Section 1115 Demonstration Extension Section 1115(a) Fast Track Application Supporting Documentation

Texas Healthcare Transformation and Quality Improvement Program

Project #11-W-00278/6

Texas Health and Human Services Commission

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TEXAS
Health and Human Services

Appendix A. Historical Summary

Waiver Approval: 2011 – 2022

Based on direction from the Texas Legislature in 2011, the State sought a section 1115 Demonstration as the vehicle to transform healthcare in Texas by expanding the Medicaid managed care delivery system statewide, while operating funding pools, supported by managed care savings and diverted supplemental payments, to reimburse providers for uncompensated care costs and to provide incentive payments to providers that implement and operate delivery system reforms. The waiver was designed to build on existing Texas health care reforms and to redesign health care delivery in Texas consistent with Centers for Medicare & Medicaid Services (CMS) goals to improve the experience of care, improve population health, and reduce the cost of health care.

CMS initially approved the waiver on December 12, 2011. The Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver, commonly called the 1115 Transformation Waiver, is currently approved through September 30, 2022.

Through the 1115 Transformation Waiver, the State expanded its use of Medicaid managed care to achieve program savings, while also preserving locally funded supplemental payments to hospitals under two new funding pools. Through this Demonstration, the State has aimed 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 hospitals.

Texas has made substantial progress toward achieving these four goals and requests a five-year extension utilizing the fast track template as provided by the CMS to reduce uncertainty for our health care systems during the Public Health Emergency, as determined and renewed by Secretary Azar on October 2, 2020.

Texas Medicaid has met its initial goal of expanding risk-based managed care statewide. Texas Medicaid has a mature 1115 Waiver inclusive of 17 Medicaid Managed Care Organizations (MCOs) and three Dental Maintenance Organizations. The State's managed care contracts require our health and dental plan contractors to meet goals related to quality improvement and alternative payment arrangements or value-based purchasing.

The waiver also includes the Delivery System Incentive Reform Payment (DSRIP) and Uncompensated Care (UC) Programs. Currently, 288 Performing Providers participate in DSRIP, and 529 providers participate in the Uncompensated Care Program. Significant participation in these programs has led to successful outcomes. As DSRIP transitions, it has also led to significant financial stress on providers. Texas is on target and will continue working with CMS to successfully achieve the DSRIP Transition goals as approved. Uncompensated Care revisions were implemented successfully.

Waiver Extension

Under a 5-year extension of the current demonstration period through 2027, the State will continue the goals of the current 1115 Transformation Waiver. While the State has made significant progress toward the achievement of these goals, they remain ongoing priorities that will evolve and strengthen over time. For example, Texas Medicaid is working to transition additional services under the MCOs, such as medical transportation and certain long-term services and supports for individuals with Intellectual and Developmental Disabilities or similar functional needs. Texas Medicaid also continues to advance value by expanding performance measurement and implementing new ways to incentivize quality and cost efficiency. Under the extension, DSRIP will fully transition and Medicaid managed care expenditures will adjust to promote access to care and provide incentives that drive value.

Appendix B. Budget

In compliance with CMS-approved STCs, the extended demonstration period continues current budget neutrality methodologies as illustrated in the relevant STC tables and charts. No changes have been incorporated as the STCs reflect:

- Without Waiver PMPM methodology with current trends, the UPL is held flat at the current level;
- Uncompensated Care maintained at current size of $3.87 billion annually; and
- Continued savings phase down policy as developed by CMS.

The budget neutrality 5-year "roll over" is held flat at $9.47 billion through the continued DY 07-16 demonstration period.

This extension request continues current budget neutrality policies through the end of the extended demonstration period. No deviations from current financial performance are expected as no methodology changes have been requested.

Appendix C. Interim Evaluation

The current CMS-approved 1115 evaluation design examines the three components of the THTQIP demonstration (DSRIP, UC Pool, Medicaid Managed Care (MMC) expansion), as well as the overall impact of the THTQIP demonstration (as measured by quality-based payment systems in Texas Medicaid and transformation of the health care system for the Medicaid/low-income population in Texas). The interim evaluation is still on schedule to be submitted to CMS by September 30, 2021. The current evaluation design includes 5 evaluation questions and 13 hypotheses. The THTQIP demonstration waiver extension does not alter the overall goals and objectives of the evaluation; therefore, HHSC is not proposing modifications to the approved evaluation questions. HHSC is also not proposing changes to hypotheses, data sources, statistical methods, and/or outcome measures for the evaluation of the UC Pool or components related to the overall impact of the THTQIP demonstration. HHSC is proposing changes to further the DSRIP and MMC expansion components.

