



1115 Waiver

Texas Healthcare Transformation and Quality Improvement Program

Stephanie Stephens, State Medicaid Director

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Historical Overview

Since 2011, the waiver has enabled the State to expand its use of Medicaid managed care to achieve program savings, while also preserving locally funded supplemental payments to hospitals.

The goals of the demonstration are to:

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



Medicaid Managed Care

The waiver is the federal authority that Texas uses to deliver Medicaid managed care.

The following programs are under the 1115 authority:

- STAR - acute care services primarily to low-income families, children, and pregnant women.
- STAR+PLUS - acute and long-term service and supports primarily to older adults and adults with disabilities.
- STAR Kids - acute and long-term service and supports to children with disabilities.
- Children's dental program - dental care to most children under the age of 21.



January 2021 Approval

CMS approved a 10-year extension.

- On January 15, 2021, the Centers for Medicare and Medicaid Services (CMS) approved a 10-year extension of the 1115 Transformation Waiver.
- On April 16, 2021, the CMS rescinded their approval letter issued on January 15, 2021.
- On May 14, 2021, the Texas Office of the Attorney General (OAG) sought legal redress and filed a complaint in federal court.
- On August 20, 2021, the court ordered, through a preliminary injunction, that the waiver approval was in effect.
- On April 22, 2022, CMS withdrew their rescission letter and confirmed the January 2021 Special Terms and Conditions as in effect.



DSRIP

Delivery System Reform Incentive Payments

- \$2.49 billion.
- Ended Sept. 30, 2021.
- DSRIP transition plan advances value-based care and other effective delivery system reforms.



Successful DSRIP Transition to State Directed Payments

- **Comprehensive Hospital Increased Reimbursement Program (CHIRP)** \$4.7 billion
- **Quality Incentive Payment Program (QIPP)** \$1.1 billion
- **Texas Incentives for Physicians and Professional Services (TIPPS)** \$600 million
- **Rural Access Primary and Preventive Services (RAPPS)** \$11 million
- **DPP for Behavioral Health Services (DPP BHS)** \$175 million



Successful DSRIP Transition to State Directed Payments

Key Milestones

- CMS approved all State Directed Payment Programs.
- The final approvals were received March 25, 2022.
- All approvals are retroactive to September 1, 2021.
- HHSC directed MCOs to
 - Update their claims system by June 1, 2022; and
 - Reprocess all claims impacted within 120 days from April 1, 2022.



Uncompensated Care

Uncompensated Care (UC) & Charity Care Payments (CCP)

- Uncompensated Care payments transitioned to charity care on October 1, 2019 (\$3.87 billion).
- Public Health Providers Charity Care Payment program launched October 1, 2021 (\$500 million).



Uncompensated Care Pool Resizing

The UC Pool will be resized twice.

- First re-sizing started this year to take effect in FY 2023.
 - The new total pool size for Demonstration Year (DY) 12 to DY 16 is expected to be \$4.5 billion.
 - In recognition that the PHE will impact FY 20 and FY 21 cost report data, re-sizing used the 2019 cost reports and the 2017 DSH payment data.
- Second re-sizing will take effect in FY 2028.
 - Sizing will use the 2025 cost reports and 2023 DSH payment data.
- Re-sizing allows for adjustments to uncompensated care pool based on actual charity care.



Budget Neutrality

Key Principles

- Expenditures authorized under the waiver must not exceed what they would otherwise be without the waiver.
- The extension preserves budget neutrality and creates room for DSRIP transition, including state directed payment and charity care programs.
- It sustains an estimated \$7 billion per year in vital budget neutrality for directed payment programs.



Budget Neutrality

Key Principles (cont.)

- Rebasing with actual data is also required.
 - Without waiver expenditures will be rebased and include directed payment program funding using fiscal year 2022 data.
 - Potential adjustments are included for COVID-19 adverse impacts to enrollment and expenditures.
- DSRIP Transition Programs and Public Health Provider funding is sustainable.



Monitoring & Reporting

New Special Terms and Conditions emphasize the importance of monitoring and reporting.

- COVID-19 public health emergency disrupted data collection.
- Terms negotiated with CMS:
 - Emphasize the responsibility of the state to provide oversight of funds;
 - Require additional reporting on sources of funds;
 - Require new Home and Community Based Services (HCBS) reporting;
 - Require a new HCBS Quality Assurance Report; and
 - Require more frequent monitoring reports.



