Presentation to the Senate Committee on Health & Human Services

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Executive Commissioner

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Foster Care Litigation

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Chief Policy & Regulatory Officer

Foster Care Litigation (FCL) Overview

- On March 29, 2011, Children's Rights, acting on behalf of several individual foster children (Plaintiffs), filed a lawsuit against the Department of Family and Protective Services (DFPS), the Health and Human Services Commission (HHSC), and the Governor in federal district court
- Plaintiffs claimed, generally, that Texas fails to protect foster children from harm and to provide foster children with appropriate care, treatment, and services
- The Court certified a General Class: all children now, or in the future, in DFPS's Permanent Managing Conservatorship (PMC)
- The case went to trial on December 1, 2014
- The Court ruled in favor of Plaintiffs on December 17, 2015, finding that the State violated Plaintiffs' Due Process rights

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Foster Care Litigation (FCL) Overview (cont.)

- Through a series of appeals, the 5th Circuit vacated several injunctive provisions and forced the District Court to modify others
- The Court issued an injunction and appointed Monitors to review documents and information for reporting to the Court on the Defendants' compliance with the injunction
- HHSC began implementing the remedial orders on July 30, 2019
- The injunction will remain in effect for three years after Defendants reach compliance
- HHSC's efforts to comply with those injunctions are being, and will continue to be, scrutinized in detail

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FCL Remedial Orders for HHSC

RO#	Description
12	Effective immediately, ensure the Residential Child Care Licensing ("RCCL") investigators, and any successor staff, observe or interview the alleged child victims in Priority One child abuse or neglect investigations within 24 hours of intake
13	Effective immediately, ensure RCCL investigators, and any successor staff, observe or interview the alleged child victims in Priority Two child abuse or neglect investigations within 72 hours of intake
14	Effective immediately, ensure RCCL investigators, and any successor staff, complete Priority One and Priority Two child abuse and neglect investigations within 30 days of intake, consistent with DFPS policy
15	Effective immediately, ensure RCCL investigators, and any successor staff, complete Priority Three, Priority Four and Priority Five investigations within 60 days of intake, consistent with DFPS policy
16	Effective immediately, ensure RCCL investigators, and any successor staff, complete and submit documentation in Priority One and Priority Two investigations on the same day the investigation is completed
17	Effective immediately, ensure RCCL investigators, and any successor staff, complete and submit documentation in Priority Three, Priority Four and Priority Five investigations within 60 days of intake
18	Effective immediately, the State of Texas shall ensure RCCL investigators, and any successor staff, finalize and mail notification letters to the referent and provider(s) in Priority One and Priority Two investigations within five days of closing a child abuse and neglect investigation or completing a standards investigation
19	Effective immediately, ensure RCCL investigators, and any successor staff, finalize and mail notification letters to the referent(s) and provider(s) in Priority Three, Priority Four and Priority Five investigations within 60 days of intake

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FCL Remedial Orders for HHSC

RO#	Description
20	Within 120 days, RCCL, and/or any successor entity charged with inspections of child care placements, will identify, track and address concerns at facilities that show a pattern of contract or policy violations Such facilities must be subject to heightened monitoring by DFPS and any successor entity charged with inspections of child care placements and subject to more frequent inspections, corrective actions and, as appropriate, other remedial actions under DFPS' enforcement framework
21	Effective immediately, RCCL and/or its successor entity, shall have the right to directly suspend or revoke the license of a placement in order to protect children in the PMC class
22	Effective immediately, RCCL, and any successor entity charged with inspections of child care placements, must consider during the placement inspection all referrals of, and in addition all confirmed findings of, child abuse/neglect and all confirmed findings of corporal punishment occurring in the placements During inspections, RCCL, and any successor entity charged with inspections of child care placements, must monitor placement agencies' adherence to obligations to report suspected child abuse/neglect When RCCL, and any successor entity charged with inspections of child care placements, discovers a lapse in reporting, it shall refer the matter to DFPS, which shall immediately investigate to determine appropriate corrective action, up to and including termination or modification of a contract
B3	Within 150 days of the Court's Order, DFPS, in consultation with the Monitors, shall establish internal guidelines for caseload ranges that RCCL investigators, or any successor staff, can safely manage based on the findings of the RCCL investigator workload study, including time spent in actual investigations In the standard established by DFPS, caseloads for staff shall be prorated for those who are less than full-time. Additionally, caseloads for staff who spend part-time in the work described by the RCCL, or successor entity, standard and part-time in other functions shall be prorated accordingly

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Remedial Order 20 – What is Heightened Monitoring?