DSRIP funds are scheduled to phase out for the final year of the current THTQIP demonstration which begins October 1, 2021. HHSC may continue to examine DSRIP using a revised hypothesis and measure set focused on the DSRIP transition process occurring under the THTQIP extension.

Hypotheses under the MMC component of the THTQIP extension evaluation will remain the same, but HHSC will revise the study populations and/or measures associated with each hypothesis. The current THTQIP evaluation examines six populations that transitioned into MMC between March 1, 2012 and September 1, 2017. All populations included in the current THTQIP evaluation include at least five years of post-transition data. Further inquiry into these populations will not yield additional insight into whether the expansion of MMC improved health outcomes for clients in these programs.

The MMC component of the THTQIP extension evaluation will focus on recent or forthcoming changes in services or benefits provided to populations served under the THTQIP. Populations included in the MMC evaluation during the THTQIP extension may include individuals impacted by possible THTQIP amendments (e.g., individuals utilizing non-emergency transportation services, children and youth receiving early and periodic screening, diagnostic, and treatment services, individuals with disabilities), and/or additional populations as necessary based on THTQIP interim report findings and statutory changes resulting from legislation related to the THTQIP demonstration. HHSC will review and modify current MMC measures to examine access to care, care coordination, quality, outcomes, and satisfaction, as applicable to the new populations and/or benefits.

HHSC will submit a revision to the CMS-approved evaluation design incorporating these edits following approval of the THTQIP extension. HHSC does not anticipate adjustments will substantially alter the data sources or analytic methods used in the evaluation. The proposed changes to DSRIP and MMC expansion align with the current goals and objectives for the THTQIP demonstration.

Resources

The current CMS-approved evaluation design plan can be found at https://hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/1115-docs/tool-guidelines/1115-waiver-evaluation-design-plan.pdf.

Appendix D. Quality Assurance Monitoring

Texas has a strong focus on quality of care in Medicaid and CHIP that includes initiatives based on state and federal requirements, including protocols published by the Centers for Medicare & Medicaid Services (CMS). HHSC strives to ensure high-value healthcare for Texans through its monitoring and oversight of Medicaid and CHIP managed care organizations (MCOs).

External Quality Review

Federal regulations require external quality review of Medicaid managed care programs to ensure states and their contracted MCOs are compliant with established standards. The external quality review organization (EQRO) performs four CMS required functions as mandated by the Balanced Budget Act of 1997 related to Medicaid managed care quality:

- Validation of MCOs' performance improvement projects,
- Validation of performance measures,
- Determination of MCOs' compliance with certain federal Medicaid managed care regulations, and
- Validation of MCO and dental maintenance organization (DMO) network adequacy.

In addition, states may also contract with the EQRO to validate member-level data; conduct member surveys, provider surveys, or focus studies; and calculate performance measures. The Institute for Child Health Policy (ICHP) has been the EQRO for HHSC since 2002. HHSC's EQRO follows CMS protocols to assess access, utilization, and quality of care for members in Texas' CHIP and Medicaid programs.

The EQRO produces reports to support HHSC's efforts to ensure managed care clients have access to timely and quality care in each of the managed care programs. The results allow comparison of findings across MCOs in each program and are used to develop overarching goals and quality improvement activities for Medicaid and CHIP managed care programs. MCO findings are compared to HHSC standards and national percentiles, where applicable. A link to the annual EQRO Summary of Activities (SOA) Report can be found here.

The EQRO assesses care provided by MCOs participating in STAR, STAR+PLUS (including the STAR+PLUS home and community-based services waiver), STAR Health, CHIP, STAR Kids, and the Medicaid and CHIP dental managed care programs. The EQRO conducts ongoing evaluations of quality of care primarily using MCO administrative data, including claims and encounter data. The EQRO also reviews MCO documents and provider medical records, conducts interviews with

MCO administrators, and conducts surveys of Texas Medicaid and CHIP members, caregivers of members, and providers.

Quality Measures

A combination of established sets of national measures and state-developed measures validated by the EQRO are used to track and monitor program and health plan performance. Measures include:

- National Committee for Quality Assurance Healthcare Effectiveness Data and Information Set (HEDIS®) - A nationally recognized and validated set of measures used to gauge quality of care provided to members.
- Agency for Healthcare Research and Quality (AHRQ) Pediatric Quality Indicators (PDIs)/ Prevention Quality Indicators (PQIs) - PDIs use hospital discharge data to measure the quality of care provided to children and youth. PQIs use hospital discharge data to measure quality of care for specific conditions known as "ambulatory care sensitive conditions" (ACSCs). ACSCs are conditions for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications or more severe disease.
- 3M® Potentially Preventable Events (PPEs) - HHSC uses and collects data on Potentially Preventable Admissions (PPAs), Potentially Preventable Readmissions (PPRs), Potentially Preventable Emergency Department Visits (PPVs), Potentially Preventable Complications (PPCs), and Potentially Preventable Ancillary Services (PPSs).
- Consumer Assessment of Healthcare Providers & Systems (CAHPS®) Surveys - CAHPS Health Plan Surveys are nationally recognized and validated tools for collecting standardized information on members' experiences with health plans and services.

