans, live with a chronic condition. That number is projected to increase by more than one percent per year by 2030, resulting in an estimated chronically ill population of 171 million. Almost half of all people with chronic illness have multiple conditions. As a result, many managed care and integrated delivery systems have taken a great interest in correcting the many deficiencies in current management of diseases such as diabetes, heart disease, depression, asthma and others. Those deficiencies include:

- Rushed practitioners not following established practice guidelines
- Lack of care coordination
- Lack of active follow-up to ensure the best outcomes
- Patients inadequately trained to manage their illnesses

Overcoming these deficiencies will require nothing less than a transformation of health care, from a system that is essentially reactive - responding mainly when a person is sick - to one that is proactive and focused on keeping a person as healthy as possible. To speed the transition,

Improving Chronic Illness Care created the Chronic Care Model, which summarizes the basic elements for improving care in health systems at the community, organization, practice and patient levels. Evidence on the effectiveness of the Chronic Care Model has recently been summarized. [34]

34 http://content.healthaffairs.org/content/28/1/75.full

2.3 Redesign Primary Care

Project Goal:
Increase efficiency and redesign primary care clinics programs to be oriented around the patient so that primary care access and the patient experience can be improved.

Project Options:

a) Redesign primary care in order to achieve improvements in efficiency, access, continuity of care, and patient experience
Required core project components:
   - **a)** Implement the patient-centered scheduling model in primary care clinics
   - **b)** Implement patient visit redesign
   - **c)** Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.

b) "Other" project option: Implement other evidence-based project to redesign primary care in an innovative manner not described in the project options above. Providers implementing an innovative, evidence-based project using the "Other" project option may select among the process and improvement milestones specified in this project area or may include one or more customizable process milestone(s) P-X and/or improvement milestone(s) I-X, as appropriate for their project. Milestone I-18 includes suggestions for improvement metrics to use with this innovative project option.

Note: All of the project options in project area 2.3 should include a component to conduct quality improvement for the project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, "lessons learned," opportunities to scale all or part of the project to a broader patient population, and key challenges associated with expansion of the project, including special considerations for safety-net populations.

Rationale:
Primary care in the United States faces serious challenges. Many physician practices struggle to ensure that their patients have prompt access to care, consistently high-quality chronic and preventative services, and adequate coordination of care. This struggle impacts patients who may experience barriers in accessing primary care services secondary to transportation, the lack of an assigned provider, inability to receive appointments in a timely manner and a lack of knowledge about what types of services can be provided in the primary care setting. By enhancing access points, available appointment times, patient awareness of available services

and overall primary care capacity, patients and their families will align themselves with the primary care system resulting in improved health access, improved health outcome and reduced costs of services.

2.4 Redesign to Improve Patient Experience

Project Goal:
Improve how the patient experiences the care and the patient's satisfaction with the care provided. The state healthcare transformation is counting on a robust primary care sector to improve quality, reduce costs, and improve patient experience. This will require a redesign of primary care to meet the needs of patients for timely, patient-centered, continuous, and coordinated care to enhance access to care regardless of type of insurance. The overall approach to redesigning patient experience will be centered on cultural change at the organizational level. This will involve the practitioners in a clinic as well as the patients and their families or caregivers. An organizational strategy will be developed so that entities will manage patient experience and create avenues to implement the strategic plan/vision. Providers' performance will be measured, among other factors, by the extent to which patient experience improves systematically.

Patient experience with care will be assessed through focused surveys. The architecture for patient focused surveys should be modeled after the Consumer Assessment of Healthcare Providers and Systems (CAHPS) tool, which includes the following domains: patients are getting timely care, appointments, and information; how well providers communicate with patients; patients' rating of provider; and assessment office staff. [35] The Clinician and Group Consumer Assessment of Health Care Providers and Systems (CG CAHPS) survey[36] can be used to assess patient and caregiver experience of care in outpatient settings while HCAHPS can be employed to measure patient experience in the hospital setting. Certain supplemental modules for the adult survey CG-CAHPS may be used to establish additional outcomes: Health Literacy, Cultural Competence, Health Information Technology, and Patient Centered Medical Home.

These surveys will be mandatory, and will be administered at the end of the medical episode, six weeks after the visit (to avoid recall bias) and six months if no other episode of care intervened.

Project Options:

a) Implement processes to measure and improve patient experience
Required core project components:
- **a)** Organizational integration and prioritization of patient experience
- **b)** Data and performance measurement will be collected by utilizing patient experience of care measures from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) in addition to CAHPS and/or other systems and methodologies to measure patient experience;
- **c)** Implementing processes to improve patient's experience in getting through to the clinical practice;
- **d)** Develop a process to certify independent survey vendors that will be capable of administering the patient experience of care survey in

35 https://cahps.ahrq.gov/clinician_group/cgsurvey/patientexperiencemeasurescgsurveys.pdf
36 https://cahps.ahrq.gov/clinician_group/

accordance with the standardized sampling and survey administration procedures.

b) Implement other evidence based project to improve patient experience in an innovative manner not described above. Note, providers opting to implement an innovative project under this option must propose relevant process metrics and report on the improvement metrics listed under milestone I-X.

c) Project Option: Increased patient satisfaction
Implement an innovative and evidence based intervention that will lead to improvements in patient satisfaction for providers that have demonstrated need or unsatisfactory performance in this area. This project requires reporting of specific metric(s) as associated with corresponding outcome(s) listed in **Category ,3 Outcome Domain – 6 Patient Satisfaction**. Providers selecting this project option should use process milestone(s) X, improvement milestone(s) Y and the milestone development template at the conclusion of this project area to describe how the proposed milestones relate to the specific intervention goals.

d) "Other" project option: Implement other evidence-based project to redesign to improve patient experience in an innovative manner not described in the project options above. Providers implementing an innovative, evidence-based project using the "Other" project option may select among the process and improvement milestones specified in this project area or may include one or more customizable process milestone(s) P-X and/or improvement milestone(s) I-X, as appropriate for their project. Milestone I-20 includes suggestions for improvement metrics to use with this innovative project option.

Note: All of the project options in project area 2.4 should include a component to conduct quality improvement for the project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, "lessons learned," opportunities to scale all or part of the project to a broader patient population, and key challenges associated with expansion of the project, including special considerations for safety-net populations.

Rationale:
Over time, implemented projects have the potential to yield improvements in the level of care integration and coordination for patients and ultimately lead to better health and better patient experience of care.

2.5 Redesign for Cost Containment

Project Goal:
Improve cost-effectiveness of care through improved care delivery for individuals, families, employers, and the government. Measures that provide insights both into improved opportunities for health care delivery and health care cost-effectiveness are an area of particular focus in the TX-DSRIP. Many of the projects include a specific focus on improving population health inside and outside of the walls of the hospital therefore, it will be important to examine measures that develop the capability to test methodologies for measuring cost containment. These methodologies may be subsequently applied to other projects or efforts so that the ability to measure the efficacy of these initiatives is in place, so integrated care models that use data-based cost and quality measures can be developed.

Project Options:

a) Develop an integrated care model with outcome-based payments
Required core project components:
- **a)** Implement cost-accounting systems to measure intervention impacts
- **b)** Establish a method to measure cost containment
- **c)** Establish a baseline for cost
- **d)** Measure cost containment

b) Implement other evidence based project to redesign for cost containment in an innovative manner not described above. Note, providers opting to implement an innovative project under this option must propose relevant process metrics and report on the improvement metrics listed under milestone I-11.

c) Project Option: Cost Savings
Implement an innovative and evidence based intervention that will lead to **cost savings** for providers that have demonstrated need or unsatisfactory performance in this area. This project requires reporting of specific metric(s) as associated with corresponding outcome(s) listed in **Category 3, Outcome Domain – 5 Cost of Care** [37]. Providers selecting this project option should use process milestone(s) X, improvement milestone(s) Y and the milestone development template at the conclusion of this project area to describe how the proposed milestones relate to the specific intervention goals.

d) "Other" project option: Implement other evidence-based project to will impact cost efficiency in an innovative manner not described in the project options above. Providers implementing an innovative, evidence-based project using the "Other" project option may select among the process and improvement milestones specified in this project area or may include one or more customizable process milestone(s) P-X and/or improvement milestone(s) I-X, as appropriate for their

37 Category 3 Outcome Measures document

project. Milestone I-11 includes suggestions for improvement metrics to use with this innovative project option.

Note: All of the project options in project area 2.5 should include a component to conduct quality improvement for the project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, "lessons learned," opportunities to scale all or part of the project to a broader patient population, and key challenges associated with expansion of the project, including special considerations for safety-net populations.

Rationale:
Health care spending for a given population might be roughly defined as a function of five basic factors[38]:

- Population needs or morbidity,
- Access to services,
- Propensity to seek services,
- Volume, nature, or intensity of services supplied or ordered, and
- Unit cost or price of services.

For the purpose of this project area, "cost containment" will be defined as any set of policies or measures intended to affect any one or more of these factors.

38 http://www.policyarchive.org/handle/10207/bitstreams/21904.pdf

Category 2

2.6 Implement Evidence-based Health Promotion Programs

Project Goal:
Implement innovative evidence based health promotion strategies such as use of community health workers, innovations in social media and messaging for targeted populations.

Project Options:

a) Engage in population-based campaigns or programs to promote healthy lifestyles using evidence-based methodologies including social media and text messaging in an identified population.

b) Establish self-management programs and wellness using evidence-based designs.

c) Engage community health workers in an evidence-based program to increase health literacy of a targeted population.

d) "Other" project option: Implement other evidence-based project to implement evidence-based health promotion programs in an innovative manner not described in the project options above. Providers implementing an innovative, evidence-based project using the "Other" project option may select among the process and improvement milestones specified in this project area or may include one or more customizable process milestone(s) P-X and/or improvement milestone(s) I-X, as appropriate for their project. Milestone I-8 includes suggestions for improvement metrics to use with this innovative project option.

Note: All of the project options in project area 2.6 should include a component to conduct quality improvement for the project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, "lessons learned," opportunities to scale all or part of the project to a broader patient population, and key challenges associated with expansion of the project, including special considerations for safety-net populations.

Note: All of the project options in 2.6 should include a component to conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.

Rationale:
The current prevention and treatment system is an unconnected, silo-based approach, which reduces the effectiveness and increases the cost of health care. [1] As the US health care system strives to deliver better health, improved care and lower costs, the potential exists for innovative evidenced based health promotion strategies to further these goals.

Delivery Mechanisms: Community health workers can increase access to care and facilitate appropriate use of health resources by providing outreach and cultural linkages between communities and delivery systems; reduce costs by providing health education, screening, detection, and basic emergency care; and improve quality by contributing to patient-provider communication, continuity of care, and consumer protection. Information sharing, program support, program evaluation, and continuing education are needed to expand the use of community health workers and better integrate them into the health care delivery system.

Self-Management education complements traditional patient education in supporting patients to live the best possible quality of life with their chronic condition. Whereas traditional patient education offers information and technical skills, self-management education teaches problem-solving skills. A central concept in self-management is self-efficacy—confidence to carry out a behavior necessary to reach a desired goal. Self-efficacy is enhanced when patients succeed in solving patient-identified problems. Evidence from controlled clinical trials suggests that[39] (1) programs teaching self-management skills are more effective than information-only patient education in improving clinical outcomes; (2) in some circumstances, self-management education improves outcomes and can reduce costs for arthritis and probably for adult asthma patients[40]; and (3) in initial studies, a self-management education program bringing together patients with a variety of chronic conditions may improve outcomes and reduce costs.[41]

39 1Thorpe, K, The Affordable Care Act lays the groundwork for a national diabetes prevention and treatment strategy. Health Aff January 2012 vol. 31 no. 1 61-66

40 2A Witmer, S D Seifer, L Finocchio, J Leslie, and E H O'Neil. Community health workers: integral members of the health care work force. American Journal of Public Health August 1995: Vol. 85, No. 8_Pt_1, pp. 1055-1058. doi: 10.2105/AJPH.85.8_Pt_1.1055

41 Bodenheimer T, Lorig K, Holman H, Grumbach K. Patient Self-management of Chronic Disease in Primary Care. JAMA. 2002; 288(19):2469-2475.

2.7 Implement Evidence-based Disease Prevention Programs

Project Goal:
Implement innovative evidence-based strategies in disease prevention areas including the following: diabetes, obesity, tobacco use, prenatal care, birth spacing, and health screenings.

Project Options:

a) Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations (e.g., mammography screens, colonoscopies, prenatal alcohol use, etc.)
b) Implement innovative evidence-based strategies to reduce tobacco use.
c) Implement innovative evidence-based strategies to increase early enrollment in prenatal care.
d) Implement innovative evidence-based strategies to reduce low birth weight and preterm birth.
e) Implement innovative evidence-based strategies to reduce and prevent obesity in children and adolescents.
f) "Other" project option: Implement other evidence-based project to implement evidence-based disease prevention programs in an innovative manner not described in the project options above. Providers implementing an innovative, evidence-based project using the "Other" project option may select among the process and improvement milestones specified in this project area or may include one or more customizable process milestone(s) P-X and/or improvement milestone(s) I-X, as appropriate for their project. Milestone I-7 includes suggestions for improvement metrics to use with this innovative project option.

Note: All of the project options in project area 2.7 should include a component to conduct quality improvement for the project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, "lessons learned," opportunities to scale all or part of the project to a broader patient population, and key challenges associated with expansion of the project, including special considerations for safety-net populations.

Rationale:
Disease management emphasizes prevention of disease-related exacerbations and complications using evidence-based guidelines and patient empowerment tools. It can help manage and improve the health status of a defined patient population over the entire course of a disease.[1]

By concentrating on the causes of chronic disease, the community moves from a focus on sickness and disease to one based on wellness and prevention. The National Prevention Council strategy for Disease Prevention focuses on four areas: building healthy and safe community environments, expanding quality preventive services in clinical and community settings, helping people make healthy choices, and eliminating health disparities. To achieve these aims, the

strategy identifies seven evidence-based recommendations that are likely to reduce the leading causes of preventable death and major illness, including tobacco-free living, drug- and excessive alcohol-use prevention, healthy eating, active living, injury and violence-free living, reproductive and sexual health, and mental and emotional well-being.[2]

Delivery Mechanisms: (note this list is not inclusive of all delivery mechanisms)

- Establish and use patient registry systems to enhance the provision of patient follow-up, screenings for related risk factors and to track patient improvement.
- Establish and implement clinical practice guidelines.
- Adopt the Chronic Care Model
- Develop a mapping process linking patients treated in the emergency rooms with RFPs to improve the continuum of care and standardized procedures and outcome measures.
- Promote RHP health system supports such as reminders of care, development of clinical performance measures, and the use of case management services to increase patient's adherence to health care guidelines.
- Establish evidence-based disease and disability prevention programs for targeted populations to reduce their risk of disease, injury, and disability.

2.8 Apply Process Improvement Methodology to Improve Quality/Efficiency

Project Goal:
The goal of this project is to implement process improvement methodologies to improve safety, quality, patient experience and efficiency. Providers may design customized initiatives based on various process improvement methodologies such as Lean, Six Sigma, Continuous Improvement, Rapid Cycle, Care Logistics, Nurses Improving Care for Healthsystem Elders (NICHE) among others.

For example, the Lean methodology as applied to medicine evaluates the use of resources, measures the value to the patient, considers the use of resources in terms of their value to the patient, and eliminates those that are wasteful. Using methodologies such as Lean that are proven to eliminate waste and redundancies and optimize patient flow, hospitals may customize a project that will develop and implement a program of continuous improvement that will increase communication, integrate system workflows, provide actionable data to providers and patients, and identify and improve models of patient-centered care that address issues of safety, quality, and efficiency.

Implementation frequently requires a new "operational mindset" using tools such as Lean to identify and progressively eliminate inefficiencies while at the same time linking human performance, process performance and system performance into transformational performance in the delivery system.[42]

The process improvement, as a further example, may include elements such as identifying the value to the patient, managing the patient's journey, facilitating the smooth flow of patients and information, introducing "pull" in the patient's journey (e.g. advanced access), and/or continuously reducing waste by developing and amending processes awhile at the same time smoothing flow and enhancing quality and driving down cost.[43]

Furthermore, projects designed and implemented using the Care Logistics™ patient-centered, care coordination model involves managing the simultaneous logistics of a patient moving through the hospital. It may be used to help hospitals transform their operations to improve patient flow into cross departmental hubs and provide actionable data in real-time on key performance indicators, such as, but not limited to, length of stay, patient flow times, discharge process times, re-admission rates, and patient, provider and staff satisfaction.[44]

In addition, hospitals may design a process improvement initiative utilizing the NICHE program framework, which aims to facilitate the infusion of evidence-based geriatric best practices throughout institutions to improve nursing care for older adult patients. NICHE is based on the

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42 Oujiri J, Ferrara C. "The Phoenix Project – Integrating Effective Disease Management Into Primary Care Using Lean Six-Sigma Tools." Duluth Clinic Presentation. 2010.
43 Bibby J. "Lean in Primary Care: The Basics – Sustaining Transformation." Asian Hospital and Healthcare Management (2011) 18.
44 http://www.carelogistics.com/

use of principles and tools to support a systemic change in nursing practice and in the culture of healthcare facilities to achieve patient-centered care.[45]

Project Options:

a) Design, develop, and implement a program of continuous, rapid process improvement that will address issues of safety, quality, and efficiency. Required core project components:
   - **a)** Provide training and education to clinical and administrative staff on process improvement strategies, methodologies, and culture.
   - **b)** Develop an employee suggestion system that allows for the identification of issues that impact the work environment, patient care and satisfaction, efficiency and other issues aligned with continuous process improvement.
   - **c)** Define key safety, quality, and efficiency performance measures and develop a system for continuous data collection, analysis, and dissemination of performance on these measures ((i.e. weekly or monthly dashboard).
   - **d)** Develop standard workflow process maps, staffing and care coordination models, protocols, and documentation to support continuous process improvement.
   - **e)** Implement software to integrate workflows and provide real-time performance feedback.
   - **f)** Evaluate the impact of the process improvement program and assess opportunities to expand, refine, or change processes based on the results of key performance indicators.

b) "Other" project option: Implement other evidence-based project to apply process improvement methodology to improve quality/efficiency in an innovative manner not described in the project options above. Providers implementing an innovative, evidence-based project using the "Other" project option may select among the process and improvement milestones specified in this project area or may include one or more customizable process milestone(s) P-X and/or improvement milestone(s) I-X, as appropriate for their project. Milestone I-16 includes suggestions for improvement metrics to use with this innovative project option.

Note: All of the project options in project area 2.8 should include a component to conduct quality improvement for the project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, "lessons learned," opportunities to scale all or part of the project to a broader patient population, and key challenges associated with expansion of the project, including special considerations for safety-net populations.

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45 http://www.nicheprogram.org/

Project Options tied to a customized outcome in a specified Category 3 domain

c) Project Option: Reduction in Potentially Preventable Admission Rates (PPAs)
Implement an innovative and evidence based intervention that will lead to **reductions** in Potentially Preventable Admissions (PPAs) for providers that have demonstrated need or unsatisfactory performance in this area. This project requires reporting of specific metric(s) as associated with corresponding outcome(s) listed in **Category 3, Outcome Domain -2, Potentially Preventable Admissions**[46]. Providers selecting this project option should use process milestone(s) X, improvement milestone(s) Y, and the milestone development template listed at the conclusion of this project area to describe how the proposed milestones relate to the specific intervention goals.

d) Project Option: Reduction in 30-Day Hospital Readmission Rates (Potentially Preventable Readmissions)[47]
Implement an innovative and evidence based intervention that will lead to reductions in 30 Day Readmissions for providers that have demonstrated need or unsatisfactory performance in this area. This project requires reporting of specific metric(s) as associated with corresponding outcome(s) listed in **Category 3, Outcome Domain- 3, Potentially Preventable Readmissions**[1]. Providers selecting this project option should use process milestone(s) X, improvement milestone(s) Y, and the milestone development template listed at the conclusion of this project area to describe how the proposed milestones relate to the specific intervention goals.

e) Project Option: Reduction in Potentially Preventable Complications (PPC)
Implement an innovative and evidence based intervention that will lead to **reductions** in Potentially Preventable Complications (PPCs) for providers that have demonstrated need or unsatisfactory performance in this area. This project requires reporting of specific metric(s) as associated with corresponding outcome(s) listed in **Category 3, Outcome Domain-4, Potentially Preventable Complications**[1]. Providers selecting this project option should use process milestone(s) X, improvement milestone(s) Y and the milestone development template listed at the conclusion of this project area to describe how the proposed milestones relate to the specific intervention goals.

f) Project Option: Reduce Inappropriate ED Use
Implement an innovative and evidence based intervention that will lead to **reductions** in inappropriate Emergency Department use for providers that have demonstrated need or unsatisfactory performance in this area. This project requires reporting of specific metric(s) as associated with corresponding outcome(s) listed in **Category 3, Outcome Domain -9, Right Care, Right Setting**[1]. Providers selecting this project option should use process milestone(s) X, improvement milestone(s) Y and the milestone

46 Category 3 Outcome Measures document
47 http://www.hhsc.state.tx.us/reports/2012/potentially-preventable-readmissions.pdf

development template listed at the conclusion of this project area to describe how the proposed milestones relate to the specific intervention goals.

g) Project Option: Improved Clinical Outcome for Identified Disparity Group
Implement an innovative and evidence based intervention that will lead to **improvements** in clinical outcomes for an identified disparity group for providers that have demonstrated need or unsatisfactory performance in this area. This project requires reporting of specific metric(s) as associated with corresponding outcome(s) listed in **Category 3, Outcome Domain -11, Addressing Health Disparities in Minority Population**[48]. Providers selecting this project option should use process milestones X, improvement milestones Y and the milestone development template listed at the conclusion of this project area to describe how the proposed milestones relate to the specific intervention goals.

h) Project Option: Improved Access to Care
Implement an innovative and evidence based intervention that will lead to **increase** in access to care for providers that have demonstrated need or unsatisfactory performance in this area. This project requires reporting of specific metric(s) as associated with corresponding outcome(s) listed in **Category 3, Outcome Domain -1, Primary Care and Chronic Disease Management**[3]. Providers selecting this project option should use process milestone(s) X, improvement milestone(s) Y and the milestone development template listed at the conclusion of this project area to describe how the proposed milestones relate to the specific intervention goals.

i) Project Option: Improvement in Perinatal Health Indicator(s)
Implement an innovative and evidence based intervention that will lead to **improvements** in perinatal health outcomes for providers that have demonstrated need or unsatisfactory performance in this area. This project requires reporting of specific metric(s) as associated with corresponding outcome(s) listed in **Category 3, Outcome Domain - 8, Perinatal Care Outcomes**[3]. Providers selecting this project option should use process milestones X, improvement milestones Y and the milestone development template listed at the conclusion of this project area to describe how the proposed milestones relate to the specific intervention goals.

j) Project Option: Improve Clinical Indicator/Functional Status for Target Population
Implement an innovative and evidence based intervention that will lead to **improvements** in a selected clinical indicator for a targeted population for providers that have demonstrated need or unsatisfactory performance in this area. This project requires reporting of specific metric(s) as associated with corresponding outcome(s) listed in **Category 3, Outcome Domain - 10, Quality of Life/Functional Status**[3]. Providers selecting this project option should use process milestone(s) X, improvement milestone(s) Y and the

48 Category 3 Outcome Measures document

milestone development template listed at the conclusion of this project area to describe how the proposed milestones relate to the specific intervention goals.

k) Project Option: Sepsis
Implement an innovative and evidence based intervention that will lead to **reductions** in Sepsis Complications (mortality, prevalence and incidence) for providers that have demonstrated need or unsatisfactory performance in this area. This project requires reporting of specific metric(s) as associated with corresponding outcome(s) listed in **Category 3, Outcome Domain -3, Potentially Preventable Complications**[49]. Providers selecting this project option should use process milestone(s) X, improvement milestone(s) Y and the milestone development template listed at the conclusion of this project area to describe how the proposed milestones relate to the specific intervention goals.

l) Project Option: Other
Implement an innovative and evidence based intervention that will lead to improvements in a health outcome not include elsewhere for providers that have demonstrated need or unsatisfactory performance in this area. This project requires reporting of specific metric(s) as associated with corresponding outcome(s) titled Other Outcome Improvement Target listed in each **Outcome Domain** in **Category 3**. Providers selecting this project option should use process milestones X, improvement milestones Y and the milestone development template listed at the conclusion of this project area to describe how the proposed milestones relate to the specific intervention goals.

Rationale:
Every day, millions of Americans receive high-quality health care that helps to maintain or restore their health and ability to function. However, far too many do not. Quality problems are reflected in a wide variation in the use of health care services, underuse of some services, overuse of other services, and misuse of services, including an unacceptable level of errors.
A central goal of health care quality improvement is to maintain what is good about the existing health care system while focusing on the areas that need improvement.
Several types of quality problems in health care have been documented through peer-reviewed research. [50]

Variation in services. There continues to be a pattern of wide variation in health care practice, including regional variations and small-area variations. This is a clear indicator that health care practice has not kept pace with the evolving science of health care to ensure evidence-based practice in the United States.

Underuse of services. Millions of people do not receive necessary care and suffer needless complications that add to costs and reduce productivity. Each year, an estimated 18,000 people die because they do not receive effective interventions.

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49 Category 3 Outcome Measures document
50 http://www.ahrq.gov/news/qualfact.htm

Attachment I
Regional Healthcare Partnership (RHP) Planning Protocol

Category 2

Overuse of services. Each year, millions of Americans receive health care services that are unnecessary, increase costs, and may even endanger their health. Research has shown that this occurs across all populations.

Misuse of services. Too many Americans are injured during the course of their treatment, and some die prematurely as a result.

Disparities in quality. Although quality problems affect all populations, there may be specific groups identified that have marked differences in quality of care and health outcome. These group may be defined by racial/ethnic differences, income states, geographic area or other social determinants of health.

2.9 Establish/Expand a Patient Care Navigation Program

Project Goal:
The goal of this project is to utilize community health workers, case managers, or other types of health care professionals as patient navigators to provide enhanced social support and culturally competent care to vulnerable and/or high-risk patients. Patient navigators will help and support these patients to navigate through the continuum of health care services. Patient Navigators will ensure that patients receive coordinated, timely, and site-appropriate health care services. Navigators may assist in connecting patients to primary care physicians and/or medical home sites, as well as diverting non-urgent care from the Emergency Department to site-appropriate locations. RHPs implementing this project will identify health care workers, case managers/workers or other types of health professionals needed to engage with patients in a culturally and linguistically appropriate manner that will be essential to guiding the patients through integrated health care delivery systems.
A study on Patient Navigation funded by the National Cancer Institute was done in TX and a manual for patient navigation programs directed towards Latino audiences was released following its completion.[51]

Project Options:

a) Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care (for example, patients with multiple chronic conditions, cognitive impairments and disabilities, Limited English Proficient patients, recent immigrants, the uninsured, those with low health literacy, frequent visitors to the ED, and others)
Required core project components:
   a) Identify frequent ED users and use navigators as part of a preventable ED reduction program. Train health care navigators in cultural competency.
   b) Deploy innovative health care personnel, such as case managers/workers, community health workers and other types of health professionals as patient navigators.
   c) Connect patients to primary and preventive care.
   d) Increase access to care management and/or chronic care management, including education in chronic disease self-management.
   e) Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.

51 http://www.redesenaccion.org/sites/www.redesenaccion.org/files/PNmanualfinal.pdf

b) "Other" project option: Implement other evidence-based project to establish/expand a patient care navigation program in an innovative manner not described in the project options above. Providers implementing an innovative, evidence-based project using the "Other" project option may select among the process and improvement milestones specified in this project area or may include one or more customizable process milestone(s) P-X and/or improvement milestone(s) I-X, as appropriate for their project. Milestone I-10 includes suggestions for improvement metrics to use with this innovative project option.

Note: All of the project options in project area 2.9 should include a component to conduct quality improvement for the project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, "lessons learned," opportunities to scale all or part of the project to a broader patient population, and key challenges associated with expansion of the project, including special considerations for safety-net populations.

Rationale:
Patient navigators help patients and their families navigate the fragmented maze of doctors' offices, clinics, hospitals, out-patient centers, payment systems, support organizations and other components of the healthcare system. Services provided by patient navigators vary by program and the needs of the patient, but often include:[52]

- Facilitating communication among patients, family members, survivors and healthcare providers.
- Coordinating care among providers.
- Arranging financial support and assisting with paperwork.
- Arranging transportation and child care.
- Ensuring that appropriate medical records are available at medical appointments.
- Facilitating follow-up appointments.
- Community outreach and building partnership with local agencies and groups.
- Ensuring access to clinical trials.

There is no one common definition of patient navigators and the profile of a patient navigator vary widely by program. Many use trained community health workers who may be full-time employees or volunteers. Community health workers have close ties to the local community and serve as important links between underserved communities and the healthcare system. They also posses the linguistic and cultural skills needed to connect with patients from underserved communities. Community health workers are also known as community health advisors, lay health advocates and promotoras de salud. Healthcare navigators include trained social workers, nurses and nurse practitioners as well as trained lay persons/volunteers. Some navigation programs also use a team based approach that combines community health workers with one or more professionals with experience in healthcare or social work. While there is no set education required for a patient navigator to be successful, a successful navigator should be:

52 http://www.altfutures.com/draproject/pdfs/Report_07_02_Patient_Navigator_Program_Overview.pdf

- Compassionate, sensitive, culturally attuned to the people and community being served and able to communicate effectively.
- Knowledgeable about the environment and healthcare system.
- Connected with critical decision makers inside the system, especially financial decision makers.

2.10 Use of Palliative Care Programs

Project Goal:[53]
Provide palliative care services to improve patient outcomes and quality of life. Palliative medicine represents a different model of care, focusing not on cure at any cost but on relief and prevention of suffering. Here the priority is supporting the best possible quality of life for the patient and family, regardless of prognosis. Ideally, the principles of palliative care can be applied as far upstream as diagnosis, in tandem with cure-directed treatment, although it's still associated in most people's minds with end-of-life care. There is an economic incentive for hospitals to support palliative care -- research shows significant reductions in pharmacy, laboratory, and intensive care costs -- though there's understandable reluctance to tout such benefits. After all, accusations of "death panels" effectively shut out government funding for palliative care as national debates about health care reform took shape.

Palliative care has emerged in the past decade. It takes an interdisciplinary approach – doctors, nurses, social workers and often chaplains – and blends it with curative care for seriously ill people. While palliative care is for people who are very sick, they don't have to have a six-month life expectancy. Some palliative care programs operate in hospitals; others treat people living at home. Growing numbers of community-based hospices also have palliative care services now. Pediatric palliative care is not available everywhere, although it's becoming more common at the major children's hospitals, In addition, hospices nationwide, which traditionally were often unwilling to treat dying children, have also become more open to pediatric care. The new health reform law allows dying children on Medicaid or the state Children's Health Insurance Program to get hospice or palliative care without halting other treatment[54].

Health care reform has the potential to improve palliative care by implementing care coordination (in hospitals and community) evidence-based programs that are already proven to be working. Within palliative care, patients receive dignified and culturally appropriate end-of-life care, which is provided for patients with terminal illnesses in a manner that prioritizes pain control, social and spiritual care, and patient/family preferences

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53 The Center to Advance Palliative Care (CAPC)www.capc.org/reportcard
54 http://www.kaiserhealthnews.org/
55 Cost savings associated with US hospital palliative care consultation programs.
Morrison RS, Penrod JD, Cassel JB, Caust-Ellenbogen M, Litke A, Spragens L, Meier DE; Palliative Care Leadership Centers' Outcomes Group. Arch Intern Med. 2008 Sep 8; 168(16):1783-90.

Project Options:

a) Implement a Palliative Care Program to address patients with end-of-life decisions and care needs
Required core project components:
- **a)** Develop a business case for palliative care and conduct planning activities necessary as a precursor to implementing a palliative care program
- **b)** Transition palliative care patients from acute hospital care into home care, hospice or a skilled nursing facility
- **c)** Implement a patient/family experience survey regarding the quality of care, pain and symptom management, and degree of patient/family centeredness in care and improve scores over time
- **d)** Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.

b) "Other" project option: Implement other evidence-based project to implement use of palliative care programs in an innovative manner not described in the project options above. Providers implementing an innovative, evidence-based project using the "Other" project option may select among the process and improvement milestones specified in this project area or may include one or more customizable process milestone(s) P-X and/or improvement milestone(s) I-X, as appropriate for their project. Milestone I-14 includes suggestions for improvement metrics to use with this innovative project option.

Note: All of the project options in project area 2.10 should include a component to conduct quality improvement for the project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, "lessons learned," opportunities to scale all or part of the project to a broader patient population, and key challenges associated with expansion of the project, including special considerations for safety-net populations.

Rationale:

While end-of-life care was once associated almost exclusively with terminal cancer, today people receive end-of-life care for a number of other conditions, such as congestive heart failure, other circulatory conditions, COPD, and dementia[56]. Further, some experts have suggested that palliative and hospice care could be more widely embraced for many dying patients. However, these experts say that overly rigid quality standards and poorly aligned reimbursement incentives discourage appropriate end-of-life care and foster incentives to provide inappropriate restorative

56 MedPAC, 2008

care and technologically intensive treatments. These experts note that hospitals, nursing homes, and home health agencies need stronger incentives to provide better access to palliative care and care coordination either directly, themselves, or by contract with outside suppliers of hospice services[57]. It seems clear that improving care coordination near the end of life can improve care for patients with chronic conditions, however, in addition to the elderly with multiple chronic conditions and terminal illnesses, palliative care should also allow children who are enrolled in either Medicaid or CHIP to receive hospice services without foregoing curative treatment related to a terminal illness.

57 Zerzan, Stearns, & Hanson, 2000; Hanley, 2004

2.11 Conduct Medication Management

Project Goal:
The goal of **c**onducting Medication Management is to provide information that facilitates the appropriate use of medications in order to control illness and promote health[58]. Medication management is the monitoring of medications a patient takes to confirm that the patient is complying with a medication regimen, while also ensuring the patient is avoiding potentially dangerous drug interactions and other complications. This is especially important for patients taking large numbers of medications to address chronic illnesses and multiple diseases. Taking numerous medications is known as polypharmacy and it is particularly common among older adults, as they are more likely to need medications to manage an array of chronic conditions.

There are a number of aspects to medication management, all of which are focused on making sure that medications are used appropriately. Keeping track of all of the medications currently in use by a patient is an important part of medication management. This can include creating printed lists describing medications, their dosages, and how they are being used. These lists can be kept in patient charts and provided to patients to help them track the drugs they use and understand why various medications are being prescribed.

Monitoring medication administration is also key. Medications usually need to be taken in specific doses at set intervals. Missing doses or timing doses incorrectly can cause complications. Medication management can include everything from using devices that issue reminders to patients to take their medications to filling pill cases for patients and marking the lid of each compartment to indicate when the contents need to be taken[59].

The specific purpose of this project area is to provide the platform to conduct Medication Management so that patients receive the right medications at the right time across the Performing Provider in order to reduce medication errors and adverse effects from medication use.

Project Options:

a) Implement interventions that put in place the teams, technology, and processes to avoid medication errors
Required core project components:
   - **a)** Develop criteria and identify targeted patient populations; e.g. chronic disease patient populations that are at high risk for developing complications, co-morbidities, and/or utilizing acute and emergency care services.
   - **b)** Develop tools to provide education and support to those patients at highest risk of an adverse drug event or medication error.
   - **c)** Conduct root cause analysis of potential medication errors or adverse drug events and develop/implement processes to address those causes

58 The Patient-Centered Medical Home: Integrating Comprehensive Medication Management to Optimize Patient Outcomes. 2nd ed, 2012.
59 http://www.wisegeek.com/

d) Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.

b) Evidence-based interventions that put in place the teams, technology and processes to avoid medication errors. This project option could include one or more of the following components:

a) Implement a medication management program that serves the patient across the continuum of care targeting one or more chronic disease patient populations

b) Implement Computerized Physician Order Entry (CPOE)

c) Implement pharmacist-led chronic disease medication management services in collaboration with primary care and other health care providers.

c) "Other" project option: Implement other evidence-based project to conduct medication management in an innovative manner not described in the project options above. Providers implementing an innovative, evidence-based project using the "Other" project option may select among the process and improvement milestones specified in this project area or may include one or more customizable process milestone(s) P-X and/or improvement milestone(s) I-X, as appropriate for their project. Milestone I-20 includes suggestions for improvement metrics to use with this innovative project option.

Note: All of the project options in project area 2.11 should include a component to conduct quality improvement for the project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, "lessons learned," opportunities to scale all or part of the project to a broader patient population, and key challenges associated with expansion of the project, including special considerations for safety-net populations.

Rationale:

More than 3.5 billion prescriptions are written annually in the United States[60], and four out of five patients who visit a physician leave with at least one prescription[61]. Medications are involved in 80 percent of all treatments and impact every aspect of a patient's life. The two most commonly identified drug therapy problems in patients receiving comprehensive medication management services are: (1) the patient requires additional drug therapy for prevention, synergistic, or palliative care; and (2)the drug dosages need to be titrated to achieve therapeutic

60 Sommers JP. Prescription drug expenditures in the10 largest states for persons under age 65, 2005.2008. Agency for Healthcare Research and Quality. Available at: http://meps.ahrq.gov/mepsweb/data_files/publications/st196/stat196.pdf.
61 The chain pharmacy industry profile. National Association of Chain Drug Stores. 2001.

levels that reach the intended therapy goals[62].According to the World Health Organization, adherence to therapy for chronic diseases in developed countries averages 50 percent, and the major consequences of poor adherence to therapies are poor health outcomes and increased health care costs[63].Drug therapy problems occur every day and add substantial costs to the health care system. Drug-related morbidity and mortality costs exceed $200 billion annually in the U.S., exceeding the amount spent on the medications themselves[64]. The Institute of Medicine noted that while only 10 percent of total health care costs are spent on medications, their ability to control disease and impact overall cost, morbidity, and productivity—when appropriately used—is enormous[65].

62 Cipolle R, Strand L, Morley P. Pharmaceutical care practice: The clinician's guide. McGraw-Hill; 2004.
63 World Health Organization. Adherence to long-term therapies: Evidence for action. 2003. Available at: http://whqlibdoc.who.int/publications/2003/9241545992.pdf.
64 Johnson J, Bootman JL. Drug-related morbidity and mortality. Arch Intern Med. 1995; 155(18):1949-1956; Johnson JA, Bootman JL. Drug-related morbidity and mortality. Am J Health Syst Pharm. 1997; 54(5):554-558; Ernst, FR, Grizzle AJ. Drug-related morbidity and mortality: Updating the cost-of-illness model. J Am Pharm Assoc. 2001; 41(2):192-199.
65 Centers for Medicare & Medicaid Services. National Health Expenditures. January 2008.

2.12 Implement/Expand Care Transitions Programs

Project Goal:
The goal of this project is to implement improvements in care transitions and coordination of care from inpatient to outpatient, post-acute care, and home care settings in order to prevent increased health care costs and hospital readmissions. Care transitions refer to the movement of patients from one health care provider or setting to another. For people with serious and complex illnesses, transitions in setting of care—for example from hospital to home or nursing home, or from facility to home- and community-based services—have been shown to be prone to errors.[66] Safe, effective, and efficient care transitions and reduced risk of potentially preventable readmissions require cooperation among providers of medical services, social services, and support services in the community and in long-term care facilities. High-risk patients often have multiple chronic diseases. The implementation of effective care transitions requires practitioners to learn and develop effective ways to successfully manage one disease in order to effectively manage the complexity of multiple diseases.[67]The discontinuity of care during transitions typically results in patients with serious conditions, such as heart failure, chronic obstructive pulmonary disease, and pneumonia, falling through the cracks, which may lead to otherwise preventable hospital readmission. [68]The goal is to ensure that the hospital discharges are accomplished appropriately and that care transitions occur effectively and safely.

Project Options:

a) Develop, implement, and evaluate standardized clinical protocols and evidence-based care delivery model to improve care transitions
Required core project components:

- **a)** Review best practices from a range of models (e.g. RED, BOOST, STAAR, INTERACT, Coleman, Naylor, GRACE, BRIDGE, etc.).
- **b)** Conduct an analysis of the key drivers of 30-day hospital readmissions using a chart review tool (e.g. the Institute for Healthcare Improvement's (IHI) State Action on Avoidable Re-hospitalizations (STAAR) tool) and patient interviews.
- **c)** Integrate information systems so that continuity of care for patients is enabled
- **d)** Develop a system to identify patients being discharged potentially at risk of needing acute care services within 30-60 days
- **e)** Implement discharge planning program and post discharge support program

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66Coleman EA. "Falling Through the Cracks: Challenges and Opportunities for Improving Transitional Care for Persons with Continuous Complex Care Needs." Journal of the American Geriatrics Society (2003) 51:549-555
67 Rittenhouse D, Shortell S, et al. "Improving Chronic Illness Care: Findings from a National Study of Care Management Processes in Large Physician Practices." Medical Care Research and Review Journal (2010) 67(3): 301-320
68 Coleman, E., Parry, C., et. al. "The Care Transitions Intervention: a patient centered approach to ensuring effective transfers between sites of geriatric care." Home Health Care Serv Q (2003) 22 (3): 1-17

f) Develop a cross-continuum team comprised of clinical and administrative representatives from acute care, skilled nursing, ambulatory care, health centers, and home care providers.

g) Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.

b) Implement one or more pilot intervention(s) in care transitions targeting one or more patient care units or a defined patient population. Examples of interventions include, but are not limited to, implementation of:

- Discharge checklists
- "Hand off" communication plans with receiving providers
- Wellness initiatives targeting high-risk patients
- Patient and family education initiatives including patient self-management skills and "teach-back"
- Post-discharge medication planning
- Early follow-up such as homecare visits, primary care outreach, and/or patient call-backs.

c) "Other" project option: Implement other evidence-based project to implement/expand care transitions program in an innovative manner not described in the project options above. Providers implementing an innovative, evidence-based project using the "Other" project option may select among the process and improvement milestones specified in this project area or may include one or more customizable process milestone(s) P-X and/or improvement milestone(s) I-X, as appropriate for their project. Milestone I-15 includes suggestions for improvement metrics to use with this innovative project option.

Note: All of the project options in project area 2.12 should include a component to conduct quality improvement for the project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, "lessons learned," opportunities to scale all or part of the project to a broader patient population, and key challenges associated with expansion of the project, including special considerations for safety-net populations.

Note: Providers selecting one of these project options should ensure that overlaps do not exist with the EHR Incentive Program or other available demonstration funding.

Rationale[69]:

69 http://www.ihi.org/offerings/Training/ReduceReadmissions/July2011ReducingReadmissions/Pages/default.aspx

Attachment I
Regional Healthcare Partnership (RHP) Planning Protocol

Category 2

When a patient's transition is less than optimal, the repercussions can be far-reaching — hospital readmission, an adverse medical event, and even mortality. Without sufficient information and an understanding of their diagnoses, medication, and self-care needs, patients cannot fully participate in their care during and after hospital stays. Additionally, poorly designed discharge processes create unnecessary stress for medical staff causing failed communications, rework, and frustrations. A comprehensive and reliable discharge plan, along with post-discharge support, can reduce readmission rates, improve health outcomes, and ensure quality transitions. Patient transition is a multidimensional concept and may include transfer from the hospital to home, or nursing home, or from facility to home- and community-based services, etc.

CATEGORY 2 BEHAVIORAL HEALTH INFRASTRUCTURE PROJECTS

GOAL: Integrate behavioral health with physical health and other evidence-based services and supports.

The goals of the projects under this heading are to create service delivery models, which engage / integrate behavioral, physical and other community-based services and supports to provide services to individuals with a broad range of behavioral health conditions in the most appropriate community-based settings and to empower the individual to better manage their health / wellness.

According to a recent study released by the Robert Wood Johnson Foundation, only 33% of patients with BH conditions (24% of the adult population) receive adequate treatment.[70] Patients with BH issues experience higher risk of mortality and poor health outcomes, largely due to a lack of preventive health services and poorly controlled co-morbid medical disease. Risk increases with the severity of the behavioral health diagnoses. In Texas for example, persons with severe mental illness live over 29 years less, on average, than the general population.[71] Behavioral health conditions, also account for increased health care expenditures such as higher rates of potentially preventable inpatient admissions. Texas Medicaid data on potentially preventable inpatient readmissions demonstrates that behavioral health conditions are a significant driver of inpatient costs. Mental health and substance abuse conditions comprise 8 percent of initial inpatient readmissions to general acute and specialty inpatient hospitals but represent 24 percent of potentially preventable admissions.[72]

Complex medical and social issues including multiple chronic health conditions, low income, housing insecurity, social isolation, and lack of natural supports systems severely impact health and social functioning for persons with more severe behavioral health diagnoses such as schizophrenia, bipolar disorder and major depressive disorder. Substance use disorders, alone or in combination with mental health conditions, have significant physical consequences, leading to disability and increased acute and long term service expenditures.

Gaps in the service delivery system have far reaching costs and consequences. For example, the Texas state psychiatric hospital system is in crisis -- nearing or already over capacity, in large part due to gaps in the continuum of services and supports for individuals with more complex chronic mental health conditions. These individuals require a stable, supportive housing,

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70 Druss BG, Reisinger Walker E., "Mental Disorders and Medical Co-Morbidity." Robert Wood Johnson Foundation, The Synthesis Project: Issue 21 (2011).

71 Parks, J, Svendsen, D, et. al. "Morbidity and Mortality in People with Serious Mental Illness", National Association of State Mental Health Program Directors, 2006.

72 Potentially Preventable Readmissions in the Texas Medicaid Population, Fiscal Year 2010, Texas Health and Human Services Commission (2012)

integrated with community-based clinical and psychosocial services to prevent continual cycling through the street, to emergency room, jail and inpatient hospital.[73]

Providing adequate health care to people with behavioral health conditions requires a comprehensive, person-centered approach within an integrated, "no wrong door" access, and delivery system. The system should include early and accurate assessment. It should facilitate access to acute and long term services as well as short term, community-based alternatives for stabilizing individuals in a behavioral health crisis; discharge planning to transition the individual back to the community from the inpatient setting; and post-discharge support services.

Evidence-based and evidence-informed strategies exist which can facilitate person-centered care for people with behavioral health conditions.

These approaches include:

- organizational realignment and process improvements to better integrate behavioral and physical health care and ensure that there is "no wrong door" to accessing needed treatment;
- self-management and wellness programs which empower individuals to better manage their chronic physical and behavioral health conditions; and
- specialized services and supports directed at high need / high cost populations which integrate clinical and other interventions to address the complex needs of persons with more severe illnesses and social challenges.

Integration: Organizational Realignment and Process Improvement

Health care systems which successfully integrate behavioral health and primary care services demonstrate improved care, cost savings, increased provider and consumer satisfaction.[74] This is especially important for medically indigent populations, which have co-occurring chronic health and mental health conditions. Treatments for individuals who present with mental health and/or substance abuse concerns are integrated with physical health via person-centered approaches.

The Four Quadrant Clinical Integration Model provides a promising, person-centered conceptual framework for organizational realignment.

Each quadrant considers the behavioral health and physical health risk and complexity of the population and suggests the major system elements that would be utilized to meet the needs of the individuals within that subset of the population. The Four Quadrant model is not intended to be prescriptive about what happens in each quadrant, but to serve as a conceptual framework for collaborative planning in each local system. Ideally it would be used as a part of collaborative planning for each new HRSA BH site, with the CHC and the local provider(s) of public BH

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73 Continuity of Care Task Force Final Report, DSHS, (2010)

74 Integrating Publicly Funded Physical and Behavioral Health Services: A Description of Selected Initiatives, Health Management Associates (2007).

services using the framework to decide who will do what and how coordination for each person served will be assured.

The use of the Four Quadrant Model to consider subsets of the population, the major system elements and clinical roles would result in the following broad approaches:

- Quadrant I: Low BH-low physical health complexity/risk, served in primary care with BH staff on site; very low/low individuals served by the PCP, with the BH staff serving those with slightly elevated health or BH risk.
- Quadrant II: High BH-low physical health complexity/risk, served in a specialty BH system that coordinates with the PCP.
- Quadrant III: Low BH-high physical health complexity/risk, served in the primary care/medical specialty system with BH staff on site in primary or medical specialty care, coordinating with all medical care providers including disease managers.
- Quadrant IV: High BH-high physical health complexity/risk, served in both the specialty BH and primary care/medical specialty systems; in addition to the BH case manager, there may be a disease manager, in which case the two managers work at a high level of coordination with one another and other members of the team.

Other integration models include the IMPACT Model[75] and Wagner's Chronic Care Model.

Process improvements, such as adoption of evidence-based clinical practice guidelines for detection and treatment of depression and other conditions and for assessment of suicide risk can improve outcomes in both primary and specialty behavioral clinical settings. For example, one effective evidence-based strategy that has been shown to improve outcomes for depression, the most prevalent BH disorder, is the DIAMOND/IMPACT model of care. Key elements of such care models are screening for high prevalence mental health conditions, co-location of BH clinicians into primary care settings, collaborative meetings held by primary care and BH team members to discuss cases, training of primary care and BH staff on effective screening and collaborative care, the presence of tracking systems and registries to support effective monitoring of patients, the "Stepped Care" approach for appropriate level of treatment, care management for the highest risk patients with mental health and substance abuse disorders, and relapse prevention, among others.[76] Other examples of evidence-base practices include Screening, Brief Intervention and Referral to Treatment (SBIRT) for substance use disorders. SBIRT employs a brief assessment, performed by physical health providers in settings such as hospital emergency rooms and clinics to determine the presence of substance use issues, intervene and refer the individual to appropriate treatment. Independent evaluation of Texas SBIRT study

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75 Excerpted from the IMPACT website at the University of Washington at http://impact-uw.org/about/key.html.
76 Katon W., MD. "The Diamond Model." (based on Katon's Collaborative Care Model for depression) and Unutzer J.,MD. "IMPACT Study." (as well as numerous other controlled trials). Institute for Clinical Systems Improvement and Minnesota Family Health Services. Presentation to the Institute for HealthCare Improvement Annual Forum, Dec. 2010.

determined that it resulted in significant inpatient / emergency department savings and increased appropriate use of services in the state's largest public hospital district.[77]

Self-Management and Wellness Programs

Successfully engaging the individual consumer in disease self-management and wellness activities related to chronic physical and behavioral health conditions empowers person-centered recovery and improved health outcomes. The Chronic Disease Self-Management Program developed at Stanford University to help people manage physical conditions such as diabetes and chronic pain, and Wellness Recovery Action Planning (WRAP) which is directed toward managing severe mental illness[78], are two prominent examples of evidenced-based, self-management models. Giving the individual consumer control over health resources is another complementary promising practice.

Health navigation and individual health planning are related practices. The Texas and Minnesota Demonstrations to Maintain Independence and Employment (DMIE) studies which focused on medically indigent adults with behavioral health disorders, used health care navigation to achieve positive results in health care utilization and wellness measures.[79] In Texas DMIE, health navigation and support from case managers trained in Motivational Interviewing resulted in increased access to and use of appropriate health services, including: more use of preventative care; more outpatient, more mental health and dental visits; greater adherence and persistence in taking prescribed medications for chronic conditions such as hypertension, respiratory conditions, diabetes, high cholesterol; more medical stability for chronic conditions and greater satisfaction with healthcare.[80]

Self-directed resource use models empower the individual to purchase goods and services to promote wellness and recovery. There is an evidence base for these models. For example, adults with severe mental illness and co-occurring physical disabilities in the Arkansas Cash and Counseling program were less likely to fall, have respiratory infections, develop bed sores, or spend a night in hospital or a nursing home if they had access to individual budgets than if they did not [81]. Similarly, an evaluation of the New Jersey Cash and Counseling program found that it was equally successful for participants with SMI as those with other types of disabilities[82].

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77 Insight Project Research Group (2009). SBIRT outcomes in Houston: Final report on InSight, a hospital district-based program for patients at risk for alcohol or drug use problems. Alcoholism: Clinical and Experimental Research, 33(8): 1-8.

78 Copeland, M.E. "Wellness recovery action plan: a system for monitoring, reducing and eliminating uncomfortable or dangerous physical symptoms and emotional feelings." Occupational Therapy in Mental Health. 17, 127–150 (2002).

79 Ozaki, R., Schneider, J., Hall, J., Moore, J., Linkins, K., Brya, J., Oelschlaeger, A., Bohman, T., Christensen, K., Wallisch, L., Stoner, D., Reed, B.,Ostermeyer, B. (2011). Personal navigation, life coaching, and case management: Approaches for enhancing health and employment support services. Journal of Vocational Rehabilitation, (34)2, 83-95.

80 Bohman, T., Wallisch, L., Christensen, K., Stoner, D., Pittman, A., Reed, B.,Ostermeyer, B. (2011). Working Well – The Texas Demonstration to Maintain Independence and Employment: 18-month outcomes. Journal of Vocational Rehabilitation, (34)2, 97-106.

81 Shen, C., Smyer, M.A., Mahoney, K.J., Loughlin, D.M. et al., (2008). Does Mental Illness Affect Consumer Direction of Community-Based Care? Lessons From the Arkansas Cash and Counseling Program. The Gerontologist, 48(1), 93-104.

82 Shen, C., Smyer, M., Mahoney, K.J., Simon-Rusinowitz, L. et al., (2008). Consumer-Directed Care for Beneficiaries With Mental Illness: Lessons From New Jersey's Cash and Counseling Program. Psychiatric Services, 59, 1299-1306.

In the Texas Self-Directed Care study (SDC), individuals with severe mental illness are empowered to manage a flexible fund to purchase goods and services with assistance from an advisor. Consumers have broad latitude for making substitutions of traditional services and supports within a typical maximum budget of $4,000 / year. Experience during the first year of the SDC indicates that individuals in the intervention group are making significant gains in recovery, wellness and employment relative to the control group.

Specialized Services and Supports for High Need Sub-Populations
The Texas Continuity of Care Task Force[83] analyzed needs and recommendations for improving services to severely mentally ill individuals who move repeatedly through multiple systems, such as criminal justice, general acute inpatient and mental health. Among the recommendations was the development of:

- supported housing,
- assisted living,
- smaller, community-based living options, and
- services, such as cognitive rehabilitative modalities, to address the individual's limitations in organizing, planning and completing activities.

Services could be provided in a variety of settings, including individual homes, apartments, adult foster homes, assisted living facilities, and small group (three- to four-bed) community-supported residential settings. Examples of services could include cognitive and psychosocial rehabilitation; supported employment; transition assistance to establish a residence; peer support; specialized therapies; medical services, transportation medications and personal assistance.

83See Continuity of Care Task Force Report at: http://www.dshs.state.tx.us/mhsa/continuityofcare/)

2.13 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting (i.e., the criminal justice system, ER, urgent care etc.).

Project Goal:
Provide specialized services to complex behavioral health populations such as people with severe mental illnesses and/or a combination of behavioral health and physical health issues. These populations often have multiple concomitant issues such as substance use, traumatic injuries, homelessness, cognitive challenges, and lack of daily living skills and lack of natural supports. The State's mental health system provides rehabilitative services and pharmacotherapy to people with certain severe psychiatric diagnoses and functional limitations, but can serve only a fraction of the medically indigent population. It does not serve other high risk behavioral health populations and does not provide the range of services needed to deal with complex psychiatric and physical needs. These complex populations become frequent users of local public health systems.

The goal of this project is to avert outcomes such as potentially avoidable inpatient admission and readmissions in settings including general acute and specialty (psychiatric) hospitals; to avert disruptive and deleterious events such as criminal justice system involvement; to promote wellness and adherence to medication and other treatments; and to promote recovery in the community. This can be done by providing community based interventions for individuals to prevent them from cycling through multiple systems, such as the criminal justice system; the general acute and specialty psychiatric inpatient system; and the mental health system. Examples of interventions could include integrated medical and non-medical supports such as transition services to help individuals establish a stable living environment, peer support, specialized therapies, medical services, personal assistance, and short or long term residential options.

Residential options linked to a range of support services can effectively improve health outcomes for vulnerable individuals, such as the long-term homeless with severe mental illness. One such model in Colorado demonstrated a drastic 80 percent decrease in overnight hospital stays and a 76 percent decrease in nights in jail (Wortzel, 2007). Research indicates that among residents of permanent supportive housing:

- Rates of arrest and days incarcerated are reduced by 50%;
- Emergency room visits decrease by 57%;
- Emergency detoxification services decrease by 85%; and
- Nursing home utilization decreased by 50%.[84]

Project Options:

84 Lewis, D., Corporation for Supportive Housing, Permanent Supportive Housing Program & Financial Model for Austin/Travis County, TX, 2010. Retrieved from http://www.caction.org/homeless/documents/AustinModelPresentation.pdf

a) Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population.
Required core components:

- **a)** Assess size, characteristics and needs of target population(s) (e.g., people with severe mental illness and other factors leading to extended or repeated psychiatric inpatient stays. Factors could include chronic physical health conditions; chronic or intermittent homelessness, cognitive issues resulting from severe mental illness and/or forensic involvement.
- **b)** Review literature / experience with populations similar to target population to determine community-based interventions that are effective in averting negative outcomes such as repeated or extended inpatient psychiatric hospitalization, decreased mental and physical functional status, nursing facility admission, forensic encounters and in promoting correspondingly positive health and social outcomes / quality of life.
- **c)** Develop project evaluation plan using qualitative and quantitative metrics to determine outcomes.
- **d)** Design models which include an appropriate range of community-based services and residential supports.
- e) Assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population. Examples of data sources include: standardized assessments of functional, mental and health status (such as the ANSA and SF 36); medical, prescription drug and claims/encounter records; participant surveys; provider surveys. Identify "lessons learned," opportunities to scale all or part of the intervention(s) to a broader patient populations, and identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations.

b) "Other" project option: Implement other evidence-based project to provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in an innovative manner not described in the project options above. Providers implementing an innovative, evidence-based project using the "Other" project option may select among the process and improvement milestones specified in this project area or may include one or more customizable process milestone(s) P-X and/or improvement milestone(s) I-X, as appropriate for their project.

Note: All of the project options in project area 2.13 should include a component to conduct quality improvement for the project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, "lessons learned," opportunities to scale all or part of the project to a broader patient

population, and key challenges associated with expansion of the project, including special considerations for safety-net populations.

Note: Community-based interventions should be comprehensive and multispecialty. They should incorporate two or more components, such as those listed below depending on the needs of the target populations being served. These interventions should have significant flexibility to add more components if they are appropriate to meet the needs of the target population. Community-based components may include (but are not limited to):

- Residential Assistance (Foster/Companion Care, Supervised Living, Residential Support Services)
- Assisted living;
- Cognitive Adaptation Training (CAT) – an evidence-based service that uses tools and motivational techniques to establish and refine daily living skills;
- Psychosocial Rehabilitation;
- Supported employment;
- Minor home modifications;
- Home delivered meals;
- Transition assistance – assistance to establish a basic household, including security deposits, essential furnishings, moving expenses, bed and bath linens;
- Adaptive aids (e.g., medication-adherence equipment, communication equipment, etc.);
- Transportation to appointments and community-based activities;
- Specialized behavioral therapies:
    - Cognitive Behavioral Therapy – An empirically supported treatment that focuses on maladaptive patterns of thinking and the beliefs that underlie such thinking; and
    - Dialectical Behavior Therapy – A manualized treatment program (derived from cognitive behavioral therapy) that provides support in managing chronic crisis and stress to keep individuals in outpatient treatment settings;
- Prescription medications;
- Peer support – A service that models successful health and mental health behaviors. It is provided by certified peer specialists who are in recovery from mental illness and/or substance use disorders and are supervised by mental health professionals;
- Respite care (short term);
- Substance abuse services (specialized for individuals who have experienced prolonged or repeated institutionalization);
- Visiting Nursing and / or community health worker services;
- Employment supports

- Nutritional counseling
- Occupational therapy; Speech and language therapy; and Physical therapy.

Components must be articulated into a system which uses a CQI design such as the CMS Quality Framework for HCBS services. (Anita Yuskauskas, 2010) and/or be informed by guidance such as the SAMHSA evidence-based toolkit for permanent supported housing (http://store.samhsa.gov/product/Permanent-Supportive-Housing-Evidence-Based-Practices-EBP-KIT/SMA10-4510) or other evidence-based system

2.14 Implement person-centered wellness self-management strategies and self directed financing models that empower consumers to take charge of their own health care.

Project Goal:
Create wellness, self-management programs that employ research supported interventions singly or in combination to help individuals manage their chronic physical and behavioral health conditions. Examples of research-supported individual wellness self management strategies include Wellness Recovery Action Planning (WRAP), the Chronic Disease Self Management Program; Motivational Interviewing; client-managed wellness accounts; and health navigation / individual health planning models to empower the individual to achieve their health goals. These interventions should be closely coordinated with the patient's medical home.

Successfully engaging the individual consumer in disease self management and wellness activities related to chronic physical and behavioral health conditions empowers person-centered recovery and improved health outcomes. The Chronic Disease Self Management Program, developed at Stanford University to help people manage physical conditions such as diabetes and chronic pain, and Wellness Recovery Action Planning (WRAP) which is directed toward managing severe mental illness[85], are two prominent examples of evidenced-based, self-management models. Giving the individual consumer control over health resources is another complementary promising practice.

Health navigation and individual health planning are related practices. The Texas and Minnesota Demonstrations to Maintain Independence and Employment (DMIE), which focused on medically indigent adults with behavioral health disorders, used health care navigation to achieve positive results in health care utilization and wellness measures.[86] In Texas DMIE, health navigation and support from case managers trained in Motivational Interviewing resulted in increased access to and use of appropriate health services, including: more use of preventative care; more outpatient, more mental health and dental visits; greater adherence and persistence in taking prescribed medications for chronic conditions such as hypertension, respiratory conditions, diabetes, high cholesterol; more medical stability for chronic conditions and greater satisfaction with healthcare.[87]

Self directed resource use models empower the individual to purchase goods and services to promote wellness and recovery. There is an evidence base for these models. For example, adults with severe mental illness and co-occurring physical disabilities in the Arkansas Cash and Counseling program were less likely to fall, have respiratory infections, develop bed sores, or spend a night in hospital or a nursing home if they had access to individual budgets than if they

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85 Copeland, M.E. "Wellness recovery action plan: a system for monitoring, reducing and eliminating uncomfortable or dangerous physical symptoms and emotional feelings." Occupational Therapy in Mental Health. 17, 127–150 (2002).
86 Ozaki, R., Schneider, J., Hall, J., Moore, J., Linkins, K., Brya, J., Oelschlaeger, A., Bohman, T., Christensen, K., Wallisch, L., Stoner, D., Reed, B.,Ostermeyer, B. (2011). Personal navigation, life coaching, and case management: Approaches for enhancing health and employment support services. Journal of Vocational Rehabilitation, (34)2, 83-95.
87 Bohman, T., Wallisch, L., Christensen, K., Stoner, D., Pittman, A., Reed, B.,Ostermeyer, B. (2011). Working Well – The Texas Demonstration to Maintain Independence and Employment: 18-month outcomes. Journal of Vocational Rehabilitation, (34)2, 97-106.

did not[88]. Similarly, an evaluation of the New Jersey Cash and Counseling program found that it was equally successful for participants with SMI as those with other types of disabilities[89].

In the Texas Self-Directed Care study (SDC), individuals with severe mental illness are empowered to manage a flexible fund to purchase goods and services with assistance from an advisor. Consumers have broad latitude for making substitutions of traditional services and supports within a typical maximum budget of $4,000 / year. Experience during the first year of the SDC indicates that individuals in the intervention group are making significant gains in recovery, wellness and employment relative to the control group.

Project Options:

a) Establish interventions to promote person-centered wellness self-management strategies and train staff / contractors to empower consumers to take charge of their own health care.

Required core project components:

a) Develop screening process for project inclusion

b) Identify population for intervention using claims and encounter data, clinical records, or referrals from providers.

c) Recruit eligible individuals based on administrative and diagnostic data

d) Establish interventions and train staff / contractors

e) Hire staff (including the following minimum qualifications):

- Wellness and Health Navigation: Bachelors level professional with experience in mental health and/or wellness initiatives or a peer specialist who has successfully completed the DSHS certification program for peer specialists
- WRAP Facilitator: an individual trained and credentialed as a WRAP facilitator using the WARP model developed by Mary Ellen Copeland (See: http://www.mentalhealthrecovery.com/wrap/).

f) Train staff in motivational interviewing and person-centered planning

g) Assess project outcomes. Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.

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88 Shen, C., Smyer, M.A., Mahoney, K.J., Loughlin, D.M. et al., (2008). Does Mental Illness Affect Consumer Direction of Community-Based Care? Lessons From the Arkansas Cash and Counseling Program. The Gerontologist, 48(1), 93-104.

89 Shen, C., Smyer, M., Mahoney, K.J., Simon-Rusinowitz, L. et al., (2008). Consumer-Directed Care for Beneficiaries With Mental Illness: Lessons From New Jersey's Cash and Counseling Program. Psychiatric Services, 59, 1299-1306.

b) Implement self-directing financing models including wellness accounts. Note: If selected, this must be implemented as part of a person-centered wellness project as described in 2.14.1.
Required core project components:
- **a)** Establish wellness account funding mechanisms.
- **b)** Establish policies and procedures for program operations.
- **c)** Establish accountability systems to track outcomes and expenditures.
- **d)** Implement interventions.
- **e)** Assess project outcomes.

c) "Other" project option: Implement other evidence-based project to implement person-centered wellness self-management strategies and self-directed financing models that empower consumers to take charge of their own health care in an innovative manner not described in the project options above. Providers implementing an innovative, evidence-based project using the "Other" project option may select among the process and improvement milestones specified in this project area or may include one or more customizable process milestone(s) P-X and/or improvement milestone(s) I-X, as appropriate for their project.

Note: All of the project options in project area 2.14 should include a component to conduct quality improvement for the project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, "lessons learned," opportunities to scale all or part of the project to a broader patient population, and key challenges associated with expansion of the project, including special considerations for safety-net populations.

2.15 Integrate Primary and Behavioral Health Care Services

Project Goal

Integrate primary care and behavioral health care services in order to improve care and access to needed services.

The concept of a medical home that can address the needs of the whole person is increasingly recognized as a key in improving both access to care, continuity of care, improved outcomes. The importance of simultaneously addressing the physical health needs and the behavioral health needs of individuals has become recognized over the past three decades.

A recent study of adults discharged from psychiatric hospitals found 20% with chronic and serious conditions such as HIV infection, brain trauma, cerebral palsy and heart disease. As many as 75% of individuals with schizophrenia have been found to have high rates of serious physical illnesses, such as diabetes, respiratory, heart and/or bowel problems and high blood pressure. High rates were also seen for vision (93%), hearing (78%), and dental (60%) problems … the effects of atypical antipsychotic medications, which exacerbate this predisposition, individuals with schizophrenia have especially high rates of diabetes. Cardiovascular diseases are also very prevalent among people with mental illnesses. Again, psychiatric medications exacerbate the problem because they are associated with obesity and high triglyceride levels, known risk factors for cardiovascular disease. Adults with serious mental illnesses are known to have poor nutrition, high rates of smoking and a sedentary lifestyle—all factors that place them at greater risk for serious physical disorders, including diabetes, cardiovascular disease, stroke, arthritis and certain types of cancers. Despite such extensive medical needs, adults with serious mental illnesses often do not receive treatment… Among people with schizophrenia, fewer than 70% of those with co-occurring physical problems were currently receiving treatment for 10 of 12 physical health conditions studied.[90]

Medical Homes and similar collaborative care approaches have been determined to be beneficial in the treatment of mental illness in a variety of controlled studies.[91]

Behavioral health problems are often cyclical in nature meaning that over a course of months or years a person may experience periods of time when symptoms are well controlled (or in remission) while at other times symptoms can range from moderate to severe. The concept of a Medical home where physical and behavioral health care is integrated and provides supports for individuals who are in any quadrant of the National Council for Community Behavioral Health (NCCBH) Four Quadrant Clinical Integration Model at a given time.

The use of the Four Quadrant Model to consider subsets of the population, the major system elements and clinical roles would result in the following broad approaches:

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90 Bazelon Center for Mental Health Law (2004), GET IT TOGETHER How to Integrate Physical and Mental Health Care for People with Serious Mental Disorders

91 Thielke, S., Vannoy, S. & Unützer, J. (2007). Integrating mental health and primary care. Primary Care: Clinics in Office Practice, 34

- Quadrant I: Low BH-low physical health complexity/risk, served in primary care with BH staff on site; very low/low individuals served by the PCP, with the BH staff serving those with slightly elevated health or BH risk.
- Quadrant II: High BH-low physical health complexity/risk, served in a specialty BH system that coordinates with the PCP.
- Quadrant III: Low BH-high physical health complexity/risk, served in the primary care/medical specialty system with BH staff on site in primary or medical specialty care, coordinating with all medical care providers including disease managers.
- Quadrant IV: High BH-high physical health complexity/risk, served in both the specialty BH and primary care/medical specialty systems; in addition to the BH case manager, there may be a disease manager, in which case the two managers work at a high level of coordination with one another and other members of the team.

Other integration models include the IMPACT Model[92] and Wagner's Chronic Care Model.

Through the integration of behavioral health and physical health care services, opportunities to address both conditions during a single visit are vastly increased. Co-location, when coupled with protocols, training, technology and team building has the potential to improve communications between providers and enhance coordination of care. Additionally, access to care is enhanced because individuals do not have to incur the cost or inconvenience of arranging transportation or making multiple trips to different locations to address physical and behavioral health needs.

Finally, given the ever-increasing cost of transportation, a "one stop shopping" approach for health care improves the chances that individuals with multiple health needs will be able to access the needed care in a single visit and thereby overcome the negative synergy that exists between physical and behavioral health conditions.

Co-location alone is not synonymous with integration. Levels of interaction between physical and behavioral health providers may range from traditional minimally collaborative models to fully integrated collaborative models.

1. **Minimal Collaboration:** mental health providers and primary care providers work in separate facilities, have separate systems, and communicate sporadically.
2. **Basic Collaboration at a Distance:** separate systems at separate sites; periodic communication about shared patients, typically by telephone or letter.
3. **Basic Collaboration On-site:** separate systems, but shared facility; more communication, but each provider remains in his/her own professional culture.

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92 Excerpted from the IMPACT website at the University of Washington at http://impact-uw.org/about/key.html.

4. **Close Collaboration in a Partly Integrated System:** providers share the same facility and have some systems in common (scheduling appointments, medical records); regular face-to-face communication; sense of being part of a team.
5. **Close Collaboration in a Fully Integrated System:** providers are part of the same team and system; the patient experiences mental health treatment as part of their regular primary care or vice versa.

Delivery system reform projects proposed under this category should be structured to achieve level 4 or, preferably level 5 levels of interaction.

Project Options:

a) Design, implement, and evaluate projects that provide integrated primary and behavioral health care services.

Required core components:

a) Identify sites for integrated care projects, which would have the potential to benefit a significant number of patients in the community. Examples of selection criteria could include proximity/accessibility to target population, physical plant conducive to provider interaction; ability / willingness to integrate and share data electronically; receptivity to integrated team approach.

b) Develop provider agreements whereby co-scheduling and information sharing between physical health and behavioral health providers could be facilitated.

c) Establish protocols and processes for communication, data-sharing, and referral between behavioral and physical health providers

d) Recruit a number of specialty providers (physical health, mental health, substance abuse, etc. to provide services in the specified locations.

e) Train physical and behavioral health providers in protocols, effective communication and team approach. Build a shared culture of treatment to include specific protocols and methods of information sharing that include:

- Regular consultative meetings between physical health and behavioral health practitioners;
- Case conferences on an individualized as-needed basis to discuss individuals served by both types of practitioners; and/or
- Shared treatment plans co-developed by both physical health and behavioral health practitioners.

f) Acquire data reporting, communication and collection tools (equipment) to be used in the integrated setting, which may include an integrated Electronic health record system or participation in a health information exchange – depending on the size and scope of the local project.

g) Explore the need for and develop any necessary legal agreements that may be needed in a collaborative practice.

h) Arrange for utilities and building services for these settings

i) Develop and implement data collection and reporting mechanisms and standards to track the utilization of integrated services as well as the health care outcomes of individual treated in these integrated service settings.

j) Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.

b) "Other" project option: Implement other evidence-based project to integrate primary and behavioral health care services in an innovative manner not described in the project options above. Providers implementing an innovative, evidence-based project using the "Other" project option may select among the process and improvement milestones specified in this project area or may include one or more customizable process milestone(s) P-X and/or improvement milestone(s) I-X, as appropriate for their project.

Note: All of the project options in project area 2.15 should include a component to conduct quality improvement for the project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, "lessons learned," opportunities to scale all or part of the project to a broader patient population, and key challenges associated with expansion of the project, including special considerations for safety-net populations.

2.16 Provide virtual psychiatric and clinical guidance to all participating primary care providers delivering services to behavioral patients regionally.

Project Goal

Provide ready access to psychiatric consultation in primary care to enhance and improve treatment for individuals with behavioral health conditions. Virtual psychiatric consultation may include (but is not limited to) the following modalities of communication: telephone, instant message, video conference, facsimile, and e-mail. Primary Care Providers (PCPs) tend to be the first (and often last) stop for services for individuals with mental illness and substance use disorders. Indeed, more than 1/3 of all patients rely solely on PCPs to treat psychiatric disorders. These individuals may have medical conditions that are created or exacerbated by untreated or under-treated mental illness and substance abuse. This trend means PCPs should have adequate resources and expertise to treat behavioral health conditions. Treating behavioral health conditions during a PCP visit reduces the chances of losing the patient during the referral process.

The goal of this project is to provide PCPs delivering services regionally with the necessary resources and guidance to adequately treat patients who present with behavioral health conditions. Clinical guidance will be provided remotely via the following communication methods: telephone, instant message, video conference, facsimile, and e-mail. Access to these services will allow the medical treatment team to utilize behavioral health expertise in areas including, but not limited to: diagnostic impressions, psychiatric medication administration, trajectory and outcomes of mental health diagnoses, cultural considerations relevant to behavioral health treatment, and referral recommendations for ongoing treatment, and behavioral health self-management resources. PCPs will increase their knowledge base about behavioral health conditions while also having quick access to cutting edge and research based behavioral health interventions over several communication methods. This effort will bridge the often disparate disciplines of behavioral and physical health, providing better outcomes for patients who increasingly rely on primary care settings for treatment of their behavioral health conditions.

Project Options:

a) Design, implement, and evaluate a program to provide remote psychiatric consultative services to all participating primary care providers delivering services to patients with mental illness or substance abuse disorders
Required core project components:

- **a)** Establish the infrastructure and clinical expertise to provide remote psychiatric consultative services.
- **b)** Determine the location of primary care settings with a high number of individuals with behavioral health disorders (mental health and substance abuse) presenting for services, and where ready access to behavioral health expertise is lacking. Identify what expertise primary care providers lack and what they identify as their greatest needs for psychiatric and/or substance abuse treatment consultation via survey or other means.

c) Assess applicable models for deployment of virtual psychiatric consultative and clinical guidance models

d) Build the infrastructure needed to connect providers to virtual behavioral health consultation. This may include:

- Procuring behavioral health professional expertise (e.g., Psychiatrists, Psychologists, Psychiatric Nurses, Licensed Professional Counselors, Masters level Social Workers, Licensed Chemical Dependency Counselors, Licensed Marriage and Family Therapists, Certified Peer specialists, and Psychiatric Pharmacists,). This will include expertise in children and adolescents (e.g. Child and Adolescent Psychiatrists, Psychologists, Nurses, and Pharmacists); expertise in psychotropic medication management in severe mental illness.

e) Ensuring staff administering virtual psychiatric consultative services are available to field communication from medical staff on a 24-hour basis.

f) Identify which medical disciplines within primary care settings (nursing, nursing assistants, pharmacists, primary care physicians, etc.) could benefit from remote psychiatric consultation.

g) Provide outreach to medical disciplines in primary care settings that are in need of telephonic behavioral health expertise and communicate a clear protocol on how to access these services.

h) Identify clinical code modifiers and/or modify electronic health record data systems to allow for documenting the use of telephonic behavioral health consultation.

i) Develop and implement data collection and reporting standards for remotely delivered behavioral health consultative services.

j) Review the intervention(s) impact on access to telephonic psychiatric consults and identify "lessons learned," opportunities to scale all or part of the intervention(s) to a broader patient population, and identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations

Optional Project Components:

k) Develop a database or information resource center for behavioral health professionals to ensure appropriate research based interventions are being communicated to providers.

l) Develop or adapt best practice resources and research based literature to medical professions on a range of behavioral health topics that frequently occur in primary care settings (including guidelines for best practices for administration of psychotropic medications for specific mental health conditions and monitoring of these medications).

b) "Other" project option: Implement other evidence-based project to provide virtual psychiatric and clinical guidance to all participating primary care providers delivering services to behavioral health patients regionally in an innovative

manner not described in the project options above. Providers implementing an innovative, evidence-based project using the "Other" project option may select among the process and improvement milestones specified in this project area or may include one or more customizable process milestone(s) P-X and/or improvement milestone(s) I-X, as appropriate for their project.

Note: All of the project options in project area 2.16 should include a component to conduct quality improvement for the project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, "lessons learned," opportunities to scale all or part of the project to a broader patient population, and key challenges associated with expansion of the project, including special considerations for safety-net populations.

2.17 Establish improvements in care transition from the inpatient setting for individuals with mental health and / or substance abuse disorders.

Project Goals:
The goal of this project is to implement improvements in care transitions and coordination of care from inpatient to outpatient, post-acute care, and home care settings in order to prevent increased health care costs and hospital readmissions of individuals with mental health and substance use (behavioral health) disorders. For people with mental health and substance use disorders, these transitions are especially critical in reducing the risk of readmission. Texas Medicaid data on potentially preventable inpatient readmissions demonstrates that behavioral health conditions are a significant driver of inpatient costs. Mental health and substance abuse conditions comprise 8 percent of initial inpatient readmissions to general acute and specialty inpatient hospitals but represent 24 percent of potentially preventable admissions.[93] The implementation of effective care transitions requires that providers learn and develop effective ways to successfully manage one disease in order to effectively manage the complexity of multiple diseases.[94] Preventable admissions in Texas are commonly indicative of "the absence of excellent care, especially during the transition from inpatient care to care at home or in a post-acute facility."[95]

Relatively simple steps can make a real difference. These include scheduling the follow-up appointment before discharge, voice-to-voice transfer of care between the attending physician and the primary care physician / provider community-based services, reconciling medication instructions, and follow-up phone calls or visits after discharge. More complex populations with severe behavioral health disorders and other issues, such as homelessness may require more intensive follow-through post discharge. Strategies, such as Critical Time Intervention (CTI), are designed to prevent recurrent adverse outcomes, such as readmissions among persons with severe mental illness. Such interventions may include pre-transition planning, intensive transition support, assessment and adjustment of support and transfer to community sources of care. Peer support can be an important strategy for individuals transitioning from inpatient to community settings. In Texas, the Department of State Health Services, has developed a peer certification program which could be leveraged by partnerships to develop peer support capacity.

Project Options:

a) Design, implement, and evaluate interventions to improve care transitions from the inpatient setting for individuals with mental health and/or substance abuse disorders.
Required core project components:

93 Potentially Preventable Readmissions in the Texas Medicaid Population, Fiscal Year 2010, Texas Health and Human Services Commission (2012)

94 Rittenhouse D, Shortell S, et al. "Improving Chronic Illness Care: Findings from a National Study of Care Management Processes in Large Physician Practices." Medical Care Research and Review Journal (2010) 67(3): 301-320

95 Ibid.

- Discharge checklists
- "Hand off" communication plans with receiving medical and behavioral health providers
- Wellness initiatives targeting high-risk behavioral health patients, such as WRAP, health planning and motivation strategies, Screening, Brief Intervention and Referral to Treatment (SBIRT) for substance use disorders,
- Individual and family education initiatives including self-management skills.
- Post-discharge medication planning
- Early follow-up such as homecare visits, primary care outreach, and/or patient call-backs.
- Transition and wellness support from certified peer specialists for mental health and /or substance use disorders.
- More intensive follow-through programs, such as CTI or other evidence-informed practices, for individuals with more severe behavioral health disorders and other challenges, such as homelessness.
- Electronic data exchange for critical clinical information to support excellent continuity of care.

2.18 Recruit, train, and support consumers of mental health services to provide peer support services

Project Goal:

The goal of this project is to use consumers of mental health services who have made substantial progress in managing their own illness and recovering a successful life in the community to provide peer support services. These services are supportive and not necessarily clinical in nature. Building on a project originally established under the State's Mental Health Transformation grant, consumers are being trained to serve as peer support specialists. In addition to the basic peer specialist training and certification, an additional training is provided to certified peers specialists in "whole health". With the whole health training peer specialists learn to work with other consumers to set achievable goals to prevent or self-manage chronic diseases such as diabetes and COPD. While such training currently exists, very limited numbers of peers are trained due to resource limitations. Evidence exists that such an approach can work with particularly vulnerable populations with serious mental illness[96]. The need for strategies to improve the health outcomes for people with behavioral health disorders is evidenced by their disparate life expectancy (dying 29 years younger than the general population[97]), increased risk of mortality and poor health outcomes as severity of behavioral health disorders increase[98]

Project Options

a) Design, implement, and evaluate whole health peer support for individuals with mental health and /or substance use disorders.
Required core project components:

- **a)** Train administrators and key clinical staff in the use of peer specialists as an essential component of a comprehensive health system.
- **b)** Conduct readiness assessments of organization that will integrate peer specialists into their network.
- **c)** Identify peer specialists interested in this type of work.
- **d)** Train identified peer specialists in whole health interventions, including conducting health risk assessments, setting SMART goals, providing educational and supportive services to targeted individuals with specific disorders (e.g. hypertension, diabetes, or health risks (e.g. obesity, tobacco use, physical inactivity.
- **e)** Implement health risk assessments to identify existing and potential health risks for behavioral health consumers.

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96 Benjamin G. Druss, MD, MPH, Liping Zhao, MSPH, Silke A. von Esenwein, PhD, Joseph R. Bona, MD, MBA, Larry Fricks, Sherry Jenkins-Tucker, Evelina Sterling, MPH, CHES, Ralph DiClemente, PhD, and Kate Lorig, RN, DrPH, The Health and Recovery Peer (HARP) Program: A peer-led intervention to improve medical self-management for persons with serious mental illness, Schizophrenia Research, Volume 118, Issue 1 , Pages 264-270, May 2010

97 Parks, J, Svendsen, D, et. al. "Morbidity and Mortality in People with Serious Mental Illness", National Association of State Mental Health Program Directors, 2006.

98 Druss BG, Reisinger Walker E., "Mental Disorders and Medical Co-Morbidity." Robert Wood Johnson Foundation, The Synthesis Project: Issue 21 (2011).

f) Identify patients with serious mental illness who have health risk factors that can be modified.

g) Implement whole health peer support.

h) Connect patients to primary care and preventive services.

i) Track patient outcomes. Review the intervention(s) impact on participants and identify "lessons learned," opportunities to scale all or part of the intervention(s) to a broader patient population, and identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations.

b) "Other" project option: Implement other evidence-based project to recruit, train, and support consumers of mental health services to provide peer support services in an innovative manner not described in the project options above. Providers implementing an innovative, evidence-based project using the "Other" project option may select among the process and improvement milestones specified in this project area or may include one or more customizable process milestone(s) P-X and/or improvement milestone(s) I-X, as appropriate for their project.

Note: All of the project options in project area 2.18 should include a component to conduct quality improvement for the project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, "lessons learned," opportunities to scale all or part of the project to a broader patient population, and key challenges associated with expansion of the project, including special considerations for safety-net populations.

2.19 Develop Care Management Function that integrates primary and behavioral health needs of individuals

Project Goal:
Provide a targeted care management intervention program for the population of people with co-occurring mental health, substance use and chronic physical disorders to increase use of primary and specialty care and reducing the use of ER, crisis and jail diversion services. The prevalence of co-occurring mental health, substance use and chronic physical disorders is high in the indigent population. This is due to the lack of access to and the complexity of navigating primary care and specialty care services. These individuals end up consuming a great deal of community resources due to ER visits, involvement of crisis response systems and often unnecessary incarcerations when routine treatment would be a better alternative. Early engagement in appropriate services to address the multiple conditions for these individuals, as well as their needs for housing and social support, requires both behavioral health case managers and chronic disease care managers working closely to make service settings accessible and to track progress.

Project Options:

a) Design, implement, and evaluate care management programs and that integrate primary and behavioral health needs of individual patients
Required core project components:

a) Conduct data matching to identify individuals with co-occurring disorders who are:
- not receiving routine primary care,
- not receiving specialty care according to professionally accepted practice guidelines,
- over-utilizing ER services based on analysis of comparative data on other populations,
- over-utilizing crisis response services.
- Becoming involved with the criminal justice system due to uncontrolled/unmanaged symptoms.

b) Review chronic care management best practices such as Wagner's Chronic Care Model and select practices compatible with organizational readiness for adoption and implementation.

c) Identification of BH case managers and disease care managers to receive assignment of these individuals.

d) Develop protocols for coordinating care; identify community resources and services available for supporting people with co-occurring disorders.

e) Identify and implement specific disease management guidelines for high prevalence disorders, e.g. cardiovascular disease, diabetes, depression, asthma.

f) Train staff in protocols and guidelines.

g) Develop registries to track client outcomes.

h) Review the intervention(s) impact on quality of care and integration of care and identify "lessons learned," opportunities to scale all or part of the intervention(s) to a broader patient population, and identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations.

b) "Other" project option: Implement other evidence-based project to develop care management function that integrates primary and behavioral health needs in an innovative manner not described in the project options above. Providers implementing an innovative, evidence-based project using the "Other" project option may select among the process and improvement milestones specified in this project area or may include one or more customizable process milestone(s) P-X and/or improvement milestone(s) I-X, as appropriate for their project.

Note: All of the project options in project area 2.19 should include a component to conduct quality improvement for the project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, "lessons learned," opportunities to scale all or part of the project to a broader patient population, and key challenges associated with expansion of the project, including special considerations for safety-net populations.

Category 3 Quality Improvements

Attachment I
Regional Healthcare Partnership (RHP) Planning Protocol
Category 3

Category 3 Overview

a. Introduction

The overall objective of Category 3 is to assess the effectiveness of Category 1 and 2 interventions in improving outcomes in the Texas healthcare delivery system. As described in the Program Funding and Mechanics (PFM) Protocol, each project selected in Categories 1 and 2 will have one or more associated outcome measures from Category 3.

For the purposes of the RHP Planning and PFM Protocols, outcome measures are defined as "*measures that assess the results of care experienced by patients, including patients' clinical events, patients' recovery and health status, patients' experiences in the health system, and efficiency/cost."*

All Category 3 outcome measures must be reported to specifications, except that a Performing Provider may customize the population measured by an outcome as allowed by CMS and HHSC to more closely reflect the patient population targeted in the related Category 1 or 2 project.

b. Pay for Performance Measures

The Category 3 menu of measures contains a large proportion of Pay for Performance (P4P) measures that providers may select from to receive incentive payments for demonstrating incremental improvements in the selected outcome. These measures are considered the stronger, more validated measures. If there is a P4P measure appropriate to the Category 1 or 2 project that the provider can report to the specifications in the attached Compendium (Appendix C), then the provider must select a P4P measure.

There will be standard achievement levels for P4P measures to earn Category 3 funds in demonstration year (DY) 4 and DY 5. In October 2014, providers may request to deviate from the standard achievement levels based on extenuating circumstances to be determined by the Texas Health and Human Services Commission (HHSC) and Centers for Medicare and Medicaid Services (CMS), such as if the intervention population is much smaller, significantly different than the denominator required in the measure specifications or if the benchmarks provided are not an appropriate fit for the denominator population (e.g., with the use of denominator subsets for age). Providers may request a deviation from the standard achievement levels established during the October 2014 baseline reporting period within parameters as agreed to by HHSC and CMS.

c. Pay for Reporting Measures

The Category 3 menu also contains some measures that are designated as Pay for Reporting (P4R). To accommodate the wide variety of Texas DSRIP providers and projects, these P4R measures were approved for inclusion in the menu as "exploratory" measures even though they do not have the strongest rigor of validation or evidence.
All P4R measures require prior authorization by HHSC and CMS. The prior authorization process will determine a) if the measure was a previously selected by the provider and was approved for use for a Category 1 or 2 project (if so, this serves as the authorization) and b) if not

previously approved, whether there is a P4P measure that would be an appropriate fit for the project that the provider can report to specifications.

Providers that need to use a P4R measure will not receive payment for improving its rate, but instead will receive payment for reporting the measure to the associated specifications. Providers may still demonstrate improvement in these measures; however, that improvement will not be the basis for incentive payment. For these reporting only or "exploratory" measures providers must engage in an alternate improvement activity - either a Population-Focused Priority Measure or a Stretch Activity. These alternate improvement activities are detailed in Appendix (A).

For Hospital, Community Mental Health Center, and Physician Group provider types, providers with a P4R measure should select an outcome from the Population-Focused Priority Measure list. These outcomes do not have to be tied to the associated Category 1 or 2 project and instead represent a larger health priority for the health system.

For Local Health Department providers and for those providers above who cannot identify a measure to report from the Population-Focused Priority Measure list, providers may select a Stretch Activity. These activities are intended to improve data infrastructure and capacity.

d. Minimum Category 3 Requirements for Each Category 1 or 2 Project

Each outcome measure (IT-X.X) is labeled as a standalone measure or non-standalone measure. Providers can select among the following methods to meet Category 3 requirements for each Category 1 or 2 project:

- **At least one standalone measure:** Providers can select a standalone measure from any outcome domain listed in the table below for Category 1 and 2 projects. Cost-related outcomes may be used as the standalone outcome only for project area 2.5 (Cost Containment). Cost outcomes can be selected as non-standalone measures for other project areas.
- **At least one standalone measure and additional non-standalone measure(s):** One or more non-standalone measures from any outcome domain can be combined with at least one standalone measure.
- **A combination of at least 3 non-standalone measures:** A provider can select a combination of 3 non-standalone measures for a Category 1 or 2 project and these measures may be from different outcome domains if needed.

The measures selected for each Category 1 or 2 project may be a combination of P4P and P4R measures. Each measure is treated separately for reporting and payment purposes.

e. Types of Category 3 Milestones

The terms “process milestone” and “achievement milestone” are used to classify Category 3 milestones in each demonstration year. Process milestones will be those milestones in which a provider is not earning DSRIP funds based on reaching a goal achievement level over baseline, i.e., it will be used for DY2 and DY3 planning activities to prepare for Category 3 reporting, in DY4 and DY5 for reporting to specifications (for P4R measures), and in DY5 for stretch activities. Achievement milestones will be used for milestones in which the provider will earn

funds based on progress towards a goal achievement level for the measure, i.e., for P4P measures in DY4 and DY5 and Population-Focused Priority Measures in DY5.

The table below describes the milestones each year for both P4P and P4R outcomes.

	Pay for Performance (P4P) outcome measures	**Pay for Reporting (P4R) outcome measures**
DY2	Each provider selected process milestones from the original menu (P-1 through P-7) and designated the valuation per milestone; a status update was allowed in lieu of specific milestone documentation for DY2	
DY3	2 process milestones (P-8 & P-9) - DY3 Category 3 status update (50% of DY3 allocation) and establishing baseline (50% of DY3 allocation)	
DY4	Process Milestone 10 - 50% of DY4 allocation for reporting P4P measure to specifications Achievement Milestone 1 - 50% of DY4 allocation for demonstrating improvement in P4P measure over baseline	Process Milestone 10 - 100% of DY4 allocation for reporting P4R measure to specifications
DY5	Achievement Milestone 1 - 100% of DY5 allocation for demonstrating improvement in P4P measure over baseline	Process Milestone 10 - 50% of DY5 allocation for reporting P4R measure to specifications <u>Alternate Improvement Activity</u> EITHER Achievement Milestone 2 – 50% of DY5 allocation for demonstrating improvement in a Population Focused Priority Measure OR Process Milestone 11 – 50% of DY5 allocation for reporting as required on a stretch activity

*Per the PFM Protocol, all Category 3 milestones are eligible for carry forward into the subsequent year and achievement milestones only are eligible for payment for partial achievement.

Category 3 Outcome Measures

All of the measures included in the Category 3 menu have been approved by CMS. Often the source of these measures is an authoritative agency around outcome measurement (e.g., AHRQ, NCQA, CDC, NQF). Most of these measures have been validated and tested to ensure that the outcomes are measuring what they purport to measure. In some instances, these evidence based measures are modified in order to be used by DSRIP providers to change the specifications to describe a provider focus as opposed to a health plan focus. These modifications are described

in detail within the compendium document (Appendix C). In some cases, where validated measures did not previously exist, measures were created based on evidence based guidelines and practices. These measures were included in the menu to reflect outcomes pertinent to approved Category 1 and 2 projects. The outcomes are salient to aspects of patient care that reflect better health and satisfaction with services, improved efficiencies in health care delivery and cost savings.