- Required by the court in Remedial Order 20, Heightened Monitoring (HM) is an increased frequency of on- and off-site monitoring of residential child care operations, including General Residential Operations and Child Placing Agencies, that serve youth in the permanent managing conservatorship of DFPS and have a pattern of deficiencies and/or concerns over a 5-year period
- HM is a coordinated effort between HHSC and DFPS, and it involves conducting an in-depth assessment of every operation on Heightened Monitoring
- HHSC develops an individualized and customized plan to address the patterns that led to the operation being placed on HM
- Operations will remain on Heightened Monitoring for a minimum of one year

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Remedial Order 20 Heightened Monitoring Requirements

- To assess compliance with the Heightened Monitoring plan, HHSC and DFPS must conduct weekly visits
- HHSC Child Care Regulation and DFPS residential child care contracts share responsibility for conducting weekly unannounced visits to each operation on Heightened Monitoring to ensure compliance and progress with the operation's plan
- Child Protective Services (CPS) can also assist with unannounced visits
- There are currently 70 operations on Heightened Monitoring

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Remedial Order 22

- RO 22 requires HHSC to do two separate items:
  - Consider during inspections all referrals of alleged abuse/neglect; all confirmed findings of abuse/neglect; and all deficiencies related to discipline – called an extended compliance history review
  - When HHSC discovers an operation's failure to report suspected abuse or neglect, this must be referred to DFPS
- The court found HHSC in contempt of this Remedial Order in its December 18, 2020 ruling
- HHSC has taken multiple steps to comply with this Remedial Order including:
  - Providing automated reports to DFPS daily related to failure to report
  - Automating extended compliance history reviews
  - Extending the information considered as part of the extended compliance history review to include closed operations with connections to the open operation
  - Providing job aides to staff on how to thoroughly complete an extended compliance history review

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Remedial Order B3 Residential Child Care Caseloads

- On December 17, 2019, HHSC entered into an agreement with the plaintiffs and court to have a guideline of 14-17 tasks per inspector
- There are four tasks that comprise an inspector's caseload:
  - Operations that require regulatory monitoring and oversight
  - Investigations alleging an operation failed to meet required minimum standards
  - Investigations transferred from DFPS investigations to make a determination if minimum standards were violated
  - Agency homes assigned for random sampling visits

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HHSC Exceptional Item Request

Exceptional Item #2

	Fiscal Year 2022	Fiscal Year 2023	Biennium
General Revenue	$20.9 million	$17.2 million	$38.2 million
All Funds	$20.9 million	$17.2 million	$38.2 million
FTEs	149.9	153.0	

- This request is in response to Foster Care Lawsuit and the requirements that must be met by HHSC to remain in compliance with the remedial orders
  - Funds increases in the number of staff needed to address the agreed upon workload guidelines, heightened monitoring, and implement associated IT system changes to CLASS, CLASSMate, and public and provider applications
  - Includes additional staff for quality assurance reviews and compliance tracking

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HHSC Exceptional Item Request

Heightened Monitoring

- To fully implement the process, address the needs of identified facilities, and comply with the order, an additional 64 FTEs are required

FY 22: ***64 FTEs*** */ FY 23:* ***64 FTEs***

Caseload Alignment

- HHSC entered into an agreement with the court and plaintiffs to maintain a guideline of 14 -17 tasks per inspector
- In addition to the 111 current positions, an estimated 20 additional FTEs are required to maintain caseloads guidelines as agreed upon

FY 22: ***20 FTEs*** */ FY 23:* ***20 FTEs***

Compliance/Quality Assurance Teams

- Two regional, six-member teams to focus on quality assurance and investigation reviews
- One four-member compliance team focusing on data, reporting and coordinating with IT staff
- Two FTEs dedicated to overseeing and tracking compliance with all the provisions of the remedial orders

FY 22: ***18 FTEs*** */ FY 23:* ***18 FTEs***

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HHSC Exceptional Item Request

Information Technology Upgrades

- Implementation of system changes to the CLASS, CLASSMate, and Public and Provider applications such as:
  - Documentation of each facility's heightened monitoring plan
  - Evaluation of the facility's compliance with the plan
  - Notation of weekly visits to the facility, including documents and photographs obtained during the visit.
  - Upgrades also include new letters, coding, case assignments, and the ability to generate additional reports.