Initiatives

HHSC uses quality measures to evaluate health plan performance and develop initiatives to improve the quality of care provided to Medicaid and CHIP members in managed care.

Administrative Interviews

In accordance with 42 CFR 438.358, the EQRO conducts administrative interviews with each plan in Medicaid/CHIP—within a three-year period—to assess MCO/dental maintenance organization compliance with state standards for access to care, structure and operations, and quality assessment and performance improvement (QAPI). The administrative interview process consists of four main deliverables,

namely Administrative Interview (AI) tool, AI evaluations, onsite visits, and AI reports.

Core Measure Reporting

CMS has a Children's and an Adult Health Care Quality Core Set of measures which states voluntarily report on for children in Medicaid and CHIP and adults in Medicaid. The EQRO assists HHSC in reporting core measures to CMS each year.[1]

MCO Report Cards

HHSC provides information on outcome and process measures to Medicaid and CHIP members regarding MCO performance during the enrollment process. To comply with this requirement and the quality rating system required by 42 CFR 438.334, HHSC develops report cards for each program service area to allow members to compare the MCOs on specific quality measures. These report cards are intended to assist potential enrollees in selecting an MCO based on quality metrics. Report cards are posted on the HHSC website and included in the Medicaid enrollment packets. Report cards are updated annually.[2]

Network Adequacy

SB 760, 84th Legislature, Regular Session, 2015 directed HHSC to establish and implement a process for direct monitoring of a MCO's provider network, including the length of time a recipient must wait between scheduling an appointment with a provider and receiving treatment from the provider. To fulfill this direction, Section 8.1.3 of the Texas Uniform Managed Care Contract specifies that Medicaid and CHIP MCOs must assure that all members have access to all covered services on a timely basis, consistent with medically appropriate guidelines and accepted practice parameters.

Network adequacy initiatives include the Appointment Availability (AA) Study and the Primary Care Provider (PCP) Referral Study. The AA study is a series of sub-studies completed by the state's EQRO. The AA Study is comprised of four reports in the areas of prenatal, primary care, vision, and behavioral health. MCO performance is assessed by determining provider compliance with contract standards for appointment availability and wait time for an appointment. The PCP Referral Study is conducted annually and examines PCP experiences when referring Medicaid managed care and CHIP beneficiaries for specialty care.

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[1] https://www.medicaid.gov/medicaid/quality-of-care/quality-of-care-performance-measurement/adult-and-child-health-care-quality-measures/index.html

[2] https://hhs.texas.gov/services/health/medicaid-chip/programs/managed-care-report-cards

Pay-for-Quality

Senate Bill 7, 83rd Legislature, Regular Session, 2013, focused on the use of quality-based outcome and process measures in quality-based payment systems by measuring PPEs, rewarding use of evidence-based practices, and promoting health care coordination, collaboration, and efficacy. To comply with this legislative direction HHSC implemented redesigned medical and dental Pay-for-Quality (P4Q) programs in January 2018. The P4Q programs create financial incentives and disincentives based on health plan performance on a set of quality measures. Contracted health plans are at-risk.

Medicaid Value-Based Enrollment

Pursuant to Texas Government Code §533.00511, HHS is implementing an incentive program that automatically enrolls a greater percentage of Medicaid recipients who have not selected a managed care plan into a plan based on quality of care, efficiency and effectiveness of service provision, and performance. The state's new autoenrollment method uses metrics aligned with the Triple Aim to promote value-based healthcare that achieves better care at lower costs.[3]

Alternative Payment Model (APM) Requirements

The P4Q and value-based enrollment programs serve as catalysts for managed care to pursue value-based payment arrangements with providers to achieve improved outcomes. In addition, HHSC's managed care contracts require them to reach APM targets each year, beginning with calendar year 2018. APMs are payment arrangements in which some portion of an MCOs reimbursement to a provider is linked to measures of quality and outcomes. HHSC uses the Healthcare Payment Learning and Action Network (HCP LAN) Alternative Payment Model (APM) Framework[4] to help guide this effort. This framework provides a menu of payment models from which MCOs could choose to develop alternative payment contracts with their providers. Moving from one category to the next adds a level of risk to the payment model.

