Texas Health and Human Services Commission

Texas Healthcare Transformation and Quality Improvement Program

Medicaid 1115 Waiver

Proposal

July 13, 2011

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Texas 1115 Waiver Proposal

Introduction

This proposal outlines a demonstration waiver under section 1115 of the Social Security Act that is designed to build on existing Texas health care reforms and to redesign health care delivery in Texas consistent with the CMS triple aim to improve the experience of care, improve the health of populations, and to reduce the cost of health care without compromising quality. The overarching goals of this waiver are to:

- Expand risk-based managed care statewide;
- Support the development and maintenance of a coordinated care delivery system through the creation of Regional Healthcare Partnerships (RHPs) and RHP five year care and quality improvement transformation plans;
- Improve outcomes while containing cost growth;
- Protect and leverage financing to improve and prepare the health care infrastructure to serve a newly insured population;
- Transition to quality-based payment systems across managed care and hospitals; and
- Provide a mechanism for investments in delivery system reform including improved coordination in the current indigent care system now providing services to individuals likely to gain coverage in 2014.

Texas believes that the proposed demonstration will help transform the current delivery of care and payment systems in Texas to a system that is more transparent, accountable, and ready to serve newly insured individuals who would enroll in Medicaid or federally subsidized insurance under current law starting in 2014.

Texas' proposal includes several elements that all relate to the overarching goals mentioned above. In summary, the waiver elements Texas is requesting are:

- Authority to expand risk-based managed care in all areas of the State.
- Flexibility to direct waiver savings into a pool to cover uncompensated care costs by hospitals and other providers.
- Flexibility to reinvest waiver savings for delivery system reforms that expand provider capacity, improve care efficiencies, and align provider incentives in a manner that promotes quality of care and helps prepare providers for health coverage expansion in 2014.

Managed Care Expansion

The proposed 1115 waiver will encompass several existing waiver programs and expand risk-based managed care statewide in the following manner:

- Transfer the STAR 1915(b) waiver program and STAR+PLUS combination 1915(b)/1915(c) waiver program into the 1115 waiver. Texas will maintain the current program structure, design and operation except for the specific changes in populations and covered services described herein. Texas will maintain the program names of STAR and STAR+PLUS to minimize confusion or disruption to clients that may result if the program names are changed.
- By September 2011, expand the managed care delivery systems in the STAR 1915(b) waiver and the STAR+PLUS combination 1915(b)/1915(c) waivers to counties that are contiguous to current service areas, including the new Jefferson service area.
- By March 2012, expand the STAR managed care program into 164 rural counties in the Medicaid rural service area (MRSA). Clients in this service area are currently served by Primary Care Case Management (PCCM) services under the State Plan.
- By March 2012, expand the STAR+PLUS program to the Lubbock and El Paso service areas.
- By March 2012, expand STAR and STAR+PLUS managed care programs to ten counties in the Hidalgo Service Area of South Texas. Currently, the beneficiaries in these counties are enrolled in PCCM.
- By March 2012, convert the delivery model for primary and preventative dental services from fee-for-service (FFS) to a statewide risk-based model (known as Children's Medicaid Dental Services).

Four other modifications that merit highlighting are:

- Prescription drug benefits, currently provided under the FFS program, will be carved into managed care benefit and capitation rates effective March 1, 2012;
- Non-behavioral health inpatient hospital services, currently carved out of the STAR+PLUS program, will be carved into the managed care benefit and capitation rates effective March 1, 2012;
- For Medicaid eligible individuals who are dually eligible for Medicare, Medicaid pays for some acute physical health services ("wrap services") in addition to what Medicare covers. These Medicaid wrap services, currently carved out of Medicaid managed care, will be carved into the managed care benefit and capitation rates in all STAR+PLUS service areas effective March 1, 2012. Medicaid wrap services will also be carved into the STAR benefit and capitation rates in the Medicaid Rural Service Area, where STAR+PLUS will not be available.

- Texas will apply the current limit applied to most adults in Fee-for-Service of a three prescription limit per month for adults in STAR and STAR+PLUS, effective December 1, 2011 for most drugs. The limit will not apply to children age 20 and under in these programs. Certain drugs, such as insulin, and drugs for smoking cessation and contraception, are excluded from the three prescription limit. Additionally, STAR+PLUS members who qualify for home and community-based long-term services and supports (formerly included in Texas' STAR+PLUS 1915(c) waivers) and individuals in 1915(c) waivers receiving acute care services in the Medicaid Rural Service Area will be able to receive unlimited prescriptions.

Altogether, these programs cover more than 3 million Medicaid beneficiaries and shift 1.5 million individuals into risk-based managed care programs. Given the positive results to date of the managed care programs, Texas is anxious to gain approval to expand these programs, thus improving health outcomes for a greater number of beneficiaries. HHSC will ensure that Medicaid beneficiaries have a choice of at least two managed care plans in all programs and service areas covered by this waiver. More detailed descriptions of the five managed care expansions are included in Appendices A - D. Appendix A is a summary of state plan eligibility groups and services covered under the demonstration for Children's Medicaid Dental Services, and the expanded STAR and STAR+PLUS programs; Appendix B is a Summary of Managed Care Expansion and a table and maps showing managed care expansions by geographical areas. Appendix C contains the managed care contract procurement schedules. Appendix D summarizes the public notices and stakeholder involvement that have occurred to date.

Benefits of MCO Expansion

A full-risk, capitated approach like that used in the STAR and STAR+PLUS programs is the most comprehensive solution to address the complex medical, behavioral, and social needs of Medicaid clients. The full-risk, capitated managed care approach also offers the maximum cost control benefit to the State. A full-risk model combines the responsibility for both the financing and delivery of health care services under one entity and drives a patient-centered management approach to addressing multiple and complex health care needs. Under the full-risk model, MCOs have incentives to coordinate care and services that reduce the costs of inpatient care, over-utilization of prescription drugs, and other expensive categories of health care services.

Enrollees in STAR+PLUS are generally those with the most complex health needs and most costly potential expenditures. However, through improved service coordination and management, STAR+PLUS has improved access to services, reduced duplication, and created a more effective delivery of health care services that benefits both the clients and the State. The

STAR+PLUS program has improved cost containment this population, while also establishing greater accountability for the Medicaid services delivered to individuals.

Medicaid Managed Care Benefits:

* *Increased accountability*. STAR and STAR+PLUS health plans are contractually responsible for providing their members with medically necessary services for a fixed payment amount. The delivery and the cost for these services are monitored and accounted for by the State. STAR and STAR+PLUS health plans also provide an additional level of review for potential Medicaid fraud and abuse.

* *Better coordinated and quality health care*. STAR and STAR+PLUS provide care coordination, which assists in locating specialist providers and in member outreach. Care coordination has reduced burdens on physicians and their employees, while at the same time providing better outcomes. Member satisfaction ratings are consistently higher than non-managed care Medicaid recipient satisfaction ratings. STAR and STAR+PLUS focus on preventative measures to keep their members healthy.

* *Improved Access*. STAR and STAR+PLUS health plans must ensure access to physicians per contract requirements which include access to routine, urgent, and emergency care. Every member has a primary care physician, and all network providers must meet specific quality standards.

The STAR program performs above the Medicaid national average on many measures, including:

* Well-child visits for ages 3-6
* Adolescent well-care visits
* Children and adolescent access to primary care practitioners
* Appropriate medications for asthma
* Follow-up within 30 days after hospitalization for mental illness

Additionally, the STAR program performs above the Medicaid national average on adult inpatient admission rates for:

* Long-term diabetes complications
* Chronic obstructive pulmonary disease
* Congestive heart failure

* Dehydration
* Bacterial pneumonia
* Angina without procedure
* Lower extremity amputation in diabetes

The STAR program also performs above the Medicaid national average for pediatric inpatient admission rates due to pediatric gastroenteritis.

Many members in the STAR program report having a relationship with their physician for over two years and report satisfaction with their physician. The vast majority of STAR enrollees (93 percent) who saw a provider other than their personal doctor were pleased with the care coordination that they received from their health plan, doctor's office, or clinic.

The STAR+PLUS program performs above the Medicaid national average for the following measures:

* Well-child visits for ages 3-6
* Diabetic Nephropathy Care
* HbA1c Testing
* LDL-C Screening
* Follow-up within 7 days after hospitalization for mental illness
* Follow-up within 30 days after hospitalization for mental illness

In STAR+PLUS, which emphasizes service coordination, 82 percent of Medicaid only members have a specific person—a personal doctor or nurse—from whom they received health care. Members' personal doctors are most often general doctors rather than specialists. The majority of members have been seeing their personal doctor for at least one year, which improves continuity of care. Only 24 percent of members were with their personal doctor for less than one year and 27 percent of members had the same personal doctor for five years or more. While 53 percent of members with a personal doctor needed care from other health providers in the last six months, communication between respondents' personal doctors and other providers was rated as good. The majority of members report their personal doctor is always up-to-date on care received from other providers.

Members with a service coordinator reported satisfaction with the coordinator's performance over the past six months. These positive indicators suggest the value of continuing and expanding managed care. In addition, Texas has contracted with a value-based purchasing

consultant group to further improve the quality of care and overall value provided in these programs, and Texas will include a five percent performance-based withhold in MCO contracts, effective March 2012.

Excluded and Voluntary Populations

The proposed 1115 waiver would cover the majority of Medicaid beneficiaries statewide including children, adults, pregnant women, persons with disabilities, and individuals over age 65, including dual eligibles. However, certain populations will be excluded from the 1115 demonstration or permitted to enroll on a voluntary basis.

Excluded populations include: (1) individuals receiving care in institutions; (2) children enrolled in the capitated STAR Health model, which primarily serves children in State conservatorship; (3) individuals eligible through medically needy spend down; and (4) individuals in other 1915 (c) programs, with the following exception. In the Medicaid Rural Service Area (MRSA), where STAR+PLUS is not available, STAR members may enroll in a 1915(c) waiver program.

Individuals age 20 and under who are receiving SSI are eligible to enroll in STAR and STAR+PLUS (but are not mandatory); however, these clients will be mandatory enrollees in STAR in the MRSA if they are dual eligibles. Individuals age 20 and under who are receiving SSI will also be mandatory enrollees in Children's Medicaid Dental Services.

Inclusion of Key Components of the STAR and STAR+PLUS Waivers

The STAR program is Texas' primary managed care program for acute care services, and has been operated pursuant to a 1915(b) waiver. The STAR+PLUS Program is a program providing integrated acute and long term care for individuals age 65 and over and the disabled. The STAR+PLUS Program has been operated pursuant to one 1915(b) and two 1915(c) waivers – one for the Medical Assistance Only (MAO) population, and another for the Supplemental Security Income (SSI) population. There is an interest list for the MAO population, but not for the SSI population. Other than as specified elsewhere in this document, Texas will maintain the current programs' structure, design and operation in the 1115 waiver (including provisions of law waived, program entrance criteria, exclusions, template contracts already reviewed by CMS, etc.). Key components of the waivers that will be preserved under the 1115 waiver are included in Appendices G-H.

Texas Delivery System Redesign

Texas proposes to create a funding pool under the demonstration that supports the development and maintenance of a coordinated care delivery system through Regional Healthcare Partnerships (RHPs), and to provide a mechanism for investments in delivery system reform. The funding pool will have two distinct components for which federal financial

participation would be requested: (1) payments to hospitals and other eligible providers to cover uncompensated care (UC) costs; and (2) a delivery system reform incentive payment (DSRIP) program for hospitals.

Funding for the pool will reflect the full difference between the without-waiver baseline and with-waiver baseline. A description of the Budget Neutrality methodology is included in this document in Appendices E and F, and the Budget Neutrality Spreadsheet is included as a separate document, Attachment 1. The sources that make up the difference between the without-waiver baseline and the with-waiver baseline and that will be in the funding pool include:

(1) inpatient hospital supplemental payments previously allocated through the upper payment limit program for all waiver and non-waiver populations. With respect to waiver populations, the UPL costs are built into the per-member-per-month (PMPM) allowances as a component of FFS historical spending;

(2) a fee-for-service equivalent adjustment and corresponding UPL adjustment to inpatient hospital services in the PMPM allowance for the STAR program to reflect a planned FFS "carve out" of this service from MCO contracts, absent the 1115 waiver;

(3) supplemental payments allocated through the physician upper payment limit (UPL) program; and

(4) cost efficiencies achieved from moving populations and services to risk-based managed care.

These components are discussed in more detail in Appendices E and F.

Federal policy that prohibits States to continue UPL hospital supplemental payments for Medicaid beneficiaries who transition from fee-for-service to risk-based managed care has proven to be a major obstacle to expanding managed care in Texas. That policy has resulted in fragmented patient care, most notably in STAR+PLUS, where inpatient non-behavioral health hospital services are carved out of the capitated benefit package and delivered under the fee-for-service program.

The Texas Legislature has given specific direction regarding Medicaid managed care expansion for 2012-2013. The Legislature instructed in the appropriations bill for 2012-2013 that Texas Medicaid must preserve supplemental payments to hospitals in the expansion of managed care

and achieve program savings associated with the expansion.[1] Thus, if the 1115 demonstration waiver is not approved, Texas would meet this Legislative direction by leaving inpatient hospital services out of the STAR+PLUS program and by carving inpatient hospital services out of the STAR program.

Texas believes that the proposed payment pools—UC and DSRIP—strike the right balance to meet hospital concerns with changes to hospital UPL, while at the same time ensuring that federal and state Medicaid dollars are spent wisely and appropriately. The pool payment methodologies will increase payment transparency and accountability, align hospital payments with the cost of providing services, and help fund delivery system reforms that will lead to lasting improvements in health care delivery across Texas hospitals and community-based care systems. On the whole, payments from these two pools will help providers prepare to meet new coverage demands beginning in 2014.

Hospitals eligible to receive funding from the payment pools must meet the following criteria:

- Submit a Waiver Application, including uncompensated care and related cost and payment data to be used as the basis for qualifying payments from the UC pool.
- Provide IGT or have an affiliation or agreement with an entity that provides IGT as the basis for the payments.
- Participate in and meet the criteria for payments from the DSRIP, including participation on a Regional Healthcare Partnership plan, and meeting related RHP objectives, reporting and metrics as identified for the hospital.

The proposed changes to hospital funding under the waiver will impact more than 300 hospitals (state, non-state public, and private) that currently receive supplemental payments under the state plan. Hospitals are crucial partners in Texas' Medicaid reform plans to expand managed care and to redesign the health care delivery system. Texas recognizes that hospitals will need to adapt to new payment structures proposed under the demonstration. Therefore, Texas proposes in the early years of the demonstration allocating a larger percentage of funding to the UC pool and incrementally shifting waiver resources to the DSRIP pool in the later years of the demonstration. During the first year of the waiver, hospitals will also have an opportunity to receive UC and incentive payments that at least equal the same level of funding they

[1] 2012-13 General Appropriations Act (Article II, Health and Human Services Commission, Riders 76 & 77, H.B. 1, 82nd Legislature, Regular Session, 2011).

received in UPL supplemental payments in the previous year. This approach will help ensure a smooth transition from the existing UPL payment program to the proposed delivery system reform program, while beginning real transformation in the first year.

The non-federal share of pool expenditures for uncompensated care and DSRIP will largely be financed by state and local intergovernmental transfers. However, given the fiscal challenges faced by Texas and local governments, Texas requests authority to recognize costs not otherwise matchable for mutually agreed upon local and state designated health programs (DSHP). The freed up state and local funding would provide needed financial assistance to pursue meaningful delivery system reforms that will help prepare the Texas health care system for major coverage expansion in 2014.

Texas proposes the following distribution of funding across these categories over the five-year waiver period:

	DY 1	DY 2	DY 3	DY 4	DY 5
DSHP	Up to $500M	Up to $500M	Up to $500M	UP to $400M	Up to $400M
Uncompensated Care Pool	80% after DSHP	80% after DSHP	70% after DSHP	60% after DSHP	50% after DSHP
Incentive Pool	20% after DSHP	20% after DSHP	30% after DSHP	40% after DSHP	50% after DSHP

Texas requests the flexibility to shift funding across pool categories and from DSHP to the two pools to address funding needs and evolving priorities. This flexibility is especially crucial in the first year of the demonstration when Texas collects data from hospitals on their uncompensated care costs and when the DSRIP program begins implementation. With more information and experience, Texas will be better equipped to estimate funding needs across these categories.

Uncompensated Care Pool

Texas uncompensated care totaled $15.1 billion in 2009 with hospitals bearing the majority of the financial burden of these costs. Payments from this component of the pool would help defray the costs of uncompensated care provided to individuals who have no source of third party coverage for the services provided by hospitals or other providers identified by HHSC.

Texas currently makes UPL supplemental payments to hospitals within three hospital classes (state, non-state public, and private), with each class having its own aggregate cap. DSH

hospitals may receive UPL payments that cannot exceed the lesser of their DSH room (defined as DSH hospital specific limit minus DSH payments) or Charge room (defined as the hospital's billed charges for Medicaid claims minus payments received for those claims). Hospitals that do not participate in the DSH program may be reimbursed up to their Medicaid charges, net of Medicaid payments.

As Medicaid populations move into risk-based managed care programs, a share of former UPL funds associated with these individuals will flow through the "without waiver" PMPM allowance and into the UC pool. Under the UC payment methodology, Texas would align hospital reimbursement with actual costs of services provided, and eliminate reimbursement based on Medicaid charges, which some hospitals receive today. To promote a comprehensive payment reform approach, Texas will also apply the UC payment methodology to UPL payments that would have been generated under the FFS program for populations not included in this managed care expansion. These UPL payments will be incorporated in this waiver, added to the without waiver budget cap, and redirected to the UC and DSRIP pools.

Reimbursement Method. Qualified Medicaid DSH hospitals and non-DSH hospitals that participate in Medicaid would be eligible to apply for a UC payment. The proposed UC pool would reimburse uncompensated hospital services and some non-hospital services furnished to Medicaid recipients and individuals with no source of third party coverage.

Payments from the UC pool would be based on these cost components:

- Uncompensated costs, not otherwise covered by the Disproportionate Share Hospital (DSH) program, for furnishing inpatient and outpatient hospital services to Medicaid managed care enrollees, i.e., Medicaid shortfall;

- Uncompensated costs, not otherwise covered by the Disproportionate Share Hospital (DSH) program, for furnishing inpatient and outpatient hospital services to individuals with no source of third party coverage. This would include costs for hospitals that are not otherwise eligible for DSH and/or hospitals that are eligible for DSH but that do not receive DSH payments up to the allowable hospital-specific limit for DSH. These would be consistent with the Medicaid DSH audit requirements; and

- Uncompensated costs for furnishing non-hospital services, including physician, other professional, pharmacy, and clinic costs, to Medicaid individuals and individuals with no source of third party coverage for such services. All such costs will be calculated in a manner consistent with Medicare cost principles.

DSH program. The Texas Medicaid DSH program would continue to operate under the state plan in coordination with the 1115 waiver. Any changes to the DSH program would be

requested to CMS through the normal state plan amendment process. Texas intends to make changes to the DSH program to complement the system transformation made possible through this waiver.

Hospital UC Application. To qualify for a UC payment, a Texas hospital would be required to complete an annual Waiver Application that will collect cost and payment data on services eligible for reimbursement under the pool. Data collected from the application would form the basis for payments made to individual hospitals under the UC pool. Hospitals would be required to report data in a manner that adheres to Medicare cost principles as they are represented on the Medicare cost report. DSH hospitals would continue to be required to report inpatient hospital and outpatient hospital costs consistent with DSH audit requirements. Texas will administer the UC pool payments in a manner that ensures no duplication of payment between the DSH program and the UC program.

Texas is in the process of developing the Waiver Application and expects to complete it for collection of federal fiscal year 2010 hospital data in the coming weeks. Texas proposes making payments based on cost data from the federal fiscal year that is two years prior to the year in which the quarterly payments are made in order to allow time for hospitals to finalize their cost reports from that data year and submit their application data to HHSC. Thus, 2010 would be the data year for payments under the UC pool in DY 1. 2011 would be the data year for payments under the UC pool in DY 2, and so on. HHSC would trend the data to model costs incurred in the year in which payments are made.

Transitional Flexibility for Pool Payments in the First Year. Given the timing of UC application development and data collection, Texas requests authority in Demonstration Year 1 (which would begin September 1, 2011) to make interim UC payments based on historical UPL payments during the first two quarters while the hospital data is being collected and payment methodologies are put in place. At the end of the second quarter, Waiver Application data will be used to identify each hospital's annual uncompensated care provided, consistent with the waiver methodology.[2] The final two quarterly payments will be made from the UC pool not to exceed annual UC costs identified on the Waiver Application. Hospitals with UC costs less than prior year UPL payments will have the opportunity to receive payments from the DSRIP up to prior year UPL payment amounts contingent on their participation in Regional Healthcare Partnership planning, development and reporting data, and subject to approval of the affiliated

[2] On a cost basis to include DSH-allowable UC costs, as well as new costs allowed in the waiver included in the Waiver Application but not allowable under DSH, e.g., for clinics, physicians, and drugs.

public hospital. This approach allows hospitals to receive payments in the first transitional year consistent with prior year UPL payments.

