Community Health Access and Rural Transformation Model

Community Transformation Track

CMS-2G2-21-001

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CHARTing a Course for Rural Hospital Transformation in Texas

Texas Health and Human Services

Fiscal Program Coordination

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Texas Health and Human Services Commission

CHART Model Community Transformation Track
Project Narrative - Notice of Funding Opportunity Number: CMS-2G2-21-001

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E.1.2 Project Narrative

E.1.2.1. Model Context

E.1.2.1.1. Characteristics of Proposed Community

Community Characteristic	Community-level Data	Source
A list of the contiguous or non-contiguous rural counties or rural census tracts that comprise the Community	• Angelina County • Brown County • Burnet County • Dawson County • DeWitt County • Haskell County • Maverick County • Mitchell County • Polk County • San Augustine County • Wichita County • Young County • Census Tracts 48187210100, 48187210200, 48187210300, 48187210400, 48187210504, 48187210508, 48187210801, 48187210901, and 48187210902 in Guadalupe County [i] • Census Tracts 48485013700 and 48485013800 in Wichita County [ii]	
The number of each provider type [iii] and payer mix [iv]	9 Ambulatory Surgical Centers 58.6% Medicare beneficiaries 35.8% Medicaid beneficiaries 5.6% Medicare & Medicaid dual eligible	CMS Providers of Service File (Dec. 2020);CMS Geographic Variation Public Use File (2018); HHSC Center for Analytics and Decision Support (2018); Medicare Fee-for-Service Beneficiaries Reported by Participant Hospitals (2018)

Community Characteristic	Community-level Data	Source
	6 Critical Access Hospitals 74.2% Medicare beneficiaries 19.5% Medicaid beneficiaries 6.3% Medicare & Medicaid dual eligible	CMS Providers of Service File (Dec. 2020);CMS Geographic Variation Public Use File (2018); HHSC Center for Analytics and Decision Support (2018); Medicare Fee-for-Service Beneficiaries Reported by Participant Hospitals (2018)
	22 Federally Qualified Health Centers 48.5% Medicare beneficiaries 41.2% Medicaid beneficiaries 10.3% Medicare & Medicaid dual eligible	CMS Providers of Service File (Dec. 2020);CMS Geographic Variation Public Use File (2018); HHSC Center for Analytics and Decision Support (2018); Medicare Fee-for-Service Beneficiaries Reported by Participant Hospitals (2018)
	42 Home Health Agencies 51.3% Medicare beneficiaries 20.1% Medicaid beneficiaries 28.6% Medicare & Medicaid dual eligible	CMS Providers of Service File (Dec. 2020);CMS Geographic Variation Public Use File (2018); HHSC Center for Analytics and Decision Support (2018); Medicare Fee-for-Service Beneficiaries Reported by Participant Hospitals (2018)
	14 Acute Care Hospitals 52.1% Medicare beneficiaries 37.8% Medicaid beneficiaries 10.1% Medicare & Medicaid dual eligible	CMS Providers of Service File (Dec. 2020);CMS Geographic Variation Public Use File (2018); HHSC Center for Analytics and Decision Support (2018); Medicare Fee-for-Service Beneficiaries Reported by Participant Hospitals (2018)
	2 Opioid Treatment Programs [v]	CMS Medicare Enrollment of Opioid Treatment Program Providers (2020)

Community Characteristic	Community-level Data	Source
	958 Physician Practices 47.4% Medicare beneficiaries 43.4% Medicaid beneficiaries 9.2% Medicare & Medicaid dual eligible	Texas Department of State Health Services' Center for Health Statistics on Direct Patient Care Physicians in Texas (2020); HHSC Center for Analytics and Decision Support (2018); CMS Physician and Other Supplier Data (2018)
	19 Rural Health Clinics 51.0% Medicare beneficiaries 42.7% Medicaid beneficiaries 6.3% Medicare & Medicaid dual eligible	CMS Providers of Service File (Dec. 2020);CMS Geographic Variation Public Use File (2018); HHSC Center for Analytics and Decision Support (2018); Medicare Fee-for-Service Beneficiaries Reported by Participant Hospitals (2018)
	57 Skilled Nursing Facilities 58.0% Medicare beneficiaries 4.5% Medicaid beneficiaries 37.6% Medicare & Medicaid dual eligible	CMS Providers of Service File (Dec. 2020);CMS Geographic Variation Public Use File (2018); HHSC Center for Analytics and Decision Support (2018); Medicare Fee-for-Service Beneficiaries Reported by Participant Hospitals (2018)
Annual FFS Medicare Revenue	FY 2018: $918,503,307	CMS 2018 FFS Data
	FY 2019: $938,278,527	CMS 2019 FFS Data
Number of beneficiaries whose primary residence is within the Community and average annual total cost of care.	Number of FFS Medicare beneficiaries (excluding dually-eligible beneficiaries): 94,707 Average Annual Total Cost of Care: $986,407,894	CMS Yearly Medicare Enrollment Dashboard (2019); CMS Geographic Variation Public Use File (2018)
	Number of FFS Medicaid beneficiaries (excluding dually-eligible beneficiaries): 4,669 Average Annual Total Cost of Care: $34,774,457 [vi]	HHSC Forecasting (2019)

Community Characteristic	Community-level Data	Source
	Number of Medicare and Medicaid Managed Care beneficiaries: 120,332 Average Annual Total Cost of Care: $451,954,792 [vii] Number of Medicare Managed Care beneficiaries: 41,0125 Number of Medicaid Managed Care beneficiaries: 79,307	CMS Yearly Medicare Enrollment Dashboard (2019); HHSC Forecasting (2019)
	Number of Medicare and Medicaid Dual Eligible beneficiaries: 22,859 [viii] Average Annual Total Cost of Care: $233,898,586 [ix]	CMS Medicare-Medicaid Duals Enrollment Annual Release (2019); HHSC Forecasting (2019)
	Number of Medicare FFS beneficiaries: 94,707 Number of Medicare Managed Care beneficiaries: 41,025	CMS Yearly Medicare Enrollment Dashboard (2019)
Number of beneficiaries with commercial insurance	195,714	U.S. Census Bureau, American Community Survey (2015-2019)
Number of uninsured residents	99,488	U.S. Census Bureau Small Area Health Insurance Estimates (2018)

Additional Information – at the discretion of the applicant, no more than three additional data points that describe the Community:

Community Characteristic	Community-level Data	Source
Health Professional Shortage Area (HPSA) Designation	8 - Mental Health 2 - Primary Care 2 - High Needs Primary Care 2 - High Needs Geographic	Health Resources and Services Administration
County Rankings for Diabetes Prevalence	15% average	Robert Wood Johnson 2020 County Health Ranking State Reports
Medically Underserved Areas	6 counties (46.15%) are designated as a medically underserved area for primary care providers. 2 counties (13.38%) are designated as a partial medically underserved area for primary care providers.	Health Resources and Services Administration

Table Footnotes

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[i] Data could not be obtained at the census-level for all required characteristics. Therefore, data is reported at the county-level.

[ii] Ibid

[iii] The number of Urgent Care Center providers is not reflected in the table because HHSC does not have readily available data to identify the number of providers in Texas Medicaid. Additionally, HHSC was unable to find public data on active providers in each county of the Community.

[iv] The payer mix is calculated by taking the number of beneficiaries for each payer (Medicaid, Medicare, and Medicaid/Medicare dual eligible) divided by the total number of beneficiaries for all payers. The payer mix does not account for beneficiaries with commercial insurance because HHSC was unable to obtain data by each provider type or by county.

[v] HHSC does not have sufficient data to calculate the payer mix for Opioid Treatment Program (OTP) providers. The two OTP providers in the Community are enrolled in Medicare but not enrolled as an OTP provider in Texas Medicaid and thus, there are no Medicaid beneficiaries in the Community. Additionally, HHSC was unable to find data on the number of Medicare and Medicaid-Medicare dual eligible beneficiaries receiving services from the OTP providers in the Community.

[vi] Includes FFS costs for both dual and non-dual eligible beneficiaries as cost data maintained by HHSC does not have a dual/non-dual break down available.

[vii] Includes Medicaid Managed Care costs only. HHSC was unable to find data on Medicare Managed Care costs for the Community.

[viii] Includes dually eligible beneficiaries with full and partial benefits.

[ix] Includes FFS costs for both dual and non-dual eligible beneficiaries as FFS cost data maintained by HHSC does not have a dual/non-dual break down available, and Managed Care costs for dual eligible beneficiaries.

Assessment of Legal Authorities and Barriers to Health Care Delivery System Redesign

No legal barriers have been identified to impede or prevent health care delivery system redesign envisioned through the CHART Model. The following legal authorities are identified that enable HHSC to participate in the CHART Model and support its goals:

- Texas Government Code, Section 531.021 designates HHSC to administer federal Medicaid funds.
- Texas Government Code, Section 531.038 allows HHSC to accept a gift or grant from a public or private source to perform any of the commission's powers or duties.
- Texas Human Resources Code Chapters 22 and 32 and Texas Government Code Chapter 536 grants HHSC authority to operate Medicaid, apply for and run demonstration projects, and develop or test effectiveness of health care delivery models and quality-based payments.
- Texas Government Code, Section 531.038 authorizes HHSC to accept grants from public sources to perform any of HHSC's powers or duties.
- House Bill 3301, 86th Legislature, 2019, Regular Session, added Chapter 314A to the Texas Health and Safety Code identifies the eight Texas counties that can apply for a certificate of public advantage based on standards identified in the statute.

Certificate of Public Advantage (COPA) Arrangements

There are eight counties with hospitals that can apply for a COPA based on the statutory applicability standards of Texas Health and Safety Code, Section 314A.002. These include: Angelina, Bowie, Cherokee, Colorado, Taylor, Tom Green, Wichita, and Wood counties. HHSC has issued two COPAs to date: Hendrick Health System in Abilene (Taylor County) and Shannon Health System in San Angelo (Tom Green County). The agency has not received any more applications. The COPA for Hendrick Health System involves two hospitals in Abilene. An additional hospital in the Hendrix Health System is in Brownwood (Brown County) but it is not in an eligible county to apply for a COPA. None of the current participant hospitals are affected by COPAs.

E.1.2.1.2. Community Selection Rationale

Community Benefits from CHART Model

Small, rural Texas hospitals operate on an edge. Certain health events encountered by an urban hospital, like a rattlesnake bite that requires multiple doses of expensive antivenom, a chemotherapy regimen, or a multi-car crash with several trauma victims could mean financial ruin for a rural hospital. The CHART Model project benefits rural hospitals by helping lessen, if not eliminate, the financial impact of certain events with stable Medicare capitated monthly payments, cooperative agreement funding, and operational flexibilities.