External Evaluation

New Evaluation Design for the Extension

- **Purpose:** Provide insight into whether the state is progressing on the overarching goals of the Demonstration
- **Main components:**
 - Medicaid Managed Care
 - Supplemental Payment Pools
 - Uncompensated Care
 - Public Health Providers Charity Care
 - Cost outcomes for the demonstration as a whole



Amendments

Pending

- SB 1096 (86R) - Exempt STAR Kids members from all preferred drug list prior authorizations.
- HB 4533 (86R) - Allow medically fragile individuals in STAR+PLUS HCBS to be exempt from cost caps.

In Process

- HB 133 (87R) - Carve in certain case management services into managed care and extend Medicaid coverage to six months postpartum for women.
- HB 4533 (86R) - Pilot person-centered managed care strategies and improvements.





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Comprehensive Hospital Increased Reimbursement Program (CHIRP)

- **Concept:** Statewide program that provides for increased Medicaid payments to hospitals for inpatient and outpatient services covered under Medicaid managed care.
- **First Implemented:** September 1, 2021
 - a. CMS approval received March 25, 2022, retroactive to September 1, 2021.
- **Participants:** This is a voluntary program under STAR and STAR+PLUS.
- **Funding:** Estimated \$4.7 billion in All Funds for FY 2022.



Quality Incentive Payment Program (QIPP)

- **Concept:** Statewide program that provides for increased Medicaid payments to nursing facilities based on the facilities' performance on required metrics.
- **First Implemented:** September 1, 2017
 - CMS approval received November 15, 2021, retroactive to September 1, 2021.
- **Participants:** This is a voluntary program under STAR+PLUS. Public and private nursing facilities are allowed to participate. Approximately 900 of 1,200 nursing facilities participate.
- **Funding:** Estimated \$1.1 billion AF for FY 2022.



Texas Incentives for Physicians and Professional Services (TIPPS)

- **Concept:** Statewide program that provides for increased Medicaid payments for enrolled physician groups for health care services covered under Medicaid managed care.
- **First Implemented:** September 1, 2021
 - CMS approval received March 25, 2022, retroactive to September 1, 2021.
- **Participants:** This is a voluntary program under STAR, STAR+PLUS, and STAR Kids.
- **Funding:** Estimated \$600 million in All Funds for FY 2022.



Directed Payment Program for Behavioral Health Services (DPP BHS)

- **Concept:** Statewide program that provides for increased Medicaid payments to Community Mental Health Centers (CMHCs) to incentivize the Certified Community Behavioral Health Clinic (CCBHC) model of care under Medicaid managed care.
- **First Implemented:** September 1, 2021
 - CMS approval received November 15, 2021, retroactive to September 1, 2021.
- **Participants:** This is a voluntary program for providers under STAR, STAR+PLUS, and STAR Kids.
- **Funding:** Estimated \$175 million in All Funds for FY 2022.



Rural Access to Primary and Preventive Services (RAPPS)

- **Concept:** Statewide program that provides for increased Medicaid managed care payments to Rural Health Clinics and incentivizes primary and preventive services in rural areas.
- **First Implemented:** September 1, 2021
 - a. CMS approval received March 25, 2021, retroactive to September 1, 2021.
- **Participants:** This is a voluntary program for providers under STAR, STAR+PLUS, and STAR Kids.
- **Funding:** Estimated \$11.3 million in All Funds for FY 2022.



Public Health Providers

Public Health Provider-Charity Care Program (PHP-CCP)

- Began on October 1, 2021.
- Offsets costs associated with care, including behavioral health, immunizations, chronic disease prevention and other preventive services for the uninsured
- Public providers only
- State share is financed by certified public expenditures
- Year 1 & 2 will be up to \$500 million



Uncompensated Care Pool

Uncompensated Care (UC)

- Began FY 2012.
- Transitioned to charity care in FY 20.
- Reduces the actual uncompensated cost of medical services provided to uninsured individuals who meet a provider's charity care policy.
- Providers include public and private hospitals, public ambulance providers, government dental providers, and physician practice groups.
- State share is financed by local governments.
- FY 22 is \$3.87 billion.