Outcome Domains

All of the Category 3 outcome measures are organized into 15 Outcome Domains (ODs) to facilitate measure selection.

- OD-1: Primary Care and Chronic Disease Management
- OD-2: Potentially Preventable Admissions
- OD-3: Potentially Preventable Readmissions (PPRs) – 30-day Readmission Rates
- OD-4: Potentially Preventable Complications, Healthcare Acquired Conditions, and Patient Safety
- OD-5: Cost of Care
- OD-6: Patient Satisfaction
- OD-7: Oral Health
- OD-8: Perinatal Outcomes and Maternal Child Health
- OD-9: Right Care, Right Setting
- OD-10: Quality of Life/Functional Status
- OD-11: Behavioral Health/Substance Abuse Care
- OD-12: Primary Prevention
- OD-13: Palliative Care
- OD-14: Healthcare Workforce
- OD-15: Infectious Disease Management

List of Category 3 Outcome Measures

The table below lists the outcome measures from which providers may choose. The Compendium (Appendix C) contains further details on how each measure is to be reported and the Category 3 Companion (Appendix D) contains guidance for providers selection of their Category 3 outcome measures in March 2014 based on the revised Category 3 framework agreed to by CMS and HHSC in February 2014 and reflected in this protocol and the PFM Protocol.

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Regional Healthcare Partnership (RHP) Planning Protocol
Category 3

OD	IT reference number	Measure type	Performance Type	Prior Authorization Required	Title of measure
1	IT-1.1	Non-Standalone (NSA)	P4P	No	Third next available appointment
1	IT-1.2	Non-Standalone (NSA)	P4P	No	Annual monitoring for patients on persistent medications - Angiotensin Converting Enzyme (ACE) inhibitors or Angiotensin Receptor Blockers (ARBs)
1	IT-1.3	Non-Standalone (NSA)	P4P	No	Annual monitoring for patients on persistent medications - Digoxin
1	IT-1.4	Non-Standalone (NSA)	P4P	No	Annual monitoring for patients on persistent medications- Diuretic
1	IT-1.5	Non-Standalone (NSA)	P4P	No	Annual monitoring for patients on persistent medications - Anticonvulsant
1	IT-1.6	Standalone (SA)	P4P	No	Cholesterol management for patients with cardiovascular conditions
1	IT-1.7	Standalone (SA)	P4P	No	Controlling high blood pressure
1	IT-1.8	Non-Standalone (NSA)	P4P	No	Depression management: Screening and Treatment Plan for Clinical Depression
1	IT-1.9	Standalone (SA)	P4P	No	Depression management: Depression Remission at Twelve Months
1	IT-1.10	Standalone (SA)	P4P	No	Diabetes care: HbA1c poor control (>9.0%)
1	IT-1.11	Standalone (SA)	P4P	No	Diabetes care: BP control (<140/90mm Hg)
1	IT-1.12	Non-Standalone (NSA)	P4P	No	Diabetes care: Retinal eye exam
1	IT-1.13	Non-Standalone (NSA)	P4P	No	Diabetes care: Foot exam
1	IT-1.14	Non-Standalone (NSA)	P4P	No	Diabetes care: Nephropathy
1	IT-1.15	Standalone (SA)	P4P	No	Peritoneal Dialysis Adequacy Clinical Performance Measure III
1	IT-1.16	Standalone (SA)	P4P	No	Hemodialysis Adequacy Clinical Performance Measure III
1	IT-1.17	Standalone (SA)	P4P	No	Hemodialysis Adequacy for Pediatric Hemodialysis Patients
1	IT-1.18	Standalone (SA)	P4P	No	Follow-Up After Hospitalization for Mental Illness
1	IT-1.19	Standalone (SA)	P4P	No	Antidepressant Medication Management
1	IT-1.20	Non-Standalone (NSA)	P4P	No	Comprehensive Diabetes Care LDL Screening
1	IT-1.21	Non-Standalone (NSA)	P4P	No	Adult Body Mass Index (BMI) Assessment

Attachment I
Regional Healthcare Partnership (RHP) Planning Protocol
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OD	IT reference number	Measure type	Performance Type	Prior Authorization Required	Title of measure
1	IT-1.22	Standalone (SA)	P4P	No	Asthma Percent of Opportunity Achieved
1	IT-1.23	Non-Standalone (NSA)	P4P	No	Tobacco Use: Screening & Cessation
1	IT-1.24	Standalone (SA)	P4R	Yes	Adolescent tobacco use
1	IT-1.25	Standalone (SA)	P4R	Yes	Adult tobacco use
1	IT-1.26	Non-Standalone (NSA)	P4P	No	Seizure type(s) and current seizure frequency(ies)
1	IT-1.27	Non-Standalone (NSA)	P4P	No	Pain Assessment and Follow-up
1	IT-1.28	Non-Standalone (NSA)	P4P	No	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented
1	IT-1.29	Non-Standalone (NSA)	P4P	No	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
1	IT-1.30	Non-Standalone (NSA)	P4P	No	Hemoglobin A1c (HbA1c) Testing for Pediatric Patients
1	IT-1.31	Standalone (SA)	P4P	No	Medication Management for People with Asthma (MMA)
1	IT-1.32	Standalone (SA)	P4P	No	Asthma Medication Ratio (AMR)
1	IT-1.33	Non-Standalone (NSA)	P4P	No	Medical Assistance With Smoking and Tobacco Use Cessation
1	IT-1.34	Standalone (SA)	P4P	No	Appropriate Testing for Children With Pharyngitis
2	IT-2.1	Standalone (SA)	P4R	Yes	Congestive Heart Failure (CHF) Admission rate
2	IT-2.2	Standalone (SA)	P4P	No	Risk Adjusted Congestive Heart Failure (CHF) Admission rate
2	IT-2.3	Standalone (SA)	P4R	Yes	End-Stage Renal Disease (ESRD) Admission Rate
2	IT-2.4	Standalone (SA)	P4P	No	Risk Adjusted End-Stage Renal Disease (ESRD) Admission Rate
2	IT-2.5	Standalone (SA)	P4R	Yes	Hypertension (HTN) Admission Rate
2	IT-2.6	Standalone (SA)	P4P	No	Risk Adjusted Hypertension (HTN) Admission Rate
2	IT-2.7	Standalone (SA)	P4R	Yes	Behavioral Health/Substance Abuse (BH/SA) Admission Rate
2	IT-2.8	Standalone (SA)	P4P	No	Risk Adjusted Behavioral Health/Substance Abuse (BH/SA)
2	IT-2.9	Standalone (SA)	P4R	Yes	Chronic Obstructive Pulmonary Disease (COPD) Admission Rate
2	IT-2.10	Standalone (SA)	P4P	No	Risk Adjusted Chronic Obstructive Pulmonary Disease (COPD) Admission Rate

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2	IT-2.11	Standalone (SA)	P4R	Yes	Adult Asthma Admission Rate
2	IT-2.12	Standalone (SA)	P4P	No	Risk Adjusted Adult Asthma Admission Rate
2	IT-2.13	Standalone (SA)	P4R	Yes	Diabetes Short Term Complication Admission Rate
2	IT-2.14	Standalone (SA)	P4P	No	Risk Adjusted Diabetes Short Term Complication Admission Rate
2	IT-2.15	Standalone (SA)	P4R	Yes	Diabetes Long Term Complications Admission Rate
2	IT-2.16	Standalone (SA)	P4P	No	Risk Adjusted Diabetes Long Term Complications Admission Rate
2	IT-2.17	Standalone (SA)	P4R	Yes	Uncontrolled Diabetes Admissions Rate
2	IT-2.18	Standalone (SA)	P4P	No	Risk Adjusted Uncontrolled Diabetes Admissions Rate
2	IT-2.19	Standalone (SA)	P4R	Yes	Flu and pneumonia Admission Rate
2	IT-2.20	Standalone (SA)	P4P	No	Risk Adjusted Flu and pneumonia Admission Rate
2	IT-2.21	Standalone (SA)	P4P	No	Ambulatory Care Sensitive Conditions Admissions Rate
2	IT-2.22	Standalone (SA)	P4P	No	Prevention Quality Indicators (PQI) Composite Measure Potentially Preventable Hospitalizations for Ambulatory Care Sensitive Conditions
2	IT-2.23	Standalone (SA)	P4R	Yes	Pediatric Asthma Admission Rate
2	IT-2.24	Standalone (SA)	P4P	No	Risk Adjusted Pediatric Asthma Admission Rate
2	IT-2.25	Standalone (SA)	P4R	Yes	Pain Admission Rate
2	IT-2.26	Standalone (SA)	P4P	No	Risk Adjusted Pain Admission Rate
2	IT-2.27	Standalone (SA)	P4R	Yes	Cancer Admission Rate
2	IT-2.28	Standalone (SA)	P4P	No	Risk Adjusted Cancer Admission Rate
2	IT-2.29	Standalone (SA)	P4R	Yes	Cellulitis Admission Rate
2	IT-2.30	Standalone (SA)	P4P	No	Risk Adjusted Cellulitis Admission Rate
3	IT-3.1	Standalone (SA)	P4P	No	Hospital-Wide All-Cause Unplanned Readmission Rate
3	IT-3.2	Standalone (SA)	P4R	Yes	Congestive Heart Failure (CHF) 30-day Readmission Rate
3	IT-3.3	Standalone (SA)	P4P	No	Risk Adjusted Congestive Heart Failure (CHF) 30-day Readmission Rate
3	IT-3.4	Standalone (SA)	P4R	Yes	Diabetes 30-day Readmission Rate
3	IT-3.5	Standalone (SA)	P4P	No	Risk Adjusted Diabetes 30-day Readmission Rate

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3	IT-3.6	Standalone (SA)	P4R	Yes	Renal Disease 30-day Readmission Rate
3	IT-3.7	Standalone (SA)	P4P	No	Risk Adjusted Renal Disease 30-day Readmission Rate
3	IT-3.8	Standalone (SA)	P4R	Yes	Acute Myocardial Infarction (AMI) 30-day Readmission Rate
3	IT-3.9	Standalone (SA)	P4P	No	Risk Adjusted Acute Myocardial Infarction (AMI) 30-day Readmission Rate
3	IT-3.10	Standalone (SA)	P4R	Yes	Coronary Artery Disease (CAD) 30-day Readmission Rate
3	IT-3.11	Standalone (SA)	P4P	No	Risk Adjusted Coronary Artery Disease (CAD) 30-day Readmission Rate
3	IT-3.12	Standalone (SA)	P4R	Yes	Stroke (CVA) 30-day Readmission Rate
3	IT-3.13	Standalone (SA)	P4P	No	Risk Adjusted Stroke (CVA) 30-day Readmission Rate
3	IT-3.14	Standalone (SA)	P4R	Yes	Behavioral Health /Substance Abuse 30-day Readmission Rate
3	IT-3.15	Standalone (SA)	P4P	No	Risk Adjusted Behavioral Health /Substance Abuse 30-day Readmission Rate
3	IT-3.16	Standalone (SA)	P4R	Yes	Chronic Obstructive Pulmonary Disease (COPD) 30-day Readmission Rate
3	IT-3.17	Standalone (SA)	P4P	No	Risk Adjusted Chronic Obstructive Pulmonary Disease (COPD) 30-day Readmission Rate
3	IT-3.18	Standalone (SA)	P4R	Yes	Adult Asthma 30-day Readmission Rate
3	IT-3.19	Standalone (SA)	P4P	No	Risk Adjusted Adult Asthma 30-day Readmission Rate
3	IT-3.20	Standalone (SA)	P4R	Yes	Pediatric Asthma 30-day Readmission Rate
3	IT-3.21	Standalone (SA)	P4P	No	Risk Adjusted Pediatric Asthma 30-day Readmission Rate
3	IT-3.22	Standalone (SA)	P4P	No	Risk Adjusted All-Cause Readmission
3	IT-3.23	Standalone (SA)	P4R	Yes	Ventricular Assist Device 30-day Readmission Rate
3	IT-3.24	Standalone (SA)	P4P	No	Risk Adjusted Ventricular Assist Device 30-day Readmission Rate
3	IT-3.25	Standalone (SA)	P4R	Yes	Post-Surgical 30-day Readmission Rate
3	IT-3.26	Standalone (SA)	P4P	No	Risk Adjusted Post-Surgical 30-day Readmission Rate
3	IT-3.27	Standalone (SA)	P4R	Yes	Cancer Related 30-day Readmission Rate
3	IT-3.28	Standalone (SA)	P4R	Yes	Medication Complication 30-day Readmission Rate

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3	IT-3.29	Standalone (SA)	P4P	No	Risk Adjusted Medication Complication 30-day Readmission Rate
4	IT-4.1	Standalone (SA)	P4P	No	Improvement in risk adjusted Potentially Preventable Complications rate(s)
4	IT-4.2	Standalone (SA)	P4P	No	Central line-associated bloodstream infections (CLABSI) rates
4	IT-4.3	Standalone (SA)	P4P	No	Catheter-associated Urinary Tract Infections (CAUTI) rates
4	IT-4.4	Standalone (SA)	P4P	No	Surgical site infections (SSI) rates
4	IT-4.5	Standalone (SA)	P4P	No	Patient Fall Rate
4	IT-4.6	Standalone (SA)	P4P	No	Incidence of Hospital-acquired Venous Thromboembolism (VTE)
4	IT-4.7	Standalone (SA)	P4P	No	Pressure Ulcer Rate
4	IT-4.8	Standalone (SA)	P4R	Yes	Sepsis mortality
4	IT-4.9	Non-Standalone (NSA)	P4R	Yes	Average length of stay: Sepsis
4	IT-4.10	Standalone (SA)	P4P	No	Sepsis bundle (NQF 0500)
4	IT-4.11	Non-Standalone (NSA)	P4P	No	Risk-Adjusted Average Length of Inpatient Hospital Stay
4	IT-4.12.1	Non-Standalone (NSA)	P4P	No	Average Length of Stay for patients of Medication Errors
4	IT-4.13	Non-Standalone (NSA)	P4R	Yes	Patients receiving language services supported by qualified language services providers
4	IT-4.14	Standalone (SA)	P4P	No	Intensive Care: In-hospital mortality rate
4	IT-4.15	Standalone (SA)	P4P	No	Venous Thromboembolism Prophylaxis Bundle
4	IT-4.16	Standalone (SA)	P4R	Yes	Reduce Unplanned Re-operations
4	IT-4.12.2	Non-Standalone (NSA)	P4P	No	Adverse drug events
4	IT-4.17	Non-Standalone (NSA)	P4P	No	Stroke - Thrombolytic Therapy
4	IT-4.18	Non-Standalone (NSA)	P4P	No	Warfarin management: percentage of patients on warfarin with an international normalized ratio (INR) result of 4 or above whose dosage has been adjusted or reviewed prior to the next warfarin dose, during the 6 month time period

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4	IT-4.19	Non-Standalone (NSA)	P4P	Yes	Falls: Screening, Risk-Assessment, and Plan of Care to Prevent Future Falls
5	IT-5.1 a	SA for project area 2.5, NSA for all other project areas	P4P	Yes	Improved Cost Savings: Demonstrate cost savings in care delivery - Cost of Illness Analysis
5	IT-5.1 b	SA for project area 2.5, NSA for all other project areas	P4P	Yes	Improved Cost Savings: Demonstrate cost savings in care delivery - Cost Minimization Analysis
5	IT-5.1 c	SA for project area 2.5, NSA for all other project areas	P4P	Yes	Improved Cost Savings: Demonstrate cost savings in care delivery - Cost Effectiveness Analysis
5	IT-5.1 d	SA for project area 2.5, NSA for all other project areas	P4P	Yes	Improved Cost Savings: Demonstrate cost savings in care delivery - Cost Utility Analysis
5	IT-5.1 e	SA for project area 2.5, NSA for all other project areas	P4P	Yes	Improved Cost Savings: Demonstrate cost savings in care delivery - Cost Benefit Analysis
5	IT-5.2	SA for project area 2.5, NSA for all other project areas	P4P	Yes	Per Episode Cost of Care
5	IT-5.3	SA for project area 2.5, NSA for all other project areas	P4P	Yes	Total Cost of Care
6	IT-6.1.a.i	Standalone (SA)	P4P	No	HCAHPS Communication with Doctors
6	IT-6.1.a.ii	Standalone (SA)	P4P	No	HCAHPS Communication with Nurses
6	IT-6.1.a.iii	Standalone (SA)	P4P	No	HCAHPS Responsiveness of Hospital Staff
6	IT-6.1.a.iv	Standalone (SA)	P4P	No	HCAHPS Pain Control
6	IT-6.1.a.v	Standalone (SA)	P4P	No	HCAHPS Communication about Medicine
6	IT-6.1.a.vi	Standalone (SA)	P4P	No	HCAHPS Cleanliness of Hospital Environment
6	IT-6.1.a.vii	Standalone (SA)	P4P	No	HCAHPS Quietness of Hospital Environment

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6	IT-6.1.a.viii	Standalone (SA)	P4P	No	HCAHPS Discharging Information
6	IT-6.1.a.ix	Standalone (SA)	P4P	No	HCAHPS Overall Hospital Rating
6	IT-6.1.a.x	Standalone (SA)	P4P	No	HCAHPS Likelihood to Recommend
6	IT-6.1.b.i	Standalone (SA)	P4P	No	CG-CAHPS 12-month: Timeliness of Appointments, Care, & Information
6	IT-6.1.b.ii	Standalone (SA)	P4P	No	CG-CAHPS 12-month: Provider Communication
6	IT-6.1.b.iii	Standalone (SA)	P4P	No	CG-CAHPS 12-month: Office Staff
6	IT-6.1.b.iv	Standalone (SA)	P4P	No	CG-CAHPS 12-month: Overall Provider Rating
6	IT-6.1.b.v	Standalone (SA)	P4P	No	CG-CAHPS 12-month: Provider's Attention to Child's Growth and Development(Pediatric)
6	IT-6.1.b.vi	Standalone (SA)	P4P	No	CG-CAHPS 12-month: Provider's Advice on Keeping Child Safe and Healthy(Pediatric)
6	IT-6.1.c.i	Standalone (SA)	P4P	No	CG-CAHPS 12-month: Cultural Competence Survey Supplement
6	IT-6.1.c.ii	Standalone (SA)	P4P	No	CG-CAHPS 12-month: Health Information Technology Supplement
6	IT-6.1.c.iii	Standalone (SA)	P4P	No	CG-CAHPS 12-month: Health Literacy Supplement
6	IT-6.1.c.iv	Standalone (SA)	P4P	No	CG-CAHPS 12-month: PCMH Supplement (includes Shared Decision Making)
6	IT-6.1.d.i	Standalone (SA)	P4P	No	CG-CAHPS Visit Survey 2.0: Timeliness of Appointments, Care, & Information
6	IT-6.1.d.ii	Standalone (SA)	P4P	No	CG-CAHPS Visit Survey 2.0: Provider Communication
6	IT-6.1.d.iii	Standalone (SA)	P4P	No	CG-CAHPS Visit Survey 2.0: Office Staff
6	IT-6.1.d.iv	Standalone (SA)	P4P	No	CG-CAHPS Visit Survey 2.0: Overall Provider Rating
6	IT-6.1.d.v	Standalone (SA)	P4P	No	CG-CAHPS Visit Survey 2.0: Provider's Attention to Child's Growth and Development (Pediatric)
6	IT-6.1.d.vi	Standalone (SA)	P4P	No	CG-CAHPS Visit Survey 2.0: Providers Advice on Keeping Child Safe and healthy (Pediatric)
6	IT-6.2.a	Standalone (SA)	P4P	No	Client Satisfaction Questionnaire 8 (CSQ-8)
6	IT-6.2.b	Standalone (SA)	P4P	No	Visit-Specific Satisfaction Instrument (VSQ-9)

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6	IT-6.2.c	Standalone (SA)	P4R	Yes	Health Center Patient Satisfaction Survey
6	IT-6.2.d.i	Standalone (SA)	P4P	No	PSQ-III General Satisfaction
6	IT-6.2.d.ii	Standalone (SA)	P4P	No	PSQ-III Technical Quality
6	IT-6.2.d.iii	Standalone (SA)	P4P	No	PSQ-III Interpersonal Aspects
6	IT-6.2.d.iv	Standalone (SA)	P4P	No	PSQ-III Communication
6	IT-6.2.d.v	Standalone (SA)	P4P	No	PSQ-III Financial Aspects
6	IT-6.2.d.vi	Standalone (SA)	P4P	No	PSQ-III Time Spent w/ Doctors
6	IT-6.2.d.vii	Standalone (SA)	P4P	No	PSQ-III Access, Availability, & Convenience
6	IT-6.2.d.viii	Standalone (SA)	P4P	No	PSQ-18 General Satisfaction
6	IT-6.2.d.ix	Standalone (SA)	P4P	No	PSQ-18 Technical Quality
6	IT-6.2.d.x	Standalone (SA)	P4P	No	PSQ-18 Interpersonal Aspects
6	IT-6.2.d.xi	Standalone (SA)	P4P	No	PSQ-18 Communication
6	IT-6.2.d.xii	Standalone (SA)	P4P	No	PSQ-18 Financial Aspects
6	IT-6.2.d.xiii	Standalone (SA)	P4P	No	PSQ-18 Time Spent w/ Doctors
6	IT-6.2.d.xiv	Standalone (SA)	P4P	No	PSQ-18 Access, Availability, & Convenience
6	IT-6.2.e	Standalone (SA)	P4R	Yes	Experience of Care and Health Outcomes (ECHO) 3.0
7	IT-7.1	Non-Standalone (NSA)	P4P	Yes	Dental Sealant: Children
7	IT-7.2	Standalone (SA)	P4P	Yes	Cavities: Children
7	IT-7.3	Non-Standalone (NSA)	P4P	Yes	Early Childhood Caries – Fluoride Applications
7	IT-7.4	Non-Standalone (NSA)	P4P	Yes	Topical Fluoride application
7	IT-7.5	Standalone (SA)	P4P	Yes	Proportion of older adults aged 65 to 74 years who have lost all their natural teeth
7	IT-7.6	Standalone (SA)	P4P	Yes	Urgent Dental Care Needs in Children: Percentage of children with urgent dental care needs
7	IT-7.7	Standalone (SA)	P4P	Yes	Urgent Dental Care Need in Older Adults
7	IT-7.8	Standalone (SA)	P4P	Yes	Chronic Disease Patients Accessing Dental Services
7	IT-7.9	Standalone (SA)	P4P	Yes	Dental Treatment Needs Among Chronic Disease Patients
7	IT-7.10	Standalone (SA)	P4P	No	Cavities: Adults
7	IT-7.11	Non-Standalone (NSA)	P4P	No	Utilization of Services: Children
7	IT-7.12	Non-Standalone (NSA)	P4P	No	Oral Evaluation: Children

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7	IT-7.13	Non-Standalone (NSA)	P4P	No	Prevention: Sealants for 6 – 9 year-old Children at Elevated Risk
7	IT-7.14	Non-Standalone (NSA)	P4P	No	Prevention: Sealants for 10 – 14 year-old Children at Elevated Risk
7	IT-7.15	Non-Standalone (NSA)	P4P	No	Prevention: Topical Fluoride Intensity for Children at Elevated Caries Risk
7	IT-7.16	Non-Standalone (NSA)	P4P	No	Preventive Services for Children at Elevated Caries Risk
7	IT-7.17	Non-Standalone (NSA)	P4P	No	Treatment Services: Children
7	IT-7.18	Non-Standalone (NSA)	P4P	No	Usual Source of Services
7	IT-7.19	Non-Standalone (NSA)	P4P	No	Care Continuity: Children
7	IT-7.20	Non-Standalone (NSA)	P4P	No	Per Member Per Month Cost of Clinical Services (PMPM Cost): Children
7	IT-7.21	Non-Standalone (NSA)	P4P	No	Annual Dental Visit
7	IT-7.22	Non-Standalone (NSA)	P4R	Yes	Diabetes mellitus: percent of patients who obtained a dental exam in the last 12 months (NQMC:1600)
8	IT-8.1	Non-Standalone (NSA)	P4P	No	Timeliness of Prenatal/Postnatal Care
8	IT-8.2	Standalone (SA)	P4P	No	Percentage of Low Birth- weight births
8	IT-8.3	Standalone (SA)	P4P	No	Early Elective Delivery
8	IT-8.4	Non-Standalone (NSA)	P4P	No	Antenatal Steroids
8	IT-8.5	Non-Standalone (NSA)	P4P	No	Frequency of ongoing prenatal care
8	IT-8.6	Non-Standalone (NSA)	P4P	No	Cesarean Rate for Nulliparous Singleton Vertex
8	IT-8.7	Non-Standalone (NSA)	P4P	No	Birth Trauma Rates
8	IT-8.8	Standalone (SA)	P4P	Yes	Neonatal Mortality
8	IT-8.9	Standalone (SA)	P4R	Yes	Youth Pregnancy Rate

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8	IT-8.10	Standalone (SA)	P4R	Yes	Pregnancy Rate
8	IT-8.11	Standalone (SA)	P4R	Yes	Healthy term newborn
8	IT-8.12	Standalone (SA)	P4P	No	Pre-term birth rate
8	IT-8.13	Standalone (SA)	P4R	Yes	NICU days/delivery
8	IT-8.14	Non-Standalone (NSA)	P4R	Yes	Exclusive Breastfeeding at 3 Months
8	IT-8.15	Non-Standalone (NSA)	P4R	Yes	Exclusive Breastfeeding at 6 Months
8	IT-8.16	Non-Standalone (NSA)	P4R	Yes	Any Breastfeeding at 6 Months
8	IT-8.17	Non-Standalone (NSA)	P4R	Yes	Any Breastfeeding at 12 Months
8	IT-8.18	Non-Standalone (NSA)	P4P	No	Rate of Exclusive Breastfeeding
8	IT-8.19	Standalone (SA)	P4P	No	Post-Partum Follow-Up and Care Coordination
8	IT-8.20	Non-Standalone (NSA)	P4P	No	Developmental Screening in the First Three Years of Life
8	IT-8.21	Non-Standalone (NSA)	P4P	No	Well-Child Visits in the First 15 Months of Life (6 or more visits)
8	IT-8.22	Non-Standalone (NSA)	P4P	No	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life
8	IT-8.23	Non-Standalone (NSA)	P4P	No	Children and Adolescents' Access to Primary Care Practitioners (CAP)
8	IT-8.24	Non-Standalone (NSA)	P4P	No	Adolescent Well-Care Visits (AWC)
8	IT-8.25	Non-Standalone (NSA)	P4R	Yes	Sudden Infant Death Syndrome Counseling
8	IT-8.26	Non-Standalone (NSA)	P4R	Yes	Routine prenatal care: percentage of pregnant patients who receive counseling about aneuploidy screening in the first trimester (NQMC:8031)
8	IT-8.27	Non-Standalone (NSA)	P4R	Yes	Behavioral health risk assessment (for pregnant women)
9	IT-9.1	Standalone (SA)	P4P	Yes	Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons
9	IT-9.2	Standalone (SA)	P4P	No	Reduce Emergency Department (ED) visits for Ambulatory Care Sensitive Conditions (ACSC) per 100,000

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9	IT-9.3	Standalone (SA)	P4P	No	Reduce Pediatric Emergency Department (ED) visits for Ambulatory Care Sensitive Conditions (ACSC) per 100,000
9	IT-9.2.a	Standalone (SA)	P4P	No	Emergency Department (ED) visits per 100,000
9	IT-9.3.a	Standalone (SA)	P4P	No	Pediatric Emergency Department (ED) visits per 100,000
9	IT-9.4.a	Standalone (SA)	P4P	No	Reduce Emergency Department visits for Congestive Heart Failure
9	IT-9.4.b	Standalone (SA)	P4P	No	Reduce Emergency Department visits for Diabetes
9	IT-9.4.c	Standalone (SA)	P4P	No	Reduce Emergency Department visits for End Stage Renal Disease
9	IT-9.4.d	Standalone (SA)	P4P	No	Reduce Emergency Department visits for Angina and Hypertension
9	IT-9.4.e	Standalone (SA)	P4P	No	Reduce Emergency Department visits for Behavioral Health/Substance Abuse
9	IT-9.4.f	Standalone (SA)	P4P	No	Reduce Emergency Department visits for Chronic Obstructive Pulmonary Disease
9	IT-9.4.g	Standalone (SA)	P4P	No	Reduce Emergency Department visits for Asthma
9	IT-9.4.i	Standalone (SA)	P4P	No	Reduce Emergency Department visits for Dental Conditions
9	IT-9.4.h	Standalone (SA)	P4P	No	Pediatric/Young Adult Asthma Emergency Department Visits
9	IT-9.5	Non-Standalone (NSA)	P4R	Yes	Reduce low acuity ED visits
9	IT-9.6	Non-Standalone (NSA)	P4P	No	Emergency department (ED) visits where patients left without being seen
9	IT-9.7	Non-Standalone (NSA)	P4P	No	Emergency department (ED) visits where patients with a mental health complaint without being seen
9	IT-9.8	Non-Standalone (NSA)	P4P	No	Care Transition: Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)

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9	IT-9.9	Non-Standalone (NSA)	P4P	No	Transition Record with Specified Elements Received by Discharged Patients (Inpatient Discharges to Home/Self Care or Any Other Site of Care)
9	IT-9.10	Standalone (SA)	P4P	No	ED throughput Measure bundle
9	IT-9.10.a	Non-Standalone (NSA)	P4P	No	Median Time from ED Arrival to ED Departure for Discharged ED Patients
9	IT-9.10.b	Non-Standalone (NSA)	P4P	No	Median time from admit decision time to time of departure from the ED for ED patients admitted to inpatient status
9	IT-9.10.c	Non-Standalone (NSA)	P4P	No	Median time from ED arrival to time of departure from the emergency room for patients admitted to the facility from the ED
10	IT-10.1.a.i	Standalone (SA)	P4P	No	Assessment of Quality of Life (AQoL-4D)
10	IT-10.1.a.ii	Standalone (SA)	P4P	No	Assessment of Quality of Life (AQoL-6D)
10	IT-10.1.a.iii	Standalone (SA)	P4P	No	Assessment of Quality of Life (AQoL-7D)
10	IT-10.1.a.iv	Standalone (SA)	P4P	No	Assessment of Quality of Life (AQoL-8D)
10	IT-10.1.a.v	Standalone (SA)	P4P	No	Pediatric Quality of Life Inventory (PedsQL)
10	IT-10.1.b.i	Standalone (SA)	P4P	No	RAND Medical Outcomes Study: Measures of Quality of Life Survey Core Survey (MOS)
10	IT-10.1.b.ii	Standalone (SA)	P4P	No	RAND Short Form 12 (SF-12v2) Health Survey
10	IT-10.1.b.iii	Standalone (SA)	P4P	No	RAND Short Form 36[1] (SF-36) Health Survey
10	IT-10.1.c	Standalone (SA)	P4R	Yes	Quality of Life Enjoyment and Satisfaction Questionnaire (Q-LES-Q)
10	IT-10.1.d	Standalone (SA)	P4P	No	McGill Quality of Life (MQOL) Index
10	IT-10.1.e.i	Standalone (SA)	P4P	No	Palliative Care Outcome Scale (POSv1)
10	IT-10.1.e.ii	Standalone (SA)	P4P	No	Palliative Care Outcome Scale (POSv2)
10	IT-10.1.f	Standalone (SA)	P4P	No	Functional Assessment of Cancer Therapy (FACT-G)
10	IT-10.1.g	Standalone (SA)	P4P	No	Missoula-VITAS Quality of Life Index (MVQOLI)
10	IT-10.1.h	Standalone (SA)	P4P	No	CDC Health-Related Quality of Life (HRQoL) Measures
10	IT-10.1.i.i	Standalone (SA)	P4R	Yes	Child Health Questionnaire Parent CHQ-PF50
10	IT-10.1.i.ii	Standalone (SA)	P4R	Yes	Child Health Questionnaire Parent CHQ-PF28

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OD	IT reference number	Measure type	Performance Type	Prior Authorization Required	Title of measure
10	IT-10.1.i.iii	Standalone (SA)	P4R	Yes	Child Health Questionnaire Child Form (CHQ-CF87)
10	IT-10.1.j	Standalone (SA)	P4R	Yes	Family Experiences Interview Schedule (FEIS)
10	IT-10.2.a	Standalone (SA)	P4R	Yes	Supports Intensity Scale (SIS)
10	IT-10.2.b	Standalone (SA)	P4P	No	Lawton Instrumental Activities of Daily Living (IADLs) Scale
10	IT-10.3.a	Standalone (SA)	P4P	No	Activity Measure for Post-Acute Care (AMPAC)
10	IT-10.3.b	Standalone (SA)	P4R	Yes	The Duke Health Profile (Duke)
10	IT-10.3.d	Standalone (SA)	P4P	No	Battelle Development Inventory-2 (BDI-2)
10	IT-10.3.e	Standalone (SA)	P4P	No	Problem Areas in Diabetes (PAID) Scale
10	IT-10.4.a	Standalone (SA)	P4R	Yes	Developmental Profile 3 (DP-3)
10	IT-10.4.b	Standalone (SA)	P4R	Yes	Vineland Adaptive Behavior Scales, 2nd Edition (VABS II)
10	IT-10.5	Standalone (SA)	P4R	Yes	Bayley Scales of Infant and Toddler Development-Third Edition (Bayley-III)
11	IT-11.1	Non-Standalone (NSA)	P4R	Yes	Adult Mental Health Facility Admission Rate
11	IT-11.2	Non-Standalone (NSA)	P4R	Yes	Youth Mental Health Facility Admission Rate
11	IT-11.3	Non-Standalone (NSA)	P4R	Yes	IDD/ICF Admissions to a Care Facility
11	IT-11.4	Non-Standalone (NSA)	P4R	Yes	IDD/SPMI Admissions and Readmissions to State Institutions
11	IT-11.5	Standalone (SA)	P4P	No	Adherence to Antipsychotic Medications for Individuals with Schizophrenia
11	IT-11.6	Standalone (SA)	P4P	No	Follow-up Care for Children Prescribed ADHD Medication (ADD)
11	IT-11.7	Non-Standalone (NSA)	P4P	No	Initiation of Depression Treatment
11	IT-11.8	Standalone (SA)	P4P	No	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
11	IT-11.9	Non-Standalone (NSA)	P4P	No	Care Planning for Dual Diagnosis
11	IT-11.10	Non-Standalone (NSA)	P4R	Yes	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Prescribed Antipsychotic Medications (SSD)
11	IT-11.11	Non-Standalone (NSA)	P4R	Yes	Diabetes Monitoring for People With Diabetes and Schizophrenia

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OD	IT reference number	Measure type	Performance Type	Prior Authorization Required	Title of measure
11	IT-11.12	Non-Standalone (NSA)	P4P	No	Cardiovascular monitoring for people with cardiovascular disease and schizophrenia (SMC)
11	IT-11.13	Non-Standalone (NSA)	P4R	Yes	Assignment of Primary Care Physician to Individuals with Schizophrenia
11	IT-11.14	Non-Standalone (NSA)	P4R	Yes	Annual Physical Exam for Persons with Mental Illness
11	IT-11.15	Non-Standalone (NSA)	P4R	Yes	Depression Screening by 18 years of age
11	IT-11.16	Non-Standalone (NSA)	P4P	Yes	Assessment for Substance Abuse Problems of Psychiatric Patients
11	IT-11.17	Non-Standalone (NSA)	P4P	Yes	Assessment of Risk to Self/Others
11	IT-11.18	Non-Standalone (NSA)	P4R	Yes	Bipolar Disorder (BD) and Major Depression (MD): Appraisal for alcohol or substance use
11	IT-11.19	Non-Standalone (NSA)	P4P	Yes	Assessment for Psychosocial Issues of Psychiatric Patients
11	IT-11.20	Non-Standalone (NSA)	P4R	Yes	Bipolar Disorder and Major Depression: Assessment for Manic or hypomanic behaviors
11	IT-11.21	Non-Standalone (NSA)	P4R	Yes	Assessment of Major Depressive Symptoms
11	IT-11.22	Non-Standalone (NSA)	P4R	Yes	Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment
11	IT-11.27	Non-Standalone (NSA)	P4P	No	Vocational Rehabilitation for Schizophrenia
11	IT-11.28	Non-Standalone (NSA)	P4R	Yes	Housing Assessment for Individuals with Schizophrenia
11	IT-11.29	Non-Standalone (NSA)	P4R	Yes	Independent Living Skills Assessment for Individuals with Schizophrenia
11	IT-11.23.a	Standalone (SA)	P4R	Yes	Texas Adult Mental Health (AMH) Consumer Survey
11	IT-11.23.b	Standalone (SA)	P4R	Yes	Quick Inventory of Depressive Symptomatology (QIDS)
11	IT-11.24	Standalone (SA)	P4R	Yes	Generalized Anxiety Disorder (GAD-7)
11	IT-11.25	Standalone (SA)	P4R	Yes	Daily Living Activities (DLA-20)
11	IT-11.26.a	Standalone (SA)	P4R	Yes	Positive Symptom Rating Scale (PSRS)
11	IT-11.26.b	Standalone (SA)	P4R	Yes	Aberrant Behavior Checklist (ABC)
11	IT-11.26.c	Standalone (SA)	P4R	Yes	Adult Needs and Strength Assessment (ANSA)

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OD	IT reference number	Measure type	Performance Type	Prior Authorization Required	Title of measure
11	IT-11.26.d	Standalone (SA)	P4R	Yes	Children and Adolescent Needs and Strengths Assessment (CANS-MH)
11	IT-11.26.e.i	Standalone (SA)	P4P	No	Patient Health Questionnaire 9 (PHQ-9)
11	IT-11.26.e.ii	Standalone (SA)	P4P	No	Patient Health Questionnaire 15 (PHQ-15)
11	IT-11.26.e.iii	Standalone (SA)	P4P	No	Patient Health Questionnaire: Somatic, Anxiety, and Depressive Symptoms (PHQ-SADS)
11	IT-11.26.e.iv	Standalone (SA)	P4P	No	Patient Health Questionnaire 4 (PHQ-4)
11	IT-11.26.e.v	Standalone (SA)	P4R	Yes	Edinburg Postpartum Depression Scale
12	IT-12.1	Non-Standalone (NSA)	P4P	No	Breast Cancer Screening
12	IT-12.2	Non-Standalone (NSA)	P4P	No	Cervical Cancer Screening
12	IT-12.3	Non-Standalone (NSA)	P4P	No	Colorectal Cancer Screening
12	IT-12.4	Non-Standalone (NSA)	P4P	No	Pneumonia vaccination status for older adults
12	IT-12.5	Non-Standalone (NSA)	P4P	No	Pneumococcal Immunization- Inpatient
12	IT-12.6	Non-Standalone (NSA)	P4P	No	Influenza Immunization -- Ambulatory
12	IT-12.7	Non-Standalone (NSA)	P4P	No	Influenza Immunization- Inpatient
12	IT-12.8	Non-Standalone (NSA)	P4P	No	Immunization for Adolescents- Tdap/TD and MCV
12	IT-12.9	Non-Standalone (NSA)	P4P	No	Childhood immunization status
12	IT-12.10	Non-Standalone (NSA)	P4P	No	Adults (18+ years) Immunization status
12	IT-12.11	Non-Standalone (NSA)	P4P	No	HPV vaccine for adolescents
12	IT-12.12	Non-Standalone (NSA)	P4R	Yes	Immunization and Recommended Immunization Schedule Education
12	IT-12.13	Standalone (SA)	P4P	No	Mammography follow-up rate
12	IT-12.14	Non-Standalone (NSA)	P4R	Yes	Prostate Cancer: Avoidance of Overuse Measure – Bone Scan for Staging Low-Risk Patients
12	IT-12.15	Standalone (SA)	P4P	No	Abnormal Pap test follow-up rate
12	IT-12.16	Standalone (SA)	P4P	No	High-risk Colorectal Cancer Follow-up rate within one year
12	IT-12.17	Non-Standalone (NSA)	P4R	Yes	Intensive behavioral dietary counseling for adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease

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12	IT-12.18	Non-Standalone (NSA)	P4R	Yes	ABI Screening for Peripheral Arterial Disease
12	IT-12.19	Non-Standalone (NSA)	P4P	No	Osteoporosis: Screening or Therapy for Women Aged 65 Years and Older
13	IT-13.1	Non-Standalone (NSA)	P4P	Yes	Hospice and Palliative Care – Pain assessment
13	IT-13.2	Non-Standalone (NSA)	P4P	No	Hospice and Palliative Care – Treatment Preferences
13	IT-13.3	Standalone (SA)	P4P	Yes	Hospice and Palliative Care – Proportion with more than one emergency room visit in the last days of life
13	IT-13.4	Standalone (SA)	P4P	Yes	Hospice and Palliative Care – Proportion admitted to the ICU in the last 30 days of life
13	IT-13.5	Non-Standalone (NSA)	P4P	No	Hospice and Palliative Care – Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religions concerns or documentation that the patient/caregiver did not want to discuss
13	IT-13.6	Non-Standalone (NSA)	P4P	No	Palliative Care: Percent of patients who have documentation in the medical record that an interdisciplinary family meeting was conducted on or before day five of ICU admission
13	IT-13.7	Standalone (SA)	P4R	Yes	Oncology: Pain Intensity Quantified – Medical Oncology and Radiation Oncology
13	IT-13.8	Non-Standalone (NSA)	P4R	Yes	Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology
14	IT-14.1	Standalone (SA)	P4R	Yes	Number of practicing primary care practitioners per 1000 individual in HPSAs or MUAs
14	IT-14.2	Standalone (SA)	P4R	Yes	Number of practicing nurse practitioners and physician assistants per 1000 individuals in HPSAs or MUAs
14	IT-14.3	Standalone (SA)	P4R	Yes	Number of practicing psychiatrists per 1000 individuals in HPSAs or MUAs
14	IT-14.4	Non-Standalone (NSA)	P4R	Yes	Percent of graduates who practice in a HPSA or MUA

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OD	IT reference number	Measure type	Performance Type	Prior Authorization Required	Title of measure
14	IT-14.5	Non-Standalone (NSA)	P4R	Yes	Percent of graduates who work in a practice that has a high Medicaid share that reflects the distribution of Medicaid in the population
14	IT-14.6	Non-Standalone (NSA)	P4R	Yes	Percent of trainees who have spent at least 5 years living in a health- professional shortage area (HPSA) or medically underserved area
14	IT-14.7	Non-Standalone (NSA)	P4R	Yes	Percent of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey
14	IT-14.8	Non-Standalone (NSA)	P4R	Yes	Percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey
14	IT-14.9	Standalone (SA)	P4R	Yes	Number of practicing specialty care practitioners per 1000 individuals in HPSA or MUA
15	IT-15.1	Non-Standalone (NSA)	P4P	No	HIV medical visit frequency
15	IT-15.2	Standalone (SA)	P4P	No	Prescription of Antiretroviral Medications
15	IT-15.3	Non-Standalone (NSA)	P4P	No	HIV Screening: Patients at High Risk of HIV
15	IT-15.4	Non-Standalone (NSA)	P4P	No	HIV/AIDS: Tuberculosis (TB) Screening
15	IT-15.5	Non-Standalone (NSA)	P4P	No	HIV/AIDS: Sexually Transmitted Diseases - Screening for Chlamydia, Gonorrhea, and Syphilis
15	IT-15.6	Non-Standalone (NSA)	P4P	No	Chlamydia screening in women
15	IT-15.7	Non-Standalone (NSA)	P4P	No	Chlamydia Screening and Follow up in adolescents
15	IT-15.8	Standalone (SA)	P4R	Yes	Follow-up testing for C. trachomatis among recently infected men and women
15	IT-15.9	Non-Standalone (NSA)	P4R	Yes	Syphilis screening
15	IT-15.10	Non-Standalone (NSA)	P4P	No	Syphilis positive screening rates
15	IT-15.11	Standalone (SA)	P4P	No	Follow-up after Treatment for Primary or Secondary Syphilis
15	IT-15.12	Non-Standalone (NSA)	P4R	Yes	Gonorrhea screening rates
15	IT-15.13	Non-Standalone (NSA)	P4P	No	Gonorrhea Positive Screening Rates
15	IT-15.14	Standalone (SA)	P4P	No	Follow-up testing for N. gonorrhoeae among recently infected men and women

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OD	IT reference number	Measure type	Performance Type	Prior Authorization Required	Title of measure
15	IT-15.15	Non-Standalone (NSA)	P4R	Yes	High Intensity Behavioral Counseling to prevent STIs for all sexually active adolescents and for adults at increased risk for STIs
15	IT-15.16	Standalone (SA)	P4P	No	Curative Tuberculosis (TB) treatment rate
15	IT-15.17	Standalone (SA)	P4P	No	Latent Tuberculosis Infection (LTBI) treatment rate
15	IT-15.18	Standalone (SA)	P4P	No	Hepatitis C Cure Rate

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Category 4

Grouping Patients for Outcomes

For the purpose of Category 3 outcomes, there are three main groups of patients to consider.

Intervention population - This is the group of individuals that receives the intervention outlined in the Category 1 or 2 project. In almost all cases (and based on measure specifications), a provider will not report on the intervention-level population for the purposes of Category 3 reporting.

Target population - This is the group of individuals that is eligible to receive the intervention (the broader group of individuals the intervention is designed to serve). While Category 3 must be reported to measure specifications, providers may narrow the measure denominator based on certain criteria to more closely represent the Category 1 or 2 project's target population.

Outcome population - This is the group of patients that meet the criteria for outcome measurement based on the specifications for each measure. This often is a broader population than the project target population.

Allowable Denominator Subsets

All Category 3 outcome measures are required to be reported to the specifications required for the measure as outlined in the menu and the compendium. However, as appropriate to the Category 1 or 2 project, the provider can propose a more narrow denominator (a subset of the outcome population) based on one or more of the following criteria:

- Payer source (Medicaid or Indigent or both),
- Target condition (including co-morbid condition/diagnosis)
- Demographic factors - age, race/ethnicity, and/or gender, or
- Clinic or other location where the Category 1 or 2 project is taking place.

Using allowable denominator subsets is a way to more closely reflect the target population for each project (which will still be broader than the intervention population in almost all cases).

Establishing a Baseline for Each Category 3 Measure

Each DSRIP provider will need to establish a baseline for all Category 3 outcome measures, both P4P and P4R. Baselines also must be established for any selected Population-Focused Priority measures used as an alternative performance activity. The baseline will be specific to the patients served by that provider. Baselines will be formally reported in October 2014 or later if needed.

The provider's baseline for each measure will determine both the achievement goals for the measure in DY4 and DY5. The baseline period should be as recent as possible, DY3 is preferred, and will generally be a 12-month or 6-month period. The DY4 measurement period will be set as the 12 months immediately following the end of baseline period and the DY5 measurement period will be the 12 months immediately following the end of DY4 measurement

period. Providers should review the measure specifications to help determine the appropriate baseline period.
If providers need to request an earlier baseline measurement period than DY2, provider will need to submit justification as to why DY2 or DY3 baseline is not appropriate or available. HHSC will review these on a case by case basis and make a determination on appropriate DY4 and DY5 measurement periods.

Standard Achievement Target Methodology for Achievement Milestones

For achievement milestones for P4P measures in DY4-5 and Population-Focused Priority Measures in DY5, providers will receive incentive payments for demonstrating improvements in rate performance towards an achievement target. Achievement targets are determined based on a provider's baseline performance in the measure and are calculated by one of the two methodologies described below. Achievement milestones are eligible for partial achievement in increments of 25% as outlined in the PFM Protocol.

Quality Improvement System for Managed Care (QISMC)*:* For those P4P measures where the improvement methodology is designated as QISMC, providers will receive incentive payments for closing the gap between their baseline performance and the benchmark rates listed. For DSRIP, Texas is using a hybrid of this system used for managed care, and the benchmarks are a proxy for performance based on national or state data and may not be an exact match to the population or delivery system for a DSRIP project. If a provider, at baseline, is performing above the high performance benchmark it is required to select another measure unless the provider can make a compelling justification for how improvement can be demonstrated beyond the high performance benchmark.

The achievement level goal for DY4 will be determined as follows:

- IF a provider's reported baseline rate falls below the low performance benchmark (also called minimum performance level or MPL) the DY4 Achievement Target is equal to the rate listed for the MPL.
- IF a provider's reported baseline rate falls above the MPL but below the high performance level (HPL) benchmark, the provider must close the gap between baseline performance and the HPL rate by 10%.

The achievement level goal for DY5 will be determined as follows.

- IF a provider's reported baseline rate falls below the low performance benchmark (also called minimum performance level or MPL) the DY5 Achievement Target is equal to a 10% gap reduction between the MPL and HPL.
- IF a provider's reported baseline rate falls above the MPL but below the high performance level (HPL) benchmark providers must close the gap between baseline performance and the HPL rate by 20%.

Example:

IT-1.10 A1C poor control (>9%)			MPL = 50.7%	HPL = 28.95%
Baseline performance	**DY4** Achievement Target **(goal)**	**DY5** Achievement target **(goal)**	**DY4 performance**/ payment	**DY5 performance**/ payment

Scenario 1: **63.4%**	50.7% (= MPL)	48.53% = MPL – ([HPL-MPL] * 10%)	53.4%: 78% achievement towards goal- earns 75% of allocation	47.50%: 100% achievement towards goal- earns 100% of allocation
Scenario 2: **36.7%**	35.93% (= (baseline - HPL)* 10% improvement over baseline)	35.15% (= (baseline - HPL)* 20% improvement over baseline	35.50%: 100% achievement towards goal- earns 100% of allocation	35.40%: 84% achievement towards goal- earns 75% of allocation

Improvement over Self (IOS)*:* There are some P4P measures where QSMIC appropriate benchmarks (HPL and MPL) are not available. For these P4P measures, the improvement methodology is designated as "IOS", or Improvement over self, providers earn incentive payments for demonstrating improvement over baseline performance.

The achievement level goals will be determined as follows:

- DY4 achievement level goal is equal to a 5% improvement over the provider's baseline and is calculated as a 5% gap reduction between baseline performance and highest possible performance in the measure (e.g., 0% or 100% depending on the directionality of a rate based measure).
- DY5 achievement level goal is equal to 10% improvement over the provider's baseline and is calculated as a 10% gap reduction between baseline performance and highest possible performance in the measure.

The IOS methodology is further described and specified in Appendix B for measures that are categorized as rates, frequencies or counts and survey scores

Example of IOS achievement methodology for a rate based measure:

IT-1.9	Depression Management: Depression Remission at 12 months			No high and low performing benchmark information available, therefore assume highest possible performance (100%) as performance gap upper limit.
Baseline	DY4 Achievement target (goal)	DY4 performance/payment	DY5 Achievement target (goal)	DY5 performance/payment
40.25%	5%* (100-40.25) + baseline= **43.24%**	**42.5%**: ((performance – baseline)/(goal – baseline)) = 2.25/2.99 * 100 = 75.25% achievement towards	10%* (100-40.25) + baseline = **46.23%**	**47.5%**: ((performance – baseline)/(goal – baseline)) = 7.25/5.98 * 100 = 121%

		goal - earns 75% of allocation		achievement towards goal - earns 100% of allocation.

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Category 3 Reporting

i. DY2 Reporting

For DY2, providers were able to select their Category 3 process milestones from the below options and also designate the valuation for each milestone as long as their total Category 3 valuation met the minimum percentage level required in the PFM Protocol. Metrics, data sources, goals and rationale were specified by the performing provider for each of the selected process milestones listed below.

- P- 1 Project planning - engage stakeholders, identify current capacity and needed resources,
- determine timelines and document implementation plans
- P- 2 Establish baseline rates
- P- 3 Develop and test data systems
- P- 4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
- P- 5 Disseminate findings, including lessons learned and best practices, to stakeholders
- P- 7 Other activities not described above

HHSC and CMS also allowed performing providers in DY2 to provider a Category 3 status update in lieu of documentation specific to the milestones above since the revised Category 3 menu and framework was not final by the end of DY2.

ii. DY3 Reporting

For all Category 3 measures, there will be two process milestones in DY3 - providers will be eligible to earn 50% of the funding for each Category 3 measure based on a status report and the other 50% during the based on establishing or validating the baseline for each measure.

iii. DY4 Reporting

Reporting in DY4 will vary depending on the type of outcome selected (P4P or P4R).

Measure and performance type	Milestone type and % fund allocation	Successful Achievement
P4P – QISMC	Process Milestone (PM) - 50% allocation Achievement Milestone (AM) - 50% allocation	PM - accurate reporting of DY4 rate per approved measure specifications. AM - achievement of DY4 goal (MPL achieved or 10% gap reduction between baseline rate and HPL benchmark)
P4P- IOS	Process Milestone (PM) - 50% allocation Achievement Milestone (AM) - 50% allocation	PM - accurate reporting of DY4 rate per approved measure specifications. AM - achievement of DY4 goal (5% improvement over baseline rate)

P4R	Process Milestone (PM) - 100% allocation	PM - accurate reporting of DY4 rate per approved measure specifications.

iv. DY5 Reporting

DY5 reporting will vary depending on the type of outcome selected (P4P or P4R) as well as the type of Alternate Improvement Activity selected.

Measure and performance type	**Milestone type and % fund allocation**	**Successful Achievement**
P4P - QISMC	Achievement Milestone - 100% allocation	AM- achievement of DY5 goal (improvement over MPL goal by a 10% gap reduction between MPL and HPL or 20% gap reduction between baseline rate and HPL benchmark)
P4P – IOS	Achievement Milestone - 100% allocation	AM- achievement of DY5 goal (10% improvement over baseline rate)
P4R	Process Milestone - 50% allocation Alternate Improvement Activity – 50% allocation for Achievement Milestone for Population-Focused Priority Measure improvement OR Process Milestone for Stretch Activity	PM - accurate reporting of DY5 rate per approved measure specifications. AM - for Population-Focused Priority measures- achievement of DY5 goal OR PM- successful reporting of Stretch Activity

Category 4 Population-focused Improvements

The Category 4 measures are:

- Aligned with the low-income, Medicaid, and uninsured population;
- Identified as high priority given the health care needs and issues of the patient population served; and
- Viewed as valid health care indicators to inform and identify areas for improvement in population health within the health care system.

Category 4 Structure:

- Required Reporting Domains: Category 4 contains five domains on which hospital performing providers must report, as specified in the *Program Funding and Mechanics Protocol*. The required reporting domains include:
  - Potentially Preventable Admissions (PPAs)
  - Potentially Preventable Readmissions (PPRs) - 30-day
  - Potentially preventable Complications (PPCs)
  - Patient-centered healthcare, including patient satisfaction and medication management
  - Emergency department
- Optional Reporting Domain: At their option, hospital performing providers may report on Reporting Domain (RD) 6, which is the CMS Initial Core Set of Measures for Adults and Children in Medicaid/CHIP. While reporting on this domain is optional, participation in Domain 6 reporting is required to value Category 4 at the 15 percent maximum (see *Category 4 Valuation* below.)
- Hospital performing providers, with the exception of those that are exempt from Category 4 reporting in accordance with paragraph 11.f of the *Program Funding and Mechanics Protocol*, must report on Category 4 measures in the required reporting domains. Each hospital performing provider subject to required Category 4 reporting must report on all measures in the required reporting domains, unless for certain measures the provider does not have statistically valid data, as defined in paragraph 11.e of the *Program Funding and Mechanics Protocol*. Hospitals designated as Institutes of Mental Disease (IMDs) report on an alternate set of measures listed at the end of this section.
- HHSC will collect all Category 4 data for each hospital, but based on Texas statutory requirements pertaining to the confidentiality of individual hospital data for some of the Category 4 measures, HHSC will summarize certain data related to Category 4 for CMS at the RHP level rather than at the individual provider level.
- Each performing provider subject to Category 4 required reporting will include Category 4 measures for PPCs (RD-3) during DY 4-5 and for all other required reporting domains during DY 3-5.
- The Category 4 emphasis is on the reporting of population health measures to gain information on and understanding of the health status of key populations and to build the capacity for reporting on a comprehensive set of population health metrics; therefore, hospital performing providers will not be required to achieve improvement in Category 4.

Category 4 Valuation:

- Maximum valuation: In order to value Category 4 up to the 15 percent maximum for DY 3-5, hospital performing providers must report on the optional reporting domain (RD-6) in addition to the five required reporting domains.
- 10 percent valuation: Hospital performing providers that do not report on the optional reporting domain (RD-6) only may value Category 4 at the minimum 10 percent for DY 3-5. Performing providers that only report on the required reporting domains may designate to Categories 1, 2, or 3 the 5 percent valuation they are unable to obtain in Category 4 by foregoing reporting on the optional domain.

Category 4 Reporting Measures by Domain:

RD-1: Potentially Preventable Admissions
Texas Medicaid's External Quality Review Organization (EQRO) supplies Potentially Preventable Admissions (PPA) reports for DSRIP participating hospital providers for the duration of the Waiver. These PPA reports are produced with the 3M methodology and describe admissions for the providers Medicaid and CHIP populations. For reporting in this domain, providers submit the PPA data on the following categories:

Category
Congestive Heart Failure
Diabetes
Behavioral Health or Substance Abuse
Chronic Obstructive Pulmonary Disease
Adult Asthma (Age>18yrs)
Pediatric Asthma (Age<=18yrs)
Angina and Coronary Artery Disease
Hypertension
Cellulitis
Bacterial PNA (Respiratory Infection)
Pulmonary Edema and Respiratory Failure
Others

Additional technical specifications are available in the DSRIP Provider Reporting Potentially Preventable Events Technical Notes (Appendix E), including APR-DRGs associated with these categories.

RD-2: Potentially Preventable Readmission - 30-day

Texas Medicaid's External Quality Review Organization (EQRO) supplies Potentially Preventable 30-day Readmissions (PPR) reports for the duration of the waiver. These PPR reports are produced with the 3M methodology and describe readmissions for the providers Medicaid and CHIP populations. For reporting in this domain, providers submit PPR data on the following categories:

Category
Congestive Heart Failure
Diabetes
Behavioral Health or Substance Abuse
Chronic Obstructive Pulmonary Disease
Cerebrovascular Accident
Adult Asthma (Age>18yrs)
Pediatric Asthma (Age<=18yrs)
Acute Myocardial Infarction
Angina and Coronary Artery Disease
Hypertension
Cellulitis
Renal Failure
Cesarean delivery
Sepsis
Others

Additional technical specifications are available in the DSRIP Provider Reporting Potentially Preventable Events Technical Notes (Appendix E), including APR-DRGs associated with these categories.

RD-3: Potentially Preventable Complications (PPCs)

Hospital performing providers subject to required Category 4 reporting must report on the 64 PPC measures listed below in DY 4-5. Texas Medicaid's External Quality Review Organization (EQRO) supplies PPC reports for the duration of the waiver.

- **Metric:** Risk-adjusted PPC rates for the 64 PPCs below. (As calculated by the 3M software.[99])

PPC	PPC Description
1	Stroke & Intracranial Hemorrhage
2	Extreme CNS Complications

[99] For measure specifications see 3M's Users Manual.

3	Acute Pulmonary Edema and Respiratory Failure without Ventilation
4	Acute Pulmonary Edema and Respiratory Failure with Ventilation
5	Pneumonia & Other Lung Infections
6	Aspiration Pneumonia
7	Pulmonary Embolism
8	Other Pulmonary Complications
9	Shock
10	Congestive Heart Failure
11	Acute Myocardial Infarction
12	Cardiac Arrhythmias & Conduction Disturbances
13	Other Cardiac Complications
14	Ventricular Fibrillation/Cardiac Arrest
15	Peripheral Vascular Complications except Venous Thrombosis
16	Venous Thrombosis
17	Major Gastrointestinal Complications without Transfusion or Significant Bleeding
18	Major Gastrointestinal Complications with Transfusion or Significant Bleeding
19	Major Liver Complications
20	Other Gastrointestinal Complications without Transfusion or Significant Bleeding
21	Clostridium Difficile Colitis
23	GU Complications except UTI
24	Renal Failure without Dialysis
25	Renal Failure with Dialysis
26	Diabetic Ketoacidosis & Coma
27	Post-Hemorrhagic & Other Acute Anemia with Transfusion
28	In-Hospital Trauma and Fractures
29	Poisonings except from Anesthesia
30	Poisonings due to Anesthesia
31	Decubitus Ulcer
32	Transfusion Incompatibility Reaction
33	Cellulitis
34	Moderate Infections
35	Septicemia & Severe Infections
36	Acute Mental Health Changes
37	Post-Operative Infection & Deep Wound Disruption without Procedure
38	Post-Operative Wound Infection & Deep Wound Disruption with Procedure
39	Reopening Surgical Site
40	Post-Operative Hemorrhage & Hematoma without Hemorrhage Control Procedure or I&D Procedure
41	Post-Operative Hemorrhage & Hematoma with Hemorrhage Control Procedure or I&D Procedure

42	Accidental Puncture/Laceration during Invasive Procedure
43	Accidental Cut or Hemorrhage during Other Medical Care
44	Other Surgical Complication - Moderate
45	Post-procedure Foreign Bodies
46	Post-Operative Substance Reaction & Non-O.R. Procedure for Foreign Body
47	Encephalopathy
48	Other Complications of Medical Care
49	Iatrogenic Pneumothorax
50	Mechanical Complication of Device, Implant & Graft
51	Gastrointestinal Ostomy Complications
52	Inflammation & Other Complications of Devices, Implants or Grafts except Vascular Infection
53	Infection, Inflammation and Clotting Complications of Peripheral Vascular Catheters and Infusions
54	Infections due to Central Venous Catheters
55	Obstetrical Hemorrhage without Transfusion
56	Obstetrical Hemorrhage with Transfusion
57	Obstetric Lacerations & Other Trauma Without Instrumentation
58	Obstetric Lacerations & Other Trauma With Instrumentation
59	Medical & Anesthesia Obstetric Complications
60	Major Puerperal Infection and Other Major Obstetric Complications
61	Other Complications of Obstetrical Surgical & Perineal Wounds
62	Delivery with Placental Complications
63	Post-Operative Respiratory Failure with Tracheostomy
64	Other In-Hospital Adverse Events
65	Urinary Tract Infection
66	Catheter-Related Urinary Tract Infection

- Additional technical specifications will be available in the DSRIP Provider Reporting Potentially Preventable Events Technical Notes (Appendix E).

RD-4: Patient-centered Healthcare

1. **Patient Satisfaction**

The reporting of the measures is limited to the inpatient setting only utilizing Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. IMDs and children's facilities not eligible to use HCAHPs report any other relevant survey results in the qualitative reporting section.

Additional guidance is available in the Category 4 compendium. (Appendix F)

2. **Medication management**

1.

Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) (NQF 0646)

STEWARD: American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI), http://www.qualitymeasures.ahrq.gov/content.aspx?id=28139

Detailed measure specifications are described in Category 4 compendium (Appendix F).

i.

RD-5: Emergency Department

Emergency department throughput time—admitted patients: admit decision time to ED departure time for admitted patients (NQF 0497)

Measure Steward Information: Center for Medicare and Medicaid Services; http://www.qualitymeasures.ahrq.gov/hhs/content.aspx?id=44602#.U1-9VvldWCU

Additional guidance is available in the Category 4 compendium (Appendix F).

RD-6. (Optional Domain) Initial Core Set of Measures for Adults and Children in Medicaid/CHIP

Initial Core Set for Children in Medicaid/CHIP: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/ChildCoreMeasures.pdf

Child Core Set Technical Specifications: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Medicaid-and-CHIP-Child-Core-Set-Manual.pdf

Initial Core Set for Adults in Medicaid: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/AdultCoreMeasures.pdf

Adult Core Set Technical Specifications: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Medicaid-Adult-Core-Set-Manual.pdf

Measures designed for health plans and will require minor modifications of specifications for reporting by hospital providers.

Attachment I
Regional Healthcare Partnership (RHP) Planning Protocol

Hospital providers will report measures appropriate to settings of care. Hospitals that provide inpatient services only are not required to report measures that are specific to ambulatory settings. Hospitals that have outpatient clinics are required to report measures appropriate to ambulatory care settings. HHSC and CMS will jointly agree on a minimum data set for inpatient and outpatient providers (Appendix G)

Attachment I
Regional Healthcare Partnership (RHP) Planning Protocol

Alternate Measures for Institutes of Mental Disease (IMDs) :

Public and private Institutes for Mental Disease (IMDs) report an alternative set of Category 4 measures:

RD-1
1. – Potentially Preventable Admissions for behavioral health/ substance abuse conditions (with a preference for distinguishing behavioral health and substance abuse)
2. All-cause Potentially Preventable Admissions

RD-2
1. Behavioral health/ substance abuse readmission rates (with a preference for distinguishing behavioral health and substance abuse)
2. All-cause Potentially Preventable Readmissions

RD-4
1. - Patient satisfaction
    - Psychiatric facilities for which using HCAHPS is not appropriate should report "0" in the HCAHPS reporting section. Facilities should include all relevant data from their satisfaction surveys in the qualitative reporting section.
2. - Medication reconciliation (NQF 0646 specifications)

Additional Measures:

Bacterial pneumonia immunization
- Pneumococcal Immunization (PPV23) – Overall Rate (CMS IQR/Joint Commission measure IMM-1a)
  Specifications Found Here:
  http://www.jointcommission.org/specifications_manual_for_national_hospital_inpatient_quality_measures.aspx

Influenza Immunization
- Influenza Immunization (CMS IQR/Joint Commission measure IMM-2)
  Specifications Found Here:
  http://www.jointcommission.org/specifications_manual_for_national_hospital_inpatient_quality_measures.aspx

The Texas state IMDs will be able to report on the Category 4 measures suggested by CMS above with the following caveats:

- State mental health hospitals will have admission rates for BH and not substance abuse as a separate reportable item.
- The "all cause PPAs" will only report on mental health PPA since that is the only diagnosis the state admits a patient to a state mental health facility.

- State mental health hospitals can report on mental health readmission rates but not substance abuse, since patients would have not been admitted for only substance abuse disorders.
- The "all cause PPRs" will only report on mental health PPR since that is the only diagnosis DSHS admits a patients into a state mental health facility.

Addendum to RHP Planning Protocol - Demonstration Year 6A

Attachment I
Regional Healthcare Partnership (RHP) Planning Protocol

Attachment I -Regional Healthcare Partnership (RHP) planning protocol is amended for Demonstration Year (DY) 6A as follows:

Category 1 and 2

- All Process and Improvement Milestones in all Category 1 and 2 project areas are replaced with the following milestones under each project area:

DY6A Milestones:

1. Milestone: Total Quantifiable Patient Impact (QPI)
   Q.1.1 Number of individuals served or encounters provided over pre-DSRIP baseline

2. Milestone: Medicaid and Low-Income Uninsured (MLIU) QPI
   MQ. 1.1 Number of MLIU individuals served or MLIU encounters provided over MLIU pre-DSRIP baseline

3. Milestone: Project Summary and Core Components
   3.1. Project Overview: Accomplishments
   3.2. Project Overview: Challenges
   3.3. Project Overview: Lessons Learned
   3.4. Progress on Core Components, including quality improvement activities
   3.5. Description of other federal funding sources available for the project
   3.6. Participation in learning collaboratives, stakeholder forum, or other stakeholder meeting during DY6A
   3.7. The progress and completion of the next step taken (if required for a particular project)

4. Milestone: Sustainability Planning

   Responses to questions related to sustainability planning efforts:
   4.1 Collaboration with Medicaid Managed Care
   4.2 Value Based Purchasing and/or Alternative Payment Models
   4.3 Availability of other funding sources
   4.4 Project Evaluation
   4.5 Health Information Exchange (HIE)

- Project areas and project options remain unchanged.

Attachment I
Regional Healthcare Partnership (RHP) Planning Protocol

- Reporting for the DY6A milestones should be done in the manner specified in the Program Funding and Mechanics (PFM) Protocol.
- This amendment does not apply to any of the DY5 carryforward milestones, which should be reported based on the milestones in the RHP Planning Protocol (initially approved or updated for 3-year projects).

Attachment I
Regional Healthcare Partnership (RHP) Planning Protocol

Category 3

- Category 3 updates include a DY6 milestone structure for Category 3 measures, DY6 goal calculation, measurement period, partial payment calculation, stretch activities, and the listing of Population Focused Priority Measure (PFPM) Menu.

DSRIP Category 3 Milestones for DY6 (based on DYs 3 - 5 milestone structure)

Standard P4P Milestone Structure (baseline ending by 09/30/2014)			
Year	Milestone	Milestone Description	Payment
DY3	*PM-8*	*Submission of Category 3 DY3 Status Report*	*50% of Cat 3 DY3 Value*
	PM-9	*Validation and submission of baseline performance*	*50% of Cat 3 DY3 Value*
DY4	*PM-10*	*Successful reporting to approved measure specifications*	*50% of Cat 3 DY4 Value*
	*AM-1.x**	*Achievement of PY1 performance goal*	*50% of Cat 3 DY4 Value*
DY5	*AM-2.x**	*Achievement of PY2 performance goal*	*100% of Cat 3 DY5 Value*
DY6	AM-3.x*	Achievement of PY3 performance goal	100% of Cat 3 DY6 Value

Standard P4R w/ PFPM Milestone Structure (baseline ending by 09/30/2014)			
Year	Milestone	Milestone Description	Payment
DY3	*PM-8*	*Submission of Category 3 DY3 Status Report*	*50% of Cat 3 DY3 Value*
	PM-9	*Validation and submission of baseline performance*	*50% of Cat 3 DY3 Value*
DY4	*PM-10*	*Successful reporting to approved measure specifications*	*100% of Cat 3 DY4 Value*
DY5	*PM-10*	*Successful reporting to approved measure specifications*	*50% of Cat 3 DY5 Value*
	*AM-3.x**	*Achievement of DY5 PFPM Goal*	*50% of Cat 3 DY5 Value*
DY6	AM-3.x*	Achievement of DY6 PFPM Goal	100% of Cat 3 DY6 Value

Standard P4R w/ Stretch Activity Milestone Structure (baseline ending by 09/30/2014)			
Year	Milestone	Milestone Description	Payment

DY3	*PM-8*	*Submission of Category 3 DY3 Status Report*	*50% of Cat 3 DY3 Value*
	PM-9	*Validation and submission of baseline performance*	*50% of Cat 3 DY3 Value*
DY4	*PM-10*	*Successful reporting to approved measure specifications*	*100% of Cat 3 DY4 Value*
DY5	*PM-10*	*Successful reporting to approved measure specifications*	*50% of Cat 3 DY5 Value*
	PM-11	*Successful Achievement of Stretch Activity*	*50% of Cat 3 DY5 Value*
DY6	PM-10	Successful reporting to approved measure specifications	50% of Cat 3 DY6 Value
	PM-11	Successful Achievement of Stretch Activity	50% of Cat 3 DY6 Value
	or		
	AM-3.x*	Achievement of DY6 PFPM PY3 Goal	100% of Cat 3 DY6 Value

Standard Maintenance w/ PFPM Milestone Structure (baseline ending by 09/30/2014)			
Year	Milestone	Milestone Description	Payment
DY3	*PM-8*	*Submission of Category 3 DY3 Status Report*	*50% of Cat 3 DY3 Value*
	PM-9	*Validation and submission of baseline performance*	*50% of Cat 3 DY3 Value*
DY4	*PM-10*	*Successful reporting to approved measure specifications*	*50% of Cat 3 DY4 Value*
	PM-12	*Maintain Baseline High Performance Level*	*50% of Cat 3 DY4 Value*
DY5	*PM-12*	*Maintain Baseline High Performance Level*	*50% of Cat 3 DY5 Value*
	*AM-3.x**	*Achievement of DY5 PFPM Goal*	*50% of Cat 3 DY5 Value*
DY6	AM-3.x*	Achievement of DY6 PFPM Goal	100% of Cat 3 DY6 Value

Standard Maintenance w/ Stretch Activity Milestone Structure (baseline ending by 09/30/2014)			
Year	Milestone	Milestone Description	Payment
DY3	*PM-8*	*Submission of Category 3 DY3 Status Report*	*50% of Cat 3 DY3 Value*
	PM-9	*Validation and submission of baseline performance*	*50% of Cat 3 DY3 Value*
DY4	*PM-10*	*Successful reporting to approved measure specifications*	*50% of Cat 3 DY4 Value*
	PM-12	*Maintain Baseline High Performance Level*	*50% of Cat 3 DY4 Value*
DY5	*PM-12*	*Maintain Baseline High Performance Level*	*50% of Cat 3 DY5 Value*
	PM-11	*Successful Achievement of Stretch Activity*	*50% of Cat 3 DY5 Value*
DY6	PM-12	Maintain Baseline High Performance Level	100% of Cat 3 DY6 Value
DY4 Baseline P4P Milestone Structure (baseline established with DY4 data)			
Year	Milestone	Milestone Description	Payment
DY3	*PM-8*	*Submission of Category 3 DY3 Status Report*	*50% of Cat 3 DY3 Value*

	PM-9	*Validation and submission of baseline performance (functions as a status update)*	*50% of Cat 3 DY3 Value*
DY4	*PM-10*	*Successful reporting to approved measure specifications (functions as a final baseline)*	*100% of Cat 3 DY4 Value*
DY5	*AM-2.x**	*Achievement of PY2 performance goal*	*100% of Cat 3 DY5 Value*
DY6	AM-3.x*	Achievement of PY3 performance goal	100% of Cat 3 DY6 Value

DY4 Baseline P4R w/ Stretch Activity Milestone Structure (baseline established with DY4 data)			
Year	Milestone	Milestone Description	Payment
DY3	*PM-8*	*Submission of Category 3 DY3 Status Report*	*50% of Cat 3 DY3 Value*
	PM-9	*Validation and submission of baseline performance (functions as a status update)*	*50% of Cat 3 DY3 Value*
DY4	*PM-10*	*Successful reporting to approved measure specifications (functions as a final baseline)*	*100% of Cat 3 DY4 Value*
DY5	*PM-10*	*Successful reporting to approved measure specifications*	*50% of Cat 3 DY5 Value*
	PM-11	*Successful Achievement of Stretch Activity*	*50% of Cat 3 DY5 Value*
DY6	PM-10	Successful reporting to approved measure specifications	50% of Cat 3 DY6 Value
	PM-11	Successful Achievement of Stretch Activity	50% of Cat 3 DY6 Value
	or		
	AM-3.x*	Achievement of DY6 PFPM Goal	100% of Cat 3 DY6 Value

DY4 Baseline P4R w/ PFPM Milestone Structure (baseline established with DY4 data)			
Year	Milestone	Milestone Description	Payment
DY3	*PM-8*	*Submission of Category 3 DY3 Status Report*	*50% of Cat 3 DY3 Value*
	PM-9	*Validation and submission of baseline performance (functions as a status update)*	*50% of Cat 3 DY3 Value*
DY4	*PM-10*	*Successful reporting to approved measure specifications (functions as a final baseline)*	*100% of Cat 3 DY4 Value*
DY5	*PM-10*	*Successful reporting to approved measure specifications*	*50% of Cat 3 DY5 Value*
	AM-3.x	*Achievement of DY5 PFPM Goal*	*50% of Cat 3 DY5 Value*
DY6	AM-3.x	Achievement of DY6 PFPM Goal	100% of Cat 3 DY6 Value

DY4 Baseline Maintenance w/ Stretch Activity Milestone Structure (baseline established with DY4 data)			
Year	Milestone	Milestone Description	Payment
DY3	*PM-8*	*Submission of Category 3 DY3 Status Report*	*50% of Cat 3 DY3 Value*

	PM-9	*Validation and submission of baseline performance (functions as status update)*	*50% of Cat 3 DY3 Value*
DY4	*PM-10*	*Successful reporting to approved measure specifications (functions as final baseline)*	*100% of Cat 3 DY4 Value*
DY5	*PM-12*	*Maintain Baseline High Performance Level*	*50% of Cat 3 DY5 Value*
	PM-11	*Successful Achievement of Stretch Activity*	*50% of Cat 3 DY5 Value*
DY6	PM-12	Maintain Baseline High Performance Level	100% of Cat 3 DY6 Value

DY6 goal calculations

The following goal calculations apply to Category 3 outcomes and PFPM outcomes in DY6. P4P outcomes approved to use a standard baseline, outcomes approved to use a DY4 baseline, and PFPM outcomes will all use the same goal calculations to determine goals for DY6 milestone AM-3.x.

PY3 QISMC Goal Setting for Category 3 P4P Outcomes		
Direction	Baseline	PY3 Goal
Positive	Below the MPL	MPL + .15*(HPL - MPL)
	Between the MPL & HPL	the greater of: baseline + .25*(HPL - baseline); or baseline + .10*(HPL - MPL) †
	Above the HPL	the lesser of: baseline + .125*(1-baseline); or baseline + .10*(HPL - MPL) †
Negative	Above the MPL	MPL -.15*(MPL - HPL)
	Between the MPL & HPL	the lesser of: baseline - .25*(baseline - HPL); or baseline - .10*(MPL - HPL) †
	Below the HPL	the greater of: baseline - .125*(baseline); or baseline - .10*(MPL - HPL) †
† *Goal set using the improvement floor*		

PY3 IOS Goal Setting for Category 3 P4P Outcomes	
Direction	PY3 Goal
Positive	baseline + .125*(perfect - baseline)

Negative	baseline -.125*(baseline)

PY3 IOS - Survey Goal Setting for Category 3 P4P Outcomes		
Direction	Reporting Scenario	PY3 Goal
Positive	Scenario 1	Posttest baseline + .125*(posttest baseline - pretest baseline)
	Scenario 2 & Scenario 3	Baseline + .125*(max score - baseline)
Negative	Scenario 1	Posttest baseline - .125*(pretest baseline - posttest baseline)
	Scenario 2 & Scenario 3	Baseline - .125*(baseline - min score)

Alternate Achievement Requests

If an outcome has an HHSC approved alternate achievement request in DY5, the performer must submit to HHSC, by a date determined by HHSC in a form determined by HHSC, a request to use a PY3 goal that is a continuation of the goals approved in DYs 4-5. Such requests will be approved by HHSC on a case-by-case basis.

If an outcome, including a PFPM outcome, is designated as QISMC in DY5, with a baseline that is below the MPL, and the performer is measuring a population substantially dissimilar from the population used to establish the MPL benchmark, the performer may submit, by a date determined by HHSC in a form determined by HHSC, an alternate achievement request to set the PY3 goal as a 12.5 percent gap closure towards perfect over the baseline.

Measurement Periods
If a Category 3 outcome is designated as P4P or maintenance in DY5, performance year (PY) 3 is the 12-month period immediately following the PY2 approved for use in DYs 3-5, or a performer may request, by a date to be determined by HHSC, to use DY6A as PY3. PY4 is the 12-month period immediately following PY3. The selected PY3 is used to report achievement of DY6 milestones AM-3.x and PM-12, and PY4 is used to report any partial achievement carried forward from DY6 milestone AM-3.x.

If a Category 3 outcome is designated as P4R in DY5, PY3 is the 12-month period immediately following the PY2 approved for use in DYs 3-5, and is used for reporting achievement of DY6 milestone PM-10.

Partial Payment Calculations
Partial payment for a Category 3 P4P outcome is available in quartiles as defined in the RHP Planning Protocol, measured between the outcome's PY1 goal and PY3 goal.

Each Category 3 P4P outcome has an associated achievement milestone that is assigned an achievement value based on the performer's achievement of the outcome's goal as follows:

- if 100 percent of the goal is achieved, the achievement milestone is assigned an achievement value of 1.0;
- if at least 75 percent of the goal is achieved, the achievement milestone is assigned an achievement value of 0.75;
- if at least 50 percent of the goal is achieved, the achievement milestone is assigned an achievement value of 0.5;
- if at least 25 percent of the goal is achieved, the achievement milestone is assigned an achievement value of 0.25; or
- if less than 25 percent of the goal is achieved, the achievement milestone is assigned an achievement value of 0.

The percent of the goal achieved for DY6 milestones AM-3.x is determined as follows:

Percent of Goal Achieved for Category 3 P4P Outcomes			
PY	Milestone	Positive Direction (higher rates indicate improvement)	Negative Direction (lower rates indicate improvement)
PY3	DY6A AM-3.x	(PY3 achieved - PY1 goal or equivalent)/(PY3 goal - PY1 goal or equivalent)	(PY1 goal or equivalent - PY3 achieved)/(PY1 goal or equivalent - PY3 goal)
PY4	Carry forward of DY6A AM-3.x	(PY4 achieved - PY1 goal or equivalent)/(PY3 goal - PY1 goal or equivalent)	(PY1 goal or equivalent - PY4 achieved)/(PY1 goal or equivalent - PY3 goal)

PY1 Equivalent Goals

For P4P outcomes where there is no PY1 goal or where the PY3 goal is set using a different methodology than used to determine the PY1 goal, partial payment will be measured as the percent of goal achieved between PY3 goal and a PY1 equivalent goal, as defined below.

If a category 3 outcome is approved to use a baseline established in DY4 and does not have a DY4 achievement milestone, partial payment will be measured over a PY1 equivalent goal. For PFPM outcomes, partial payment will be measured over a PY1 equivalent goal. The PY1 equivalent goal

for category 3 outcomes without and DY4 achievement milestone and for PFPM outcomes will follow the QISMC or IOS goal calculations for PY1 as approved in the RHP Planning Protocol.

If a QISMC outcome has a PY3 goal that was determined using the improvement floor, partial payment will be measured over the PY1 equivalent goal. If a higher rate indicates improvement for the outcome, the PY1 equivalent goal is the baseline plus 40 percent of the improvement floor. If a lower rate indicates improvement for the outcome, the PY1 equivalent goal is the baseline minus 40 percent of the improvement floor.

If an IOS - Survey outcome is using reporting scenario 2 or reporting scenario 3, partial payment will be over the PY1 equivalent goal. If a higher rate indicates improvement for the outcome, the PY1 equivalent goal is the baseline plus a five percent gap closure towards the maximum score. If a lower rate indicates improvement for the outcome, the PY1 equivalent goal is the baseline minus a five percent gap closure towards the minimum score.

DY6 Stretch Activities
If a Category 3 outcome is designated as P4R with an associated stretch activity in DY5, the Performing Provider must choose one of the following options by a date determined by HHSC in a form determined by HHSC:

A. The Performing Provider may maintain the Category 3 outcome designated as P4R from DY5 and select a new stretch activity that does not duplicate the DY5 stretch activity; or
B. The Performing Provider may select a PFPM to replace the Category 3 outcome designated as P4R. If a Performing Provider chooses this option, 100 percent of the Category 3 outcome's value is P4P of the newly selected PFPM.

If the Performing Provider chooses option A, the Performing Provider must select a stretch activity from the following:

a) Program evaluation (SA-3: Alternate approaches to program and outcome linkages).
b) New participation in Health Information Exchange (HIE), or improvement of existing HIE structure.
c) Cost analysis and value-based purchasing planning

DY6 Category 3 Stretch Activities	
Activity	**Description**
SA-3 Program Evaluation	Submission of a report evaluating one or more aspects of the project intervention and its outcomes. The program evaluation may include a quantitative and/or qualitative analysis of the project. Providers have discretion in determining the components and framework of the program evaluation. The end product/output should be beneficial and useful to the provider. Providers will submit the final program evaluation along with a one-page HHSC coversheet that includes fields for providers to input

	provider/project information and respond to qualitative questions related to the program evaluation.
SA-7 New Participation or Improvement in Health Information Exchange	Demonstration of new participation in a community-based HIE program (such as the Local HIE Program or the Texas White Space Program), or demonstration of improvements or enhancements in the use of health information exchanges (HIE). Providers will submit a report detailing one or more of the following: Participation activities Partnerships developed (i.e. treating physicians, hospitals, healthcare payers, and other health care providers involved in the care of the patient and exchange of health-related information) The impact to the provider's data infrastructure and the usefulness of data System improvements (specifically how involvement improved data infrastructure and reporting capabilities) The number of times a portion (such as medication history) or all of a patient's health record was either received or transmitted by a practice for the purpose of care (this could include pre and post HIE-participation or improvement) Detailed plans for further enhancement For additional details on HIE, please visit the following websites: http://www.hietexas.org http://linktexas.healthcare/
SA-9 Cost-Benefit analysis of Project to move towards Value-based purchasing plan	Submission of cost-benefit analysis (CBA) or return-on-investment analysis of the project. Costs could include, but would not be limited to, costs associated with ongoing overhead needs, staff/labor, supplies and equipment costs. Savings/benefits could include, but would not be limited to, reduced utilization of healthcare services and improved health outcomes. The CBA or ROI would function as a way to demonstrate that a project is a worthwhile investment to payors (MCOs, community, health systems etc…) to include as a value-based service.

Population Focused Priority Measure Menu

Final Selection PFP ID	PFP Measure Description	Related Cat 3 Outcome	Related Cat 3 Outcome Title	Methodology
PPR.1	Risk Adjusted CHF PPR	IT-3.3	Risk Adjusted Congestive Heart Failure (CHF) 30-day Readmission Rate	IOS
PPR.2	Risk Adjusted DM PPR	IT-3.5	Risk Adjusted Diabetes 30-day Readmission Rate	IOS
PPR.3	Risk Adjusted BH/SA PPR	IT-3.15	Risk Adjusted Behavioral Health /Substance Abuse 30-day Readmission Rate	IOS

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PPR.4	Risk Adjusted Pediatric Asthma PPR	IT-3.21	Risk Adjusted Pediatric Asthma 30-day Readmission Rate	IOS
PPR.5	Risk Adjusted Chronic Obstructive Pulmonary Disease Related PPR	IT-3.17	Risk Adjusted Chronic Obstructive Pulmonary Disease (COPD) 30-day Readmission Rate	IOS
PPR.6	Risk Adjusted Cerebrovascular Accident (Stroke) Related PPR	IT-3.13	Risk Adjusted Stroke (CVA) 30-day Readmission Rate	IOS
PPR.7	Risk Adjusted Acute Myocardial Infarction (AMI) Related PPRs	IT-3.9	Risk Adjusted Acute Myocardial Infarction (AMI) 30-day Readmission Rate	IOS
PPR.8	Risk Adjusted Angina and Coronary Artery Disease related PPR	IT-3.11	Risk Adjusted Coronary Artery Disease (CAD) 30-day Readmission Rate	IOS
PPR.10	Risk Adjusted Renal Failure Related PPR	IT-3.7	Risk Adjusted Renal Disease 30-day Readmission Rate	IOS
PPR.12	Risk Adjusted All Cause PPR	IT-3.22	Risk Adjusted All-Cause Readmission	IOS
CMHC.1	Follow-up after hospitalization for mental illness	IT-1.18	Follow-Up After Hospitalization for Mental Illness	QISMC
CMHC.2	Follow-up care for children prescribed ADHD medication	IT-11.6	Follow-up Care for Children Prescribed ADHD Medication (ADD)	QISMC
CMHC.3	Antidepressant Medication Management - Effective Acute Phase Treatment	IT-1.19	Antidepressant Medication Management	QISMC
CMHC.4	Depression Remission at 12-months	IT-1.9	Depression management: Depression Remission at Twelve Months	IOS
CMHC.5	Adherence to Antipsychotic Medications	IT-11.5	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	IOS
CMHC.6	Depression Management: Screening and Treatment Plan for Clinical Depression	IT-1.8	Depression management: Screening and Treatment Plan for Clinical Depression	IOS
PP.1	Medication Management for People with Asthma	IT-1.31	Medication Management for People with Asthma (MMA)	IOS
PP.2	Follow-up Care for Children Prescribed ADHD Medication	IT-11.6	Follow-up Care for Children Prescribed ADHD Medication (ADD)	QISMC
PP.4	Heart Failure Admission Rate	IT-2.2	Risk Adjusted Congestive Heart Failure (CHF) Admission rate	IOS
PP.6	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	IT-1.29	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	QISMC
PP.7	Adult Body Mass Index (BMI) Assessment	IT-1.21	Adult Body Mass Index (BMI) Assessment	QISMC
PP.8	Immunization Status for Adolescents	IT-12.8	Immunization for Adolescents-Tdap/TD and MCV	QISMC
PP.9	Prenatal and Postnatal Care	IT-8.1	Timeliness of Prenatal/Postnatal Care	QISMC
PP.10	Live Births Weighing Less than 2,500 grams	IT-8.2	Percentage of Low Birth- weight births	IOS
PP.11	Cesarean Rate for Nulliparous Singleton Vertex	IT-8.6	Cesarean Rate for Nulliparous Singleton Vertex	IOS

PP.12	Annual Percentage of Asthma Patients 2 Through 20 Years Old with One or More Asthma-related Emergency Room Visits	IT-9.4.h	Pediatric/Young Adult Asthma Emergency Department Visits	IOS

Note: Providers can select to report on a Potentially Preventable Admission rate for all-causes or for a specific diagnosis with prior approval from HHSC.

Selecting a new PFPM to replace a P4R outcome and Stretch Activity and Establishing a Baseline

Providers who are newly selecting a PFPM in DY6 must select one of the above PFPM outcomes and report a baseline by a date determined by HHSC in a form determined by HHSC.

PFPM Measurement Periods

For providers with a newly selected PFPM in DY6, the baseline should be a 12-month measurement period aligned with either DY4 (ending by 9/30/2014) or DY5 (ending by 9/30/2016), with some exceptions to be confirmed with HHSC prior to reporting a PFPM baseline. For these providers, the first opportunity to report performance of the PFPM will be called performance year (PY) 3, to align with other Category 3 outcomes. PY3 will be DY6 (10/1/2016 to 9/30/2017), and PY4 will be the 12 months following PY3. PY3 is used to report achievement of DY6 milestone AM-3.x., and PY4 is used to report any partial achievement carried forward from DY6 milestone AM-3.x

Example: if a provider with a newly selected PFPM in DY6 reports a baseline with a measurement period of 10/1/2014 to 9/30/2015, their PY3 measurement period would be from 10/1/2016 to 9/30/2017.

Example of PFPM Measurement Periods for newly selected PFPM	
Baseline (DY4)	10/1/2014 to 9/30/2015
PY2/DY5 milestones	Not applicable
PY3/ DY6 milestones	10/1/2016 to 9/30/2017
PY4/DY7 milestones	10/1/2017 to 9/30/2018

The protocols related to goal calculations, partial payment calculations and alternate achievement requests that apply to Category 3 outcomes will also apply to PPFM outcomes in DY6.

Category 4 Population-focused Improvements

- Reporting on Optional Domain RD-6 is eliminated for DY6A. The following language is removed from the RHP Planning Protocol.

~~**RD-6. (Optional Domain) Initial Core Set of Measures for Adults and Children in Medicaid/CHIP**~~

~~**Initial Core Set for Children in Medicaid/CHIP: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/ChildCoreMeasures.pdf**~~

~~**Child Core Set Technical Specifications**: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Medicaid-and-CHIP-Child-Core-Set-Manual.pdf~~
~~**Initial Core Set for Adults in Medicaid: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/AdultCoreMeasures.pdf**~~
~~**Adult Core Set Technical Specifications: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Medicaid-Adult-Core-Set-Manual.pdf**~~
~~**Measures designed for health plans and will require minor modifications of specifications for reporting by hospital providers.**~~
~~Hospital providers will report measures appropriate to settings of care. Hospitals that provide inpatient services only are not required to report measures that are specific to ambulatory settings. Hospitals that have outpatient clinics are required to report measures appropriate to ambulatory care settings. HHSC and CMS will jointly agree on a minimum data set for inpatient and outpatient providers (Appendix G)~~

Appendix

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Regional Healthcare Partnership (RHP) Planning Protocol

CMS-Provided Key Elements for Learning Collaboratives and Continuous Quality Improvement

Learning Collaboratives – The key elements in the design of any learning collaborative include:

1. *It should review data and respond to it - with tests of new solutions and ideas - every week.*

2. *It should bring all participating sites together by phone or webinar on a weekly or bi-weekly basis to learn from one another.* All sites should share results of their testing, a breakthrough idea, and a challenge each week at the start of each call and they should leave with a public commitment to test a new idea the following week.

3. *It should set one or two quantifiable, project-level goals, with a deadline, preferably defined in terms of outcomes, related to the project's area of work.* Participants should actively manage toward this goal over the course of the work.

4. *It should invest more in learning than in teaching.* Huge proportional investments in web sites and conferences do not typically result in performance improvement or transformation of care delivery. It is more effective to get out into the field and support learning and exchange at the front lines where care is delivered.

5. *It should support a small, lightweight web site to help site share ideas and simple data over time.* The website should not be developed from scratch for the program. Rather, it should be possible to "rent" space on a portal already designed to support this kind of improvement work.