Continuation of enhanced payments to physicians. Texas also proposes to continue to provide enhanced payments from the UC pool to physicians serving Medicaid. UPL physician payments are included in the without waiver calculations, and in the UC pool under with waiver as detailed in the budget neutrality section.

Delivery System Reform Incentive Payment (DSRIP) Program

The incentive payment pool proposed in Texas' 1115 waiver embodies the principles of CMS' overarching triple aim: improving the experience of care, improving the health of populations, and containing costs. Intergovernmental transfers provided by public hospital districts and local governments will finance the non-federal share of incentive payments. Qualifying Medicaid participating hospitals would be eligible to participate in the incentive payment program through Regional Healthcare Partnerships (RHPs) led by the public hospitals and local governments responsible for funding the state match.

RHPs created and led by public hospitals or local governmental entities in partnership with regional health stakeholders, would be responsible for developing a five-year plan that outlines projects and interventions that support delivery system reforms tailored to the needs of the communities and populations served by the hospitals. The plans will include regional assessments, and identify the regional goals, rationale for projects, annual milestones associated metrics, and expected results from the interventions. Plans will also include coordination of current state-funded indigent care programs to transition those programs to anticipated coverage expansions in 2014. The plans will be submitted to Texas HHSC for review and approval. Once approved by the state, the plans will be forwarded to CMS for federal approval.

Broad Goals of Incentive Program

Texas proposes to design the Delivery System Reform Incentive Program as the vehicle to support coordinated systemic care and quality improvements through RHPs. In addition, specific RHP plan components would follow guidelines and approaches approved in the California Medicaid 1115 waiver last year.

The incentive payment program seeks to transform hospital care delivery systems by:

- Integrating systems of care in a highly effective manner that ensures patients receive the right care, at the right time, in the right setting;
- Delivering high-quality care and serving as a model for ongoing improvement in quality, safety, and efficiency;

- Delivering proactive and planned prevention and primary care services for all patients, and increasing patient access by expanding the primary care workforce;
- Providing patients with a positive health care experience;
- Offering timely, proactive, coordinated medical home care from a multi-disciplinary team that is highly adept at managing chronic disease; and
- Providing equitable care in a respectful manner that is tailored to patient-specific health care needs, desires, and backgrounds.

To support these goals, the incentive program includes four broad categories of projects that would be included within each Regional Healthcare Partnership Plan.

1. **Infrastructure development** –Category 1 lays the foundation for delivery system transformation through investments in people, places, processes and technology.
2. **Program innovation and redesign –** Category 2 includes the piloting, testing, and replicating of innovative care models.
3. **Population-focused improvement** – Category 3 would require hospitals to report on a predetermined set of measures across four domains: (1) the patient's experience; (2) the effectiveness of care coordination; (3) prevention; and (4) health outcomes of at-risk populations.
4. **Urgent clinical improvements** –Category 4 requires hospitals to achieve improvement in targeted quality and patient safety measures.

Texas proposes to model these categories after the California DSRIP program and consider additional projects/interventions/clinical improvements that are described in the table below. Similar to California, in the early years, more resources and emphasis will be placed on Category 1 and 2 projects, and in later years emphasis will shift towards Categories 3 and 4 improvement measures. Over the five-year plan, measures will evolve from process measures to improvement measures that are more outcome-oriented. During demonstration year 1, regional health partnerships will receive an initial payment to develop the five-year plan. Also in Demonstration Year 1, hospitals that report UC costs on the waiver application form will qualify to receive an incentive payment. Similar to California, DSRIP payments would not be considered patient care revenue and thus would not be counted against DSH expenditures or other activities defined in the 1115 waiver or under the State Plan.

Each project will identify documentation and data sources used to establish a baseline and to measure progress and change over the five-year period. The year in which data measurement begins will depend on the project; some may begin as early as DY 1 and other projects would begin no later than DY 3. In addition starting the first year, HHSC would make DSRIP payments based on hospitals implementing system changes to support system redesign. Given the large number of hospitals that may participate in the incentive program, Texas proposes aggregate

measures across hospitals in a region where it is appropriate rather than hospital specific measures.

Additional Texas-specific Projects and Measures

Texas is considering the following projects and interventions for its program, in addition to ones identified in the California's DSRIP program.

Category 1: Infrastructure Development

1 Implement All Patient Refined Diagnosis Related Groups (APR-DRGs)
2 Implement enhanced ambulatory patient groups
3 Implement electronic health records and health information technology
4 Implement potentially preventable readmission data systems (PPRs)
5 Implement potentially preventable admissions (PPAs)
6 Certification by hospital accrediting organizations
7 Others

Category 2: Innovation and Redesign

1 Develop regional systems of care that encourage increased primary care capacity in rural areas and integrate with increased access to tertiary care in urban area
2 Develop strategies that reduce unnecessary emergency department visit
3 Develop bundled payment systems, including accountable care organizations

Category 4: Urgent Improvement in Care

1 Implement strategies to eliminate hospital acquired conditions
2 Implement strategies to reduce NICU utilization rates
3 Implement strategies to eliminate pre-39 week elective inductions.

Texas will collaborate with hospitals and CMS to finalize RHP plans that include mutually acceptable projects and interventions with associated milestones within a timeline agreed to with CMS after initial waiver approval.

Allocation Between Funding Pools

The exhibit below describes the implementation plan for the pools over the five-year waiver period.

	Uncompensated Care Pool	Incentive Payment Pool

	Uncompensated Care Pool	Incentive Payment Pool
DY 1[3]	**80% allocation** • UC application issued and completed by hospitals by end of quarter 2 • Interim payments to hospitals made in quarters 1 and 2 based on historical UPL amounts; payments adjusted to reflect UC costs in quarters 3 and 4 • Enhanced physician payments issued to qualified providers and coordinated with other UC payments. • UPL charge cap room ends	**20% allocation** • Regional Healthcare Partnerships (RHP) are established statewide and develop 5-year delivery system redesign plan. Plans are submitted to HHSC for review; once approved by state, the plans are forwarded to CMS for approval • RHPs receive initial payment/seed money to develop plans for reporting UC costs in Waiver Application. RHPs approve payments to qualifying hospitals. • On a parallel track, HHSC develops templates for selected projects that individual hospitals may implement and receive incentive payments. Projects will be integrated into RHPs and hospitals will be required to establish baselines to measure progress from DY 1
DY 2	**80% allocation** • UC application completed; quarterly payments made to hospitals based on survey results • Enhanced physician payments issued to qualified providers and coordinated with other UC payments	**20% allocation** • Implementation begins for projects identified in approved regional plans • Baselines established; depending on project, process and/or improvement measures are reported • Regional partnerships submit semi-annual reports to HHSC and CMS on progress to date; incentive payments disbursed following submission of reports • Greater emphasis on infrastructure development and program redesign
DY 3	**70% allocation** • Same as above * * If UC exceeds available funding, HHSC will develop a methodology for distributing funding across providers.	**30% allocation** • Implementation for approved projects continue • Begin transition from progress measures to improvement measures across projects • Regional partnerships continue semi-annual reporting and expand program to more hospitals or identification of new projects • Incentive payments disbursed twice per year following submission of reports

[3] Year 1 payments would be consistent with the proposed transition period payment flexibility discussed elsewhere in this proposal

	Uncompensated Care Pool	Incentive Payment Pool
DYs 4-5	**60%, 50% allocation** • Same as above	**40%, 50% allocation** • Current projects continue with greater emphasis on improvement measures reporting • Semi-annual reporting and incentive payment disbursement continues • Program expansion continues to new projects and hospitals identified by regional partnership

Designated State Health Programs

Texas requests federal financial participation for selected state and local programs that serve low-income populations. The programs are housed in the following state agencies and local government:

- Department of State Health Services
- Department of Family and Protective Services
- Department of Aging and Disability Services
- Department of Assistive and Rehabilitative Services
- Texas Higher Education Coordinating Board
- Texas Department of Insurance
- County Indigent Health Care expenditures

These programs provide vital services that today are not reimbursed by Medicaid or any other Federal source. The annual estimates of DSHP costs are reduced by 17.1 percent to reflect an adjustment for services provided to undocumented immigrants.

Under this waiver proposal, approved DSHP programs such as mental health and primary health care programs would be integrated into the five year RHP plans within each RHP region. This integration will include these programs in the original assessment, identify services and populations within each community, and develop plans for coordinating DSHP services provided with the larger set of RHP services to improve coordination, efficiency and effectiveness of services provided as well as preparing programs and populations served for coverage changes in 2014.

Texas believes that federal funding for these services is critical to help stabilize these programs and lay the groundwork to Medicaid coverage in 2014 when many recipients of these services will gain health care coverage. After 2014, a portion of these state services may be scaled back

to account for the reduced need for some of these services as these individuals access health insurance. In recognition of these developments, Texas proposes to include a level funding amount for the DSHP program in Years 1 through 3 of the waiver (up to $500 million in each year) and lower amounts in Year 4 and Year 5 (up to $400 million in each year). Texas believes that DSHP should be maintained at some level after 2014 to account for state programs that continue to support low-income populations who transition to coverage.

Integrated Payment Models

Looking farther ahead, Texas has a long-term vision of moving towards an integrated payment model for hospitals. With that in mind, throughout the five-year waiver period, Texas will study the feasibility of integrating DRG-based hospital payments with the DSRIP payments described above. The integrated payment would be based on performance measures being applied at the time. Under managed care, the integrated payment would flow through the MCOs to the hospitals, and the amount would increasingly be based on the hospital's performance.

Budget Neutrality

Texas is requesting that budget neutrality be measured with a hybrid model based on a per capita cap combined with a UPL ceiling. The without-waiver ceiling for each year would be the sum of: (1) the number of waiver-eligible individuals multiplied by an agreed-upon per member per month (PMPM) allowance based on spending for services, including UPL hospital supplemental payments, covered under the demonstration; and (2) all remaining inpatient hospital UPL payments and physician UPL payments.

As noted earlier, absent the demonstration, Texas would establish a new-carve out of inpatient services for the STAR program. As such, Texas is incorporating an estimate of STAR UPL and a fee-for-service equivalent (FFSE) in the without waiver budget cap. The estimate represents what the STAR program would cost if STAR inpatient services were carved out of managed care contracts and delivered through FFS.

The with-waiver expenditures will consist of Medicaid costs for waiver enrollees and all expenditures made under the pool, i.e., uncompensated care and incentive payments.

Texas would make a future adjustment to the without-waiver budget cap to reflect payment increases up to Medicare levels in 2013 and 2014 for primary care services as established under Section 1202 of the Health Care and Education Reconciliation Act of 2010 (Public Law 111–152), amending Section 1902(a)(13) of the Social Security Act.

Budget neutrality estimates are presented in a separate attachment. Appendices E & F include additional documentation on the development of budget neutrality and the UPL allocation.

Waivers Requested

Statewideness **Section §1902(a)(1)**

A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in selected geographic areas or political subdivisions of the State.

Freedom of Choice **Section§1902(a)(23)**

Section §1902(a)(23) of the Act requires a state to allow an individual eligible for medical assistance (including drugs) to obtain such assistance from any qualified person, institution, or pharmacy. A waiver is required if the state intends to restrict who an individual may choose to provide their Medicaid services. This restriction is a component of the 1115; therefore, we request a waiver of these requirements.

Comparability of Services **Section§1902(a)(10)(B)**

Section §1902(a)(10)(B) of the Act requires a state to provide Medicaid services that are equal in amount, duration, and scope to the Medicaid services available to all Medicaid beneficiaries. The long-term services and supports that are included in the 1115 are only available to certain Medicaid beneficiaries; therefore, we request a waiver of these requirements.

Cost Not Otherwise Matchable Authority

Texas seeks federal financial participation for costs not otherwise matchable under Medicaid to enable Texas to implement the 1115 demonstration. The items identified below, which are not otherwise included as expenditures under Social Security Act §1903, would be regarded as expenditures under the State's Title XIX plan for the period of the demonstration. They include costs of the following services and activities:

(1) Additional services currently provided under the STAR and STAR+PLUS 1915(b)(3) waiver programs;
(2) Incentive payments made under the DSRIP;
(3) Services and activities for which payments are made under the uncompensated care pool; and
(4) Home and community-based waiver services currently provided under two STAR+PLUS 1915(c) waivers.

Legislative Authority

As the single state agency for the administration of Medicaid in Texas, the Texas Health and Human Services Commission is given broad authority by the Texas Legislature to seek waivers in the Medicaid program, under Texas Human Resources Code § 32.021(b). Additionally, the

Texas Legislature passed specific legislation in June 2011 amending Chapter 531 of the Texas Government Code, authorizing HHSC to implement an 1115 demonstration waiver as described in this proposal. Act of June 27, 2011, 82nd Leg., 1st C.S. S.B. 7, § 1.11 (to be codified at Tex. Gov't Code § 531.502).

Appendix A: Tables of Medicaid Eligibility Groups and Services Included in the Waiver.

STATE PLAN ELIGIBILITY GROUPS COVERED BY STAR

Effective September 1, 2011

**Notes: See Dental chart for information on groups eligible to receive Medicaid Children's Dental Services. Individuals receiving SSI without Medicare are eligible to enroll in STAR on a voluntary basis.*

Medicaid Eligibility Group	Description	FPL	Resource Standard	Currently Receiving Services? Y/N	Delivery System	Prescription Limit for Adults
TP01/61 SAVERR money grant and Medicaid for caretakers and deprived children with income below TANF recognizable needs TANF State Program (TANF-SP) – two parent household eligible for money grant and Medicaid with income below TANF recognized needs TP08 TIERS MA - TANF Level Families	Low Income Families SSA 1902(1)(10)(A)(i)(I) SSA 1931	Apprx. 14% - uses TANF	$2000/$3000 if there is a member who is aged or disabled and meets the relationship requirement	Y		X

Medicaid Eligibility Group	Description	FPL	Resource Standard	Currently Receiving Services? Y/N	Delivery System	Prescription Limit for Adults
TP-07 SAVERR twelve months transitional Medicaid resulting from increase in earnings or combined increase in earnings and child support TP07 TIERS MA - Earnings Transitional	Individuals who lose eligibility under SSA 1931 due to increase in income or new employment SSA 1902(a)(52) SSA 1925	185%	N/A	Y		X
TP20 SAVERR four months post Medicaid resulting from child support TP20 TIERS MA - Child Support Transitional	Individuals who lose eligibility under SSA 1931 because of child or spousal support income SSA 1902(a)(10)(A)(i)(I)	185%	N/A	Y		X
TP37 SAVERR twelve months transitional Medicaid coverage resulting from loss of 90% earned income disregard TP37 TIERS MA - EID Transitional	Individuals who lose eligibility under SSA 1931 due to loss of earned income disregard SSA 1902(a)(52) SSA 1925	185%	N/A	Y		X

Medicaid Eligibility Group	Description	FPL	Resource Standard	Currently Receiving Services? Y/N	Delivery System	Prescription Limit for Adults
TP40 SAVERR pregnant women TP40 TIERS MA - Pregnant Women	1 – Qualified Pregnant Women SSA 1902(a)(10)(A)(i)(III) 2 – Poverty Level Pregnant Women SSA 1902(a)(10)(A)(i)(IV) – 133% FPL 3 – Also includes 1902(e)(5) and 1902(e)(6) – coverage post partum.	133%[4]	N/A	Y		X
TP43 SAVERR children under age one with income below 185% FPIL TP43 TIERS MA - Children Under 1	Poverty Level Infants (under 1 year old) – 133% SSA 1902(a)(10)(A)(i)(IV)	133%[5]	$2000/$3000 if there is a member who is aged or disabled and meets the relationship requirement	Y		N/A

[4] See Option TP-40 and TP-43 – mandatory to cover at 133% and an option up to 185%. Texas covers up to 185%.

[5] See Option TP-40 and TP-43 – mandatory to cover at 133% and an option up to 185%. Texas covers up to 185%.

Medicaid Eligibility Group	Description	FPL	Resource Standard	Currently Receiving Services? Y/N	Delivery System	Prescription Limit for Adults
TP45 SAVERR children to age one born to Medicaid eligible mother TP45 TIERS MA - Newborn Children	Deemed Newborn – provided to a newborn who's mother was eligible for and received Medicaid for the birth SSA 1902(e)(4)	N/A	N/A	Y		N/A
TP48 SAVERR children age 1 – 5 with income below 133% FPIL TP48 TIERS MA - Children 1-5	Poverty Level Children under 6 SSA 1902(a)(10(A)(i)(VI)	133%	$2000/$3000 if there is a member who is aged or disabled and meets the relationship requirement	Y		N/A
TP44 SAVERR children age 6 – 18 with income below 100% FPIL TP44 TIERS MA - Children 6-18	Poverty Level Children under 19 SSA 1902(a)(10)(A)(i)(VII)	100%	$2000/$3000 if there is a member who is aged or disabled and meets the relationship requirement	Y		N/A

Medicaid Eligibility Group	Description	FPL	Resource Standard	Currently Receiving Services? Y/N	Delivery System	Prescription Limit for Adults
TP47 SAVERR children ineligible for TANF, TANF-SP, or the age-appropriate medical program due to stepparent or grandparent's applied income, or stepparent's income when included on the case TP47 TIERS MA - Children denied TANF w/Applied Inc	Individuals who are ineligible for SSA 1931 due to stepparent/ grandparent income 42 CFR 435.113	TANF	$2000/$3000 if there is a member who is aged or disabled and meets the relationship requirement	Y		N/A
TP29 SAVERR 12 Months post Medicaid following end of state time limited TANF TP29 TIERS MA - State Time Limit Transitional	Ineligible for TANF cash because individual has reached the end of state time limit to receive cash assistance. This is only SAVERR. In TIERS these individuals are under TP-08. This was just a program the state created to track these individuals.	N/A	N/A	Y - limited		X

Medicaid Eligibility Group	Description	FPL	Resource Standard	Currently Receiving Services? Y/N	Delivery System	Prescription Limit for Adults
SAVERR: TP12 – SSI manually certified TP13 – SSI recipient TIERS: TP12 – ME – Temp Manual SSI TP13 – ME - SSI	Individuals receiving SSI cash benefits 1902(a)(10)(A)(i)(II)	SSI limit Appx 74% FPL	$2,000 Individual $3,000 Couple	Y		X
TP03 SAVERR Pickle TP03 TIERS ME- Pickle	Pickle Amendment – Would be eligible for SSI if Title II COLAs were deducted from income. Section 503 of P.L. 94-566 42 CFR §435.135	SSI limit Appx 74% FPL	$2,000 Individual $3,000 Couple	Y		X
TP18 SAVERR Disabled Adult Children (DAC) TP18 TIERS ME-Disabled Adult Child	Disabled Adult Children 1634(c);1935	SSI limit Appx 74% FPL	$2,000 Individual $3,000 Couple	Y		X
TP22 SAVERR Widow(er)s (Medicaid-only) TP21 TIERS ME-Disabled Widow(er)	Disabled Widows/Widowers 1634(b); 1935	SSI limit Appx 74% FPL	$2,000 Individual $3,000 Couple	Y		X

Medicaid Eligibility Group	Description	FPL	Resource Standard	Currently Receiving Services? Y/N	Delivery System	Prescription Limit for Adults
TP19 SAVERR SSI Denied Children TA01 TIERS ME – Interim SSI Denied Child TP19 TIERS ME-SSI Denied Children	Children no longer eligible for SSI because of change in definition of disability. 1902(a)(10)(A)(i)(II)	SSI limit Appx 74% FPL	$2,000 Individual $3,000 Couple	Y		N/A
TP40 SAVERR pregnant women TP40 TIERS MA - Pregnant Women	1 – Poverty Level Pregnant Women SSA 1902(a)(10)(A)(ii)(IX) – 134-185% FPL 2 – Also includes 1902(e)(5) and 1902(e)(6) –post partum coverage.	185%	N/A	Y		X
TP43 SAVERR children under age one with income below 185% FPIL TP43 TIERS MA - Children Under 1	Poverty Level Infants (under 1 year old) – 134-185% SSA 1902(a)(10)(A)(ii)(IX)	185%	$2000/$3000 if there is a member who is aged or disabled and meets the relationship requirement	Y		N/A

Medicaid Eligibility Group	Description	FPL	Resource Standard	Currently Receiving Services? Y/N	Delivery System	Prescription Limit for Adults
TP87 TIERS Medicaid Buy-In (MBI) Worked only in TIERS TP02 SAVERR only for reverse conversion.	Medicaid Buy-In BBA Work Incentives Group (MBI) 1902(a)(10)(ii)(XIII)	250%	$2,000	Y		X
TA88 TIERS only ME-MBIC	Medicaid Buy-In for Children Family Opportunity Act (MBIC) 1902(a)(10)(A)(ii)(XIX)	300%	No resource standard	Y		N/A

STAR Included Services

Please indicate which services you are proposing to cover for the population(s) in your Demonstration, including scope of coverage defined below_, as well as any services the State intends to exclude from coverage. Provide additional detail on the proposed covered and excluded services as necessary if the State plans to limit any services provided. In addition, this chart should be completed for individual populations if services vary by population.

