UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF TEXAS
TYLER DIVISION

THE STATE OF TEXAS; TEXAS HEALTH AND HUMAN SERVICES COMMISSION,	§	
Plaintiffs,	§	
v.	§	Case No. 6:21-cv-00191
CHIQUITA BROOKS-LASURE, in her official capacity as Administrator of the Centers for Medicare & Medicaid Services, *et al.*,	§	
Defendants.	§	

PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

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INTRODUCTION

A seventh of Texas's population depends on Texas's Medicaid program, a state-federal partnership that has proceeded in large part under the Texas Healthcare Transformation and Quality Improvement Program (the "Demonstration Project") for nearly a decade. Per that partnership, and following arm's-length negotiations, Texas[1] and the federal government agreed to extend that project through 2030. Months later, without prior notice of any kind, the federal government concluded that the putative procedural rights of unnamed third parties required the government to rescind that extension unilaterally. The federal government never expressed reservations to Texas; never examined less-disruptive options to vindicate these procedural rights; and never considered the massive reliance interests that Texas, its healthcare providers, and beneficiaries had built up around the stable operation of the Demonstration Project, save for a breezy assurance that no one had any legitimate reliance interests in the extension. If anything, *arbitrary* and *capricious* are not strong enough to describe the pairing of such a profoundly destructive decision with a profoundly informal, off-the-cuff process for coming to that decision.

Defendants' decision is indeed proving profoundly destructive and will continue to do so if not enjoined. The decision has led to significant disruption and is likely to lead to a severe market contraction amongst healthcare providers—a contraction from which the market will not recover for, at a minimum, years. Texans on Medicaid will be directly harmed by this contraction, as they will have fewer choices of healthcare providers and fewer available services in many regions across the State, including precious mental-health services. Rural communities are likely to be especially impacted, but the harms will affect both the State itself and the State's Medicaid patients and providers.

[1] For simplicity, this motion will refer to the Plaintiffs collectively as "Texas."

The State urgently requires this Court's intervention to prevent this contraction and its attendant harms, and requests preliminary injunctive relief no later than **August 31, 2021** to ensure the continuous provision of Medicaid funding and services throughout the State. If the Court has not yet ruled by **August 24, 2021**, the State respectfully requests that this Court further construe this motion as a request for a temporary restraining order as of that date.

STATEMENT OF FACTS

I. CMS Approves the 2021 Extension of Texas's Demonstration Project.

One in seven Texans—more than 4.3 million in total—relies on the State's Medicaid program for healthcare. Bilse Decl. ¶¶ 6, 16. As explained more fully in Texas's Complaint (¶¶ 38-46), Texas's Medicaid program depends on waivers that the federal government routinely grants to States like Texas. Grady Decl. ¶¶ 4-5, 11; Ex. J at 2, 46;[2] ECF No. 1-2, Ex. A at 1-5; *see also* 42 U.S.C. § 1315(a), (a)(1); *Forrest Gen. Hosp. v. Azar*, 926 F.3d 221, 224 (5th Cir. 2019). These waivers provide Texas and other States with the flexibility to depart from the default requirements of the Social Security Act to better serve their citizens. *Forrest Gen. Hosp.*, 926 F.3d at 224. Waivers under Section 1115 of the Social Security Act allow a State to create healthcare-delivery innovations that, while deviating from Medicaid's strict default requirements, nonetheless serve Medicaid's objectives. *See* 42 U.S.C. § 1315(a), (d), (e).

Texas has employed the waiver at issue in some form since 2011. Bilse Decl. ¶ 4; Grady Decl. ¶¶ 4-5, 8, 10-11; ECF No. 1-2, Ex. A at 1-5. Initially approved for a five-year term, the Demonstration Project expanded Medicaid managed care statewide and established funding pools for uncompensated-care costs. Grady Decl. ¶¶ 4-5, 11; Ex. K at 1. During these initial five years,

[2] Unless otherwise specified, references to exhibits are to the Declaration of Jeffrey M. White. References to declarations are to those attached as exhibits hereto.

Texas gradually expanded services covered and service areas operated through the Demonstration Project. Grady Decl. ¶¶ 5-8; ECF No. 1-2, Ex. D, Attachment M. Texas and CMS agreed to extend the Demonstration Project in May 2016 to allow Texas to show the results that it had obtained during the initial years of the Demonstration Project, Grady Decl. ¶ 12; Ex. L, and again on January 1, 2018 for five years, with that extension set to expire on September 30, 2022. Grady Decl. ¶ 13; Ex. M.

The Demonstration Project enabled Texas to shift from an inefficient fee-for-service model that was too dependent on emergency-room care to a managed-care model that focuses on preventative care. Bilse Decl. ¶ 4; Grady Decl. ¶ 4; *see generally* Ex. N at 4; Ex. O. At present, 96 percent of all Medicaid beneficiaries in Texas—approximately 4 million people—receive managed care through the Demonstration Project. Grady Decl. ¶ 5. The transition to the managed-care model both improved healthcare quality and reduced cost compared to the fee-for-service model. Bilse Decl. ¶ 4; Grady Decl. ¶ 4.

The State used the savings from that shift to finance an incentive program to transform health-care delivery, particularly in rural and semi-urban areas. Bilse Decl. ¶¶ 4-5, 7; Grady Decl. ¶¶ 7-8, 11; *see generally* ECF No. 1-2, Ex. D, Attachment I (describing creation of Regional Healthcare Partnerships). Instrumental to this expansion was the Delivery System Reform Incentive Program, or "DSRIP." Grady Decl. ¶ 11, 13; ECF No. 1-2; ECF No. 1-2, Ex. D, Special Terms and Conditions at 33, 39-42. DSRIP provided a pool of funds for incentive payments to participating providers for demonstrating improvement on certain metrics and selected quality measures related to specific healthcare focus areas, such as primary care and prevention, behavioral health, pediatric primary care, chronic-disease management, and maternal care. ECF No.1-2, Ex. D, Attachment Q. Since these incentives were implemented, DSRIP participants have

responded with tens of billions of dollars' worth of innovations, delivery of additional services to Medicaid recipients, and improved health outcomes of Medicaid beneficiaries and low-income uninsured individuals. ECF No. 1-2, Ex. G at 2; Ex. J at 89.

DSRIP is set to expire in September 2021. Ex. M; ECF No. 1-2, Ex. D at 4. If it expires without a replacement, entities benefitting from DSRIP will lose a substantial amount of funding. This will devastate Texas healthcare providers—especially rural healthcare providers. Grady Decl. ¶¶ 22-23; ECF No.1-2, Ex. G at 3.[3] While Texas has been aware of and planned for DSRIP's extension for some time, its plans to account for DSRIP's expiration were ultimately included in the extension of the Demonstration Project. Grady Decl. ¶¶18, 39.

Before Texas's extension request, the "looming financial cliff" caused by DSRIP's expiration threatened a severe market contraction. *Id.* ¶¶ 19-20, 28. That threat is "now magnified multi-fold." ECF No. 1-5 ¶¶ 3-8, 13. Hospitals across the State, including some that "are the only acute care hospital provider available within miles," "will lose the funding on which they have relied to create and implement innovative collaborations with mental-health providers, case coordinators, and community leaders." Lee Decl. ¶¶ 2, 6, 8, 10. This will threaten the availability of those services in certain areas.[4]

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[3] Since the rescission, HHSC has held another state-level notice-and-comment period regarding extending the section 1115 waiver. During that period, it received numerous additional comments that underscore the devastating impact of Defendants' actions. Ex. R (describing DSRIP-funded mental-health programs in El Paso County); Ex. S (describing mental-health alternatives to incarceration in Harris County Jail); Ex. T (describing mental-health services used in conjunction with Lubbock Police Department calls).

[4] *See also* Walker Decl. ¶¶ 3, 7-8, 10-11, 13, 18-22 (loss of DSRIP would severely impact the only rural provider within sixty-five miles and its patient population); McCain Decl. ¶¶ 3-4, 10, 17 (rural health provider will be unable to provide EMS services, wellness checks, preventative care, and back-to-school fairs and will be unable to continue its "home health agency," which "is the ONLY agency in the area that accepts Medicaid patients"); Troutman Decl. ¶¶ 6-7, 11 (DSRIP funds "Chronic Disease Management of unfunded and underfunded

The COVID-19 pandemic increased hospital expenses and reduced hospital revenues, which has "only increased the importance of a financially stable Medicaid program." Lee Decl. ¶¶ 9-11, 14.[5] "Hospitals and health systems face catastrophic financial challenges in light of the COVID-19 pandemic." Ex. A at 1-3. The COVID-19 pandemic had an "unprecedented impact" on the financial viability of all hospitals, forcing them to "rethink their strategic-financial plans." Ex. B at 2-7. Medicaid providers are, however, particularly vulnerable. Ex. D at 1-2. Secure funding is "important to maintain the long-term viability of the primary care safety net after the pandemic is over." Ex. C at 4. "Losing billions of dollars in uncompensated care funding for Texas would be a disaster, particularly for small, rural hospitals who have negative margins even with these funds." Ex. E at 3. "[T]here is a growing concern that many hospitals, in particular rural hospitals, may not have the reserve to remain fiscally viable." Ex. F at 1-2.

The COVID-19 pandemic came at a particularly trying time for Texas's Medicaid providers. Arriving near the end of the Demonstration Project's five-year cycle, COVID-19 impeded Texas's efforts to gather relevant information about the ongoing efficacy of the Demonstration Project and to conduct an orderly transition away from the DSRIP. Grady Decl. ¶¶ 19-25, 30. It also created significant financial pressures on Texas Medicaid providers. *Id.* ¶¶ 19-

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patients" and losing DSRIP funding without a replacement would force service limits); Patriarca Decl. ¶¶ 8, 11 (underserved and uninsured patients will lose access to primary and specialty services without DSRIP); Huehlefeld Decl. ¶¶ 5, 12 (DSRIP funds "13 community-based outpatient clinics," and "[w]ithout fully offsetting losses from DSRIP and NAIP in the current waiver, access to care through these clinics will be eliminated").

[5] *See also* McCain Decl. ¶¶ 11-13, 16-24 (describing impacts of the pandemic and the need for certainty to perform necessary planning); Troutman Decl. ¶¶ 9-10 (explaining how COVID-19 caused "staffing, drug and supply expenses [to rise] dramatically" and the need for stability to allow "financial planning" and to "ensure . . . availability of BHSET's healthcare resources"); Parades Decl. ¶¶ 11-12, 14 ("Nursing homes have seen a decrease in total revenue while at the same time facing an increase in costs," and "[t]his impact has been particularly difficult in rural areas." "[I]t was imperative for HHS to act quickly to ensure the waiver would remain in place.").

23, 30.[6] As early as March 13, 2020, HHSC began to hear concerns from providers and other stakeholders regarding both COVID-19 and the forthcoming expiration of DSRIP. *Id.* ¶ 19.

The uncertainty surrounding the potential expiration of the Demonstration Project generally and DSRIP specifically further pressed Texas's Medicaid providers, threatening the long-term stability of Texas's Medicaid provider network unless the State acted immediately.[7] HHSC concluded that without prompt assurances of long-term stability in Texas's Medicaid delivery systems, the State would face a market contraction among Medicaid providers that would

[6] *See also* Lee Decl. ¶¶ 9-11, 18 (discussing the pandemic's financial impacts on Texas hospitals); Walker Decl. ¶¶ 11-12, 18 (explaining that the pandemic forced a regional provider to close and suspend programs, suffer increased staff turnover, and increase costs); Troutman Decl. ¶ 9 ("Our staffing, drug and supply expenses have risen dramatically."); Parades Decl. ¶¶ 10-12 (describing impacts of COVID-19 on Texas nursing homes); Patriarca Decl. ¶¶ 12-14 (The "material negative impact" of COVID-19 on revenues "has been particularly difficult in the Rio Grande Valley, a smaller community that does not have enough providers."); Huehlefeld Decl. ¶ 10 (describing decreased revenue new infrastructure investments required to support vaccine distribution); Ex. A at 1-3 (describing historic financial pressures); Ex. B at 1, 4-7 (discussing impact on hospital margins and the uncertain future of hospitals); Ex. C at 2-4 (describing financial instability threatening permanent health center closures and staff reductions); Ex. D at 1-2 (discussing "disproportionate risk" faced by Medicaid providers).

[7] *See* Lee Decl. ¶¶ 6, 8, 10-11, 14, 17-18 (explaining how heavily Texas hospitals rely on the Demonstration Project and how "the expiration of DSRIP in the context of the current uncertainty regarding the future of the Texas 1115 waiver program" creates extreme concern that Texas hospitals "will not have the financial ability to maintain services" for needy patients); McCain Decl. ¶ 16 (explaining that the initial application was submitted "in the middle of the COVID-19 pandemic surge" when the rural hospital was "desperate for a quick resolution to assure financial viability in the future"); Troutman Decl. ¶ 10 (explaining that the pandemic "made quick resolution of the application necessary"); Parades Decl. ¶¶ 3-7, 13-15 ("Medicaid is the single greatest source of nursing home revenue within the State of Texas," but the pandemic "created chaos within the Texas healthcare community" and "it was imperative for HHSC to act quickly."); *see also* ECF No. 1-2, Ex H at 5, 7, 19 (reflecting that 76% of survey respondents were at least very concerned about their financial health, 42% reported reducing service hours, 23% reported closing facilities or locations, and 27% reported that COVID-19 demand exceeded provider capacity); ECF No. 1-5 ¶¶ 3-8 (describing provider financial concerns and threat of market contraction).

take years to remedy. Grady Decl. ¶¶ 20, 22, 30; *see also* ECF No. 1-5 ¶¶ 3-8 (explaining that an extension of the Demonstration Project was needed to remedy "system-wide concerns").

If it were to occur, such a market contraction would last far longer than the current public-health emergency. In HHSC's experience, "when a hospital in a community closes," especially in a rural community, "attempts to re-open have failed, leaving Texans in those communities with more challenges in accessing care." Grady Decl. ¶ 23. Further, decisions such as whether to "operate clinic locations and renew employment contracts . . . take months and even years to plan." *Id.* And "[o]pening a new facility requires assurance of financial viability and up-front capital to invest in employment and operational expenses." *Id.* In sum, "the decline of a facility or a decision for someone to leave the workforce can occur much more rapidly than the decision to create a new location or build a workforce." *Id.*

Texas sought from CMS a one-year extension of DSRIP, then a five-year extension of the Demonstration Project to address the economic harms that such a market contraction would cause to Texas, participating Medicaid providers, and Texas's Medicaid beneficiaries. Grady Decl. ¶¶ 26, 27-31; *see also* ECF No. 1-5 ¶¶ 3-9; ECF No. 1-2, Ex. A at 2, 7. Acknowledging the effects of the COVID-19 pandemic and the attendant financial pressures on Texas's provider network, CMS granted the State an exception to notice requirements typically attendant to extension applications, including, as relevant here, the requirement that Texas's application go through federal notice-and-comment procedures. ECF No. 1-2, Ex. K; Grady Decl. ¶ 31.

On January 15, 2021, following significant negotiations between HHSC and CMS, CMS approved a nearly ten-year extension of Texas's Demonstration Project, continuing the Demonstration Project through 2030. ECF No. 1-2, Ex. B at 1; ECF No. 1-5 ¶¶ 9-12 (describing

negotiations between November 2020 and January 2021).[8] As explained above, HHSC initially requested a one-year extension of DSRIP separate from the request to extend the Demonstration Project. Grady Decl. ¶ 29; ECF No. 1-5 ¶ 10. Later, "CMS encouraged HHSC to think creatively about whether there were any solutions that could be formed under the new waiver extension that would assist with the DSRIP transition." Grady Decl. ¶ 33. "At this suggestion, HHSC proposed to CMS a new Uncompensated Care pool for certain public-health providers known as the Public Health Provider Charity Care Program (PHP-CCP)." Grady Decl. ¶ 29. This program focused on "historical DSRIP participants" that "were directly engaged in COVID-19 response," such as "local mental-health authorities and local health departments." *Id.* PHP-CCP would partially replace DSRIP and reimburse providers for mental-health services, preventative care, and certain other healthcare services when the costs of that care were not offset by another source. Grady Decl. ¶¶ 33-34; ECF No. 1-2, Ex. B at 3-5.

Relying on CMS's approval, Texas began implementing the new components of the Demonstration Project immediately. "Within hours," senior HHSC staffers were re-tasked with "forming external stakeholder workgroups to implement the waiver and create the new program. . . ." Grady Decl. ¶ 41. HHSC immediately began developing new timelines, evaluation designs, and reports. ECF No. 1-5 ¶ 6. HHSC also acted to increase its staffing levels and finalize rules for other directed-payment programs contemplated in the extension agreement. *Id.* To implement the PHP-CCP as required in the terms of the extended Demonstration Project, existing HHSC staff were temporarily re-tasked, and the Texas Legislature appropriated additional funds to HHSC to support the program permanently. *Id.* HHSC "created and adopted rules, launched

[8] The extension became effective on January 15, 2021 and would expire on September 30, 2030. For additional information regarding the negotiations, see Bilse Decl. ¶ 11; Grady Decl. ¶¶ 28-33.

application processes, held public-comment periods, and worked with providers," all in reliance on CMS's approval of the Demonstration Project. *Id.*; *see also* Grady Decl. ¶ 41. "[H]undreds of staff hours were dedicated to implementing the new terms of the waiver," and "external stakeholders joined weekly meetings and also contributed hundreds of hours to providing expertise and input into the development of the protocols and tools that would be required to implement the waiver." *Id.* With the changes negotiated with CMS, including the creation of the PHP-CCP pool, HHSC also abandoned its opportunity to extend DSRIP. *Id.* ¶ 39.

Texas healthcare providers similarly acted in reliance on the extension. They engaged with local governments to set mandatory payment rates that they would not otherwise have supported. Lee Decl. ¶¶ 15, 17. They also increased staffing, established training programs, and prepared to meet new billing and reporting requirements. McCain Decl. ¶¶ 20-21; Walker Decl. ¶ 16; Troutman Decl. ¶ 13; Parades Decl. ¶ 16. "[C]apital and operating budgets were developed and approved." Troutman Decl. ¶ 12.

The extension of the Demonstration Project and the implementation of PHP-CCP also promised to relieve the uncertainty and significant financial pressure that plagued healthcare providers before the extension. Grady Decl. ¶ 42; *see also id.* ¶¶ 39-40. HHSC's stakeholders supported the agreement and the concessions HHSC had made to achieve stability, certainty, and sustainability. *Id.* ¶ 42; *see also id.* ¶ 30 (explaining that the extension would "ensure providers would know that they could renew leases, continue employment contracts, and continue providing care to clients"). The reaction of "providers and their representatives" to the extension was "overwhelmingly positive." *Id.* ¶ 42. Indeed, when HHSC's Director of Provider Finance shared the news of the extension with "the provider association that represents the local mental-health authorities," she "was met with gratitude and joy." *Id.*

II. CMS Illegally Rescinds that Approval, Causing Massive Uncertainty for Texas Medicaid.

On April 16, 2021—122 days after CMS declared Texas's application complete, and 91 days after approving Texas's waiver request—Acting Administrator Richter sent HHSC a letter purporting to rescind CMS's extension of the Demonstration Project (and thus PHP-CCP), which, if effective, would have returned Texas to the version of the Demonstration Project approved following negotiations in 2017 subject to minor technical corrections that are not relevant to this suit. ECF No. 1-2, Ex. D.[9]

CMS provided Texas with neither notice nor an opportunity to be heard. Texas lacked notice of CMS's plans in any sense: neither Texas nor HHSC were previously informed that CMS had reexamined its approval, identified defects in that approval, or determined that the approval was so defective that it had to be rescinded. ECF No. 1-6 ¶ 7. Texas was further denied an opportunity to be heard: CMS did not seek input from Texas at any point prior to its purported rescission. *Id.*; Bilse Decl. ¶ 20; Grady Decl. ¶ 43. And the letter did not offer a mechanism to seek reconsideration of CMS's decision or advise that Texas had a right to appeal the decision further. *See generally* ECF No. 1-2, Ex. D.

The eight-page letter relied on purely procedural defects as the basis for CMS's putative rescission. It asserted that CMS had "materially erred in granting Texas's request for an exemption from the normal public notice process under 42 C.F.R. § 431.416(g)," because "the [S]tate's exemption request did not articulate a sufficient basis for us to conclude . . . [it] was needed to address a public health emergency or other sudden emergency" as required by regulation. ECF No. 1-2, Ex. D at 1-2. The letter also vaguely asserted that the exemption was "contrary to the

[9] Chiquita Brooks-LaSure was sworn in as the Administrator of CMS on May 27, 2021. She was automatically substituted as a defendant for Acting Administrator Richter under Federal Rule of Civil Procedure 25(d).

interest[s] of beneficiaries, as well as . . . other interested stakeholders." *Id.* at 2. But it identified neither the interests the rescission vindicated, nor how those interests outweighed any potential dislocation that Texas or Texas's Medicaid recipients would suffer due to the rescission. *Id.* Finally, the letter faulted Texas's state notice-and-comment procedures, claiming they "did not reflect the substantial modifications" to the Demonstration Project "that were ultimately approved." *Id.* at 1. But it failed to acknowledge that those modifications were suggested or required by CMS. Bilse Decl. ¶ 11; Grady Decl. ¶¶ 36-37; *see* ECF No. 1-5 ¶¶ 10-11; 42 C.F.R. § 431.412(a)(2).

Having announced that CMS's prior extension was defective, Acting Administrator Richter then explained that Defendants had "determined that leaving" the extension approval "in effect would not be an appropriate approach to remedy the underlying procedural errors." ECF No. 1-2, Ex. D at 7. She announced that CMS was "instead withdrawing that extension approval." *Id.* At no point did the letter explain what Texas might have done to remedy the claimed "procedural errors," or what harms were caused to Texas, Medicaid beneficiaries, CMS, or other parties through those alleged errors. *See generally* ECF No. 1-2, Ex. D. Nor did it analyze whether some action less disruptive than full rescission might have remedied the perceived harms. *Id.* It completely failed to address: the cost to Texas to fix those errors absent rescission; how those costs compared to the costs of leaving the purported errors uncorrected; the costs Texas and healthcare providers undertook in reliance on CMS's decision; or the costs to the State, its Medicaid population, and healthcare providers resulting from the uncertainty caused by the putative rescission. *Id.* Indeed, the only reference to reliance interests at all was the letter's assurance that none existed "because payments from the new uncompensated care pool are not authorized until October 1, 2021." *Id.* at 7.

This letter immediately sent shockwaves through the Texas healthcare system. It "created incredible uncertainty" for Texas hospitals in budgeting and planning to provide care. Lee Decl. ¶¶ 17-18. This particularly affected rural hospitals because the threatened funds comprise a larger percentage of their budgets and are necessary to provide critical services to patients with few alternatives.[10] But the impacts were felt statewide: the president of a healthcare group representing 72 hospitals in the Dallas–Fort Worth region characterized the rescission as "catastrophic, not just for the hospitals, but for all Texans." Ex. G. The president and CEO of the Texas Hospital Association explained that the rescission "undermines the safety net and hospitals' ability to protect people" and "puts the state's health at serious risk and creates unprecedented levels of uncertainty." Ex. H. It immediately sparked questions in the Legislature as to whether CMS's actions would functionally or even formally end Medicaid within the State. ECF Nos. 1-3, 1.4.

It likewise caused Texas's Medicaid providers and beneficiaries to suffer immense risks to their finances and quality of care in multiple ways. *First*, by rescinding the extension of the Demonstration Project, CMS cast into doubt approximately $7 billion in funding for future

[10] *See* Walker Decl. ¶ 8 ("These funds have been instrumental to the organization that already operates in a very thin margin, to keeping our doors open."); *id* at ¶¶ 3-10, 13, 17-22; McCain Decl. ¶¶ 3-7, 10, 15-24 (rescission threatens the availability of services made possible by the threatened funding, "creat[ing] incredible uncertainty," and has stopped implementation of programs in their tracks); Troutman Decl. ¶¶ 15-16 (rescission threatens elimination of "critical service offerings" and necessitates "resource-intensive" discussions related to services and staffing, which will create immeasurable and possibly irreparable harm to morale, staffing, and "relationships within the community and with donors, lenders, and the suppliers and Medicaid managed care organizations"); Parades Decl. ¶¶ 18-20 (rescission will have a "disastrous" impact, halting investments in quality that "not only accrue . . . to Texas Medicaid but also benefit other payers" and leading to "the very real potential impact of limiting access to care"); Patriarca Decl. ¶¶ 17-18 (rescission will have "an overwhelmingly negative and detrimental impact on [the] medically underserved community" in the Rio Grande Valley); Huehlefeld Decl. ¶¶ 12-13, 18 (estimating the losses resulting from rescission would total "more than $100 million annually" and "crippl[e] our state's health care safety net;" predicting that clinics would close and hundreds would be laid off, "and more importantly, [it means] the loss of access to care for thousands of Medicaid and low-income patients").

directed-payment programs. Grady Decl. ¶ 44. HHSC still has not received approval of directed-payment programs that were proposed for September 1, 2021, and it must now determine whether and to what extent it may proceed with these payments, further increasing uncertainty for Texas's Medicaid providers and beneficiaries. *Id.*[11] *Second*, the rescission has disrupted the orderly transition from DSRIP to programs such as the PHP-CCP. DSRIP—along with its billions of dollars in annual funding[12]—is set to expire in mere months. ECF No. 1-2, Ex. D at 4. This contributes to a $3 billion cliff that threatens an immediate contraction of Texas's Medicaid service providers, undermining medical care for both the vulnerable citizens benefiting from DSRIP and the individuals requiring mental-health and behavioral services which PHP-CCP would provide. Grady Decl. ¶¶ 22, 30, 42. *Third*, if the underlying Demonstration Project expires, federal Medicaid funding for Texas would dramatically decline—depriving Texas and Texans of approximately $30 billion in federal funding. Bilse Decl. ¶ 16-19; *see also* Ex. P at 77. This loss would drastically increase Texas's healthcare expenditures—which already exceed a quarter of its biennial budget—and would inflict untold damage on Texas's healthcare markets and Texans

[11] *See also* Lee Decl. ¶¶ 8, 18 (explaining that it is "very difficult" for providers "to understand what funds may or may not be available," and that hospitals "have no idea how much funding will be available"); Walker Decl. ¶ 18 ("That purported rescission created incredible uncertainty. . . ."); McCain Decl. ¶¶ 22-24 ("Without clear direction, it is very difficult to give direction."); Troutman Decl. ¶ 16 (describing harm that will result unless hospitals "get some clarity soon on whether the UC pool will remain, whether DSRIP can be extended, and whether the budget neutrality negotiated under the original January 2021 waiver extension will be available"); Parades Decl. ¶¶ 18-20 ("[T]he rescission created significant uncertainty in the financial markets because of projected changes in revenue forecasts" and required nursing homes to "reassess operations."); Patriarca Decl. ¶¶ 17-18 ("UT Health RGV will once again need to revise accounting, billing, and clinical infrastructure systems" and "examine our ability to continue with the healthcare access channels and outreach services we have established.").

[12] Grady Decl. ¶ 14-15; Ex. Q at 3-4.

statewide. Bilse Decl. at ¶ 18. *Compare* General Appropriations Act, SB1, 87th Leg., art. II (2021), *with id.* Recap.

SUMMARY OF THE ARGUMENT

Acting Administrator Richter's April 16 letter fails to conform to the requirements of the Administrative Procedure Act in almost every way imaginable. CMS lacks the authority to "withdraw" or "rescind" an extension in the first place: while the Social Security Act grants the Administrator of CMS the power to approve or deny an application for an extension of a project like the Demonstration Project (within certain parameters), it says nothing about the power to "withdraw" or "rescind" an approved application—let alone for the procedural reasons on which Defendants rely. Even if CMS had the power to rescind an extension, Congress has explicitly constrained the time period within which CMS must act on extensions, and the April 16 letter was issued outside that timeframe. Congress has likewise instructed that CMS may exercise the power to approve or disapprove an extension of a demonstration project only to the extent the choice is "likely to assist in promoting the objectives" of the Medicaid program, 42 U.S.C. § 1315(a)—which the April 16 letter fails to do.

The April 16 letter further fails to comply with CMS's own procedures. CMS has, by regulation, the power only to terminate, suspend, or withdraw approval for a demonstration project—not the power to rescind the extension of a demonstration project. If CMS wishes to assert this new power, it must promulgate regulations allowing it to do so by the usual process. But even if the April 16 letter were construed as a withdrawal of approval of the Demonstration Project itself (which it should not be), CMS failed to follow its own regulations, which require CMS to provide Texas with specific findings of fact and an opportunity to contest that decision. The April 16 letter

contains neither. This flaw reflects CMS's general failure to provide Texas with the basic notice-and-comment procedures that the APA requires—which, again, is fatal.

If that were not enough, the April 16 letter is arbitrary and capricious. The letter's assertion that no reliance interests exist in the extension of the Demonstration Project (with its creation of the PHP-CCP) does not withstand even the most cursory scrutiny. As previously discussed, HHSC immediately began to implement the new terms of the Demonstration Project by developing new processes, procedures, timelines, evaluation designs, reports, and rules. Grady Decl. ¶ 41; ECF No. 1-5 ¶ 12; ECF No. 1-6 ¶ 6. HHSC also increased its staffing to support new reporting requirements and began working with providers and external stakeholders to implement the terms negotiated with CMS. Grady Decl. ¶ 41. Critically, "HHSC abandoned its opportunity to extend the DSRIP based on the exemption and approved extension." ECF No. 1-5 ¶ 12; *see also* Grady Decl. ¶ 39. CMS's failure to account for these interests or to consider less disruptive ways to achieve its goals renders its decision arbitrary and capricious. Finally, the letter is based on the incorrect legal and factual determination that CMS improperly granted a waiver of federal notice-and-comment requirements to Texas, which was based on the express and incorrect factual assertion that the extension of the Demonstration Project did not address COVID-19.

Texas, Texas healthcare providers, and the millions of Texans who rely on the Demonstration Project will suffer irreparable harm in the absence of a preliminary injunction. The April 16 letter imposes significant unrecoverable costs on the State and healthcare providers, threatens a massive contraction in the healthcare market that will reduce the quality and availability of care in the State, and threatens the availability and quality of care for those millions of Texans relying on Medicaid.

Finally, the equities and the public interest favor a preliminary injunction. The harms that will accrue to Texas, healthcare providers, and Medicaid patients in the State overwhelm whatever equities inhere in the purely procedural right to notice-and-comment-procedures that the April 16 letter purports to vindicate. And the public has no interest in unlawful agency action.

ARGUMENT

The issuance of a preliminary injunction is appropriate when the movant shows (1) a likelihood of success on the merits, (2) that he is likely to suffer irreparable harm in the absence of preliminary relief, (3) that the balance of equities tips in his favor, and (4) that an injunction is in the public interest. *Valley v. Rapides Par. Sch. Bd.*, 118 F.3d 1047, 1051 (5th Cir. 1997) (citing *Roho, Inc. v. Marquis*, 902 F.2d 356, 358 (5th Cir. 1990)). Texas easily satisfies this standard.

I. Texas is Likely to Succeed on the Merits.

Texas is likely to succeed on the merits of its claims because Defendants' actions violate the Social Security Act, CMS's own regulations, and the APA in numerous ways.

A. The April 16 letter violates the Social Security Act.

Like every administrative agency, CMS only has the authority granted to it by statute. *FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 125 (2000) ("Regardless of how serious the problem an administrative agency seeks to address . . . it may not exercise its authority 'in a manner that is inconsistent with the administrative structure that Congress enacted into law.'") (quoting *ETSI Pipeline Project v. Missouri*, 484 U.S. 495, 517 (1988)).

The April 16 letter is premised on the notion that CMS has the authority to rescind or withdraw the extension of any waiver that it grants. Section 1115 of the Social Security Act, 42 U.S.C. § 1315, gives the Administrator power to "waive compliance with" Medicaid requirements,

id. § 1315(a)(1); to promulgate regulations relating to demonstration projects, *id*. § 1315(d)(1)-(2); and to approve or disapprove such projects, *id*. § 1315(f).

But the Social Security Act does not include a power to "withdraw" or "rescind" these waivers—and particularly extensions of longstanding waivers in which significant reliance interests have accumulated. Far from confirming the Administrator's authority to rescind a waiver or extension, the Social Security Act contemplates finality by providing the Administrator with a single up-or-down choice to approve or disapprove. *See id.* § 1315(f)(5)(A)(i)-(ii) ("[T]he Secretary shall . . . approve the application" subject to terms and conditions or "disapprove the application."). Thus, as the Fifth Circuit has recognized in a related context, the statute authorizes approval or disapproval of a demonstration project or an extension of a project, but "[o]nce the [Administrator] authorizes a demonstration project, no take-backs." *Forrest Gen. Hosp.*, 926 F.3d at 233. By purporting to exercise power that Congress did not provide the Administrator, the April 16 letter is contrary to law, exceeds the agency's statutory limitations, and must be set aside. 5 U.S.C. § 706(2)(A), (C).

Even if Acting Administrator Richter had the power to rescind a waiver, Congress has constrained *when* she may use it. Per the Act, the Administrator "shall" approve or deny an application to extend a waiver project like the Demonstration Project within 120 days. 42 U.S.C. § 1315(f)(5)(A). Failure to act within this period approves an application by operation of law. *Id.* § 1315(f)(5)(B). So whatever power Defendants ever have to rescind the grant of a waiver, that power is extinguished at the close of the 120-day period, when the application is approved as a matter of law. Once this window has run, the Administrator's decision is final; if the Administrator has failed to decide, the Act decides for her after 120 days.

This is no idle timing requirement. *Cf.* 5 U.S.C. § 706(1) (courts "shall . . . compel agency action unlawfully withheld"). While "[a] statutory time period is not mandatory unless it both expressly requires an agency or public official to act within a particular time period and specifies a consequence for failure to comply with the provision," *Fort Worth Nat'l Corp. v. Fed. Sav. & Loan Ins. Corp.*, 469 F.2d 47, 58 (5th Cir. 1972), here the statute provides an express consequence. If the Administrator does not either approve or disapprove an extension within 120 days, the extension is approved by operation of law and the clock.

Texas submitted its application to CMS on November 30, 2020, and CMS acknowledged it was complete no later than December 15, 2020. ECF No.1-2, Ex. K. The purported rescission of that decision occurred at the earliest when Acting Administrator Richter sent her letter on April 16, 2021—122 days later. Because the letter was sent outside the 120-day window, the Defendants lacked the power to rescind or reconsider the approval by the time they did so (assuming such power ever existed), and thus acted unlawfully.

Congress has also restricted *why* the Administrator may exercise whatever powers the Act vests in the CMS administrator—which, again, do not include a rescission power. The Administrator may only approve or disapprove an extension of a demonstration project to the extent that choice "is likely to assist in promoting the objectives" of the Medicaid program. 42 U.S.C. § 1315(a). Thus, even if the Administrator were not statutorily constrained as to both the power to rescind approval of demonstration projects like the this one and the time within which to make that choice, she could only exercise the authority consistent with promoting the objectives of the Medicaid program within the limits of Congress's delegation of authority to HHS and CMS. "[A] Section 1115 waiver project can be vacated if a court finds that the Secretary could not have rationally found the program likely to advance the objectives of Medicaid," and just so with the

putative rescission of a waiver. *Nazareth Hosp. v. Sec'y U.S. Dep't of Health & Hum. Servs.*, 747 F.3d 172, 181 (3d Cir. 2014) (collecting cases).

The April 16 letter does not serve the purpose of Medicaid, namely to "provide federal financial assistance for all legitimate state expenditures" for the provision of healthcare to citizens of limited means "under an approved Medicaid plan." *Harris v. McRae*, 448 U.S. 297, 308-09 (1980) (citation omitted).[13] Defendants' putative rescission of the extension of the Demonstration Project is contrary to this purpose. Rather than assisting with the provision of healthcare services to Texans, it threatens the viability of Medicaid in Texas—both by threatening the survival of providers and by eliminating spending authority for certain types of care. *Supra*, 12-13; *see also Stewart v. Azar*, 313 F. Supp. 3d 237, 262 (D.D.C. 2018) (holding the Secretary's action arbitrary and capricious where he failed to consider whether decrease in covered individuals was consistent with Medicaid's purpose). Insofar as the Demonstration Project is not extended before its expiration, the putative rescission threatens the very existence of Medicaid in Texas.

In addition, the April 16 letter violates Congress's express policy in response to the COVID-19 pandemic. Indeed, Congress has repeatedly passed laws expanding the availability of healthcare during the COVID-19 pandemic. *E.g.*, American Rescue Plan Act of 2021, Pub. L. No. 117-2, §§ 9811-19, 135 Stat. 4, 208-18 ("ARPA"); Coronavirus Aid, Relief, and Economic Security Act, Pub. L. No. 116-136, §§ 3801-32, 134 Stat. 281, 427-34 (2020) ("CARES Act"); Families First Coronavirus Response Act, Pub. L. No. 116-127, §§ 6008-09, 134 Stat. 178, 208-10 (2020) ("FFCPA"). In addition to the Social Security Act, these laws likewise inform the scope

[13] *See also* 42 U.S.C. § 1396-1 (identifying the purpose of Medicaid as "enabling each State . . . to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services").

of the Administrator's discretion, even if they do not amend the organic statute. *Brown & Williamson*, 529 U.S. at 133, 157-59 ("[T]he meaning of one statute may be affected by other Acts, particularly where Congress has spoken subsequently and more specifically to the topic at hand."). These laws recognize the unique pressures that the COVID-19 pandemic placed on State Medicaid systems, *e.g.*, FFCPA § 6008; ARPA § 9814; Medicaid providers, *e.g.*, CARES Act §§ 3811-13; and Medicaid beneficiaries, CARES Act, §§ 3811-12. Individually and collectively, these laws work to minimize disruption to the provision of vital healthcare to populations made all the more vulnerable by the spread of COVID-19.

Rescinding the extension of the Demonstration Project is contrary to these laws because it threatens healthcare for more than four million Texans during the COVID-19 pandemic. If the Defendants ever had the power to take such a drastic step, threatening the contraction of Medicaid in view of the Act's goal of expanding coverage, they surely lack that power now given Congress's repeated, more specific, and later-in-time emphasis on mitigating the physical and economic harms of the pandemic.

Defendants' only stated reason for rescinding the extension of the Demonstration Project—vindicating the procedural rights of third parties—cannot possibly justify placing millions of Texans' healthcare at risk during the pandemic, at least not without any consideration of how the rescission is consistent with Medicaid's goal of making healthcare available to those in need or whether less disruptive means could have vindicated CMS's interests. *DHS v. Regents of the Univ. of Cal.*, 140 S. Ct. 1891, 1914-15 (2020). The April 16 letter wholly failed to evaluate such considerations.

B. Acting Administrator Richter's letter violates CMS's regulations.

In addition to violating the relevant statutes, the April 16 letter also violates CMS's regulations. Though the letter cited no specific power enabling CMS to do so, *see generally* ECF

No. 1-2, Ex. D, CMS's regulations provide only two avenues for ending a demonstration project or a waiver related to a demonstration project. *First*, the CMS Administrator may "suspend or terminate a demonstration in whole or in part" if she "determines that the State has materially failed to comply with the terms of the demonstration project." 42 C.F.R. § 431.420(d)(1). *Second*, she "may also withdraw waivers . . . based on a finding that the demonstration project is not likely to achieve the statutory purposes." *Id.* § 431.420(d)(2). This limitation has two implications.

First, the enumeration of the powers to rescind or terminate a demonstration project under certain conditions or otherwise to withdraw waivers under other conditions implies the exclusion of other avenues to end demonstration projects or terminate waivers. Antonin Scalia & Bryan A. Garner, *Reading Law: The Interpretation of Legal Texts* 107-11 (2012); *accord Moore v. Hannon Food Serv., Inc.*, 317 F.3d 489, 497 & n.13 (5th Cir. 2003) (discussing role of *expressio unius* canon in interpreting administrative regulations). Specifically, that these dual powers enable the Administrator to terminate projects in whole or part or otherwise to withdraw a project, but not the extension of a project, implies she lacks the power to rescind an extension of a project: if she wishes to undo a project's extension, she must terminate the project in whole or part under subsection (d)(1), or otherwise withdraw waivers on which the demonstration project relies under subsection (d)(2). The April 16 letter comports with neither of these powers: it neither determined that the State failed to materially comply with the terms of the Demonstration Project as needed for (d)(1), nor did it find that the Demonstration Project "is not likely to achieve the statutory purposes," as needed for (d)(2). The purported rescission therefore fails.

Second, that CMS enumerated these dual powers implies that there is no third, free-floating power to rescind decisions regarding demonstration projects and their waivers: Defendants cannot simply evade the limitations in (d)(1) or (d)(2) by ignoring them both. The power to rescind an

extension of an existing waiver is a significant power, because reliance interests build up during the existence of a demonstration project that do not exist at its outset. *Regents*, 140 S. Ct. at 1913-14. The power to rescind such a waiver would thus need to be created through a substantive rule requiring notice and comment, in the same manner as other substantive CMS regulations. *Chrysler Corp. v. Brown*, 441 U.S. 281, 302 (1979) (defining substantive rules requiring notice and comment as those that "affect[] individual rights and obligations") (quoting *Morton v. Ruiz*, 415 U.S. 199, 232 (1974)); *see also, e.g.*, *Nat'l Mining Ass'n v. McCarthy*, 758 F.3d 243, 251-52 (D.C. Cir. 2014) (Kavanaugh, J.). CMS has not done so.

Even if Acting Administrator Richter had the power to rescind a waiver or extension under existing regulations, CMS failed to follow its regulations regarding that rescission, rendering the decision arbitrary and capricious. If the agency "announces and follows—by rule or by settled course of adjudication—a general policy by which its exercise of discretion will be governed, an irrational departure from that policy . . . could constitute action that must be overturned." *INS v. Yang*, 519 U.S. 26, 32 (1996); *see also, e.g.*, *U.S. ex rel. Accardi v. Shaughnessy*, 347 U.S. 260, 267-68 (1954). "In addition, prior notice is required where a private party justifiably relies upon an agency's past practice and is substantially affected by a change in that practice." *Nat'l Conservative Pol. Action Comm. v. FEC*, 626 F.2d 953, 959 (D.C. Cir. 1980) (per curiam) (citing *Indep. Broker-Dealers' Trade Ass'n v. SEC*, 442 F.2d 132 (D.C. Cir. 1971)).

To the extent the April 16 letter was intended as a termination of the Demonstration Project under subsection (d)(1), Acting Administrator Richter was required to "determine[] that the State has materially failed to comply with the terms of the demonstration project" in order to effect a termination. 42 C.F.R. § 431.420(d)(1). She did not. *See generally* ECF No.1-2, Ex. D.

To the extent the April 16 letter was intended to withdraw the waiver of Medicaid requirements necessary for the Demonstration Project to function, Richter was required to make—and then base her decision on—"a finding that the demonstration project is not likely to achieve the statutory purposes." 42 C.F.R. § 431.420(d)(2). Again, she did not. *See generally* ECF No.1-2, Ex. D.

In either event, under the terms and conditions of the Demonstration Project, Defendants would have been required to "afford the State an opportunity to request a hearing to challenge CMS's determination prior to the effective date" of the termination or suspension. *Id.*, Ex. D, Special Terms and Conditions at 7. Yet again, she did not. *Id.* Ex. D.

Instead, the April 16 letter asserted without further explanation that "CMS materially erred in granting Texas's request" before concluding that the extension of the Demonstration Project should be rescinded for failing to go through federal notice-and-comment procedures. *Id.* at 1. That was not good enough. These failures mean that Defendants failed to abide by regulations that CMS and HHS place on the Administrator's discretion. This defect is fatal to the April 16 letter. *E.g.*, *Big Horn Coal Co. v. Temple*, 793 F.2d 1165, 1169 (10th Cir. 1986) (per curiam) (finding agency decision unlawful where it failed to consider rebuttal evidence as required by agency procedures).

Defendants cannot rescue the April 16 letter by making such findings now. The Administrator is confined to the reasons her predecessor actually provided in the April 16 letter, and she cannot supplement those here. *Regents*, 140 S. Ct. at 1907-08; *SEC v. Chenery Corp.*, 332 U.S. 194, 196 (1947). Nor can she rely on stated reasons that are pretextual. *Dep't of Commerce v. New York*, 139 S. Ct. 2551, 2574-75 (2019). Because the Acting Administrator failed to make either an essential finding or determination—and because she attempted to rescind something

CMS's regulations do not allow her to rescind—she failed to follow regulations regarding how she may use her authority, and her letter must be set aside. 5 U.S.C. § 706(2)(A).

C. The April 16 letter violates the APA.

Aside from violating both the Social Security Act and CMS's own regulations, Defendants' purported rescission violates the APA's requirements: (1) to provide notice to Texas and the public, and an opportunity for comments from both before attempting to rescind the Demonstration Project's extension; (2) to consider stakeholders' reliance interests—both those of Texas and of Medicaid providers—in the extension before rescinding it; (3) to consider a less-intrusive remedy short of rescission that could have vindicated CMS's or third-parties' procedural interests; and (4) to make decisions free of legal and factual errors. The Acting Administrator failed in each obligation, and each renders her April 16 decision a violation of the APA.

1. The APA obligated Defendants to provide notice and an opportunity for public comment before rescinding the extension.

The April 16 rescission should be set aside for failing to go through notice and comment. CMS must provide notice-and-comment procedures on pending applications for extensions to demonstration projects, 42 C.F.R. §§ 431.408(a), .416(a), unless an exemption applies, *id.* § 431.416(g). While CMS was free to exempt Texas from this notice-and-comment process—and it correctly did so—it cannot thereby exempt itself from notice and comment in its rescission. *Regents*, 140 S. Ct. at 1913-14; *Motor Vehicle Mfr's Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S 29, 41, 46-47 (1983) (that which generally must be done with notice and comment may only be undone with notice and comment). And where significant reliance interests exist, as they do here, *infra*, 26-27, notice-and-comment procedures are required even when an initial action did not require them. *Regents*, 140 S. Ct. at 1913-14. Because of the reliance interests

implicated by many healthcare policy decisions, HHS and CMS have recently formalized that principle by regulation. 45 C.F.R. § 1.3(b)(1)-(2).

Acting Administrator Richter's April 16 rescission came without notice and comment or any explanation why these procedures were unnecessary. It further failed to acknowledge that it was a final agency action affecting the medical care of millions of Texans, risking a major contraction for Medicaid providers in Texas, and potentially costing the State hundreds of millions or billions of dollars. *See* Ex. P at 77; General Appropriations Act, *supra*., at art. II. It also fails to recognize the significant efforts that Texas had taken related to the extension of the Demonstration Project—including implementing new programs to replace the DSRIP—and the reliance interests of third-parties too numerous to count, like providers who began to organize their affairs to comply with and in reliance upon the extension. Grady Decl. ¶ 41; *see also supra*, 8-9.

Notice-and-comment procedures require agencies to at least consider these sorts of interests before taking sweeping regulatory actions. *United States v. Johnson*, 632 F.3d 912, 931 (5th Cir. 2011) ("The purpose of notice-and-comment rulemaking is to 'assure[] fairness and mature consideration of rules having a substantial impact on those regulated' and to allow "the agency to 'educate itself before adopting a final order.'") (quoting *Pennzoil Co. v. Fed. Energy Regulatory Comm'n*, 645 F.2d 360, 371 (5th Cir.1981)). And there are necessarily greater reliance interests in an extension or waiver after it has been granted than before it has: both HHSC and Texas healthcare providers reasonably planned their affairs in reliance on the extension. These plans take at least six months to implement due to procurement and contract timelines. *See* Grady Decl. ¶¶ 20-23.

CMS could, given Texas's situation, waive notice-and-comment procedures relating to the extension in the first place, but it cannot rescind that extension without taking account of the

interests that have accrued in the meantime. *Regents*, 140 S. Ct. at 1913 ("When an agency changes course, as [CMS] did here, it must be cognizant that longstanding policies may have engendered serious reliance interests that must be taken into account.") (quotation marks omitted) (quoting *Encino Motorcars, LLC v. Navarro*, 136 S. Ct. 2117, 2126 (2016)). Defendants' failure to do so—and to provide notice-and-comment procedures before reversing CMS's earlier decision—prevents that purported rescission from having any legal force. *Id.* at 1927-28 (Thomas, J., concurring in part and dissenting in part). This failure provides another independent reason that the April 16 letter must be set aside.

2. Acting Administrator Richter's wholesale refusal to consider Texas's reliance interests was arbitrary and capricious.

Acting Administrator Richter's failure to consider Texas's (and Texas providers') reliance interests likewise renders her decision arbitrary and capricious. "In exercising [CMS's] waiver authority," the Administrator "may not 'act out of unbridled discretion or whim . . . any more than in any other aspect of [CMS's] regulatory function." *Keller Commcn's, Inc. v. FCC*, 130 F.3d 1073, 1076 (D.C. Cir. 1997) (quoting *WAIT Radio v. FCC*, 418 F.2d 1153, 1159 (D.C. Cir. 1969)). Those affected by an administrative agency's change in its rules or policies are entitled, at the least, to consideration of any reliance interests that developed around the since-rejected policy. *Regents*, 140 S. Ct. at 1913-14.