House Bill 133

87th Legislature, Regular Session, 2021

Stephanie Stephens, State Medicaid Director

Hilary Davis, Access and Eligibility Services Policy and Program



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Case Management for Children and Pregnant Women

- Case management for children and pregnant women (CPW) is a Medicaid state plan benefit currently delivered through fee-for-service.
 - Provides health-related case management to children and young adults under age 21 and high-risk pregnant women.
- House Bill (HB) 133 requires HHSC to transition the service to a managed care delivery system.
- HHSC plans to implement CPW in managed care effective September 1, 2022.
 - Contingent on CMS approval of an 1115 waiver amendment. HHSC will submit in May 2022 for federal approval.



Healthy Texas Women

- Healthy Texas Women (HTW) provides women's health and family planning to low-income women through a fee-for-service delivery model.
- HHSC is incorporating requirements for HTW in the STAR and CHIP managed care request for proposal (RFP).
 - RFP posting- First quarter of FY 2023
 - Notice of award- Fourth quarter of FY 2023
 - Operational start- Fourth quarter of FY 2024
- Transition will require an amendment to the 1115 waiver.
- HHSC is working with external stakeholders to keep them informed and address concerns about the transition.



Postpartum Eligibility Extension

- Extends Medicaid for Pregnant Women coverage from 60 days to six months following birth or an involuntary miscarriage.
- Implementation requires federal approval and eligibility system changes.
 - HHSC will submit an 1115 waiver amendment to CMS in May 2022 for federal approval.
 - Eligibility system changes will be made in Fall 2022 assuming CMS approval as proposed.





House Bill 2658

87th Legislature, Regular Session, 2021

**Hilary Davis, Deputy Associate
Commissioner for Access and
Eligibility Services, Program Policy**



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Modifying Periodic Income Checks (PICs) for Children's Medicaid

- The number of PICs for Children's Medicaid was reduced from four to one.
 - The result of the PIC will impact eligibility in the 7th month of the child's 12-month certification period.
- Households are now allowed 30 days to provide requested income verification after the PIC.
- Income is considered verified by electronic data sources if the household does not return their requested income verification after a PIC.
 - Children will be tested for other healthcare programs using the income information from electronic data sources and will be referred to the Federal marketplace if they are not eligible for another Medicaid program or CHIP



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Modifying Periodic Income Checks (PICs) for Children's Medicaid

- Language on the eligibility notice was modified for households who do not provide requested income verification after the PIC to include a statement that the child may be eligible for CHIP.
- Eligibility system changes for H.B. 2658 were completed on April 2, 2022.
 - PICs are currently suspended due to the COVID-19 Public Health Emergency.
 - H.B. 2658 will be implemented when continuous Medicaid coverage authorized under the FFCRA ends.



Texas Medicaid Waivers and Interest Lists

Emily Zalkovsky

Deputy State Medicaid Director, Health and Human Services Commission

May 5, 2022



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Historical Context

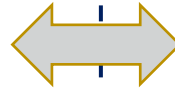
1981



Medicaid Home and Community Based Services (HCBS) waiver programs are enacted at the federal level.

Before

Individuals requiring long-term services could only receive Medicaid-funded care through institutional settings.



After

States are allowed to provide an array of HCBS that assist Medicaid beneficiaries to live in the community and avoid institutionalization.

Allows states to waive certain Medicaid requirements.



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HCBS Waiver Programs

- 1 Home and Community-based Services (HCS)
- 2 Texas Home Living (TxHmL)
- 3 Community Living Assistance and Support Services (CLASS)
- 4 Deaf Blind with Multiple Disabilities (DBMD)
- 5 Medically Dependent Children Program (MDCP)
- 6 STAR+PLUS HCBS
- 7 Youth Empowerment Services (YES)



Interest Lists

Why they exist

Unlike regular Medicaid, states are allowed to set caps on the number of people served under a waiver and establish interest lists when demand exceeds the waiver's approved capacity.

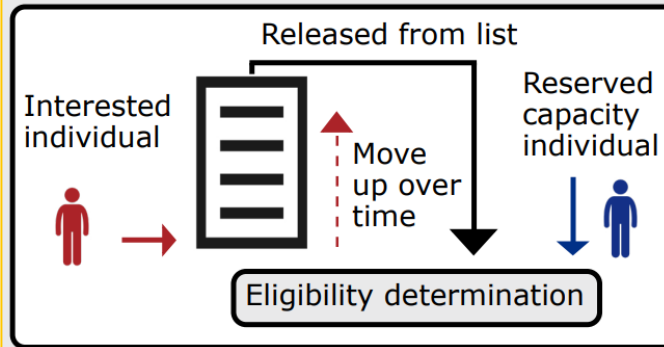
Who can be on them

- Anyone can put their name on the list on a first-come, first-served basis.
- A person can be on multiple lists at the same time.
- Eligibility for a waiver program is not determined until a slot opens and a person is at the top of the list.