These services are currently included in the Managed Care Organizations' capitation for the STAR program and will be included in the demonstration waiver.

State Plan Services:

A./C	**Service**	**Description**
A/C	Inpatient Hospital Services	Mandatory 1905(a)(1)
A/C	Outpatient Hospital Services	Mandatory 1905(a)(2)
A/C	Rural health clinic services	Mandatory 1905(a)(2)
A/C	FQHC services	Mandatory 1905(a)(2)
A/C	Laboratory and x-ray services	Mandatory 1905(a)(3)
A/C	Diagnostic Services	Optional 1905(a)(13)
C	EPSDT	Mandatory 1905(a)(4)
A/C	Family Planning	Mandatory 1905(a)(4)
A/C	Physicians' services	Mandatory 1905(a)(5)
A/C	Medical and Surgical services furnished by a dentist	Mandatory 1905(a)(5)
A/C	Podiatrists' services	Optional 1905(a)(6)
A/C	Optometrists' services	Optional 1905(a)(6)

A/C	Intermittent or part-time nursing services provided by a home health agency	Mandatory for individuals who, under the State Plan, are entitled to nursing facility services 1902(a)(10)(D)
A/C	Home health aide services provided by a home health agency	Mandatory for individuals who, under the State Plan, are entitled to nursing facility services 1902(a)(10)(D)
A/C	Medical supplies, equipment, and appliances	Mandatory for individuals who, under the State Plan, are entitled to nursing facility services 1902(a)(10)(D)
A/C	Physical therapy; occupational therapy; speech pathology; audiology provided by a home health agency	Optional 1902(a)(10)(D) 42 CFR 440.70
A/C	Clinic Services	Optional 1905(a)(9)
C	Dental Services (beginning March 1, 2012)	Optional 1905(a)(10)
A/C	Prescribed Drugs (beginning March 1, 2012)	Optional 1905(a)(12)
A/C	Non-Prescription Drugs (beginning March 1, 2012)	Optional 1927(d)
C	Dentures	Optional 1905(a)(12)
A/C	Prosthetic Devices	Optional 1905(a)(12)
A/C	Eyeglasses	Optional 1905(a)(12)
A/C	Preventive Services	Optional 1905(a)(13)
A/C	Services for individuals over age 65 in IMDs – Inpatient, Not Nursing Facility	Optional 1905(a)(14)
C	Inpatient psychiatric facility services for under 22	Optional 1905(a)(16)
A/C	Nurse-midwife services	Mandatory 1905(a)(17)
A/C	Certified pediatric or family nurse practitioners' services	Mandatory 1905(a)(21)
C	Personal care services in recipient's home	Optional 1905(a)(28) 42 CFR 440.170

“A” means adult. “C” means child.

STATE PLAN ELIGIBILITY GROUPS AND SERVICES COVERED BY STAR+PLUS

Effective September 1, 2011

Notes: See Dental chart for information on groups eligible to receive Medicaid Children's Dental Services. Individuals age 20 and under receiving SSI are eligible to enroll in STAR+PLUS on a voluntary basis. Members age 20 and under receive an unlimited number of prescriptions. Dual-eligible members receive a limited number of prescriptions. STAR+PLUS members who qualify for home and community-based long-term services and supports (formerly included in Texas' STAR+PLUS 1915(c) waivers) will be able to receive unlimited prescriptions.

Medicaid Eligibility Group	Description	FPL	Resource Standard	Currently Receiving Services? Y/N	Delivery System
SAVERR: TP12 – SSI manually certified TP13 – SSI recipient TIERS: TP12 – ME – Temp Manual SSI TP13 – ME - SSI	Individuals receiving SSI cash benefits 1902(a)(10)(A)(i)(II)	SSI limit Appx 74% FPL	$2,000 Individual $3,000 Couple	Y	
TP03 SAVERR Pickle TP03 TIERS ME- Pickle S	Pickle Amendment – Would be eligible for SSI if Title II COLAs were deducted from income. Section 503 of P.L. 94-566 42 CFR §435.135	SSI limit Appx 74% FPL	$2,000 Individual $3,000 Couple	Y	

Medicaid Eligibility Group	Description	FPL	Resource Standard	Currently Receiving Services? Y/N	Delivery System
TP18 SAVERR Disabled Adult Children (DAC) TP18 TIERS ME-Disabled Adult Child	Disabled Adult Children 1634(c);1935	SSI limit Appx 74% FPL	$2,000 Individual $3,000 Couple	Y	
TP22 SAVERR Widow(er)s TP21 TIERS ME-Disabled Widow(er)	Disabled Widows/Widowers 1634(b); 1935	SSI limit Appx 74% FPL	$2,000 Individual $3,000 Couple	Y	
TP22 SAVERR Widow(er)s TP22 TIERS ME – Early Aged Widow(er	Early Widows/Widowers 1634(d); 1935	SSI limit Appx 74% FPL	$2,000 Individual $3,000 Couple	Y	
TP19 SAVERR SSI Denied Children TA01 TIERS ME – Interim SSI Denied Child TP19 TIERS ME-SSI Denied Children	Children no longer eligible for SSI because of change in definition of disability. 1902(a)(10)(A)(i)(II)	SSI limit Appx 74% FPL	$2,000 Individual $3,000 Couple	Y	

Medicaid Eligibility Group	Description	FPL	Resource Standard	Currently Receiving Services? Y/N	Delivery System
Money Follows the Person TP14 SAVERR BP10 – Title XIX Facility TIERS: TP17-ME – Nursing Facility	Special income level group – In a medical institution for at least 30 consecutive days with gross income that does not exceed 300 percent of the SSI income standard. Nursing facility. 1902(a)(10)(A)(ii)(V)	300% SSI or Apprx 220% FPL	$2,000 Individual $3,000 Couple	Y	
TP14 SAVERR BP13 –1915(c) waivers program TIERS: TA10 – ME-Waivers	Receiving home and community-based waiver services who would only be eligible for Medicaid under the state plan if they were in a medical institution. 1915(c) waivers 1902(a)(10)(A)(ii)(VI)	300% SSI or Apprx 220% FPL	$2,000 Individual $3,000 Couple	Y	
TP87 TIERS Medicaid Buy-In (MBI) Worked only in TIERS TP02 SAVERR only for reverse conversion	Medicaid Buy-In BBA Work Incentives Group (MBI) 1902(a)(10)(ii)(XIII)	250%	$2,000	Y	

Medicaid Eligibility Group	Description	FPL	Resource Standard	Currently Receiving Services? Y/N	Delivery System
TA88 TIERS only ME-MBIC	Medicaid Buy-In for Children Family Opportunity Act (MBIC) 1902(a)(10)(A)(ii)(XIX)	300%	No resource standard	Y	

STAR+PLUS Included Services

Please indicate which services you are proposing to cover for the population(s) in your Demonstration, including scope of coverage defined below_, as well as any services the State intends to exclude from coverage. Provide additional detail on the proposed covered and excluded services as necessary if the State plans to limit any services provided. In addition, this chart should be completed for individual populations if services vary by population.

These services are currently included in the Managed Care Organizations' capitation for the STAR-PLUS program and will be included in the demonstration waiver.

State Plan Services:

A./C	**Service**	**Description**
A/C	Inpatient Hospital Services	Mandatory 1905(a)(1)
A/C	Outpatient Hospital Services	Mandatory 1905(a)(2)
A/C	Rural health clinic services	Mandatory 1905(a)(2)
A/C	FQHC services	Mandatory 1905(a)(2)
A/C	Laboratory and x-ray services	Mandatory 1905(a)(3)
A/C	Diagnostic Services	Optional 1905(a)(13)
A	Nursing Facility Services for 21 and over*	Mandatory 1905(a)(4)
C	EPSDT	Mandatory 1905(a)(4)
A/C	Family Planning	Mandatory 1905(a)(4)
A/C	Physicians' services	Mandatory 1905(a)(5)
A/C	Medical and Surgical services furnished by a dentist	Mandatory 1905(a)(5)
A/C	Podiatrists' services	Optional 1905(a)(6)

* Nursing facility is covered for four months.

A/C	Optometrists' services	Optional 1905(a)(6)
A/C	Intermittent or part-time nursing services provided by a home health agency	Mandatory for individuals who, under the State Plan, are entitled to nursing facility services 1902(a)(10)(D)
A/C	Home health aide services provided by a home health agency	Mandatory for individuals who, under the State Plan, are entitled to nursing facility services 1902(a)(10)(D)
A/C	Medical supplies, equipment, and appliances	Mandatory for individuals who, under the State Plan, are entitled to nursing facility services 1902(a)(10)(D)
A/C	Physical therapy; occupational therapy; speech pathology; audiology provided by a home health agency	Optional 1902(a)(10)(D) 42 CFR 440.70
A/C	Clinic Services	Optional 1905(a)(9)
C	Dental Services (beginning March 1, 2012)	Optional 1905(a)(10)
A/C	Prescribed Drugs (beginning March 1, 2012)	Optional 1905(a)(12)
A/C	Non-Prescription Drugs (beginning March 1, 2012)	Optional 1927(d)
C	Dentures	Optional 1905(a)(12)
A/C	Prosthetic Devices	Optional 1905(a)(12)
A/C	Eyeglasses	Optional 1905(a)(12)
A/C	Preventive Services	Optional 1905(a)(13)
A/C	Services for individuals over age 65 in IMDs – Inpatient, Not Nursing Facility	Optional 1905(a)(14)
C	Inpatient psychiatric facility services for under 22	Optional 1905(a)(16)
A/C	Nurse-midwife services	Mandatory 1905(a)(17)
A/C	Certified pediatric or family nurse practitioners' services	Mandatory 1905(a)(21)
A/C	Personal care services in recipient's home	Optional 1905(a)(28) 42 CFR 440.170
A	Day Activity and Health Services	
	Home and Community Based Services (Community-Based Alternatives Services Available under 1915 (c) authority to Adults	**N/A**

A	Physical therapy; occupational therapy; speech pathology; audiology provided by a home health agency	
A	Dental	
A	Personal Care Services	
A	Respite	
A	Environmental Modifications (Home Accessibility Adaptations	
A	Vehicle Modifications	
A	Special Medical Equipment (minor assistive Devices)	
A	Home Delivered meals	
A	Assistive Technology (i.e., communication devices)	
A	Personal Emergency Response (PERS)	
A	Nursing Services	
A	Community Transition Services	
A	Adult Foster Care	
A	Consumer-Directed Options	
A	Assisted Living	

"A" means adult. "C" means child. SSI children are voluntary in STAR+PLUS and will be voluntary under the 1115 demonstration waiver.

STATE PLAN ELIGIBILITY GROUPS AND SERVICES COVERED IN THE MEDICAID RURAL SERVICE AREA (MRSA)

Effective March 1, 2012

**Notes: See Dental chart for information on groups eligible to receive Medicaid Children's Dental Services. Individuals age 20 and under receiving SSI will be mandatory enrollees in the MRSA if they are dual-eligibles. Medicaid-only (non-dual eligible) members in a (c) waiver will receive unlimited prescriptions. Individuals in 1915(c) waivers receiving acute care services in the Medicaid Rural Service Area will be able to receive unlimited prescriptions.*

Medicaid Eligibility Group	Description	FPL	Resource Standard	Currently Receiving Services? Y/N	Delivery System	Prescription Limit for Adults
TP01/61 SAVERR money grant and Medicaid for caretakers and deprived children with income below TANF recognizable needs TANF State Program (TANF-SP) – two parent household eligible for money grant and Medicaid with income below TANF recognized needs TP08 TIERS MA - TANF Level Families	Low Income Families SSA 1902(1)(10)(A)(i)(I) SSA 1931	Apprx. 14% - uses TANF	$2000/$3000 if there is a member who is aged or disabled and meets the relationship requirement	Y		X
TP-07 SAVERR twelve months transitional Medicaid resulting from increase in earnings or combined increase in earnings and child support TP07 TIERS MA - Earnings Transitional	Individuals who lose eligibility under SSA 1931 due to increase in income or new employment SSA 1902(a)(52) SSA 1925	185%	N/A	Y		X

Medicaid Eligibility Group	Description	FPL	Resource Standard	Currently Receiving Services? Y/N	Delivery System	Prescription Limit for Adults
TP20 SAVERR four months post Medicaid resulting from child support TP20 TIERS MA - Child Support Transitional	Individuals who lose eligibility under SSA 1931 because of child or spousal support income SSA 1902(a)(10)(A)(i)(I)	185%	N/A	Y		X
TP37 SAVERR twelve months transitional Medicaid coverage resulting from loss of 90% earned income disregard TP37 TIERS MA - EID Transitional	Individuals who lose eligibility under SSA 1931 due to loss of earned income disregard SSA 1902(a)(52) SSA 1925	185%	N/A	Y		X

Medicaid Eligibility Group	Description	FPL	Resource Standard	Currently Receiving Services? Y/N	Delivery System	Prescription Limit for Adults
TP40 SAVERR pregnant women TP40 TIERS MA - Pregnant Women	1 – Qualified Pregnant Women SSA 1902(a)(10)(A)(i)(III) 2 – Poverty Level Pregnant Women SSA 1902(a)(10)(A)(i)(IV) – 133% FPL 3 – Also includes 1902(e)(5) and 1902(e)(6) – coverage post partum.	133%[6]	N/A	Y		X
TP43 SAVERR children under age one with income below 185% FPIL TP43 TIERS MA - Children Under 1	Poverty Level Infants (under 1 year old) – 133% SSA 1902(a)(10)(A)(i)(IV)	133%[7]	$2000/$3000 if there is a member who is aged or disabled and meets the relationship requirement	Y		N/A

[6] See Option TP-40 and TP-43 – mandatory to cover at 133% and an option up to 185%. Texas covers up to 185%.

[7] See Option TP-40 and TP-43 – mandatory to cover at 133% and an option up to 185%. Texas covers up to 185%.

Medicaid Eligibility Group	Description	FPL	Resource Standard	Currently Receiving Services? Y/N	Delivery System	Prescription Limit for Adults
TP45 SAVERR children to age one born to Medicaid eligible mother TP45 TIERS MA - Newborn Children	Deemed Newborn – provided to a newborn who's mother was eligible for and received Medicaid for the birth SSA 1902(e)(4)	N/A	N/A	Y		N/A
TP48 SAVERR children age 1 – 5 with income below 133% FPIL TP48 TIERS MA - Children 1-5	Poverty Level Children under 6 SSA 1902(a)(10(A)(i)(VI)	133%	$2000/$3000 if there is a member who is aged or disabled and meets the relationship requirement	Y		N/A
TP44 SAVERR children age 6 – 18 with income below 100% FPIL TP44 TIERS MA - Children 6-18	Poverty Level Children under 19 SSA 1902(a)(10)(A)(i)(VII)	100%	$2000/$3000 if there is a member who is aged or disabled and meets the relationship requirement	Y		N/A

Medicaid Eligibility Group	Description	FPL	Resource Standard	Currently Receiving Services? Y/N	Delivery System	Prescription Limit for Adults
TP47 SAVERR children ineligible for TANF, TANF-SP, or the age-appropriate medical program due to stepparent or grandparent's applied income, or stepparent's income when included on the case TP47 TIERS MA - Children denied TANF w/Applied Inc	Individuals who are ineligible for SSA 1931 due to stepparent/ grandparent income 42 CFR 435.113	TANF	$2000/$3000 if there is a member who is aged or disabled and meets the relationship requirement	Y		N/A
TP29 SAVERR 12 Months post Medicaid following end of state time limited TANF TP29 TIERS MA - State Time Limit Transitional	Ineligible for TANF cash because individual has reached the end of state time limit to receive cash assistance. This is only SAVERR. In TIERS these individuals are under TP-08. This was just a program the state created to track these individuals.	N/A	N/A	Y - limited		X

Medicaid Eligibility Group	Description	FPL	Resource Standard	Currently Receiving Services? Y/N	Delivery System	Prescription Limit for Adults
SAVERR: TP12 – SSI manually certified TP13 – SSI recipient TIERS: TP12 – ME – Temp Manual SSI TP13 – ME - SSI	Individuals receiving SSI cash benefits 1902(a)(10)(A)(i)(II)	SSI limit Appx 74% FPL	$2,000 Individual $3,000 Couple	Y		X
TP03 SAVERR Pickle TP03 TIERS ME- Pickle	Pickle Amendment – Would be eligible for SSI if Title II COLAs were deducted from income. Section 503 of P.L. 94-566 42 CFR §435.135	SSI limit Appx 74% FPL	$2,000 Individual $3,000 Couple	Y		X
TP18 SAVERR Disabled Adult Children (DAC) TP18 TIERS ME-Disabled Adult Child	Disabled Adult Children 1634(c);1935	SSI limit Appx 74% FPL	$2,000 Individual $3,000 Couple	Y		X

Medicaid Eligibility Group	Description	FPL	Resource Standard	Currently Receiving Services? Y/N	Delivery System	Prescription Limit for Adults
TP22 SAVERR Widow(er)s (Medicaid-only) TP21 TIERS ME-Disabled Widow(er)	Disabled Widows/Widowers 1634(b); 1935	SSI limit Appx 74% FPL	$2,000 Individual $3,000 Couple	Y		X
TP22 SAVERR Widow(er)s TP22 TIERS ME – Early Aged Widow(er)	Early Widows/Widowers 1634(d); 1935	SSI limit Appx 74% FPL	$2,000 Individual $3,000 Couple	Y		X
TP19 SAVERR SSI Denied Children TA01 TIERS ME – Interim SSI Denied Child TP19 TIERS ME-SSI Denied Children	Children no longer eligible for SSI because of change in definition of disability. 1902(a)(10)(A)(i)(II)	SSI limit Appx 74% FPL	$2,000 Individual $3,000 Couple	Y		N/A
TP40 SAVERR pregnant women TP40 TIERS MA - Pregnant Women	1 – Poverty Level Pregnant Women SSA 1902(a)(10)(A)(ii)(IX) – 134-185% FPL 2 – Also includes 1902(e)(5) and 1902(e)(6) –post partum coverage.	185%	N/A	Y		X

Medicaid Eligibility Group	Description	FPL	Resource Standard	Currently Receiving Services? Y/N	Delivery System	Prescription Limit for Adults
TP43 SAVERR children under age one with income below 185% FPIL TP43 TIERS MA - Children Under 1	Poverty Level Infants (under 1 year old) – 134-185% SSA 1902(a)(10)(A)(ii)(IX)	185%	$2000/$3000 if there is a member who is aged or disabled and meets the relationship requirement	Y		N/A
Money Follows the Person TP14 SAVERR BP10 – Title XIX Facility BP15 – Community-based ICF-MR BP16 – Institutional State School TIERS: TP17-ME – Nursing Facility; TP15 – ME – Non-State Group Home TA12 – ME – State Group Home TP10 – ME – State School *Acute care services are provided under the 1115 waiver.	Special income level group – In a medical institution for at least 30 consecutive days with gross income that does not exceed 300 percent of the SSI income standard. Nursing facility, ICF-MR, State Supported Living Centers (SSLC) 1902(a)(10)(A)(ii)(V)	300% SSI or Apprx 220% FPL	$2,000 Individual $3,000 Couple	Y		X *Only dual-eligible members are limited.

Medicaid Eligibility Group	Description	FPL	Resource Standard	Currently Receiving Services? Y/N	Delivery System	Prescription Limit for Adults
TP14 SAVERR BP13 –1915(c) waivers program TIERS: TA10 – ME-Waivers *Acute care services are provided under the 1115 waiver.	Receiving home and community-based waiver services who would only be eligible for Medicaid under the state plan if they were in a medical institution. 1915(c) waivers 1902(a)(10)(A)(ii)(VI)	300% SSI or Apprx 220% FPL	$2,000 Individual $3,000 Couple	Y		X *Only dual-eligible members are limited.
TP87 TIERS Medicaid Buy-In (MBI) Worked only in TIERS TP02 SAVERR only for reverse conversion.	Medicaid Buy-In BBA Work Incentives Group (MBI) 1902(a)(10)(ii)(XIII)	250%	$2,000	Y		X
TA88 TIERS only ME-MBIC	Medicaid Buy-In for Children Family Opportunity Act (MBIC) 1902(a)(10)(A)(ii)(XIX)	300%	No resource standard	Y		N/A

MRSA Included Services

Please indicate which services you are proposing to cover for the population(s) in your Demonstration, including scope of coverage defined below, as well as any services the State intends to exclude from coverage. Provide additional detail on the proposed covered and excluded services as necessary if the State plans to limit any services provided. In addition, this chart should be completed for individual populations if services vary by population.