Texas, its Medicaid beneficiaries, and its healthcare providers all accrued substantial reliance interests based on the January 15 extension that were severely impacted by the putative April 16 rescission. For example, Texas abandoned its request to extend DSRIP based on the compromise that it reached with CMS to create the PHP-CCP to fill the funding gap created by DSRIP (at least in part). Grady Decl. ¶¶ 33-34, 39. Texas also expended significant resources coordinating with local Medicaid administrators, designing rules and guidance for PHP-CCP, and

organizing a transition from DSRIP to the PHP-CCP. *Id.* ¶41. The State also had important engagement with stakeholders and adopted rules for four additional direct-payment programs intended to assist in helping to replace DSRIP. *Id.* Texas healthcare providers agreed to payment rates, increased staffing, set budgets, and prepared for new billing and reporting requirements. *Supra*, 9.

The April 16 letter does not consider these reliance interests at all, but blithely asserts that Texas "ha[d] not incurred a reliance interest based on the January 15, 2021 approval." ECF No. 1-2, Ex. D at 7. The letter does not even bother to mention—much less substantively consider—the reliance interests of the more than four million Texans who rely on Medicaid, *id.*, the effect on providers of terminating DSRIP with no replacement, or the harm to Texas through a multi-billion-dollar cliff in healthcare funding if the Demonstration Project were to expire. *See generally id.* The failure to consider *any* of these serious reliance interests would be enough to set aside the April 16 rescission; combined, they plainly render the decision arbitrary and capricious.

3. Acting Administrator Richter's failure to consider an alternative to rescinding the extension altogether rendered her decision to rescind arbitrary and capricious.

In addition to ignoring these reliance interests, the April 16 letter failed to consider "alternatives" to canceling the extension of the Demonstration Project "that are within the ambit of existing policy." *Regents*, 140 S. Ct. at 1913 (cleaned up) (quoting *State Farm*, 463 U.S. at 51). The April 16 letter justifies rescission solely on the procedural interests of third parties that might have commented during notice-and-comment procedures. ECF No. 1-2, Ex. D at 7. But it fails to consider any less intrusive alternatives that might have vindicated those interests without risking the healthcare of millions of Texans and the financial viability of many Texas healthcare providers. *See generally id.*

Less intrusive alternatives were and are clearly available. For example, CMS could have sought public notice and comment on the extension after the fact, *e.g.*, *Advocs. for Highway & Auto Safety v. Fed. Highway Admin.*, 28 F.3d 1288, 1292 (D.C. Cir. 1994) (explaining when "[d]efects in an original notice may be cured by an adequate later notice"), or it could have asked for an additional state-level notice-and-comment period about the negotiated change from DSRIP to PHP-CCP. Either of those alternatives would have inflicted much less harm to Texas's reliance interests—to say nothing of those of its Medicaid beneficiaries or providers. Neither Acting Administrator Richter nor CMS indicated why these or other potential, less-drastic solutions would not have vindicated the procedural interests in a notice-and-comment period.

And insofar as CMS found the specific portions of the extension highlighted in the letter objectionable—namely, the length of the extension and the transition from DSRIP to PHP-CCP—it could as a last resort have simply excised those two portions. Texas asked for only a five-year extension in the first instance, and a longer extension was offered by CMS. ECF No. 1-2, Ex. A at 2, 7; Grady Decl. ¶¶ 29, 32. And PHP-CCP, while an important aspect of transitioning away from DSRIP, represents only about $500 million in annual funding compared to the nearly $40 billion spent on Texas's annual Medicaid budget—more than half of which comes from the federal government. *Compare* ECF No. 1-2, Ex. B, *with* Ex. P at 77.

Any of these readily identifiable, less-intrusive options might have addressed the concerns stated in the April 16 letter. Well-established principles of administrative law required Acting Administrator Richter to have at least considered them before taking the drastic measure of canceling the legal authority for 96% of Texas's Medicaid program, creating a separate multi-billion-dollar fiscal cliff for providers, Medicaid recipients, and the State. *See supra*, 12-13. These failures render Acting Administrator Richter's April 16 letter arbitrary and capricious.

4. Acting Administrator Richter's reliance on incorrect legal and factual determinations rendered her decision-making process arbitrary and capricious.

The letter is arbitrary and capricious for yet one more fundamental reason: it rests on incorrect legal and factual premises. "An agency decision is 'arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law,' 5 U.S.C. § 706(2)(A), if the agency applies an incorrect legal standard." *Gen. Land Office v. U.S. Dep't of Interior*, 947 F.3d 309, 320 (5th Cir. 2020) (citing *inter alia Caring Hearts Pers. Home Servs., Inc. v. Burwell*, 824 F.3d 968, 977 (10th Cir. 2016) (Gorsuch, J.) ("[A]n agency decision that loses track of its own controlling regulations and applies the wrong rules in order to penalize private citizens can never stand."); *Humane Soc'y of U.S. v. Pritzker*, 75 F. Supp. 3d 1, 11 (D.D.C. 2014) ("NMFS acted arbitrarily and capriciously in applying an inappropriately-stringent evidentiary requirement at the 90-day stage.")).

The letter rests on the incorrect legal premise that Texas failed to show a sufficient basis for its request for an exemption from regular public notice-and-comment obligations. Defendants' position appears to be that the Demonstration Project itself must have been created to address COVID-19. ECF No. 1-2, Ex. D at 2. But this reading is unsupported by the text: section 431.416(g) allows a waiver of the notice-and-comment period where either (1) "a proposed demonstration or demonstration extension request . . . addresses a natural disaster, public health emergency, or other sudden emergency threats to human lives," or (2) "unforeseen circumstances resulting from a natural disaster, public health emergency, or other sudden emergency . . . warrant an exception." 42 C.F.R. § 431.416(g)(1)-(2).

The extension of the Demonstration Project satisfies both prongs. *First*, even though the Demonstration Project predates the present public-health emergency, many aspects of it address that emergency. As just one example, HHSC has explained in documents not discussed in the April

16 letter that the extension of the Demonstration Project provides mechanisms to improve vaccination rates and accessible services, which will apply to COVID-19 vaccines. *See* Grady Decl. ¶¶ 33. Portions of the Demonstration Project also address mental health and immunization—the same type of care for which COVID-19 has generated increased need. *Id.* So the extension of the Demonstration Project "addresses" the emergency created by COVID-19 under the ordinary meaning of the term. *E.g.*, *The American Heritage Dictionary* 20 (5th ed. 2011) (defining "address" as "to begin to deal with").

The letter's factual assertion that COVID-19 is irrelevant because the current extension of the Demonstration Project does not expire until September 2022 is also incorrect—and contrary to the position that HHS has itself taken. In the first instance, this ignores the expiration of DSRIP in September 2021. Grady Decl. ¶ 18. Without the PHP-CCP partial replacement, this will deprive Texas providers of vitally needed funding as soon as this September, while the COVID-19 pandemic is ongoing. Grady Decl. Decl. ¶¶ 18, 40. And in any event, HHS has recognized that the public-health emergency due to the COVID-19 pandemic "will likely remain in place for the entirety of 2021." Ex. I at 1.

Second, to the extent more were necessary, "unforeseen circumstances resulting from a natural disaster, public health emergency or other sudden emergency" *do* "warrant an exception." 42 C.F.R. § 431.416(g)(2); *see also* Compl. ¶ 145. Texas provided a sound basis that disruptions caused by COVID-19 required an extension of the Demonstration Project in 2020. Texas commissioned an extensive survey regarding the impact of COVID-19. Grady Decl. ¶¶ 25, 30; ECF No. 1-2, Ex. H. During the application process, HHSC shared with CMS the survey results as well as comments made during the state notice-and-comment period. Grady Decl. ¶¶ 30-31. In particular, Texas Medicaid providers warned the State of an impending contraction in the market—

caused by a combination of factors related to COVID-19 and the impending expiration of DSRIP—that required action by the State.

The April 16 letter is arbitrary and capricious because it improperly concludes that Texas did not satisfy the test for a waiver of the notice-and-comment process based on an incorrect interpretation of law and misstatements of facts. The letter is also arbitrary because it failed to consider the full scope of Texas's communications with CMS. *See State Farm*, 463 U.S. at 43 ("[T]he agency must examine the relevant data and articulate a satisfactory explanation for its action including a rational connection between the facts found and the choice made." (quotation marks omitted)); *id.* ("[A]n agency rule would be arbitrary and capricious if the agency has . . . entirely failed to consider an important aspect of the problem [or] offered an explanation for its decision that runs counter to the evidence before the agency.").

Plaintiffs are likely to show that any one of these errors would be enough to set the April 16 rescission aside. 5 U.S.C. § 706. Taken together, it surely cannot stand.

II. Texas, Texas Medicaid Providers, and Texas Medicaid Recipients Will Each Suffer Irreparable Harm if a Preliminary Injunction Is Not Entered.

Texas—and Texans—are being and will continue to be irreparably injured by Defendants' unlawful actions. "To show irreparable injury if threatened action is not enjoined, it is not necessary to demonstrate that harm is inevitable and irreparable." *Humana, Inc. v. Avram A. Jacobson, M.D., P.A.*, 804 F.2d 1390, 1394 (5th Cir. 1986). Instead, "[t]he plaintiff need show only a significant threat of injury from the impending action, that the injury is imminent, and that money damages would not fully repair the harm." *Id.* (footnote omitted). "[A] harm is irreparable where there is no adequate remedy at law, such as monetary damages." *Janvey v. Alguire*, 647 F.3d 585, 600 (5th Cir. 2011).

Texas easily meets this standard. Absent the issuance of an injunction, the State, medical providers within the State, and the over four million Texans who count on Medicaid for medical services will each suffer irreparable harms.

First, Texas will suffer irreparable harm due to increased (and unrecoverable) costs associated with the purported rescission of the extension of the Demonstration Project. Grady Decl. ¶ 41.[14] The State has invested hundreds or thousands of hours negotiating with CMS for the extension of the Demonstration Project and then immediately moving to implement the Project's terms as extended, including implementing new programs like PHP-CCP. Grady Decl. ¶¶ 31, 41. The State's "resource investments" related solely to implementation of the waiver "are equivalent to hundreds of thousands of dollars," to say nothing of the investment by "external stakeholders" who "joined weekly meetings and also contributed hundreds of hours to providing expertise and input into the development of protocols and tools that would be required to implement the waiver." *Id.* at 34. Absent an injunction, these efforts are simply lost and are unrecoverable. Texas also has a parens patriae interest in the healthcare of its citizens, *Massachusetts. v. EPA*, 549 U.S. 497, 518-19 (2007) (citing *Georgia v. Tenn. Copper Co.*, 206 U.S. 230, 237 (1907)), which, as discussed below, will be negatively and irreparably harmed absent the entry of a preliminary injunction.

Second, Texas's healthcare providers will be irreparably harmed absent the entry of a preliminary injunction. As explained above (at 12 & n.10), Texas sought the extension of the Demonstration Project as well as ways to address the expiration of the DSRIP due to uncertainty caused by the threat of a significant contraction in the healthcare-provider market. That contraction

[14] *See also* ECF No. 1-5 ¶ 12 (describing immediate implementation actions by HHSC, including coordination with providers and external stakeholders, and explaining that "HHSC abandoned its opportunity to extend the DSRIP based on the exemption and approved extension"); ECF No. 1-6 ¶ 6 (immediate implementation actions by HHSC).

would likely take years to recover from. In particular, the funding cliff created by the September 2021 expiration of DSRIP caused serious problems for providers, who risk losing a significant funding source. *Id.* The extension, along with new funding sources like PHP-CCP alleviated these concerns. *Supra* 9. But the April 16 letter brought them immediately back to the fore. Absent a preliminary injunction, Texas expects its market for healthcare providers to contract significantly, harming the State, those providers, and the patients that rely on those providers for healthcare services. Grady Decl. ¶¶ 20, 30, 44.

Finally, and most importantly, absent a preliminary injunction, the 4.3 million Texans who depend on Medicaid for healthcare services provided through the Demonstration Project will suffer irreparable harm through an impending contraction in healthcare services and significantly decreased availability of certain types of care, including some care essential to the most vulnerable Texans, like mental healthcare. *Id.*; *see also*, *supra*, 12-13 & n.10-11. CMS's purported rescission threatens critical funding for Texas hospitals and other healthcare providers, including some that are the only option within miles, funding which many of those providers "rely on . . . for a substantial part of their operating budget" and which is critical for maintaining service levels for Medicaid and uninsured patients. *See* Lee Decl. ¶¶ 2, 6, 10, 13-14, 17-18; Walker Decl. ¶¶ 3-11, 13, 18-22; McCain Decl. ¶¶ 3-7, 10, 15-24; Troutman Decl. ¶¶ 4-7, 15-16; Parades Decl. ¶¶ 3-7, 13-15, 17-20; Patriarca Decl. ¶¶ 3-6, 8, 11, 14-15, 17-18; Huehlefeld Decl. ¶¶ 4-5, 8, 12-14, 17-18. Decreases in the quality and availability of care are the predictable—and ineluctable—consequence of the April 16 letter: it creates an impending fiscal cliff that will deprive healthcare providers of desperately needed funding with the expiration of DSRIP, increased uncertainty for providers who offer (and likely will cease to offer) services through Medicaid, and ultimately the

risk that the Demonstration Project will not be extended in time or at all, affecting the vast majority of Texas's Medicaid spending.

III. The Equities Overwhelmingly Favor an Injunction.

The balance of equities favors a preliminary injunction. The threat of injury to Texas, its healthcare providers, and its citizens who rely on Medicaid make those allegedly harmed by CMS's decision to waive federal notice and comment on Texas's extension request pale in comparison. After all, according to the April 16 letter, the interest vindicated by the putative rescission of the extension of the Demonstration Project involves the right to comment on proposed changes to its terms. *See generally* ECF No. 1-2, Ex. D. Though the procedural interests that CMS purports to vindicate might be enough to establish standing of the unnamed third parties who hold them, they must be balanced against the harms that will accrue to Texans suffering from mental-health conditions, diabetes, and a range of other ailments that require medical care who will be adversely affected by Acting Administrator Richter's decision. Even if CMS were right that it improperly waived notice-and-comment procedures (and it is not, *supra* 29-31) this would be insufficient to tip the balance of the equities in its favor. On any accounting, the threatened decreases in the number of providers and quality and availability of care—which will lead to concrete harms to many of the most vulnerable Texans—bears little comparison to the importance of vindicating the procedural right to comment on the proposed changes to the Demonstration Project, many of which are widely supported by providers and patient groups in any event. Bilse Decl. ¶¶ 12-13; Grady Decl. ¶¶ 35.[15]

[15] *See also* Lee Decl. ¶¶ 3, 10, 12-14, 19 (explaining that many Texas hospitals supported the extension and the programs it authorized); Walker Decl. ¶ 13 (stating "that discontinuation of [the] 1115 waiver and DSRIP will . . . negatively impact the services offered to [its] community"); McCain Decl. ¶ 16 (reflecting rural hospital was "desperate for a quick resolution to assure

IV. The Public Interest Favors an Injunction.

The public interest also favors an injunction. The public interest is not served by CMS's April 16 letter because it is arbitrary and capricious and contrary to law. *See League of Women Voters of U.S. v. Newby*, 838 F.3d 1, 12 (D.C. Cir. 2016) ("There is generally no public interest in the perpetuation of unlawful agency action."); *N.Y. Progress & Prot. PAC v. Walsh*, 733 F.3d 483, 488 (2d Cir. 2013) (recognizing that government officials "do[] not have an interest in the enforcement of an unconstitutional law"). In addition, many of the same factors that show the balance of equities are in Texas's favor apply equally to the public interest. A precipitate decrease in the number of healthcare providers and healthcare services is not in the public interest. *Supra*, 12-13 & nn.10-11.

CONCLUSION

Texas and HHSC respectfully request that the Court issue a preliminary injunction preventing Defendants from implementing Acting Administrator Richter's April 16 letter.

financial viability" and "extremely thankful and relieved" when the application was approved in January 2021); Parades Decl. ¶ 14 ("[I]t was imperative for HHSC to act quickly to ensure the waiver would remain in place" at a time when "financial certainty for Coalition members . . . was desperately needed.).

Respectfully submitted,

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Counsel for Plaintiffs

CERTIFICATE OF SERVICE

I certify that on July 16, 2021, in accordance with a written agreement under Federal Rule of Civil Procedure 5(b)(2)(E), a copy of this motion and proposed order were served by email upon:

Keri L. Berman
Trial Attorney, Civil Division
United States Department of Justice
950 Pennsylvania Ave. NW
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Keri.L.Berman@usdoj.gov

with an additional copy sent by email to:

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/s/ *Judd E. Stone II*
JUDD E. STONE II

CERTIFICATE OF CONFERENCE

I certify that Plaintiffs have complied with the meet and confer requirement set forth in Local Rule CV-7(h). Defendants oppose Plaintiffs' Motion for Preliminary Injunction. On July 13, 2021, Leif A. Olson, counsel for Plaintiffs, and Keri L. Berman, counsel for Defendants conferred by telephone regarding Plaintiffs' intention to file this Motion for Preliminary Injunction. No agreement could be reached by the parties, because Defendants disagree with Plaintiffs' contention that Defendants' actions violated the Administrative Procedure Act, and because Defendants disagree with Plaintiffs'

contention that a preliminary injunction is warranted. The discussions conclusively ended in an impasse, leaving the issue of whether a preliminary injunction should be issued in this case for the Court to resolve.

/s/ *Judd E. Stone II*
JUDD E. STONE II

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF TEXAS
TYLER DIVISION

STATE OF TEXAS, TEXAS HEALTH AND HUMAN SERVICES COMMISSION, Plaintiffs, v. CHIQUITA BROOKS-LASURE, in her official capacity as Administrator of the Centers for Medicare & Medicaid Services, *et al.*, Defendants.	§ § § § § § § § § § § § §	Case No. 6:21-cv-00191

[PROPOSED] ORDER GRANTING MOTION FOR PRELIMINARY INJUNCTION

Before the Court is Plaintiffs' Motion for Preliminary Injunction. The Court, having considered the arguments and evidence of the parties, is of the opinion that Plaintiffs' Motion should be GRANTED.

The Court finds that Plaintiffs are likely to succeed on the merits, Plaintiffs are likely to suffer irreparable harm in the absence of preliminary relief, the balance of the equities are in Plaintiffs' favor, and this preliminary injunction is in the public interest.

IT IS THEREFORE ORDERED that Plaintiffs' Motion for Preliminary Injunction is hereby GRANTED.

The Court hereby ORDERS that, as of the date of this order, Defendants are enjoined from implementing Acting Administrator Richter's April 16, 2021 letter. Defendants are hereby ordered to abide by the terms and conditions of the Texas Healthcare Transformation and Quality Improvement Program (Waiver Number 11-W-00278/6) as they existed on April 15, 2021, prior to Acting Administrator Richter's April 16, 2021 letter. The Court finds that Defendants will not

sustain costs and damages should this injunction be found to have issued wrongfully, and, therefore, the Court dispenses with the requirement of a bond. This injunction shall remain in force and effect until final judgment is entered in this case or as otherwise ordered by the Court.

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF TEXAS
TYLER DIVISION

STATE OF TEXAS, TEXAS HEALTH AND HUMAN SERVICES COMMISSION, Plaintiffs, v. CHIQUITA BROOKS-LASURE, in her official capacity as Administrator of the Centers for Medicare & Medicaid Services; THE CENTERS FOR MEDICARE & MEDICAID SERVICES; XAVIER BECERRA, in his official capacity as Secretary of the Department of Health and Human Services; the UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; and the UNITED STATES OF AMERICA, Defendants.	§	Case No. 6:21-cv-00191

DECLARATION OF JEFFREY M. WHITE IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

Pursuant to 28 U.S.C. § 1746, I, Jeffrey M. White, hereby declare as follows:

1. I am Special Counsel in the Special Litigation Unit at the Texas Office the Attorney General, am admitted to practice law in this Court, and am counsel to the Plaintiffs in the above-captioned matter. I am over 18 and competent to make this declaration. The facts set forth in this declaration are based on my personal knowledge based upon a reasonable investigation, and I would testify to these facts in open court if called upon to do so. This declaration is submitted in support of Plaintiffs' Motion for Preliminary Injunction.

2. Attached hereto as Exhibit A is a true and correct copy of a May 2020 report by the American Hospital Association titled "Hospitals and Health Systems Face Unprecedented Financial Pressures Due to COVID-19," which is publicly available at https://www.aha.org/system/files/media/file/2020/05/aha-covid19-financial-impact-0520-FINAL.pdf.

3. Attached hereto as Exhibit B is a true and correct copy of a July 2020 report by Kaufman Hall titled "The Effect of COVID-19 on Hospital Financial Health," which is publicly available at https://www.aha.org/system/files/media/file/2020/07/KH-COVID-Hospital-Financial-Health_FINAL.pdf.

4. Attached hereto as Exhibit C is a true and correct copy of a May 20, 2020 issue brief by Bradley Corallo and Jennifer Tolbert of the Kaiser Family Foundation titled "Impact of Coronavirus on Community Health Centers," which is publicly available at https://www.kff.org/coronavirus-covid-19/issue-brief/impact-of-coronavirus-on-community-health-centers/.

5. Attached hereto as Exhibit D is a true and correct copy of a June 17, 2020 issue brief by MaryBeth Musumeci, Robin Rudowitz, Elizabeth Hinton, Rachel Dolan, and Olivia Pham of the Kaiser Family Foundation titled "Options to Support Medicaid Providers in Response to COVID-19," which is publicly available at https://www.kff.org/coronavirus-covid-19/issue-brief/options-to-support-medicaid-providers-in-response-to-covid-19/.

6. Attached hereto as Exhibit E is a true and correct copy of an April 19, 2021 article by DJ Wilson, published by State of Reform, titled "The implications for Texas of CMS's rescission of its Medicaid waiver extension," which is publicly available at

https://stateofreform.com/news/texas/2021/04/the-implications-for-texas-of-cmss-rescission-of-its-medicaid-waiver-extension/.

7. Attached hereto as Exhibit F is a true and correct copy of a May 3, 2020 article by Adrian Diaz, Karan R. Chhabra, and John W. Scott, published by Health Affairs, titled "The COVID-19 Pandemic And Rural Hospitals—Adding Insult To Injury," which is publicly available at https://www.healthaffairs.org/do/10.1377/hblog20200429.583513/full/.

8. Attached hereto as Exhibit G is a true and correct copy of a June 28, 2021 article by Jack Fink, published by CBS DFW, titled "DFW Region's Hospitals Could Lose $1.1 Billion Annually in Funding, Healthcare Group Warns," which is publicly available at https://dfw.cbslocal.com/2021/06/28/dfw-region-hospitals-lose-billion-annually-funding-healthcare-group-warns/.

9. Attached hereto as Exhibit H is a true and correct copy of an April 16, 2021 press release by the Texas Hospital Association titled "THA Statement on Medicaid Waiver Action," which is publicly available at https://www.tha.org/Public-Policy/Newsroom/THA-Statement-on-Medicaid-Waiver-Action.

10. Attached hereto as Exhibit I is a true and correct copy of a January 22, 2021 Letter to Governors from Norris Cochran from the United States Department of Health and Human Services, which is publicly available at https://ccf.georgetown.edu/wp-content/uploads/2021/01/Public-Health-Emergency-Message-to-Governors.pdf.

11. Attached hereto as Exhibit J is a true and correct copy of the Texas Medicaid and CHIP Reference Guide, Thirteenth Edition, published by the Texas Health and Human Services Commission, which is publicly available at

https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2020/medicaid-chip-perspective-13th-edition/13th-edition-complete.pdf.

12. Attached hereto as Exhibit K is a true and correct copy of a December 12, 2011 letter from Marilyn Tavenner, Acting Administrator of the United States Centers for Medicare & Medicaid Services, to Billy Millwee, State Medicaid Director, Texas Health and Human Services Commission, which is publicly available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/tx/Healthcare-Transformation-and-Quality-Improvement-Program/tx-healthcare-transformation-amend-appvl-ltr-12122011.pdf.

13. Attached hereto as Exhibit L is a true and correct copy of a May 2, 2016 letter from Vikki Wachino, Director of the United States Centers for Medicare & Medicaid Services, to Gary Jessee, Associate Commissioner for Medicaid/CHIP, Texas Health and Human Services Commission, which is publicly available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/tx/Healthcare-Transformation-and-Quality-Improvement-Program/tx-healthcare-transformation-temp-ext-app-05022016.pdf.

14. Attached hereto as Exhibit M is a true and correct copy of a December 21, 2017 letter from Seema Verma, Administrator of the United States Centers for Medicare & Medicaid Services, to Charles Smith, Executive Commissioner, Texas Health and Human Services Commission, which is publicly available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/tx/Healthcare-Transformation-and-Quality-Improvement-Program/tx-healthcare-transformation-demo-ext-12212017.pdf.

15. Attached hereto as Exhibit N is a true and correct copy of the August 2005 Health Practice Council Practice Note developed by the Medicaid Rate Certification Work Group of the American Academy of Actuaries titled "Actuarial Certification of Rates for Medicaid Managed

Care Programs," which is publicly available at https://www.actuary.org/sites/default/files/files/publications/Practice_Note_Actuarial_Certification_Rates_for_Medicaid_Managed_Care_Programs_aug2005.pdf.

16. Attached hereto as Exhibit O is a true and correct copy of a January 26, 2015 fact sheet published by the United States Centers for Medicare & Medicaid Services titled "Better Care. Smarter Spending. Healthier People: Why It Matters," which is publicly available at https://www.cms.gov/newsroom/fact-sheets/better-care-smarter-spending-healthier-people-why-it-matters.

17. Attached as Exhibit P is a true and correct copy of the Consolidated Budget Request, Fiscal Years 2020-21 for the Texas Health and Human Services Commission, which is publicly available at https://www.hhs.texas.gov/sites/default/files/documents/about-hhs/budget-planning/consolidated-budget-request-2020-2021.pdf.

18. Attached as Exhibit Q is a true and correct copy of the Texas Health and Human Services Commission deliverable titled "DSRIP Transition Plan Milestone: Support Further Delivery System Reform," which is publicly available at https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/Waivers/medicaid-1115-waiver/dsrip-support-delivery-system-reform.pdf.

19. Attached as Exhibit R is a true and correct copy of a June 15, 2021 public comment submitted by Elisa M. Tamayo, Director of Policy and Governmental Affairs of the Emergence Health Network, to the Texas Health and Human Services Commission.

20. Attached as Exhibit S is a true and correct copy of a June 25, 2021 public comment submitted by Shannon J. Herklotz, Chief of Detentions at the Harris County Jail, to the Texas Health and Human Services Commission.

21. Attached as Exhibit T is a true and correct copy of a June 10, 2021 public comment submitted by Jon Caspell, Assistant Chief of the Lubbock Police Department, to the Texas Health and Human Services Commission.

I declare under the penalty of perjury that the foregoing is true and correct.

Executed on July 16, 2021

/s/ Jeffrey M. White
JEFFREY M. WHITE

Exhibit A

American Hospital Association™
Advancing Health in America

Hospitals and Health Systems Face Unprecedented Financial Pressures Due to COVID-19

Introduction

America's hospitals and health systems have stepped up in heroic and unprecedented ways to meet the challenges of COVID-19. As outbreaks have occurred across the country infecting more than 1 million people, hospitals have ramped up testing efforts and are treating hundreds of thousands of Americans in an effort to save lives and minimize the virus' spread.[1] This includes establishing testing tents, adding general and intensive care unit (ICU) bed capacity, and developing COVID-19 units to isolate and treat patients with the disease while safeguarding the health of other patients and hospital staff.

These challenges have created historic financial pressures for America's hospitals and health systems. Hospitals have cancelled non-emergency procedures, and many Americans are postponing care as they shelter in place to stop the spread of the virus. Treatment for COVID-19 has created incredible demand for certain medical equipment and supplies as the virus has disrupted supply chains, increasing the costs that hospitals face to treat COVID-19 patients. At the same time, COVID-19 has led to unprecedented job losses, giving way to a rise in the number of uninsured. And while doctors, nurses, and other health care workers have met the COVID-19 challenge with heroic efforts, many hospitals and health systems, especially those located in hotspot areas of the pandemic, are supporting them by providing essentials like child care, transportation, and in some cases, housing.

Hospitals and health systems face catastrophic financial challenges in light of the COVID-19 pandemic. The American Hospital Association (AHA) undertook four analyses to better understand and quantify these financial challenges. Including:

- the effect of COVID-19 hospitalizations on hospital costs;
- the effect of cancelled and forgone services, caused by COVID-19, on hospital revenue;
- the additional costs associated with purchasing needed personal protective equipment (PPE); and
- the costs of the additional support some hospitals are providing to their workers.

This report attempts to quantify these effects over the short-term, which are limited to the impacts over a four-month period from March 1, 2020 to June 30, 2020. Based on these analyses, the AHA estimates a **total four-month financial impact of $202.6 billion** in losses for America's hospitals and health systems, or an average of **$50.7 billion per month**.

Although the federal government moved quickly to provide relief, more help is needed. Critics have argued that hospitals were well funded prior to the COVID-19 public health emergency, however, the reality is that many hospitals were already facing financial pressures. Experts have raised concerns about low payment rates from government payers, which in part led the Congressional Budget Office to project that between 40% and 50% of hospitals could have negative margins by 2025 prior to the pandemic.[2,3,4] Congress created a provider relief fund to support health care providers during the pandemic, but this fund is intended to stabilize providers in order to keep

American Hospital Association™
Advancing Health in America

their doors open, rather than fully restore compensation to pre-COVID-19 levels. Further, these funds are being distributed to all health care providers with only a portion of these funds going directly to hospitals.[5] Other providers – such as physicians and other clinicians, laboratory and testing facilities, and durable medical equipment providers – are drawing down from health care provider relief funds as well.[6] Hospitals and health systems will need more funds to treat patients, save lives, and get America back on its feet.

This report assesses the financial impact of COVID-19 on hospitals and health systems. It begins with an overview of the crisis and how it has affected hospitals and health systems. Then, it describes the approach used to model the impacts, including key assumptions and data sources used to complete the analysis. Then, the report presents the findings in greater detail and concludes with a discussion of these findings.

Background

In mid-January, 2020, the first case of COVID-19 in the U.S. was reported in Snohomish County, Wash.[7] Confirmed cases increased to 1,000 by March 11, 100,000 by March 27, and over 1 million on April 28. The effect of the virus on daily life was swift and catastrophic with the advent of strict social distancing practices and stay-at-home orders. California Gov. Gavin Newsom was the first governor to issue a stay-at-home order on March 19, and by early April every state had restrictions in place to mitigate the spread of the disease.[8]

The virus has effectively grounded both local and national economies to a halt. More than 30 million Americans have filed for unemployment insurance since the end of February.[9] The St. Louis Federal Reserve estimated that this number could rise as high as 47 million by the end of the second quarter of 2020.[10] On April 29, the U.S. Department of Commerce found that first quarter gross domestic product contracted by 4.8% – an important signal of the pandemic's deleterious effects on the American economy.[11] These economic impacts have devastated many industries including our nation's hospitals and health systems.

Hospital and health system revenues have declined sharply as a result of the COVID-19 pandemic. To increase personal and public safety across the country while conserving PPE, hospitals moved to cancel non-emergency procedures. At the same time, many Americans have forgone care, including primary care and other specialty care visits. On March 18, the Centers for Medicare & Medicaid Services (CMS) recommended that most elective surgeries and non-essential medical, surgical and dental procedures be cancelled or delayed during the COVID-19 outbreak.[12] Since then, several governors mandated cancellation of non-essential services in their state.

These measures have resulted in adjusted discharges – a measure that accounts for both inpatient and outpatient services – decreasing by 13% from the previous year.[13] Health care providers have raised concerns that patients are forgoing important care, such as chronic disease management, which can further jeopardize their health.[14] An additional consequence of these factors has been steep reductions in revenue for all hospitals and health systems across the country.

These losses in revenue have been met with a sharp increase in costs for hospitals since the beginning of the pandemic. COVID-19 outbreaks in parts of the country have resulted in surges in hospitalizations and ICU patients. The Centers for Disease Control and Prevention estimated the cumulative hospitalization rate to be 29.2 per 100,000 people, with even higher rates for Medicare-aged individuals (95.5 per 100,000) and adults aged 50-64 (47.2 per 100,000).[15] COVID-19-related hospitalizations are associated with high costs of treatment:

- The Kaiser Family Foundation estimates that the cost of treating a patient with COVID-19 could be more than $20,000, and over $88,000 for patients that require ventilator support.[16]

- A study by FAIR Health estimated the average cost of treating patients with commercial coverage to be $38,221.[17]

At the same time, experts anticipate that millions of Americans could become uninsured given the spike in unemployment. The number of people without insurance could increase to over 40 million.[18] These coverage losses put families at financial risk and increase uncompensated care at hospitals. Hospitals have already seen some of the effects manifest; bad debt and charity care increased 13% over the previous year in March, according to a recent study from Kaufman Hall.[19]

The above estimates do not include the additional costs of acquiring drugs, medical supplies and equipment that hospitals must incur to meet the demand for services. COVID-19 increased the demand for medical equipment and supplies, such as hospital beds and ventilators, and disrupted many supply chains. As a result, prices for these necessary supplies have increased exponentially since the beginning of the pandemic. For example:

- The Society for Healthcare Organization Procurement Professionals (SHOPP) estimated that costs of certain medical supplies have increased tenfold since the beginning of the pandemic.[20]

- Hospitals in New York City reported paying four times the usual price for medical gloves and 15 times the usual price for masks.[21]

Moreover, these estimates do not account for increased labor costs. Many hospitals are experiencing increased overtime costs as hospitals experience a surge in patients or front-line workers become sick. Some hospitals have implemented bonus pay for front-line employees. Some have turned to staffing firms to address health care worker shortages or meet surge demand, and staffing firms have increased their prices due to an increase in demand for health care workers.

Supporting front-line health care workers. Physicians, nurses, and health care workers are on the frontlines of battle against the disease. Some hospitals have incurred costs to ensure that workers and their families are cared for while the workers are providing care to COVID-19 patients. For example, many health care workers need child care while they are working.[22] Housing, transportation, and COVID-19 screening and testing costs have also emerged as important needs for health care workers. Hospitals and health systems are working to develop solutions that meet the needs of their employees.

Methodology

The AHA undertook four analyses to estimate the financial impact of these challenges. This includes:

- the net financial impact of COVID-19 on hospital costs;

- total revenue losses from cancelled surgeries and other services;

- the additional costs associated with purchasing needed PPE; and

- the costs of the additional support some hospitals are providing to their workers.

Below is an overview of the methodology used in these analyses. Additional detail about the methodology is found in the appendix at the end of this report.

The estimates described here are limited to the impacts over a four-month period from March 1, 2020 to June 30, 2020. This study does not assess the financial impact of continued revenue losses or increased costs beyond June 30. Any future waves of COVID-19 infections may result in additional net losses. Further, this study also does not assess the long-term, systemic financial impacts of the COVID-19 pandemic on hospitals or the communities they serve. Therefore, these estimates likely under represent the full financial losses that hospitals and health systems face.

Net Financial Impact of COVID-19 Hospitalizations

The net financial impact of COVID-19 hospitalizations was calculated by relying on a variety of data sources and recent modeling to estimate the three primary components of the model: (1) the total number of COVID-19 hospitalizations in the U.S. over a four-month period; (2) the incremental cost of a COVID-19 hospitalization; and (3) the expected reimbursement from private and government payers for COVID-19 hospitalizations.

To estimate the total number of expected hospitalizations, local COVID-19 hospitalization data to date were scaled-up to the U.S. population. Payer mix data were then applied to generate estimates of hospitalizations by payer. The incremental cost of a COVID-19 hospitalization was estimated by segmenting the hospitalizations into two cohorts – those who require mechanical ventilation and those who do not – and applying published cost estimates for clinical diagnoses most similar to COVID-19. To estimate payments received for these hospitalizations, Medicare payment data were used for the same clinical diagnoses used to estimate costs. These amounts were adjusted to include the 20% MS-DRG add-on for COVID-19 treatment. The Medicare payments were scaled to Medicaid, commercial payers, and the uninsured based on available published payment ratios. The final step was to subtract payments from costs for each payer and aggregate those net impacts to generate a total financial impact across all payers.

Total Revenue Losses from Cancelled Surgeries and Other Services

Estimates of the lost revenue from cancelled hospital services due to the COVID-19 pandemic were calculated using a combination of 2018 Medicare inpatient and outpatient claims files and the 2018 AHA Annual Survey Database (ASDB). Claims were classified into three categories: emergency department (ED)-related; non-ED-related medical; and non ED-related surgical. Medicare revenues were calculated from claims data, and revenues for other payers were estimated using ratios of net revenues from the other payers to those from Medicare, derived from the ASDB. Three different levels of service interruptions under which hospitals may operate were then identified:

- Level 1: cancellation of 67% of ED-related services; cancellation of all non ED-related services
- Level 2: cancellation of 67% of ED-related services; cancellation of 50% of non ED-related medical services; cancellation of all non ED-related surgical services
- Level 3: cancellation of 67% of ED-related services; cancellation of 50% of all non ED-related services

Finally, these levels of service interruptions were blended over a four-month timeframe to estimate the lost revenue due to cancelled services.

Additional Costs Associated with Purchasing Needed PPE

Data from SHOPP were used to estimate the increased costs of purchasing PPE. SHOPP provided estimated costs for acquiring PPE prior to the COVID-19 pandemic and the current estimated costs for acquiring PPE during the pandemic, using CDC guidelines. The difference in prices was calculated and then scaled up by the total number of U.S. hospital beds.

Costs of Additional Support Some Hospitals are Providing to their Workers

This analysis estimates the costs of providing support to front-line hospital workers located in COVID-19 hotspots and their families, including child care, housing, transportation, and COVID-19 screening and treatment. Hotspots were identified as the top 100 counties with the highest COVID-19 infection rate, using county-level data matched against the AHA ASDB.[23] Publicly available data on the daily costs of child care, daily public transportation costs, and the estimated federal per diem rates for lodging were used to generate estimates for each of these support services. Cost estimates of COVID-19 hospitalizations were used for estimating treatment costs for hospital workers infected with COVID-19 and estimates of laboratory test costs were used for the total cost of screening hospital workers for COVID-19 were aggregated to generate the total estimate of the cost hospitals are incurring in providing these support services. We assume hospitals are bearing some portion of these costs.

Results

The AHA estimates a **total four-month financial impact of $202.6 billion** in losses for America's hospitals and health systems, or an average of **$50.7 billion per month**. This estimate was derived by combining the estimates of various components of reduced revenue and increased costs described below.

Net Financial Impact of COVID-19 Hospitalizations

- The AHA estimates the net financial impact of COVID-19 hospitalizations over a four-month period will be $36.6 billion. In other words, the nation's hospitals and health systems will collectively lose $36.6 billion, including payments for COVID-19 patients, from March to June 2020 treating COVID-19 patients alone.

Total Revenue Losses from Cancelled Surgeries and Other Services

- The AHA estimates that, as a result of cancelled hospital services due to the COVID-19 pandemic, U.S. non-federal hospitals stand to lose approximately $161.4 billion in revenue over a period of four months, from March to June 2020. This includes cancelled surgeries, various levels of cancelled non-elective surgeries and outpatient treatment, and reduced emergency department services.

Additional Costs Associated with Purchasing Needed PPE

- The AHA estimates the non-treatment costs for hospitals and health systems to be $2.4 billion over a period of four months, from March to June 2020, or roughly $600 million per month. Demand for equipment and supplies, such as PPE, has increased as a result of the COVID-19 pandemic. Hospitals have incurred additional costs as they struggle to acquire additional supplies to meet the needs of their patients and staff. Moreover, current guidelines require all hospital workers to wear some PPE, regardless of whether they are in direct contact with COVID-19 patients. These guidelines increase the need and expense for PPE relative to normal operations.

Costs of Additional Support Some Hospitals are Providing to their Front-line Workers

- The AHA estimates the cost of support for front-line hospital workers in COVID-19 hotspots to be $2.2 billion through the end of June, or just under $550 million per month. This includes the costs of providing child care, housing, transportation, and medical screening and treatment for COVID-19 for front-line workers. This estimate could increase as more outbreaks of COVID-19 occur, or if the policy decision was made to extend these benefits to all health care workers during the pandemic.

Discussion

Hospitals face catastrophic financial challenges in light of the COVID-19 pandemic. The AHA estimates a **total four-month financial impact of $202.6 billion** in losses for America's hospitals and health systems, or an average of **$50.7 billion per month**.

As with any model, these findings are sensitive to underlying assumptions. While the model accounts for the many costs borne by hospitals during this pandemic, there are additional costs that were not included due to limited available data. Therefore, the four-month financial impact estimate likely under-represents the true financial impact our hospitals and health systems face. Some of these important additional costs are:

- **Drug Shortage Costs.** Every year, hospitals expend financial resources to cope with ongoing drug shortages, with one estimate putting this cost at nearly $400 million per year.[24] Due to the pandemic, lower than normal drug supply due to fractured pharmaceutical supply chains has been met with increasing demand for certain drugs necessary to treat the surge of patients with COVID-19 infections. This situation has created a perfect storm for drug shortages for many vital drugs resulting in higher costs for hospitals.

- **Wage and Labor Costs.** Salary and wage costs have risen during the COVID-19 pandemic. Many hospitals are experiencing increased overtime costs as hospitals experience a surge in patients or front-line workers become sick. Some hospitals have implemented bonus pay for front-line workers. Some have turned to staffing firms to address health care worker shortages or meet surge demand, and staffing firms have increased their prices due to an increase in demand for health care workers. The effect of the virus on hospital wages and labor costs is clear. However, it is not evenly distributed across the country and there are not yet reliable data that can be analyzed to understand the magnitude of the effect.

- **Non-PPE Medical Supplies and Equipment Costs.** Hospitals have experienced increased costs for non-PPE medical supplies and equipment. For example, many hospitals acquired ventilators in anticipation of a surge of COVID-19 patients. There are limited data available to understand the additional cost-burden hospitals face as they acquire non-PPE medical supplies and equipment in preparation for COVID-19 patients.

- **Capital Costs.** As the demand for hospital services has increased due to the pandemic, many hospitals and health systems around the country have worked to expand their treatment capacity by incurring costs to set up additional space for COVID-19 testing tents, ICU beds, and other treatment beds.

The totality of these costs combined with the uncertainty of the pandemic's duration is certain to imperil hospital finances. After years of declining margins, it was only recently that many of the credit rating agencies expressed optimism about hospitals' ability to weather low payment rates from government providers amidst increasing enrollment in government programs, competition from tech disruptors, and other increasing costs such as prescription drugs, and salary and wages. A third of U.S. community hospitals had negative operating margins in 2018.[25]

Congress has moved quickly to support the country during the COVID-19 pandemic. Congress allocated $100 billion for provider relief in the Coronavirus Aid, Relief, and Economic Security Act, and added $75 billion to the relief fund in the Paycheck Protection Program and Health Care Enhancement Act. However, the AHA has expressed concern with how the funds have been distributed and the timeliness of these payments.[26]

More support is needed. Hospitals continue to experience losses from cancelled and delayed procedures, while

incurring increased costs for treating patients suffering from COVID-19 and purchasing the equipment and supplies necessary to ensure the health and safety of patients, providers, and their families. Additional support will be critical as the country moves into a new phase of recovery and rebuilding. During this time, we'll need to address health disparities and ensure the health and safety of vulnerable communities. We'll face new behavioral health challenges in light of all that our nation has experienced. And we'll need increased resources to address clinical resiliency to support the health care workers who answered the call when the country needed them.

As the country faces the inimitable challenges of COVID-19 head-on, Americans cannot afford the cost of closed hospitals and restricted access to life saving treatment – action is needed urgently to support our nation's hospitals and health systems and the heroes that work there.

Appendix: Methodology

The detailed methodology used in the AHA's modeling of the net financial impact of COVID-19 to hospitals and health systems is outlined below. The AHA undertook four analyses to estimate the financial impact of these challenges:

- the net financial impact of COVID-19 on hospital costs;
- total revenue losses from cancelled surgeries and other services;
- the additional costs associated with purchasing needed PPE and other supplies; and
- the costs of the additional support some hospitals are providing to their workers.

Net Financial Impact of COVID-19 Hospitalizations

The total number of COVID-19 hospitalizations in the U.S. over a four-month period. For the first component, a nationwide estimate of COVID-19 hospitalizations was calculated using data published by the New York City Department of Health and Mental Hygiene on the total number of hospitalized COVID-19 cases in New York City to date.[27] The hospitalization rate was then scaled up to a national estimate using U.S. Census population estimates, converted to hospitalizations per day and then applied over the four-month period of the AHA model. To estimate COVID-19 hospitalizations by payer, a payer mix estimate was derived from a 2019 study that evaluated emergency department visits by payer using Healthcare Cost and Utilization Project (HCUP) data for pulmonary conditions (pneumonia and other similar respiratory illnesses).[28] Our model did not adjust for any potential changes in payer mix due to the projected increases in the uninsured, as data on the exact nature of these changes are limited and it is unclear how changes in insurance status would manifest in changes in payer mix for COVID-19 hospitalizations.

The incremental cost of a COVID-19 hospitalization. For the second component, patients were segmented into two cohorts based on available clinical data: those who require mechanical ventilation and those who do not. Because mechanical ventilation use is often a sign of significant morbidity and impending mortality, the costs associated with its use are much higher than for patients who do not require that level of treatment. Therefore, total costs of treatment were estimated separately for patients who require mechanical ventilation and those who do not based on a set of corresponding diagnosis groups (DRGs) commonly used in payment for inpatient hospital services. These separate costs were then blended based on literature suggesting that only 20% of COVID-19 hospitalizations require ventilator use.[29] Rather than focusing on the total cost of COVID-19 treatment, the incremental cost of a COVID-19 hospitalization was then calculated.

The expected reimbursement from private and government payers for COVID-19 hospitalizations. The third component involved estimating reimbursements for COVID-19 hospitalizations for the two cohorts of patients mentioned above. Since reimbursement data for COVID-19 are not yet publicly available, Medicare data from the FY 2020 inpatient final rule were relied on to estimate a Medicare payment amount for COVID-19 hospitalization for each cohort of patients. These amounts were adjusted to include the 20% MS-DRG add-on for COVID-19 treatment. As with the estimate of costs, Medicare payment amounts for patients requiring mechanical ventilation were blended with those who do not. This blended Medicare payment amount was scaled to commercial payers and Medicaid based on published Medicare payment ratios.[30,31] It is unclear what the mechanism or level of payment for the uninsured will be at this time. Although the Department of Health and Human Services has announced that a portion of the $100 billion Provider Relief Fund will be used to reimburse health care providers

who have provided treatment for uninsured COVID-19 patients on or after Feb. 4, 2020 at Medicare rates, it also stated that this would be "subject to available funding." Since it is uncertain how much funding will be available and for how long, this analysis assumes reimbursement at 50% of Medicare rates.

Finally, the net financial impact of COVID-19 hospitalizations over a four-month period for each payer was calculated by multiplying the number of hospitalizations for that payer by the estimated cost of and payment for, a COVID-19 hospitalization. The net financial impacts for each payer were then summed to generate a total net financial impact estimate.

Total Revenue Losses from Cancelled Surgeries and Other Services

Claims were classified into three categories of services: emergency department (ED)-related; non ED-related medical; and non ED-related surgical. For inpatient claims, ED-related services were identified if ED charges on the claim exceeded $2,500: these were considered hospital inpatients that were admitted through the ED. For outpatient services, any claim with an ED charge was considered ED-related. Of the remaining non ED-related claims, inpatient services were classified as medical or surgical based on a crosswalk created by CMS that identifies Medicare severity diagnosis-related groups (MS-DRGs) as either medical or surgical. Outpatient surgical claims were identified using a range of current procedural terminology (CPT) codes for surgery of 10004 - 69990. Claims with CPT codes in the range of 36400 – 36425 (venipuncture) were not counted as surgical but instead placed in the medical service category.

Using provider net revenues for different payer types in the AHA Annual Survey Database, Medicare revenues calculated from the claims were estimated for other payers using the ratio of other payer net revenues to Medicare net revenues, and the resulting revenues were summed across providers. Furthermore, since the Medicare claims only included PPS and Maryland hospitals, total revenues across these hospitals were scaled to estimate total impacts for all hospitals in the U.S. (excluding federal hospitals).

Three levels of service interruptions were considered:

- Level 1: cancellation of 67% of ED-related services; cancellation of all non ED-related services
- Level 2: cancellation of 67% of ED-related services; cancellation of 50% of non ED-related medical services; cancellation of all non ED-related surgical services
- Level 3: cancellation of 67% of ED-related services; cancellation of 50% of all non ED-related services

This analysis uses a time period of four months, but given the uncertainty of what might happen beyond that time period, the estimated loss is most probably understated. The different levels of service interruptions over the four-month period were blended to reflect differences state-instituted moratoriums on non-ED procedures and differences in when states are easing these restrictions.