FY 22: ***42.2 FTEs*** */ FY 23:* ***45.1 FTEs***

Legal Services and Human Resources

- Includes one FTE for legal services and one for HR for each fiscal year to maintain additional workload

Agency Administration Support Costs

FY 22: ***3.7 FTE*** *and FY 23:* ***3.9 FTE***

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Senate Bill 781

Jean Shaw

Associate Commissioner, Child Care Regulation

HHSC Implementation of Senate Bill 781

- The bill created new requirements for General Residential Operations (GROs) that provide treatment services for children with emotional disorders and adds requirements regarding the Child Care Regulation (CCR) enforcement framework impact all child care operations HHSC regulates
- SECTIONS 5 and 10 made multiple changes to requirements for GRO applicants planning to serve children with emotional disorders, renewal of these permits, and required collaboration with the Texas Education Agency (TEA)
  - Changed requirements for public hearings for GROs who serve children with emotional disorders
  - Added public hearing requirements for permit renewals for GROs when requested by the County Commissioner
  - Added an operational plan as an application requirement
- SECTIONS 6-9 impacted CCR's enforcement framework, removed evaluation as a type of corrective action available, and updated language in statute accordingly
- SECTION 8 broadened the 5-year application ban to operations that choose to voluntarily close in lieu of disciplinary action

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HHSC Implementation of Senate Bill 781

Public Hearings

- Statute was amended to remove the waiver for public hearings for a GRO applicant that plans to provide services to children or young adults with emotional disorders, even if the GRO plans to provide services to trafficking victim services
- Statute was amended to require a hearing in order to receive public input on the renewal of a GRO's license if requested by a county commissioners court
- HHSC is adopting procedures regarding the hearing through the rule making process
- Rules are anticipated to be effective in April 2021

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HHSC Implementation of Senate Bill 781

Operational Plans

- As of September 1, 2019, anyone who submits an application for a GRO license must submit an operational plan during the application process
- HHSC created a form to assist applicants in capturing all required elements of the operational plan
- The operational plan is evaluated by HHSC prior to acceptance of any GRO application

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HHSC Implementation of Senate Bill 781

Enforcement Framework

- Statute was amended to remove evaluation as a corrective action
- Statute was amended to require a five-year ban to an operation that voluntarily closes or relinquishes a permit in lieu of disciplinary action
- CCR updated policies for determining appropriate disciplinary action for providers

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HHSC Implementation of Senate Bill 781

Coordination with TEA

- HHSC was tasked with collaborating with TEA to develop best practices for the education of children placed in GROs
- HHSC, in coordination with TEA, gathered feedback from GRO providers about their needs and questions relating to the education provided in their operations
- HHSC and TEA are creating a best practices document that will be made available to the public by April 2021