In our health care redesign strategy, HHSC proposes to use the cooperative agreement funding to help hospitals establish and/or expand their telemedicine capabilities. There is enormous potential in telemedicine and it is an extremely positive and promising innovation for isolated, rural communities that have been pushed beyond their limits because of the novel

coronavirus (COVID-19) pandemic. Texas rural communities are ready to harness the opportunity, overcome connectivity/broadband issues and reimagine the way health care is accessed so that it is easier to do no matter your zip code. Our Community rural hospitals are ready to use technology to explore new strategies in preventing and managing chronic conditions, reducing hospital readmissions, and expanding wellness activities especially for disparate populations. Reducing the burden of chronic disease helps the individual, their family, and the health care system.

HHSC proposes a staged implementation for transforming certain Medicaid payments to a capitated arrangement. The approach helps rural hospitals continue along the payment continuum and towards improving the value of the health care delivery system by providing quality care in an efficient and cost-effective manner. Moreover, the CHART Model funding can help rural Texas hospitals with quality improvement activities, improve their performance benchmark, and manage their long-term financial performance.

(1) Community Geographic Parameters and Community Selection Rationale

Texas is a geographically vast state with a diverse provider base of hospitals. To notify Texas hospitals about the CHART Model funding opportunity, HHSC created web pages, fact sheets, frequently asked questions, and sent out stakeholder emails to call attention to these resources and HHSC's intention to apply as the lead organization. Interest in the CHART Model was evident statewide. To maximize the CHART Model funding opportunity for rural Texas, hospitals were able to self-select for consideration to participate. Because the CHART Model funding opportunity is a significant time and organizational commitment, involves community-wide transformation, and dramatically changes how a hospital gets paid, HHSC used hospital

self-selection to allow potential participant hospitals to evaluate their own readiness and fitness to participate.

While several factors influenced HHSC's decision to use self-selection as a strategy to define our CHART Community, the main factor was the novel coronavirus (COVID-19) and its ongoing impact on rural Texas hospitals. The short- and long-term effects of COVID-19 on a community and a hospital's operations continue to be identified. Selecting hospitals not ready to assume the long-term commitment required of the CHART Model would not benefit the hospital or the county's health care system. HHSC believed rural hospital leadership was in the best position to determine if this was the appropriate time to participate in a transformation project.

Because of HHSC's self-selection strategy, the geographic boundaries of our Community are made up of noncontiguous rural counties spread out across the state consisting of 13 rural counties including 11 census tracts. Within this boundary, there are 14 potential participating hospitals: Angelina County- CHI St. Luke's Health Memorial Lufkin, Brown County - Hendrick Medical Center Brownwood, Burnet County- Ascension Seton Highland Lakes, DeWitt County - Cuero Regional Hospital, Dawson County - Medical Arts Hospital, Census Tracts 48187210100 48187210200, 48187210300, 48187210400, 48187210504, 48187210508, 48187210801, 48187210901, and 48187210902 in Guadalupe County - Guadalupe Regional Medical Center, Haskell County - Haskell Memorial Hospital, Maverick County - Fort Duncan Regional Medical Center, Mitchell County - Mitchell County Hospital District, Polk County - CHI St. Luke's Health Memorial Livingston Hospital, San Augustine County - CHI St. Luke's Health Memorial San Augustine Hospital, Census Tracts 48485013700 and 48485013800 in Wichita County - Electra

Memorial Hospital and Young County - Olney Hamilton Hospital and Graham Regional Medical Center.

HHSC developed contingency plans should the cooperative funding award not support all 14 hospitals. Seven criteria developed by an interagency and stakeholder workgroup will be used to make decisions about participation and funding allocations, if needed. The criteria include: geographic region – the distance to other hospitals; size of the population impacted by hospital; status of hospital's telemedicine infrastructure; hospital's partnerships with other care facilities or community organizations; hospital's staff resources; hospital's financial solvency; and hospital's past or present participation in Medicare and/or Medicaid Alternative Payment Model (APM).

(2) Summary of any health care delivery system redesign efforts in the Community

Several providers in the Community are working with CMS to transform their local health care delivery system by participating in new payment and service delivery models in accordance with the requirements of section 1115A of the Social Security Act. Providers in Maverick, Wichita, and Angelina Counties are participating in the Medicare Bundle Payment for Care Improvement Advanced Model. Its goal is to encourage clinicians to redesign care delivery by adopting best practices, reducing variation from standards of care, and providing a clinically appropriate level of services for patients throughout a Clinical Episode. A Brown County provider is participating in the Medicare Emergency Triage, Treat, and Transport five-year payment model that is meant to bring greater flexibility to ambulance care teams to address emergency health care needs of Medicare Fee-for-Service beneficiaries following a 911 call.

The Texas CHART Model Community is impacted by HHSC's statewide efforts to support Medicaid providers and MCOs to transition from volume-based care to value-based. For example, HHSC operates the Delivery System Reform Incentive Payment (DSRIP) program under the approval of the Medicaid 1115 Transformation waiver. It provides 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. DSRIP funds are Medicaid incentive payments that performing providers earn for achieving approved metrics at agreed-upon values.

Ten of the 14 potential CHART Model participant hospitals are participating in DSRIP. It is a locally driven program, based on community needs, and as an incentive payment program it offers the 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.

DSRIP providers are organized across the state into 20 Regional Healthcare Partnerships (RHPs). The RHPs are based on geographic boundaries that generally reflect patient flow patterns for the region. Multiple hospitals from RHPs 11 and 19 and one hospital in RHPs 2, 6, 8, and 12 have each expressed interest in participating in the CHART Model. Through DSRIP, these hospitals are working to impact multiple areas including management of chronic conditions, rural emergency care, rural preventive care. More specifically, four hospitals are working to improve rural emergency care, which includes improving the documentation of current

medication records, internal process for admitted patients, and emergency transfer communication. Three hospitals are focused on chronic disease management, like diabetes care and another is also working to address heart disease management. Three hospitals are improving rural preventive care, including screening for tobacco use and providing the necessary intervention; pneumonia vaccination, and advanced care planning. One hospital is working on primary care prevention including screening for tobacco use and providing the necessary intervention, as well as diabetes care, provision of vaccinations, testing, and BMI assessments. Lastly, one hospital is working in multiple areas that include improving care transition and hospital readmission, maternal care, and hospital safety. Nearly all of ten rural hospitals participating in DSRIP report achievement of the goals for the selected quality measures that are consistent, if not above, the overall statewide achievements.

Since 2012, all Medicaid managed care organizations (MCO) are required to submit an annual report on its value-based care activities with providers to HHSC for information and planning purposes. HHSC instituted a significant change for calendar year 2018, when it added two types of value-based care targets to the managed care contracts that the MCOs must meet. Beginning in calendar year 2018, 25 percent of the MCO's payments to providers must be APMs for each Medicaid program with certain exceptions. In 2021 targets increase to 50 percent. A portion of APMs are required to include downside financial risk for providers: 10 percent of MCO payments in 2018 with certain exceptions increasing to 25 percent by 2021.

During calendar year 2019, two MCOs had 27 APM contracts with their providers in all three Medicaid Rural Service Areas (MRSAs). Ten of the 14 potential participant hospitals in the Community are included in one of the three Medicaid Rural Service Areas where these MCOs

operate. Ten APMs had upside incentives and downside risk for providers and most had shared savings and condition-specific population-based payments; while, 17 APMs had no downside risk and focused on pay-for-performance, foundational payments for infrastructure and operations, and pay-for-reporting. Providers participating in these APMS included: primary care, specialists, pharmacists, and outpatient services.

Statewide all Medicaid inpatient claims by hospitals are considered part of the APMs because of their participation in the Hospital Quality-Based Payment Program related to their performance in Potentially Preventable Readmissions and Complications. In 2018, the total expenses associated with these models is more than $1.1 billion and nearly $5 million of it was paid directly to providers as financial incentives. For Texas' MRSAs there were 47 APMs in MRSA-Central SDA, 36 in MRSA-East SDA, and 30 in MRSA-West SDA. These APMs accounted for $2.6 billion ($9.7 million in incentives) in MRSA Central SDA, nearly $1.6 billion ($2.1 million in incentives) in MRSA East SDA, and almost $1.5 billion ($5.3 million in incentives) in MRSA West SDA. (See References Attachment, Texas Managed Care Service Areas, Figure 9, p. 14)

(3) Findings from Gap Analysis

Between 2013 and 2018, a series of meetings, focus groups, and community needs assessments were conducted and allowed Texas stakeholders to provide feedback about community health care-related needs, needs of specific populations, impact of geographies, proposed interventions, and health care challenges and opportunities. Stakeholders included: local health care providers, health care systems, government officials, hospital districts, community mental health centers, local health departments, and others. The purpose of these assessments was to inform HHSC of the gaps between services and resources available and the

community needs, as well as to and identify opportunities to improve communities through health care transformation projects across the state. The assessments helped the state understand issues faced by communities and were not payer-specific. Several similar and related health challenges in counties included in the CHART Community were cited in these community assessments. They include these four community health challenges (hereafter referred to as Community health challenges): (1) lack of coordinated care, (2) uncoordinated care transitions resulting in unplanned hospital readmissions, (3) improved treatment and prevention of chronic conditions like diabetes, cardiovascular disease, and congestive heart failure, and (4) limited or no access to primary and specialty care. (See References Attachment, Community Needs Assessment Summary, Figure 5, p. 5) HHSC and its CHART community partners propose to address one or more of the Community health challenges in our transformation plan.

The Community health challenges can contribute to unplanned hospital admissions/readmissions and nonemergent use of the emergency department. Community stakeholders recognized the interrelatedness of these health challenges and some of the non-health related problems that contribute to their continuation. Stakeholders in Dawson, DeWitt, Guadalupe, and Mitchell counties pointed out the effect a lack of transportation has on treatment of chronic conditions: patients will delay care until conditions become critical and results in a visit to the emergency department or hospital admission due to a lack of access to primary and specialty care. Community stakeholders also recognized that in addition to improving health outcomes, there are financial benefits to addressing these challenges. Savings could result from lowering rates of complications from chronic disease, reducing unplanned

readmissions/admission, and improving how chronic conditions are monitored. Savings generated could be used to invest in additional improvements or reforms, such as new technologies that benefit the community and better address their needs. (See References Attachment, Excerpts from Community Assessment and Focus Groups, pp. 7 to 10 for additional stakeholder quotes.)

Quality Outcomes

Quality outcomes that interest our Community include: (1) Decreasing number of hospital readmissions after an overnight stay for certain conditions; (2) Reducing unplanned hospital admissions/readmissions for certain chronic conditions; (3) Reducing nonemergent use of the emergency department; (4) Increasing the number of county residents able to receive care in the Community for certain conditions; (5) Reducing the hospital admissions from long term care facilities; (6) Ensuring reconciled a medication list is received by discharged patients (inpatient discharges to home/self- care or other site of care); and (7) Increasing timely transmission of transition record (inpatient discharges to home/self-care or other site of care).

Population Health, Access, and Socioeconomic Data

Researchers find significant associations exist between income, education, and health measures.[1] The importance of socioeconomic factors for disparities in chronic disease are known and often referred to as social determinants of health.[1] Researchers describe them as "fundamental causes of disease" and their impact influences prevention or advancement of disease.[1]

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[1] Oates GR, Jackson BE, Partridge EE, Singh KP, Fouad MN, Bae S. Sociodemographic Patterns of Chronic Disease: How the Mid-South Region Compares to the Rest of the Country. Am J Prev Med. 2017 Jan;52(1S1): S31-S39.