Process Snapshot

Interest List Process



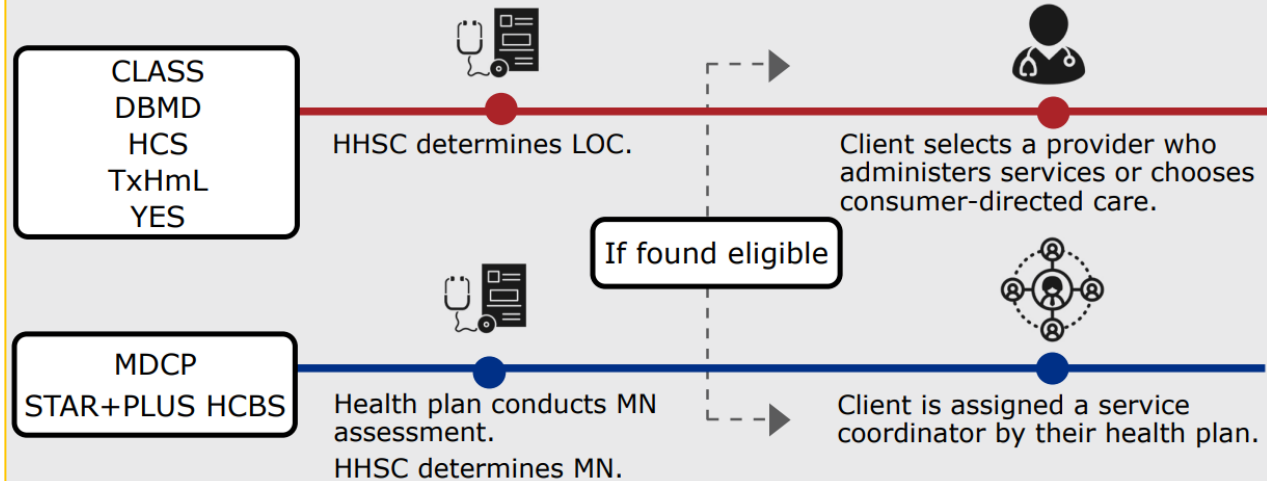
When a program slot opens, the individual at the top of the list is released.

As individuals are released, others move up the interest list.

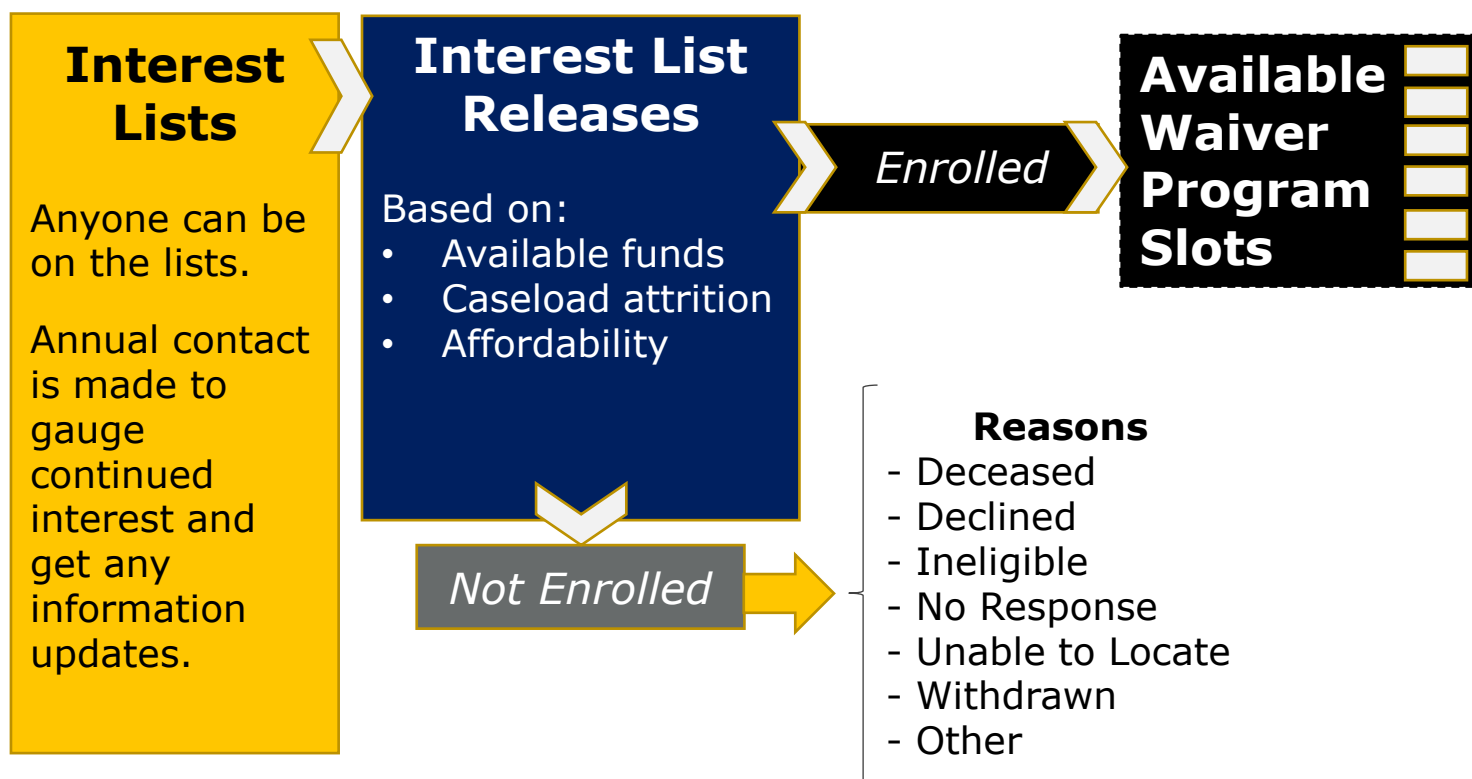
After an individual is released, they go through the eligibility determination process.