Performance Improvement Projects

The Balanced Budget Act of 1997 requires all states with Medicaid managed care to ensure MCOs conduct performance improvement projects (PIPs). 42 CFR 438.330

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[3] The *Triple Aim* is a framework developed by the Institute for Healthcare Improvement that describes an approach to optimizing health system performance by improving the patient experience, improving population health, and reducing costs. These dimensions are also reflected in the Centers for Medicare and Medicaid Services' value-based programs guidance.

[4] LAN Framework available at: http://hcp-lan.org/workproducts/apm-framework-onepager.pdf

requires projects be designed to achieve, through ongoing measurements and interventions, significant improvement, sustained over time, in clinical care and nonclinical care areas that have a favorable effect on health outcomes and enrollee satisfaction. Health plans conduct PIPs to examine and improve areas of service or care identified by HHSC in consultation with Texas's EQRO as needing improvement. Topics are selected based on health plan performance on quality measures and member surveys. HHSC requires each health plan to conduct two PIPs per program. One PIP per health plan must be a collaborative with another health plan or a Delivery System Reform Incentive Payment project, or a community-based organization.

Performance Indicator Dashboards

The Performance Indicator Dashboards include a series of measures that identify key aspects of performance to support MCO accountability. Dashboard measures include high and minimum performance standards by program. MCO program level performance on each measure is compared to the standards and MCOs falling below minimum performance standards on one-third or more of the dashboard measures are subject to corrective action plans.

Quality Assessment and Performance Improvement Programs

42 CFR 438.330 requires Medicaid MCOs to operate QAPI programs. These programs evaluate performance using objective quality standards, foster data-driven decision-making, and support programmatic improvements. MCOs report on their QAPI programs each year and these reports are evaluated by Texas's EQRO.

Hospital Quality-Based Payment Program

HHSC administers a Hospital Quality-Based Payment Program for all hospitals in Medicaid and CHIP in both the managed care and FFS delivery systems. Hospitals are measured on their performance for risk-adjusted rates of potentially preventable hospital readmissions within 15 days of discharge (PPR) and potentially preventable inpatient hospital complications (PPC) across all Medicaid and CHIP programs, as these measures have been determined to be reasonably within hospitals' ability to improve. Under the program, hospitals can experience reductions to their payments for inpatient stays: up to 2 percent for high rates of PPRs and 2.5 percent for PPCs. Measurement, reporting, and application of payment adjustments occur on an annual cycle.

Texas Healthcare Learning Collaborative Portal

The Texas Healthcare Learning Collaborative (THLC) portal is a secure web portal developed for use by HHSC and their Medicaid contractors to track performance data on key quality of care measures, including potentially preventable events

(PPEs), Healthcare Effectiveness Data and Information Set (HEDIS) data, and other quality of care information. The data is interactive and can be queried to create more customized summaries of the quality results. Most of the data is available to the public with some additional information available to HHSC and MCO staff with a login.

Resources

- HHSC quality webpage:
  - https://hhs.texas.gov/about-hhs/process-improvement/medicaid-and-chip-quality-and-efficiency-improvement
- Texas Healthcare Learning Collaborative Portal:
  - https://thlcportal.com

Appendix E. Public Notice

The state's health care system is experiencing significant pressure and uncertainty as Texas continues to respond to the Public Health Emergency. Therefore, this application seeks to utilize the authority under § 431.416(g) (including waiver of public notice procedures), and Texas requests that CMS grant approval of this fast track extension as soon as possible. Approval of this *fast track* extension will sustain the achievements of the demonstration and support the needs of beneficiaries and Texans.

Texas Medicaid has sought to be timely in this application request as our providers across Texas continue to face challenges daily. Federal approval of this "fast track" extension of five years will stabilize our Medicaid delivery system during this Public Health Emergency. Texas Medicaid remains committed to achieving the goals set forward and agreed to with the Centers for Medicare and Medicaid Services under our current Special Terms and Conditions (STCs).

Summary of Public Notice

In accordance with federal public notice requirements for an 1115 extension, Texas will hold 2 public meetings: a public hearing on December 7, 2020 and a meeting of the HHSC Executive Council on December 8, 2020. Given the current concerns regarding in-person meetings during the public health emergency, both meetings will be held virtually. The public will be able to provide public comment in both meetings and submit written comments by December 27, 2020. Comments will be summarized and included below. Additionally, Texas allowed for a 30 day public comment period and notice of the extension was published in the Texas Register on November 27, 2020. Texas invited the federally-recognized tribes in Texas to a call to discuss the extension and provided them with written notice on November 27, 2020. The application packet was posted November 27, 2020, on the Texas Health and Human Services Commission website at https://hhs.texas.gov/laws-regulations/policies-rules/waivers/waiver-renewal. The documents were made accessible and requests for copies were sent to TX_Medicaid_Waivers@hhsc.state.tx.us.