These services are currently provided to clients in FFS and will be included in the demonstration waiver beginning March 1, 2012.

State Plan Services:

A./C	**Service**	**Description**
A/C	Inpatient Hospital Services	Mandatory 1905(a)(1)
A/C	Outpatient Hospital Services	Mandatory 1905(a)(2)
A/C	Rural health clinic services	Mandatory 1905(a)(2)
A/C	FQHC services	Mandatory 1905(a)(2)
A/C	Laboratory and x-ray services	Mandatory 1905(a)(3)
A/C	Diagnostic Services	Optional 1905(a)(13)
A	Nursing Facility Services for 21 and over *	Mandatory 1905(a)(4)
C	EPSDT	Mandatory 1905(a)(4)
A/C	Family Planning	Mandatory 1905(a)(4)
A/C	Physicians' services	Mandatory 1905(a)(5)
A/C	Medical and Surgical services furnished by a dentist	Mandatory 1905(a)(5)
A/C	Podiatrists' services	Optional 1905(a)(6)
A/C	Optometrists' services	Optional 1905(a)(6)
A/C	Intermittent or part-time nursing services provided by a home health agency	Mandatory for individuals who, under the State Plan, are entitled to nursing facility services 1902(a)(10)(D)
A/C	Home health aide services provided by a home health agency	Mandatory for individuals who, under the State Plan, are entitled to nursing facility services 1902(a)(10)(D)

A/C	Medical supplies, equipment, and appliances	Mandatory for individuals who, under the State Plan, are entitled to nursing facility services 1902(a)(10)(D)
A/C	Physical therapy; occupational therapy; speech pathology; audiology provided by a home health agency	Optional 1902(a)(10)(D) 42 CFR 440.70
A/C	Clinic Services	Optional 1905(a)(9)
C	Dental Services (beginning March 1, 2012)	Optional 1905(a)(10)
A/C	Prescribed Drugs (beginning March 1, 2012)	Optional 1905(a)(12)
A/C	Non-Prescription Drugs (beginning March 1, 2012)	Optional 1927(d)
C	Dentures	Optional 1905(a)(12)
A/C	Prosthetic Devices	Optional 1905(a)(12)
A/C	Eyeglasses	Optional 1905(a)(12)
A/C	Preventive Services	Optional 1905(a)(13)
A/C	Services for individuals over age 65 in IMDs – Inpatient, Not Nursing Facility	Optional 1905(a)(14)
C	Inpatient psychiatric facility services for under 22	Optional 1905(a)(16)
A/C	Nurse-midwife services	Mandatory 1905(a)(17)
A/C	Certified pediatric or family nurse practitioners' services	Mandatory 1905(a)(21)
C	Personal care services in recipient's home	Optional 1905(a)(28) 42 CFR 440.170

"A" means adult. "C" means child.

* Nursing facilities are covered for four months.

STATE PLAN ELIGIBILITY GROUPS RECEIVING MEDICAID CHILDREN'S DENTAL SERVICES

THROUGH THE DENTAL MAINTANCE ORGANIZATION

Effective March 1, 2012

**Notes: Most children age 20 and under will receive dental services through the DMO; enrollment into the DMO will be mandatory. Exceptions include children residing in a nursing facility, ICF/MR, state supported living center, children in STAR Health, or children with retroactive eligibility. Dental services are included as part of a Medicaid-paid facility's provider rate.*

Medicaid Eligibility Group	Description	FPL	Resource Standard	Currently Receiving Services? Y/N	Delivery System
TP01/61 SAVERR money grant and Medicaid for caretakers and deprived children with income below TANF recognizable needs TANF State Program (TANF-SP) – two parent household eligible for money grant and Medicaid with income below TANF recognized needs TP08 TIERS MA - TANF Level Families	Low Income Families SSA 1902(1)(10)(A)(i)(I) SSA 1931	Apprx. 14% - uses TANF	$2000/$3000 if there is a member who is aged or disabled and meets the relationship requirement	Y	
TP-07 SAVERR twelve months transitional Medicaid resulting from increase in earnings or combined increase in earnings and child support TP07 TIERS MA - Earnings Transitional	Individuals who lose eligibility under SSA 1931 due to increase in income or new employment SSA 1902(a)(52) SSA 1925	185%	N/A	Y	

Medicaid Eligibility Group	Description	FPL	Resource Standard	Currently Receiving Services? Y/N	Delivery System
TP20 SAVERR four months post Medicaid resulting from child support TP20 TIERS MA - Child Support Transitional	Individuals who lose eligibility under SSA 1931 because of child or spousal support income SSA 1902(a)(10)(A)(i)(I)	185%	N/A	Y	
TP37 SAVERR twelve months transitional Medicaid coverage resulting from loss of 90% earned income disregard TP37 TIERS MA - EID Transitional	Individuals who lose eligibility under SSA 1931 due to loss of earned income disregard SSA 1902(a)(52) SSA 1925	185%	N/A	Y	
TP43 SAVERR children under age one with income below 185% FPIL TP43 TIERS MA - Children Under 1	Poverty Level Infants (under 1 year old) – 133% SSA 1902(a)(10)(A)(i)(IV)	133%[8]	$2000/$3000 if there is a member who is aged or disabled and meets the relationship requirement	Y	

[8] See Option TP-40 and TP-43 – mandatory to cover at 133% and an option up to 185%. Texas covers up to 185%.

Medicaid Eligibility Group	Description	FPL	Resource Standard	Currently Receiving Services? Y/N	Delivery System
TP45 SAVERR children to age one born to Medicaid eligible mother TP45 TIERS MA - Newborn Children	Deemed Newborn – provided to a newborn who's mother was eligible for and received Medicaid for the birth SSA 1902(e)(4)	N/A	N/A	Y	
TP48 SAVERR children age 1 – 5 with income below 133% FPIL TP48 TIERS MA - Children 1-5	Poverty Level Children under 6 SSA 1902(a)(10(A)(i)(VI)	133%	$2000/$3000 if there is a member who is aged or disabled and meets the relationship requirement	Y	
TP44 SAVERR children age 6 – 18 with income below 100% FPIL TP44 TIERS MA - Children 6-18	Poverty Level Children under 19 SSA 1902(a)(10)(A)(i)(VII)	100%	$2000/$3000 if there is a member who is aged or disabled and meets the relationship requirement	Y	

Medicaid Eligibility Group	Description	FPL	Resource Standard	Currently Receiving Services? Y/N	Delivery System
TP47 SAVERR children ineligible for TANF, TANF-SP, or the age-appropriate medical program due to stepparent or grandparent's applied income, or stepparent's income when included on the case TP47 TIERS MA - Children denied TANF w/Applied Inc	Individuals who are ineligible for SSA 1931 due to stepparent/ grandparent income 42 CFR 435.113	TANF	$2000/$3000 if there is a member who is aged or disabled and meets the relationship requirement	Y	
TP29 SAVERR 12 Months post Medicaid following end of state time limited TANF TP29 TIERS MA - State Time Limit Transitional	Ineligible for TANF cash because individual has reached the end of state time limit to receive cash assistance. This is only SAVERR. In TIERS these individuals are under TP-08. This was just a program the state created to track these individuals.	N/A	N/A	Y - limited	

Medicaid Eligibility Group	Description	FPL	Resource Standard	Currently Receiving Services? Y/N	Delivery System
SAVERR: TP12 – SSI manually certified TP13 – SSI recipient TIERS: TP12 – ME – Temp Manual SSI TP13 – ME - SSI	Individuals receiving SSI cash benefits 1902(a)(10)(A)(i)(II)	SSI limit Appx 74% FPL	$2,000 Individual $3,000 Couple	Y	
TP03 SAVERR Pickle TP03 TIERS ME- Pickle	Pickle Amendment – Would be eligible for SSI if Title II COLAs were deducted from income. Section 503 of P.L. 94-566 42 CFR §435.135	SSI limit Appx 74% FPL	$2,000 Individual $3,000 Couple	Y	
TP18 SAVERR Disabled Adult Children (DAC) TP18 TIERS ME-Disabled Adult Child	Disabled Adult Children 1634(c);1935	SSI limit Appx 74% FPL	$2,000 Individual $3,000 Couple	Y	

Medicaid Eligibility Group	Description	FPL	Resource Standard	Currently Receiving Services? Y/N	Delivery System
TP19 SAVERR SSI Denied Children TA01 TIERS ME – Interim SSI Denied Child TP19 TIERS ME-SSI Denied Children	Children no longer eligible for SSI because of change in definition of disability. 1902(a)(10)(A)(i)(II)	SSI limit Appx 74% FPL	$2,000 Individual $3,000 Couple	Y	
TP43 SAVERR children under age one with income below 185% FPIL TP43 TIERS MA - Children Under 1	Poverty Level Infants (under 1 year old) – 134-185% SSA 1902(a)(10)(A)(ii)(IX)	185%	$2000/$3000 if there is a member who is aged or disabled and meets the relationship requirement	Y	
Money Follows the Person TP14 SAVERR BP10 – Title XIX Facility TIERS: TP17-ME – Nursing Facility	Special income level group – In a medical institution for at least 30 consecutive days with gross income that does not exceed 300 percent of the SSI income standard. Nursing facility. 1902(a)(10)(A)(ii)(V)	300% SSI or Apprx 220% FPL	$2,000 Individual $3,000 Couple	Y	

Medicaid Eligibility Group	Description	FPL	Resource Standard	Currently Receiving Services? Y/N	Delivery System
TP14 SAVERR BP13 –1915(c) waivers program TIERS: TA10 – ME-Waivers	Receiving home and community-based waiver services who would only be eligible for Medicaid under the state plan if they were in a medical institution. 1915(c) waivers 1902(a)(10)(A)(ii)(VI)	300% SSI or Apprx 220% FPL	$2,000 Individual $3,000 Couple	Y	
TP87 TIERS Medicaid Buy-In (MBI) Worked only in TIERS TP02 SAVERR only for reverse conversion	Medicaid Buy-In BBA Work Incentives Group (MBI) 1902(a)(10)(ii)(XIII)	250%	$2,000	Y	
TA88 TIERS only ME-MBIC	Medicaid Buy-In for Children Family Opportunity Act (MBIC) 1902(a)(10)(A)(ii)(XIX)	300%	No resource standard	Y	

Medicaid Eligibility Group	Description	FPL	Resource Standard	Currently Receiving Services? Y/N	Delivery System
SSI Voluntary Children	Children with SSI who choose to receive medical benefits through fee-for-service instead of managed care				

Appendix B: Summary of Managed Care Expansion

Below is a description of the five programs affected by the expansion to risk-based managed care.

STAR Program

The STAR program is Texas' primary managed care program. Capitated managed care organizations (MCOs) accept comprehensive risk and operate under Section 1915(b) waiver authority.

STAR MCOs served 1.3 million enrollees in 2010. Populations included in STAR are: TANF adults, TANF children, newborns, Expansion children, Federal Mandate children, and pregnant women. MCOs provide comprehensive acute care services to enrolled populations. MCO enrollees also receive selected enhanced benefits through Section 1915(b)(3) authority.

As previously indicated, HHSC will conduct two managed care expansion projects, in September 2011 and March 2012, into areas currently served by PCCM. Starting in September 2011, STAR MCO will expand into 28 contiguous counties, moving approximately 140,000 clients to capitated models, some from FFS, and most from PCCM**.** MCOs serving STAR enrollees today will serve new enrollees in the expansion counties, including the new Jefferson service area. Current MCO contracts will be amended to include these expansion areas and populations. In March 2012, STAR will further expand into the Medicaid rural and Hidalgo service areas, which currently serve clients through the FFS and PCCM models. In March 2012, the STAR program will become statewide, when MCOs selected through the reprocurement begin serving members in all service areas, including the new Hidalgo service area.

The STAR service array will remain in place under this waiver, with one exception. Texas will apply the current limit applied to most adults in Fee-for-Service of a three prescription limit per month for adults in STAR, effective December 1, 2011 for most drugs. The limit will not apply to children age 20 and under. Certain drugs, such as insulin, and drugs for smoking cessation and contraception, are excluded from the three prescription limit. On March 1, 2012, additional services will be added to the STAR capitation: (1) prescription drug benefits, and (2) Medicaid wrap services for dual eligibles in the Medicaid rural service area (MRSA).

STAR+PLUS Program

STAR+PLUS is a capitated, integrated delivery system of acute care services and community-based long term service and supports (LTSS) for approximately 255,000 disabled and chronically ill Medicaid beneficiaries. STAR+PLUS serves Aged/Medicare-related and Disabled/Blind Medicaid beneficiaries. STAR+PLUS operates under one Section 1915(b) waiver and two Section 1915(c) home and community based waivers. As with the current STAR+PLUS program,

the State will not apply an interest list to SSI clients eligible for services under the waiver, but will maintain an interest list for Medical Assistance Only (MAO 217 group) clients. This is consistent with present eligibility policy.

STAR+PLUS MCOs receive a capitation payment and are responsible for coordinating both acute care and LTSS through the use of a service coordinator. Service coordinators work with network providers to ensure that members have access to Medicaid covered services, as well as Medicare and community service providers to ensure assess to other available resources.

STAR+PLUS Medicaid-only members choose or are assigned a primary care provider.

Medicare-Medicaid dual eligible individuals make up more than half of STAR+PLUS members. Dual eligibles enrolled in STAR+PLUS will receive acute care services through Medicare and, beginning March 2012, wrap services through the STAR+PLUS MCOs.

MCOs serving STAR+PLUS enrollees today will serve new STAR+PLUS enrollees in 21 counties of the contiguous county expansion in September 2011. The State will amend current MCO contracts to include these expansion areas and populations. Effective March 2012, STAR+PLUS will continue expansion into the Lubbock, El Paso, and Hidalgo service areas.

Currently, non-behavioral health inpatient hospital services are carved out of the STAR+PLUS managed care benefit. Under the waiver, all inpatient hospital services will be carved back into the capitated benefit package effective March 2012.

Except as provided below, the STAR+PLUS service array will remain in place under the 1115 waiver. Both acute care services currently available under the STAR+PLUS 1915(b) waiver, and long-term services and supports home and community-based services (LTSS-HCBS) available under the STAR+PLUS 1915(c) waivers, will be provided to persons eligible for those services under the 1115 waiver. Texas will apply the current limit applied to most adults in Fee-for-Service of a three prescription limit per month for adults in STAR+PLUS, effective December 1, 2011 for most drugs. The limit will not apply to children age 20 and under. Certain drugs, such as insulin, and drugs for smoking cessation and contraception, are excluded from the three prescription limit. Additionally, STAR+PLUS members who qualify for home and community-based long-term services and supports (currently included in Texas' STAR+PLUS 1915(c) waivers) and individuals in 1915(c) waivers receiving acute care services in the Medicaid Rural Service Area will be able to receive unlimited prescriptions. Beginning March 1, 2012, additional services will be added to the STAR+PLUS capitation: (1) prescription drug benefits, (2) non-behavioral health inpatient hospital services, and as described above, and (3) Medicaid wrap services for dual eligibles.

Risk-based Managed Care Expansion to Medicaid Rural Service Areas

Approximately 800,000 Medicaid beneficiaries in 164 rural counties currently receive services through the non-capitated PCCM program under the state plan. Under PCCM, covered populations receive coordinated, comprehensive acute care services that are reimbursed on a FFS basis. The 1115 waiver will convert the PCCM program into a risked-based managed care model, operated by health maintenance organizations (HMOs) or exclusive provider organizations (EPOs) (collectively "MCOs"). EPOs are comparable to HMOs except that the Texas Department of Insurance regulates these entities under health insurance statutes and not HMO statutes. The conversion will begin in March 2012 following the selection of MCOs through a competitive procurement. STAR MCOs in the 164 county Medicaid Rural Service Area will be responsible for coordinating comprehensive acute care services to enrollees under a capitation payment arrangement. There will be no STAR+PLUS program in Medicaid Rural Service Areas. Therefore, individuals who qualify for long-term services and supports (including dual eligibles) in this service area will be enrolled in STAR and will receive their acute care services through STAR (or for dual eligible individuals, Medicare), but will receive their long-term services and supports through other 1915(c) waiver programs that will not be affected by this demonstration, such as the Community Based Alternatives Program and the Community Living Assistance and Support Services program. In the Medicaid Rural Service Area, STAR MCOs will coordinate acute and long-term care services and will provide Medicaid wrap services for dual eligible individuals.

Managed Care Expansion to South Texas

Approximately 500,000 Medicaid beneficiaries in the Hidalgo Service Area currently receive services under PCCM. The 1115 waiver proposes to expand the STAR and STAR+PLUS programs into the ten counties that make up the Hidalgo Service Area in March 2012.

Children's Medicaid Dental Sevices

Beginning in March 2012, Medicaid clients age 20 and under will receive primary and preventative dental services under a managed care model whereby individuals will be given a choice of at least two dental management organizations (DMOs). DMOs will provide the full array of primary and preventative services available to children under the state plan, including: diagnostic, preventive, therapeutic, restorative, endodontic, periodontal, prosthodontics (removable and fixed), implant and oral and maxillofacial surgery services and adjunctive general services. This service model is referred to as "Children's Medicaid Dental Services."

DMOs will develop networks of Main Dental Home providers, consisting of general dentists and pediatric dentists, who will provide preventative care and refer members to specialty care as needed. If a member does not select a Main Dental Home provider, the DMO will assign one.

DMOs will not be responsible for coverage or payment for non-capitated services, including emergency dental services provided in a hospital or ambulatory surgical center setting. These services will be part of the medical benefit provided by Medicaid MCOs, or through FFS for clients who are not enrolled in STAR or STAR+PLUS.

Except as provided below, all Medicaid children will receive Children's Medicaid Dental Services. The following clients will not receive Children's Medicaid Dental Services:

- Medicaid recipients age 21 and over;
- All Medicaid recipients, regardless of age, residing in Medicaid-paid facilities such as nursing homes, state supported living centers or Intermediate Care Facilities for Mentally Retarded Persons (ICFs/MR); and
- STAR Health Program recipients (children in State conservatorship).

The Medicaid 1115 waiver will account for dental coverage expenditures for children receiving the acute care coverage normally provided under a 1915(b) waiver.