A person's work and income affect their health. Adults living in poverty are more than five times as likely to report fair or poor health as adults with incomes at least four times the federal poverty limit.[1] The median household income for Texas is $61,874,[2] which is lower than national median household income of 68,703.[3] The median income for the Community ranges from $38,613 in Haskell County to $78,801 in Guadalupe County. The unemployment rate in Texas as of December 2020 was 7.2 percent, according to the Texas Workforce Commission. The Texas economy is reported to be experiencing a slow and staggered recovery since the novel coronavirus (COVID-19) public health emergency began. Approximately half of the Community's counties are experiencing unemployment rates greater than the state average. Maverick is experiencing an unemployment rate of 16.3 percent, more than double the state average. [4] In addition, Angelina County is experiencing a 7.7 percent unemployment rate, Mitchell 8.9 percent, Polk 9.55 percent, San Augustine 9.1 percent, and Dawson 9.1 percent. [5] Overall, most counties in the Community (11 of 13) have an equal or higher percentage of their population living in poverty when compared to the statewide average of 13.6 percent. The percentage of people living in poverty in the Community ranges from a low of 7.4 percent in Guadalupe County to a high of 27 percent in San Augustine County.

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[2] U.S. Census Bureau, July 1, 2019.

[3] U.S. Census Bureau, September 15, 2020.

[4] Accessed February 24, 2021: https://apps.texastribune.org/features/2020/texas-unemployment/

[5] Accessed February 24, 2021: https://apps.texastribune.org/features/2020/texas-unemployment/

Research identifies that chronic conditions affect almost half of the adult population in the United States. [6] Moreover, the prevalence of some chronic conditions like, hypertension, asthma, cancer, and diabetes continue to be on the rise.[6] Older patients with multiple chronic conditions have greater health care needs that can lead to higher medical costs resulting in a significant financial burden to patients, their caregivers, and the health care system.[6] In Texas, approximately 13 percent of the population is age 65 or older. In the Community, 12 of the 13 counties exceed the state average; the percentages range from a low of 14.2 percent to a high of 27 percent of the county population identified as age 65 and older. (See References Attachment, Population Data and Heath Care Workforce Shortages, Figure 1, p. 1.) Meeting the needs of older adults with chronic conditions presents an opportunity to include as a focus area in the Transformation Plan to help older adults improve how their chronic conditions are monitored. Improved monitoring might result in positive outcomes for older adults, like improved quality of life and decreases in health care costs related to their conditions. The county and Community benefit by reducing avoidable hospitalizations and non-emergent hospital visits.

Health Care Access

The Community has a documented lack of access to primary care services and demonstrate a shortage of providers in a defined geographic area. All 13 counties comprising our Community are designated as either a primary care health professional shortage area

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[6] He, Zhe, Bien, Jiang, Carretta, Henry, et. al., Prevalence of Multiple Chronic Conditions Among Older Adults in Florida and the United States: Comparative Analysis of the OneFlorida Data Trust and National Inpatient Sample. Journal of Medical Internet Research, 2018 Apr. 20(4): e137

(HPSAs) or as a mental health care HPSAs. (See References Attachment, Population Data and Heath Care Workforce Shortages, Figure 1, p. 1.) Maverick and San Augustine Counties have the distinction of being high needs HPSA for both primary care and mental health, while remaining counties are designated as a low income or geographic HPSA. Eight of the 13 Community counties are also designed as medically underserved areas: Brown, Burnet, Guadalupe, Haskell, Maverick, Polk, San Augustine, and Wichita Counties.[7]

Population Health

Some lifestyle habits, identified as behavioral risk factors, might increase the prevalence of certain diseases like cardiovascular disease, diabetes, cancer, and chronic respiratory disease. [8] Risk factors include obesity, smoking, physical inactivity and risky alcohol consumption according to the Centers for Disease Control and Prevention (CDC).[8] The CDC reports that overweight and obesity are direct consequences of physical inactivity and an unhealthy diet and have been responsible for 2.8 million deaths annually.[8]

The Community reports the percentage of smokers is equal to or near the state average of 16 percent in all Community counties. While nearly one-third (30 percent) of Texans are obese, 10 Community counties reported adult obesity rates to be higher than the state average, with Polk County reporting an obesity rate as high as 44 percent. (See References Attachment, Population Health Data by Risk Factor and Health Care Provider Data. Figure 4, p. 3*)* Despite data showing smoking rates near average for the Community, research shows positive effects,

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[7] Accessed on February 19, 2021 at: https://data.hrsa.gov/tools/shortage-area/mua-find.
[8] Linardakis M, Papadaki A, Smpokos E, Micheli K, Vozikaki M, Philalithis A. Association of Behavioral Risk Factors for Chronic Diseases with Physical and Mental Health in European Adults Aged 50 Years or Older, 2004–2005. Prev Chronic Dis 2015;12:150134.

such as increased life expectancy, from declining smoking rates are overshadowed by the negative effects of increased obesity rates. The negative effects of increasing body mass index can overwhelm the positive impacts of declining smoking rates in multiple tested scenarios.[9] Supporting these statistics is the rate of physical inactivity among Texans. Nearly one quarter (24 percent) of Texans report being physically inactive. Additionally, 12 of 13 of the Community counties have higher physical inactivity rates than the state ranging from 24 to 35 percent. Guadalupe has a lower physical inactivity rate than the state average at 23 percent. (See References Attachment, Population Health Data by Risk Factor and Health Care Provider Data, Figure 4, p. 3) Regular physical activity can be an important lifestyle factor and is associated with lower blood pressure and reduced cardiovascular risk.[10] Hypertension is the most common reason for doctor visits by non-pregnant adults and for the use of prescription drugs.[11] In Community counties the rates of adults with a hypertension diagnosis are equal to or higher than the Texas average of 31 percent. Ten of 13 Community counties report hypertension rates among adults to be between 38 percent and 45 percent. (See References Attachment, Percent of Adults with Hypertension Diagnosis by County, 2017-2019, Figure 2, p. 2 and Population Health Data by Risk Factor and Health Care Provider Data, Figure 4, p. 3.)

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[9] Stewart, S. Ph.D., Cutler, D. Ph.D., and Rosen, A. M.D.; Sc.D;N Engl J Med. 2009 December 3; 361(23): 2252–2260. doi:10.1056/NEJMsa0900459.
[10] Hegde, S. and Solomon, D., Curr Hypertens. Influence of Physical Activity on Hypertension & Cardiac Structure & Function, Rep. 2015 October; 17(10): 77. doi:10.1007/s11906-015-0588-3.
[11] Cherry, DK, Burt, CW, Woodwell, DA. Advance data from vital and health statistics. No 337. Hyattsville, MD. National Center for Health Statistics, 2003.

Demographic Data

The Community is comprised of 13 noncontiguous counties that span across the state. As of 2019, the total population for the Community is 655,224 or slightly more than 2 percent of the state's population according to the U.S. Census Bureau. A large percentage of the persons in the Texas Community population identify as predominately White. African Americans are the second largest racial demographic in the Community. San Augustine and Angelina report 22 percent and 15 percent of their population respectively identify as African American. In all 13 counties of the Community, persons identifying as Hispanic make up between 7 and 95 percent of the population. In nine counties, 20 percent or more identify as Hispanic. Maverick identifies almost entirely Hispanic (95 percent). Dawson and Mitchell each report 58 percent and 41 percent of its population respectively as Hispanic. (See References Figure 3. Percent of Hispanic Population by County in Texas Community.)

E.1.2.2. Implementation Strategy

E.1.2.2.1. Organizational Capacity of Lead Organization

a) Description of Lead Organization

Texas Health and Human Services is comprised of two agencies: HHSC, the state Medicaid agency, and the Department of State Health Services. These agencies serve millions of people across all 254 counties each month and affect the lives of all Texans, both directly and indirectly. The client-focused HHSC delivers hundreds of programs and services. It provides for those who need help to buy necessities, eat nutritious foods, and pay for health care costs, by administering and managing programs such as Temporary Assistance for Needy Families (TANF), Supplemental Nutrition Assistance Program (SNAP); special supplemental program for

Women, Infants and Children (WIC); Medicaid; Children's Health Insurance Program (CHIP); Social Security Disability Insurance, the Social Services Block Grant (SSBG).

HHSC has 23 facilities statewide that include: 13 state supported living centers providing direct services and supports to persons with intellectual and developmental disabilities and 10 state hospitals serving persons who need inpatient psychiatric care. HHSC also provides a multitude of additional mental health and substance use services, regulation of childcare and nursing facilities, help for people with special health care needs, community supports and services for older Texans, disaster relief assistance, and resources to fight human trafficking. HHSC programs account for approximately $38 billion in fiscal year 2020, or about one-third of state spending combined. Ninety percent of funding is used for grants and client services and 3.6 percent is for state-operated, facility-based services.

In fiscal year 2020, HHS system agencies used almost 200 different sources of federal funds. Medicaid is the largest federal funding source at $21.2 billion, accounting for 76.6 percent of all federal funding. CHIP is the next largest at approximately $1.1 billion, accounting for 3.8 percent.

b) Eligibility Requirements described in A.4.3 Lead Organization and the Community (b1-b5)

(b1) As the lead organization, HHSC offers its role in the state health and human services system and as the state Medicaid agency as evidence demonstrating its presence in the Community for a period of longer than one year prior to this application. HHSC is responsible for administering the state Medicaid program that provides health care and long-term services and supports to low-income children and their families, pregnant women, former foster care youth, individuals with disabilities and people age 65 and older. HHSC provides Medicaid

services to beneficiaries within the CHART Community through two service delivery models: managed care and fee-for-service (FFS). Most individuals receiving Texas Medicaid services are enrolled in one of HHSC's Medicaid managed care programs: STAR, STAR+PLUS, STAR Kids, or STAR Health.

The DSRIP program is one of the largest and most diverse programs managed by HHSC because of its statewide reach and the diversity of the transformation initiatives implemented. DSRIP's purpose is 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. For the first six demonstration years, approximately 300 DSRIP providers implemented more than 1,450 locally driven projects to increase access to health care, improve the quality of care, and enhance the health of patients and families served. DSRIP ends September 30, 2021.

(b2) HHSC has taken several steps to improve health care access and outcomes in rural communities. First, at the direction of the Texas Legislature[12] HHSC created a strategic plan to ensure that Texans residing in rural areas have access to hospital services. Through the strategic plan, HHSC sought solutions to support Texans and rural communities to prevent the closure of additional hospitals and to help with accessing services in communities where closures had already occurred. In the most recent Rural Hospital Services Strategic Plan Progress Report, HHSC identified three key strategies to further the goal of ensuring access to hospital services and reducing rural hospital closures: (1) Ensure Medicaid reimbursements are adequate and appropriate; (2) Increase access to established revenue opportunities to maximize

[12] Senate Bill 1621, 86th Legislature, Regular Session, 2019.

reimbursement for hospitals; and (3) Identify challenges hospitals experience in providing services to persons covered by Medicare and other payers.