Eligibility Determination

Eligibility determination is based on household income and level of care (LOC) or medical necessity (MN). The criteria for LOC or MN an individual must meet varies by program.



Maintaining the Lists and Releases





Waiver Program Snapshots



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Similar Across All



Provides an Alternative to Living in an Institution

- Institutions include nursing facilities and intermediate care facilities for individuals with intellectual disabilities (ICF/IID)



Certain Eligibility Requirements

- Must meet financial eligibility*
- Must not be enrolled in another HCBS waiver
- Must meet institutional level of care
- Must meet citizenship and residency requirements



How Services Are Delivered

- Delivered in home and community settings
- Five programs are fee-for-service
- Two programs are managed care (MDCP, STAR+PLUS HCBS)



Types of Services Delivered**

- | | |
|-------------------------------------------------------------------------|--------------------------------------------------|
| • Adaptive aids and minor home modifications | • Nursing |
| • Medical supplies | • Respite |
| • Professional therapies like physical, occupational and speech therapy | • Employment assistance and supported employment |
| | • Residential services |

*Financial eligibility varies by program.

**Exact services by waiver program vary. For a full list of services by waiver program, see Appendix B, page 133 in the 13th edition of the *Texas Medicaid and CHIP Reference Guide* (Pink Book)



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HCS

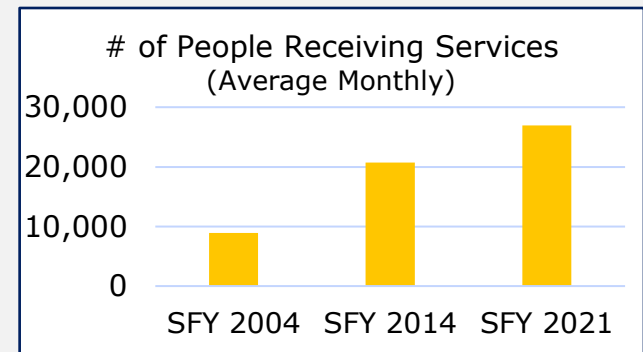
Year started: 1985

Additional Waiver Information

- Serves all ages
- Must meet specific Level of Care criteria for the program (see Appendix)
- May live in their own home, their family home, or a residence with other individuals with similar needs that is operated by a program provider

Enrollment Data

Total Enrolled: 29,665



Interest List Data

List Count	108,838
Receiving Other Services*	50%
Uptake Rate	52%



Average Years on List:
7.4 years



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Enrollment and interest list data as of March 31, 2022. # of People Receiving Services = Average # of individuals per month receiving at least one service during that state fiscal year (SFY).