Additional Costs Associated with Purchasing Needed PPE

To estimate the increased costs of purchasing PPE, data from the Society for Healthcare Organization Procurement Professionals (SHOPP) were relied upon. SHOPP estimated the cost per day per bed for acquiring PPE "pre-COVID" ($0.35/per bed day) and the current costs of acquiring PPE ($25.58/ per bed day), accounting for the increase in demand and the need for more PPE based on CDC guidelines. The estimated daily costs under both

scenarios were scaled-up by the total number of U.S. hospital beds (excluding federal hospitals) and scaled up to generate monthly estimated totals.

Costs of Additional Support Some Hospitals are Providing to their Workers

This analysis estimates the costs of providing support to front-line hospital workers and their families, including child care, housing, transportation, and COVID-19 screening and treatment. While hospitals and health systems around the country are providing these supports to their front-line workers, it is especially the case for hospitals located in areas deemed as "hotspots" for COVID-19. Hotspots were identified as the top 100 counties with the highest COVID-19 infection rate, using county-level data matched against the AHA ASDB.[32] To be conservative in estimating national costs, these costs were calculated assuming these support services were being offered at 50% of hospitals and health systems located in these COVID-19 hotspot areas.

For child care services, the number of hospital workers located in hotspots that had children under the age of 12 that may require child care were estimated and multiplied that by the average hourly cost of child care as estimated by the Office of Planning, Research & Evaluation at the Department of Health and Human Services.[33]

For transportation services, 21.3% of hospital workers in hotspots were estimated to commute using public transportation based on data from the American Community Survey and multiplied that by the average daily cost of public transportation as estimated by the Bureau of Transportation Services.[34]

For the cost of providing housing, 5% of hospital workers were estimated to require housing services and multiplied by the average per diem lodging rates published by the General Services Administration.[35]

To estimate the costs of providing free daily testing for COVID-19, lab cost estimates ($120/test) by Covered California were used, and multiplied by CDC estimates of the number of all COVID-19 cases among health care workers (11%), based on current testing capacity data.[36] Finally, to estimate the cost of covering hospitalization for hospital workers with COVID-19, CDC data for the number of hospital workers infected with COVID-19 in the U.S. were used, and the model assumes that 20% of all COVID-19 infections of hospital workers would require hospitalization. The COVID-19 hospitalization cost estimate was applied and multiplied by the number of estimated hospital workers requiring hospitalization.

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Exhibit B

July 2020

The Effect of COVID-19 on Hospital Financial Health

KaufmanHall

Exceptional Partners. Exceptional Performance.

Hospitals Require a Positive Margin to Serve Their Communities

For any organization, a positive operating margin is essential for long-term survival. Few organizations can maintain themselves for an extended period when total expenses are greater than total revenues.

For hospitals, positive financial margins allow them to invest in new facilities, treatments, and technologies to better care for patients, and to build reserves to meet unexpected expenses or revenue shortfalls.

Before COVID-19

Compared with other industries, healthcare margins typically have been very thin. Even before COVID-19, a number of U.S. hospitals struggled with negative margins—in other words, they were losing money on operations. In fact the median hospital margin was a very modest 3.5%.

This situation has been a serious threat to the future viability of many of America's hospitals.

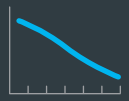
The Effect of COVID-19 on Hospital Margins

When the COVID-19 pandemic emerged, hospitals had to stop all but the most urgent non-COVID care. The result was a dramatic slowdown in volume of patients and in revenue, while expenses remained high. To date, no one knows when and to what degree these patients will return. The result has been an unprecedented impact and an uncertain future about the ability of hospitals to serve their communities and remain financially viable.

At the request of the American Hospital Association, Kaufman Hall presents our analysis of the critical question of how COVID-19 could affect hospital margins during 2020.

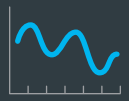
The Path of COVID-19 Remains Unpredictable

This analysis is based on two broad scenarios for the COVID-19 virus.



MORE OPTIMISTIC:
a slow but steady decrease in COVID-19 cases

- This scenario assumes a continued increase in patient confidence and associated return to the hospital setting
- This scenario assumes a higher likelihood of a long slog than a quick return, given current COVID-19 case projections.
- We give this scenario 40% weight in our analysis



LESS OPTIMISTIC:
periodic surges in COVID-19 cases

- This scenario assumes that patient demand will be affected by incremental surges in cases, and by associated government and public health interventions, such as enhancing social distancing requirements or re-enacting stay-to-home orders
- This scenario includes the possibility of both secondary and seasonal surges beginning in the summer and extending through the Fall of 2020.
- We give this scenario 60% weight in our analysis

For more information about our methodology, see page 8.

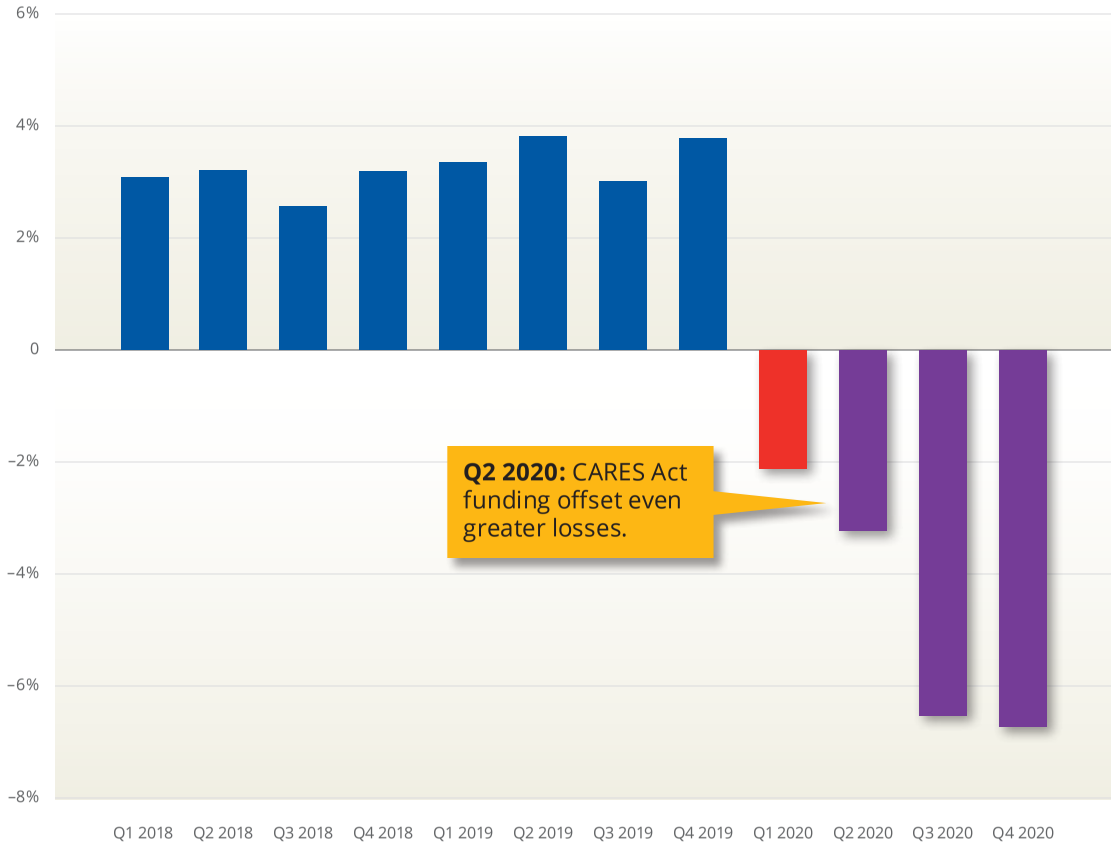
COVID-19 Is Expected to Drive Median Hospital Margins from Positive to Negative

COVID-19 has created immediate and significant damage to hospital margins, as well as great uncertainty about the path forward toward financial stability.

Funding from the CARES Act distributed in April and May—along with estimated distribution in June—is mitigating that impact to a certain degree. Median margins are forecast to drop to –3% in the second quarter of 2020; however, those margins would have been –15% without CARES Act funding.

Our forecast shows that, without further government support, margins could sink to –7% in the second half of 2020. This is an unsustainable level for America's hospitals.

Adjusted Operating Margin Index
Median by Quarter



July 2020

The Effect of COVID-19 on Hospital Financial Health

KaufmanHall

Exceptional Partners. Exceptional Performance.

Hospitals Require a Positive Margin to Serve Their Communities

For any organization, a positive operating margin is essential for long-term survival. Few organizations can maintain themselves for an extended period when total expenses are greater than total revenues.

For hospitals, positive financial margins allow them to invest in new facilities, treatments, and technologies to better care for patients, and to build reserves to meet unexpected expenses or revenue shortfalls.

Before COVID-19

Compared with other industries, healthcare margins typically have been very thin. Even before COVID-19, a number of U.S. hospitals struggled with negative margins—in other words, they were losing money on operations. In fact the median hospital margin was a very modest 3.5%.

This situation has been a serious threat to the future viability of many of America's hospitals.

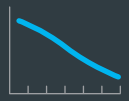
The Effect of COVID-19 on Hospital Margins

When the COVID-19 pandemic emerged, hospitals had to stop all but the most urgent non-COVID care. The result was a dramatic slowdown in volume of patients and in revenue, while expenses remained high. To date, no one knows when and to what degree these patients will return. The result has been an unprecedented impact and an uncertain future about the ability of hospitals to serve their communities and remain financially viable.

At the request of the American Hospital Association, Kaufman Hall presents our analysis of the critical question of how COVID-19 could affect hospital margins during 2020.

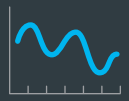
The Path of COVID-19 Remains Unpredictable

This analysis is based on two broad scenarios for the COVID-19 virus.



MORE OPTIMISTIC:
a slow but steady decrease in COVID-19 cases

- This scenario assumes a continued increase in patient confidence and associated return to the hospital setting
- This scenario assumes a higher likelihood of a long slog than a quick return, given current COVID-19 case projections.
- We give this scenario 40% weight in our analysis



LESS OPTIMISTIC:
periodic surges in COVID-19 cases

- This scenario assumes that patient demand will be affected by incremental surges in cases, and by associated government and public health interventions, such as enhancing social distancing requirements or re-enacting stay-to-home orders
- This scenario includes the possibility of both secondary and seasonal surges beginning in the summer and extending through the Fall of 2020.
- We give this scenario 60% weight in our analysis

For more information about our methodology, see page 8.

The Degree of Margin Damage Could Vary Depending on COVID-19's Path

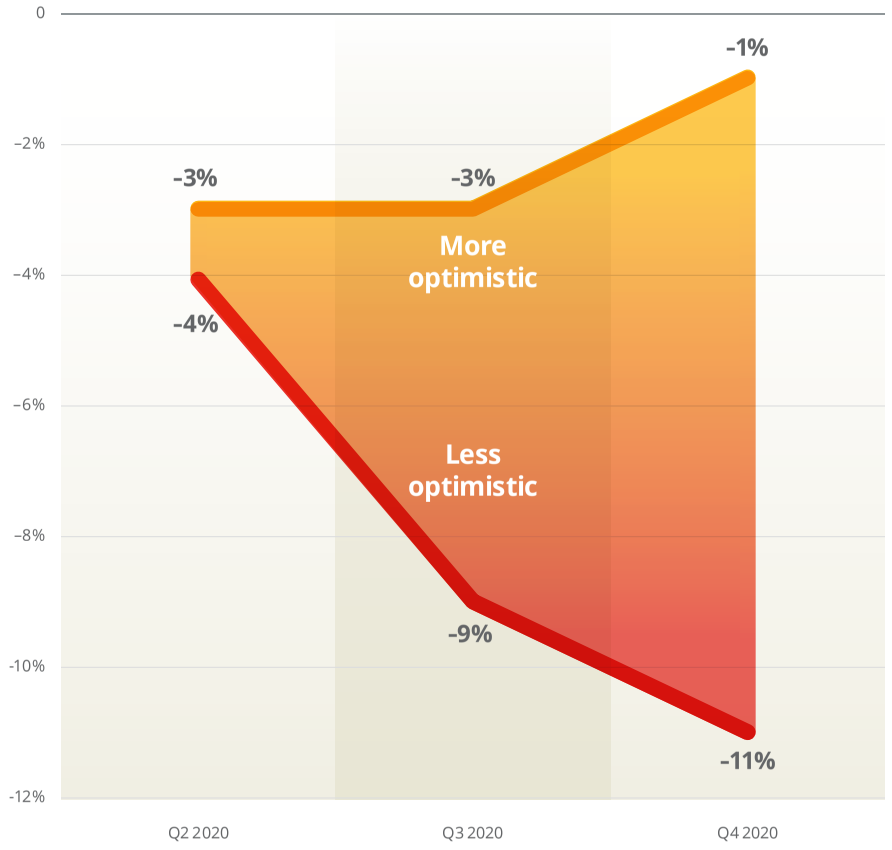
COVID-19's path—whether we see a gradual recovery or new surges—will affect the degree of damage to hospital margins for the remainder of 2020 and into the future.

In the most optimistic scenario, median margins could be –1% by the fourth quarter of the year. In a less optimistic scenario, margins could sink to –11%.

Both of the scenarios shown are possible. Both would undermine the ability of hospitals to serve their communities while COVID-19 continues and in the post-COVID-19 environment.

CARES Act funding delayed a more devastating financial impact of COVID-19. However, without further government assistance, the financial picture will quickly worsen, no matter COVID-19's path.

Adjusted Operating Margin Index*
Median by Quarter



* Margins in Q2 are are different points because the two different scenarios are applied to the forecast for June 2020.

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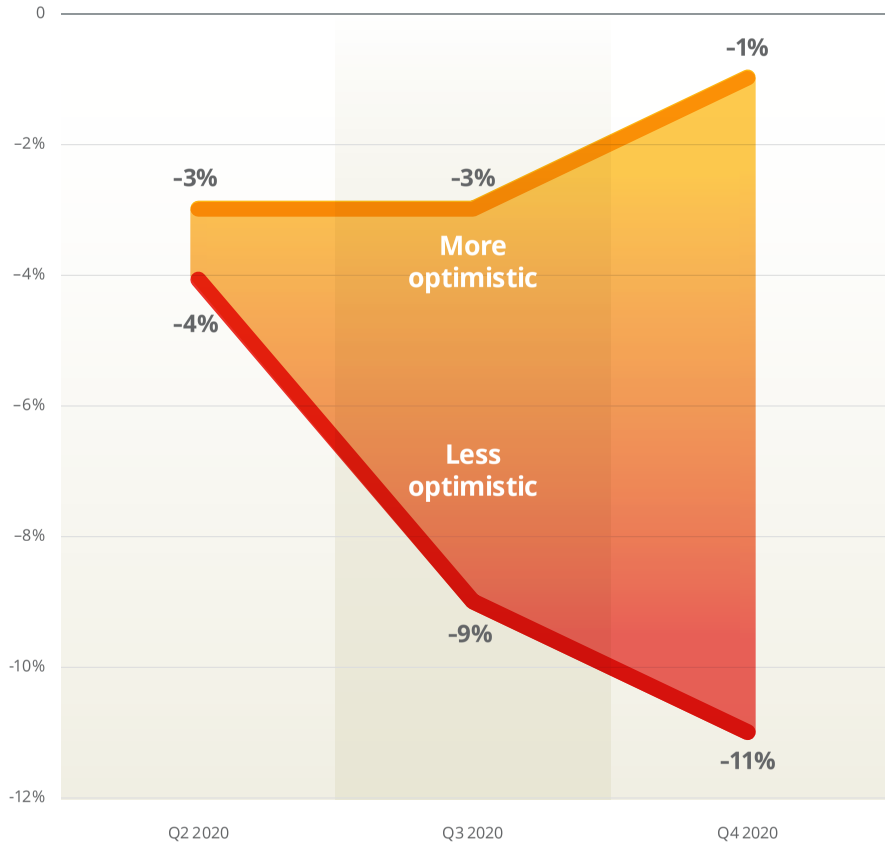
Adjusted Operating Margin Index*
Median by Quarter



* Margins in Q2 are are different points because the two different scenarios are applied to the forecast for June 2020.

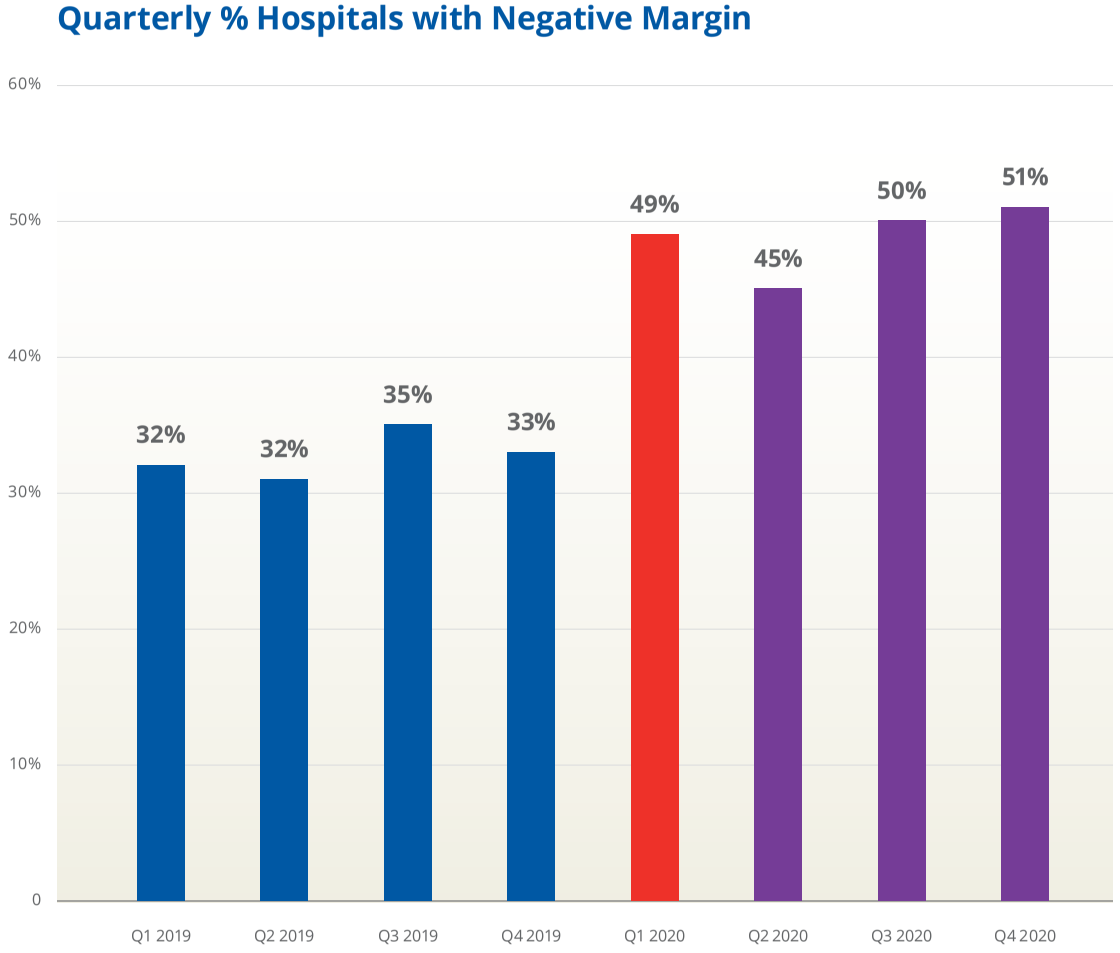
COVID-19 Could Leave Half of America's Hospitals With Negative Margins

Prior to COVID-19, in 2019, a number of hospitals already had a negative margin—an indicator of the economically fragile state of the industry.

In the second quarter of 2020, when we experienced COVID-19's initial impact, we saw almost half of America's hospitals with negative margins—a figure that was far worse prior to distribution of CARES Act funds.

However, even as COVID-19 recedes, our analysis shows half of America's hospitals will remain with negative margins without any further support.

This is a dire and unsustainable outlook for a major portion of the country's hospitals and communities.



The Possible Long-Term Impact of COVID-19 on Hospitals

To date, the financial impact of COVID-19 has been significant, even with Federal emergency funding, and the financial damage is likely to continue.

Adding to this financial impact is the unpredictability of COVID-19's trajectory, and the pace and degree of patients' return to hospitals.

In the face of greatly eroded volume and revenue, and a long recovery period, many hospitals are confronted with extremely difficult choices about their paths forward as vital community assets.

Now more than ever, hospitals will need support from governments, and will need to rethink their strategic–financial plans for what is likely to be a highly challenging environment even as COVID-19 cases diminish.

Methodology

Several variables were considered to create projections of hospital operating margins.

Demand

- This is considered the most significant factor and primary driver of margin projection moving forward.
- Kaufman Hall wrote about four potential scenarios for scheduled procedure resumption, including: optimistic, long slog, secondary surge, and seasonal surge – all of these scenarios are considered in the projections, as explained on page 3.
- Surveys indicate a growing proportion of patients are willing to return in the next 3 to 6 months.
- External projections show wide variation in outcomes relative to COVID case modeling, hospital bed demand, and pace of secondary surges.

Expenses and CARES Act Impact

- Response varies across hospitals with regard to labor and non-labor expense categories; many hospitals have significant fixed and de facto fixed cost structures.
- For projection purposes, we assume organizations will continue to manage expenses in a similarly prudent fashion as during the initial onset of COVID from March to May of 2020. Further analysis in this area is warranted and ongoing.
- We include the offsetting impact of CARES funds received to-date in April & May, along with an estimated offsetting impact for June.

COVID-19 Margin Impact

- Margin impacts from COVID-19 have been broadly similar across geographies, hospital sizes, and other variables such as case mix index and inpatient/outpatient revenue mix
- For projection purposes at a national level, we assume these generalized trends will continue.

About Kaufman Hall

For more than 30 years, Kaufman Hall has been providing organizations in Healthcare, Higher Education, and Financial Institutions with independent, objective insight and financially-centered software tools that support decision making and enable the development and execution of sustainable strategies and goals.

Kaufman Hall currently provides consulting services and software to 80 of the 100 largest health systems in the United States.

For more information contact

COVIDrecovery@kaufmanhall.com or visit kaufmanhall.com

KaufmanHall

Contact Kaufman, Hall & Associates at 10 South Wacker Drive, Suite 3375, Chicago, IL 60606
Phone 847.441.8780. **kaufmanhall.com**

Exhibit C

Impact of Coronavirus on Community Health Centers

Bradley Corallo (https://www.kff.org/person/bradley-corallo/) and

Jennifer Tolbert (https://www.kff.org/person/jennifer-tolbert/)

Published: May 20, 2020

Background

Community health centers are a national network of safety net primary care providers that fill an important role in national, state, and local responses to the coronavirus pandemic. Health centers primarily contribute to response efforts by providing tests, triaging patients, and reducing the burden on hospitals, although they also play a role in addressing demand for behavioral health services (https://www.kff.org/health-reform/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/) and continuing primary care for patients with chronic conditions. Patients at health centers are disproportionately low-income and people of color, groups (https://www.kff.org/disparities-policy/issue-brief/low-income-and-communities-of-color-at-higher-risk-of-serious-illness-if-infected-with-coronavirus/) especially hard hit by the pandemic. Among the roughly 28 million patients (https://bphc.hrsa.gov/uds/datacenter.aspx) served by health centers, 91% are low-income and 63% are racial or ethnic minorities. Like other outpatient health care providers (https://www.commonwealthfund.org/publications/2020/apr/impact-covid-19-outpatient-visits), health centers are having to adjust to stay-at-home orders, drops in patient visits for non-essential health care, and workforce challenges. This brief presents findings from new data (https://bphc.hrsa.gov/emergency-response/coronavirus-health-center-data) collected by the Health Resources and Services Administration (HRSA) to provide insights into how health centers are adapting their services in response to the pandemic and how coronavirus is affecting their operations and long-term financial outlook with patient visits and revenue from those visits dropping precipitously. (For more detail on the data underlying this Data Note, see the text box at the end of the brief.)

COVID-19 Testing at Health Centers

Nine out of ten (90%) health centers are providing COVID-19 tests, and in 16 states and DC, all health centers are providing tests. Of those that provide testing, the majority (67%) offer walk-up or drive-through testing as of May 8, which can expand access to testing. In the week preceding May 8, health centers reported providing 127,816 tests, with 36,155 patients (28%) testing positive, roughly double the national positive test rate of 13% (https://www.cdc.gov/coronavirus/2019-ncov/covid-data/pdf/covidview-05-08-2020.pdf) during a similar period.

People of color represented more than half of all people tested (57%) and confirmed cases (56%) at health centers. Among all individuals receiving tests, 24% were White and 57% were among people of color, including 32% who were Hispanic and 16% who were Black (Table 1). Race/ethnicity was unknown for about 1 in 5 tests (19%) and 1 in 4 confirmed cases (24%). Hispanics made up a higher share of positive tests, compared to their share of total tested patients (42% vs. 32%), while White patients made up a slightly lower share of positive tests compared to their share of total tested

patients (19% vs. 24%). The ability of health centers to report testing data by race/ethnicity is important for broader efforts to ensure access to COVID-19 testing for people of color and to address disparities that existed prior to COVID-19 and may be widening due to the pandemic.

Table 1: Share of COVID-19 Tests and Confirmed Cases at Health Centers by Race and Ethnicity, Week Ending May 8, 2020

Race/Ethnicity	Percent of Tests	Percent of Positive Tests
White	23.7%	19.5%
Hispanic	32.2%	42.5%
Black	15.8%	7.0%
Asian	1.9%	1.1%
American Indian/Alaska Native	1.1%	0.3%
Native Hawaiian/Other Pacific Islander	0.4%	0.4%
More than One Race	5.9%	4.8%
Unknown Race/Ethnicity	19.0%	24.4%
Total	**100%**	**100%**

NOTES: Persons of Hispanic origin may be of any race. For this analysis, Hispanic patients include those who report Hispanic ethnicity and White, Black, or unknown race. Patients classified as White or Black are non-Hispanic. Other racial categories include both Hispanic and non-Hispanic individuals.
SOURCES: HRSA. Health Center COVID-19 Survey. Latest data for the week ending May 8, 2020.

Effects of Coronavirus on Health Center Operations

Despite ramping up testing and virtual visits, health centers are reporting steep declines in patient visits and many staff who are unable to work. Health center organizations reported a 43% drop in the number of patient visits compared to before the pandemic, as many people across the country are avoiding non-essential trips to health care providers. The drop in visits comes even after health centers have been increasing the number of telehealth visits, with health centers conducting roughly half (51%) of visits virtually or over the phone. Additionally, health centers report that 11% of staff are not working due to exposure to the coronavirus, lack of protective equipment, site closures, or family obligations, among other reasons.

There have been 1,954 temporary health center site closures due to repercussions from the coronavirus as of May 8. Most health centers operate multiple service delivery sites – in 2018, 1,362 health centers operated 11,744 sites (https://www.kff.org/other/state-indicator/community-health-center-sites-and-visits/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D). The number of temporary site closures likely undercounts total closures, given that more than a quarter of health centers did not respond to the survey and are not included in the total. The survey data also do not provide details on the types of sites that have closed, such as whether the closed sites are brick-and-mortar, mobile vans, or school-based clinics. Still, site closures are occurring in states hard hit by the virus as well as in states less affected. Connecticut, close to the epicenter of the pandemic in the US, has seen nearly three-quarters (73%) of its sites closed, while Kentucky and Mississippi, which had fewer cases, have each seen 49% of sites closed. At least one-third of sites have closed in Nebraska (48%), Kansas (36%), West Virginia (36%), and Michigan (33%).

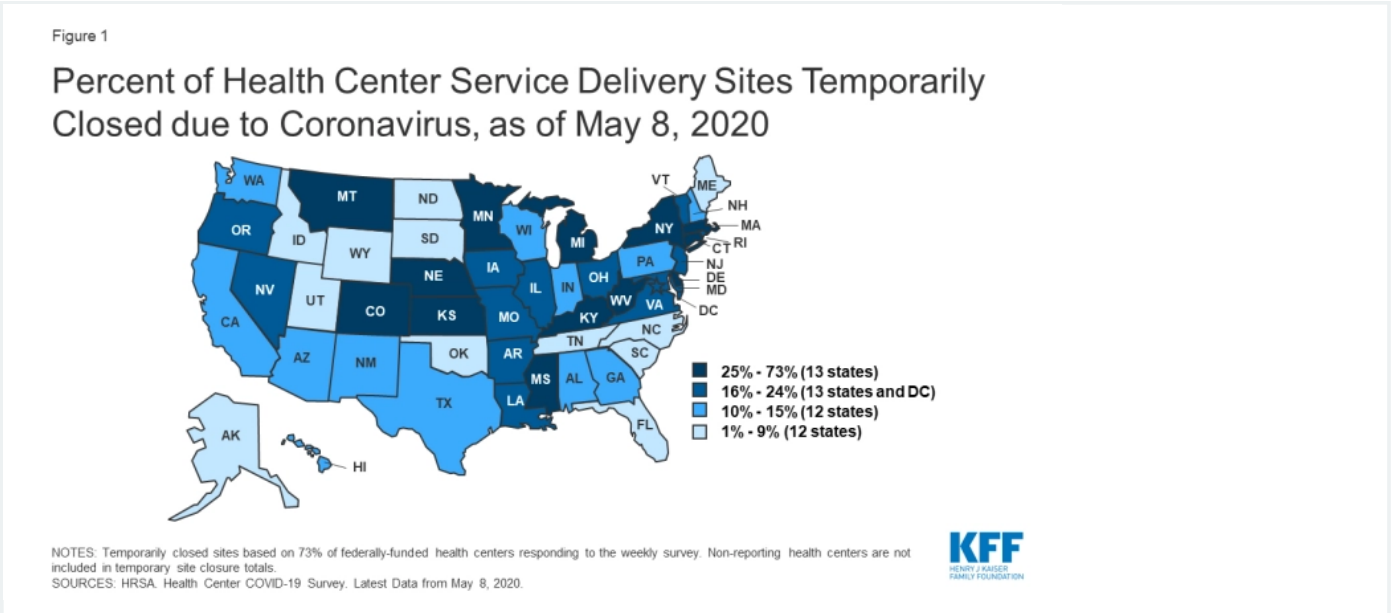


Figure 1: Percent of Health Center Service Delivery Sites Temporarily Closed due to Coronavirus, as of May 8, 2020

Financial Challenges

Health centers have received $1.98 billion in rapid response grants from the federal government, though more financial support may be needed to sustain services. These grants include $100 million in emergency grant funding and $1.3 billion through the Coronavirus Aid, Relief and Economic Security Act (CARES) that can be used to support response efforts, including buying testing materials and personal protective equipment (PPE), as well as to maintain or increase health center capacity generally. In early May, health centers received $583 million in grants to support COVID-19 testing capacity through the Paycheck Protection Program and Health Care Enhancement Act. All federally-funded health centers received each of these grants through an expedited awards process based on the size of the health center patient population and the number of uninsured patients reported to the Uniform Data System (https://bphc.hrsa.gov/uds/datacenter.aspx?q=d). While this funding is significant in aiding the coronavirus response, the combined $1.98 billion in additional appropriations represents just 7% of total health center revenues in 2018 (the most recent year of data available). Although data on the impact of the pandemic on overall health center finances are not available, the majority of health center revenues (68%) come from patient visits (https://bphc.hrsa.gov/uds/datacenter.aspx?q=t9d&year=2018&state=&fd=), and the drop in those visits could be contributing to a roughly 30% decrease in health center revenues. Adding to the uncertainty for health centers' finances is the Community Health Center Fund (CHCF), an important source of federal funding representing $4 billion of the $5.6 billion appropriated to health centers in FY 2019. The CHCF has been extended through November – though it has not been reauthorized longer term as of mid-May 2020.

The effects of patient declines and staffing issues could have major implications for health centers even after the pandemic. Leading up to the pandemic, the two most commonly cited challenges (https://www.kff.org/medicaid/issue-brief/community-health-centers-in-a-time-of-change-results-from-an-annual-survey/) for health centers were financial and workforce issues, both of which have been exacerbated by the economic effects of the coronavirus. The precipitous drop in patient volume has likely led to steep declines in patient care revenue that may contribute to future financial instability.

Depending on how long the crisis lasts, some of the temporary site closures and staff reductions could become permanent, further exacerbating long-standing health care access issues in communities served by health centers.

Conclusion

Health centers will continue to play an important role in responding to the coronavirus pandemic and in providing access to care for communities disproportionately affected by COVID-19, especially as job losses mount and the number of people who are uninsured or covered by Medicaid rises. However, key findings from the HRSA survey highlight the significant operational challenges health centers are facing, which threaten their longer-term financial viability. While the emergency federal funding provided so far has aided health centers' coronavirus response, secure future funding will also be important to maintain the long-term viability of the primary care safety net after the pandemic is over.

About the Health Center COVID-19 Data

In April 2020, HRSA began a weekly, rapid-response survey of all federally-funded health centers to track the impact of the coronavirus on health centers and identify needs for training, technical assistance, funding, and other resources. The survey instrument (https://bphc.hrsa.gov/emergency-response/covid-19-survey-tools-questions) asks health centers to report on experiences from the previous week. All findings are reported at the health center organization level, although most health center organizations operate multiple clinic sites. Unless otherwise specified, all results discussed in this Data Note report findings at the health center organization (versus site) level. HRSA reports findings from the data as unweighted totals and percentages that do not account for non-responding health centers. The most recent survey data in this report is based on responses from the week ending May 8, 2020, with 1,011 (73%) federally-funded health centers responding to the survey.

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Exhibit D

Options to Support Medicaid Providers in Response to COVID-19

MaryBeth Musumeci (https://www.kff.org/person/marybeth-musumeci/) (https://twitter.com/mmusumec) ,

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Elizabeth Hinton (https://www.kff.org/person/elizabeth-hinton/) ,

Rachel Dolan (https://www.kff.org/person/rachel-dolan/) (https://twitter.com/_rachel_dolan) , and

Olivia Pham (https://www.kff.org/person/olivia-pham/)

Published: Jun 17, 2020

As with other payers, the coronavirus pandemic has resulted in financial strain for Medicaid providers. Some providers are dealing with both increased utilization and costs related to testing and treatment of COVID-19, while others are facing substantial losses in revenue as utilization has declined for non-urgent care. Medicaid providers include those that serve a high share of Medicaid enrollees and/or deliver services primarily financed by Medicaid, such as behavioral health or long-term care. These providers may face disproportionate risks to their continued financial viability as they may already have lower reimbursement levels relative to costs and lower operating margins. Within broad federal rules, states determine how Medicaid services are delivered and set reimbursement rates (or capitation payments for managed care).

In light of the pandemic, CMS has provided some guidance about options under current Medicaid rules that states can use to provide financial support for some providers. In addition, Congress has authorized $175 billion in new provider relief grants in the Coronavirus Aid, Relief, and Economic Security (CARES) Act and the Paycheck Protection Program and Health Care Enhancement Act to help bolster providers; however, the Administration's plans to allocate those funds may not adequately address issues for providers that serve a disproportionate share of Medicaid enrollees. This brief provides an overview of how states currently reimburse providers and the challenges for Medicaid providers that have emerged from the pandemic and state budget issues. It presents new data on state actions to date to help bolster Medicaid providers dealing with the effects of COVID-19 and discusses support available for Medicaid providers from the federal provider relief fund.

What Challenges are Providers Facing Due to COVID-19?

Many Medicaid providers (https://medicaiddirectors.org/wp-content/uploads/2020/05/Azar-Letter_Final-5-8-2020.pdf) **may be under fiscal strain as a result of the pandemic.** Some providers are dealing with both increased utilization and costs related to testing and treatment of COVID-19, while others are facing substantial losses in revenue as utilization has declined for non-urgent care. For providers in states that rely heavily on managed care, states have made payments to the plans, but those funds may not be flowing to providers where utilization has decreased.

Medicaid providers may have been more fiscally vulnerable prior to the pandemic. Community health centers are a key source of primary care, and safety-net hospitals, including public hospitals and academic medical centers, provide a lot of emergency and inpatient hospital care for Medicaid enrollees. Safety-net hospitals and clinics as well as other providers that rely on Medicaid funding, including behavioral health providers, substance use disorder treatment providers, home and community-based service providers, children's hospitals, pediatricians, and maternal health providers, may operate with lower operating margins and are vulnerable to fiscal stress from the pandemic. For example, recent data show that significant numbers of community health centers are closing (https://www.kff.org/coronavirus-covid-19/issue-brief/impact-of-coronavirus-on-community-health-centers/), and federal fiscal relief from the Coronavirus Aid, Relief and Economic Security Act (CARES) and Paycheck Protection Program and Health Care Enhancement Act may not be sufficient to address financial and workforce issues that have been exacerbated by the pandemic.

How Does Medicaid Reimburse Providers Now?

Within broad federal rules, states have considerable flexibility in how they deliver and pay for services for Medicaid enrollees. States have latitude to determine provider payments so long as the payments are consistent with efficiency, economy, quality and access and safeguard against unnecessary utilization. Within these broad guidelines, provider payments must be sufficient to ensure Medicaid beneficiaries with access to care that is equal to others in the same geographic area. Over the years, beneficiaries and providers used this legal requirement, known as the "equal access provision (https://healthlaw.org/proposed-hhs-rules-will-reduce-access-to-medicaid-services/)," to ensure that states use Medicaid provider payment rate setting methodologies that provide equal access. In 2015, however, the Supreme Court ruled in *Armstrong v. Exceptional Child* (https://www.kff.org/medicaid/issue-brief/explaining-armstrong-v-exceptional-child-center-the-supreme-court-considers-private-enforcement-of-the-medicaid-act/) that providers could not bring lawsuits to enforce the equal access provision in federal court. Following the case, HHS issued regulations requiring states to measure access in fee-for-service delivery systems. Under the Trump Administration, HHS has proposed (https://www.federalregister.gov/documents/2019/07/15/2019-14943/medicaid-program-methods-for-assuring-access-to-covered-medicaid-services-rescission) to rescind the regulations that require states to document access to care and service payment rates and include input from Medicaid providers, beneficiaries, and other stakeholders about the impact on access to care when proposing to reduce or restructure payment rates. That proposal is still pending at CMS.

Under current law, states can pay certain types of fee-for-service providers up to what Medicare would have paid in aggregate across the type and class of provider. States often use these upper payment limit (UPL) arrangements to direct supplemental payments to certain Medicaid providers to offer additional financial support. The use of UPL arrangements was under intense scrutiny at CMS prior to the pandemic, and the future of some of these arrangements is in question depending on the fate of the proposed Medicaid Fiscal Accountability Rule (MFAR) (https://www.kff.org/medicaid/issue-brief/what-you-need-to-know-about-the-medicaid-fiscal-accountability-rule-mfar/) that is pending at CMS. If finalized as proposed, that rule would limit states' ability to use supplemental payments and restrict what funds states can use for their state share of Medicaid spending. MFAR could affect existing Medicaid financing arrangements in most states, and there were over 4,000 comments on the proposed rule. The Health and Economic Recovery Omnibus Emergency Solutions Act (HEROES Act) (https://www.congress.gov/bill/116th-congress/house-bill/6800/actions?KWICView=false) passed by the House on May 15, prohibits the Secretary from taking any action to finalize or implement the proposed rule through the end of the public health emergency; that bill has not been taken up by the Senate to date.

Payments to Medicaid managed care organizations (MCOs) must be actuarially sound. Actuarial soundness (https://www.law.cornell.edu/cfr/text/42/438.4) means that "the capitation rates are projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the managed care plan for the time period and the population covered under the terms of the contract." Unlike fee-for-service, capitation provides upfront fixed payments to plans for expected utilization of covered services, administrative costs, and profit. States generally pay the plans a capitation payment, but then the plans determine how to pay the providers in their network. Information is limited regarding the rates paid by plans to providers in managed care.

Under current MCO rules, states are prohibited from directing how a managed care plan pays its providers except for certain payment methodologies that have been approved and reviewed by CMS. States may require MCOs to adopt minimum or maximum provider payment fee schedules or provide uniform dollar or percentage increases for network providers that provide a particular service under the contract, as approved by CMS. States also can seek CMS approval to require MCOs to implement value-based purchasing models for provider reimbursement (e.g., pay for performance, bundled payments) or participate in multi-payer or Medicaid-specific delivery system reform or performance improvement initiatives. State directed payments must be based on utilization and delivery of services covered under the managed care plan contract. The proposed MCO rule (https://www.kff.org/report-section/cmss-2018-proposed-medicaid-managed-care-rule-a-summary-of-major-provisions-issue-brief-9271/) pending at CMS would make some changes to minimum fee schedule arrangements for directed payments. The 2016 final rule phases out state supplemental pass-through provider payments in the capitation rates paid to managed care plans because these payments are not tied to the provision of services covered under plan contracts and therefore conflict with the actuarial soundness requirement. Specifically, the 2016 rule phases out pass-through payments to hospitals from 2017- 2027, and to physicians and nursing facilities from 2017-2022. The proposed rule (https://files.kff.org/attachment/Issue-Brief-CMSs-2018-Proposed-Medicaid-Managed-Care-Rule-A-Summary-of-Major-Provisions) would allow states to make new supplemental provider pass-through payments during a time-limited period when states are transitioning populations or services from fee-for-service to managed care.

What Are State Options Under Current Medicaid Rules to Support Providers?

To address current fiscal challenges faced by providers, states have various options to support providers directly or by directing plans to do so. CMS has described some of these options in its COVID-19 frequently asked questions (https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf) and an informational bulletin (https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/cib051420.pdf) on Medicaid managed care options for responding to COVID-19.

State Options to Financially Support Providers

COVID-Related Rate Increases and Payment Methodology Adjustments. States can increase provider rates to account for increased costs or decreased service utilization as a result of the public health emergency. For example, states could increase payments to providers that are seeing an influx of Medicaid patients due to the emergency, incurring additional costs related to COVID-19 like personal protective equipment (PPE) or additional staff, or experiencing decreased utilization but an increased cost per unit due to allocation of fixed costs or increase in patient acuity. States also could increase payments for services delivered via telehealth. Payment increases can be in the form of dollar or percentage increases in base payment rates or fee schedule amounts, rate add-ons, or supplemental payments. Depending on the Medicaid authority that states are using for the covered service, states

are using Home and Community Based Services Waiver (HCBS) Appendix K, Disaster-Relief State Plan Amendments (SPAs) and Section 1115 demonstration waivers to adopt COVID-related rate increases for providers.

Payment Increases through Upper Payment Limit (UPL) Adjustments. States may be able to make adjustments within the bounds of the UPL ceiling to direct supplemental payments to providers during the emergency or potentially make changes to UPL demonstrations already submitted to CMS to support UPL estimates for the fiscal year. With regard to proposed increases to nursing facility rates, CMS guidance (https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf) related to UPL demonstrations recognizes that states can use either a cost-based approach or a payment-based approach to comply with the UPL ceiling. Under a cost-based approach, an increase in nursing facility costs due to the emergency can be accounted for in the UPL ceiling. Under a payment-based approach, states can adjust the UPL ceiling to the extent that Medicare payment equivalents have increased. CMS guidance says that it will work with states if they are concerned about UPL calculations, but the guidance also notes that states cannot use Medicaid Disaster Relief SPAs to waive applicable UPLs, and payments still must meet all applicable legal requirements.

Advance and Interim Payments. CMS has said in recent guidance (https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf) that under state plan authority, states can make periodic interim advance payments to providers to help providers remain viable during the emergency so that they are available when the emergency period is over. The interim payment methodology must describe how states will compute interim payment amounts for providers (e.g., based on the provider's prior claims payment experience), and subsequently reconcile the interim payments with final payments for which providers are eligible based on billed claims. CMS has said that it will consider such requests on an expedited basis.

Retainer Payments. States can request authority to make retainer payments to certain habilitation and personal care providers to maintain capacity during the emergency. Unlike interim payments, which are made before services are provided and subsequently reconciled so that providers are paid only for services actually rendered, retainer payments allow providers to continue to bill and be paid for certain services that are authorized in person-centered service plans to enable providers to maintain capacity when circumstances prevent enrollees from actually receiving those services. For example, during the current pandemic, enrollees may not be able to receive in-person services due to self-quarantine rules. Such retainer payments are limited to personal care or attendant service providers while the enrollee is hospitalized or absent from their home. CMS has permitted states to make retainer payments since 2000, in *Olmstead* guidance (https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/downloads/smd072500b.pdf), to equalize treatment of personal assistance services and nursing facility services, for which bed hold payments are permitted. In the *Olmstead* decision, the U.S. Supreme Court found that states have community integration obligations under the Americans with Disabilities Act. The 2000 guidance applies to personal assistance services provided through HCBS waivers, and CMS's Section 1115 COVID-19 demonstration waiver template allows states to request authority for retainer payments to habilitation and personal care providers such as adult day health centers that have closed due to social distancing orders and could go out of business and be unavailable to provide services after the pandemic. The National Association of Medicaid Directors has requested (https://medicaiddirectors.org/wp-content/uploads/2020/04/Letter-to-CMS-and-OMB-on-retainer-payments_4_6_20_FINAL.pdf) additional flexibility from CMS to enable states to make retainer payments to a broader set of providers using Section 1115 waiver authority.

Directed Payment Through MCOs. States can direct that managed care plans make payments to their network providers using methodologies approved by CMS to further state goals and priorities, including COVID-19 response. This strategy can address the scenario in which states are making capitation payments to plans, but providers are not receiving reimbursement from plans due to decreased service utilization while social distancing measures are in place and non-urgent services are suspended. For example, states could require plans to adopt a uniform temporary increase in per-service provider payment amounts for services covered under the managed care contract, or states could combine different state directed payments to temporarily increase provider payments, according to recent CMS guidance (https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/cib051420.pdf).

CMS explains that state directed increased payments for actual utilization of services can preserve the availability of covered services for enrollees during a time when providers may be experiencing dramatic utilization declines or incurring additional costs due to the public health emergency. The guidance also says that states may use directed payments to address increased use of telehealth or other approaches to maintain access to care for all enrollees or specific subgroups with specialized needs during the emergency. States can direct payments to a class of providers, such as dental, behavioral health, home health and personal care, pediatric, federally-qualified health centers, or safety-net hospitals, to support providers that may serve a high proportion of Medicaid enrollees and may be disproportionately affected by the public health emergency. Directed payments must be appropriate and reasonable compared to the total payments the provider would have received in the absence of the public health emergency. For states that have approved directed payment proposals, CMS guidance says that states wishing to make changes to such arrangements in light of COVID-19 can submit an amended directed payment preprint and/or contract and rate certification amendments to CMS.

Section 1115 Waiver Disaster Relief Funds. In prior emergencies, states have used Section 1115 waivers to create disaster relief funds to support Medicaid providers experiencing high levels of uncompensated care or fiscal instability. For example, disaster waivers approved in response to Hurricane Katrina (https://www.kff.org/medicaid/fact-sheet/a-comparison-of-the-seventeen-approved-katrina/) included uncompensated care funds for affected states. During the COVID-19 emergency, CMS told Washington (https://www.kff.org/coronavirus-covid-19/issue-brief/what-does-cms-approval-of-first-covid-19-section-1115-waiver-in-washington-mean-for-other-states/) that it would continue to review the state's request to use Section 1115 authority to create a Disaster Relief Fund to cover costs associated with the treatment of uninsured individuals with COVID-19, housing, nutrition supports and other COVID related expenditures. During state stakeholder calls (https://www.cms.gov/files/zip/covid19allstatecall04032020.zip), CMS has said it will consider other available federal funds before approving state requests for Section 1115 authority for certain activities. For example, CMS pointed to relief funds available through CARES as rationale for not approving Washington's request to cover treatment costs for the uninsured through Medicaid. However, the amount and allocation of those funds is still a question.

State Adoption of Provider Payment Policies During COVID-19

States have taken a number of actions (https://www.kff.org/medicaid/issue-brief/medicaid-emergency-authority-tracker-approved-state-actions-to-address-covid-19/) to provide support to Medicaid providers in response to COVID-19 through Disaster-Relief State Plan Amendments (SPAs) and other administrative authorities, HCBS waiver Appendix K, and Section 1115 demonstration waivers. The Disaster-Relief SPA allows states to make temporary changes to their Medicaid state plans to address access and coverage issues during the COVID-19 emergency. States can also make changes through traditional SPAs (though no state to date has changed provider payment policies in response to COVID-19 using a traditional SPA)

and can implement other changes under existing administrative authority that do not require SPA approval. Most Medicaid home and community-based services (HCBS) are provided through Section 1915 (c) waivers. Other states use Section 1115 to authorize HCBS that could have been provided under Section 1915 (c). States can use Section 1915 (c) waiver Appendix K to amend either of these HCBS waivers **t**o respond to an emergency. CMS also developed a COVID-19 Section 1115 demonstration waiver template that identifies options for states to address the pandemic. The section below highlights the most common actions that states are taking regarding provider payment under these authorities (Figure 1).