Over the course of several legislative sessions, Texas expanded the options for Texas providers to use telemedicine in ways that address concerns in rural areas and promote health care delivery system reform. In 2017, the Texas Legislature (House Bill 1697) created a new pediatric tele-connectivity grant program to be administered by HHSC that will provide funding to non-urban health care facilities to obtain telemedicine services from pediatric specialist physicians. The grant program provides financial assistance to eligible healthcare facilities to establish and/or support a program for providing telemedicine services, connect with pediatric specialists who provide telemedicine services, and to cover related expenses, including necessary equipment. In 2019, the Texas Legislature enacted H.B. 1063 that required HHSC to provide reimbursement for home telemonitoring services to children who are diagnosed with end-stage solid organ disease, have received an organ transplant, or require mechanical ventilation. HHSC amended its medical policies to implement the benefit effective October 1, 2020. Senate Bill 670 also enacted in 2019 prohibits MCOs from denying reimbursement for covered health services solely because they were delivered remotely as telemedicine or telehealth services.

In 2020, HHSC worked with the Texas Organization of Rural & Community Hospitals (TORCH), the Texas Association of Rural Health Clinics, the e-Health Advisory Committee, and staff from the Institute of Child Health Policy to develop a survey to assess the participation of Texas rural hospitals and rural health clinics (RHCs) in telemedicine and telehealth services prior to COVID-19 and during COVID-19, as well as barriers to their participation in these services.

The survey was disseminated to rural hospitals and RHCs in September 2020. HHSC is using the results of the survey to assess the current capacity and use of telemedicine and telehealth services, particularly in rural areas of Texas, to determine next steps to address access gaps.

(b3) In 2011, the Texas Legislature enacted legislation that required HHSC to develop quality-based outcome and process measures that promote the provision of efficient, quality health care and that can be used in the child health plan program and Medicaid to implement quality-based payments for acute care services and long-term services and supports across all delivery models and payment systems, including fee-for-service and managed care payment systems.[13] In developing quality-based payment systems, HHSC was required to examine and consider implementing APMs. Since the legislation was enacted, HHSC is shifting from paying for volume (e.g. fee-for-service) to paying for value of health care services (e.g. value-based purchasing). This transformation aims to achieve better care for individuals, better health for populations, and lower cost for the state. HHSC has undertaken multiple efforts to transition to value-based purchasing (VBP), including the implementation of APMs. HHSC involved multiple stakeholders in the design and implementation of APMs by providing updates at the Value-based Purchasing & Quality Improvement Advisory Committee, surveys of MCOs and DSRIP performing providers, and meetings with professional associations throughout the state. HHSC conducted surveys with providers and MCOs to learn more about their views regarding the VBP reform efforts and shift to APMs.

In March 2020, HHSC surveyed Medicaid MCOs for feedback on APMs. MCOs were asked what barriers exist to expanding or enhancing the quality-based APMs. MCOs (9 of 15)

[13] Senate Bill 7, 82nd Legislature, 1st Called Session, 2011.

responded that the administrative burden of designing, establishing, and reporting on an APM was a barrier. Providers also indicated complexities with collecting and reporting data for a multitude of performance measures is a barrier to new or continued participation in VBP arrangements. In HHSC's March 2020 survey, 86.7 percent of MCOs indicated a barrier to expanding or enhancing quality-based APMs was, *"Patient churn in Medicaid or patient's ability to change providers limits MCO's ability to measure outcomes attributable to providers."* Strategies that minimize enrollment changes while maintaining patients' freedom of choice could enhance the effectiveness of incentives for VBP by better rewarding success.

(b4) In fiscal year 2020, HHS system agencies used almost 200 different sources of federal funds. Medicaid is the largest federal funding source at $21.2 billion, accounting for 76.6 percent of all federal funding at HHSC. CHIP is the next largest at approximately $1.1 billion, accounting for 3.8 percent. HHSC receives additional health-related grants including the Block Grants for Community Mental Health, Substance Abuse Prevention and Treatment Block Grants, the Comprehensive Cancer Control Program and the Maternal Opioid Misuse (MOM) Model.

(b5) In 2020, HHSC received funding from CMS for the MOM Model Cooperative Agreement. The project period is January 1, 2020, to December 31, 2024. To date, HHSC has received $1,591,589 in funding with total potential funding capped at $5,000,000. HHSC's Care Delivery Partner for this project is Harris County Hospital District dba Harris Health System. Harris Health is the first accredited health care institution in Harris County to be designated by the National Committee for Quality Assurance as a Patient-Centered Medical Home and is one of the largest systems in the country to achieve the quality standard. Harris Health is a teaching

system for Baylor College of Medicine and the University of Texas Health Science Center at Houston. After full implementation of the MOM Model, HHSC plans to develop APMs with MCOs in Harris County to support this integrated multidisciplinary care model.

HHSC has hundreds of programs and services that are administered through contracts with providers and other vendors. All providers participating in state health care programs must first enroll in Texas Medicaid and maintain a written agreement with HHSC. The Texas Medicaid & Healthcare Partnership (TMHP) is responsible for enrolling most providers in the Texas Medicaid program and other state health care programs. Additionally, HHSC contracts with MCOs to provide all covered, medically necessary Medicaid and CHIP services to individuals receiving services through managed care. The Uniform Managed Care Contract establishes the baseline requirements for all MCOs. Additional contract terms are developed specific to the program.

HHSC hosts quarterly quality forums with several Texas hospital associations including Texas Hospital Association, Texas Medical Association, Texas Organization of Rural and Community Hospitals, the Children's Hospital Association of Texas, and Teaching Hospitals of Texas. HHSC also has a Social Determinants of Health Learning Collaborative with the Texas Association of Health Plans and Episcopal Health Foundation.

c) Community Engagement

HHSC has several community engagement efforts to ensure Texans receive the benefits for which they qualify. The Community Partners Program connects HHSC with community organizations to help Texans manage their benefits, including food, cash and medical assistance using the *YourTexasBenefits* website. Community Support Specialists throughout the state link

government resources to families, medical and dental providers, hospitals, faith- and community-based organizations, schools and others to promote improvements to the health care system.

HHSC's Aging Texas Well initiative brings together local organizations and community partners to share resources and information, create and promote wellness programs, and identify opportunities for residents to age and live well. Collaboratives are comprised of public, private and nonprofit organizations for the quality and well-being of older residents. The Aging Texas Well Advisory Committee makes recommendations to HHSC on implementation of the Aging Texas Well Initiative.

HHSC also undertakes efforts to address disparities in minority populations. In FY 2020, HHSC led efforts in coordination with its community partners to improve the timeliness of prenatal care and the rate of postpartum care for minorities. On behalf of HHS, the Office of Border Public Health at DSHS addresses critical issues affecting the Texas border population through coordination with local and regional partners, including the Task Force of Border Health Officials. This task force is an advisory body and addresses border public health issues affecting Texans living in the Texas-Mexico border region and informs DSHS of major public health priorities on the border.

HHSC implemented a pilot program, Texas Works Path to Success (TWPS), in the Houston area that offers job training and career opportunities to low-income adults and high school seniors at selected schools. The program is a partnership between Texas Health and Human Services, Houston Independent School District, Goodwill Houston and the U.S. Department of Agriculture-Food and Nutrition Service. TWPS aims to increase economic self-

reliance, housing stability, educational advancement and quality of life by providing participants with training to learn valuable and practical job skills.

HHSC also leverages its advisory committees to collaborate with and seek input from its community partners. HHSC oversees more than 20 advisory committees that allow stakeholders and members of the public to provide input and recommendations to the agency on rules, policies and programs. A full list of the advisory committees is available on HHSC's website: https://hhs.texas.gov/about-hhs/leadership/advisory-committees.

d) Health Care Delivery System Redesign Experience

HHSC is charting a fundamental change in course away from paying for volume to paying for the value of healthcare services in Texas Medicaid and CHIP. This transformation aims to achieve better care for individuals, better health for populations and lower cost for the state. The primary vehicle for this transition in Texas has been through managed care. Over time, Texas has transitioned most of its Medicaid population from fee-for-service to managed care. As of November 2020, 94 percent of Texas Medicaid and 100 percent of CHIP beneficiaries are now enrolled with a MCO. HHSC contracts with 17 medical MCOs and three Dental Maintenance Organizations (DMO) that provide healthcare services to clients through their provider networks. MCOs and DMOs have flexibility and incentives to use value-based payments to encourage providers to engage in evidence-based practices, collaborate with peers and connect people to needed services.

To track and facilitate health care payment transformation in Medicaid, HHSC developed a comprehensive approach to quality-based (or value-based) payment initiatives and the quality measures adopted to evaluate these initiatives through the Medicaid Managed Care

Quality and Program Improvement. The initiatives are developed across the entire spectrum of the Texas Medicaid program and CHIP and are grouped in the following main domains: managed care value-based payment programs, 1115 Healthcare Transformation Waiver, directed payment programs, and key quality measures.

HHSC has implemented contract requirements for MCOs to achieve minimum levels of APM agreements with their providers. HHSC uses the Healthcare Payment Learning and Action Network (HCP LAN) Alternative Payment Model (APM) Framework to help guide this effort. This framework provides a menu of payment models from which MCOs and DMOs can choose to develop APM contracts with their providers including overall and risk-based APM targets. HHSC collects the MCO and DMO reports about their APMs annually.

In 2018, MCOs reported that 40 percent of their payments to providers were in an APM and approximately 22 percent in a risk-based APM. Collectively the Texas Medicaid and CHIP programs performed at or above contractually-required thresholds and national goals in 2018, though performance varied by program.

Pay-for-Quality (P4Q) is a statewide program and requires all Texas Medicaid MCOs and DMOs participate. It uses financial risks and rewards, coupled with performance measures, to promote performance improvement. For the medical P4Q program, up to three percent of each MCO's capitation is at-risk of recoupment if MCOs do not meet target performance thresholds. Performance is measured against benchmarks (performance within the year relative to state and national norms or established standards) and against self (year-to-year improvement over MCO's performance). In the dental P4Q program, 1.5 percent of each DMO's total calendar year capitation is at-risk of recoupment. Each DMO's performance on selected measures is

compared to performance from the prior two years. DMOs that decline in performance overall could lose some of their at-risk capitation payments.

HHSC is also actively working to sustain a Texas Medicaid program that continues to advance value-based care and other effective delivery system reforms as funding for the DSRIP program ends this year. Under the Medicaid 1115 Transformation Waiver, DSRIP funded locally developed, innovative and value-based solutions for uninsured and Medicaid populations. During the first six years of the waiver, DSRIP providers reported on process and outcome measures for specific projects that were selected based on regional assessments of community needs performed by each Regional Healthcare Partnerships. Beginning in Demonstration Year 7 (federal fiscal year 2018), DSRIP providers began reporting on achievement of health outcomes at their system level to measure the continued transformation of the Texas healthcare system.