6. *It should set up simple, interim measurement systems, based on self-reported data and sampling, that can be shared at the local level and are sufficient for the purposes of improvement.*

7. *It should employ individuals (regional "innovator agents") to travel from site to site in the network to (a) rapidly answer practical questions about implementation and (b) harvest good ideas and practices that they systematically spread to others. The regional "innovator agents" should all attend the same initial training in improvement tools and skills organized by the State or RHP and should receive periodic continuing education on improvement.*

8. *It should set up face-to-face learning (meetings or seminars) at least a couple of times a year.*

9. *It should celebrate success every week.*

10. *It should mandate some improvements (simple things that everyone can do to "raise the floor" on performance) and it should unleash vanguard sites to pursue previously unseen levels ("raise the bar" on performance).*

11. *It should use metrics to measure its success such as:*
    - Rate of testing
    - Rate of spread
    - Time from idea to full implementation
    - Commitment rate (rate at which 50% of organizations take action for any specific request)
    - Number of questions asked per day
    - Network affinity/reported affection for the network

Continuous Quality Improvement:
In order to incentivize engagement in meaningful quality improvement (QI) activities that can lead to successful projects, this protocol includes optional process milestones and metrics for quality improvement activities. The process milestones and metrics for quality improvement activities listed below (which are also included as process milestone in the relevant project areas) further reflect CMS thinking on the type of QI activities that should be part of the QI core component for projects and provide direct insight into how CMS will review projects for this core element.

Attachment J
Program Funding and Mechanics Protocol

TEXAS
Health and Human Services

I. PREFACE

On December 12, 2011, the Centers for Medicare and Medicaid Services (CMS) approved Texas' request for a new Medicaid demonstration waiver ("Demonstration") entitled "Texas Healthcare Transformation and Quality Improvement Program" (Project # 11-W-00278/6) in accordance with section 1115 of the Social Security Act. This waiver authorized the establishment of the Delivery System Reform Incentive Payment (DSRIP) program. The initial waiver was approved through September 30, 2016, and an initial extension was granted through December 31, 2017. An additional 5 year extension was granted on December 21, 2017. This section of the DSRIP Program Funding and Mechanics Protocol applies to demonstration years (DY) 7 through 10. Policies for DY 1 through 6 are provided in the Addendum.

1. Delivery System Reform Incentive Payment (DSRIP) Program

Special Terms and Conditions (STC) 34 of the Demonstration authorizes Texas to establish a Delivery System Reform Incentive Payment (DSRIP) program. The DSRIP program is designed to provide incentive payments to hospitals and other Performing Providers for investments in delivery system reforms that increase access to health care, improve the quality of care, and enhance the health of patients and families they serve.

Activities funded by DSRIP shall be based on Regional Healthcare Partnerships (RHPs). Each RHP shall have geographic boundaries and will be coordinated by a public hospital or local governmental entity (the Anchoring Entity). The Anchoring Entity shall collaborate with Performing Providers and other stakeholders in the RHP on the RHP Plan Updates (updates of the RHP Plan that was originally developed in 2012 to accelerate meaningful delivery system reforms that improve patient care for low-income populations in the RHP). The RHP Plan Updates must be consistent with the RHP's mission and quality goals, as well as CMS's triple aims to: improve care for individuals (including access to care, quality of care, and health outcomes); improve health for the population; and lower costs through improvements (without any harm whatsoever to individuals, families, or communities).

RHP Plan Updates for DY7-8 will reflect the evolution of the DSRIP program from project-level reporting to provider Core Activities supporting Performing Provider-level outcomes that measure continued transformation of the Texas healthcare system. RHP Plan Updates for DY9-10 will give Performing Providers an opportunity to update their selections of outcomes and Core Activities.

DY7-10 will serve as an opportunity for Performing Providers to move further towards sustainability of their transformed systems, including development of Alternative Payment Models (APMs) to continue services for Medicaid and low-income or uninsured (MLIU) individuals after the waiver ends.

To that end, Performing Providers will define and update the system they will utilize in DY7-10 for Category B and Category C measurements in the RHP Plan Updates. As DSRIP shifts from project-level reporting to system-level reporting, HHSC wants to ensure that Performing Providers maintain a focus on serving the target population: MLIU patients. Because DSRIP reporting will no longer be project-specific, HHSC requires that Performing Providers demonstrate that they are maintaining a certain level of service to the MLIU target population. In addition, HHSC does not want Performing Providers to stop serving the MLIU population in an effort to enhance achievement of Category C measures. The Category B system definition and Patient Population by Provider (PPP) is meant to define the universe of patients that will be served by a Performing Provider; Category C measure denominators will naturally be limited by settings of services or measure specifications.

A Performing Provider's system definition should capture all aspects of the Performing Provider's patient services. There are required and optional components of a Performing Provider's system definition for each Performing Provider type. The required components must be included in a Performing Provider's system definition if the Performing Provider's organization has that business component. Optional components are less common among a provider type, but with the exception of contracted providers, should be included if they are a prominent component of a Performing Provider's system of care. Performing Providers may also add contracted partners to their system definition. Please refer to the Measure Bundle Protocol for the optional and required components of the system definition. Performing Providers will define and update their system in the RHP Plan Updates.

Categories 1-4 in DY2-6 are transitioned to the following Categories in DY7-10:

- Category A - Required reporting that includes progress on Core Activities, Alternative Payment Model (APM) arrangements, costs and savings, and collaborative activities as described in paragraph 17.
- Category B - Medicaid and Low-income or Uninsured (MLIU) Patient Population by Provider (PPP)
- Category C - Measure Bundles and Measures
- Category D - Statewide Reporting Measure Bundle, similar to hospital Category 4 reporting during the initial demonstration period and DY6, expanded to include all Performing Providers.

2. Measure Bundle Protocol and Program Funding and Mechanics Protocol

In accordance with STC 34, the Measure Bundle Protocol (Attachment R) defines the Performing Provider system-level measures that are bundled to align closely with transformative DSRIP project areas from the Initial Demonstration Period and includes an appendix for measure specifications. The Program Funding and Mechanics Protocol (Attachment J) describes the State review process for RHP Plans and RHP Plan Updates, incentive payment methodologies, RHP and State reporting requirements, and penalties for missed milestones.

Following CMS approval of Attachment R and Attachment J, each RHP must submit an RHP Plan Update that identifies the selected Measure Bundles and measures for each Performing Provider for DY7-8 and later for DY9-10 in accordance with these attachments and the STCs.

This version of the Program Funding and Mechanics Protocol is approved as of TBD 2019.

3. Organization of "Attachment J: Program Funding and Mechanics Protocol"

Attachment J has been organized into the following sections:

I. Preface
II. DSRIP Eligibility Criteria
III. Key Elements of RHP Plan Updates
IV. Review and Approval Process of RHP Plan Updates
V. RHP Plan Update Modifications for DY7-10
VI. Performing Provider Requirements for DY7-10
VII. Disbursement of DSRIP Funds for DY7-10
VIII. RHP and State Reporting Requirements
IX. Data Quality Assurance

4. Definitions

a. Core Activity - An activity implemented by a Performing Provider to achieve the Performing Provider's Category C measure goals. A Core Activity may include an activity implemented by a Performing Provider as part of a DY2-6 DSRIP project that the Performing Provider continues in DY7-10, or a new activity implemented by a Performing Provider in DY7-10.

b. Demonstration Year (DY) 6 - The initial 15-month period of time, as approved by the Centers for Medicare & Medicaid Services (CMS), for which the waiver is extended beyond the Initial Demonstration Period, or October 1, 2016 - December 31, 2017.

    i. Demonstration Year (DY) 6A - Federal fiscal year (FFY) 2017, or the first 12 months of DY6 (October 1, 2016 - September 30, 2017).

    ii. Demonstration Year (DY) 6B - The last three months of DY6 (October 1, 2017 - December 31, 2017).

c. Demonstration Year (DY) 7 - Federal fiscal year (FFY) 2018, which includes DY6B (October 1, 2017 - September 30, 2018). This is also reporting year (RY) 1.

d. Demonstration Year (DY) 8 - Federal fiscal year (FFY) 2019 (October 1, 2018 - September 30, 2019). This is also reporting year (RY) 2.

e. Demonstration Year (DY) 9 - Federal fiscal year (FFY) 2020 (October 1, 2019 - September 30, 2020). This is also reporting year (RY) 3.

f. Demonstration Year (DY) 10 - Federal fiscal year (FFY) 2021 (October 1, 2020 - September 30, 2021). This is also reporting year (RY) 4.

g. Demonstration Year (DY) 11 - Federal fiscal year (FFY) 2022 (October 1, 2021 - September 30, 2022).

h. Initial Demonstration Period - The first five demonstration years (DY) of the waiver, or December 12, 2011, through September 30, 2016.

i. Measure Bundle - A grouping of measures that share a unified theme, apply to a similar population, and are impacted by similar activities. Measure Bundles are selected by hospitals and physician practices. Each Measure Bundle may include required measures and optional measures that may be selected by hospitals and physician practices in addition to the required measures.

j. Medicaid and Low-income or Uninsured (MLIU)

    i. To qualify as a Medicaid individual for purposes of MLIU Patient Population by Provider (PPP), the individual must be enrolled in Medicaid or Children's Health Insurance Program (CHIP) at the time of at least one encounter during the applicable DY.

    ii. To qualify as a low-income or uninsured individual for purposes of MLIU PPP, the individual must either be below 200 percent of the federal poverty level (FPL) or must not have health insurance at the time of at least one encounter during the applicable DY.

    iii. If an individual was enrolled in Medicaid at the time of one encounter during the applicable DY, and was low-income or uninsured at the time of a separate encounter during the applicable DY, that individual is classified as a Medicaid individual for purposes of MLIU PPP.

k. Medicaid and Low-income or Uninsured (MLIU) Patient Population by Provider (PPP) - The number of MLIU individuals served by the Performing Provider during an applicable DY.

l. Medicaid and Low-income or Uninsured (MLIU) Patient Population by Provider (PPP) Goal - The number of MLIU individuals that a Performing Provider must serve in accordance with paragraph 16, during an applicable DY. The goal is based on the average of the number of MLIU individuals served in DY5 and the number of MLIU individuals served in DY6.

m. Performance Year (PY) - The measurement period used for achievement of a Category C measure. Each performance year corresponds to a calendar year. PY1 is CY 2018, PY2 is CY 2019, PY3 is CY 2020, and PY4 is CY 2021.

n. System - A Performing Provider's patient care landscape, as defined by the Performing Provider. The system should include all required components, if the Performing Provider has that business component. The system definition may also include optional components, including contracted providers. Optional components should be included if they are a prominent component of a Performing Provider's system of care. The system may not be limited by patient type, payer or diagnosis.

o. Total Patient Population by Provider (PPP) - The total number of individuals served by the Performing Provider during an applicable DY. The Total PPP shall include all individuals provided a service during the applicable DY within the Performing Provider's defined system.

p. Uncompensated Care (UC) Only Hospital - A hospital eligible to be a Performing Provider that is not a Performing Provider but receives UC payments.

II. DSRIP ELIGIBILITY CRITERIA

5. RHP Regions

a. RHP Composition

Texas has approved 20 Regional Healthcare Partnerships (RHPs) whose members may participate in the DSRIP program. The approved RHPs share the following characteristics:

- The RHPs are based on distinct geographic boundaries that generally reflect patient flow patterns for the region;
- The RHPs have identified local funding sources to help finance the non-federal share of DSRIP payments for Performing Providers; and
- The RHPs have identified an Anchoring Entity to help coordinate RHP activities.

The approved RHPs include the following counties:

- RHP 1: Anderson, Bowie, Camp, Cass, Cherokee, Delta, Fannin, Franklin, Freestone, Gregg, Harrison, Henderson, Hopkins, Houston, Hunt, Lamar, Marion, Morris, Panola, Rains, Red River, Rusk, Smith, Titus, Trinity, Upshur, Van Zandt, Wood
- RHP 2: Angelina, Brazoria, Galveston, Hardin, Jasper, Jefferson, Liberty, Nacogdoches, Newton, Orange, Polk, Sabine, San Augustine, San Jacinto, Shelby, Tyler

- RHP 3: Austin, Calhoun, Chambers, Colorado, Fort Bend, Harris, Matagorda, Waller, Wharton
- RHP 4: Aransas, Bee, Brooks, DeWitt, Duval, Goliad, Gonzales, Jackson, Jim Wells, Karnes, Kenedy, Kleberg, Lavaca, Live Oak, Nueces, Refugio, San Patricio, Victoria
- RHP 5: Cameron, Hidalgo, Starr, Willacy
- RHP 6: Atascosa, Bandera, Bexar, Comal, Dimmit, Edwards, Frio, Gillespie, Guadalupe, Kendall, Kerr, Kinney, La Salle, McMullen, Medina, Real, Uvalde, Val Verde, Wilson, Zavala
- RHP 7: Bastrop, Caldwell, Fayette, Hays, Lee, Travis
- RHP 8: Bell, Blanco, Burnet, Lampasas, Llano, Milam, Mills, San Saba, Williamson
- RHP 9: Dallas, Denton, Kaufman
- RHP 10: Ellis, Erath, Hood, Johnson, Navarro, Parker, Somervell, Tarrant, Wise
- RHP 11: Brown, Callahan, Comanche, Eastland, Fisher, Haskell, Jones, Knox, Mitchell, Nolan, Palo Pinto, Shackelford, Stephens, Stonewall, Taylor
- RHP 12: Armstrong, Bailey, Borden, Briscoe, Carson, Castro, Childress, Cochran, Collingsworth, Cottle, Crosby, Dallam, Dawson, Deaf Smith, Dickens, Donley, Floyd, Gaines, Garza, Gray, Hale, Hall, Hansford, Hartley, Hemphill, Hockley, Hutchinson, Kent, King, Lamb, Lipscomb, Lubbock, Lynn, Moore, Motley 0, Ochiltree, Oldham, Parmer, Potter, Randall, Roberts, Scurry, Sherman, Swisher, Terry, Wheeler, Yoakum
- RHP 13: Coke, Coleman, Concho, Crockett, Irion, Kimble, Mason, McCulloch, Menard, Pecos, Reagan, Runnels, Schleicher, Sterling, Sutton, Terrell, Tom Green
- RHP 14: Andrews, Brewster, Crane, Culberson, Ector, Glasscock, Howard, Jeff Davis, Loving, Martin, Midland, Presidio, Reeves, Upton, Ward, Winkler
- RHP 15: El Paso, Hudspeth
- RHP 16: Bosque, Coryell, Falls, Hamilton, Hill, Limestone, McLennan
- RHP 17: Brazos, Burleson, Grimes, Leon, Madison, Montgomery, Robertson, Walker, Washington
- RHP 18: Collin, Grayson, Rockwall
- RHP 19: Archer, Baylor, Clay, Cooke, Foard, Hardeman, Jack, Montague, Throckmorton, Wichita, Wilbarger, Young
- RHP 20: Jim Hogg, Maverick, Webb, Zapata

b. RHP Tier Definition

i. Tier 1 RHP
An RHP that contains more than 15 percent share of the statewide population under 200 percent of the federal poverty level (FPL) as defined by the U.S. Census Bureau: 2006-2010 American Community Survey for Texas (ACS).

ii. Tier 2 RHP

An RHP that contains at least 7 percent and less than 15 percent share of the statewide population under 200 percent FPL as defined by the U.S. Census Bureau: 2006-2010 American Community Survey for Texas (ACS).

iii. Tier 3 RHP
An RHP that contains at least 3 percent and less than 7 percent share of the statewide population under 200 percent FPL as defined by the U.S. Census Bureau: 2006-2010 American Community Survey for Texas (ACS).

iv. Tier 4 RHP
An RHP is classified in Tier 4 if one of the following three criteria are met: (1) the RHP contains less than 3 percent share of the statewide population under 200 percent FPL as defined by the U.S. Census Bureau: 2006-2010 American Community Survey for Texas (ACS); (2) the RHP does not have a public hospital; or (3) the RHP has public hospitals that provide less than 1 percent of the region's uncompensated care.

6. RHP Anchoring Entity

The Texas Health and Human Services Commission (HHSC) delegates to the Anchoring Entity the responsibility of coordination with the RHP participants on the RHP Plan Updates for that RHP. Each RHP shall have one Anchoring Entity that coordinates the RHP Plan Updates for that RHP. In RHPs that have a public hospital, a public hospital shall serve as the Anchoring Entity. In RHPs without a public hospital, the following entities may serve as Anchoring Entities: (1) a hospital district; (2) a hospital authority; (3) a county; or (4) a State university with a health science center or medical school. RHP Anchoring Entities shall be responsible for coordinating RHP activities and assisting HHSC in performing key oversight and reporting responsibilities.

Anchoring Entities' activities shall include:

- Coordinating the community needs assessment update for the RHP as needed;
- Engaging stakeholders in the RHP, including the public and through the learning collaborative plan (as required in paragraph 38);
- Coordinating the RHP Plan Updates that best meet community needs in collaboration with RHP participants;
- Ensuring that the RHP Plan Updates are consistent with Attachment R, Attachment J, and all other State/waiver requirements;
- Transmitting the RHP Plan Updates to HHSC on behalf of the RHP;
- Ongoing monitoring and annual reporting (as required in paragraphs 37 and 41) on status of activities and performance of Performing Providers in the RHP; and
- Ongoing communication with HHSC on behalf of the RHP.

7. IGT Entities

Intergovernmental transfer (IGT) Entities are entities that fund the non-federal share of DSRIP payments for an RHP. They include Anchoring Entities, government-owned Performing Providers, community mental health centers (CMHCs), local health departments (LHDs), academic health science centers, and other government entities such as counties.

An IGT Entity may fund DSRIP, Uncompensated Care (UC), or both DSRIP and UC as long as requirements described herein are met and the IGT funding source comports with federal requirements outlined in STC 46.

IGT Entities may fund Performing Providers outside of their RHP. Such funding must be documented in the RHP Plan Updates for the RHP in which the Performing Provider is participating.

8. Performing Providers

"Performing Providers" are providers that are responsible for: 1) implementing Core Activities to achieve the Category C measure goals in the RHP Plan Updates; and 2) measuring, reporting, and improving performance on the Category C measure goals in the RHP Plan Updates, among other reporting requirements outlined in this protocol. All Performing Providers must have a current Medicaid provider identification number. Performing Providers that complete milestones and measures as specified in Attachment R, "Measure Bundle Protocol" are the only entities that are eligible to receive DSRIP incentive payments in DY7-10. Performing Providers will primarily be hospitals, but CMHCs, LHDs, and physician practices may also receive DSRIP payments.

A Performing Provider may only participate in the RHP Plan Updates for the RHP where it is physically located except that physician practices affiliated with an academic health science center, major cancer hospitals, or children's hospitals may perform DSRIP outside of the RHP where the Performing Provider's institution is physically located. Performing Providers participating in multiple RHPs may be assigned to a single "home" RHP.

9. DSRIP Requirements for Uncompensated Care (UC) Only Hospitals

In DY7-8, a UC only hospital must participate annually in a regional learning collaborative and/or smaller, targeted learning collaborative or stakeholder meeting and report on mandatory Category D measures identified in Attachment R, "Measure Bundle Protocol."

III. KEY ELEMENTS OF RHP PLAN UPDATES

10. RHP Plan Updates for DY7-8

Each RHP Anchoring Entity must submit an RHP Plan Update for its RHP for DY7-8 using a State-approved template that identifies the participants, objectives, Measure Bundles, measures, milestones, and associated DSRIP values adopted from Attachment R, "Measure Bundle Protocol," and meets all requirements pursuant to the STCs and described herein.

The RHP Plan Updates shall include the following sections:

- RHP Organization including collaborating organizations
- Community Needs Assessment
- Stakeholder Engagement
- The Performing Provider's system definition
- Category A reporting including: 1) the Performing Provider's description of the transition of its DY2-6 projects to its selected Category C Measure Bundles or measures; and 2) the Performing Provider's Core Activities for DY7-8
- Category B MLIU Patient Population by Provider (PPP) baselines
- Category C Measure Bundles and measures for each Performing Provider
- Category D Statewide Reporting Measure Bundles for each Performing Provider
- DSRIP valuation amounts
- Signed certifications from the leadership of Performing Providers and their affiliated IGT Entities

11. RHP Plan Updates for DY9-10

Each RHP Anchoring Entity must submit an RHP Plan Update for its RHP for DY9-10 using a State-approved template that identifies the participants, objectives, Measure Bundles, measures, milestones, and associated DSRIP values adopted from Attachment R, "Measure Bundle Protocol," and meets all requirements pursuant to the STCs and described herein.

The RHP Plan Updates shall include the following sections:

- RHP Organization.
- Updates to Community Needs Assessment, if needed.
- Stakeholder Engagement.
- Anchor hosts at least one public meeting prior to submission of the RHP Plan Update for DY9-10.
- Updates to each Performing Provider's system definition, if needed.
- Category A reporting, including updates to the Performing Provider’s Core Activities for DY9-10.

- Updates to Category B MLIU Patient Population by Provider (PPP), if needed. Forecasted breakout of Medicaid individuals and LIU individuals served in DY9-10 based on MLIU individuals served in DY7-8.
- Category C Measure Bundles and measures for each Performing Provider including:
  - Optional addition or discontinuation of Measure Bundles or measures to meet the updated Minimum Point Threshold (MPT) for DY9-10. This includes allowing Performing Providers with an MPT of less than 75 to update population-based clinical outcomes as pay-for-performance (P4P) or pay-for-reporting (P4R). Providers may replace Measure Bundles and measures up to a maximum of 20 points of a provider's assigned MPT for DY9-10 with good cause limited to significant system changes such as a hospital merger or significant change in a measure bundle's required system component of outpatient services or hospital services as identified in Attachment R, "Measure Bundle Protocol".
  - Related Strategies reporting associated with DY9-10 Measure Bundle selections for hospitals and physician practices or DY9-10 measure selections for CMHCs and LHDs.
  - Justification for any Category C changes from DY7-8 and requested exceptions for new selections in DY9-10.
- Category D Statewide Reporting Measure Bundles for each Performing Provider.
- DSRIP valuation amounts.
- Certifications from the leadership of Performing Providers and their affiliated IGT Entities.

IV. REVIEW AND APPROVAL PROCESS OF RHP PLAN UPDATES

12. HHSC Review and Approval Process for DY7-8

a. Submission of RHP Plan Updates

By January 31, 2018, or 90 days after the approval of Attachment R, "Measure Bundle Protocol," and Attachment J, "Program Funding and Mechanics Protocol" (whichever is later), each RHP Anchoring Entity will submit the completed RHP Plan Update for DY7-8 for HHSC review.

b. Anchoring Entity Review of RHP Plan Updates

To support HHSC's review process, the RHP Anchoring Entity shall perform an initial review of each Performing Provider's submission for the RHP Plan Update for DY7-8 to ensure compliance with elements described in 12.c. below prior to submitting the RHP Plan Update to HHSC.

c. HHSC Review of RHP Plan Updates

i. HHSC shall review and assess each RHP Plan Update according to the following criteria:
   A. The RHP Plan Update is in the prescribed format.
   B. The RHP Plan Update contains and completes all required elements described herein and is consistent with the STCs.
   C. The RHP Plan Update conforms to the requirements for Category A Required reporting, Category B MLIU Patient Population by Provider (PPP), Category C Measure Bundles and measures, and Category D Statewide Reporting Measure Bundles as described herein, as well as in Attachment R, "Measure Bundle Protocol."
   D. The amount and distribution of funding is in accordance with Section VI "Performing Provider Requirements for DY7-8" and Section VII "Disbursement of DSRIP Funds for DY7-8" of this protocol.
   E. The RHP Plan Update is consistent with the overall goals of the DSRIP program and the objectives of the Medicaid program.

ii. By February 28, 2018, or 30 days following the due date for submission of the RHP Plan Updates, HHSC will complete its review of each RHP Plan Update and will notify the RHP Anchoring Entity in writing of any questions, concerns, or problems identified.

iii. The RHP Anchoring Entity shall respond in writing to any notification by HHSC of questions, concerns, and problems by the date specified in the aforementioned notification.

iv. By March 31, 2018, or 60 days following the due date for submission of the RHP Plan Updates, HHSC will approve or disapprove each RHP Plan Update.

13. HHSC Review and Approval Process for DY9-10

a. Submission of RHP Plan Updates

By November 30, 2019, or 60 days after the approval of Attachment R, "Measure Bundle Protocol," and Attachment J, "Program Funding and Mechanics Protocol" (whichever is later), each RHP Anchoring Entity will submit the completed RHP Plan Update for DY9-10 for HHSC review.

b. Anchoring Entity Review of RHP Plan Updates

To support HHSC's review process, the RHP Anchoring Entity shall perform an initial review of each Performing Provider's submission for the RHP Plan Update for DY9-10 to ensure compliance with elements described in 13.c. below prior to submitting the RHP Plan Update to HHSC.

c. HHSC Review of RHP Plan Updates

i. HHSC shall review and assess each RHP Plan Update according to the following criteria:

A. The RHP Plan Update is in the prescribed format.
B. The RHP Plan Update contains and completes all required elements described herein and is consistent with the STCs.
C. The RHP Plan Update conforms to the requirements for Category A Required reporting, Category B MLIU Patient Population by Provider (PPP), Category C Measure Bundles and measures, and Category D Statewide Reporting Measure Bundles as described herein, as well as in Attachment R, "Measure Bundle Protocol."
D. The amount and distribution of funding is in accordance with Section VI "Performing Provider Requirements for DY7-10" and Section VII "Disbursement of DSRIP Funds for DY7-10" of this protocol.
E. The RHP Plan Update is consistent with the overall goals of the DSRIP program and the objectives of the Medicaid program.

ii. By January 15, 2020, or 45 days following the due date for submission of the RHP Plan Updates, HHSC will complete its review of each RHP Plan Update and will notify the RHP Anchoring Entity in writing of any questions, concerns, or problems identified.
iii. The RHP Anchoring Entity shall respond in writing to any notification by HHSC of questions, concerns, and problems by the date specified in the aforementioned notification.
iv. By February 28, 2020, or 90 days following the due date for submission of the RHP Plan Updates, HHSC will approve or disapprove each RHP Plan Update.

V. RHP PLAN UPDATE MODIFICATIONS FOR DY7-10

Consistent with the recognized need to provide RHPs with flexibility to modify their RHP Plan Updates over time and take into account evidence and learning from their own experience over time, as well as for unforeseen circumstances or other good cause, a Performing Provider may request prospective changes to the RHP Plan Update for the RHP(s) in which it participates through an RHP Plan Update modification process.

14. RHP Plan Update Modification Process

A Performing Provider may request to modify the RHP Plan Update for the RHP(s) in which it participates under the following circumstances:

a. Requests to Modify a Performing Provider's System Definition

A Performing Provider may submit a request to HHSC to change its system definition with good cause. The Performing Provider must submit the request to HHSC no later than 30 days prior to the first day of the semi-annual reporting period. HHSC will evaluate how the change to the Performing Provider's system definition impacts Category B and/or Category C.

b. Requests to Modify MLIU Patient Population by Provider (PPP)

A Performing Provider may submit a request to HHSC to change its MLIU PPP baseline and goals with good cause. Good cause may include:

i. A significant change to the Performing Provider's system definition as approved under paragraph 12.a.;
ii. An error in the data uncovered subsequent to baseline reporting;
iii. A significant policy change at the state or federal level that redefines eligibility for Medicaid or other eligibility-based programs that would be captured in the MLIU population; or
iv. A significant shift in the demographic served by the Performing Provider.

The Performing Provider must submit the request to HHSC no later than 30 days prior to the first day of the semi-annual reporting period.

c. Requests to Modify Category C Measures

i. Category C Measure Payer Types for Reporting Milestones

A Performing Provider may submit a request to HHSC to be exempted from reporting its performance on the Medicaid-only payer type and/or the LIU-only payer type for a measure's reporting milestone with good cause, such as data limitations or low volume. The Performing Provider must submit the request to HHSC prior to reporting a baseline for the measure and the first day of the second reporting period of DY7 for DY7-10 measures and the first day of the second reporting period of DY9 for DY9-10 new measures.

ii. Category C P4P Measure Payer Type for Goal Achievement Milestones

A Performing Provider may submit a request to HHSC to change the payer a measure's goal achievement milestone is based with good cause, such as a small denominator or data limitations. The Performing Provider must submit the request to HHSC prior to reporting a baseline for the measure and no later than 30 days prior to the first day of the second reporting period of DY7 for DY7-10 measures and no later than 30 days prior to the first day of the second reporting period of DY9 for DY9-10 new measures.

iii. Category C Optional Measures for Hospitals and Physician Practices

A hospital or physician practice may submit a request to HHSC to delete an optional measure from a selected Category C Measure Bundle. The hospital or physician practice must submit the request to HHSC prior to reporting a baseline for the measure and no later than 30 days prior to the first day of the second reporting period of DY7 for DY7-10 measures and no later than 30 days prior to the first day of the second reporting period of DY9 for DY9-10 new measures. Optional measures that add point(s) to a Category C

Measure Bundle may only be deleted if a hospital's or physician practice's MPT is still met without the deleted optional measure's point(s). The funds associated with the deleted optional measure will be reallocated to the remaining measures in the Measure Bundle such that the remaining measures' valuations are equal.

iv. Category C Measures for CMHCs and LHDs

A CMHC or LHD may submit a request to HHSC to replace a selected Category C measure with one or more other Category C measures with point values greater than or equal to the point value of the measure being replaced. This request is based on good cause, such as a low volume or data limitations. The CMHC or LHD must submit the request to HHSC prior to reporting a baseline for the measure and no later than 30 days prior to the first day of the second reporting period of DY7 for DY7-10 measures and no later than 30 days prior to the first day of the second reporting period of DY9 for DY9-10 new measures.

d. Submission, Review, and Approval Process

A Performing Provider must submit an RHP Plan Update modification request in writing to HHSC. HHSC will review the RHP Plan Update modification request and notify the Performing Provider in writing of any questions or concerns identified. HHSC will then notify the Performing Provider in writing of its decision on the RHP Plan Update modification request. Substantial changes to system definitions, Category C Measure Bundles or measures, or Category B MLIU PPP, may be subject to a secondary review and ongoing compliance monitoring by the independent assessor.

VI. PERFORMING PROVIDER REQUIREMENTS FOR DY7-10

15. DY7-11 Pool Allocation

a. The DSRIP pool allocation for DY7-12 comports with STC 41.

DSRIP Pool Allocation According to Demonstration Year (total computable)

DY7	DY8	DY9	DY10	DY11	DY 12
3,100,000,000	3,100,000,000	2,910,000,000	2,490,000,000	0*	0*

* Incentive payments may be made in DY11 and DY12 for prior periods of performance and administrative activities to close out the DSRIP program. Total DSRIP payments for the section 1115 demonstration may not exceed total authorized limits.

b. No later than March 31, 2019, HHSC will submit an updated PFM Protocol to CMS that includes DSRIP requirements for DY9-10.

c. CMS will aim to approve the updated PFM protocol no later than 45 days after its submission.

d. No later than July 31, 2019, HHSC will submit an updated Measure Bundle Protocol to CMS that includes revised measures and changes to innovative measures for DY9-10.

e. CMS and Texas will collaborate together and aim to approve the updated Measure Bundle Protocol within 60 days after its submission.

16. Performing Provider Valuation

a. A Performing Provider's total valuation for each demonstration year of DY7 and DY8 is equal to its total valuation for DY6A with the following exceptions:

   i. If HHSC determined that a DSRIP project was ineligible to continue in DY6A, the Performing Provider affected by such a determination may use the funds associated with the DSRIP project beginning in DY7; or

   ii. If a Performing Provider withdrew a DSRIP project between June 30, 2014, and June 30, 2016, the Performing Provider may use the funds associated with the DSRIP project beginning in DY7.

   iii. Performing Providers beginning DSRIP participation in DY7 with a total valuation less than $250,000 for DY7 may increase their total valuation to up to $250,000 per each subsequent DY beginning in DY7. Performing Providers eligible for this option must make this choice in the RHP Plan Update.

b. A Performing Provider’s total valuation for each demonstration year of DY9 and DY10 is calculated as follows:

   i. If a Performing Provider has a DY8 total valuation that is less than or equal to $1 million, its total valuation for each demonstration year of DY9 and DY10 is equal to its total valuation for DY8. These valuations are subtracted from the DY9 and DY10 pool amounts.

   ii. If a Performing Provider has a DY8 total valuation that is greater than $1 million, its total valuation for each demonstration year of DY9 and DY10 is calculated as follows:

      A. The remaining DY9 and DY10 pool amounts are divided by the DY8 valuation for all Performing Providers with a DY8 total valuation greater than $1 million to determine the percentage reductions for DY9 and DY10;

B. The Performing Provider's DY8 valuation is multiplied by the percentage reduction in valuation from DY8 for the applicable DY to determine the total valuation for each demonstration year of DY9 and DY10; and
C. The Performing Provider's total valuation for each demonstration year of DY9 and DY10 is not reduced to less than $1 million.

iii. If a Performing Provider withdrew from participating in DSRIP during DY8 or withdraws during the RHP Plan Update for DY9-10, the Performing Provider's valuation is proportionately distributed among the remaining Performing Providers in the RHP based on each Performing Provider's percent share of DY8 valuation in the RHP.

c. Each Performing Provider's valuation must comport with the following funding distribution in DY7-10.

DSRIP Funding Distribution

	DY7*	**DY8***	**DY9**	**DY10**
RHP Plan Update Submission	20%	NA	NA	NA
Category A - required reporting	0%	0%	0%	0%
Category B - MLIU PPP	10%	10%	10%	10%
Category C- Measure Bundles and Measures	55 or 65%	75 or 85%	75%	75%
Category D - Statewide Reporting Measure Bundle	15 or 5%	15 or 5%	15%	15%

*If an RHP's private hospital participation minimums are met, as described in paragraph 25, then Performing Providers in the RHP may increase the Statewide Reporting Measure Bundle funding distribution to 15% in DY7-8.

17. Category A - Eligibility for DY7-10 Payments

Each Performing Provider is required to complete the following for Category A to be eligible for payment of Categories B-D.

a. Core Activities

Each Performing Provider must report on progress and updates to one or more Core Activities as indicated in the RHP Plan Updates during the second reporting period of each DY.

b. Alternative Payment Models

Each Performing Provider must report on any progress toward, or implementation of, Alternative Payment Model (APM) arrangements with

Medicaid managed care organizations (MCOs) or other payers during the second reporting period of each DY.

c. Costs and Savings

Performing Providers who have a total valuation of $1 million or more per DY are required to submit the costs of at least one Core Activity of choice and the forecasted or generated savings of that Core Activity. Performing Providers must analyze: 1) a different Core Activity for the Costs and Savings analysis in DY9-10 than was used for the Costs and Savings analysis in DY7-8; or 2) a different aspect of the same Core Activity for the Costs and Savings analysis in DY9-10 than was used for the Costs and Savings analysis in DY7-8. Performing Providers must submit this information in a template approved by HHSC or a comparable template. Performing Providers should include costs and savings specific to their organization and other contracted providers if that information is available. A progress update must be submitted during the second reporting period of DY7 and DY9, and a final report of costs and savings must be submitted during the second reporting period of DY8 and DY10.

d. Collaborative Activities

Each Performing Provider is required to attend at least one learning collaborative, stakeholder forum, or other stakeholder meeting each DY and report on participation during the second reporting period of each DY.

18. Category B - Medicaid and Low-income or Uninsured (MLIU) Patient Population by Provider (PPP)

a. Each Performing Provider is required to report for each DY the total number of individuals served by their system, as well as the number of MLIU individuals served by their system, to be eligible for up to 10 percent of the Performing Provider's total valuation.

For purposes of PPP, an individual is a patient receiving a face-to-face or virtual encounter (a service, billable or not) that is the equivalent of a service that would be provided within the physical confines of the defined system. This could include home-visits or other venue-based services that are documented. The service should be billable or charted. Providers are not allowed to count text messages or undocumented encounters.

For DY7-8, Providers are not allowed to count telephone encounters. For DY9-10, individuals who receive a telephone encounter that is the equivalent of a service that would be provided within the physical confines of the defined system may be included in the PPP count.

b. Each Performing Provider is required to submit the baseline total number of individuals served by their system, as well as the baseline number of MLIU

individuals served by their system, in the RHP Plan Update for DY7-8 and revise as needed in the RHP Plan Update for DY9-10. Each Performing Provider is required to submit the forecasted breakout of the total Medicaid individuals and LIU individuals that will be served in DY9-10 based on the MLIU individuals served in DY7-8.

c. To calculate the MLIU PPP baseline, the Performing Provider will include in their RHP Plan Update the Total PPP in DY5 and DY6 and the MLIU PPP in DY5 and DY6. HHSC will calculate the average of the DYs and set the MLIU PPP maintenance goal. These are new baselines and are not tied to the QPI reported during DY3-6. The reported baselines will be subject to compliance monitoring.

d. The Performing Provider is required to report the total number of MLIU individuals served each DY and in DY9-10, provide a breakout of the total Medicaid individuals and LIU individuals served during each DY. The number of MLIU individuals served must be maintained or increased each DY with an allowable variation. The allowable variation from the goal will be a maximum percentage below the 100% goal, as determined by HHSC and is meant to account for natural fluctuation that may occur from one year to the next in the number of patients seeking services at a provider. The allowable variation is to be determined by HHSC once Performing Providers have submitted their baselines, and calculation of allowable variance will consider Performing Provider size, type, and the MLIU percentage of Total PPP served in the baseline years. The Performing Provider is also required to report the Total PPP numeric value. The Performing Provider is not required to maintain the ratio of MLIU PPP to Total PPP from the baseline year to earn a Category B payment, but must provide an explanation for any changes in the ratio.

e. The numbers of MLIU individuals served and total individuals served may be reported in the second reporting period of the DY being reported. Performing Providers may request to carry-forward reporting of MLIU PPP until the first round of reporting following the end of the DY being reported if they need additional time to compile or clean up data. If MLIU PPP reporting is not submitted on time or does not meet the requirements of the reporting, future DSRIP payments may be withheld until the complete report is submitted.

19. Category C - Measure Bundle Requirements for Hospitals and Physician Practices

a. The Category C Measure Bundle topics for hospitals and physician practices include the following and are described in Attachment R, "Measure Bundle Protocol."

   i. Chronic Disease Management: Diabetes Care
   ii. Chronic Disease Management: Heart Disease
   iii. Care Transitions & Hospital Readmissions
   iv. Patient Navigation & Emergency Department Diversion

v. Primary Care Prevention - Healthy Texans
vi. Primary Care Prevention - Cancer Screening
vii. Hepatitis C
viii. Pediatric Primary Care
ix. Pediatric Hospital Safety
x. Pediatric Chronic Disease Management: Asthma
xi. Pediatric Chronic Disease Management: Diabetes
xii. Improved Maternal Care
xiii. Maternal Safety
xiv. Improved Access to Adult Dental Care
xv. Preventive Pediatric Dental
xvi. Palliative Care
xvii. Integration of Behavioral Health in a Primary or Specialty Care Setting
xviii. Behavioral Health and Appropriate Utilization
xix. Chronic Non-Malignant Pain Management
xx. Integrated Care for People with Serious Mental Illness
xxi. Specialty Care
xxii. Hospital Safety
xxiii. Rural Preventive Care
xxiv. Rural Emergency Care

b. Each hospital and physician practice must determine a DSRIP attributed population to apply to its selected Measure Bundles as described in Attachment R, "Measure Bundle Protocol".

c. Each Measure Bundle includes required measures and may include optional measures.

d. Each measure within a Measure Bundle will be pay-for-performance (P4P) or pay-for-reporting (P4R).

e. Each Measure Bundle and measure is assigned a point value as described in Attachment R, "Measure Bundle Protocol."

f. Each hospital and physician practice is assigned a Minimum Point Threshold (MPT) for Measure Bundle selection.

g. Each hospital and physician practice must select Measure Bundles worth enough points to meet its MPT in order to maintain its valuation for DY7-10.

    i. If a hospital or physician practice does not select Measure Bundles worth enough points to meet its MPT, its total DY7 valuation will be reduced proportionately across its RHP Plan Update funds and Categories B-D based on the number of Measure Bundle points selected, and its total DY8-10

valuation will be reduced proportionately across its Categories B-D based on the number of Measure Bundle points selected.

Example: A hospital's DY7 valuation is $5 million and its MPT is 50. The RHP's private participation requirements are met, so if it were to select Measure Bundles worth 50 points, its DY7 valuation would be allocated as follows: $1 million for the RHP Plan Update (20%); $500,000 for Category B (10%); $2.75 million for Category C (55%); and $750,000 for Category D (15%).

However, the hospital selects Measure Bundles worth only 40 points, so its DY7 valuation is decreased to $4 million and is allocated as follows: $800,000 for the RHP Plan Update (20%), $400,000 for Category B (10%), $2.2 million for Category C (55%), and $600,000 for Category D (15%).

h. Each hospital or physician practice with a valuation greater than $2,500,000 per DY in DY7-8 or greater than $2 million in DY10 must: 1) select at least one Measure Bundle with at least one required 3 point measure; or 2) select at least one Measure Bundle with at least one optional 3 point measure, and select an optional 3 point measure in that Measure Bundle. The 3 point measure must have significant volume to meet the requirement.

i. Certain Measure Bundles may include population based clinical outcomes that are required as P4P or P4R based on the measure and a provider's MPT as described in Attachment R, "Measure Bundle Protocol."

j. Each hospital or physician practice with an MPT of 75 must report at least two population-based clinical outcomes as P4P, as specified in Attachment R, "Measure Bundle Protocol."

k. Only hospitals with a valuation equal to or less than $2,500,000 per DY may select the rural Measure Bundles in DY7-8 as identified in Attachment R, "Measure Bundle Protocol."

    i. If a rural Measure Bundle is selected, then certain Measure Bundles and duplicate measures may not be selected as specified in Attachment R, "Measure Bundle Protocol."

l. A hospital or physician practice may only select a Measure Bundle for which the hospital's or physician practice's MLIU denominator for the baseline measurement period for at least half of the required measures in the Measure Bundle has significant volume as defined in Attachment R, "Measure Bundle Protocol," unless an exception is granted by HHSC to use an all-payer, Medicaid-only, or LIU-only denominator with significant volume for one or more required measures.

m. A hospital or physician practice may only select an optional measure in a selected Measure Bundle for which the hospital or physician practice's MLIU

denominator for the baseline measurement period has significant volume as defined in Attachment R, "Measure Bundle Protocol," unless an exception is granted by HHSC to use an all-payer, Medicaid-only, or LIU-only denominator with significant volume.

n. Each hospital or physician practice must indicate required measures with an MLIU denominator with less than significant volume in the RHP Plan Update. HHSC may identify measures with less than significant volume during reporting review and adjust valuation as described in paragraph 19.q.

o. Each hospital and physician practice may allocate its Category C valuation among its DY7-8 selected Measure Bundles as it wishes, so long as: 1) no single Measure Bundle is allocated a percentage of the Category C valuation that is less than seventy-five percent of its point value as a percentage of all the selected Measure Bundles' point values; 2) no Measure Bundle without any required or selected optional 3 point measures is allocated a higher percentage of the hospital's or physician's Category C allocation than the Measure Bundle's point value as a percentage of all its selected Measure Bundles' point values; and 3) no Measure Bundle with at least one required or selected optional 3 point measure is allocated a higher percentage of the hospital's or physician practice's Category C allocation than the Measure Bundle's point value multiplied by 1.25 as a percentage of all its selected Measure Bundles' point values.

   The minimum Measure Bundle valuation is calculated using the following formula:

   (Measure Bundle point value/ all selected Measure Bundles' point values) * .75 * Category C valuation

   The maximum Measure Bundle valuation for a Measure Bundle without any required or selected optional 3-point measures is calculated using the following formula:

   (Measure Bundle point value/ all selected Measure Bundles' point values) * Category C valuation

   The maximum Measure Bundle valuation for a Measure Bundle with at least one required or selected optional 3 point measure is calculated using the following formula:

   (Measure Bundle point value/ all selected Measure Bundles' point values) * 1.25 * Category C valuation

   Example:

   - A hospital has selected four Measure Bundles. Measure Bundle A is worth 4 points, Measure Bundles B-C are each worth 10 points, and Measure Bundle D is worth 6 points, for a total of 30 selected points.

- Measure Bundle A has no required or selected optional 3-point measures. Measure Bundles B-D have required 3 point measures.
- The hospital or physician practice may not allocate to Measure Bundle A less than 10% [(4/ 30) * .75] of its Category C valuation, Measure Bundles B-C less than 25% [(10/ 30) * .75] of its Category C valuation, and Measure Bundle D less than 15% [(6/ 30) * .75] of its Category C valuation.
- The hospital or physician practice may not allocate to Measure Bundle A more than 13.33% (4/30) of its Category C valuation, Measure Bundle B-C more than 41.67% [(10/30)* 1.25] of its Category C valuation, and Measure Bundle D more than 25.00% [(6/30)* 1.25] of its Category C valuation.

For valuation changes greater than one percent of a Measure Bundle's point value as a percentage of all the selected Measure Bundles' point values, a justification is required addressing amount of improvement required, level of effort required for improvement, and population impacted. HHSC will review and approve or deny these changes in the RHP Plan Update.

p. For DY9-10, each Measure Bundle selected by the hospital or physician practice is allocated a percentage of the hospital's or physician practice's Category C valuation that is equal to the Measure Bundle's point value as a percentage of all of the hospital's or physician practice's selected Measure Bundles' point values.

q. The valuation for each measure in a Measure Bundle selected by the hospital or physician practice is determined by dividing the Measure Bundle valuation by the number of measures in the Measure Bundle, so that the measures' valuations are equal with the exception of Measure Bundles with innovative measures. Innovative measures are 50 percent of the value of a measure that is not an innovative measure.

    i. The valuation for each innovative measure in a Measure Bundle with innovative measures is determined by dividing the Measure Bundle valuation by the number of measures in the Measure Bundle subtracted by .5 for each innovative measure and divided by 2. The valuation for the remaining measures in a Measure Bundle with innovative measures is determined by dividing the Measure Bundle valuation by the number of measures in the Measure Bundle subtracted by .5.

    ii. If a hospital or physician practice selects a Measure Bundle with a required measure with an MLIU denominator with no volume as defined in Attachment R, "Measure Bundle Protocol", the measure is removed from the Measure Bundle, and its valuation for the DY is redistributed equally among the remaining measures in the Measure Bundle with significant volume as defined in Attachment R, "Measure Bundle Protocol". This measure valuation also applies to population based clinical outcomes that are approved with no numerator volume.

iii. If a hospital or physician practice selects a Measure Bundle with a required measure with an MLIU denominator with insignificant volume as defined in Attachment R, "Measure Bundle Protocol", the valuation for the measure's baseline reporting milestone and reporting milestones is maintained, unless an exception is granted by HHSC to use an all-payer, Medicaid-only, or LIU-only denominator with significant volume. The valuation for the measure's goal achievement milestone for the DY is redistributed equally among the goal achievement milestones for the remaining measures in the Measure Bundle with significant volume as defined in Attachment R, "Measure Bundle Protocol." This measure valuation also applies to population based clinical outcomes that are approved to be reported as pay-for-reporting.

r. The standard point valuation (or value per point) is $500,000.

s. Minimum Point Thresholds for Hospitals.

i. A hospital's MPT is based on the following factors:

A. The hospital's DY7 valuation.
B. The hospital's DY7 valuation as a percentage of the DY7 valuations for all hospitals.
C. The hospital MPT cap of 75.
D. The hospital's size and its role in serving Medicaid and uninsured individuals, which is measured by:
I. The hospital's Medicaid and uninsured inpatient days as a percentage of all hospitals' Medicaid and uninsured inpatient days as reported in the Texas Hospital Uncompensated Care Tool (TXHUC) for FFY 2016 weighted at .64.
II. The hospital's outpatient Medicaid and uninsured costs as a percentage of all hospitals' Medicaid and uninsured outpatient costs as reported in the TXHUC for FFY 2016 weighted at .36.

ii. A hospital's MPT is calculated as follows:

A. First, the hospital's Statewide Hospital Factor (SHF) is determined as follows:

Statewide Hospital Factor (SHF) =

.64 multiplied by (the hospital's Medicaid and uninsured inpatient days divided by all hospitals' Medicaid and uninsured inpatient days) plus

.36 multiplied by (the hospital's outpatient Medicaid and uninsured costs divided by all hospitals' Medicaid and uninsured outpatient costs)

B. Second, the hospital's Statewide Hospital Ratio (SHR) is determined as follows:

Statewide Hospital Ratio (SHR) =

(DY7 valuation divided by all hospitals' DY7 valuations) divided by SHF

C. Third, the hospital's MPT is determined as follows:

- If SHR ≤ 3:

  MPT = the lesser of:
  a) DY7 valuation divided by standard point valuation ($500,000); or
  b) MPT cap (75 points)

- If SHR > 3 but ≤ 10:

  MPT = the lesser of:
  a) (DY7 valuation divided by standard point valuation [$500,000]) multiplied by (SHR divided by 3); or
  b) MPT cap (75 points)

- If SHR > 10 and DY7 valuation ≤ $15 million:

  MPT = the lesser of:
  a) (DY7 valuation divided by standard point valuation [$500,000]) multiplied by (SHR divided by 3); or
  b) 40 points

- If SHR > 10 and DY7 valuation > $15 million:

  MPT = the lesser of:
  a) (DY7 valuation divided by standard point valuation [$500,000]) multiplied by (SHR divided by 3); or
  b) MPT cap (75 points)

iii. If a hospital does not have data for the factors under paragraph 19.s.i.D, is a specialty hospital with a limited scope of practice, or has system overlap with a physician practice Performing Provider, its MPT will be determined using an alternate methodology to be determined by HHSC.

iv. For DY9-10, a hospital's MPT is recalculated using the DY10 valuation in place of the DY7 valuation, with a maximum reduction of 10 points from the MPT used in DY7-8.

t. Minimum Point Thresholds for Physician Practices

i. A physician practice's MPT is the lesser of:

A. DY7 valuation divided by standard point valuation ($500,000); or

B. MPT cap (75 points)

ii. If a physician practice is a specialty physician practice with a limited scope of practice, its MPT will be determined using an alternate methodology to be determined by HHSC.

iii. For DY9-10, a physician practice's MPT is recalculated using the DY10 valuation in place of the DY7 valuation, with a maximum reduction of 10 points from the MPT used in DY7-8.

20. Category C - Measure Selection Requirements for CMHCs and LHDs

a. The Category C measures for CMHCs and LHDs are described in Attachment R, "Measure Bundle Protocol".

b. Each CMHC and LHD must determine a DSRIP attributed population to apply to its selected measures as described in Attachment R, "Measure Bundle Protocol".

c. Each measure is assigned a point value as described in Attachment R, "Measure Bundle Protocol".

d. Each CMHC and LHD is assigned a Minimum Point Threshold (MPT) for selection of measures.

e. Each CMHC and LHD must select a measure or a combination of measures worth enough points to meet its MPT in order to maintain its valuation for DY7-10.

i. If a CMHC or an LHD does not select measures worth enough points to meet its MPT, its total DY7 valuation will be reduced proportionately across its RHP Plan Update funds and Categories B-D based on the number of measure points selected, and its total DY8-10 valuation will be reduced proportionately across its Categories B-D based on the number of measure points selected.

f. A CMHC or LHD must select and report on at least two unique measures.

g. Each CMHC or LHD with a valuation of more than $2,500,000 per DY in DY7-8 and more than $2,000,000 in DY10 must select at least one 3 point measure.

h. An LHD may select P4P measures that the LHD reported for Category 3 in DY6 to meet their DY7-8 MPT as described in Attachment R, "Measure Bundle Protocol."

i. A CMHC or LHD may only select a measure for which the CMHC's or LHD's MLIU denominator for the baseline measurement period has significant volume as defined in Attachment R, "Measure Bundle Protocol", unless an exception is granted by HHSC to use an all-payer, Medicaid-only, or LIU-only denominator with significant volume.

j. All measures selected by a CMHC or LHD are valued equally; however, a CMHC or an LHD may allocate its Category C valuation among its selected measures in DY7-8 as long as: 1) no single measure is allocated a valuation that is less than 75 percent of its initial measure valuation ((total Category C valuation/number of measures selected) /2); 2) no single 1-point or 2-point measure is allocated a valuation that exceeds its initial measure valuation (total valuation/number of measures selected); and 3) no single 3-point or 4-point measure is allocated a valuation that exceeds its initial measure valuation (total valuation/number of measures) multiplied by 1.25.

   Example:

   - A CMHC selected four measures.
   - Measures A and B are 3-point measures. Measures C and D are 1-point measures.
   - The total Category C valuation for the CMHC is $400,000 with each measure initially valued at $100,000 ($400,000 /4).
   - The CMHC may not allocate to Measures A-D less than $75,000 ($100,000 * .75).
   - The CMHC may not allocate to Measures A-B more than $125,000 ($100,000 * 1.25) and Measures C and D more than $100,000 ($400,000 /4).

   For valuation changes greater than one percent of initial measure valuation, a justification is required addressing amount of improvement required, level of effort required for improvement, and population impacted. HHSC will review and approve or deny these changes in the RHP Plan Update.

   For DY9-10, all measures selected by a CMHC or LHD are valued equally.

k. The standard point valuation (or value per point) is $500,000.

l. Minimum Point Thresholds for CMHCs and LHDs

   i. A CMHC's MPT is the lesser of:

      A. DY7 valuation/ standard point valuation ($500,000); or
      B. The CMHC MPT cap of 40.

   ii. An LHD’s MPT is the lesser of:

      A. DY7 valuation/ standard point valuation ($500,000); or
      B. The LHD MPT cap of 20.

   iii. For DY9-10, a CMHC’s or LHD’s MPT is recalculated using the DY10 valuation in place of the DY7 valuation, with a maximum reduction of 10 points from the MPT used in DY7-8.

21. Category C - Measurement Periods for P4P Measures

a. The baseline measurement period is calendar year (CY) 2017 (January 1, 2017 - December 31, 2017) for measures selected for DY7-10. The baseline measurement period is CY 2019 (January 1, 2019 - December 31, 2019) for measures newly-selected for DY9-10.

   i. A measure may be eligible for a shorter baseline measurement period consisting of no fewer than six months if it: 1) has a denominator or eligible cases greater than or equal to 30 for the requested baseline measurement period; and 2) would not be compromised by a shorter baseline measurement period. Examples of measures that would be compromised by a shorter baseline measurement period include blood pressure control (for which the denominator is individuals diagnosed with hypertension in the first six months of the measurement period), outcomes sensitive to flu season or other seasonal variation, and numerators with a low frequency of probability of occurrence. A Performing Provider may request HHSC approval to use a shorter baseline measurement period for an eligible measure in the RHP Plan Update submission.

   ii. A P4P measure may be eligible for a delayed baseline measurement period that ends no later than September 30, 2018 for measures selected for DY7-10 and no later than September 30, 2020 for measures newly-selected for DY9-10. In cases where a provider has no or insufficient volume to establish a baseline that ends by December 31, 2017 for measures selected for DY7-10 or December 31, 2019 for measures newly-selected for DY9-10, a Performing Provider may request HHSC approval to use a delayed baseline measurement period for a measure. If HHSC approves the Performing Provider's request, the Performance Year (PY) measurement periods do not change. The measure’s goal achievement will begin with PY2 for measures selected for DY7-10 and PY4 for measures newly-selected for DY9-10. A Performing Provider must report PY1 and PY2 for a measure with a delayed baseline measurement period for measures selected for DY7-10. A Performing Provider must report PY3 and PY4 for a measure with a delayed baseline measurement period for measures newly-selected for DY9-10.

   iii. For LHD P4P measures that were reported in Category 3 in DY6 and selected for DY7-10, the baseline measurement period is DY6 (October 1, 2016 - September 30, 2017).

b. PY1 is CY 2018 (January 1, 2018 - December 31, 2018).

c. PY2 is CY 2019 (January 1, 2019 - December 31, 2019).

d. PY3 is CY 2020 (January 1, 2020 - December 31, 2020).

e. PY4 is CY 2021 (January 1, 2021 - December 31, 2021).

f. Exceptions to measurement periods may be indicated in Attachment R, "Measure Bundle Protocol" for P4P measures for which a CY measurement period would impact the continuity of data reported (example: NQF 0041 Influenza Immunization, where the measure steward specifies a denominator inclusion period of visits between October 1 and March 31 to align with the flu season).

22. Category C - Measure Milestones

a. The Category C measure milestone structure and valuation for DY7-10 is as follows:

	DY7	**DY8**	**DY9**	**DY10**
Innovative Measure or Quality Improvement Collaborative Activity	100% Reporting Year (RY) 1 reporting milestone	100% RY2 reporting milestone	100% RY3 reporting milestone	25% RY4 reporting milestone 75% achievement milestone
P4P Measure - Baseline Reporting Milestone	25%	NA	NA	NA
P4P Measure - Reporting Milestone	PY1 25%	PY2 25%	PY3 25%	PY4 25%
P4P Measure - Achievement Milestone	DY7 Goal 50%	DY8 Goal 75%	DY9 Goal 75%	DY10 Goal 75%
New DY9-10 P4P Measure - Baseline Reporting Milestone	NA	NA	12.5%	NA
New DY9-10 P4P Measure - Reporting Milestone	NA	NA	PY3 12.5%	PY4 25%
New DY9-10 P4P Measure - Achievement Milestone	NA	NA	DY9 Goal 75%	DY10 Goal 75%

b. A Performing Provider must report a baseline for a measure, and HHSC must approve the reported baseline for reporting purposes, before a Performing Provider can report PY1 (or PY2 for measures with a delayed baseline measurement period or PY3 for measures newly-selected for DY9-10).

    i. Performing Providers must adhere to measure specifications and maintain a record of any variances that were approved by HHSC prior to reporting a baseline for a measure.

    ii. HHSC's approval of a reported baseline for reporting purposes does not constitute approval for a Performing Provider to report a measure outside measure specifications. If at any point HHSC or the independent assessor identifies that a Performing Provider is reporting a measure outside measure specifications, reporting and goal achievement milestone payment may be withheld or recouped while the Performing Provider works to bring reporting into compliance with specifications.

c. Performing Providers must report the reporting and goal achievement milestones for a P4P measure for a given PY during the same reporting period with some exceptions for measures with a delayed measurement period.

d. As part of the DY9 and DY10 reporting milestones, Performing Providers are required to update Related Strategies reporting, as indicated in Attachment R, "Measure Bundle Protocol."

e. Some measures have multiple parts as outlined in Attachment R, "Measure Bundle Protocol."

    i. A measure with multiple parts has one baseline reporting milestone, one PY reporting milestone for each DY, and multiple goal achievement milestones for each DY.

    ii. The valuation for each measure part's goal achievement milestone is determined by dividing the measure's total goal achievement milestone valuation by the number of measure parts, so that each measure part's goal achievement milestone is valued equally.

    iii. All measure parts for a given baseline or achievement for a PY must be reported in the same reporting period.

    iv. Each measure part's goal achievement milestone will be measured independently to determine percent of goal achieved as defined in paragraph 29.

23. Category C - Measure Denominator Population

a. Each Category C measure's eligible denominator population must include all individuals served by the Performing Provider system during a given

measurement period that are included in the Measure Bundle target population as defined in Attachment R "Measure Bundle Protocol."

b. Performing Providers may not select Performing Provider specific facility, co-morbid condition, age, gender, and race/ethnicity subsets not otherwise specified in Attachment R "Measure Bundle Protocol."

c. In order to be eligible for payment for a measure's reporting milestone, the Performing Provider must report its performance on the all-payer, Medicaid-only, and LIU-only payer types.

    i. A Performing Provider may request in the RHP Plan Update submission to be exempted from reporting its performance on the Medicaid-only payer type or the LIU-only payer type for a measure's reporting milestone with good cause, such as data limitations.

    ii. A Performing Provider may also submit an RHP Plan Update modification request to HHSC to be exempted from reporting its performance on the Medicaid-only payer type or the LIU-only payer type for a measure's reporting milestone with good cause, such as data limitations, prior to reporting a baseline for the measure and no later than the first day of the second reporting period of DY7 for DY7-10 measures and the first day of the second reporting period of DY9 for DY9-10 new measures.

d. Payment for a P4P measure's goal achievement milestone is based on the Performing Provider's performance on the MLIU payer type.

    i. A Performing Provider may request in the RHP Plan Update submission that payment for a P4P measure's goal achievement milestone be based on the Performing Provider's performance on the all-payer, Medicaid-only, or LIU-only payer type with good cause, such as a small denominator or data limitations.

    ii. A Performing Provider may also submit an RHP Plan Update modification request to HHSC to change the payer type on which payment for a measure's goal achievement milestone is based with good cause, such as a small denominator or data limitations; the Performing Provider must submit the request to HHSC prior to reporting a baseline for the measure and no later than 30 days prior to the first day of the second reporting period of DY7 for DY7-10 measures and no later than 30 days prior to the first day of the second reporting period of DY9 for DY9-10 new measures.

    iii. In order to be eligible for payment for a measure's DY9 goal achievement milestone, the Performing Provider must report the measure’s PY3 performance, PY2 performance for measures selected in DY7-8, and ongoing continuous quality improvement activities in the Core Activities reporting for DY9-10.

24. Category C - Methodology for Setting P4P Measure Goals

a. Category C P4P measure goals are set as an improvement over the baseline. Each P4P measure will be designated in Attachment R, "Measure Bundle Protocol" as either Quality Improvement System for Managed Care (QISMC) or Improvement over Self (IOS). QISMC measures will have a defined High Performance Level (HPL) and Minimum Performance Level (MPL) based on state or national benchmarks.

P4P Measure Goals for Measures Selected for DY7-10

	QISMC - Baseline below MPL	**QISMC -** Baseline equal to or greater than the MPL and lower than the HPL	**QISMC -** Baseline equal to or greater than the HPL	**IOS**
DY7	MPL	The greater absolute value of improvement between: 5% gap closure towards HPL, or baseline plus (minus) 2% of the difference between the HPL and MPL	The lesser absolute value of improvement of baseline plus (minus) 2% of the difference between the HPL and MPL or the IOS goal	2.5% gap closure
DY8	10% gap closure between the MPL and HPL	The greater absolute value of improvement between: 20% gap closure towards HPL, or baseline plus (minus) 8% of the difference between the HPL and MPL	The lesser absolute value of improvement of baseline plus (minus) 8% of the difference between the HPL and MPL or the IOS goal	10% gap closure
DY9	MPL plus 12% gap closure between the MPL and HPL	The greater absolute value of improvement between: 22.5% gap closure towards HPL, or baseline plus (minus) 9% of the difference between the HPL and MPL	The lesser absolute value of improvement of baseline plus (minus) 9% of the difference between the HPL and MPL or the IOS goal	11.75% gap closure
DY10	MPL plus 15% gap closure between the MPL and HPL	The greater absolute value of improvement between: 25% gap closure towards HPL, or baseline plus (minus) 10% of the difference between the HPL and MPL	The lesser absolute value of improvement of baseline plus (minus) 10% of the difference between the HPL and MPL or the IOS goal	12.5% gap closure*

* Innovative Measure F1-T03 continued in DY9-10 will be treated as an IOS measure in DY10 and will have a gap closure of 12.5% over baseline unless an alternate goal based on benchmark data is recommended by the measure steward as part of the measure validation process.

P4P Measure Goals for Measures Newly-Selected for DY9-10

	QISMC - Baseline below MPL	**QISMC** - Baseline equal to or greater than the MPL and lower than the HPL	**QISMC** - Baseline equal to or greater than the HPL	**IOS**
DY9	MPL plus 2.5% gap closure between the MPL and HPL	The greater absolute value of improvement between: 10% gap closure towards HPL, or baseline plus (minus) 4% of the difference between the HPL and MPL	The lesser absolute value of improvement of baseline plus (minus) 4% of the difference between the HPL and MPL or the IOS goal	5% gap closure
DY10	MPL plus 10% gap closure between the MPL and HPL	The greater absolute value of improvement between: 20% gap closure towards HPL, or baseline plus (minus) 8% of the difference between the HPL and MPL	The lesser absolute value of improvement of baseline plus (minus) 8% of the difference between the HPL and MPL or the IOS goal	10% gap closure*

*Innovative Measure FI-T03 newly selected in DY9-10 will be treated as an IOS measure in DY10 and will have a gap closure of 10% over baseline unless an alternate goal based on benchmark data is recommended by the measure steward as part of the measure validation process.

b. In cases where a Performing Provider has significant denominator volume and no measurable numerator because required numerator inclusions and exclusions are not tracked during the baseline measurement period, a Performing Provider may request in the RHP Plan Update for DY7-8 to use a baseline numerator of 0 for certain measures designated as process measures and QISMC. Measures that are eligible for a numerator of 0 are indicated in Attachment R, "Measure Bundle Protocol."

    i. If a provider is approved by HHSC to report a baseline numerator of 0, the goal for the DY7 goal achievement milestone will be equal to the 75th percentile as indicated in Attachment R, "Measure Bundle Protocol" and the goal for the DY8 goal achievement milestone will be equal to a 10% gap closure between the 75th percentile and the HPL. For measures approved for a baseline numerator of 0 that are continuing in DY9-10, the DY9-10 goals are determined according to the table in paragraph 24.a. using an updated baseline that is set at the PY1 rate. Measures approved to report with a numerator of 0 in DY7-8 will have standard baseline and PY measurement periods as described in paragraph 21.

25. Category D - Statewide Reporting Measure Bundle

a. Each Performing Provider is required to report on the Statewide Reporting Measure Bundle specific to the type of Performing Provider (hospital, physician practice, CMHC, or LHD) as described in Attachment R, "Measure Bundle Protocol."

b. Category D is valued at 5 percent of a Performing Provider's total valuation for DY7-8. Category D may be increased to 15 percent of a Performing Provider's total valuation if the requirements under paragraph 25.c. are met.

c. An RHP must maintain the following total private hospital valuation amounts at submission of the RHP Plan Update for DY7-8. A 3 percent decrease may be allowed in each RHP and considered maintenance.

Private Hospital Participation

RHP	Private Hospital Valuation	Minimum Private Hospital Valuation in each DY
1	$38,856,709	$37,691,007
2	$12,933,175	$12,545,180
3	$133,630,962	$129,622,034
4	$64,989,767	$63,040,074
5	$108,996,712	$105,726,810
6	$68,777,524	$66,714,199
7	$84,513,275	$81,977,876
8	$9,607,121	$9,318,907
9	$120,556,063	$116,939,381
10	$50,540,564	$49,024,347
11	$21,345,261	$20,704,903
12	$40,896,051	$39,669,169
13	$14,111,711	$13,688,360
14	$13,799,933	$13,385,935
15	$39,491,671	$38,306,921
16	$8,476,165	$8,221,880
17	$12,637,136	$12,258,022
18	$5,311,040	$5,151,709
19	$5,832,483	$5,657,509
20	$11,173,926	$10,838,708
TOTAL	$870,343,929	$844,233,611

d. Category D is valued at 15 percent of a Performing Provider's total valuation for DY9-10.

e. Each measure within the Category D Statewide Reporting Measure Bundle is valued equally.

VII. DISBURSEMENT OF DSRIP FUNDS FOR DY7-10

26. RHP Plan Update Submission for Payment in DY 7

Submission of a State-approved RHP Plan Update shall serve as the basis for payment of 20 percent of a Performing Provider's DY7 total valuation.

27. Category A - Eligibility for DY7-10 Payments

Each Performing Provider is required to complete Category A to be eligible for payment of Categories B-D.

a. Category A must be reported in the second reporting period of each demonstration year to be eligible for payment of Categories B-D of the applicable demonstration year.

b. If Category A is not reported in the second reporting period of each demonstration year, then previous payments for the RHP Plan Update submission and Categories B-D for the applicable demonstration year may be recouped and prospective payments including those in the next reporting period may be withheld until Category A is completed.

28. Basis for Payment of Category B - MLIU PPP

The number of MLIU individuals served by the Performing Provider must be maintained or increased each DY with an allowable variation below the baseline, as described in paragraph 18.d. to be eligible for payment of the MLIU PPP milestone. The allowable variation below the maintenance goal (baseline) will be determined by HHSC and is to be based on the size and type of Performing Provider and will also account for the baseline MLIU percentage of Total PPP.

If a Performing Provider is unable to maintain the MLIU PPP number within the allowable variation, then the payment associated with the number will be reduced. Partial payment will be tiered in the following manner: 100% valuation for achievement at 100% of goal (with allowable variation); 90% of valuation for achievement of 90% to 99% (or 100% less allowable variation as the upper limit); 75% of valuation for achievement of 75% - 89% of goal; or 50% of valuation for achievement of 50% - 74% of goal. A Performing Provider will not earn any payment for maintaining less than 50% of its MLIU patient population. For DY9-10 MLIU PPP, partial payment will be tiered in the following manner: 100% valuation for achievement at 100% of goal (with allowable variation) and remaining valuation

at quartiles based on maximum allowable variation, as determined by HHSC. For example, if allowable variation is 30%, then a provider would earn 100% of valuation for achieving 70% -100% of the provider's goal; or 50% of valuation for achieving 50% - 69% of the goal.

29. Basis for Payment of Category C - Measure Bundles and Measures

a. P4P and P4R Measure Reporting Milestones

A Performing Provider must fully achieve reporting milestones to qualify for a DSRIP payment related to these milestones.

b. P4P Measure Goal Achievement Milestones

Partial payment for P4P measure goal achievement milestones is available in quartiles for partial achievement measured over baseline in PY1, PY2, PY3, and PY4. The achievement value is multiplied by the milestone valuation to determine payment. P4P measures with a baseline above the HPL are not eligible for partial achievement.

i. Each P4P measure has an associated goal achievement milestone that is assigned an achievement value based on the Performing Provider's achievement of the measure's goal as follows:

- If 100 percent of the goal is achieved, the achievement milestone is assigned an achievement value of 1.0;
- If at least 75 percent of the goal is achieved, the achievement milestone is assigned an achievement value of 0.75;
- If at least 50 percent of the goal is achieved, the achievement milestone is assigned an achievement value of 0.5;
- If at least 25 percent of the goal is achieved, the achievement milestone is assigned an achievement value of 0.25; or
- If less than 25 percent of the goal is achieved, the achievement milestone is assigned an achievement value of 0.

ii. For DY9-10, hospital safety measures as identified in Attachment R, "Measure Bundle Protocol" with perfect performance at baseline are eligible for full payment based on maintenance of high performance. If maintenance of high performance is achieved, the achievement milestone is assigned an achievement value of 1.0. Perfect performance at baseline is one in which no numerator cases are reported during the baseline measurement period with one or more eligible denominator cases. Maintenance of high performance is defined as an increase of one numerator case that was not preventable during a performance year. Each provider eligible for maintenance of high performance may determine a valid definition for a numerator case that is not preventable and will submit

documentation to HHSC if reporting maintenance of high performance in a performance year.

iii. The percent of the goal achieved for DY7-10 milestones is determined as follows:

- Measures with a positive directionality where higher scores indicate improvement in measure:
  - DY7 achievement = (PY1 Achieved - Baseline)/(DY7 Goal - Baseline)
  - Carryforward of DY7 achievement = (PY2 Achieved - Baseline)/(DY7 Goal - Baseline)
  - DY8 achievement = (PY2 Achieved - Baseline)/(DY8 Goal - Baseline)
  - Carryforward of DY8 achievement = (PY3 Achieved - Baseline)/(DY8 Goal - Baseline)
  - DY9 achievement = (PY3 Achieved - Baseline)/(DY9 Goal - Baseline)
  - Carryforward of DY9 achievement = (PY4 Achieved - Baseline)/(DY9 Goal - Baseline)
  - DY10 achievement = (PY4 Achieved - Baseline)/(DY10 Goal - Baseline)
- Measures with a negative directionality where lower scores indicate improvement in a measure:
  - DY7 achievement = (Baseline - PY1 Achieved)/(Baseline - DY7 Goal)
  - Carryforward of DY7 achievement = (Baseline - PY2 Achieved)/(Baseline - DY7 Goal)
  - DY8 achievement = (Baseline - PY2 Achieved)/(Baseline - DY8 Goal)
  - Carryforward of DY8 achievement = (Baseline - PY3 Achieved)/(Baseline - DY8 Goal)
  - DY9 achievement = (Baseline - PY3 Achieved)/(Baseline - DY9 Goal)
  - Carryforward of DY9 achievement = (Baseline - PY4 Achieved)/(Baseline - DY9 Goal)
  - DY10 achievement = (Baseline - PY4 Achieved)/(Baseline - DY10 Goal)

iv. For measures selected for DY7-10, the PY3 achievement value for DY9 achievement milestones and DY8 carryforward achievement milestones will be based on the greater of:
- Provider’s approved DY8 achievement value for the measure;
- Average approved DY8 achievement value for the measure if 10 or more providers selected the P4P measure for DY7-8,rounded down to the quartile;

- Average approved DY8 achievement value for the Measure Bundle if less than 10 providers selected the P4P measure for DY7-8, rounded down to the quartile; or
- Percent of DY9 goal achieved as described in paragraph 29.b.iii for DY9 achievement and carryforward of DY8 achievement plus achievement value as described in paragraph 29.b.i.

v. For measures newly-selected for DY9-10, the PY3 achievement value for DY9 achievement milestones will be based on the greater of:
   - Average approved DY8 achievement value for the measure if 10 or more providers selected the P4P measure for DY7-8, rounded down to the quartile;
   - Average approved DY8 achievement value for the Measure Bundle if less than 10 providers selected the P4P measure for DY7-8, rounded down to the quartile; or
   - Percent of DY9 goal achieved as described in paragraph 29.b.iii for DY9 achievement and carryforward of DY8 achievement plus achievement value as described in paragraph 29.b.i.

vi. For measures selected for DY7-11, the PY4 achievement value for DY10 achievement milestones and DY9 carryforward achievement milestones will be based on the greater of:
   - Provider's approved DY8 achievement value for the measure;
   - Average approved DY8 achievement value for the measure if 10 or more providers selected the P4P measure for DY7-8, rounded down to the quartile;
   - Average approved DY8 achievement value for the Measure Bundle if less than 10 providers selected the P4P measure for DY7-8, rounded down to the quartile; or
   - Percent of DY10 goal achieved as described in paragraph 29.b.iii for DY10 achievement and carryforward of DY9 achievement plus achievement value as described in paragraph 29.b.i.

vii. For measures newly-selected for DY9-11, the PY4 achievement value for DY10 achievement milestones and DY9 carryforward achievement milestones will be based on the greater of:
   - Average approved DY8 achievement value for the measure if 10 or more providers selected the P4P measure for DY7-8, rounded down to the quartile;
   - Average approved DY8 achievement value for the Measure Bundle if less than 10 providers selected the P4P measure for DY7-8, rounded down to the quartile; or
   - Percent of DY10 goal achieved as described in paragraph 29.b.iii for DY10 achievement and carryforward of DY9 achievement plus achievement value as described in paragraph 29.b.i.

30. Basis for Payment of Category D - Statewide Reporting Measure Bundle

The amount of the incentive funding paid to a Performing Provider will be based on the amount of progress made in successfully reporting measures included in the Statewide Reporting Measure Bundle specific to the type of Performing Provider. A Performing Provider must complete reporting on a Category D measure to be eligible for Category D payment for the measure.

31. Carry-forward Policy

Carry forward is allowed for Category B and C. Carry forward is not allowed for Category A or D.

If a Performing Provider is unable to report a Category B MLIU PPP and Total PPP in the second reporting period of the achievement DY, the Performing Provider may request to carry forward reporting of the Category B milestone to the first reporting round of the following DY. The measurement period will not change.

If a Performing Provider does not report a baseline or performance year in the first reporting period after the end of the measurement period, the Performing Provider may request to carry forward reporting of the associated Category C milestone to the next reporting round. For measures with a delayed baseline measurement period, a Performing Provider may request to carry forward reporting of the baseline until the first reporting period of DY8 for DY7-10 measures and until the first reporting period of DY10 for DY9-10 new measures. Carrying forward reporting does not change baseline or performance measurement periods.

Performing Providers may carry forward achievement of the Category C goal achievement milestones so that the DY7 goal achievement milestone can be achieved in PY1 or PY2, the DY8 goal achievement milestone can be achieved in PY2 or PY3, the DY9 goal achievement can be achieved in PY3 or PY4, and the DY10 goal achievement can be achieved in PY4. For DY7-10 measures with a delayed baseline measurement period, DY7 goal achievement can only be achieved in PY2 and the DY8 goal achievement milestone can be achieved in PY2 or PY3. For new DY9-10 measures with a delayed baseline measurement period, the DY9 goal achievement and DY10 goal achievement can only be achieved in PY4. The carried forward achievement must be reported in the first reporting period after the end of the carried forward measurement period.

Incentive funding that is carried forward still remains associated with the original DY for all accounting purposes (including calculation of the annual DSRIP payment limits). Carried forward DSRIP funding is subject to all Medicaid claiming requirements and may be paid no later than two years after the end of a DY in which it was to have been completed (e.g., for DY7, which ends September 30, 2018, payments may be made no later than September 30, 2020). Incentive payments may be made in DY11 and DY12 for prior periods of performance and administrative activities to close out the DSRIP program.

32. Penalties for Missed Milestones

If a Performing Provider does not report the milestones during the carry-forward period or the reporting year with respect to Category D - Statewide Reporting Measure Bundle, funding for the incentive payment shall be forfeited by the Performing Provider.

33. Remaining DY7-8 DSRIP Funds

a. Available DY7-8 DSRIP Funds

The funds remaining from each demonstration year for DY7 and DY8 is based on the difference between the available pool allocation as described in paragraph 13 and all Performing Providers' valuation as described in paragraph 14.a.

b. Regional Allocation

The remaining DY7-8 DSRIP funds are allocated to RHPs that did not fully utilize their original regional DY5 allocation based on the regional DY6 valuation and the valuation available to the region according to paragraph 14.a, excluding regional changes due to DY6 combined projects and DY7 assignment of "home" regions.

Regional Allocation of Additional DSRIP Funds from Remaining DY7-8 DSRIP Funds

RHP	Additional Regional Allocation per DY
RHP 1	$866,635
RHP 2	$2,308,000
RHP 3	$0
RHP 4	$522,345
RHP 5	$4,797,112
RHP 6	$0
RHP 7	$0
RHP 8	$5,739,571
RHP 9	$0
RHP 10	$0
RHP 11	$0
RHP 12	$0
RHP 13	$0
RHP 14	$0
RHP 15	$0
RHP 16	$0
RHP 17	$9,284,861
RHP 18	$1,318,286
RHP 19	$0
RHP 20	$4,062,821
TOTAL	**$28,899,632**

c. Allocation Requirements

The RHP may determine how to allocate the additional DY7-8 DSRIP funds among Performing Providers based on the community needs assessment. New Performing Providers that did not participate in DSRIP in DY2-6 and are an eligible Performing Provider type may be allocated funds to begin participation in DY7-8.

i. Each RHP must conduct at least two public stakeholder meetings to determine the uses for the additional funding.

ii. Each Performing Provider must certify that there is a source of IGT for the additional funding.

iii. The RHP Plan Update must include a description of the process to determine the uses for the additional funding and indicate the interested Performing Providers that were or were not allocated additional funding.

iv. Existing and new Performing Providers allocated additional funds must follow all DSRIP requirements.

34. Withdrawal of a Performing Provider

If a Performing Provider withdraws from DSRIP during the RHP Plan Update submission for DY7-8 or in DY7, DY8, DY9, or DY10, then the funding may not be transferred to other Performing Providers or to the RHP.

If a Performing Provider withdraws after the RHP Plan Update submission for DY9-10, then all DY9-10 DSRIP payments received prior to the withdrawal are recouped and the provider forfeits any remaining DY9-10 DSRIP payments.

VIII. RHP AND STATE REPORTING REQUIREMENTS

35. RHP Reporting in DY7-10

Two times per year, Performing Providers seeking payment under the DSRIP program shall submit reports to HHSC demonstrating progress achieved during the reporting period. The reports shall be submitted using the standardized reporting form approved by HHSC. IGT Entities will review the submission of the reported performance. Based on the reports, HHSC will calculate the incentive payments for the progress achieved in accordance with Section VII "Disbursement of DSRIP Funds for DY7-10." The Performing Provider shall have available for review by HHSC or CMS, upon request, all supporting data and back-up documentation. These reports will be due as indicated below after the end of each reporting period:

- Reporting period of October 1 through March 31: the reporting and request for payment is due April 30.
- Reporting period of April 1 through September 30: the reporting and request for payment is due October 31.

These reports will serve as the basis for authorizing incentive payments to Performing Providers in an RHP for achievement of DSRIP milestones. HHSC shall have 30 days to review and approve or request additional information regarding the data reported for each milestone. If additional information is requested, the Performing Provider shall respond to the request within 15 days and HHSC shall have an additional 15 days to review, approve, or deny the request for payment, based on the data provided. HHSC shall schedule the payment transaction for each RHP Performing Provider within 30 days following HHSC approval of the Performing Provider's RHP report.

<u>Reporting Exceptions</u>

HHSC and CMS may allow a subset of Category B-D milestones to be fully reported after the reporting period. In such instances, HHSC and CMS will designate those milestones as "provisionally approved." Performing Providers will be required to report in full to HHSC such "provisionally approved" milestones prior to when HHSC processes payments for the next reporting period. HHSC will report to CMS which milestones were "provisionally approved."

For milestones that are "provisionally approved," the Performing Provider will be eligible for full DSRIP payment or payment based on historic achievement, thereby waiving the requirements under paragraphs 27, 28, 29, and 30. For Category B carryforward, payments are based on the most recently reported DY achievement levels. Category C reporting milestones and carryforward of achievement milestones are eligible for full DSRIP payment. If a Category C carryforward milestone is provisionally approved, then the measure's reporting milestone is not eligible for provisional approval. Category D milestones are eligible for full DSRIP payment.

After a "provisionally approved" milestone is fully reported, HHSC will request, if necessary, additional information regarding the data reported by the Performing Provider for each milestone. Additional payments may also be made based on full reporting. If the initial supporting documentation, and any additional information reviewed by HHSC, does not form a sufficient basis for actual milestone achievement, HHSC will recoup the associated overpayments from the Performing Provider. If the Performing Provider does not comply with the recoupment, future Medicaid payments will be withheld.

36. Intergovernmental Transfer Process

HHSC will calculate the nonfederal share amount to be transferred by an IGT Entity in order to draw the federal funding for the incentive payments related to the milestone achievement that is reported by the Performing Provider in accordance with paragraph 35 and approved by the IGT Entity and the State. Within 14 days after notification by HHSC of the identified nonfederal share amount, the IGT Entity will make an intergovernmental transfer of funds. The State will draw the federal funding and pay both the nonfederal and federal shares of the incentive payment to the Performing Provider. If the IGT is made within the appropriate 14-day timeframe, the incentive payment will be disbursed within 30 days. The total computable incentive payment must remain with the Performing Provider.

At the time that HHSC requests IGT funding for DSRIP incentive payments, the State may also require the IGT Entity to transfer additional funds to provide a portion of the non-federal share of the state's administrative costs related to waiver monitoring activities.

37. RHP Annual Year End Report

Each RHP Anchoring Entity shall submit an annual report by December 15 following the end of each demonstration year during DY7-10. The annual report shall be prepared and submitted using the standardized reporting form approved by HHSC. The report will include information provided in the interim reports previously submitted for the DY. Additionally, the RHP will provide a narrative description of the progress made, lessons learned, challenges faced, stakeholder engagement, and other pertinent findings.

38. Learning Collaborative Plans

Recognizing the importance of learning collaboratives in supporting continuous quality improvement, RHPs will submit learning collaborative plans with the RHP Plan Updates, to reflect opportunities and requirements for shared learning among the DSRIP Performing Providers in the region. The DY7-8 and DY9-10 learning collaborative plans may include an annual regional learning collaborative and/or smaller, targeted learning collaboratives or stakeholder meetings. Two or more regions may work together to submit a cross-regional DY7-8 or DY9-10 learning collaborative plan. HHSC will develop a template for submission of RHP learning collaborative plans.

39. Texas Reporting to CMS

a. Quarterly and Annual Reporting

DSRIP will be a component of the State's quarterly operational reports and annual reports related to the Demonstration. These reports will include:

i. All DSRIP payments made to Performing Providers that occurred in the quarter as required in the quarterly payment report pursuant to STC 42(c);

ii. Expenditure projections reflecting the expected pace of future disbursements for each RHP and Performing Providers; and

iii. A summary assessment of each RHP's DSRIP activities during the given period including progress on milestones.

b. Claiming Federal Financial Participation

Texas will claim federal financial participation (FFP) for DSRIP incentive payments on the CMS 64.9 waiver form. FFP will be available only for DSRIP payments made in accordance with all pertinent STCs and Attachment R, "Measure Bundle Protocol" and Attachment J, "Program Funding and Mechanics Protocol."

IX. DATA QUALITY ASSURANCE

40. Data validation and alignment with managed care

Data and milestones that form the basis of incentive payments in DSRIP should have a high degree of accuracy and validity. The state must require that each Performing Provider certify that data received to demonstrate DSRIP achievement is accurate and complete. Data accuracy and validity also will be subject to review by the independent assessor.

41. Compliance Monitoring of DSRIP

All RHP Plan Updates are subject to potential audits, including review by the independent assessor. Upon request, Performing Providers must have available for review by the independent assessor, HHSC, and CMS, all supporting data and back-up documentation demonstrating performance of a milestone as described under an RHP Plan Update for DSRIP payments.

Failure of a Performing Provider to provide supporting documentation of performance of a milestone to the independent assessor or HHSC within the defined period of time may result in recoupment of DSRIP payments.

HHSC may recoup payments for milestones when a Performing Provider's documentation does not support the information reported.

Attachment K

Administrative Cost Claiming Protocol

Preface

The following guidance and protocols have been developed to inform and assist the TX Health and Human Services Commission (HHSC) and their partner Anchor and/or contractors in their efforts to comply with Federal statute, regulations, protocols, and guidance regarding claiming for Federal Financial Participation (FFP) for Medicaid administrative expenditures necessary to implement and operate this waiver.

I. General Requirements/Assurances

A. The HHSC/Anchor hospital under this waiver must fully describe the administrative expenditures to be claimed to Medicaid, including the methodology used to identify allowable expenditures, and submit a detailed narrative description and a budget summary for all costs for claiming administrative expenditures in writing to CMS.

State Response:

Texas has 20 Regional Healthcare Partnerships (RHPs), whose members may participate in the Delivery System Reform Incentive Payment (DSRIP) program. A map of the Texas RHPs is provided (reference *Attachment C – RHP Map*).

The RHPs share the following characteristics:

- The RHPs are based on distinct geographic boundaries that generally reflect patient flow patterns for the region;
- The RHPs have identified local funding sources to help finance the non-federal share of DSRIP payment for Performing Providers;
- The RHPs have identified an Anchoring Entity to help coordinate RHP activities.

RHPs vary in geographic and population size. RHP 3 represents the largest region which includes Houston and surrounding areas. This RHP contains more than 15% share of the statewide population under 200 percent of the federal poverty level (FPL) as defined by the U.S. Census Bureau: 2006 – 2010 American Community Survey for Texas (ACS). Approximately one half of the RHPs contain less than 3 percent share of the statewide population under 200 percent of the population. Narrative descriptions from Anchors and the methodologies proposed will vary based on the size of the RHP they are serving, and the type of organization.

Each RHP has one of its members designated as an "Anchor" entity. Anchors provide certain administrative services with respect to the Texas Transformation and Quality Improvement Program 1115 Waiver. The Anchor is a member of an RHP, and is one of the following types of public organizations:

- public hospital,
- hospital district,
- other hospital authority,

- county government, or
- State university with a health science center or medical school.

Description of Administrative Expenditures

Costs for Anchor activities allowable under this protocol for administrative claiming include the following:

1. The provision of appropriate accounting, human resources, and data management resources for the RHP;
2. The coordination of RHP annual reporting, as specified in the Program Protocol, on the status of projects and the performance of Performing Providers (as defined in the Program Protocol) in the region;
3. The provision of RHP data management for purposes of evaluation;
4. The development and facilitation of one or more regional learning collaboratives;
5. Communication with stakeholders in the region, including the public; and
6. Communication on behalf of the RHP with HHSC.

Methodology used to identify allowable expenditures

Parameters of allowable costs for the six activities listed above are addressed in the "Cost Principles for Expenses" specific to the 1115 Waiver document (reference *Attachment A – Cost Principles*). (Note that this document is also included as an attachment to the contract with each Anchor.) The Cost Principles describe in detail that not all types of costs that might be incurred by the Anchor in connection with the performance of its administrative functions under the Contract are allowable. It is the function of these Cost Principles for Expenses to clarify this issue. While this Attachment was derived from similar cost principles used by HHSC with respect to managed care and other contracts, there are substantive differences. The specific terms of this Attachment are the definitive cost principles with respect to the Anchor function.

The Cost Reporting Template (reference *Attachment B – Cost Template*) provides additional framework and controls for reporting of costs for each Anchor. The protected Excel spreadsheet has rows set up for each of the six activities listed above. Cost limits placed in the spreadsheet by HHSC that are specific to each Anchor prevent the Anchor from submitting costs per FFY to HHSC in excess of the limits established by CMS (i.e., the lesser of: $2,000,000 or 2.5% of the RHP DSRIP allocation per FFY). (Note that Anchors may submit a request for additional funding above the maximum to support additional transformation activities for the RHP for approval by HHSC and CMS.)

Narrative description and a budget summary

Each Anchor has submitted a narrative description (reference *Attachment D - RHP Narratives*) and a corresponding budget summary (reference *Attachment E - RHP Budget (Projected Costs)*). Within each of the twenty RHP Narratives, there are three sections, as follows:

- The first section, “Information about the Anchor Organization” includes a general description of the type of organization, any 1115 Waiver activities other than the role as an Anchor (including DSRIP activities), and, any other Administrative Costs or Claiming in which the organization participates.
- The next section, “Administrative Activities,” outlines a detailed narrative description and budget (projected costs) summary for each of the six allowable activities for this Protocol. Each Anchor has also submitted an Excel budget (projected costs) spreadsheet (reference Attachment E, which contains RHP 1 through RHP 20 Budget (Projected Costs). The documents also include the indirect rate proposed. If the rate proposed is higher than 10 %, the Anchor provides a justification proposed for the higher amount that is specific to the Anchor functions for the 1115 Waiver.
- The last section, “Cost Allocation Methodology,” describes the specific method that the particular Anchor uses to account for its relevant staff and/or contract time, and to allocate the staff/contractor time according to multiple activities or cost objectives. The methodology described is required to provide sufficient detail to demonstrate that costs are not duplicated in other programs. Anchors are using a similar methodology for cost allocation that results in a Percent Effort Spreadsheet (Attachment D.1) The approach is consistent with the "2003 CMS Medicaid School-Based Administrative Claiming Guide" incorporating the following requirements:
    a. Reflect an after the fact distribution of the actual activity of each employee;
    b. Are prepared monthly and coincide with one or more pay period;
    c. Are signed by the employee as being a true statement of activities and the employee/office will retain the documentation to support the report;
    d. Account for the total activity for which each employee is compensated.

    The Anchors will utilize a “Time and Effort” reporting process similar to the process utilized by the Texas A&M University System for federally sponsored projects. This process is required for all federally sponsored projects in order to validate that direct salaries and wages charged are reasonable and accurately reflect the work performed. The Anchors will use a spreadsheet and designate a percent effort for each activity by individual employee based on time spent on each activity on a monthly basis.

A narrative overview description of each Anchor is provided below; see the attachments for further details for each Anchor. Also see the *Attachment E* - which includes a *Consolidated Budget Summary* that adds all twenty Anchors into a single total cost projection.

Anchors are using the Percent Effort Spreadsheet as a consistent methodology beginning DY 3 (October 2013) and will also use DY 4 and 5. Anchors have also described a methodology used for DY 2 (October 2012 through August 2013) in their narratives attached.

RHP 1: University of Texas Health Science Center at Tyler (UTHSCT) participates in the 1115 Waiver as an Anchor, as a Performing Provider for DSRIP, and also in the Uncompensated Care (UC) Program. Expenses for Anchor activities are maintained separately from any other administrative functions of the institution. UTHSCT participates in Medicaid, Medicare, and federal funding for graduate medical education programs; none of these programs provide administrative match.

RHP 2: University of Texas Medical Branch (UTMB) participates in the 1115 Waiver as an Anchor, as a Performing Provider for DSRIP, and in UC. For the Anchor function, UTMB created the Office of Waiver Operations.

RHP 3: Harris Health System participates in the 1115 Waiver as an Anchor, as a Performing Provider for DSRIP, and in UC. The organization's DSRIP projects are all related to patient care, with no costs that could also be considered Anchor administration. There are no Anchor administrative costs that could be claimed under other state or federal programs. RHP 3 is Texas' largest region and has included significant detail in attached narrative for the staff involved in Anchor administrative activities.

RHP 4: Nueces County Hospital District (NCHD) participates in the 1115 Waiver as an Anchor. NCHD is not a provider for Medicaid, Medicare, or any other federal program, nor does it operate any healthcare facilities. The organization does not participate in any programs that have administrative cost claiming. It is an IGT entity for DSRIP and Uncompensated Care.

RHP 5: Hidalgo County is a local governmental entity and participates in the 1115 Waiver as an Anchor. It is also an IGT entity for funding for Uncompensated Care. Hidalgo County currently participates in the Medicaid Administrative Claiming (MAC) program. Hidalgo County is not planning to submit administrative costs at this time. Narrative information is not included.