Figure 1: State Emergency Actions to Provide Support to Medicaid Providers as of June 11, 2020

The most common policy adopted by states to support providers across service type and authority is increasing payment rates. As of June 11, 2020, twenty-five states have taken action to increase provider payment rates for state plan services through Disaster-Relief SPA or other administrative authority, 29 states have done so for HCBS waiver services using Appendix K, and one state is using a Section 1115 waiver to increase rates for HCBS.

States adopting temporary provider payment rate increases for state plan services using Disaster-Relief SPA or other administrative authority are most frequently targeting nursing facility services. Some states limit the additional payments to nursing facilities or patients with a COVID-19 diagnosis, while others apply them to all nursing facilities to account for increased costs related to staffing, equipment and cleaning as a result of the emergency. For example, some states are increasing facility per diem payments by a flat dollar amount or percentage (AL, CA, CO, KS, KY, LA, MT, NC, NM, OH, SC, WA, VA). Alabama also is providing an additional add-on cleaning fee. Arkansas adopted temporary supplemental payments that increase weekly pay of direct care workers in nursing facilities, intermediate care facilities, and psychiatric treatment centers; the payments include a base supplemental payment according to number of hours worked and an additional tiered acuity payment for those working in facilities with COVID-19 positive patients. Michigan is providing a $5,000 per bed supplemental payment in the first month for COVID-19 regional hub nursing facilities to address immediate infrastructure and staffing needs and a $200 per diem rate increase in subsequent months to account for the higher costs of caring for COVID-19 patients. Four states (CO, IL, MT, WV) are increasing payment rates for other institutional settings, such as ICF/IDDs, in light of COVID-19, using Disaster-Relief SPA or other administrative authority.

A couple of states have adopted temporary payment rate increases that apply to a range of providers. In March, Arizona (https://www.azleg.gov/legtext/54leg/2R/laws/0046.pdf) passed legislation to increase payment rates for Medicaid physicians and dental providers, funded through a hospital assessment. Massachusetts (https://www.mass.gov/news/baker-polito-administration-announces-increased-resources-for-health-care-providers-expanded) has set up an $800 million dollar fund for Medicaid providers impacted by COVID-19, including hospitals, nursing facilities, physicians, community health centers, HCBS, and community behavioral health providers. For example, as part of this initiative, Massachusetts is increasing hospital rates by 20% for COVID-19 care and 7.5% for other hospital care. In addition, Tennessee is seeking (https://www.tn.gov/content/dam/tn/tenncare/documents/CMHCSUDMemo.pdf) federal approval to distribute $5 million in targeted payments to behavioral health providers to preserve the community mental health and substance use disorder provider network for Medicaid beneficiaries.

Among the 29 states using Appendix K to temporarily increase provider payment rates for HCBS waiver services, the types of services commonly targeted for increases are residential habilitation, home health, respite, personal care, and nursing. Five of these states (KY, LA, NE, WA, WY) have broad approval to increase rates for any services in some or all of their HCBS waivers, up to a cap; the approved caps range from 15% to 50% of current rates. Some states are increasing HCBS payment rates only or particularly in case where waiver enrollees are COVID-19 positive; an example is Wyoming. In addition, six states (AK, AR, DC, MI, NC, OK) have increased payments for state plan HCBS using Disaster-Relief SPA authority, and Washington has done so using Section 1115 demonstration waiver authority. State plan HCBS rate increases include targeted case management (AK), day habilitation (AR), skilled and/or private duty nursing (DC, OK), and home health and adult care homes (NC). Arkansas's temporary supplemental payments for direct care workers in nursing facilities, described above, also apply to direct care workers in assisted living facilities and those providing home health and personal care services in the community. Michigan is adding a supplemental payment for providers of personal care and behavioral health treatment technician in-person services. Washington's Section 1115 demonstration waiver allows the state to increase rates for Community First Choice attendant care services by up to 50 percent to maintain provider capacity during the public health emergency.

Many states are adopting retainer payments for HCBS (the only services for which they are available). Thirty-seven states have established retainer payments through Appendix K to support HCBS waiver service providers and address emergency-related issues. Two states (WA and NH) have an approved Section 1115 waiver that authorizes retainer payments for personal care and habilitation services provided under state plan authority. Vermont (https://dvha.vermont.gov/sites/dvha/files/documents/News/COVID-19%20Sustained%20Monthly%20Retainer%20Payments%20Cover%20Letter%20and%20Process%20DVHA%20FINAL.pdf) is only state providing temporary retainer payments to a broader set of Medicaid providers through existing authority to set provider payments under its Section 1115 waver. Vermont has a unique managed care-like delivery system in which the state Medicaid agency contracts with another state entity that operates as a non-risk prepaid health inpatient plan. Vermont's temporary payment model gives providers the option to combine fee-for-service reimbursement with prospective monthly payments that are intended to reimburse providers for the difference between their long-term average monthly Medicaid fee-for-service revenues and the actual amount of Medicaid fee-for-service claims payments issued to them for services they continue to provide. After the state of emergency ends, up to 10% of prospective payments may be subject to recoupment based on the provider's performance on access to care and financial impact metrics, except that providers that have been ordered to close as a result of the emergency and cannot provide remote services will not be subject to recoupment.

Few states are using interim or advance payments to support providers. Five states (AZ, CA, GA, NC, OK) have received approval through a Disaster-Relief SPA to make interim payments to providers. In North Carolina, any Medicaid-enrolled provider may request that their reimbursement be converted to an interim payment methodology. Arizona is providing interim payments to Medicaid-enrolled hospitals, while Oklahoma is providing interim payments to rural/ independent Medicaid-enrolled hospitals. Georgia is making interim payments to skilled nursing facilities. California is providing interim payments for non-narcotic treatment program and specialty metal health services.

A small number of states are using directed payments through MCOs or are working with MCOs to increase funding to providers during the emergency. Arizona (https://www.azleg.gov/legtext/54leg/2R/laws/0046.pdf)'s March legislation includes directed payments to hospitals, funded through a hospital assessment. New Hampshire (https://homecarenh.org/wp-

content/uploads/2020/05/Directed-payments-FAQ_20200513vF-1.pdf) directed its MCOs to provide temporary add-on payments to safety net providers including federally qualified health centers, rural health centers, critical access hospitals, and providers of residential substance use disorder treatment, home health, personal care, and private duty nursing services. Tennessee (https://www.tn.gov/content/dam/tn/tenncare/documents/CHOICESAndECFCHOICESCOVIDRelatedPayments.pdf) has adopted temporary payment rate increases for community-based residential, personal care, attendant care, personal assistance and intensive behavioral treatment stabilization and treatment services and a temporary per diem add-on to community-based residential and personal care payment rates to account for direct support staff hazard pay, overtime, and PPE costs using its existing directed payment authority; these services are provided under a Section 1115 HCBS waiver. Washington (https://www.hca.wa.gov/assets/billers-and-providers/integrated-managed-care-BH-providers-COVID-19.pdf) is identifying behavioral health providers at financial risk and directing its MCOs to reach out and offer support, such as advance payments, adjustments to capitated contracts, or other relief on a case-by-case basis, such as release of provider enhancement funds or budget-based contracts. Colorado (https://www.colorado.gov/pacific/sites/default/files/Alternative%20Funding%20for%20CMHC%20During%20COVID-19%20State%20of%20Emergency%20Fact%20Sheet%204-3-2020.pdf) is encouraging its managed care entities to use alternative funding strategies to support community mental health centers, such as sub-capitated arrangements. Rhode Island (http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/11152nd%201115%20Waiver_3.27.20%20for%20web.pdf) is seeking Section 1115 approval to make pass-through payments to MCOs during the public health emergency to effectuate rate increases to hospitals and HCBS providers and retainer payments to personal care, habilitation, rehabilitation, and adult day HCBS providers, to the extent those payments are approved by CMS.

A limited number of states are using nursing facility bed hold increases and other payment methodology adjustments. Seven states have received approval through a Disaster-Relief SPA to increase the number of days they will provide payment to nursing facilities to reserve the bed of a beneficiary that is hospitalized or otherwise temporarily absent. Three states (HI, KY, OH) have received SPA approval to increase the number of nursing facility bed hold days, and three states (LA, OK, PA) have received approval to increase the number of therapeutic leave days. Utah is increasing both bed hold and therapeutic leave days. Two states are making other payment methodology changes in response to COVID-19. Kentucky has received approval through a Disaster-Relief SPA to temporarily avoid applying per diem rate sanctions to nursing facilities that are unable to meet medical record review thresholds to validate assignment of patients to reimbursement groups based on acuity during the public health emergency. To aid drive-through testing facilities, Washington received approval through a Disaster-Relief SPA to unbundle payments and instead set a flat rate for the handling and/or conveyance of specimens for transfer from the patient (other than in an office) to a laboratory.

How are Provider Relief Funds Supporting Medicaid Providers?

The Coronavirus Aid, Relief, and Economic Security (CARES) Act and the Paycheck Protection Program and Health Care Enhancement Act provide $175 billion in provider relief funds (https://www.kff.org/coronavirus-policy-watch/update-on-covid-19-funding-for-hospitals-and-other-providers/) to reimburse eligible health care providers for health care related expenses or lost revenues that are attributable to coronavirus. The funds are available to reimburse providers for health care related expenses or lost revenues that are attributable to coronavirus. Specifically, funds are available for building or constructing temporary structures, leasing properties, medical supplies & equipment including PPE and testing supplies, increased workforce and trainings, emergency operation centers, retrofitting facilities, and surge capacity.

To date, $112.4 billion of these funds have been allocated to specific sets of providers (https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/general-information/index.html)**.** The $112.4 billion consists of $50 billion that HHS allocated in April to Medicare fee-for-service providers based on each provider's share of total 2018 net patient revenue from all sources, plus $22 billion in two (https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/general-information/index.html) rounds (https://www.hhs.gov/about/news/2020/06/09/hhs-announces-enhanced-provider-portal-relief-fund-payments-for-safety-net-hospitals-medicaid-chip-providers.html) of funding to hospitals that treated a high number of COVID-19 patients; $10 billion to rural providers (including hospitals, health clinics, and health centers); $4.9 billion for skilled nursing facilities; $500 million to Indian Health Service programs; $10 billion to safety net hospitals; and $15 billion to Medicaid/CHIP providers who did not receive funds in the distribution to Medicare fee-for-service providers.

Prior to the new $15 billion allocation, there had been concern that Medicaid providers were disadvantaged in the funding distribution to date, both in the amount of funding received and delays in allocations. HHS estimates that about 62% of all Medicaid/CHIP participating providers (https://www.hhs.gov/about/news/2020/06/09/hhs-announces-enhanced-provider-portal-relief-fund-payments-for-safety-net-hospitals-medicaid-chip-providers.html) received funds as part of the $50B general allocation to Medicare fee-for-service providers based on net patient revenue from all sources distributed in April. An analysis (https://www.kff.org/coronavirus-covid-19/issue-brief/distribution-of-cares-act-funding-among-hospitals/) of those funds shows that the distribution disadvantaged providers less reliant on private insurance payments (and therefore likely more reliant on Medicaid)**.** This resulted because private insurance reimburses at a higher rate than public payers. Provider relief funds specifically allocated to Medicaid providers were not announced until June 2020 (https://www.hhs.gov/about/news/2020/06/09/hhs-announces-enhanced-provider-portal-relief-fund-payments-for-safety-net-hospitals-medicaid-chip-providers.html). HHS notes that some of the earlier targeted funding allocations, including base payments to rural health clinics and rural community health centers (https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/general-information/index.html#collapseNine), accounted for providers with no reported Medicare claims. To help allocate funds to Medicaid providers, CMS asked states to provide data on Medicaid provider revenues. Due to data reporting challenges, CMS instructed states (https://www.cms.gov/files/zip/covid19allstate05052020.zip) to not include data for self-directed direct care providers (HCBS) and PACE organizations, making it unclear whether those provider types were sufficiently reflected in the funding allocation.

HHS estimates that close to one million Medicaid/CHIP providers (https://www.hhs.gov/about/news/2020/06/09/hhs-announces-enhanced-provider-portal-relief-fund-payments-for-safety-net-hospitals-medicaid-chip-providers.html) **are eligible for grants from the new $15 billion allocation for those who did not receive funds in the distribution to Medicare fee-for-service providers.** According to HHS (https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/general-information/index.html), payments to each provider will be at least 2% of reported gross revenue from patient care. While this is the same level provided to Medicare fee-for-service providers in the April distribution, Medicaid providers may have more narrow operating margins than providers that rely more heavily on private insurance and Medicare so it is unclear if the allocation will be adequate. The final amount will be determined after providers submit data, including the number of Medicaid patients served. The submission deadline (https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/faqs/index.html#collapseMedicaidEleven) is July 20. HHS anticipates (https://www.hhs.gov/about/news/2020/06/09/hhs-announces-enhanced-provider-portal-relief-fund-payments-for-safety-net-hospitals-medicaid-chip-providers.html) that provider types potentially eligible for this funding include pediatricians, OB-GYNs, dentists, opioid treatment and behavioral health providers, assisted living facilities, and other HCBS providers. However, Medicaid providers who received any amount of

funding, no matter how small, from the April distribution to providers who participate in Medicare fee-for-service cannot receive additional funds from the new Medicaid provider allocation. This could disadvantage providers highly reliant upon Medicaid, such as community health centers (https://www.washingtonpost.com/news/powerpost/paloma/the-health-202/2020/06/12/the-health-202-medicaid-providers-had-to-wait-weeks-for-coronavirus-relief-dollars/5ee255c188e0fa32f82388f9/). Funding will be distributed directly to providers and will not flow through state Medicaid agencies.

The remaining $62.6 billion from the provider relief fund may not be sufficient for the other purposes identified by HHS, including paying for COVID-19 treatment costs for the uninsured and supporting other targeted provider groups affected by COVID-19. HHS has allocated (https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/general-information/index.html) an unspecified amount of the provider relief fund to reimburse providers for the cost of providing COVID-19 treatment to uninsured people at Medicare rates, until funding is exhausted. KFF has estimated (https://www.kff.org/coronavirus-covid-19/issue-brief/estimated-cost-of-treating-the-uninsured-hospitalized-with-covid-19/) that hospital costs alone could run between $13.9 billion to $41.8 billion – not taking into account costs incurred for services provided in other settings. The decision to use a portion of the limited pool of provider relief funds to cover COVID-19 treatment costs for the uninsured (instead of through new or expanded insurance coverage options) means that less funding will be available for other purposes identified by Congress and for direct support for Medicaid providers.

HHS's website (https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/index.html) refers to "future provider relief funding, and HHS has stated (https://www.hhs.gov/about/news/2020/06/09/hhs-announces-enhanced-provider-portal-relief-fund-payments-for-safety-net-hospitals-medicaid-chip-providers.html) that it is working on an additional allocation for dentists. It is unclear whether there will be further, separate allocations for other provider groups. The HEROES Act (https://www.congress.gov/bill/116th-congress/house-bill/6800/actions?KWICView=false) passed by the House would allocate additional money to the provider relief fund, specify a reimbursement formula that weights Medicaid reimbursement at 200% when determining net patient revenue, and require that not more than $10 billion of the provider relief fund be used to reimburse uncompensated care costs.

What is the Outlook?

While states have some have taken some action under existing Medicaid authority to help bolster providers using increased payment rates, retainer payments, interim payments, directed payments, and some other methods, these actions have been largely directed to nursing facilities and some targeted community based long-term services and supports providers. Fiscal relief provided through the CARES Act to temporarily increase the Medicaid match rate (https://www.kff.org/coronavirus-covid-19/issue-brief/key-questions-about-the-new-increase-in-federal-medicaid-matching-funds-for-covid-19/) by 6.2 percentage points may help states make such payment adjustments in the short term. However, as the economic crisis continues, more individuals are likely to enroll in Medicaid while state revenues are expected to decline significantly. States that had projections available in late April were already anticipating Medicaid budget shortfalls (https://www.kff.org/coronavirus-covid-19/issue-brief/early-look-at-medicaid-spending-and-enrollment-trends-amid-covid-19/) in the next fiscal year. In prior economic downturns, states have turned to provider rate cuts, so it may be difficult in the current economic realities for states to continue to maintain or increase provider rates. At the same time, Congress has enacted legislation with $175 billion in provider relief grants. While these grants were designed to serve many purposes, the initial allocation of funds was disadvantageous to Medicaid providers. HHS recently announced that $15 billion has been set aside to more directly support Medicaid providers, and an unspecified amount has been allocated to reimburse providers for COVID-19 treatment costs for the

uninsured. However, it is not clear if the current provider relief fund allocations will be sufficient to meet providers' needs resulting from the pandemic. Congress will likely continue to debate additional funding for states through Medicaid and for providers. Without additional fiscal relief, states may be limited in their ability to support Medicaid providers and provider relief grants may not be adequate.

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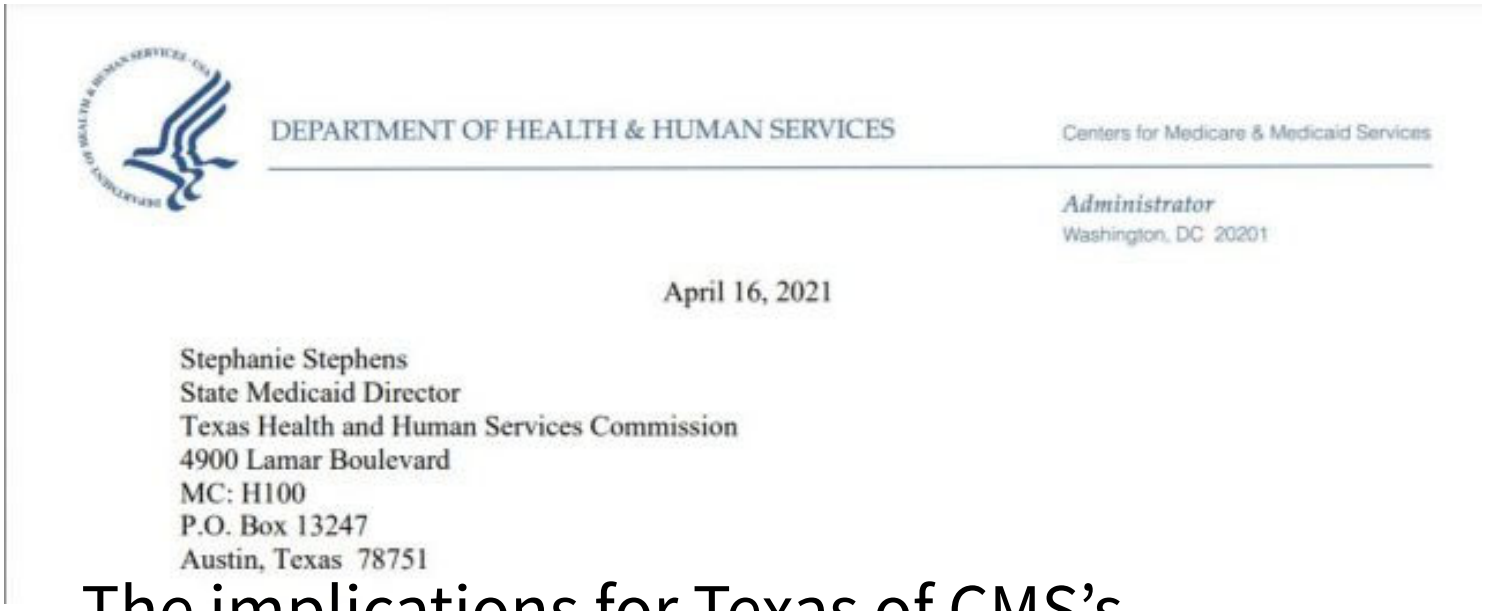
Exhibit E



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The implications for Texas of CMS's rescission of its Medicaid waiver extension

DJ Wilson | Apr 19, 2021

Last week's news that the Biden administration was rescinding the 1115 waiver extension the Trump administration had granted Texas was felt from California to Florida, and certainly throughout the Lone Star State.

Austin was buzzing with the implications for the state, a reality that only began to settle in on Monday as staff at the Texas Health and Human Services Commission (HHSC) were able to make sense of the 669-page transmission.

Here is an excerpt from the Centers for Medicare and Medicaid Services' (CMS) announcement on Friday:

> "While the Delivery System Reform Incentive Payment program is being phased out in September 2021, the waiver extension would have allowed the state to develop and implement directed-payment programs for Medicaid-managed care services to improve quality and access, stabilizing Texas' health care safety-net while providers are continuing to respond to the ongoing public health pandemic. Examples of new directed-payment programs would have included funding to hospitals, physicians, rural health clinics, and community behavioral health providers."

Yes, the waiver will remain in place through September 2022. But a primary element of the waiver that caused the greatest amount of concern for health care and health policy leaders is the Delivery System Reform Incentive Payment (DSRIP) program.

With CMS's action, that DSRIP program is set to sunset in less than six months at the end of September 2021.

When that program goes away, so will billions of dollars Texas has relied on in recent years to fund Medicaid services.

DSRIP funds support hospital reimbursement rates, support community and population health activities that support hospital ER diversion, and they help fund services that would otherwise be uncompensated care.

Put differently, without those funds, hospital rates will fall, ER use will increase and hospitals will receive fewer funds to support uncompensated care.

The Abbott administration has tried to extend the funding currently provided by DSRIP.

HHSC submitted a request for a $2.49 billion, 1-year extension of DSRIP on October 16, 2020. However, the Trump administration was not willing at that time to grant an extension.

In fact, it was the Trump administration that specifically required a "sunset" provision of the DSRIP funds with an expiration date a year prior to the expiration of the full waiver.

CMS's thinking, as conveyed by former HHSC officials, was to give Texas a "runway" to come up with a different option for funding uncompensated care and hospital reimbursement before coming back to CMS for a full waiver extension.

After President Trump's election loss, however, Texas applied for a full waiver extension on November 30, 2020, just shy of two years before the waiver was set to expire.

The extension request asked for a five-year extension of the existing waiver. According to a brief provided by Every Texan, a social justice non-profit and one of the organizations to write to CMS with a request that the waiver extension be rescinded, the extension didn't add many new components to Texas's Medicaid system. Texas did request an expansion of the "uncompensated care" pool of funds, and a new "Charity Care Pool" for public health providers.

This time, however, the Trump administration was more willing to provide support to Texas. It provided a 10-year approval period instead of the 5 years that Texas had requested. It also allowed Texas to use a "fast track" process for review. While the "fast track" process is a useful tool for many states in this predicament, according to Every Texan's brief, the rules for the process specifically exclude consideration of "Uncompensated Care pool extensions."

The Biden administration first put states like Texas on notice 8 days into the new administration that their waiver would be reviewed. In an Executive Order on Jan. 28, President Biden directed agencies to review "demonstrations and waivers under Medicaid and the ACA that may reduce coverage or undermine the programs, including work requirements…"

For some Texas hospitals, this might be too much to try to overcome.

According to the Texas Organization of Rural and Community Hospitals (TORCH), 26 Texas rural hospitals have closed since 2010, 37% of the nation's total. John Henderson is the CEO of the organization. In comments first provided to State of Reform in February 2020, Henderson said the elimination of DSRIP would put a majority of Texas rural and community hospitals out of business.

> "Forty-six percent of rural Texas hospitals have negative operating margins and you can't exist for long when you do that, so we're just trying to get them back to even."

On Monday, Henderson reiterated his point in a comment to State of Reform.

> "Losing billions of dollars in uncompensated care funding for Texas would be a disaster, particularly for small, rural hospitals who have negative margins even with these funds.'

Henderson noted that while DSRIP funds will expire on September 30, 2021, the remaining Uncompensated Care Program funding will remain until September 30, 2022.

Taken together, Texas policymakers now seem to have a set of politically difficult options with which to stabilize hospitals in the state.

Doing nothing is likely to eviscerate the Texas health care system starting in September. That's never good. It's even worse in a never-ending pandemic.

Going back to CMS with the same extension model is less likely to be successful now than it would have been with a Republican president. Moreover, the comments from stakeholders are not likely to be uniformly positive for the Abbott administration. Many stakeholders will simply call for Medicaid expansion.

It's not clear that Texas will get any new money by simply resubmitting its current waiver. In fact, federal rules generally require a budget neutrality reset in these considerations which specifically preclude new funds for existing service delivery models.

So, without a clear pathway to maintain Texas's hospital safety net, and with the clock ticking, the Legislature is likely to be forced to come up with a near-term budget appropriation to make it through until a new waiver can be negotiated.

This means the Legislature will need to figure out how to spend more state funds on Medicaid to keep providers afloat. This is where things get even more difficult.

Generally speaking, the federal matching contribution (FMAP) can only go to costs that are actuarially sound. Moreover, once a benefit is added, it is often very difficult to remove the benefit, depending on what benefit is added (required versus optional).

What this means is that the easiest way to make up a big shortfall is for Texas to cover all of the costs to uphold these new benefits. California often does something similar, paying for services out of general fund dollars without any positive FMAP contribution.

However, that is the most expensive option. And, for a state like Texas that has consistently relied upon federal dollars to offset state investment, that's an unlikely scenario.

That leaves one other option — have the feds pay for almost all of the shortfall in uncompensated care the way 38 other states do: expand the Medicaid program to draw down over 90% of the cost from the feds.

That is not politically palatable among Republican legislators, either.

But those are the three primary options on the table:

1. Let the safety net collapse
2. Fund shortfalls with primarily state-only funds
3. Fund shortfalls with primarily federal-only funds (ie: expand Medicaid)

There are 47 days left in the Texas legislative session. Get your popcorn.

Exhibit F

HEALTH AFFAIRS BLOG

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The COVID-19 Pandemic And Rural Hospitals—Adding Insult To Injury

Adrian Diaz, Karan R. Chhabra, John W. Scott

MAY 3, 2020 **DOI:** 10.1377/hblog20200429.583513

As the COVID-19 outbreak continues to tax hospitals throughout the country, there is a growing concern that many hospitals, in particular rural hospitals, may not have the reserve to remain fiscally viable. Because most rural hospitals operate on razor thin

margins, high margin services such as elective surgery keep them afloat. For many rural hospitals, canceling these profitable services to cope with the outbreak may be the tipping point for financial catastrophe. As Congress puts together economic relief plans, little is known about how this relief will aid rural hospitals and their workforce—if at all.

Rural Hospitals Already Financially Strained

Since 2010, at least 128 rural hospitals have closed, with at least an additional 450 (21 percent of rural hospitals) found to be financially unstable. In total, more than 21,500 beds are in jeopardy.

Both the Centers for Medicare and Medicaid Services (CMS) and the American College of Surgeons have advised that elective surgeries and non-essential medical and surgical procedures should be delayed during the COVID-19 outbreak. While hospitals are canceling profitable elective surgeries to make way for costly patients with COVID-19, they also have higher staffing and supply costs with no way to predict reimbursement. Putting off high-margin surgery is one of many important strategies to contain the spread of SARS-COV-2, the virus that causes COVID-19, but will undoubtedly shrink an important revenue source for hospitals.

For rural hospitals, COVID-19 will likely add insult to injury. The effect of the pandemic on acute hospital admissions for non-infected patients remains unknown. However, even if providers choose not to cancel elective care, patients are apprehensive to seek non-urgent, non-COVID related care due to social distancing and concerns of contracting SARS-COV-2.

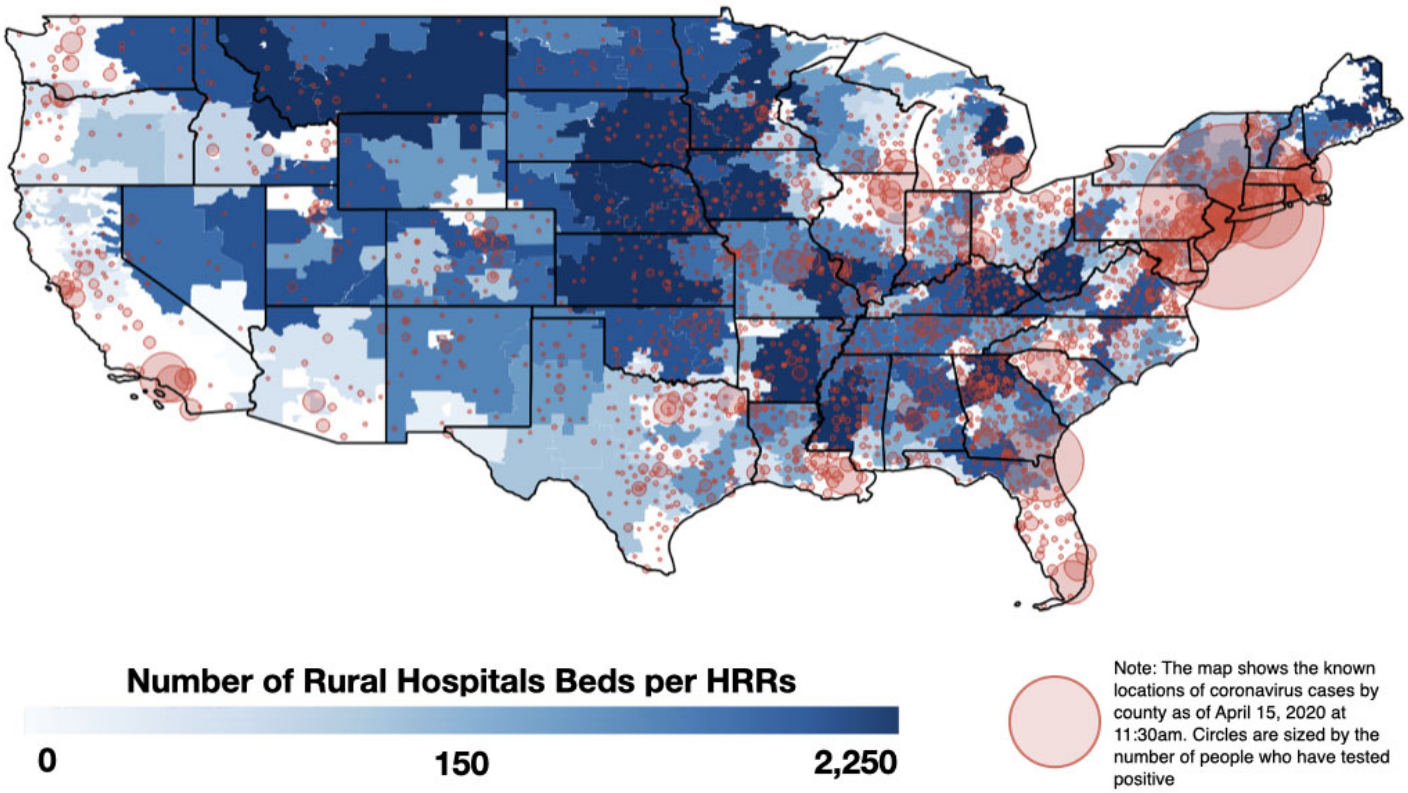
Furthermore, rural hospitals are already facing dwindling occupancy rates with an average occupancy of 52 percent in 2016, well below the healthy benchmark level of 75 percent. Whether rural hospitals will feel the influx of patients with COVID-19 remains unknown at the moment as most communities served by rural hospitals have been largely spared (exhibit 1). However, should the pandemic reach rural communities, many rural hospitals are not as equipped as larger hospital systems to handle large numbers of serious coronavirus cases. That means they may either have to transfer those patients to larger hospitals or make use of unconventional care models.

“If we’re not able to address the short-term cash needs of rural hospitals, we’re going to see hundreds of rural hospitals close before this crisis ends,” cautioned Alan Morgan, the head of the National Rural Health Association.

But, Rural Hospital Capacity Is Crucial To Fighting The Outbreak

Dwindling occupancy rates may prove to be an opportunity for rural hospitals to help decant patients from hospitals overwhelmed from the influx of patients with COVID-19. In an analysis by the Harvard Global Health Institute, rural areas have significant slack in the system, allowing them to handle an influx of non-infected patients. Our own analyses suggest that there are nearly 47,000 unoccupied beds in rural hospitals, most of which are located in hospital referral regions that have not been heavily affected by COVID-19 (exhibit 1).

Figure 1: Rural Hospital Beds in Relation to COVID-19 Spread



Source: Authors' analysis. Notes: Estimated number of rural hospitals beds per hospital referral region comes from the authors' analysis of 2018 American Annual Survey database. The number of COVID-19 cases per county comes from each county as of April 15, 2020, at 11:30 am.

The sudden rise in rural hospital capacity due to low occupancy, compounded by postponement of elective surgery and transfer of the most serious COVID-19 cases, could create an opportunity for rural hospitals to help decompress large urban medical centers that are already facing bed constraints. For instance, even before the COVID-19 pandemic, Alberta, Canada, developed a plan to funnel patients from major cities who need minor surgery to private clinics and hospitals in smaller rural communities as part of the government's attempt to cut wait times. A similar model in the US may be a double win in that it would offload demand from overloaded metropolitan centers while also generating much needed revenue at rural hospitals. Moreover, at least 60 percent of rural hospitals report having skilled nursing facility swing bed capacity that could play an important role in providing postacute care for the projected demand following the surge of hospitalizations involving patients with COVID-19.

Federal Responses Neglect Rural Hospital Concerns

The first supplemental funding package enacted by Congress set aside $8.3 billion in emergency aid, including $500 million for the Department of Health and Human Services (HHS) to provide drugs, medical supplies, training, and additional funding to increase medical surge capacity. The law also relaxed regulations to facilitate the use of telehealth services so that patients can receive care at home. However, the telemedicine rules largely exclude in-hospital services, such as telemedicine in the emergency department (ED) or the intensive care unit (ICU), known as tele-ED and tele-ICU. Moreover, while the new telemedicine rules will benefit rural physician practices, the rules do not directly address hospital capacity and finances. (Future legislation should consider lessening the barriers for implementing tele-ED and tele-ICU programs, which can benefit both rural and urban hospitals. For instance, providers in rural hospitals may provide tele-ED services to help decant the influx of patients in emergency departments while intensivists in urban centers who have most of the experience taking care of patients with COVID-19 may provide tele-ICU services for patients in rural hospitals.

The second coronavirus economic relief bill, the Families First Coronavirus Response Act, provides paid sick leave, food assistance for vulnerable populations, and financial help for coronavirus testing. Additionally the bill includes an increase in state Medicaid funding and a requirement that insurers do not charge cost sharing for services related to coronavirus testing. Through the federal government's Medicaid matching, Medicaid funds will increase nationwide by 6.2 percent. Enhancing states' Medicaid budgets could help head off provider reimbursement cuts in a time when providers will be squeezed by having to delay high-margin procedures and an increase in uncompensated care.

The third wave of relief, the Coronavirus Aid, Relief, and Economic Security (CARES) Act, provides roughly $2 trillion in economic stimulus. About $130 billion is set aside for the health care system including $100 billion in a fund to reimburse providers for COVID-19–related expenses and lost revenue. Other provisions include $16 billion to address supply shortages; $11 billion to fund the development of vaccines, therapeutics, diagnostics, and other medical needs; $200 million to help health care providers offering telehealth; and at least $250 million to boost the capacity of health care facilities. Finally, Medicare reimbursements for COVID-19 patients will increase by 20 percent within the inpatient prospective payment system. However, this proposed increase in COVID-19–related Medicare reimbursement is unlikely to benefit critical access hospitals, which are not paid under the Inpatient Prospective Payment System. Approximately 70 percent of rural hospitals are critical access hospitals.

Although none of the previously described provisions would target rural hospitals in particular, additional aid to rural hospitals may come through several mechanisms in the CARES Act, including reimbursement for health care related expenses or lost revenues that are attributable to coronavirus. First, the law would provide funding, grants, and other authority to help ensure an adequate hospital workforce, including reauthorizing Health Resources and Services Administration grants that would provide supplemental funding related to telehealth and rural health. Telehealth would offer flexibility for rural patients to access screening or monitoring care while avoiding exposure to infected patients and allowing providers to be reimbursed for providing this care. Second, the legislation would delay the implementation of the Medicaid disproportionate-share hospital cuts by two years. Finally, $180 million would be used to carry out telehealth and rural health activities. This may be an opportunity for rural hospitals to expand their tele-ED and tele-ICU capability.

Priorities For New Policy

Although the $100 billion fund to reimburse providers for COVID-19–related expenses and lost revenue will be critical for hospitals, the details will matter. First, there isn't much in the legislative text regarding how it will be disbursed or what will qualify as lost revenue. Second, the aid will be administered by the HHS's assistant secretary for preparedness and response—an office that was already understaffed and underresourced, raising concerns as to whether this aid will be distributed in a timely and equitable manner. On the one hand, rural hospitals are already vulnerable, and their financial situation dire; on the other hand, urban hospitals are caring for the bulk of infected patients. Without earmarked funds, much of the aid may run out before it gets to

rural hospitals. As a consequence, rural hospitals may need a direct influx of relief similar to what has been proposed for the airline and hotel industry.

State governments could help close the gap by pursuing Medicaid expansion—which would decrease their hospitals' uncompensated care burden. To encourage this, Congress could reinstate 100 percent federal matching for any state that chooses to adopt the Affordable Care Act Medicaid expansion. Rural hospitals in states that have not expanded Medicaid recorded a median operating margin of -0.3 percent, compared to +0.8 percent for rural facilities in expansion states. Expanding Medicaid would help state budgets, hospitals, and providers by increasing funds to states and decreasing uncompensated care.

There also are mechanisms to shore up rural hospital finances apart from Medicaid expansion. For example, additional financial support may come through section 1135 waivers. When the president or HHS secretary declares an emergency, either states/territories or individual health care facilities may apply for a section 1135 waiver. The purpose of the waivers is to help assure that sufficient health care items and services are available to meet the needs of Medicare, Medicaid, and Children's Health Insurance Program beneficiaries and that health care providers that provide such services in good faith can be reimbursed for them. These waivers could remove administrative burdens and expand access to needed services such as streamlining provider enrollment processes to ensure access to care for patients and allow care to be provided in alternative settings. This would directly help specialty facilities and rural hospitals to overcome some administrative and credentialing hurdles. At least 29 states have applied for and have been granted a waiver during the COVID-19 crisis.

Finally, several levers may be available to secure some financial stability through critical access hospital designation. With a critical access hospital designation, hospitals are more generously reimbursed (on a cost plus 1 percent basis) for inpatient and outpatient services. Critical access designation is allowable for hospitals if they provide 24/7 emergency care services, have fewer than 25 inpatient beds, have a length-of-stay averaging 96 hours or less, and are located more than 35 miles away from another hospital. Through section 1135 waivers previously described, CMS may waive both the limit of 25 inpatient beds and the 96-hour length-of-stay limitation. Not only would this increase revenue for rural hospitals with greater than 25 beds but would also allow these hospitals longer length-of-stays to provide postacute care for the projected surge of COVID-19 patients.

Making Rural Hospitals Part Of The Solution

As more and more hospitals reach their capacity in this pandemic, rural hospitals have a real opportunity to become part of the solution. While many urban health centers are in need of personnel and resources, rural hospitals have been finding themselves with excess workforce and capacity, only for it to be further exacerbated by the need to postpone non-urgent services. Several rural hospitals have found themselves furloughing staff due to COVID-19, while urban hospitals are asking health care providers to come out of retirement. By matching patients' needs to where the resources are, rural hospitals could offload less complex patients from urban centers and free up beds and resources for more complex patients with COVID-19, and the influx of patients to rural hospitals would be a much welcomed source of revenue.

As we recover from this pandemic, there will inevitably be a backlog of non-urgent procedures that have been postponed, and patients may find themselves waiting months for non-urgent procedures. By investing the time and resources in strengthening the urban-rural hospital network now, in the future we will have the mechanisms in place whereby appropriate patients may undergo postponed procedures sooner at a rural hospital. Furthermore, with such arrangements in place, revenue may be shared between hospitals in the network—a win-win both for patients and hospitals.

Rural hospitals are an essential part of the US health care delivery system, caring for nearly one in five Americans. Amidst turbulent times, not only do we have the opportunity to use rural hospitals to help end this pandemic, but we can also financially secure the backbone of health care delivery for the 20 percent of Americans who receive care at rural hospitals. The viability of these hospitals is critical to both the national response to COVID-19 and the future of rural health care for years to come.

Authors' Note

Adrian Diaz and Karan Chhabra receive funding from the University of Michigan Institute for Healthcare Policy and Innovation Clinician Scholars Program.

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Exhibit G

DFW Region's Hospitals Could Lose $1.1 Billion Annually In Funding, Healthcare Group Warns

By Jack Fink June 28, 2021 at 4:53 pm **Filed Under:** DFW News, healthcare, Hospitals, Texas Essential Healthcare Partnerships

DALLAS (CBSDFW.COM) – A healthcare group is sounding the alarm that hospitals in the DFW region could collectively lose $1.1 billion each year.

The President of Texas Essential Healthcare Partnerships or TEHP, Don Lee said, "We believe it'd be catastrophic, not just for the hospitals, but for all Texans."

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2 Sisters Drown In Lake Lewisville After Falling Off Boat During Birthday Celebration


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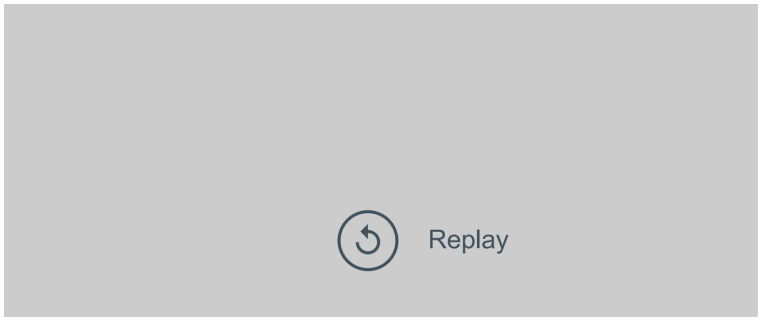
As Lumber Futures Fall, Cost Of Home Construction And DIY Projects Could, Too



READ MORE: MS-13 Gang Members, Convicted Rapist And Child Sex Offender Arrested At Southern Border

The TEHP represents 72 hospitals in the DFW region, including those operated by Tenet, Methodist, Texas Health Resources, and Baylor Scott & White.

Lee said he's concerned about the impact of the federal government's recent decision to rescind what's called the 1115 waiver in October of next year.

What's worse he said, is that some of the cuts could be felt in just three months.

"There's about $330 million of very important mental health care funding for mental healthcare services for the poor, that will be lost starting in September of this year," said Lee.

When compared to other states, Texas has a limited medicaid program, so the 1115 waiver provides funding to hospitals in DFW and across the state to provide what's called uncompensated or charitable care for the uninsured and those who could otherwise not afford to pay.

READ MORE: When Unemployment Ended Early, Workers Sued And Some Are Winning

The Biden administration said the state should not have been granted an extension of the 1115 waiver by the Trump administration until 2030 because Texas didn't seek the necessary public input.

At the time, Lee said there was a reason the federal government granted the waiver. "That was due to timing and the need to get certainty behind funding to hospitals so that they can feel comfortable to go ahead and spend money on pandemic response efforts."

A Texas Health and Human Services Commission spokeswoman tells CBS 11 the agency held four public hearings this month on the matter and that public comment ends today.

The state will soon submit its new waiver application.


Teen Girl Dies After Jumping Out Of Moving Car On Texas Highway While Arguing With Her Mother


COVID-19 Hospitalizations Increasing In Dallas And Tarrant Counties


WATCH: Customers Stop To Sing National Anthem At Walmart In Haslet


At Least 31 People Shot Over Holiday Weekend In Dallas And Fort Worth


Police: Fourth Of July Parade Participant Tried To Evade Arrest On Tractor In Rockwall

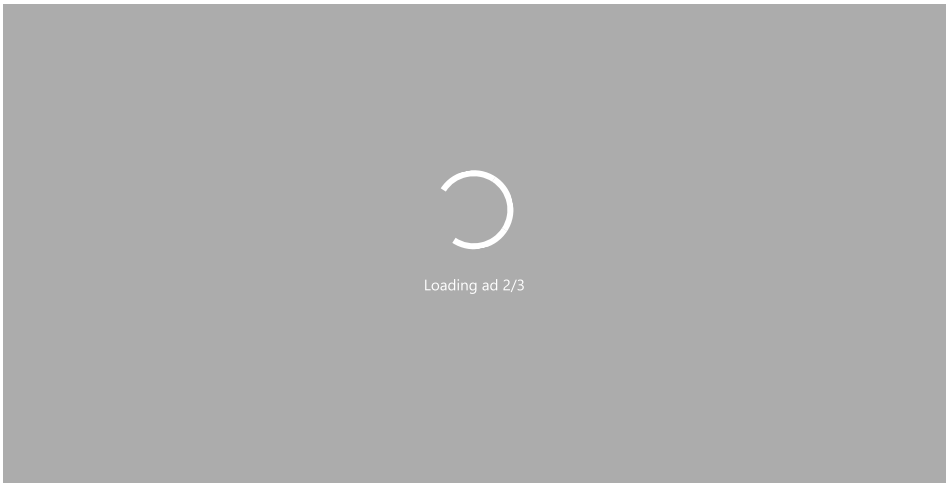

Fort Worth Hospital Experiences Summertime 'Baby Boom' Of 100 Babies Within Two Stretches Totaling 91 Hours

Without the extension of that 1115 waiver, Lee said some hospitals in the North Texas region may have to close. "Those hospital systems run numerous hospitals throughout the DFW area, and they may not be able to keep them all open."

He said aside from cuts in services, the lack of a waiver extension could raise healthcare prices for those who are insured.

MORE NEWS: Texas Leaders Among Those Pressuring Biden Administration To Lift Restrictions At US Borders

WATCH INTERVIEW WITH DON LEE



CBS DFW

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Exhibit H

(AUSTIN, Texas – April 16, 2021) – The following is a statement from Ted Shaw, Texas Hospital Association president/CEO, on the federal government's action today to rescind the 10-year Medicaid 1115 waiver extension that was granted by the previous administration. Set to be in place through 2030, the waiver extension would have provided life-saving health care funding for Texas.

"The Texas Hospital Association is extremely disappointed by today's action by CMS to abruptly rescind the previously approved waiver extension for Texas. With an ongoing pandemic and millions of uninsured Texans, Texas hospitals have been stretched like never before and clearly have a critical role in protecting the health and wellbeing of all Texans. This action undermines the safety net and hospitals' ability to protect people. It puts the state's health at serious risk and creates unprecedented levels of uncertainty for an industry that is charged with saving lives. The waiver extension would have helped the state to seamlessly continue support for much-needed health care improvements and would have continued stable funding for hospitals that serve large numbers of uninsured patients."

FOR IMMEDIATE RELEASE.
FOR MORE INFORMATION, CONTACT:

Carrie Williams
Chief Communications Officer
512/465-1052 | cwilliams@tha.org

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About THA

Founded in 1930, the Texas Hospital Association is the leadership organization and principal advocate for the state's hospitals and health care systems. Based in Austin, THA enhances its members' abilities to improve accessibility, quality and cost-effectiveness of health care for all Texans. One of the largest hospital associations in the country, THA represents 452 of the state's non-federal general and specialty hospitals and health care systems, which employ some 400,000 health care professionals statewide. Learn more about THA at www.tha.org or follow THA on Twitter at https://twitter.com/texashospitals .

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Exhibit I

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

Dear Governor:

Thank you for your continued partnership as we further coordinate the Coronavirus Disease 2019 (COVID-19) response. This unprecedented time has shown the resilience and adaptability of states, and the importance of our shared planning and preparation.

We are writing to you today to share more details regarding the public health emergency (PHE) for COVID-19, as declared by the Secretary of Health and Human Services (HHS) under section 319 of the Public Health Service Act (42 U.S.C. §247d). The current public health emergency was renewed effective January 21, 2021, and will be in effect for 90 days. To assure you of our commitment to the ongoing response, we have determined that the PHE will likely remain in place for the entirety of 2021, and when a decision is made to terminate the declaration or let it expire, HHS will provide states with 60 days' notice prior to termination.

Predictability and stability are important given the foundation and flexibilities offered to states that are tied to the designation of the PHE. Among other things, the PHE determination provides for the ability to streamline and increase the accessibility of healthcare, such as the practice of telemedicine. It allows under section 1135 of the Social Security Act, in conjunction with a Presidential Declaration under the National Emergencies Act or Stafford Act, the Secretary to waive or modify certain Medicare, Medicaid, Children's Health Insurance Program (CHIP), and Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule requirements. The goal is to ensure to the maximum extent feasible that, in an emergency area during an emergency period, sufficient health care items and services are available to meet the needs of individuals receiving Medicare, Medicaid, and CHIP and that providers that furnish such items and services can be reimbursed for them and exempt from sanctions, absent fraud or abuse.

Additionally, the available temporary 6.2 percentage point increase in the Medicaid Federal Medical Assistance Percentage (FMAP) included in the Families First Coronavirus Response Act (Pub. L. 116-127) expires at the end of the quarter in which the PHE ends. With the extension and additional advance notice, we seek to provide you with increased budgetary stability and predictability during this challenging time.