The continued shift to value-based care requires collaboration between HHSC, MCOs, providers and other stakeholders. HHSC's Value-Based Payment and Quality Improvement Advisory Committee (VBPQIAC) plays an important role in supporting collaboration with all stakeholders in the system and advancing value-based care. It provides a forum to promote public-private, multi-stakeholder collaboration in support of quality improvement and value-based payment initiatives for Medicaid, other publicly funded health services and the wider health care system. VBPQIAC studies and makes recommendations regarding: (1) value-based payment and quality improvement initiatives to promote better care, better outcomes and lower costs for publicly funded health care services; (2) core metrics and a data analytics framework to support value-based purchasing and quality improvement in Medicaid/CHIP;

(3) HHSC and managed care organization incentive and disincentive programs based on value; and (4) the strategic direction for Medicaid/CHIP value-based programs.

To complement its collaboration and communication efforts, HHSC provides information about VBP initiatives on its website, including payment arrangements between MCOs and their providers through its Texas Healthcare Learning Collaborative (THLC) portal. HHSC is exploring additional ways to leverage its THLC portal to support APMs that improve outcomes and efficiency. In November 2019, HHSC finalized and submitted to CMS a Health Information Technology Strategic Plan that identifies strategies to promote greater sharing of electronic health records and other data among providers, MCOs, DMOs and HHSC.

The Texas Legislature continues to recognize the importance of advancing value and transparency in the Medicaid program and directs HHSC through legislation in support of these goals. House Bill 1, 86th Texas Legislature, Regular Session, 2019 (Article II, HHSC, Rider 43) required HHSC to implement an incentive program that automatically enrolls a greater percentage of Medicaid recipients who have not selected an MCO into a plan based on quality of care, efficiency and effectiveness of service provision and performance. HHSC implemented a Value-Based Enrollment for MCO enrollments effective December 1st, 2020. House Bill 4533, 86th Texas Legislature, Regular Session, 2019, required HHSC to make available via its website in an easy-to-read format data about the health care quality and health outcomes of Medicaid beneficiaries. HHSC added P4Q results and member survey data to the THLC portal to support quality improvement and VBP programs. Other legislation enacted by the 86th Texas Legislature requires HHSC to develop initiatives for MCOs to improve the quality of maternal health care (Senate Bill 750), evaluate risk-adjustment methods for the Hospital Quality-based Program in

STAR Kids (Senate Bill 1207) and enhance quality monitoring for the Medically Dependent Children Program (Senate Bill 1207). HHSC has implemented these initiatives.

The Texas Medicaid program started transitioning to a value-based model more than 20 years ago. Texas has gradually moved health care delivered through the traditional Medicaid fee-for-service system to a managed care system. HHSC operates the Uniform Hospital Rate Increase Program (UHRIP) to support and further its transition to a value-based care. UHRIP is a directed payment program that provides increased Medicaid payment for inpatient and outpatient hospital services. CMS approved UHRIP in December 2017 as a pilot program and it was later implemented statewide in state fiscal year 2019. UHRIP is authorized under 42 CFR 438.6(c) which permits states to operate directed payment programs to advance at least one goal or objective included in the state's managed care quality strategy. States are also required to evaluate the degree to which the directed payment program advances the quality goal(s) or objective(s). For state fiscal years 2018 through 2020, HHSC identified "Hospital quality performance measurement" and "Improve member satisfaction with care" as the quality strategy goals that UHRIP is expected to advance. HHSC anticipates that increased hospital payment rates act as an incentive to encourage hospitals to continue participation in the Medicaid program while strengthening their ability to provide inpatient and outpatient services to Medicaid beneficiaries. The UHRIP payment arrangement expects to advance the goals of measuring and reducing hospital preventable events and improving beneficiary satisfaction with care.

Health Care Delivery System Redesign Outcomes

HHSC routinely monitors and reports on key indicators of health care quality and efficiency. For most indicators, results are reported by Medicaid managed care program (e.g. STAR, STAR+PLUS), hospital, MCO, service area and statewide. Quality measures tracked by HHSC reflect industry standards from reliable sources such as the Healthcare Effectiveness Data and Information Set and the Agency for Healthcare Research and Quality (AHRQ). Progress on the frequency and relative costs of potentially preventable inpatient complications, potentially preventable hospital admissions, potentially preventable emergency room visits, and potentially preventable hospital readmissions is also documented yearly by HHSC.

HHSC is required to publish on its website an easy-to-read format with data about health care quality and health outcomes of Medicaid beneficiaries. The THLC portal serves as a public reporting platform that enables users to compare performance across programs, MCOs, DMOs and service areas on process and outcome measures. HHSC recently added P4Q results and member survey data to the THLC portal and continues to explore additional ways to leverage the THLC portal to support quality improvement and VBP programs.

HHSC recently conducted an evaluation of the impact of implementing UHRIP to advance Texas's quality strategy. The evaluation period included two years pre-UHRIP implementation and two years post-UHRIP implementation. HHSC developed four hypotheses to evaluate the impact of UHRIP on the intended quality outcomes: (1) UHRIP will support beneficiaries' satisfaction with their care. (2) UHRIP will keep patients free from harm. (3) UHRIP will provide the right care in the right place at the right time. (4) UHRIP will support an adequate MCO provider network to ensure beneficiaries' access to care. The evaluation

primarily relied on measures used by Texas's External Quality Review Organization to evaluate performance in Texas Medicaid. These include measures from the AHRQ's Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey and measures of potentially preventable events.

For hypothesis 1, the evaluation relied on CAHPS composite scores for adult and child STAR and STAR+PLUS beneficiaries. Statewide surveys showed the percentage of adult and child beneficiaries who reported they can get needed care remained above national benchmarks after UHRIP implementation. For hypothesis 2 and 3, the evaluation included two measures of potentially preventable events: potentially preventable complications (PPCs) and potentially preventable admissions (PPAs). Trends in potentially preventable events were generally positive during the UHRIP evaluation period. Medicaid STAR beneficiaries generally experienced similar rates in PPCs before and after UHRIP implementation. However, PPC rates improved (decreased) for Medicaid STAR+PLUS beneficiaries after UHRIP implementation suggesting UHRIP might play a supportive role in keeping patients free from harm. The rate of PPAs during UHRIP implementation was consistent with the rate prior to UHRIP implementation for both STAR and STAR+PLUS beneficiaries. This suggests UHRIP supports provision of the right care in the right place at the right time. For hypothesis 4, the evaluation relied on MCO network adequacy results among STAR and STAR+PLUS beneficiaries during the two years post-UHRIP implementation. MCO hospital network adequacy remained above compliance thresholds during UHRIP implementation. Although the evaluation did not have access to estimates of hospital network adequacy prior to UHRIP implementation, this finding suggests that UHRIP helps to support adequate access to MCO hospital networks.

e) Not applicable because HHSC is the state Medicaid agency and is applying as the lead organization.

f) Staff Capacity

HHSC's organizational structure is comprised of six chief officers reporting to the executive commissioner: chief operating officer, chief financial officer (CFO), chief counsel, chief program and services officer, chief public affairs officer, and chief policy and regulatory officer. See Attachment A, HHSC Organizational Chart, p. 18.

If awarded, the CHART Model project will be managed in the Fiscal Program Coordination (FPC) department in the CFO division. Currently, the FPC is a three-person department that concentrates on high-level policy issues regarding supplemental and directed Medicaid payments, non-federal share of these payments, and special projects and initiatives. FPC provides CFO leadership a global perspective of how Medicaid supplemental and directed payments contribute to improving health outcomes ensuring access to care by giving providers incentives to continue and expand care for persons with Medicaid and the uninsured. It is the only department that coordinates multiple lines of analyses about the financing of Medicaid supplemental and directed payments and synthesizes them into a cohesive set of options and improvement initiatives. FPC monitors and provides recommendations to executive leadership about Medicaid payment policy; budget neutrality; monitoring of non-federal share; 1115 waiver; and negotiating with CMS. See Attachment A, HHSC CHART Key Staff Resumes and Job Descriptions, pp. 2 to 17.

- Trey Wood, CFO, will have authority to direct the CHART project.

- April Ferrino, Director of Fiscal Program Coordination (FPC), will have managing authority to direct day-to-day tasks associated with implementation of the CHART Model and operations throughout the project period. She will serve as project director and primary liaison with CMS for HHSC. Ferrino has 20 years of public service employment in state government including managing a variety of complex health and human services projects. FPC will provide project management to ensure timely execution of project tasks.
- 2 Program specialists (currently vacant positions) will coordinate all implementation activities at HHSC for the entire duration of the CHART model (during the pre-implementation period and the performance periods years 1 through 6), meetings with CMS to finalize performance milestones and evaluation plan, meetings with the Advisory Council, and data systems to capture and report data.

g) Advisory Council Collaboration

HHSC will ensure effective communication occurs so that effective collaboration results. HHSC already uses its web site and topic-specific subscription service to communicate with stakeholders about the CHART Model. This method and strategy was extremely effective in soliciting and notifying stakeholders about the CHART Model funding opportunity. A specific CHART Model project email box that is monitored daily by multiple staff remains an excellent method for stakeholders to direct questions to HHSC about its application and other CHART Model developments. HHSC will continue to use these methods to communicate to participant hospitals, advisory council members, and other community groups regarding the execution of this project.

HHSC plans to use a committee system with advisory council so members can work in smaller groups on specific topics outside of the larger council meetings and ensure meetings are an efficient use of time. Additionally, a committee system helps establish member buy-in and ensures responsibility is shared among members. Sub-committees could be responsible for identifying agenda topics, speakers, goals, training, payment methodologies, quality measures, and other aspects related to development of the transformation plan and implementation of the CHART Model project. Participant hospitals and aligned payers not on the council could use their council representatives to raise subjects or questions. Sub-committee chairs could serve as liaisons with HHSC staff regarding the council's needs and to ensure questions and requests are addressed timely. Establishing this structure helps to ensure project coordination is occurring between HHSC staff and its Community partners.

h) Role of Subrecipients or Contractors

HHSC anticipates using a percentage of the cooperative award funding to contract with an organization to fulfill some of the CHART Model's requirements. The contractor may provide technical assistance to the advisory council and hospitals when drafting the transformation plan, as well as to help hospitals identify a telemedicine model for their telemedicine project so that it will address one or more of the Community health challenges. Specifically, HHSC is initially proposing to have a contractor to: (1) support the development of the transformation plan and prepare participant hospitals to enter capitated payment arrangements with CMS (2) help hospitals contribute updates to the transformation plan annually and implement it; (3) provide strategic and operational technical assistance (e.g., to support participant hospitals, support the advisory council, or perform research to identify emerging needs within the

Community); (4) track Medicaid participation targets, as discussed in section A.4.5.3.2. Medicaid Alignment of the Notice of Funding Opportunity (NOFO); (5) oversee aligned payers compliance with the requirements outlined in section A.4.5.3. Multi-payer Alignment of the NOFO; (6) collaborate and create quarterly progress reports and annual performance progress reports for HHSC; (7) collaborate with the HHSC to submit progress updates on executing CHART financial alignment; and (8) assist participants to respond to the evaluator's data related and other requests.