RHP 6: The Bexar County Hospital District, doing business as University Health System (UHS), participates in the 1115 Waiver as an Anchor, as a Performing Provider for DSRIP projects, and in UC. University Health System prepares an annual Medicare/Medicaid cost report and submits administrative reports as required through grants and research programs. UHS has proposed an indirect cost rate of 34.8 %, which is the current federal negotiated cost rate with the Department of Health and Human Services (DHHS) used for grants and research.

RHP 7: The Travis County Healthcare District, doing business as Central Health, participates in the 1115 Waiver as an Anchor and IGT entity for DSRIP and UC. Central Health does not provide direct services but rather contracts with providers such as the Seton Healthcare Family. Central Health is the 51% owner of the Community Care Collaborative (Seton Healthcare Family is 49% owner). The Community Care Collaborative is a performing provider for DSRIP projects. Central Health is also the sole owner of Sendero Health Plan Medicaid Health Maintenance Organization (HMO). Sendero has a separate board, staff and facilities. Central Health does not participate in any other administrative costs or claiming.

RHP 8: Texas A&M Health Science Center (TAMHSC) is the anchoring entity for both RHP 8 and RHP 17. There is separate Anchor staff for the two regions. RHP 8's Anchor staff is at TAMHSC's Round Rock campus; RHP 17 is at the Bryan campus. TAMHSC is a health related institution operating as a component under Texas A&M University and, in addition to the anchor role, participates in the 1115 Waiver as an IGT entity, and as a performing provider for DSRIP projects in RHP 17. TAMHSC's School of Rural Public Health is currently under contract with HHSC to conduct the Statewide Evaluation of the 1115 Waiver.

RHP 9: Dallas County Hospital District, DBA Parkland Health and Hospital System, "Parkland" is the anchoring entity for RHP 9. Parkland is the largest public safety net hospital in the Dallas area and participates in the 1115 Waiver as an Anchor, IGT entity for DSRIP and UC, a performing provider for DSRIP projects, and participates in UC. Parkland does not receive any other administrative match for Medicaid or any other federal program in which they participate. No costs related to Parkland as a participating provider are included in the costs.

RHP 10: Tarrant County Hospital District, DBA JPS Health Network, is the anchoring entity for RHP 10 and also participates in the 1115 Waiver as an IGT entity for DSRIP and UC, DSRIP performing provider, and in UC.

RHP 11: Palo Pinto General Hospital, in Mineral Wells, TX (about 50 miles west of Ft. Worth), is the anchoring entity in RHP 11. It is a small rural hospital and reports that it does not have resources to document administrative activities, and thus is not planning to participate in administrative match claiming at this time.

RHP 12: Lubbock County Hospital District, *dba* University Medical Center (UMC), is the anchoring entity in RHP 12, and participates in the 1115 Waiver as Anchor, DSRIP performing provider, UC, and as an IGT entity. UMC does not participate in any other administrative costs or claiming.

RHP 13: McCulloch County Hospital District, in Brady, TX (about 75 miles east of San Angelo), the anchoring entity in RHP 13, and is not planning to submit administrative costs at this time. Narrative and cost information is not included.

RHP 14: Ector County Hospital District, DBA Medical Center Health System (MCHS), is the anchoring entity in RHP 14 and also participates as a performing provider in DSRIP, in UC and as an IGT entity. MCHS does not participate in other administrative match or claiming activities. For the purposes of Anchor functions, MCHS relies solely on one lead staff person.

RHP 15: El Paso County Hospital District, DBA University Medical Center of El Paso (UMC) is the anchoring entity in RHP 15 and also participates in the 1115 Waiver as a performing provider for DSRIP, UC, and an IGT entity for both DSRIP and UC. UMC also claims administrative types of costs on the Medicare and Medicaid cost reports. The anchor administrative costs will be excluded from these filings.

RHP 16: Coryell County Memorial Hospital Authority, the anchoring entity in RHP 16, is not planning to submit administrative costs at this time. Narrative and cost information is not included.

RHP 17: Texas A&M Health Science Center (TAMHSC) is the anchoring entity for RHP 8 and RHP 17. The RHP 17 Anchor team, as well as RHP 8 Anchor team, operates under the Rural and Community Health Institute which is a component of the College of Medicine. TAMHSC is a health related institution operating as a component under Texas A&M University and, in addition to the anchor role, participates in the 1115 Waiver as an IGT entity, and as a performing provider for DSRIP projects in RHP 17. RHP 17 Anchor team is housed at the Bryan TX campus.

RHP 18: Collin County is the anchoring entity for RHP 18. Collin County is not a Medicaid provider and does not participate as a Performing Provider in DSRIP or in UC.

RHP 19: Electra Hospital District (*dba* Electra Memorial Hospital) is the anchoring entity in RHP 19, and is not planning to submit administrative costs at this time. Narrative and cost information is not included.

RHP 20: Webb County is the anchoring entity in RHP 20. The Anchor did not submit a narrative, so cannot claim any costs unless this is rectified. Note that although narrative information was not submitted, preliminary costs information was submitted in an earlier request: $371,000 for DY2, and $395,000 for DY3.

B. The state is at risk for loss of FFP should an audit of this waiver find non-compliance with Federal statute, regulations, protocols, and guidance.

State Response:

Understood. Language is incorporated in Cost Principles that hold the Anchors to this same standard and risks.

C. The state may be required to develop an administrative claiming plan (protocol) that is described in a later section of this agreement and to amend its cost allocation plan.

In order for the costs of administrative activities to be claimed as Medicaid administrative expenditures at the 50% FFP rate, the state assures that the following requirements are understood and met:

- ✓ The state complies with all Federal statute, regulations and guidance for all claims for FFP.
- ✓ Costs are "necessary for the proper and efficient administration of the Medicaid State Plan" (Section 1903(a)(7) of the Social Security Act).
- ✓ If applicable, costs are allocated in accordance with the relative benefits received by all programs, not just Medicaid.

- ✓ Claims for costs are not duplicate costs that have been, or should have been, paid for through another federal funding source or paid as part of a rate for direct medical services.
- ✓ State or local governmental agency costs are supported by an allocation methodology under the applicable approved public assistance Cost Allocation Plan (42 Code of Federal Regulations (CFR) 433.34) submitted to the Division of Cost Allocation.
- ✓ Costs do not include funding for a portion of general public health initiatives that are made available to all persons, such as public health education campaigns.
- ✓ Costs do not include the overhead costs of operating a provider facility or otherwise include costs of a direct medical services to beneficiaries (these should be claimed as medical service costs, and not plan administration).
- ✓ Costs do not duplicate activities that are already being offered or should be provided by other entities, or through other programs.
- ✓ Costs are supported by adequate source documentation.
- ✓ Costs are not federally-funded or used for any other federal matching purposes.

State Response:

Understood. As a result of the specific guidance, the state has now added language to the Cost Principles that holds the Anchors to the above requirements. See new section I.E. entitled "Core CMS requirements for cost allowability" in the revised version of 1115 Waiver Cost Principles (reference Attachment A).

D. Under the waiver, the state must:

1. **Provide a detailed summary budget and a narrative description of all administrative expenditures for review and approval.**

   State Response:

   The total net impact to the Federal government of the administrative claiming hereunder, after incorporating offsetting IGT, shows the 50% Federal match at $4.0 Million for DY2, and $5.1M for DY3.

   In terms of what they will be claiming (in total dollars, before the impact/offset of IGTs), the twenty RHPs report that they have spent $8.0M during DY2, and plan to spend $10.1M in DY3. Actual expenditures are higher, in that five RHPs plan to not claim administrative expenses hereunder.

   Most RHPs are far under their individual maximum allowed amounts, and the aggregate amount of administrative claiming is about one-third of the maximum state-wide amount allowed.

   A summary of each Anchor's narrative is provided in Section A above. The full Anchor narratives are provided in Attachment D. Further, an aggregate budget narrative is included within Attachment E. Attachment E also includes substantial budget details,

including an aggregate overview by Administrative Activity, a summary overview by RHP, and a detailed numerical page for each individual RHP.

2. **Submit a narrative budget of administrative expenditures for review purposes to be referenced in the administrative claiming section of the standard terms and conditions for the waiver.**

   State Response:
   A summary of each Anchor's narrative is provided in Section A above. The full Anchor narratives are provided in Attachment D. An aggregate budget narrative is included within Attachment E, along with additional budget details.

3. **Obtain prior approval from CMS for any changes to the methodology used to capture or claim FFP for administrative costs associated with the Waiver/Demonstration**

   State Response:
   Understood.

4. **Describe how the State and its partners will offset other revenue sources for administrative expenditures associated with the Waiver/Demonstration, if applicable.**

   State Response:
   N/A

5. **Detail the oversight and monitoring protocol to oversee all aspects of the Waiver/Demonstration including administrative claiming for the Waiver/Demonstration.**

   State Response:
   A monitoring function is planned for the Waiver that is under development with CMS that may include staff and/or contracted activities.

6. **Obtain prior approval for any new categories of administrative expenditures to be claimed under the Demonstration.**

   State Response:
   Understood.

7. **Agree to permit CMS to review any time study forms and/or allocation methodology related documents that are subsequently developed for use by this program, prior to modification or execution.**

   State Response:
   Understood.

8. **Submit a Medicaid administrative claiming plan to CMS for review and approval prior to implementation and/or claiming costs.**

   State Response:
   Initial Medicaid administrative claiming plan was submitted February 2012.

9. **Submit copies of all of the interagency agreements/MOUs/ and signed contracts for vendors that include administrative costs under this Waiver/Demonstration.**

   State Response:
   Understood.

II. Interagency Agreements/Memorandum of Understanding (MOU)/Contracts

A. Only the state Medicaid agency may submit a claim to CMS to receive FFP for allowable Medicaid costs. Therefore, every participating entity that is performing administrative activities on behalf of the Medicaid agency must be covered, either directly or indirectly, through an interagency agreement, memorandum of understanding (MOU) or contractual arrangement.

These agreements must describe and define the relationships between the state Medicaid agency and the sister agency or sub-grantee claiming entity and document the scope of the activities to be performed by all parties. The interagency agreements must be in effect before the Medicaid agency may submit claims for federal matching funds for any administrative activities conducted by the entity as detailed in the agreement with the Medicaid agency. Although CMS does not have approval authority for interagency agreements, nor are we party to them, the agency reserves the right to review interagency agreements executed for purposes of administering the waiver.

State Response:

See anchor list in box below. Contracts will be executed with each Anchor utilizing the Anchor Contract Template (Attachment F). Anchor Administrative Costs reimbursement is contingent on signed MOU or Contract.

Agency Name/Sub-grantee	Date of Signed MOU or Contract
University of Texas Health Science Center at Tyler	
University of Texas Medical Branch	
Harris Health System	
Nueces County Hospital District	
Hidalgo County	
University Health System	

Travis County Healthcare District (Central Health)	
Texas A&M Health Science Center	
Dallas Cty Hosp District (Parkland Health & Hosp)	
Tarrant Cty Hosp District (JPS Health Network)	
Palo Pinto General Hospital District	
Lubbock County Hospital District - University Medical Center	
McCulloch County Hospital District	
Ector County Hospital District (Medical Center Health System)	
University Med Ctr of El Paso (El Paso Hosp Dist)	
Coryell County Memorial Hospital Authority	
Texas A&M Health Science Center	
Collin County	
Electra Hosp District (Electra Memorial Hospital)	
Webb County	

B. The agreements above describe and define the relationships between the state Medicaid agency and the sister agency or sub-grantee claiming entity and document the scope of the activities being performed by all parties.

State Response:

Understood.

C. The interagency agreement or sub-grant contract must describe the Medicaid administrative claiming process, including an allocation methodology, (i.e., time study) to identify the services the state Medicaid agency will provide as well as those to be performed by the local entity, including any related reimbursement and funding mechanisms, and define oversight and monitoring activities and the responsibilities of all parties.

State Response:

See cost reporting template (Attachment B).

D. All requirements of participation the state Medicaid agency determines to be mandatory for ensuring a valid process should be detailed in the agreement. Maintenance of records, participation in audits, designation of local project coordinators, training

timetables and criteria, and submission of fiscal information are all important elements of the interagency agreement.

The interagency agreement includes:

- ✓ Mutual objectives of the agreement;
- ✓ Responsibilities of all the parties to the agreement;
- ✓ A description of the activities or services each party to the agreement offers and under what circumstances;
- ✓ Cooperative and collaborative relationships at the state and local levels;
- ✓ Specific administrative claiming time study activity codes which have been approved by CMS, by reference or inclusion;
- ✓ Specific methodology which has been approved by CMS for computation of the claim, by reference or inclusion;
- ✓ Methods for reimbursement, exchange of reports and documentation, and liaison between the parties, including designation of state and local liaison staff.

State Response:

See updated contract form (Attachment G), Cost Principles (Attachment A), and cost reporting template (Attachment B).

E. Many interagency agreements require the governmental agency that performs the administrative activities to provide the required state match for Medicaid administrative claiming.

State Response:

Anchors will be required to provide the required state match.

III. Non-federal Share Funding Source

For each activity and/or agreement to provide an activity please specify the source of the non-federal share of funding below. The non-federal share of the Medicaid payments must be derived from permissible sources (e.g., appropriations, Intergovernmental transfers, certified public expenditures, provider taxes) and must comply with federal regulations and policy.

Activity/Agreement	Funding Source
RHP01 Anchor Administrative Costs	UT Health Science Center Tyler
RHP02 Anchor Administrative Costs	The University of Texas Medical Branch at Galveston (UTMB)
RHP03 Anchor Administrative Costs	Harris Health System
RHP04 Anchor Administrative Costs	Anchor Entity (Nueces County Hospital District)
RHP05 Anchor Administrative Costs Not planning to submit at this time	Anchor – Hidalgo County
RHP06 Anchor Administrative Costs	University Hospital

RHP07 Anchor Administrative Costs	Public funds as defined in Rule 355.8202 of the Texas Administrative Code
RHP08 Anchor Administrative Costs	Texas A&M Health Science Center
RHP 09 Anchor Administrative Costs	Parkland Health & Hospital System
RHP10 Anchor Administrative Costs	Anchor – JPS Health Network
RHP11 Not planning to submit costs as this time	
RHP12 Anchor Administrative Costs	Lubbock County Hospital District dba University Medical Center
RHP13 Not planning to submit costs as this time	
RHP 14 Anchor Administrative Costs	Ector County Hospital District
RHP 15 Anchor Administrative Costs	El Paso County Hospital District d/b/a UMC of El Paso
RHP16 Not planning to submit costs as this time	
RHP 17 Anchor Administrative Costs	Texas A&M Health Science Center
RHP18 Anchor Administrative Costs	Collin County Healthcare Foundation
RHP19 Not planning to submit costs as this time	
RHP20 Did not submit narrative	

State Response:

See anchor list above.

IV. Administrative Activities

The state and its partners must describe the proposed administrative activities to be performed in the section below.

Activity	Provider
The provision of appropriate accounting, human resources, and data management resources for the RHP;	Anchors
The coordination of RHP annual reporting, as specified in the Program Protocol, on the status of projects and the performance of Performing Providers (as defined in the Program Protocol) in the region;	Anchors

The provision of RHP data management for purposes of evaluation;	Anchors
The development and facilitation of one or more regional learning collaboratives;	Anchors
Communication with stakeholders in the region	Anchors
Communication on behalf of the RHP with HHSC.	Anchors

State Response:

See the list of proposed administrative activities in the box immediately above. For additional details, further see the cost reporting template (Attachment B), the contract form (Attachment F), and updated Cost Principles (Attachment A).

V. Identification, Documentation and Allocation of Costs

A. Public Assistance Cost Allocation Plan

1. **The Public Assistance Cost Allocation Plan (CAP) is a narrative description of the procedures that the state agency will use to identify, measure, and allocate costs incurred under this Waiver/Demonstration. All administrative costs (direct and indirect) are normally charged to federal grant awards such as Medicaid through the state's public assistance Cost Allocation Plan (CAP).**

   State Response:
   Submitted February 2012.

2. The single state agency has an approved public assistance cost allocation plan (CAP) on file with the Division of Cost Allocation in the U.S. Department of Health and Human Services that meets certain regulatory requirements, which are specified at Subpart E of 45 CFR part 95 and referenced in OMB Circular A-87, Attachment D.

   State Response:
   Submitted February 2012.

3. Upon approval of this Waiver/Demonstration, it is the responsibility of the state Medicaid agency to amend their CAP plan and submit to the DCA for review and approval.

   State Response:
   Understood.

4. In accordance with the statute, the regulations, and the Medicaid state plan, the state will maintain/retain adequate source documentation to support Medicaid payments.

   State Response:

Understood.

5. Upon approval, the CAP must reference the claiming mechanism, the interagency agreement, and the time study methodology and other relevant issues pertinent to the allocation of costs to submit claims. The time study requirements are described in the next section.

State Response:

Understood. Note: the State is not proposing time studies.

B. <u>Cost Allocation Methodology and/or Time Study Description</u>

The state will describe the methodology used to account for 100% of staff time (i.e., time study and/or sampling system) to allocate the staff time accordingly to multiple activities or cost objectives. The time study allocates the share of costs to administrative activities (both Medicaid and non-Medicaid) and direct medical services as well as all other funding sources that are not reimbursable under this administrative claiming protocol. The time study must be described in sufficient detail to include a description of each Medicaid and non-Medicaid codes (to allocate to other federal and non-federal programs) to account for 100% of staff time.

The state and its partners are responsible to develop a time study methodology and instructions to capture costs and reflect all of the time and activities performed by staff. The time study must include careful documentation of all of the work performed by staff over a set period of time and is used to identify, measure and allocate staff time devoted to Medicaid reimbursable administrative activities.

A Medicaid allocation statistic is applied to the resulting recognized administrative cost pool to determine Medicaid's reimbursable administrative cost. Note: Overhead costs incurred that are an integral part of, or an extension of, the provision of services by medical providers, are to be included in the rate paid by the state or its fiscal agent for the medical service. These costs are not claimable as administrative expenditures and there is no additional FFP available under this section.

In accordance with the statute, regulations and the Medicaid state plan, the state is required to maintain and retain source documentation to support Medicaid payments for administrative activities. The basis of this requirement can be found in statute and regulations.

See section 1902 (a)(4) of the Act and 42 CFR 431.17. Documentation maintained in support of administrative claims must be sufficiently detailed to permit CMS to determine whether activities are necessary for the proper and efficient administration of the state plan.

Provide the cost identification and time study methodology descriptions here, if applicable.

State Response:

Anchors are using a similar methodology for cost allocation that results in a Percent Effort Spreadsheet (Attachment D.1)

a. Reflect an after the fact distribution of the actual activity of each employee;
b. Are prepared monthly and coincide with one or more pay period;
c. Are signed by the employee as being a true statement of activities and the employee/office will retain the documentation to support the report;
d. Account for the total activity for which each employee is compensated.

VI. Authorized Collaborations/Partnerships

A. As part of the total amount payable under this Waiver/Demonstration authority granted under section 1115(a)(2) of the Social Security Act (the Act) by the Centers for Medicare & Medicaid Services (CMS) Federal Financial Participation (FFP) as authorized by 42 Code of Federal Regulations (CFR) 433.15 is available at the 50 percent matching rate for administrative costs required for "proper and efficient" administration of the Waiver/Demonstration and subject to the limitations outlined below.

State Response:

Understood.

VII. Administrative Claiming Budget and Budget Narrative

Provide a detailed budget and budget narrative. The budget must crosswalk all of the administrative activities and staff positions associated with administrative services.

State Response:

Each anchor has provided based on draft cost reporting template, and contract and updated cost principles.

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Attachment B – Cost Template – This is the cost reporting template, in the form of a locked Excel spreadsheet, which provides additional framework and controls for reporting of administrative costs by each Anchor. Among other data, the spreadsheet shows costs by activity by Demonstration Year for each Anchor.

Attachment C – RHP Map – This map of the state of Texas shows the locations of the twenty Regional Healthcare Partnerships, whose members may participate in the Delivery System Reform Incentive Payment (DSRIP) program.

Attachment D – RHP Narratives – Each Anchor has submitted a narrative description, per the CMS requirements herein, which has been reviewed by HHSC. This attachment shows this narrative detail for each of the twenty Anchors.

Attachment D.1 -- Percent Effort Spreadsheet -- Each Anchor will utilize this spreadsheet for cost allocation methodology.

Attachment E – RHP Budget (Projected Costs) and Consolidated Budget Summary – Each Anchor has submitted a cost projection / budget by Demonstration Year, which is subject to the maximums as established by CMS. There is a separate spreadsheet for each of the twenty Anchors. HHSC has consolidated the individual submittals from the twenty Anchors into a combined state total by activity by Demonstration Year.

Attachment F – Anchor Contract template -- This is the proposed form for the contracts between HHSC and each of the separate Anchors. Among other things, the contract outlines tasks and

responsibilities, payment terms, and various requirements, such as adherence to the Cost Principles for submission of allowable costs for reimbursement hereunder.

Attachment L
Independent Consumer Support System Plan

1. Introduction

The Health and Human Services Commission (HHSC) is submitting this report as required by the Centers for Medicare and Medicaid Services (CMS) in its agreement with the State of Texas to operate Medicaid managed care under the authority of the Texas Healthcare Transformation and Quality Improvement Program, Section 1115(a) Demonstration (THTQIP 1115(a)). The THTQIP 1115(a) demonstration requires an independent consumer supports system to support beneficiary experience receiving medical assistance and long term services and supports in a managed care environment. Texas is required to maintain a consumer support system that is independent of the managed care organizations to assist enrollees in understanding the coverage model and in the resolution of problems regarding services, coverage, access and rights. see THTQIP 1115(a), STC 20.e.ii.)

2.
Independent Consumer Support System (ICSS)

Texas' independent consumer supports system consists of the HHSC's Medicaid/CHIP Division, Office of the Ombudsman (Ombudsman), the State's managed care Enrollment Broker (EB, "MAXIMUS"), and community support from the Aging and Disability Resource Centers (ADRCs). These entities operate independently of any Medicaid managed care organization (MCO) and work with beneficiaries and MCOs to ensure beneficiaries working to enroll with a MCO understand their managed program, MCO options, and the process for resolving issues.

HHSC's Medicaid/CHIP Division includes staff devoted to providing guidance to the MCOs on Medicaid policy and managed care program requirements, reviewing MCO materials, monitoring the MCO's contractual obligations, answering managed care inquiries, and resolving managed care complaints. HHSC also implements MCO corrective action plans and assesses damages when necessary.

Data related to the ICSS is reported and monitored regularly, on at least a quarterly basis, by all entities discussed in this report. Within each system, the data is reported consistently and across all systems; the data reported is similar.

Ombudsman

The Ombudsman consists of three units dedicated to assisting beneficiaries with health and human services related concerns and a fourth unit specializing in operations and reporting. The units consist of the Hotline unit which receives and triages general health and human services inquiries and complaints, the Special Services unit which assists consumers with more in-depth, complex complaints, and the Medicaid Managed Care Helpline (MMCH) unit that was created to serve Medicaid managed care beneficiaries. These units work under the same Ombudsman leadership. The Ombudsman exists outside of agency program areas and

operates independently of the Medicaid/CHIP Division and any MCO. The Ombudsman's primary purpose is to facilitate the resolution of complaints and inquiries through a collaborative and transparent operation. The office serves as the central point of contact when any Medicaid beneficiary needs assistance obtaining health care services or has a complaint or issue regarding an agency, MCO, or program.

To fulfill its purpose, the Ombudsman offers several ways beneficiaries can access the Ombudsman's assistance: toll-free hotline, online submission, fax, and mail. Similarly, staff are able to work with beneficiaries over the phone, email, fax, and mail, in addition to offering notices by text message or email to provide beneficiaries with updates regarding the status of their concern. The toll-free line offers bilingual services (English and Spanish) and employs two language interpreter vendors for other languages as needed. The Ombudsman strives to make contact information widely available to consumers and maintains a dedicated legislative line for public officials.

The Ombudsman serves as a central access point for beneficiaries to voice complaints or raise issues of concern, specifically related to MCO enrollment and access to services. The office assists beneficiaries through the navigation of the Medicaid managed care system, and educates about the enrollment process and services available under this system. Staff is available to help resolve problems and is trained to educate beneficiaries about their rights related to grievance and appeal processes both through the MCO and through the State, including their right to request a fair hearing. Staff encourages individuals to seek to resolve issues first with the entity or program providing services, but staff will also work directly with MCOs, other State staff, and beneficiaries to assist with issue resolution where appropriate. The MMCH unit was created to teach beneficiaries to advocate for themselves. Staff also advocates on the beneficiary's behalf to resolve problems, including access to care issues, through direct coordination with the beneficiary's MCO. At times, the Ombudsman staff will assist beneficiaries to achieve self-advocacy skills by modeling these skills on a three-way call between the Ombudsman, the beneficiary, and the other entity (such as the MCO).

To ensure staff is adequately prepared to assist beneficiaries, the Ombudsman employs staff with a wide background of experience and knowledge of health and human services programs, services, and individual populations. Ombudsman staff are not typically entry-level employees. New staff receive training designed to expand their knowledge of the State's Medicaid programs and services, including beneficiary protections and rights, in order to best meet consumer needs. Formal training is provided to enhance customer service and the office ensures ongoing training to keep staff abreast of agency initiatives and policy changes, specifically those related to Medicaid, STAR, STAR+PLUS, waiver programs, and Medicare, as well as relevant Social Security Administration policy.

The Ombudsman regularly hosts representatives from various organizations and programs who train staff to better serve individuals with complex needs and/or diverse backgrounds in

an effort to better understand the needs of populations served through the system and resources available, including: National Alliance on Mental Illness, the Department of Aging and Disability Services (DADS), Area Agencies on Aging (AAAs), as well as the following HHSC offices: 2-1-1 Information and Referral, Office of Acquired Brain Injury, Medical Transportation Program, Center for Elimination of Disproportionality and Disparities (CEDD), and the Data Integrity Division, which assists with concerns related to Social Security Income (SSI-related) Medicaid and the Medicare Savings Program processes. Staff have opportunities to attend external training events such as the Central Texas African American Family Support Conference where they interact with consumers of agency services, CEDD annual conference, various health expositions, and professional development trainings. Additionally, Ombudsman staff and leadership attend stakeholder meetings at HHSC and DADS, as well as advisory committee meetings, and communicate to all Ombudsman staff the needs and concerns expressed at such meetings. The Ombudsman staff and Medicaid/CHIP Division staff meet regularly to share information and discuss trends and issues.

The HHSC Ombudsman utilizes a custom designed and secure web-based data tracking system to document each contact received. Staff use the tracking system to collect detailed information such as: specific beneficiary information, the nature of the contact, the type of Medicaid program, beneficiary demographic and residence information, the related MCO, whether a complaint is substantiated or unsubstantiated, and the resolution.

The fourth unit within the Ombudsman, Operations and Reporting, compiles and analyzes inquiry and complaint data from this system and prepares ad hoc and routine reports for internal and external use. Trend analysis is conducted to examine: the types of issues beneficiaries experience, the demographic service area, the responsible MCO, and to identify potential serious, systemic and emerging issues and trends. Reports and analysis are routinely shared, no less than quarterly, with the appropriate program areas including the Medicaid/CHIP Division and executive HHSC leadership, in an effort to address potential systemic issues and improve service to beneficiaries.

Enrollment Broker (EB)

The EB is an entity contracted with HHSC and operates independently of any MCO. The EB serves as an intermediary between the MCOs, beneficiaries, and the State regarding all aspects of enrolling a beneficiary into a MCO. The EB's purpose is to improve access to health and human service programs and reduce administrative burden on beneficiaries, providers, and the State of Texas.

The EB fulfills its contractual obligations by educating beneficiaries about their managed care options and the enrollment process, issuing enrollment packets, operating a call center for beneficiaries, conducting outreach and enrollment events for beneficiaries, conducting home visits, and working one-on-one with beneficiaries to assist with completion of

managed care enrollment. To complete enrollment into a MCO, beneficiaries may submit enrollment forms via fax, mail, and online, or call the EB's toll-free hotline to complete the MCO enrollment process. Spanish speaking hotline staff is available, as needed. The EB is also required to provide language translation for all languages as needed. The EB accepts complaints from beneficiaries about the Medicaid and CHIP programs and MCOs. Any complaint is escalated to HHSC if it cannot be resolved by the EB.

When additional types of beneficiaries become eligible for managed care, the EB implements a specific outreach plan to assist and educate the new beneficiaries locally. For example, for the 2014-15 enrollment period, the EB will conduct enrollment events, community education sessions, and home visits for individuals with intellectual and developmental disabilities and individuals residing in nursing facilities statewide, and to individuals residing in the Medicaid Rural Service Area to educate them about Medicaid managed care and enrolling in the STAR+PLUS program. These events will include collaboration with the AAAs and local intellectual and developmental disability authorities.

To ensure staff are adequately prepared to assist with managed care enrollment and handle complaints as required by their contract with HHSC, the EB employs staff that are properly trained and qualified to perform the functions required by their contract and requires staff complete required training on each of the managed care programs: STAR, STAR+PLUS, STAR Health, CHIP, and Dental. Specific training is provided when new populations are added to Medicaid or CHIP managed care, such as training about providing acute care for individuals with intellectual and developmental disabilities through the managed care system. The EB is required to ensure staff participates in trainings on population-specific sensitivity and effective communication training.

In order to provide adequate oversight, HHSC requires the EB to submit relevant reports, policies and procedures on a regular basis and expects the EB to maintain policies or procedures approved by HHSC. The EB provides HHSC a monthly report on the following: staff training provided , including the types of trainings, the number of participants that passed or failed the class and any remediation plans if a participant did not pass; quality assurance trend analysis related to evaluations; MCO provider network reports, including the number of primary care providers and specialists; enrollment reports summarizing the number of monthly and year-to-date enrollments for each managed care program; call center performance, including results and recommendations for improvement; complaint and dispute information that includes the reason or type of complaint, resolution by incidence, and issues or complaints escalated to HHSC. Separate enrollment reports are submitted for pregnant women and beneficiaries with special health care needs who have been enrolled.

The EB is required to annually submit and maintain a communication and coordination management plan that outlines its overall approach for communications with HHSC, other contractors, and stakeholders. The EB submits an annual progress and statistical report that includes trend analyses, performance data and metrics. The EB submits outreach and

informing policies, procedures, and business rules on a quarterly and annual basis. A complaint and dispute analysis report is sent to HHSC quarterly. Reports are also submitted regarding the EB's outreach and informing efforts.

Aging and Disability Resource Centers

The Aging and Disability Resource Centers (ADRCs) operate independently of any MCO and have historically been grantees of the Department of Aging and Disability Services (DADS). Coordinated through DADS and made up of key partners including the area agencies on aging, local intellectual and developmental disability authorities, and regional DADS staff, the ADRCs provide information about state and federal benefits, primarily to individuals who are aged or disabled seeking assistance.

The ADRCs are a point of contact in the state for people who are aged or have a disability; have physical or intellectual disabilities; or have mental health or substance abuse issues. The ADRCs work with individuals at an individual ADRC, over the phone, or in a person's home if needed. ADRCs offer language assistance through their staff, a statewide language line, or through external vendors under language assistance contracts. The ADRCs assist individuals to determine their needs, provide information about services, and provide person-centered planning to discuss options that most closely meet an individual's needs, which could include assisting an individual enrolling in managed care and accessing other state or federal programs.

According to their contracts, ADRCs must report performance metrics to DADS on a quarterly basis. Current measures relate to outreach and training events, information and referral data, and certain caller demographic data (age, need, conditions, caregiver information). In September 2015, ADRCs will also report data related to the provision of the Long Term Services and Supports (LTSS) pre-screening assessment tool. These metrics and the development of uniform intake, assessment, reporting and referral management processes will ensure a standardized and consistent consumer experience statewide.

The ADRCs play a key role in the statewide "No Wrong Door" system of information and access by promoting better coordination and integration among existing networks of aging and disability services. ADRC partners employ extensive cross-training to ensure consistent service delivery at all ADRC access points. This cross-training includes but is not limited to extensive training in cultural competence; the health and service options of individuals with complex, multiple needs, chronic conditions, disabilities and cognitive or behavioral needs; the state's Medicaid Programs; and beneficiary protections. Training also includes specific information about existing state-level consumer support access points including the Ombudsman, Medicaid Managed Care Helpline, Enrollment Broker services, DADS Consumer Rights and Services and the Long Term Care Ombudsman Program.

3. Conclusion

Attachment L
Independent Consumer Support System Plan

HHSC primarily relies on Medicaid/CHIP Division staff, the Ombudsman and EB to support consumers receiving Medicaid managed care. These entities assist beneficiaries navigating the managed care system by educating about options, rights, and processes for enrollment and issue resolution. ADRCs are an integral community support in the consumer support system for the State of Texas, as they also assist, educate, counsel, and advocate on behalf of beneficiaries seeking services. Together, these entities ensure beneficiaries are able to understand their options and the services available to them, successfully enroll in Medicaid managed care, and resolve any issues that may arise.

Attachment M

Historical Demonstration Information

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.

STAR and STAR+PLUS Programs

STAR is the primary managed care program providing acute care services to low-income families, children, and pregnant women. STAR+PLUS provides acute and long-term service and supports to older adults and adults with disabilities.

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

Effective March 1, 2012, the STAR program expanded statewide to include the three Medicaid rural service areas (MRSAs). Following this expansion, Medicaid eligible adults who were not enrolled in Medicare, met the level of care for Home and Community Based Services (HCBS), and resided in the MRSA, had to enroll in a STAR managed care organization (MCO); children meeting these criteria could voluntarily enroll in STAR. STAR MCOs in the MRSA provided acute care services, and will coordinate acute and long-term care services with section 1915(c) waivers, such as the Community Based Alternatives Program and the Community Living Assistance and Support Services Program, that exist outside of this section 1115 demonstration.

Effective September 1, 2014, STAR+PLUS expanded to the MRSA and Medicaid eligible adults over age 21 meeting STAR+PLUS eligibility criteria and residing in the MRSA were required to enroll in STAR+PLUS. Clients under 21 who meet the criteria may able to voluntarily enroll in STAR+PLUS effective September 1, 2014, and until the implementation of STAR Kids on November 1, 2016.

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

Effective March 6, 2014, cognitive rehabilitation therapy services (CRT) will be provided through the STAR+PLUS HCBS program.

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

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

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

Beginning January 1, 2014, children ages 6 - 18 with family incomes between 100 – 133 percent of the federal poverty level were transferred from the state's separate Children's Health Insurance Program (CHIP) to Medicaid in accordance with section 1902(a)(10)(A)(i)(VII) of the Act. Under the demonstration these targeted low-income children (M-CHIP) are required to enroll in managed care. For the purposes of eligibility and benefits, these children are considered a mandatory Medicaid group for poverty-level related children and title XIX eligibility and benefit requirements apply. The state may claim enhanced match from the state's title XXI allotment for these M-CHIP children in accordance with title XXI funding requirements and regulations. All references to CHIP and title XXI in this document apply to these M-CHIP children only. Other requirements of title XXI (for separate CHIP programs) are not applicable to this demonstration.

STAR Kids Program

Effective November 1, 2016, the following four groups of Medicaid clients from birth through age 20 will become mandatory populations through a new program under the 1115 waiver -- the STAR Kids Medicaid managed care program.

1. Clients receiving SSI and disability-related (including SSI-related) Medicaid who do not participate in a 1915(c) waiver: these children will receive their state plan acute care services and their state plan long term services and supports (LTSS) through STAR Kids.
2. Clients receiving HCBS services through the MDCP 1915(c) waiver: these children and young adults will receive the full range of state plan acute care services and state plan LTSS as well as MDCP 1915(c) HCBS waiver services through STAR Kids. The MDCP waiver will continue, but will be operated by HHSC effective November 1, 2016. This is to ensure that options for MDCP services provided under the 1915(c) authority remain available to individuals in STAR Health, which services children and young adults in the conservatorship of the Department of Family and Protective Services.
3. Clients receiving HCBS through the following 1915(c) waivers -- CLASS, DBMD, HCS, TxHmL, and YES:
    a. Clients enrolled in CLASS, DBMD, HCS and TxHmL receive their 1915(c) LTSS and 1915(k) (Community First Choice) services through their current waiver provider, which are contracted with DADS. These clients receive all other state plan LTSS and acute care services through STAR Kids.
    b. Clients enrolled in the YES waiver receive their 1915(c) LTSS through their current HCBS delivery system, which is operated by DSHS. These clients receive all state plan LTSS, including 1915(k) services, as well as all acute care services through STAR Kids.
4. Clients receiving SSI and disability-related (including SSI-related) Medicaid who reside in a community-based intermediate care facility for individuals with intellectual disabilities or a nursing facility: clients will continue to receive all long term services and supports provided by the facility through the current delivery system. All non-facility related services will be paid through STAR Kids.

Individuals in all four categories will receive a continuum of services, including acute care, behavioral health, and state plan long-term services and supports. STAR Kids managed care organizations will provide service coordination for all members, including coordination with non-capitated HCBS services that exist outside of this section 1115 demonstration. Indian children and young adults who are members of federally-recognized tribes, and have SSI or disability-related (including SSI-related) Medicaid or who are served through one of the 1915(c) waivers, will be able to voluntarily enroll in STAR Kids or opt to remain in traditional fee-for-service Medicaid.

Effective January 1, 2017, the NorthSTAR program (currently operated in Dallas, Ellis, Collin, Hunt, Navarro, Rockwall and Kaufman counties) will discontinue. All Medicaid behavioral health services previously provided to Medicaid-eligible individuals by NorthSTAR will be provided through the 1115 Medicaid STAR, STAR+PLUS and STAR Kids MCOs.[1,2]

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

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[1] For members enrolled in STAR Kids, these services will be available through MCOs beginning November 1, 2016.

[2] As with all other service areas, Mental Health Targeted Case Management and Mental Health Rehabilitative services will be paid through FFS for individuals who receive Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI) funded services or PASSAR services. All wrap-around services and crossover claims will be paid via FFS for dually eligible individuals not enrolled in the duals demonstration.

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;
- 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.

In May of 2016, CMS granted the demonstration a 15 month temporary extension to allow additional time for DSRIP projects to demonstrate their results. The extension also allows Texas to study its Medicaid payment and financing policies and providers' uncompensated care burdens, and prepare for the next stage in delivery system reform.

Effective September 1, 2017, the following populations are mandatory for managed care. Those who meet the STAR Kids eligibility criteria are mandatory to enroll in STAR Kids, and the remainder are mandatory to enroll in STAR.

- Clients enrolled in the Department for Family and Protective Services (DFPS) Adoption Assistance program.
- Clients enrolled in the DFPS Permanency Care Assistance program.

Effective September 1, 2017, women participating in the Medicaid for Breast and Cervical Cancer will transition to STAR+PLUS Medicaid managed care.

Attachment N

Health Information Technology (Health IT) Strategic Plan

November 2019

Submitted to:

Centers for Medicare and Medicaid Services

Submitted by:

Texas Health and Human Services Commission

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Executive Summary

The Centers for Medicare & Medicaid Services (CMS) approved the renewal of the Texas Medicaid 1115 Healthcare Transformation and Quality Improvement Program demonstration waiver on December 17, 2017. Special Terms and Conditions (STC) 39 of the waiver renewal requires the Texas Health and Human Services Commission (HHSC) to develop a Health Information Technology (Health IT) Strategic Plan related to activities in the demonstration that will "link services and core providers across the continuum of care to the greatest extent possible" using Health IT initiatives and strategies.

In Texas, the 1115 waiver governs the Uncompensated Care and Delivery System Reform Incentive Payment (DSRIP) programs. The waiver also represents the authority for most Texas Medicaid managed care, which is the service delivery model for about 93 percent of Texas Medicaid clients. As such a large purchaser of healthcare, Texas Medicaid has the unique opportunity to contribute to a global Health IT approach for the state. Texas Medicaid supports the Texas Health Information Exchange (HIE), five active community-based Health Information Exchanges (Local HIEs) and the health provider community by providing governance and infrastructure to ensure greater interoperability within the state. The Health IT Strategic Plan outlined in this document is designed to implement capabilities complementary to Texas Medicaid and the state's Health IT ecosystem.

Texas is working to increase access to health data across the healthcare continuum, through improvements in provider technologies, such as electronic health record (EHR) systems and strategic use of limited resources to develop methods for establishing interoperability. Access to Medicaid client information supports decision-making by a wide range of entities, including patients, healthcare workers, government agencies and others.

The following three Health IT/HIE strategies detailed in the Texas Health Information Exchange Implementation Advance Planning Document (HIE IAPD) provide the foundation and building blocks for bringing this Health IT Strategic Plan to fruition:

1. **Strategy 1: Medicaid Provider HIE Connectivity** – This strategy is intended to assist Local HIEs with connecting the ambulatory providers and hospitals in their respective areas.
2. **Strategy 2: Texas Health Information Exchange (HIE) Infrastructure** – This strategy aids with building connectivity between the Texas Health Services Authority (THSA), which has a statutory charge to facilitate HIE statewide, and the state's Local HIEs.
3. **Strategy 3: Emergency Department Encounter Notification (EDEN) system** – Texas statewide Health Information Exchange Plan promotes Local HIEs connecting hospitals to their information technology systems and exchanging Admission, Discharge, Transfer (ADT) messages.

This Health IT Strategic Plan discusses how Medicaid managed care can be leveraged to inform the transition to value-based care as a growing proportion of managed care organization (MCO) contracts with providers embrace alternative payment models (APMs). As Medicaid MCO payment models change, health information sharing across the state's Health IT ecosystem becomes more relevant. Texas Medicaid also has several managed care oversight initiatives underway that relate to information sharing, such as a focus on continuous organizational improvement and increasing transparency between providers and members.

Through this Health IT Strategic Plan, HHSC demonstrates compliance with STC 39. STC 39 requires the Health IT Strategic Plan to describe the state's existing Health IT environment and develop an approach to support the following capabilities in furtherance of the programmatic objectives of the demonstration:

1. **C-CDA Format** - Electronic exchange of clinical health information via Consolidated Clinical Document Architecture (C-CDA), when multiple providers provide coordinated care to a client.
2. **Master Patient Index** - Access to a comprehensive enterprise master patient index that supports the programmatic objectives of the demonstration.
3. **Provider Directory** - A comprehensive Medicaid service provider directory strategy that supports the programmatic objectives of the demonstration.
4. **Care Coordination** - Improved coordination and integration between Medicaid behavioral health, physical health, home and community-based services providers and community-level collaborators through the adoption of provider-level Health IT infrastructure and software.
5. **Care Quality** - A comprehensive Health IT enabled quality measurement strategy that supports the collection of data necessary for Texas to monitor and evaluate the demonstration's programmatic objectives.

This Health IT Strategic Plan defines achievable milestones relating to Health IT adoption by Medicaid service providers, plans for the exchange of clinical health information related to Medicaid clients statewide and advances the standards identified in the "Interoperability Standards Advisory—Best Available Standards and Implementation Specifications" (ISA). Such efforts will be undertaken in alignment with critical initiatives advanced by the 21st Century Cures Act (H.R. 34, 114th Congress, 2016) to enhance interoperability, prohibit information blocking and provide patients with easier access to their electronic health data.

This plan provides background information, including detailing Texas Medicaid's Health IT goals, providing an overview of the Healthcare Transformation and Quality Improvement Program Waiver and detailing the strategic plan development activities. This plan then highlights the findings from using CMS' "1115 Health IT Toolkit,"[1] as directed by STC 39, in conducting an assessment of seven key Health IT topic areas. Finally, the plan includes goals and milestones for Health IT in furtherance of the programmatic objectives of the demonstration.

Texas HHS Vision and Mission and Medicaid Health IT Goals

Texas HHS' vision is: "Making a difference in the lives of the people we serve" and the mission is: "Improving the health, safety and well-being of Texans with good stewardship of public resources."

The Health IT Strategic Plan supports this vision, mission and goals of the Texas Health and Human Services agencies as well as those of the Medicaid and CHIP Services Department. The plan provides a roadmap for improving the health and well-being of our citizens by identifying actions and capabilities using information from the Texas Health IT ecosystem. The plan focuses on increasing the adoption of certified EHR systems, particularly among providers not included in previous federal incentive programs; connecting Texas providers to Local HIEs and leveraging clinical and non-clinical data, data analytics, telemedicine and telehealth to facilitate improved outcomes and care coordination.

Texas Medicaid has developed the following Health IT goals specific to the 1115 Waiver:

1. Incorporate Health IT as a foundational component for the Medicaid managed care delivery model, procurement and HHSC contract oversight efforts.

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[1] CMS, in coordination with the Office of the National Coordinator (ONC) for Health IT, has created a series of toolkits and resources for Medicaid focused on health information exchange, Health IT and interoperability. "1115 Health IT Toolkit" materials accessed July 17, 2019 at: https://www.healthit.gov/topic/advancing-interoperability-medicaid

2. Support the development and maintenance of a coordinated care delivery system by facilitating the timely exchange of clinical, health risk and other data among Texas Medicaid stakeholders.
3. Support transition to value-based models across managed care and providers by:
    a. Expanding the use of metrics that integrate administrative, clinical, relevant health risk and other data.
    b. Improving the timely availability of actionable information for decision making by patients, providers and payers.
    c. Translating Health IT best practices from the DSRIP program into managed care programs.
4. Promote MCOs' use of Health IT to manage member healthcare and related needs, with an emphasis on prevention.
5. Promote Medicaid provider connectivity to the overall Texas Health IT ecosystem.

Healthcare Transformation and Quality Improvement Program Waiver Background

In December 2011, Texas received approval for a Section 1115 Medicaid demonstration waiver to expand existing Medicaid managed care programs statewide while preserving certain safety net provider funding and promoting health system transformation. The Healthcare Transformation and Quality Improvement Program Waiver successfully enabled Texas to expand the STAR and STAR+PLUS Medicaid managed care programs statewide and established the following two funding pools:

1. The Uncompensated Care Pool, which allowed for payments for the unreimbursed costs of services, provided to Medicaid clients and uninsured individuals.
2. The DSRIP Pool, which initially enabled providers participating in 20 Regional Healthcare Partnerships (RHPs) to receive incentive payments for projects, and was designed to promote healthcare infrastructure development and implement program innovation and redesign.

In December 2017, CMS approved an extension of the demonstration for five years through September 30, 2022. Texas' objectives for the demonstration renewal are to:

- expand risk-based managed care to new populations and services;
- support the development and maintenance of a coordinated care delivery system;
- improve health outcomes while containing cost growth; and
- transition to quality-based payment systems across managed care and providers.

The demonstration extension represents an evolution from the initial waiver terms as Texas Medicaid managed care now includes:

- additional programs and services;
- a narrowing of the definition of uncompensated care to charity care only; and
- a shift in the focus of the DSRIP program from individual provider projects to more strategic efforts aimed at provider system-level performance measurement and improvement.

The following information provides a brief history on the elements of the demonstration with the closest ties to Health IT – the Medicaid managed care expansion and DSRIP.

Medicaid Managed Care Expansion

Over the past 25 years, Texas has gradually transitioned Medicaid from fee-for-service reimbursement to a managed care system that holds health plans accountable for producing value. Under the managed care system, HHSC contracts with MCOs competing within 13 service delivery areas and pays a per

member per month rate, called a capitation rate or premium, to coordinate care and reimburse providers for health services provided to Medicaid or CHIP members enrolled in their plan.

Texas Medicaid managed care includes the following statewide programs covering the noted populations:

- STAR – children, newborns, pregnant women and some parents with low incomes;
- STAR+PLUS – adults who have disabilities, are age 65 or older or have breast and/or cervical cancer;
- STAR Health – children and youth who receive Medicaid because they either currently are or formerly were in the conservatorship of the state;
- STAR Kids – children and youth age 20 or younger who have disabilities; and
- Children's Medicaid Dental Services – most children and youth under age 21.

The managed care model has become the centerpiece of the state's strategy to promote value-based care in Medicaid. As of November 2018, about 93 percent of Texas Medicaid and CHIP clients received services through risk-bearing MCOs, making Texas a national leader for delivering healthcare through a value-based model to people with low income or disabilities.

Delivery System Reform Incentive Payment (DSRIP) Program

Since 2012, 300 healthcare providers in Texas have earned over $16 billion (all funds) through DSRIP for increasing access to care, piloting care innovations and improving health outcomes. DSRIP providers include public and private hospitals, community mental health centers, local health departments and physician practices - mostly affiliated with academic health science centers.

In demonstration years one through six, DSRIP providers earned funds by achieving process and outcome measures related to projects they chose from an approved "menu" of initiatives, designed to either develop infrastructure or test healthcare innovations. The most common focus points of DSRIP projects over the first six years of the program were:

- behavioral healthcare (mental health and substance use care);
- primary care (expansion/redesign/Patient-Centered Medical Homes);
- patient navigation/care coordination/care transitions;
- chronic care management; and
- health promotion/disease prevention.

An early success of the DSRIP program was the establishment of 20 Regional Healthcare Partnerships (RHPs) covering the state, which led to increased local collaboration to identify and address priority community healthcare needs. Activities are underway in many regions to further connect MCOs and DSRIP providers to better coordinate their efforts. These sorts of connections among healthcare providers and between healthcare providers and MCOs either benefit from the current use of Health IT or could be further enhanced through future utilization of Health IT, including standards-based health information exchange.

The DSRIP funding pool was extended in the latest waiver renewal under a model that shifts the focus of delivery system transformation from individual provider projects to more strategic efforts aimed at provider system-level performance measurement and improvement. The current DSRIP funding ends October 1, 2021. Transition planning is under way to further develop delivery system reform efforts after DSRIP ends. This Health IT Strategic Plan is a crucial component to identify areas where Health IT is already supporting the objectives of the demonstration as well as additional opportunities for advancing care coordination and other quality improvement efforts.

Strategic Plan Development Activities

The development of the Health IT Strategic Plan began with review and consultations regarding the Texas State Medicaid Health IT Plan (SMHP), SMHPs from other states and the 2015 Texas Medicaid Information Technology Architecture (MITA) State Self-Assessment (SS-A). The next Texas MITA SS-A is in progress as of the development of this plan.

Additional early information-gathering activities included meetings and discussions in 2018 with a broad range of Texas Health IT stakeholders and HHSC leadership and staff. Input was received from HHS advisory groups, Health IT stakeholders, MCOs, providers and HHS staff. In June 2019, an overview of draft milestones was provided at a public meeting of the HHSC e-Health Advisory Committee (eHAC), where committee members provided preliminary feedback. Further discussions regarding the information presented were held with workgroup members of eHAC.

Changes resulting from these eHAC discussions were incorporated into the draft Health IT Strategic Plan that was posted to HHSC's website on October 11th, 2019, giving the public an opportunity to comment through November 9th, 2019. Stakeholders interested in Health IT efforts, along with those on the distribution list for DSRIP and the broader 1115 waiver, were sent emails notifying them that the draft plan had posted.

HHSC received substantive comments from 17 respondents. Many comments were supportive of various aspects of the plan. Some of the responses were programmatic questions or suggestions that will be considered by operations staff. Other comments discussed topics not under the authority of Texas HHS or that would suggest changes to the scope of the HIE IAPD, which includes parameters already agreed upon with the federal government.

In response to stakeholder comments, HHSC made several changes to this plan, including defining Local HIEs, adding further detail about 21st Century Cures Act requirements, noting provider types not eligible for federal incentive funds for EHR adoption and emphasizing that Health IT can support delivery of services related to social drivers of health. The updated plan also clarifies that providers would only connect directly to HIETexas if they do not have the capability to connect directly to a Local HIE.

HHSC recognizes strong collaboration is required to increase the flow of clinical data in the state. Internally as well as in HHSC discussions with healthcare stakeholders about Health IT in Texas, a consistent theme in stakeholder feedback was the limited exchange of health information. Additional concerns included the items listed below:

- The low percentage of Medicaid ambulatory providers that are connected to health information networks;
- Lack of trust among providers and payers;
- Lack of standardized processes for connectivity;
- Lack of standardized approaches to value-based purchasing;
- The low percentage of long-term care, behavioral health and home and community-based service providers using electronic health records and connected to health information networks; and
- The cost and administrative barriers providers face regarding participation in the Health IT ecosystem.

Texas HHS agencies have aligned in their pursuit of strategies to advance Health IT, improve care coordination and reduce provider burden. This includes several connectivity strategies, modernization of HHS' infrastructure interfaces to its Health IT information systems, implementation of a provider

management and enrollment system, ongoing enterprise data governance efforts building patient and provider master indices, updating of the registry systems supporting clinical data exchange with providers and using clinical data to provide HHS staff with additional tools to aid and support program innovation.

1115 Health IT Toolkit Health IT Topic Discussion

This strategic plan used the seven Health IT topics outlined in the CMS "1115 Health IT Toolkit" [2] to assess Health IT considerations. This section of the strategic plan provides an overview of the considerations for each Health IT topic followed by the results of HHSC's assessment for each topic area.

Overview of Health IT Topics

This section provides a brief overview of considerations for each Health IT topic identified in the "1115 Health IT Toolkit." Texas has considered the principles and guidelines outlined in the CMS toolkit to align with the Health IT Strategic Plan.

The Use of Standards in Health Information Technology Procurement:
Contracts with providers, vendors and other healthcare entities should require the use of messaging and data standards specified in the ISA maintained by the Office of the National Coordinator (ONC) for Health IT.

Leveraging State Health IT Ecosystem:
Where practical, new or expanded services using Health IT should leverage previous investments in health information technology. For example:

- No unnecessary duplicative networks should be established;
- Where practical and appropriate back-up systems exist, health information exchanges should be leveraged to facilitate data exchange; and
- Technology standards for telemedicine should be standard across programs to facilitate re-use of equipment.

Accountable Oversight and Rules of Engagement for Health IT and Health Information Exchange (a.k.a. Governance):
Governance of health information exchanges, selection of standards for exchange and quality standards must be managed in as transparent a manner as possible, in alignment with applicable federal regulations and policies developed by ONC and CMS. Collaboration in governance-related activities should be promoted.

Identity Management, Provider Directories and Attribution:
Health IT can be used to manage individual patients' identities. Accurate patient identification and matching across disparate systems is critical to minimize patient risk and improve the efficiency of healthcare delivery, inclusive of care coordination. Provider directories can be established and used to facilitate data exchange and reporting, payment services and assisting patients in identifying potential care providers. Using a provider directory enables longitudinal tracking of provider behavior as well as facilitates matching provider-related records across information systems.

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[2] "1115 Health IT Toolkit" materials accessed July 17, 2019 at: https://www.healthit.gov/topic/advancing-interoperability-medicaid

Promoting and Funding Provider Health IT Adoption and Use:
Appropriate technical and financial assistance for healthcare providers helps to promote the adoption and use of Health IT. Examples of relevant activities include, but are not limited to:

- providing funding supporting the adoption and use of Health IT, including EHR technology;
- providing grants for purchasing/using technologies supporting telehealth/telemedicine;
- conducting programs focused on encouraging providers to use health information technology; and
- a provider public relations team assisting to educate and drive adoption.

Advancing Use of Health IT to Support Quality Measurement:
The use of health information technology should support improved quality measurement. This includes the exchange of quality measures between providers and other parties and the transparency of quality measure data to the public. Quality measures may be used by providers, payers and patients to understand, select and improve healthcare options.

Health IT and Service Delivery:
Ultimately, effective Health IT must deliver services that improve the patient experience of care, improve the health of individuals and communities, lower costs and be valued by patients as well as the professionals and organizations accountable for providing and coordinating their care. Beyond traditional healthcare, Health IT can also support the coordination of services that address social drivers of health, such as food insecurity, housing and transportation issues.

Examples of successful Health IT services include, but are not limited to, providing the following:

- An interoperable health registry to reduce administrative activities while facilitating compliance with applicable law;
- An interoperable health registry that supports bi-directional flow of information to facilitate the coordination of care;
- Near real-time alerts on meaningful healthcare events such as patient admissions, discharges and transfers involving hospital emergency and inpatient departments;
- Technology-based tools that enable providers and/or patients to better manage an individual's health;
- Closed-loop referral systems to community-based organizations that address the social drivers of health;
- Computer-based support for decision-making by healthcare providers; and
- A patient portal, messaging support or Fast Healthcare Interoperability Resources (FHIR)-based platform to enable patients to access their own health records.

Health IT Topic: The Use of Standards in Health Information Technology Procurement

HHS agencies have a long history of using systems that support standards-based interoperability with trading partners. A combination of federal laws, state laws and regulations have shaped the Health IT infrastructure. Both HHSC and the Department of State Health Services (DSHS) have implemented technologies in response to national directives, whether it was a highly choreographed revision of all healthcare stakeholder systems for compliance with *International Classification of Diseases, 10th Revision* (ICD-10) or the implementation of commercially available, off-the-shelf software provided by the Centers for Disease Control and Prevention. Texas HHS strategically recognizes Health IT as foundational to advances in many of its business areas and that a standard-based approach maximizes

interoperability with the Certified EHR Technology (CEHRT) technologies used across the Health IT ecosystem.

House Bill 2641, 84th Legislature, Regular Session, 2015 (HB 2641) requires that information systems planned or procured on or after September 1, 2015 and used by a Texas Health and Human Services agency to send or receive protected health information to and from healthcare providers, use applicable standards and be interoperable with each other. HB 2641 aligns with federal legislation and promotes the use of certified electronic health record technology as well as requires the use of standards such as those included in the ISA.

Modernization procurements associated with Medicaid Management Information Systems (MMIS) must adhere to use of standards in Health IT platforms for all secure web services, file and data transmission. The same requirements apply to Health IT systems related to a distributed Service Oriented Architecture, which is essentially a collection of services that communicate with each other. The communication can involve either simple data passing, or two or more services coordinating some activity and Electronic Data Interchange (EDI), which is the electronic interchange of business information using a standardized format.

HHS' Current MMIS EDI System

The current Texas Medicaid EDI system is a Council for Affordable Quality Healthcare CORE-compliant, standards-based gateway for receiving, validating, tracking and routing transactions. The system is composed of reusable business and technical services, with business processes orchestrating the flow. Common file tracking services are used across all subsystems and common reprocessing and alerts are configured for all business processes.

Use of Common Standards in Healthcare

Some common standards used in healthcare today are: Health Level 7 (HL7); Fast Healthcare Interoperability Resources (FHIR); Digital Imaging and Communications in Medicine; and North American Association of Central Cancer Registries Version 15. All these standards are included in the ISA. HHSC addresses standards in a biennial report on interoperability as required by HB 2641. *Interoperability for Texas: Powering Health 2016*[3] identifies some of the national and international standards development organizations involved in standards used in healthcare.

The HL7 standard is structured to accommodate various types of message transfers using different implementation guides. There are different HL7 structures for a broad range of purposes, including electronic laboratory reporting and exchanging immunization data. Even though these HL7 message types differ, the healthcare industry understands the different subtypes as parts of a broader system. HL7 is leading a project known as the HL7 Da Vinci Project with vendors, providers and payers to promote industry-wide standards and adoption through the development of unique solutions to improve care. One area of focus is automating support for prior authorizations. The goal is to standardize the information exchange required between payers and providers for payer authorizations.

The FHIR standard is a new specification from HL7, based on emerging industry approaches, but informed by years of lessons around requirements, successes and challenges from previous experience

[3] *Interoperability for Texas: Powering Health 2016.* HHSC. Accessed July 18, 2019 at: https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/interoperability-texas-powering-health-2016.pdf.

with standards. FHIR can be used as a stand-alone standard or can be used in conjunction with other standards. FHIR is easy to implement compared to most standards presently used in the healthcare industry. The ONC notably included FHIR in proposed interoperability rulemaking as the standard for application programming interfaces (APIs) for patient and population services.[4] The use of FHIR for patient platforms enables patients to access and share specific content from their medical records easily.

As the state's public health agency, DSHS operates numerous public health registries that contain valuable clinical information used to understand, plan for and manage health services and needs across Texas. Each of the registries use standardized messages, usually in formats specified by federal partners, HL7 or other national standards development organizations. Data for several systems are received via implementations of Orion gateway services. In other cases, data may be exchanged through standard messages directly between providers' EHRs and DSHS' receiving systems or through web-based data entry. More information regarding DSHS may be found in Appendix C.

Health IT Topic: Leveraging the Texas Health IT Ecosystem

This Health IT Strategic Plan fully leverages Health IT infrastructure already built and in use by internal state and external healthcare entities. The 1115 demonstration is building on the existing Health IT infrastructure and initiatives, including findings of the MITA state self-assessment, state SMHP and active IAPDs. An example of one such initiative, and referenced subsequently in this document, is the Medicaid Electronic Health Record Incentive/Promoting Interoperability (PI) Program established via the Health Information Technology for Economic and Clinical Health (HITECH) Act. The EHR Incentive/PI Program has allowed HHSC to deliver more than $864 million in federal EHR incentive funding to more than 10,000 providers and hospitals since the inception of the program in 2011. This approach ensures Texas' tax dollars are judiciously spent and invested, and that Federal Medical Assistance Percentages (FMAP) funds are used in accordance with CMS rules and regulations. Texas adopts national and state best business practices and leverages systems and experience from other states who also use FMAP funds. Policy and standards adopted in Texas are commonplace in the healthcare industry. Specific examples of how this works include:

- Many state and local for-profit and nonprofit HIEs that support bi-directional exchange across providers are currently operational and committed to the statewide exchange of clinical data and ADT data;
- MCOs, as Medicaid payers charged with facilitating care coordination for their members, work directly with hospitals and providers to provide funding and technical assistance for connectivity to HIEs and EHR interoperability for added value services related to health data exchange;
- HHSC, the state's designated entity for agreements with the Office of the National Coordinator and the state's Medicaid agency, signed a contract in May 2019 with THSA to build infrastructure to connect Texas' HIEs; and
- National networks (e.g., CommonWell, eHealth Exchange, etc.) with products that support interoperability or certified EHR technologies are motivated to leverage existing data connections to propagate and share data.

Texas' Health IT ecosystem consists of a combination of public and private payers, professional entities, providers, associations and HIEs at various stages of maturity and connectivity. Since 2006, the Texas Legislature has passed laws supporting Texas Medicaid and other health agencies strengthening the use

[4] 84 FR 7424 available at: https://www.federalregister.gov/documents/2019/03/04/2019-02224/21st-century-cures-act-interoperability-information-blocking-and-the-onc-health-it-certification

of Health IT and aligning with federal initiatives. Appendix A of this plan provides a chronology of Texas legislation supporting health information exchange.

Health IT Exchange Barriers

Like other states, Texas has challenges with data sharing across the healthcare provider community. The lack of interoperability across the varying CEHRT products used by providers makes true data sharing an ongoing challenge. Providers continue to feel overburdened by quality reporting requirements in the Promoting Interoperability Program as well as other CMS quality programs.

Other barriers to provider participation include the costs to establish interfaces with trusted networks (HIEs), and the hesitancy of providers to share clinical data with payers and other providers. Some providers fear that the data they share could be used against provider and patient interests, such as fear over payer intervention in care decisions or that the information they share could influence patient premiums.

Trust can potentially be built among the provider community and payers by bringing value through provision of clinical data and ADT to automate payer processes, such as prior authorizations. This example underlines the improvements that can result from transparency and information sharing between provider and payer. Additionally, value-based payment models could shift providers' view of claims data and lessen the reticence to payer participation in HIE.

Multiple federal initiatives designed to enhance interoperability and overcome concerns over trust and other barriers resulted from passage of the 21st Century Cures Act. Initiatives included prohibitions on information blocking and development of the Trusted Exchange Framework and Common Agreement (TEFCA). TEFCA outlines a common set of principles, terms and conditions to support the development of a Common Agreement that would help enable nationwide information exchange across disparate networks and ensure that HIEs, healthcare providers, health plans, public health agencies and individuals have secure access to electronic health information when and where it is needed. [5]

Health IT Ecosystem Strategies

Some of the strategies Texas is pursuing to address obstacles include working around the cost barriers of connectivity (see the following discussion of HIE IAPD Strategy 1: HIE Connectivity) and building incentives for data sharing through Medicaid managed care requirements for alternate payment models between health plans and providers. With the passage of the 21st Century Cures Act in FFY 2017, there has been a succession of federal rules strengthening the interoperability requirements of Health IT products and services. Current and proposed rulings promote CEHRT product offerings and information exchange capabilities that make interoperability accessible for a wider reach of healthcare providers. Texas' Health IT strategies align with federal laws and rules, enabling the state to fully benefit from these recent advances in interoperability.

Texas recognizes that public and private Health IT proponents must strategically focus and collaborate to ensure the state has not transitioned from paper to electronic silos. Texas also recognizes that it is important to continue to promote the benefits of information sharing in healthcare.

[5] https://www.healthit.gov/topic/interoperability/trusted-exchange-framework-and-common-agreement

State of Health IT and HIE opportunity in Texas

Texas has multiple Health Information Exchanges (HIEs) that are national, state, local or aligned based on EHR products. Professional participants in HIEs are primarily hospitals or large provider groups. Texas has a statewide framework for exchange, THSA, that supports connectivity to the national HIE networks. Texas' plan to implement electronic HIE statewide is market-based and community-driven. To foster HIE growth and adoption across the state, THSA provides ongoing strategic support to Local HIEs. THSA has made available a set of shared services through HIETexas. Some of the most significant benefits of joining HIETexas are the HIE-to-HIE connectivity between authorized HIEs in Texas, the use of the EDEN system and the development of a platform that may facilitate connectivity to the nationwide eHealth exchange, which allows for connectivity with other states' HIEs, as well as federal government agencies such as the Department of Veterans Affairs and the Department of Health and Human Services.

During Hurricane Harvey, there was a need to offer query-based HIE to assist in the recovery efforts by allowing patients' health information to be available to provide services to those in mass shelters. This access to data proved to be invaluable during the disaster response activities.

Discussion of the strategies within the HIE IAPD that follow demonstrate how THSA will play a major role in services that are essential for ensuring the delivery of health information, such as routing ADT messages for Medicaid members and supporting updates to clinical registries.

HIE IAPD Strategy 2: HIE Infrastructure

This strategy aids with building connectivity between THSA and the state's Local HIEs[6] and other authorized entities. Funding is used to implement systems to benefit Medicaid's goals of supporting Medicaid client data collected by the Local HIEs. These activities continue with the THSA contract.

This strategy teams HHSC and THSA to develop and implement projects that make HIE services available statewide and continue to enhance state-level shared services. Projects include, but are not limited to:

- implementation of an HL7 integration engine;
- implementation of a Master Patient Index related to HIE;
- implementation of an audit and logging system to monitor all data flow pertaining to Medicaid's HIE IAPD Strategies 1 and 3, regarding provider connectivity and EDEN;
- implementation of an Administrative User Interface and statistical dashboard for Medicaid to monitor data flows pertaining to HIE IAPD Strategies 1 and 3;
- configuration of implemented systems supporting Medicaid's HIE IAPD Strategies 1 and 3;
- maintenance of systems implemented in support of Medicaid's HIE IAPD Strategies 1 and 3, for the term of this IAPD;
- integration required with Local HIEs to assist them in connecting to THSA in support of Medicaid's HIE IAPD Strategies 1 and 3; and

[6] "Local HIE" with respect to the HIE IAPD strategies uses the definition at (Texas) Government Code, Sec. 531.901(4): "Local or regional health information exchange" means a health information exchange operating in this state that securely exchanges electronic health information, including information for patients receiving services under the child health plan program or Medicaid, among hospitals, clinics, physicians' offices, and other health care providers that are not owned by a single entity or included in a single operational unit or network.

- integration work necessary to deliver required data to Medicaid.

This project supports fundamental, statewide infrastructure necessary for exchange of HL7 v2 and CDA-based documents. This functionality promotes the following Promoting Interoperability measures:

- Lab results;
- Transitions of care;
- Immunization registry reporting;
- Electronic laboratory results reporting to public health;
- Syndromic surveillance; and
- Reporting to specialized registries.

HIE IAPD Strategy 3: Emergency Department Encounter Notifications (EDEN)

This strategy establishes the EDEN system, which provides the ADT processing infrastructure to be used by hospital systems to exchange ADT data between HIEs connected to each other via THSA. If a hospital cannot be served by a Local HIE, they may connect directly to HIETexas. Using EDEN, Medicaid clients' admission, discharge or transfer status will be transmitted to Texas Medicaid and MCOs. EDEN will evolve to support the exchange of patient information with primary care physicians (PCPs) and other care team members. Information about hospital admissions, discharges and transfers are of great value to PCPs for care coordination.

Current emergency department (ED) information systems do not always allow ADT messages/notifications to be exchanged outside the hospital's system (i.e., with MCOs or with a patient's primary care provider). Diagnosis and admissions data is valuable to care coordination and can be used by MCOs to automate prior authorizations, which is a key benefit for both MCOs and hospitals. HHSC intends to increase the exchange of ADT messages by reducing the cost burden for hospitals connecting to their Local HIEs, and establishing ADT processing infrastructure at the statewide level, which can be utilized by all the state's HIEs and other entities connected to THSA's hub.

Once THSA receives an ADT message, it will utilize its integration engine to create a standardized notification message comprised of core data elements such as the patient's name, hospital providing service and date/time of when the admission, discharge or transfer occurred. These notifications will then be forwarded to Texas Medicaid, MCOs and/or to HIEs that have partnered with Medicaid to use notification data for care coordination activities.

Texas Medicaid will direct funding toward obtaining timely encounter notifications via HL7 ADT data streams from hospitals. Other states have shown beneficial effects of providing alerts to PCPs and other care team members when a patient enters an ED. Texas Medicaid seeks to reduce inappropriate ED use, by educating patients on non-emergent ED alternatives, and provide improved follow-up care to reduce the need for individuals to re-visit an ED. Gathering timely ADT data from EDs and publishing alerts to care team members will facilitate these goals.

HHSC aims to build ADT processing infrastructure complementing HIE notification systems, but on a standardized, statewide scale. The systems implemented by THSA will act solely as a data brokerage, supplying encounter notifications based upon patient matches found in ADT data-streams submitted by hospitals.

This EDEN strategy is complemented by the HIE IAPD Strategy 1, which provides funding for Local HIEs to connect hospitals, enabling the exchange of HL7 clinical data feeds necessary for EDEN.

Clinical Data and the Integration and Data Exchange Center of Excellence

DSHS, in partnership with HHSC, has been exploring a strategy to establish an Integration and Data Exchange Center of Excellence (iCoE) technology service as a primary point of exchange between Texas' state-level health and human services agencies and healthcare providers, MCOs and other entities. Incorporating a commercial-off-the-shelf integration engine, the iCoE currently supports the exchange of select public health data, such as syndromic surveillance, and will evolve to support the exchange of data for a broad range of systems operated by Texas' health and human services agencies, including data from the EDEN system at THSA, data from the state's local mental health authorities and data for additional registries and information systems operated by DSHS. The intention of the iCoE is to be flexible, enabling the exchange of data either through HIEs or directly between healthcare providers and state agencies. The system allows state staff to route messages to the appropriate receiving system(s), transforming messages into the appropriate formats and supporting real-time FHIR-based connections.

THSA is a primary connection point for the iCoE, supporting HHSC's receipt of statewide clinical data from Medicaid providers linked to HIEs that are connected to HIETexas. HHSC may leverage the capabilities of the iCoE for anticipated large volumes of clinical data transmitted from Medicaid providers including ADT data, other clinical data and lab reports for Medicaid clients.

DSHS is transforming its information systems to use the iCoE. As each DSHS system that relies on data exchange with external systems is replaced or undergoes a major overhaul, the iCoE is reviewed as part of the IT governance process. Concerns about using the iCoE include funding and the time required to modify commercial-off-the-shelf systems to use its service. Some systems are not modular and may be complicated to integrate with the iCoE.

Health IT Topic: Accountable Oversight and Rules of Engagement for Health IT and Health Information Exchange (a.k.a. Governance)

Health IT governance facilitates the appropriate use and secure exchange of health information in Texas. Enacted through policies, processes and practices, the state has instituted a set of governance bodies that offer guidance, establish standards and provide oversight for public and private entities operating in the Health IT space. The following section describes the roles and responsibilities of these organizations.

Texas Health Services Authority

THSA, established by the Texas Legislature, with Chapter 182 of the Health and Safety Code, operates a set of shared services called HIETexas, has a governance structure that enables trusted and secure connections between it and the Local HIEs and may connect to national networks such as the e-Health Exchange, Carequality and/or Commonwell. It requires its participant members to operate in accordance with privacy and security rules that are aligned with Health Insurance Portability and Accountability Act (HIPAA) and other relevant federal and state statutes and rules. THSA's governor-appointed board is responsible for decision-making with regards to the policies and operations of the shared services THSA provides to its members. The board intends to regularly review performance and utilization reports to ensure services align with the needs of the Texas Health IT ecosystem. The Local HIEs, HHS agencies and members of the healthcare community are represented on the THSA board. The THSA Texas State HIE Plan details more about the THSA structure, plan and HIETexas..[7]

[7] *Texas State HIE Strategic Plan* accessed July 18, 2019 at: http://www.thsa.org/hie/state-hie-plan/

For statewide activities, HHSC and DSHS are active participant members on the board of the THSA. The HHS system has an internal policy for the exchange of clinical data to use when applicable national standards are identified by the ONC, ensuring compliance with state and federal laws and rules. Internal HHS policy also permits information systems procured, planned or built after September 1, 2015 that exchange clinical data with providers to enable pathways through state and Local HIEs, minimizing the number of connections a provider is required to use for exchanging data with HHS agencies.

The Local HIEs also have a governance structure. Each of the Local HIEs are overseen by a board that approves their policies and procedures and reviews their operations. Participant users must also demonstrate and agree to abidance of privacy and security rules.

This governance structure is critical as Texas navigates toward the U.S. Core Data for Interoperability (USCDI) and its proposed expansion process aims to achieve the goals set forth in the 21st Century Cures Act by specifying a common set of data classes that are required for interoperable exchange and identifying a predictable, transparent and collaborative process for achieving those goals.

The 21st Century Cures Act contains several requirements aimed at improving interoperability in healthcare and information exchange. As the use of the Trusted Exchange Framework and Common Agreement (TEFCA**)** expands, more states have the opportunity of working together to meet national interoperability initiatives and standards. As states join into interoperability partnerships, governance becomes more critical as the foundation for decision making and strategic direction.

e-Health Advisory Committee

In 2009, the Texas Legislature established the Electronic Health Information Exchange System Advisory Committee to implement HIEs in Texas (HB 1218, 81st Legislature, Regular Session). In 2015, after an agency-wide restructuring of advisory committees, the eHAC was established to advise HHS leadership on activities that could advance Health IT adoption and use in Medicaid. Members of eHAC include healthcare stakeholders from the academic, industrial and medical professions, as well as other state agencies, health information exchanges and professional associations.

A key objective of eHAC is to ensure Medicaid Health IT is interoperable with broader statewide infrastructure. To this end, eHAC counsels HHSC on the development and implementation of the HIE system and related issues, including: data to be included, presentation of data, useful measures for quality of services and patient health outcomes, federal and state laws regarding privacy of private patient information, incentives for increasing adoption and use and data exchange with HIEs.

Past eHAC recommendations include the following:

- Incorporate the ONC's Patient Unified Look-up System for Emergencies (PULSE) into the state's disaster response protocols;
- Use of the HIETexas platform, when applicable, to communicate and collaborate with trading partners and HIEs to increase Health IT adoption and use among providers;
- Enable provider access to the state's prescription drug monitoring program through HIEs to help combat the opioid epidemic;[8] and

[8] In Texas, the Prescription Monitoring Program (PMP) is managed by the Texas Board of Pharmacy.

- Adopt additional communication methods based on stakeholder surveys and research ofthe constituent groups' messages.

HHSC's internal governance structure also considers eHAC input in the decision-making process regarding Health IT products, including telemedicine, telehealth and home telemonitoring.

The Office of eHealth Coordination (OeHC)

OeHC was established in 2010 to serve as the single point of contact in HHS for health information policy and state funding opportunities under the HITECH Act.

Currently, OeHC coordinates health technology initiatives that exchange protected health information across the HHS system and promotes the use of CEHRT in discussions across the state with healthcare stakeholders.

HHS Enterprise Data Governance

HHS agencies follow a data governance policy implemented by the Chief Data and Analytics Officer (CDAO). The CDAO leads the Center for Analytics and Decision Support and resides within the Office of Performance division. In addition to being responsible for general data and analytics strategies implemented at HHS, the CDAO runs the Enterprise Data Governance (EDG) program, which identified five project tracks to implement Medicaid-focused data governance solutions.

The following table lists and describes the various tracks:

EDG Track	Purpose
Data and information management (DIM)	The DIM track is to implement an enterprise master data management (MDM) system for use across the Health and Human Services (HHS) system.
Data quality and standards (DQS)	The DQS track, which includes claims, encounter and clinical data, ensures that the HHS system can measure the data quality within key HHS systems and make necessary recommendations to improve data quality through the creation of data standards.
Metadata and reference data management (MRDM)	The MRDM track alleviates challenges arising from different standards, definitions and reference codes by collecting information from disparate source systems and storing that information in a centralized repository.
Data architecture	The data architecture track ensures key Medicaid-focused data domains are identified, defined and managed appropriately within the HHS system.
Data and information controls (DIC)	The DIC track is responsible for the identification, definition, creation and implementation of various controls and metrics. It also identifies and monitors various data controls like data security and data access.

Texas HHS also partners with academic institutions, such as Dell Medical School to leverage expertise available to help expand HHS's ability to analyze data.

Health IT Topic: Identity Management, Provider Directories and Attribution

The ability to accurately and irrefutably identify the Medicaid community – both providers and members – is essential to ensuring the right services are delivered to the right individual at the right time. Denying an individual Medicaid services because of inaccurate information presents risks and unnecessary hardships to those the state is committed to serve. Additionally, the availability of location and contact information for Medicaid services providers is essential to all facets of care delivery.

The Texas HHS strategy to mitigate these risks is to make the best information easily accessible on member eligibility and provider locations on platforms and media used by Medicaid clients and healthcare providers.

Eligibility as a Service

Eligibility as a Service (EaaS) is a web service implemented at the Texas Medicaid claim administrator's, Texas Medicaid Healthcare Partnership (TMHP), website. This near real-time Medicaid eligibility service enables MCOs' and providers' systems to obtain access to a Medicaid member's current eligibility status. Access to eligibility information ensures MCOs' and providers' decisions are based on the most current eligibility information available. This minimizes the likelihood of a client being incorrectly denied services and assures providers reimbursement for the services provided to a client. The EaaS service is also interfaced with the TMHP client portal, TexMed Client Portal, which enables members to obtain access to their history and eligibility information in near real-time. Providers also use this portal to obtain access to clients' claims data, which is helpful when dentists or physicians are seeing patients for the first time and require relevant history prior to performing tests or procedures.

The EaaS web services uses the Texas Integrated Eligibility Redesign System data to produce a HIPAA compliant X12 standard-based client eligibility query and response electronic data interchange. HHS is using the near-real time accuracy of the data to incentivize its stakeholders to use the web services instead of older format, legacy eligibility information which is updated less frequently. To date, many of the high-volume users, including the behavioral health system used by many of the state's providers, have converted to the EaaS web service. HHS continues to work with its stakeholders as they adapt their systems to the EaaS format.

EaaS is also used by the HHS/DSHS Data Integration and Exchange Platform. Using EaaS, DSHS can identify the state laboratory's test results belonging to Medicaid-eligible clients. The results are sent to Medicaid and used to update the appropriate health information records.

Provider Directories

HHSC is in the process of implementing a Provider Management and Enrollment System (PMES) for provider enrollment and management. PMES is fully compliant with all state and federal laws, including but not limited to the Patient Protection and Affordable Care Act; 42 Code of Federal Regulations (CFR) 455; SB 200, 84th Texas Legislature, Regular Session, 2015, requiring the state to consolidate and streamline its provider enrollment and data management processes; the 2016-17 Texas General Appropriations Act (HB 1, 84th Legislature, Regular Session, Article II, HHSC, Rider 95); and SB 760, 84th Texas Legislature, Regular Session, 2015, regarding provider credentialing and monitoring.

The implementation of a PMES modernizes, streamlines, consolidates and advances the Provider Enrollment and Provider Management activities and supports electronic signatures and attachments. PMES is a cornerstone of the MMIS modernization process. The PMES solution replaces multiple paper and online enrollment applications with a single online application and provides the ability to manage,

correspond, track, monitor and report on all aspects of provider enrollment, disenrollment, re-enrollment, revalidation, inquiry and maintenance of Medicaid providers and any additional non-Medicaid providers currently within the scope of operations supported by the Medicaid program. The system will utilize the National Provider Identifier fully. Implementation includes an Online Provider Directory with information on HHSC Medicaid providers classified by type, specialties, credentials, demographics and service locations. The system is scalable and can be expanded to include attributes and information needed to support the management of providers across the HHS system in the future. Other benefits include:

- Lowers provider frustration by offering one place to enroll in all HHS programs;
- Improves the accuracy of provider location information and network adequacy metrics;
- Provides the capability to access comprehensive data needed to effectively monitor providers;
- Delivers a centralized provider repository that aligns with the ongoing data governance provider efforts and streamlines provider enrollment and management processes; and
- Secures efficient and effective business functionality and processes in support of Texas providers, clients and medical, dental and pharmacy benefit programs.

PMES will serve as the authoritative Medicaid provider information source for the master provider index under development by the Enterprise Data Governance project. Future PMES deployments will integrate the remaining HHS provider groups with the implementation of additional HHS program requirements.

Patient and Provider Master Indices

HHS currently has an IAPD with CMS to implement master data, metadata improvement and data quality controls. HHS has already implemented a Medicaid provider and member master data system to resolve identities across a variety of HHS systems.

As standards-based clinical data sources from provider EHRs are made available through the iCoE, these mastered records will be updated to assist in matching clinical records. Master records will also assist data analytics teams in creating connections to services data for ad hoc analytic uses. They are also foundational for development of future analytics architectures that could be capable of longitudinal views or aggregate groupings of the data (e.g. by care episodes or cohort types).

A Medicaid master provider record has been published for enterprise consumption in Fiscal Year 2019. These mastered records are easily extensible for use in managing clinical records as they arrive at HHS. A Medicaid master member record has also been implemented and is scheduled to be published for internal use in Fiscal Year 2020. These mastered records can also be extended for use as a master patient index to coordinate consumption of electronic health records or messages, as those become available to HHS.

Health IT Topic: Promoting and Funding Provider Health IT Adoption and Use

The Health IT adoption strategies build on Texas' Health IT ecosystem by increasing the number of connected Medicaid providers, expanding the HIE network and establishing a single state-designated connection point for the secure exchange of clinical data with Texas HHS, MCOs and national networks. It is critical to solidify a pathway that can be shared across the state and with Medicaid for the receipt of clinical data.

Medicaid MCO and Dental Contractor HIE Participation

In August 2016, HHSC polled the 19 Medicaid MCOs and two Medicaid dental contractors about their participation in health information exchange. With respect to health information exchange, 4 of the 19 healthcare MCOs, or 21 percent, indicated they exchanged member health information with a health information organization. Among the 79 percent who did not exchange member health information, several gave reasons including concerns over privacy and HIPAA compliance. Other responses included that the MCO lacked exchange access in their service area or that the limited functionality of the exchange in their service area did not warrant participation.

Seven of the 19 healthcare MCOs, or 37 percent, responded that they or their network providers receive or share patient encounter alerts or raw HL7 ADT messages upon which these are based. Five of the 19 healthcare MCOs, or 26 percent, indicated their network providers receive alerts after patients are admitted to hospital emergency departments.

The two dental contractors did not participate in HIEs.

DSRIP Provider Health IT Adoption and Use

As part of DSRIP semi-annual reporting in 2017, DSRIP providers were required to respond to questions relating to the extent to which they participated in health information exchange with other providers and organizations, the types of information shared and factors impacting their participation. Of the 297 DSRIP providers, 55.6 percent indicated they exchanged data, such as claims and clinical information, related to their DSRIP projects. However, about 17 percent of all DSRIP providers indicated that they used manual data exchange processes (e.g., fax and email). Only 22.6 percent of DSRIP providers indicated they participated in a formal HIE related to their DSRIP projects. Of those, 56.7 percent participated in one of the public, Local HIEs. The remaining 43.3 percent either participated in a private (e.g., hospital system HIE) or an interoperable vendor HIE that allows all providers using the same EHR vendor platform to exchange information.

The most common obstacle the providers identified to participating in the exchange of health-related information was lack of technology. Many of the providers operate in the “white space” where no HIE is available. The second most common obstacle was the cost of technology. Additionally, several providers indicated there were “other” barriers, with the most common “other” challenge being a lack of compatibility and interoperability across HIE systems.

Medicaid Electronic Health Record Incentive / Promoting Interoperability (PI) Program

In Texas, EHR use has climbed to rates close to those of national levels. The Texas Medical Association reports that over 85 percent of physicians are using EHRs in their daily practice.. [9]

Texas’ Medicaid EHR Incentive/PI Program is a federal program administered by HHSC which provides incentives to eligible professionals and eligible hospitals participating in Medicaid. The incentive payments, via 100 percent federal funds, are provided for the adoption and subsequent meaningful use of CEHRT. Providers report on PI/meaningful use and clinical quality measures established by CMS. One

[9] Texas Medical Association 2018 Survey of Texas Physicians: Research Findings. Accessed September 26, 2019 at: https://www.texmed.org/uploadedFiles/Current/2016_Advocacy/2018_Final_Survey_Report_v2_3_14_19.et_FINAL.pdf

limitation of the program cited by providers is that certain provider types were not eligible for the incentive funds per federal regulations.

Texas' EHR Incentive/PI Program has provided almost 11,000 Medicaid providers with financial resources to implement electronic systems. Projected outcomes include:

- more accurate and complete information about a client's health, which allows them to deliver more quality care;
- decreases in fragmented care across care coordination teams, which is important for managing chronic and serious medical conditions;
- secure information sharing with clients electronically, allowing for more client engagement in decisions regarding their health; and
- timely information to help diagnose health problems sooner, reduce medical errors and provide safer care at potentially lower costs.

As of September 1, 2019, the program had disbursed over $864 million federal incentive dollars to 10,472 eligible Medicaid professionals and 343 hospitals. Texas providers have attested to 200 different CEHRT products. The top 20 CEHRT products nationwide are used by 77 percent of Texas program participants.

Eligible Professionals and Eligible Hospitals Achieving Meaningful Use Stage 1 (MU1) and Incentives Paid as of September 1, 2019

	Provider Count	Provider Count Achieving MU1	MU1 Achievement Percent	Incentives Paid
Eligible Professional	10,472	5,160	49.3%	$332,554,171
Eligible Hospital	343	313	90.5%	$532,081,350
Total Incentives Paid				$864,635,521

HIE IAPD Strategy 1: Medicaid Provider HIE Connectivity

HIE IAPD Strategy 1 is intended to assist Local HIEs with connecting to ambulatory providers and hospitals in their respective areas, including by reimbursing Local HIEs for connectivity costs incurred during the connection process. This strategy will build the critical mass of connected providers needed to create meaningful exchange of clinical data across Texas.

This HIE Connectivity strategy enables Local HIEs to transmit data through a set of state-level shared services made available to each local network by the Texas HIE platform. This model enables electronic exchange of clinical data among providers as well as with Texas Medicaid for better care coordination benefiting Medicaid patients.

HHSC recently concluded an open enrollment process to solicit Local HIEs for participation in this program. These activities continue through federal Fiscal Year (FFY) 2021. Funding allocated to Local HIEs through the enrollment process is a deliverable-based model, with the deliverables demonstrating

connections result in active transfer of CDA-based[10] or ADT-based clinical data to state Medicaid and between Medicaid providers.

Funds are targeted toward offsetting the cost HIEs absorb when establishing new connectivity for providers, are paid on a per provider basis and are based upon the type of connectivity for which a Local HIE requests reimbursement. Providers are responsible for their ongoing costs.

Responses to the open enrollment will include each Local HIE's average cost of connecting providers and hospitals to their HIE for the purposes of this program. Costs provided by the Local HIEs must be approved by HHSC prior to awarding contracts for connectivity implementation. Local HIEs must demonstrate the costs presented are comparable to their existing connectivity cost model and are aligned with current industry norms.

HIEs must demonstrate their technical readiness to establish EHR connectivity, including the capability of delivering CDA Transition of Care (CDA ToC) documents to Medicaid and the capability of enabling query-based exchange of those Transition of Care documents across the network to other Medicaid providers.

Locall HIEs accepted into this program conduct business with Texas Medicaid by submitting the Medicaid Practice Onboarding Form for each Medicaid provider the HIE proposes to connect. This onboarding form provides Medicaid with the ability to ensure the provider for which connectivity is being proposed meets the eligibility criteria of the program. The Onboarding Form provides assurance that the HIE has the capability to connect the provider in a manner that meets the technical standards and program timelines set forth for the program. To ease the burden of HIEs in financing the expenditures involved in connecting providers, HIEs may elect on the Onboarding Form to apply for up-front payment of 20 percent of the approved cost of connecting the provider. HIEs will invoice HHSC per connection.

Incenting Provider HIE Participation through Low-Cost Connection Model

Texas Local HIEs are working to address the barriers faced by all levels of providers in connecting to the Health IT ecosystem. In El Paso, the Paso Del Norte Health Information Exchange (PHIX) is working one-on-one with providers to get their CEHRT connected. El Paso has many veterans whose visits to the U.S. Department of Veterans Affairs (VA) require them to provide their health histories. If PHIX HIE was connected to their PCP, this information could be provided to the VA using a database query. Without these connections, veterans are required to bring a paper copy of their health histories.

With PHIX's HIE vendor, each new connection required significant upfront costs for both the provider and HIE, as well as significant ongoing costs for providers. This is especially true for small practices. PHIX researched options for obtaining vendor integration services at more reasonable pricing. In 2018, PHIX concluded that using an open-sourced version of MIRTH to connect to the front-end of their HIE and using PHIX staff to solution the secure infrastructure and connectivity was the most economical approach. This solution, priced on a sliding scale based on the size of the practice, implements routine transmissions of standards-based clinical data C-CDA transactions to PHIX. To date, this solution has worked for three Federally Qualified Health Centers and one Local Mental Health Authority. Plans are in

[10] "CDA-based clinical record" is defined as the C-CDA Transition of Care document referenced in Promoting Interoperability and 2015 EHR Certification Final Rule published by CMS, conforming to the requirements and standards referenced at 45 CFR §170.315(b)(1)(iii)

the works to expand this solution to 10 additional provider locations with less than 5 physicians by January 2020.

This interoperable information exchange between healthcare providers serving the same veteran has improved services for patient, payer and provider with costs at a fraction of commercial prices. This approach is being shared among the HIEs in Texas as way to overcome the cost barrier.

Model for Data Exchange with Community-Based Providers

HHSC has been selected for CMS' Maternal Opioid Misuse Model (MOM) grant program, which requires the ability to exchange EHRs across a participant's caregiver community that includes both Medicaid and non-Medicaid services. The HIE Connectivity Project, Strategy 1 of the HIE IAPD discussed in the prior section, provides the data exchange capabilities needed for Texas Medicaid to participate in innovative care models like the MOM program.

Community-based caregivers connected to a HIE can access and update patient records for services provided outside of the typical healthcare setting. The clinical data in combination with the claims and encounter data Medicaid already receives would enable data analytics teams to identify and assess member populations' healthcare costs and outcomes required for program oversight and reporting needs. This not only meets the requirements for the grant participation but serves as a model that can be extrapolated across the state.

Health IT Topic: Advancing the Use of Health IT to Support Quality Measurement

The ability of the Texas Medicaid Managed Care Program to transition to value-based payment and pursue meaningful healthcare quality improvement goals depends crucially on the availability of performance metrics that can reliably and consistently measure progress across all aspects of the program. These measures should leverage established data standards and consensus specifications to advance the aims endorsed by the National Academy of Medicine (formerly the Institutes of Medicine) in *Crossing the Quality Chasm*[11] that care should be safe, effective, patient-centered, timely, efficient and equitable. Within the Texas Medicaid managed care program, all major initiatives focused on improving quality and building value begin with data and center on measurement (see Appendix B for a description of the Texas Medicaid Value-Based Initiatives).

Despite this commitment to data driven decision-making, Texas Medicaid, like nearly all healthcare organizations, has opportunity for improvement. A recent review by the state's Value-Based Payment and Quality Improvement Advisory Committee, a multi-disciplinary panel of experts and healthcare industry leaders established by the Executive Commissioner of HHSC to help shape the direction of the APMs and other value-based initiatives in Medicaid, found that a significant amount of data is potentially available to support healthcare quality. This panel, however, found "that doesn't mean that HHSC, its contracted health plans and their network providers always have the information necessary to provide high-value, coordinated care. HHSC must have informative data –- both clinical and administrative -– to guide the program, and health plans and providers must have access to timely, trusted information as a foundation for engaging in value-based payment arrangements."[12] Ultimately, according to the advisory

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[11] *Crossing the Quality Chasm: A New Health System for the 21st Century*. Institute of Medicine (US) Committee on Quality of Health Care in America. Washington (DC): National Academies Press (US); 2001.