In light of the PHE extension, you can expect the continued use of other emergency authorities, including Public Readiness and Emergency Preparedness (PREP) Act declarations and emergency use authorizations (EUA) for diagnostics, treatments, and vaccines. The Department will consider the use of any available flexibility to aid states in their response to this PHE.

We stand ready to support you as we continue to improve the nation's response to the COVID-19 pandemic. Please do not hesitate to reach out to the HHS Office of Intergovernmental and External Affairs with questions or for further assistance.

Sincerely,

Norris W. Cochran IV - S

Digitally signed by Norris W. Cochran IV - S
Date: 2021.01.22 17:17:08 -05'00'

Norris Cochran

Exhibit J

TEXAS
Health and Human
Services

Texas Medicaid and CHIP Reference Guide

THIRTEENTH EDITION

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Texas Medicaid and CHIP Reference Guide

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The information presented in this book is intended to provide a helpful reference for the subjects discussed. This book is not meant to be used, nor should it be used, as an official record of Texas Medicaid and CHIP policies. Readers should be aware that the information listed in this book, including any websites, may change.

Foreword

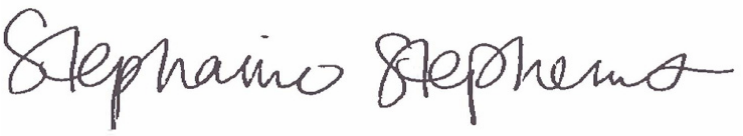
As a lifelong Texan, I am honored to serve as the State Medicaid Director, especially during these unprecedented times. Our organization's impact is significant. Over 4 million individuals rely on Texas Medicaid and the Children's Health Insurance Program (CHIP) to deliver quality, cost-effective services to improve their health and wellbeing.

I am proud of this team's commitment to our mission and their tenacity, which have been amplified in our response to the COVID-19 public health emergency. As we move forward, our stakeholders want to know the future of Texas Medicaid and CHIP. That begins by looking at where we've been and where we are now.

With this 13th edition of the Texas Medicaid and CHIP Reference Guide, we hope you find a valuable resource for understanding the work we do. Our organization has a history of innovation and national leadership. We aim to continue this legacy and achieve our goals for the people we serve, their families and their providers.

Thank you to all our partners that support our programs every day. Our success is only possible with you.

Onwards and upwards,



Stephanie Stephens
State Medicaid Director

Texans living healthy and fulfilling lives.

The Data in This Guide

Below outlines the details about the data referenced throughout the 13th edition. Information contained in this book was current as of August 2020, unless otherwise noted. Program and financial information may change after publication due to unforeseen changes to federal and state regulations, the state of the economy, and other factors.

About	Details
Time period	All data is state fiscal year (SFY) 2019, unless otherwise noted. Income limits are effective as of March 1, 2020.
Caseload count	Caseload trends and numbers are based on the monthly average number of clients covered by Medicaid or CHIP. The unduplicated count, which is the total number of individual Texans who received Medicaid or CHIP services over a period of time, is noted if used. Total caseload numbers combine Medicaid and CHIP, unless otherwise noted.
Cost information	Costs include both partial- and full-benefit clients, unless otherwise noted. Funds exclude Disproportionate Share Hospital (DSH), Uncompensated Care (UC), and Delivery System Reform Incentive Payment (DSRIP) funds, unless otherwise noted.
Sources	Health and Human Services Commission (HHSC) Financial Services, including Forecasting, provided the majority of data contained in this book. Their primary sources are: • Premiums Payable System data provides a summary of all Medicaid-eligible clients each month. Both monthly Premiums Payable System files and final eight-month files, which contain all retroactive adjustments, are used in the analyses. • Expenditure information is obtained from the Texas Medicaid & Healthcare Partnership through the databases in the Vision 21 platform, which includes paid claims, managerial reporting of cash flow, provider and client information, and managed care encounter data. Expenditures include direct payments to physicians, hospitals and entities that provide ancillary services. Financial information is provided using the Form CMS 64–Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program and the Medicaid Program Budget Report–CMS 37. Additional financial information is provided by the Medicaid Statistical Information System. • Unpublished analyses conducted by HHSC Financial Services staff are also used to provide financial information. Alternative sources are noted throughout the book.

Helpful Websites

Website Name	Link	What You'll Find
Health and Human Services Commission (HHSC)	HHS.Texas.gov/Services/Health/Medicaid-CHIP	The Medicaid and CHIP landing page provides access to descriptions about programs and services, resources for members (including managed care report cards, Service Delivery Area maps, etc.), topics for business partners, and general information about Medicaid and CHIP, including enrollment statistics.
Health Care Payment Learning and Action Network (HCP-LAN)	HCP-LAN.org	A website with resources focused on increasing the percentage of U.S. health care payments tied to quality and value, including the HCP-LAN Alternative Payment Model (APM) framework, a consensus framework for classifying APMs. HHSC uses this framework for its Texas Medicaid value-based payment requirements for managed care organizations (MCOs).
Office of the Ombudsman	HHS.Texas.gov/About-HHS/Your-Rights/HHS-Office-Ombudsman	The Office of the Ombudsman manages and resolves complaints submitted by Texans receiving Health and Human Services benefits, including Medicaid.
Report Texas Fraud	ReportTexasFraud.com	The public, clients and providers may refer potential fraud, waste and abuse on this website or call the Office of Inspector General's (OIG) fraud hotline at 800-436-6184.
Texas Healthcare Learning Collaborative (THLC) Portal	THLCPortal.com	A public reporting platform and a tool for contract oversight and MCO quality improvement efforts, including MCO report cards and other key performance data.
Your Texas Benefits	YourTexasBenefits.com	A self-service website where Texans can apply for HHSC programs and manage their benefits.
Uniform Managed Care Manual	HHS.Texas.gov/Services/Health/Medicaid-CHIP/Provider-Information/Contracts-Manuals/Texas-Medicaid-CHIP-Uniform-Managed-Care-Manual	Defines procedures that MCOs must follow to meet certain requirements in HHSC managed care contracts.
Vendor Drug Program (VDP)	TxVendorDrug.com	Information about VDP, including the Texas Formulary, the Preferred Drug List (PDL), prior authorizations, enrollment in the program and resources for providers.

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Quick facts about Medicaid and CHIP

Quick Facts About Medicaid and CHIP

General Information

Medicaid

A health care and long-term services program for certain groups of low-income persons

Serves children and their caretakers, pregnant women, and individuals over age 65 or those with disabilities

Funded through state funds, matched with uncapped federal dollars at a set percentage rate

91% of total enrollment

CHIP

A similar program for children whose families earn too much to qualify for Medicaid

Serves children and the unborn children of pregnant women (CHIP Perinatal)

Funded through state funds, matched with capped federal dollars at a set percentage rate

9% of total enrollment

Snapshot of Texas Medicaid and CHIP Clients

4.3 million Texans receiving services

15% of Texans covered

+12% Enrollment Growth (2010 – 2019)

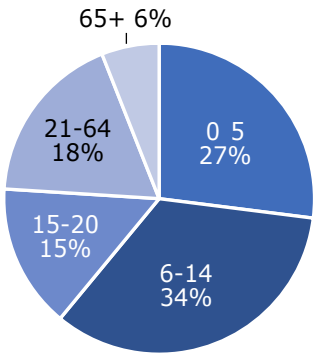
53% of Texas births covered by Medicaid

43% of Texas children on Medicaid or CHIP

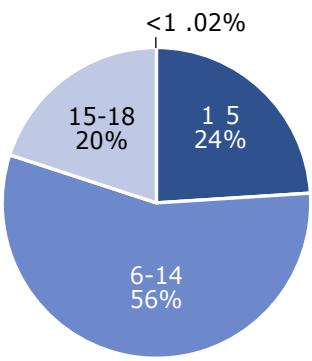
82% take-up rate for Texas children below 200% of FPL*

62% of nursing home residents covered by Medicaid

Medicaid Ages



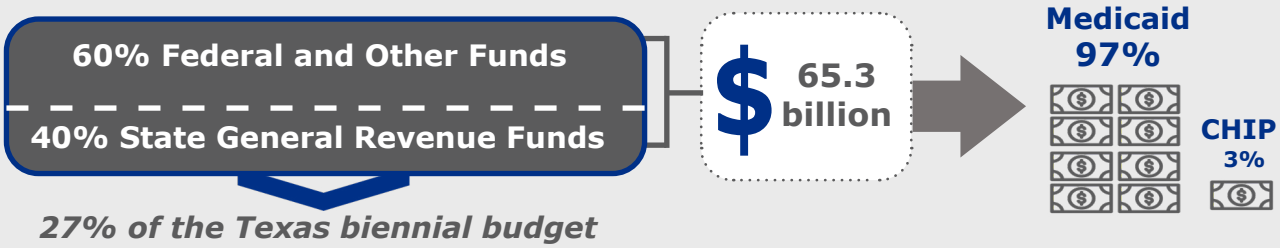
CHIP Ages



*The take-up rate, or the estimated percentage of eligible people who choose to enroll, is calculated based on FY18 Medicaid and CHIP caseloads and projected 2018 census by Texas Demographic Office using latest American Community Survey and migration analysis.

Quick Facts About Medicaid and CHIP

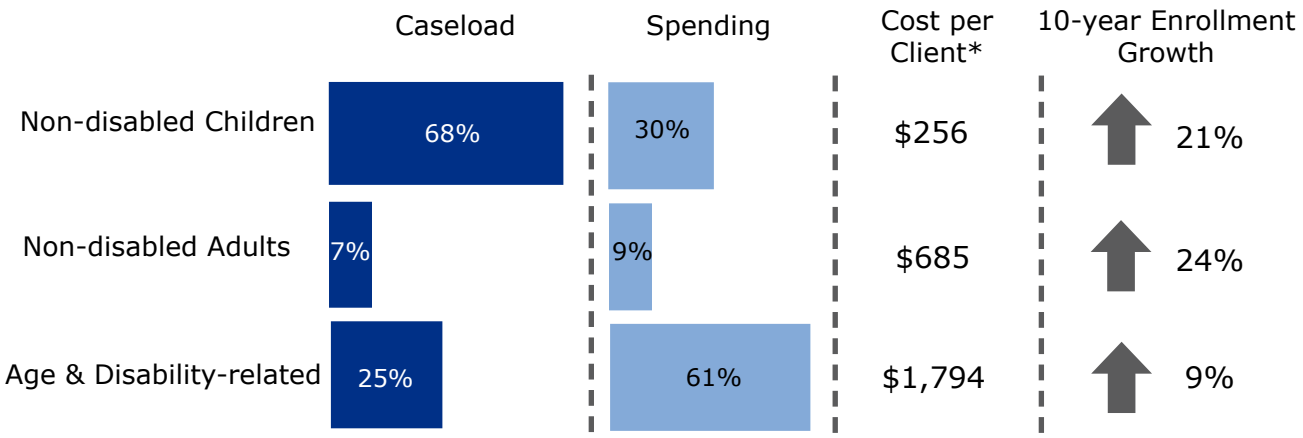
Funding



27% of the Texas biennial budget

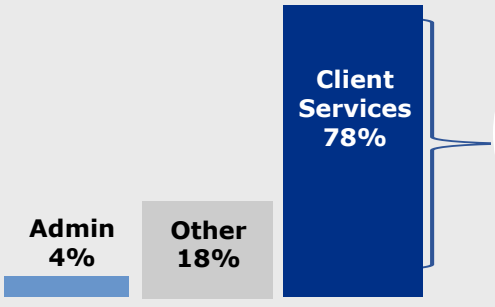
Spending

Trends in Caseload and Spending for Major Medicaid Client Categories

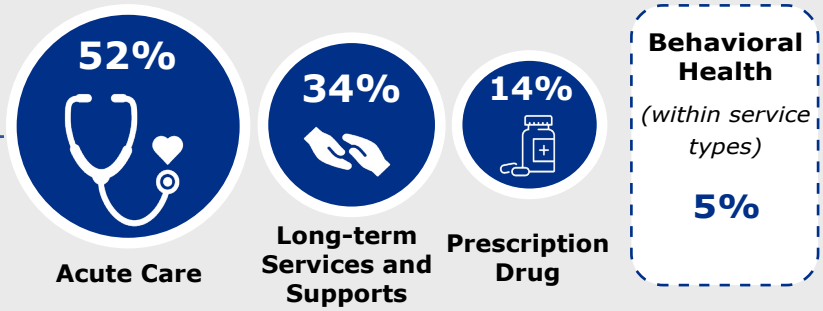


*Average cost per client per month is based on full-benefit clients only.

Spending by Category



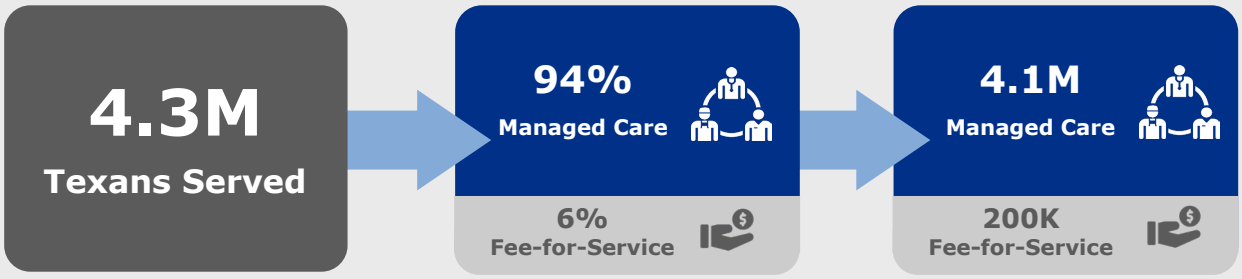
Spending by Service Type



Other: includes DSH, UC and DSRIP
Acute Care: includes Medicare, MTP, Dental and HIIT
Presciption Drug: includes Clawback
Behavioral Health: excludes DSH, UC, DSRIP and agency administration costs

Quick Facts About Medicaid and CHIP

Service Delivery Model

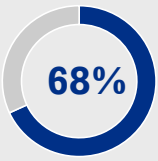


Key Attributes of the Managed Care Service Delivery Model

- Delivers services through MCOs that are paid a fixed amount per member enrolled per month
- Achieves value by incentivizing MCO improvements in quality of care and cost-effectiveness
- Serves as the member's "medical home" by providing comprehensive preventive and primary care

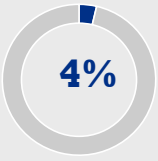
Managed Care Product Lines

STAR



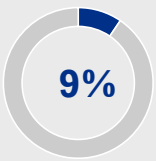
Children, pregnant women and some families

STAR Kids



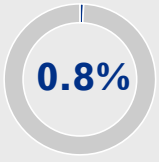
Children and youth with disabilities

CHIP



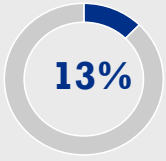
Children and youth who don't qualify for Medicaid due to family income

STAR Health



Children who get Medicaid through the Department of Family and Protective Services and young adults previously in foster care

STAR+PLUS

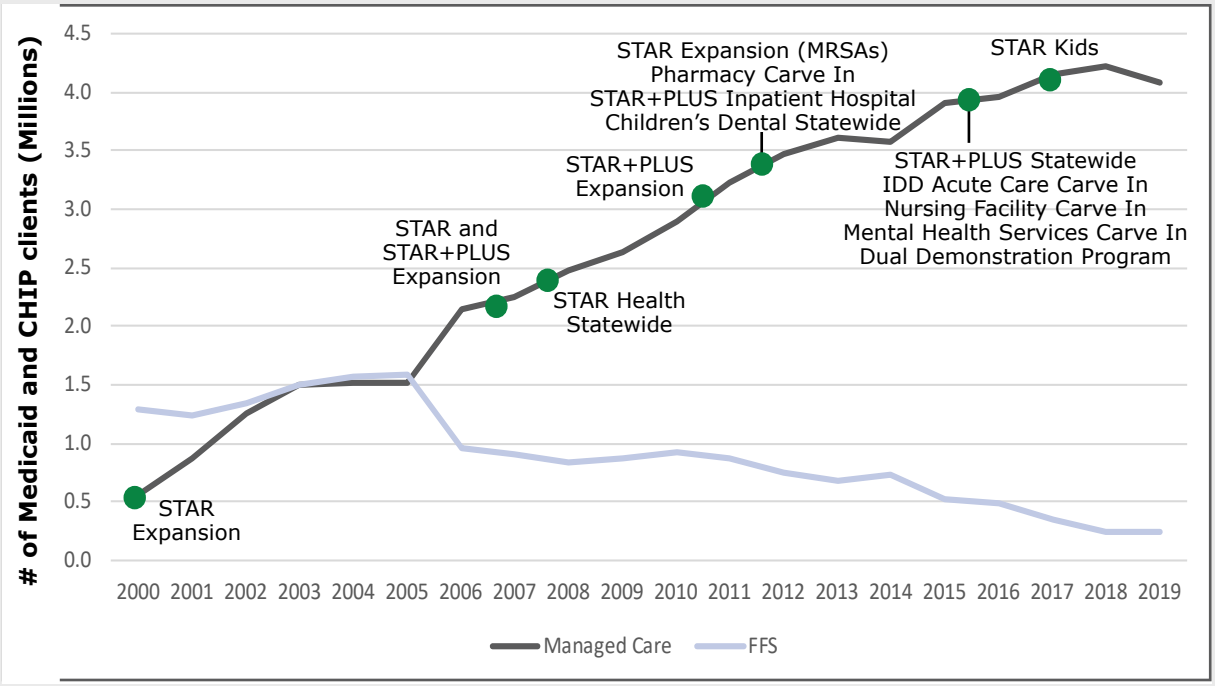


Adults with a disability, people age 65 and older (including those dually eligible for Medicare and Medicaid), and women with breast or cervical cancer

CHIP includes CHIP-Perinatal. Remaining percentage is FFS.

Quick Facts About Medicaid and CHIP

Managed Care Growth Over Time



Over the Past 10 Years

Texas Medicaid managed care enrollment has increased by 56%

Preventative Care Improved

Early Childhood Health
Children receiving six or more well visits in the first 15 months of life **+24%**

Adolescent Health
Adolescents receiving an annual well visit **+26%**

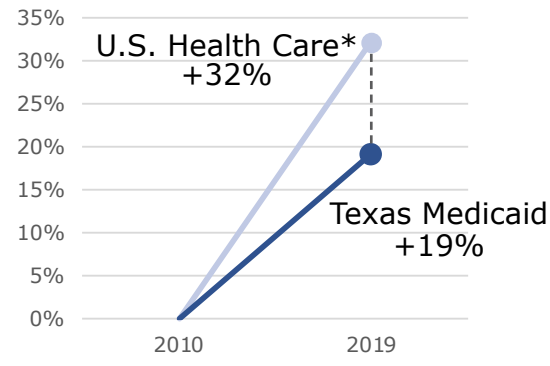
Maternal Health
Timeliness in prenatal care **+14%**

Data: STAR only, 2008 vs. 2018. Percentages are estimates due to methodology changes that occurred over the 10-year period.

Cost Growth Contained

Increased enrollment and improved preventative care within managed care keeps Texas Medicaid costs contained—13 percentage points lower than the U.S. national average

Cost per Person Increase



Texas Medicaid is based on full-benefit clients.
*Source: CMS, Office of the Actuary—data is for CY09 to CY18.

Chapter 1

Who can get Medicaid or CHIP, and how can they get it?

At-a-Glance

Who can get Medicaid or CHIP?

Medicaid provides health care and long-term services and supports (LTSS) to low-income children and their families, pregnant women, former foster care youth, individuals with disabilities and people age 65 and older.

The Children's Health Insurance Program (CHIP) provides health care to children who are not eligible for Medicaid based on their family's income. Texans who apply for benefits and do not qualify for Medicaid are automatically tested for CHIP eligibility.

How can Texans get Medicaid or CHIP?

Apply for Benefits → **Eligibility Determination** → **Enrollment**

Four ways to apply:

- YourTexasBenefits.com
- Local eligibility offices and community partners
- 2-1-1 phone service
- Mail or fax

Eligibility is determined by:

- Household income
- Citizenship and residency
- Program requirements

Most clients are enrolled in managed care, where they:

1. Choose a health plan
2. Pick a primary care provider
3. Receive a Your Texas Benefits Card and health plan ID card

Residency and Citizenship

To qualify for Medicaid, an applicant must:

- Live and intend to remain in Texas.
- Have a Social Security number (SSN) or apply for one.
- Be a citizen of the U.S. or meet alien status requirements.

All U.S. citizens and nationals are entitled to apply for and get Medicaid if they meet all eligibility requirements and can provide proof of citizenship.

Qualified Aliens

Most non-citizens cannot qualify for regular Medicaid or CHIP benefits. Qualified aliens are usually subject to limited eligibility or to a waiting period. The following categories do not have limited eligibility or a waiting period:

- Veterans; active duty members of the U.S. armed forces, including their spouses and dependent children; and Canadian-born American Indians.
- Victims of human trafficking.
- Aliens with Supplemental Security Income (SSI) and lawful permanent residents (LPRs) admitted before August 22, 1996.

Limited Eligibility

Some aliens may qualify for Medicaid, but only for up to seven years. These include asylees, refugees, Cuban/Haitian entrants, Amerasians, and aliens whose deportations are being withheld.

Lawful Permanent Residents

LPRs are non-citizens who are lawfully authorized to live permanently within the U.S. LPRs who arrived on or after August 22, 1996, are typically subject to a five-year waiting period.

Some qualified immigrant and non-immigrant alien children lawfully residing in the U.S. may qualify for Medicaid or CHIP regardless of their date of entry (see Appendix A, page 118, for The Children's Health Insurance Program Reauthorization Act [CHIPRA] of 2009).

Emergency Medicaid

Undocumented aliens and certain LPRs may qualify for Emergency Medicaid coverage, if all other eligibility requirements are met except for alien status. Undocumented aliens are not required to provide a SSN. If determined eligible, Medicaid only covers their care until the emergency medical condition is stabilized.

Financial Eligibility

Financial eligibility for the Medicaid and CHIP programs is primarily based on how an applicant's household income compares to the U.S. Department of Health and Human Services' definition of the federal poverty level (FPL). The FPL is updated yearly.

Federal law requires financial eligibility for most Medicaid and CHIP applicants to be determined through the Modified Adjusted Gross Income (MAGI) methodology. MAGI uses federal income tax rules to decide if an applicant qualifies based on how they file their taxes and their countable income.

Some groups are excluded from MAGI, including:

- People who are age 65 and older.
- Individuals with disabilities.
- People receiving SSI.

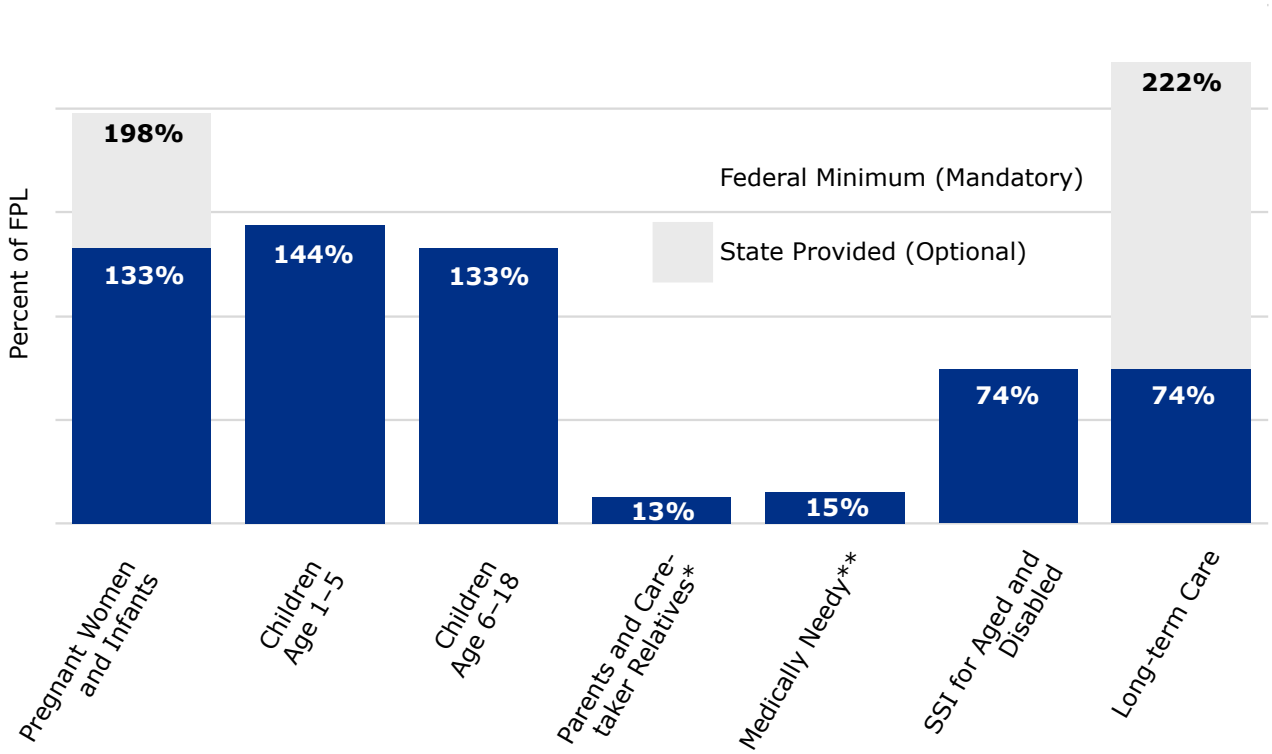
These groups must report and give proof of property such as vehicles, bank accounts or rental homes.

Mandatory vs. Optional Coverage

Federal law requires states to cover Medicaid-eligible groups up to a minimum percentage of the FPL and allows states the option to expand eligibility beyond federal standards.

The following figure depicts the 2020 Texas Medicaid income levels for the most common Medicaid eligibility categories. Mandatory levels identify the coverage required by the federal government. Optional levels show the coverage Texas has implemented.

Texas Medicaid Income Eligibility Levels for Selected Programs, March 2020 (as a Percent of the FPL)



This figure reflects eligibility levels as of March 2020. In 2014, the Affordable Care Act (ACA) required states to adjust income limits for pregnant women, children, and parents and caretaker relatives to account for MAGI changes.

*For Parents and Caretaker Relatives, maximum monthly income limit in SFY20 was $230 for a family of three, or about 13 percent of the FPL.
**For Medically Needy pregnant women and children, the maximum monthly income limit in SFY20 was $275 for a family of three, or about 15 percent of the FPL.

Children and Youth

Children's Medicaid

Most Medicaid clients are children. To qualify for Children's Medicaid, a child must be age 18 or younger.

Newborns (under 12 months) born to mothers getting Medicaid for Pregnant Women are automatically eligible for Children's Medicaid and remain eligible through the month of their first birthday.

The table shows the Children's Medicaid monthly income limits by household size.

Children's Medicaid Maximum Monthly Income Limits by Household Size	
Household Size (Adults Plus Children)	**Household Income**
1*	$1,415
2	$1,931
3	$2,408
4	$2,904
For each additional person, add:	$497

*A family of one might be a child who does not live with a parent or other relative.

Former Foster Care Youth

Medicaid for Former Foster Care Children

Children who aged out of the foster care system in Texas at age 18 and were receiving federally-funded Medicaid at the time may continue to be eligible for Medicaid up to the month of their 26th birthday. Income and resource limits do not apply.

Medicaid for Transitioning Foster Care Youth

Former foster care youths who were not receiving Medicaid when they aged out of foster care at age 18 may still be eligible for Medicaid under Medicaid for Transitioning Foster Care Youth (MTFCY) up to the month of their 21st birthday.

To qualify, an individual must meet residency and citizenship requirements and:

- Not have adequate health coverage.

- Be at or below 413 percent of the FPL (or $4,392 per month for a household of one).

Resource limits do not apply to MTFCY. In addition, individuals under an Interstate Compact on the Placement of Children agreement may be eligible for MTFCY if all other requirements are met.

Children's Health Insurance Program

CHIP covers children who do not qualify for Medicaid based on household income but do not have other health insurance. To qualify for CHIP, a child must be:

- Age 18 or younger.
- Uninsured for at least 90 days or have a "good cause" exemption.
- Living in a household with an income at or below 201 percent of the FPL.

Enrollment fees and co-pays are determined based on household income. Yearly enrollment fees are $50 or less per family. Co-pays for both doctor visits and medicine range from $3 to $5 for lower-income families and $20 to $35 for higher-income families.

See the table below for the CHIP monthly income limits by household size.

CHIP Maximum Monthly Income Limits by Household Size

Household Size (Adults Plus Children)	Household Income
1*	$2,138
2	$2,918
3	$3,639
4	$4,389
For each additional person, add:	$751

*A family of one might be a child who does not live with a parent or other relative.

Incarcerated Youth

Individuals, including pregnant women, age 18 and younger incarcerated by the Texas Department of Criminal Justice may be eligible for Medicaid coverage for inpatient medical services provided in a "free-world" medical facility not located on the premises of a jail or prison. If determined eligible, Medicaid covers only services provided during the individual's inpatient stay.

Juveniles receiving Children's Medicaid may have their coverage suspended upon entrance into a juvenile facility and reinstated upon release. Children who enter a juvenile facility and receive CHIP will have their coverage terminated and must reapply upon release.

Women

Medicaid for Pregnant Women

Texas extends Medicaid eligibility to pregnant women with a household income at or below 198 percent of the FPL.

See the table below for the Medicaid for Pregnant Women monthly income limits by household size, which includes unborn children.

Household Size	Monthly Household Income
1	$2,106
2	$2,875
3	$3,584
4	$4,323
For each additional person, add:	$740

CHIP Perinatal

CHIP Perinatal services are for the unborn children of uninsured pregnant women who do not qualify for Medicaid for Pregnant Women. To qualify, pregnant women must have an income at or below 202 percent of the FPL.

For CHIP Perinatal clients at or below 198 percent of the FPL, the mother must apply for Emergency Medicaid to cover her labor and delivery. If the mother's labor and delivery are covered by Emergency Medicaid, her CHIP Perinatal newborn may receive 12 months of continuous Medicaid coverage from date of birth.

CHIP Perinatal newborns in families with incomes above 198 percent of the FPL receive CHIP benefits for 12 months from date of birth.

See the table below for the CHIP Perinatal monthly income limits by household size.

Household Size	Monthly Household Income
1	$2,148
2	$2,933
3	$3,657
4	$4,411
For each additional person, add:	$755

Healthy Texas Women

Healthy Texas Women (HTW) provides free health and family planning services to low-income women ages 18 to 45 who qualify. Women ages 15 through 17 may also qualify for the program, but they must have a parent or legal guardian apply, renew and report changes on their behalf.

To qualify for HTW, a woman must:

- Not be eligible to receive full Medicaid benefits, CHIP, or Medicare Part A or B.
- Not be pregnant.
- Not have any other creditable health coverage—unless filing a claim would cause physical, emotional, or other harm from a spouse, parent or another person.
- Have a household income at or below 200 percent of the FPL.

To provide continuity of care, Medicaid for Pregnant Women clients are automatically enrolled into HTW when their Medicaid coverage ends.

Breast and Cervical Cancer Screening Services

Breast and Cervical Cancer Screening (BCCS) services are diagnostic services for women age 18 and older who either need to be tested for or already have a breast or cervical cancer diagnosis, including pre-cancerous conditions. These services are offered at clinic sites across Texas.

BCCS clinics serve as the point of access for applying for Medicaid for Breast and Cervical Cancer (MBCC). To qualify for diagnostic services, women must:

- Not have health insurance.
- Have a net household income at or below 200 percent of the FPL.

Medicaid for Breast and Cervical Cancer Program

The MBCC program provides full Medicaid benefits, including services beyond the treatment of breast and cervical cancer, to eligible women screened at BCCS clinics. Women cannot apply through a Health and Human Services Commission (HHSC) benefits office. To qualify, a woman must:

- Be age 18 through 64.
- Be uninsured.
- Be diagnosed and in need of treatment for either certain pre-cancerous conditions or a biopsy-confirmed, metastatic, or recurrent breast or cervical cancer.

Women continue to receive full Medicaid benefits, as long as they meet the eligibility criteria at their coverage renewal period and provide proof from their attending doctor that they are receiving treatment for breast or cervical cancer.

Parents and Families

Medicaid for Parents and Caretaker Relatives

Adults who care for a child receiving Medicaid can also be eligible for Medicaid. To qualify, they must be a related caretaker to a child who has Medicaid and meet the program's income limits. The child must be living with them, and be age 17 or younger, or be age 18 and attending school full-time.

Related caretakers may be:

- A parent or step-parent.
- A sibling or step-sibling.
- A grandparent.
- An uncle or aunt.
- A nephew or niece.
- A first cousin or the child of a first cousin.

See the table below for the monthly income limits by household size.

Household Size	Monthly Income for One Parent Household	Monthly Income for Two Parent Household
1	$103	------
2	$196	$161
3	$230	$251
4	$277	$285
For each additional person, add:	$52	$52

Medically Needy with Spend Down Program

The Medically Needy with Spend Down program helps both families with children age 18 and younger and pregnant women who do not qualify for Medicaid to pay for unpaid medical expenses.

To qualify, an individual or family subtracts their health care expenses from their income until they meet the program's income and asset limits, also called "spending down." The income limit is $275 per month for a family of three. The asset limit is $2,000 to $3,000 for households with a member who is elderly or has a disability. Assets are not considered for pregnant women.

The spend-down amount is different for each household and is any amount over the income limit. Clients enrolled through this program submit their paid and unpaid medical bills each month. Medical bills greater than the monthly spend-down amount are covered or reimbursed by Medicaid.

The Health Insurance Premium Payment Program

The Health Insurance Premium Payment (HIPP) program helps families where at least one person receives Medicaid pay for employer-sponsored health insurance premiums. HIPP reimburses members for their share of their employer-sponsored health insurance premium when the cost of the premium is less than the cost of projected Medicaid expenditures.

HIPP members eligible for Medicaid do not pay out-of-pocket deductibles, co-payments or co-insurance for Medicaid services delivered by a Medicaid provider. If a Medicaid service is not covered by their employer-sponsored health plan, members can still get the service at no cost to them if a Medicaid provider administers the service.

HIPP members not eligible for Medicaid must pay deductibles, co-payments and co-insurance as required.

Children and Adults with Disabilities

Children and adults with disabilities who get Medicaid are usually in one or more of the following groups:

- They could be or have been placed in a nursing facility or an intermediate care facility for individuals with an intellectual disability or related condition (ICFs/IID).
- They get SSI.
- They get home and community-based services through a waiver program (see also A Closer Look, page 21).

Children with disabilities can get coverage through the Children's Medicaid program or the Medicaid for the Elderly and People with Disabilities (MEPD) program. To qualify, children with disabilities must be age 20 and younger.

Medicaid for the Elderly and People with Disabilities

Adults with disabilities, some children with disabilities, and people age 65 and older may be able to get health coverage through the MEPD program.

To qualify, individuals with disabilities must meet the income limits for Medicaid. Those with disabilities who do not receive SSI may qualify for MEPD through a facility, such as a nursing facility or ICF/IID, or through a waiver program.

Medicaid Buy-In for Children

The Medicaid Buy-In for Children (MBIC) program offers low-cost Medicaid services to children with disabilities in families that make too much money to get Medicaid. MBIC members make monthly payments, which vary based on household income and health insurance status.

If a member has insurance through an employer, the payment could be up to $230 per month. If they have insurance through an employer and get HIPP, the payment could be up to $70 per month.

Those without health insurance through an employer and who cannot get HIPP do not have to make a monthly payment.

See the table below for the MBIC monthly income limits by household size.

Household Size (Adults Plus Children)	Monthly Household Income
1*	$1,595
2	$2,178
3	$2,715
4	$3,275
For each additional person, add:	$560

*A family of one might be a child who does not live with a parent or other relative.

Medicaid Buy-In for Adults

The Medicaid Buy-In (MBI) for Adults program offers low-cost Medicaid services to adults with disabilities who work. Adults may qualify if they meet all of the following criteria:

- They have a disability. The MBI program uses the Social Security disability guidelines to determine if applicants have a disability.
- They are working and meet the income limits for the program.
- They are not living in a state institution or nursing home continuously.
- They are getting home and community-based services through a Medicaid waiver program.

The income limit for MBI is $2,659 per month. Countable assets must be no more than $2,000.

How Individuals Can Access Long-term Services and Supports

Aging and Disability Resource Centers

Aging and Disability Resource Centers (ADRCs) provide person-centered services to individuals and caregivers, regardless of age, income and disability. ADRCs partner with a network of local service agencies to coordinate information and referrals for individuals needing access to long-term services and support (LTSS) programs and benefits, including Medicaid and Medicaid waiver programs.

LIDDAs and LMHAs

Local intellectual and development disability authorities (LIDDAs) serve as the point of entry for publicly funded intellectual and developmental disability (IDD) programs. LIDDAs help individuals enroll into Medicaid programs.

Local mental health authorities (LMHAs) provide information, recommendatations and referrals to individuals seeking mental health services, including Medicaid.

People Age 65 and Older

Medicaid for the Elderly and People with Disabilities

The MEPD program covers people age 65 and older and those with disabilities who do not receive SSI. Applicants must meet income limits for the program. People age 65 and older may qualify for MEPD through a facility, such as a nursing facility or an ICF/IID, or through a waiver program. They may also qualify for MEPD if they are dually eligible for Medicare and Medicaid.

People Eligible for Medicare and Medicaid

Medicare is a federally paid and administered health insurance program. Medicare covers inpatient hospital services (Part A), physician and related health services (Part B), Medicare managed care (Part C), and prescription drugs (Part D).

Some Medicare clients may be eligible for partial or full Medicaid benefits. Medicare clients who qualify for partial, but not full Medicaid benefits may receive assistance through Medicare savings programs.

Medicare Savings Programs

Medicare clients who are eligible for partial Medicaid benefits and meet established income and resource criteria may qualify for the Medicare Savings Program.

Individuals and couples in the program receive assistance with all or a portion of Medicare premiums, deductibles and co-payments through Medicaid. Medicaid also covers their Medicare Part D premiums and deductibles.

Resource limits for 2020 were $7,860 per individual and $11,800 per couple for most dually eligible people. The only exception is for Qualified Disabled Working Individuals, where the resource limits for 2020 were $4,000 for an individual and $6,000 for a couple.

Supplemental Security Income Recipients

SSI is a federal cash assistance program for low-income individuals with disabilities. Low-income individuals age 65 and older may also qualify for SSI. The Social Security Administration sets income eligibility limits, asset limits and benefit rates, and determines eligibility. In Texas, all people eligible for SSI are automatically eligible for Medicaid.

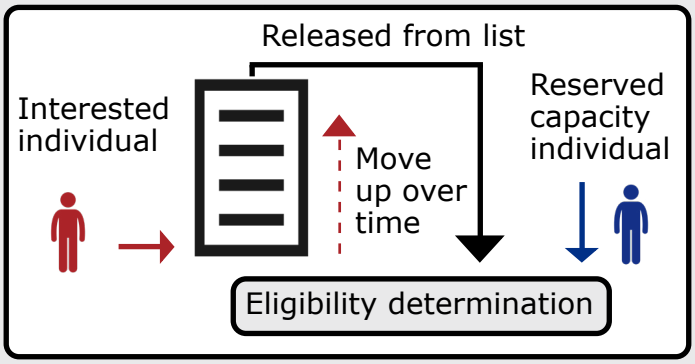
A Closer Look: Waiver Program Interest List and Eligibility Process

Texas' waiver programs include:

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

There are a limited number of slots per program. Individuals in reserved capacity groups, such as the Promoting Independence Initiative or Crisis Diversion, are given priority when program slots become available.

Interest List Process



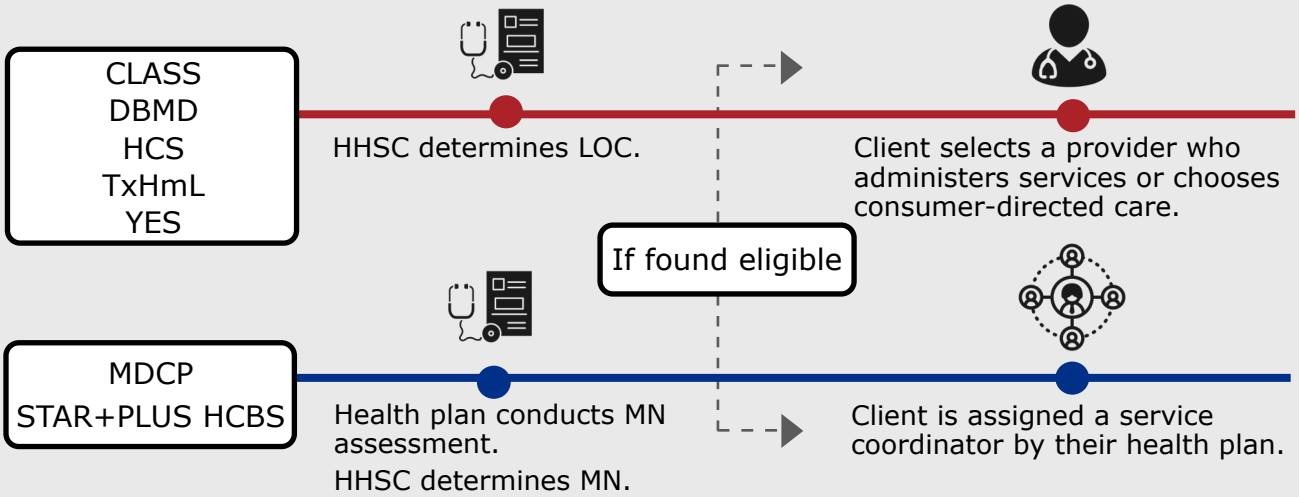
When a program slot opens, the individual at the top of the list is released.

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

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

Eligibility Determination

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



Chapter 2

What Medicaid and CHIP services are available for Texans?

At-a-Glance

What programs and services are available for Texans?

Two Service Delivery Models

94% of Texans who receive services get them through **Managed Care**.

- HHSC contracts with managed care organizations (MCOs), also called health plans.
- Health plans must provide all covered, medically necessary Medicaid and CHIP services to members.
- In most cases, members go to providers contracted with their health plan.

6% of Texans who receive services get them through **Fee-for-Service**.

- Under the fee-for-service (FFS) model, clients can go to any Medicaid provider.
- Clients can receive some services through managed care and others through FFS.
- Most FFS clients transition to managed care.

Main Types of Services

Acute Care Services

Preventive care, diagnostics and medical treatments

Behavioral Health Services

Screening and treatment for mental health conditions and substance use disorders (SUD)

Long-term Services and Supports

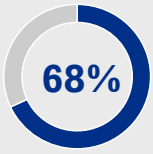
Support with ongoing, daily activities for individuals with disabilities and older adults

Pharmacy Services

Medical Transportation Services

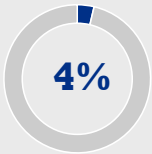
Programs That Deliver Services

STAR



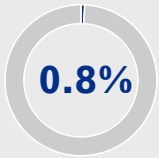
Children, pregnant women and some families

STAR Kids



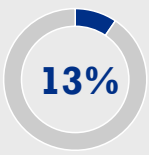
Children and youth with disabilities

STAR Health



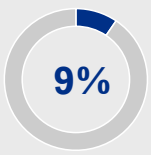
Children who get Medicaid through the Department of Family and Protective Services and young adults previously in foster care

STAR+PLUS



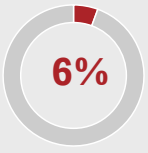
Adults with a disability, people age 65 and older (including those dually eligible for Medicare and Medicaid), and women with breast or cervical cancer

CHIP



Children and youth who don't qualify for Medicaid due to family income

Fee-for-Service



What Medicaid and CHIP Cover

Mandatory vs. Optional Services

Federal law requires state Medicaid programs to provide specific acute care services, long-term services and supports (LTSS), and behavioral health services—and allows states the option to provide additional services. States may choose to provide some, all or no optional services.

States with a separate Children's Health Insurance Program (CHIP), like Texas, have flexibility in determining benefits. The Texas CHIP benefit package focuses on acute care services, but also includes some behavioral health services and dental benefits. (See Appendix B, page 130, for a full list of Medicaid and CHIP programs and services.)

Acute Care Services

Medicaid and CHIP members can receive preventive care, diagnostics and medical treatments called acute care services. Acute care services may include:

- Doctor or clinic visits.
- Prescription drugs.
- Emergency services.
- Hospital inpatient and outpatient care.
- Vaccines.
- Vision and hearing care.
- X-rays and laboratory tests.
- Prenatal care and childbirth.

Both Medicaid and CHIP cover dental services for children and youth.

Behavioral Health Services

Both Medicaid and CHIP cover screening and treatment services for mental health conditions and substance use disorders (SUD), called behavioral health services. These services include:

- Psychiatric diagnostic evaluation.
- Psychological, neurobehavioral and neuropsychological testing.
- Inpatient mental health services in a psychiatric hospital or general acute care hospital.
- Mental health rehabilitation services.
- Peer specialist services.
- Mental health targeted case management.
- Medication management.
- Residential and outpatient withdrawal management.
- Mental health outpatient treatment, including individual and group outpatient counseling and psychotherapy.
- SUD residential treatment.
- SUD group and individual counseling.
- Screening and brief intervention for SUD.

There are two Medicaid programs that provide specialized behavioral health services in Texas: Youth Empowerment Services (YES) and Home and Community-based Services-Adult Mental Health (HCBS-AMH).

Long-term Services and Supports

LTSS are provided to adults age 65 and older and individuals of all ages with physical, intellectual or developmental disabilities who require nursing care or need help with tasks of daily living.

Medicaid covers LTSS through the Texas state plan and through waiver programs. Their services may be delivered through managed care, fee-for-service (FFS), or both.

The types of LTSS individuals get is largely related to where the services are delivered. The goal is to ensure individuals have seamless access to services and supports in the most appropriate, least restrictive settings. LTSS may be provided in long-term care facilities, in community settings or within an individual's home.

Long-term Care Facilities

Nursing Facilities

Nursing facilities provide services with the goal to maximize resident autonomy, function, dignity and comfort. Required services provided in a nursing facility setting include:

- Room and board.
- Nursing.
- Social services and activities.
- Over-the-counter drugs.
- Medical supplies and equipment.
- Personal-need items.

Add-on services provided in a nursing facility setting may include:

- Ventilator care.
- Tracheostomy care for residents age 21 and younger.
- Emergency dental services.
- Custom power wheelchairs.
- Augmentative communication devices.
- Rehabilitative therapies.

Intermediate Care Facilities for Individuals with an Intellectual Disability

Intermediate care facilities for individuals with an intellectual disability or related condition (ICFs/IID) provide ongoing evaluation and individual program planning, 24-hour supervision, coordination, and integration of health or rehabilitative services. ICF/IID residential settings vary in size, from community settings serving six to 12 individuals (currently 98 percent of ICFs/IID) to large state supported living centers (SSLCs) serving several hundred.

Home and Community-based Services

State Plan Home and Community-based Services

Medicaid covers some home and community-based services like Personal Assistance Services (PAS), Community Attendant Services (CAS), Day Activity and Health Services (DAHS), Community First Choice (CFC), and Personal Care Services (PCS).

These services help individuals with:

- Activities of daily living like bathing, dressing and eating.
- Instrumental activities of daily living like cooking, grocery shopping and cleaning.
- Other essential tasks for home and personal care.
- Some services, like DAHS, include nursing care, meals and community programs.

Medicaid Waiver Programs

Medicaid waiver programs provide individuals alternative settings to placement in an institution, such as a long-term care or psychiatric facility. Most of Texas' waiver programs are granted through Home and Community-based 1915(c) Waivers.

In Texas, services delivered through these programs may include:

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

(See Appendix B, page 133, for a list of services provided by each waiver program.)

Texas Medicaid Waiver Programs

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

*STAR+PLUS HCBS operates like a 1915(c), but is provided through the 1115 Healthcare Transformation Waiver (see Chapter 5, page 98).

How Home and Community-based Services Are Delivered

Individuals who receive LTSS services can choose how certain services, like attendant care, are delivered.

Agency Option
Services are delivered through a provider agency, which employs attendants or other service providers.

Consumer-directed Services Option
The individual or their legally authorized representative (LAR) employs the attendants or other service providers. This gives the individual greater choice and control over their services. Individuals using the consumer-directed services (CDS) option are required to select a Financial Management Services Agency (FMSA) that provides orientation, writes paychecks for their employees, and pays federal and state employer taxes on the employer's behalf. Individuals may choose the agency option for some services and the CDS option for others.

Service Responsibility Option
The Managed Care Organization (MCO), if applicable, and a provider agency work with the individual to provide them with increased control over the delivery of their services. The provider agency employs the attendants or other service providers. Individuals choose their provider agency and work with the agency to determine which attendants will provide their services. The individual or their LAR trains the staff to meet the individual's needs and manages them on a day-to-day basis.