E.1.2.2.2. Advisory Council

Member	Job Title	Organization	Member Category	Responsibilities*	Estimated Time Commitment
April Ferrino	Dir., Fiscal Program Coord.	HHSC	Lead Organization	A, B, C, D, E	20 hrs./MTH
Gary Young	Senior Advisor	HHSC	Lead Organization	A, B, C, D, E	5 hrs./MTH
Trina Ita	Assoc. Comm. for Behavioral Health Services	HHSC	Lead Organization	A, C, D, E	5 hrs./MTH
Fabian Borrego	Regional CFO – South Texas	Fort Duncan Regional Hospital	Participant Hospital	A, B, C, D, E	10 hrs./MTH
Rebecca McCain	Chief Executive Officer	Electra Hospital	Participant Hospital	A, B, C, D, E	5 hrs./MTH
Lydia Long	Performance Improvement Mgr.	Ascension Texas	Additional Participant Hospital	A, B, C, D, E	As needed for quarterly meetings/prep
Bernita G. Chance	DSRIP Program Coordinator; RN	CHI St. Luke's Health	Additional Participant Hospital	A, B, C, D, E	16-20 hrs. / MTH
J. Michelle Stevens	Chief Operating Officer	Haskell Co. Hospital District	Additional Participant Hospital	A, B, C, D, E	8 hrs./MTH

Member	Job Title	Organization	Member Category	Responsibilities*	Estimated Time Commitment
Michael Diel	Senior Vice President of Network Development & Contracting	Superior Health Plan	Aligned payer	A, B, C, D, E	8 hrs./MTH
Daverick Isaac	Chief Finance Officer	Community First Health Plans	Additional Aligned payer	A, B, C, D, E	4 hrs./Qtr.
J.M. Henderson MD	Retired Physician	Self	Medicare Beneficiary and Primary Care Doctor	D, E	8 hrs./MTH
Shenita Guillory	VISN 17/Telehealth & Rural Access Mgr.	U.S. Dept. of Veteran Affairs	U.S. Dept. of Veteran Affairs	A, D, E	5 hrs./MTH
Robert Shaw	Flex Coordinator	State Office of Rural Health	State Office of Rural Health	A, C, D, E	15 hrs./MTH
John Henderson	Chief Executive Officer	Texas Organization for Rural & Community Hospitals (TORCH)	Community Stakeholder Group	A, B, C, D, E	8 hrs./MTH
Jessica Whitesides	Administrator	Mitchell County Nursing & Rehabilitation Center	LTC or Home Health	A, B, C, D, E	5 hrs./MTH

*Key for Roles and Responsibilities:

A – contribute feedback for transformation plan

B - contribute feedback for capitation arrangements

C – contribute to data sharing and outcomes

D - collaborate and monitor progress

E – contribute feedback about community needs/impact

b) Advisory Council Objectives for Pre-Implementation Period

Securing hospital participation from those that submitted letters of intent (LOIs) is the first goal of the pre-implementation period. Much of the Council's work during the pre-implementation period will be dependent on CMS' timeline for providing potential hospitals their capitated payment amount. HHSC's objectives for the Advisory Council during the pre-implementation period include: (1) identify technical assistance needs of participating hospitals related to their telemedicine projects and Community health challenges; (2) identify potential outpatient services to implement an outpatient prospective payment system (OPPS) model, using a bundled payment arrangement like enhanced ambulatory patient groups (EAPG); (3) identify three or more measures for the transformation plan; (4) recruit a university health science center to join the council so hospitals can cultivate relationships to address Community health challenges in future performance periods; (5) secure needed technical assistance contractor for the hospitals; and (6) develop transformation plan and identify a timeline and method for updating.

HHSC plans to use a committee system to ensure council member participation. See also Advisory Council Collaboration. A sub-committee could be responsible for identifying aspects of the transformation plan that should be reviewed for updating as the project progresses. A sub-committee chair could serve as liaison with HHSC staff to ensure the plan's changes are addressed timely.

c) Documentation of Advisory Council (See Attachment A, pp. 27 to 44; Advisory Council letters of intent.)

E.1.2.2.3. Health Care Delivery System Redesign Concept

(1) Health Care Delivery System Redesign Concept Summary

Texas is a geographically vast state with more than 150 rural hospitals and more than 300 rural health clinics. The geographic boundaries of the Community are 13 noncontiguous rural counties and census tracts spread across the state. Within this boundary are 14 potential participating hospitals. (See also References Attachment, Texas CHART Model Community Counties, Figure 6, p. 6.) HHSC's proposed health care delivery system redesign concept is to bring improved financial stability to participant hospitals through capitated arrangements and provide opportunities to address Community health challenges through telemedicine.

Throughout the duration of the CHART Model, participant hospitals will use the CHART Medicare capitated payment amount, as envisioned -- acting as a stable revenue stream for the hospital. To support the Community's Transformation Plan, HHSC is proposing that a significant portion of the cooperative funding be used in the following ways: (1) to provide technical assistance related to transformation, (2) to allow hospitals to purchase telemedicine equipment, training, software, and (3) to hire additional staff, if needed, to implement their plans. HHSC envisions each participant hospital will design or replicate a proven telemedicine model that will help them address one or more of the Community health challenges. Although, Texas is a geographically large state, and the distance between the counties in the Community may limit the coordination efforts between hospitals; it does not prevent transformation from occurring at the hospitals and their immediate surrounding communities.

HHSC envisions a framework from which participating hospitals can customize their role in the transformation plan by selecting one or more of the Community health challenges to address through a telemedicine project(s) that fits the needs of their county. Participant hospitals will have an opportunity to review telemedicine models the CHART Model Interagency and stakeholder workgroup researched and identified. These telemedicine models implemented in other rural areas have demonstrated success with health challenges like the Community's health challenges. Participant hospitals will not be required to use these models. (See References Attachment, Rural Telemedicine Models Matrix, Figure 7, p. 11 for a summary identifying the telemedicine models and the Community health challenges for which they could be used.) Using the cooperative agreement funding award for telemedicine produces two benefits: (1) hospitals can use the funding to purchase new or additional telemedicine equipment to address a Community health challenge; and (2) hospitals can create new services to generate new or expanded revenue streams leading to improved financial stability for the facility.

The sheer size of Texas and the total number of rural communities, hospitals, and clinics make it challenging to transition abruptly to new payment models. Consequently, HHSC views the CHART Model as an incremental step towards APMs and global budgeting. To help hospitals transform larger percentages of their Medicaid revenue to a capitated arrangement, HHSC is proposing a staged implementation. Because Texas' Medicaid program has established a prospective payment system for inpatient services by using the All Patient Refined Diagnosis Related Groups, HHSC is proposing to a value-based payment arrangement using an outpatient prospective payment system (OPPS), like an Enhanced Ambulatory Patient Groups (EAPG).

EAPG is a patient classification system designed to explain the amount and type of resources used during a hospital ambulatory visit. Patients in each EAPG have similar clinical characteristics, resource use and cost. Under the EAPG classification system, reimbursement for outpatient hospital services is based on the quantity and type of services provided. The aim of this system is to ensure that both low- and high-cost services are reimbursed appropriately. Implementing an OPPS allows payers and providers to share financial risk, which gives both an incentive to manage the overall cost of care. This strategy allows HHSC to continue to promote ways to increase efficiencies under this cost contained reimbursement method that could be gradually expanded each performance period based on hospital and community input to meet Medicaid participation targets and address community health goals. It also aligns with HHSC's current payment methodology for inpatient services with the All Patient Refined Diagnosis Related Groups.

The advisory council may provide input about the selection of outpatient services each performance period. Eventually, as providers learn and gain comfort with a prospective payment model, we envision exploring the opportunity to move to a full capitated model that is not service or diagnosis specific.

As mentioned in HHSC's CHART Model Medicaid Needs Assessment Questionnaire, HHSC would submit a state plan amendment to implement an OPPS. Initially, we anticipate only certain outpatient services would be reimbursed using a prospective payment, but the services could be expanded based on hospital and community input. HHSC anticipates that implementing the EAPG patient classification system for outpatient episodes will satisfy the Medicaid target participation requirement of the CHART Model. However, as a contingency

plan that it does not, HHSC plans to implement bundled payment arrangements, like the Medicare Bundled Payments for Care Improvement Advanced (BPMI) Model, for certain clinical episodes. The BPMI Advanced model aims to support health care providers who invest in practice innovation and care redesign to better coordinate care and reduce expenditures, while improving the quality of care for Medicare beneficiaries. Replicating it for Medicaid beneficiaries with chronic conditions who might benefit from better care coordination could contribute to addressing the Community health challenges. Should additional bundled payment arrangements need to be implemented, HHSC would conduct internal analysis and receive input from the Advisory Council to determine what clinical episodes and care could be bundled to ensure there was not a conflict with the EAPG classification system.

The advisory council will play a key role in advising hospitals and helping with the development of the transformation plan. Gathering relevant parties as members of the council provides a unique opportunity for payers, providers, and HHSC to meet regularly to discuss the transformation of rural health care services in the Community. HHSC's collaboration with its community partners will be important when developing and implementing capitated payment arrangements throughout the performance periods. Specifically, the Council will provide input into discussions about APMs, including capitated arrangements identified in this application, as well as suggest other alternative payment arrangements that would benefit the Community. HHSC envisions that council members could provide detailed input about how to transition to an OPPS. The council will help identify: strategies or resources related to telemedicine models, changes hospitals might need to make when rolling out new services, strategies for working with patients and caregivers with telemedicine/telehealth equipment, sustainability ideas for

new and/or expanded services, ways to increase access to primary and specialty care, regional collaboration and ways to cultivate partnerships with university health science systems , quality improvement, and sharing of best practices.

Additionally, HHSC proposes recruiting at least one member from a Texas university health science center to contribute to discussions about primary and specialty care expansion and partner with participant hospitals in telemedicine services to potentially provide access to remote site specialists, as needed. Because Texas has several university systems with whom participant hospitals could collaborate, one or more would be invited to join the advisory council once formal partnerships are finalized.

The advisory council will provide important input to HHSC, as the state Medicaid agency, and its Medicaid MCOs about the expansion and integration of telemedicine services into rural practice environments. This experience will help inform and complement existing work by HHSC's State Medicaid Managed Care Advisory Committee and e-Health Advisory Committee to provide Medicaid coverage recommendations for telemedicine services. In a September 2020 survey, HHSC, as part of its DSRIP transition activities, asked rural hospitals and rural health clinics statewide to assess current capacity and barriers to use telemedicine considering the COVID-19 pandemic. Of the hospitals that responded and reside in the Community and that are in counties that applied for CHART Model funding, all 16[14] identified that it would be "significantly helpful" to have a more comprehensive reimbursement structure for telemedicine and telehealth services and clearer reimbursement policies from payers. Bringing aligned

[14] Of the 16 hospitals, not all applied to participate in the CHART Model.

payers, participant hospitals, and HHSC to the table as members of the advisory council puts the council in an opportune position to ensure this issue is addressed.