*Services include other HCBS services (another waiver), state plan Medicaid benefits, or general revenue-funded LTSS.

TxHmL

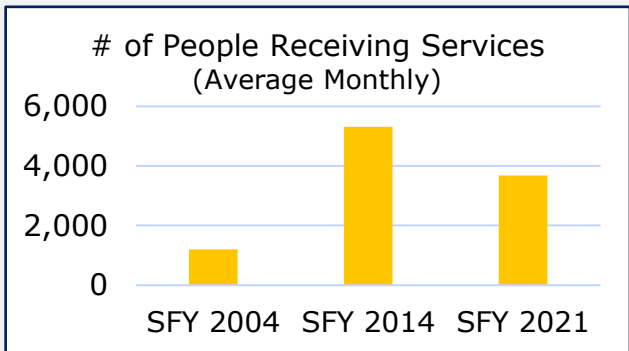
Year started: 2004

Additional Waiver Information

- Serves all ages
- Must meet specific Level of Care criteria for the program (see Appendix)
- Must live in their own home or their family home

Enrollment Data

Total Enrolled: 3,965



Interest List Data

List Count	96,893
Receiving Other Services*	49%
Uptake Rate	19%



Average Years on List:
6.6 years



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Enrollment and interest list data as of March 31, 2022. # of People Receiving Services = Average # of individuals per month receiving at least one service during that state fiscal year (SFY).

*Services include other HCBS services (another waiver), state plan Medicaid benefits, or general revenue-funded LTSS.

CLASS

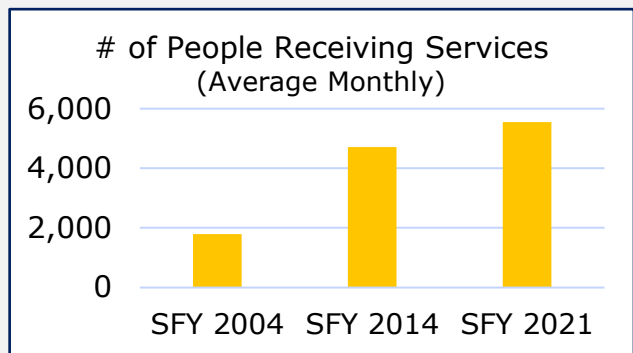
Year started: 1991

Additional Waiver Information

- Serves all ages
- Must have a related condition as the primary diagnosis and moderate to extreme deficits in adaptive behavior
- Must have substantial functional limitations in areas like self-care, language and capacity for independent living
- May live in their own home or their family home

Enrollment Data

Total Enrolled: 6,021



Interest List Data

List Count	78,259
Receiving Other Services*	52%
Uptake Rate	30%



Average Years on List:
7.3 years



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Enrollment and interest list data as of March 31, 2022. # of People Receiving Services = Average # of individuals per month receiving at least one service during that state fiscal year (SFY).

*Services include other HCBS services (another waiver), state plan Medicaid benefits, or general revenue-funded LTSS.

DBMD

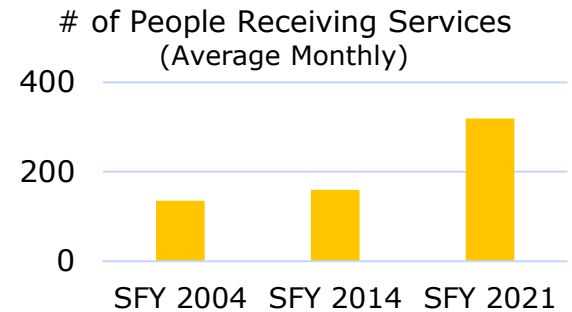
Year started: 1995

Additional Waiver Information

- Serves all ages
- Must have a diagnosis of deafblindness (or have a related condition that will result in deafblindness) and have one other disability that results in impairment to independent functioning
- Must have substantial functional limitations in areas like self-care, language and capacity for independent living
- May live in their own home, their family home, or a residence with other individuals with similar needs that is operated by a program provider

Enrollment Data

Total Enrolled: 313



Interest List Data

List Count	1,239
Receiving Other Services*	51%
Uptake Rate	8%



Average Years on List:
2.5 years



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Enrollment and interest list data as of March 31, 2022. # of People Receiving Services = Average # of individuals per month receiving at least one service during that state fiscal year (SFY).

*Services include other HCBS services (another waiver), state plan Medicaid benefits, or general revenue-funded LTSS.