Prescription Drugs

People eligible for Medicaid or CHIP receive coverage for prescription drugs. The Vendor Drug Program (VDP) oversees the prescription drug benefit. This includes managing the Texas Formulary, which is a list of all covered drugs, and the Preferred Drug List (PDL). Drugs may be listed on the PDL as "preferred" or "non-preferred" based on their safety, efficacy and cost-effectiveness (see Chapter 3, page 56). Drugs listed as "non-preferred" on the PDL require prior authorization before they can be prescribed.

VDP also delivers outpatient prescription drugs for FFS clients, while MCOs cover the benefit in managed care. The PDL is not required for CHIP, but MCOs are required to use the PDL in administering pharmacy benefits for Medicaid.

Adults enrolled in FFS are limited to three prescriptions per month. There are no limits on prescription drugs that can be authorized for children age 20 and younger enrolled in any

Medicaid or CHIP program, adults enrolled in managed care, clients in nursing facilities, and clients enrolled in certain Medicaid waiver programs.

For Medicare clients dually eligible for Medicaid, Medicare Part D covers their prescription drugs.

Medical Transportation Services

The Medical Transportation Program (MTP) provides cost-effective, non-emergency medical transportation (NEMT) for Medicaid members who need help going to a doctor or specialist, a pharmacy, or other providers for covered health care services. MTP services are only for Medicaid members, Children with Special Health Care Needs members, and qualified low-income cancer patients.

Services provided through MTP include:

- Demand response transportation—curb-to-curb transportation using dispatched vehicles, including shared rides and transportation network company (TNC) vehicles.
- Mass transit tickets—including bus, rail, ferry, publicly or privately-owned transit providing general or special service on a regular or continuing basis, and commercial airline transportation services.
- Mileage reimbursement through Individual Transportation Participant (ITP) requests. ITPs must register to participate in the mileage reimbursement program.
- Meals and lodging, when covered health care services require an overnight stay outside the county of residence.
- Advanced funds for transportation or travel-related services.
- Out-of-state travel to contiguous counties in adjoining states (Louisiana, Arkansas, Oklahoma and New Mexico) and travel to states outside of the adjoining states for covered health care services not provided in Texas.

Effective June 2021, NEMT services for individuals in managed care will be coordinated by their MCO. In addition to the NEMT services above, MCOs will be required to provide nonmedical transportation (NMT) services, a subset of demand response transportation services, for certain trips requested with less than 48-hour notice. Examples of NMT include trips to obtain pharmacy services or prescription drugs, urgent care services, or upon discharge from a healthcare facility.

The STAR Managed Care Program

STAR is the first and largest managed care program in Texas. Most people who receive Medicaid in Texas are enrolled in STAR. The program primarily covers children, pregnant women and some families. STAR MCOs also provide service management to members with special health care needs (see A Closer Look, page 43). There are 15 MCOs delivering the STAR program across 13 STAR service areas.

Children and Youth

Medicaid

Children eligible for Medicaid can receive a wider range of health care services than adults, including services like physical, occupational and speech therapy; private duty nursing; and hearing and vision care.

Children and youth with Medicaid are eligible for behavioral health care, including Health and Behavior Assessment and Intervention (HBAI) services. These services identify the psychological, behavioral, emotional, cognitive and social factors important to preventing, treating and managing physical health symptoms.

Children and youth also receive comprehensive dental services. Most dental benefits are provided through managed care and delivered by one of three dental maintenance organizations. Children, who are either enrolled in STAR Health or who reside in a long-term care facility, receive dental care through the STAR Health MCO or their assigned facility.

Texas Health Steps

Children enrolled in any Medicaid program receive Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services—also known as Texas Health Steps. This program provides comprehensive medical, dental and case management services for children, birth through age 20, with Medicaid. This includes the Comprehensive Care Program, which expands coverage to any medically necessary services, even if the services are not covered by the state plan.

Texas Health Steps also provides case management for eligible children and pregnant women. Case managers help ensure their clients have access to needed medical, social, educational and other services related to their health condition, health risk or high-risk condition. Examples of services include: developing a service plan with clients and families, making referrals, and advocacy.

Texas Health Steps is not a benefit option for children enrolled in CHIP.

Children's Medicaid

Most children receiving Children's Medicaid are enrolled in STAR. Children's Medicaid services—including acute care, pharmacy services, behavioral health and LTSS—are primarily delivered through managed care, although some LTSS may be covered through FFS.

Some individuals with disabilities who receive Children's Medicaid are enrolled in the STAR Kids managed care program (see STAR Kids, page 36).

Medicaid for Children in Foster Care

In partnership with Texas Department of Family and Protective Services (DFPS), Medicaid provides STAR Health, a managed care program for children in state conservatorship. The program is administered by a single, statewide MCO.

Children in foster care and kinship care are a high-risk population with greater medical and behavioral health needs than most children with Medicaid. STAR Health provides acute care; LTSS; behavioral health care; and dental, vision and pharmacy services. The program provides a medical home for children as soon as they enter state conservatorship, and continues to serve them through these transition categories:

- Children in the Adoption Assistance or Permanency Care Assistance program who are transitioning from STAR Health to STAR or STAR Kids.
- Some children in the Adoption Assistance or Permanency Care Assistance program who have a disability and who choose to remain in STAR Health.
- Youth age 21 years and younger with voluntary extended foster care placement agreements (Extended Foster Care).
- Youth age 20 and younger who are Former Foster Care Children (FFCC).

STAR Health also offers services, including:

- Service management and service coordination (see A Closer Look, page 43).
- A 24/7 nurse hotline for caregivers and caseworkers.
- The Health Passport—a web-based, claims-based electronic medical record.

Children may be enrolled in the MDCP and receive their MDCP services through STAR Health (see MDCP, page 37).

In addition, STAR Health trains and certifies behavioral health providers, caregivers and caseworkers in trauma-informed care—including evidence-based practices, such as Trauma-Focused Cognitive Behavioral Therapy. Use of psychotropic medication among STAR Health clients is carefully monitored for compliance with the DFPS psychotropic medication utilization parameters.

Youth Empowerment Services

YES is a Medicaid waiver program that provides intensive community-based services for children and youth—who have severe mental, emotional or behavioral disturbances—and their families.

Services include but are not limited to: community living supports, family supports and supportive family-based alternatives, non-medical transportation, paraprofessional services, and transition services. (See Appendix B, page 136, for a full list of services.)

Children's Health Insurance Program

CHIP provides acute care, behavioral health care and pharmacy services for children in families who have too much income to qualify for Medicaid, but cannot afford to buy other health insurance.

CHIP offers mental health and SUD screening and treatment services similar to Medicaid. CHIP also provides SUD prevention and intervention services.

CHIP also provides dental benefits. CHIP members receive up to $564 in dental benefits per 12-month enrollment period—not including emergency dental services—to cover preventive and therapeutic services like periodontics and prosthodontic services. Clients may receive certain preventive and medically necessary services beyond this cap through a prior authorization process.

Women

Medicaid covers family planning. Medicaid and CHIP cover reproductive health care services, including: screening and treatment for sexually transmitted infections, contraception, prenatal care services, and labor and delivery. Medicaid also covers breast and cervical cancer screening and treatment. CHIP only covers contraception for medically necessary purposes.

Medicaid for Pregnant Women

Women who receive Medicaid for Pregnant Women are enrolled in STAR. Pregnant women who qualify for Medicaid receive full Medicaid benefits and coverage for perinatal services including:

- Prenatal visits.
- Prescription prenatal vitamins.
- Labor and delivery.
- Postpartum care.

Women with high-risk pregnancies may receive service management through their STAR health plan (see page 43). They may also receive case management services through Case Management for Children and Pregnant Women. Case managers assist pregnant women with high-risk health conditions to use medically necessary health, social, educational and other services related to their health condition.

CHIP Perinatal

The CHIP Perinatal program is for the unborn children of pregnant women who are uninsured and do not qualify for Medicaid. The program provides a basic prenatal care package. Services include:

- Prenatal visits.
- Prescription prenatal vitamins.
- Labor and delivery.
- Postpartum care.

Members receiving the CHIP Perinatal benefit are exempt from the 90-day waiting period and all cost-sharing, including enrollment fees and co-pays, for the duration of their coverage period.

Healthy Texas Women

Healthy Texas Women (HTW) is a Medicaid waiver program that provides women's health and family planning services at no cost to eligible women. HTW provides women's health and core family planning services, including:

- Pregnancy testing.
- Pelvic examinations.
- Sexually transmitted infection services.
- HIV screenings.
- Breast and cervical cancer screenings.
- Screening and treatment for cholesterol, diabetes and high blood pressure.
- Contraception, including condoms, birth control pills, long-acting reversible contraceptives and permanent sterilization.
- Screening and treatment for postpartum depression.

In January 2020, the Centers for Medicare and Medicaid Services (CMS) approved the Texas 1115 Demonstration Waiver application for HTW. The Health and Human Services

Commission (HHSC) began receiving federal matching funds for HTW services provided to adults on February 18, 2020 (see Chapter 4, page 75).

Healthy Texas Women Plus

HTW Plus is an enhanced postpartum services package. HTW Plus clients are eligible to receive additional services to treat certain health conditions including mental health conditions, like postpartum depression or substance use disorders, and cardiovascular conditions. To receive HTW Plus, an HTW client must have been pregnant within the 12 months prior to their enrollment. Services include:

- Individual, family and group psychotherapy services.
- Peer specialist services.
- Imaging studies; blood pressure monitoring; and anticoagulant, antiplatelet and antihypertensive medications.
- Screenings, brief interventions and referrals to treatment for substance use disorders.
- Outpatient substance use counseling.
- Smoking cessation services.
- Medication-assisted treatment.

Medicaid for Breast and Cervical Cancer

Women who receive Medicaid for Breast and Cervical Cancer (MBCC) are enrolled in STAR+PLUS. MBCC covers active cancer treatments, including:

- Chemotherapy and radiation.
- Surgery.
- Disease surveillance for clients with triple-negative receptor breast cancer.
- Hormone treatments.

Women eligible for MBCC receive full Medicaid benefits and remain in the program for the duration of their cancer treatment, if they continue to meet all other eligibility criteria.

Women can apply for MBCC through Breast and Cervical Cancer Screening (BCCS) clinics. BCCS is not a Medicaid program. BCCS clinics provide breast and cervical cancer screening and diagnostic services to women, plus serve as a point of access for MBCC.

A Closer Look

Better Birth Outcomes

Better Birth Outcomes (BBO) initiatives aim to improve women's perinatal health care. There are several BBO initiatives, including the following:

Maternal Opioid Misuse Model

Opioid use in pregnant women contributes to maternal mortality, preterm birth, low birth weight and neonatal abstinence syndrome in newborns. Senate Bill 750, 86th Legislature, Regular Session 2019, directed HHSC to apply for federal funding to implement a model of care that improves access to care and quality of care for pregnant women with opioid use disorder enrolled in Medicaid.

HHSC partnered with the Harris Health System, Ben Taub Hospital, Baylor College of Medicine, and Santa Maria Hostel to apply for funding under the Maternal Opioid Misuse (MOM) model. The MOM model is a five-year project that seeks to facilitate better integration of prenatal care, addiction medicine and psychiatric care for pregnant women enrolled in Medicaid with an opioid use disorder (OUD).

The federally funded project is being piloted in Harris County. Women who qualify will receive a comprehensive set of acute care and behavioral health services delivered in a coordinated and integrated approach, including:

- Prenatal and postpartum care and family planning services, like long-acting reversible contraception (LARC).
- Mental health and OUD screening and treatments, including medication assisted therapy (MAT), outpatient services, residential treatment and peer specialist services.

Postpartum Depression

Postpartum depression (PPD) is a common and potentially serious condition typically diagnosed after pregnancy. The impact of PPD and related conditions can be far-reaching. Numerous studies demonstrate women suffering from PPD develop behaviors that negatively impact their parenting abilities and compromise the mother-child bond. In order to increase awareness, education and continuity of care for women with PPD, HHSC has launched several initiatives and has published a five-year PPD strategic plan.

Long-acting Reversible Contraception

Texas is working to increase access to the LARC method of contraception to stop unintended pregnancies. LARC devices are highly effective for preventing pregnancy, are easy to use and last for several years. HHSC incentivizes the use of immediate postpartum (IP) LARC for pregnant women enrolled in Medicaid with add-on reimbursement—allowing providers to bill for the LARC device and insertion, in addition to the labor and delivery service.

Children and Adults with Disabilities

As previously described, individuals with disabilities may receive LTSS through Medicaid.

LTSS may be provided in long-term care facilities, or in home and community-based settings (see Long-term Services and Supports, page 26).

Children

Children with disabilities can receive their acute care, behavioral health services and LTSS through Children's Medicaid or Medicaid for the Elderly and People with Disabilities (MEPD). Some may receive home and community-based services through a Medicaid waiver program. Children, who are both in foster care and enrolled in STAR Health, receive all their acute care, behavioral health services and LTSS services through the STAR Health MCO (see Medicaid for Children in Foster Care, page 31).

STAR Kids

STAR Kids is a managed care program that provides acute care services and LTSS to children and youth with disabilities. Children and youth are enrolled into STAR Kids if they:

- Receive Supplemental Security Income (SSI) or SSI-related Medicaid.
- Are eligible for MEPD or a Medicaid Buy-in program.
- Are enrolled in a Medicaid waiver program.
- Reside in a long-term care facility.
- Are dually eligible for Medicare.

All STAR Kids members have access to service coordination through their MCO. Their service coordinator organizes acute care services and LTSS (see A Closer Look, page 43). If an individual is enrolled in multiple programs, their STAR Kids service coordinator works with all their other service coordinators or case managers to determine which programs will provide each of their services.

Medicaid for the Elderly and People with Disabilities

Children and adults with disabilities and individuals age 65 and older who do not receive SSI may qualify for Medicaid through MEPD.

Through MEPD, individuals may access programs and services like care in long-term care facilities and state plan home and community-based services—which may be delivered through managed care, fee-for-service or a combination of these models.

While STAR Kids can provide both acute care and LTSS to members, sometimes it may only provide acute care. For example, an individual residing in a long-term care facility may be enrolled in STAR Kids for their acute care only, while their LTSS are provided by their assigned facility and paid for through the FFS model.

In addition, FFS waiver programs can provide many of the same LTSS available through STAR Kids. If an individual needs a service available in both STAR Kids and their waiver program, they must get the service through STAR Kids.

Medically Dependent Children Program

MDCP is a Medicaid waiver program delivered through managed care that provides home and community-based services to children and youth age 20 and younger, as a cost-effective alternative to residing in a nursing facility.

Individuals enrolled in MDCP receive all services through their STAR Kids or STAR Health MCO. (See Appendix B, page 135, for a full list of services available through MDCP.)

School Health and Related Services Program

The School Health and Related Services (SHARS) program allows independent school districts, including public charter schools, to receive federal reimbursement for providing Medicaid services to participating Medicaid-eligible students age 20 and younger. Management of the SHARS program is a cooperative effort between the Texas Education Agency and HHSC. This program covers certain health-related services documented in a student's Individualized Education Program or, for audiology services only, a student's 504 plan. Services include:

- Audiology services.
- Physician and nursing services.
- Physical, speech and occupational therapies.
- Personal care services.
- Psychological services, including assessments and counseling.
- Transportation in a school setting.

Early Childhood Intervention

Early Childhood Intervention (ECI) is a statewide program that provides services to families with children from birth up to age 3 with developmental delays or disabilities. HHSC contracts with local entities, such as nonprofit organizations and some school districts, to provide services in all Texas counties. ECI provides targeted case management, specialized skills training, therapy services and other benefits for children on Medicaid.

A Closer Look

Waiver Programs for Individuals With Intellectual and Developmental Disabilities

Medicaid 1915(c) waiver programs are designed to provide home and community-based services to individuals with intellectual and developmental disabilities (IDD), or related conditions, as an alternative to placement in an ICF/IID.

Demand for some waiver programs exceed capacity. The programs maintain interest lists that people can join at any time (see A Closer Look, page 21).

There are four waiver programs for individuals with IDD, described below, which are delivered through the FFS model. These programs deliver many of the same services (see Appendix B, page 133).

Community Living Assistance and Support Services

CLASS provides home and community-based services to clients who have a related condition diagnosis qualifying them for placement in an ICF/IID. Services include: case management, prevocational services, transportation-residential habilitation, prescriptions, support family services and transition assistance services.

Deaf Blind with Multiple Disabilities

Deaf Blind with Multiple Disabilities (DBMD) provides home and community-based services, as an alternative to residing in an ICF/IID, to people of all ages who have deaf-blindness or have a condition that will result in deaf-blindness and have additional disabilities. Services include: case management, day habilitation, transportation-residential habilitation, assisted living, prescriptions, audiology services, dietary services, behavioral support and intervener.

Home and Community-based Services

HCS provides individualized services to clients of all ages, who qualify for ICF/IID level of care, yet live in their family's home, their own home, or other settings in the community. Services include: day habilitation and residential services, supported home living, transportation and transition assistance services.

Texas Home Living

TxHmL provides selected services and supports for individuals with IDD who live in their own home or their family's home. Services include: behavioral support, community support, transportation and day habilitation.

Adults

Adults with disabilities can receive their acute care, behavioral health services and LTSS through Medicaid. Some may receive home and community-based services through a Medicaid waiver program. Like children with disabilities, adults may receive their services through managed care, FFS or a combination of these models.

Other programs available to eligible adults with disabilities include: Program of All-inclusive Care for the Elderly (PACE), Medicaid-Medicare Plans (MMP), and Dual Eligible Special Needs Plans (D-SNPs) (see People Age 65 and Older, page 41).

STAR+PLUS

The STAR+PLUS managed care program provides acute care, behavioral health care and LTSS for adults who have a disability or who are age 65 and older. STAR+PLUS serves adults who:

- Receive SSI or SSI-related Medicaid.
- Are enrolled in STAR+PLUS HCBS.
- Reside in an ICF/IID, or are enrolled in an IDD waiver program while not dually eligible for Medicare.
- Are enrolled in the MBCC program.
- Are nursing facility residents.
- Are dually eligible for Medicare.

Members who are dually eligible for Medicare receive LTSS through STAR+PLUS and their acute care services through Medicare. Clients with complex medical conditions are assigned a service coordinator, who develops an Individual Service Plan (ISP) with the client and manages the client's acute care and LTSS.

Individuals can choose whether they participate in STAR+PLUS if they meet one or both criteria:

- Are enrolled in PACE.
- Are a member of Federally Recognized Native American Tribes.

Individuals are excluded from participation in STAR+PLUS if they:

- Are age 20 and younger, except for participants in MBCC who may be ages 18 to 64.
- Are dually eligible and currently living in an ICF/IID or receiving IDD waiver services.
- Reside in an SSLC.
- Reside in a state veteran home or the Truman Smith Care Center.

STAR+PLUS Home and Community-based Services Program

STAR+PLUS HCBS is a managed care program delivered through the Texas 1115 Health-care Transformation Waiver that provides a cost-effective alternative to living in a nursing facility to adults age 21 and older who have disabilities or who are elderly.

Individuals enrolled in the program receive all services through their STAR+PLUS MCO. Services offered include but are not limited to: adult foster care, assisted living services, emergency response services, home delivered meals and transition assistance services (see Appendix B, page 135).

Home and Community-based Services–Adult Mental Health

HCBS-AMH is a state plan program under Section 1915(i) that helps individuals with serious mental illness remain in their community. Adults with a diagnosis of serious mental illness have complex needs that can lead to extended psychiatric hospitalizations, repeated arrests and frequent emergency department visits. The HCBS-AMH program provides an array of intensive home and community-based services tailored to an individual's assessed needs and considering the individual's preferences and goals.

Services include, but are not limited to: host home/companion care, supervised living services, supported home living and psychosocial rehabilitative services. Services are provided in CMS-approved settings, which can be an individual's home or apartment, an assisted living setting, or small community-based residence.

Medicaid Substance Use Disorders Treatment Services

Medicaid SUD treatment services must be provided by a chemical dependency treatment facility (CDTF) or opioid treatment providers (OTP), either of which must be licensed and regulated by HHSC—except for Medication Assisted Therapy (MAT) services. MAT, including methadone and buprenorphine, is primarily used for opioid-use disorder, but can also be used for alcohol-use disorder. Methadone for an opioid-use disorder may only be provided in an OTP. Buprenorphine treatment may be provided by OTPs, CDTFs, physicians and other qualified prescribers—including nurse practitioners, physician assistants, nurse midwives and nurse anesthetists.

Screening, Brief Intervention and Referral to Treatment
Screening, Brief Intervention and Referral to Treatment provides early intervention and treatment services for clients age 10 and older who have a SUD, or who are at risk of developing SUD. The benefit is available in community-based settings and hospitals.

People Age 65 and Older

Adults age 65 and older can receive Medicaid through MEPD, delivered through the STAR+PLUS managed care program (as previously described on page 39). People who are aging and need LTSS can also get these services through MMPs, D-SNPs or PACE.

Medicare-Medicaid Plans

MMPs are designed to provide a fully integrated managed care model for people who are dually eligible for Medicare and Medicaid. Participating individuals may be age 21 and older, with the majority falling into the age 65 and older demographic. If eligible, individuals are required to be passively enrolled into the STAR+PLUS program, but may choose to opt-out.

The model involves a three-party contract between an MMP, HHSC, and CMS for the provision of the full array of Medicaid and Medicare services. All covered services, including acute care and LTSS, are provided by a single health plan. Services provided through an ICF/IID or through a Medicaid waiver program, such as CLASS, DBMD, HCS, or TxHmL, are excluded.

MMPs operate in Bexar, Dallas, El Paso, Harris, Hidalgo and Tarrant counties.

Medicaid Hospice Services

Hospice services provide palliative care to terminally ill individuals for whom curative treatment is no longer desired and who have a physician's prognosis of six months or less to live.

Services include: physician services, nursing, PAS, therapies, prescription drugs, respite care and counseling—plus supportive care for their loved ones. These services can be administered in the home or in community settings, long-term care facilities, or in hospital settings.

Children age 20 and younger receiving hospice services may continue to receive curative care from non-hospice acute care providers.

Medicare Advantage Dual Eligible Special Needs Plans

D-SNPs are managed care plans specifically designed to coordinate care between Medicare and Medicaid.

The plan must be designed for and offered to individuals who are eligible for Medicare and entitled to medical assistance under the Texas State Plan. D–SNPs can serve both full- and partial-benefit dual eligibles.

D-SNPs can operate within or without the STAR+PLUS program.

If in STAR+PLUS, a D-SNP must deliver Medicaid services through STAR+PLUS. D-SNPs that do not operate in STAR+PLUS are only responsible for covering member cost-sharing payments.

Program of All-inclusive Care for the Elderly

The PACE program provides acute care and LTSS services for a capitated monthly fee below the cost of comparable care in a long-term care facility. PACE participants must be age 55 and older, live in a PACE service area, qualify for nursing facility level of care, and be able to live safely in the community. PACE participants receive all medical and social services they need through their PACE provider.

PACE offers all health-related services for each participant, including: inpatient and outpatient medical care, specialty services (e.g., dentistry, podiatry, physical therapy and occupational therapy), social services, in-home care, meals, transportation, and day activity services.

PACE is available in Amarillo/Canyon, El Paso and Lubbock. Individuals in these service areas who are also eligible for STAR+PLUS may choose to receive services either through STAR+PLUS or PACE, but not both.

A Closer Look

Service Coordination in Managed Care

STAR Kids and STAR+PLUS

All STAR Kids members get connected with a service coordinator through their health plan. STAR+PLUS members with complex medical conditions can also get a service coordinator.

Service coordination helps ensure members get the services they need. Using a person-centered approach, service coordinators help manage the member's health care and long-term care needs—including access to community resources and help with food and housing. Service coordinators work with the member, their primary care provider, and their specialty and non-medical providers to develop and carry out an Individualized Service Plan.

STAR and CHIP

STAR and CHIP members with special health care needs can get help from their health plans through service management. Special health care needs include: serious, ongoing illnesses; chronic or complex conditions; disabilities; and conditions that require therapeutic intervention and evaluation by appropriately trained staff.

Like a service coordinator, a service manager helps ensure members with special health care requirements get the services they need from their health plan. They can also help members get non-capitated services, which are services that might not be covered in STAR or CHIP but are a Medicaid benefit. For example, for STAR members, these services might include programs like Community First Choice or personal care services.

STAR Health

STAR Health members with a specific medical and behavioral need get service coordination or service management.

In STAR Health, service coordination helps caregivers manage information like medical records for court hearings or get services from other programs. Service management is for members with complex medical or behavioral needs.

A STAR Health service manager works with the member, member's caregivers, primary care provider and specialty care providers to create and carry out a service plan. Service managers ensure access to and use of medically needed, covered services.

Chapter 3

How does HHSC make sure clients get good care?

At-a-Glance

4.3 million Texans served

94% served through managed care

17 Managed Care Organizations (MCOs)
3 Dental Maintenance Organizations (DMOs)

40+ Contracts

HHSC Contract Oversight Tools

Tools span a multitude of areas, administered by various expertise.

Access to services
Network adequacy monitoring, appointment availability studies, member satisfaction studies

Service delivery
Acute care utilization module in operational reviews, managed care long-term services and supports utilization reviews, drug utilization reviews, electronic visit verification

Quality of care
Performance indicator dashboard for key quality measure indicators, custom evaluations, improvement projects, pay-for-quality, alternative payment models, MCO report cards

Operations
Readiness reviews prior to serving members, biennial operational reviews, targeted reviews conducted on-site

Financial
Validation of financial statistical reports, administrative expenses cap, profit limits, experience rebate, independent auditing

Contractual Non-compliance:
There are multiple stages of remedies for non-compliance discovered through oversight tools, each with an increased level of impact. The remedy issued is contingent on the type of non-compliance, and is not necessarily sequential.

1. Corrective Action Plan
2. Accelerated Monitoring
3. Liquidated Damages
4. Suspension of Default Enrollment
5. Contract Termination

Numbers are subject to change. Number of MCOs and contracts current as of November 2020.

The Managed Care Delivery System

The Health and Human Services Commission (HHSC) has shifted its service delivery for Medicaid and the Children's Health Insurance Program (CHIP) from the fee-for-service (FFS) model to managed care. There are now 17 managed care organizations (MCOs) serving 94 percent of Medicaid clients and all CHIP clients.

Managed care is an integrated service delivery system where HHSC contracts with MCOs to provide all covered, medically necessary services to people receiving Medicaid or CHIP benefits. HHSC pays each MCO a monthly capitation rate for every member enrolled in their plan, and MCOs reimburse providers for services provided to their members.

The goal of transitioning from FFS to managed care is to provide value-based care. This is achieved through the care coordination provided by the MCOs—a function that serves to establish a medical home for members; improve access to care; and ensure quality, cost-effective services are delivered.

Achieving Value-based Care

MCOs can achieve value-based care by improving or stabilizing member health and delivering services in a cost-effective manner. MCOs are paid a fixed amount per member per month (PMPM) in advance based on historical costs.

This model places MCOs at financial risk if the cost of care exceeds this rate, which incentivizes them to improve care quality while keeping costs low. The "medical home" leverages the patient-provider relationship to improve health outcomes and ensure appropriate use of covered services.

The Medical Home

When members enroll with an MCO, they choose a primary care provider (PCP)—usually a family or general practice doctor, a pediatrician, or an OB/GYN—who serves as the member's medical home. PCPs are a central access point for their patients' health care. They deliver comprehensive preventive and primary care, as well as provide referrals for specialty care and other covered services.

The medical home helps with cost management and service delivery. The system of referrals and emphasis on preventive and primary care can limit over-utilization of care, while still improving access to covered, medically necessary services.

Members with chronic, complex health care needs also benefit from the medical home, as it promotes a patient-centered approach to care. The member's PCP, specialists and other caregivers directly engage with them to address any high-risk health conditions or other co-morbid conditions.

HHSC's Managed Care Contract Oversight

HHSC's oversight of managed care seeks to ensure that the Texas Medicaid and CHIP programs are improving health outcomes and MCOs are delivering quality, cost-effective services.

HHSC contracts with MCOs to coordinate services for 4.1 million Medicaid and CHIP clients. Because of the size, scope and complexity of managed care contracts and the types of services MCOs provide, there is no single oversight strategy.

MCO Selection and Contract Terms

Each MCO is selected through a competitive contract process that requires ongoing involvement from staff and leadership across the organization—starting with the solicitation phase, and then continuing throughout the evaluation phase, negotiations and contract formation.

The relationship between HHSC and any selected MCO is best described as a "partnership with accountability." This is established through robust contract terms at the onset, which outline MCO responsibilities, including but not limited to:

- Reporting financial, member enrollment and encounter data.
- Providing member benefit packages that cover services required by the Texas Medicaid or CHIP programs.
- Delivering service management and service coordination to eligible members.
- Establishing adequate and accessible provider networks.
- Timely processing of provider claims.
- Maintaining member and provider call centers.
- Resolving member and provider complaints and appeals.

The Uniform Managed Care Contract establishes the baseline requirements for all MCOs and then additional contract terms are developed specific to the program.

Readiness Reviews

After they have been selected through the competitive contracting process, the MCO builds out its operations. Prior to serving members, HHSC conducts readiness reviews to ensure the MCO can provide all contracted services.

Major areas examined by HHSC to ensure MCOs are ready to serve members are:

- IT system readiness.
- Claims processing.
- Complaint and appeal process.
- Member education materials.
- Utilization management policies and procedures.
- Behavioral health referral process.
- Provider relations.
- Provider network.
- Pharmacy services.
- Member and provider hotlines.
- Website functionality and content for members and providers.

In addition, program-specific areas are reviewed, such as service coordination and service management for STAR, STAR Kids, STAR+PLUS, and STAR Health.

Contract Management and Oversight

Once the MCO is actively serving members, HHSC employs several oversight tools to monitor MCOs based on the requirements laid out in the contract. The main areas of contract oversight include:

- Access to services.
- Service delivery.
- Quality of care.
- Onsite operations.
- Financial practices.

The oversight tools within these areas enable HHSC to verify MCO compliance with state and federal law and the terms of their contract. If issues of non-compliance are found, HHSC applies a graduated remedy process to address these issues.

Access to Services

MCOs can reduce the use of emergent care by ensuring members have timely access to primary and preventive care. They are contractually required to build adequate networks of providers so their members can access care when needed, near where they live.

In Texas and across the U.S., network adequacy for commercial health plans and Medicaid and CHIP MCOs is influenced by many factors, including provider availability, administrative complexity and payment rates.

MCO Network Adequacy

HHSC uses a variety of tools to monitor MCO networks—including time and distance standards, provider directory quality checks, appointment availability studies, provider referral surveys, and member satisfaction surveys. When deficiencies are discovered, HHSC addresses them through its established graduated remedy process (see Non-compliance Remedies, page 69).

Time and Distance Standards

In March 2017, HHSC implemented new access standards for MCO provider networks. These access, or time and distance, standards were developed based on those used for Medicare Advantage and by the Texas Department Insurance (TDI). The standards are either consistent with or more stringent than state and federal requirements.

In September 2018, HHSC adopted time and distance standards for long-term services and supports (LTSS) and pharmacy. Standards for personal attendant services will be implemented in 2021.

HHSC is also seeking to improve member access to behavioral health services like substance use disorder (SUD) treatment. In 2020, HHSC adopted new provider network standards for outpatient chemical dependency treatment facilities and outpatient opioid treatment programs.

MCOs must allow each member to choose their network provider to the extent possible. MCOs must also ensure that 90 percent of their members have access to at least two network providers within specific time or distance requirements.

Time and Distance Standards							
		Distance in Miles			Travel Time in Minutes		
Provider Type		Metro County	Micro County	Rural County	Metro County	Micro County	Rural County
Behavioral Health-Outpatient		30	30	75	45	45	90
Hospital-Acute Care		30	30	30	45	45	45
Prenatal		10	20	30	15	30	40
Primary Care Provider*		10	20	30	15	30	40
Specialty Care Provider	Cardiovascular Disease	20	35	60	30	50	75
	ENT (otolaryngology)	30	60	75	45	80	90
	General Surgeon	20	35	60	30	50	75
	OB/GYN	30	60	75	45	80	90
	Ophthalmologist	20	35	60	30	50	75
	Orthopedist	20	35	60	30	50	75
	Pediatric Sub-specialists	20	35	60	30	50	75
	Psychiatrist	30	45	60	45	60	75
	Urologist	30	45	60	45	60	75
Occupational, Physical or Speech Therapy		30	60	60	45	80	75
Nursing Facility		75	75	75	N/A	N/A	N/A
Pharmacy		2	5	15	5	10	25
Pharmacy (24-hour)		75	75	75	90	90	90
Substance Use Disorder-Outpatient	Chemical Dependency Treatment Facilities	30	30	75	45	45	90
	Opioid Treatment Programs	30	30	75	45	45	90
Main Dentist (general or pediatric)		30	30	75	45	45	90
Dental Specialists	Pediatric Dental	30	30	75	45	45	90
	Endodontist, Periodontist or Prosthodontist	75	75	75	90	90	90
	Orthodontist	75	75	75	90	90	90
	Oral Surgeons	75	75	75	90	90	90

Metro = county with a population of 200,000 or greater; Micro = county with a population between 50,000-199,999; Rural = county with a population of 49,999 or less.
*Services for both adults and children include acute, chronic, preventive, routine or urgent care.

HHSC uses geo-access mapping to monitor the network access of individual MCOs and to look for areas of the state where there are provider capacity issues.

Analysis from the third quarter of SFY 2020 for all MCOs collectively, across all programs has shown:

- Regardless of county size, MCOs perform above the 90 percent standard for primary care providers, OB/GYNs, main dentists, outpatient behavioral health care, prenatal care, and for occupational, physical or speech therapy.
- In larger counties (metro counties), MCOs meet or exceed the standard for the following specialty care providers: cardiovascular disease, psychiatrists, ophthalmologists, orthodontists, pediatric sub-specialties, and urologists.
- Regardless of county size, MCOs fall below the standard for some of the dental specialist provider types including pediatric dentists, prosthodontists, and endodontists.

Building a strong network of providers is an ongoing effort for MCOs. In rural areas, telemedicine has become an important tool in bridging access to services.

Appointment Availability

Appointment availability studies monitor the length of time a member must wait between scheduling an appointment with a provider and receiving treatment from the provider. HHSC contracts with an external quality review organization (EQRO) to conduct these studies periodically. Historically, the EQRO performed four studies by provider type, two per year. Due to the public health emergency, three studies were conducted in 2020. Two studies will be conducted in 2021 with the goal of resuming four studies per year in 2022.

The EQRO uses a mystery shopper method, where they call a random sample of providers to determine how soon an appointment can be scheduled. The samples of provider offices for the studies are pulled from member-facing, provider directories submitted by the MCOs.

Previously, HHSC has imposed corrective action plans (CAPs) and liquidated damages (LDs) on all the MCOs in at least one service area for not meeting appointment availability standards.

HHSC also uses results from these studies to target improvement efforts. For example, HHSC placed greater focus on prenatal care through the 2018 MCO Performance Improvement Projects (PIPs) and Pay-for-Quality (P4Q) measures.

STAR MCOs improved on P4Q measures for pregnant members receiving a prenatal care visit in the first trimester or within 42 days of enrollment, moving the program rate from

the national 50th-75th percentile in 2017 to the national 75th-90th percentile in 2018. 2018 PIP scores will be posted to the HHSC website in 2021.

MCO Appointment Availability Standards	
Level/Type of Care	**Time to Treatment**
Urgent Care (child and adult)	Within 24 hours
Routine Primary Care (child and adult)	Within 14 calendar days
Preventive Health Services for New Child Members	No later than 90 calendar days after enrollment
Initial Outpatient Behavioral Health Visits (child and adult)	Within 14 calendar days
Preventive Health Services for Adults	Within 90 calendar days
Prenatal Care (not high-risk)*	Within 14 calendar days
Prenatal Care (high risk)*	Within five calendar days
Prenatal Care (new member in third trimester)	Within five calendar days

*Prenatal care appointment availability studies are only conducted for STAR.

Appointment availability is closely related to other network adequacy oversight tools, like provider directory validation. HHSC uses these oversight methods together to help ensure access to care for members.

Provider Directory Quality

MCOs use the information submitted by providers during credentialing for their directories. However, inaccurate or out-of-date information can impact members' ability to access services. HHSC requires MCOs to update online provider directories weekly and monitors their directories for accuracy.

HHSC makes quarterly calls to a random sample of providers from MCO directories to confirm:

- The provider's contact information is accurate.
- The provider is accepting patients.
- The provider is meeting appointment availability standards.
- The provider covers certain age limits if they are a specialist.

The EQRO also collects data related to provider directory quality when it conducts appointment availability studies.

HHSC and the EQRO share findings with MCOs, and then request plans for addressing any identified issues from MCOs. As needed, HHSC also uses claims data to validate provider

activity and eliminate inactive providers. Improvements to the quality of provider directories are ongoing.

Member Satisfaction

To understand the patient experience with health care, HHSC reviews member complaints, as well as results from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) and the National Core Indicators–Aging and Disabilities (NCI-AD) surveys.

CAHPS surveys focus on consumer perceptions of quality, such as the communication skills of providers and ease of access to health care services. The 2018 CAHPS survey results showed that 13 out of 16 MCOs in STAR met the minimum standard for "good access to routine care" for children. However, only four MCOs in the STAR program met the minimum standard for "good access to specialist appointment." MCOs are subject to contract remedies for failing to meet minimum standards for one-third or more quality measures, which includes member survey measures.

Texas rates for most CAHPS survey composites and ratings were equal to or higher than national averages for Medicaid (child population) in 2019. CHIP rates were lower than national averages for both "Getting Needed Care" and "Getting Care Quickly," and were equal to or higher than national averages for other composites published by the Agency for Healthcare Research and Quality. HHSC uses these results in its annual MCO report cards, performance indicator dashboards and in P4Q (see Transparency with the Public, page 61).

Service Delivery

MCOs are required to provide all covered, medically necessary services to their Medicaid and CHIP members in the appropriate amount, duration and scope. HHSC monitors MCO service delivery compliance through utilization reviews (URs).

Utilization Reviews

URs examine requests for medical treatments to confirm MCOs are delivering appropriate, medically necessary services in compliance with their contract requirements. URs are overseen by the Office of the Medical Director and are conducted by a team of nurses, clinicians and contract experts. URs ensure MCOs are authorizing, justifying and providing

services without over-utilization or under-utilization. The reviews also assure MCO adherence to federal and state laws and rules, their contracts with HHSC, and their own policies.

URs consist of two review units: Acute Care Utilization Review (ACUR) and Managed Care Long-term Services and Supports (MLTSS).

Acute Care Utilization Review

MCOs must appropriately approve and deny medical services in accordance with state and federal regulations and HHSC contracts. The ACUR unit oversees the authorization of medical benefits—a key component of an MCO's management of service utilization in Medicaid. This oversight reduces authorizations of unnecessary services, while ensuring members have access to the care they need.

The reviews are typically done as part of HHSC's comprehensive readiness and operational reviews. They can also be conducted as a targeted review if a need is identified (see Targeted Reviews, page 66). The team is comprised of registered nurses; occupational, speech and physical therapists; behavioral health specialists; and contract specialists. Activities include analysis of prior authorization data for a targeted sample of members to determine whether MCOs appropriately and accurately: deliver medically necessary, requested services; process requests timely; provide contractually required service coordination; and ensure members have appeal and fair hearing opportunities when a service is denied.

Managed Care Long-term Services and Supports Utilization Review

The initial scope of the MLTSS UR was for review of the STAR+PLUS program only. In 2018, the Texas Legislature approved additional staff, which expanded the scope to include review of STAR Kids and STAR Health Medically Dependent Children Program (MDCP).

The MLTSS UR team samples STAR+PLUS Home and Community-based Services (STAR+PLUS HCBS), STAR Kids and STAR Health MDCP members to review how MCOs conduct assessments—their procedures and related information used to determine appropriateness of member enrollment in these programs. The review includes ensuring MCOs are providing services according to their assessment of service needs. The team conducts desk reviews of MCO documentation and home visits with each of the members in the sample.

UR findings inform policy and contract clarifications, MCO consultation and training, internal process improvements, and remediation actions with MCOs. Additionally, UR

teams coordinate and communicate with MCOs to find solutions that are consistent with HHSC's standards and expectations.

Prescription Drug Oversight

Medicaid and CHIP programs must adhere to the Texas Formulary—a list of covered, CMS-approved drugs—when administering pharmacy benefits. The Vendor Drug Program (VDP) oversees the Formulary and protocols for drug-use management across Medicaid, CHIP and other HHSC programs.

The VDP also manages the Preferred Drug List (PDL)—a subset of many, but not all drugs on the Formulary. Drugs listed as "preferred" are available without prior authorization, while drugs listed as "non-preferred" require a prior authorization before they may be dispensed. A drug's status on the PDL is based on its safety, efficacy and cost-effectiveness. The PDL is required in FFS and managed care.

The Texas Drug Utilization Review Board

The Texas Drug Utilization Review (DUR) Board is an HHSC advisory board whose members are appointed by the HHSC Executive Commissioner. The board is composed of physicians and pharmacists who provide services across the Medicaid population and represent a variety of specialties. In addition, two representatives (one physician and one pharmacist) from the MCOs and one consumer advocate for Texas' Medicaid members are included on the board. The two representatives from MCOs serve as non-voting members.

The duties of the board include submitting recommendation to HHSC for the PDL, approving clinical prior authorizations, developing and reviewing educational interventions for Medicaid providers, and reviewing drug utilization across the Medicaid program.

Drug Utilization Reviews

HHSC and MCOs perform drug utilization reviews (DURs) before and after dispensing medications to Medicaid clients. These reviews evaluate the safety and appropriate use of drug therapies, while seeking to contain costs.

Prospective DURs

Prospective DURs are performed before each prescription is filled or delivered to the client or member, typically at the point-of-sale or point-of-distribution. This review evaluates the client's medication history to ensure appropriate and medically necessary drug utilization. It also includes screening for therapeutic duplication, interactions with other health conditions or drugs, incorrect drug dosage or duration of treatment, and clinical abuse or misuse.

Advisory messages concerning clinically significant conditions or situations are part of the point-of-sale claim adjudication process. Upon identifying any clinically significant conditions or situations, the pharmacist should take appropriate steps to avoid or resolve the problem, including consultation with the prescribing provider.

Pharmacy Prior Authorizations

There are two types of prior authorizations (PAs) for prescription drugs: non-preferred and clinical.

Non-preferred PAs may occur when prescribers choose medications listed on the PDL as non-preferred for their Medicaid patients. To prescribe the medication, the provider must obtain prior authorization from HHSC or their patient's MCO before the drug is dispensed.

Clinical PAs may be required for an individual drug or an entire drug class included on the Formulary. The drug(s) may also have preferred or non-preferred status on the PDL. Clinical PAs are determined using evidence-based clinical criteria and nationally recognized peer-reviewed information. Participating MCOs are required to perform certain clinical PAs and may perform others at their discretion.

Retrospective DURs

After a client has received medication, retrospective DURs are conducted to review the drug therapy. Reviews examine claims data to analyze prescribing practices, the client's medication use and pharmacy dispensing practices. This helps identify patterns of fraud and abuse, gross overuse, and inappropriate or medically unnecessary care. This also allows for active, ongoing educational outreach for prescribing providers and pharmacists with the aim of improving prescribing and dispensing practices.

Pharmacy Benefits Manager Oversight

MCOs contract with pharmacy benefits managers (PBMs), who build the MCOs' pharmacy networks and negotiate rates with and pay claims to pharmacists. By extension, PBMs are required to comply with state and federal regulations, use the PDL, and follow the prior authorization criteria established by the VDP and the MCO.

Many of the same tools used to monitor MCOs are also used to ensure PBM compliance, including desk reviews, onsite reviews, readiness reviews and targeted reviews. These activities include review of MCOs' policies, procedures, contract deliverables, and self-reported data for encounters and claims.

HHSC contracts also prohibit "spread pricing"—when a PBM keeps a portion of the reimbursement rates intended for pharmacies instead of passing the full payments from the MCO to pharmacies. Drug prices and dispensing fees paid to the pharmacies from the PBM must be transparent to the state.

Electronic Visit Verification

Electronic Visit Verification (EVV) is a computer-based system that electronically verifies the occurrence of personal attendant service visits by documenting the precise time service delivery begins and ends. EVV helps prevent fraud, waste and abuse, while ensuring Medicaid recipients receive care that is authorized for them.

Texas requires EVV for certain Medicaid funded home and community-based services provided through HHSC and MCOs. Only services delivered through the agency option are required to use EVV. The following programs and services are currently using EVV:

- 1915(c) Community Living Assistance and Support Services (CLASS) waiver.
- 1915(k) Community First Choice (CFC) program.
- Community Attendant Services (CAS), Personal Care Services (PCS), Primary Home Care (PHC) and Family Care.
- STAR Health.
- MDCP in STAR Kids.
- STAR+PLUS, including state plan and the HCBS portion.

The 21st Century Cures Act

The 21st Century Cures Act is a federal law passed in December 2016, requiring the use of EVV for all Medicaid personal care services and home health care services. The law expands the scope of programs and services required to use EVV to include:

- Individuals participating in the Consumer-directed Services (CDS) option or Service Responsibility Option for their service delivery.
- Home health nursing and therapy services.
- Deaf Blind with Multiple Disabilities (DBMD), Home and Community-based Services (HCS), and Texas Home Living (TxHmL) 1915(c) waiver providers.

The effective date for implementing EVV for all PCS services is January 1, 2021.

Quality of Care

HHSC has a strong focus on quality of care in Medicaid and CHIP and uses multiple approaches to measure and improve care quality. HHSC collects data from several sources to monitor health outcomes. Quality-based payment programs and other initiatives incentivize MCOs, DMOs, facilities and other providers to improve care quality and increase value.

Under federal regulations, HHSC contracts with EQRO. Texas' EQRO follows CMS protocols to assess access, utilization and quality of care provided by MCOs participating in all Medicaid and CHIP medical and dental managed care programs.

In addition to ensuring state programs, MCOs and DMOs are compliant with established regulations, HHSC uses the EQRO to perform custom evaluations related to quality of care. The EQRO uses a variety of tools and measures, including analyzing MCO documents, provider medical records, and administrative data, like enrollment and encounter data; interviewing MCO and DMO administrators; and surveying members, caregivers of members and providers.

EQRO reports allow comparison of results across MCOs in each program and are used to develop overarching goals and quality improvement activities for Medicaid and CHIP managed care programs. MCO and DMO results are compared to HHSC standards and national benchmarks, where applicable.

Accountability for MCO continuous improvement in quality of care for members is primarily accomplished through a variety of improvement projects and quality-based payment reforms.

Performance Improvement Projects

PIPs are an integral part of Texas' Managed Care Quality Improvement Strategy. Federal regulations require all states with Medicaid managed care programs to ensure health plans conduct PIPs. HHSC, in consultation with the EQRO, determines topics for PIPs based on health plan performance. Health plans create a PIP plan, report on their progress yearly, and provide a final report. The EQRO evaluates the PIPs in accordance with CMS protocols.

Projects must be designed to achieve, through ongoing measurements and interventions, significant improvement over time with a favorable effect on health outcomes and member satisfaction. Each PIP lasts two years—and HHSC requires each MCO and DMO to implement two PIPs per program on a staggered schedule, such that one is implemented each calendar year. One PIP must be a collaborative project with another MCO and DMO, a Delivery System Reform Incentive Payment (DSRIP) program, or a community organization.

For 2020, DMO PIPs used a Dental Quality Alliance measure to aim at rate increases for topical fluoride treatments for children at an elevated risk for tooth decay and cavities. MCO topics focused on behavioral health integration—including follow-up after hospitalization for mental illness, metabolic monitoring for children and adolescents on antipsychotics, and follow-up care for children prescribed ADHD medication. More information and current PIP topics can be found on the HHSC website.

Quality Assessment and Performance Improvement

Federal regulations also require Medicaid health plans to develop, maintain and operate quality assessment and performance improvement (QAPI) programs. MCOs and DMOs report on their QAPI programs each year and these reports are evaluated by Texas' EQRO.

QAPI programs are ongoing, comprehensive quality-assessment and performance-improvement programs for all the services the MCO provides, while PIPs are time-limited interventions targeting a specific aspect of care.

Long-term Care Facility Monitoring

HHSC oversees the quality of care received by Texans in long-term care (LTC) facilities and helps providers optimize the care they deliver. Staff use several tools for monitoring, including onsite visits, technical assistance and training.

HHSC nurses, dieticians, pharmacists and qualified intellectual development professionals conduct onsite quality monitoring visits. These visits help staff understand the changing needs of individuals living in the LTC facility and identify otherwise unseen problems. Staff use an early warning system to identify medium to high-risk LTC facilities and dispatch a rapid response team to facilities identified as an immediate risk to the health and safety of residents.