Planned STAR and STAR+PLUS Managed Care Expansions by Geographic Areas

BEFORE

SFY 2011	Bexar	Contiguous	Dallas	Fort Worth	El Paso	Harris	Harris Expansion	Jefferson, etc.	Lubbock	Nueces	Travis	South TX	Rural
TANF Child	MCO	PCCM	MCO	MCO	MCO	MCO	MCO	PCCM	MCO	MCO	MCO	PCCM	PCCM
TANF Adult	MCO	PCCM	MCO	MCO	MCO	MCO	MCO	PCCM	MCO	MCO	MCO	PCCM	PCCM
Newborn	MCO	PCCM	MCO	MCO	MCO	MCO	MCO	PCCM	MCO	MCO	MCO	PCCM	PCCM
Expansion	MCO	PCCM	MCO	MCO	MCO	MCO	MCO	PCCM	MCO	MCO	MCO	PCCM	PCCM
Fed Mandate	MCO	PCCM	MCO	MCO	MCO	MCO	MCO	PCCM	MCO	MCO	MCO	PCCM	PCCM
Pg. woman	MCO	PCCM	MCO	MCO	MCO	MCO	MCO	PCCM	MCO	MCO	MCO	PCCM	PCCM
SSI child	vol S+OUT	vol PCCM	vol S+OUT	vol S+OUT	vol MCO	vol S+OUT	vol S+OUT	vol PCCM	vol MCO	vol S+OUT	vol S+OUT	vol PCCM	vol PCCM
SSI adult	S+OUT	PCCM	S+OUT	S+OUT	vol MCO	S+OUT	S+OUT	PCCM	vol MCO	S+OUT	S+OUT	PCCM	PCCM

February 2011 - S+ expands to Dallas/Fort Worth

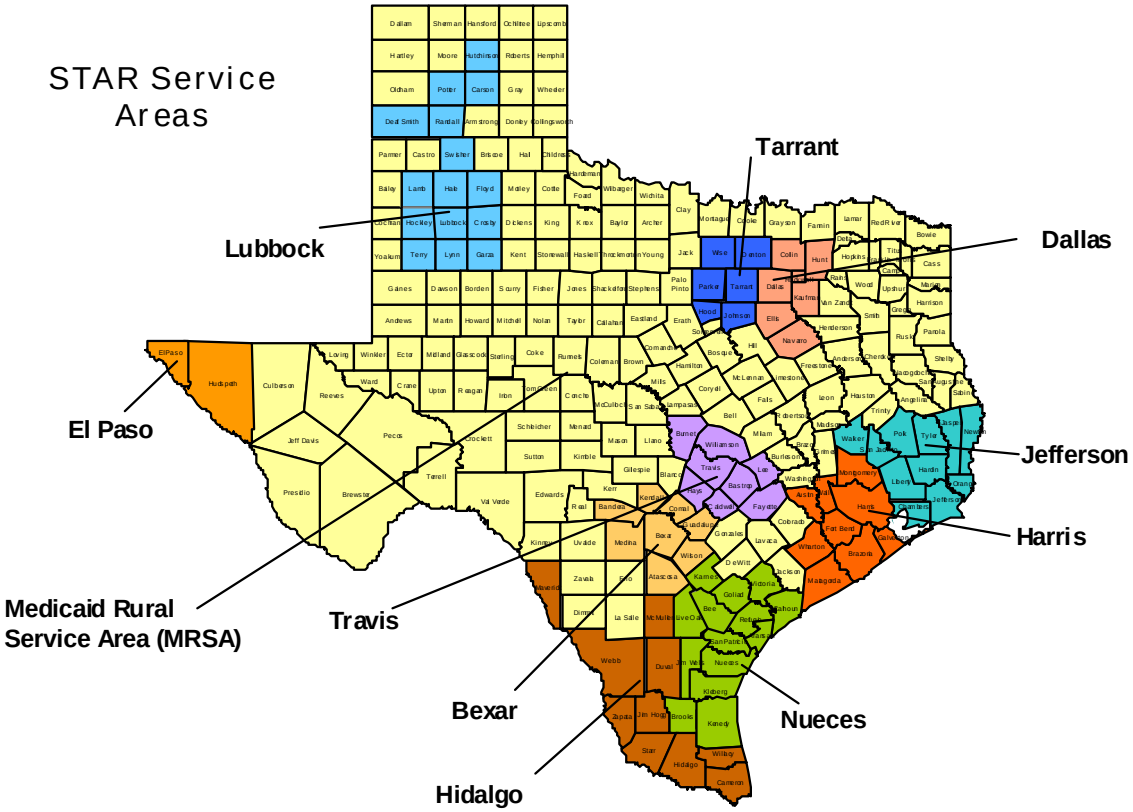
AFTER

SFY 2012	Bexar	Contiguous	Dallas	Fort Worth	El Paso	Harris	Harris Expansion	Jefferson, etc.	Lubbock	Nueces	Travis	South TX	Rural
TANF Child	MCO	MCO	MCO	MCO	MCO	MCO	MCO	MCO	MCO	MCO	MCO	MCO	MCO
TANF Adult	MCO	MCO	MCO	MCO	MCO	MCO	MCO	MCO	MCO	MCO	MCO	MCO	MCO
Newborn	MCO	MCO	MCO	MCO	MCO	MCO	MCO	MCO	MCO	MCO	MCO	MCO	MCO
Expansion	MCO	MCO	MCO	MCO	MCO	MCO	MCO	MCO	MCO	MCO	MCO	MCO	MCO
Fed Mandate	MCO	MCO	MCO	MCO	MCO	MCO	MCO	MCO	MCO	MCO	MCO	MCO	MCO
Pg. woman	MCO	MCO	MCO	MCO	MCO	MCO	MCO	MCO	MCO	MCO	MCO	MCO	MCO
SSI child	vol S+IN	vol S+IN	vol S+IN	vol S+IN	vol S+IN	vol S+IN	vol S+IN	vol S+IN	vol S+IN	vol S+IN	vol S+IN	vol S+IN	vol MCO
SSI adult	S+IN	S+IN	S+IN	S+IN	S+IN	S+IN	S+IN	S+IN	S+IN	S+IN	S+IN	S+IN	MCO

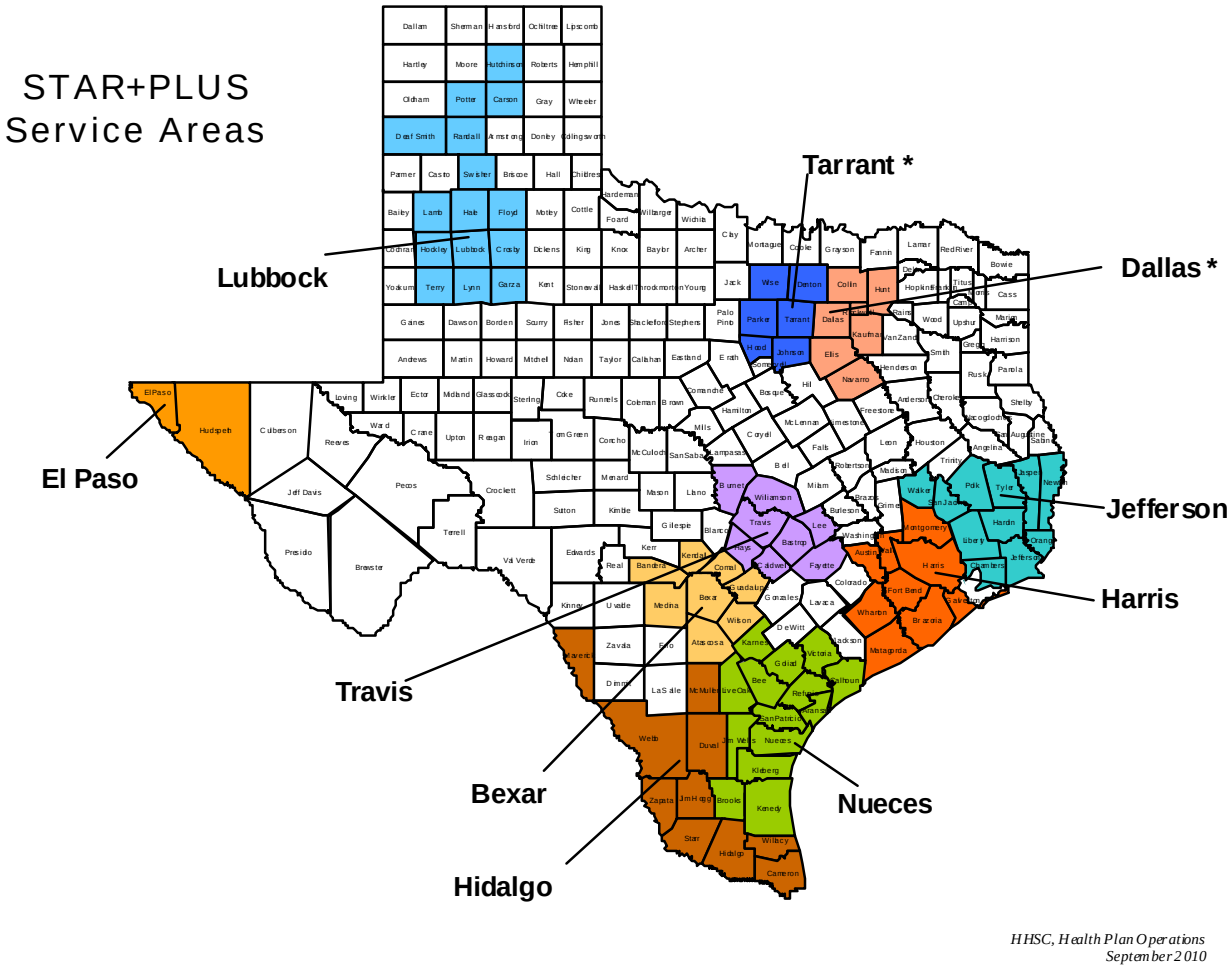
March 2012 - STAR+PLUS expands to El Paso, Lubbock; STAR expands to Rural, All S+ hospitals carved-in

*SSI kids are always voluntary in STAR, including PCCM and STAR HMO. If they are in a STAR+PLUS area, they are voluntary in STAR+PLUS.
*SSI adults are voluntary in STAR and mandatory in STAR+PLUS and PCCM.

MCO = STAR and/or STAR+PLUS; PCCM = PCCM only; Vol = voluntary managed care; S+ IN = STAR+PLUS Hospitals carved-in; S+ OUT = STAR+PLUS Hospitals carved-out



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



Service Area	Counties Served
Bexar	Atascosa, Bandera, Bexar, Comal, Guadalupe, Kendall, Medina, Wilson
Dallas* (Not Included in the Scope of MCO Procurement)	Collin, Dallas, Ellis, Hurt, Kaufman, Navarro, Rockwall
El Paso	El Paso, Hudspeth
Harris	Austin, Brazoria, Fort Bend, Galveston, Harris, Matagorda, Montgomery, Waller, Wharton
Hidalgo	Cameron, Duval, Hidalgo, Jim Hogg, Maverick, McMullen, Starr, Webb, Willacy, Zapata
Jefferson	Chambers, Hardin, Jasper, Jefferson, Liberty, Newton, Orange, Polk, San Jacinto, Tyler, Walker
Lubbock	Carson, Crosby, Deaf Smith, Floyd, Garza, Hale, Hockley, Hutchinson, Lamb, Lubbock, Lynn, Potter, Randall, Swisher, Terry
Nueces	Aransas, Bee, Brooks, Calhoun, Jim Wells, Karnes, Kenedy, Kleberg, Live Oak, Nueces, Refugio, San Patricio, Victoria
Tarrant* (Not Included in the Scope of MCO Procurement)	Denton, Hood, Johnson, Parker, Tarrant, Wise
Travis	Bastrop, Burnet, Caldwell, Fayette, Hays, Lee, Travis, Williamson

Appendix C: Procurement Schedules

The STAR and STAR+PLUS expansions to the contiguous counties will be implemented via contract amendments with existing MCO providers. HHSC is currently in the process of reprocuring STAR and STAR+PLUS health care services. Selected MCOs will begin serving beneficiaries in March 2012. The Dallas and Tarrant STAR+PLUS service areas were recently awarded, and are the only areas not covered by the procurement. This competitive procurement will include the March 2012 expansion of STAR into the rural counties, STAR+PLUS into the Lubbock and El Paso service areas, and STAR and STAR+PLUS into the Hidalgo Service Area. Texas proposes an ambitious schedule to implement the managed care expansion:

STAR and STAR+PLUS Procurement Schedule	
Draft RFP Release Date	November 5, 2010
Draft RFP Respondent Comments Due	December 6, 2010
RFP Release Date	April 8, 2011
Vendor Conference	April 18, 2011
Respondent Questions Due	April 19, 2011
Letters Claiming Mandatory Contract Status Due	April 28, 2011
HHSC Posts Responses to Respondent Questions	April 29, 2011
Proposals Due	May 23, 2011
Deadline for Proposal Withdrawal	May 23, 2011
Respondent Demonstrations/Oral Presentations (HHSC option)	TBD
Tentative Award Announcement	August 2011
Anticipated Contract Start Date	August 2011
Operational Start Date	March 1, 2012

HHSC also is in the process of procuring a statewide risk-based model for primary and preventive dental services, which will begin serving Medicaid children in March 2012. HHSC will ensure that beneficiaries have a choice of at least two dental plans.

Medicaid Dental Services Procurement Schedule	
Draft RFP Released	December 13, 2010
Comments to the Draft RFP Due	January 12, 2011
Final RFP Released	February 22, 2011
Vendor Conference	March 1, 2011
Respondent Questions Due	March 11, 2011
HHSC Posts Responses to Respondent Questions	April 11, 2011
Proposals Due	May 10, 2011
Deadline for Proposal Withdrawal	May 10, 2011
Tentative Award Announcement	On or before August 15, 2011
Anticipated Contract Start Date	On or before September 1, 2011
Operational Start Date	March 1, 2012

Appendix D: Public Notice and Stakeholder Involvement

On May 27, 2011, the state published in the Texas Register a public notice of intent to seek an 1115 demonstration waiver from CMS (36 *Tex.Reg*. 3354). Tribal notification letters were mailed to the three tribal governments in Texas on May 3, 2011. No comments were received from the Tribes.

Texas solicited public comment through the Texas Register and the HHSC website on its proposed federal waiver to expand Medicaid managed care to 28 additional counties effective September 1, 2011, and a second expansion effective March 1, 2012. The vast majority of comments received were from independent pharmacists opposed to moving the Texas Vendor Drug Program to a managed care model. In particular, many expressed concern that the proposed changes would cause members to lose access to local independent pharmacies, and consequently, lose access to additional personalized services such as free pick-up and delivery. Loss of these types of services could adversely impact members with limited mobility, or those in rural areas where transportation issues can be a barrier to receiving services.

Other respondents raised concerns about members' inability to understand the changes to their pharmacy benefits that might result from this proposed waiver, particularly among non-English speaking populations or those with low literacy. There were also concerns about low reimbursement rates from Pharmacy Benefit Managers and the financial impact this proposed change would have on local independent pharmacists; many of whom expressed concern that these changes might force them out of business.

Texas also received one comment from a physical and occupational therapy provider regarding their difficulty in becoming an MCO network provider. HHSC uses a generous definition of Significant Traditional Provider (STP), allowing providers that provide even a modest level of service in fee-for-service to be designated as STPs.

Factors/Actions to Mitigate Pharmacy Concerns:

Texas' goal with the transition of pharmacy benefits into managed care is to provide greater utilization management and care coordination for recipients at a lower cost than today's model. Recipients' continued access to quality pharmaceutical care and ability to choose providers will be supported by HHSC through a variety of statutory and contractual requirements, including:

- Statutory Provisions
  - MCOs will be required to accept any Medicaid-enrolled pharmacy into their network if they are willing to accept the terms and conditions.
  - MCOs may not require clients to use a mail-order pharmacy.
  - MCOs may not use varying co-pays to limit recipients' choices of providers.

  - MCOs must adhere to a single state-wide formulary and single preferred drug list (PDL) to provide consistent benefits across the state and to prevent providers from having to learn multiple formularies and PDLs.
  - MCOs may not implement step-therapies or prior approval criteria that are more stringent than under the fee-for-service model.
- Contract/Policy Provisions
  - MCOs must reach out to all currently enrolled Medicaid pharmacy providers as significant traditional providers (STP), for potential inclusion in their network.
  - HHSC will conduct readiness reviews with all plans prior to MCO's operational start date to verify they have an adequate pharmacy provider network; and will monitor network adequacy over the term of the contract.
  - HHSC requires all recipient communications to be in both English and Spanish and to be approved by HHSC.
  - MCOs will be rewarded based on quality measures – including adherence to some drug therapies, such as for the treatment of asthma.
  - MCOs will be required to use electronic prescribing to improve prescribers' knowledge of members' medication history at the point of care.

For the 28 counties expansion effective September 1, 2011, the State has contracted with its enrollment broker, MAXIMUS, to conduct the 127 community events held between June 1st - August 31st. MAXIMUS posted the calendar of events on a website and other community forums to notify members. Member handbooks are provided at these events.

The state has held managed care initiatives stakeholder meetings (these meetings included information on the contiguous expansion) in the afternoon and evening between December 1, 2010 and April 30, 2011. The following events occurred:

December 9 (Brownsville)
December 10 (McAllen)
February 2 (Beaumont)
February 3 (Orange)
February 7 (Laredo)
February 8 (Eagle Pass)
February 14 (El Paso)
March 16 (Lubbock)
March 17 (Amarillo)
March 23 (Waco)
March 24 (Temple)
March 30 (Midland)
April 06 (San Angelo)
April 07 (Abilene)
April 19 (Tyler)
April 20 (Lufkin)
April 27 (Wichita Falls)

Medicaid notices will be mailed with the July and August Med IDs to clients in contiguous counties for the expansion on September 1, 2011. Enrollment packets were mailed from May 31st to June 14th.

The following provider training sessions have occurred:

Provider Training	
January 18, 2011	STAR/STAR+PLUS Provider Training in Beaumont
January 19, 2011	STAR/STAR+PLUS Provider Training in Jasper
January 24, 2011	STAR Provider Training in Amarillo
February 15, 2011	STAR/STAR+PLUS Provider Training in Bandera
February 16, 2011	STAR/STAR+PLUS Provider Training in Kingsville
February 17, 2011	STAR/STAR+PLUS Provider Training in Goliad
February 22, 2011	STAR/STAR+PLUS Provider Training in La Grange
February 23, 2011	STAR/STAR+PLUS Provider Training in Bellville
February 24, 2011	STAR Provider Training in El Paso
March 2, 2011	STAR/STAR+PLUS Provider Training in Orange
March 3, 2011	STAR/STAR+PLUS Provider Training in Beaumont
March 15, 2011	STAR Provider Training in Amarillo

For the next phase of expansion to occur on March 2012, the State is in the process of contracting with MAXIMUS to perform outreach events between December 1, 2011 and February 29, 2012.

Engagement with Hospital Stakeholders

HHSC has engaged hospital stakeholders throughout the development of the 1115 waiver. During the planning of managed care expansion, hospital stakeholders were included in the impact discussions beginning October 4, 2010. Initial waiver discussions were held April 14, 2011 and the direction of the current waiver was shared with representatives of the eleven public transferring hospitals on June 1, 2011 and June 29, 2011. HHSC is also obtaining feedback from other hospitals through engagement of the Texas Hospital Association (THA). Meetings on July 7th and 8th, 2011 continued discussions with the transferring hospitals, THA and other hospital associations, including Teaching Hospitals of Texas (THOT) and Children's Hospital Association of Texas (CHAT). The Texas Organization of Rural & Community Hospitals (TORCH) was also invited. Planning meetings on the Regional Healthcare Partnerships are scheduled with the largest public hospitals for July with additional meetings to be scheduled in August. Given the amount of time needed to finalize details of the program, Texas is committed to work with CMS and hospitals on developing specific RHP plan standard

components, and specific milestones, metrics, and payment methodologies by a specified date after waiver approval. The public funding hospitals were very supportive of the direction of the waiver and the regional planning aspects of the waiver. The other hospitals associations were receptive to the waiver approach based on the general overviews of the waiver and pool funding methodologies. Private hospital concerns involved elimination of the charge cap but they understood that their active participation in regional planning and system transformation would allow them to receive funding from DSRIP. Hospitals also were concerned about the need for a transition to the new payment methodology given the waiver start in September 2011.

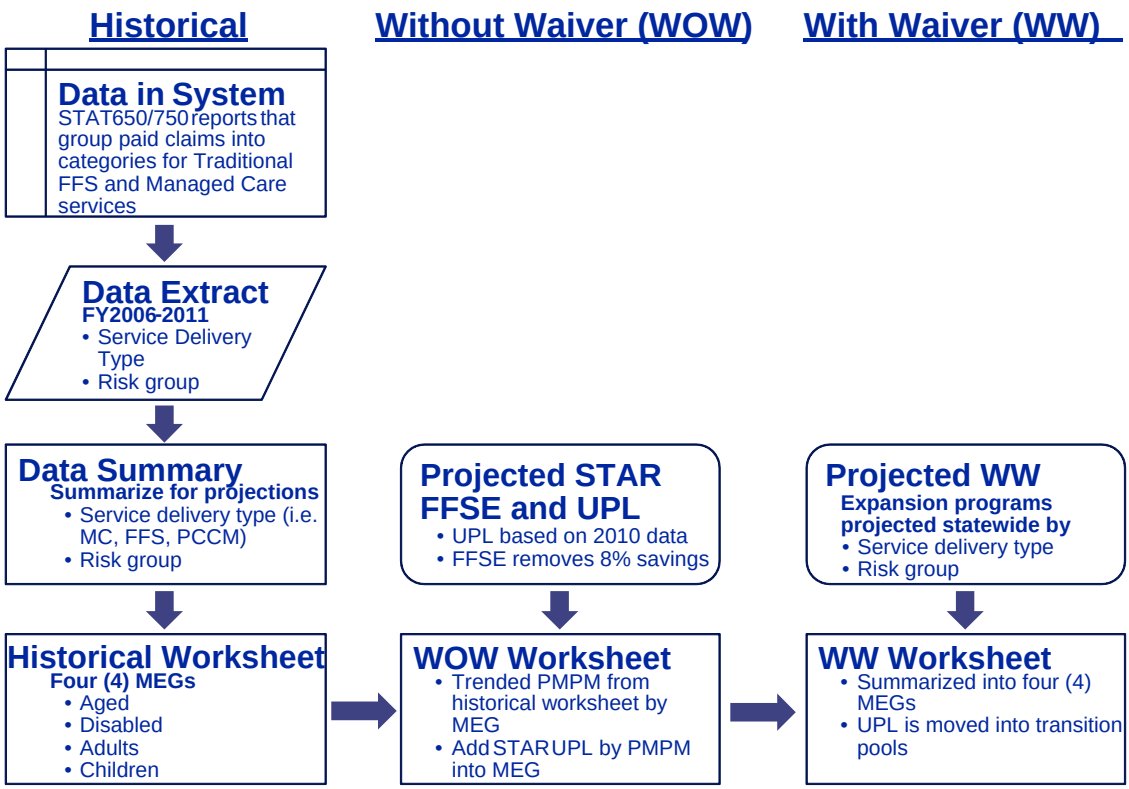
Appendix E: Documentation of Budget Neutrality Development

Overview

This summary describes the preparation of the budget neutrality demonstration for the Texas Managed Care Hospital Transition 1115 waiver. Overall, the budget neutrality demonstration is displayed in three primary worksheets:

- **Historical Data Worksheet**
- **Without Waiver (WOW) Worksheet**
- **With Waiver (WW) Worksheet**

This document describes the development of each worksheet in three (3) different sections, one for each worksheet. The diagram below shows an overview of the process flow used to develop each of the worksheets.