MDCP

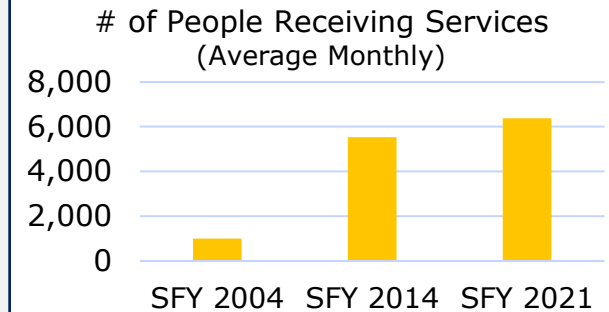
Year started: 1984

Additional Waiver Information

- Must be age 20 and younger
- Must live in own home, their family home, or foster care home

Enrollment Data

Total Enrolled: 5,689



Interest List Data

List Count	7,650
Receiving Other Services*	41%
Uptake Rate	18%



Average Years on List:
1.7 years



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Enrollment and interest list data as of March 31, 2022. # of People Receiving Services = Average # of individuals per month receiving at least one service during that state fiscal year (SFY).

*Services include other HCBS services (another waiver), state plan Medicaid benefits, or general revenue-funded LTSS.

STAR+PLUS HCBS

Year started: 2014

Additional Waiver Information

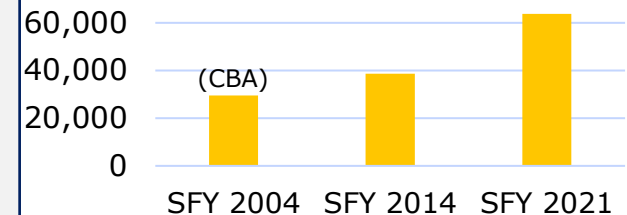
- Must be age 21 or older
- Must have an unmet need for at least one STAR+PLUS HCBS service

The Community-Based Alternatives (CBA) waiver was implemented in 1993. STAR+PLUS HCBS replaced CBA and became statewide in 2014.

Enrollment Data

Total Enrolled: 62,738*

of People Receiving Services
(Average Monthly)



Interest List Data

List Count	19,723
Receiving Other Services**	39%
Uptake Rate	8%



Average Years on List:
0.5 year

Enrollment and interest list data as of March 31, 2022. # of People Receiving Services = Average # of individuals per month receiving at least one service during that state fiscal year (SFY).

*Includes Dual Demonstration

**Services include other HCBS services (another waiver), state plan Medicaid benefits, or general revenue-funded LTSS.



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Planned Interest List Improvements



HHSC is revising the current Interest List Questionnaire to comply with HB 3720.



HHSC will implement a system to allow individuals or their representative to add an interest list request and update information in an online portal.



Approaches by Other States

States use different waiting list management strategies for their waiver programs.

According to a state survey conducted by the Kaiser Family Foundation, in FY 2018, the average wait time across 30 states for HCBS waivers with waiting lists was 39 months.

Waiting list management	Category definition	Number of 1915(c) waivers	Number of 1115 waivers
First come, first served	Individuals are offered waiver slots based on how long they have been on the waiting list and the order in which they have been waiting. Waivers may explicitly say they operate their waiting lists on a first-come, first-served basis, or they may mention the order is based on other criteria, such as chronological order or the date of request for services.	62	2
Priority	States may prioritize individuals based on age, diagnosis, or situational factors. States may base priority on needs assessments or criticality, such as loss of a primary caregiver. States may also use screening tools.	46	4
Priority and wait time	States combine use of priority categorizations and time spent waiting.	21	0
No waiting list	The state does not have a waiting list for that waiver. All who are eligible for services receive them.	59	2
No mention of waiting list	Waiver documents do not mention waiting lists and thus the existence of a waiting list for that waiver is unknown, as is how a state manages capacity and unmet need for services.	55	3
Unspecified	Waiver documents mention a waiting list exists but does not specify how it is managed.	4	2
Other	Waivers that do not fit into another category.	7	1

Based on a review by Medicaid and CHIP Payment and Access Commission (MACPAC) of 199 Section 1915(c) waivers and 11 Section 1115 waivers. States have multiple waiver programs which is why the total is greater than 50.



Themes from Other States

Three themes emerged for actions states are taking to address long standing interest list wait times.