[12] Texas Value Based Payment and Quality Improvement Advisory Committee (2018). *Recommendations to the 86th Texas Legislature: Opportunities to Advance Value-Based Payment in Texas.* Accessed July

committee, to fully implement effective value-based and quality improvement initiatives, the HHS System and Medicaid Program will need an informatics strategy that enables near real-time learning and incorporates both clinical and administrative data into robust measures of performance. These next generation informatics tools increasingly will guide decisions at every level, from state policy maker to clinician to individual patient.

To support this emerging emphasis on analytics, best practice and patient empowerment, HHS is working to bring analytics that include both clinical and administrative data to the forefront of healthcare quality measurement and improvement. Clinical data refers to the information derived from the medical interaction between a provider and a patient, including: medications, allergies, problem list, physical examination findings, laboratory and results from other diagnostic testing. Integrating this data with existing administrative or claims data submitted to document healthcare reimbursements promises to broaden the possibilities for successful value-based payment and quality improvement initiatives.

Over the past two decades, analytics based on administrative data have evolved to more reliably measure fidelity to recommended processes of care, i.e., whether a patient received appropriate services. However, in a value-based environment, measures used for decision making, quality improvement and payment must look beyond process to consider outcomes, the prevention and control of disease, as well as environmental and behavioral risks for poor health.

For example, as value-based payment and quality improvement systems become more advanced, indicators recommended by experts through organizations such as the National Quality Forum to identify high achievement in a field such as diabetes care generally look something like the following:

- A patient's most recent HbA1C in the measurement period has a value < 8.0;
- The most recent blood pressure in the measurement period has a systolic value of < 140 and a diastolic value <90; and
- The patient is currently a nonsmoker.

While claims are suitable for identifying a population of individuals with diabetes and some basic measures of quality, clinical and health risk data such as blood pressure control and tobacco use are needed to truly understand and improve the effectiveness of care delivery. Moreover, the near real time availability of electronically exchanged clinical data will significantly accelerate the time horizon for clinical and evaluative decision-making, expanding the possibilities for rapid-cycle improvement approaches.

Ultimately, individuals and the public will benefit from the timely computation, analysis and reporting of enhanced quality indicators based on combined clinical and administrative data because it paves the way to a more accountable, learning healthcare system.

HHSC began assessing payment methodologies between MCOs and providers beginning in 2012. These early reviews indicated that while MCOs received capitated premiums from HHSC and generally operated in a value-based environment, they still predominantly reimbursed providers using a fee-for-service approach, thus maintaining incentives for volume over value in the payment model.

To help promote transformation to a Medicaid system that rewards the achievement of good patient outcomes at lower cost, HHSC created contractual targets for MCOs to link a portion of provider

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18, 2019 at: https://hhs.texas.gov/sites/default/files/documents/about-hhs/communications-events/meetings-events/vbpqi/jan-2019-vbpqi-agenda-item-6.pdf

payments to value using APMs starting in calendar year 2018. APMs are value-based contracting models where providers assume increased accountability for both quality and total cost of care. The term is often used synonymously with value-based payment (VBP) but may also refer to a more systematic approach to VBP where APMs exist along a continuum with progressively greater emphasis on the management of a population (e.g. shared savings, bundled payments and capitation). MCOs must meet targets both for overall value-based payment and for risk-based APMs. If an MCO fails to meet the APM targets or certain allowed exceptions for high performing plans, the MCO must submit a corrective action plan and HHSC may impose contractual remedies, including liquidated damages.

APM Contract Targets with Providers

Year	Overall Target	Risk Based Target
2018	25% of medical expense in a VBP model for MCOs and dental contractors (DCs)	10% of medical expense in a risk based VBP model for MCOs; 2% for DCs
2021	50% of medical expense in a VBP model for MCOs and DCs	25% of medical expense in a risk based VBP model for MCOs; 10% for DCs

The APM initiative, which aligns with the nationally recognized framework established by the Health Care Payment Learning and Action Network,[13] has already seen some initial progress at aligning payment with value. As of the beginning of 2018, even before the effective date of initial contractual targets, about 40 percent of MCO payments to providers for medical services has migrated to a value-based model.

Electronic clinical quality measures (eCQMs) help to measure and track the quality of healthcare services, based on data generated by a provider's EHR. The availability of clinical metrics will strengthen opportunities for MCOs and providers to adopt more powerful APMs that move closer to population-based payment. The state also sees potential for these measures to help reduce any administrative complexity associated with the changing payment model.

Administrative complexity lowers provider productivity, satisfaction and diverts energy and resources that otherwise could go toward improving patient care. The Value-Based Payment and Quality Improvement Advisory Committee plans to devote a significant portion of its upcoming work on ideas to harmonize VBP approaches, including by recommending common outcome measures for use in APMs. Standardized eCQMs will be considered as part of these deliberations and should support administrative simplification related to the APM initiative.

Federal and state law for Medicaid Managed Care require ongoing reporting on MCO performance, as well as continuous quality improvement. The electronic exchange of data and availability of robust clinical quality measures will invigorate these current efforts. The state's External Quality Review Organization (EQRO) routinely assesses quality, timeliness and access to healthcare for Texas Medicaid and CHIP

[13] Health Care Payment Learning & Action Network. *Alternative Payment Models (APM) Framework*. July 11, 2017. Accessed July 18, 2019 at: https://hcp-lan.org/apm-refresh-white-paper/

recipients. [14] Metrics reported by the EQRO are used for several critical purposes to promote quality improvement and value, including the development of report card ratings for individual health plans. In addition, the EQRO plays a central role in facilitating MCO Performance Improvement Projects (PIPs). Each health plan is required to conduct two, two-year PIPs per Medicaid program.

At least one of these projects must be collaborative, involving another MCO, DSRIP providers and/or community-based organizations. PIPs typically follow a recognizable quality improvement (QI) cycle encompassing root cause analysis, baseline measurement, intervention, remeasurement and assessment.

Recent projects have covered priority QI topics such as improving control of asthma and high blood pressure and reducing potentially preventable hospital and emergency department admissions, all areas that intersect with eCQMs.

Health IT Topic: Health IT and Service Delivery

Health IT presents the opportunity to improve service delivery through a variety of mechanisms. It is a major tool to facilitate improved coordination and integration between Medicaid providers, including physical health, behavioral health and home- and community-based services providers. Beyond coordinating delivery of traditional healthcare services, Health IT can facilitate engagement of community-based organizations that deliver services addressing the social drivers of health, such as food insecurity, housing and transportation issues. Obtaining measurable, actionable data is at the heart of value-based care models. Quantitative and qualitative data analysis to assess performance against meaningful outcome measures identifies where the health system can deliver value. Further, tools such as telehealth and telemedicine are critical in supporting health system goals, such as achieving provider network adequacy in Texas' vast rural regions.

Care Coordination under the Managed Care Delivery System

To address their care needs comprehensively, patients often require multiple touchpoints within a single provider's care team or must be seen by multiple provider types across the spectrum of physical health, behavioral health and home- and community-based services providers. Further, as the complexity of a patient's needs increases, so does the potential for medical errors, duplication of services and unnecessary tests. To compound this complexity, the ability of a patient to achieve optimal health outcomes may be intertwined with medically relevant non-clinical factors, such as access to adequate housing, transportation and social supports.

One of the promises of Medicaid managed care both in Texas and across the nation is to optimize care coordination. The long-term pathway to the most effective care coordination would include providers using EHR technology to integrate all relevant patient care information and distribute that information effectively among authorized providers..[15]

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[14] Institute for Child Health Policy (2018). *Summary of Activities and Value-Added Services State Fiscal Year 2018: Quality, Timeliness, and Access to Health Care for Texas Medicaid and CHIP Recipients*. Accessed July 18, 2019 at: https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2019/eqro-summary-of-activites-report-contract-yr-2018.pdf

[15] https://www.healthit.gov/topic/health-it-basics/improve-care-coordination

Findings of a study directed by the 2018-19 Texas General Appropriations Act,[16] which required that HHSC conduct a review of the agency's contract management and oversight for Medicaid managed care contracts, further supports the role of Health IT in care coordination. The Rider 61 report acknowledged that the HIE Connectivity Project was introduced with "the primary objectives of advancing care coordination through increased HIE adoption and use by Texas Medicaid providers and creating additional capacity in Texas that can support that use and adoption."[17]

Consistent with Rider 61, HHSC developed several focused initiatives for improving Medicaid managed care oversight, including an initiative to make improvements related to service and care coordination within managed care. HHSC's Managed Care Oversight Improvement Initiative related to care coordination and service management intends to:

- analyze other state Medicaid programs to assess best practices for care coordination within Texas' managed care programs;
- address any state-level barriers that hinder MCO delivery of care coordination services;
- simplify terminology and clarify definitions of service coordination and service management activities across product lines; and
- identify possible improvements to ensure service coordination and service management is consistent within HHSC contract requirements.

Within these initiatives is the opportunity to assess how Health IT and HIE can overcome barriers to care coordination and service management and identify opportunities for improvement in the contract requirements within Texas' Medicaid managed care models. For example, there could be an assessment of the clinical information exchanged between HHSC, MCOs and Medicaid providers and requirements for how information is conveyed from MCOs to their staff who serve care coordination functions.

Medicaid MCO and Dental Contractor (DC) Portals

MCO and DC portals present the opportunity to empower providers with information to effectively coordinate member care and provide members with the information to understand their health and better advocate for their needs.

In August 2016, HHSC polled the 19 Medicaid healthcare MCOs and two Medicaid dental contractors about their portal capacity. MCOs were asked about the data that network providers could access as well as the types of data that MCO members could access. More MCOs made health data about members available to network providers than to the MCO members themselves. Only 8 of the 19 MCOs made data about the primary categories of health data about which the MCOs were polled (claims-based data, prescription history and clinical data) available to MCO members. These portal poll results follow:

[16] SB 1, 85th Legislature, Regular Session, Article II, HHSC, Rider 61(b)
[17] HHSC. *Rider 61: Evaluation of Medicaid and CHIP Managed Care,* August 17, 2018. Accessed July 18, 2019 at: https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2018/sb1-rider61-evaluation-medicaid-chip-august-2018.pdf

Information Accessible to MCO Network Providers about their Clients via MCO Portal

Response	Claims-based Data (e.g., diagnosis and procedures)	Prescription History	Clinical Data (e.g., lab results and immunizations)
Yes	84%	32%	32%
No	16%	68%	68%

Information Accessible to MCO Members about their Health Data via MCO Portal

Response	Claims-based Data (e.g., diagnosis and procedures)	Prescription History	Clinical Data (e.g., lab results and immunizations)
Yes	11%	42%	16%
No	32%	0%	26%
N/A	58%	58%	58%

Both DCs had a portal that enabled network providers to see their clients' claims-based data, but not prescription history or clinical data. Also, neither of the DCs had a member portal that shared health data as of August 2016, though one of the DCs indicated they were about to launch their member portal that would enable members to view their claims, including which procedures they had.

Advances in the sophistication of MCO and DC portals has occurred since 2016, presenting an opportunity to reassess current portal capabilities and identify if any improvements could be made to portal-related managed care contract requirements.

Health IT in DSRIP

Many of the most transformative types of DSRIP projects, including integrating physical and behavioral healthcare, patient-centered medical homes, chronic care management and patient care navigation, fundamentally benefit from the timely exchange of accurate health data. DSRIP has incentivized providers to implement Health IT tools and build local data-sharing relationships that enhance care transitions, care coordination and health system navigation. Further, DSRIP has motivated providers to build internal Health IT infrastructure as well as connect to external data sources to elevate data-driven decision-making, conduct more meaningful performance measurement and engage in continuous quality improvement. Finding ways to sustain and expand upon the successful use of Health IT in DSRIP is a critical component of DSRIP transition planning for when program funding ends October 1, 2021.

Emergency Department Encounter Notification System

HHSC's EDEN system, discussed in greater detail in this plan's Health IT Ecosystem section, implements a major tool for handling care transitions with the transmission of ADT information to MCOs, providers and the state. This is the first step in Texas Medicaid's use of clinical data to facilitate care coordination.

EDEN is implemented utilizing push technology which is recognized as the preferred method for sending electronic notifications. Push technology is a recently added exchange modality in the TEFCA proposed by the ONC.

Telemedicine/Telehealth

Telemedicine and telehealth are part of the larger Texas strategy to deliver services in a more efficient, innovative way and enhances network adequacy, including in rural areas. Telemedicine services are defined in Texas law as healthcare services delivered remotely to a patient by a physician, or other healthcare professional under physician delegation and supervision.

It has the potential to offer convenient access to routine care for Medicaid clients who might otherwise be unable to receive in-person services. Using telemedicine, physicians and other healthcare providers can receive supervision and guidance on patient care from specialty-care physicians. Telemedicine can improve both the access and quality of care.

Telehealth services are defined in state law as healthcare services delivered remotely to a patient by a healthcare practitioner who does not deliver telemedicine services. In practice, this means that telehealth services are non-physician delivered services. Licensed professionals such as counselors, midwives and dieticians can deliver telehealth services.

The number of Texas Medicaid clients using telemedicine and telehealth services grew 30 percent from Fiscal Year 2016 to Fiscal Year 2017. The number of providers offering these services increased 32 percent during that same period. Texas Medicaid's spending on telemedicine, telehealth and telemonitoring services nearly doubled, from $9.6 million in Fiscal Year 2016 to $18.4 million in Fiscal Year 2017. The spending increase is primarily due to a significant uptick in the use of home telemonitoring services. Home telemonitoring services, also referred to as remote patient monitoring, are the scheduled review of a client's transmitted clinical data. Types of clinical data include blood pressure and blood glucose measurements.

Telemedicine and Network Adequacy. State and federal laws require that MCOs meet travel time and distance standards, which measure access to care on a quarterly basis for 35 provider types in all 254 counties in the state. Medicaid is considering how to count telemedicine and telehealth services toward meeting travel time and distance standards.

Telemedicine in Rural Areas. Texas' strategy to address rural healthcare shortages includes telemedicine. Among Texas' 254 counties, 189 counties, in mostly rural areas, are at least partially designated as a primary care Health Professionals Shortage Area (HPSA).[18] Finding efficient, patient-centered approaches to deliver high-quality healthcare services to underserved rural regions is a critical issue for Texas. Telemedicine programs can enhance the viability of rural hospitals through the provision of specialized medical services.

Over the course of several legislative sessions, Texas has been expanding the options for Texas providers to engage in telemedicine in ways that address access concerns in rural areas. For example, in 2017, the Texas Legislature created a new pediatric tele-connectivity grant program to provide funding to non-urban healthcare facilities to obtain telemedicine services from pediatric specialist physicians (HB 1697, 85th Legislature, Regular Session, 2017). The grant program will enable facilities that lack

[18] Health Resources & Services Administration. Health Professional Shortage Areas (HPSAs). https://bhw.hrsa.gov/shortage-designation/hpsas

advanced neonatal intensive care unit capabilities to make appropriate and rapid medical decisions for the care of their newborns. In 2019, the Texas Legislature passed legislation enabling satisfaction of physician requirements for Level IV trauma facility designation in counties with populations less than 30,000 using telemedicine (HB 871, 86th Legislature, Regular Session, 2019). Also, in 2019, legislation was passed to further clarify the array of Medicaid services available for telemedicine reimbursement under Medicaid managed care (SB 670, 86th Legislature, Regular Session, 2019).

HIE and Emergency Medical Services

Texas HIEs have also explored methods for enhancing service delivery. The Harlingen, Texas based Trauma Regional Advisory Council asked their HIE, the Rio Grande Valley Health Information Exchange (RGVHIE), to identify a method for improving communications between EMS 911 providers (EMS) and hospital EDs. RGVHIE developed three approaches for improving communications:

1. **EMS Data-hub.** The EMS Hub integrates with a wide range of EMS Electronic Patient Care Reporting (ePCR) software serving as a conduit for health information exchange by storing "run reports" and making them available via a Provider Portal. Run Reports are required from an EMS organization within 12-24 hours after a patient is delivered to an emergency room. Run reports were typically delivered via fax or paper. The process was fraught with inefficiencies and timeliness issues. Hospital and EMS personnel now have real-time access to run reports stored in the EMS data hub using the HIE-based web portal.
2. **EMS App and Hospital Notifications System.** This service allows for EMS to send a pre-notification alert to a receiving hospital about an individual's status directly onto a dashboard in the Hospital Emergency Department to provide decision support and prepare for an individual's arrival—especially for conditions requiring time-sensitive treatment or therapy—such as trauma, heart attack or stroke. The EMS App is a tool for paramedics on the field responding to 911 emergency calls to capture patient information and send real time to Hospital Emergency Room personnel.
3. **EMS access to real time patient information at the point of care.** There was consensus across RGVHIE EMS stakeholders that access to patient information would be beneficial at the point of care. Since most of the ePCRs did not have integration capabilities, RGVHIE initially solutioned this with an EMS app external to the EMS workflow. There was minimal participation and difficulty with the patient identification process. RGVHIE is continuing to work through these challenges and others.

RGVHIE learned that while it is beneficial to have maximum patient information available, the system must account for workflow adoption and variations in infrastructure standards. RGVHIE surveyed their customers and had a 77 percent response rate. A resounding 80.5 percent of respondents indicated it is extremely useful for them to be able to retrieve patient information from other hospitals, EDs and physician practices through HIE. One hundred percent of participants noted that the most important function of HIE will be obtaining mental health diagnoses and pathology reports.

Disaster Response - PULSE

PULSE is a nationwide Health IT disaster response platform that can be deployed at the city, county or state level to authenticate and assist disaster healthcare volunteer providers.

PULSE allows disaster workers to query and view patient documents from all connected healthcare organizations. To ensure the maximum amount of medical information is electronically available about Texans during a disaster, HHSC is proposing to implement PULSE in partnership with THSA. In 2017, the THSA's query-based HIE services were scheduled to terminate as THSA was in the process of converting

HIETexas, the THSA's state-level HIE network, from query-based exchange services to an alerts-based care coordination platform. However, THSA delayed that transition after Hurricane Harvey hit Texas and there was a need to continue offering query-based HIE to assist in the recovery efforts by allowing patients' health information to follow them.

During the response to Hurricane Harvey, Texas HIEs set up access in select shelters and provided patient look-up services to medical teams operating in those environments. Although several successful information hits resulted, the process needs to be scaled and standardized across the state.

PULSE, initially developed by the State of California with ONC grant funding (2015-2017), is a non-proprietary, open-source software solution operated for California by Audacious Inquiry (Maryland) and hosted by The Sequoia Project. PULSE was designed to be expandable to all parts of the United States.

PULSE represents a significant improvement over the HIE involvement during the Hurricane Harvey response. It provides emergency healthcare workers direct access to broader sources of critical health information. Texas is proposing to implement PULSE through IAPD funding requested to leverage and expand the state-level services, HIE and provider connectivity included in all the strategies of the previous IAPD.

During disasters, Texas' large and highly complex healthcare delivery system performs as a health information exchange model with HIEs that have limited interoperability across the state. An interoperable model is required to support meaningful coordination of care as services are delivered in shelter sites. It is essential that the most clinically relevant information be available to support individuals involved in disaster situations. The access and use of health information is critical to patient quality of care during these times of crisis.

The project is based on a use case that incorporates interoperable health information technology tools and services that support disaster response activities in shelter locations. It will incorporate national standards that facilitate health information exchange and build upon the HIE work already accomplished in Texas.

Behavioral Health

Behavioral health has been a priority focus for Texas over the last several years as demonstrated through significant policy-making, strategic planning and legislative funding commitments. Texas Medicaid and CHIP has been working on several initiatives to improve outcomes and reduce costs for providing services to individuals with Behavioral Health (BH) diagnoses. The capacity for providers to coordinate care through the sharing of health information will help Texas Medicaid achieve these initiatives, which are as follows:

- Implementation of federal and state mental health parity standards, which require that individuals do not experience more barriers accessing mental health and substance use disorder services than they do accessing medical and surgical services;
- The creation of managed care requirements around integrating behavioral and physical healthcare at the MCO and provider levels;
- Evaluation of a pilot program studying integrated behavioral and physical healthcare led by behavioral health clinics and including the implementation of alternative payment methodologies in integrated care clinics;
- Implementation of a peer support benefit for individuals with mental health and substance use disorder conditions; and

- Improving access to medication assisted therapy and other evidence-based treatments for substance use disorders.

The Health IT approach to behavioral health cross-cuts many Health IT topics, which necessitates the comprehensive discussion that follows.

Prevalence of BH diagnoses in Texas Medicaid

More than 290,000 Texas Medicaid and CHIP clients had a diagnosed serious emotional disturbance (SED) or serious mental illness (SMI) in state Fiscal Year 2016. The most common SED/SMI diagnoses are major depression, schizophrenia and bipolar disorder. A much larger number of clients experience mental health conditions that do not rise to the level of a SED/SMI but do impact daily life, such as anxiety disorders. Still others have diagnosed substance use disorders, such as opioid use disorder or alcoholism.

Health IT's potential for physical and behavioral health integration

Care coordination across physical and behavioral health is of sentinel importance to ensuring good outcomes. Behavioral health conditions are associated with significant physical comorbidities, which can increase the cost of care and result in poor health outcomes. Individuals with mental illness are also more likely to develop chronic medical conditions and become physically debilitated earlier in life, increasing acute and long-term costs. Behavioral health conditions are associated with 22 percent of Texas Medicaid managed care potentially preventable admissions and 46 percent of potentially preventable readmissions. Almost 66 percent of Texas Medicaid clients with three or more ED visits and two or more admissions in a year have a chronic behavioral health condition. According to a national study, significant numbers of nursing facility residents had a primary diagnosis of mental illness, with 25 percent being younger than age 65. Some medications required to manage the symptoms of serious mental illness can increase the risk of chronic physical conditions, such as metabolic disorders (e.g., diabetes).

When health information, such as medical history, lab results, medication lists and treatment plans for physical and behavioral health is not electronically exchanged, providers may prescribe treatment that compromises the person's safety, disrupts their recovery or otherwise negatively affects their overall well-being. In cases where people with more severe conditions must see multiple providers, the risk that they will receive fragmented and inconsistent episodic care increases (e.g., people with depression are three times more likely to be noncompliant with their medical treatment regimens), which contributes to a shorter life expectancy.

The ability for behavioral and physical health providers to electronically share data on conditions and treatments enhances coordination of care, reduces/prevents adverse health events and improves outcomes of care.

Without connectivity to the Health IT ecosystem, the state must rely on its medical benefits claims processing system (Compass21) and outpatient pharmacy claims processing system (OS+, which is managed by Conduent) to manage whole-person care in individuals with behavioral health conditions. These systems are not connected and, as an example: a client could receive the buprenorphine implant (J0570) in a physician's office or outpatient hospital as a medical benefit (Compass21) and also receive an outpatient prescription by a different provider (i.e., pharmacy claims processed by OS+) that would interact negatively with the buprenorphine without either provider being aware, which could result in serious complications for the client.

Behavioral health providers have been working to use EHRs. This has been an issue for both behavioral and physical health providers who are working to integrate care within their practice, as many EHRs are not built to accommodate the needs of an integrated provider and require technical modifications. In addition, behavioral health providers are beginning to enter APMs with some MCOs, which often require EHR modification for quality measure data. These types of modifications can assist providers in addressing the needs of individuals with co-occurring conditions, but can be expensive and cost prohibitive. Assistance to providers will be necessary to support advances in an integrated care model.

HHSC maintains an electronic data system known as Clinical Management for Behavioral Health Services (CMBHS). CMBHS serves as an EHR for contracted providers of substance use disorder (SUD) services, and it serves as a data reporting system for contracted providers of mental health services.

For SUD services, CMBHS captures clinical documentation at a detailed level, including such things as client profile, screening, assessment, service type, treatment, progress notes, lab results, medication administration and service authorization. CMBHS also supports submitting claims to TMHP both for block-grant-funded SUD services and for a limited set of Medicaid-funded SUD services. Entering data for SUD services is currently only supported through a web-based interface in which providers directly enter the data. SUD providers who maintain their own electronic health record have the option of exporting their data, so it may be imported into their local systems.

For mental health services, CMBHS primarily serves as a data reporting system. It captures client profile, diagnosis, assessment, service authorization and it supports submitting claims to TMHP for certain Medicaid mental health programs. The system is primarily used by the Local Mental Health Authorities (LMHAs) and by other Medicaid providers of mental health case management and mental health rehabilitation services. Data for mental health services may be entered directly through the web interface, but LMHAs, with their own electronic health records, may submit information through an electronic data exchange.

Although CMBHS supports a variety of nationally-recognized vocabulary standards including the Diagnostic and Statistical Manual, ICD-10, and the National Drug Code, at the time of development there were no available national data standards that sufficiently addressed the medical and care delivery needs for patients with serious mental illness. This was recognized by HL7, which, at the time, had a workgroup on community-based collaborative care. To enable the LMHAs to extract data from their local EHRs and submit it electronically to CMBHS, the state worked with the primary EHR vendors of the LMHAs (Cerner, iServe, & Netsmart) as well as IT directors from the LMHAs to develop a set of standards and data definitions which are still in use today. All 39 of the LMHAs in Texas engage in some form of data exchange with CMHBS; but 35 of them utilize all the data exchange functions. The other four use a combination of data exchange and direct entry.

CMBHS is planned to be the system of record for commitment information, which is currently captured in various systems. Outpatient community center commitments are captured in CMBHS. State hospital commitments are captured in the Avatar systems maintained by the state hospitals, but it is also transmitted to the legacy mental health system, known as CARE. Current plans are to migrate remaining CARE functions to CMBHS when funding becomes available.

CMBHS could play an effective role in integrating behavioral health services into a care coordination system, but not without enhancements to its data exchange process. As CMBHS currently only supports the exchange of behavioral health data using custom interfaces, further development work would be required to make CMBHS compliant with ONC proposed national standard for USCDI and to meet the HL7 C-CDA standards. Making these enhancements in CMBHS and having our contracted users make

the same enhancements to their local systems would allow CMBHS to be interoperable, exchange behavioral health data and receive other forms of health data in a meaningful way.

The state's and MCOs' ability to effectively manage the Medicaid system to achieve good outcomes for Medicaid and CHIP members with behavioral health conditions can also be enabled through improvements, standardization and connectivity to the Health IT ecosystem.

Connection of BH provider EHRs and CMBHS

Once behavioral health provider EHRs and CMBHS are connected to the Health IT ecosystem, MCOs and state staff would be able to access clinical data on member characteristics that would aid in the identification of specific needs. These denotations include certain behavioral health diagnoses for whom MCOs are contractually required to provide high levels of care coordination, and members enrollment in specific waiver programs with whom MCOs are contractually required to coordinate in creating service plans and authorizing medically necessary services. This information could also assist the state in data analysis to identify common diagnoses on which policies or programs to improve outcomes may be focused, and to ensure that members are not enrolled in more than one waiver program at a time.

Connectivity to provider EHRs would also enable access to information on court-ordered psychiatric services and would assist MCOs and the state to ensure that all court-ordered services are delivered and reimbursed, and that members who have been court-ordered into services get needed supports as court orders expire to prevent further criminal justice involvement and reduce emergency department use and hospitalizations.

As non-medical clinically necessary information is integrated into CEHRT, provider EHRs would also indicate when a member is experiencing a non-healthcare need that impacts health, such as housing instability or interaction with the criminal justice system. This would allow MCOs to identify members with further care coordination needs and would allow the state to work with other state-level systems such as the Texas Department of Housing & Community Affairs and the Texas Commission on Jail Standards to coordinate needs of Medicaid and CHIP participants.

Goals/Milestones

While this Health IT Strategic Plan details many important initiatives that advance Health IT, the milestones described in the table that follows represent core activities to services and providers across the continuum of care. HHSC considers this plan a living document that may be adapted to meet evolving needs.

Health IT/ HIE Strategy	Service or Application	Measure	FFY 2020/2021 Milestones
HIE IAPD Strategy 1	**Connections**	Number of Medicaid providers connected to Local HIEs by this project, with capability to transfer C-CDA and/or ADT-based clinical data	Goal is two hundred (200) Medicaid providers (including hospital and ambulatory providers) connected to Local HIEs as an outcome of this project

Health IT/ HIE Strategy	Service or Application	Measure	FFY 2020/2021 Milestones
HIE IAPD Strategy 2	**Onboarding Local HIEs to THSA**	Number of HIEs connected to the THSA by this project	Goal is eight (8) HIEs connected to THSA as an outcome of this project
HIE IAPD Strategy 2	**Master Patient Index**	Implementation of Master Patient Index	Master Patient Index implemented
HIE IAPD Strategy 3	**Medicaid Emergency Department Encounter Notification**	Number of HIEs contributing hospital emergency department ADT data	Goal is eight (8) HIEs contributing hospital emergency department ADT data as an outcome of this project
Initiative	**PULSE**	Program Planning and Implementation	Develop Plan and PULSE Application. Test and Launch PULSE Application and Implement Program

Conclusion

The primary objectives of this Health IT Strategic Plan are to establish a Health IT or HIE model that achieves better health outcomes for Texas Medicaid clients and to bring increased value to healthcare providers, institutions and community partners to best serve the Texas Medicaid population. Our intent is to develop a pragmatic, achievable and meaningful strategy that motivates state agencies and healthcare providers to adopt interoperability and Health IT infrastructure in support of achieving better health outcomes for the people we serve. Meaningful health data collection strengthens understanding of the relationship between social drivers of health and healthcare use across diverse populations, allowing the state to develop solutions to better connect patients to much needed services.

Propagating the transmission of ED ADT data will demonstrate the value to PCPs and healthcare providers of participating in data exchange. This is a first step in the use of clinical data for care coordination, but we must take subsequent steps beyond ED data notifications. Push technology is one way of exchanging information, but not the only one and not for all use cases. The ability to ask for information that is needed for care is another widely used method to support APMs. This Health IT Strategic Plan demonstrates an initial pathway, but Texas must also scale the solution beyond ED data to enabling push notifications between healthcare providers and payers. True care coordination will happen with information exchange among all care providers on the care team throughout the care continuum.

Not all healthcare providers and Medicaid payers will swiftly adopt the idea of connecting to HIEs to transmit data to other providers, other HIEs or state HHS entities. Many of the reasons for this reluctance are described in this plan. Large hospitals, provider groups and MCOs may recognize the most value in client data transmission and with their more robust resources are likely to adopt and implement HIE. However, it is unrealistic to expect 100 percent adoption from the healthcare community. Rural providers and practices that treat a small population of patients are likely to be the last to adopt HIE due to resource constraints.

Texas HHS must diligently work directly with HIE networks, THSA, provider associations, healthcare providers and MCOs to communicate the HIE value proposition and assist with bringing value to their respective organizations. Every organization strives to improve health outcomes for their patients, but how to achieve this vastly differs among organizations as the approach is governed by entity-specific priorities. Over the last five years, providers have encountered great expense and dedicated a significant amount of resources toward adopting and implementing EHR technologies. Their primary purpose is to provide high-quality services to the patients they serve, and Texas HHS can play a significant role in shaping a Health IT landscape that advances this objective.

The buildout of Health IT and HIE infrastructure is a critical component of furthering Texas HHS' vision of "Making a difference in the lives of the people we serve" and the mission of "Improving the health, safety and well-being of Texans with good stewardship of public resources."

Appendix A – Timeline of Health IT Legislation in Texas

Legislative action has been a significant driver for the advancement of Health IT in Texas. In 2005, the Texas Legislature created a multi-agency Texas Health Care Policy Council (Council) that was charged, among other directives, with "promoting the use of technology in health care to decrease administrative costs and to increase and improve the quality of health care."[19] In 2006, Governor Rick Perry established the Texas Health Care System Integrity Partnership, which recommended mechanisms for operationalizing the state-level recommendations of the Council.

In 2007, the Texas Legislature enacted Chapter 182 of the Health and Safety Code, which established the THSA. THSA is "a public-private collaborative to implement the state-level health information technology functions" and is intended to serve "as a catalyst for the development of a seamless electronic health information infrastructure to support the healthcare system in the state and to improve patient safety and quality of care."[20]

HHS agencies serve as ex officio representatives on the THSA board of directors. Texas HHS agencies work with THSA, HIEs and other stakeholders to advance the use of standards to support interoperability. Currently, the THSA is focused on:

1) expanding connectivity;
2) emergency department notifications;
3) support for statewide disaster response; and
4) public health reporting.

The Electronic Health Information Exchange System Advisory Committee was established to advise HHSC on issues regarding the development and implementation of the electronic health information exchange system in accordance with HB 1218, 81st Legislature, Regular Session, 2009. The committee was chaired by a member of the healthcare provider community and offered valuable stakeholder insight regarding HHS Health IT and HIE activities.

In 2010, HHS established the OeHC to serve as a single point of contact in HHS for health policy information, coordinate state level activities with THSA and serve as the State Health IT Coordinator and the central Health IT coordinator within the Texas HHS agency system.

In 2015, SB 200, 84th Legislature, Regular Sesion removed over 20 advisory committees from statute, including the Electronic Health Information Exchange System Advisory Committee, and HHSC subsequently created the eHAC to advise HHS agencies on strategic planning, policy, rules and services related to the use of Health IT, health information exchange systems, telemedicine, telehealth and telemonitoring services.

HB 2641, 84th Legislature, Regular Session, 2015 required that information systems planned or procured on or after September 1, 2015 and used by a Texas Health and Human Services Agency to send or receive protected health information to and from healthcare providers use applicable standards and be interoperable with each other. HB 2641 aligns with federal legislation and promotes the use of certified electronic health record technology as well as requires information systems to follow the ONC's ISA.

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[19] House Bill 916, 79th Legislature, Regular Session, 2005
[20] House Bill 1066, 80th Legislature, Regular Session, 2007

Appendix B – Texas Medicaid Value-Based Initiatives

Initiative	Description	Quality and/or Efficiency Measures	Benefit from Improved Health IT/HIE
Transition from Fee-for-Service to Managed Care	Over 90 percent of Medicaid and CHIP clients receive services through risk bearing MCOs and DCs. The transition to managed care has occurred in carefully planned stages over a 24-year period.	Federal and state law require several quality related activities including routine reporting on evidence-based measures of MCO and DC performance.	Care coordination is a foundation of the MCO service delivery model. The state's Health IT strategy will establish a reliable pathway for the expeditious exchange of high-quality data with MCOs and across providers engaged in the care of an individual. The availability of clinical data will also improve the relevance of program performance measures, including eCQMs.
MCO Pay for Quality (P4Q)	Budget neutral program that creates incentives and disincentives for MCOs and DCs. Health plans that excel on specified quality metrics are eligible for additional funds above their existing premium payments; health plans that do not meet their measures can lose funds.	P4Q includes industry recognized process and outcome measures within a model that: 1) is easy to understand; 2) allows health plans to track performance and improvement; 3) rewards both high performance and improvement; and 4) promotes transformation and innovation.	Improved HIE will allow for more timely assessment of MCO performance using the most meaningful metrics possible, including metrics showing clinical outcomes and that are appropriately adjusted for clinical and social risk.

Initiative	Description	Quality and/or Efficiency Measures	Benefit from Improved Health IT/HIE
Hospital Quality Based Payment Program for Potentially Preventable Readmissions and Complications	Provides incentives and disincentives to hospitals to reduce potentially preventable readmissions and complications. MCOs pass incentives and disincentives to hospitals based on a hospital's overall performance for Medicaid clients as calculated by HHSC.	Potentially Preventable Readmissions and Potentially Preventable Complications.	Real time exchange of health information is crucial for care transitions that reduce preventable events. Admission, discharge and transfer data has been demonstrated to reduce preventable hospital admissions and readmissions.
MCO Performance Improvement Projects (PIPs)	Two-year projects designed to follow a common quality improvement cycle. Projects should demonstrate significant improvement sustained over time for clinical and non-clinical care that has a favorable effect on health outcomes and client satisfaction.	HHSC, with the EQRO, determines topics for PIPs based on improvement goals. MCOs create a PIP plan, report on progress annually and provide a final report.	HIE will reduce data lag, promoting the integration of rapid-cycle improvement approaches into the PIPs. Wider use of electronically exchanged clinical data/metrics will expand the range of viable QI projects, particularly collaborative projects.

Initiative	Description	Quality and/or Efficiency Measures	Benefit from Improved Health IT/HIE
Quality Incentive Payment Program (QIPP)	Incentivizes nursing facilities to improve quality and innovation in the provision of services using the CMS five-star rating system as a basis.	Performance measures include: 1) high-risk residents with pressure ulcers; 2) percent of residents who received an antipsychotic medication; 3) residents experiencing one or more falls with major injury; and 4) residents who were physically restrained.	Nursing homes maintain data in electronic format but may not participate in electronic health information exchange with other providers, despite the complex medical backgrounds of their residents. Real time data exchange involving nursing homes is crucial for optimal care coordination and, in particular, will promote better transitions across care settings and higher performance on both nursing home and hospital metrics.
MCO Value-Based Contracting (or Alternative Payment Models) with Providers	HHSC, through contract, requires MCOs to develop value-based payment models with providers.	HHSC has established overall and risk-based targets for the level of MCO reimbursement to providers through value-based payments relative to a plan's total medical expenses.	More clinically relevant data, metrics and data sharing across providers, MCOs and agency programs is needed for the state to fully transition to a value-based Medicaid program.

Appendix C – Public Health Collaborations Advancing Health IT

The Department of State Health Services (DSHS) is Texas' state-level public health agency and is an important component of Texas' Health IT ecosystem. DSHS receives health data from healthcare providers, including general practitioners, specialty care providers and hospitals across the state and uses it to advance DSHS' goals:

- Improve health outcomes through public and population health strategies, including prevention and intervention.
- Optimize public health response to disasters, disease threats and outbreaks.
- Promote the use of science and data to drive decision-making and best practices.

DSHS recognizes the value in using Health IT and health information exchange to reduce provider burden in reporting information to the state. It also recognizes the value in transforming the data it receives into timely, accurate, actionable information that supports providers in their delivery of high-quality care to patients.

DSHS is continuously investing in its technology systems that support the state's Health IT ecosystem. Key services DSHS provides that rely on the exchange of health information with providers include:

- Operating the State Laboratory, which performs a variety of tests, including newborn blood spot testing.
- Operating the state's immunization registry, which allows healthcare providers and other authorized users to use ImmTrac2 to access immunization histories and vaccination forecasts for children and adults who have consented to have their information included in the immunization registry.
- Disease investigations conducted by the state and local health departments using DSHS' implementation of the National Electronic Disease Surveillance System (NEDSS).
- The Texas syndromic surveillance system, which collects information from hospitals and urgent care centers and makes that information available to local health departments across the state.
- The Texas Cancer Registry, which collects patient-level information from healthcare providers who diagnose and treat cancer. This data can be used to help coordinate patients' care, conduct cancer research and investigate cancer clusters in communities across the state.
- The newborn hearing screening program, which focuses on early detection of hearing issues in newborns and appropriate follow-up care.
- Managing HIV services funded through the Ryan White grant program.

DSHS-run information systems supply actionable information to providers, DSHS program staff, local health departments and other entities. DSHS and its partners use data from these systems to target preventative and early intervention services intended to minimize the health impacts and manage the costs of detected diseases or conditions.

DSHS and HHSC share the same information technology services team, core system architecture requirements, data center and internal IT project approval and governance processes. This sharing eases coordination and helps align resources to meet core needs such as data exchange between the agencies and external partners. This collaboration includes sharing plans and technologies to connect with health information exchanges (HIEs) and other trading partners.

Both DSHS and HHSC will benefit from the improved connectivity for providers and HIEs described in the HIE Implementation Advanced Planning Document. The connection established to support the Emergency Department Encounter Notifications system messages (described in this Plan) between the Texas Health Services Authority's HIETexas and HHSC can also be used to support the exchange of data with DSHS' registries and information systems.

The capabilities provided through the Medicaid provider directory system index being implemented can be extended to serve DSHS' registry systems, reducing duplicative activities by providers and improving DSHS' ability to link information from disparate systems together. Similarly, access to a master patient index will be of use to DSHS programs as they match patient records from different systems.

DSHS is working to improve its implementation of NEDSS. Modernizing NEDSS and its affiliated tools will improve providers' ability to submit data, including support for electronic case reporting. The transition to electronic case reporting will reduce manual activities currently required of providers, by enabling direct reporting of conditions from providers' electronic health records (EHRs), leveraging the Reportable Condition Knowledge Management System or similar technologies.

DSHS continues to improve its IT systems, complying with interoperability standards requirements from House Bill 2641, 84th Legislature, Regular Session, 2015, with an aim to provide actionable data to decision-makers at the local, state and national levels. Funding to implement technology changes comes from general revenue, the Centers for Disease Control and Prevention, other grant-making entities and through partnerships with HHSC to implement projects funded through the Advanced Planning Document process.

DSHS recognizes the importance of governance in managing internal systems, the state's Health IT ecosystem, as well as at the national level including both exchange networks and messaging standards. Representatives from DSHS are active in all levels of governance and work to ensure that public health's needs, as well as the services it can provide, are recognized.

Attachment O

Reserved

Attachment P

Reserved

Attachment Q

Delivery System Reform Incentive Payment (DSRIP) Transition Plan

As Required by

1115 Waiver Special Terms and Conditions #37

Health and Human Services Commission

August 27, 2020

TEXAS
Health and Human Services

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1. Executive Summary

The Delivery System Reform Incentive Payment (DSRIP) pool in the Texas Healthcare Transformation and Quality Improvement Program Medicaid 1115 Demonstration (Waiver) benefits Texans and the Texas healthcare delivery system. Texas providers earned over $15 billion in DSRIP funds from 2012 to January 2019, and served 11.7 million people and provided 29.4 million encounters from October 1, 2013 to September 30, 2017.[1] In the initial phase of the Waiver, most providers succeeded in achieving their outcome goals, including goals related to diabetes and high blood pressure control, reducing emergency department visits for ambulatory care sensitive conditions, and reducing the risk-adjusted congestive heart failure hospital readmission rate.

DSRIP is locally driven, based on community needs, and as an incentive payment program, offers flexibility to: 1) innovate to deliver better care and improve health outcomes; and 2) deliver services not traditionally billable to insurance but that can improve health. Major DSRIP focus areas include:

- Behavioral health;
- Primary care;
- Patient navigation, care coordination, and care transitions, especially for complex populations;
- Chronic care management; and
- Health promotion and disease prevention.

When the Centers for Medicare and Medicaid Services (CMS) renewed the Waiver in December 2017, it authorized DSRIP through September 30, 2021 with a Waiver end date of September 2022. Special Terms and Conditions (STCs) 37 of the Waiver requires Texas to submit a draft DSRIP Transition Plan to CMS no later than October 1, 2019 (Appendix A).

The Texas Health and Human Services Commission (HHSC) and CMS agreed upon certain assumptions for the DSRIP Transition Plan during the Waiver renewal negotiations in 2017.

- CMS is not prescribing the content of the Transition Plan except that it may relate to the use of alternative payment models (APMs), the state's adoption of managed care payment models that support providers' delivery system reform efforts, and other opportunities.
- The Transition Plan does not require Texas to sustain specific DSRIP projects or core activities.

[1] The numbers of people served and encounters provided are for demonstration years (DYs) 3-6 and are not unduplicated counts.

- The Transition Plan does not require Texas to sustain a certain level of funding to support ongoing transformation efforts.
- The Transition Plan will describe how the Texas DSRIP program will hand off to other Texas initiatives such as those in the Value-Based Purchasing (VBP) Roadmap.
- Texas will define the milestones for DY 9-10, which will relate to Texas' planned progress in advancing initiatives such as those outlined in the VBP Roadmap or other state or federal initiatives.

HHSC asked stakeholders to submit initial program ideas for DSRIP transition that used existing funding sources by November 30, 2018, to share with Texas state leadership and help inform the development of the DSRIP Transition Plan. HHSC received responses from more than 30 entities. Proposals focused on broad systems of care, community-based and hospital care, rural health, behavioral health, public health, and academic medicine. They ranged from statewide to regional to individual provider level. A high-level summary of these stakeholder proposals is included as Appendix B.

Using the initial proposals as a starting point, HHSC will work with Texas stakeholders and leadership to develop and propose to CMS new programs, policies, and other Medicaid strategies in key areas to build on successful DSRIP work and advance delivery system reform, while leveraging existing resources and financing structures. These key areas include some issues that have gained attention both in Texas and nationally since the initial Texas Waiver, such as maternal morbidity and mortality, the opioid epidemic, and social drivers of health. DSRIP afforded Texas the opportunity to address social drivers of health, such as through care navigation for individuals with complex conditions, housing supports, and transportation assistance. An increased knowledge base nationally, along with the early work in DSRIP, offers opportunities for next steps.

The milestones included in this transition plan lay the groundwork to develop strategies, programs, and policies to sustain successful DSRIP activities and for emerging areas of innovation in health care. The following are key focus areas for the state (listed in no particular order).

- Sustain access to critical health care services;
- Behavioral health;
- Primary care;
- Patient navigation, care coordination, and care transitions, especially for patients with complex conditions that have high costs and high utilization;
- Chronic care management;
- Health promotion and disease prevention;
- Maternal health and birth outcomes, including in rural areas of the state;
- Pediatric care;
- Rural health care;
- Integration of public health with Medicaid;

- Telemedicine and telehealth; and
- Social drivers of health.

The DSRIP Transition Plan contains specific goals for next steps in delivery system transformation. Milestones are categorized by the following broad goals:

- Advance APMs that target specific quality improvements.
- Support further delivery system reform that builds on the successes of the Waiver and includes current priorities in health care.
- Explore innovative financing models.
- Develop cross-focus areas such as social drivers of health that use the latest national data and analysis to continue to innovate in Texas.
- Strengthen supporting infrastructure for increased access to health care and improved health for Texans.

These goals represent the work that Texas will undertake during the last two years of the DSRIP program to enhance the state Medicaid program and inform the next 1115 Waiver renewal submission to CMS. Milestones and deliverables linked to these goals are listed below. HHSC is committed to achieving the outlined milestones and deliverables. The outcome of this work will be determined over the next two years, working with Texas stakeholders and CMS.

The proposed milestones are state-level milestones (versus provider-level milestones). Each milestone is an independent activity. While HHSC will coordinate with DSRIP providers and other stakeholders to accomplish each of these milestones during DY 9-10, DSRIP providers' mechanism to earn DY 9-10 funds is specified in the Program Funding and Mechanics Protocol.

In addition to the DSRIP Transition Plan, there is also a requirement in the Waiver renewal STCs for a Health Information Technology (Health IT) Strategic Plan. Texas is developing both plans in concert with one another, and the work undertaken for the plans will inform each other. It is necessary for the state to continue to improve health information data sharing so that Medicaid and CHIP managed care organizations (MCOs) and providers have access to timely data for VBP and advancing delivery system transformation.

Proposed Milestones for DY 9-10

Advance APMs to Promote Healthcare Quality

- HHSC advances Alternative Payment Models (APMs) in the Medicaid program and delivery system by updating the Texas Medicaid Quality Strategy and Texas Value-Based Payment (VBP) Roadmap to address program and stakeholder goals. [March 31, 2021]

    - HHSC will address strategies to:

- ◊ Promote data sharing and transparency among HHSC, health plans, and providers to support VBP.
- ◊ Advance potential APMs for Medicaid recipients with high needs and high costs by identifying measurement approaches for services and populations that traditionally have been challenging to measure. Potential areas for refined measurement approaches: severe mental illness (SMI)/severe emotional disturbance; pediatric populations; and community integration for people with disabilities.
- ◊ Develop or enhance statewide initiatives to improve quality and outcomes. Maternal and newborn health is an initial focus area.

- HHSC will require ongoing that at least 25 percent of all Medicaid MCO payments to providers be associated with quality-based APMs. HHSC will increase the use of APMs in managed care over time.

- Deliverables: HHSC will submit to CMS its updated Texas Medicaid Quality Strategy, Texas VBP Roadmap, and MCO APM rates for each available measurement year.

Support Further Delivery System Reform

- HHSC identifies and submits to CMS any proposals for new programs, including state-directed payment programs, to sustain key DSRIP initiative areas. This would include programs that require an amendment to the Waiver to begin in DY 11. [December 31, 2020]
  - Deliverable: HHSC submits to CMS a summary of its analysis of options for new programs. If HHSC decides to propose any new program(s) to begin in DY 11, HHSC submits to CMS proposal(s) for these program(s).

- In alignment with Texas' 2020-21 General Appropriations Act (House Bill 1, 86th Legislature, Regular Session, 2019, HHSC Rider 38), HHSC conducts a preliminary analysis of DY 7-8 (October 1, 2017 - September 30, 2019) DSRIP quality data and related core activities to identify interventions associated with improvement in key health outcomes and any lessons learned or best practices in health system performance measurement and improvement. This analysis will use data from DSRIP 2.0 which providers began to report to HHSC in October 2019 and will continue to report through 2022.This analysis, along with engagement from DSRIP stakeholders, research into emerging areas of innovations in healthcare, and value-based initiatives in other states, will help inform HHSC strategies for continuing to advance alternative payment models and further develop delivery system reform. [December 31, 2020]
  - Deliverable: HHSC submits to CMS the analysis of DY 7-8 DSRIP quality data.

- HHSC identifies and submits to CMS any proposals for new programs to sustain key DSRIP initiative areas that would start in the next Waiver renewal period. Among other options, this may include new Medicaid benefits or policy changes based on a review of DSRIP activities. Potential examples include community health workers, chronic care management, comprehensive care codes for integration of behavioral and physical health, and the Diabetes Prevention Program. [September 30, 2021]
    - Deliverable: HHSC submits to CMS a summary of its analysis of options for new programs that could be implemented under an 1115 demonstration waiver or other authority. If HHSC decides to propose any new program(s) to begin upon waiver renewal, HHSC submits with its waiver renewal request proposal(s) for these new program(s). If Texas pursues the addition of new benefits to the Medicaid program that require CMS approval, HHSC will submit requests through the standard approval process.

Explore Innovative Financing Models

- HHSC assesses Texas' current financial incentives for Medicaid MCOs and providers to enter into meaningful quality-based alternative payment models and identifies potential opportunities to strengthen or align incentives. This work includes providing additional guidance to Medicaid MCOs and providers for allowable Quality Improvement costs[2] to help sustain certain successful DSRIP strategies. [June 30, 2021]
    - Deliverable: HHSC submits to CMS its assessment of financial incentives for MCOs and providers in managed care, as well as the additional guidance provided for allowable Quality Improvement costs.

Cross-Focus Areas

- HHSC completes an assessment of which social factors are correlated with Texas Medicaid health outcomes, including pediatric health outcomes. In DY9-10, providers will begin reporting on Related Strategies, of which nine strategies specifically indicate whether providers have already implemented or are planning to implement strategies focused on Social Determinants of Health (SDOH). Analysis of this data will help inform HHSC strategies for continuing to advance alternative payment models and further develop delivery system reform post waiver. [March 31, 2021]
    - Deliverable: HHSC submits to CMS the assessment of social factors.

[2] Quality improvement costs are Texas MCO expenditures for "Activities that improve health care quality" (45 CFR §158.150) and "Expenditures related to Health Information Technology and meaningful use requirements" (45 CFR §158.151).

Strengthen Supporting Infrastructure to Improve Health

- HHSC assesses the current capacity and use of telemedicine and telehealth, particularly in rural areas of Texas, to inform next steps to address access gaps.[3] [June 30, 2021]
  - Deliverable: HHSC submits to CMS the assessment of telemedicine and telehealth. The assessment results will help inform HHSC strategies for continuing to further develop delivery system reform post waiver, and enhancing access to care, particularly in rural and underserved areas.

- HHSC identifies options for the Regional Healthcare Partnership structure post-DSRIP. [June 30, 2021]
  - Deliverable: HHSC submits to CMS options to maintain regional stakeholder collaboration consistent with approaches for sustaining delivery system reform.

DSRIP has increased the infrastructure and capacity of Texas' health care delivery system, including for meaningful stakeholder collaboration and quality measurement, reporting, and improvement. It is also testing models and services to promote appropriate access and value-based care. Under the waiver, Texas' Medicaid managed care model has expanded with an enhanced focus on measuring and paying for value. Through the development and implementation of the DSRIP Transition Plan, Texas will identify opportunities to further integrate the work occurring under the waiver in DSRIP and Medicaid managed care to continue to reform the health care delivery system.

The milestones, specifically, represent the work that HHSC plans to complete in DY 9-10 for changes in the Medicaid program to support DSRIP sustainability and other innovations. In addition, new programs and policies that leverage existing resources and financing structures will be explored to build on DSRIP's successes in increasing access to care and delivering cost-effective care for Texans. HHSC looks forward to working with CMS, Texas leadership, and stakeholders on next steps to transform health care and improve health in Texas.

[3] State law [Texas Government Code, Section 531.0216(f)] requires HHSC to report on the effects, including costs and savings, of telemedicine, telehealth, and home telemonitoring services by December 1 of each even-numbered year. The next report is due by December 2020.

2. Introduction

The Centers for Medicare and Medicaid Services (CMS) initially approved the Texas Healthcare Transformation and Quality Improvement Program Medicaid 1115 Demonstration (Waiver) in December 2011. A key component of the Waiver is the Delivery System Reform Incentive Payment (DSRIP) program.

Texas received CMS approval of a five-year Waiver renewal on December 21, 2017. Under the renewal, the DSRIP pool is $3.1 billion each year in federal fiscal years 2018 and 2019, $2.91 billion in 2020, $2.49 billion in 2021, and $0 in 2022. As shown in the table below and described in more detail later in this plan, there was a shift in the focus of DSRIP beginning in demonstration year (DY) 7 from the original Texas DSRIP program (DSRIP 1.0) to the current DSRIP program (DSRIP 2.0) to evolve from project-level reporting to provider system-level reporting on health quality measures.

DSRIP	Demonstration Year (DY)	Pool Amount (All Funds)
DSRIP 1.0	DY1	$0.50B
	DY2 (10/1/12 – 9/30/13)	$2.30B
	DY3 (10/1/13 – 9/30/14)	$2.67B
	DY4 (10/1/14 – 9/30/15)	$2.85B
	DY5 (10/1/15 – 9/30/16)	$3.10B
	DY6 (10/1/16 – 9/30/17)	$3.10B
DSRIP 2.0	DY7 (10/1/17 – 9/30/18)	$3.10B
	DY8 (10/1/18 – 9/30/19)	$3.10B
	DY9 (10/1/19 – 9/30/20)	$2.91B
	DY10 (10/1/20 – 9/30/21)	$2.49B
	DY11 (10/1/21 – 9/30/22)	**$0**

The Special Terms and Conditions (STCs) of the Waiver require Texas to submit a draft DSRIP Transition Plan to CMS no later than October 1, 2019 (the beginning of DY 9). STC 37 includes the following:

- The plan will describe how the state will further develop its delivery system reform efforts without DSRIP funding and/or phase out DSRIP funded activities.
- The plan will be finalized within six months of submission to CMS (April 1, 2020).
- Texas will propose milestones by which it will be accountable for measuring sustainability of its delivery system reform efforts absent DSRIP funding.
- Milestones may relate to use of alternative payment models, the state's adoption of managed care payment models, payment mechanisms that support providers' delivery system reform efforts, and other opportunities.
- Portions of overall Federal Financial Participation (FFP) for DSRIP will be at-risk for the state's achievement on achievement milestones.

This DSRIP Transition Plan outlines milestones that lay the groundwork for further development of delivery system reform efforts without DSRIP funding and/or phase out of DSRIP-funded activities. To provide necessary context and foundation for the milestones, this plan also:

- Provides background information on the initial Waiver period and on the Waiver renewal that Texas is currently implementing.
- Describes quality efforts in Texas Medicaid, including DSRIP.
- Summarizes health care priorities in Texas, including legislation from the 86th Legislature, Regular Session, 2019, and CMS focus areas.

The milestones are categorized by goals and represent next steps for Texas' health care delivery transformation. They do not focus on DSRIP in isolation, but rather on the overall Texas Medicaid program and improving the health of Texans.

3. Overview of Texas Medicaid in Relation to DSRIP

Who's Covered By Texas Medicaid - Texas Medicaid and the Children's Health Insurance Program (CHIP) serve about 4.5 million people each month, primarily through the managed care delivery system. Over three million of these enrollees are children, and most of the others are low-income adults with disabilities, aged and Medicare-related adults (dual eligibles), and pregnant women.

Managed Care Delivery System - A key component of the Waiver is roll out of Medicaid managed care statewide, in addition to bringing additional Medicaid populations and benefits into managed care. Texas now has 92 percent of its Medicaid-enrolled population served through managed care organizations (MCOs), which HHSC pays a fixed amount per member, per month.[4] MCOs provide a medical home to their members through primary care providers and have incentives to improve quality of care.

How Texas Medicaid is Financed - In Texas, for most Medicaid costs, the federal fiscal year (FFY) 2019 federal matching rate is 58.19 percent, which means that for every one dollar spent on Medicaid services, federal funds pay 58.19 cents and non-federal funds pay 41.81 cents. State General Revenue (GR) funds are the non-federal funds source for the monthly capitation payments Texas Medicaid makes to MCOs (other than for the specific programs referenced below). However, Texas also uses intergovernmental transfers (IGT) from local government entities and other public entities as the non-federal share for certain supplemental payments and directed payment programs.[5] The following Texas Medicaid programs currently rely on IGT:

- Disproportionate Share Hospital (DSH);
- Uncompensated Care (UC);
- DSRIP;
- Network Access Improvement Program (NAIP);
- Nursing Facility Quality Incentive Payment Program (QIPP);
- Uniform Hospital Rate Increase Program (UHRIP); and
- Graduate Medical Education (GME) for eligible non-state hospitals.

Some of the supplemental payments (DSH, UC, DSRIP, and GME) go directly to providers, while others (NAIP, QIPP, and UHRIP) flow through the MCOs. In fiscal year 2017, 32 percent of Texas Medicaid payments to hospitals ($4.2 billion) was from the federal share of supplemental payment programs.[6]

[4] Ibid, p. 4.
[5] The IGTs are comprised of local property, sales, and health care-related taxes, and other allowable public sources of funds.
[6] Information provided by HHSC Rate Analysis Department, June 2019.

Texas Geography and Medicaid - Texas is the second largest state in the U.S. both in terms of area and population, with wide variation in population and healthcare infrastructure across its 254 counties. According to the Rural Health Information Hub, almost 11 percent of Texas' over 28 million people (about 3 million) live in rural Texas.[7] While Texas has some of the largest cities in the country (Houston, San Antonio, Dallas, and Austin), it also has many rural, frontier, and border communities with varying health care needs.

As of April 2019, Texas had:

- 85 Critical Access Hospitals
- 302 Rural Health Clinics
- 179 Federally Qualified Health Center sites located outside of Urbanized Areas.[8]

Since CMS approved Texas' waiver in 2011, 20 rural hospitals in Texas have closed.[9] Those that remain open are facing increasing challenges, and Texas ranks among the states at highest risk of additional rural hospital closures.[10] DSRIP has been a resource to rural communities to improve health care access and quality.

According to the Texas Department of State Health Services (DSHS) Office of Border Health, the Texas border region currently has a population of three million residents. The border is disproportionately affected by higher rates of obesity, diabetes, cervical cancer, caesarian section deliveries, and certain contagious diseases, including tuberculosis. Like other parts of Texas, rapid growth on the border poses multiple challenges, including the development of a sufficient health workforce and access to primary, preventive, and specialty care.[11]

Texas' experience both with Medicaid managed care and DSRIP underscores the importance of thinking about distinct geographical needs and issues in program development and implementation. One of the strengths of DSRIP is that provider initiatives have been based on regional community needs assessments and supported by the Regional Healthcare Partnership (RHP) structure to foster provider collaboration at the local and regional level.

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[7] https://www.ruralhealthinfo.org/states/texas. (Accessed June 4, 2019)
[8] Ibid.
[9] Texas Organization of Rural & Community Hospitals, Letter to HHSC dated August 12, 2019.
[10] Texas A&M University Rural and Community Health Institute (ARCHI). (2018). *Optimizing Rural Health: A community healthcare blueprint*. https://architexas.org/ruralhealth/activities.html (Accessed August 21, 2019)
[11] https://www.dshs.texas.gov/borderhealth/. (Accessed June 4, 2019)

4. Texas 1115 Transformation and Quality Improvement Program Accomplishments

The initial five-year Waiver was approved December 12, 2011, with an end date of September 30, 2016. CMS approved the Waiver with a two-fold purpose: "to expand the existing Medicaid managed care programs, STAR and STAR+PLUS, statewide, and to establish two funding pools, that will assist providers with uncompensated care costs and promote health system transformation." CMS also stated:

> The Demonstration also takes an important step forward by redirecting the supplemental payments that currently exist under the Medicaid State plan [Upper Payment Limit, or UPL programs] to the Demonstration in order to improve care delivery systems and capacity, while emphasizing accountability and transparency, and requiring demonstrated improvements at the provider level for the receipt of such payments.[12]

HHSC distributed the supplemental funds through two pools: Uncompensated Care (UC) and DSRIP. The non-federal share of payments for both pools is financed by IGT, primarily from hospital districts and other local public entities.

The goals in the initial Waiver period were as follows:

- Expand risk-based managed care statewide;
- Support the development and maintenance of a coordinated care delivery system;
- Improve outcomes while containing cost growth;
- Protect and leverage financing to improve Texas' health care infrastructure; and
- Transition to quality-based payment systems across managed care and hospitals.

Texas was the second state to implement a DSRIP program as part of an 1115 Demonstration. A key feature of Texas' DSRIP program was the ability of providers to focus on quality initiatives without regard to payer and that could benefit all patients.

The first five years of DSRIP initiated statewide transformation through more than 1,400 projects delivered by 300 performing providers to improve access to care, test innovative care models, and address regional needs. DSRIP performing

[12] www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Downloads/TexasHealthcareTransformationandQualityImprovementProgramCurrentApprovalDocuments.pdf. (Accessed June 4, 2019)

providers included hospitals (public and private), community mental health centers, physician practices (largely academic health science centers), and local health departments. The inclusion of mental health centers and local health departments in DSRIP as performing providers enabled greater integration and coordination between physical, behavioral, and public health.

After a necessary startup period to develop the program protocols, conduct regional community needs assessments, and develop DSRIP projects based on community needs, CMS approved DSRIP projects to move forward from mid-2013 through mid-2014. Initial key areas of transformation included:

- Behavioral Health;
- Primary Care;
- Patient Navigation, Care Coordination, Care Transitions;
- Chronic Care Management; and
- Health Promotion and Disease Prevention.

Performing providers earned incentive payments for achievement of goals, including serving greater numbers of Medicaid and low income or uninsured (LIU) individuals, and achievement of process milestones and outcome metrics.

One of the early successes of the DSRIP program was the establishment of 20 RHPs covering the state, which led to increased local and regional collaboration to identify and address priority community healthcare needs. RHPs help support the development and maintenance of a coordinated delivery system. Many of the DSRIP projects by their nature involved coordinating care delivery, including projects related to integrated physical and behavioral healthcare, patient-centered medical homes, chronic care management, and patient care navigation. To achieve metrics, the performing providers were often dependent on coordinating with other providers and other community-based organizations.

In addition, Texas Medicaid MCOs must have performance improvement projects (PIPs), some of which have goals in common with one or more DSRIP projects in a given geographic area. Learning collaboratives in many regions were designed to connect MCOs and DSRIP providers to better coordinate their efforts.

DSRIP enabled groundbreaking work, including increased regional and cross-regional collaboration between diverse healthcare providers and stakeholders and investments in infrastructure and innovation to improve systems of care. Texas' DSRIP projects resulted in increased access to primary and preventive care, emergency department (ED) diversion, and enhanced services for individuals with behavioral health needs. Over a four-year period, DSRIP projects provided 29.4 million encounters and served 11.7 million people (cumulative totals from DY3-6 reporting, not unduplicated counts).

DSRIP 1.0 required reporting for each project, including reporting on outcome measures. Each DSRIP project in the initial phase of the Waiver reported on at least

one associated outcome measure, which they selected from the options provided in Category 3 of the RHP Planning Protocol. Each selected Category 3 outcome was related to a DSRIP project, but generally outcomes measured improvement at a level broader than the DSRIP project intervention. Providers earned partial payment for achieving at least 25 percent of the goal for a given performance year.

The table below shows a sample of outcome achievement in DSRIP 1.0.[13]

Measure	Projects with Selected P4P Outcome	Projects Reporting 100% Achievement of DY6 Goal	Projects Reporting 25% - 75% Achievement of DY6 Goal	Median Improvement
IT-1.10: Diabetes care: A1c Control >9.0%	103	83%	5%	23%
IT-1.7: Controlling high blood pressure	72	89%	0%	23%
IT-3.3: Risk Adjusted Congestive Heart Failure (CHF) 30-day Readmission Rate	48	90%	0%	21%
IT-12.1 Breast Cancer Screening	28	84%	8%	41%
IT-8.19: Post-Partum Follow-Up and Care Coordination	13	100%	0%	75%
IT-1.18: Follow-Up After Hospitalization for Mental Illness	25	84%	8%	42%

[13] From HHSC presentation at Children's Hospital Association of Texas DSRIP learning collaborative event, June 5, 2019 (Noelle Gaughen).

Texas submitted a companion document to the Waiver evaluation to CMS in May 2017 that provides more detailed information on Category 3 outcome measures that show Texas' progress in improving the health of Texans in the first five years of the Waiver.[14]

DSRIP facilitated a significant expansion of healthcare quality measurement in Texas. Both DSRIP and Medicaid managed care have focused on cost-effective care delivery. The impact of DSRIP cannot be measured in isolation due to the number of quality initiatives employed in Medicaid and other healthcare programs. DSRIP and other initiatives in Texas have shown progress in cost-effective care, as explained in the Evaluation Companion referenced above:

> "In the broader sense, data from [Texas'] External Quality Review Organization, the Institute for Child Health Policy (ICHP) at the University of Florida, shows that there has been a reduction in Potentially Preventable Admissions expenditures for the Texas Medicaid/CHIP population, which decreased from a total of $6,966 per 1,000 member months in calendar year 2013 to $5,831 in calendar year 2015. This represents a decrease in Potentially Preventable Admissions (PPAs) expenditures of 16% per member month over two years. While not directly attributable to DSRIP, many DSRIP projects have focused on this area. ICHP has urged HHSC to use caution in interpreting the state level data. For example, the sample sizes are very large so even if something is statistically significant, the issue of practical significance can be raised. In other words, is the difference observed practically meaningful, which can be challenging to answer." [15]

The UC and DSRIP pools have been complementary programs to provide financing to improve Texas' health care infrastructure. Funding from the UC pool is a major contributor to the active participation of both public and private hospitals in Medicaid, giving Medicaid enrollees access to hospital care. For DY 7 (October 2017 - September 2018), 367 hospitals and public physician groups earned UC pool funds. Of the almost $3.1 billion earned by these providers for DY 7, almost 68 percent went to private and not-for-profit hospitals, 26 percent went to public hospitals, and about 3.4 percent went to state-owned hospitals and physician groups. Public ambulance providers earned 2.8 percent.[16]

To further improve Texas' health care safety net, the DSRIP program enabled hospitals, other healthcare providers, and community partners to improve Texas' healthcare infrastructure through innovative care delivery models and increased access to care. These improvements in care benefit not only Medicaid and LIU

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[14] https://hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/1115-docs/Evaluation-Companion-Document.pdf. (Accessed June 5, 2019)
[15] https://hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/1115-docs/Evaluation-Companion-Document.pdf. (Accessed June 5, 2019)
[16] Information provided by HHSC Rate Analysis Department, May 2019.

patients, but all Texans in need of care, including Medicare patients and those insured via their employers or the marketplace.

Texas made progress in the initial Waiver period toward transitioning to quality-based payment systems across managed care and hospitals, and this continues to be a major goal of the Medicaid program. The initial Waiver enabled providers to undertake initiatives to improve care delivery and to earn incentive funds based on achieving project milestones and related outcomes. In that sense, DSRIP has been an incubator for VBP in Medicaid managed care, as the findings from DSRIP demonstrate which types of initiatives may be promising for value-based reimbursement arrangements between MCOs and providers in their networks. In 2014, HHSC began requiring MCOs to develop and submit a written plan for expansion of value-based provider payment structures that includes an inventory of different payment models being deployed, provider types involved, performance metrics and evaluation methods used, and payment models planned for the future. This laid the groundwork for the requirement HHSC implemented in 2018 for a certain percentage of MCO payments to providers to be value-based, with increased requirements over time.

5. Waiver Renewal

In May 2016, CMS granted Texas a 15-month extension to the Waiver through December 31, 2017. In December 2017, CMS approved a five-year renewal for DY 7-11. In the Waiver renewal application, Texas proposed to focus the renewal period on:

- Strengthening the Waiver programs and the connections between them.
- Further aligning the Medicaid managed care programs within the Waiver with DSRIP projects to support systems of care for Medicaid enrollees and LIU individuals and support sustainability of the innovative work underway in DSRIP.
- Developing a quality roadmap that includes both managed care and DSRIP and actively engage health plans to coordinate with the DSRIP initiatives that benefit their members.
- Partnering with clinical and quality experts from around the state to identify best practices and lessons learned from DSRIP to help inform Medicaid benefits and VBP arrangements in managed care.
- Promoting increased data sharing across providers and publish data to show whether Texas, the RHPs, and the managed care service areas are making progress on key quality indicators.

The Waiver renewal also noted the UC pool would continue to be essential to ensure access to quality care for low-income Texans and enable hospitals and other providers to undertake initiatives to improve how care is delivered.

Texas Medicaid has met its initial goal of expanding risk-based managed care statewide through the STAR, STAR+PLUS, and Children's Medicaid Dental Services programs. HHSC expanded all three of these capitated managed care programs statewide, including carving into managed care inpatient hospital services and pharmacy services. Texas Medicaid managed care programs cover over 3.6 million Medicaid enrollees per month (February 2019).[17] HHSC successfully implemented several other major managed care expansions and initiatives during the demonstration period, including adding eligible persons with intellectual and developmental disabilities (IDD) into STAR+PLUS for their acute care (September 2014), carving mental health targeted case management and rehabilitation services into managed care (September 2014), implementing the Texas Dual Eligible Integrated Care project (March 2015), carving nursing facility services into managed care (March 2015), and implementing the Community First Choice program (June 2015). STAR Kids is a Medicaid managed care program that provides Medicaid benefits to children and adults 20 and younger who have disabilities

[17] https://hhs.texas.gov/about-hhs/records-statistics/data-statistics/healthcare-statistics - Medicaid and CHIP MCO Enrollment by SDA, Preliminary (February 2019, Updated Quarterly), (Accessed June 4, 2019)

(November 2016). In addition to these newer programs, for many years the STAR Health program has provided primary, acute, and behavioral health care, as well as dental, vision, and pharmacy services to children in Texas state conservatorship through the Department of Family and Protective Services (DFPS).

DSRIP 2.0

A significant transition occurred between the initial Waiver period and the renewal period. During the 15-month extension, new DSRIP program protocols were developed to evolve from project-level reporting to provider system-level reporting (DSRIP 2.0).

The DSRIP program is designed to provide incentive payments to Texas hospitals, physician practices, community mental health centers, and local health departments for investments in delivery system reforms that increase access to health care, improve the quality of care, and enhance the health of patients and families they serve. Program parameters for DSRIP are outlined in two protocols.

- Measure Bundle Protocol - Defines the performing provider system-level measures that are bundled to align closely with transformative DSRIP project areas from the initial demonstration period and includes an appendix for measure specifications.
- Program Funding and Mechanics Protocol - Describes the State review process for RHP Plans and RHP Plan updates, incentive payment methodologies, RHP and state reporting requirements, and penalties for missed milestones.[18]

The Measure Bundle Protocol for DSRIP 2.0 reflects the evolution of the DSRIP program from project-level reporting to provider-level quality measure reporting to assess the continued transformation of the Texas healthcare system. In DSRIP 2.0, performing providers report on required reporting categories (A, B, C, and D) at their provider system level.[19]

Category A includes progress on core activities, APM arrangements, costs and savings, and collaborative activities. The Category A requirements were developed to serve as an opportunity for DSRIP performing providers to move further towards sustainability of their transformed systems, including development of APMs to continue services for Medicaid and LIU individuals after DSRIP ends. The listing of core activities in the Measure Bundle Protocol reflects those project areas that have been determined to be the most transformational and will support continuation of the work begun by performing providers during the first years of DSRIP. These core

[18] https://hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/1115-waiver/waiver-renewal/AttachmentJ-PFM-DY7-8-05.21.18.pdf, p.2. (Accessed June 4, 2019)
[19] https://hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/1115-waiver/waiver-renewal/MeasureBundleProtocol_05.21.18.pdf. (Accessed June 4, 2019)

activities are continued or implemented by a performing provider to support achievement of its Category C measure goals.

Category B defines the provider system. As DSRIP shifts from project-level reporting to system-level reporting, HHSC wants to ensure that providers maintain a focus on serving Medicaid and LIU individuals. To that end, Category B requires each performing provider to report the total number of individuals and the number of Medicaid and LIU individuals served by its system during each DY. The Measure Bundle Protocol sets out parameters for a performing provider to define its "system" to reflect the provider's current care landscape in which they are striving to advance the Triple Aim: improving the patient experience of care; improving the health of populations; and reducing the per capita cost of health care.

The shift to DSRIP 2.0 focusing on provider systems rather than specific projects allowed for:

- Transition from "DSRIP clients" to all patients in the system measured for health care quality achievement as applicable.
- Increased focus on health care quality measures over outputs to know not just how many individuals were seen but how many individuals' health has changed or improved.
- Increased focus on quality measures laying the foundation for value-based care.

For Category C, targeted measure bundles were developed for hospitals and physician practices, and lists of measures are available for community mental health centers and local health departments. Measure bundles consist of measures that share a unified theme, apply to a similar population, and are impacted by similar activities. Bundling measures allowed for ease in measure selection and approval, increases standardization of measures across the state for hospitals and physician practices with similar activities, facilitates the use of regional networks to identify best practices and share innovative ideas, and continues to build on the foundation set in the initial Waiver period while providing additional opportunities for transforming the health care system and bending the cost curve.

Category D represents a population health perspective for all DSRIP performing providers. Whereas the initial Waiver period included Category 4 statewide reporting for hospitals, Category D includes measures for all DSRIP performing provider types. This reporting is designed to assist providers, MCOs, RHPs, and state and federal agencies to have regional and statewide views of important health care trends. The Category D reporting measure bundles are:

- Aligned with Medicaid and LIU populations;
- Identified as high priority given the health care needs and issues of the patient population served; and
- Viewed as valid health care indicators to inform and identify areas for improvement in population health within the health care system.

DSRIP 2.0 was designed to strengthen the programs within the Waiver and the connections between them. Introducing "measure bundles" to measure the provider system was designed to further align the Medicaid managed care programs with DSRIP to support systems of care for Medicaid enrollees and LIU individuals and support sustainability of the innovative work underway in DSRIP. There is also considerable crossover between the Category C quality measures and the MCO Pay-for-Quality (P4Q) program measures, which is discussed in more detail later in this plan.

Measure Development Process

HHSC formed a DSRIP Clinical Champions stakeholder group in 2015 to provide clinical expertise for next steps in the development of DSRIP. The Clinical Champions consisted of clinical, health quality, and operational professionals in Texas. In 2015, the Clinical Champions reviewed provider-submitted Transformational Impact Summaries—brief, structured project descriptions and evaluations—and identified DSRIP projects' high impact practices. HHSC used these high impact practices to inform the initial selection of the DSRIP 2.0 Category C measure bundle topics. The Clinical Champions also helped HHSC refine the DSRIP project menu to include only the most transformational project areas.

In 2017, Texas HHSC began a new process with the Clinical Champions to seek their input on the meaningfulness, improvability, and clinical appropriateness of proposed measures to include in the hospital and physician practice measure bundles, as well identify any gaps in measurement. HHSC implemented a multi-round process with the Clinical Champions to choose the draft measures for each of the Category C measure bundles. The Bundle Advisory Teams rated each potential measure based on the measure's importance according to the member's clinical judgement. Additionally, Bundle Advisory Team members had the opportunity to suggest new and innovative measures. Community mental health centers and the Texas Council of Community Centers provided recommendations for measures related to behavioral health. Local health departments were engaged in the development of measures for those providers. Some measure bundles were designated as "high state priority" or "state priority". These designations were focused on the most pressing health needs in Texas. HHSC incentivized providers to select these measure bundles by assigning them a higher point value.

High state priority measure bundles:

- Maternal Care
- Chronic Non-Malignant Pain Management

State priority measure bundles:

- Chronic Disease Management: Diabetes
- Chronic Disease Management: Heart Disease
- Healthy Texans
- Pediatric Primary Care

- Pediatric Chronic Disease Management: Asthma
- Behavioral Health in a Primary Care Setting
- Behavioral Health & Appropriate Utilization
- Integrated Care for People with Serious Mental Illness

Promoting Data Exchange

DSRIP has been a significant catalyst for various forms of data sharing. The RHP structure is designed to respond to the needs and characteristics of the populations and communities of each region. The foundation for developing DSRIP regional goals was data sources describing local demographics and key health challenges. Providers then built projects around these shared goals, focusing on objectives such as care coordination, patient care navigation, and physical and behavioral health integration, for which the level of success is partially driven by the ability to share timely and accurate data with other providers. As DSRIP has shifted to more strategic systemic efforts under the renewal, it has also intensified the need for providers to build relationships that enable health system performance measurement and improvement. The renewal has also prompted increased emphasis on MCO and DSRIP provider collaboration to determine ways to incorporate DSRIP models under managed care and conduct meaningful quality measurement for these efforts.

The Texas Healthcare Learning Collaborative (THLC) portal serves as a public reporting platform, contract oversight tool, and a tool for Medicaid and CHIP MCO quality improvement efforts.[20] The website was developed for use by HHSC, MCOs, providers, and the public to obtain up-to-date MCO and hospital performance data on key quality of care measures, including potentially preventable events (PPEs), Healthcare Effectiveness Data and Information Set (HEDIS®), and other quality of care information. Providers also have the ability to see performance data by MCO within a service area over time. These data may serve as an important tool for providers, including DSRIP providers, to engage MCOs on value-based contracting. The THLC portal is updated and expanded on an ongoing basis. For example, in 2017, in-depth data visualizations of key quality measures were added.

The Portal also enables increased data sharing across providers and publishes data to show whether Texas, the RHPs, and the managed care service areas are making progress on key quality indicators.

[20] https://thlcportal.com/home. (Accessed June 5, 2019)

6. Texas Medicaid Quality Initiatives and Value-Based Care

Value-Based Purchasing Roadmap

HHSC released its draft VBP Roadmap (Roadmap) in August 2017 as part of its Waiver renewal submission to CMS.[21] The Roadmap described the quality initiatives in Texas Medicaid, including DSRIP, and goals to further value-based care in Texas. The Roadmap noted:

Healthcare payment transformation (also referred to as VBP or alternative payment models) is essential to advancing HHSC's healthcare quality plan priorities:[22]

1. Keeping Texans healthy
2. Providing the right care in the right place
3. Keeping patients free from harm
4. Promoting effective practices for chronic disease
5. Supporting patients and families facing serious illness
6. Attracting high performing providers.[23]

The Roadmap also noted:

"Through its managed care contracting model, HHSC is making progress on a multiyear transformation of provider reimbursement models that have been historically volume based (i.e., fee-for-service) toward models that are structured to reward patient access, care coordination and/or integration, and improved health care outcomes and efficiency. In concert with other policy levers, VBP has the strong potential to accelerate improvement in health care outcomes and increase efficiency. The Texas Medicaid program is one of the largest Medicaid programs in the country, with almost $40 billion in expenditures annually. Because it is such a significant payer, the Medicaid program can be a driving force behind payment transformation".[24]

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[21] https://hhs.texas.gov/sites/default/files/documents/about-hhs/process-improvement/quality-efficiency-improvement/draft-texas-vbp-apm-roadmap-august-2017.pdf. (Accessed June 5, 2019)
[22] Ibid, page 1.
[23] *HHS Healthcare Quality Plan*, November 2017. Available at https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2017/HHS-Healthcare-Quality-Plan-2017.pdf. (Accessed June 5, 2019)
[24] https://hhs.texas.gov/sites/default/files/documents/about-hhs/process-improvement/quality-efficiency-improvement/draft-texas-vbp-apm-roadmap-august-2017.pdf, pp. 1-2.

The Roadmap broadly defined VBP as linking health care payments to measures of quality and/or efficiency (i.e., "value") rather than only paying based on service volume. In its guidance to the Medicaid and CHIP MCOs regarding the new VBP contract requirements for state fiscal year 2018, HHSC defined value "as either a measure of quality or a composite measure of quality (outcomes) and efficiency (cost)."[25] The Roadmap includes guiding principles, anticipated outcomes, and descriptions of HHSC's major initiatives related to VBP.

Roadmap guiding principles of VBP:

- Continuous engagement of stakeholders
- Harmonize efforts
- Administrative simplification
- Data driven decision-making
- Movement through the VBP continuum
- Reward success

Roadmap anticipated outcomes of VBP:

- Aligned incentives between State, MCOs and providers
- Optimal health care outcomes and patient experience
- Improved health care efficiency

Included in the Roadmap are the major initiatives focused on improving access, quality and efficiency in Texas Medicaid. Summaries of these initiatives follow.

Medical and Dental Pay-for-Quality (P4Q) Programs[26]

Effective January 1, 2018, HHSC replaced its managed care At-Risk and Quality Challenge program with the Medical Pay for Quality (P4Q) program. In the redesigned program, three percent of each MCO's capitation is at risk based on their performance on designated outcome measures (improvement over self, performance against benchmarks, and performance on bonus pool measures). The 2018 program measures were selected to focus on prevention, chronic disease management (including behavioral health), and maternal and infant health.[27] The

[25] Email from HHSC (Matt Ferrara), December 2017, regarding guidance (entitled VBP_APM Overview) sent to MCOs and Dental Contractors (DCs) regarding contract APMs targets effective January 1, 2018.
[26] https://hhs.texas.gov/about-hhs/process-improvement/medicaid-chip-quality-efficiency-improvement/pay-quality-p4q-program
[27] HHSC Presentation, November 13, 2017, Quality Forum. For more information: Overview of the program on HHSC main quality webpage: https://hhs.texas.gov/about-hhs/process-improvement/medicaid-chip-quality-efficiency-improvement. (Accessed June 5, 2019) Detailed methodology and benchmarks in UMCM, Ch. 6.2.14 available at: https://hhs.texas.gov/sites/default/files/documents/laws-regulations/handbooks/umcm/6-2-14.pdf. (Accessed June 5, 2019). Additional information on Texas Healthcare Learning Collaborative (THLC) Portal: https://thlcportal.com/.

medical care P4Q measures follow. A similar P4Q program is in place for the two dental contractors that serve children in Medicaid.

DSRIP activity, both in the initial phase of the Waiver and in DSRIP 2.0, relates closely to Medicaid managed care P4Q focus areas, including primary and preventive care, chronic care management, behavioral health care, and reducing unnecessary ED use. Since DSRIP payments are incentive-based (rather than service-based), DSRIP providers have had flexibility to deliver care that currently is not a Texas Medicaid billable service, including some services that Medicare now reimburses, such as chronic care management, integration of behavioral and physical health services, and diabetes prevention. There may be opportunities to add some of these types of services as Texas Medicaid benefits to enable this work to continue.

P4Q At-Risk and Bonus Pool Measures for STAR Effective January 1, 2018

STAR At-Risk Measures	STAR Bonus Pool
Potentially Preventable Emergency Room Visits (PPVs)	Potentially Preventable Admissions (PPAs)
Appropriate Treatment for Children with Upper Respiratory Infection (URI)	Low Birth Weight (LBW)
Prenatal and Postpartum Care (PPC) ● Timeliness of Prenatal Care ● Postpartum care	CAHPS Children with Good Access to Urgent Care (child)
Six or more Well Child Visits in the First 15 months of Life (W15)	CAHPS Adults Rating their MCO a 9 or 10 (adult)

P4Q At-Risk and Bonus Pool Measures for STAR Effective January 1, 2018

STAR+PLUS At-Risk Measures	STAR+PLUS Bonus Pool
Potentially Preventable Emergency Room Visits (PPVs)	Potentially Preventable Readmissions (PPRs)
Diabetes Control - HbA1c < 8% (CDC)	Potentially Preventable Complications (PPCs)
High Blood Pressure Controlled (CBP)	Prevention Quality Indicator (PQI) Composite
Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotics (SSD)	CAHPS Adults with Good Access to Urgent Care
Cervical Cancer Screening (CCS)	CAHPS Adults Rating their MCO a 9 or 10

P4Q At-Risk and Bonus Pool Measures for CHIP Effective January 1, 2018

CHIP At-Risk Measures	CHIP Bonus Pool
Potentially Preventable Emergency Room Visits (PPVs)	CAHPS Children with Good Access to Urgent Care
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC) • Counseling for nutrition. • Counseling for physical activity	CAHPS Caregivers Rating their Child's MCO a 9 or 10
Appropriate Treatment for Children with Upper Respiratory Infection (URI)	Childhood Immunization Status (CIS) Combination 10
Adolescent Well Care (AWC)	

MCO VBP Targets with Contracted Providers[28]

Since 2012, HHSC has required that each MCO and dental contractor (DC) submit an annual report on its VBP activities with providers for HHSC information and planning purposes. HHSC instituted a significant change for calendar year 2018, when it added to the managed care contracts two types of VBP targets that the MCOs must meet.[29]

For 2018, for each MCO by program type (STAR, STAR+PLUS, CHIP), 25 percent of the MCO's and DC's payments to providers must be value-based, increasing to 50 percent in 2021, with certain exceptions.[30] A portion of these value-based models are required to include downside financial risk for providers: 10 percent of MCO payments in 2018, increasing to 25 percent by 2021, with certain exceptions. HHSC uses the nationally recognized Healthcare Payment Learning and Action Network (HCP LAN) Alternative Payment Model (APM) Framework to help guide this effort and to align definitions. This framework describes a range of payment model concepts, encompassing varying degrees of risk on providers.

HHSC also included contractual requirements that the MCOs and DCs adequately resource their VBP activities, including by establishing and maintaining data sharing processes with providers, and dedicating resources to evaluating the impact of APMs on utilization, quality, and cost.

Examples of the types of programs that count as value-based:

- incentive-only programs built on fee-for-service payments,
- alternative payment models in which the MCO and provider agree to incentives and/or disincentives based on performance on agreed upon metrics,
- "gold carding" high-value providers defined as conditional relief from a prior authorization or other administrative requirement, or
- other arrangements that link some of the overall payment to quality or value measure(s).

Examples of the types of programs that will count as value-based with provider financial risk:

- partial or full capitation with a linkage to quality metrics,
- episode-based payments with a linkage to quality metrics,

[28] https://hhs.texas.gov/about-hhs/process-improvement/medicaid-chip-quality-efficiency-improvement/value-based-contracting
[29] HHSC *Uniform Managed Care Contract*, sec. 8.1.7.8.2. Available at: https://hhs.texas.gov/sites/default/files/documents/services/health/medicaid-chip/programs/contracts/uniform-managed-care-contract.pdf. (Accessed June 4, 2019)
[30] These percentage targets could be lower for an MCO based on exceptions, such as achieving a higher than expected level of performance on both potentially preventable hospital admissions and potentially preventable ED visits (PPVs) as defined in the contract.

- bundled payments with a linkage to quality metrics, or
- arrangements based on enrollee total cost of care with a linkage to quality metrics, etc.

Hospital Quality-based Potentially Preventable Readmissions and Complications Program[31]

HHSC administers the Hospital Quality-based Potentially Preventable Readmissions and Complications Program for all hospitals in Medicaid and CHIP. All hospitals are measured on their performance for risk- adjusted rates of potentially preventable readmissions (PPR) and potentially preventable complications (PPC) across all Medicaid and CHIP programs. Hospitals can experience up to a 4 percent reduction to their payments for inpatient stays for high rates of PPR and 4.5 percent reduction for high rates of PPC. Safety net hospitals can meet certain criteria and receive bonus payments above their base payments for low risk-adjusted rates of PPRs and/or PPCs. Measurement, reporting, and application of disincentives and incentives occurs on an annual cycle.

MCO Performance Improvement Projects (PIPs)

PIPs are required in Medicaid managed care to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical or non-clinical care areas that are expected to have a favorable effect on health outcomes. HHSC, in consultation with its External Quality Review Organization (EQRO), determines topics for PIPs based on historical MCO performance. MCOs create a PIP plan, report on their progress annually, and provide a final report on their PIP, which the EQRO also evaluates.

HHSC requires each MCO and DC to conduct two PIPs per program. Each PIP is two years and they are implemented on a staggered schedule so that one PIP per program is being implemented each calendar year. One PIP must be a collaborative with another Medicaid/CHIP MCO, DC, or DSRIP project. Ideally, over time, PIPs should incorporate VBP approaches between MCOs and providers, and leverage measures identified in the medical P4Q program.

The STAR PIPs for 2016-2018 related to reducing potentially preventable ED visits for upper respiratory tract infections, well child visits in the first 15 months of life, prenatal and postpartum care, asthma, diabetes, and behavioral health. The STAR+PLUS PIPs for 2016-2018 focused on care transitions and care coordination to reduce behavioral health-related admissions and readmissions, mental health

[31] https://hhs.texas.gov/about-hhs/process-improvement/medicaid-chip-quality-efficiency-improvement/potentially-preventable-events. (Accessed June 5, 2019)

self-direction, chronic obstructive pulmonary disease (COPD) management, breast and cervical cancer screening, and diabetes control.[32]

For 2019, HHSC and the EQRO worked with the health plans to develop PIPs related to Medicaid enrollees with complex needs (high costs/high utilization). This is a statewide PIP initiative for all managed care programs (STAR, STAR+PLUS, CHIP, STAR Health, and STAR Kids) and may be in collaboration with DSRIP providers. While outcome measures may vary by program and MCO, a consistent goal is to reduce potentially preventable ED visits (PPVs) and PPAs among members with anxiety or depression through improved treatment for these conditions.

Texas Dual-Eligibles Integrated Care Demonstration Project (The Dual Demonstration)[33]

The Dual Demonstration is a CMS and HHSC joint project designed to test whether an innovative and coordinated payment and service delivery model can improve coordination of services for recipients who have Medicare and Medicaid benefits (dual eligible enrollees), enhance quality of care, and reduce costs for both the state and the federal government. By having one Medicare-Medicaid plan (MMP), Medicare and Medicaid benefits work together to better meet the member's healthcare needs.

The key objectives of the Dual Demonstration are:

1. Make it easier for clients to get care.
2. Promote independence in the community.
3. Eliminate cost shifting between Medicare and Medicaid.
4. Achieve cost savings for the state and federal government through improvements in care and coordination.

The Dual Demonstration is in five urban counties – Bexar, Dallas, El Paso, Harris, and Hidalgo.

Nursing Facility Quality Incentive Payment Program (QIPP)[34]

QIPP is a Medicaid managed care delivery system and provider payment initiative under 42 Code of Federal Regulations §438.6(c). QIPP payments to nursing facilities flow through the STAR+PLUS MCOs.

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[32] https://hhs.texas.gov/about-hhs/process-improvement/medicaid-chip-quality-efficiency-improvement/performance-improvement-projects. (Accessed June 5, 2019)
[33] https://hhs.texas.gov/services/health/medicaid-chip/programs/dual-eligible-project-mmp. (Accessed June 5, 2019)
[34] https://hhs.texas.gov/services/health/provider-information/quality-incentive-payment-program-nursing-homes. (Accessed June 5, 2019)

CMS has indicated to HHSC that directed payment programs are a potential model for Texas to consider as it transitions the DSRIP program. The nursing facility program, which has been approved by CMS, features some elements familiar to HHSC and DSRIP providers, including the requirement for inter-governmental transfers as the state share and a mix of pay-for-reporting and pay-for-performance measurements for quality.

Under QIPP, incentive payments are based on improvements in quality and innovation in the provision of nursing facility services. This includes payment incentives to improve the quality of care for residents. Facilities are able to achieve this goal by showing improvement over baselines as they relate to specified quality measures.

QIPP operates on a state fiscal year basis and is currently in its second year of implementation. HHSC is making significant changes to QIPP for year three beginning September 1, 2019.[35]

Beginning September 1, 2019, QIPP will include 10 measures across four domains:

- Quality Assurance and Performance Improvement Meetings
- Workforce Development (registered nurse staffing levels, staff recruitment and retention program)
- Minimum Data Set CMS Five-Star Quality Measures (pressure ulcers, antipsychotic medication use, ability to move independently)
- Infection Control (urinary tract infections, pneumococcal vaccine, antibiotic stewardship)

DSRIP

HHSC's VBP Roadmap includes DSRIP because it has been effectively testing how alternative VBP models can support patient-centered care and clinical innovation. HHSC continues to work closely with MCOs and DSRIP providers on ways to incorporate promising clinical models into the MCO provider payment stream in the form of a VBP model.