Definition of Medicaid Eligibility Groups (MEGs)

The State of Texas Health and Human Services Commission (HHSC) has developed the budget neutrality demonstration based on the MEGs recommended by CMS. The following table displays the MEGs and the HHSC Medicaid eligibility risk groups included within each MEG:

Medicaid Eligibility Group (MEG)	**Risk Groups Included**
Aged and Medicare Related	• Aged and Medicare Related
Blind and Disabled	• Blind and Disabled 21+ • Blind and Disabled under 21
Adults	• TANF Adults • Pregnant Women
Children	• TANF Children • Federally Mandated Children • Expansion Children • Newborns

Excluded Populations

The following is a list of the populations excluded from the waiver:

• Medically Needy	• Refugees
• Perinatal	• Foster Care (TP 08, 09, 10)
• Foster Care	• Women's Health Program (TP 41)
• Undocumented Aliens (TP 30)	• Nursing Facility residents in the STAR+PLUS program

Section 1: Historical Data Worksheet Development

The Historical Data worksheet includes the total expenditures, caseloads, and PMPM over a four (4) year historical period, State Fiscal Year (SFY) 2007 through SFY 2010.

The development of the historical worksheet included the following steps:

1. Consolidated expenditures and caseload by risk group from STAT 650/750 reports
2. Adjusted data for services not captured in consolidated source historical data
3. Incorporated aggregate limit UPL for the current UPL program

Historical Expenditures and Caseload

The historical expenditures and caseload were pulled from HHSC's STAT 650/750 reports, which are the STMR650A, STRR650A, STMR750A, and STRR750A reports that group paid claims into categories for Traditional FFS and Managed Care services. This data is provided by Texas Medicaid & Healthcare Partnership (TMHP) Funds Management team to report claims expenses to the HHSC System Forecasting team. TMHP is a State Medicaid contractor which has been under contract with the State of Texas since January 1, 2004 for the administration of claims processing for the Texas Medicaid program.

At a high level, all paid claims receive STAT assignment during claims processing. First, an electronic or paper claim is submitted to TMHP for claims processing. Then the paid claims will receive a STAT assignment via the STAT Assigner, which groups claims into the appropriate report (based on type of service delivery model), and assigns variables that forecasting uses to determine risk groups and type of services for a claim. Next, the claim data is pulled into a weekly STAT cycle which populates the MARS/STAT Vision21 (V21) Universe. Weekly and monthly STAT 650/750 reports are created in OnBase where they can be accessed by business users.

STAT assignment is a process that determines how claim expenses should be reported on the STAT expenditure reports. The STAT Assigner contains the rules for the STAT assignment process. During this process, each claim record is evaluated on claims engine using a set of hierarchical rules. The hierarchy of those rules was created in such a way as to accurately record expenses and to comply with federal reporting requirements. The business rules are used in determining which report, section, and page will contain the expense.

The STAT caseload and expenditure data was summarized by HHSC's Forecasting group over the historical period (FY 2006 – FY 2010) by risk group and service delivery type (i.e. FFS, PCCM, and HMO/MC). The expenditures were provided in a PMPM format to be incorporated into the budget neutrality demonstration.

Data Adjustments

The consolidated data did not incorporate historical claims for some of the services that are included in the waiver. Therefore, the following adjustments were made to the historical claims data to account for all services covered under the waiver:

Historical Data Adjustments	Description
Long Term Care (LTC) Costs for Managed Care Expansion Areas	Added LTC costs for expansion populations and counties moving to STAR+PLUS that were not included in the historical data but will be covered under waiver. These costs were estimated based on SFY 2010 claims.
Long Term Care (LTC) Costs for Dallas and Tarrant Counties	Added LTC costs for Dallas and Tarrant which is currently in STAR+PLUS but were not included in that program until 2011. These costs were based on actual historical claims.
Prescription Drug Costs	Prescription drug costs are currently carved out of the managed care programs and were excluded from the source data, but will be included under the waiver and added to the historical worksheet PMPM. These cost were based on historical PMPMs.
Dental Costs	Dental costs for primary and preventative care are currently carved out of the managed care programs and were excluded from the source data, but will be included under the waiver and added to the historical worksheet PMPM. These cost were based on historical PMPMs.

Current UPL Program Included (Aggregate Limit)

The historical aggregate limit for the current UPL program is included in the historical worksheet. The UPL was allocated by risk group, for populations included in the waiver, and incorporated into the overall MEG expenditures. The current UPL related to the excluded populations have been included as a separate line item called "UPL for Excluded Populations." A more detailed description of the aggregate limit UPL and the allocation of the UPL to MEGs is included in Appendix F.

Summarized Data into MEGs

The historical claims and UPL expenditures, caseload, and adjustments were extracted and summarized at the risk group level. For purposes of this waiver, HHSC developed the budget

neutrality demonstration based on the MEGs recommended by CMS. The following table displays the crosswalk between HHSC Medicaid eligibility risk groups and MEGs:

Medicaid Eligibility Group (MEG)	Risk Groups Included
Aged and Medicare Related	• Aged and Medicare Related
Blind and Disabled	• Blind and Disabled 21+ • Blind and Disabled under 21
Adults	• TANF Adults • Pregnant Women
Children	• TANF Children • Federally Mandated Children • Expansion Children • Newborns

Other UPL Included in Historical

In addition to the UPL related to the populations included in the waiver, we have incorporated the historical UPL expenditures under the current program for populations excluded from the waiver and the physician UPL program. Each UPL program is treated as a separate line item in the historical worksheet.

Summarized Historical PMPMs by MEG

The following table shows the historical costs and UPL expenditures by MEG included in the Historical worksheet.

Medical PMPM	2007	2008	2009	2010
Aged and Medicare Related	$ 350.24	$ 392.09	$ 432.19	$ 461.10
Blind and Disabled	$ 864.89	$ 937.19	$ 1,005.99	$ 1,084.92
Adults	$ 512.18	$ 582.49	$ 632.52	$ 643.08
Children	$ 188.37	$ 222.55	$ 235.66	$ 232.87

Current UPL PMPM	2007	2008	2009	2010
Aged and Medicare Related	$ 2.44	$ 2.50	$ 2.55	$ 2.76
Blind and Disabled	$ 129.91	$ 126.41	$ 123.21	$ 128.04
Adults	$ 121.80	$ 130.69	$ 134.87	$ 141.22
Children	$ 20.26	$ 20.63	$ 20.32	$ 19.60

Historical PMPM	2007	2008	2009	2010
Aged and Medicare Related	$ 352.68	$ 394.59	$ 434.74	$ 463.87
Blind and Disabled	$ 994.80	$ 1,063.59	$ 1,129.20	$ 1,212.96
Adults	$ 633.98	$ 713.17	$ 767.39	$ 784.30
Children	$ 208.63	$ 243.18	$ 255.98	$ 252.48

Section 2: Without Waiver (WOW) Worksheet Development

The Without Waiver (WOW) data worksheet includes the total expenditures (costs and UPL), caseloads, and PMPM from Demonstration Year One (DY1) to DY 5, which corresponds with SFY 2012 through SFY 2016. This section describes the caseload projection process and the cost projections for the WOW worksheet.

Caseload Projection Method

Medicaid caseload is projected statewide by risk group. Projections are typically performed using a tournament method, where time-series models using up to fifteen years of historical data are analyzed so that performance can be measured and compared. There may be as many as twenty different models run and compared for each series. Packages used include SAS, Forecast Master Pro, and Autobox. A naïve forecast, prior period's forecast, is also included in every tournament, for traditional statistical comparison purposes against more sophisticated models. A best model and alternate model are chosen based on performance in the tournament, and the final model is chosen by HHSC.

Using the tournament method described above, the caseload is projected for the following nine major Risk Groups:

- Aged and Medicare-Related
- Disabled and Blind
- TANF Adults
- TANF Children (including Foster Care, which is not in Waiver)
- Pregnant Women
- Newborns
- Children Ages 1-5 (Expansion Children)
- Children Ages 6 – 18 (Federal Mandate Children)
- Medically Needy (not in Waiver)

Once projected, caseload is allocated into the Service Delivery Area (SDA) based on historical proportions. Caseload is first allocated into the HMOs and PCCMs, and then residual caseload is categorized as FFS. When a new Service Delivery Area is created, or managed care is expanded into an area, projections are done by proportioning the caseload by county, using statewide experience as a proxy for choice of managed care or fee for service if choice is an option.

Caseload projections were performed in the summer of 2010, as part of the Legislative Appropriations Request submitted in the fall of 2010, in preparation for the legislative session beginning January 2011. Data used were from May 2010. At that time, the caseload for Non-Disabled Children was growing at a rate of 14 percent. Since that time, the growth has slowed, such that current growth is approximately 9 percent, but the projection has not been updated, as it is being used for the Managed Care Expansion Requests for Proposals and for all estimates during the legislative session. For the Without Waiver (WOW) projections, caseload and costs were done as if there was no expansion with the allocation of caseload to different Service Delivery Types based on historical and statewide distributions.

Cost Projections

The without waiver (WOW) worksheet was developed using the base year of SFY 2010 PMPMs by MEG. Please note that this base year PMPM includes both medical and UPL expenditures.

STAR Inpatient Carve Out

Absent the approval of a demonstration, the State of Texas would maintain the existing inpatient hospital carve-out in STAR+PLUS and establish a new carve-out arrangement for inpatient hospital services in the STAR program. Without the demonstration, these programs essentially would operate much like fee-for-service (FFS), with few incentives to manage inpatient hospital services. As such, Texas is incorporating an estimate of existing STAR

population UPL and a fee-for-service equivalent (FFSE) in the WOW to build an allowance if the STAR inpatient services are carved out to FFS.

- **STAR UPL:** The projected aggregate limit for the existing STAR program is included in the without waiver (WOW) worksheet. The estimated SFY 2010 STAR UPL was allocated to each MEG based on SFY 2009 claim distribution. A more detailed description of the STAR UPL calculation and allocation to MEGs is included in Appendix F.

- **STAR Inpatient FFSE:** For the WOW DYs, we estimated the FFSE for the existing STAR population inpatient services, assuming that an 8 percent savings on the managed care inpatient services. Historically, HHSC has incorporated a 30 percent savings on inpatient services when converting STAR populations from FFS to managed care. Based on HHSC's STAR+PLUS experience with a carve-out conversion from managed care to FFS, hospitals were required to achieve and demonstrate that a 22 percent savings from traditional FFS would be achieved under the carve-out program. Assuming a similar approach would be required during the carve-out of the STAR inpatient services, we believe that a reasonable assumption for the difference in expected cost between an inpatient carve-in model and an inpatient carve-out model would be 8 percent (the difference between the 30 percent and 22 percent).

  To appropriately adjust only the inpatient portion of the managed care projected premium, we used SFY 2010 managed care claims to estimate the portion of premium attributable to inpatient services. We then increased the inpatient portion of the managed care premium by removing the estimated savings (i.e., 1/.92).

  The following table shows the calculation of the FFSE for the TANF Adult risk group:

STAR Inpatient (IP) FFSE Development Example - TANF Adult	
(a) Percent Inpatient of Total MC Claims	22.5%
(b) Percent Managed Care of Total Medical Costs	20.9%
(c) Percent Total Medical to Adjust for FFSE (= a x b)	4.68%
(d) Estimated savings percentage	8.00%
(e) 2010 Total Medical Costs	$483,863,610
(f) Inpatient Managed Care Cost (= e x c)	$22,655,345
(g) All Other Costs (= e – f)	$461,208,265

(h) Adjusted Inpatient FFSE (= f / (1-(d)))	$24,625,375
(i) Adjusted Total TANF Adult Medical Costs (= g + h)	$485,833,640

Final Base Year PMPM with STAR Adjustment

The following table shows the FY 2010 base year PMPM by MEG used for the WOW projection inclusive of the STAR UPL and FFSE adjustments. The adjusted base year PMPM was projected for the WOW using the four (4) year historical PMPM as displayed in the historical worksheet of the BN demonstration. The trend, as shown in the historical worksheet, includes both historical medical and the aggregate limit UPL applied to the adjusted base year for each of the demonstration year.

Development of Adjusted Base Year for WOW				
Medicaid Eligibility Group (MEG)	**FY 2010 Historical PMPM**	**STAR UPL Adjustment**	**STAR FFSE Adjustment**	**Adjusted Base Year PMPM**
Aged and Medicare Related	$463.87	$0.00	$0.00	**$463.87**
Blind and Disabled	$1,212.96	$0.00	$0.00	**$1,212.96**
Adults	$784.30	$142.66	$10.11	**$937.06**
Children	$252.48	$17.57	$2.45	**$272.49**

WOW Projected PMPMs (using 4-Year Historical MEG trends)							
Medicaid Eligibility Group (MEG)	**Adjusted Base Year PMPM**	**Hist. Trend**	**DY01**	**DY02**	**DY03**	**DY03**	**DY03**
Aged and Medicare Related	**$463.87**	9.6%	$556.85	$610.11	$668.47	$732.41	$802.47

Blind and Disabled	**$1,212.96**	6.8%	$1,384.37	$1,478.95	$1,580.00	$1,687.95	$1,803.28
Adults	**$937.06**	7.4%	$1,079.87	$1,159.24	$1,244.44	$1,335.91	$1,434.10
Children	**$272.49**	6.6%	$309.45	$329.76	$351.41	$374.48	$399.06

Other UPL Included in WOW

- **UPL for populations excluded from the waiver:** The UPL was projected based on the four year historical 5.72 percent total expenditure trend. This trend is shown in the historical worksheet.
- **Physician UPL:** The physician UPL was projected from the FY 2011 base year total cost at three percent. The estimated FY 2011 base costs are based on actual quarter 1 and 2 Physician UPL payments made. The table below shows the development of the projected Physician UPL expenditures included in the WOW. The reduction in historical UPL was driven by approval of State Plan Amendment 04-029 in 2007, in which refinements were made to the Physician UPL calculation methodology that significantly reduced reimbursement going forward. The primary enhancements included application of Medicaid pricing modifier reductions and restriction of UPL payment to the professional component only of radiology and laboratory services (eliminating payment for procedures billed as total or technical components).

Physician UPL Historical and Projected Payments

	HISTORICAL					
	2005	**2006**	**2007**	**2008**	**2009**	**2010**
Total Private	2,410,110	7,832,860	3,744,852	2,443,271	2,831,433	5,091,894
Total State	113,965,556	93,876,344	93,803,802	41,201,174	37,373,837	53,850,011
Total Physician UPL	**116,375,666**	**101,709,204**	**97,548,654**	**43,644,446**	**40,205,270**	**58,941,905**
	Annual Trend	-12.6%	-4.1%	-55.3%	-7.9%	46.6%

	Projected (2011 based on Qtr 1 & 2 payments, 2012-2016 projected at 3%)					
	2011	**2012**	**2013**	**2014**	**2015**	**2016**
Total Private	4,519,752	4,655,345	4,795,005	4,938,855	5,087,021	5,239,632
Total State	60,269,721	62,077,812	63,940,147	65,858,351	67,834,102	69,869,125
Hospital Districts with Taxing Authority	2,529,424	2,605,307	2,683,466	2,763,970	2,846,889	2,932,296
Texas A&M	79,691	82,081	84,544	87,080	89,693	92,383
Physician Groups Affiliated with Scott & White	3,930,620	5,239,227	5,396,404	5,558,296	5,725,045	5,896,796
Total Physician UPL	**71,329,208**	**74,659,772**	**76,899,565**	**79,206,552**	**81,582,749**	**84,030,231**
Annual Trend	21.0%	4.7%	3.0%	3.0%	3.0%	3.0%

Notes:
- 2011 payments are based on payments made in the first 2 quarters
- The increase from 2010 to 2011 is due to the addition of the Chapter 281 hospitals, Texas A&M, and Scott & White Associated Physicians
- Scott & White physician groups have a outstanding state plan amendment that will allow for retroactive payments back to January 2011
- Scott & White is expected to grow more than 3% from 2011 to 2012 because the 2011 payment is only for a partial year.

Section 3: With Waiver (WW) Worksheet Development

The WW data worksheet includes the total expenditures, caseloads, and PMPM from Demonstration Year One (DY1) to DY 5, which corresponds with SFY 2012 through SFY 2016. This section describes the overall projection methodology and the with waiver worksheet development.

While the final waiver demonstration is shown at the MEG level, the caseload, expenditures, and PMPM cost were summarized and projected at the risk group level and then consolidated into the MEGs. This methodology is consistent with HHSC's development of its fiscal budgets, which are analyzed and projected by eligibility category (i.e. risk group).

Caseload Projections: Expansion of Managed Care

The total caseload for the WW is the same as projected under the WOW. As the managed care expansions were designed, the May 2010 projections were allocated based on the historical proportions each affected county contributed to the overall caseload. For the WOW projections, caseload and costs were done as if there was no expansion, but for the WW projections, the allocation of caseload to different Service Delivery Types was made, based on historical and statewide distributions. For example, in the case of STAR+PLUS, the allocation of Disabled Clients under age 21 was based on the historical choice of STAR+PLUS (compared to FFS) of Disabled Clients under 21 in other STAR+PLUS areas of the state.

Once all expansions were allocated by caseload, preliminary rates, obtained from the HHSC consulting actuarial firm and based on the savings assumptions for managed care expansion, were applied. The only FFS costs remaining are either for those populations not shifting to Managed Care, residual costs for first month of service (prior to signing up for a managed care plan), and any retrospective costs (the 3-month look back), as well as those costs which are not managed care eligible, including Medicare premiums and Medical Transportation (not part of the waiver). After all populations were allocated to a Managed Care plan, the Dental Managed Care capitation was added, and the capitation was changed to reflect the addition of inpatient services for STAR+PLUS and Vendor Drugs.

With Waiver Worksheet Development

The WW worksheet was developed using projected caseload and costs, as described above, by risk group and service delivery type for each of the projected waiver years (SFY 2012 – SFY 2016). The projections were based on a statewide expansion to manage care and an inclusion of services not currently included under the existing manage care capitation rate.

Data Adjustments

The consolidated data did not incorporate within the forecasting model claims for some of the services that are included in the waiver. Therefore, the following adjustments were made to the forecasting data to account for all services covered under the waiver:

Services not included in MC Premium	Description
Long Term Care (LTC) Costs	Added LTC expenditures to the Aged and Medicare related risk group to capture the costs incurred during DY2012 prior to managed care expansion (phases in March 2012). These costs were projected based on SFY 2010 costs.
Prescription Drugs Costs	Prescription drugs costs weren't included in the projected costs but will be included under the waiver.
Dental Costs	Dental costs weren't included in the projected costs but will be included under the waiver.

Summarized Data into MEGs

Once all caseloads and expenditures were projected under the expansion Medicaid managed care delivery model, we summarized the without waiver costs into the following MEGs:

Medicaid Eligibility Group (MEG)	Risk Groups Included
Aged and Medicare Related	• Aged and Medicare Related
Blind and Disabled	• Blind and Disabled 21+ • Blind and Disabled under 21
Adults	• TANF Adults • Pregnant Women
Children	• TANF Children • Federally Mandated Children • Expansion Children • Newborns

Appendix F: Documentation of UPL Allocation

For purposes of the 1115 waiver, the State of Texas is including UPL in the Budget Neutrality Model. There are three primary forms of UPL included in the 1115 waiver:

1. UPL Aggregate Limit (Current UPL Program)
2. STAR UPL
3. Physician UPL

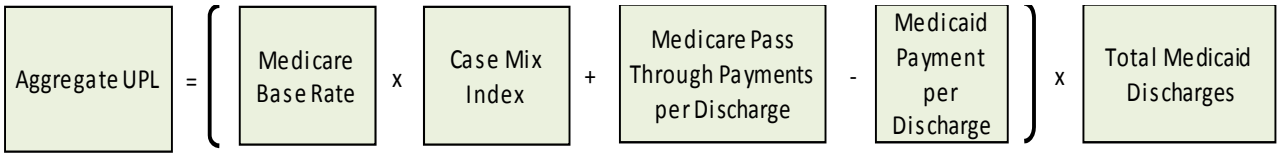
The UPL amounts are incorporated into the Historical and/or WOW worksheets of the Budget Neutrality Model and then move into the waiver pool in the WW worksheet. The remainder of this document describes the three forms of UPL, how the UPL is calculated for the Historical and WOW worksheets, and how the UPL is allocated into the corresponding MEGs or expenditure line items in the Budget Neutrality Model.