HHSC plans to use additional partnerships with a state agency and a statewide community organization to support hospitals' implementation of the CHART Model. Upon notification of a CHART Model award, partnerships with the State Office of Rural Health (SORH) and the Texas Organization of Rural and Community Hospitals (TORCH) would be formalized with a Memorandum of Understanding to delineate their roles and responsibilities. Each organization would serve as an *unpaid* resource advisor and both are members of the advisory council. SORH is within the Office of Rural Affairs under the Texas Department of Agriculture and serves as the federally designated state contact for rural health care needs. HHSC envisions SORH will help participant hospitals by providing them technical assistance by leveraging its state and federal resources when appropriate. For example, SORH facilitates a network of experts whose goal is to assist rural hospitals in achieving financial and operational excellence while delivering high quality health care. Their expertise may be tapped to assist participant hospitals address challenges related to health care delivery transformation. Additionally, SORH has pioneered an initiative to assist critical access hospitals (CAH) with quality reporting for the Medicare Beneficiary Quality Improvement Project and have successfully achieved significant improvement for 75 percent of the state's CAHs now meet the reporting compliance measure.

Like SORH, TORCH will also serve as an *unpaid* resource advisor. TORCH was formed as a 501(c)6 trade association in 1990 and has been representing and advocating for rural Texas hospitals for more than 30 years. TORCH has experience with developing specialized programs, education, activities and services for rural hospitals and the relationships to connect HHSC to

rural hospitals and community leaders. TORCH can convene and engage stakeholder groups in meaningful ways and work to share education, benchmarks, financial analysis, best practices in financial assessment and forecasting, operational, telemedicine deployment, and quality initiatives. TORCH has relevant experience regarding the regulatory/ technical environment rural Texas communities face and can convene a venue to share information and coordinate site visits to facilitate cross pollination learning among participant hospitals.

(2) Participant Hospital Interest

Collaborating for the CHART Model application began by HHSC and its community partners convening a CHART Model interagency and stakeholder workgroup. Interest in the CHART Model was evident statewide by the number of rural hospitals expressing interest by submitting a letter of intent to support of HHSC's application. HHSC did not have to conduct large-scale promotions or additional communication strategies to find interested participants. More than 30 hospitals expressed initial interest in the CHART Model funding opportunity; however, fewer submitted LOIs because COVID-19 infection rates were surging in Texas during December 2020 and January 2021. Seventeen hospitals submitted completed letters of intent by our deadline and only 14 were determined to be eligible participants. *Figure A* shows additional required information of each potential participant hospital. Hospital Participant LOIs can be found in Attachment A, pp. 45 to 69. Each LOI identifies the hospital type; its annual fee-for-service Medicare revenue for the past 5 years; the number of fee-for-service Medicare beneficiaries served by each hospital in the Community in each of the past five years; whether the physical location is within the Community, and an attestation to perform the required activities.

Figure A: Texas Potential Participant Hospitals by Type and Annual Fee-for-service Revenue

Hospital	Hospital Type	Estimated Annual FFS Medicare Revenue FFY 20	County
Cuero Regional Hospital	Acute Care Hospital	$28,946,486	DeWitt
Electra Memorial Hospital	Critical Access Hospital	$8,800,000	Wichita
Graham Regional Medical Center	Acute Care Hospital	$5,200,000	Young
Medical Arts Hospital	Acute Care Hospital	$5,038,192	Dawson
Mitchell County Hospital District	Critical Access Hospital	$5,318,137	Mitchell
Olney Hamilton Hospital	Critical Access Hospital	$13,699,488	Young
CHI St. Luke's Health Memorial Lufkin	Acute Care Hospital	$36,158,288	Angelina
Hendrick Medical Center Brownwood	Acute Care Hospital	$16,996,464	Brown
Haskell Memorial Hospital	Critical Access Hospital	$2,500,000	Haskell
Fort Duncan Regional Medical Ctr.	Acute Care Hospital	$19,884,717	Maverick
Ascension Seton Highland Lakes	Critical Access Hospital	$11,220,446	Burnet
CHI St. Luke's Health Memorial Livingston Hospital	Acute Care Hospital	$8,808,557	Polk
CHI St. Luke's Health Memorial San Augustine Hospital	Critical Access Hospital	$1,984,933	San Augustine
Guadalupe Regional Medical Center	Acute Care Hospital	$27,295,998	Guadalupe

Source: Health and Human Services Commission and Potential Participant Hospitals

(3) Pre-implementation Recruitment Strategy

To begin work on the CHART Model application, HHSC convened an interagency and stakeholder workgroup in October 2020. The workgroup met weekly to discuss the CHART Model application, recruitment and communication efforts, and craft an approach for the health care delivery redesign concept. During the pre-implementation period, if needed, HHSC

would use a similar strategy as the one used for the initial recruitment of participating hospitals. Specific recruitment steps HHSC would take include reconvening the CHART Model interagency and stakeholder workgroup to identify specific characteristics (e.g. geographic location, population size) in rural hospitals for the Community. Second, HHSC would update the its web site with information regarding the award notification. Third, HHSC would send out a subscriber-based emails about the CHART Model award and recruitment efforts. This strategy could be adjusted to narrow or widen the reach of interested stakeholders.

HHSC would use our most effective recruitment tools—hospitals that have already agreed to participate in the CHART Model and members of our advisory committees. Peer-to-peer recruitment is the most effective method because colleagues and industry leaders are more trusted, convincing, and authentic to give an honest assessment about the initiative and the reasons for their participation. Additionally, because the rural community can be small and tight-knit, already established relationships are more credible and trusted.

(4) Operational Flexibilities

The operational flexibilities offered in the CHART Model will be helpful to HHSC's effort to redesign the rural health care delivery system and effectively manage hospital capacity issues. Following consultation with participant hospitals, HHSC is considering requesting at least two model design flexibilities: (1) the use in collaborative funding and (2) to include or exclude outliers in the capitated payment amount. As previously mentioned in E.1.2.2.3. Health Care Delivery System Redesign Concept, HHSC is proposing to pass most of the cooperative agreement funding directly to participating hospitals for system redesign efforts at the hospital level. HHSC is proposing to allow hospitals to purchase telemedicine equipment, training,

software and to hire additional staff, if needed. Stakeholder feedback identified that there is enormous potential in telemedicine and it would be a significant innovation for isolated, rural communities. Rural hospitals are ready to use technology to address chronic conditions, reduce avoidable hospital readmissions, and begin wellness initiatives. An indirect effect from the funding may also help hospitals to improve quality improvement activities, benchmark performance, and forecast financial performance.

Adjusting for outliers would give participant hospitals an added comfort with the proposed health care delivery system redesign effort. As of 2019, more than 40 percent of rural Texas hospitals had less than 30 days cash available and were in a perilous position when the pandemic began. In small, rural Texas hospitals a single, extraordinarily high cost claim can immediately threaten their survival. Moreover, depending on whether a claim occurs before or after the measurement period, it could cause a material swing to the capitated payment amount (CPA) calculation affecting a hospital's viability. Consequently, HHSC may request the flexibility to participate in an optional outlier policy to limit participating hospitals' impact of extraordinarily high cost claims on CPA.

(5) Aligned Payer Interest

Medicaid aligned payers will include HHSC for fee-for-service (FFS) payments and MCOs. Currently, HHSC has secured potential interest from two MCOs: Superior Health Plan and Community First Health Plans.

Because of Texas' long history with managed care and the state's priority to deliver quality care in a cost-effective way, HHSC received immediate interest from multiple Medicaid MCOs to participate in CHART. Superior Health Plan and Community First Health Plans,

submitted a LOI to HHSC by the required deadline. Each also expressed interest in joining the CHART Model Advisory Council. Superior participates in all Medicaid programs (STAR, STAR+PLUS, STAR Kids, and STAR Health) and in Texas Children's Health Insurance Program (CHIP). Superior Health Plan is the sole statewide MCO contracted with HHSC to provide health care services to children in the foster care system through the STAR Health program. Superior Health Plan serves Medicaid beneficiaries throughout the Community. Community First Health Plans is a Texas owned and managed non-profit health plan in the Bexar service delivery area. Community First Health Plans contracts with HHSC to provide services to CHIP beneficiaries and Medicaid beneficiaries in the STAR and STAR Kids programs in the 8-county Bexar service delivery area, which includes Guadalupe, one of the Community counties. County membership for both Aligned Payers are identified below in Figures B and C, respectively. To date, HHSC continues to receive informal inquiries from potential aligned payers.

Figure B: Community First Health Plans Membership by County, 2021

COMMUNITY FIRST HEALTH PLANS

	Medicaid Managed Care						
COUNTY MEMBERSHIP	**STAR**	**STAR+PLUS**	**STAR Kids**	**CHIP**	**CHIP Neonate**	**Medicare Advantage**	**Employer-Sponsored**
GUADALUPE	6866	0	345	518	0	0	353

Figure C: Superior Health Plan Membership by County, 2021

SUPERIOR HEALTH PLAN							
	Medicaid Managed Care						
COUNTY MEMBERSHIP	**STAR**	**STAR+PLUS**	**STAR Kids**	**STAR Health**	**Medicare Advantage**	**Medicare MMP**	**Employer Sponsored**
Angelina	11,602	4	3	180	0	1	0
Brown	2,355	784	107	242	1	1	0
Burnet	3,548	24	57	144	DSNP-1 MAPD - 8	0	0
Dawson	1,009	147	25	21	0	0	0
DeWitt	1,748	277	0	55	DSNP-13 MAPD-49	0	0
Guadalupe	5,598	1,280	265	247	DSNP-44 MAPD - 13	0	0
Haskell	274	98	10	16	0	0	0
Maverick	8,348	1,303	378	38	DSNP-52 MAPD - 17	0	0
Mitchell	409	108	20	30	DSNP - 7 MAPD - 38	0	0
Polk	36	4	0	68	0	0	0
San Augustine	872	0	0	23	0	0	0
Wichita	8,914	2,089	621	317	0	1	0
Young	1,111	268	43	63	MAPD - 1	0	0

As of August 2021, HHSC continues to discuss informally with United Healthcare to participate as an additional Aligned Payer in Angelina, Burnet, DeWitt, Polk, and San Augustine Counties. Without additional specific information about the financial requirement and mechanisms of the CHART Model, some managed care organizations may be reluctant to commit to participation at this time. Should Texas be selected for CHART Model funding, we would try to recruit the additional Medicaid MCOs to participate including: Cigna HealthSpring, Texas Children's Health Plan, Amerigroup, Community Health Choice, and Molina. Of these, Amerigroup and Cigna HealthSpring also offer Medicare Advantage plans. If HHSC is unable to

secure United Healthcare's participation or other Medicaid MCOs, we will continue to have a minimum of two aligned payers for every Community county and three in Guadalupe County.

(6) Documentation of SMA commitment

HHSC is the Texas state Medicaid agency and is applying as the lead organization for the CHART Model-Community Transformation Track. The Medicaid Needs Assessment is a required component of the MOU for the CHART Model application and can be found in Attachment A, pp. 70 to 74.