- 1 Prioritizing access to waiver services based on urgency of need, rather than first come first served, using an assessment or screening tool. This requires conducting regular assessments of people on the list.
- 2 Enrolling individuals in non-waiver Medicaid state plan HCBS services or less expensive support waivers (often not offering 24-hour residential supports) if these services can meet the individual's needs.
- 3 Limiting access to comprehensive waivers with higher cost caps and 24-hour residential services for individuals whose assessed needs cannot be met with other lower cost options.





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Level of Care Criteria

In order as they appear in the presentation.

Waiver Program	Level of Care (LOC) Criteria
HCS	<p>Must meet LOC I criteria or, if transitioning or diverting from a nursing facility, meet LOC VIII criteria</p> <p>To meet LOC I criteria, an individual must have an IQ of 69 or below or have an approved related condition with an IQ of 75 or below; and must have mild to severe deficits in adaptive behavior.</p> <p>To meet LOC VIII criteria, an individual must have a primary diagnosis of a related condition that is included on the list of diagnostic codes for persons with related conditions that are approved by HHSC and have moderate to extreme deficits in adaptive behavior.</p>
TxHmL	<p>Must meet LOC I criteria or, if transitioning or diverting from a nursing facility, meet LOC VIII criteria</p> <p>To meet LOC I criteria, an individual must have an IQ of 69 or below or have an approved related condition with an IQ of 75 or below; and must have mild to severe deficits in adaptive behavior.</p> <p>To meet LOC VIII criteria, an individual must have a primary diagnosis of a related condition that is included on the list of diagnostic codes for persons with related conditions that are approved by HHSC and have moderate to extreme deficits in adaptive behavior.</p>



Detailed Definitions

In order as they appear in the presentation.

Term	Definition
Related Conditions	<p>In accordance with the Code of Federal Regulations, Title 42, 435.1010, a related condition is a severe and chronic disability that:</p> <ul style="list-style-type: none">A. is attributed to:<ul style="list-style-type: none">• i. cerebral palsy or epilepsy; or• ii. any other condition, other than mental illness, found to be closely related to intellectual disability because the condition results in impairment of general intellectual functioning or adaptive behavior similar to that of individuals with intellectual disability, and requires treatment or services similar to those required for individuals with intellectual disability;B. is manifested before the individual reaches age 22;C. is likely to continue indefinitely; andD. results in substantial functional limitation in at least three of the following areas of major life activity: i. self-care; ii. understanding and use of language; iii. learning; iv. mobility; v. self-direction; and vi. capacity for independent living.
Adaptive Behavior	<p>The effectiveness with or degree to which an individual meets the standards of personal independence and social responsibility expected of the individual's age and cultural group as assessed by a standardized measure</p>
Adaptive Behavior Level	<p>The categorization of an individual's functioning level of adaptive behavior into one of five levels ranging from minimal limitations (0) through profound limitations (IV).</p>

Rider 30 - Rates: Intermediate Care Facilities and Certain Waiver Programs

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Rider 30

- Included in amounts appropriated above in Strategy A.2.7, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), and Strategy A.3.1. Home and Community-based Services (HCS), is funding to maintain rate increases authorized by House Bill 1, Eighty-sixth Legislature, Health and Human Services Commission Rider 44, Rate Increases: Intermediate Care Facilities and Certain Waiver Providers, through the 2022-23 biennium.
- It is the intent of the Legislature that the Health and Human Services Commission, in collaboration with stakeholders, shall evaluate the rate setting methodology for these programs, including collection of any necessary data, in order to develop reimbursement methodologies that more accurately reflect the costs of services and report back to the Eighty-eighth Legislature.

Maintain Rate Increases

- Title 1 of Texas Administrative (1 TAC) 355.727, Add-on Payment Methodology for Home and Community-Based Services Supervised Living and Residential Support Services, was amended to maintain rate increase through August 31, 2023.
- HCS Waiver Amendment was submitted and approved.



Rate Setting Methodology Evaluation

- HHSC contracted with a third-party vendor to conduct an independent evaluation of the HCS, Texas Home Living (TxHmL) and ICF/IID rate setting methodologies, which includes collaboration with HHSC representatives and identified stakeholders.
- Began in September 2021 and will conclude prior to the 88th Legislative Session.
- The Rate Setting Methodology Evaluation includes:
 - a national scan of comparable states' programs;
 - provider/stakeholder interview sessions;
 - discussion of the consolidated national scan results and approach considerations with HHSC and the workgroup;
 - data collection from identified providers/stakeholders; and
 - the development of the rate model to include an impact assessment.