HHSC program staff research and connect providers statewide with training, tools and best practices, including in-service events and annual conferences. Staff also help facilities comply with state and federal regulations, including Pre-Admission Screening and Resident Review (PASRR).

Pay-for-Quality and Quality-based Payment Reform

P4Q programs are an integral part of health care payment reform through which provider payments become linked to improved quality and efficiency rather than volume of services delivered.

The medical P4Q program evaluates MCOs on a set of quality measures—including disease prevention, chronic disease management, and maternal and infant health—and places a percentage of the MCOs' capitation at risk, depending on their performance. The dental P4Q program places a portion of the DMOs' capitation at risk based on their performance on a set of dental care quality measures.

These programs incentivize health plans and providers to implement alternative payment models (APMs)—also called value-based payments—which help them meet or exceed their P4Q performance targets. MCOs and DMOs must have a certain percentage of their overall provider payments associated with an APM. For a certain percentage of these payments, the provider must have some degree of risk (see Chapter 4, page 90). HHSC is using the Healthcare Payment-Learning and Action Network (HCP-LAN) alternative payment model framework (HCP-LAN.org) to help guide this effort.

HHSC also administers similar programs for health care and long-term care facilities, like the Hospital Quality-based Payment Program and the Quality Incentive Payment Program (QIPP) for nursing facilities (see Chapter 4, pages 91-92). The Hospital Quality-based Payment Program holds hospitals and MCOs financially accountable for potentially preventable events (PPEs). Through QIPP, payments are made by STAR+PLUS MCOs to nursing facilities based on their improvement activities and performance on certain quality measures.

Measurement, reporting and fiscal actions are applied on an annual cycle. More information about P4Q programs and quality-based payment reform can be found on the HHSC website.

Transparency with the Public

HHSC is committed to increasing transparency with the public related to managed care performance and quality-related measures, including MCO report cards and the Texas Healthcare Learning Collaborative (THLC) portal.

Managed Care Report Cards

HHSC uses a one- through five-star rating system to evaluate MCOs on their overall performance and on specific measures—such as the quality of care provided for chronic conditions, like asthma or diabetes. Ratings are developed by surveying current members and analyzing claims data, and are updated annually.

These report cards allow members to compare the health plans in their service area and make an informed selection during their enrollment or if they want to change health plans. MCO report cards are posted on the HHSC website and are included in the Medicaid and CHIP enrollment packets.

Texas Healthcare Learning Collaborative Portal

This website serves as a public reporting platform, contract oversight tool and a tool for MCO quality improvement efforts. HHSC, MCOs, providers and the public can use the site to get up-to-date MCO and hospital performance data on key quality-of-care measures—including PPEs, Healthcare Effectiveness Data and Information Set (HEDIS), and other care quality information.

Providers can also see performance data by MCO within a service area over time. This data may serve as an important tool for providers to find unmet needs they can address—and those who excel in an area of care in which an MCO needs improvement may find common ground to engage the MCO on value-based contracting. The THLC portal can be accessed at THLCPortal.com.

A Closer Look

Quality Monitoring Sources and Measures

HHSC tracks and monitors program performance using a performance indicator dashboard—a combination of national and state-developed measures by program. Contracts require MCOs to perform above the minimum standard on more than two-thirds of the dashboard measures.

Sources	Measures
National Committee for Quality Assurance Healthcare	• Nationally recognized and validated set of measures used to gauge quality of care provided to members, including Healthcare Effectiveness Data and Information Set (HEDIS).
Healthcare Effectiveness Data and Information Set (HEDIS)	• Domains include effectiveness of care, access and availability of care, experience with care, and health care utilization.
Agency for Healthcare Research and Quality Pediatric Quality Indicators (PDIs)/ Prevention Quality Indicators (PQIs)	• PDIs and PQIs use hospital discharge data to measure quality of care for ambulatory care sensitive conditions—which are conditions where good outpatient care or early intervention can prevent hospitalization, complications or more severe disease. • PDIs specifically screen for problems that children and youth may experience.
3M Software for Potentially Preventable Events (PPEs)	The EQRO calculates rates across all MCOs and programs for the following PPEs: • Potentially preventable admissions. • Potentially preventable readmissions. • Potentially preventable emergency department visits. • Potentially preventable complications. • Potentially preventable ancillary services.
Consumer Assessment of Healthcare Providers & Systems (CAHPS) Surveys	• CAHPS health plan survey is a nationally recognized and validated tool for collecting standardized information on members' experiences with health plans and services. • The EQRO alternates CAHPS surveys so that members or caregivers from each program are surveyed every other year.
Dental Quality Alliance (DQA)	• The DQA is an organization convened by the American Dental Association at the request of CMS. DQA has developed national evidence-based oral health care performance measures that have been tested for feasibility, validity, reliability and usability.

Member Complaints and Appeals

When members are unhappy with their Medicaid services, they can formally let their MCO and HHSC know. The process they follow depends on what the issue is.

1. Submit a complaint: A member can submit a complaint if they have an issue with the care they receive. Examples include concerns with customer service, delays in getting an appointment, prior authorization issues, finding an in-network doctor, and problems contacting their MCO.

2. File an appeal: A member can file an appeal if they have an issue with an MCO's denial to cover a service, medical supply, durable medical equipment or prescription.

HHSC monitors member complaints and appeals as an oversight tool to look for early warnings of potential systemic problems, larger MCO operational issues or the need for policy clarifications.

Member Complaints

Over the last few years, HHSC has focused on improving the member complaints experience and the data available for analysis.

HHSC has centralized all member managed care complaint intake with the Office of the Ombudsman. This reduces confusion for members about who they should contact to submit a complaint and where they can find resources that explain how to submit a complaint and what to expect.

Centralization with the Ombudsman also allows for more comprehensive tracking. Standard definitions for categories have been established to improve trending and identification of systemic issues. For example, now MCOs, DMOs and HHSC track access to care, customer service, and quality of care complaints the same way, making the data more reliable. To align with the new approach, MCOs and DMOs submit complaint data more frequently to allow for timelier analysis and action.

Submission and Resolution

Members are encouraged to first submit their complaints directly to their MCO. If they still need assistance, they can also submit complaints to the Ombudsman.

MCOs are required to resolve complaints within 30 days, regardless of point of entry. Complaints regarding urgent access to care concerns are escalated for a faster resolution. CHIP MCO complaints are submitted to TDI. FFS complaints are handled through the Medicaid helpline.

Provider Complaints

Providers can also submit complaints. The most common provider complaints are related to aspects of MCO or DMO administrative functions, including claims or billing disputes and service authorizations.

Providers are encouraged to first exhaust the relevant MCO complaints process before submitting a complaint to HHSC. Provider managed care complaints are addressed by Medicaid and CHIP Services. Provider complaints not related to managed care are submitted to the Texas Medicaid and Healthcare Partnership.

Member Appeals

When a member gets a letter from their MCO letting them know a service, medical supply, durable medical equipment or prescription is not covered or denied, they can ask the MCO to reconsider by asking for a 'Health Plan Appeal'.

If the member still disagrees with their MCO's decision after their appeal, they can ask for a fair hearing with HHSC. Members can request to keep getting services during the health plan appeal and fair hearings process that follows.

External Medical Reviews

HHSC plans to implement an external medical review (EMR) option for members who request a fair hearing. Once available, a member will be able to ask for a fair hearing with or without an EMR.

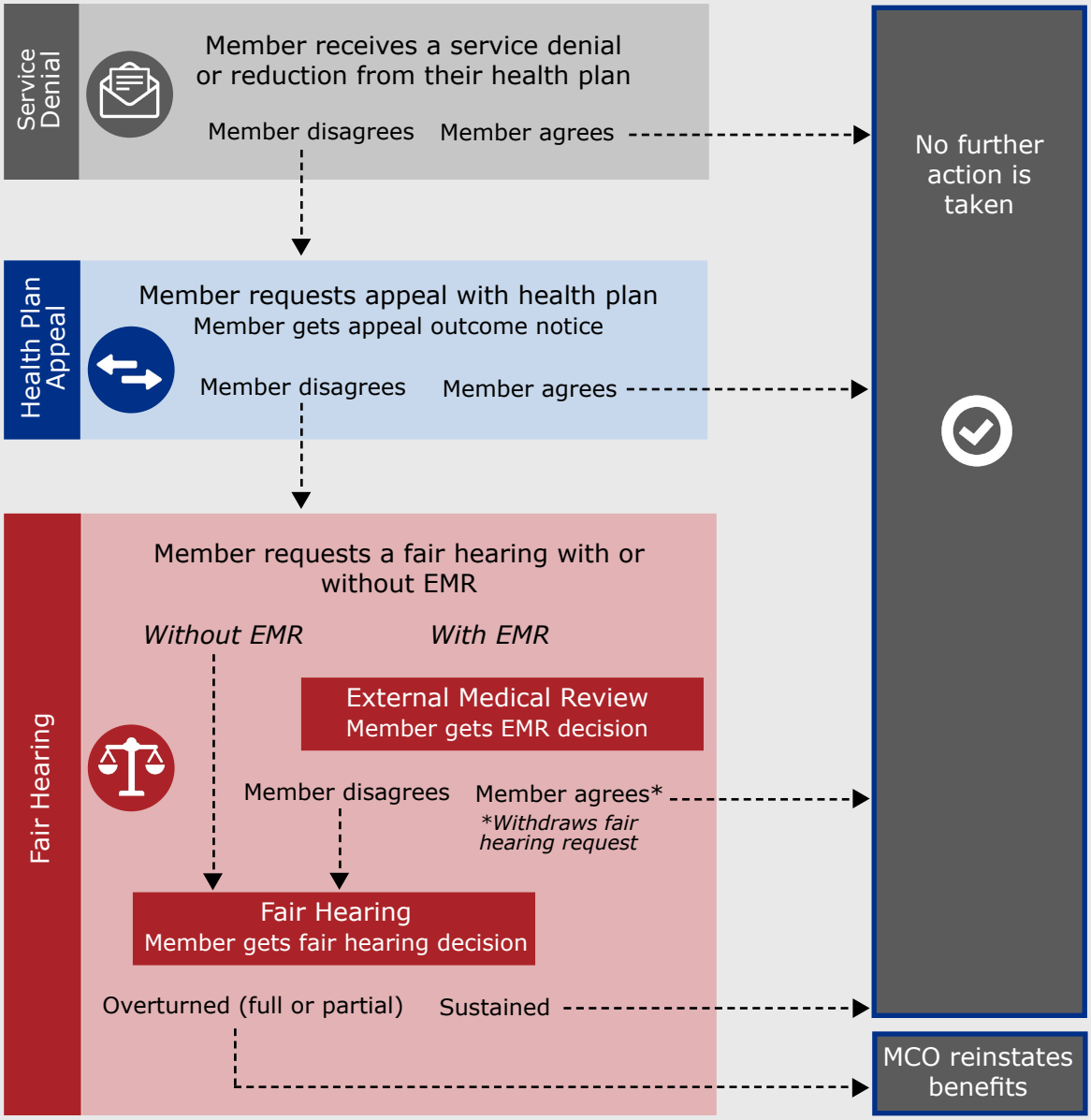
If a member requests an EMR, the review will occur before their fair hearing. HHSC will send the member's case to an independent review organization (IRO) where medical experts will privately review the MCO's decision. They can uphold or change the MCO's decision. Once the member gets the results of the EMR, they can decide if they want to cancel or move forward with their fair hearing.

(See A Closer Look, page 65, for a more detailed look at the member's journey through the health plan appeal process.)

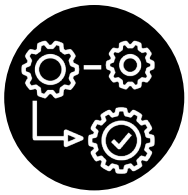
A Closer Look

Health Plan Appeal Process

Below is a high-level visual illustration of the member's journey through the health plan appeal process. A member can ask for a fair hearing with or without an EMR* after he or she gets their MCO's health plan appeal decision.



*EMR will be effective 2021, pending the outcome of the IRO contracting process.



Operations

The way MCOs conduct their business operations can have a direct impact on the care members receive.

Operational Reviews

HHSC conducts on-site biennial operational reviews of MCOs. These operational reviews are comprised of an in-depth review of MCO operational compliance and performance across several areas to ensure policies and practices align with performance standards. A multi-disciplinary team reviews key functions and requirements as stipulated in the MCO's contract. Each subject area has their own tools for data collection. The HHSC Office of the Inspector General (OIG) is also invited to participate. MCO staff interviews are also part of the review process.

Examples of operations reviewed when on-site include:

- Claims processing.
- Member and provider training.
- Complaints and appeals.
- Encounter data.
- Prior authorization processes.

If any problems are discovered during the operational reviews, HHSC takes appropriate steps to address performance. Additionally, operational reviews can inform planned third-party performance audits.

Third-party Performance Audits

Performance audits are conducted by independent auditors biennially or more frequently, if needed, as determined by risks. The target of the audits varies, but typically focuses on two areas:

1. MCO data, such as complaints and appeals.

2. Operational processes, such as claims processing or subcontractor monitoring, including pharmacy benefit managers.

Targeted Reviews

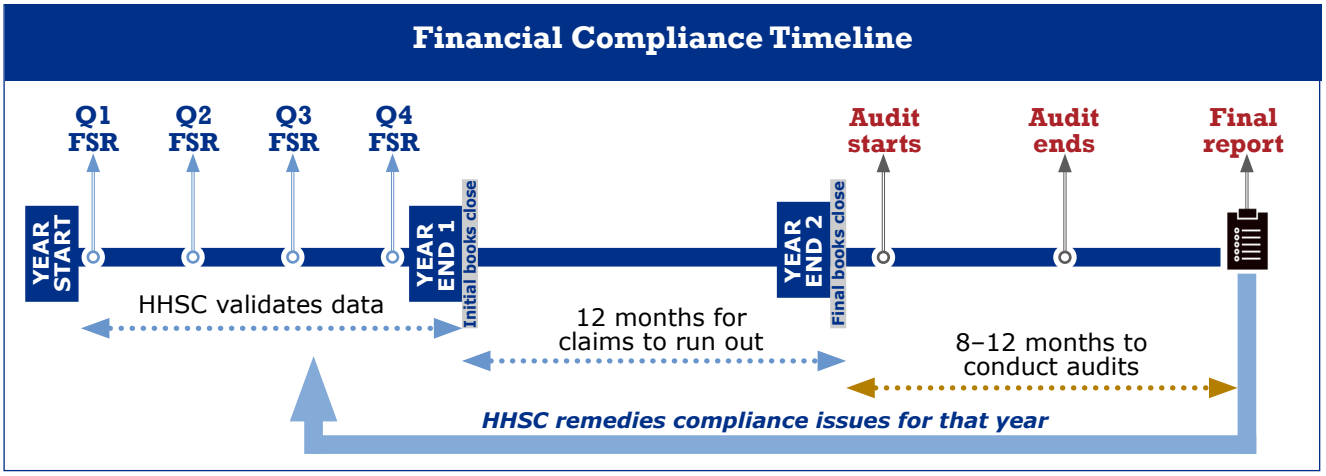
In addition to the established on-site biennial operational review process for MCOs, HHSC also conducts targeted reviews when a significant or recurring problem with an MCO is identified—for example, claims timeliness. This can occur in response to review of other compliance deliverables or to complaints from members, providers or other stakeholder groups. The scope, entity and focus of targeted reviews vary based on the topics raised by complaints received and past instances of non-compliance.

Financial

Financial requirements of the MCOs and DMOs are defined in the contract, including the standards for the financial data they must report to HHSC. MCOs submit financial statistical reports (FSRs) that include information on medical and administrative expenses. MCO contracts include limitations on administrative expenses recognized by the Medicaid program and establish profit-sharing provisions to limit profits. The process of determining the amount of profit sharing with the state is called experience rebates (see A Closer Look, page 68).

FSRs are one source for establishing capitation rates in future years, making the validation of them an important component of contract oversight. HHSC financial analysts validate MCO-reported medical expenses to encounter data on a quarterly basis. Independent auditors review the administrative expenses reported by the MCOs and provide additional data validation by comparing medical expenses to paid claims.

The timeline to complete oversight for MCO financial activity for a given year is 20–24 months after the end of that year. This is because a full audit by the independent auditors can only occur after the final books close and all claims have run out for that given year.



While audits occur annually, HHSC financial analysts can also determine the need for any supplemental audits or reviews based on other identified issues.

As mentioned, unlike FFS, managed care is not a "per service" reimbursement model. MCOs are paid PMPM capitation rates for the delivery of services. These capitation rates are established each year based on actual MCO expenditures on medical services from previous time periods. Reductions in spending on medical services will have the effect of

reducing future capitation rates. If spending to provide contracted services exceeds their capitation rate payments, MCO profit margins are at risk.

A Closer Look — Administrative Expense and Profit Limits

MCO Administrative Expense Limits

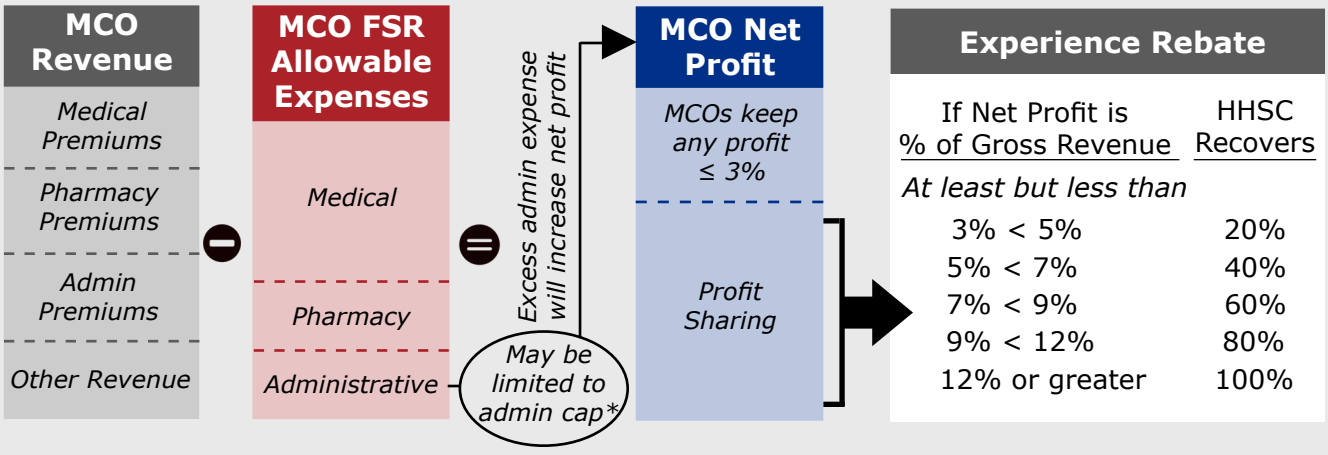
Contract terms define an allowed and disallowed administrative expense. Additionally, HHSC limits administrative expenses that Medicaid will pay in the contract, and this is referred to as the admin cap.

- The cap is compared to MCO's reported administrative expenses.
- Any amounts over the admin cap also become disallowed expenses, and the MCO's net income is increased by that amount.

MCO Profit Limits

- MCOs will retain all their net income before taxes that is equal to or less than 3 percent of the total revenues received.
- Net income greater than 3 percent of total revenues will be shared based on a graduated experience rebate method.
- The experience rebate structure is tier-based.

Net Profit and Experience Rebate

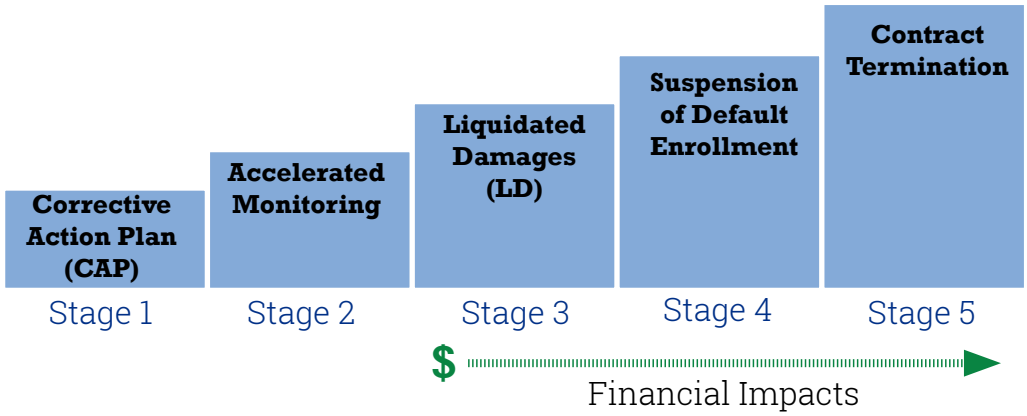


While HHSC does not recognize certain MCO expenditures in the Medicaid program, this does not prevent MCOs from spending money on expenses they consider necessary for the successful operation of their business. Examples include certain marketing and legal expenses, lobbying, and bonuses that exceed the compensation limit.

*Admin cap is set by program.

Non-compliance Remedies

HHSC may use multiple types of enforcement actions, including monetary damages and CAPs, to hold MCOs accountable for not meeting contract terms. As specified in the managed care contracts, HHSC may impose one or more of the following remedies at its discretion:



The type of remedy issued is contingent upon the type and severity of the non-compliance. Remedies may not be issued sequentially.

Assessment of Contract Remedies

CAPs and LDs are the primary remedies HHSC uses to address performance issues or contractual non-compliance. The goal of any contract action is to encourage compliance with contract standards.

Corrective Action Plans

HHSC assesses the need for CAPs monthly. Through the CAP process, MCOs are required to provide HHSC with:

1. A detailed explanation of the reasons for the deficiency.
2. An assessment or diagnosis of the cause.
3. Actions taken to resolve the deficiencies.
4. Actions taken to prevent future occurrences.

HHSC reviews, approves and closes the CAP once the MCO demonstrates it has taken appropriate action to address contractual non-compliance. Examples of CAPs include non-compliance with network adequacy standards and issues identified through utilization reviews.

To increase transparency, the issuance of CAPs was added to the HHSC website. This allows the public and other states that are contemplating contracting with an MCO to see its performance history.

Accelerated Monitoring

HHSC can implement accelerated monitoring practices on an MCO, which are more frequent or extensive than standard monitoring practices.

Examples of accelerated monitoring practices include additional reporting requirements, escalated CAPs and onsite reviews.

Liquidated Damages

LDs are not intended to be a penalty but are meant to assess and recover HHSC's projected financial loss and damage resulting from MCO non-compliance, including losses due to project delays.

HHSC assesses LDs quarterly. Examples of LDs include non-compliance when submitting encounter data, provider payment timeliness and delivery of appropriate services.

All LD decisions and reconsideration determinations require written approval. LDs less than $1 million are approved by the State Medicaid Director, and LDs greater than $1 million must be approved by the Chief Program and Services Officer.

Starting in 2017, HHSC shifted to a more focused managed care business model that included more standardized processes, refined reporting and enhanced training for staff. Remedies and CAPs have become more robust as oversight has improved and become more stringent. For example, in 2018, HHSC assessed over $13 million in LDs, compared to $5.2 million in 2016. Increased compliance is accomplished through clear and consistent reinforcement of contractual standards. The goal is to have LDs at zero dollars.

Suspension of Default Enrollment

Members who do not proactively choose an MCO are automatically assigned one through a process known as default enrollment. Every MCO receives a percentage of their members through default enrollment, and HHSC may suspend default enrollment for a MCO with persistent contractual non-compliance.

The executive commissioner must approve the suspension of default enrollment, and it is effective either for a minimum of 90 days or until HHSC determines the issue is resolved or identifies another appropriate timeline.

The Office of Inspector General

The mission of the Office of Inspector General (OIG) is to ensure the health and safety of Texans through the prevention, detection, audit, inspection and investigation of fraud, waste and abuse. Fraud, waste and abuse impact the provision and delivery of state health and human services in several ways, including:

- Preventing or delaying medically necessary care or social services.
- Providing care that is not medically necessary and potentially harmful to clients.
- Using staff and financial resources from the health care system inefficiently, which contributes to the rising cost of health care.

To address the range of risks to health and human services' program integrity, the OIG employs several methods to prevent and detect fraud, waste and abuse. Because of its financial impact and the large number of Texans it touches, many of the OIG's efforts focus on evaluating Texas' Medicaid program. Investigations, audits, inspections and reviews are several of the tools the OIG uses in its work within the Medicaid program. The OIG uses data research and analytics to identify, monitor and assess trends and patterns of behavior of clients, providers and other vendors (or contractors) participating in Medicaid.

The OIG acts to prevent unqualified and ineligible Medicaid clients, providers and contractors from using its resources inappropriately and takes enforcement actions in cases of fraud, waste and abuse.

Investigations

Provider Field Investigations

These investigations look into allegations of fraud, waste and abuse by health care providers. The results of an investigation may lead to recoupment of overpayments, imposition of sanctions or administrative actions, referrals to licensing boards, and referrals to the Office of Attorney General's Medicaid Fraud Control Unit.

Benefits Program Integrity

This unit examines clients suspected of abusing HHSC programs—including Medicaid; CHIP; the Supplemental Nutrition Assistance Program; Temporary Assistance for Needy Families; and the Women, Infants and Children program. Findings can include the provision of false information to apply for services or using someone else's insurance coverage for services.

Audits

The audit division identifies program policy gaps and overpayments, as well as proposes recommendations to prevent fraud, waste and abuse. Staff conduct risk-based performance audits, including audits of HHSC agencies, contractors and providers. Those audits cover a

range of topics, such as the accuracy of medical provider payments; the performance of HHSC contractors; information technology; and the functions, processes and systems within HHSC programs. Examples of previous audits include providers, MCOs and DMOs effectiveness in complying with contract requirements, achieving related contract outcomes, and financial and performance reporting to HHSC.

Inspections

Inspections are targeted examinations into specific programmatic areas of HHSC programs, systems or functions that may identify systemic trends of fraud, waste and abuse. Findings from an inspection may result in the OIG's use of another tool to further review the topic or actions by HHSC to address the OIG's observations. Topics from past inspections include attendant background checks, power wheelchairs and the program integrity efforts of PBMs.

Reviews

Medicaid claims and medical record reviews include utilization reviews of acute care services (e.g., provider office visits, laboratory and x-ray services), hospital services (e.g., surgical specialists), nursing facility services (e.g., rehabilitation, long-term care), and the Medicaid Lock-in program.

Medicaid Lock-in Program

The Medicaid Lock-in program operates by "locking in" an individual to one provider and pharmacy to prescribe and dispense certain drugs, like controlled substances (e.g., opioids) to prevent their abuse or overuse. This makes it difficult for clients to visit multiple providers and deceptively attain prescriptions for controlled substances. The OIG analyzes Medicaid claims data to identify clients who reach a pre-defined threshold of prescriptions or provider visits. Treating providers and MCOs also make referrals to the program.

Provider Enrollment Screening

The OIG uses preventative measures in the enrollment and re-enrollment of health and human service providers (e.g., medical and dental providers, durable medical equipment suppliers, home health agencies) into Medicaid, CHIP and other HHSC programs. Preventive measures include activities such as completion of required federal and state disclosure activities for high-risk providers.

Chapter 4

What are the financial features of Medicaid and CHIP?

At-a-Glance

Funding

2018–2019 HHSC Biennial Appropriations

	State General Revenue (GR) Funds	Federal and Other Funds*
Total Funds $77.3 billion	$30.8 billion	$46.5 billion
	State GR is 40% of total HHSC budget.	Federal and other funds are 60% of total HHSC budget.
Total Funds for Medicaid and CHIP $65.3 billion *85% of total funds*	$25.9 billion	$39.4 billion
	Medicaid and CHIP are 84% of HHSC State GR.	Medicaid and CHIP are 85% of HHSC federal and other funds.

*Other funds include, but are not limited to, Appropriated Receipts, Interagency Contracts, Medicaid Subrogation Receipts (State Share), and WIC Rates.

Payments

3 Types of Payments

1. MCO Capitation Payments
2. Reimbursement for Providers
3. Supplemental Hospital Funding

Growth Trends

Annual Expenditures

	2010	2014	2019
Medicaid	$27.7 billion	$33.4 billion	$42.6 billion
CHIP	$1.1 billion	$1.1 billion	$928 million

Annual Caseloads

	2010	2014	2019
Medicaid	3.3 million	3.7 million	3.9 million
CHIP	570 thousand	561 thousand	408 thousand

Full details for annual expenditures and caseloads can be found on page 145.

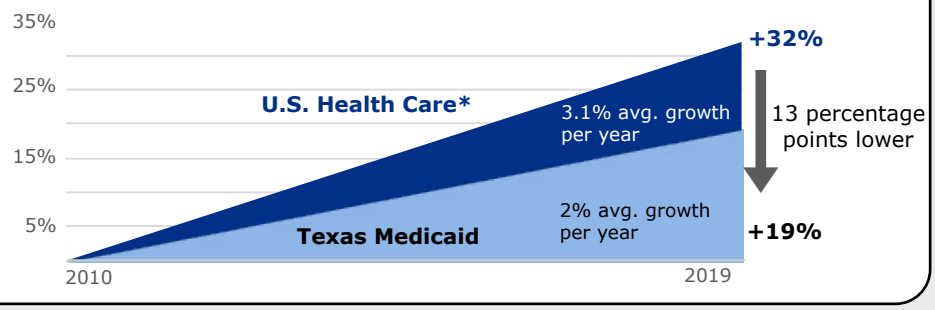
10-Year Cost Growth Comparison

The number of Texans enrolled in Medicaid managed care has grown by 1.3 million in 10 years. The value of managed care is demonstrated by Texas Medicaid's cost per person growth trending lower than U.S. national average.

Managed Care Percent of Caseload

72% → 94%

Cost per Person



Texas Medicaid cost per person is based on full benefit clients.
**Source: CMS, Office of the Actuary–data is for CY09–CY18*

Budget Development

There are several factors that impact the state Medicaid budget, including what types of services Texas chooses to cover and the amount of federal matching funds that certain programs will receive.

Health and Human Services Commission (HHSC) staff develop the estimates of future Medicaid caseloads and spending that, in turn, form the basis for state appropriations requests. Estimates are based on:

- Projections of the number of people eligible for and applying for the program.
- Estimations of cost trends.
- Analyses of any new federal mandates or state changes affecting eligibility, services or program policy.

Ultimately, decisions about funding are determined by the Texas Legislature.

The budget takes effect at the beginning of the biennium in September of odd-numbered years. A significant amount of time elapses between the development of the initial agency budget request and the passage of a finalized appropriations bill.

Legislative Appropriations Timeline	
August	State agencies submit legislative appropriations requests for the next biennium
January	Legislature convenes
April	Legislature works on appropriations bills; last chance to provide up-to-date Medicaid projections for bills
May	Legislature finishes appropriations for the next biennium
September	New biennium begins (in odd-numbered years only)

Current biennium varied due to public health emergency.

Medicaid Matching Funds

Federal funds are a critical component of health care financing for the state of Texas. The amount of federal Medicaid funds Texas receives is based primarily on the federal medical

assistance percentage (FMAP), or Medicaid matching rate. With some exceptions, such as waivers or the Disproportionate Share Hospital (DSH) program, there is no cap on federal funds for Medicaid expenditures.

Derived from each state's average per capita income, the Centers for Medicare and Medicaid Services (CMS) updates the rate annually. Consequently, the percentage of total Medicaid spending that is paid with federal funds also changes annually. As the state's per capita income increases in relation to the national per capita income, the FMAP rate decreases. For federal fiscal year (FFY) 2021, Texas' Medicaid FMAP is 64.91 percent.

Texas uses a one-month differential FMAP figure that considers differences between the FFY, which runs October through September, and the state fiscal year (SFY), which runs September through August. The one-month differential FMAP for Texas in SFY 2021 is 65.35 percent—which includes one month of the FFY 2020 rate of 65.54 percent and 11 months of the FFY 2021 rate of 64.91 percent.

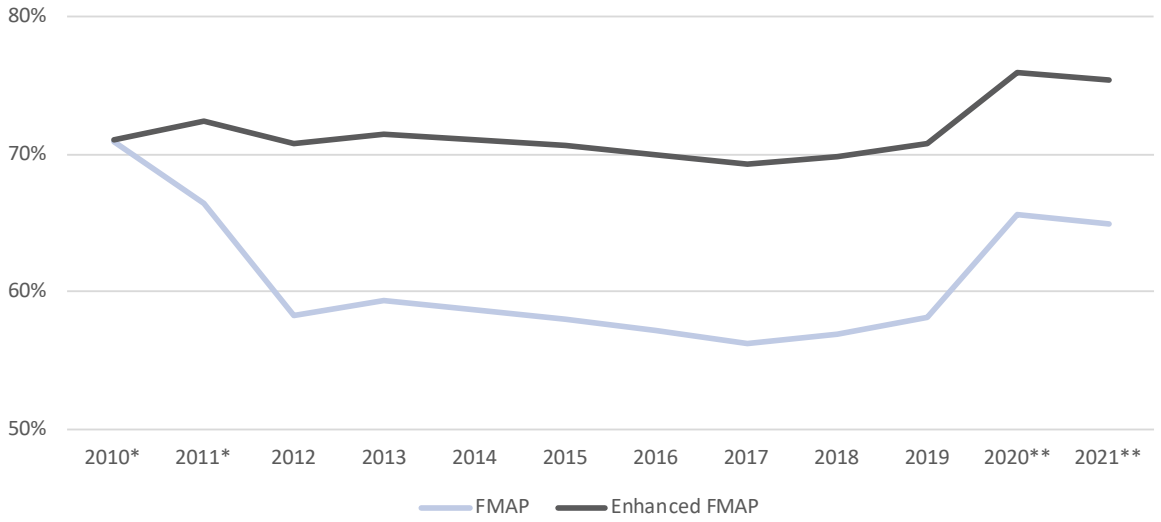
CHIP Matching Funds

Unlike Medicaid, Children's Health Insurance Program (CHIP) is a federal block program rather than an entitlement program. Total federal funds allotted to CHIP each year are capped, as are the funds allotted to each state. Each state is allotted a portion of the total federal funds based on a formula set in federal statute, and each state receives federal matching payments up to the allotment. The FFY 2019 allocation was fully expended, and the 2020 allocation is estimated to be fully expended in 2021. The federal allocation for Texas in FFY 2019 was $1.5 billion.

In addition, CHIP offers a more favorable federal matching rate than Medicaid. The federal CHIP funds that states receive are based on the enhanced federal medical assistance percentage (EFMAP). Derived from each state's average per capita income, CMS updates this rate annually. Consequently, the percentage of total CHIP spending that is paid with federal funds also changes annually.

The Affordable Care Act (ACA) temporarily increased the EFMAP for FFYs 2016 through 2019. Following the end of this increase, the EFMAP rate was decreased by 23 percentage points. The EFMAP for Texas in FFY 2021 is 75.44 percent and in SFY 2021 is 75.75 percent.

Texas Federal Medical Assistance Percentages, FFYs 2010–2021



*2010–2011 FMAP temporarily increased (see the American Recovery and Reinvestment Act, Appendix A, page 111).
**The 2020–2021 FMAP temporarily increased (see the Families First Coronavirus Response Act, Appendix A, page 111).

Deferrals and Disallowances

Deferrals and disallowances impact the availability of federal financial participation:

- Deferral: If CMS determines that Texas may be out of compliance with federal regulations or its Medicaid state plan, then CMS may withhold funds until compliance is proven or until the state provides additional information to support the validity of the claim.
- Disallowance: If CMS alleges a claim is not allowable, then it can recoup federal funds.

CMS can impose deferrals or disallowances following a federal audit or a change to the Medicaid state plan.

A deferral or disallowance may be imposed for the federal fiscal quarters for which CMS asserts the state is out of compliance with CMS regulations or its Medicaid state plan. In the case of a disallowance, CMS may retroactively encompass several years of claims.

States have the option to appeal the CMS determination with the U.S. Department of Health and Human Services' Departmental Appeals Board. The Departmental Appeals Board will make a ruling based on the written records provided by both parties or can hold a hearing prior to making a ruling.

Mandatory and Optional Spending

Texas Medicaid is federally required to provide certain acute care services and long-term services and supports (LTSS)—including inpatient and outpatient care, physician services, family planning services and supplies, extended services for pregnant women, and nursing facility services for clients age 21 and older (see Appendix B, page 130).

Texas also chooses to cover some of the optional services allowed, but not required by, the federal government. These services do not necessarily increase costs.

In fact, eliminating some optional services and eligibility categories could increase Medicaid costs. For example, dropping the option of covering prescription drugs could ultimately cost Medicaid more. People who do not receive needed drugs may require more physician services, increased hospitalizations or even LTSS. Similarly, Texas potentially saves money by covering pregnant women up to 198 percent of the federal poverty level (FPL), because some women may not otherwise receive adequate prenatal care. This coverage helps prevent adverse and costly pregnancy outcomes.

In addition, some of the optional services covered by Texas Medicaid were originally paid with 100 percent state or local funds. By adding coverage for those services through Medicaid, part of the cost is now covered with federal matching dollars.

For example, services for individuals with intellectual or developmental disabilities (IDD), that are provided by state supported living centers and community-based residential settings, now receive federal Medicaid matching dollars in addition to state funds.

Rate Setting

Managed Care Organization Rates

Since most Medicaid clients are enrolled in managed care, managed care organization (MCO) capitation rates are the primary way that the state pays for services. These rates act as the state's payments to MCOs for contractually required services. MCOs then negotiate rates for services with providers and pay them to administer services to members. Payment rates to MCOs are developed using actuarially sound practices and principles. Payments are based on a "per member per month" (PMPM) rate for each risk group within each service delivery area, and the MCOs membership enrollment. PMPM rates differ

across risk groups and service delivery areas, and differ by MCO based on the acuity of the MCOs' membership.

For example, STAR MCO capitation rates are derived from MCO historical claims experience, also called encounter data, from a base period of time. Encounter data includes records of the health care services for which MCOs pay, and the amounts MCOs pay to providers of those services. Rates are established each year based on actual MCO expenditures. Reductions in spending for Medicaid services will have the effect of reducing future capitation rates.

From this, the base cost data are totaled, and trends are calculated for the prospective time period during which the rates will apply. The cost data are also adjusted for MCO expenses, such as re-insurance, capitated contract payments and changes in plan benefits. A reasonable provision for administrative expenses, taxes and risk margin is also added to the claims component in order to project the total cost for the rating period. A risk margin is included to recognize financial risk.

For STAR MCOs, newborn delivery expenses are removed from the PMPM rates, resulting in an adjusted capitation rate for each service area. A separate lump-sum payment, called the delivery supplemental payment, is computed for each service area for expenses related to each newborn delivery.

A final adjustment is made to reflect the health status, or acuity, of the population enrolled in each MCO. The purpose of the acuity risk adjustment is to recognize the anticipated cost differential among multiple MCOs in a service area, due to the variable health status of their respective memberships. The final capitated premiums paid to the MCOs are based on this risk-adjusted PMPM for each combination of service area and risk group.

Pharmacy rates are similarly calculated. Certain high-cost drugs are paid for outside of the capitation rate.

Rates for the other Medicaid managed care programs—STAR+PLUS, STAR Kids and STAR Health—are also determined using the same methods, with certain exceptions:

- STAR+PLUS, STAR Kids and STAR Health MCOs do not receive a delivery supplemental payment for newborn deliveries. Provision for these costs are included in the capitation rates.
- Due to low caseload among risk groups for STAR Kids clients less than age 1 and receiving services through the Youth Empowerment Services (YES) waiver, capitation rates for these risk groups are calculated on a statewide basis.
- There is only one STAR Health MCO. This MCO is reimbursed using a single capitation rate that does not vary by age, gender or area.

- For the STAR Health MCO, there is a special allowance for the additional administrative services in the program, including the Health Passport.

In addition to the above, HHSC includes provision for three directed payment programs in the STAR, STAR+PLUS, and Dual Demonstration programs' capitation rates: Network Access Improvement Program (NAIP), the Uniform Hospital Rate Increase Program (UHRIP), and Quality Incentive Payment Program (QIPP).

NAIP is a directed payment program in STAR and STAR+PLUS designed to increase the availability and effectiveness of primary care for members by incentivizing various institutions to provide high quality, well-coordinated and continuous care.

UHRIP is a supplemental payment program for hospitals (see page 89). QIPP is a quality-based payment program for nursing facilities (see Nursing Facility Quality Incentive Payment Program, page 92).

Children's Medicaid Dental Services Rates

Children's Medicaid Dental Services (CMDS) capitation rates are based on claims from the covered population in the base period. The base cost is totaled, and it trends to the time period for which the applicable rates are calculated. A reasonable provision for administrative expenses, taxes and risk margin is added to the claims component to project the total cost for the rating period. These projected total costs are used to set statewide rates that vary by age group.

CHIP Rates

The rate-setting process for CHIP is like the process used for the STAR MCO. CHIP MCO rates, including pharmacy costs, are derived from MCO historical claims experience, also called encounter data, for a base period of time.

From this, the base cost data are totaled, and trends are calculated for the prospective time period during which the rates will apply. The cost data are also adjusted for MCO expenses, such as re-insurance, capitated contract payments and changes in plan benefits. A reasonable provision for administrative expenses, taxes and risk margin is also added to the claims component to project the total cost for the rating period. A risk margin is included to recognize financial risk.

The removal of newborn delivery expenses from the total cost rate results in an adjusted capitation rate for each service area. A separate lump-sum payment, called the delivery supplemental payment, is computed for expenses related to each newborn delivery. While the delivery supplemental payment can vary by service area for the STAR MCOs, all CHIP MCOs receive the same lump-sum payment of $3,100 for each birth.

The resulting underlying base rates vary by service area and age group. A final adjustment is made to reflect the health status, or acuity, of the population enrolled in each MCO. The purpose of the acuity risk adjustment is to recognize the anticipated cost differential among multiple MCOs in a service area due to the variable health status of their respective memberships. The final capitated premium paid to the MCOs is based on this acuity risk-adjusted premium and covers all non-maternity medical services.

CHIP dental benefits are reimbursed through a separate set of capitation rates, and dental maintenance organizations (DMOs) manage this benefit. The rate-setting process for these services is similar to the CMDS program.

CHIP Perinatal Rates

Capitation rates for the CHIP Perinatal program are derived using a methodology similar to that described for CHIP. CHIP Perinatal covers the unborn children of pregnant women who are uninsured and do not qualify for Medicaid. The more focused scope of benefits and eligibility for CHIP Perinatal clients and the absence of an acuity adjustment produce some differences in the methodology.

MCO historical claims are totaled, and trends are calculated to project forward to the time period for which rates are to apply. The cost data is adjusted for MCO expenses, changes in plan benefits and other miscellaneous costs. Final rates vary by risk group and service area. However, due to low caseload among risk groups with income over 198 percent and up to and including 202 percent of the FPL, capitation rates for these risk groups are calculated on a statewide basis.

CHIP Cost-sharing

Most families in CHIP pay an annual enrollment fee to cover all children in the family. All CHIP families pay co-payments for doctor visits, prescription drugs, inpatient hospital care, and non-emergent care provided in an emergency room setting. CHIP annual enrollment fees and co-payments vary based on family income. The total amount a family can be required to contribute out-of-pocket toward the cost of healthcare services will not exceed five percent of family income.

CHIP cost-sharing rates are published online annually (HHS.Texas.gov/Services/Health/Medicaid-CHIP/Programs-Services/Children-Families/Childrens-Medicaid-CHIP).

A Closer Look

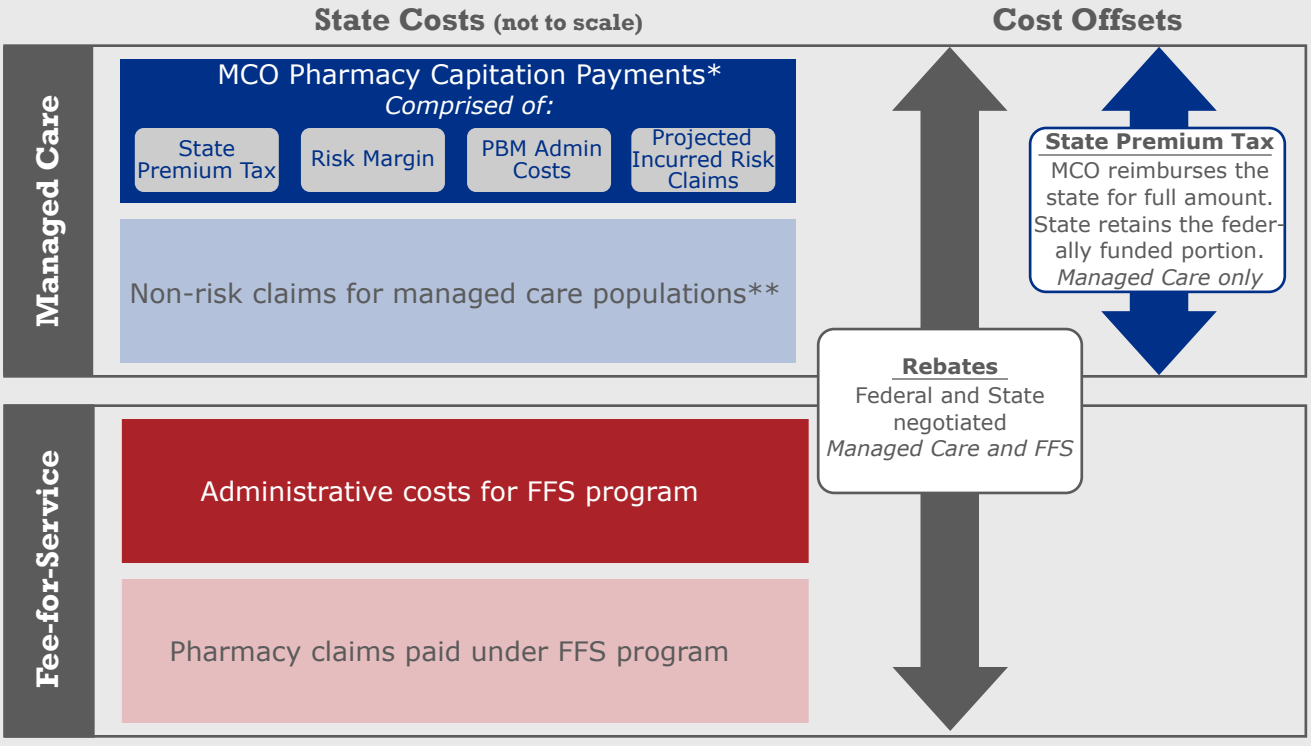
How HHSC Pays for Prescription Drugs

In recent years, prescription drugs have become increasingly associated with rising costs. For Medicaid and CHIP, MCOs administer most of the prescription drug benefit. A small portion of the benefit is administered by HHSC on a FFS basis.

In managed care, pharmacies are paid through Pharmacy Benefit Managers (PBMs) contracted with MCOs (see Chapter 3, page 57). PBMs negotiate ingredient costs and dispensing fees with pharmacies. MCO pharmacy capitation rates are developed to cover pharmacy claims and administrative costs and to include a risk margin. As part of the capitation rate, MCOs must pay the state premium tax through which HHSC receives federal matching dollars.

In FFS, pharmacies are paid directly. Rates for prescription drugs include fees to cover the cost of ingredients–which are determined using the National Average Drug Acquisition Cost (NADAC) or the wholesale acquisition cost, and a dispensing fee.

The primary drivers of cost are rising drug prices and client utilization. HHSC offsets some of these costs through the state premium tax in managed care and through federal and state rebate programs. HHSC also regulates how MCOs administer the prescription drug benefit to manage costs and limit over-utilization (see Chapter 3, page 56).



*The ACA Health Insurance Providers Fee will be repealed as of January 1, 2021.
**Certain drugs are not included in the capitation rate and are paid on a cost-settlement basis with the MCO.

Fee-for-Service Rates

Even though most Medicaid clients are under managed care, 6 percent of clients continue to get services paid through FFS. HHSC is responsible for establishing FFS reimbursement methodologies. Changes may be authorized by rule or approval from CMS. FFS rates are paid directly to providers, physicians, other medical practitioners, pharmacists and hospitals.

HHSC consults with stakeholders and advisory committees when considering changes to FFS reimbursement rates. All proposed rates are subject to a public hearing, and all proposed reimbursement methodology rule changes are subject to a 30-day public comment period, as part of the approval process. Changes in FFS reimbursement rates will often impact MCO rates. Many contracts between MCOs and providers incorporate payment rates based on a percentage of the FFS rate for the same service. HHSC does not require MCOs to use the FFS rates, and some MCOs use alternate reimbursement models.

Rates for services delivered by physicians and other practitioners are uniform statewide and are either access-based fees (ABFs) or resource-based fees (RBFs) (see Glossary, page 150 and page 189, respectively).

HHSC also establishes reimbursement rates for services such as laboratory services, x-ray services, radiation therapy services, physical and occupational therapy services, dental services, and maternity clinic services. Reimbursement rates for most services are evaluated biennially.

For physician-administered drugs and biologicals, physicians are reimbursed at the lesser of their billed charges and the reimbursement rate, which is an estimate of the provider's acquisition cost for the specific drug or biological. Rates for physician-administered drugs and biologicals are reviewed semi-annually.