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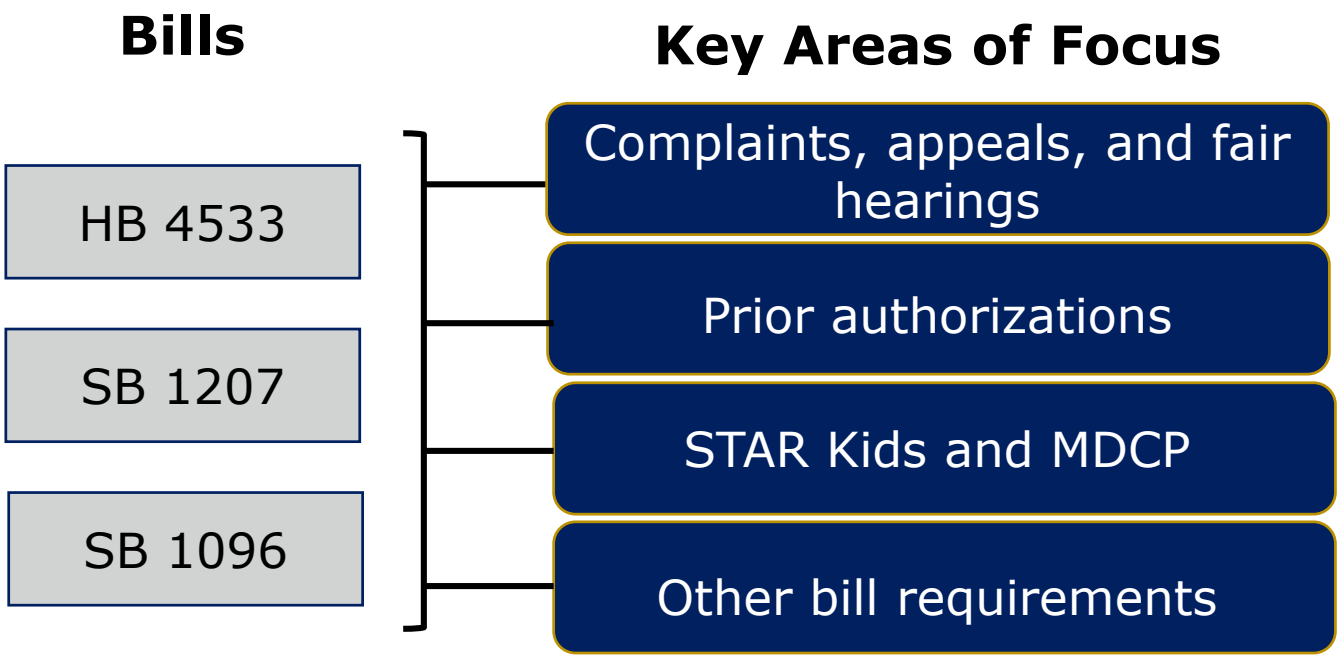
Medicaid Managed Care Reform Implementation

Stephanie Stephens

State Medicaid Director

Overview



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Complaints, Appeals, and Fair Hearings

Topic	Overview
Complaints	**HB 4533** *(posting of data completes implementation)* • Create a no wrong door process for Medicaid managed care complaint submission • Standardize definitions and categorizations of managed care complaints within HHSC and managed care organizations (MCOs) • Establish procedures to expedite resolution of access to care complaints; and make public verified complaints data
Independent Review Organization	**SB 1207** *(timeline contingent on solicitation responses)* • Requires an independent review organization (IRO) to perform an external medical review when requested by members who have had a denial or reduction of Medicaid managed care services based on medical necessity and for denials based on eligibility for certain programs
Member Communication	**SB 1207** *(implements fall 2021)* • Notices sent by HHSC or a Medicaid MCO to a Medicaid recipient or provider regarding denial of coverage or prior authorization for a service must include certain elements

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Prior Authorization

Topic	Overview
Communication	**SB 1207** *(implementation complete)* • Requires MCOs or other entities responsible for authorizing coverage for health care services under Medicaid to maintain prior authorization information on their website
Timelines and Re-consideration	**SB 1207** *(implements spring 2021)* • Establish a process and timeline for MCOs to reconsider adverse determinations on requests that resulted from insufficient or inadequate documentation in consultation with the State Managed Care Advisory Committee
Timelines for Hospitalized Individuals	**SB 1096** *(implementation complete)* • MCOs must review and issue prior authorization determinations within specific timeframes for members who are hospitalized
Oversight	**SB 1207** *(implementation complete)* • Annual review of MCO's prior authorization requirements, not including prior authorizations for the vendor drug program

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STAR Kids and MDCP

Topic	Overview
Eligibility	**SB 1207** • Requires consideration of compassionate allowances conditions and Medicaid hospice or palliative care service receipt in MDCP and DBMD eligibility *(CMS indicates not allowable)* • Ensures children do not have to stay in a nursing facility for an extended period of time before being determined eligible for MDCP *(aligns with Medicaid policy)*
Interest List	**SB 1207** *(implementation complete)* • Allows a child denied MDCP the option to: (a) be placed at the top of the MDCP interest list in to receive a new assessment from a different MCO, or (b) join another waiver interest list in a position based on the date the child was first placed on the MDCP interest list
SK-SAI	**SB 1207** • Streamlines the SK-SAI and reassessment process *(implements winter 2021/2022)* • MCOs must ensure STAR Kids service coordinators provide results of MDCP assessment to parent/LAR, and offer an opportunity for a peer-to-peer with a physician of the member's choosing. *(implementation complete)*