There are a number of challenges to incorporating DSRIP into the MCO model, including payments directly to providers, the broader population served by DSRIP, and the timelines for MCO premium setting and incentive payment structures. Nevertheless, DSRIP is building capacity for providers to participate in VBP models with MCOs through better use of health information technology and better measurement processes. HHSC anticipates the transition from specific projects and discrete measures to broader measure bundles will promote greater coordination

[35] https://hhs.texas.gov/services/health/medicaid-chip/provider-information/quality-incentive-payment-program/qipp-resources, QIPP Year Three Quality Metrics (PDF). (Accessed June 4, 2019)

among DSRIP providers, improved population health, and negotiation of VBP arrangements between DSRIP providers and MCOs.

Quality Improvement (QI) Costs

Effective September 1, 2016, HHSC added a new quality improvement (QI) cost provision in managed care contracts to allow certain MCO quality-related costs that previously had been counted as administrative expenses to instead count as medical expenses. As medical expenses, QI costs count toward each MCO's medical loss ratio and are not subject to administrative caps. This change was enabled by federal regulation (45 CFR §§158.150-151), which recognized increasing evidence that targeted non-clinical interventions can have a substantial impact on improving health outcomes and lowering medical spending, particularly for low-income populations and individuals with serious mental illness and other complex health risks.

The HHSC *Uniform Managed Care Manual* provides some guidance on how MCOs should count QI expenditures.[36] In general, the types of expenses that qualify as QI costs are activities that improve health quality and health outcomes or increase the likelihood of good health outcomes and are grounded in evidence-based medicine or widely accepted best clinical practices. Examples include effective case management, patient education and counseling, discharge planning, wellness assessments, and health information technology to support these activities.

In its November 2018 report, HHSC's Value-Based Payment and Quality Improvement Advisory Committee recommended that HHSC provide additional guidance for MCOs and providers on how to leverage the QI cost strategy to provide patient navigation services to patients with high needs and high utilization patterns. Some of the activities supported by DSRIP likely could be counted as QI costs, including patient navigation for complex patients, chronic care management activities, and community health worker services, whether handled directly by an MCO or delegated to a provider.[37]

Managed Care Capitation and Rates

HHSC develops its managed care capitation rates from historical claims experience, trended forward with a number of adjustments. A challenge for all payers, including Medicaid managed care programs, is how to reward successful VBP programs in the long term. When a health plan invests in a VBP strategy that reduces high cost services such as emergency department care or hospitalization, associated savings

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[36] HHSC *Uniform Managed Care Manual*, Ch. 5.3.1.62 available at: https://hhs.texas.gov/sites/default/files/documents/laws-regulations/handbooks/umcm/5-3-1-62.pdf. (Accessed June 4, 2019)

[37] https://hhs.texas.gov/sites/default/files/documents/about-hhs/communications-events/meetings-events/vbpqi/jan-2019-vbpqi-agenda-item-6.pdf, Report pages 19-20. (Accessed June 4, 2019)

may be removed from the plan's future funding base through the capitation rate-setting process. This challenge is not unique to Texas. In early 2018, the California Health Care Foundation commissioned a report on precisely this topic - how to encourage through the rate setting process sustained Medicaid health plan investments in health-related benefits and services that improve care and lower costs.[38]

Texas Medicaid's capitation rate setting process encourages cost-effective, high quality care in various ways, including through mechanisms such as experience rebates, capped administrative expenditures, and quality programs. As HHSC requires its contracted MCOs to increase their VBP arrangements with providers, it will explore how to reward MCOs and providers that implement VBP arrangements that improve health quality while reducing costs.

Value-Based Payment and Quality Improvement Advisory Committee (VBPQI)

Established by the Texas Legislature in 2016, the VBPQI includes healthcare experts and provides a forum to promote public-private, multi-stakeholder collaboration in support of quality improvement and VBP initiatives for Medicaid, other publicly-funded health services, and the wider health care system. The VBPQI released its first report in November 2018 with recommendations related to enhanced data analytics and data sharing; pursuing VBP models related to maternity and newborn care and mental health and substance use disorders (SUD); providing additional guidance on Medicaid-allowable quality improvement costs; and working to standardize HHSC's managed care VBP efforts to reduce administrative burden and encourage provider participation. The VBPQI's work plan for 2019-2020 will focus on standardized measures for maternal and newborn care and behavioral health, use cases for quality improvement costs, and continued engagement of stakeholders regarding HHSC's VBP initiatives to increase awareness and participation of different types of providers.

Emerging Initiatives to Advance VBP Currently Underway in Texas

Accountable Health Communities (AHC): Three healthcare organizations in Texas received CMS AHC grant awards. HHSC, as the state Medicaid agency, is a partner to this project. This grant tests whether identification of and/or linkages to the health-related social needs of enrollees impacts total health care costs and

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[38] *Intended Consequences: Modernizing Medi-Cal Rate-Setting to Improve Health and Manage Costs,* March 2018, Prepared by Manatt Health for the California Health Care Foundation. Accessed at https://www.manatt.com/Insights/White-Papers/2018/Modernizing-Medi-Cal-Rate-Setting-to-Improve-Healt

improves health and quality of care. This grant will inform HHSC on ways to structure and support effective VBP approaches related to social drivers of health.

Certified Community Behavioral Health Clinics (CCBHC): HHSC received a CMS and Substance Abuse and Mental Health Services Administration (SAMHSA) planning grant for CCBHC, and this supported the development of the clinic certification process and payment model for patient-centered, integrated care. HHSC applied for, but did not receive, a demonstration grant award for model implementation. However, HHSC now requires its STAR and STAR+PLUS MCOs that have CCBHC-certified providers in their areas to enter into some type of VBP arrangement with each CCBHC to continue to support this care model.

VBP to Support Interventions for Populations with Complex Needs and High Cost: All HHSC-contracted MCOs are required to have targeting, outreach, and intervention strategies in place for enrollees with complex needs and high cost (sometimes referred to as "superutilizers"). In 2019, HHSC is requiring MCO PIPs to focus on the needs and outcomes of this population, specifically for members with anxiety or depression. A flexible VBP model could support patient-centered care for complex populations like these.

Innovation Accelerator Programs: CMS began offering technical assistance to states through its Innovation Accelerator Program (IAP) in 2014, and Texas has participated in a number of CMS' IAP initiatives, including related to SUD services, beneficiaries with complex care needs and high costs, and promoting community integration through long-term services and supports.[39]

From February 2016 through June 2018, Texas participated in two CMS-sponsored IAPs to promote community integration for Medicaid beneficiaries through improved partnerships between state Medicaid and housing agencies. The first developed an inventory of tenancy supports available under Medicaid waivers, non-waiver supports, and general revenue funded DSHS programs and Texas Department of Housing and Community Affairs programs. The second included development of a Medicaid crosswalk, which identified current Medicaid services that support people with disabilities in housing, and a housing gaps analysis, which identified key resources for expanding housing opportunities in Texas. The Housing IAP also resulted in an improved partnership with the Texas State Affordable Housing Corporation, which has the potential to create additional housing for Medicaid enrollees in the future.

Texas is furthering the work of the IAP through participation in the National Academy for State Health Policy (NASHP) Housing and Health Institute. Texas is one of five states chosen to participate in the NASHP technical assistance project, and many Texas stakeholders are involved. HHSC has identified the NASHP work group as an opportunity to further explore ways to expand community integration

[39] https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/index.html. (Accessed June 5, 2019)

for all individuals with disabilities receiving Medicaid, including those with IDD and behavioral health issues.

In Spring 2018, Texas HHSC was selected by CMS to participate in the "Value-Based Payment for Home and Community-Based Services" IAP.[40] The overall goal of this initiative is to expand Medicaid VBP, now focused mainly on acute care, to include home and community-based services (HCBS). The specific aim is to determine whether and how to structure VBP for HCBS programs between MCOs and HCBS providers, by developing measures of community integration outcomes (opportunity, community participation, well-being, and recovery). The target population is adults and children receiving long-term services and supports (LTSS) through two managed LTSS (MLTSS) programs, STAR+PLUS (adults) and STAR Kids (children). Most Medicaid LTSS are provided through these two programs.

HHSC's main areas of interest for the VBP for HCBS IAP include:

- Identifying standardized measures for a VBP strategy and appropriate data sources to support VBP for an HCBS initiative;
- Designing VBP for HCBS strategies that offer both financial and non-financial incentives;
- Learning about successful VBP strategies in other MLTSS states; and
- Aligning HCBS VBP with the HHSC VBP Roadmap to the maximum extent possible.

HHSC is working to develop a detailed project plan for implementation of HCBS VBP over several years.

Health IT Strategic Plan

STC 39 of the Waiver renewal requires HHSC to use Health Information Technology (Health IT) within the demonstration to link services and core providers across the continuum of care to the greatest extent possible. The state is expected to achieve minimum standards in foundational areas of Health IT and to develop goals for the transformational areas of Health IT use. The state must report semi-annually on how it has met or plans to meet required health IT goals/milestones.

Specifically, STC 39 directs HHSC to use the CMS "1115 Health IT Toolkit" for Health IT considerations in conducting an assessment and developing a Health IT Strategic Plan.[41] HHSC is targeting to submit the plan in January 2020. The strategic plan must support a number of goals, including:

- exchange of clinical health information to coordinate care;

[40] https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/program-areas/community-integration-ltss/index.html
[41] *1115 Health IT Toolkit* available at: https://www.healthit.gov/topic/advancing-interoperability-medicaid. (Accessed June 5, 2019)

- a comprehensive Medicaid enterprise master patient index;
- a comprehensive Medicaid provider directory;
- improved coordination and integration between Medicaid behavioral health, physical health, home and community-based, and community-level collaborators for improved care coordination; and
- a quality measurement strategy that supports appropriate data collection to monitor and evaluate the objectives of the demonstration.

Further, the Health IT Strategic Plan must have milestones that are achievable for Health IT adoption by Medicaid service providers both eligible and ineligible for Medicaid Electronic Health Record (EHR) Incentive Programs, plan for the exchange of clinical health information related to Medicaid beneficiaries statewide, and advance the standards identified in the "Interoperability Standards Advisory—Best Available Standards and Implementation Specifications" (ISA) in developing and implementing state policies.

Health IT, and health information exchange (HIE), in particular, is a critical component of expanding upon the successes of DSRIP. The exchange of timely and accurate data facilitates key areas of transformation under DSRIP, such as chronic care management, patient care navigation, and integration of physical and behavioral health care. The activities that will be conducted under the Health IT Strategic Plan will be crucial to furthering transformation efforts, including as MCOs and DSRIP providers collaborate on ways to incorporate DSRIP models under managed care and conduct meaningful quality measurement for these efforts.

Medicaid-CHIP IAPD for HIE Connectivity

Health Information Technology for Economic and Clinical Health Act (HITECH) funding is available through 2020. In late 2017, Texas received federal approval for a Medicaid HIE Implementation Advanced Planning Document (IAPD) to receive enhanced federal funding to take next steps to advance HIE to support the Medicaid program. The HIE Connectivity Project is the current Texas Medicaid HIE initiative funded by CMS through the HIE IAPD. The primary objectives of this project are to increase HIE use and adoption by Texas Medicaid providers and create additional capacity in Texas that can support that use and adoption.

The HIE Connectivity Project will accomplish its primary objectives by implementing the following three strategies.[42] Successful implementation of the three strategies will result in increased HIE adoption and use by Medicaid providers, creation of new HIE capacity in the state, and bring clinical information into the Texas Medicaid program via HIE. Reducing barriers to provider participation in data exchange, and as a result improving timely access to data and performance measurement, will support the value-driven payment methodologies.

[42] https://hhs.texas.gov/about-hhs/process-improvement/health-informatics-services-quality/local-hie-grant-program. (Accessed June 5, 2019)

- *Strategy 1: Medicaid Provider HIE Connectivity* - This strategy will help Medicaid providers connect to HHSC-approved local HIE organizations. These connections will facilitate electronic reporting and data exchange between providers and Texas Medicaid.
- *Strategy 2: HIE Infrastructure* - This strategy includes enhancing the state's HIE infrastructure to support connectivity with the state's Medicaid system and assisting local HIEs in implementing connections to HIETexas, which is a set of state-level shared services managed by the Texas Health Services Authority.
- *Strategy 3: Emergency Department Encounter Notifications (EDEN)* - This strategy will help Texas Medicaid reduce emergency department (ED) utilization and hospital readmissions by enabling better follow-up care through the electronic receipt of Health Level Seven (HL7) Admission, Discharge, and Transfer (ADT) data from hospital EDs and publishing alerts to MCOs or DCs when a patient in their network is admitted to the ED, facilitating timely care coordination.

7. Next Steps in Delivery System Reform

As Texas works on planning for post-DSRIP and next steps to advance delivery system reform, it will be mindful of CMS and state policy context and priorities.

CMS Health Policy Priorities

CMS's mission is to transform the health care delivery system to focus on value for patients – to provide high quality, accessible care, at the lowest cost. In a May 2018 speech on Medicare, CMS Administrator Seema Verma explained that CMS seeks to do this by:

- empowering patients (e.g., giving them better access to their own health care data);
- increasing competition (e.g., giving Medicare Advantage health plans more flexibility to cover and compete on supplemental benefits that go beyond traditional Medicare benefits, such as home modifications and respite care for caregivers);
- realigning incentives (e.g. testing out new ways of paying for care through the CMS Innovation Center, including for patients with complex conditions) and
- reducing regulatory and other barriers to value driven care.[43]

In 2019, CMS also noted as priorities advancing the use of technology in Medicare and special consideration for rural providers to improve systems of care and focus on quality improvements (Rethinking Rural Health strategy).[44]

Specific to Medicaid, when Administrator Verma spoke at the 2018 Medicaid Managed Care Summit in September 2018, she emphasized three key pillars of CMS' strategy around Medicaid.[45]

- Flexibility – Empower states to best serve the citizens in their community by giving them flexibility to innovate in Medicaid policy.
- Accountability – Standardize waiver evaluation and increase transparency for stronger accountability, including through tools such as the CMS Medicaid & CHIP Scorecard.
- Integrity – Strengthen the regulatory framework around Medicaid supplemental payments, in particular to promote integrity by ensuring that

[43] https://www.cms.gov/newsroom/press-releases/speech-medicare-remarks-cms-administrator-seema-verma-commonwealth-club-california. (Accessed June 3, 2019)
[44] https://aasm.org/verma-identifies-several-cms-priorities-for-2019/. (Accessed June 3, 2019)
[45] https://www.cms.gov/newsroom/press-releases/speech-remarks-administrator-seema-verma-2018-medicaid-managed-care-summit. (Accessed June 3, 2019)

states put up their fair share of state matching funds only from permissible sources.

Both for Medicare and Medicaid, CMS has acknowledged the role social drivers of health play in health outcomes. In a recent speech, Health and Human Services Secretary Alex Azar said the current federal administration is deeply interested in this question, and thinking about how to improve health and human services through greater integration.[46] He noted that the CMS is allowing its Medicare Advantage health plans to pay for a wider array of health-related benefits beginning in 2019 (transportation, home health visits) and 2020 (home modifications, home delivered meals, and more). CMS recently approved new Medicaid pilots for North Carolina through which Medicaid health plans similarly will be able to pay for enhanced services for high needs enrollees who have risk factors related to food, housing, transportation, and interpersonal violence.

In approving North Carolina's 1115 waiver proposal in October 2018, CMS strongly emphasized health outcomes:

- whether the demonstration was likely to assist in improving health outcomes,
- whether it would address health drivers that influence health outcomes, and
- whether it would incentivize beneficiaries to engage in their own health care and achieve better health outcomes.[47]

HHSC will build on DSRIP's emphasis on health outcomes, particularly in DSRIP 2.0, to better care for Texans after the DSRIP pool ends.

Key Health Priorities in Texas

During Texas' 86th Legislature, Regular Session, 2019, state policymakers and stakeholders discussed major health priorities, including improving Medicaid managed care oversight, behavioral health, maternal and newborn health, and telemedicine and telehealth. These high priority areas for the state align with Texas' DSRIP work and Medicaid managed care VBP strategies.

MCO Oversight

Texas has evolved its MCO oversight continually since the state began implementing Medicaid managed care. The State Medicaid Managed Care Advisory Committee provides recommendations and ongoing input to HHSC on the statewide implementation and operation of Medicaid managed care. The STAR Kids Managed Care Advisory Committee was established to advise specifically on the

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[46] *The Root of the Problem: America's Social Determinants of Health*, Alex M. Azar II, Hatch Foundation for Civility and Solutions, November 14, 2018, Washington, D.C., https://www.hhs.gov/about/leadership/secretary/speeches/2018-speeches/the-root-of-the-problem-americas-social-determinants-of-health.html. (Accessed June 3, 2019)

[47] https://files.nc.gov/ncdhhs/CMS-1115-DemonstrationWaiver-Approval-Letter.pdf. (Accessed June 3, 2019)

implementation of the STAR Kids Medicaid managed care program for children and youth with disabilities.

The 2018-19 General Appropriations Act required HHSC to conduct a review of the agency's contract management and oversight for Medicaid managed care contracts (S.B. 1, 85th Legislature, Regular Session, Article II, HHSC, Rider 61). As a result of Rider 61, HHSC developed the following Medicaid managed care oversight improvement initiatives:

- Administrative Simplification
- Complaints Process and Data Analytics
- Network Adequacy and Access to Care
- Outcome-Focused Performance Management
- Strengthening Clinical Oversight
- Service and Care Coordination

The 86th Legislature, Regular Session, 2019 also provided funding and policy direction in these areas to help strengthen HHSC managed care oversight and operations.

Behavioral Health

Improving mental health and addressing substance use disorders has been and continues to be an area of focus for Texas. In addition to major DSRIP investment in behavioral health since 2012, over the past several legislative sessions, Texas has increased state funding to improve behavioral health services. Like other states, Texas also is leveraging federal funds from the Substance Abuse & Mental Health Services Administration (SAMSHA) to work with local partners to tackle the opioid epidemic. Texas has appropriated about $7.8 billion in all funds for the 2020-21 biennium for behavioral health services across all state agencies of which $3.4 billion is appropriated to Medicaid and CHIP.[48] In addition, legislation from the most recent session (86th Legislature, Regular Session, 2019) increases access to services for substance use disorder and mental health conditions.

The 84th Legislature in 2015 established and the 86th Legislature in 2019 codified into state law the Statewide Behavioral Health Coordinating Council, which includes representatives of 23 state agencies, boards, and higher education entities that expend funds on behavioral health services, to develop a five-year statewide behavioral health strategic plan. The strategic plan, among other objectives, inventories behavioral health programs and services offered by the state, reports statistics on individuals served with BH diagnoses, and details plans to coordinate behavioral health services to eliminate redundancy and ensure optimal service

[48] 2020-21 General Appropriations Act, H.B. 1, 86th Legislature, Regular Session, 2019 (Article IX, Section 10.04)

delivery. Texas published the Second Edition of the *Texas Statewide Behavioral Health Strategic Plan* in February 2019.[49]

Maternal and Newborn Health

Improving maternal and newborn health continues to be a major focus for Texas leadership and stakeholders. There are several state advisory groups focused on this issue, including the Texas Collaborative for Healthy Mothers and Babies, the Perinatal Advisory Council, and the Texas Maternal Mortality and Morbidity Task Force. Legislation from the 86th Legislature, Regular Session, 2019, aims to enhance prenatal and postpartum services and ensure continuity of care for women transitioning between programs. It also creates pilot programs to establish pregnancy medical homes and deliver prenatal and postpartum care through telehealth or telemedicine.

Telemedicine and Telehealth

Over the course of several legislative sessions, Texas has been expanding the options for Texas providers to engage in telemedicine and telehealth. This expansion has been a key strategy particularly for addressing provider access concerns in rural areas of the state.

During the 85th Legislature, Regular Session, 2017, S.B. 1107 standardized practice requirements for telemedicine and telehealth services by specifying acceptable telemedicine and telehealth service delivery modalities, clarifying necessary physician-patient relationship requirements, and directing Texas Medical Board, Texas Board of Nursing, Texas Physician Assistant Board, and Texas State Board of Pharmacy to jointly develop administrative rules for valid prescriptions generated during a telemedicine visit.

The emphasis on telehealth and telemedicine continued in the 86th Legislature, Regular Session, 2019 and could be seen benefiting other areas of emphasis already discussed in this section, including maternal and newborn health and behavioral health. Other key telehealth and telemedicine legislation this session includes the following:

- H.B. 871: Enables satisfaction of physician requirements for Level IV trauma facility designation in counties with populations less than 30,000 through the use of telemedicine by an on-call physician who has special competence in the care of critically injured patients and provides assessment, diagnosis, consultation, or treatment.

[49] The 2016-17 General Appropriations Act, H.B. 1, 84th Legislature, Regular Session, 2015 (Article IX, Section 10.04) required Texas to create a statewide BH strategic plan. *Texas Statewide Behavioral Health Strategic Plan Update (February 2019)* available at: https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2019/hb1-statewide-behv-hlth-idd-plan-feb-2019.pdf.

- S.B. 670: Allows Federally Qualified Health Centers (FQHCs) to be telemedicine distant and patient site providers, prohibits MCOs from denying reimbursement for covered services and procedures solely on the basis of delivery via telemedicine or telehealth, and prohibits limiting a provider's choice of telemedicine delivery platform or reducing reimbursement on the basis of this choice.

Effectiveness of DSRIP

As the DSRIP pool phases out in the Waiver, the Texas Legislature is interested in better understanding how DSRIP has improved the health and care of Texans. The 2020-21 General Appropriations Act[50] requires HHSC to report by December 1, 2020, on the cost effectiveness and performance of the DSRIP program in DYs 7-8. The report is to include information on provider performance improving health quality measures and which DSRIP activities were determined to have a positive return on investment based on cost and savings reports.

Planning for Post-DSRIP

Texas will develop the next 1115 Waiver renewal proposal to take further steps in delivery system reform, building on successes and lessons learned from early and current Waiver activities, and mindful of CMS and Texas health priorities. Texas will pursue the following goals as it develops its next renewal proposal:

- Advance APMs that target specific quality improvements.
- Support further delivery system reform that builds on the successes of the Waiver and includes current priorities in health care.
- Explore innovative financing models.
- Develop cross-focus areas such as social drivers of health that use the latest national data and analysis to continue to innovate in Texas.
- Strengthen supporting infrastructure for increased access to health care and improved health for Texans.

Reflected in the milestones are key strategies and areas of innovation that have been described throughout this plan related to Texas Medicaid quality initiatives, including DSRIP. HHSC also has solicited stakeholder input for program ideas.

Stakeholder Input

HHSC asked stakeholders to submit initial program ideas using existing funding sources by November 30, 2018, to share with state leadership and help inform the development of the DSRIP Transition Plan. (Appendix B). HHSC received responses from more than 30 entities, including:

[50] 2020-21 General Appropriations Act (H.B. 1, 86th Legislature, Regular Session, 2019 (Article II, Rider 38))

- provider associations,
- hospitals,
- academic institutions and providers,
- behavioral health providers,
- local health departments,
- RHPs, and
- Individuals and coalitions.

Proposals focused on broad systems of care, community-based and hospital care, rural health, behavioral health, public health, and academic medicine. They ranged from statewide to regional to individual provider level.

HHSC released a draft of this transition plan for stakeholder comment in August 2019 and received over 80 responses. Many comments were supportive of various aspects of the plan, and others focused more on next steps related to the proposed milestones than suggested changes to the plan itself. HHSC plans to continue working closely with stakeholders as it develops and implements work plans for each of the milestones.

In response to stakeholder comments, HHSC made changes to this plan, including related to key focus areas, rural context, increased coordination across physical health, behavioral health and public health, and the importance of data sharing. HHSC added "Sustain access to critical health care services" and "Integration of public health with Medicaid" as two key areas identified by many stakeholders as Texas plans for post-DSRIP.

The next steps are to develop and propose to CMS new programs, policies, and other Medicaid strategies in key focus areas (listed below in no particular order) to further delivery system reform. The milestones included in this transition plan lay the groundwork for development of approaches to sustain successful DSRIP initiative areas and address emerging areas of innovation in health care.

- Sustain access to critical health care services;
- Behavioral health;
- Primary care;
- Patient navigation, care coordination, and care transitions, including for patients with complex conditions that have high costs and high utilization;
- Chronic care management;
- Health promotion and disease prevention;
- Maternal health and birth outcomes, including in rural areas of the state;
- Pediatric care;
- Rural health care;
- Integration of public health with Medicaid;
- Telemedicine and telehealth; and
- Social drivers of health.

Proposed Milestones for DY 9-10

Advance APMs to Promote Healthcare Quality

- HHSC advances Alternative Payment Models (APMs) in the Medicaid program and delivery system. HHSC updates the Texas Medicaid Quality Strategy and Texas Value-Based Payment (VBP) Roadmap to address program and stakeholder goals. [March 31, 2021]

  - HHSC will address strategies to:

    - Promote data sharing and transparency among HHSC, health plans, and providers to support VBP.
    - Advance potential APMs for Medicaid recipients with high needs and high costs by identifying measurement approaches for services and populations that traditionally have been challenging to measure. Potential areas for refined measurement approaches: severe mental illness (SMI)/severe emotional disturbance; pediatric populations; and community integration for people with disabilities.
    - Develop or enhance statewide initiatives to improve quality and outcomes. Maternal and newborn health is an initial focus area.

  - HHSC will require ongoing that at least 25 percent of all Medicaid MCO payments to providers be associated with quality-based APMs. HHSC will increase the use of APMs in managed care over time.

  - Deliverables: HHSC will submit to CMS its updated Texas Medicaid Quality Strategy, Texas VBP Roadmap, and MCO APM rates for each available measurement year.

Support Further Delivery System Reform

- HHSC identifies and submits to CMS any proposals for new programs, including state-directed payment programs, to sustain key DSRIP initiative areas. This would include programs that require an amendment to the Waiver to begin in DY 11. HHSC is focusing DY11 on directed payment programs due to timing for implementation and to serve as a bridge to DY12 programs. [December 31, 2020]

  - Deliverable: HHSC submits to CMS a summary of its analysis of options for new programs. If HHSC decides to propose any new program(s) to begin in DY 11, HHSC submits to CMS proposal(s) for these program(s).

- In alignment with Texas' 2020-21 General Appropriations Act (House Bill 1, 86th Legislature, Regular Session, 2019, HHSC Rider 38), HHSC conducts a preliminary analysis of DY 7-8 (October 1, 2017 - September 30, 2019) DSRIP quality data and related core activities to identify interventions associated with improvement in key health outcomes and any lessons

learned or best practices in health system performance measurement and improvement. This analysis will use data from DSRIP 2.0 which providers began to report to HHSC in October 2019 and will continue to report through 2022. This analysis, along with engagement from DSRIP stakeholders, research into emerging areas of innovations in healthcare, and value-based initiatives in other states, will help inform HHSC strategies for continuing to advance alternative payment models and further develop delivery system reform. [December 31, 2020]

  - Deliverable: HHSC submits to CMS the analysis of DY 7-8 DSRIP quality data.

- HHSC identifies and submits to CMS any proposals for new programs to sustain key DSRIP initiative areas that would start in the next Waiver renewal period. Among other options, this may include new Medicaid benefits or policy changes based on a review of DSRIP activities. Potential examples include community health workers, chronic care management, comprehensive care codes for integration of behavioral and physical health, and the Diabetes Prevention Program. [September 30, 2021]

  - Deliverable: HHSC submits to CMS a summary of its analysis of options for new programs that could be implemented under an 1115 demonstration waiver or other authority. If HHSC decides to propose any new program(s) to begin upon waiver renewal, HHSC submits with its waiver renewal request proposal(s) for these new program(s). If Texas pursues the addition of new benefits to the Medicaid program that require CMS approval, HHSC will submit requests through the standard approval process.

Explore Innovative Financing Models

- HHSC assesses Texas' current financial incentives for Medicaid MCOs and providers to enter into meaningful quality-based alternative payment models and identifies potential opportunities to strengthen or align incentives. This work includes providing additional guidance to Medicaid MCOs and providers for allowable Quality Improvement costs[51] to help sustain certain successful DSRIP strategies. [June 30, 2021]

  - Deliverable: HHSC submits to CMS its assessment of financial incentives for MCOs and providers in managed care, as well as the additional guidance provided for allowable Quality Improvement costs.

Cross-Focus Areas

- HHSC completes an assessment of which social factors are correlated with Texas Medicaid health outcomes, including pediatric health outcomes. In

[51] Quality improvement costs are Texas MCO expenditures for "Activities that improve health care quality" (45 CFR §158.150) and "Expenditures related to Health Information Technology and meaningful use requirements" (45 CFR §158.151).

DY9-10, providers will begin reporting on Related Strategies, of which nine strategies specifically indicate whether providers have already implemented or are planning to implement strategies focused on Social Determinants of Health (SDOH). Analysis of this data will help inform HHSC strategies for continuing to advance alternative payment models and further develop delivery system reform post waiver. [March 31, 2021]

- Deliverable: HHSC submits to CMS the assessment of social factors.

Strengthen Supporting Infrastructure to Improve Health

- HHSC assesses the current capacity and use of telemedicine and telehealth, particularly in rural areas of Texas, to inform next steps to address access gaps. [June 30, 2021]
  - Deliverable: HHSC submits to CMS the assessment of telemedicine and telehealth. The assessment results will help inform HHSC strategies for continuing to further develop delivery system reform post waiver, and enhancing access to care, particularly in rural and underserved areas.
- HHSC identifies options for the Regional Healthcare Partnership structure post-DSRIP. [June 30, 2021]
  - Deliverable: HHSC submits to CMS options to maintain regional stakeholder collaboration consistent with approaches for sustaining delivery system reform.

Conclusion

HHSC looks forward to working with CMS, Texas leadership, and stakeholders on next steps to transform health care and improve health in Texas. Texas will continue to analyze stakeholder proposals using the goals outlined in this Transition Plan. The milestones included in this Transition Plan represent the work that HHSC plans to complete in DY 9-10 for changes in the Medicaid program to support DSRIP sustainability and other innovations. In addition, new programs, policies, and other strategies that leverage existing resources and financing structures will be explored to build on DSRIP's successes in increasing access to care and delivering cost-effective care for Texans.

Appendix A. 1115 Waiver Special Terms and Conditions - STC #37

37. Transition Plan for DSRIP Pool.

a. Texas will submit a draft transition plan to CMS by October 1, 2019 for CMS review and approval, describing how the state will further develop its delivery system reform efforts without DSRIP funding and/or phase out DSRIP funded activities. The final transition plan will become Attachment Q of the STCs for this demonstration. It must be finalized within 6 months of submission to CMS. As Texas' DSRIP is a time-limited federal investment that will conclude by October 2021, Texas will propose milestones by which it will be accountable for measuring sustainability of its delivery system reform efforts absent DSRIP funding. Milestones may relate to the use of alternative payment models, the state's adoption of managed care payment models, payment mechanisms that support providers' delivery system reform efforts, and other opportunities.

b. Portions of overall FFP for DSRIP will be at-risk for the state's achievement on achievement milestones, as specified below. If Texas fails to submit a complete sustainability plan by October 1, 2019, CMS will defer 10 percent of FFP for DSRIP funding starting in the next quarter, and an amount in all subsequent quarters indefinitely until the state comes into compliance. Accountability for performance on these milestones will be as follows: an additional 15 percent for FFP for DSRIP will be at risk in demonstration year 9, and additional 20 percent off FFP for DSRIP will be at risk in demonstration year 10.

c. This deliverable will not be subject to the deferral as described to STC 56; all accountability for the Transition Plan will be applied as per this STC.

Appendix B. Summary of DSRIP Transition Stakeholder Proposals

The Delivery System Reform Incentive Payment (DSRIP) funding pool in the Texas' Medicaid 1115 Transformation Waiver ends on October 1, 2021. The Texas Health and Human Services Commission (HHSC) must submit a transition plan to the Centers for Medicare & Medicaid Services (CMS) by October 1, 2019, describing how the state will further develop its delivery system reform efforts without DSRIP funding when the pool ends.

HHSC asked stakeholders to submit initial program ideas by November 30, 2018, to share with State leadership and help inform the development of the DSRIP Transition Plan. Programs must have a funding source, other than new General Revenue, for the non-federal share of payments.

- HHSC received proposals, letters and comments from 30+ entities, including:
  - provider associations [6],
  - hospitals [5],
  - academic institutions/providers [6],
  - behavioral health providers [3],
  - local health departments [7],
  - regional healthcare partnerships (RHPs) [4], and
  - individuals/coalitions [2].
- Proposals focused on broad systems of care, community-based and hospital care, rural health, behavioral health, public health, and academic medicine. They ranged from statewide to regional to individual provider level.
- HHSC will analyze all the proposals to share with State leadership and stakeholders, including financing models. Below is a high-level summary of the program themes and geographic/target populations in the proposals. Note the Public Health line reflects proposals from seven (7) separate local health departments.
- The table does not reflect several letters that did not include a specific program proposal.

Multi-Provider/System Proposals

Program Proposal	Target Geography & Population(s)
Texas Community Access and Reform Engagement (Tex-CARE) – a community-based system of care coverage program for adults ages 19-64, anchored by a public hospital system	Optional statewide, locally-driven program targeted to low-income uninsured
Alternative Payment Models with managed care organizations for innovative initiatives and non-traditional services including maternal health; reduce admissions/ED visits; and chronic disease	Statewide – Medicaid (with possible secondary population of low-income and/or uninsured)
Texas Care Connection – allows adults ages 19-64 to participate in the commercial insurance market, which would include value-based purchasing strategies, organized statewide by RHP boundaries	Statewide – Texas citizens and certain legal immigrants under the Federal Poverty Level
DSRIP program replacement focused on affordable access to healthcare, coordination of care, and connecting patients to social safety net programs to improve outcomes	Statewide through current 20 RHPs, targeted to Medicaid and low-income uninsured
Community Health Works! plan – Comprehensive plan to cover social, clinical, and wellness needs. Provide incentive-based supplements to patients to obtain health insurance that is not just catastrophic coverage and that would also help to reimburse providers, limited specialty care funding, funds for social drivers and wrap around services, carve out for mental health.	Statewide -- uninsured and underinsured
Telemedicine program to provide services to all patients in need of inpatient, outpatient, and emergent care services using advanced technology such as	Statewide – pediatric patients

Program Proposal	Target Geography & Population(s)
telemedicine/telehealth and/or digital health services	
Improve the Texas Medical Transportation Program for non-emergency transportation for individuals with chronic conditions at risk for potentially preventable emergency department visits, hospital admissions and readmissions (PPVs, PPAs & PPRs)	Statewide – Medicaid and low-income uninsured

Hospitals

Program Proposal	Target Geography & Population(s)
Children's hospitals propose programs focused on: behavioral health; medically complex children; special health care needs of children in foster care; well-defined, well-disseminated standards of care for disease-specific care; and improving transitions from pediatric to adult systems of care.	Statewide for pediatric patients; for children in foster care, those enrolled in STAR Health
A hospital managed care value-based purchasing program that would provide enhanced hospital reimbursement to hospitals the meet performance goals on defined measures.	Statewide by Medicaid managed care service delivery areas
A south Texas hospital proposes GME expansion; Care Link service establishment and/or expansion; diabetes comprehensive care and remote tele-monitoring; expansion of urgent and behavioral health emergency care services; and OB/Gyn care coordination	RHP 5, but could be expanded statewide

Rural Health

Program Proposal	Target Geography & Population(s)
Open telehealth network of inpatient clinical and outpatient specialty services focused on rural parts of the state with a rural or community hospital	Statewide (rural parts of the state) for Medicaid and/or low-income/uninsured
Regional payments for quality initiatives proposed to be negotiated with Medicaid Managed Care Organizations (MCOs), providers, and HHSC	Certain rural RHPs
Psychiatric and clinical guidance for the criminal justice system for individuals with behavioral health symptoms	Statewide in rural counties (population less than 100,000)
A rural RHP proposes vital access for essential services	Rural RHP boundaries; Medicaid and low-income uninsured

Behavioral Health

Program Proposal	Target Geography & Population(s)
Coordinated system of care for Medicaid and Low-Income Uninsured adults 18-64 with SMI	Could be statewide or certain geographic regions
Partial hospitalization and intensive outpatient services proposed for children and adolescents ages 3-17	Population served by the provider is primarily in Bexar County, but could be applicable in other areas of the state.
Youth Crisis Respite Center to provide brief out-of-home residential services for youth whose psychiatric and/or high-risk behaviors have created significant crisis within the family such that the child may not be able to remain at home. Also provides respite care to prevent such a crisis.	Currently in place in 21 rural counties through DSRIP; could be expanded statewide. Serves youth on Medicaid and low income/uninsured

Public Health

Program Proposal	Target Geography & Population(s)
Seven (7) local health departments proposed the continued inclusion of public health in Medicaid waiver financing and transformation, to continue to support valuable local public health initiatives, including traditional and enhanced services, such as screening/testing, immunizations, oral health, children with asthma, service linkage (some include health information technology), behavior modification intervention, chronic disease such as diabetes, crisis care, and/or health promotion activities to prevent severe and/or disabling preventable conditions. Some are also providing primary care and services to pregnant women & post-partum. Some also focus on certain populations to address health disparities	Could be administered statewide through local health depts. for Medicaid, low-income/uninsured adults & children; some services focus on those with chronic conditions or at risk for them

Academics

Program Proposal	Target Geography & Population(s)
Incentives for physician practices to expand successful DSRIP initiatives, care coordination and community collaboration with MCOs and Anchors forming leadership teams to select quality measures specific to Medicaid managed care regions.	Statewide -- Medicaid and uninsured
Community Wide Campaign & Diabetes Prevention Program – broad structure for healthy living and specific supports for individual change targeted to adults who are pre-diabetic, overweight and/or have elevated blood pressure/hypertension	Medicaid and low-income uninsured adults in RHP 5 (south Texas)
Sustain a particular DSRIP diabetes self-management program (Salud y Vida) that	RHP 5 (scalable to other regions and statewide); Medicaid and low-income uninsured

Program Proposal	Target Geography & Population(s)
focuses on adults with Type 2 diabetes that is poorly controlled or uncontrolled	
Accountable Health Communities (AHC) Alternative Payment Model – screening, referral and patient navigation to community resources to address social drivers of health in coordination with MCOs and RHPs	Statewide – Medicaid and low-income uninsured
Formalize a working relationship or partnership between HHSC and Texas academic medicine to improve programs and contain costs. Academic institutions may have various proposals. One example is a recent article from *Academic Medicine* titled "A New Community Health Center/Academic Medicine Partnership for Medicaid Cost Control, Powered by the Mega Teaching Health Center."	Statewide

Appendix C. Abbreviations

ACO – Accountable care organization
AHC – Accountable Health Communities
APM – Alternative payment model
BH – Behavioral health
CCBHC – Certified Community Behavioral Health Clinics
CHIP – Children's Health Insurance Program
CMS – Centers for Medicare & Medicaid Services
DFPS – Texas Department of Family and Protective Services
DSH – Disproportionate Share Hospital program
DSHS – Texas Department of State Health Services
DSRIP – Delivery System Reform Incentive Payment program
DY – Demonstration year
ED – Emergency department
EQRO – External Quality Review Organization
FFP – Federal financial participation
FFY – Federal Fiscal Year
FY – Fiscal year
GME – Graduate Medical Education
GR – State General Revenue
HEDIS – Healthcare Effectiveness Data and Information Set
HHSC – Texas Health and Human Services Commission
HIE – Health Information Exchange
HITECH – Health Information Technology for Economic and Clinical Health Act
IAP – Innovation Accelerator Program
IAPD – Implementation Advance Planning Document
ICHP – Institute for Child Health Policy, University of Florida
IDD – Intellectual and developmental disabilities
IGT – Intergovernmental transfer
IT – Information technology
LAN – Health Care Payment Learning & Action Network
LIU – Low-Income or Uninsured
MCO – Managed care organization
MMP – Medicare-Medicaid plan
NAIP – Network Access Improvement Program
NASHP – National Academy of State Health Policy
P4Q – Pay For Quality program
PCP – Primary Care Provider
PIP – Performance improvement project
PPA – Potentially Preventable Admission

PPC – Potentially Preventable Complication
PPE – Potentially Preventable Event
PPR – Potentially Preventable Readmission
PPV – Potentially Preventable ED Visit
QI – Quality improvement
QIPP – Nursing Facility Quality Incentive Payment Program
RHP – Regional Healthcare Partnership
Roadmap – Value-Based Purchasing Roadmap
SAMHSA – Substance Abuse and Mental Health Services Administration
SDA – Managed care service delivery area
SMI – Severe mental illness
STC – Special Terms and Conditions
THLC Portal – Texas Healthcare Learning Collaborative Portal
UC – Uncompensated care
UHRIP – Uniform Hospital Rate Increase Program
UPL – Upper Payment Limit
VBP – Value-Based Payment/Purchasing
Waiver – Texas Healthcare Transformation and Quality Improvement Program Medicaid 1115 Demonstration Waiver

Attachment R

Texas DSRIP Measure Bundle Protocol Demonstration Years 7-10

TEXAS
Health and Human Services

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Introduction

The Delivery System Reform Incentive Payment (DSRIP) program is designed to provide incentive payments to Texas hospitals, physician practices, Community Mental Health Centers (CMHCs), and Local Health Departments (LHDs) for investments in delivery system reforms that increase access to health care, improve the quality of care, and enhance the health of patients and families they serve. This Measure Bundle Protocol for the DSRIP program is effective for Demonstration Years (DYs) 7-10 beginning October 1, 2017 [contingent on negotiations with the Centers for Medicare and Medicaid Services (CMS)].

The DY7-10 Measure Bundle Protocol reflects the evolution of the DSRIP program from project-level reporting to provider-level outcome reporting to measure the continued transformation of the Texas healthcare system. In DY7-10, DSRIP Performing Providers will report on required reporting categories at their provider system level.

Category A

Required reporting for Category A in DY7-10 includes progress on Core Activities, Alternative Payment Model (APM) arrangements, Costs and Savings, and Collaborative Activities. The Category A requirements were developed to serve as an opportunity for Performing Providers to move further towards sustainability of their transformed systems, including development of APMs to continue services for Medicaid and Low-Income or Uninsured (MLIU) individuals after DSRIP ends. The listing of Core Activities in the Measure Bundle Protocol reflects those project areas that have been determined to be the most transformational and will support continuation of the work begun by Performing Providers during the first years of DSRIP. These Core Activities will be continued or implemented by a Performing Provider to support achievement of its Category C measure goals.

Category B

As DSRIP shifts from project-level reporting to system-level reporting, the Texas Health and Human Services Commission (HHSC) wants to ensure that Performing Providers maintain a focus on serving the DSRIP target population: MLIU individuals. To that end, Category B will require each Performing Provider to report the total number of individuals and the number of MLIU individuals served by its system during each DY. In addition, Performing Providers will also report a breakout of MLIU individuals served by its system during DY9-10. The Measure Bundle Protocol sets out parameters for a Performing Provider to define its "system" to reflect the Performing Provider's current care landscape that is striving to advance the Triple Aim: improving the patient experience of care; improving the health of populations; and reducing the per capita cost of health care.

Category C

For Category C, targeted Measure Bundles have been developed for hospitals and physician practices and lists of measures are available for CMHCs and LHDs. Measure Bundles consist of measures that share a unified theme, apply to a similar population, and are impacted by similar activities. Bundling measures for DY7-10 allows for ease in measure selection and approval, increases standardization of measures across the state for hospitals and physician practices with similar activities, facilitates the use of regional networks to identify best practices and share innovative ideas, and continues to build on the foundation set in the initial waiver period while

providing additional opportunities for transforming the healthcare system and bending the cost curve.

The menu of available Measure Bundles for hospitals and physician practices and measures for CMHCs and LHDs were built with measures from common DY2-6 Category 3 pay-for-performance (P4P) measures; new P4P measures added from authoritative sources, with a preference for measures endorsed by the National Quality Forum; and innovative measures as needed, which will be pay-for-reporting (P4R) for DY7-8 and function as a measure testing process.

Additionally, in DY9-10, Category C includes required reporting on Lists of Related Strategies as determined by Measure Bundle selection for hospitals and physician practices or measure selection for CMHCs and LHDs. The individual Related Strategies within a List represent strategies Performing Providers may have implemented that impact the Category C Measure Bundle or measure target population. HHSC aims to examine the relationship between Related Strategies reporting and Performing Providers demonstrating higher Category C performance achievement among shared Measure Bundles or measures.

Related Strategies (Category C) and Core Activities (Category A) are similar in that they both involve better understanding what kinds of strategies Performing Providers are implementing to meet Category C achievement goals. In fact, the individual Related Strategy descriptions were informed by, but not limited to, Core Activity descriptions.

However, there are key differences between Related Strategies and Core Activities. First, the Lists of Related Strategies include strategies a Performing Provider may have implemented, even apart from DSRIP, which may not be included in Core Activities reporting. Second, unlike Core Activities reporting, Related Strategies reporting does not include a qualitative reporting component. Moreover, even if multiple Category C measures are selected, Performing Providers are only required to report on at least one Core Activity, leaving a gap in understanding what strategies were implemented across all selected Measure Bundles/measures for a given Performing Provider or across Performing Providers selecting shared Measure Bundles/measures.

Measure Development Process

HHSC formed a DSRIP Clinical Champions stakeholder group in 2015 to provide clinical expertise for development of DSRIP processes. The Clinical Champions consist of clinical, health quality, and operational professionals in Texas. In 2015, the Clinical Champions reviewed Performing Provider-submitted Transformational Impact Summaries—brief, structured project descriptions and evaluations—and identified DSRIP projects' high impact practices. HHSC used these high impact practices to inform the initial selection of the Category C Measure Bundle topics. The Clinical Champions also helped HHSC refine the DSRIP project menu to include only the most transformational project areas.

In 2017, Texas HHSC began a new process with the Clinical Champions to seek their input on the meaningfulness, improvability, and clinical appropriateness of proposed measures to include in the Hospital and Physician Practice Measure Bundles, as well as any identified gaps in measurement. HHSC implemented a multi-round process with the Clinical Champions to choose the draft measures for each of the Category C Measure Bundles. The process entailed three rounds of anonymous voting by Measure Bundle topic subgroups—termed Bundle Advisory Teams—via online surveys. Each round was followed by an advisory team conference call to discuss the survey results.

HHSC assigned Clinical Champions to 11 Bundle Advisory Teams based on their areas of clinical expertise and interest. Additionally, some Clinical Champions with operational expertise were assigned to a Technical Advisory Team, which provided feedback to the Bundle Advisory Teams

and HHSC about the feasibility of implementing suggested quality measures in a variety of settings.

The Bundle Advisory Teams rated each potential measure using a 5-point Likert scale, based on the measure's importance according to the member's clinical judgement. During the second and third survey rounds, participants reviewed the anonymous results of previous rounds, including both numerical ratings for each measure and qualitative comments submitted on the surveys and during conference calls. Each round resulted in the exclusion of measures with limited support. Additionally, Bundle Advisory Team members had the opportunity to suggest new and innovative measures, and those were included in the last round of voting.

CMHCs and the Texas Council of Community Centers provided recommendations for measures related to behavioral health, and LHDs were engaged in the development of measures for those Performing Providers.

Points were assigned to measures as outlined in the Measure Bundle Protocol.

HHSC will submit an updated Measure Bundle Protocol for DY7-10 to CMS (including a review of innovative measures tested in DY7 and DY8 for possible inclusion as P4P in the DY9-10 menu) no later than July 31, 2019.

Category D

For DY7-10, the Category D Statewide Reporting Measure Bundles have replaced the former Category 4 reporting on population-focused measures. While Category 4 was only for hospitals, all Performing Provider types can report on Category D in DY7-10. The Statewide Reporting Measure Bundles align with the MLIU population, are identified as high priority given the health care needs and issues of the patient population served, and are viewed as valid health care indicators to inform and identify areas for improvement in population health within the health care system. These bundles refine the hospital measures from the former Category 4 and add measures for physician practices, CMHCs, and LHDs. The emphasis of Category D is on the reporting of population health measures to gain information on and understanding of the health status of key populations and to build the capacity for reporting on a comprehensive set of population health metrics.

Category A

Each Performing Provider is required to report on the following for Category A:

- Core Activities;
- APMs;
- Costs and Savings; and
- Collaborative Activities.

Category A is designed to support DSRIP sustainability through Performing Providers' reporting on progress on the four key areas outlined above. Performing Providers design the structure of their next-step initiatives based on the foundation of quality improvements from DY2-6 projects and the experience from implementing Core Activities in DY7-8. This approach offers Performing Providers the flexibility to choose the elements for these four key areas with the goal to continue improvement in health care access and coordination. Category A reporting is required for all Performing Providers; its structure allows the flexibility for continuous quality improvement for the P4P in quality measurement in Category C.

Core Activities

With the transition from project-level to Performing Provider-level reporting, Performing Providers no longer report on projects; instead, they report on achievement of the goals for the Category C measures they select. To understand what enables Performing Providers to achieve these goals, Performing Providers report the Core Activities they implement to meet their Category C goals.

As defined in the Program Funding and Mechanics Protocol (PFM), a Core Activity is an activity implemented by a Performing Provider to achieve its Category C measure goals. A Core Activity can be an activity implemented by a Performing Provider as part of a DY2-6 DSRIP project that the Performing Provider chooses to continue in DY7-10, or it can be a new activity that the Performing Provider is implementing in DY7-10.

Core Activities included in this Measure Bundle Protocol are connected to the Transformational Extension Menu (TEM) that HHSC and the Clinical Champions developed in 2015-2016. In the TEM, HHSC and the Clinical Champions identified the most transformative initiatives from the initial waiver period, many of which are based on effective models that can be implemented by Performing Providers in the transition from project-level reporting to Performing Provider-level, quality-based reporting. In addition to activities learned through Texas DSRIP, Performing Providers can also propose activities from other national quality initiatives such as the MACRA Merit-based Incentive Payment System.

There are certain activities that Performing Providers can incorporate in any Core Activity as a sub-activity if it contributes to improving quality of care, such as technology improvements (e.g., Electronic Medical Records or Health Information Exchange connectivity) and continuous quality improvement (CQI), but the technological advances activities or the CQI should not be the only activity that Performing Providers choose to report on.

Core Activities Selection and Reporting

A Performing Provider needs to select and report on at least one Core Activity that supports the achievement of its Category C measure goals for the selected Measure Bundle(s) or measures. There is no maximum number of Core Activities that the Performing Provider may select.

Performing Providers can select Core Activities from the list created by HHSC, and they can include their own Core Activity by using the *Other* option and providing a description. In addition to reporting on Core Activities supporting Category C measures, a Performing Provider may include a Core Activity tied to the mission of the Performing Provider's organization, even if the activity does not have a strong connection to the selected measures. Selection of a Core Activity not tied to the Measure Bundles or measures cannot be the only selection but can be chosen as an additional Core Activity that the Performing Provider is reporting.

Requirement of at least one Core Activity was designed to increase the flexibility for Performing Providers and to lessen the reporting commitment by the Performing Providers. It is reasonable to assume that some Performing Providers will have just one main activity and requiring them to report on many initiatives would not benefit the Performing Provider or state and federal entities. However, Performing Providers with many initiatives can benefit from sharing what activities they are implementing. If some Performing Providers are successful at achieving the goals for the measures they are working on, understanding the main drivers for this success is beneficial to the state and federal government as well as other Performing Providers who are working on similar quality initiatives. In addition, sharing information on Core Activities can lead to further collaboration among Performing Providers within and across the regions.

In the RHP Plan Update for DY7-8, Performing Providers indicated which DY2-6 projects had Core Activities that continued in DY7-8 and which projects have been completed. The template for the RHP Plan Update for DY7-8 allowed Performing Providers to select Core Activities that continued from DY2-6 projects and new Core Activities that Performing Providers selected for implementation. In DY9-10, Performing Providers can continue working on the Core Activities from DY7-8 if they contribute to the Performing Providers' goals, or new Core Activities can be selected if Performing Providers need to adjust their initiatives based on their experience.

For example, a Performing Provider that expanded its primary care clinic in DSRIP DY2-6 decided to continue that expansion in DY7-8 (e.g., space expansion, increase in hours that clinic is in operation, or additional staffing) and selected *Provision of coordinated services for patents under Patent Centered Medical Home (PCMH) model* as a Core Activity that assisted the Performing Provider in achieving the goals for Improved Chronic Disease Management: Diabetes Care Measure Bundle in DY7-8. This Performing Provider can continue with the same Core Activity in DY9-10 but adjust it if needed. The Performing Provider may also decide to add a new Core Activity to reflect additional work that currently takes place or will be done in DY9-10.

As another example, a Performing Provider who increased access to different types of specialty care during DY2-6 could then decide in DY7-8 to maintain the same level of specialty care only in some areas but provide telemedicine services to other areas of specialty care. This Performing Provider may have selected *Use telehealth to deliver specialty services* as a Core Activity for DY7-8. In DY9-10, this Performing Provider may decide to continue with the existing Core Activity and adjust it as needed and select a new Core Activity, *Implementation of remote patient monitoring programs for diagnosis and/or management of care,* that will reflect additional plans that the Performing Provider is selecting to further promote its goals tied to quality measures selected under Category C*.*

In general, Performing Providers can select Core Activities from various groupings as long as it reflects what the Performing Provider is carrying out. Performing Providers working on quality initiatives in the area of behavioral health are not limited to areas directly related to behavioral health Core Activities and can select items in other areas.

During the second reporting period of each DY, Performing Providers report on all Core Activities selected, both continuing and those that are newly added. If adjustments are needed, Performing Providers can revise their strategies used in achieving Category C goals and update their selection of Core Activities at any time without HHSC approval. During the second reporting

period of each DY, Performing Providers provide a description of any newly selected Core Activity and the reason for selecting it along with reporting progress on previously selected Core Activities. If a Performing Provider has more than one Core Activity in the initial selection, and the Performing Provider needs to delete one of these activities due to the changes, then the Performing Provider is not required to choose a replacement activity to report on. Performing Providers may also add new Core Activities and discontinue those that are not showing results. It is recommended that Performing Providers use continuous quality improvement to monitor their progress. Providers report on Core Activities using the DSRIP online reporting system.

Menu of Core Activities

Access to Primary Care Services

- Increase in utilization of mobile clinics
- Increase in capacity and access to services by utilizing Community Health Workers (CHWs)/promotors, health coaches, peer specialists and other alternative clinical staff working in primary care
- Expanded Practice Access (e.g., increased hours, telemedicine, etc.)
- Establishment of care coordination and active referral management that integrates information from referrals into the plan of care
- Provision of screening and follow up services
- Provision of vaccinations to target population
- Integrated physical and behavioral health care services
- Use telemedicine/telehealth to deliver specialty services
- Provision of services to individuals that address social determinants of health
- Other

Access to Specialty Care Services

- Improvement in access to specialty care services with the concentration on underserved areas, so Performing Providers can continue to increase access to specialty care in the areas with limited access to services
- Use telemedicine/telehealth to deliver specialty services
- Implementation of remote patient monitoring programs for diagnosis and/or management of care
- Provision of services to individuals that address social determinants of health
- Other

Expansion or Enhancement of Oral Health Services

- Utilization of targeted dental intervention for vulnerable and underserved population in alternate setting (e.g., mobile clinics, teledentistry, Federally Qualified Health Centers (FQHCs), etc.)
- Expanded use of existing dental clinics for underserved population
- Expansion of school-based sealant and/or fluoride varnish initiatives to otherwise unserved school-aged children by enhancing dental workforce capacity through partnerships with dental and dental hygiene schools, LHDs, FQHCs, and/or local dental providers
- Other

Maternal and Infant Health Care

- Implementation of evidence-based strategies to reduce low birth weight and preterm birth (Evidence-based strategies include Nurse Family Partnership, Centering Pregnancy, IMPLICIT: Interventions to Minimize Preterm and Low birth weight Infants through Continuous Improvement Techniques among others)
- Develop and implement standard protocols for the leading causes of preventable death and complications for mothers and infants (Early Elective Delivery, Hemorrhage, Preeclampsia, and Supporting Vaginal Birth and Reducing Primary Cesareans)
- Provision of coordinated prenatal and postpartum care
- Use telemedicine/telehealth to deliver specialty services
- Provision of services to individuals that address social determinants of health
- Other

Patient Centered Medical Home

- Provision of coordinated services for patients under Patent Centered Medical Home (PCMH) model, which incorporates empanelment of patients to physicians, and management or chronic conditions and preventive care
- Integration of care management and coordination for high-risk patients based on the best practices (Agency for Healthcare Research and Quality (AHRQ) PCMH framework; Risk Stratified Care Management — High Risk, Rising Risk, and Low Risk designations; ACP PCMH model Safety Net Medical Home Initiative — Change Concepts for Practice Transformation, etc.)
- Enhancement in data exchange between hospitals and affiliated medical home sites
- Utilization of care teams that are tailored to the patient's health care needs, including non-physician health professionals, such as pharmacists doing medication management; case managers providing care outside of the clinic setting via phone, email, and home visits; etc.
- Provision of services to individuals that address social determinants of health
- Other

Expansion of Patient Care Navigation and Transition Service

- Provision of navigation services to targeted patients (e.g., patients with multiple chronic conditions, cognitive impairments and disabilities, Limited English Proficient patients, the uninsured, those with low health literacy, frequent visitors to the Emergency Department (ED), and others)
- Enhancement in coordination between primary care, urgent care, and EDs to increase communication and improve care transitions for patients
- Identification of frequent ED users and use of care navigators as part of a preventable ED reduction program, which includes a connection of ED patients to primary and preventive care
- Implementation of a care transition and/or a discharge planning program and post discharge support program. This could include a development of a cross-continuum team comprised of clinical and administrative representatives from acute care, skilled nursing, ambulatory care, health centers, and home care providers.
- Utilization of a comprehensive, multidisciplinary intervention to address the needs of high-risk patients
- Expansion of access to medical advice and direction to the appropriate level of care to reduce ED use for non-emergent conditions
- Provision of services to individuals that address social determinants of health
- Other

Prevention and Wellness

- Self-management programs and wellness programs using evidence-based designs (e.g., Stanford Small-Group Self-Management Programs for people with arthritis, diabetes, HIV, cancer, chronic pain, and other chronic diseases; and SAMHSA's Whole Health Action Management among others)
- Implementation of strategies to reduce tobacco use (Example of evidence-based models: 5R's (Relevance, Risks, Rewards, Roadblocks, Repetition) for patients not ready to quit; Ottawa Model; Freedom From Smoking Curriculum- American Lung Association among others)
- Implementation of evidence-based strategies to reduce and prevent obesity in children and adolescents (e.g., Technology Supported Multi Component Coaching or Counseling Interventions to Reduce Weight and Maintain Weight Loss; Coordinated Approach to Child Health - CATCH; and SPARK among others)
- Implementation of evidence-based strategies to empower patients to make lifestyle changes to stay healthy and self-manage their chronic conditions
- Utilization of whole health peer support, which could include conducting health risk assessments, setting SMART goals, providing educational and supportive services to targeted individuals with specific disorders (e.g., hypertension, diabetes, and health risks such as obesity, tobacco use, and physical inactivity)
- Use of CHWs to improve prevention efforts
- Implementation of evidence-based strategies to reduce sexually transmitted diseases
- Implementation of interventions focusing on social determinants of health that can lead to improvement in well-being of an individual
- Other

Chronic Care Management

- Utilization of evidence-based care management models for patients identified as having high-risk health care needs and/or individuals with complex needs (e.g., Primary care–integrated complex care management (CCM), Complex Patient Care Model Redesign-enhanced multidisciplinary care teams, The Transitional Care Model, etc.)
- Utilization of care management and/or chronic care management services, including education in chronic disease self-management
- Management of targeted patient populations (e.g., chronic disease patient populations that are at high risk for developing complications, co-morbidities, and/or utilizing acute and emergency care services)
- Implementation of a medication management program that serves patients across the continuum of care
- Utilization of pharmacist-led chronic disease medication management services in collaboration with primary care and other health care providers
- Utilization of enhanced patient portal that provides up-to-date information related to relevant chronic disease health or blood pressure control and allows patients to enter health information and/or enables bidirectional communication about medication changes and adherence
- Use telemedicine/telehealth to deliver specialty services
- Education and alternatives designed to curb prescriptions of narcotic drugs to patients
- Provision of services to individuals that address social determinants of health
- Other

Availability of Appropriate Levels of Behavioral Health Care Services

- Utilization of mobile clinics that can provide access to behavioral health care in very remote, inaccessible, or impoverished areas of Texas
- Utilization of telehealth/telemedicine in delivering behavioral services
- Increasing access to services by utilizing staff with the following qualifications: Wellness and Health Navigation: Bachelors level professional with experience in mental health and/or wellness initiatives or a peer specialist who has successfully completed the DSHS certification program for peer specialists
- Provision of care aligned with Certified Community Behavioral Health Clinic (CCBHC) model
- Utilization of Care Management function that integrates primary and behavioral health needs of individuals
- Provision of services to individuals that address social determinants of health and/or family support services.
- Other

Substance Use Disorder

- Provision of Medication Assisted Treatment
- Education of primary care practitioners on preventive treatment option
- Utilization of telehealth/telemedicine in delivering behavioral health services
- Utilization of Prescription Drug Monitoring program (can include targeted communications campaign)
- Supported employment services for individuals in recovery
- Office-based additional treatment for uninsured individuals
- Peer recovery support
- Provision of services to individuals that address social determinants of health including housing navigation services
- Utilization of telehealth/telemedicine in delivering behavioral services

Behavioral Health Crisis Stabilization Services

- Provision of crisis stabilization services based on the best practices (e.g., Critical Time Intervention, Critical Intervention Team, START model)
- Implementation of community-based crisis stabilization alternatives that meet the behavioral health needs of the patients
- Implement models supporting recovery of individuals with behavioral health needs
- Provision of services to individuals that address social determinants of health
- Other

Palliative Care

- Provision of coordinated palliative care to address patients with end-of-life decisions and care needs
- Provision of palliative care services in outpatient setting
- Transitioning of palliative care patients from acute hospital care into home care, hospice, or a skilled nursing facility and management of patients' needs
- Provision of services to individuals that address social determinants of health
- Utilization of services assisting individuals with pain management
- Other

Hospital Safety and Quality

- Development and implementation of standard protocols and/or evidence-based practices to address leading causes of hospital infections and injuries (e.g., CLABSI, CAUTI, SSI, Sepsis, and Falls)
- Implementation of evidence-based practices to improve quality of care (e.g., Quality Departments, monitoring and evaluation, etc.)
- Other

Other

If a Core Activity is not on this list, a Performing Provider can include a Core Activity and provide a description. As stated previously, Performing Providers may not add activities such as continuous quality improvement or a technology improvement as a stand-alone Core Activity. HHSC reserves the right to determine the appropriateness of "other" Core Activities chosen by a Performing Provider.

Alternative Payment Models

Based on numerous studies and research articles related to categories of healthcare spending and opportunities for increased efficiencies, there is a widespread trend towards linking health care payments to measures of quality and/or efficiency (aka "value"). Texas Medicaid and Children's Health Insurance Program programs are following this trend and have developed a Value-Based Purchasing Roadmap. Through its managed care contracting model, HHSC is making progress on a multiyear transformation of provider reimbursement models that have been historically volume based (i.e., fee-for-service) toward models that are structured to reward patient access, care coordination and/or integration, and improved healthcare outcomes and efficiency.

Because the initial DSRIP program has been a very effective incubator for testing how alternative, value-based payment models can support patient centered care and clinical innovation, HHSC continues to work with Managed Care Organizations (MCOs) and DSRIP Performing Providers on ways to incorporate promising clinical models as Value-Based Purchasing (VBP) arrangements in the Medicaid MCO provision of care. Performing Providers will report on progress in building the capacity to participate in a VBP model with MCOs through better utilization of Health Information Technologies and better measurement processes.

Costs and Savings Analysis

Based on the requirement included in the PFM for DY7-8, Performing Providers with a total valuation of $1 million or more per DY are required to submit information related to the costs of at least one Core Activity of their choice and the forecasted or generated savings of that Core Activity. In DY9-10, Performing Providers will continue with the Costs and Savings review and must analyze: 1) a different Core Activity than was used for the Costs and Savings analysis in DY7-8; or 2) a different aspect of the same Core Activity for the Costs and Savings analysis than was used for the Costs and Savings analysis in DY7-8. Along with other required information, Performing Providers will submit a short narrative including Core Activity chosen, methodologies, and assumptions made for the analysis. Information related to Costs and Savings analysis will be submitted in a template approved by HHSC or a comparable template. Performing Providers may use the Return on Investment Forecasting Calculator for Quality Initiatives by the Center for Health Care Strategies, Inc. or a comparable template that includes information such as the duration of the initiative, target population, costs, utilization changes, and/or savings.

Performing Providers will include costs and savings specific to their organization and other contracted providers if that information is available. If the Core Activity selected for the analysis is broad in scope, Performing Providers can concentrate their analysis on a component of this Core Activity and provide an explanation for such selection during reporting. In DY7-8, Performing Providers submitted a progress update on the analysis during the second reporting period of DY7, and the final report of costs and savings will be submitted during the second reporting period of DY8. For DY9-10, Performing Providers will submit a progress update for the new analysis to HHSC during the second reporting period of DY9, and a final report of costs and savings will be submitted during the second reporting period of DY10. This information is key to assist Performing Providers to work with Medicaid MCOs and other health care payers for sustainability.

Collaborative Activities

To continue to foster growth of collaboration within and among regions, all Performing Providers are required to attend at least one learning collaborative, stakeholder forum, or other stakeholder meeting each DY and report on participation during the second reporting period of each DY. A Performing Provider's participation in the learning collaborative, stakeholder forum, or other stakeholder meeting in DY7-10 can be done in person, via conference call, or via other telecommunications applications, and these meetings should include individuals from other entities in this region or other regions. Lessons learned from these meetings should be relevant at the Performing Provider level or applicable to some of the Performing Provider's Core Activities. Performing Providers will report on Collaborative Activities via the DSRIP online reporting system.

Category B

System Definition

DSRIP is shifting from project-based reporting to system-level reporting and a focus on system-wide changes and quality outcomes for DY7-10. As such, each Performing Provider will be required to define its system in the RHP Plan Update for its RHP.

In the broadest sense, the system is defined by the location(s) where patients are served by the Performing Provider and the types of services patients are receiving. The system definition will provide a broad structure in which Performing Providers work to improve care and transform the way healthcare is delivered in the state of Texas. While DSRIP will maintain its overall emphasis of improving care and access for the MLIU population in Texas, DSRIP reporting will no longer be limited by project-specific interventions or project-defined target populations.

A Performing Provider's system definition should capture all aspects of the Performing Provider's patient services. The Patient Population by Provider (PPP) (reported in Category B) is intended to reflect the universe of patients served by the Performing Provider's system; and, therefore, the Performing Provider's system definition should incorporate all aspects of its organization that serve patients. The system definition may not exclude certain populations (with the exception of incarcerated populations served by hospital systems under contract with a government entity). The system definition should include all of a Performing Provider's service areas that will be measured in its Category C measures but may not be limited to those populations or locations if other services are provided by the Performing Provider. In DY9-10, Performing Providers report a breakout of Medicaid and low-income or uninsured (LIU) served by their systems. In DY7-8 MLIU was reported as one number.

Systems may be limited by geographic location. For example, a Performing Provider that operates one hospital in one RHP and another hospital in a separate RHP will have two systems if the separate hospitals were each DSRIP Performing Providers in DY2-6, though they are technically owned by the same company. System is not exclusively defined by ownership. Alternatively, the system may cross geographic locations. For example, a Performing Provider that operates a variety of clinics in one RHP and multiple clinics in another RHP may be one system. DSRIP Performing Providers with the same ownership may not combine two currently separate DSRIP Performing Providers into one system for DY7-10, unless this has been previously approved. A Performing Provider's delineation of system should consider data systems and the extent to which the various components are coordinating to improve health of the patients served.

There are required and optional components of a Performing Provider's system definition for each Performing-Provider type. The required components are elements of a system that, through discussion with stakeholders and the technical advisory team, should be included as a Performing Provider's "base unit"; it has been determined that these components are essential functions and/or departments of the Performing Provider type. Therefore, the required components must be included in a Performing Provider's system definition if the Performing Provider's organization has that business component. A Performing Provider may then include optional components in its system definition and patient count, including contracted partners for certain services. Unless otherwise granted permission from HHSC, a Performing Provider should not count within its system definition or patient population another DSRIP Performing Provider's required components. There may be overlap in system definition for contracted partners; for example, System A that contracts with FQHC A and System B that contracts with FQHC A may both count the FQHC A as part of their system definition.

As indicated in the PFM, Performing Providers may add contracted entities to their system definition. Certain options will be specified by HHSC, but Performing Providers will also have the option to add an "other" category. Performing Providers will be required to explain any "other" optional component of the system definition. Inclusion of the population served in the optional components may be disallowed by HHSC. Performing Providers should include optional components in their system definition only if the Performing Provider will have access to all data necessary for reporting. Performing Providers should be mindful of data arrangements when contracting with entities that they intend to include in their system definition.

Required and Optional System Components

The following tables display the required and optional components of the system definition by Performing Provider type.

Hospitals

Required*	Optional
Inpatient Services	Contracted Specialty Clinics
Emergency Department	Contracted Primary Care Clinics
Owned or Operated Outpatient Clinics	School-based Clinics
Maternal Department	Contracted Palliative Care Programs
Owned or Operated Urgent Care Clinics	Contracted Mobile Health Programs
	Other

*Required only if the Performing Provider has this business component.

Physician Practices

Required*	Optional
Owned or Operated Primary Care Clinics	Contracted Specialty Clinics
Owned or Operated Specialty Care Clinics	Contracted Primary Care Clinics
Owned or Operated Hospital	Contracted Community-based Programs
Owned or Operated Urgent Care Clinics	Other

*Required only if the Performing Provider has this business component.

Community Mental Health Centers

Required*	Optional
Home-based services	Hospital
Office/Clinic	Contracted Clinic
	School-based Clinic
	Contracted Inpatient Beds
	State-funded Community Hospital
	Community Institution for Mental Disease (IMD)
	General Medical Hospital
	State Mental Health Facility
	State Mental Retardation Facility
	Other

*Required only if the Performing Provider has this business component.

Local Health Departments

Required*	Optional
Clinics	Mobile Outreach
Immunization Locations	Other

*Required only if the Performing Provider has this business component.

Once the Performing Provider has defined its system and the definition has been approved by HHSC, then the Performing Provider will focus its system population according to the measure denominators for Category C reporting. Denominators for Category C will be naturally limited by the encounter types defined in the measure specifications

Category C

Each Performing Provider must select Category C Measure Bundles or measures from the following menus included in this section based on Performing Provider type: 1) Hospital and Physician Practice Measure Bundle Menu; 2) Local Health Department Measure Menu; or 3) Community Mental Health Center Measure Menu. These menus include the number of points that each Measure Bundle or measure is worth.

Each Performing Provider is assigned a minimum point threshold (MPT) for Measure Bundle or measure selection as described in the PFM. Each Performing Provider must select Measure Bundles or measures worth enough points to meet its MPT in order to maintain its valuation for DY7 and DY8, and in DY9 and DY10.

Additionally, in DY9-10, Performing Providers will report on Lists of Related Strategies as determined by Measure Bundle selection for hospitals and physician practices or by measure selection for LHDs and CMHCs. For each Related Strategy within a required List, Performing Providers will make two reporting indications regarding the strategy's implementation (e.g., Implementation Date and Implementation Status). Performing Providers are required to report on Related Strategies in the DY9-10 RHP Plan Update and required to update Related Strategies reporting as part of the DY9 and DY10 Category C reporting milestones.

1. Measure Points

a. Each measure is assigned a point value based on the following classifications:
   i. Clinical Outcome: Patient clinical measures for which improvement in the measure represents an improvement in patient health outcomes or utilization patterns are valued at 3 points.
   ii. Population Based Clinical Outcome (PBCO): Clinical Outcomes that measures ED utilization or admissions for selected conditions for all individuals in the target population of a Measure Bundle are valued at 4 points.
   iii. Cancer Screening: Cancer screening measures are valued at 2 points.
   iv. Hospital Safety: Hospital safety and infection measures are valued at 2 points.
   v. Process Measure: Measures of clinical practice are valued at 1 point.
   vi. Immunization: Immunization rates are valued at 1 point.
   vii. Quality of Life: Measures related to quality of life or functional assessment are valued at 1 point.
   viii. Innovative Measure: Innovative measures are P4R in DY7-8 and valued at 0 points; the innovative measure is P4P in DY10 and valued at 1 point for DY9-10.
   ix. Quality Improvement Collaborative Activity: Participation in quality improvement activities is valued at 0 points.

b. Measure classification is specified for each measure in Appendix A Category C Specifications Document.

c. All measures are designated as P4P except for Innovative Measures and Quality Improvement Collaborative Activities which are P4R in DY7 and DY8 and P4P if selected or continued in DY9 and DY10. Measures that are P4R are noted in Measure Bundles for Hospital & Physician Practices section.

2. Hospital and Physician Practice Measure Bundle Points & Selection Requirements

a. The base point value of a Measure Bundle is equal to the sum of the points for the required measures in the Measure Bundle during the initial selection period. The base point value of a Measure Bundle designated as High State Priority is then multiplied by 2, and the base point value of a Measure Bundle designated as State Priority is then multiplied by 1.5.
   i. High State Priority Measure Bundles (sum of the required measures' points multiplied by 2)
      1. E1: Improved Maternal Care
      2. E2: Maternal Safety
      3. H3: Chronic Non-Malignant Pain Management
   ii. State Priority Measure Bundles (sum of the required measures' points multiplied by 1.5)
      1. A1: Chronic Disease Management: Diabetes
      2. A2: Chronic Disease Management: Heart Disease
      3. C1: Healthy Texans
      4. D1: Pediatric Primary Care
      5. D4: Pediatric Chronic Disease Management: Asthma
      6. D5: Pediatric Chronic Disease Management: Diabetes
      7. H1: Behavioral Health in a Primary Care Setting
      8. H2: Behavioral Health & Appropriate Utilization
      9. H4: Integrated Care for People with Serious Mental Illness

b. Optional measures in a Measure Bundle, if selected, add points to the Measure Bundle.
   i. Optional measures that add points, if selected, are not impacted by a high state priority or a state priority multiplier.

      EXAMPLE: Measure Bundle A1 - Chronic Disease Management: Diabetes is a State Priority Measure Bundle with required measures equaling 7 points and a multiplier of 1.5 for a base point value of 11 points. If a hospital selects Measure Bundle A1 and selects measures A1-500 Diabetes Composite and A1-508 Rate of ED Visits for Diabetes as P4P (A1-500 and A1-508 PBCOs worth an additional four points each and are required as P4P for Performing Providers with an MPT of 75 and optional as P4P for Performing Providers with an MPT less than 75), 8 points will be added to the Measure Bundle for a total of 19 points towards the hospital's MPT.

c. Limitations on Hospital and Physician Practice Measure Bundle Selections and Optional Measure Selections
   i. Measure Bundles K1 Rural Preventive Care and K2 Rural Emergency Care can only be selected in DY7-8 by hospitals with a valuation less than or equal to $2,500,000 per DY. Performing Providers that select Measure Bundle K1 cannot also select Measure Bundles A1, A2, B1, C1, D1, E1, or H1. Measure K2-285 cannot be selected if Measure Bundle K1 is selected.
   ii. In DY7 and DY8, each hospital or physician practice with an MPT of 75 must select at least one Measure Bundle with a PBCO. In DY9 and DY10, each hospital or physician practice with an MPT of 75 must select Measure Bundles that result in a minimum of two PBCOs.
   iii. For Measure Bundles A1, A2, B1, C1, D1, and H2, Population Based Clinical Outcomes are required for Performing Providers with an MPT of 75 and optional as P4P with 4 additional points for Performing Providers with an MPT below 75. Providers that do not opt to select a PBCO as P4P but have a measurable numerator greater than 0 are

required to report the PBCO as P4R following the requirements for a measure with insignificant volume.

iv. For Measure Bundles D4 and D5, the PBCO is a required measure for any Performing Provider that selects that Measure Bundle as the PBCO in each Measure Bundle is essential to the Measure Bundle objective.

v. Each hospital or physician practice with a valuation of more than $2,500,000 per DY in DY7-8 or $2,000,000 in DY10 must either: 1) select at least one Measure Bundle with at least one required 3 point clinical outcome measure; or 2) select at least one Measure Bundle with at least one optional 3 point clinical outcome measure selected. Three-point clinical measures must have significant volume and be P4P to qualify as the required 3-point measure.

vi. If bundles D3 Pediatric Hospital Safety and J1 Hospital Safety are both selected, the points of each bundle will be reduced by 50%.

3. Community Mental Health Center and Local Health Department Measure Points & Selection Requirements

a. Certain measures designated as a state priority, if selected, add an additional point.
b. CMHCs and LHDs must select and report on at least two unique measures.
c. Each CMHC or LHD with a valuation of more than $2,500,000 per DY in DY7-8 or $2,000,000 in DY10 must select at least one 3 point clinical outcome measure.
d. If a CMHC selects more than one of the depression response measures M1-165, M1-181, or M1-286, only 4 points will be counted towards the Performing Provider's MPT.

4. Minimum Volume Definitions & Requirements

a. Minimum Volume Definitions
   i. *Significant volume* is defined, for most outcome measures, as an MLIU denominator for the measurement period that is greater than or equal to 30, unless an exception has been granted by HHSC to use an all-payer denominator as defined in the PFM.
   ii. *Insignificant volume* is defined, for most outcome measures, as an MLIU denominator for the measurement period that is less than 30, but greater than 0, unless an exception has been granted by HHSC to use an all-payer denominator.
   iii. *No volume* is defined as an MLIU denominator for the measurement period that is 0. For a PBCO, no volume is defined as a numerator for the 12 month measurement period that is 0.
b. Hospital and Physician Practice Minimum Volume Requirements
   i. A hospital or physician practice may only select a Measure Bundle for which the hospital's or physician practice's MLIU denominator for the baseline measurement period for at least half of the required measures in the Measure Bundle has *significant volume.*
   ii. A hospital or physician practice may only select an optional measure in a selected Measure Bundle for which the hospital or physician practice's MLIU denominator for the baseline measurement period has *significant volume.*
   iii. **Insignificant Volume:** If a hospital or physician practice selects a Measure Bundle with a required measure for which the hospital or physician practice has *insignificant volume*, the valuations of the measure's reporting milestones will remain the same, but the valuations of the measure's achievement milestones will be redistributed proportionally among the achievement milestones for the other measures in the Measure Bundle with *significant volume.*

EXAMPLE: A physician practice selects a Measure Bundle with four required measures, selects one optional measure in the Measure Bundle, and has *insignificant volume* for one required measure. The selected Measure Bundle is assigned a valuation of $1,000,000 for DY7 and $1,000,000 for DY8. The milestone valuations for DY7 and DY8 are as follows:

Measure	Volume	DY7 Baseline Milestone ($250,000)	DY7 PY1 Reporting Milestone ($250,000)	DY7 Achievement Milestone ($500,000)	DY8 PY2 Reporting Milestone ($250,000)	DY8 Achievement Milestone ($750,000)
1 (required)	Significant	$62,500	$62,500	$166,667	$62,500	$250,000
2 (required)	Significant	$62,500	$62,500	$166,667	$62,500	$250,000
3 (required)	Insignificant	$62,500	$62,500	$0	$62,500	$0
4 (optional)	Significant	$62,500	$62,500	$166,667	$62,500	$250,000

1. If a hospital or physician practice has *insignificant volume* for the baseline measurement period for a required measure in a selected Measure Bundle at the time of RHP Plan Update submission, the hospital or physician practice will notify HHSC in the RHP Plan Update that it has *insignificant volume* for the measure.
2. If a hospital or physician practice reports the baseline or performance for a required measure in a selected Measure Bundle with *insignificant volume* for the measurement period, the measure's achievement milestone valuation may be redistributed as described in this subsection.

iv. **No Volume:** Required measures with *no volume* because the hospital or physician practice does not serve the population measured will be removed from the Measure Bundle and the valuations of the associated reporting and achievement milestones will be redistributed proportionally among the remaining measures in the Measure Bundle.

EXAMPLE: A physician practice selects a Measure Bundle with four required measures, selects one optional measure in the Measure Bundle, and has *no volume* for one required measure. The selected Measure Bundle is assigned a valuation of $1,000,000 in DY7 and $1,000,000 in DY8. The valuations for DY7 and DY8 are as follows:

Measure	Volume	DY7 Baseline Milestone ($250,000)	DY7 PY1 Reporting Milestone ($250,000)	DY7 Achievement Milestone ($500,000)	DY8 PY2 Reporting Milestone ($250,000)	DY8 Achievement Milestone ($750,000)
1 (required)	Significant	$83,333	$83,333	$166,667	$83,333	$250,000
2 (required)	Significant	$83,333	$83,333	$166,667	$83,333	$250,000
3 (required)	None	$0	$0	$0	$0	$0
4 (optional)	Significant	$83,333	$83,333	$166,667	$83,333	$250,000

1. If a hospital or physician practice has *no volume* for the baseline measurement period for a required measure in a selected Measure Bundle at the time of RHP Plan Update submission, the hospital or physician practice will notify HHSC in the RHP Plan Update that it has *no volume* for the measure.
2. If a hospital or physician practice reports the baseline or performance for a required measure in a selected Measure Bundle with *no volume* for the measurement period, the measure's reporting and achievement milestone valuation may be redistributed as described in this subsection.

c. CMHC and LHD Minimum Volume Requirements
   i. A CMHC or LHD may only select measures for which it has *significant volume.*

5. Eligible Denominator Population

All Measure Bundles will be based on the DSRIP attributed population defined below. Each Measure Bundle has a target population (or pool of people) for which the Performing Provider system is accountable for improvement under the DSRIP incentive arrangements. The target population identifies all individuals in the DSRIP attributed population for each Performing Provider system, which then serves as the starting point for all the measures within the Measure Bundle and includes all individuals that would fall into the measure specifications for the included measure.

When reporting data for measures in a Measure Bundle, the eligible denominator population for each measure will be determined by the following process:

Step 1: Determine the DSRIP attributed population using the prescribed attribution methodology defined below.

Step 2: Determine the individuals from step one that are included in the Measure Bundle or measure target population.

Step 3: Determine the individuals from the Measure Bundle target population that meet the measure specific denominator inclusion criteria.

Step 4: Determine payer type for individuals or encounters in the denominator following standardized specifications to determine the all payer, Medicaid, and LIU rate for each measure.

Step 1: Determine the DSRIP attributed population using the prescribed retroactive attribution methodology defined below based on the Performing Provider type indicated in the RHP Plan Submission:

1. For hospital organizations and physician practices, the DSRIP attributed population includes individuals from the DSRIP system defined in Category B that meet at least one of the criteria below. Individuals do not need to meet all or multiple criteria to be included.
   a. Medicaid beneficiary attributed to the Performing Provider during the measurement period as determined by assignment to a primary care provider (PCP), medical home, or clinic in the Performing Providers DSRIP defined system OR
   b. Individuals enrolled in a local coverage program (for example, a county-based indigent care program) assigned to a PCP, medical home, or clinic in the Performing Providers DSRIP defined system OR
   c. One preventive service provided during the measurement period (Includes value sets of visit type codes for annual wellness visit, preventive care services - initial office visit, preventive care services - established office visit, and preventive care individual counseling) OR
   d. One ambulatory encounter during the measurement year and one ambulatory encounter during the year prior to the measurement year OR
   e. Two ambulatory encounters during the measurement year OR
   f. Other populations managed with chronic disease in specialty care clinics in the Performing Providers DSRIP defined system
   g. One ED visit during the measurement year OR
   h. One admission for inpatient or observation status during the measurement year OR
   i. One prenatal or postnatal visit during the measurement year OR

j. One delivery during the measurement year OR
k. One dental encounter during the measurement year OR
l. Enrolled in a palliative care or hospice program during the measurement year OR
m. Other populations not included above that should be included in a Measure Bundle target population included in the RHP plan submission and approved by HHSC (for example, individuals enrolled in community-based education programs)

2. For CMHCs, the DSRIP attributed population includes:
   a. All individuals from the DSRIP system defined in Category B that meet one of the following criteria during the measurement period:
      i. One encounter with the Performing Providers system during the measurement year and one encounter during the year prior to the measurement year OR
      ii. Two encounters with the Performing Providers system during the measurement year OR
      iii. Other populations defined by the CMHC in the RHP Plan Submission and approved by HHSC
3. For LHDs, the DSRIP attributed population includes:
   a. Individuals with one eligible encounter during the measurement period OR
   b. Other populations defined by the LHD in the RHP Plan Submission and approved by HHSC
4. Allowable Exclusions for all Performing Provider types:
   a. Performing Providers may remove from the DSRIP attributed population any individual for which the Performing Provider has documentation of any one of the following during the measurement year:
      i. The individual that was previously assigned a PCP, medical home, or clinic with the Performing Provider but has changed their care to a PCP, medical home, or clinic that is not with the Performing Providers DSRIP system.
      ii. The patient has had a total time of incarceration during the measurement period that exceeded 45 days.

For Steps 2 - 4, refer to the introduction section of Appendix A Category C Measure Specifications.

6. Exceptions to MPTs and Measure Bundle Selection for Hospital and Physician Practices with a Limited Scope of Practice

a. Certain Performing Providers have a limited scope of practice. These Performing Providers may include children's hospitals and specialty hospitals such as infectious disease hospitals and Institutions for Mental Disease.
   i. If such a Performing Provider is not able to reasonably report on enough Measure Bundles to meet its MPT based on its limited scope of practice and available community partnerships, the Performing Provider may request a lowered MPT equal to the sum of all Measure Bundles that the Performing Provider could reasonably report. The Performing Provider must request a lowered MPT prior to the RHP Plan Update submission, by a date determined by HHSC.
   ii. If such a Performing Provider is not able to reasonably report on at least half of the required measures in Measure Bundles needed to meet its MPT based on its limited scope of practice and available community partnerships, the Performing Provider may request approval to select measures outside of the Measure Bundle structure prior to the RHP Plan Update submission, by a date determined by HHSC.

1. The hospital or physician practice must select measures from the Hospital and Physician Practice Measure Bundle Menu, the Local Health Department Measure Menu, or the Community Mental Health Center Measure Menu in accordance with the measure selection requirements for LHDs and CMHCs.

iii. A hospital's or physician practice's request to lower the MPT or to select measures outside of the Measure Bundle structure may be subject to review by CMS. If HHSC and CMS, as appropriate, approve the request, the hospital's or physician practice's total valuation may be reduced.

7. Exceptions to Measure Selection for Local Health Department

a. LHDs may continue to report measures that an LHD reported for Category 3 in DY6 that are P4P in DY6 and not otherwise included in the L1 Local Health Department Menu.
   i. Grandfathered measures that are classified as standalone measures in DY2-6 will be valued at 3 points. Grandfathered measures that are non-standalone in DY2-6 will be valued at 1 point unless a measure has been given a categorization with a valuation of 2 points in the Measure Bundle Protocol.
   ii. Grandfathered measures will use DY6 (10/01/2016 - 09/30/2017) as the baseline measurement period for determining DY7 and DY8 goal achievement milestones and standard performance measurement periods so that PY1 is CY2018, PY2 is CY2019, and PY3 is CY2020.
   iii. Duplicated measures will only count once towards a Performing Providers MPT. For example, if an LHD has two non-standalone measures that are the same measure selection in DY6 but report different rates for different facilities, the Performing Provider may continue to report both measures, but both measures will only contribute 3 points towards the MPT.
b. LHDs may use a combination of grandfathered DY6 Category 3 measures and new measures selected from the L1 Local Health Department Menu in the Measure Bundle Protocol. New measures cannot duplicate grandfathered measures.
c. LHDs may continue to report grandfathered measures that were approved for use in DY7 and DY8 as P4P in DY9 and DY10.
d. LHDs may not select new grandfathered measures for use in DY9 and DY10.

Hospital & Physician Practice Measure Bundle Menu

Hospital & Physician Practice Measure Bundles	Any PBCO (4 points)	Any Clinical Outcome (3 Points)	Base Points	Additional Points	Max Points
A1: Chronic Disease Management: Diabetes *[SP]*	*Required* [1]	Required	11	9	**20**
A2: Chronic Disease Management: Heart Disease *[SP]*	*Required* [1]	Required	8	11	**19**
B1: Care Transitions & Hospital Readmissions	None	Required	11	0	**11**
B2: Patient Navigation & ED Diversion	None	Required	3	9	**12**
C1: Primary Care Prevention - Healthy Texans *[SP]*	*Required* [1]	None	12	4	**16**
C2: Primary Care Prevention - Cancer Screening	None	None	6	0	**6**
C3: Hepatitis C	None	None	4	0	**4**
D1: Pediatric Primary Care *[SP]* DY7/8	*Required* [1]	Required	14	6	**20**
D1: Pediatric Primary Care *[SP]* DY9/10	*Required* [1]	Required	12	6	**18**
D3: Pediatric Hospital Safety	None	None	10	0	**10**
D4: Pediatric Chronic Disease Management: Asthma *[SP]*	Required	None	9	0	**9**
D5: Pediatric Chronic Disease Management: Diabetes *[SP]*	Required	None	8	0	**8**
E1: Improved Maternal Care *[HSP]* DY7/8	None	Required	10	1	**11**
E1: Improved Maternal Care *[HSP]* DY9/10	None	Required	10	0	**10**
E2: Maternal Safety *[HSP]* DY7/8	None	Required	8	0	**8**
E2: Maternal Safety *[HSP]* DY9/10	None	Required	12	0	**12**
F1: Improved Access to Adult Dental Care DY7/8	None	Required	7	0	**7**
F1 Improved Access to Adult Dental Care DY9/10	None	Required	7	1	**8**
F2: Preventive Pediatric Dental	None	None	2	0	**2**
G1: Palliative Care	None	*None* [2]	6	0	**6**
H1: Integration of Behavioral Health in a Primary or Specialty Care Setting *[SP]*	None	Required	12	0	**12**
H2: Behavioral Health & Appropriate Utilization *[SP]*	*Required* [1]	Optional	8	11	**19**
H3: Chronic Non-Malignant Pain Management *[HSP]*	None	None	10	0	**10**
H4: Integrated Care for People with Serious Mental Illness *[SP]*	None	None	5	0	**5**
I1: Specialty Care [3]	None	None	2	0	**2**
J1: Hospital Safety	None	None	10	0	**10**
K1: Rural Preventive Care [4]	None	Optional	3	10	**13**
K2: Rural Emergency Care [4]	None	None	3	1	**4**
Total Possible Points DY7/8	N/A	N/A	182	62	244
Total Possible Points DY9/10	N/A	N/A	184	63	247

[SP] Measure Bundle Designated as a State Priority.
[HSP] Measure Bundle Designated as a High State Priority.
[1]One or more PBCOs are required as P4P for Performing Providers with an MPT 0f 75 that select bundle, optional as P4P for others.
[2]Clinical outcomes included for cancer hospital only (optional 6 additional points).
[3]Requires prior authorization.
[4]Can only be selected in DY7-8 by hospitals with a valuation at or below $2,500,000 per DY.

A1: Improved Chronic Disease Management: Diabetes Care

This bundle is a State Priority.

Objective:
Develop and implement chronic disease management interventions that are geared toward improving management of diabetes and comorbidities, improving health outcomes and quality of life, preventing disease complications, and reducing unnecessary acute and emergency care utilization.

Target Population:
Adults with diabetes

Base Points: 7*1.5 (state priority) = 11

Possible Additional Points: 9

Maximum Total Possible Points: 20

ID	Measure	Steward	NQF #	Required in DY7/8	Required in DY9/10	Measure Points
A1-111	Comprehensive Diabetes Care: Eye Exam (retinal) performed	NCQA	0055	No	No	+1
A1-112	Comprehensive Diabetes Care: Foot Exam	NCQA	0056	Yes	Yes	1
A1-115	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	NCQA	0059	Yes	Yes	3
A1-207	Diabetes care: BP control (<140/90mm Hg)	NCQA	0061	Yes	Yes	3
A1-500	PQI 93 Diabetes Composite (Adult short-term complications, long-term complications, uncontrolled diabetes, lower-extremity amputation admission rates)	AHRQ	N/A	Yes*	Yes*	+4 if P4P +0 if P4R
A1-508	Reduce Rate of Emergency Department visits for Diabetes	N/A	N/A	Yes*	Yes*	+4 if P4P +0 if P4R

*For Performing Providers that select Measure Bundle A1:

- Measures A1-500 AND A1-508 are PBCOs and are required P4P measures for Performing Providers with an MPT of 75.
- Performing Providers with an MPT less than 75 may opt to report measures as P4P.
  Performing Providers with an MPT below 75 that do not opt to report as P4P that have any numerator volume will report as P4R. Measures reported as P4R will not count towards the Measure Bundle's point value and do not contribute towards a Performing Provider's MPT

A2: Improved Chronic Disease Management: Heart Disease

This bundle is a State Priority.