Current UPL Program

Aggregate Limit Calculation

For the current UPL program, the Aggregate Limit is calculated by the State using an approved methodology and Texas Medicaid BlueRibbon data. This data contains FFS and PCCM inpatient claims at the claim line level by member for all Texas hospitals and is developed by using adjudicated claims data from the Texas Medicaid Management Information System (MMIS). The BlueRibbon data is created each year by TMHP. TMHP is a State Medicaid contractor that has been under contract with the State of Texas since January 1, 2004, for the administration of claims processing for the Texas Medicaid program.

The Aggregate Limit calculation compares the actual Medicaid cost at the claim level to the expected reimbursement for the claim under the Medicare program. The difference between the Medicare reimbursement and actual Medicaid cost is how the UPL is calculated for each claim. The graphic below provides a visual of how this calculation is completed by claim for the majority of the aggregate UPL (note: Children's and Psychiatric hospitals are calculated differently and account for less than two percent of the total).



Why Aggregate Limit?

There are three primary reasons why the State of Texas believes the Aggregate Limit methodology is more appropriate in calculating UPL for the 1115 waiver:

1. Recent UPL payments have been paid at or near the aggregate cap for the majority of UPL payments (in SFY 2010 over 95 percent of the aggregate limit was paid out).

2. The Aggregate Limit calculation can be calculated and allocated at the member level which allows UPL to be accurately assigned to Risk Groups and MEGs.

3. The historical Aggregate Limit trend provides a more realistic projection of future UPL costs versus the historical UPL payment trends due to the recent growth of the Texas Medicaid UPL program.

Allocation to MEGs: Since the UPL is determined for the Aggregate Limit using claim level data, the State is able to tie payments, utilization, and therefore UPL directly to a member. Using member risk group and client program type, the State is able to map a MEG to each claim. This allows the State to accurately summarize and allocate UPL to each MEG in the Budget Neutrality Model.

Trend: Due to the growth of the UPL program in the State of Texas over the past four (4) years, historical UPL payments have increased substantially. As shown in the exhibit below, historical UPL payments have increased 18% annually on an expenditure basis between SFY 2007 and SFY 2010, whereas the Aggregate Limit has increased 5.72 percent annually on an expenditure basis during the same time period. We believe the Aggregate Limit calculation provides a more stable and reasonable indication of future UPL growth versus actual UPL payments.

Hospital Inpatient UPL

	2007	2008	2009	2010	Avg. Trend
Actual UPL Payments	**$1,580,580,571**	**$1,825,044,886**	**$2,226,467,952**	**$2,596,073,227**	**18.0%**
Total Aggregate Limit	**$2,291,289,763**	**$2,366,902,325**	**$2,452,110,809**	**$2,707,299,490**	**5.72%**

Historical UPL Aggregate Limit Allocation

Detailed analysis was performed to calculate and allocate UPL into MEGs using the SFY 2010 Aggregate Limit. The SFY 2010 Aggregate Limit is calculated using SFY 2009 inpatient claims from the Texas BlueRibbon data. As described in the *Aggregate Limit Calculation* section, for each claim line the Aggregate Limit formula was applied, and the corresponding UPL for the claim was assigned to a risk group and MEG. The UPL was then summarized by risk group and MEG to determine the breakdown of UPL Aggregate Limit for purposes of the Budget Neutrality Model. The exhibit below displays the breakdown of the SFY 2010 UPL Aggregate Limit used in the Budget Neutrality Model.

SFY 2010 UPL Aggregate Limit Breakdown		
Risk Group	**MEG**	**UPL Aggregate Limit**
Included Waiver Services:		
Aged and Medicare Related	Aged	$ 11,600,000
Blind and Disabled Age <21	Disabled	$ 56,500,000
Blind and Disabled Age 21+	Disabled	$ 509,800,000
TANF ADULTS	Adults	$ 30,000,000
TANF CHILDREN	Children	$ 38,000,000
Pregnant Women	Adults	$ 342,700,000
Newborns	Children	$ 335,900,000
Expansion Children	Children	$ 120,200,000
Federal Mandate Children	Children	$ 63,700,000
Total Included Waiver Services		**$ 1,508,400,000**
Excluded Waiver Services:		
Medically Needy	Not Assigned [2]	$ 48,900,000
Perinatal, etc.		$ 464,900,000
All Others [1]		$ 685,100,000
Total Excluded Services		**$ 1,198,900,000**
Total SFY 2010 Aggregate Limit		**$ 2,707,300,000**

1. Includes undocumented aliens, refugees, foster care and women's health programs

2. UPL Aggregate Limit for excluded services not assigned to MEGS, included as separate line item as pass-through expenditures in the Budget Neutrality Model

The SFY 2007 – SFY 2010 Aggregate Limit used in the Budget Neutrality Model is based on actual prior Aggregate Limit for the Texas Medicaid program. The distribution of SFY 2010 UPL Aggregate Limit by risk group as shown in the above exhibit was also used to allocate historical SFY 2007 – SFY 2009 UPL Aggregate Limit into the respective risk groups. The UPL was distributed proportionately across risk groups based on the allocation in SFY 2010 and the total UPL Aggregate Limit for each historical year. In other words, the portion of UPL Aggregate Limit

assigned to a specific risk group remained constant over each of the historical years. The following provides an example of how the allocation of SFY 2007-2009 UPL by risk group was calculated:

A.	TANF Adults SFY 2010 UPL: $30,000,000
B.	SFY 2010 Aggregate Limit: $2,707,300,000
C.	% of Agg. Limit for TANF Adults (=A/B): **1.1%**
D.	SFY 2007 Aggregate Limit: $2,291,300,000
E.	% of Agg. Limit for TANF Adults (=C): 1.1%
F.	SFY 2007 TANF Adult UPL (=D*E): **$25,400,000**

The exhibit below summarizes the breakdown of the historical UPL Aggregate Limit by risk group and MEG by year. The breakdowns were calculated using the above-described methodology. Please note that the caseload used to calculate the PMPM trend excluded the STAR managed care caseload. We excluded this caseload because the STAR program does not currently carve-out inpatient services and therefore does not generate UPL payments.

Historical UPL Caseload (excludes STAR Managed Care)	2007	2008	2009	2010
Aged and Medicare Related	4,025,497	4,062,872	4,117,268	4,195,291
Blind and Disabled	3,689,783	3,917,271	4,163,667	4,423,582
Adults	1,567,309	1,453,747	1,463,255	1,581,637
Children	11,861,180	11,317,298	12,034,141	13,766,831
TOTAL	**21,143,769**	**20,751,188**	**21,778,331**	**23,967,341**

Historical Aggregate Limit for Current Program	2007	2008	2009	2010
Aged and Medicare Related	$9,813,671	$10,137,523	$10,502,473	$11,595,455
Blind and Disabled	$479,345,927	$495,164,342	$512,990,259	$566,376,634
Adults	$315,407,513	$325,815,961	$337,545,335	$372,673,335
Children	$472,056,294	$487,634,151	$505,188,981	$557,763,485
Total Aggregate Limit for Included Population	**$1,276,623,404**	**$1,318,751,977**	**$1,366,227,048**	**$1,508,408,909**
Total Aggregate Limit for Excluded Population	**$1,014,666,359**	**$1,048,150,348**	**$1,085,883,761**	**$1,198,890,581**
Total Aggregate Limit	**$2,291,289,763**	**$2,366,902,325**	**$2,452,110,809**	**$2,707,299,490**

Historical UPL PMPM for Included Populations	2007	2008	2009	2010
Aged and Medicare Related	$2.44	$2.50	$2.55	$2.76
Blind and Disabled	$129.91	$126.41	$123.21	$128.04
Adults	$201.24	$224.12	$230.68	$235.63
Children	$39.80	$43.09	$41.98	$40.52

UPL for Populations Excluded from the Waiver

The UPL identified above for populations excluded from the waiver are included in the historical budget neutrality (BN) worksheet as a separate expenditure line item. These costs were projected forward into the WOW based on the four year historical trend shown on the Historical worksheet.

STAR UPL

Why STAR UPL?

Absent the approval of a demonstration, the State of Texas would maintain the existing inpatient hospital carve-out in STAR+PLUS and establish a new carve-out arrangement for inpatient hospital services in the STAR program. Without the demonstration, these programs essentially would operate much like FFS, with few incentives to manage inpatient hospital services. As such, Texas is incorporating an estimate of the existing STAR program UPL in the WOW to build an allowance if STAR inpatient services are carved out to FFS, which would generate UPL payments.

SFY 2010 Historical STAR UPL Calculation

For purposes of the WOW worksheet in the Budget Neutrality Model, we estimated what the UPL payment would be for the existing STAR managed care program if hospital claims for these members had been paid under FFS. To estimate the UPL, we used the SFY 2010 Medicaid UPL Aggregate Limit data (SFY 2009 BlueRibbon) and SFY 2009 STAR managed care encounter data.

To estimate the difference between Medicare and Medicaid FFS for the existing STAR managed care population, we used the average SFY 2010 UPL Aggregate Limit per discharge and case mix for the FFS population based on the SFY 2009 BlueRibbon data. SFY 2009 encounter data was used to determine the number of admissions and the case mix index (CMI) for the STAR managed care population. The formula below shows how the UPL was estimated for the STAR managed care population.

$$\left[\frac{\text{SFY 2010 UPL Aggregate Limit}}{\text{SFY 2009 FFS Discharges x FFS CMI}}\right] \text{x STAR Encounter Admissions x STAR Encounter CMI}$$

The analysis described above excluded admissions for populations excluded from the waiver such as TANF Perinatal, Foster Care, undocumented aliens, etc. We used client type program codes and PPS risk group codes to identify these programs and populations to remove them from the SFY 2009 BlueRibbon data and SFY 2009 STAR managed care encounter data prior to performing the calculations described above.

Based on our analysis, the estimated SFY 2010 STAR managed care hospital UPL payment would be approximately $876,300,000 if STAR inpatient claims are paid on a FFS basis.

Similar to the approach utilized to allocate the current UPL program for populations included in the waiver into MEGs, the claim-level STAR managed care encounter data allowed Texas to assign claims to risk groups and MEGs. The formula outlined above was applied by risk group to

determine the estimated SFY 2010 STAR UPL by risk group in order to allocate the amounts correctly into the MEGs of the Budget Neutrality Model. The following exhibit displays the breakdown of the estimated SFY 2010 STAR UPL by risk group.

SFY 2010 STAR UPL Breakdown		
Risk Group	**MEG**	**STAR UPL**
Aged and Medicare Related	Aged	$ -
Blind and Disabled Age <21	Disabled	$ -
Blind and Disabled Age 21+	Disabled	$ -
TANF ADULTS	Adults	$ 25,200,000
TANF CHILDREN	Children	$ 20,000,000
Pregnant Women	Adults	$ 351,300,000
Newborns	Children	$ 348,700,000
Expansion Children	Children	$ 68,200,000
Federal Mandate Children	Children	$ 62,900,000
Total STAR UPL		**$ 876,300,000**

Projecting Aggregate Limit and STAR UPL

The SFY 2010 aggregate limit and STAR UPL are included in the SFY 2010 base year PMPM shown on the without waiver (WOW) worksheet. These costs are projected based on the historical four year PMPM trend by MEG as shown in the historical worksheet. The table below shows the estimated UPL included for each program in the SFY 2010 base year.

SFY 2010 Base Year PMPM Development						
MEG	**Caseload**	**Medical PMPM**	**Current UPL (Agg Limit) PMPM**	**STAR UPL PMPM**	**STAR FFSE Adjustment**	**Total Base Year PMPM**
Aged and Medicare Related	4,195,291	$461.10	$2.76	$0.00	$0.00	$463.87
Blind and Disabled	4,423,582	$1,084.92	$128.04	$0.00	$0.00	$1,212.96
Adults	2,638,972	$643.08	$141.22	$142.66	$10.11	$937.06
Children	28,450,334	$232.87	$19.60	$17.57	$2.45	$272.49

Physician UPL

In addition to the current UPL program (aggregate limit UPL) and STAR UPL, Texas is also including costs of the Physician UPL program. This UPL is incorporated as a separate expenditure line item, similar to the UPL for excluded populations. The estimated FY 2011 base costs are based on actual quarter 1 and 2 Physician UPL payments made. The table below shows the development of the projected Physician UPL expenditures included in the WOW.

The reduction in historical UPL was driven by approval of State Plan Amendment 04-029 in 2007, in which refinements were made to the Physician UPL calculation methodology that significantly reduced reimbursements. The primary enhancements included application of Medicaid pricing modifier reductions and restriction of UPL payment to the professional component only of radiology and laboratory services (eliminating payment for procedures billed as total or technical components).

Physician UPL Historical and Projected Payments

	HISTORICAL					
	2005	**2006**	**2007**	**2008**	**2009**	**2010**
Total Private	2,410,110	7,832,860	3,744,852	2,443,271	2,831,433	5,091,894
Total State	113,965,556	93,876,344	93,803,802	41,201,174	37,373,837	53,850,011
Total Physician UPL	**116,375,666**	**101,709,204**	**97,548,654**	**43,644,446**	**40,205,270**	**58,941,905**
Annual Trend		-12.6%	-4.1%	-55.3%	-7.9%	46.6%

	Projected (2011 based on Qtr 1 & 2 payments, 2012-2016 projected at 3%)					
	2011	**2012**	**2013**	**2014**	**2015**	**2016**
Total Private	4,519,752	4,655,345	4,795,005	4,938,855	5,087,021	5,239,632
Total State	60,269,721	62,077,812	63,940,147	65,858,351	67,834,102	69,869,125
Hospital Districts with Taxing Authority	2,529,424	2,605,307	2,683,466	2,763,970	2,846,889	2,932,296
Texas A&M	79,691	82,081	84,544	87,080	89,693	92,383
Physician Groups Affiliated with Scott & White	3,930,620	5,239,227	5,396,404	5,558,296	5,725,045	5,896,796
Total Physician UPL	**71,329,208**	**74,659,772**	**76,899,565**	**79,206,552**	**81,582,749**	**84,030,231**
Annual Trend	21.0%	4.7%	3.0%	3.0%	3.0%	3.0%

Notes:
- 2011 payments are based on payments made in the first 2 quarters
- The increase from 2010 to 2011 is due to the addition of the Chapter 281 hospitals, Texas A&M, and Scott & White Associated Physicians
- Scott & White physician groups have a outstanding state plan amendment that will allow for retroactive payments back to January 2011
- Scott & White is expected to grow more than 3% from 2011 to 2012 because the 2011 payment is only for a partial year.

Appendix G: Components of the Texas 1915(b) Managed Care Waivers

This document includes items previously negotiated in the Texas 1915(b) Waivers for the STAR and STAR+PLUS Programs. The State has noted items that will change under the 1115 Demonstration Waiver.

In addition, this document includes items that the State believes will apply to the Children's Medicaid Dental Services model under the 1115 Demonstration Waiver. This capitated model will include primary and preventative care for individuals age 20 and under.

Section A, "Program Description," Part 1

A. Statutory Authority

1. *Waiver Authority* -- STAR, STAR+PLUS, and Children's Medicaid Dental Services

   1915(b)(2) - A locality will act as a central broker in assisting eligible individuals in choosing among competing managed care organizations (MCO) in order to provide enrollees with more information about the range of health care options open to them.

   1915(b)(3) - The State will share cost savings resulting from the use of more cost-effective medical care with enrollees by providing them with additional services.

   1915(b)(4) - The State requires enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services.

2. *Sections Waived* -- STAR, STAR+PLUS, and Children's Medicaid Dental Services

   Section 1902(a)(1) - Statewideness--The STAR+PLUS program will not be available throughout the state. STAR and Children's Dental Services will be available statewide.

   Section 1902(a)(10)(B) - Comparability of Services-- This waiver program includes additional benefits such as case management and health education that will not be available to other Medicaid beneficiaries not enrolled in the waiver program.

   Section 1902(a)(23) - Freedom of Choice-- Under this program, free choice of providers is restricted. That is, beneficiaries enrolled in this program must receive certain services through an MCO.

B. Delivery System

STAR and STAR+PLUS: MCO risk-comprehensive contracts.

Children's Medicaid Dental Services: PAHP (MCOs will provide risk-based primary and preventative dental services under a fully-capitated fee structure. Members will receive inpatient hospital services through STAR or STAR+PLUS).

D. Geographic Areas

STAR and Children's Medicaid Dental Services: Statewide.

STAR+PLUS: All parts of the state except the Medicaid Rural Service Area (MRSA).

E. Populations Included in the Waiver

1. Included Populations

STAR:

Mandatory throughout the State:

Section 1931 Children and Related Populations are children, including those eligible under Section 1931, poverty-level related groups, and optional groups of older children.

Section 1931 Adults and Related Populations are adults, including those eligible under Section 1931, poverty-level pregnant women, and optional groups of caretaker relatives.

Mandatory in the MRSA (where STAR+PLUS is not an option):

Blind/Disabled Adults and Related Populations are beneficiaries, age 18 or older, who are eligible for Medicaid due to blindness or disability. Report Blind/Disabled Adults who are age 65 or older in this category, not in Aged.

Individuals who are receiving both Medicaid and Medicare services (Dual Eligibles), including children age 20 and under receiving Supplemental Security Income (SSI).

Voluntary in the Medicaid Rural Services Area:

Medicaid-only Blind/Disabled Children and Related Populations are beneficiaries, generally under age 18, who are eligible for Medicaid due to blindness or disability.

STAR+PLUS:

Mandatory throughout the State:

Blind/Disabled Adults and Related Populations are beneficiaries, age 18 or older, who are eligible for Medicaid due to blindness or disability. Report Blind/Disabled Adults who are age 65 or older in this category, not in Aged.

Voluntary throughout the State:

Blind/Disabled Children and Related Populations are beneficiaries, generally under age 18, who are eligible for Medicaid due to blindness or disability.

Children's Medicaid Dental Services:

Section 1931 Children and Related Populations are children, including those eligible under Section 1931, poverty-level related groups, and optional groups of older children. These are mandatory enrollees.

Blind/Disabled Children and Related Populations are beneficiaries who are eligible for Medicaid due to blindness or disability. These are mandatory enrollees.

2. Excluded Populations

STAR, STAR+PLUS, and Children's Medicaid Dental Services:

Reside in Nursing Facility or ICF/MR - Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for the Mentally Retarded (ICF/MR) will be excluded from entry into the 1115 waiver. If a STAR or STAR+PLUS member enters a NF, the member will remain enrolled for up to four months.

Retroactive Eligibility – Medicaid beneficiaries are excluded for the period of retroactive eligibility.

STAR Health program recipients. STAR Health is the State's capitated model for Medicaid recipients who are in the Department of Family and Protective Services' conservatorship (e.g. foster care).

For a full list of excluded populations under the 1115 Demonstration Waiver, please refer to the State's waiver application.

Children's Medicaid Dental Services:

Medicaid recipients age 21 and over will be excluded from Children's Medicaid Dental Services.

F. Services

STAR, STAR+PLUS, and Children's Medicaid Dental Services:

FQHC Services. In accordance with section 2088.6 of the State Medicaid Manual, access to Federally Qualified Health Center (FQHC) services will be assured in the following manner: The program is mandatory and the enrollee is guaranteed a choice of at least one MCO which has at least one FQHC as a participating provider. If the enrollee elects not to select an MCO that gives him or her access to FQHC services, no FQHC services will be required to be furnished to the enrollee while the enrollee is enrolled with the MCO he or she selected. Since reasonable access to FQHC services will be available under the waiver program, FQHC services outside the program will not be available.

STAR and STAR+PLUS:

1915(b)(3) Services. The waiver includes one 1915(b)(3) service:

- Elimination of the 30-day spell-of-illness limitation that applies in fee-for-service. All STAR and STAR+PLUS members are eligible for this benefit. The first 30 days' costs for this benefit are included in the capitation paid to MCOs, and costs for services after 30 days are paid out of cost savings. This benefit is available in all Service Areas in the state.

Self-referrals. In addition to emergency, family planning, vision care and obstetric or gynecological services, members may self-refer to outpatient behavioral health services and to services through the Early Childhood Intervention (ECI) program.

Outpatient Behavioral Health. The 30-visit limit for outpatient behavioral health services (applicable to adults ages 21 and over) is waived for members in order to comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) (codified at 42 U.S.C. §300gg-5), which is made applicable to Medicaid group health plans under §1932(b)(8) of the Social Security Act (42 U.S.C. §1396u-2). Non-quantitative treatment limitations may apply to outpatient behavioral health services, provided such limitations comply with the MHPAEA.