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STAR Kids and MDCP

Topic	Overview
Service Delivery	**SB 1207** • Develop policy for coordination of benefits when a child has private health insurance and Medicaid *(implements spring and summer 2021)* • Create a Medicaid escalation helpline for individuals in MDCP and DBMD waivers *(implementation complete)* • Conduct an evaluation of risk adjustment for STAR Kids *(evaluation complete)* **HB 4533** • Expands the availability of the Consumer Directed Services (CDS) option in the MDCP waiver program *(implementation complete)* • Requires HHSC to explore with STAR Kids Advisory Committee the feasibility of providing Medicaid benefits to children enrolled in STAR Kids through an accountable care organization (ACO) or a proposed alternative model *(RFI posts spring 2021)*
Oversight	**SB 1207** *(ongoing implementation of quality improvement)* • Conduct annual surveys of MDCP caregivers, annual focus groups, and measure performance of MCOs **SB 1096** *(implementation complete)* • Conduct a utilization review on a sample of cases for children enrolled in the STAR Kids managed care program
Administration	**HB 4533** • Extends the STAR Kids Advisory Committee through December 31, 2023 - also required in SB 1207 *(implementation complete)*

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Other Bill Requirements

Topic	Overview
MCO Accreditation	**HB 4533** *(implements September 2022)* • HHSC must ensure MCOs are accredited

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Access to Services: Telemedicine and Telehealth

Stephanie Stephens

State Medicaid Director

Telemedicine and Telehealth

Bill	Overview
SB 670	• Removed the requirement for a health professional to be present with a client during a school-based telemedicine service • Required HHSC to ensure MCOs meet specified requirements for reimbursing telemedicine and telehealth services and promoting patient-centered medical homes • Prohibits MCOs from denying reimbursement for covered services solely because they are delivered remotely and requires MCOs to consider clinical and cost-effectiveness to determine whether a telemedicine or telehealth service is appropriate • Authorized HHSC to allow Federally Qualified Health Centers (FQHCs) to be telemedicine distant and patient site providers, contingent on appropriations

Implementation complete with ongoing monitoring

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Telemonitoring Services

Bill	Overview
HB 1063	• Required HHSC to provide reimbursement for home telemonitoring services provided to pediatric clients with end-stage solid organ disease, who have received an organ transplant, or who require mechanical ventilation • Removed the reimbursement sunset date for the Medicaid home telemonitoring services • Required HHSC to include a cost-savings analysis of telemedicine, telehealth, and home telemonitoring services in its 2020 biennial report • HHSC Rider 178 is a contingency for HB 1063 that requires HHSC to implement the provisions of the bill out of funds appropriated to the agency

Implementation complete

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Rural Pediatric Health Teleconnectivity

Bill	Overview
Rider 94, Article II, HB 1	• A pediatric telemedicine grant program to enable non-urban healthcare facilities to obtain pediatric telemedicine services • Rider 94 specifies that appropriations include $1.2 million in General Revenue and $1.3 million in Federal Funds in fiscal year 2020 and $1.2 in General Revenue and $1.3 million in Federal Funds in fiscal year 2021 to establish a pediatric tele-connectivity resource program for rural Texas

Implements spring 2021

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Medicaid Managed Care Carve-ins

Stephanie Stephens

State Medicaid Director

Non-Emergency Medical Transportation Carve-In

Bill	Overview
HB 1576	• Required HHSC to add non-emergency transportation (NEMT) services to managed care for coordination by the MCO • Nonmedical transportation services, which are a subset of demand response transportation services, will be provided for certain trips requested with less than 48-hour notice. – Limited to pharmacy trips, hospital discharge, and trips to access treatment for an urgent condition. • Increases opportunities for transportation network companies (TNCs) to deliver NEMT services. • HHSC MTP will continue to provide NEMT services to clients not enrolled in managed care.

Date for carve-in is June 2021

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STAR+PLUS Pilot Program

Bill	Overview
HB 4533	• Develop, implement, and evaluate a pilot program through the STAR+PLUS Medicaid managed care program to test person-centered managed care strategies for delivery of LTSS for people with IDD, traumatic brain injury, and similar functional needs as a person with IDD • Establish the STAR+PLUS Pilot Program Workgroup to work in collaboration with HHSC and the IDD System Redesign Advisory Committee to inform pilot development and implementation • Complete dental study to evaluate dental benefits provided through certain Medicaid waiver programs and Medicaid managed care to determine which set of benefits is most cost-effective in reducing emergency department visits and inpatient hospital admissions due to poor oral health