Objective:
Develop and implement chronic disease management interventions that are geared toward improving management of heart disease and comorbidities, improving health outcomes and quality of life, preventing disease complications, and reducing unnecessary acute and emergency care utilization.

Target Population:
Adults with heart disease

Base Points: 5*1.5 (state priority) = 8

Possible Additional Points: 11

Maximum Total Possible Points: 19

ID	Measure	Steward	NQF #	Required in DY7/8	Required in DY9/10	Measure Points
A2-103	Controlling High Blood Pressure	NCQA	0018	Yes	Yes	3
A2-210	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	CMS	N/A	Yes	Yes	1
A2-384	Risk Adjusted CHF 30-Day Readmission Rate	N/A	N/A	No	No	+3
A2-404	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	CMS	N/A	Yes	Yes	1
A2-501	PQI 08 Heart Failure Admission Rate (Adult)	AHRQ	N/A	Yes*	Yes*	+4 if P4P +0 if P4R
A2-509	Reduce Rate of Emergency Department visits for CHF, Angina, and Hypertension	N/A	N/A	Yes*	Yes*	+4 if P4P +0 if P4R

*For Performing Providers that select Measure Bundle A2:

- Measures A2-501 and A2-509 are PBCOs and are required P4P measures for Performing Providers with an MPT of 75.
- Performing Providers with an MPT less than 75 may opt to report measures as P4P.
- Performing Providers with an MPT below 75 that do not opt to report as P4P that have any numerator volume will report as P4R. Measures reported as P4R will not count towards the Measure Bundle's point value and do not contribute towards a Performing Provider's MPT.

B1: Care Transitions & Hospital Readmissions

Objective:
Implement improvements in care transitions and coordination of care from inpatient to outpatient, post-acute care, and home care settings in order to improve health outcomes and prevent increased health care costs and hospital readmissions.

Target Population:
Individuals transitioning out of inpatient care

Base Points: 11

Possible Additional Points: N/A

Maximum Total Possible Points: 11

ID	Measure	Steward	NQF #	Required in DY7/8	Required in DY9/10	Measure Points
B1-124	Medication Reconciliation Post-Discharge	NCQA	0097	Yes	Yes	1
B1-141	Risk Adjusted All-Cause 30-Day Readmission for Targeted Conditions: coronary artery bypass graft (CABG) surgery, CHF, Diabetes, AMI, Stroke, COPD, Behavioral Health, Substance Use	N/A	N/A	Yes	Yes	3
B1-217	Risk Adjusted All-Cause 30-Day Readmission	N/A	N/A	Yes	Yes	3
B1-252	Care Transition: Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)	AMA	0649	Yes	Yes	1
B1-253	Transition Record with Specified Elements Received by Discharged Patients (Inpatient Discharges to Home/Self Care or Any Other Site of Care)	AMA	0647	Yes	Yes	1
B1-287	Documentation of Current Medications in the Medical Record	CMS	0419	Yes	Yes	1
B1-352	Post-Discharge Appointment	AHA/ASA, TJC	2455/ 2439	Yes	Yes	1

B2: Patient Navigation & ED Diversion

Objective:
Utilize patient navigators (CHWs, case managers, or other types of professionals) and/or develop other strategies to provide enhanced social support and culturally competent care to connect high risk patients to primary care or medical home sites, improve patient outcomes, and divert patients needing non-urgent care to appropriate settings.

Target Population:
Adults utilizing the emergency department

Base Points: 3

Possible Additional Points: 9

Maximum Total Possible Points: 12

ID	Measure	Steward	NQF #	Required in DY7/8	Required in DY9/10	Measure Points
B2-242	Reduce Emergency Department (ED) visits for Chronic Ambulatory Care Sensitive Conditions (ACSC)	N/A	N/A	Yes**	Yes**	*(+3)*
B2-387	Reduce Emergency Department visits for Behavioral Health and Substance Abuse	N/A	N/A	Yes**	Yes**	*(+3)*
B2-392	Reduce Emergency Department visits for Acute Ambulatory Care Sensitive Conditions (ACSC)	N/A	N/A	Yes	Yes	*3*
B2-393	Reduce Emergency Department visits for Dental Conditions	N/A	N/A	Yes**	Yes**	*(+3)*

**Must select one of either B2-242, B2-387, B2-393

May select one or more additional from B2-242, B2-387, B2-393 for up to an additional 6 points.

C1: Primary Care Prevention - Healthy Texans

This bundle is a State Priority.

Objective:
Provide comprehensive, integrated primary care services that are focused on person-centered preventive care and chronic disease screening.

Target Population:
Adults

Base Points: 8*1.5 (state priority) = 12

Possible Additional Points: 4

Maximum Total Possible Points: 16

ID	Measure	Steward	NQF #	Required in DY7/8	Required in DY9/10	Measure Points
C1-105	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	NCQA	0028	Yes	Yes	1
C1-113	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) testing	NCQA	0057	Yes	Yes	1
C1-147	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	CMS	0421 / 2828	Yes	Yes	1
C1-268	Pneumonia vaccination status for older adults	CMS	0043	Yes	Yes	1
C1-269	Preventive Care and Screening: Influenza Immunization	AMA / PCPI	0041 / 3070	Yes	Yes	1
C1-272	Adults (18+ years) Immunization status	ICSI	N/A	Yes	Yes	1
C1-280	Chlamydia Screening in Women (CHL)	NCQA	0033	Yes	Yes	1
C1-389	Human Papillomavirus Vaccine (age 18 -26)	N/A	N/A	Yes	Yes	1
C1-502	PQI 91 Acute Composite (Adult Dehydration, Bacterial Pneumonia, Urinary Tract Infection Admission Rates)	AHRQ	N/A	Yes*	Yes*	+4 if P4P +0 if P4R

*For Performing Providers that select Measure Bundle C1:

- Measure C1-502 is a PBCOs and is a required P4P measures for Performing Providers with an MPT of 75.
- Performing Providers with an MPT less than 75 may opt to report measure as P4P.
- Performing Providers with an MPT below 75 that do not opt to report as P4P that have any numerator volume will report as P4R. Measures reported as P4R will not count towards the Measure Bundle's point value and do not contribute towards a Performing Provider's MPT.

C2: Primary Care Prevention - Cancer Screening

Objective:
Increase access to cancer screening in the primary care setting.

Target Population:
Adults

Base Points: 6

Possible Additional Points: N/A

Maximum Total Possible Points: 6

ID	Measure	Steward	NQF #	Required in DY7/8	Required in DY9/10	Measure Points
C2-106	Cervical Cancer Screening	NCQA	0032	Yes	Yes	2
C2-107	Colorectal Cancer Screening	NCQA	0034	Yes	Yes	2
C2-186	Breast Cancer Screening	NCQA	2372	Yes	Yes	2

C3: Hepatitis C

Objective:
Implement screening program in high risk populations to detect and treat Hepatitis C infections.

Target Population:
Adults

Base Points: 4

Possible Additional Points: N/A

Maximum Total Possible Points: 4

ID	Measure	Steward	NQF #	Required in DY7/8	Required in DY9/10	Measure Points
C3-203	Hepatitis C: One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk	AMA-PCPI	3059	Yes	Yes	1
C3-328	Appropriate Screening Follow-up for Patients Identified with Hepatitis C Virus (HCV) Infection	PCPI	3061	Yes	Yes	1
C3-368	Hepatitis C: Hepatitis A Vaccination	American Gastroenterological Association	0399	Yes	Yes	1
C3-369	Hepatitis C: Hepatitis B Vaccination	American Gastroenterological Association	0400	Yes	Yes	1

D1: Pediatric Primary Care

This bundle is a State Priority.

Objective: Increase access to comprehensive, coordinated primary care & preventive services focused on accountable, child-centered care that improves quality of life and health outcomes.

Target Population: Children

Base Points:

DY7/8: 9*1.5 (high state priority) = 14
DY9/10: 8*1.5 (high state priority) = 12**

Possible Additional Points: 6

Maximum Total Possible Points: 20 for DY7/8, 18 for DY9/10**

ID	Measure	Steward	NQF #	Required in DY7/8	Required in DY9/10	Measure Points
D1-108	Childhood Immunization Status (CIS)	NCQA	0038	Yes	Yes	1
D1-211	Weight Assessment and Counseling for Nutrition and Physical Activity	NCQA	0024	Yes	Yes	1
D1-212	Appropriate Testing for Children With Pharyngitis	AHRQ	0002	Yes	Yes	3
D1-237	Well-Child Visits in the First 15 Months of Life	NCQA	1392	Yes	Discontinued**	DY7/8: 1 DY9/10: 0
D1-271	Immunization for Adolescents	NCQA	1407	Yes	Yes	1
D1-284	Appropriate Treatment for Children with URI	NCQA	0069	Yes	Yes	1
D1-301	Maternal Depression Screening	NCQA	1401	No	No	+1
D1-389	Human Papillomavirus Vaccine (age 15-18)	N/A	N/A	No	No	+1
D1-400	Tobacco Use and Help with Quitting Among Adolescents	CMS	N/A	Yes	Yes	1
D1-503	PDI 97 Acute Composite (Gastroenteritis, Urinary Tract Infection Admission Rate)	AHRQ	N/A	Yes*	Yes*	*+4 if P4P +0 if P4R
D1-T01	*Innovative Measure:* Behavioral Health Counselling for Childhood Obesity	Meadows	N/A	No	Discontinued	0

*For Performing Providers that select Measure Bundle D1:

- Measure D-503 is a PBCOs and is a required P4P measures for Performing Providers with an MPT of 75.
- Performing Providers with an MPT less than 75 may opt to report measure as P4P.
- Performing Providers with an MPT below 75 that do not opt to report as P4P that have any numerator volume will report as P4R. Measures reported as P4R will not count towards the Measure Bundle's point value and do not contribute towards a Performing Provider's MPT.

**D1-237 may be continued as P4P in DY9/10 for continued selection with a D1 base point value of 14.

D3: Pediatric Hospital Safety

Objective:
Reduce hospital errors, improve effectiveness of staff communication (both internally and with patients and their caregivers), improve medication management, and reduce the risk of health-care associated infections.

Target Population:
Children receiving inpatient care

Base Points: 10

Possible Additional Points: N/A

Maximum Total Possible Points: 10

If D3 and J1 are both selected, the points of each bundle will be reduced by 50%.

ID	Measure	Steward	NQF #	Required in DY7/8	Required in DY9/10	Measure Points
D3-330	Pediatric CLABSI	Children's Hospitals' Solutions for Patient Safety National Children's Network	N/A	Yes	Yes	2
D3-331	Pediatric CAUTI	Children's Hospitals' Solutions for Patient Safety National Children's Network	N/A	Yes	Yes	2
D3-333	Pediatric Surgical site infections (SSI)	Children's Hospitals' Solutions for Patient Safety National Children's Network	N/A	Yes	Yes	2
D3-334	Pediatric Adverse Drug Events	Children's Hospitals' Solutions for Patient Safety National Children's Network	N/A	Yes	Yes	2
D3-335	Pediatric Pressure Injuries	Children's Hospitals' Solutions for Patient Safety National Children's Network	N/A	Yes	Yes	2

D4: Pediatric Chronic Disease Management: Asthma

This bundle is a State Priority.

Objective:
Develop and implement chronic disease management interventions that are geared toward improving management of asthma to improve patient health outcomes and quality of life and reduce unnecessary acute and emergency care utilization.

Target Population:
Children with asthma

Base Points: 6*1.5 (state priority) = 9

Possible Additional Points: N/A

Maximum Total Possible Points: 9

ID	Measure	Steward	NQF #	Required in DY7/8	Required in DY9/10	Measure Points
D4-139	Asthma Admission Rate (PDI 14)	AHRQ	07228	Yes	Yes	4
D4-353	Proportion of Children with ED Visits for Asthma with Evidence of Primary Care Connection Before the ED Visit	University Hospitals Cleveland Medical Center	3170	Yes	Yes	1
D4-375	Asthma: Pharmacologic Therapy for Persistent Asthma (Rate 3 only)	The American Academy of Asthma Allergy and Immunology	0047	Yes	Yes	1

D5: Pediatric Chronic Disease Management: Diabetes

Objective:
Develop and implement diabetes management interventions that improve patient health outcomes and quality of life, prevent onset or progression of comorbidities, and reduce unnecessary acute and emergency care utilization.

Target Population:
Children with Type 1 and Type 2 Diabetes

Base Points: 5*1.5 (state priority) = 8

Possible Additional Points: N/A

Maximum Total Possible Points: 8

ID	Measure	Steward	NQF #	Required in DY7/8	Required in DY9/10	Measure Points
D5-211	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents	NCQA	0024	Yes	Yes	1
D5-406	Diabetes Short-term Complications Admission Rate (PDI 15)	AHRQ	N/A	Yes	Yes	4
D5-T07	*Innovative Measure:* Diabetes Care Coordination	TBD	N/A	No	Discontinued	0

E1: Improved Maternal Care

This bundle is a High State Priority.

Objective:
Improve maternal health outcomes by implementing evidence-based practices to provide pre-conception, prenatal, and postpartum care including early detection and management of comorbidities like hypertension, diabetes, and depression.

Target Population:
Pregnant and postpartum women

Base Points: 5*2 (high state priority) = 10

Possible Additional Points: 1 for DY7/8

Maximum Total Possible Points: 11 for DY7/8, 10 for DY9/10

ID	Measure	Steward	NQF #	Required in DY7/8	Required in DY9/10	Measure Points
E1-193	Contraceptive Care – Postpartum Women Ages 15–44	US Office of Population Affairs	2902	No	Discontinued	DY7/8: +1
E1-232	Timeliness of Prenatal Care	NCQA	1517	Yes	Yes	1
E1-235	Post-Partum Follow-Up and Care Coordination	CMS	N/A	Yes	Yes	3
E1-300	Behavioral Health Risk Assessment for Pregnant Women	AMA-PCPI	N/A	Yes	Yes	1

E2: Maternal Safety

This bundle is a High State Priority.

Objective:
Improve maternal safety and reduce maternal morbidity through data driven interventions to prevent and manage obstetric hemorrhage.

Target Population:
Women with preterm or full-term deliveries

Base Points:

DY7/8: 4*2 (high state priority) = 8

DY9/10: 6*2 (high state priority) = 12

Possible Additional Points: N/A

Maximum Total Possible Points: 8 for DY7/8, 12 for DY9/10

ID	Measure	Steward	NQF #	Required in DY7/8	Required in DY9/10	Measure Points
E2-150	PC-02 Cesarean Section	The Joint Commission	0471	Yes	Yes	3
E2-151	PC-03 Antenatal Steroids	The Joint Commission	0476	Yes	Yes	1
E2-A01	Quality Improvement Collaborative Activity: Participation in OB Hemorrhage Safety Bundle Collaborative (TexasAIM Plus) through the Texas Department of State Health Services *(P4R for participation in collaborative and implementation of recommended practices in DY7-8)*	N/A	N/A	Yes	Discontinued	0
E2-601	Hemorrhage Risk Assessment *(Requires participating in TexasAIM Plus)*	Alliance for Innovation in Maternal Care	N/A	N/A	Yes	1
E2-602	Quantified Blood Loss *(Requires participating in TexasAIM Plus)*	Alliance for Innovation in Maternal Care	N/A	N/A	Yes	1

F1: Improved Access to Adult Dental Care

Objective:
Increase access to timely, appropriate dental care.

Target Population:
Adults

Base Points: 7

Possible Additional Points: DY9/10: 1

Maximum Total Possible Points: 7 for DY7/8, 8 for DY9/10

ID	Measure	Steward	NQF #	Required in DY7/8	Required in DY9/10	Measure Points
F1-105	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	NCQA	0028	Yes	Yes	1
F1-226	Chronic Disease Patients Accessing Dental Services	N/A	N/A	Yes	Yes	3
F1-227	Dental Caries: Adults	Healthy People 2020	N/A	Yes	Yes	3
F1-T03	*Innovative Measure:* Oral Cancer Screening (DY7/8: P4R, DY9: P4R, DY10: P4P)	A&M College of Dentistry	N/A	No	No	DY7-8: 0 DY9-10: +1

F2: Preventive Pediatric Dental Care

Objective:
Expand access to dental care including screening and preventive dental services to improve long term oral health and quality of life and reduce costs by preventing the need for more intensive treatments.

Target Population:
Children

Base Points: 2

Possible Additional Points: N/A

Maximum Total Possible Points: 2

ID	Measure	Steward	NQF #	Required in DY7/8	Required in DY9/10	Measure Points
F2-224	Dental Sealant: Children	Healthy People 2020	N/A	Yes	Yes	1
F2-229	Oral Evaluation: Children	American Dental Association	2517	Yes	Yes	1

G1: Palliative Care

Objective:
Provide palliative care services to patients and their families and/or caregivers to improve patient outcomes and quality of life with a focus on relief from symptoms, stress, and pain related to serious, debilitating, or terminal illness.

Target Population:
Individuals with serious or terminal illness enrolled in a hospice or palliative care program

Base Points: 6

Possible Additional Points: N/A or 6*

Maximum Total Possible Points: 6 or 12*

ID	Measure	Steward	NQF #	Required in DY7/8	Required in DY9/10	Measure Points
G1-276	Hospice and Palliative Care – Pain assessment	University of North Carolina-Chapel Hill	1637	Yes	Yes	1
G1-277	Hospice and Palliative Care – Treatment Preferences	University of North Carolina-Chapel Hill	1614	Yes	Yes	1
G1-278	Beliefs and Values	University of North Carolina-Chapel Hill	1647	Yes	Yes	1
G1-361	Patients Treated with an Opioid who are Given a Bowel Regimen	RAND Corporation/UCLA	1617	Yes	Yes	1
G1-362	Hospice and Palliative Care -- Dyspnea Treatment	University of North Carolina-Chapel Hill	1638	Yes	Yes	1
G1-363	Hospice and Palliative Care -- Dyspnea Screening	University of North Carolina-Chapel Hill	1639	Yes	Yes	1
G1-505	Proportion Admitted to Hospice for less than 3 days	American Society of Clinical Oncology	0216	No*	No*	+3
G1-507	Proportion not Admitted to Hospice	American Society of Clinical Oncology	0215	No*	No*	+3

*Measures G1-505 and G1-507 may only be selected by a cancer hospital in DY7/8 but may be selected by any performing provider with a cancer hospital as a part of their system definition in DY9/10.

H1: Integration of Behavioral Health in a Primary or Specialty Care Setting

This bundle is a State Priority.

Objective:
Implement depression, substance use disorder, and behavioral health screening and multi-modal treatment in a primary or non-psychiatric specialty care setting.

Target Population:
Individuals receiving primary care services or specialty care services

Base Points: 8*1.5 (state priority) = 12

Additional Points: N/A

Maximum Total Possible Points: 12

ID	Measure	Steward	NQF #	Required in DY7/8	Required in DY9/10	Measure Points
H1-146	Screening for Clinical Depression and Follow-Up Plan	CMS	0418	Yes	Yes	1
H1-255	Follow-up Care for Children Prescribed ADHD Medication	NCQA	0108	Yes	Yes	3
H1-286	Depression Remission at Six Months	MN Community Measurement	0711	Yes	Yes	3
H1-317	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	AMA-PCPI	2152	Yes	Yes	1
H1-T04	*Innovative Measure:* Engagement in Integrated Behavioral Health	Meadows	N/A	No	Discontinued	0

H2: Behavioral Health and Appropriate Utilization

This bundle is a State Priority.

Objective:
Provide specialized and coordinated services to individuals with serious mental illness and/or a combination of behavioral health and physical health issues to reduce emergency department utilization and avoidable inpatient admission and readmissions.

Target Population:
Individuals with serious mental illness

Base Points: 5*1.5 (state priority) = 8

Possible Additional Points: 11

Maximum Total Possible Points: 19

ID	Measure	Steward	NQF #	Required in DY7/8	Required in DY9/10	Measure Points
H2-160	Follow-Up After Hospitalization for Mental Illness	NCQA	0576	*(Yes)**	*(Yes)**	*+3*
H2-216	Risk Adjusted Behavioral Health /Substance Abuse 30-day Readmission Rate	N/A	N/A	*(Yes)**	*(Yes)**	*+3*
H2-259	Assignment of Primary Care Physician to Individuals with Schizophrenia	CQAIMH	N/A	Yes	Yes	1
H2-265	Housing Assessment for Individuals with Schizophrenia	CQAIMH	N/A	No	No	+1
H2-266	Independent Living Skills Assessment for Individuals with Schizophrenia	CQAIMH	N/A	Yes	Yes	1
H2-305	Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment	AMA-PCPI	1365	Yes	Yes	1
H2-319	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment	AMA-PCPI	0104	Yes	Yes	1
H2-405	Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use	CMS	N/A	Yes	Yes	1
H2-510	Reduce Rate of Emergency Department visits for Behavioral Health and Substance Abuse	N/A	N/A	Yes * †	Yes * †	+4 if P4P +0 if P4R

† For Performing Providers that select Measure Bundle H2 and have an MPT of 75:Measure H2-510 is a PBCO and is a required P4P measure for Performing Providers with an MPT of 75.

† * For Performing Providers that select Measure Bundle H2 and have an MPT of less than 75: Performing Providers with an MPT less than 75 must select one of either H2-160, H2-216, or H2-510 as P4P.

Performing Providers that do not opt to report H2-510 as P4P that have any numerator volume must report as P4R and select one of either H2-160 or H2-216. Measures reported as P4R will not count towards the Measure Bundle's point value and do not contribute towards a Performing Provider's MPT.

H3: Chronic Non-Malignant Pain Management

This bundle is a High State Priority.

Objective:
Improve individuals' quality of life and reduce pain through lifestyle modification, psychological approaches, interventional pain management, and/or pharmacotherapy while recognizing current or potential substance abuse disorders. Improve providers' ability to identify and manage chronic, non-malignant pain using a function-based multimodal approach and ability to screen for substance use disorder and connect individuals to appropriate treatment.

Target Population:
Adults with chronic pain or on long-term opioid therapy

Base Points: 5*2 (high state priority) = 10

Possible Additional Points: N/A

Maximum Total Possible Points: 10

ID	Measure	Steward	NQF #	Required in DY7/8	Required in DY9/10	Measure Points
H3-144	Screening for Clinical Depression and Follow-Up Plan (CDF-AD) for individuals with a diagnosis of chronic pain	CMS	0418	Yes	Yes	1
H3-287	Documentation of Current Medications in the Medical Record	CMS	0419	Yes	Yes	1
H3-288	Pain Assessment and Follow-up	CMS	0420	Yes	Yes	1
H3-401	Opioid Therapy Follow-up Evaluation	N/A	N/A	Yes	Yes	1
H3-403	Evaluation or Interview for Risk of Opioid Misuse	N/A	N/A	Yes	Yes	1
H3-T05	*Innovative Measure:* Treatment of Chronic Non-Malignant Pain Management with Multi-Modal Therapy (DY7/8: P4R)	San Francisco Health Network, Alameda Health Systems, UC San Diego	N/A	No	Discontinued	0
H3-T06	*Innovative Measure:* Patients on long-term opioid therapy checked in prescription drug monitoring programs (PDMPs) (DY7/8: P4R)	San Francisco Health Network, Alameda Health Systems, UC San Diego	N/A	No	Discontinued	0

H4: Integrated Care for People with Serious Mental Illness

This bundle is a State Priority.

Objective:
Improve physical health outcomes for individuals with serious mental illness.

Target Population:
Individuals with Serious Mental Illness

Base Points: 3*1.5 (state priority) = 5

Possible Additional Points: N/A

Maximum Total Possible Points: 5

ID	Measure	Steward	NQF #	Required in DY7/8	Required in DY9/10	Measure Points
H4-182	Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications	NCQA	1932	Yes	Yes	1
H4-258	Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	NCQA	1933	Yes	Yes	1
H4-260	Annual Physical Exam for Persons with Mental Illness	CQAIMH	N/A	Yes	Yes	1

I1: Specialty Care

Objective:
Improve quality of life and functional status for individuals with chronic and life impacting conditions receiving services in an outpatient specialty care setting.

Target Population:
Adults & Children with chronic and life impacting conditions

Base Points: 2

Possible Additional Points: N/A

Maximum Total Possible Points: 2

Requires prior authorization and can only be selected once by hospital and physician practices with a specialty care project in DY6. Cannot be selected for the first time in DY9/10.

ID	Measure	Steward	NQF #	Required in DY7/8	Required in DY9/10	Measure Points
I1-385	Assessment of Functional Status or QoL	N/A	N/A	Yes	Yes	1
I1-386	Improvement in Functional Status or QoL	N/A	N/A	Yes	Yes	1

J1: Hospital Safety

Objective:
Improve patient health outcomes and experience of care by reducing the risk of health-care associated infections and reducing hospital errors.

Target Population:
Individuals receiving inpatient care

Base Points: 10

Possible Additional Points: N/A

Maximum Total Possible Points: 10

If D3 and J1 are both selected, the points of each bundle will be reduced by 50%.

ID	Measure	Steward	NQF #	Required in DY7/8	Required in DY9/10	Measure Points
J1-218	Central line-associated bloodstream infections (CLABSI) rates	CDC	0139	Yes	Yes	2
J1-219	Catheter-associated Urinary Tract Infections (CAUTI) rates	CDC	0138	Yes	Yes	2
J1-220	Surgical site infections (SSI) rates	CDC	0299	Yes	Yes	2
J1-221	Patient Fall Rate	American Nurses Association	0141	Yes	Yes	2
J1-506	PSI 13 Post-Operative Sepsis Rate	AHRQ	N/A	Yes	Yes	2

K1: Rural Preventive Care

This bundle is only available to hospitals with a valuation less than or equal to $2,500,000 per DY in DY7-8. This bundle may not be selected for the first time in DY9-10.

Objective:
Improve provision of preventive care in rural and critical access hospitals to improve patient health.

Target Population:
Adults and Children in Rural Areas

Base Points: 3

Possible Additional Points: 10

Maximum Total Possible Points: 13

Measure Bundles A1, A2, C1, D1, E1, and H1 cannot be selected if Measure Bundle K1 is selected.

ID	Measure	Steward	NQF #	Required in DY7/8	Required in DY9/10	Measure Points
K1-103	Controlling High Blood Pressure	NCQA	0018	No	No	+3
K1-105	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	NCQA	0028	Yes	Yes	1
K1-112	Comprehensive Diabetes Care: Foot Exam	NCQA	0056	No	No	+1
K1-115	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	NCQA	0059	No	No	+3
K1-146	Screening for Clinical Depression and Follow-Up Plan	CMS	0418	No	No	+1
K1-268	Pneumonia vaccination status for older adults	CMS	0043	Yes	Yes	1
K1-269	Preventive Care and Screening: Influenza Immunization	AMA / PCPI	0041/ 3070	No	No	+1
K1-285	Advance Care Plan	NCQA	0326	Yes	Yes	1
K1-300	Behavioral Health Risk Assessment for Pregnant Women	AMA / PCPI	N/A	No	No	+1

K2: Rural Emergency Care

This bundle is only available to hospitals with a valuation less than or equal to $2,500,000 per DY in DY7-8. This bundle may not be selected for the first time in DY9-10.

Objective:
Improve quality of emergency care in rural and critical access hospital to improve patient health.

Target Population:
Adults and Children receiving emergency services in rural areas

Base Points: 3

Possible Additional Points: 1

Maximum Total Possible Points: 4

ID	Measure	Steward	NQF #	Required in DY7/8	Required in DY9/10	Measure Points
K2-285	Advance Care Plan	NCQA	0326	No*	No*	+1
K2-287	Documentation of Current Medications in the Medical Record	CMS	0419	Yes	Yes	1
K2-355	Admit Decision Time to ED Departure Time for Admitted Patients	CMS	0497	Yes	Yes	1
K2-359	Emergency Transfer Communication Measure	University of Minnesota Rural Health Research Center	0291	Yes	Yes	1

*K2-285 cannot be selected if Measure Bundle K1 is selected.

Local Health Department Measure Menu

LHD Measures

ID	Measure	Steward	NQF #	Points
L1-103	Controlling High Blood Pressure	NCQA	0018	3
L1-105	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	NCQA	0028	1
L1-107	Colorectal Cancer Screening	NCQA	0034	2
L1-108	Childhood Immunization Status (CIS)	NCQA	0038	1
L1-115	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	NCQA	0059	3
L1-147	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	CMS	0421 / 2828	1
L1-160	Follow-Up After Hospitalization for Mental Illness	NCQA	0576	3
L1-186	Breast Cancer Screening	NCQA	2372	2
L1-205	Third next available appointment	Wisconsin Collaborative for Healthcare Quality	N/A	1
L1-207	Diabetes care: BP control (<140/90mm Hg)	NCQA	0061	3
L1-210	317 Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	CMS	N/A	1
L1-211	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	NCQA	0024	1
L1-224	Dental Sealant: Children	Healthy People 2020	N/A	1
L1-225	Dental Caries - Children	Healthy People 2020	N/A	3
L1-227	Dental Caries - Adults	Healthy People 2020	N/A	3
L1-231	Preventive Services for Children at Elevated Caries Risk - Modified Denominator	American Dental Association	N/A	1
L1-235	Post-Partum Follow-Up and Care Coordination	CMS	N/A	3
L1-237	Well-Child Visits in the First 15 Months of Life (6 or more visits)	NCQA	1392	1
L1-241	Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons	None	N/A	3
L1-242	Reduce Emergency Department (ED) visits for Ambulatory Care Sensitive Conditions (ACSC)	None	N/A	3
L1-262	Assessment of Risk to Self/Others	CQAIMH	N/A	1
L1-263	Assessment for Psychosocial Issues of Psychiatric Patients	CQAIMH	N/A	1
L1-265	Housing Assessment for Individuals with Schizophrenia	CQAIMH	N/A	1
L1-268	Pneumonia vaccination status for older adults	CMS	0043	1

ID	Measure	Steward	NQF #	Points
L1-269	Preventive Care and Screening: Influenza Immunization	AMA / PCPI	0041 / 3070	1
L1-271	Immunization for Adolescents - Tdap/TD and MCV	NCQA	1407	1
L1-272	Adults (18+ years) Immunization status	Institute for Clinical Systems Improvement	N/A	1
L1-280	Chlamydia Screening in Women	NCQA	0033	1
L1-342	Time to Initial Evaluation: Evaluation within 10 Business Days	SAMHSA/ CCBHC	N/A	1
L1-343	Syphilis positive screening rates	CDC	N/A	1
L1-344	Follow-up after Treatment for Primary or Secondary Syphilis	CDC	N/A	3
L1-345	Gonorrhea Positive Screening Rates	CDC	N/A	1
L1-346	Follow-up testing for N. gonorrhoeae among recently infected men and women	CDC	N/A	3
L1-347	Latent Tuberculosis Infection (LTBI) treatment rate	CDC	N/A	3
L1-387	Reduce Emergency Department visits for Behavioral Health and Substance Abuse	N/A	N/A	3
L1-400	Tobacco Use and Help with Quitting Among Adolescents	CMS	N/A	1

Measures L1-262, L1-263, L1-265, and L1-342 are added for new selection in DY9-DY10 only.

Community Mental Health Center Measure Menu

CMHC Measures

ID	Measure	Steward	NQF #	Points	Additional Points for State Priority Measures
M1-100	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)	NCQA	0004	3	+1
M1-103	Controlling High Blood Pressure	NCQA	0018	3	+1
M1-105	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	NCQA	0028	1	+1
M1-115	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	NCQA	0059	3	
M1-124	Medication Reconciliation Post-Discharge	NCQA	0097	1	
M1-125	Antidepressant Medication Management (AMM-AD)	NCQA	0105	3	
M1-146	Screening for Clinical Depression and Follow-Up Plan (CDF-AD)	CMS	0418	1	
M1-147	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	CMS	0421 / 2828 eMeasure	1	
M1-160	Follow-Up After Hospitalization for Mental Illness	NCQA	0576	3	
M1-165	Depression Remission at 12 Months	MN Community Measurement	0710	*(3)**	+1
M1-180	Adherence to Antipsychotics for Individuals with Schizophrenia	CMS	1879	3	
M1-181	Depression Response at Twelve Months- Progress Towards Remission	MN Community Measurement	1885	*(3)**	+1
M1-182	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	NCQA	1932	1	+1
M1-203	Hepatitis C: One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk	AMA-PCPI	N/A / 3059 eMeasure	1	+1
M1-205	Third next available appointment	Wisconsin Collaborative for Healthcare Quality	N/A	1	
M1-207	Diabetes care: BP control (<140/90mm Hg)	NCQA	0061	3	
M1-210	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	CMS	N/A	1	
M1-211	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	NCQA	0024	1	+1

ID	Measure	Steward	NQF #	Points	Additional Points for State Priority Measures
M1-216	Risk Adjusted Behavioral Health /Substance Abuse 30-day Readmission Rate	N/A	N/A	3	
M1-241	Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons	None	N/A	3	
M1-255	Follow-up Care for Children Prescribed ADHD Medication	NCQA	0108	3	
M1-256	Initiation of Depression Treatment	CQAIMH	N/A	1	
M1-257	Care Planning for Dual Diagnosis	CQAIMH	N/A	1	
M1-259	Assignment of Primary Care Physician to Individuals with Schizophrenia	CQAIMH	N/A	1	
M1-260	Annual Physical Exam for Persons with Mental Illness	CQAIMH	N/A	1	+1
M1-261	Assessment for Substance Abuse Problems of Psychiatric Patients	CQAIMH	N/A	1	+1
M1-262	Assessment of Risk to Self/Others	CQAIMH	N/A	1	
M1-263	Assessment for Psychosocial Issues of Psychiatric Patients	CQAIMH	N/A	1	
M1-264	Vocational Rehabilitation for Schizophrenia	CQAIMH	N/A	1	
M1-265	Housing Assessment for Individuals with Schizophrenia	CQAIMH	N/A	1	+1
M1-266	Independent Living Skills Assessment for Individuals with Schizophrenia	CQAIMH	N/A	1	
M1-280	Chlamydia Screening in Women	NCQA	0033	1	+1
M1-286	Depression Remission at Six Months	MN Community Measurement	0711	*(3)**	+1
M1-287	Documentation of Current Medications in the Medical Record	CMS	0419	1	+1
M1-305	Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment	AMA-PCPI	1365	1	+1
M1-306	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	NCQA	2801	1	
M1-317	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	AMA-PCPI	2152	1	+1
M1-319	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment	AMA-PCPI	0104	1	+1
M1-339	Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge	The Joint Commission	1664	1	+1

ID	Measure	Steward	NQF #	Points	Additional Points for State Priority Measures
M1-340	Substance use disorders: percentage of patients aged 18 years and older with a diagnosis of current opioid addiction who were counseled regarding psychosocial AND pharmacologic treatment options for opioid addiction within the 12-month reporting period.	APA/ NCQA/ PCPI	N/A	1	+1
M1-341	Substance use disorders: percentage of patients aged 18 years and older with a diagnosis of current alcohol dependence who were counseled regarding psychosocial AND pharmacologic treatment options for alcohol dependence within the 12 month reporting period	APA/ NCQA/ PCPI	N/A	1	+1
M1-342	Time to Initial Evaluation: Evaluation within 10 Business Days	SAMHSA/ CCBHC	N/A	1	
M1-385	Assessment of Functional Status or QoL *Specific to IDD Services*	N/A	N/A	1	
M1-386	Improvement in Functional Status or QoL *Specific to IDD Services*	N/A	N/A	1	
M1-387	Reduce Emergency Department visits for Behavioral Health and Substance Abuse	N/A	N/A	3	+1
M1-390	Time to Initial Evaluation: Mean Days to Evaluation	SAMHSA/ CCBHC	N/A	1	
M1-400	Tobacco Use and Help with Quitting Among Adolescents	CMS		1	+1
M1-405	Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use	CMS/CQAIMH	N/A	1	+1

**If more than one of M1-165, M1-181, and/or M1-286 are selected, only 4 points will be added to meet MPT.*

Related Strategies Reporting for Hospitals & Physician Practices

In DY9-10, as determined by Measure Bundle selection, hospitals and physician practices will report on one or more Related Strategies Lists. As identified in the table below, Measure Bundles with similar interventions, service settings, and/or populations may be associated with a single Related Strategies List.

Within each Related Strategies List, there are multiple individual Related Strategies organized by Themes: *Access to Care, Care Coordination, Data Analytics, Disease Management, and Social Determinants of Health.* Individual Related Strategies may be limited to specific Related Strategies Lists.

Hospitals & Physician Practices Measure Bundles and associated Related Strategies Lists

Adult Primary Care and Chronic Disease Management

ID	Measure Bundle
A1	Chronic Disease Management: Diabetes
A2	Chronic Disease Management: Heart Disease
C1	Primary Care Prevention - Healthy Texans
C2	Primary Care Prevention - Cancer Screening
C3	Hepatitis C

Hospital Readmissions and Emergency Department Utilization

ID	Measure Bundle
B1	Care Transitions and Hospital Readmissions
B2	Patient Navigation & ED Diversion

Pediatric Primary Care and Chronic Disease Management

ID	Measure Bundle
D1	Pediatric Primary Care
D4	Pediatric Chronic Disease Management: Asthma
D5	Pediatric Chronic Disease Management: Diabetes

Maternal Care and Safety

ID	Measure Bundle
E1	Improved Maternal Care
E2	Maternal Safety

Dental Care

ID	Measure Bundle
F1	Improved Access to Adult Dental Care
F2	Preventive Pediatric Dental

Palliative Care and Specialty Care (Chronic and Life Impacting Conditions)

ID	Measure Bundle
G1	Palliative Care
I1	Specialty Care

Behavioral Health Integration

ID	Measure Bundle
H1	Mental Health Comorbidities
H2	Behavioral Health and Appropriate Utilization
H3	Chronic Non-Malignant Pain Management
H4	Integrated Care for People with Serious Mental Illness

Hospital Safety

ID	Measure Bundle
J1	Hospital Safety
D3	Pediatric Hospital Safety

Rural Primary Care

ID	Measure Bundle
K1	Rural Primary Care

Rural Emergency Care

ID	Measure Bundle
K2	Rural Emergency Care

Example:
In DY9-10, a hospital or physician practice selects seven Measure Bundles: A1, A2, C1, C2, D1, F2, and J1.

The Performing Provider will report on the following four Related Strategies Lists associated with those seven Measure Bundle selections:

- *Adult Primary Care Prevention and Chronic Disease Management (A1, A2, C1, C2)*
- *Pediatric Primary Care Prevention and Chronic Disease Management (D1)*
- *Dental Care (F1)*
- *Hospital Safety (J1)*

H/PP Theme: Access to Care

Related Strategies in the *Access to Care* Theme shown in the table below are included in all of the following Related Strategies Lists unless the individual Related Strategy is separately noted as "*Limited to"* a specific List:

- Adult Primary Care and Chronic Disease Management
- Hospital Readmissions and ED Utilization
- Pediatric Primary Care and Chronic Disease Management
- Maternal Care and Safety
- Dental Care
- Behavioral Health Integration
- Rural Primary Care

RS-ID	Related Strategies Description
1.00	Same-day and/or walk-in appointments in the outpatient setting
1.01	Night and/or weekend appointments in the outpatient setting
1.10	Integration or co-location of primary care and specialty care (physical health only) services in the outpatient setting
1.11	Telehealth to provide virtual medical appointments and/or consultations with a primary care provider
1.12	Telehealth to provide virtual medical appointments and/or consultations with a specialty care physician (physical health only)
1.20	Integration or co-location of primary care and psychiatric services in the outpatient setting
1.21	Telehealth to provide virtual medical appointments and/or consultations with a psychiatrist
1.30	Mobile clinic or other community-based delivery model to provide care outside of the traditional office (excludes home-based care)
1.40	Integration or co-location of primary care and dental services in the outpatient setting *(Limited to: Hospital Readmissions and ED Utilization; Dental Care)*
1.41	Telehealth to provide virtual appointments and/or consultations with a dentist *(Limited to: Hospital Readmissions and ED Utilization; Dental Care)*

H/PP Theme: Care Coordination

Related Strategies in the *Care Coordination* Theme shown in the table below are included in all of the following Related Strategies Lists unless the individual Related Strategy is separately noted as "*Limited to"* a specific List:

- Adult Primary Care and Chronic Disease Management
- Hospital Readmissions and ED Utilization
- Pediatric Primary Care and Chronic Disease Management
- Maternal Care and Safety
- Dental Care
- Palliative/Specialty Care
- Behavioral Health Integration
- Rural Primary Care
- Rural Emergency Care

RS-ID	Related Strategies Description
2.00	Culturally and linguistically appropriate care planning for patients
2.01	Pre-visit planning and/or standing order protocols (e.g. for screenings/assessments, immunization status, tests/results, prescription changes/refills, scheduling follow-up visits, evidence-based practices, etc.)
2.02	Automated reminders/flags within the E.H.R. or other electronic care platform (e.g. for screenings/assessments, immunization status, tests/results, prescription changes/refills, scheduling follow-up visits, evidence-based practices, etc.)
2.10	Care team includes personnel in a care coordination role not requiring clinical licensure (e.g. non-clinical social worker, community health worker, medical assistant, etc.)
2.11	Care team includes personnel in a care coordination role requiring clinical licensure (e.g. registered nurse, licensed clinical social worker, etc.)
2.12	Hotline, call center, or other similar programming staffed by personnel with clinical licensure to answer questions for patients (and their families) related to medications, clinical triage, care transitions, etc.
2.20	Formal closed loop process for scheduling a follow-up visit with a primary care provider and/or assigning a primary care provider when none is identified
2.30	Formal closed loop process for scheduling referral visits as needed
2.40	Data sharing connectivity or arrangement with Medicaid Managed Care Organization(s) for patient claims data
2.50	Data sharing connectivity across care settings within provider's integrated delivery system (includes inpatient, outpatient, post-acute, urgent care, pharmacy, etc.) for patient medical records
2.51	Data sharing connectivity or Health Information Exchange (HIE) arrangement across care settings external to provider's office/integrated delivery system (includes inpatient, outpatient, post-acute, urgent care, pharmacy, etc.) for patient medical records
2.60	Formal closed loop process for coordinating the transition from pediatric to adult care *(Limited to: Pediatric Primary Care and Chronic Disease Management)*

H/PP Theme: Data Analytics

Related Strategies in the *Data Analytics* Theme shown in the table below are included in all of the following Related Strategies Lists unless the individual Related Strategy is separately noted as *"Limited to"* a specific List:

- Adult Primary Care and Chronic Disease Management
- Hospital Readmissions and ED Utilization
- Pediatric Primary Care and Chronic Disease Management
- Maternal Care and Safety
- Dental Care
- Palliative/Specialty Care
- Behavioral Health Integration
- Hospital Safety**
- Rural Primary Care
- Rural Emergency Care

RS-ID	Related Strategies Description
3.00	Panel management and/or proactive outreach of patients using a gap analysis method (i.e. strategically targeting patients with missing or overdue screenings, immunizations, assessments, lab work, etc.)
3.01	Panel management and/or proactive outreach of patients using a risk-stratification method (i.e. strategically targeting patients based on risk factors associated with worsening disease states)
3.10	Database or registry to track quality and clinical outcomes data on patients
3.20	Analysis of appointment "no-show" rates
3.30	Formal partnership or arrangement with post-acute care facilities (e.g. skilled nursing facility, inpatient rehabilitation facility, long-term acute care hospital, home health agency, hospice, etc.) to track/share quality measures such as length of stay and readmission rates, etc. *(Limited to: Hospital Readmissions and ED Utilization; Palliative/Specialty Care; Rural Emergency Care)*
3.40	Formal partnership or arrangement with schools/school districts to track/share data such as absenteeism, classroom behaviors, etc. *(Limited to: Pediatric Primary Care and Chronic Disease Management; Dental Care)*

**Within this Theme, the Hospital Safety List only includes RS-IDs 3.00, 3.01, and 3.10.

H/PP Theme: Disease Management

Related Strategies in the *Disease Management* Theme shown in the table below are included in all of the following Related Strategies Lists unless the individual Related Strategy is separately noted as "*Limited to"* a specific List:

- Adult Primary Care and Chronic Disease Management
- Pediatric Primary Care and Chronic Disease Management
- Maternal Care and Safety
- Dental Care
- Palliative/Specialty Care
- Behavioral Health Integration
- Hospital Safety**
- Rural Primary Care
- Rural Emergency Care

RS-ID	Related Strategies Description
4.00	Care team includes a clinical pharmacist(s)
4.01	Care team includes a behavioral health professional such as a psychologist, licensed clinical social worker, licensed counselor (LPC, LMHC), etc.
4.02	Care team includes a registered dietician(s)
4.10	Group visit model or similar non-traditional appointment format that includes at least one provider and a group of patients with shared clinical and/or social experiences
4.20	Home visit model of providing clinical services at a patient's residence (may be restricted to specific patient subpopulations)
4.30	Classes for patients focused on disease self-management (e.g. lifestyle changes, symptom recognition, clinical triage guidance, etc.)
4.31	Classes for patients focused on diet, nutrition counseling, and/or cooking
4.32	Classes for patients focused on physical activity
4.40	Peer-based programming (includes support groups, peer coaching/mentoring, etc.)
4.50	Telehealth to provide remote monitoring of patient biometric data (e.g. HbA1c levels, blood pressure, etc.) and/or medication adherence
4.60	Patient educational materials or campaigns about preventive care (e.g. immunizations, preventive screenings, etc.)
4.61	Patient educational materials or campaigns about advance care planning/directives *(Limited to: Adult Primary Care and Chronic Disease Management; Palliative/Specialty Care; Rural Primary Care; Rural Emergency Care)*
4.70	SBIRT (Screening, Brief Intervention, Referral, and Treatment) workflow actively in place *(Limited to: Maternal Care and Safety; Palliative/Specialty Care; Behavioral Health Integration; Rural Primary Care)*
4.71	Medication-Assisted Treatment (MAT) services actively offered *(Limited to: Behavioral Health Integration)*
4.80	Hospital hand hygiene protocol/programming (Limited to: Hospital Safety)
4.81	Checklist(s) (or similar standardized protocol) tailored to prevent hospital safety-related events *(Limited to: Hospital Safety*)
4.82	Formal process for monitoring compliance with hospital safety-related protocols (includes reviews, "secret shopper" approaches, etc.) *(Limited to: Hospital Safety)*
4.83	Formal process for analyzing and addressing hospital safety-related events (includes root-cause analyses, remediation policies, etc.) *(Limited to: Hospital Safety)*

**Within this Theme, the Hospital Safety List only includes RS-IDs 4.80, 4.81, 4.82, and 4.83.

H/PP Theme: Social Determinants of Health

Related Strategies in the *Social Determinants of Health* Theme shown in the table below are included in all of the following Related Strategies Lists unless the individual Related Strategy is separately noted as "*Limited to"* a specific List:

- Adult Primary Care and Chronic Disease Management
- Hospital Readmissions and ED Utilization
- Pediatric Primary Care and Chronic Disease Management
- Maternal Care and Safety
- Dental Care
- Behavioral Health Integration
- Rural Primary Care
- Rural Emergency Care

RS-ID	Related Strategies Description
5.00	Screening patients for food insecurity
5.01	Formal partnership or arrangement with food resources to support patient health status (e.g. local food banks, grocery stores, etc.)
5.10	Screening patients for housing needs
5.11	Formal partnership or arrangement with housing resources to support patient health status (e.g. affordable housing units, transitional housing, rental assistance, etc.)
5.12	Screening patients for housing quality needs
5.13	Formal partnership or arrangement with housing quality resources to support patient health status (e.g. housing inspections, pest control management, heating and other utility services, etc.)
5.20	Screening patients for transportation needs
5.21	Formal partnership or arrangement with transportation resources to support patient access to care (e.g. public or private transit, etc.)
5.30	Formal partnership or arrangement with schools/school districts to collaborate on health-promoting initiatives (e.g. addressing environmental triggers, healthy lunch options, field day activities, etc.) *(Limited to: Pediatric Primary Care and Chronic Disease Management; Dental Care)*

Related Strategies Reporting for Local Health Departments

In DY9-10, as determined by measure selection, Local Health Departments will report on one or more Related Strategies Lists. As identified in the table below, measures with similar interventions, service settings, and/or populations may be associated with a single Related Strategies List.

Within each Related Strategies List, there are multiple individual Related Strategies organized by Themes: *Access to Care, Care Coordination, Data Analytics, Disease Management, and Social Determinants of Health.* Individual Related Strategies may be limited to specific Related Strategies Lists.

Local Health Department Measures and associated Related Strategies Lists

Adult Primary Care Prevention and Chronic Disease Management

ID	Measure
L1-103	Controlling High Blood Pressure
L1-115	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)
L1-210	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented
L1-105	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention
L1-107	Colorectal Cancer Screening
L1-147	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up
L1-186	Breast Cancer Screening
L1-268	Pneumonia vaccination status for older adults
L1-269	Preventive Care and Screening: Influenza Immunization
L1-272	Adults (18+ years) Immunization status
L1-280	Chlamydia Screening in Women (CHL)
L1-343	Syphilis positive screening rates
L1-344	Follow-up after Treatment for Primary or Secondary Syphilis
L1-345	Gonorrhea Positive Screening Rates
L1-346	Follow-up testing for N. gonorrhoeae among recently infected men and women
L1-347	Latent Tuberculosis Infection (LTBI) treatment rate
L1-207	Diabetes care: BP control (<140/90mm Hg)

Hospital Readmissions and Emergency Department Utilization

ID	Measure
L1-160	Follow-Up After Hospitalization for Mental Illness
L1-242	Reduce Emergency Department visits for Chronic Ambulatory Care Sensitive Conditions (ACSC)
L1-387	Reduce Emergency Department visits for Behavioral Health and Substance Abuse (Reported as two rates)

Pediatric Primary Care

ID	Measure
L1-108	Childhood Immunization Status (CIS)
L1-211	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents
L1-237	Well-Child Visits in the First 15 Months of Life (6 or more visits)
L1-271	Immunization for Adolescents
L1-400	Tobacco Use and Help with Quitting Among Adolescents

Maternal Care and Safety

ID	Measure
L1-235	Post-Partum Follow-Up and Care Coordination

Dental Care

ID	Measure
L1-224	Dental Sealant: Children
L1-225	Dental Caries: Children
L1-227	Dental Caries: Adults
L1-231	Preventive Services for Children at Elevated Caries Risk

Access to Care

ID	Measure
L1-205	Third next available appointment
L1-342	Time to Initial Evaluation: Evaluation within 10 Business Days

Criminal Justice

ID	Measure
L1-241	Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons

Serious Mental Illness

ID	Measure
L1-262	Assessment of Risk to Self/ Others
L1-263	Assessment for Psychosocial Issues of Psychiatric Patients
L1-265	Housing Assessment for Individuals with Schizophrenia

Example:
In DY9-10, an LHD selects five measures: L1-103 Controlling High Blood Pressure, L1-105 Tobacco Screening & Cessation, L1-115 HbA1C Poor Control, L1-225 Dental Caries: Children, and L1-227 Dental Caries: Adult.

The Performing Provider will report on the following two Related Strategies Lists associated with those five measure selections:

- *Primary Care Prevention and Chronic Disease Management (L1-103, L1-105, L1-115)*
- *Dental Care (L1-225, L1-227)*

LHD Theme: Access to Care

Related Strategies in the *Access to Care* Theme shown in the table below are included in all of the following Related Strategies Lists unless the individual Related Strategy is separately noted as "*Limited to"* a specific List:

- Adult Primary Care and Chronic Disease Management
- Hospital Readmissions and ED Utilization
- Pediatric Primary Care and Chronic Disease Management
- Maternal Care and Safety
- Dental Care
- Access to Care
- Criminal Justice
- Serious Mental Illness

RS-ID	Related Strategies Description
1.00	Same-day and/or walk-in appointments in the outpatient setting
1.01	Night and/or weekend appointments in the outpatient setting
1.10	Integration or co-location of primary care and specialty care (physical health only) services in the outpatient setting
1.11	Telehealth to provide virtual medical appointments and/or consultations with a primary care provider
1.12	Telehealth to provide virtual medical appointments and/or consultations with a specialty care physician (physical health only)
1.20	Integration or co-location of primary care and psychiatric services in the outpatient setting
1.21	Telehealth to provide virtual medical appointments and/or consultations with a psychiatrist
1.22	Integration or co-location of psychiatry and substance use disorder treatment services in the outpatient setting *(Limited to: Serious Mental Illness)*
1.30	Mobile clinic or other community-based delivery model to provide care outside of the traditional office (excludes home-based care)
1.40	Integration or co-location of primary care and dental services in the outpatient setting *(Limited to: Dental Care)*
1.41	Telehealth to provide virtual appointments and/or consultations with a dentist *(Limited to: Dental Care)*

LHD Theme: Care Coordination

Related Strategies in the *Care Coordination* Theme shown in the table below are included in all of the following Related Strategies Lists unless the individual Related Strategy is separately noted as "*Limited to"* a specific List:

- Adult Primary Care and Chronic Disease Management
- Hospital Readmissions and ED Utilization
- Pediatric Primary Care and Chronic Disease Management
- Maternal Care and Safety
- Dental Care
- Criminal Justice
- Serious Mental Illness

RS-ID	Related Strategies Description
2.00	Culturally and linguistically appropriate care planning for patients
2.01	Pre-visit planning and/or standing order protocols (e.g. for screenings/assessments, immunization status, tests/results, prescription changes/refills, scheduling follow-up visits, evidence-based practices, etc.)
2.02	Automated reminders/flags within the E.H.R. or other electronic care platform (e.g. for screenings/assessments, immunization status, tests/results, prescription changes/refills, scheduling follow-up visits, evidence-based practices, etc.)
2.10	Care team includes personnel in a care coordination role not requiring clinical licensure (e.g. non-clinical social worker, community health worker, medical assistant, etc.)
2.11	Care team includes personnel in a care coordination role requiring clinical licensure (e.g. registered nurse, licensed clinical social worker, etc.)
2.12	Hotline, call center, or other similar programming staffed by personnel with clinical licensure to answer questions for patients (and their families) related to medications, clinical triage, care transitions, etc.
2.20	Formal closed loop process for scheduling a follow-up visit with a primary care provider and/or assigning a primary care provider when none is identified
2.30	Formal closed loop process for scheduling referral visits as needed
2.40	Data sharing connectivity or arrangement with Medicaid Managed Care Organization(s) for patient claims data
2.50	Data sharing connectivity across care settings within provider's integrated delivery system (includes inpatient, outpatient, post-acute, urgent care, pharmacy, etc.) for patient medical records
2.51	Data sharing connectivity or Health Information Exchange (HIE) arrangement across care settings external to provider's office/integrated delivery system (includes inpatient, outpatient, post-acute, urgent care, pharmacy, etc.) for patient medical records
2.60	Formal closed loop process for coordinating the transition from pediatric to adult care *(Limited to: Pediatric Primary Care and Chronic Disease Management)*

LHD Theme: Data Analytics

Related Strategies in the *Data Analytics* Theme shown in the table below are included in all of the following Related Strategies Lists unless the individual Related Strategy is separately noted as *"Limited to"* a specific List:

- Adult Primary Care and Chronic Disease Management
- Hospital Readmissions and ED Utilization
- Pediatric Primary Care and Chronic Disease Management
- Maternal Care and Safety
- Dental Care
- Access to Care
- Criminal Justice
- Serious Mental Illness

RS-ID	Related Strategies Description
3.00	Panel management and/or proactive outreach of patients using a gap analysis method (i.e. strategically targeting patients with missing or overdue screenings, immunizations, assessments, lab work, etc.)
3.01	Panel management and/or proactive outreach of patients using a risk-stratification method (i.e. strategically targeting patients based on risk factors associated with worsening disease states)
3.10	Database or registry to track quality and clinical outcomes data on patients
3.20	Analysis of appointment "no-show" rates
3.30	Formal partnership or arrangement with post-acute care facilities (e.g. skilled nursing facility, inpatient rehabilitation facility, long-term acute care hospital, home health agency, hospice, etc.) to track/share quality measures such as length of stay and readmission rates, etc. *(Limited to: Hospital Readmissions and ED Utilization)*
3.40	Formal partnership or arrangement with schools/school districts to track/share data such as absenteeism, classroom behaviors, etc. *(Limited to: Pediatric Primary Care and Chronic Disease Management; Dental Care)*

LHD Theme: Disease Management

Related Strategies in the *Disease Management* Theme shown in the table below are included in all of the following Related Strategies Lists unless the individual Related Strategy is separately noted as "*Limited to"* a specific List:

- Adult Primary Care and Chronic Disease Management
- Pediatric Primary Care and Chronic Disease Management
- Maternal Care and Safety
- Dental Care
- Criminal Justice
- Serious Mental Illness

RS-ID	Related Strategies Description
4.00	Care team includes a clinical pharmacist(s)
4.01	Care team includes a behavioral health professional such as a psychologist, licensed clinical social worker, licensed counselor (LPC, LMHC), etc.
4.02	Care team includes a registered dietician(s)
4.10	Group visit model or similar non-traditional appointment format that includes at least one provider and a group of patients with shared clinical and/or social experiences
4.20	Home visit model of providing clinical services at a patient's residence (may be restricted to specific patient subpopulations)
4.30	Classes for patients focused on disease self-management (e.g. lifestyle changes, symptom recognition, clinical triage guidance, etc.)
4.31	Classes for patients focused on diet, nutrition counseling, and/or cooking
4.32	Classes for patients focused on physical activity
4.40	Peer-based programming (includes support groups, peer coaching/mentoring, etc.)
4.50	Telehealth to provide remote monitoring of patient biometric data (e.g. HbA1c levels, blood pressure, etc.) and/or medication adherence
4.60	Patient educational materials or campaigns about preventive care (e.g. immunizations, preventive screenings, etc.)
4.70	SBIRT (Screening, Brief Intervention, Referral, and Treatment) workflow actively in place *(Limited to: Maternal Care and Safety; Criminal Justice; Serious Mental Illness)*
4.71	Medication-Assisted Treatment (MAT) services actively offered *(Limited to: Criminal Justice)*

LHD Theme: Social Determinants of Health

Related Strategies in the *Social Determinants of Health* Theme shown in the table below are included in all of the following Related Strategies Lists unless the individual Related Strategy is separately noted as "*Limited to"* a specific List:

- Adult Primary Care and Chronic Disease Management
- Hospital Readmissions and ED Utilization
- Pediatric Primary Care and Chronic Disease Management
- Maternal Care and Safety
- Dental Care
- Access to Care**
- Criminal Justice
- Serious Mental Illness

RS-ID	Related Strategies Description
5.00	Screening patients for food insecurity
5.01	Formal partnership or arrangement with food resources to support patient health status (e.g. local food banks, grocery stores, etc.)
5.10	Screening patients for housing needs
5.11	Formal partnership or arrangement with housing resources to support patient health status (e.g. affordable housing units, transitional housing, rental assistance, etc.)
5.12	Screening patients for housing quality needs
5.13	Formal partnership or arrangement with housing quality resources to support patient health status (e.g. housing inspections, pest control management, heating and other utility services, etc.)
5.20	Screening patients for transportation needs
5.21	Formal partnership or arrangement with transportation resources to support patient access to care (e.g. public or private transit, etc.)
5.30	Formal partnership or arrangement with schools/school districts to collaborate on health-promoting initiatives (e.g. addressing environmental triggers, healthy lunch options, field day activities, etc.) *(Limited to: Pediatric Primary Care and Chronic Disease Management; Dental Care)*

**Within this Theme, the Access to Care List only includes RS-IDs 5.20 and 5.21.

Related Strategies Reporting for Community Mental Health Centers

In DY9-10, as determined by measure selection, Community Mental Health Centers will report on one or more Related Strategies Lists. As identified in the table below, measures with similar interventions, service settings, and/or populations may be associated with a single Related Strategies List.

Within each Related Strategies List, there are multiple individual Related Strategies organized by Themes: *Access to Care, Care Coordination, Data Analytics, Disease Management, and Social Determinants of Health.* Individual Related Strategies may be limited to specific Related Strategies Lists.

Community Mental Health Centers Measures and associated Related Strategies Lists

Physical Health Comorbidities

ID	Measure
M1-103	Controlling High Blood Pressure
M1-105	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention
M1-115	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)
M1-147	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up
M1-182	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD)
M1-203	Hepatitis C: One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk
M1-207	Diabetes care: BP control (<140/90mm Hg)
M1-210	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented
M1-259	Assignment of Primary Care Physician to Individuals with Schizophrenia
M1-260	Annual Physical Exam for Persons with Mental Illness
M1-280	Chlamydia Screening in Women (CHL)

Hospital Readmissions and Emergency Department Utilization

ID	Measure
M1-124	Medication Reconciliation Post-Discharge
M1-160	Follow-Up After Hospitalization for Mental Illness
M1-216	Risk Adjusted Behavioral Health/ Substance Abuse 30-Day Readmission Rate
M1-287	Documentation of Current Medications in the Medical Record
M1-387	Reduce Emergency Department visits for Behavioral Health and Substance Abuse (Reported as two rates)

Children and Adolescents

ID	Measure
M1-211	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents
M1-255	Follow-up Care for Children Prescribed ADHD Medication (ADD)
M1-305	Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-CH)
M1-306	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)*
M1-400	Tobacco Use and Help with Quitting Among Adolescents

Specialty Care (Chronic and Life Impacting Conditions)

ID	Measure
M1-385	Assessment of Functional Status or QoL (Modified from NQF# 0260/2624)
M1-386	Improvement in Functional Status or QoL (Modified from PQRS #435)

Serious Mental Illness (SMI): Depression

ID	Measure
M1-125	Antidepressant Medication Management (AMM-AD)
M1-146	Screening for Clinical Depression and Follow-Up Plan (CDF-AD)
M1-165	Depression Remission at Twelve Months
M1-181	Depression Response at Twelve Months- Progress Towards Remission
M1-256	Initiation of Depression Treatment
M1-262	Assessment of Risk to Self/ Others
M1-286	Depression Remission at Six Months
M1-319	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (eMeasure)

Serious Mental Illness: Schizophrenia

ID	Measure
M1-180	Adherence to Antipsychotics for Individuals with Schizophrenia (SAA-AD)
M1-263	Assessment for Psychosocial Issues of Psychiatric Patients
M1-264	Vocational Rehabilitation for Schizophrenia
M1-265	Housing Assessment for Individuals with Schizophrenia
M1-266	Independent Living Skills Assessment for Individuals with Schizophrenia

Dual Diagnosis and Substance Use Disorder (SUD) Treatment

ID	Measure
M1-100	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)
M1-257	Care Planning for Dual Diagnosis
M1-261	Assessment for Substance Abuse Problems of Psychiatric Patients
M1-317	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling
M1-339	Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge SUB-3 / Alcohol and Other Drug Use Disorder Treatment at Discharge SUB-3a
M1-340	Substance use disorders: Percentage of patients aged 18 years and older with a diagnosis of current opioid addiction who were counseled regarding psychosocial AND pharmacologic treatment options for opioid addiction within the 12-month reporting period
M1-341	Substance use disorders: Percentage of patients aged 18 years and older with a diagnosis of current alcohol dependence who were counseled regarding psychosocial AND pharmacologic treatment options for alcohol dependence within the 12-month reporting period
M1-405	Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use

Access to Care

ID	Measure
M1-205	Third next available appointment
M1-342	Time to Initial Evaluation: Evaluation within 10 Business Days
M1-390	Time to Initial Evaluation: Mean Days to Evaluation

Criminal Justice

ID	Measure
M1-241	Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons

Example:
In DY9-10, a CMHC selects five measures: M1-103 Controlling High Blood Pressure, M1-115 HbA1c Poor Control, M1-147 BMI Screening and Follow-Up, M1-125 Antidepressant Medication Management, and M1-146 Screening for Clinical Depression and Follow Up Plan.

The Performing Provider will report on the following two Related Strategies Lists associated with those five measure selections:

- *Physical Health Comorbidities (M1-103, M1-115, M1-147)*
- *Serious Mental Illness: Depression (M1-125, M1-146)*

CMHC Theme: Access to Care

Related Strategies in the *Access to Care* Theme shown in the table below are included in all of the following Related Strategies Lists unless the individual Related Strategy is separately noted as "*Limited to"* a specific List:

- Physical Health Comorbidities
- Hospital Readmissions and ED Utilization
- Children and Adolescents
- SMI: Depression
- SMI: Schizophrenia
- Dual Diagnosis/SUD Treatment
- Access to Care
- Criminal Justice

RS-ID	Related Strategies Description
1.00	Same-day and/or walk-in appointments in the outpatient setting
1.01	Night and/or weekend appointments in the outpatient setting
1.10	Integration or co-location of primary care and specialty care (physical health only) services in the outpatient setting
1.11	Telehealth to provide virtual medical appointments and/or consultations with a primary care provider
1.12	Telehealth to provide virtual medical appointments and/or consultations with a specialty care physician (physical health only)
1.20	Integration or co-location of primary care and psychiatric services in the outpatient setting
1.21	Telehealth to provide virtual medical appointments and/or consultations with a psychiatrist
1.22	Integration or co-location of psychiatry and substance use disorder treatment services in the outpatient setting
1.30	Mobile clinic or other community-based delivery model to provide care outside of the traditional office (excludes home-based care)

CMHC Theme: Care Coordination

Related Strategies in the *Care Coordination* Theme shown in the table below are included in all of the following Related Strategies Lists unless the individual Related Strategy is separately noted as "*Limited to"* a specific List:

- Physical Health Comorbidities
- Hospital Readmissions and ED Utilization
- Children and Adolescents
- Specialty Care
- SMI: Depression
- SMI: Schizophrenia
- Dual Diagnosis/SUD Treatment
- Criminal Justice

RS-ID	Related Strategies Description
2.00	Culturally and linguistically appropriate care planning for patients
2.01	Pre-visit planning and/or standing order protocols (e.g. for screenings/assessments, immunization status, tests/results, prescription changes/refills, scheduling follow-up visits, evidence-based practices, etc.)
2.02	Automated reminders/flags within the E.H.R. or other electronic care platform (e.g. for screenings/assessments, immunization status, tests/results, prescription changes/refills, scheduling follow-up visits, evidence-based practices, etc.)
2.10	Care team includes personnel in a care coordination role not requiring clinical licensure (e.g. non-clinical social worker, community health worker, medical assistant, etc.)
2.11	Care team includes personnel in a care coordination role requiring clinical licensure (e.g. registered nurse, licensed clinical social worker, etc.)
2.12	Hotline, call center, or other similar programming staffed by personnel with clinical licensure to answer questions for patients (and their families) related to medications, clinical triage, care transitions, etc.
2.20	Formal closed loop process for scheduling a follow-up visit with a primary care provider and/or assigning a primary care provider when none is identified
2.30	Formal closed loop process for scheduling referral visits as needed
2.40	Data sharing connectivity or arrangement with Medicaid Managed Care Organization(s) for patient claims data
2.50	Data sharing connectivity across care settings within provider's integrated delivery system (includes inpatient, outpatient, post-acute, urgent care, pharmacy, etc.) for patient medical records
2.51	Data sharing connectivity or Health Information Exchange (HIE) arrangement across care settings external to provider's office/integrated delivery system (includes inpatient, outpatient, post-acute, urgent care, pharmacy, etc.) for patient medical records
2.60	Formal closed loop process for coordinating the transition from pediatric to adult care *(Limited to: Children and Adolescents)*

CMHC Theme: Data Analytics

Related Strategies in the *Data Analytics* Theme shown in the table below are included in all of the following Related Strategies Lists unless the individual Related Strategy is separately noted as "*Limited to"* a specific List:

- Physical Health Comorbidities
- Hospital Readmissions and ED Utilization
- Children and Adolescents
- Specialty Care
- SMI: Depression
- SMI: Schizophrenia
- Dual Diagnosis/SUD Treatment
- Access to Care
- Criminal Justice

RS-ID	Related Strategies Description
3.00	Panel management and/or proactive outreach of patients using a gap analysis method (i.e. strategically targeting patients with missing or overdue screenings, immunizations, assessments, lab work, etc.)
3.01	Panel management and/or proactive outreach of patients using a risk-stratification method (i.e. strategically targeting patients based on risk factors associated with worsening disease states)
3.10	Database or registry to track quality and clinical outcomes data on patients
3.20	Analysis of appointment "no-show" rates
3.30	Formal partnership or arrangement with post-acute care facilities (e.g. skilled nursing facility, inpatient rehabilitation facility, long-term acute care hospital, home health agency, hospice, etc.) to track/share quality measures such as length of stay and readmission rates, etc. *(Limited to: Hospital Readmissions & ED Utilization; Specialty Care)*
3.40	Formal partnership or arrangement with schools/school districts to track/share data such as absenteeism, classroom behaviors, etc. *(Limited to: Children and Adolescents)*

CMHC Theme: Disease Management

Related Strategies in the *Disease Management* Theme shown in the table below are included in all of the following Related Strategies Lists unless the individual Related Strategy is separately noted as "*Limited to"* a specific List:

- Physical Health Comorbidities
- Children and Adolescents
- Specialty Care
- SMI: Depression
- SMI: Schizophrenia
- Dual Diagnosis/SUD Treatment
- Criminal Justice

RS-ID	Related Strategies Description
4.00	Care team includes a clinical pharmacist(s)
4.01	Care team includes a behavioral health professional such as a psychologist, licensed clinical social worker, licensed counselor (LPC, LMHC), etc.
4.02	Care team includes a registered dietician(s)
4.10	Group visit model or similar non-traditional appointment format that includes at least one provider and a group of patients with shared clinical and/or social experiences
4.20	Home visit model of providing clinical services at a patient's residence (may be restricted to specific patient subpopulations)
4.30	Classes for patients focused on disease self-management (e.g. lifestyle changes, symptom recognition, clinical triage guidance, etc.)
4.31	Classes for patients focused on diet, nutrition counseling, and/or cooking
4.32	Classes for patients focused on physical activity
4.40	Peer-based programming (includes support groups, peer coaching/mentoring, etc.)
4.50	Telehealth to provide remote monitoring of patient biometric data (e.g. HbA1c levels, blood pressure, etc.) and/or medication adherence
4.60	Patient educational materials or campaigns about preventive care (e.g. immunizations, preventive screenings, etc.)
4.70	SBIRT (Screening, Brief Intervention, Referral, and Treatment) workflow actively in place
4.71	Medication-Assisted Treatment (MAT) services actively offered *(Limited to: Dual Diagnosis/SUD Treatment; Criminal Justice)*

CMHC Theme: Social Determinants of Health

Related Strategies in the *Social Determinants of Health* Theme shown in the table below are included in all of the following Related Strategies Lists unless the individual Related Strategy is separately noted as "*Limited to"* a specific List:

- Physical Health Comorbidities
- Hospital Readmissions and ED Utilization
- Children and Adolescents
- Specialty Care
- SMI: Depression
- SMI: Schizophrenia
- Dual Diagnosis/SUD Treatment
- Access to Care**
- Criminal Justice

RS-ID	Related Strategies Description
5.00	Screening patients for food insecurity
5.01	Formal partnership or arrangement with food resources to support patient health status (e.g. local food banks, grocery stores, etc.)
5.10	Screening patients for housing needs
5.11	Formal partnership or arrangement with housing resources to support patient health status (e.g. affordable housing units, transitional housing, rental assistance, etc.)
5.12	Screening patients for housing quality needs
5.13	Formal partnership or arrangement with housing quality resources to support patient health status (e.g. housing inspections, pest control management, heating and other utility services, etc.)
5.20	Screening patients for transportation needs
5.21	Formal partnership or arrangement with transportation resources to support patient access to care (e.g. public or private transit, etc.)
5.30	Formal partnership or arrangement with schools/school districts to collaborate on health-promoting initiatives (e.g. addressing environmental triggers, healthy lunch options, field day activities, etc.) *(Limited to: Children and Adolescents)*

** Within this Theme, the Access to Care List only includes RS-IDs 5.20 and 5.21.

Category D

Category D represents a population health perspective for all DSRIP Performing Providers. Whereas the initial waiver period included Category 4 statewide reporting for hospitals, Category D includes measures for all DSRIP Performing Provider types including hospitals, CMHCs, physician practices, and LHDs. This reporting is designed to assist Performing Providers, MCOs, Regional Healthcare Partnerships (RHP), and state and federal agencies to have regional and statewide views of important health care trends. The Category D reporting Measure Bundles are:

- Aligned with Medicaid and LIU populations;
- Identified as high priority given the health care needs and issues of the patient population served; and
- Viewed as valid health care indicators to inform and identify areas for improvement in population health within the health care system.

Category D Structure

Required Statewide Reporting Measure Bundles for each of the Performing Provider types:

- Hospitals
- CMHCs
- Physician practices
- LHDs

The Category D emphasis is on the reporting of population health measures to gain information on and understanding of the health status of key populations and to build the capacity for reporting on a comprehensive set of population health metrics; therefore, Performing Providers will not be required to achieve improvement in Category D. All measures are required and may be reported in the first or second reporting period of each DY. Performing Providers will also submit qualitative information describing Performing Providers' activities impacting measures. Measure reporting and qualitative information will be submitted in the form prescribed by HHSC.

Hospital Statewide Reporting Measure Bundle

As specified in the PFM, hospital Performing Providers must report on all measures included in this bundle:

- Potentially preventable admissions (PPAs)
- Potentially Preventable 30-day readmissions (PPRs)
- Potentially preventable complications (PPCs)
- Potentially Preventable ED visits (PPVs)
- Patient satisfaction

Hospital Performing Providers report on the Category D Statewide Hospital Reporting Measure Bundle, including hospitals that were previously exempt from the reporting on population health measures during DY2-6. Each hospital Performing Provider subject to required Category D reporting must report on all measures.

For PPAs, PPRs, PPCs and PPVs, hospitals with low volume are still required to respond to qualitative questions.

Hospital Reporting Measures

Potentially Preventable Admissions (PPAs)

PPAs are facility admissions that may have resulted from the lack of adequate access to care or ambulatory care coordination. Circumstances associated with PPAs are ambulatory sensitive conditions (e.g., asthma) for which adequate patient monitoring and follow-up (e.g., medication management) can often avoid the need for admission. The occurrence of high rates of PPAs may represent a failure of the ambulatory care provided to the patient. In addition to a significant quality problem, excess PPAs result in unnecessary increases in cost. From the perspective of care providers, one way to improve efficiency and quality and to generate greater value is to better identify and avoid unnecessary hospitalizations.

PPA by Category

- CHF (Congestive Heart Failure)
- DM (Diabetes)
- BH/SA (Behavioral Health/Substance Abuse)
- COPD (Chronic Obstructive Pulmonary Disease)
- Adult Asthma
- Pediatric Asthma
- CP & CAD (Angina and Coronary Artery Disease)
- HTN (Hypertension)
- Cellulitis
- Bacterial PNA (Respiratory Infection)
- PE & RF (Pulmonary Edema and Respiratory Failure)
- Others

Potentially Preventable Readmissions (PPRs)

Readmissions have potential value as an indicator of quality of care because they may reflect poor clinical care and poor coordination of services either during hospitalization or in the immediate post discharge period. A potentially preventable readmission is a readmission (return hospitalization within the specified readmission time interval) that is clinically related to the initial hospital admission. "Clinically related" is defined as a requirement that the underlying reason for readmission be plausibly related to the care rendered during or immediately following a prior hospital admission. A readmission is defined as a return hospitalization to an acute care hospital that follows a prior acute care admission within a specified time interval, called the readmission time interval. The readmission time interval is the maximum number of days allowed between the discharge date of a prior admission and the admitting date of a subsequent admission. If a subsequent admission occurs within the readmission time interval and is clinically related to a prior admission, it is considered a PPR. The hospitalization triggering a PPR is called an Initial Admission. Subsequent PPRs relate back to the care rendered during or following the Initial Admission.

PPR by Category

- CHF (Congestive Heart Failure)
- DM (Diabetes)
- BH/SA (Behavioral Health or Substance Abuse)
- COPD (Chronic Obstructive Pulmonary Disease)
- CVA (Cerebrovascular Accident)
- Adult Asthma

- Pediatric Asthma
- AMI (Acute Myocardial Infarction)
- CP & CAD (Angina and Coronary Artery Disease)
- HTN (Hypertension)
- Cellulitis
- Renal Failure
- C Section (Cesarean delivery)
- Sepsis
- Others

Potentially Preventable Complications (PPCs)

PPCs are in-hospital complications that are not present on admission but result from treatment during the inpatient stay. As indicators of quality of care, PPCs represent harmful events or negative outcomes that might result from processes of care and treatment rather than from natural progression of the underlying disease. Increased costs resulting from complications are passed on to payers because the diagnosis codes linked to complications frequently increase Diagnosis Related Group (DRG) payment.

The 3M PPC methodology identifies PPCs based on risk at admission, using information from inpatient encounters, such as diagnosis codes, procedure codes, procedure dates, present on admission (POA) indicators, patient age, sex, and discharge status. Accurate coding of the POA indicators is particularly important as it serves two primary purposes: (1) to identify potentially preventable complications from among diagnoses not present on admission and (2) to allow only those diagnoses designated as present on admission to be used for assessing the risk of incurring complications.

PPC by Category

- Renal Failure without Dialysis
- Urinary Tract Infection
- Clostridium Difficile Colitis
- Encephalopathy
- Shock
- Pneumonia & Other Lung Infections
- Acute Pulmonary Edema and Respiratory Failure without Ventilation
- Stroke and Intracranial Hemorrhage
- Post Hemorrhagic & Other Acute Anemia with Transfusion
- Venous Thrombosis
- Ventricular Fibrillation/Cardiac Arrest
- Major Gastrointestinal Complications without Transfusion or Significant Bleeding
- Other Complications of Medical Care
- Moderate Infections
- Inflammation & Other Complications of Devices, Implants or Grafts except Vascular Infection
- Post-Operative Hemorrhage & Hematoma without Hemorrhage Control Procedure or I&D Procedure
- Septicemia & Severe Infections
- Acute Pulmonary Edema and Respiratory Failure with Ventilation
- Post-Operative Infection & Deep Wound Disruption without Procedure
- Infections due to Central Venous Catheters

Potentially Preventable ED visits (PPVs)

A PPV is an emergency treatment for a condition that could have been treated or prevented by a physician or other health care provider in a nonemergency setting. Because some visits are preventable, they may indicate poor care management, inadequate access to care, or poor choices on the part of the patient. ED visits for conditions that are preventable or treatable with appropriate primary care lower health system efficiency and raise costs.

PPV by Category

- Skin and Integumentary System
- Breast
- Musculoskeletal System
- Respiratory System
- Cardiovascular System
- Hematologic, Lymphatic and Endocrine
- Gastrointestinal
- Genitourinary System
- Male Reproductive System
- Female Reproductive System
- Neurologic System
- Ophthalmologic System
- Otolaryngologic System
- Radiologic Procedures
- Rehabilitation
- Mental Illness and Substance Abuse Therapies
- Nuclear Medicine
- Radiation Oncology
- Dental Procedures

Patient Satisfaction

Reporting on Patient Satisfaction is limited to the inpatient setting.

For Patient Satisfaction, Performing Providers will report the percentage of survey respondents who choose the most positive, or "top-box," response for the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Reporting Measures:

- Percent of patients who reported that their doctors "Always" communicated well
- Percent of patients who reported that their nurses "Always" communicated well
- Percent of patients who reported that their pain was "Always" well controlled[1]
- Percent of patients who reported that staff "Always" explained about medicines before giving it to them
- Percent of patients who reported that YES, they were given information about what to do during their recovery at home
- Percent of patients who reported that their room and bathroom were "Always" clean
- Percent of patients who reported that the area around their room was "Always" quiet at night
- Percent of patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest)
- Percent of patients who reported YES, they would definitely recommend the hospital.

[1] This question will most likely be substituted for DY9-10 reporting.

Hospitals that do not report HCAHPS as part of Medicare Inpatient Prospective Payment System due to low volume or other exempt status may use an alternative hospital patient satisfaction survey.

Community Mental Health Center Statewide Reporting Measure Bundle

CMHCs will report on their activities being carried out to impact rates on the following measures and provide qualitative reporting as required by HHSC:[2]

1. Effective Crisis Response

This measure is the percent of individuals receiving crisis services who avoid inpatient admission after the crisis episode.

2. Crisis Follow up

This measure is the percent of individuals receiving crisis services who receive a crisis follow up services within a defined time period.

3. Community Tenure (Adult and Child/Youth)

This measure is the percent of individuals who successfully avoid psychiatric inpatient care.

4. Reduction in Juvenile Justice Involvement

This measure is the percent of children and youth who demonstrate improvement on indicators of juvenile justice involvement.

5. Adult Jail Diversion

This measure is the percent adults who demonstrate improvement on indicators of criminal justice involvement.

Physician Practices Statewide Reporting Measure Bundle

Physician practices report on their activities being carried out to impact rates measured by Prevention Quality Indicators (PQIs). Based on the description by the AHRQ, PQIs are a set of measures that can be used with hospital inpatient discharge data to identify quality of care for "ambulatory care sensitive conditions." These are conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease.

Even though these indicators are based on hospital inpatient data, they provide insight into the community health care system or services outside the hospital setting. For example, patients with diabetes may be hospitalized for diabetic complications if their conditions are not adequately monitored or if they do not receive the patient education needed for appropriate self-management.

Based on the regional summary of the PQIs that HHSC will make available to the Performing Providers, each physician practice will provide qualitative information on their efforts to impact these rates.

[2] Some measures may be modified at the end of DY9-10. CMHCs will report based on the modified measure specifications once approved by HHSC.

1. Diabetes Short-term Complications Admission Rate
2. Perforated Appendix Admission Rate
3. Diabetes Long-term Complications Admission Rate
4. Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate
5. Hypertension Admission Rate
6. Heart Failure Admission Rate
7. Low Birth Weight Rate
8. Dehydration Admission Rate
9. Bacterial Pneumonia Admission Rate
10. Urinary Tract Infection Admission Rate
11. Uncontrolled Diabetes Admission Rate
12. Asthma in Younger Adults Admission Rate
13. Lower-Extremity Amputation among Patients with Diabetes Rate

Local Health Departments Statewide Reporting Measure Bundle

Based on the information available via Texas Behavioral Risk Factor Surveillance System (BRFSS)[3], HHS agencies will provide a RHP specific summary for the following areas:

- Access to health care services
- Health status of the population
- Selected immunizations
- Prevention of sexually transmitted diseases

Each LHD will provide a qualitative description of what is carried out by that LHD in its region to impact the rates and trends of the following measures:

1. Time Since Routine Checkup

- BRFSS Questionnaire: About how long has it been since you last visited a doctor for a routine checkup?

2. High Blood Pressure Status

- BRFSS Calculated Variable: Doctor diagnosed high blood pressure

3. Diabetes Status

- BRFSS Calculated Variable: Doctor diagnosed diabetes

4. Overweight or Obese

- BRFSS Calculated Variable: Overweight or obese

5. Smoker Status

- BRFSS Calculated Variable: Four-level smoker status (Current Smoker - Every Day; Current Smoker - Some Days; Former Smoker; and Never Smoker)

6. Selected Immunizations

- **Flu Shot Past Year**
  - BRFSS Questionnaire: During the past 12 months, have you had either a seasonal flu shot or a seasonal flu vaccine that was sprayed in your nose?

[3] Additional information on BRFSS is available in Appendix B.

- **Ever Had Pneumonia Shot**
  - BRFSS Questionnaire: Have you ever had a pneumonia shot?
- **Received Tetanus Shot Since 2005**
  - BRFSS Questionnaire: Since 2005, have you had a tetanus shot? Was this Tdap, the tetanus shot that also has pertussis or whooping cough vaccine?
- **Ever Had MMR Vaccine**
  - BRFSS Questionnaire: Have you ever received the MMR vaccine?
- **Had All HPV Shots**
  - Calculated Variable: Received all 3 HPV shots

7. Prevention of Sexually Transmitted Diseases

- Ever Had HIV Test
  - BRFSS Questionnaire: Have you ever been tested for HIV?

Appendix A

Category C Measure Specifications

Appendix B

Regional summaries with selected health information are generated based on the data collected by the Department of State Health Services via BRFSS. BRFSS, initiated in 1987, is a federally supported landline and cellular telephone survey that collects data about Texas residents regarding their health-related risk behaviors, chronic health conditions, and use of preventive services. Texas BRFSS is an important tool for decision-making throughout the Texas Health and Human Services, Texas Department of State Health Services and the public health community. Public and private health officials at the federal, state, and local levels rely on the BRFSS to identify public health problems, set priorities and goals, design policies and interventions, as well as evaluate the long-term impact of these efforts.

This surveillance can be used to monitor the Healthy People 2020 Objectives for current smoking, obesity, high blood pressure, exercise and physical activity, flu and pneumonia vaccinations, cholesterol and cancer screenings, seat belt use, as well as other risk factors.

The BRFSS is administered under the direction of the Centers for Disease Control and Prevention (CDC) so that survey methods and much of the questionnaire are standardized across all BRFSS surveys in the 50 states, three territories, and the District of Columbia. As a result, comparisons can be made among states and to the nation.

Attachment S

Reserved

Attachment T

Public Health Provider Charity

Care Program FFY 2022

Community Mental Health Centers

& Local Health Departments

For the PHP-CCP App/Cost Report

Provider Finance Department

May 2021

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Overview

The purpose of this document is to provide information regarding the Public Provider Charity Care Program (PHP-CCP) for federal fiscal year 2022. PHP-CCP is designed to allow qualified providers to receive reimbursement for healthcare service delivery costs when not reimbursed by another source. The healthcare services included are:

- Behavioral health services
- Immunizations
- Public health services
- Other preventative services

Authority

PHP-CCP is authorized under Section 1115 of the Social Security Act, otherwise known as *the 1115 Waiver*. In accordance with the Special Terms and Conditions of the 1115 Waiver, providers must be funded by a unit of government able to certify expenditures to participate in the program. Pursuant to 42 C.F.R. §433.51, entities with 501(c)(3) designation are not governmental entities and ineligible to participate in Certified Public Expenditure.

In accordance with Texas Health and Safety Code Chapters 533 and 534, the following publicly-owned and operated entities providing behavioral health services are eligible to participate:

- Community Mental Health Clinics (CHMCs)
- Community Centers
- Local Mental Health Authorities (LMHAs)
- Local Behavioral Health Authorities (LBHAs)

Additionally, under Title 2 Texas Health and Safety Code Chapter 121, the following publicly-owned and operated entities established under Chapter 121 are eligible to participate in the program:

- Local Health Departments (LHDs)
- Public Health Districts (PHDs)

Provider Reimbursement Qualification

The provider must be able to certify public expenditures to qualify for reimbursement. Certified public expenditures will be paid an annual lump sum based upon actual expenditures.

PHP-CCP Payments are considered Medicaid payments to providers and must be treated as Medicaid revenue when determining the total Title XIX funding received.

Cost Report Criteria

A provider must annually prepare and complete a Public Health Provider Cost Report according to the following criteria:

- The cost report must be submitted by the provider no later than 45 days after the close of the reporting period.
- The cost report period begins on October 1 and ends on September 30 of the following year.
- If a provider receives approval to participate in the PHP-CCP program after October 1, the cost report period begins on the effective date of the supplemental payment request approval.
- Costs are eligible for reimbursement for only 24 months after the date the cost was incurred.
- Completed cost reports must be sent via electronic mail or U.S. mail to the Texas Health and Human Services Commission (HHSC).
- **The cost report can only include allocable expenditures related to Medicaid, Medicaid Managed Care, and Uncompensated Care**. The Texas Healthcare Transformation and Quality Improvement 1115 Waiver Program defines these expenditures as those pertaining to Medicaid, Medicaid Managed Care, and Uncompensated Care.
- The cost report **may not** include costs for services delivered to persons who are incarcerated at the time of the service.
- The cost report **may not** include costs for services delivered by an institution for mental diseases.
- Only complete the **shaded areas** of the cost report.

- Many worksheets, or *exhibits*, will automatically populate information provided in completed worksheets.

- Be sure to carefully review the information provided in the cost report before submission.

- Providers must attest to and certify its cost report of the total actual incurred Medicaid and Uncompensated (uninsured) costs and expenditures, including the federal share and the non-federal share applicable to the cost report period.

- The cost reporting guidelines will be governed by:

  - Title 1 Texas Administrative Code Section 355.101 (relating to Introduction);

  - Title 1 Texas Administrative Code Section 355.102 (relating to General Principles of Allowable and Unallowable Costs);

  - Title 1 Texas Administrative Code Section 355.103 (relating to Specifications for Allowable and Unallowable Costs);

  - Title 1 Texas Administrative Code Section 355.104 (relating to Revenues);

  - Title 1 Texas Administrative Code Section 355.105 (relating to General Reporting and Documentation Requirements, Methods, and Procedures);

  - Title 1 Texas Administrative Code Section 355.106 (relating to Basic Objectives and Criteria for Audit and Desk Review of Cost Reports);

  - Title 1 Texas Administrative Code Section 355.107 (relating to Notification of Exclusions and Adjustments);

  - Title 1 Texas Administrative Code Section 355.108 (relating to Determination of Inflation Indices);

  - Title 1 Texas Administrative Code Section 355.109 (relating to Adjusting Reimbursement When New Legislation, Regulations, or Economic Factors Affect Costs); and

  - Title 1 Texas Administrative Code Section 355.110 (relating to Informal Reviews and Formal Appeals).

- During HHSC's desk review, providers will have to show documentation to demonstrate this information matches their submission and that the covered services are provided appropriately. Any additional information needed will be requested during the desk review.

For questions on completing the cost report, please contact the Health and Human Services Commission, Provider Finance Department at the email address: PHP-CCP@hhs.texas.gov.

Definitions

Charity Care

Healthcare services provided without expectation of reimbursement to uninsured patients who meet the provider's charity-care policy. The charity-care policy should adhere to the charity-care principles of the Healthcare Financial Management Association Principles and Practices Board Statement 15 (December 2019). Charity care includes full or partial discounts given to uninsured patients who meet the provider's financial assistance policy. Charity care does not include bad debt, courtesy allowances, or discounts given to patients who do not meet the provider's charity-care policy or financial assistance policy.

Cognizant Agency

Agency responsible for reviewing, negotiating, and approving cost allocation plans or indirect cost proposals developed in accordance with the Office of Management and Budget Circular A-87.

Cost Allocation Plans

The means by which costs are identified in a logical and systematic manner for reimbursement under federal grants and agreements.

Cost-to-Charge Ratio

A provider's reported costs are allocated to the Medicaid program based on a cost-to-charge ratio. Cost-to-charge ratio is calculated as the Total Allowable Cost reported for the service period to represent the numerator of the ratio to the billed charges of the total all claims for the service period that represents the denominator of the ratio (see below). This ratio is applied to calculate total billed charges associated with Medicaid paid claims or total computable amount for the cost report.

$$\text{Cost-to-Charge Ratio} = \frac{\text{Total Allowable Cost Reported}}{\text{Billed Charges of All Claims}}$$

Direct Cost

This term refers to any cost explicitly associated with a particular final cost objective. Direct costs are not limited to items incorporated in the end product as material or labor. Costs identified specifically with a contract are direct costs of that contract. All costs identified specifically with other final cost objectives of the contractor are direct costs of those cost objectives.

Federal Medical Assistance Participation (FMAP) Rate

The share of state Medicaid benefit costs paid for by the federal government.

Indirect Costs

These are costs incurred identified with two or more cost objectives but not specifically identified with any final cost objective.

Medicaid Fee-For-Service (FFS) Paid Claims

These claims are Medicaid payments made by HHSC through the Texas Medicaid Healthcare Partnership to enrolled providers for services provided to Medicaid recipients.

Medicaid Managed Care

Medicaid Managed Care delivers Medicaid health benefits and additional services through an arrangement between a state Medicaid agency and managed care organizations (MCOs) that accept a set payment for these services. Medicaid payments are made by the MCOs to providers for services provided to Medicaid recipients.

Medicare

Medicare is a federal system of health insurance for people over 65 years of age and for certain younger people with disabilities.

Other Third-Party Coverage:

Commercial Pay Insurance:

Commercial Pay Insurance is health insurance that covers medical expenses and disability income for the insured. Commercial health insurance can be categorized

according to its renewal provisions and the type of medical benefits provided. Commercial policies can be sold individually or as part of a group plan.

Self-Pay:

A self-pay patient pays in full at the time of visit for services and does not file a claim with an insurance carrier.

Total Computable Amount

The Total Computable Amount is the total Medicaid allowable amount payable for services.

Uncompensated Care (UC)

Healthcare provided for which a charge was recorded, but no payment was received. UC consists of two components: (1) charity care, in which the patient is unable to pay, and (2) bad debt, in which payment was expected but not received. Uncompensated care excludes other unfunded costs of care, such as underpayment from Medicaid and Medicare.

Uninsured

An individual who has no health insurance or other source of third-party coverage for medical/health services.

Uninsured Cost

Uninsured Cost is the cost to provide services to uninsured patients as defined by the Centers for Medicare and Medicaid Services (CMS). An individual whose third-party coverage does not include the service provided is considered by HHSC to be uninsured for that service.