Substance Use Disorder Treatment. The MCOs will be responsible under their contract to provide substance use disorder treatment services and may provide these services in a chemical dependency treatment facility in lieu of acute care inpatient hospital settings. The Texas Health and Human Services Commission (HHSC) does not include non-state plan services, such as room and board, in the STAR or STAR+PLUS scope of covered services; however, the MCO is not restricted to only the delivery of state plan services when

alternative services are a cost-effective and medically appropriate response to the needs of the member.

Section A: "Program Description," Part II, "Access"

C. Coordination and Continuity of Care Standards

STAR, STAR+PLUS, and Children's Medicaid Dental Services:

Identification. The State has a mechanism to identify persons with special health care needs to MCOs.

Section A: "Program Description," Part III, "Quality."

1. Assurances for programs – *STAR, STAR+PLUS and Children's Medicaid Dental Services*

External Quality Review (EQR). The State contracts with an independent External Quality Review Organization (EQRO) that performs the following activities:

EQR Study	Mandatory Activities	Optional Activities
Annual focused studies and ad hoc queries identified by the State.	Annual quality of care, access to care, and financial performance measures for all MCOs.	Assist state with identification of new performance measures for MCOs.

Section A: "Program Description," Part IV, "Program Operations."

A. Marketing-- *STAR, STAR+PLUS and Children's Medicaid Dental Services*

The State permits indirect marketing by MCOs including: radio, TV, billboard, bus signs, bench displays, newspaper, decals and banners.

Direct mail marketing is prohibited; however, MCOs are permitted to conduct direct marketing during HHSC-approved enrollment events.

HHSC's managed care contracts and Uniform Managed Care Manual include restrictions on offering gifts and other incentives to potential enrollees, and reporting and investigating alleged marketing violations.

The State requires MCOs to translate marketing materials into the languages of major population groups (making up 10 percent or more of the population). Currently, English and Spanish meet this definition.

B. Information to Potential Enrollees and Enrollees -- *STAR, STAR+PLUS and Children's Medicaid Dental Services*

Non-English Languages. Potential enrollee and enrollee materials are translated into the languages of major population groups (making up 10 percent or more of the population).

Translation Services. The Enrollment Broker uses AT&T Language Line Services for any language for which it does not have in-house capability. (A description of AT&T Language Line Services can be found at http://www.languageline.com/.)

Other. The State provides potential enrollees with enrollment materials, helpline assistance, and health care orientation.

C. Enrollment and Disenrollment -- *STAR, STAR+PLUS and Children's Medicaid Dental Services.*

Outreach. The State or its Enrollment Broker will conduct outreach activities.

Default & Auto-assignment. Enrollees who do not select a plan within a specified period are auto-assigned with an MCO.

Generally, the auto-assignment process considers an enrollee's history with a primary care provider or main dental provider in making an assignment. This consideration is not limited to persons with special health care needs. The process does not consider a physician's capability to service particular health care needs.

The State also uses the "Frew Default Assignment Methodology" as an incentive for MCOs to provide timely Texas Health Steps checkups to new members. MCO default assignment percentages may be increased or reduced by up to 20 percent, depending on whether they have met the State's participation goals.

The State automatically re-enrolls a beneficiary with the same MCO if there is a loss of Medicaid eligibility of six months or less.

MCO Disenrollment of Member. HHSC's contract with the MCO spells out the limited reasons for which an MCO may make a disenrollment request.

E. Grievance System

For standard grievances and appeals, the State does not require enrollees to exhaust the MCO grievance and appeals process before enrollees may request a State fair hearing. Clarification item: enrollees must exhaust the MCO's expedited appeals process before making a request for an expedited State fair hearing.

Section B, "Monitoring Plan," Part I, "Summary Chart of Monitoring Activities"

STAR, STAR+PLUS and Children's Medicaid Dental Services:

Please refer to the current 1915(b) waiver charts for a description of the State's monitoring activities.

Section B, "Monitoring Plan," Part II, "Details of Monitoring Activities"

STAR, STAR+PLUS and Children's Medicaid Dental Services:

Accreditation. HHSC does not use accreditation for non-duplication because HHSC has its own standards and monitoring processes. HHSC does not require national accreditation for an MCO to enter into a Medicaid contract. In Texas, the Texas Department of Insurance (TDI) is the single state agency responsible for licensing health and dental plans. TDI's licensing requirements and standards are stricter than those established by the national organizations, with the exception of NCQA's Quality Improvement program. On an annual basis, the EQRO reviews MCO accreditation status and provides feedback to HHSC. Should an MCO receive NCQA accreditation in the QI program, TDI and HHSC would presume compliance in order to meet state standards and deem that portion of the MCO accredited without further exam by TDI or HHSC. To date, no MCO has been so deemed and they continue to undergo full TDI exam to meet licensing standards. Additionally, HHSC Medicaid MCO contracts require adherence to TDI standards and have developed other specific areas of performance and standards. MCO contract and performance compliance are monitored by HHSC and/or the EQRO. HHSC has jurisdiction of the Texas Medicaid Managed Care Program.

HHSC does not require accreditation for participation as an MCO in Texas because HHSC has its own standards and monitoring processes. Accreditation by these organizations is also expensive, and may be burdensome for the smaller community-based MCO's.

Monitoring Activities.

Please refer to the current 1915(b) waivers for detail regarding the State's monitoring activities.

Appendix H: Components of the Texas 1915(c) Managed Care Waivers

The Texas Health and Human Services Commission (HHSC) operates the STAR+PLUS Program to integrate delivery of acute and long-term services through a managed care system.

Home and Community Based Services in the STAR+PLUS Program

Basic Components

This purpose of the STAR+PLUS home and community based services program is to provide home and community-based services (HCBS) to individuals who, but for the provision of such services, would require a nursing facility level of care as defined in 42 C.F.R. 440.40 and 42 C.F.R. 440.155, the costs of which would be reimbursed under the approved Medicaid State plan. These HCBS services are provided in non-institutional settings such as the member's or a family member's home, an adult foster care home, or an assisted living facility. HHSC does not provide STAR+PLUS waiver services to individuals who are inpatients of a hospital, Nursing Facility, or Intermediate Care Facilities for the Mentally Retarded.

The Texas Health and Human Service Commission (HHSC), the single State Medicaid agency, administers the operations of the program and promulgates policies and rules related to the program.

This program also provides home and community based services to individuals who are eligible for both Medicare and Medicaid (hereinafter "dual eligible").

Those individuals who are Medical Assistance Only (MAO) must meet all eligibility criteria and must reach the top of the interest list (waiting list) for entry into the program. Individuals receiving Supplemental Security Income (SSI) must meet all eligibility criteria, but there is no interest list for these individuals.

HHSC makes all financial eligibility determinations for MAO individuals. Since HHSC is a 1634 state, pursuant to an agreement with the Social Security Administration (SSA), SSA determines whether an individual is eligible for SSI and provides that list to HHSC. HHSC then enrolls the individual in Medicaid, pursuant to CMS regulation.

HHSC delegates to the Texas Department of Aging and Disability Services (DADS) – (primarily the DADS STAR+PLUS Support Unit) --certain functions necessary for determining entry into and continuance in the STAR+PLUS HCBS program. These functions include: authorizing levels of care and reviewing the service plan to ensure that program requirements are met.

HHSC contracts with Managed Care Organizations (MCOs) to manage the care of individuals in the HCBS program and contracts with a Management Information System (MMIS) contractor (TMHP) to assist in determination of the participant's level of need.

When an aged or disabled individual in a community setting in an area covered by STAR+PLUS applies for Medicaid, a case worker from HHSC's Medicaid eligibility office determines financial eligibility for Medicaid. If the individual is determined to be financially eligible for the STAR+PLUS program by an HHSC caseworker, a registered nurse from the MCO selected by the applicant determines functional eligibility (medical necessity) for STAR+PLUS home and community based services based on nursing facility risk criteria. This is reviewed by the DADS STAR+PLUS Support Unit.

Once financial and functional eligibility are established, the DADS STAR+PLUS Support Unit coordinator makes a referral to the MCO the applicant chooses. The MCO completes an assessment to establish level of need for STAR+PLUS waiver services. Texas' Medicaid Management Information System (MMIS) contractor calculates the level of need.

Once HHSC determines that all eligibility requirements are met, the MCO, the applicant, and other persons requested by the applicant, develop a person-directed service plan, that addresses the applicant's needs. Only the services within the 202% cost ceiling are STAR+PLUS program services. As such, only those services are Medicaid services subject to Medicaid requirements and for which Federal Financial Participation may be available. Any other services that may be provided outside the cost ceiling are not Medicaid services and are not part of this waiver program. The process emphasizes the provision of supports and services necessary to maintain successful integration in the community.

The member's service plan describes the medical and other services (regardless of funding source) to be furnished, their frequency, and the type of provider who will furnish each. Providers deliver all waiver services according to this written service plan. The member's service plan must have costs that are within the applicable cost ceiling. An applicant must apply for entry into the STAR+PLUS HCBS program and meet financial, functional, level of need, and service plan requirements to be eligible for the program.

Individuals who are accepted into the STAR+PLUS program are mandatorily enrolled in Managed Care for acute care services, unless they are SSI children, under the age of 21 who participate in that program on a voluntary basis.

When the service plan is developed, the applicant also chooses whether to self-direct the services provided through member-direction. HHSC offers STAR+PLUS waiver services through both self-directed and traditional service delivery methods.

Appendix A: Waiver Administration and Operation

3. Use of Contracted Entities:

Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).

6. Assessment Methods and Frequency:

The State delegates to the Department of Aging and Disability Services (DADS) the following: assessment functions; participant waiver enrollment; waiver enrollment managed against approved limits; level of care evaluation; and review of participant service plans.

The State contracts with managed care organizations (MCOs) for the following: prior authorization of waiver services; utilization management; and qualified provider enrollment.

The State contracts with an independent external quality review organization (EQRO) to support many of the State's managed care quality and performance goals and objectives.

7. Distribution of Waiver Operational and Administrative Functions: The following table specifies the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed.

Function	Medicaid Agency	Contracted Entity
Participant waiver enrollment	X	X
Waiver enrollment managed against approved limits	X	
Waiver expenditures managed against approved levels	X	
Level of care evaluation	X	X
Review of Participant service plans	X	X
Prior authorization of waiver services	X	X
Utilization management	X	X
Qualified provider enrollment	X	X
Execution of Medicaid provider agreements	X	X
Establishment of a statewide rate methodology	X	
Rules, policies, procedures and information development governing the waiver program	X	
Quality assurance and quality improvement activities	X	

Appendix B: Participant Access and Eligibility; B-1 Specification for the waiver Target Groups

a. Target Group(s):

Aged with a minimum age of 65 and no maximum age limit and Disabled (physical) with a minimum age of 21 and a maximum age limit of 64.

Appendix B: Participant Access and Eligibility; B -2 Individual Cost Limit

a. Individual Cost Limit:

202 percent of the institutional (nursing facility) average.

b. Method of Implementation of the Individual Cost Limit:

The State will not claim federal financial participation for services that exceed the 202 percent cost limit.

Appendix B: Participant Access and Eligibility; B-3: Number of Individuals Served

f. Selection of Entrants to the Waiver:

Supplemental Security Income (SSI) and Medical Assistance Only (MAO) adults must meet waiver eligibility requirements. There is no interest list for adults with SSI. There is an interest list for the MAO (217 group) population in this waiver. MAO individuals meeting all eligibility criteria are enrolled into this waiver on a "first-come, first-served" basis.

a. Unduplicated Number of Participants:

Unduplicated Number of Participants for the MAO (217 group) for September 2011:

Year one: 8,794

Year two: 9,064

Year three: 9,347

Year four: 9,644

Year five: 9,957

Unduplicated Number of Participants for the MAO (217 group) for March 2012: (The State will provide an update)

Year one:

Year two:

Year three:

Year four:

Year five:

The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.

Appendix B: Participant Access and Eligibility; B-4: Eligibility Groups served in the Waiver

Clarification item: The State is including individuals entering this 1115 waiver through the Money Follows the Person Demonstration Program with the understanding that the State will receive the enhanced match associated with the Money Follows the Person Demonstration Program.

a.1. State Classification is a 1634 State.

a.2. State is classified as a Miller Trust State.

b. Medicaid Eligibility Groups Served in Waiver

- SSI recipients

- Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in 1902(a)(10)(A)(ii)(XIII) of the Act)

- Other specified groups:

  - 42 CFR §435.134

  - 42 CFR §435.135

  - 42 CFR §435.137

  - 42 CFR §435.138

  - Social Security Act 1634(c)

  - Social Security Act 1634(d)

Special home and community-based waiver group under 42 CFR §435.217:

Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217: For MAO, a special income level equal to 300 percent of the SSI Federal Benefit Rate (FBR).

Appendix B: Participant Access and Eligibility; B-5 Post-Eligibility Treatment of Income

a. Use of Spousal Impoverishment Rules:

In the case of a participant with a community spouse, the State uses regular post-eligibility rules under 42 CFR §435.726 (SSI State) and uses the SSI standard as the allowance for the spouse only and AFDC need standard as the allowance for the family.

Appendix B: Participant Access and Eligibility; B-6 Evaluation/Reevaluation of Level of Care

d. Level of Care Criteria:

The State uses the Medical Necessity/Level of Care assessment to determine the level of care and for the assignment of a Resource Utilization Group level.

Appendix C: Participant Services; C-1: Summary of Services Covered

a. Waiver Services Summary. The services available through the waiver are in the following table. See Appendix C for additional information.

Service
Personal Assistance Service
Respite
Financial Management Services
Support Consultation
Adaptive Aids and Medical Supplies
Adult Foster Care
Assisted Living
Dental Services
Emergency Response Services
Home Delivered Meals
Minor Home Modifications
Nursing
Occupational Therapy
Physical Therapy
Speech, Hearing, and Language Therapy
Transition Assistance Services
Unlimited Prescriptions (extended state plan service)*

***Effective September 1, 2011, adults receiving only state plan services are limited to three prescriptions per month. Adults in the Community-Based Long-Term Services and Supports program have no monthly limit.**

Appendix D: Participant-Centered Planning and Service Delivery; D-1: Service Plan Development

d. Service Plan Development Process:

The service planning team develops the service plan. The service planning team is comprised of the member, the service coordinator, and other individuals chosen by the member. The service planning team reevaluates the service plan annually and a new service plan is developed for the next year. The member, designated representative, or the home and community support services agency on behalf of the member can request changes in the service plan. If necessary, the service planning team discusses the requested service plan changes and recommends approval or denial of the changes.

Service coordination:

The MCO service coordinator is responsible for coordinating all services, waiver and non-waiver, that the member is receiving. The service coordinator may need to consult with providers of State plan services, as well as community services, to ensure that all needs are being met, that there is no duplication of services, and that the services are being provided in accordance with the service plan.

The State Medicaid Agency has the final approval authority for the service plan.

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency:

The State Medicaid Agency delegates to the MCO the authority to develop, conduct, approve and monitor the member service plan for the waiver applicant/member. The MCO submits the completed service plan to DADS for verification that the service plan total cost is within the approved waiver limits.

Service plans are reviewed by DADS for verification of waiver eligibility. The single State Medicaid Agency performs oversight of the service plans. During onsite review visits of the MCO, State Medicaid Agency staff review case records that include the member's service plans. The State Medicaid Agency, on a quarterly basis, reviews DADS processes that include timely and accurate verification of service plans. The State Medicaid Agency reports deficiencies to DADS for corrective actions.

Appendix D: Participant-Centered Planning and Service Delivery; D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring:

The service plan reassessment process must occur at least annually and must mirror the initial assessment and service planning process in evaluating goals and outcomes and revising the service plan as needed. The process must include the member, the service coordinator, the MCOs registered nurse or other representative, other service providers or representatives, and any other person requested by the member. All STAR+PLUS services must be available to the member on a timely basis.

The service coordinator monitors implementation of the service plan at regular intervals by contacting the member and the providers.

The service coordinator and the MCO registered nurse must reevaluate the appropriateness of the service plan whenever there are changes in the member's situation(s), or upon request of the member.

Appendix E: Participant Direction of Services; E-1: Overview

a. Description of Participant Direction:

(a) Opportunities for Member Direction: STAR+PLUS members who live in their own private residences or the home of a family member may choose to self-direct seven of their 1915(c) STAR+PLUS waiver services: personal assistance services; nursing; physical therapy; occupational therapy; speech, hearing, and language therapy; support consultation; and respite care.

(c) Entities Supporting Members who Choose to Self-direct: The consumer directed service agency (CDSA) provides financial management services, including: assisting the member with verifying each potential service provider's criminal conviction history; processing payroll to include withholding applicable federal, state and local employment-related taxes; making deposits of withholdings and filing reports with applicable governmental agencies as the employer-agent; collecting and processing time sheets and other documentation for payment of services; and generating status reports to the member related to transactions and budget status. The CDSA also provides initial orientation and ongoing support and training to the member on how to be an employer.

c. Availability of Participant Direction by Type of Living Arrangement:

Participant direction opportunities are available to members who live in their own private residence or the home of a family member.

f. Participant Direction by a Representative:

Waiver services may be directed by a legal or non-legal representative (designated representative) of the member/employer. A designated representative is a willing adult appointed by the member/employer to assist with or perform the member/employer's responsibilities to the extent approved by the member/employer.

The CDSA monitors performance of employer responsibilities performed by the member/employer and, when applicable, the designated representative in accordance with the member/employer's documented directions. The designated representative may not be the employee and may not be paid for participation.

g. Participant-Directed Services:

Participant-Directed Waiver Service	Employer Authority	Budget Authority
Speech, Hearing, and Language Therapy	☒	☒
Occupational Therapy	☒	☒
Support Consultation	☒	☒
Physical Therapy	☒	☒
Respite	☒	☒
Personnel Assistance Service	☒	☒
Nursing	☒	☒

i. Provision of Financial Management Services

i. Types of Entities:

Financial management services providers, CDSAs hold Medicaid provider agreements with the State. In addition, the MCO uses a contract with the CDSAs that includes the requirements for the Medicaid Provider Agreement and exceeds the Medicaid requirements and covers additional state requirements.

CDSAs are prohibited from providing case management or other waiver services, with the exception of Support Consultation, to a member/employer who has chosen the consumer directed services option.

l. Voluntary Termination of Participant Direction:

A member/employer or the member/employer's designated representative can change from self-directed service delivery to the traditional agency service delivery method at any time. The service coordinator works with the member/employer and the service delivery agency to prevent any break in service.

m. Involuntary Termination of Participant Direction:

If the member/employer is having difficulty directing his or her own services, the service coordinator and member/employer discuss whether or not additional supports are needed for the member/employer to effectively direct services or if the self-direction option should be terminated. Termination of self-direction is the choice of last resort.

Immediate termination of the self-direction option may occur if:

- The member's/employer's health or welfare is immediately jeopardized;
- The member/employer has been convicted of certain criminal offenses;
- If another governmental agency with regulatory authority over employer responsibilities has recommended termination of the self-direction option; or
- If the member/employer has not implemented a corrective action that was required to continue in the self-direction option.

The service coordinator works with the member and the service delivery agency to prevent any break in service.

Appendix E: Participant Direction of Services; E-2: Opportunities for Participant-Direction

b. Participant-Budget Authority

i. Member Decision Making Authority:

The member/employer has budget authority and decision-making authority over the budget as follows:

- Reallocate funds among services included in the budget
- Determine the amount paid for services within the State's established limits
- Substitute service providers

- Schedule the provision of services
- Specify additional service provider qualifications consistent with the qualifications specified in Appendix E
- Specify how services are provided, consistent with the service specifications contained in Appendix E
- Identify service providers and refer for provider enrollment
- Authorize payment for waiver goods and services
- Review and approve provider invoices for services rendered.

ii. Participant-Directed Budget:

All members/employers, in conjunction with the CDSA, must develop a budget. The amount of funds included in a service plan is calculated by the service planning team based on the planned waiver services and the adopted reimbursement rate. The service plan is developed in the same manner for the member/employer who elects to have services delivered through the consumer directed services option as it is for the member/employer who elects to have services delivered through the traditional provider-managed option.

With approval of the CDSA, the member/employer may make revisions to a specific service budget that does not change the amount of funds available for the service in the approved service plan. Revisions to the service plan amount available for a particular service, or a request to shift funds from one self-directed waiver service component to another, must be justified by the member/employer's service planning team and authorized by the MCO. With assistance of the CDSA, the member/employer revises the consumer directed services budget to reflect a revision in the service plan.

iv. Participant Exercise of Budget Flexibility:

Modifications to the participant directed budget must be preceded by a change in the service plan.