Date for pilot start is September 2023

1115 Waiver

Trey Wood

Chief Financial Officer

Stephanie Stephens

State Medicaid Director

Public Health Emergency

- COVID–19 is an unprecedented public health emergency
- The 1115 waiver was initially approved in 2011
  - Current waiver was set to expire September 30, 2022
- The extension adequately enables Texas to respond to the pandemic while also working with providers through the Delivery System Reform Incentive Payment (DSRIP) program transition
- Intent is to sustain funding for access to:
  - Community behavioral health services
  - Public health services
  - Hospital services
  - Primary care services provided by physician groups
- The extension provides approval from January 15, 2021 through September 30, 2030

Waiver Successes

- Texas 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
  - Transition to quality-based payment systems across managed care and hospitals

Continuity

- Texas Medicaid has a mature 1115 waiver inclusive of:
  - 17 Medicaid managed care organizations
  - 3 dental maintenance organizations
  - 288 performing providers in Delivery System Reform Incentive Payment (DSRIP) program
  - 864 nursing facilities in Quality Incentive Payment Program (QIPP)
  - 529 providers in the Uncompensated Care program
- HHSC will continue to advance the goals of the 1115 waiver under this extension and align new programs with overall Medicaid

New Pool for Public Health Providers (PHP-CCP)

Creates the Public Health Provider-Charity Care Program

- Begins 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
- Financed by certified public expenditures
- Year 1 (Fiscal Year (FY) 2022) pool will be $500 million and providers will be reimbursed for Medicaid shortfall & uncompensated care costs

PHP-CCP (cont.)

- Year 2 and onward pool will be up to $500 million; payments will be based on charity care costs
- Year 3 (for FY 2024) program will be resized based upon actual charity care cost data from Year 2
  - As a result of the resizing, funding may be reduced or grow from $500 million
- HHSC is launching a stakeholder engagement process to assist with development of the program and to provide feedback as the agency works towards meeting the milestones with the Centers for Medicare & Medicaid Services (CMS)

Framework for DPP Approvals

Directed-Payment Programs for FY22

- Directed-Payment Programs (DPP) are key to the DSRIP and Network Access Improvement Program (NAIP) transitions
- DPP levels in FY 2022 are also critical in the determination of budget neutrality (BN) for the rest of the waiver
- The waiver includes a framework for the state and CMS to work together to get FY 2022 DPPs approved
- Includes new reporting requirements about provider-level payments and achievements
- Programs include: Comprehensive Hospital Increased Reimbursement Program (CHIRP); Quality Incentive Payment Program (QIPP); Texas Incentives for Physicians and Professional Services (TIPPS); Rural Access PPS (RAPPS); Ambulance Average Commercial Reimbursement Program; and Behavioral Health Services

Milestone Dates for DPP Approvals

Timelines	Description	Responsible Party
Day 1	Texas submits pre-prints to CMS	Texas
Day 31 (+30 days)	CMS sends Texas Requests for Additional Information (RAIs) necessary for approval	CMS
Day 45 (+15 days)	Texas provides responses to RAIs	Texas
Day 65 (+20 days)	CMS notifies Texas of anticipated approval or sends Round 2 RAIs	CMS
Day 67 (+2 days, and every 2 business days after)	If Round 2 RAIs are sent, Texas and CMS have call to discuss outstanding questions	Both
Day 70 (+5 days, and every 5 days after any additional RAIs)	Texas provides responses to Round 2 RAIs	Texas

*Programs must be approved annually by CMS

Anticipated DPPs

Comprehensive Hospital Increased Reimbursement Program (CHIRP)

- Proposed Program Size: $5,020,000,000

Quality Incentive Payment Program (QIPP)

- Proposed Program Size: $1,100,000,000

Texas Incentives for Physicians and Professional Services (TIPPS)

- Proposed Program Size: $600,000,000

Rural Access PPS (RAPPS)

- Proposed Program Size: $18,700,000

Ambulance Average Commercial Reimbursement Program

- Proposed Program Size: $150,000,000

Behavioral Health Services

- Proposed Program Size: $43,500,000

Budget Neutrality

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Key Take-Aways

- Extension preserved budget neutrality and created room for new programs
- Rebase of Without Waiver expenditures will include directed payment program funding, both current and new DSRIP transition replacement programs (upwards of $6.9 billion per year)
- In addition to sustained DSRIP level funding and Public Health Charity Care Pool, achievement of an estimated $10 billion in budget neutrality room over the 1115 extension