Unit of Government

A state, city, county, special purpose district, or other governmental units in the State that: has taxing authority, direct access to tax revenues, is a State university teaching hospital with direct appropriations from the State treasury, or is an Indian tribe as defined in Section 4 of the Indian Self-Determination and Education Assistance Act, as amended, 25 U.S.C. 450b.

Exhibit A: Cost Report Cover Page

Exhibit A is the cost report cover page. This form includes a provider's National and State Provider Identification Number used by HHSC to obtain the fee-for-service cost data included in the cost report. Each government entity must enter information for its entity, including the:

- entity's Legal name;
- name of the person responsible for submitting the cost report;
- name of the cost report preparer;
- name of the person responsible for making financial decisions on behalf of the organization, if different than the preparer; and
- the physical location, mailing address, phone number, fax number, and email address of all contacts listed.

HHSC will use the information to contact the provider as necessary throughout the cost reconciliation and cost settlement process.

DIRECTIONS TO COMPLETE EXHIBIT A:

Reporting Period

Enter the actual **Reporting Period** for which the cost report will be completed (e.g., 10/01/10 to 09/30/11).

Primary Texas Provider Identification Number (TPI)

Enter the main **9-digit TPI** number for the provider completing the cost report (e.g., 123456789).

Primary National Provider Identification Number (NPI)

Enter the main **10-digit NPI** number for the provider completing the cost report (e.g., 1234567890).

Associated Texas Provider Identification Numbers (TPIs)

Enter the other associated **9-digit TPI** numbers for the provider completing the cost report (e.g., 123456789, 987654321, 012345678, etc.).

Associated National Provider Identification Number (NPIs)

Enter the other associated **10-digit NPI** numbers for the provider completing the cost report (e.g., 1234567890, 0123456789, 1231231230, etc.).

Provider Information

Provider Legal Name:

Enter the **Provider Legal Name** (e.g., Health and Human Services Commission EMS). The name of the provider completing the cost report should be listed here.

Street Address:

Enter the provider's **Street Address** (e.g., 11209 Metric Blvd., Bldg. H., Austin, TX 78758). Include the city, state, and zip code in this field.

Mailing Address:

Enter the provider's **Mailing Address** (e.g., 11209 Metric Blvd., Bldg. H., Austin, TX 78758 or P.O. Box 85700, Mail Code H-400, Austin, TX 78708-5200). Include the city, state, and zip code in this field.

Phone Number:

Enter the **Phone Number** of the provider's contact (e.g., (512) 123-4567).

Fax Number:

Enter the **Fax Number** of the provider's contact (e.g., (512) 987-6543).

Email Address:

Enter the **Email** address of the provider's contact (e.g., iampublic@xyzabc.com).

Business Manager or Financial Director

Business Manager or Financial Director's Name:

Enter the **Name** of the provider's business manager or financial director (e.g., Jane Doe).

Title:

Enter the **Title** of the provider's business manager or financial director identified in the field above (e.g., Director).

Agency Name:

Enter the name of the agency or municipality or provider submitting the cost report.

Mailing Address:

Enter the provider's **Mailing Address** (e.g., 11209 Metric Blvd., Bldg. H., Austin, TX 78758 or P.O. Box 85700, Mail Code H-400, Austin, TX 78708-5200). Include the city, state, and zip code in this field.

Phone Number:

Enter the **Phone Number** of the provider's contact (e.g., (512) 123-4567).

Fax Number:

Enter the **Fax Number** of the provider's contact (e.g., (512) 987-6543).

Email Address:

Enter the **Email** address of the provider's contact (e.g., jqpublic@xyzabc.com).

Report Preparer Identification

Report Preparer Name:

Enter the **Name** of the provider's contact or person responsible for preparing the cost report (e.g., Jane Doe). HHSC may contact the individual if there are questions.

Title:

Enter the **Title** of the provider's contact identified in the field above (e.g., Director).

Mailing Address:

Enter provider's **Mailing Address** (e.g., 11209 Metric Blvd., Bldg. H., Austin, TX 78758 or P.O. Box 85700, Mail Code H-400, Austin, TX 78708-5200). Include the city, state, and zip code in this field.

Phone Number:

Enter the **Phone Number** of the provider's contact (e.g., (512) 123-4567).

Fax Number:

Enter the **Fax Number** of the provider's contact (e.g., (512) 987-6543).

Location of Accounting Records that Support this Report

Records Location:

Enter the **physical address** of the location where the provider maintains the accounting records in support of the cost report (e.g., 11209 Metric Blvd., Bldg. H., Austin, TX 78781). Include the city, state, and zip code in this field.

Exhibit 1: General and Statistical Information

Exhibit 1 is the General and Statistical Information page of the cost report. This exhibit includes general provider information and statistical information.

DIRECTIONS TO COMPLETE EXHIBIT 1

General Provider Information

Reporting Period – Begin Date:

Enter the **Reporting Period – Beginning** date or the beginning date of the cost report period (e.g., 10/1/2010).

Reporting Period – End Date:

Enter the **Reporting Period – Ending** date or the ending date of the cost report period (e.g., 9/30/2011).

Part-Year Cost Report:

Enter an answer to the question "**Is Reporting Period less than a full year?**" This question identifies if the cost report is being prepared for a period that is not an entire fiscal year. If the cost report is for an entire fiscal year (October 1 to September 30), then enter **No** in the field. If the cost report is being prepared for a partial fiscal year, enter a response that explains the reason why (e.g., Supplemental Payment Request Approval was effective beginning on 7/1/20XX).

Statistical Information

This cost report uses a cost-to-billed charge ratio methodology applied to determine the portion of costs eligible for reimbursement under the Direct Medical settlement exhibit (*see* Exhibit 2).

Summary of Payments and Billed Charge Data (Applicable to Cost Report)

Medicaid Fee for Service Paid Claims Amount:

Enter the **Total Medicaid fee-for-service (FFS) Paid Claims Amount** for the applicable cost report period identified on the form associated with the NPI and TPI

identified in Exhibit A. The Medicaid fee-for-service paid claims amount entered must only be for **dates of service** during the cost report period.

Total Billed Charges Associated with Medicaid FFS Paid Claims:

Enter the **Total Billed Charges associated with Medicaid FFS Paid Claims** for the applicable cost report period identified on the form. The total billed charges associated with Medicaid FFS paid claims entered must only be for **dates of service** during the cost report period. Billed charges are based on the local chargemaster that sets the usual and customary rate for services.

Medicaid Managed Care Organization (MCO) Paid Claims Amount:

Enter the total **MCO** Paid Claims Amount for services provided for the applicable Cost Report period identified on the form. The Medicaid MCO paid claims amount for services entered should be for dates of service during the cost report period.

Total Billed Charges Associated with MCO Paid Claims:

Enter the **Total Billed Charges associated with Medicaid MCO Paid Claims** for the applicable cost report period identified on the form. The total billed charges associated with MCO paid claims entered must only be for **dates of service** during the cost report period. Billed charges are based on the local chargemaster that sets the usual and customary rate for services.

Uninsured/Uncompensated Care (UC) Reimbursements Received Associated with UC Claims:

Enter the **reimbursements received associated with UC Claims** for the applicable cost report period identified on the form. The total reimbursements received associated with UC claims entered must only be for **dates of service** during the cost report period.

Uninsured/Uncompensated Care (UC) Uninsured Charges:

Enter the total **UC** Charity and Bad Debt charges for services provided for the applicable Cost Report period identified on the form. The UC charges entered should be for dates of service during the cost report period and must exclude all unfunded Medicaid and Medicare costs. Billed charges are based on the local chargemaster that sets the usual and customary rate for services.

Grants/Donations/Appropriations Paid for Direct Medical Services:

Enter the total **Grants/Donations/Appropriations Paid for Direct Medical Services** provided for the applicable cost report period identified on the form. The amount entered should be for dates of service during the cost report period. Note that the amount should reflect funds used to pay for direct medical services and that these funds are reported separately from the funds directly related to payroll and positions (entered in Exhibit 6). Note that the amount is also separate from Uninsured/Uncompensated Care (UC) Reimbursements Received Associated with UC Costs.

Total Billed Charges Associated with Grants/Donations/Appropriations Paid for Direct Medical Services:

Enter the **Total Billed Charges Associated with Grants/Donations/Appropriations Paid for Direct Medical Services** for the applicable cost report period identified on the form. The total billed charges associated entered must only be for **dates of service** during the cost report period. Billed charges are based on the local chargemaster that sets the usual and customary rate for services.

Total Allowable Costs for Reporting Period:

The **Total Allowable Costs** calculated are for the applicable cost report period identified on the direct service tab. The total allowable costs are only for dates of service during the cost report period.

Total Billed Charges for Reporting Period:

The **Total Billed Charges** calculated are for the applicable cost report period identified on the form, less the total allowable costs and less any reimbursements received. The total billed charges entered are only for dates of service during the cost report period.

Additional Statistical Information:

In addition to the statistical information entered for the Cost Reporting period, other cost data is required.

Medicare Charges:

Enter the total **Medicare Charges** for services provided for the applicable cost report period identified on the form. The Medicare charges for services entered should be for dates of service during the cost report period.

Self-Pay, County, or City Indigent Recipient Program Charges:

Enter the total **Self-pay or County or City Indigent Charges** for services provided for the applicable cost report period identified on the form. The "other" charges for services entered should be for dates of service during the cost report period.

Other Third-Party Insurance Coverage Charges:

Enter the total **Other Third-party Coverage Commercial Pay** Charges for services provided for the applicable cost report period identified on the form. The "other" charges for services entered should be for dates of service during the cost report period.

Exhibit 2: Direct Medical

Exhibit 2 identifies and summarizes all service costs within the cost report from other exhibits. Much of the information contained within this exhibit is pulled from either Exhibit 5 or Exhibit 6. However, unique cost items are identified in this exhibit.

Only allocable expenditures related to Medicaid FFS, Medicaid Managed Care, and Uncompensated Care as defined and approved in the Texas Healthcare Transformation and Quality Improvement 1115 Waiver Program will be included for supplemental payment(s).

This exhibit provides a sum of the personnel expenses and adds additional costs to calculate the total cost of Medical and Uncompensated Care Services.

Direct Cost Methods

Direct Cost methods must be used. Direct Cost means that allowable costs for medical services for the benefit of, and directly attributable to, a specific service delivery component must be charged directly to that business component. Providers may use reasonable cost allocation methods for operational costs related to direct service delivery.

Supplemental Schedule

The amounts from the supplemental schedule allocated to the Medicaid and Uncompensated Care programs should match the amounts entered on the following forms:

- Exhibit 6, Schedule B.
- Exhibit 7, Schedule C - Cost Allocation Methodologies Employed by the provider (additional detail is entered here).
- Exhibit 8, Schedule D - Collections Tracking Form, if applicable.
- Other forms or reports used to track and calculate Uncompensated Care costs may be used in place of Exhibit 8, Schedule D.

The provider must fully disclose any change in cost-reporting allocation methods from one year to the next on its cost report.

Identified Reductions

As part of the cost report, identified reductions from Exhibit 1 and Exhibit 6 are subtracted to calculate the settlement amount. The cost report identifies the portion of allowable costs related to:

- Medicaid FFS
- Medicaid Managed Care
- Uncompensated Care

Cost-to-Charge Ratio

The cost-to-charge ratio for the applicable cost report period is for all billed charges incurred by the facility regardless of payer resulting in the total computable amount for services. That amount is then reduced by the amount of Medicaid FFS, Medicaid Managed Care paid claims, and any reimbursement received for Uncompensated Care. The resulting amount is then multiplied by the applicable federal medical assistance percentage to calculate the amount of settlement due to or owed by (if negative) the provider.

$$\textbf{Cost-to-Charge Ratio} = \frac{\text{Total Allowable Cost Reported}}{\text{Billed Charges of All Claims}}$$

Medicaid and Uninsured Cost = Cost-to-Charge Ratio x Total Billed Charges Associated with Medicaid and Uninsured Cost Claims

Settlement Amount = Medicaid and Uninsured Cost – Medicaid Payments and Uninsured Fees Collected

Amount Due to Provider = Settlement Amount x FMAP Percentage

Exhibit 2 Sections

Exhibit 2 is separated into the sections identifying:

- **Personnel or Payroll Expenses.** This section of the exhibit includes, in part, expenditures from Exhibit 6.
- **Other Operating Costs.** This section of the exhibit includes, in part, expenditures from Exhibit 5.

- **Reductions to Allowable Costs.** This section of the exhibit includes reductions to expenditures identified in Exhibit 6.
- **Cost Settlement Calculation.** This section applies the cost-to-charge ratio calculation methodology to arrive at the final settlement due to or from the provider.

DIRECTIONS TO COMPLETE EXHIBIT 2

Personnel or Payroll Expenses

This section of the exhibit includes all personnel-related expenditures and hours for the job classifications identified.

Hours:

Enter the number of **Hours** for each of the job classifications identified in this exhibit and for which costs are identified in Exhibit 6. Hours for this exhibit represent total paid hours that are reported by the provider on payroll reports. Total paid hours include, but are not limited to:

- regular wage hours,
- sick hours, and
- vacation hours.

Payroll Taxes or Unemployment Compensation

If applicable, enter the amount of the following payroll expenses:

- State Unemployment Payroll Taxes
- Federal Unemployment Payroll Taxes
- Unemployment Compensation (Reimbursing Employer)

Other Operating Costs

This section of the exhibit identifies other operating costs not related to the job classifications identified above. Within this section, Support Services or Other may include personnel-related expenditures not identified in the job classifications in the section above.

All costs identified in this section of the exhibit are supported by supplemental schedules to the cost report and will be supplied at the time of cost report submission.

Supplies, Materials, and Equipment Costs:

Enter the amount of **Supplies and Materials,** and **Equipment** expenditures incurred by the provider during the cost report period. Please see Appendix A with examples of supplies, materials, and equipment. Supplies and materials include, but are not limited to:

- medical supplies,
- office supplies,
- maintenance supplies, and
- medical materials.

Support Services Costs:

Enter the amount of **Support Services** expenditures incurred by the provider during the cost report period. Support Services expenditures may include personnel and non-personnel expenditures if the personnel expenditures are represented in the job classification categories identified in this exhibit and detailed in Exhibit 6. Support Services expenditures include, but are not limited to, information technology salaries, benefits, and operating expenditures.

Depreciation Expense:

All assets must be depreciated. Asset costs are only accepted on the Cost Report if the asset is depreciated in accordance with the Medicare cost report requirements. If the item is not depreciable pursuant to the Medicare requirements, prior approval from HHSC and CMS is required before recording the entry on the Cost Report.

Other Costs:

Enter the amount of **Other** expenditures incurred by the provider during the Cost Report period. Other expenditures may include personnel and non-personnel expenditures if the expenditures are represented in the job classification categories identified in this exhibit and detailed in Exhibit 6.

Allocation Ratio:

Enter the number of **Medical Clients Served** by the provider during the Cost Report period. Enter the number of **All Clients Served** by the provider during the Cost Report period, both medical and non-medical. The **Allocation Ratio** is calculated by dividing the medical clients served over all clients served. The total direct other costs is multipled by the allocation ratio to get the **Total Direct Medical Other Costs**.

Because all costs must be related to Medicaid covered services and providers offer a variety of services, HHSC may require a provider to use a separate allocation mechanism for the Allocation Ratio that more accurately allocates direct and indirect costs. Further, at a provider's request, HHSC may allow for a separate allocation mechanism for the Allocation Ratio that more accurately allocates direct and indirect costs, so long as the provider is able to provide support and justification.

Reductions to Allowable Costs

This section of the exhibit includes reductions to expenditures identified in Exhibit 1 and Exhibit 6. Identified reductions from Exhibit 1 and Exhibit 6 are subtracted to calculate the adjusted amount of Direct Medical Costs allowable as part of the cost report.

Cost Settlement Calculation

Period of Service for Applicable Cost Report Period: Enter the **Period of Service** for the applicable cost report period. Example: 10/01/20XX to 09/30/20XX. For partial year cost reports, enter the period of service applicable only to the time frame a cost report is submitted to cover.

Total Billed Charges for Period of Service:

The **Total Billed Charges** for the applicable period of service. (No entry is required).

Total Allowable Costs for Period of Services:

The total allowable costs entered into the cost report, less any "other federal funding" received. (No entry is required).

Cost-to-Charge Ratio:

This ratio is the result of dividing a provider's Total Allowable Costs for the reporting period by the provider's Total Billed Charges for the same period.

$$\text{Cost to Charge Ratio} = \frac{\text{Total Allowable Costs}}{\text{Provider's Total Billed Charges}}$$

Total Charges Associated with Medicaid, Paid Claims, Medicaid Managed Care Claims, and Uncompensated Care Paid Fees:

Enter the **Total Billed Charges Associated with Medicaid FFS and Medicaid Managed Care Paid Claims** for the period of service applicable to the cost report. (No entry is required).

Total Computable

The total Medicaid Allowable Costs for the period of service applicable to the cost report. The **Total Computable** amount is reduced by the amount of Medicaid Claims paid (Interim Payments) by a provider for the service period applicable to the cost report. This calculation is equal to the **Settlement Amount** for the reporting period. (No entry is required).

Exhibit 3 – Cost Report Certification

Exhibit 3 is the Certification of costs included in the cost report. This form attests to and certifies the accuracy of the financial information contained within the cost report.

DIRECTIONS TO COMPLETE EXHIBIT 3

Most of the information in Exhibit 3 will be updated automatically with information from previous exhibits. This exhibit must be signed and included **UPON COMPLETION OF ALL OTHER EXHIBITS**.

Upon completion of all other exhibits in the cost report, please **print this exhibit, sign the exhibit, have the form notarized, scan the exhibit, and include the signed exhibit** when sending the electronic version of the cost report to HHSC. Please be sure the form is read and signed by the provider or a representative with authority to sign on behalf of the provider.

Preparer Identification

Preparer or Contractor Name:

Enter the **Name** of the person that will prepare or has prepared the cost report (e.g., Jane Doe).

Title:

Enter the **Title of Signer**, or the title of the person that will prepare or has prepared the cost report (e.g., Director).

Vendor/Company Name:

Enter the **Name of the Company or Business** with whom the report preparer/contractor is affiliated.

Signature Authority or Certifying Signature

Certifier Name:

Enter the **Name of** the person that will be certifying the costs identified in the cost report (e.g., Jane Doe).

Title:

Enter the **Title of Signer** or the title of the person that will be certifying the costs identified in the cost report (e.g., Director).

Print:

Please print this exhibit and have the appropriate person identified above sign the certification form.

Date:

Enter the **Date** that the appropriate person identified above signs the certification form (e.g., 1/1/2011).

Signature Authority Check Box:

Check the appropriate box that corresponds to the person signing this exhibit.

Notary:

Upon printing and signing this exhibit, please have this form **Notarized**.

Exhibit 4 – Certification of Funds

Exhibit 4 is the Certification of Public Expenditure. It allows the State to use the computable Medicaid expenditures as the non-federal match of expenditures to draw the federal portion of Medicaid funding as identified in the settlement. This form attests to and certifies the following:

- The accuracy of the financial information provided.
- The report was prepared in accordance with State and Federal audit and cost principle standards.
- The costs have not been claimed on any other cost report for federal reimbursement purposes.
- This exhibit also identifies the amount of local provider expenditure allowable for use as the State match.

DIRECTIONS TO COMPLETE EXHIBIT 4

Most of the information in Exhibit 4 will be updated automatically with information from previous exhibits. This exhibit must be signed and included **UPON COMPLETION OF ALL OTHER EXHIBITS**.

Upon completion of all other exhibits in the cost report, please **print this exhibit, sign the exhibit, have the form notarized, scan the exhibit, and include the signed exhibit** when sending the electronic version of the cost report to HHSC. Please be sure the form is read and signed by the provider or a representative with authority to sign on behalf of the provider.

Signature Authority/Certifying Signature

Print:

Please print this exhibit and have the appropriate person sign the certification form.

Date:

Enter the **Date** that the appropriate person identified above signs the certification form (e.g., 1/1/2011).

Certifier Name:

Enter the **Name of Signer**, or the person that will be certifying the public expenditures identified in the cost report (e.g., Jane Doe).

Title:

Enter the **Title of Signer**, or the title of the person that will be certifying the public expenditures identified in the cost report (e.g., Director).

Certifier Check Box:

Check the appropriate box that corresponds to the title of the person signing this exhibit. If **Other Agent/Representative** is selected, please include the appropriate title.

Notary:

Upon printing and signing this exhibit, please have this form **Notarized**.

Exhibit 5 – Schedule A (Depreciation Schedule)

Exhibit 5 identifies allowable depreciation expenses incurred by the provider related to Medicaid, Medicaid Managed Care, and Uncompensated Care. This exhibit will identify depreciable assets for which there was a depreciation expense during the Cost Report period. Information on this exhibit must come from a depreciation schedule maintained by the provider in accordance with appropriate accounting guidelines established by the provider. For depreciation expenses, the straight-line method should be used. Prior Period Accumulated Depreciation plus Depreciation for Reporting Period cannot exceed the total cost of an asset. In addition, assets that have been fully expensed should not be reported.

DIRECTIONS TO COMPLETE EXHIBIT 5

Vehicles: Depreciation of vehicles is limited to only the vehicles used in the delivery and/or transportation of recipients to and from a Title XIX medical service. No other vehicles are to be included in the costing or depreciation application for this pool payment.

For depreciation expenses related to vehicles, the provider must follow Medicare depreciation instructions. The vehicle depreciation expense as reported on the Cost Report must come from the provider's depreciation schedule.

Asset Description:

Enter the **Description of the Asset** that will be included in this depreciation schedule. The name or account code, or both, will suffice. If there is the need to add additional lines, please do so.

Month/Year Placed in Service:

Enter the **Month/Year Placed in Service** as identified on the provider's depreciation schedule (e.g., January 2000, or 1/2000). This date is the month and the year that the depreciable asset was first put into service.

Years Useful Life:

Enter the number of **Years of Useful Life** of the asset as identified on the provider's depreciation schedule (e.g., 20 for twenty years of useful life).

Cost:

Enter the amount of the initial **Cost** of the asset identified on the provider's depreciation schedule.

Salvage Value:

Enter the value of the asset after depreciation has been fully expensed.

Prior Period Accumulated Depreciation:

Enter the amount of **Prior Period Accumulated Depreciation** related to the asset as identified on the provider's depreciation schedule. This amount is the total depreciable expenses to date, related to the depreciable asset.

Month/Year of Disposal:

Enter the **Month/Year of Disposal** identified on the provider's depreciation schedule (e.g., January 2000, or 1/2000). This date is the month and the year that the depreciable asset was removed from service.

Depreciation for Reporting Period:

The calculated amount of current period depreciation expense is the **HHSC Allowable Depreciation**. This amount is the total depreciable expense incurred during the Cost Report period.

Equipment

For depreciation expenses related to equipment, the provider must follow Medicare depreciation instructions. The equipment depreciation expense reported on the Cost Report must come from the provider's depreciation schedule.

Asset Description:

Enter the **Description of the Asset** that will be included in this depreciation schedule. The name or account code, or both, will suffice. If there is the need to add additional lines, please do so.

Month/Year Placed in Service:

Enter the **Month/Year Placed in Service** as identified on the provider's depreciation schedule (e.g., January 2000, or 1/2000). This date is the month and the year that the depreciable asset was first put into service.

Years Useful Life:

Enter the number of **Years of Useful Life** of the asset as identified on the provider's depreciation schedule (e.g., 20 for twenty years of useful life).

Cost:

Enter the amount of the initial **Cost** of the asset identified on the provider's depreciation schedule.

Salvage Value:

Enter the value of the asset after depreciation has been fully expensed.

Prior Period Accumulated Depreciation:

Enter the amount of **Prior Period Accumulated Depreciation** related to the asset as identified on the provider's depreciation schedule. This amount is the total depreciable expenses to date related to the depreciable asset.

Month/Year of Disposal:

Enter the **Month/Year of Disposal** as identified on the provider's depreciation schedule (e.g., January 2000, or 1/2000). This date is the month and the year that the depreciable asset was removed from service.

Depreciation for Reporting Period:

The calculated amount of current period depreciation expense in the **HHSC Allowable Depreciation**. This amount is the total depreciable expense incurred during the Cost Report period.

Building

For depreciation expense related to buildings where the provider's vehicles or staff are housed with other agencies or entities, **ONLY the portion related to the provider** may be reported, and the provider must follow Medicare depreciation instructions. The provider must attach a supplemental exhibit showing how the portion of the building related to the provider was calculated.

Asset Description:

Enter the **Description of the Asset** that will be included in this depreciation schedule. The name or account code, or both, will suffice. If there is the need to add additional lines, please do so.

Month/Year Placed in Service:

Enter the **Month/Year Placed in Service** as identified on the provider's depreciation schedule (e.g., January 2000, or 1/2000). This date is the month and the year that the depreciable asset was first put into service.

Years of Useful Life:

Enter the number of **Years of Useful Life** of the asset as identified on the provider's depreciation schedule (e.g., 20 for twenty years of useful life).

Cost:

Enter the amount of the initial **Cost** of the asset identified on the provider's depreciation schedule.

Salvage Value:

Enter the value of the asset after depreciation has been fully expensed. For buildings, this amount is 10% of the building cost.

Prior Period Accumulated Depreciation:

Enter the amount of **Prior Period Accumulated Depreciation** related to the asset as identified on the provider's depreciation schedule. This amount is the total depreciable expenses to date, related to the depreciable asset.

Month/Year of Disposal:

Enter the **Month/Year of Disposal** as identified on the provider's depreciation schedule (e.g., January 2000, or 1/2000). This date is the month and the year that the depreciable asset was removed from service.

Depreciation for Reporting Period:

The calculated amount of current period depreciation expense in the **HHSC Allowable Depreciation**. This amount is the total depreciable expense incurred during the Cost Report period.

Exhibit 6 – Worksheet B (Payroll and Benefits)

This exhibit includes the salary and benefits and appropriate reductions related to contracted and employed staff of the provider for Medicaid, Medicaid Managed Care, and Uncompensated Care. For this exhibit, all employed and contracted staff related to the provision of direct medical services should be identified here. HHSC may pre-populate certain staffing classifications for which information will need to be completed. Any payroll related item that is not directly related to medical services should not be included in this section.

DIRECTIONS TO COMPLETE EXHIBIT 6

Employee Information

This section of the exhibit is designed to identify employee information for the specific job classifications identified. This section of the exhibit is also intended to discretely identify the employee information for any individual employee or contractor that must have a portion of their salaries or benefits, or both reduced from allowable expenditures on the Cost Report.

For each of the job classifications identified, the following information must be included:

Employee #:

Enter the **Employee #** for the employee for which a portion of their salary or benefits, or both must be reduced from the total allowable costs.

Last Name:

Enter the **Last Name** of the employee for which a portion of their salary or benefits, or both must be reduced from the total allowable costs.

First Name:

Enter the **First Name** of the employee for which a portion of their salary or benefits, or both must be reduced from the total allowable costs.

Job Title/Credentials:

Enter the **Job Title/Credentials** of the employee for which a portion of their salary or benefits, or both must be reduced from the total allowable costs.

Employee (E) or Contractor (C):

Enter the appropriate designation, **either an E or C,** of the employee for which a portion of their salary and/or benefits must be reduced from the total allowable costs. E designates an employee; C designates a contractor.

Payroll and Benefits

This section of the exhibit is designed to identify payroll and benefit expenditures for the specific job classifications identified. This section of the exhibit is also intended to discretely identify the payroll and benefit expenditures for any individual employee/contractor that must have a portion of their salary or benefits, or both reduced from allowable expenditures on the Cost Report.

For each of the job classifications identified, the following information must be included:

Gross Salary:

Enter the **Gross Salary** amount for the employee for which a portion of his or her salary or benefits, or both must be reduced from the total allowable costs.

Contractor Payments:

Enter the amount of **Contractor Payments** for the employee for which a portion of his or her salary or benefits, or both must be reduced from the total allowable costs.

Employee Benefits:

Enter the amount of **Employee Benefits** for the employee for which a portion of his or her salary or benefits, or both must be reduced from the total allowable costs. This includes all benefits that are not discretely identified this exhibit.

Employer Retirement:

Enter the amount of **Employer Retirement** expenditure for the employee for which a portion of his or her salary or benefits, or both must be reduced from the total allowable costs.

FICA:

Enter the employer portion amount of **FICA** expenditure for the employee for which a portion of his or her salary or benefits, or both must be reduced from the total allowable costs.

Payroll Taxes:

Enter the employer portion amount of **Other Payroll Taxes** expenditure for the employee for which a portion of his or her salary or benefits, or both must be reduced from the total allowable costs.

Federal Funding Reductions

This section of the exhibit is designed to identify the federal funding or other payroll and benefit expenditure reduction necessary for the specific job classifications identified. This section of the exhibit is intended to discretely identify the payroll and benefit expenditures for any individual employee/contractor that must have a portion of his or her salary or benefits, or both, reduced from allowable expenditures on the Cost Report.

For each of the job classifications identified, the following information must be included:

Allocated Funded Positions Entry:

Enter the appropriate designation, **either a Y or a N**, for the employee for which a portion of his or her salary or benefits, or both, must be reduced from the total allowable costs. A "Y" in this field designates an employee for which a portion or all of his or her salary and benefit expenditures are funded by federal funds or grants. A "N" in this field designates an employee for which a portion or all of his or her salary and benefit expenditures are not funded by federal funds or grants but still need to be removed from allowable expenditures, as reported on the Cost Report.

Federal Funding:

If the answer to the field previously is "Y," then enter the amount of **Federal Funding** related to the employee's salary and benefits that must be reduced from the total allowable costs, as reported on the Cost Report.

Other Funds:

Enter the amount of **Other Amount to be Removed** related to the employee's salary and benefits that must be reduced from the total allowable costs, as reported on the Cost Report.

Supplemental Schedule:

A provider may enter information on a summary basis rather than entering each employee individually if a supplemental personnel schedule is provided.

Exhibit 7-Schedule C – Cost Allocation Methodologies

This exhibit is designed to include detailed cost allocation methodologies employed by the provider.

- Does your agency have a Cost Allocation Plan (CAP)? If so, please provide a copy of your agency's proposed CAP. If not, enter in detail the allocation methodology that will be used for allocating costs on the cost report.

- Please provide a list of personnel cost worksheets that support your CAP. Attach the Detailed Explanation Externally.

Exhibit 8-Schedule D – Reasonable Collections Effort Tracking Form

REASONABLE COLLECTION EFFORT

To be considered a reasonable collection effort, a provider's effort to collect fees for services rendered must involve the issuance of a bill on or shortly after discharge or death of the beneficiary to the party responsible for the patient's personal financial obligations. It also includes other actions such as subsequent billings, collection letters, telephone calls, or personal contacts with this party which constitute a genuine, rather than a token, collection effort. The provider's collection effort may include using or threatening to use court action to obtain payment.

If a separate Texas Administrative Code (TAC) rule does not allow for providers to collect fees from clients, providers must provide this reasoning in place of this documentation.

Collection Agencies

A provider's collection effort may include the use of a collection agency in addition to or in lieu of subsequent billings, follow-up letters, telephone, and personal contacts. Where a collection agency is used, it is expected that the provider refers all uncollected patient charges of like amount to the agency without regard to the class of patient. The "like amount" requirement may include uncollected charges above a specified minimum amount. Where a collection agency is used, the agency's practices may include using or threatening to use court action to obtain payment.

Documentation Required

The provider's collection effort should be documented in the patient's file by copies of the bill(s), follow-up letters, reports of telephone and personal contact, etc. During HHSC's desk review, a provider will have to show documentation to demonstrate this information matches their submission and that the covered services are provided appropriately. Any additional information needed will be requested during the desk review.

Collection Fees

Where a provider utilizes the services of a third party, non-related collection agency, and the reasonable collection effort is applied, the fees the collection

agency charges the provider are recognized as an allowable administrative cost of the provider.

When a collection agency obtains payment of an account receivable, the full amount collected must be credited to the patient's account, and the collection fee charged to administrative costs. For example, if an agency collects $40 from the patient/responsible party, and its fee is 50 percent, the agency keeps $20 as its fee for the collection services and remits $20 (the balance) to the provider. The provider records the full amount collected from the patient by the agency ($40) in the patient's account receivable and records the collection fee ($20) in administrative costs. The fee charged by the collection agency is merely a charge for providing the collection service; therefore, it is not treated as a bad debt.

Presumption of Non-collectability

If after reasonable and customary attempts to collect a bill, the debt remains unpaid more than 120 days from the date the first bill is mailed to the beneficiary, the debt may be deemed uncollectible.

This exhibit is designed to provide an example of collections attempts for written-off charges. The form is not a required form. Governmental Entities may utilize other internal data or reports to capture and show bad debt costs applicable to the cost report.

Column 1 – Procedure or Transaction ID (Identifier)

Enter the Process or Transaction identifier for service provided to patient.

Column 2 – Procedure Codes

Enter the applicable procedure codes for the services provided to the patient.

Column 3 – Procedure Descriptions

Enter the descriptions for the procedure codes used when services were provided to the patient.

Column 4 – Date of Service

Enter the date the service was provided.

Column 5 – Insurance Carrier Name

Enter the name of the patient’s insurance carrier. If no insurance, enter NA.

Column 6 – Medicaid Recipient Number

Enter the Medicaid/Medicaid Managed Care Recipient Number if the patient is covered by Medicaid or if the patient has coverage through a managed care organization. Leave this field blank or enter "NA" if the patient is insured by any other means.

Column 7 – Units

Enter the unit of service allowable for services provided to a client.

Column 8 – Charge Amounts

Total billed charges for services provided to the patient.

Column 9 – Paid Amount(s)

Amounts paid by patient/responsible party for services provided.

Column 10 – If Uninsured, Dates Billed/Notices Sent, Call made

Dates of attempted bill collections or notice sent to the patient/responsible party for services provided.

Column 11 – If Uninsured/Uncollectible, Write Off Date

Enter the date receivable was written off.

Column 12 – Total Uncompensated Costs

Enter the amount of uncompensated costs for the reporting periods of service.

Appendix A. Exhibit 2

Exhibit 2: Examples of Supplies, Materials, and Equipment

- Audiometer (calibrated annually), tympanometer
- Bandages, including adhesive (e.g., Band-Aids) and elastic, of various
- Battery testers, hearing aid stethoscopes, and earmold cleaning materials
- Blood Glucose Meter
- BMI Calculator
- Clinical audiometer with sound field capabilities
- Cold packs
- Cotton balls
- Cotton-tip applicators (swabs)
- Dental floss
- Diapers and other incontinence supplies
- Disinfectant
- Disposable gloves (latex-free)
- Disposable gowns
- Disposable Suction Unit
- Ear mold impression materials
- Electroacoustic hearing aid analyzer
- Electronic Suction Unit
- Evaluation tools (e.g., goniometers, dynamometers, cameras)
- Eye pads
- FM amplification systems or other assistive listening devices
- Gauze
- Immunization supplies and materials
- Loaner or demonstration hearing aids
- Medicine cabinet (with lock)
- Nebulizers
- Otoscope
- Otoscope/ophthalmoscope with battery
- Peak Flow Meters
- Physician's scale that has a height rod and is balanced
- Portable acoustic immittance meter
- Portable audiometer
- Reflex hammer
- Sanitary pads, individually wrapped (may be used for compression)
- Scales
- Scoliometer
- Slings
- Sound-level meter
- Sound-treated test booth
- Sphygmomanometer (calibrated annually) and appropriate cuff sizes
- Splints (assorted)
- Stethoscope
- Surgi-pads
- Syringes (Medication administration or bolus feeding)
- Test materials for central auditory processing assessment
- Tissues
- Tongue depressors
- Triangular bandage
- Vision testing machine, such as Titmus

Addendum to Attachment T

Public Health Provider Charity Care Program FFY 2023

Community Mental Health Centers & Local Health Departments

For the PHP-CCP App/Cost Report

Provider Finance Department

May 2022

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Overview

The purpose of this document is to provide information regarding the Public Provider Charity Care Program (PHP-CCP) for federal fiscal year 2023. PHP-CCP is designed to allow qualified providers to receive reimbursement for healthcare service delivery costs when not reimbursed by another source. The healthcare services included are:

- Behavioral health services,
- Immunizations,
- Public health services, and
- Other preventative services.

Authority

PHP-CCP is authorized under Section 1115 of the Social Security Act, otherwise known as *the 1115 Waiver*. In accordance with the Special Terms and Conditions of the 1115 Waiver, providers must be funded by a unit of government able to certify expenditures to participate in the program. Pursuant to 42 CFR, 433.51, entities with 501(c)(3) designation are not governmental entities and ineligible to participate in Certified Public Expenditure.

In accordance with Texas Health and Safety Code Chapters 533 and 534, the following publicly-owned and operated entities providing behavioral health services are eligible to participate:

- Community Mental Health Clinics (CHMCs),
- Community Centers,
- Local Mental Health Authorities (LMHAs), and
- Local Behavioral Health Authorities (LBHAs).

Additionally, under Title 2 Texas Health and Safety Code Chapter 121, the following publicly-owned and operated entities established under Chapter 121 are eligible to participate in the program:

- Local Health Departments (LHDs) and
- Public Health Districts (PHDs).

Provider Reimbursement Qualification

The provider must be able to certify public expenditures to qualify for reimbursement. Certified public expenditures will be paid an annual lump sum based upon actual expenditures.

PHP-CCP Payments are considered Medicaid payments to providers and must be treated as Medicaid revenue when determining the total Title XIX funding received.

Cost Report Criteria

A provider must prepare and complete a Public Health Provider Cost Report annually according to the following criteria:

- The provider must submit the cost report no later than 45 days after the close of the reporting period.
- The cost report period begins on October 1 and ends on September 30 of the following year.
- If a provider receives approval to participate in the PHP-CCP program after October 1, the cost report period begins on the effective date of the supplemental payment request approval.
- Costs are eligible for reimbursement for only 24 months after the date the cost was incurred.
- Completed cost reports must be sent via electronic mail or U.S. mail to the Texas Health and Human Services Commission (HHSC).
- **The cost report can include only allocable expenditures related to charity care as defined and approved in** the Texas Healthcare Transformation and Quality Improvement 1115 Waiver Program.
- The cost report **may not** include costs for services delivered to persons who are incarcerated at the time of the service.
- The cost report **may not** include costs for services delivered by an institution for mental diseases.
- Only complete the **shaded areas** of the cost report.
- Many worksheets, or *exhibits*, will automatically populate information provided in completed worksheets.

- Be sure to carefully review the information provided in the cost report before submission.
- Providers must attest to and certify its cost report of the total actual incurred charity care costs and expenditures, including the federal share and the non-federal share applicable to the cost report period.
- The cost reporting guidelines will be governed by:
    - Chapter 2 Code of Federal Regulations § 200 (Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards)
    - Chapter 45 Code of Federal Regulations § 75 (Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards).
    - Title 1 Texas Administrative Code Section 355.101 (relating to Introduction);
    - Title 1 Texas Administrative Code Section 355.102 (relating to General Principles of Allowable and Unallowable Costs);
    - Title 1 Texas Administrative Code Section 355.103 (relating to Specifications for Allowable and Unallowable Costs);
    - Title 1 Texas Administrative Code Section 355.104 (relating to Revenues);
    - Title 1 Texas Administrative Code Section 355.105 (relating to General Reporting and Documentation Requirements, Methods, and Procedures);
    - Title 1 Texas Administrative Code Section 355.106 (relating to Basic Objectives and Criteria for Audit and Desk Review of Cost Reports);
    - Title 1 Texas Administrative Code Section 355.107 (relating to Notification of Exclusions and Adjustments);
    - Title 1 Texas Administrative Code Section 355.108 (relating to Determination of Inflation Indices);
    - Title 1 Texas Administrative Code Section 355.109 (relating to Adjusting Reimbursement When New Legislation, Regulations, or Economic Factors Affect Costs); and

    - Title 1 Texas Administrative Code Section 355.110 (relating to Informal Reviews and Formal Appeals).

- During HHSC's desk review, providers will have to show documentation to demonstrate this information matches their submission and that the covered services are provided appropriately. Any additional information needed will be requested during the desk review.

For questions on completing the cost report, please contact the Health and Human Services Commission, Provider Finance Department at this email address: PHP-CCP@hhs.texas.gov.

Definitions

Charity Care

Healthcare services provided without expectation of reimbursement to uninsured patients who meet the provider's charity-care policy. The charity-care policy should adhere to the charity-care principles of the Healthcare Financial Management Association Principles and Practices Board Statement 15 (December 2019). Charity care includes full or partial discounts given to uninsured patients who meet the provider's financial assistance policy. Charity care does not include bad debt, courtesy allowances, or discounts given to patients who do not meet the provider's charity-care policy or financial assistance policy.

Cognizant Agency

Agency responsible for reviewing, negotiating, and approving cost allocation plans or indirect cost proposals developed in accordance with the Office of Management and Budget Circular A-87.

Cost Allocation Plans

The means by which costs are identified in a logical and systematic manner for reimbursement under federal grants and agreements.

Cost-to-Charge Ratio

A provider's reported costs are allocated to the Medicaid program based on a cost-to-charge ratio. The cost-to-charge ratio is calculated as the Total Allowable Cost reported for the service period to represent the numerator of the ratio and the billed charges of the all claims for the service period that represents the denominator of the ratio (see below). This ratio is applied to the total charity charges to calculate the total computable charity costs for the cost report.

$$\text{Cost-to-Charge Ratio} = \frac{\text{Total Allowable Cost Reported}}{\text{Billed Charges of All Claims}}$$

Direct Cost

This term refers to any cost explicitly associated with a particular final cost objective. Direct costs are not limited to items incorporated in the end product, such as material or labor. Direct costs of a contract are the costs explicitly identified with that contract. All costs identified specifically with other final cost objectives of the contractor are direct costs of those cost objectives.

Federal Medical Assistance Participation (FMAP) Rate

FMAP is the share of state Medicaid benefit costs paid for by the federal government.

Indirect Costs

These are costs incurred identified with two or more cost objectives but not specifically identified with any final cost objective.

Medicaid Fee-For-Service (FFS) Paid Claims

These claims are Medicaid payments made by HHSC through the Texas Medicaid Healthcare Partnership to enrolled providers for services provided to Medicaid recipients.

Medicaid Managed Care

Medicaid Managed Care delivers Medicaid health benefits and additional services through an arrangement between a state Medicaid agency and managed care organizations (MCOs) that accept a set payment for these services. Medicaid payments are made by the MCOs to providers for services provided to Medicaid recipients.

Medicare

Medicare is a federal system of health insurance for people over 65 years of age and for certain younger people with disabilities.

Other Third-Party Coverage

Commercial Pay Insurance:

Commercial Pay Insurance is health insurance that covers medical expenses and disability income for the insured. Commercial health insurance can be categorized

according to its renewal provisions and the type of medical benefits provided. Commercial policies can be sold individually or as part of a group plan.

Self-Pay:

A self-pay patient pays in full for services at the time of the visit and does not file a claim with an insurance carrier.

Total Computable Amount

The Total Computable Amount is the total Medicaid allowable amount payable for services.

Uninsured

An uninsured individual has no health insurance or other source of third-party coverage for medical/health services.

Uninsured Cost

Uninsured Cost is the cost to provide services to uninsured patients as defined by the Centers for Medicare and Medicaid Services (CMS). An individual whose third-party coverage does not include the service provided is considered by HHSC to be uninsured for that service.

Unit of Government

A state, city, county, special purpose district, or other governmental units in the State that: has taxing authority, direct access to tax revenues, is a State university teaching hospital with direct appropriations from the State treasury, or is an Indian tribe as defined in Section 4 of the Indian Self-Determination and Education Assistance Act, as amended, 25 U.S.C.450b.

Exhibit A: Cost Report Cover Page

Exhibit A is the cost report cover page. This form includes the provider's National and State Provider Identification Number used by HHSC to obtain the fee-for-service cost data included in the cost report. Each government entity must enter information for its entity, including the following:

- Entity's Legal name;
- Name of the person responsible for submitting the cost report;
- Name of the cost report preparer;
- Name of the person responsible for making financial decisions on behalf of the organization, if different than the preparer; and
- Physical location, mailing address, phone number, fax number, and email address of all contacts listed.

HHSC will use the information to contact the provider as necessary throughout the cost reconciliation and cost settlement process.

DIRECTIONS TO COMPLETE EXHIBIT A

Reporting Period

Enter the actual **Reporting Period** for which the cost report will be completed (e.g., 10/01/10 to 09/30/11).

Primary Texas Provider Identification Number (TPI)

Enter the main **9-digit TPI** number for the provider completing the cost report (e.g., 123456789).

Primary National Provider Identification Number (NPI)

Enter the main **10-digit NPI** number for the provider completing the cost report (e.g., 1234567890).

Associated Texas Provider Identification Numbers (TPIs)

Enter the other associated **9-digit TPI** numbers for the provider completing the cost report (e.g., 123456789, 987654321, 012345678, etc.).

Associated National Provider Identification Number (NPIs)

Enter the other associated **10-digit NPI** numbers for the provider completing the cost report (e.g., 1234567890, 0123456789, 1231231230, etc.).

Provider Information

Provider Name:

Enter the **Provider's Name** (e.g., Health and Human Services Commission EMS). The name of the provider completing the cost report should be listed here.

Street Address:

Enter the provider's **Street Address** (e.g., 11209 Metric Blvd., Bldg. H., Austin, TX 78758). Include the city, state, and zip code in this field.

Mailing Address:

Enter the provider's **Mailing Address** (e.g., 11209 Metric Blvd., Bldg. H., Austin, TX 78758 or P.O. Box 85700, Mail Code H-400, Austin, TX 78708-5200). Include the city, state, and zip code in this field.

Phone Number:

Enter the **Phone Number** of the provider's contact (e.g., (512) 123-4567).

Fax Number:

Enter the **Fax Number** of the provider's contact (e.g., (512) 987-6543).

Email Address:

Enter the **Email** address of the provider's contact (e.g., iampublic@xyzabc.com).

Business Manager or Financial Director

Business Manager or Financial Director's Name:

Enter the **Name** of the provider's business manager or financial director (e.g., Jane Doe).

Title:

Enter the **Title** of the provider's business manager or financial director identified in the field above (e.g., Director).

Agency Name:

Enter the name of the agency, municipality, or provider submitting the cost report.

Mailing Address:

Enter the provider's **Mailing Address** (e.g., 11209 Metric Blvd., Bldg. H., Austin, TX 78758 or P.O. Box 85700, Mail Code H-400, Austin, TX 78708-5200). Include the city, state, and zip code in this field.

Phone Number:

Enter the **Phone Number** of the provider's contact (e.g., (512) 123-4567).

Fax Number:

Enter the **Fax Number** of the provider's contact (e.g., (512) 987-6543).

Email Address:

Enter the **Email** address of the provider's contact (e.g., jqpublic@xyzabc.com).

Report Preparer Identification

Report Preparer Name:

Enter the **Name** of the provider's contact or person responsible for preparing the cost report (e.g., Jane Doe). HHSC may contact the individual if there are questions.

Title:

Enter the **Title** of the provider's contact identified in the field above (e.g., Director).

Mailing Address:

Enter provider's **Mailing Address** (e.g., 11209 Metric Blvd., Bldg. H., Austin, TX 78758 or P.O. Box 85700, Mail Code H-400, Austin, TX 78708-5200). Include the city, state, and zip code in this field.

Phone Number:

Enter the **Phone Number** of the provider's contact (e.g., (512) 123-4567).

Fax Number:

Enter the **Fax Number** of the provider's contact (e.g., (512) 987-6543).

Location of Accounting Records that Support this Report

Records Location:

Enter the **physical address** of the location where the provider maintains the accounting records in support of the cost report (e.g., 11209 Metric Blvd., Bldg. H., Austin, TX 78781). Include the city, state, and zip code in this field.

Exhibit 1: General and Statistical Information

Exhibit 1 is the General and Statistical Information page of the cost report. This exhibit includes general provider information and statistical information.

DIRECTIONS TO COMPLETE EXHIBIT 1

General Provider Information

Reporting Period – Begin Date:

The **Reporting Period – Beginning** date or the beginning date of the cost report period (e.g., 10/1/2010) derives from Exhibit A. No entry is required.

Reporting Period – End Date:

The **Reporting Period – Ending** date or the ending date of the cost report period (e.g., 9/30/2011) derives from Exhibit A. No entry is required.

Part-Year Cost Report:

Enter an answer to the question "**Is Reporting Period less than a full year?**" This question identifies if the cost report is being prepared for a period that is not an entire fiscal year. If the cost report is for an entire fiscal year (October 1 to September 30), then enter **No** in the field. If the cost report is being prepared for a partial fiscal year, enter a response that explains the reason why (e.g., Supplemental Payment Request Approval was effective beginning on 7/1/20XX).

Statistical Information

This cost report uses a cost-to-billed charge ratio methodology applied to determine the portion of costs eligible for reimbursement under the Direct Medical settlement exhibit (*see* Exhibit 2).

Summary of Payments and Billed Charge Data (Applicable to Cost Report)

Charity Reimbursements:

Enter the total charity reimbursements for services provided for the applicable Cost Report period identified on the form. The reimbursements entered must be only for

dates of service during the cost report period and must exclude all unfunded Medicaid and Medicare costs.

Total Billed Charges Associated with Charity Care:

Enter the **Total Billed Charges Associated with Charity Care** for the applicable cost report period identified on the form. The total billed charges entered must be only for **dates of service** during the cost report period. Billed charges are based on the local chargemaster that sets the usual and customary rate for services.

Total Uninsured Billed Charges (excluding Charity Care):

Enter the **Total Uninsured Billed Charges Associated (excluding Charity Care)** for the applicable cost report period identified on the form. The total billed charges entered must be only for **dates of service** during the cost report period. Billed charges are based on the local chargemaster that sets the usual and customary rate for services.

Total Billed Charges Associated with Medicaid FFS Paid Claims:

Enter the **Total Billed Charges associated with Medicaid FFS Paid Claims** for the applicable cost report period identified on the form. The total billed charges associated with Medicaid FFS paid claims must be entered only for **dates of service** during the cost report period. Billed charges are based on the local chargemaster that sets the usual and customary rate for services.

Total Billed Charges Associated with MCO Paid Claims:

Enter the **Total Billed Charges associated with Medicaid MCO Paid Claims** for the applicable cost report period identified on the form. The total billed charges associated with MCO paid claims must be entered only for **dates of service** during the cost report period. Billed charges are based on the local chargemaster that sets the usual and customary rate for services.

Medicare Charges:

Enter the total **Medicare Charges** for services provided for the applicable cost report period identified on the form. The Medicare charges for services entered should be for dates of service during the cost report period.

Other Third-Party Insurance Coverage Charges:

Enter the total **Other Third-party Coverage Commercial Pay Charges** for services provided for the applicable cost report period identified on the form. The

"other" charges for services entered should be for dates of service during the cost report period.

Self-Pay, County, or City Indigent Recipient Program Charges:

Enter the total **Self-pay or County or City Indigent Charges** for services provided for the applicable cost report period identified on the form. The "other" charges for services entered should be for dates of service during the cost report period.

Total Charges (All Sources):

The **Total Charges (All Sources)** is calculated by combining all the different charge amounts for the applicable cost report period identified on the form.

Total Charity Care Encounters:

Enter the **Total Charity Care Encounters** for the dates of service during the cost report period.

Exhibit 2: Direct Medical

Exhibit 2 identifies and summarizes all service costs within the cost report from other exhibits. Much of the information contained within this exhibit is pulled from either Exhibits 5 or 6. However, unique cost items are identified in this exhibit.

Only allocable expenditures related to Charity Care, as defined and approved in the Texas Healthcare Transformation and Quality Improvement 1115 Waiver Program, will be included for supplemental payment(s).

This exhibit provides a sum of the personnel expenses and adds additional costs to calculate the total cost of Charity Care Services.

Direct Cost Methods

Direct cost methods must be used. Direct cost means that allowable costs for medical services for the benefit of, and directly attributable to, a specific service delivery component must be charged directly to that business component. Providers may use reasonable cost allocation methods for operational costs related to direct service delivery.

Supplemental Schedule

The amounts from the supplemental schedule allocated to the Charity Care programs should match the amounts entered on the following forms:

- Exhibit 6, Schedule B.
- Exhibit 7, Schedule C - Cost Allocation Methodologies Employed by the provider (additional detail is entered here).

The provider must fully disclose any change in cost-reporting allocation methods from one year to the next on its cost report.

Identified Reductions

As part of the cost report, identified reductions from Exhibit 6 are subtracted to calculate the settlement amount. The cost report identifies the portion of allowable costs that are related to Charity Care.

Cost-to-Charge Ratio

The cost-to-charge ratio for the applicable cost report period covers all billed charges incurred by the facility regardless of payer resulting in the total computable amount for services. That amount is then reduced by the amount of any reimbursement received for Charity Care. The resulting amount is then multiplied by the applicable federal medical assistance percentage to calculate the amount of settlement due to or owed by (if negative) the provider.

Cost-to-Charge Ratio = $\frac{\text{Total Allowable Cost Reported}}{\text{Billed Charges of All Claims}}$

Total Charity Care Cost = Cost-to-Charge Ratio x Total Billed Charges Associated with Charity Care

Settlement Amount = Total Charity Care Cost – Charity Care Reimbursement

Amount Due to Provider = Settlement Amount x FMAP Percentage

Exhibit 2 Sections

Exhibit 2 is separated into the sections identifying:

- **Personnel or Payroll Expenses.** This section of the exhibit includes, in part, expenditures from Exhibit 6.
- **Other Operating Costs.** This section of the exhibit includes, in part, expenditures from Exhibit 5.
- **Reductions to Allowable Costs.** This section of the exhibit includes reductions to expenditures identified in Exhibit 6.
- **Cost Settlement Calculation.** This section applies the cost-to-charge ratio calculation methodology to arrive at the final settlement due to or from the provider.

DIRECTIONS TO COMPLETE EXHIBIT 2

Personnel or Payroll Expenses

This section of the exhibit includes all personnel-related expenditures for the job classifications identified. This section is derived from Exhibit 6.

Other Operating Costs

This section of the exhibit identifies other operating costs not related to the job classifications identified above. Within this section, Support Services or Other may include personnel-related expenditures not identified in the job classifications in the section above.

All costs identified in this section of the exhibit are supported by supplemental schedules to the cost report and will be supplied at the time of cost report submission.

Supplies, Materials, and Equipment Costs:

Enter the amount of **Supplies, Materials,** and **Equipment** expenditures incurred by the provider during the cost report period. Please see Appendix A with examples of supplies, materials, and equipment. Supplies and materials include, but are not limited to:

- Medical supplies,
- Office supplies,
- Maintenance supplies, and
- Medical materials.

Support Services Costs:

Enter the amount of **Support Services** expenditures incurred by the provider during the cost report period. Support Services expenditures may include personnel and non-personnel expenditures if the personnel expenditures are represented in the job classification categories identified in this exhibit and detailed in Exhibit 6. Support Services expenditures include, but are not limited to, information technology salaries, benefits, and operating expenditures.

Other Costs:

Enter the amount of **Other** expenditures incurred by the provider during the Cost Report period. Other expenditures may include personnel and non-personnel expenditures if the expenditures are represented in the job classification categories identified in this exhibit and detailed in Exhibit 6.

Depreciation Expense:

All assets must be depreciated. Asset costs are accepted on the Cost Report if the asset is depreciated in accordance with the Medicare cost report requirements. If

the asset is not depreciable according to the Medicare requirements, prior approval from HHSC and CMS is required before recording the entry on the Cost Report.

Allocation Ratio:

Enter the number of **Medical Clients Served** by the provider during the Cost Report period. Enter the number of **All Clients Served** by the provider during the Cost Report period, both medical and non-medical. The **Allocation Ratio** is calculated by dividing the medical clients served by the total clients served. The total direct other costs is multiplied by the allocation ratio to get the **Total Direct Medical Other Costs**, which is added to **Total Staff Costs** to obtain **Total Staff and Direct Medical Other Costs**.

HHSC may require a provider to use a separate allocation mechanism for the Allocation Ratio that more accurately allocates direct and indirect costs because all costs must be related to Medicaid covered services, and providers offer a variety of services. Further, HHSC may allow for a separate allocation mechanism for the Allocation Ratio at a provider's request that more accurately allocates direct and indirect costs, so long as the provider can provide support and justification.

Reductions to Allowable Costs

This section of the exhibit includes reductions to expenditures identified in Exhibit 6 as well as any other reductions that are not included under direct medical services or payroll.

Cost Settlement Calculation

Period of Service for Applicable Cost Report Period: Enter the **Period of Service** for the applicable cost report period. Example: 10/01/20XX to 09/30/20XX. For partial year cost reports, enter the period of service that applies only to the time frame a cost report is submitted to cover. This section calculates automatically.

Total Billed Charges for Period of Service:

The **Total Billed Charges** for the applicable period of service derived from Exhibit 1 (no entry is required).

Total Allowable Costs for Period of Services:

The **Total Allowable Costs** entered into the cost report (no entry is required).

Cost-to-Charge Ratio:

This ratio is the result of dividing a provider's Total Allowable Costs for the reporting period by the provider's Total Billed Charges for the same period.

$$\text{Cost to Charge Ratio} = \frac{\text{Total Allowable Costs}}{\text{Provider's Total Billed Charges}}$$

Total Billed Charges Associated with Charity Care:

The **Total Billed Charges Associated with Charity care** for the period of service applicable to the cost report derived from Exhibit 1 (no entry is required).

Total Charity Care Cost

Calculation for the **Total Charity Care Cost** for the period of service applicable to the cost report (no entry is required).

Total Charity Care Reimbursement

The **Total Charity Care Reimbursement** for the period of service applicable to the cost report derived from Exhibit 1 and the Reductions section (no entry is required).

Settlement Amount

Calculation for the **Settlement Amount** for the period of service applicable to the cost report of the sum of **Charity Care Cost** and **Charity Care Reimbursement** (no entry is required).

Amount due to Provider

Calculation for the **Amount due to Provider** for the period of service applicable to the cost report with the product of the **Settlement Amount** and the **FMAP** for the appropriate fiscal year (no entry is required).

Exhibit 3 – Cost Report Certification

Exhibit 3 is the Certification of costs included in the cost report. This form attests to and certifies the accuracy of the financial information contained within the cost report.

DIRECTIONS TO COMPLETE EXHIBIT 3

This exhibit must be signed and included **UPON COMPLETION OF ALL OTHER EXHIBITS**.

Upon completion of all other exhibits in the cost report, please **print this exhibit, sign the exhibit, have the form notarized, scan the exhibit, and include the signed exhibit** when sending the electronic version of the cost report to HHSC. Please be sure the form is read and signed by the provider or a representative with authority to sign on behalf of the provider.

Preparer Identification

Preparer or Contractor Name:

Enter the **Name** of the person that will prepare or has prepared the cost report (e.g., Jane Doe).

Title:

Enter the **Title of Signer** or the title of the person that will prepare or has prepared the cost report (e.g., Director).

Vendor/Company Name:

Enter the **Name of the Company or Business** with whom the report preparer/contractor is affiliated.

Signature Authority or Certifying Signature

Certifier Name:

Enter the **Name of** the person certifying the costs identified in the cost report (e.g., Jane Doe).

Title:

Enter the **Title of Signer** or the title of the person certifying the costs identified in the cost report (e.g., Director).

Print:

Please print this exhibit and have the appropriate person identified above sign the certification form.

Date:

Enter the **Date** that the appropriate person identified above signs the certification form (e.g., 1/1/2011).

Signature Authority Check Box:

Check the appropriate box that corresponds to the person signing this exhibit.

Notary:

Upon printing and signing this exhibit, please have this form **Notarized**.

Exhibit 4 – Certification of Funds

Exhibit 4 is the Certification of Public Expenditure. It allows the State to use the computable Medicaid expenditures as the non-federal match of expenditures to draw the federal portion of Medicaid funding as identified in the settlement. This form attests to and certifies the following:

- The accuracy of the financial information provided.
- The report was prepared in accordance with State and Federal audit and cost principle standards.
- The costs have not been claimed on any other cost report for federal reimbursement purposes.
- This exhibit also identifies the amount of local provider expenditure allowable for use as the State match.

DIRECTIONS TO COMPLETE EXHIBIT 4

This exhibit must be signed and included **UPON COMPLETION OF ALL OTHER EXHIBITS**.

Upon completion of all other exhibits in the cost report, please **print this exhibit, sign the exhibit, have the form notarized, scan the exhibit, and include the signed exhibit** when sending the electronic version of the cost report to HHSC. Please be sure the form is read and signed by the provider or a representative with authority to sign on behalf of the provider.

Signature Authority/Certifying Signature

Print:

Please print this exhibit and have the appropriate person sign the certification form.

Date:

Enter the **Date** that the appropriate person identified above signs the certification form (e.g., 1/1/2011).

Certifier Name:

Enter the **Name of Signer**, or the person certifying the public expenditures identified in the cost report (e.g., Jane Doe).

Title:

Enter the **Title of Signer**, or the title of the person certifying the public expenditures identified in the cost report (e.g., Director).

Certifier Check Box:

Check the appropriate box that corresponds to the title of the person signing this exhibit. If **Other Agent/Representative** is selected, please include the appropriate title.

Notary:

Upon printing and signing this exhibit, please have this form **Notarized**.

Exhibit 5 – Schedule A (Depreciation Schedule)

Exhibit 5 identifies allowable depreciation expenses incurred by the provider related to Charity Care. This exhibit will identify depreciable assets for which there was a depreciation expense during the Cost Report period. Information on this exhibit must come from a depreciation schedule maintained by the provider in accordance with appropriate accounting guidelines established by the provider. For depreciation expenses, the straight-line method should be used. Prior Period Accumulated Depreciation plus Depreciation for Reporting Period cannot exceed the total cost of an asset. In addition, assets that have been fully expensed should not be reported.

DIRECTIONS TO COMPLETE EXHIBIT 5

Building

For depreciation expenses related to buildings where the provider's vehicles or staff are housed with other agencies or entities, **ONLY the portion related to the provider** may be reported. The provider must follow Medicare depreciation instructions. The provider must attach a supplemental exhibit showing how the portion of the building related to the provider was calculated.

Asset Description:

Enter the **Description of the Asset** that will be included in this depreciation schedule. The name or account code, or both, will suffice. If there is the need to add additional lines, please do so.

Month/Year Placed in Service:

Enter the **Month/Year Placed in Service** as identified on the provider's depreciation schedule (e.g., January 2000, or 1/2000). This date is the month and the year that the depreciable asset was first put into service.

Years of Useful Life:

Enter the number of **Years of Useful Life** of the asset as identified on the provider's depreciation schedule (e.g., 20 for twenty years of useful life).

Cost:

Enter the amount of the initial **Cost** of the asset identified on the provider's depreciation schedule.

Salvage Value:

The value of the asset after depreciation has been fully expensed. For buildings, this amount is automatically calculated as 10% of the building cost.

Prior Period Accumulated Depreciation:

Enter the amount of **Prior Period Accumulated Depreciation** related to the asset as identified on the provider's depreciation schedule. This amount is the total depreciable expenses to date related to the depreciable asset.

Month/Year of Disposal:

Enter the **Month/Year of Disposal** as identified on the provider's depreciation schedule (e.g., January 2000, or 1/2000). This date is the month and the year that the depreciable asset was removed from service.

Depreciation for Reporting Period:

The calculated amount of the current period depreciation expense in the **HHSC Allowable Depreciation**. This amount is the total depreciable expense incurred during the Cost Report period.

Vehicles

Depreciation of vehicles is limited to only the vehicles used in the delivery and/or transportation of recipients to and from a Title XIX medical service. No other vehicles are to be included in the costing or depreciation application for this pool payment.

For depreciation expenses related to vehicles, the provider must follow Medicare depreciation instructions. The vehicle depreciation expense reported on the Cost Report must come from the provider's depreciation schedule.

Asset Description:

Enter the **Description of the Asset** that will be included in this depreciation schedule. The name or account code, or both, will suffice. If there is the need to add additional lines, please do so.

Month/Year Placed in Service:

Enter the **Month/Year Placed in Service** as identified on the provider's depreciation schedule (e.g., January 2000, or 1/2000). This date is the month and the year that the depreciable asset was first put into service.

Years Useful Life:

Enter the number of **Years of Useful Life** of the asset as identified on the provider's depreciation schedule (e.g., 20 for twenty years of useful life).

Cost:

Enter the amount of the initial **Cost** of the asset identified on the provider's depreciation schedule.

Salvage Value:

Enter the value of the asset after depreciation has been fully expensed.

Prior Period Accumulated Depreciation:

Enter the amount of **Prior Period Accumulated Depreciation** related to the asset as identified on the provider's depreciation schedule. This amount is the total depreciable expenses to date related to the depreciable asset.

Month/Year of Disposal:

Enter the **Month/Year of Disposal** identified on the provider's depreciation schedule (e.g., January 2000, or 1/2000). This date is the month and the year that the depreciable asset was removed from service.

Depreciation for Reporting Period:

The calculated amount of current period depreciation expense is the **HHSC Allowable Depreciation**. This amount is the total depreciable expense incurred during the Cost Report period.

Equipment

The provider must follow the Medicare depreciation instructions for depreciation expenses related to equipment. The equipment depreciation expense reported on the Cost Report must come from the provider's depreciation schedule.

Asset Description:

Enter the **Description of the Asset** that will be included in this depreciation schedule. The name or account code, or both, will suffice. If there is the need to add additional lines, please do so.

Month/Year Placed in Service:

Enter the **Month/Year Placed in Service** as identified on the provider's depreciation schedule (e.g., January 2000, or 1/2000). This date is the month and the year that the depreciable asset was first put into service.

Years Useful Life:

Enter the number of **Years of Useful Life** of the asset as identified on the provider's depreciation schedule (e.g., 20 for twenty years of useful life).

Cost:

Enter the amount of the initial **Cost** of the asset identified on the provider's depreciation schedule.

Salvage Value:

Enter the value of the asset after depreciation has been fully expensed.

Prior Period Accumulated Depreciation:

Enter the amount of **Prior Period Accumulated Depreciation** related to the asset as identified on the provider's depreciation schedule. This amount is the total depreciable expenses to date related to the depreciable asset.

Month/Year of Disposal:

Enter the **Month/Year of Disposal** as identified on the provider's depreciation schedule (e.g., January 2000, or 1/2000). This date is the month and the year that the depreciable asset was removed from service.

Depreciation for Reporting Period:

The calculated amount of the current period depreciation expense in the **HHSC Allowable Depreciation**. This amount is the total depreciable expense incurred during the Cost Report period.

Exhibit 6 – Worksheet B (Payroll and Benefits)

This exhibit includes the salary and benefits and appropriate reductions related to contracted and employed staff of the provider for Charity Care. For this exhibit, identify all employed and contracted staff related to the provision of Charity Care here. HHSC may pre-populate certain staffing classifications for which information must be completed. Do not include any payroll-related item not directly related to medical services in this section.

DIRECTIONS TO COMPLETE EXHIBIT 6

Employee Information

This section of the exhibit identifies employee information for the specific job classifications identified. This exhibit section also discretely identifies the employee information for any individual employee or contractor that must have a portion of their salaries or benefits, or both, reduced from allowable expenditures on the Cost Report.

For each of the job classifications identified, the following information must be included:

Employee #:

Enter the **Employee #** for the employee for which a portion of their salary or benefits, or both, must be reduced from the total allowable costs.

Last Name:

Enter the **Last Name** of the employee for which a portion of their salary or benefits, or both, must be reduced from the total allowable costs.

First Name:

Enter the **First Name** of the employee for which a portion of their salary or benefits, or both, must be reduced from the total allowable costs.

Job Title/Credentials:

Enter the **Job Title/Credentials** of the employee for which a portion of their salary or benefits, or both, must be reduced from the total allowable costs.

Employee (E) or Contractor (C):

Enter the appropriate designation, **either E or C,** of the employee for which a portion of their salary and/or benefits must be reduced from the total allowable costs. E designates an employee; C designates a contractor.

Payroll and Benefits

This section of the exhibit identifies payroll and benefit expenditures for the specific job classifications identified. This exhibit section also discretely identifies the payroll and benefit expenditures for any individual employee/contractor that must have a portion of their salary or benefits, or both, reduced from allowable expenditures on the Cost Report.

For each of the job classifications identified, the following information must be included:

Gross Salary:

Enter the **Gross Salary** amount for the employee for which a portion of his or her salary or benefits, or both, must be reduced from the total allowable costs.

Total Hours Worked:

Enter the number of **Hours** for each of the job classifications identified in this exhibit and for which costs are identified in Exhibit 6. Hours for this exhibit represent total paid hours that are reported by the provider on payroll reports. Total paid hours include, but are not limited to:

- Regular wage hours,
- Sick hours, and
- Vacation hours.

Contractor Payments:

Enter the amount of **Contractor Payments** for the employee for which a portion of his or her salary or benefits, or both, must be reduced from the total allowable costs.

Employee Benefits:

Enter the amount of **Employee Benefits** for the employee for which a portion of his or her salary or benefits, or both, must be reduced from the total allowable costs. This includes all benefits that are not discretely identified in this exhibit.

Employer Retirement:

Enter the amount of **Employer Retirement** expenditure for the employee for which a portion of his or her salary or benefits, or both, must be reduced from the total allowable costs.

Payroll Taxes or Unemployment Compensation:

If applicable, enter the amount of the following payroll expenses:

- FICA Payroll Taxes,
- Other Payroll Taxes,
- State Unemployment Payroll Taxes,
- Federal Unemployment Payroll Taxes, and
- Unemployment Compensation (Reimbursing Employer).

Federal Funding Reductions

This section of the exhibit identifies the federal funding or other payroll and benefit expenditure reduction necessary for the specific job classifications identified. This exhibit section also discretely identifies the payroll and benefit expenditures for any individual employee/contractor that must have a portion of his or her salary or benefits, or both, reduced from allowable expenditures on the Cost Report.

For each of the job classifications identified, the following information must be included.

Allocated Funded Positions Entry:

Enter the appropriate designation, **either Y or N**, for the employee for which a portion of his or her salary or benefits, or both, must be reduced from the total

allowable costs. A "Y" in this field designates an employee for which a portion or all of his or her salary and benefit expenditures are funded by federal funds or grants. An "N" in this field designates an employee for which a portion or all of his or her salary and benefit expenditures are not funded by federal funds or grants but still need to be removed from allowable expenditures, as reported on the Cost Report.

Federal Funding:

If the answer to the field previously is "Y," then enter the amount of **Federal Funding** related to the employee's salary and benefits that must be reduced from the total allowable costs, as reported on the Cost Report.

Other Funds:

Enter the amount of **Other Amount to be Removed** related to the employee's salary and benefits that must be reduced from the total allowable costs, as reported on the Cost Report.

Supplemental Schedule:

A provider may enter information on a summary basis rather than entering each employee individually if a supplemental personnel schedule is provided.

Exhibit 7-Schedule C – Cost Allocation Methodologies

This exhibit includes detailed cost allocation methodologies employed by the provider.

- Does your agency have a Cost Allocation Plan (CAP)? If so, please provide a copy of your agency's proposed CAP. If not, enter in detail the allocation methodology for allocating costs on the cost report.

- Please provide a list of personnel cost worksheets that support your CAP. Attach the Detailed Explanation externally.

Appendix A. Exhibit 2

Exhibit 2: Examples of Supplies, Materials, and Equipment

- Audiometer (calibrated annually), tympanometer
- Bandages, including adhesive (e.g., Band-Aids) and elastic, of various
- Battery testers, hearing aid stethoscopes, and earmold cleaning materials
- Blood Glucose Meter
- BMI Calculator
- Clinical audiometer with sound field capabilities
- Cold packs
- Cotton balls
- Cotton-tip applicators (swabs)
- Dental floss
- Diapers and other incontinence supplies
- Disinfectant
- Disposable gloves (latex-free)
- Disposable gowns
- Disposable Suction Unit
- Ear mold impression materials
- Electroacoustic hearing aid analyzer
- Electronic Suction Unit
- Evaluation tools (e.g., goniometers, dynamometers, cameras)
- Eye pads
- FM amplification systems or other assistive listening devices
- Gauze
- Immunization supplies and materials
- Loaner or demonstration hearing aids
- Medicine cabinet (with lock)
- Nebulizers
- Otoscope
- Otoscope/ophthalmoscope with battery
- Peak Flow Meters
- Physician's scale that has a height rod and is balanced
- Portable acoustic immittance meter
- Portable audiometer
- Reflex hammer
- Sanitary pads, individually wrapped (may be used for compression)
- Scales
- Scoliometer
- Slings
- Sound-level meter
- Sound-treated test booth
- Sphygmomanometer (calibrated annually) and appropriate cuff sizes
- Splints (assorted)
- Stethoscope
- Surgi-pads
- Syringes (Medication administration or bolus feeding)
- Test materials for central auditory processing assessment
- Tissues
- Tongue depressors
- Triangular bandage
- Vision testing machine, such as Titmus

Attachment U

APPENDIX K: Emergency Preparedness and Response and COVID-19 Addendum

Background:

This standalone appendix may be utilized by the state during emergency situations to request amendments to its approved waiver, to multiple approved waivers in the state, and/or to all approved waivers in the state. It includes actions that states can take under the existing Section 1915(c) home and community-based waiver authority in order to respond to an emergency. Other activities may require the use of various other authorities such as the Section 1115 demonstrations or the Section 1135 authorities.[i] This appendix may be applied retroactively as needed by the state. Public notice requirements normally applicable under 1915(c) do not apply to information contained in this Appendix.

Appendix K-1: General Information

General Information:

A. State: Texas

B. Waiver Title(s): Texas Healthcare Transformation and Quality Improvement Program 1115

C. Control Number(s): 11-W-00278/6

D. Type of Emergency (The state may check more than one box):

X	**Pandemic or Epidemic**
○	**Natural Disaster**
○	**National Security Emergency**
○	**Environmental**
○	**Other (specify):**

E. Brief Description of Emergency. *In no more than one paragraph each*, briefly describe the: 1) nature

COVID-19 pandemic. This amendment will apply waiver-wide to the STAR+PLUS HCBS services provided through the 1115 waiver to all individuals impacted by the virus or the response to the virus (e.g. closure of day programs, etc.) This submission will also extend the requested end date of this request to the end of the PHE. HHSC reserves the right to remove flexibilities that may be approved which are no longer necessary prior to the end of the PHE.

of emergency; 2) number of individuals affected and the state's mechanism to identify individuals at risk; 3) roles of state, local and other entities involved in approved waiver operations; and 4) expected changes needed to service delivery methods, if applicable. The state should provide this information for each emergency checked if those emergencies affect different geographic areas and require different changes to the waiver.

F. Proposed Effective Date: Start Date: March 13, 2020 **Anticipated End Date:** End of PHE

G. Description of Transition Plan.

All activities will take place in response to the impact of COVID-19 as efficiently and effectively as possible based upon the complexity of the change.

H. Geographic Areas Affected:

These actions will apply across the waiver to all individuals impacted under the demonstration by the COVID-19 virus.

I. **Description of State Disaster Plan (if available)** ***Reference to external documents is acceptable:***

N/A

Appendix K-2: Temporary or Emergency-Specific Amendment to Approved Waiver

Temporary or Emergency-Specific Amendment to Approved Waiver:

These are changes that, while directly related to the state's response to an emergency situation, require amendment to the approved waiver document. These changes are time limited and tied specifically to individuals impacted by the emergency. Permanent or long-ranging changes will need to be incorporated into the main appendices of the waiver, via an amendment request in the waiver management system (WMS) upon advice from CMS.

a.___ Access and Eligibility:

i.___ Temporarily increase the cost limits for entry into the waiver. [Provide explanation of changes and specify the temporary cost limit.]

ii.__ Temporarily modify additional targeting criteria. [Explanation of changes]

b.___ Services

i.___ Temporarily modify service scope or coverage.
[Complete Section A- Services to be Added/Modified During an Emergency.]

ii. ___Temporarily exceed service limitations (including limits on sets of services as described in Appendix C-4) or requirements for amount, duration, and prior authorization to address health and welfare issues presented by the emergency.
[Explanation of changes]

iii. ___Temporarily add services to the waiver to address the emergency situation (for example, emergency counseling; heightened case management to address emergency needs; emergency medical supplies and equipment; individually directed goods and services; ancillary services to establish temporary residences for dislocated waiver enrollees; necessary technology; emergency evacuation transportation outside of the scope of non-emergency transportation or transportation already provided through the waiver).
[Complete Section A-Services to be Added/Modified During an Emergency]

iv. ___Temporarily expand setting(s) where services may be provided (e.g. hotels, shelters, schools, churches). Note for respite services only, the state should indicate any facility-based settings and indicate whether room and board is included:
[Explanation of modification, and advisement if room and board is included in the respite rate]:

v.___ Temporarily provide services in out of state settings (if not already permitted in the state's approved waiver). [Explanation of changes]

c.___ Temporarily permit payment for services rendered by family caregivers or legally responsible individuals if not already permitted under the waiver. Indicate the services to which this will apply and the safeguards to ensure that individuals receive necessary services as authorized in the plan of care, and the procedures that are used to ensure that payments are made for services rendered.

d.___ Temporarily modify provider qualifications (for example, expand provider pool, temporarily modify or suspend licensure and certification requirements).

i.___ Temporarily modify provider qualifications.

[Provide explanation of changes, list each service affected, list the provider type, and the changes in provider qualifications.]

ii.___ Temporarily modify provider types.

[Provide explanation of changes, list each service affected, and the changes in the .provider type for each service].

iii.___ Temporarily modify licensure or other requirements for settings where waiver services are furnished.

[Provide explanation of changes, description of facilities to be utilized and list each service provided in each facility utilized.]

e. _X Temporarily modify processes for level of care evaluations or re-evaluations (within regulatory requirements). [Describe]

The state will permit extending long term services and supports (LTSS) LOC authorizations that are set to expire for at least 90 days but no more than one year for individuals in STAR+PLUS.

f.___ Temporarily increase payment rates.

[Provide an explanation for the increase. List the provider types, rates by service, and specify whether this change is based on a rate development method that is different from the current approved waiver (and if different, specify and explain the rate development method). If the rate varies by provider, list the rate by service and by provider.]

g.___ Temporarily modify person-centered service plan development process and individual(s)

responsible for person-centered service plan development, including qualifications.
[Describe any modifications including qualifications of individuals responsible for service plan development, and address Participant Safeguards. Also include strategies to ensure that services are received as authorized.]

h.___ Temporarily modify incident reporting requirements, medication management or other participant safeguards to ensure individual health and welfare, and to account for emergency circumstances. [Explanation of changes]

i.___ Temporarily allow for payment for services for the purpose of supporting waiver participants in an acute care hospital or short-term institutional stay when necessary supports (including communication and intensive personal care) are not available in that setting, or when the individual requires those services for communication and behavioral stabilization, and such services are not covered in such settings. [Specify the services.]

j.___ Temporarily include retainer payments to address emergency related issues.
[Describe the circumstances under which such payments are authorized and applicable limits on their duration. Retainer payments are available for habilitation and personal care only.]

k.___ Temporarily institute or expand opportunities for self-direction.
[Provide an overview and any expansion of self-direction opportunities including a list of services that may be self-directed and an overview of participant safeguards.]

l.___ Increase Factor C.
[Explain the reason for the increase and list the current approved Factor C as well as the proposed revised Factor C]

m._X Other Changes Necessary [For example, any changes to billing processes, use of contracted entities or any other changes needed by the State to address imminent needs of individuals in the waiver program]. [Explanation of changes]

To comport with H.R. 6201, the state will temporarily suspend releasing individuals from the STAR+PLUS HCBS waiver interest list and continue to maintain their eligibility for STAR+PLUS HCBS during the PHE to the extent required by H.R. 6201.

Appendix K Addendum: COVID-19 Pandemic Response

1. HCBS Regulations

a. ☐ Not comply with the HCBS settings requirement at 42 CFR 441.301(c)(4)(vi)(D) that individuals are able to have visitors of their choosing at any time, for settings added after March 17, 2014, to minimize the spread of infection during the COVID-19 pandemic.

2. Services

a. ☒ Add an electronic method of service delivery (e.g,. telephonic) allowing services to continue to be provided remotely in the home setting for:

i. ☒ Case management

ii. ☐ Personal care services that only require verbal cueing

iii. ☐ In-home habilitation iv. ☐ Monthly monitoring (i.e., in order to meet the reasonable indication of need for services requirement in 1915(c) waivers). v. ☐ Other *[Describe]:*

b. ☐ Add home-delivered meals

c. ☐ Add medical supplies, equipment and appliances (over and above that which is in the state plan)

d. ☐ Add Assistive Technology

3. Conflict of Interest: The state is responding to the COVID-19 pandemic personnel crisis by authorizing case management entities to provide direct services. Therefore, the case management entity qualifies under 42 CFR 441.301(c)(1)(vi) as the only willing and qualified entity.

a. ☐ Current safeguards authorized in the approved waiver will apply to these entities.

b. ☐ Additional safeguards listed below will apply to these entities.

4. Provider Qualifications

a. ☐ Allow spouses and parents of minor children to provide personal care services

b. ☐ Allow a family member to be paid to render services to an individual.

c. ☐ Allow other practitioners in lieu of approved providers within the waiver. *[Indicate the providers and their qualifications]*

d. ☐ Modify service providers for home-delivered meals to allow for additional providers, including non-traditional providers.

5. Processes

a. ☒ Allow an extension for reassessments and reevaluations for up to one year past the due date.

b. ☒ Allow the option to conduct evaluations, assessments, and person-centered service planning meetings virtually/remotely in lieu of face-to-face meetings.

c. ☒ Adjust prior approval/authorization elements approved in waiver.

d. ☒ Adjust assessment requirements

e. ☒ Add an electronic method of signing off on required documents such as the personcentered service plan.

Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the request:

First Name:	Kathi
Last Name	Montalbano
Title:	Manager
Agency:	Health and Human Services Commission (HHSC)
Address 1:	4900 North Lamar Blvd
Address 2:	Click or tap here to enter text.
City	Austin
State	Texas
Zip Code	78751
Telephone:	512-771-3503
E-mail	Kathi.montalbano@hhs.texas.gov
Fax Number	Click or tap here to enter text.

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

First Name:	Stephanie
Last Name	Stephens
Title:	State Medicaid Director
Agency:	HHSC
Address 1:	4900 North Lamar Blvd

Address 2:	Click or tap here to enter text.
City	Austin
State	Texas
Zip Code	78751
Telephone:	512-428-1906
E-mail	Stephanie.Stephens01@hhs.texas.gov
Fax Number	Click or tap here to enter text.

8. Authorizing Signature

Signature: **Date:**

_____

State Medicaid Director or Designee

First Name: Click or tap here to enter text. **Last Name** Click or tap here to enter text.

Title: Click or tap here to enter text.

Agency: Click or tap here to enter text. **Address 1:** Click or tap here to enter text.

Address 2:	Click or tap here to enter text.
City	Click or tap here to enter text.
State	Click or tap here to enter text.
Zip Code	Click or tap here to enter text.
Telephone:	Click or tap here to enter text.
E-mail	Click or tap here to enter text.
Fax Number	Click or tap here to enter text.

Section A---Services to be Added/Modified During an Emergency

Complete for each service added during a time of emergency. For services in the approved waiver that the state is temporarily modifying, enter the entire service definition and highlight the change. State laws, regulations and policies referenced in the specification should be readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
Service Definition (Scope)**:**	

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Specifications					
Provider Category(s) *(check one or both)*:	☐	Individual. List types:	☐	Agency. List the types of agencies:	
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian	

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification

Service Delivery Method				
Service Delivery Metho *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☐	Provider managed

[i] Numerous changes that the state may want to make may necessitate authority outside of the scope of section 1915(c) authority. States interested in changes to administrative claiming or changes that require section 1115 or section 1135 authority should engage CMS in a discussion as soon as possible. Some examples may include: (a) changes to administrative activities, such as the establishment of a hotline; or (b) suspension of general Medicaid rules that are not addressed under section 1915(c) such as payment rules or eligibility rules or suspension of provisions of section 1902(a) to which 1915(c) is typically bound.

APPENDIX K: Emergency Preparedness and Response

Background:

This standalone appendix may be utilized by the state during emergency situations to request amendment to its approved waiver. It includes actions that states can take under the existing Section 1915(c) home and community-based waiver authority in order to respond to an emergency. Other activities may require the use of various other authorities such as the Section 1115 demonstrations or the Section 1135 authorities.[i] This appendix may be completed retroactively as needed by the state.

Appendix K-1: General Information

General Information:

A. State:_Texas_____

B. Waiver Title: Texas Healthcare Transformation and Quality Improvement Program 1115

C. Control Number:

11-W-00278/6

D. Type of Emergency (The state may check more than one box):

X	**Pandemic or Epidemic**
O	**Natural Disaster**
O	**National Security Emergency**
O	**Environmental**
O	**Other (specify):**

E. Brief Description of Emergency. *In no more than one paragraph each*, briefly describe the: 1) nature of emergency; 2) number of individuals affected and the state's mechanism to identify individuals at risk; 3) roles of state, local and other entities involved in approved waiver operations; and 4) expected changes needed to service delivery methods, if applicable. The state should provide this information for each emergency checked if those emergencies affect different geographic areas and require different changes to the waiver.

COVID-19 pandemic. This amendment requests flexibility for STAR+PLUS HCBS members with Medical Assistance Only (MAO) (described as 217-like in Texas's 1115 waiver) who left a nursing facility without community eligibility (STAR+PLUS HCBS) in place, due to concerns about COVID-19 or in accordance with local orders during the early stages of the public health emergency (PHE), to bypass the interest list and apply for STAR+PLUS HCBS.

F. Proposed Effective Date: Start Date: March 13, 2020_Anticipated End Date: _August 31, 2023_

G. Description of Transition Plan.

All activities were in response to the impact of COVID-19 and were performed as efficiently and effectively as possible based upon the complexity of the change.

H. Geographic Areas Affected:

These actions apply statewide.

I. Description of State Disaster Plan (if available) ***Reference to external documents is acceptable*****:**

N/A

Appendix K-2: Temporary or Emergency-Specific Amendment to Approved Waiver

Temporary or Emergency-Specific Amendment to Approved Waiver:

These are changes that, while directly related to the state's response to an emergency situation, require amendment to the approved waiver document. These changes are time limited and tied specifically to individuals impacted by the emergency. Permanent or long-ranging changes will need to be incorporated into the main appendices of the waiver, via an amendment request in the waiver management system (WMS) upon advice from CMS.

a.___ Access and Eligibility:

i.___ Temporarily increase the cost limits for entry into the waiver.
[Provide explanation of changes and specify the temporary cost limit.]

ii.___ Temporarily modify additional targeting criteria.
[Explanation of changes]

b.___ Services

i.___ Temporarily modify service scope or coverage.
[Complete Section A- Services to be Added/Modified During an Emergency.]

ii. ___Temporarily exceed service limitations (including limits on sets of services as described in Appendix C-4) or requirements for amount, duration, and prior authorization to address health and welfare issues presented by the emergency.

[Explanation of changes]

iii. ___Temporarily add services to the waiver to address the emergency situation (for example, emergency counseling; heightened case management to address emergency needs; emergency medical supplies and equipment; individually directed goods and services; ancillary services to establish temporary residences for dislocated waiver enrollees; necessary technology; emergency evacuation transportation outside of the scope of non-emergency transportation or transportation already provided through the waiver).

[Complete Section A-Services to be Added/Modified During an Emergency]

iv. ___Temporarily expand setting(s) where services may be provided (e.g. hotels, shelters, schools, churches) Note for respite services only, the state should indicate any facility-based settings and indicate whether room and board is included:

[Explanation of modification, and advisement if room and board is included in the respite rate]:

v.___ Temporarily provide services in out of state settings (if not already permitted in the state's approved waiver). [Explanation of changes]

c.___ Temporarily permit payment for services rendered by family caregivers or legally responsible individuals if not already permitted under the waiver. Indicate the services to which this will apply and the safeguards to ensure that individuals receive necessary services as authorized in the plan of care, and the procedures that are used to ensure that payments are made for services rendered.

d.___ Temporarily modify provider qualifications (for example, expand provider pool, temporarily modify or suspend licensure and certification requirements).

i.___ Temporarily modify provider qualifications.

[Provide explanation of changes, list each service affected, list the provider type, and the changes in provider qualifications.]

ii.___ Temporarily modify provider types.

[Provide explanation of changes, list each service affected, and the changes in the .provider type for each service].

iii.___ Temporarily modify licensure or other requirements for settings where waiver services are furnished.

[Provide explanation of changes, description of facilities to be utilized and list each service provided in each facility utilized.]

e. ___Temporarily modify processes for level of care evaluations or re-evaluations (within regulatory requirements). [Describe]

f.___ Temporarily increase payment rates

[Provide an explanation for the increase. List the provider types, rates by service, and specify whether this change is based on a rate development method that is different from the current approved waiver (and if different, specify and explain the rate development method). If the rate varies by provider, list the rate by service and by provider].

g.___ Temporarily modify person-centered service plan development process and individual(s) responsible for person-centered service plan development, including qualifications.

[Describe any modifications including qualifications of individuals responsible for service plan development, and address Participant Safeguards. Also include strategies to ensure that services are received as authorized.]

h.___ Temporarily modify incident reporting requirements, medication management or other participant safeguards to ensure individual health and welfare, and to account for emergency circumstances. [Explanation of changes]

i.___ Temporarily allow for payment for services for the purpose of supporting waiver participants in an acute care hospital or short-term institutional stay when necessary supports (including communication and intensive personal care) are not available in that setting, or when the individual requires those services for communication and behavioral stabilization, and such services are not covered in such settings.
[Specify the services.]

j.___ Temporarily include retainer payments to address emergency related issues.
[Describe the circumstances under which such payments are authorized and applicable limits on their duration. Retainer payments are available for habilitation and personal care only.]

k.___ Temporarily institute or expand opportunities for self-direction.
[Provide an overview and any expansion of self-direction opportunities including a list of services that may be self-directed and an overview of participant safeguards]

l.___ Increase Factor C.
[Explain the reason for the increase and list the current approved Factor C as well as the proposed revised Factor C]

m._X_ Other Changes Necessary [For example, any changes to billing processes, use of contracted entities or any other changes needed by the State to address imminent needs of individuals in the waiver program]. [Explanation of changes]

Pursuant to STC 28(b)(i)(1), HHSC operates an interest list for the STAR+PLUS 217-Like HCBS population who are not in the STAR+PLUS mandatory eligibility categories.

HHSC requests a flexibility to STC 28(b)(i)(1) to allow STAR+PLUS members with Medical Assistance Only (MAO) (described as 217-like in Texas's 1115 waiver) who left a nursing facility without community eligibility (STAR+PLUS HCBS) in place, due to concerns about COVID-19 or in accordance with local orders during the early stages of the PHE, to bypass the interest list and apply for STAR+PLUS HCBS.

Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the request:

First Name:	Kathi
Last Name	Montalbano
Title:	Director, Federal Coordination, Rules and Committees
Agency:	Health and Human Services Commission
Address 1:	701 W. 51st Street
Address 2:	Click or tap here to enter text.
City	Austin
State	Texas
Zip Code	78751
Telephone:	(512) 771-3503
E-mail	Kathi.Montalbano@hhs.texas.gov
Fax Number	Click or tap here to enter text.

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

First Name:	Click or tap here to enter text.
Last Name	Click or tap here to enter text.
Title:	Click or tap here to enter text.
Agency:	Click or tap here to enter text.
Address 1:	Click or tap here to enter text.
Address 2:	Click or tap here to enter text.
City	Click or tap here to enter text.
State	Click or tap here to enter text.
Zip Code	Click or tap here to enter text.
Telephone:	Click or tap here to enter text.
E-mail	Click or tap here to enter text.
Fax Number	Click or tap here to enter text.

8. Authorizing Signature

Signature:

Date:

_____

Emily Zalkovsky, Deputy State Medicaid Director
(Signing on behalf of Stephanie Stephens, State Medicaid Director)

First Name:	Emily
Last Name:	Zalkovsky
Title:	Deputy State Medicaid Director
Agency:	Health and Human Services Commission

Address 1:	4601 W. Guadalupe Street
Address 2:	Click or tap here to enter text.
City	Austin
State	Texas
Zip Code	78751
Telephone:	(512) 424-6767
E-mail	Emily.Zalkovsky@hhs.texas.gov
Fax Number	Click or tap here to enter text.

Section A---Services to be Added/Modified During an Emergency

Complete for each service added during a time of emergency. For services in the approved waiver which the state is temporarily modifying, enter the entire service definition and highlight the change. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
Service Definition (Scope)**:**	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	☐	Agency. List the types of agencies:

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☐	Provider managed

[i] Numerous changes that the state may want to make necessitate authority outside of the scope of section 1915(c) authority. States interested in changes to administrative claiming or changes that require section 1115 or section 1135 authority should engage CMS in a discussion as soon as possible. Some examples may include: (a) changes to administrative activities, such as the establishment of a hotline; (b) suspension of general Medicaid rules that are not addressed under section 1915(c) such as payment rules or eligibility rules or suspension of provisions of section 1902(a) to which 1915(c) is typically bound.