E.1.2.2.4. Impact Analysis (1, 2, 3)

(1) Proposed intervention impact

The CHART Model funding and investment into telemedicine has the potential to help the Community address long-standing health challenges in a significant and meaningful way. Using telemedicine to improve the monitoring of certain chronic diseases helps patients and providers. Telemedicine can bridge long distances and enable more patients to seek treatment who would have otherwise delayed care and missed follow-up appointments due to travel barriers, a challenge commonly seen among low-income populations.[15] With technology, it is easier for patients to participate in chronic care management as a patient or as a caregiver and to do so in familiar surroundings. Moreover, patients can provide accurate and current information to health care providers about their disease; thereby, resulting in fewer unplanned trips to emergency departments because physicians and patients can intervene sooner in a less costly setting.

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[15] Accessed on March 23, 2021 at: https://www.kff.org/medicaid/issue-brief/medicaid-non-emergency-medical-transportation-overview-and-key-issues-in-medicaid-expansion-waivers/

Even without hiring additional medical staff, telemedicine technology expands health care access because more patients may seek treatment who would have otherwise delayed it due to travel time and scheduling logistics. Adding specialty physicians at remote locations to expand access in rural communities can mean more residents receive care locally. This access may improve adherence to physician recommendations and follow-up appointments since long distance travel is not required to address their health concerns. Improved monitoring of chronic conditions helps patients receive care in a less costly setting too.

Research from the Agency for Healthcare Research and Quality show rural residents receive lower-quality health care and have worse outcomes compared with residents of more populated areas. While telemedicine can alleviate these issues, it's crucial to ensure rural communities have access to devices with internet access, access to reliable broadband connection, and the computer literacy needed to participate in telemedicine. CHART Model communities in their transformation plan will consider these challenges and include strategies for improving digital literacy and addressing Internet access in their area.

While our proposed health care delivery system concept focuses on addressing chronic disease management and prevention, using telemedicine technology presents the Community opportunities to develop new partnerships with distant sites such as a university health science center or urban hospital. These new partnerships and use of telemedicine has the potential to significantly impact the region. For example, the new partnerships will increase the ability to reach more individuals in the targeted medically underserved, primary care, and mental care health provider shortage areas.

(2) Health care delivery system redesign savings

Health care delivery system redesign as proposed in this application will likely not lead to cost increases and will likely yield overall savings in community-wide health care spending for several reasons. Proposed new payment methodologies can reduce the administrative burden on hospitals. Rural health care providers spend significant time, money and staff resources on administrative tasks like: filing prior authorizations and claims, appealing payment denials, documenting medical necessity, auditing payments and adjustments to each account, responding to records requests, and more. Several recent studies estimate a range of 8.5 to 13 percent[16] of national health care expenditures are for administrative activities. Although specific savings estimates for the Community cannot be estimated at this time, studies show significant savings are achievable with simplified payments and non-productive spending.

Allowing rural health care providers to invest in primary care, early intervention and screening yields significant long- term savings. Addressing chronic conditions in the least costly setting can produce financial savings to individuals and facilities. Additionally, using telemedicine for both primary and specialty physician services, rural community members will receive more timely care and treatment and avoid expensive transfers to urban centers.

When a rural patient must spend weeks in an urban tertiary care center or travels multiple times to a specialty care clinic in the city, there are significant costs to the system. Not only gas and lodging, but also lost productivity. This includes the spouse, child, or caregiver who must take time away from work to travel because care is not available locally. Receiving health care locally means residents are more likely to remain in the community and receive care from

[16] National Health Expenditure Accounts and Gee and Spiro

persons they know and trust. It also keeps spending local which supports the overall economic health of the area.

(3) Impact on beneficiary outcomes

Extremely positive outcomes could result from improving chronic disease prevention and management in the Community with the CHART Model funding. Through the investment in telemedicine, persons served by participant hospitals could show improved outcomes related to chronic disease monitoring resulting in increased longevity and quality of life.

Helping persons to prevent, monitor, and manage chronic diseases could produce positive ripple effects throughout each county in our Community. Proper and accurate monitoring of chronic disease allows health care teams to intervene earlier to prevent hospitalizations. Preventing chronic disease through screening and regular health check-ups can prevent disease or lessen the severity of illness.

While individual providers can help with chronic disease management, additional improvements might be seen through provider and community collaboration. When implemented properly, care coordination can result in seamless communication and access to patients' complete health history, which can reduce unnecessary tests, procedures, and medication errors. Through care coordination a complete record of prescribed drugs is available to each provider thereby, reducing the likelihood that multiple providers will prescribe the same medication or prescribe contraindicated medications. Improved patient safety contributes to improved health outcomes.

E.1.2.3. Sustainability Plan

In 2019, HHSC developed the Rural Hospital Services Strategic Plan to ensure Texans residing in rural areas have access to hospital services. One of the plan's objectives is to increase access to established revenue opportunities to maximize reimbursement for rural hospitals. By pursuing this objective, HHSC is already actively seeking rural hospital funding opportunities that may contribute to sustaining the CHART Model. When potential opportunities are identified, HHSC can screen them to determine if they are relevant to sustaining any aspects of the CHART Model project once its funding expires.

HHSC has the authority to maintain alternative payment models developed under the CHART Model funding opportunity, including the outpatient prospective payment system. Because Texas hospitals already receive Medicaid FFS payments through a prospective payment system for inpatient services, this type of payment would be familiar to rural hospitals. The number of outpatient procedure codes could be reduced or increased based on input from community partners. Similarly, HHSC believes it would be possible to maintain bundled payments arrangements created for the CHART Model based on community partners' input.

It is a deliberate choice by HHSC to pass through most of the cooperative agreement funding award to participant hospitals for their telemedicine project. Establishing or expanding a hospital's telemedicine capabilities is an investment in its long-term strategy towards sustainability and transformation. HHSC intends for hospitals to not only use the award for a telemedicine project to address one or more of the Community health challenges, but to develop new ways to deliver services that can create new and lasting revenue opportunities to

the benefit of the hospital and its surrounding community, as well as sustain the accomplishments produced by the CHART Model.

E.1.2.4. Evaluation

(1) Applicant to meet evaluation requirements

Upon notice of award and securing hospital participation, HHSC will execute subaward agreements with all participant hospitals that will outline their responsibilities to ensure all evaluation requirements of the model are met. These agreements will include roles and timelines for pre-implementation period, performance periods 1-6, and the transition period. Per the letter of intent, all participant hospitals have committed to providing all required activities:[17] (1) assume accountability for hospital expenditures[18] for the Medicare beneficiaries they serve that reside in the Community for the full duration of each performance period; (2) implement the activities outlined in the transformation plan, as applicable; and (3) report necessary quality and other data to CMS.

HHSC, as the named CHART award recipient, will be responsible for ensuring that Participant Hospitals execute certain key model activities to be outlined in forthcoming participation agreements,[19] including responding to data-related requests and other requests for the model evaluation.

[17] As described in section A.4.4.2 Participant Hospitals of the NOFO CMS-2G2-21-001
[18] As specified in Appendix XI. CPA Financial Methodology of the NOFO CMS-2G2-21-001
[19] In alignment with the activities described in Table 2. Funded Activities for Lead Organizations in of the NOFO CMS-2G2-21-001

(2) Applicant willingness to participate in evaluation activities

Upon notice of award, HHSC will execute subaward agreements with participant hospitals ensuring compliance with all activities and reporting requirements as established by CMS and the CHART Model including qualitative evaluation tasks and the arrangement of their logistics. The HHSC project director will serve as a liaison for HHSC and CMS for evaluating the project and assessing milestones. If any participant hospital needs assistance with data requirements, HHSC and the external quality review organization (EQRO) will work with participant hospitals to meet these needs. If participant-level data is required, HHSC will ensure participant hospitals obtain informed consent from CHART Model participants for all necessary processes including consent to participate in the CHART Model. The consent will include information about data sharing between the participant hospital, HHSC, and CMS. Collection, storage, and sharing data in this model will comply with all Health Insurance Portability and Accountability Act (HIPAA) and other applicable federal and state privacy, security, and breach notification regulations.

(3) Applicant willingness to submit documents, training materials, and other related materials

HHSC and participant hospitals will provide training materials, patient education materials, and other program documents to CMS and/or the CMS evaluation contractor upon request. HHSC and participant hospitals will assist with gathering qualitative data related to the CHART Model as necessary for assessment of milestones and project evaluation.

(4) Applicant demonstration to submit capacity to provide patient- and program-level data

HHSC will require participant hospitals serving model participants to execute data use agreements that require the partners to safeguard information in compliance with all

applicable federal and state privacy, security and breach notification laws and regulations. The consent to release of information signed by participant hospitals will outline data which will be shared, with whom it will be shared, and the purpose for sharing it. If applicable laws require individual consent to disclose information for purposes of this project, the participant hospitals and health care delivery partners will be required to obtain such individual consent.

Texas Medicaid's Health Information Exchange (HIE) Connectivity Project includes the use of Implementation Advance Planning Document (IAPD) funding to assist with Medicaid provider connectivity to local HIEs and their connection to statewide shared services. The HIE Connectivity Project is a federal Health Information Technology for Economic and Clinical Health (HITECH) Act initiative and promotes HIE usage in Texas. The project implements statewide connectivity across providers including HHSC, MCOs, and other health care entities. Once connected to a participating HIE, a provider can securely exchange clinical information, using standards-based transactions, with similarly connected providers serving the same Medicaid client.

Collection, storage, and sharing data through the HIE will comply with all HIPAA and other applicable federal and state privacy, security and breach notification regulations. HHSC will require that participant hospitals obtain individuals' informed consent for all necessary processes including consent to participate in the CHART Model.

HHSC is working to secure additional funding through MMIS so that HHSC can seamlessly transition from HITECH in September 2021. Until then, HHSC continues to receive Medicaid patient Admission, Discharge, Transfer and C-CDA data from providers and hospitals connected via local HIEs.

(5) Ability to share protected health information

HHSC and participant hospitals will follow Texas laws and rules as well as federal regulations regarding protected health information (PHI), and information governed by 42 C.F.R. Part 2. HHSC will offer education regarding policies for participant hospitals. Participant hospitals will receive information on mandatory reporting requirements and if PHI is required at the participant hospital level. Participants will receive information as it pertains to PHI. Participant hospitals will inform CHART Model participants of their health privacy rights and assure them that participant hospitals maintain patient privacy in all areas except those of mandatory reporting.

(6) Description of T-MSIS data submission status

Texas Medicaid is currently submitting production data to T-MSIS monthly and is up-to-date with its submissions. HHSC will continue to submit monthly claims and encounter data to CMS via T-MSIS throughout operation of the model. HHSC and CMS will determine an agreeable method to report claims and encounter data for model participants.

E.1.3. Additional Required Documentation

E.1.3.1 Model Budget Narrative

The Model Budget Narrative can be found in Attachment B, E.1.3.1 Budget Narrative.