Table 1. Supplemental and Directed-Payment Programs & Providers

Pools / Programs	Benefiting Providers
Existing Programs	
Uncompensated Care Program (UC)	Hospitals, Physician Practice Groups, Ambulance Groups, Public Dental Providers
Quality Incentive Payment Program (QIPP)	Nursing Facilities (Public & Private)
Programs Phasing Out	
Delivery System Reform Incentive Payment (DSRIP)	Hospitals, Physician Practice Groups, Local Mental Health & Local Health Depart.
Network Access Improvement Program (NAIP)	Publicly owned Academic Health Science Centers and Hospitals

Table 1. Supplemental and Directed-Payment Programs & Providers (cont.)

New or Expanding Programs	
Public Health Providers – Charity Care Pool (PHP-CCP)	Public behavioral health providers and public health providers
Comprehensive Hospital Increased Reimbursement (CHIRP)	Hospitals (public and privately owned)
Ambulance Average Commercial Reimbursement	Ambulance Providers (publicly owned)
Texas Incentives for Physician and Prof. Services (TIPPS)	Physician practice groups (public and privately owned)
Behavioral Health Services	Community Mental Health Centers (CMHCs)
Rural Access to Primary and Preventive Services (RAPPS)	Rural Health Clinics (RHCs)

Table 2. Supplemental & Directed-Payment Program Estimates

Pools / Programs	DY 10 (FFY 21)	DYXX + w/o Extension	DYXX + Post-Extension
Uncompensated Care Program	$ 3,873,206,193	$ 3,873,206,193	$ 3,873,206,193
Quality Incentive Payment Program (QIPP)	$ 1,112,777,522	$ 1,100,000,000	$ 1,100,000,000
Delivery System Reform Incentive Payment (DSRIP)	$ 2,490,000,000	$	$
Network Access Improvement Program (NAIP)[1] [2]	$ 493,364,220	$ 250,000,000	$ 250,000,000
Public Health Providers – Charity Care Pool (PHP-CHP)	$	$	$ 500,000,000
Comprehensive Hospital Increased Reimbursement (CHIRP)	$ 3,050,461,866	$ 3,050,461,866	$ 5,020,000,000
Ambulance Average Commercial Reimbursement	$	$	$ 150,000,000
Texas Incentives for Physician and Prof. Services (TIPPS)	$	$	$ 600,000,000
Behavioral Health Services	$	$	$ 43,500,000
Rural Access to Primary and Preventive Services (RAPPS)	$	$	$ 18,700,000
Total[3]	$11,019,809,801	$ 8,273,668,059	$ 11,555,406,193

1. Both NAIP and CHIRP (UHRIP) are larger then initially projected for FY2021 as a result of increased caseload.
2. NAIP is estimated to be $427.3 Min DY11 (FFY22), winding down to $250.0 M in DY12-DY16, and 0 in DY17 onward.
3. Post extension total represents estimated amounts that are subject to change based on submitted preprints.

UC Pool Resizing

The UC Pool will be resized twice

- First re-sizing will take place in Demonstration Year (DY) 11 to take effect in DY12 (FY 2023)
  - In recognition that the PHE will impact FY 2020 and FY 2021 cost report data, re-sizing will use the 2019 cost reports and the 2017 Disproportionate Share Hospitals (DSH) payment data
- Second re-sizing will take place in DY16 to take effect in DY17 (FY 2028)
  - Sizing will use the 2025 cost reports and 2023 DSH payment data
- Re-sizing will allow for adjustments to uncompensated care pool based on actual charity care

Monitoring & Reporting

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Creates new STCs to emphasize importance of Monitoring & Reporting

- Emphasizes the responsibility of the state to provide oversight of funds
- Requires some additional reporting on sources of funds
- Requires the state to reaffirm some existing certifications related to funds and payments

The extension expands transparency and reporting:

- Home and Community Based Services
- Revised External Evaluations
- Quality Improvement

Total Estimated Value of the Waiver Extension

- Potential of an average of $11.4 billion per year above base expenditures
  - Includes $3.9 billion per year for payments for uncompensated care
  - Includes $500 million per year for payments for new Public Health Provider-Charity Care Program
  - Includes opportunity for $6.9 billion per year for quality and access improvements
- Saves an estimated $10 billion for taxpayers over the life of the waiver