Fee-for-Service Pharmacy Rates

The Vendor Drug Program (VDP) administers prescription drugs under the FFS model. Rates for prescription drugs include fees to cover the cost of ingredients, which are determined using the NADAC or the wholesale acquisition cost. After the ingredient cost is calculated, the dispensing fee is calculated and added to the total reimbursement amount. Costs will differ based on the type of pharmacy.

Pharmacies that provide free delivery services to FFS clients may be eligible for a delivery incentive per prescription. Another incentive may be added if the pharmacy dispenses a premium preferred generic. Reimbursements are reduced to a pharmacy's reported "Usual and Customary" or "Gross Amount Due" price, if either is less than the total reimbursement.

Fee-for-Service Rates for Inpatient and Outpatient Hospital Care

General acute care hospital reimbursement rates for FFS clients are set using a prospective payment system (PPS) based on the All Patient Refined Diagnosis Related Groups (APR-DRG) patient classification system. Under this system, each patient is classified into a diagnosis related group (DRG) based on clinical information.

Hospitals are paid a pre-determined rate for each DRG admission. The rate is calculated using a standardized average cost of treating a Medicaid inpatient admission and a relative weight for each DRG. Outlier payments are made in addition to the base DRG payment for clients age 20 and younger, whose treatments are exceptionally costly or who have long-length stays.

Outpatient hospital services provided to FFS clients are reimbursed at a portion of the hospital's reasonable cost, and reimbursements are dependent on the type of hospital and the patient volume.

HHSC has developed several supplemental payment programs to address the difference between rate and facility costs (see Supplemental Hospital Funding, page 87).

Reimbursement Rates by Hospital Type	
Rural Hospital	Rates are based on the standard dollar amount required to treat a Medicaid inpatient admission and is derived from base year costs.
Children's Hospital	Rates are established using a statewide standard dollar amount, which is derived from base year costs. Add-ons are used with this base standard dollar amount to make payments for additional services—like medical education, geographic location and safety-net designation.
Psychiatric Hospital	Rates are reimbursed on a PPS per diem—based on the federal base per diem—with facility-specific adjustments for wages, rural location and length of stay.
State-owned Teaching Hospital	Rates paid are for the reasonable cost of providing care to Medicaid clients using the cost principles from the Tax Equity and Fiscal Responsibility Act of 1982.
Urban Hospital	Rates are established using a statewide standard dollar amount, which is derived from base year costs. Add-ons are used with this base standard dollar amount to make payments for additional services—like medical education, geographic location and safety-net designation.

Rates for Other Care Facilities

Nursing Facilities

Nursing facilities are reimbursed for services provided to Medicaid residents through daily payment rates, which are uniform statewide by level of service. Enhanced rates are available for enhanced direct care compensation and staffing. The total daily payment rate for each level of service may be retroactively adjusted, based upon failure to meet specific staffing or spending requirements.

Rates are calculated based on costs submitted by providers on applicable Medicaid cost reports collected by HHSC. The rates are limited by appropriation level. Costs are categorized into five rate components:

1. Direct care staff.
2. Other resident care.
3. Dietary and nutritional services.
4. General and administrative.
5. A fixed capital asset use fee.

Each rate component is calculated separately, based on HHSC formulas. Direct care and other resident care components vary according to residents' acuity. The total rate for each level of service is calculated by adding together the appropriate rate components.

Nursing facility cost reports are subjected to either a desk review or on-site audit to determine whether reported costs are allowable. MCOs are currently required to reimburse nursing facilities, at a minimum, the same daily payment rate—including any enhancements—as would have been paid under FFS.

Intermediate Care Facilities for Individuals With an Intellectual Disability or Related Condition

Intermediate care facilities for individuals with an intellectual disability or related condition (ICFs/IID) are reimbursed for services delivered to Medicaid residents through daily payment rates, which are prospective and uniform statewide by facility size and level of need. The total daily payment rate may be retroactively adjusted, if a provider fails to meet specific direct care spending requirements.

The modeled rates are updated, when funds are available, using the service providers' most recent audited cost reports. Enhanced rates are available for enhanced attendant compensation.

ICF/IID cost reports are subjected to a desk review or on-site audit to determine whether reported costs are allowable. ICF/IID rates are recalculated biennially.

Federally Qualified Health Centers and Rural Health Clinics

Federally qualified health centers (FQHCs) include all organizations receiving grants under Section 330 of the Public Health Service Act. FQHCs qualify for enhanced reimbursement from Medicare and Medicaid, as well as other benefits. FQHCs serve underserved areas or populations, offer a sliding-scale fee, provide comprehensive services, have an ongoing quality assurance program, and have a governing board of directors.

A rural health clinic (RHC) is a clinic located in a rural area, designated by the U.S. Health Resources and Services Administration as a shortage area. Medicare has a number of requirements in order for a clinic to qualify as an RHC, including that it must be located in a non-urbanized area that is medically underserved, as defined by the U.S. Census Bureau (see Glossary, page 190).

To participate in the Texas Medicaid program, FQHCs and RHCs must:

- Comply with all federal, state, and local laws and regulations applicable to the services provided.
- Sign a written provider agreement with HHSC, and then comply with the terms of the agreement and all requirements of the Texas Medicaid program.
- Bill for covered services in the manner and format prescribed by HHSC.

Covered services are limited to either services as described in the Social Security Act or other ambulatory services covered by the Texas Medicaid program—when provided by other enrolled providers.

FQHCs and RHCs are reimbursed 100 percent of the average reasonable and allowable costs for the clinic in the base year of 2000.

Texas Medicaid reimburses FQHCs through a PPS or an alternative prospective payment system (APPS). PPS rates are inflated annually using the Medicare Economic Index (MEI) for primary care, while APPS rates are inflated annually using 100.5 percent of the MEI. However, if increases in an FQHC's costs are greater than the inflation amount under PPS and APPS, the provider can request an adjustment to their rate. If an FQHC chooses the APPS method, rates may be prospectively reduced to better reflect the reasonable costs or the PPS rates.

RHCs are reimbursed through a PPS methodology. The intent of the state is to ensure that each RHC is reimbursed either at 100 percent of its reasonable costs or the Medicare maximum payment per visit—also called the federal ceiling—as applicable. PPS rates are inflated annually using the MEI for primary care. If the increases in an RHC's costs are greater than the inflation amount in either system, the provider can request an adjustment to their rate.

Supplemental Hospital Funding

Historically, rates paid to hospitals for services have been below the average costs facilities incur to provide Medicaid covered services. In addition, the expansion of managed care has greatly impacted the way hospitals are funded in Texas.

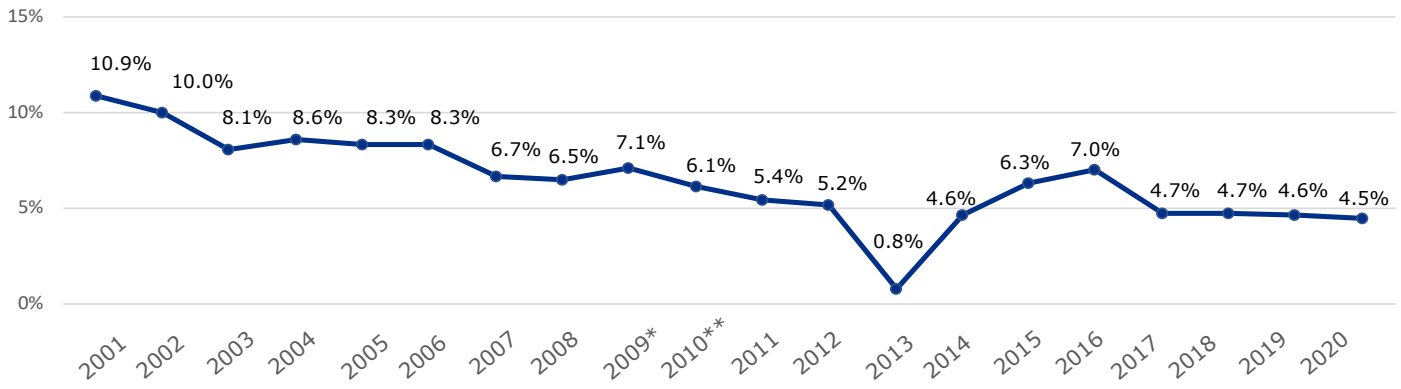
To comply with federal regulations and to preserve federal hospital funding while expanding managed care, HHSC submitted a five-year Section 1115 Transformation Waiver known as the 1115 Healthcare Transformation Waiver. CMS has approved extensions of the waiver through September 2022 (see Chapter 5, page 98).

Through various funding programs, including those under the 1115 Healthcare Transformation Waiver, HHSC administers supplemental hospital funding to help cover the cost of uncompensated care, incentivize improvements to service delivery, and fund graduate medical education. These programs also include some quality-based payment programs (see Quality-based Payment Programs, page 90).

Disproportionate Share Hospital Funding

DSH funding is special funding for hospitals that serve a disproportionately large number of Medicaid and low-income patients. DSH funds are not tied to specific services for Medicaid-eligible patients.

DSH Funds as a Percentage of the Total Medicaid Budget, FFYs 2001–2020



*2009 includes $23.5 million in American Recovery and Reinvestment Act (ARRA) federal stimulus funds.
**2010 includes $47.6 million in ARRA federal stimulus funds.

There are no federal or state restrictions on how disproportionate share hospitals can use their funds. Hospitals may use DSH payments to cover the uncompensated costs of care for low-income patients, including Medicaid patients. DSH payments have proven an important source of revenue by helping hospitals expand health care services to the uninsured, defraying the cost of treating low-income patients, and recruiting physicians and other healthcare professionals.

To qualify for DSH funds, hospitals must meet one of the following criteria:

- A disproportionate total number of inpatient days are attributed to Medicaid patients.
- A disproportionate percentage of all inpatient days are attributed to Medicaid patients.
- A disproportionate percentage of all inpatient days are attributed to low-income patients.

All children's hospitals in Texas are deemed disproportionate share hospitals, provided they meet federal and state qualification criteria.

As in other matching Medicaid programs, the federal government and non-federal sources each pay a share of total DSH program costs. Under the ACA, federal DSH allocations were set to decrease in size—in anticipation of the reduction of the uninsured population.

The Coronavirus Aid, Relief and Economic Security Act (CARES Act) delayed the FFY $4.0 billion DSH allotment reduction until December 1, 2020. Currently, the statutory reductions in the federal share of DSH payments for all states from FFY 2020 through FFY 2025 are:

FFY	2020	2021	2022	2023	2024	2025
Reduction for all states	$4.0 billion	$8.0 billion	$8.0 billion	$8.0 billion	$8.0 billion	$8.0 billion

DSH Payment Information reports are published annually online at: RAD.HHS.Texas.gov/Hospitals-Clinic/Hospital-Services/Disproportionate-Share-Hospitals.

Uncompensated Care Funding

Created under the 1115 Healthcare Transformation Waiver, the Uncompensated Care (UC) Pool includes $38.5 billion in allocated funds over the period of the waiver. To receive UC payments, providers must participate in one of the 20 Regional Healthcare Partnerships (RHPs) (see Appendix C, page 140).

UC payments are cost-based and help offset the costs of uncompensated care provided by hospitals and other providers. Though previously defined as unreimbursed costs for Medicaid and uninsured patients incurred by hospitals, uncompensated care costs are currently defined as unreimbursed charity care costs. UC payments will be based on each provider's UC costs, as reported on a UC application.

Uniform Hospital Rate Increase Program

The UHRIP program is a directed payment program designed to reduce hospitals' uncompensated care costs—through enhanced payments to hospitals for medically necessary, covered services provided to Medicaid managed care members. UHRIP is voluntary and cannot be implemented in a service delivery area (SDA)—unless all MCOs within that SDA, and the hospitals they contract with, commit to participate. Hospital rate increases vary by hospital class, and in general, both inpatient and outpatient services are included for all hospitals to calculate enhanced rates.

Delivery System Reform Incentive Payment Program

The Delivery System Reform Incentive Payment (DSRIP) program was also created by the 1115 Healthcare Transformation Waiver and had $11.4 billion in allocated funds for the first five years of the waiver. The DSRIP program was renewed for five more years (through FFY 2021) with an additional $14.7 billion in funding.

DSRIP funding provides financial incentives that encourage hospitals and other providers to focus on achieving quality health outcomes. Participating providers develop and implement programs, strategies and investments to enhance:

- Access to health care services.
- Quality of health care and health systems.
- Cost-effectiveness of services and health systems.
- Health of the patients and families served.

The waiver's special terms and conditions require HHSC to develop a DSRIP transition plan to describe how the state will further advance its delivery system reform when DSRIP funding ends in September 2022. HHSC submitted a draft transition plan to CMS in September 2019. The plan outlines the research, data analyses and partner engagement HHSC will complete to develop new programs, policies and Medicaid strategies. HHSC is analyzing populations served by DSRIP and interventions associated with improvements in key health outcomes to continue healthcare transformation and to advance alternative payment models (APMs) in Texas. Ongoing updates to DSRIP transition planning are on the HHSC website at HHS.Texas.gov/Laws-Regulations/Policies-Rules/Waivers/Waiver-Renewal.

Graduate Medical Education

Hospitals that operate medical residency training programs incur higher expenses than hospitals without training programs. Historically, the Medicaid share of these additional costs have been covered by graduate medical education (GME) payments to state-owned teaching hospitals. GME payments cover the costs of program administrative staff, allocated facility overhead, and salaries and fringe benefits for residents and teaching physicians.

HHSC is also authorized to spend Appropriated Receipts–Match for Medicaid for GME payments to state-owned teaching hospitals. These payments are contingent upon receipt of intergovernmental transfers of funds from state-owned teaching hospitals for the non-federal share of Medicaid GME payments.

Quality-based Payment Programs

Pay-for-Quality and Managed Care Payment Reform

To reward the use of evidence-based practices and promote health care coordination and efficacy among MCOs, HHSC implements medical pay-for-quality (P4Q) programs for STAR, STAR+PLUS, STAR Kids, CHIP and a dental P4Q program.

The medical P4Q program evaluates MCOs on a set of quality measures—with a focus on prevention and chronic disease management, including behavioral, maternal and infant health. Plans can earn or lose money based on their level of improvement or decline from the prior year and their performance relative to set benchmarks. For the medical P4Q program, three percent of MCOs' capitation is at-risk. In the dental P4Q program, 1.5 percent of DMOs' capitation is at-risk.

A strong medical P4Q program incentivizes MCOs to pursue quality-based alternative payment models (APMs) with providers to help them achieve higher performance on P4Q measures.

To further accelerate this effort, HHSC also has implemented contractual requirements to advance the use of APMs between MCOs and providers.

APMs are health care payment models that link a percentage of the provider's overall payment to a measure of either quality or quality and cost. MCOs and DMOs must have a certain percentage of their overall provider payments associated with an APM. For a certain percentage of these payments, the provider must have some degree of risk. MCOs and DMOs are subject to contract remedies, potentially including liquidated damages, if these thresholds are not achieved.

MCO and DMO APM Payment and Risk Thresholds for Calendar Years 2018 and 2021				
	2018 Payment Threshold	2018 Risk Threshold	2021 Payment Threshold	2021 Risk Threshold
MCOs	25%	10%	50%	25%
DMOs	25%	2%	50%	10%

If an MCO does not achieve the target APM percentages, but performs better than the state average on potentially preventable emergency department visits (PPVs) and potentially preventable admissions (PPAs) by 10 percent, then penalties are waived. Additionally, MCOs have requirements to:

- Continue reporting to HHSC on APM models that are being deployed or in the planning stage.
- Dedicate sufficient resources for provider outreach and negotiation, assistance with data and report interpretation, and other collaborative activities to support APM and provider improvement.
- Establish and maintain data sharing processes with providers, require data and report sharing between MCOs and providers, and collaborate on common formats.
- Dedicate resources to evaluate the impact of APMs on utilization, quality and cost, and return on investment.

Hospital Quality-based Payment Program

HHSC has initiated an incentive/disincentive program that pays or recoups funds from hospitals according to their performance with FFS and managed care patients—with the goal of improving quality and lowering costs.

Hospitals and MCOs are financially accountable for certain potentially preventable events (PPEs), including potentially preventable complications (PPCs) and potentially preventable readmissions (PPRs).

A PPC is a harmful event or negative outcome, such as an infection or surgical complication, which occurs after the patient's admission and may have resulted from treatment, or lack of treatment, provided—rather than from a natural progression of their condition.

A PPR is a return hospitalization that may have resulted from deficiencies in care or treatment provided during a previous hospital stay or from inadequate post-hospital discharge follow up.

If hospitals fail to meet certain PPC or PPR thresholds, then adjustments in the form of reductions are made to FFS hospital inpatient claim payments. Similar adjustments are made for each MCO's encounter data that affects MCO capitation rates.

Nursing Facility Quality Incentive Payment Program

QIPP, a directed payment program, seeks to improve quality and innovation in nursing facility services. Both public and private nursing facilities can participate in the program, and over 880 of the state's 1,200 nursing facilities are enrolled for SFY 2021.

As a directed payment program, local governmental entity funds are used to match federal Medicaid funds. The program's budget has increased from approximately $400 million in SFY 2018, the first year of the program, to $1.1 billion in SFY 2021. Funds are built into the MCO capitation payments and are then paid out to eligible providers.

Payments are made monthly and quarterly by the STAR+PLUS MCOs to the nursing facilities, based on their completion of required quality improvement activities and their performance on CMS-approved quality measures. For SFY 2018 and SFY 2019, the measures indicated whether a nursing facility reduced the following: use of restraints, inappropriate use of antipsychotic medication, development of pressure ulcers, and occurrence of falls with major injury.

HHSC adopted new quality measures, eligibility requirements and financing components for QIPP in SFYs 2020 through 2021. QIPP quality components during this biennium include workforce development; an infection control program; and long-stay quality measures focused on pressure ulcers, antipsychotic medication and independent mobility. HHSC will review the proposed revisions to quality measures during workgroups, which will include internal and external stakeholders for SFY 2022.

Fund Recovery

The Office of Inspector General (OIG) performs the functions listed below (see page 71 for more about the OIG).

Third-party Liability

Under federal law, Medicaid and CHIP are the payer of last resort. This means other sources of health insurance that a client may have—such as commercial health insurance or medical coverage under car insurance—may be responsible to pay for Medicaid and CHIP clients. This requirement, called third-party liability (TPL), ensures the responsible party other than Medicaid or CHIP pays for care.

To implement TPL requirements, federal and state rules require states to take reasonable measures to identify potentially liable third parties and process claims accordingly. As a condition of eligibility, Medicaid and CHIP clients also must cooperate with state efforts to pursue other sources of coverage.

States rely on two main sources of information to determine whether a liable third party exists for a claim: clients, and data matches with other insurers or data clearinghouses. HHSC works to reduce health care expenditures by shifting claims expense to third-party payers, utilizing either cost avoidance or cost recovery:

- Cost avoidance occurs when the state is aware that a client has potential third-party coverage when a claim is filed. The state rejects the claim and instructs the provider to submit it to the potential primary payer. After the potential primary payer has processed the claim, the provider may resubmit a claim for any portion of the claim not covered by the primary payer.
- Cost recovery, also known as "pay and chase," occurs when the state seeks reimbursement from third parties for which third parties are liable for payment of the claims.

MCOs and DMOs are subject to the state and federal requirements related to cost avoidance and cost recovery. Each MCO and DMO has the obligation to cost avoid claims and cost recover when there is a liable third party.

Medicaid Estate Recovery Program

Texas implements the Medicaid Estate Recovery Program (MERP) in compliance with federal Medicaid laws. Under MERP, the state may recover the cost of Medicaid services provided by filing claims against the estate of certain, deceased Medicaid clients—who were age 55 and older and had received LTSS benefits on or after March 1, 2005. Claims may include certain Medicaid long-term care services and related costs of hospital and prescription drug services for clients in nursing facilities, ICFs/IID, Community Attendant Services or waiver programs.

There are certain exemptions from recovery, as required by federal and state law. When no exemptions apply, the heirs may request a hardship waiver if certain conditions are met. When no exemptions or hardship conditions exist, the state files a claim against the descendant's assets that are subject to probate. The estate representative is responsible for paying the lesser of the MERP claim amount or the estate value—after all higher priority estate debts have been paid. This is paid through the estate, not the resources of any heirs or family members.

The claims filing component of the MERP program has been contracted to a private company through a competitive procurement process.

Chapter 5

What is the governing framework for Medicaid and CHIP?

At-a-Glance

Medicaid and the Children's Health Insurance Program (CHIP) change in response to federal and state requirements.

Key Federal Concepts

Fundamental Requirements:
The basic principles for Medicaid programs established by the Social Security Act (SSA).

Centers for Medicare & Medicaid Services (CMS):
The agency within the U.S. Department of Health and Human Services that oversees the Medicaid program.

Single State Agency:
Federal regulations require each state to designate a single state agency responsible for that state's Medicaid program.

Medicaid State Plan:
Submitted by states individually, this is a dynamic document that serves as the contract between each state and CMS.

Waivers:
States apply to CMS for waivers to test new ways to deliver and pay for services.

Requirements Directed by the Texas Legislature

Requirements Established by the SSA

Medicaid operates according to the following fundamental requirements:

1. **Statewide Availability**
   All Medicaid services must be available statewide and may not be restricted to residents of particular localities.
2. **Sufficient Coverage**
   States must cover each service in amount, duration and scope that is "reasonably sufficient."
3. **Service Comparability**
   The same level of services (amount, duration and scope) must be available to all clients, except where federal law specifically requires a broader range of services or allows a reduced package of services.
4. **Freedom of Choice**
   Clients must be allowed to go to any Medicaid health care provider who meets program standards.

Key Federal Mandate Categories

Services
States must provide mandated services and may provide certain optional services (see Appendix B, page 130).

Populations
States must cover certain groups at set percentages of the federal poverty level (FPL) and may expand coverage to optional groups (see Chapter 1, page 11).

Limits
States may not impose limits on services for Medicaid clients age 20 and younger, nor may a state arbitrarily limit services for any specific illness or condition. However, states may limit utili zation of some services, such as placing a limit on the number of prescriptions per month for outpatient drugs.

See Appendix A, page 103, for a list of highlights from the Texas Legislature and relevant federal changes.

How Texas Administers Medicaid and CHIP

Texas submits a state plan for both Medicaid and Children's Health Insurance Program (CHIP) that serves as the contract between the state and Centers for Medicare and Medicaid Services (CMS). These state plans describe the nature and scope of the Medicaid and CHIP programs—including administration, client eligibility, benefits and provider reimbursement.

The state plans give the Health and Human Services Commission (HHSC), as the single state agency, the authority to administer the Medicaid and CHIP programs in Texas. HHSC's responsibilities include:

- Serving as the primary point of contact with the federal government. HHSC coordinates initiatives to maximize federal funding and administers the Medical Care Advisory Committee, a committee mandated by federal Medicaid law that reviews and makes recommendations on proposed Medicaid rules.
- Establishing policy direction for the Medicaid and CHIP programs, administering the state plans, and coordinating with other HHSC departments and state agencies to carry out operations.
- Determining program eligibility for Medicaid and CHIP.
- Establishing Medicaid policies, rules, reimbursement rates and oversight of Medicaid program operations, including managed care organization (MCO) contract compliance.

Medicaid Waivers

Federal law allows states to apply to CMS for permission to depart from certain Medicaid requirements. Federal law allows three main types of waivers: Research and Demonstration 1115 waivers, Freedom of Choice 1915(b) waivers, and Home and Community-based Services (HCBS) 1915(c) waivers. These waivers allow states to develop creative alternatives to the traditional Medicaid program. States seek waivers to:

- Provide services above and beyond state plan services to selected populations.
- Expand services in certain geographical areas.
- Limit free choice of providers.
- Implement innovative new service delivery and management models.

States must provide regular reports and evaluations showing cost-effectiveness, cost neutrality or budget neutrality (based on the type of waiver), and that requirements for the waiver are being met.

Research and Demonstration 1115 Waivers

Section 1115 waivers allow flexibility for states to test new ideas for operating their Medicaid programs—including implementing statewide health system reforms; providing services not typically covered by Medicaid; or allowing innovative service delivery systems to improve care, increase efficiencies and reduce costs.

The Texas Healthcare Transformation and Quality Improvement Program

The Texas Healthcare Transformation and Quality Improvement Program, also known as the 1115 Healthcare Transformation Waiver, allows Texas to expand managed care—including pharmacy and dental services—while preserving federal hospital funding. STAR, STAR+PLUS, STAR+PLUS Home and Community-based Services (STAR+PLUS HCBS), STAR Kids and dental managed care services are covered under this waiver. CMS has approved extensions of the waiver through September 2022.

The waiver contains several funding pools, including Uncompensated Care (UC) and Delivery System Reform Incentive Payment (DSRIP). Three managed care directed payment programs also operate under the waiver: Network Access Improvement Program (NAIP), Uniform Hospital Rate Increase Program (UHRIP), and Quality Incentive Payment Program (QIPP) (see Chapter 4, page 80).

Healthy Texas Women

In January 2020, CMS approved an 1115 Demonstration Waiver for the Healthy Texas Women (HTW) program. HHSC began receiving federal funds for HTW in February 2020, and the waiver is approved through December 2024. The demonstration waiver allows HTW to receive federal matching funds and requires HTW to comply with certain Medicaid requirements—including eligibility application, verification and demonstration regulations.

The goals and objectives of the HTW Demonstration Waiver are to:

- Increase access to women's health and family planning services, in order to avert unintended pregnancies and positively impact the outcome of future pregnancies, as well as the health and well-being of women and their families.
- Increase access to preventive health care, in order to positively impact maternal health and reduce maternal mortality.
- Increase access to women's breast and cervical cancer services, in order to promote early cancer detection.
- Implement the state policy to favor childbirth and family planning services that do not include elective abortions or the promotion of elective abortions.
- Reduce the overall cost of publicly funded health care by providing low-income Texans with access to safe, effective services consistent with these above goals.

Freedom of Choice 1915(b) Waivers

Section 1915(b) waivers provide states the flexibility to modify their service delivery systems and are the authority under which Texas implements a managed care model. How states use 1915(b) authority depends on what the end goals are for the program.

For example, the selective contracting authority granted under 1915(b)(4) waivers is used for programs and services such as Community First Choice (CFC) Medicaid state plan services. This allows the state to limit the provider base for CFC clients to their waiver providers. However, since many waivers are still under a fee-for-service (FFS) delivery system, clients are not required to move into managed care to receive CFC.

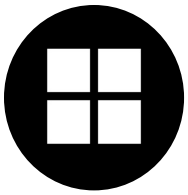
Texas also uses 1915(b) waivers for the Medical Transportation Program (MTP). Texas currently delivers MTP services through both FFS and managed care under the authority of a 1915(b)(4) and a 1915(b)(1) waiver, respectively. As part of carving MTP into managed care, beginning June 2021, Texas will use 1915(b)(4) for FFS and an 1115 waiver for managed care.

Home and Community-based Services 1915(c) Waivers

Section 1915(c) waivers allow states to provide community-based services as an alternative for people who meet eligibility criteria for care in an institution (nursing facility, intermediate care facility for individuals with an intellectual disability or related condition [ICF/IID], or hospital).

States may use these waivers to serve people age 65 and older and those with physical disabilities; an intellectual or other developmental disability; mental illness; or more specialized populations, such as individuals with traumatic brain injuries or sensory impairment.

Texas 1915(c) waivers include the Medically Dependent Children Program (MDCP); Home and Community-based Services (HCS); Texas Home Living (TxHmL); Community Living Assistance and Support Services (CLASS); Deaf Blind with Multiple Disabilities (DBMD); and Youth Empowerment Services (YES) (see Chapter 2, page 27).



Fundamental Requirements

Statewide Availability

Also referred to as "statewideness," this principle in federal law requires state Medicaid programs to offer the same benefits to everyone throughout the state. Exceptions to this requirement are possible through Medicaid waiver programs and special contracting options. Since the move toward managed care in Texas, statewide availability is primarily assured through federal and state regulations that establish minimum provider network standards and by state oversight of MCO compliance with these regulations. Texas has implemented access standards, including time and distance standards and appointment availability standards (see Chapter 3, page 50).

Sufficient Coverage

Federal law specifies a set of benefits that state Medicaid programs must provide and a set of optional benefits that states may choose to provide. Federal law allows states to determine what constitutes reasonably sufficient coverage in terms of the amount, duration and scope of services. Because each state defines these parameters, state Medicaid plans vary in what they cover and how much they cover. Limits on Texas Medicaid services include:

- A 30-day annual limit on inpatient hospital stays per spell of illness for adults served in FFS and STAR+PLUS. More than one 30-day hospital visit can be paid for in a year, if stays are separated by 60 or more consecutive days. The limit does not apply to clients receiving a pre-approved, medically necessary transplant. Clients receiving transplants are allowed an additional 30 days of inpatient care, beginning on the date of the transplant. The limit does not apply to STAR+PLUS members admitted to an inpatient hospital due to a primary diagnosis of a severe and persistent mental illness. This limit is not applicable to children age 20 and younger, whenever there is a medical necessity for additional services.
- Three prescriptions per month for adults in FFS for outpatient drugs. Family planning drugs are exempt from the three-drug limit. There are no limits on drugs for children age 20 and younger, adults enrolled in managed care, or for clients in nursing facilities or enrolled in certain 1915(c) waiver programs.

Service Comparability

In general, service comparability requires the state to provide the same level of services to all clients, except where federal law specifically requires a broader range of services or

allows a reduced package of services. There are certain demographic groups, such as children and youth, for whom additional steps have been taken to increase access to care.

Coverage for Children

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program—known in Texas as Texas Health Steps—provides preventive health and comprehensive care services for children and youth age 20 and younger who are enrolled in Medicaid (see Chapter 2, page 30). Federal changes have expanded the benefits of this program, such that children and youth age 20 and younger are eligible for any medically necessary and appropriate health care service covered by Medicaid, regardless of the limitations of the state's Medicaid program.

Children's Health Care Case Law

Court cases have played a significant role in the delivery of children's health care through the Medicaid program in Texas:

- *Alberto N. v. Young*, a federal lawsuit settled in May 2005, requires HHSC to comply with Title XIX of the SSA (42 U.S.C. §1396 et seq.) by providing all medically necessary in-home Medicaid services to children age 20 and younger who are eligible for the EPSDT program.
- *Frew v. Young*, a class action lawsuit filed against Texas in 1993, alleged that the state neither adequately informed parents and guardians about nor provided EPSDT services. In 1995, the state negotiated a consent decree that imposed certain requirements on the state. In 2007, the state negotiated a set of corrective action orders with the plaintiffs to implement the consent decree and increase access to EPSDT services. Since 2007, Texas HHSC and Department of State Health Services (DSHS) have actively worked to meet the requirements of the corrective action orders. As a result, some portions of the consent decree and corrective action orders have since been dismissed.

Freedom of Choice

In general, a state must ensure that Medicaid clients are free to obtain services from any qualified provider. Exceptions are possible through Medicaid waivers and special contract options. Texas Health Steps clients have freedom of choice with regard to a medical checkup provider, even if that provider is not the child's primary care provider (PCP).

To maintain freedom of choice under managed care, each service delivery area in the state has at least two health plans or MCOs from which clients can choose, once they are found eligible. The exception for this is STAR Health, which is administered statewide by a single MCO. Once clients select their health plan, they also choose a PCP from the MCO's provider network.

Appendix A

Key Medicaid and CHIP legislation

Texas Medicaid and Children's Health Insurance Program (CHIP) change in response to legislative requirements at the state and federal levels. This appendix provides a brief legislative history of Medicaid and CHIP, including highlights of key federal and state legislation by topic.

Medicaid

Founding Legislation

In 1965, the **Social Security Act (SSA) of 1935** was amended to add Title XIX, which created Medicaid as a state-administered health care program, jointly funded by the federal government. The SSA was further amended in 1967 to mandate inclusion of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program for children in Medicaid, and again in 1972 to allow states to cover care for children and youth in inpatient psychiatric care. In 1977, the Centers for Medicare and Medicaid (CMS) was created to oversee and manage Medicare, Medicaid and CHIP programs.

The SSA dictated the principles that state Medicaid programs must fulfill, including:

- **Section 1902(a)(1):** required that state Medicaid programs be in effect "in all political subdivisions of the state."
- **Section 1902(a)(10):** required that state Medicaid programs provide services to people that are comparable in amount, duration and scope.
- **Section 1902(a)(23):** required that state Medicaid programs ensure that clients have the freedom to choose any qualified provider to deliver a covered service.

Also included within the SSA are sections that allowed states to waive various Medicaid requirements and implement different service delivery models, eligibility criteria and benefits:

- **Section 1115(a):** allowed states to waive provisions of Medicaid law to test new concepts consistent with the goals of the Medicaid program. System-wide changes are possible under this provision. Waivers must be approved by CMS.
- **Section 1903(m):** allowed state Medicaid programs to develop risk contracts with managed care organizations (MCOs) or comparable entities.
- **Section 1915(b):** allowed states to waive freedom of choice. States may require that beneficiaries enroll in MCOs or other programs. Waivers must be approved by CMS.
- **Section 1915(c):** allowed states to waive various Medicaid requirements to establish alternative, community-based services for individuals who qualify to receive services in an intermediate care facility for individuals with an intellectual disability

or related condition (ICF/IID), nursing facility, institution for mental disease, or inpatient hospital. Waivers must be approved by CMS.

- **Section 1915(i):** allowed states to offer a variety of services under a state plan Home and Community-based Services (HCBS) benefit. Individuals must meet state-defined criteria based on need and typically get a combination of acute-care medical services and long-term services in home and community-based settings.
- **Section 1929:** allowed states to provide a broad range of home and community-based care to individuals with functional disabilities, as an optional state plan benefit. In all states but Texas, the option can serve only people age 65 and older. In Texas, individuals of any age may qualify to receive personal care services through Section 1929 if they meet the state's functional disability test and financial eligibility criteria.

Program Reforms and Expansions

Federal and state laws also determine which populations are eligible for Medicaid and what Medicaid covers. Federal and state legislation have reformed and expanded the program over time—adjusting program eligibility criteria, as well as the type, amount, duration and scope of services provided through Medicaid.

Federal Legislation

Historically, all Medicaid clients either had Supplemental Security Income (SSI) or welfare. Beginning in the 1980s, several federal laws were passed that expanded Medicaid coverage to populations ineligible for SSI or Temporary Assistance for Needy Families (TANF) and, eventually, de-linked financial assistance from Medicaid eligibility. A few of these federal laws are highlighted below:

The Omnibus Budget Reconciliation Act of 1986 (OBRA of 1986):

- Mandated states cover emergency care services, including labor and delivery, for undocumented immigrants and required them to cover homeless people.
- Allowed states to cover infants and pregnant women under 100 percent of the federal poverty level (FPL); to create a phase-in for children age 4 and younger under 100 percent of the FPL; and to cover prenatal care while a Medicaid application is pending, along with guaranteed coverage for the full term of pregnancy and postpartum care. States may waive asset tests for this group.

The Omnibus Budget Reconciliation Act of 1987 (OBRA of 1987):

- Required states to extend coverage to children age 6 and younger born after September 30, 1983, whose families meet TANF financial standards—even if the family does not qualify for TANF. Extension through age 7 is at the state's option.

- Allowed states to cover infants age 1 and younger and pregnant women under 185 percent of the FPL, with immediate coverage (no phase-in) for children age 4 and younger under 100 percent of the FPL.
- Mandated sweeping changes in nursing facility standards, including the creation of the Preadmission Screening and Resident Review process—a requirement that all current and prospective nursing facility clients be screened for mental illness, intellectual disability or related conditions.

The Medicare Catastrophic Coverage Act of 1988:

- Expanded Medicaid coverage for infants, young children and pregnant women.
- Provided phased-in coverage of infants through their first birthday and pregnant women under 100 percent of the FPL.
- Required more comprehensive coverage of hospital services for infants, and expanded payments for hospital services for infants in all hospitals and for children age 5 and younger in disproportionate share hospitals.
- Amended eligibility criteria and services provided to dually eligible Medicare clients—including providing phased-in coverage of out-of-pocket costs (premiums, deductibles and co-insurance) for Qualified Medicare Beneficiaries under 100 percent of the FPL and establishing minimum standards for income and asset protection for spouses of Medicaid clients in nursing homes.

The Omnibus Budget Reconciliation Act of 1989 (OBRA of 1989):

- Prohibited states from limiting the amount, duration, scope or availability of state plan services to children on Medicaid.

The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996:

- De-linked cash assistance and Medicaid eligibility. While Medicaid financial eligibility is determined by the FPL, the TANF monthly cap is based on a set dollar amount, and each state sets its income eligibility guidelines for TANF cash assistance. Prior to PRWORA, children age 18 and younger and their related caretakers, who qualified for TANF cash assistance, were also automatically qualified for Medicaid. Under PRWORA, if households need both TANF cash assistance and Medicaid, they must apply for both. Otherwise, they can only apply for TANF cash assistance or Medicaid.
- Required TANF clients to participate in work activities within two years of entering the program and prohibited them from receiving federally funded TANF benefits for more than 60 months over a lifetime. This requirement is thought to be partly responsible for the drop in Medicaid caseload in Texas in the mid-to-late 1990s.
- Gave states the option to decide whether to continue providing Medicaid to most legal immigrants. Most immigrants entering the U.S. after August 22, 1996, are

subject to a five-year wait period, during which no federal Medicaid funds can be accessed for their care. The Balanced Budget Act (BBA) of 1997 restored SSI benefits for legal immigrants who arrived in the U.S. prior to August 22, 1996, but limited the benefit until after the first seven years of a person's residence in the U.S. (see below).

Various laws have been passed to extend PRWORA beyond its initial expiration in September 2002. **The Deficit Reduction Act (DRA) of 2005** reauthorized TANF through 2010, and continuing resolutions have extended the program since then.

The DRA also reduced federal Medicaid and Medicare spending by $39 billion from 2006–2010, through changes to prescription drug regulations and long-term services and supports (LTSS) eligibility rules, among others.

The Balanced Budget Act (BBA) of 1997:
A landmark piece of federal legislation that:

- Created CHIP (see page 117) and changed Medicaid and Medicare rules and regulations.
- Added several new eligibility options including:
  - Guaranteed Eligibility: allowed states to choose to guarantee Medicaid coverage for up to 12 months for all children, even if they no longer meet Medicaid income eligibility tests.
  - Medicaid Buy-in: allowed states to offer individuals, with disabilities and income below 250 percent of the FPL, an opportunity to buy in to the Medicaid program.
  - Medicaid Buy-in for Children: allowed states to offer children age 18 and younger with disabilities an opportunity to buy in to the Medicaid program.
- Repealed the Boren Amendment from the Omnibus Budget Reconciliation Act of 1980 (OBRA of 1980), which linked Medicaid nursing home rates to federal and state quality-of-care standards.
- Allowed states to require most Medicaid-eligible individuals to enroll in managed care plans without a waiver, such as an 1115 or 1915(b)—but mandated all states with Medicaid managed care programs to ensure MCOs conduct Performance Improvement Projects (PIPs) (see Chapter 3, page 59).

The BBA was later amended by the Balanced Budget Refinement Act (BBRA) of 1999, which provided approximately $17 billion in "BBA relief" over five years. The BBRA also extended the phaseout of cost-based reimbursement for Federally Qualified Health Centers (FQHCs) and rural health clinics (RHCs), and changed Medicaid Disproportionate Share Hospital (DSH) payments and rules. It also prohibited states from using CHIP federal funds for DSH.

The Affordable Care Act (ACA) of 2010:
Made several important changes to the health care system in the U.S., including:

- Prohibiting coverage denials based on a pre-existing condition.
- Allowing children to remain on their parent's health plan until age 26.
- Requiring persons to have health insurance or pay a penalty; however, the **Tax Cut and Jobs Act of 2017** eliminated this penalty starting in 2019.
- Requiring states to establish health insurance marketplaces or refer people to the federally facilitated marketplace to assist individuals and small employers in accessing health insurance. Texas currently utilizes the federally facilitated marketplace.
- Mandating states modify their Medicaid and CHIP programs, including their state plans and financial eligibility criteria.
- Giving states the option to expand Medicaid eligibility up through 133 percent of the FPL for individuals age 64 and younger, with federal funds paying 100 percent for the first three calendar years of the expansion. Effective in 2017, the federal matching rate decreased gradually each year. From 2020 onward, the matching rate will be 90 percent. Texas has not expanded Medicaid eligibility to this optional adult group.

Additionally, in anticipation that the uninsured population would decrease following Medicaid expansions and the implementation of the state health insurance marketplaces, the ACA intended to decrease DSH allotments. Since 2010, various pieces of legislation have delayed the implementation of DSH funding cuts under the ACA and changed the amounts of the reductions. Currently, the **Coronavirus Aid, Relief and Economic Security (CARES) Act of 2020** has delayed the reductions in DSH allotments until December 1, 2020, and has reduced the amount of the reduction scheduled for fiscal year 2021 (see Chapter 4, page 88).

The ACA also made changes to the federal drug rebate program created under OBRA of 1990—increasing the minimum federal rebate percentages that drug manufacturers are required to pay to participate in the Medicaid program, and also expanding the rebate program to cover claims paid by Medicaid MCOs (see page 109).

State Legislation

Senate Bill (S.B.) 11, 85th Legislature, Regular Session, 2017:

- Required the Department of Family and Protective Services (DFPS) to ensure that children who are taken into state conservatorship receive an initial medical exam within three business days, if they are removed from their home as the result of:
  - Sexual abuse, physical abuse or an obvious physical injury.

    - A chronic medical condition, a medically complex condition or a diagnosed mental illness.
- Prohibited a physician or other health care provider from administering a vaccination as part of the required exam—except for an emergency tetanus vaccination—without parental consent and until DFPS has been named managing conservator.
- Required DFPS to ensure that any child who enters state conservatorship receives any necessary emergency medical care as soon as possible.

House Bill (H.B.) 2466, 85th Legislature, Regular Session, 2017:

- Required Medicaid and CHIP to cover a maternal depression screening for mothers of children who are eligible for Medicaid. This screening occurs during the covered well-child visit, which takes place before the child's first birthday.

Prescription Drugs

Federal Legislation

The Omnibus Budget Reconciliation Act of 1990 (OBRA of 1990):

- Established the Federal Rebate Program, which required drug manufacturers to pay rebates for drugs dispensed under state outpatient drug programs to be included in state Medicaid formularies.
- Required states to cover all drugs for which a manufacturer provides rebates under the terms of the law and to maintain an open formulary for all drugs of manufacturers that have signed a federal rebate agreement. Rebate amounts per unit are determined by the CMS.

OBRA of 1990 was later amended under the DRA of 2005, which extended the rebate program to outpatient drugs administered in a physician's office or another outpatient facility.

The ACA also made changes by increasing the minimum federal rebate percentages that drug manufacturers are required to pay in order to participate in the Medicaid program, and by expanding the rebate program to cover claims paid by Medicaid MCOs. The federal government keeps 100 percent of the increased rebate amount.

The Vendor Drug Program (VDP) manages the federal manufacturer drug rebate program and collects rebates for medications—that are dispensed by pharmacies and administered by physicians—to people enrolled in fee-for-service (FFS) and managed care. Texas negotiates additional state rebates for preferred drugs. The Health and Human Services Commission (HHSC) also collects rebates for drugs provided to people enrolled in CHIP and three state health programs, including Healthy Texas Women (HTW).

The Medicare Prescription Drug Improvement and Modernization Act (MMA):

- Created a new Medicare prescription drug benefit (Part D) and made other program and payment changes. Medicare Part D is a voluntary Medicare prescription drug benefit, where people in traditional Medicare may choose a private, drug-only plan. Those who choose to enroll in an MCO may choose a plan offering a drug benefit. Medicare Part D is available to dual eligibles receiving Medicaid.
- Amended provider payments, some of which had been reduced or constrained by previous legislation. Major provisions affecting the Medicaid program include:
  - Recoupment of part of the federal cost of the drug benefit by requiring states to refund a portion of their savings that result from Medicare providing drug coverage to dual eligibles (referred to as the "clawback" provision).
  - Addition of preventive benefits to Medicare and the elimination of co-pays for home health services, some of which were previously covered by Medicaid.
  - Increased premiums for Medicare Part B, which covers physician services, lab services, etc. Medicaid pays these premiums on behalf of certain clients who are dually eligible for Medicare and Medicaid.

State Legislation

H.B. 2292, 78th Legislature, Regular Session, 2003:

- Directed HHSC on how to implement the Medicaid Preferred Drug List (PDL)—a tool used by many states to control growing Medicaid drug costs (see Chapter 3, page 56).
- Required HHSC to collect supplemental rebates. Rebates are collected from both FFS and MCO prescription drug claims. Supplemental rebate revenue is shared with CMS at the same federal medical assistance percentage used to pay claims.

H.B. 1917, 85th Legislature, Regular Session, 2017:

- Provided that the PDL will carve into managed care, allowing each MCO to determine the drugs that are on their preferred drug list on September 1, 2023.

S.B. 1, 86th Legislature, Regular Session, 2019 (Article II, HHSC, Rider 115):

- Required HHSC to submit an annual report to the Legislature on rebate revenues and outstanding balances.
- Established rebate revenue as the first source of funding, before general revenue, for Medicaid and CHIP prescription drug services.

Economic and Public Health Crises

Since Medicaid primarily serves low-income individuals, a rise in unemployment can result in an increase in the number of people eligible for Medicaid. During the 2008 economic

recession, for example, the rise in unemployment—and subsequent federal legislation passed to meet the crisis—caused sudden growth in Medicaid enrollment.

Similarly, the recent public health crisis caused by the novel coronavirus (COVID-19) pandemic spurred federal legislation to address an economic recession and assist state and local governments, which included changes to the Medicaid and CHIP programs.

The American Recovery and Reinvestment Act (ARRA) of 2009:

- Temporarily increased the Federal Medical Assistance Percentage (FMAP) from October 2008 through December 2010.
- Temporarily prohibited states from making changes to any Medicaid eligibility standards, methodologies or procedures that were more restrictive than those in effect as of July 1, 2008.
- Extended the TANF Supplemental Funds, created a new TANF Emergency Fund and increased the DSH allotment.

ARRA also included reforms and financial incentives for health care technology under the Health Information Technology for Economic and Clinical Health (HITECH) Act (see page 115).

The Families First Coronavirus Response Act (FFCRA) of 2020:

- Required private and public health insurers–including Medicare, Medicaid and CHIP–to provide coverage for COVID-19 testing.
- Temporarily increased the Medicaid FMAP by 6.2 percentage points from January 1, 2020, throughout the duration of the emergency period. Because this period could be extended, the FY21 FMAP should not be considered final. As a condition of receiving the increased FMAP, states were required to maintain eligibility and services for any Medicaid recipients eligible as of March 18, 2020.
- Provided paid emergency sick leave and family medical leave for individuals and families impacted by the public health emergency.

The FFCRA has been extended through January 21, 2021.

Rights and Entitlements for People With Disabilities

Federal Legislation and Policy

The Americans with Disabilities Act (ADA) of 1990:

- Prohibited discrimination based on disability in the areas of employment; public services provided by state and local governments; and public services operated by private entities, transportation and telecommunications.

The Ticket to Work and Work Incentives Improvement Act (TWWIIA) of 1999:

- Expanded the eligibility options and funding for Medicaid Buy-in programs for individuals age 16 through age 64.
- Extended Medicare coverage for disabled individuals returning to work.
- Created the Ticket to Work Program, which enables SSI and Social Security Disability Insurance (SSDI) recipients to obtain employment services from both private and public providers.

State Legislation and Policy

Texas Government Code, Chapter 534 (established by S.B. 7, 83rd Legislature, Regular Session, 2013):

- Directed HHSC to implement an acute care and LTSS system for individuals with intellectual and developmental disabilities (IDD), a managed care delivery system, and the federal Community First Choice (CFC) option.
- Authorized HHSC to operate a pilot program by September 1, 2018, to test one or more managed care service delivery models to deliver Medicaid LTSS to individuals with IDD.

H.B. 3295, 85th Legislature, Regular Session, 2017:

- Extended completion of the managed care pilot program for individuals with IDD (under Chapter 534) from September 1, 2018, to September 1, 2019.
- Changed the transition of the Texas Home Living (TxHmL) waiver program from September 1, 2018, to September 1, 2020. The transition date of the TxHmL program into managed care was changed to September 1, 2027, by H.B. 4533, 86th Legislature, Regular Session, 2019. More information on H.B. 4533 is found on pages 120-122.

S.B. 547, 85th Legislature, Regular Session, 2017:

- Allowed state supported living centers (SSLCs) to provide certain non-residential Medicaid services to support individuals with IDD and directed HHSC to establish reimbursement rates for SSLCs for these services.

Home and Community-based Services and Promoting Independence

The 1999 Supreme Court decision, *Olmstead v. L.C.*, determined that individuals with intellectual disabilities or serious mental illnesses have the right to live in community-based settings rather than in institutions. The ruling mandated that publicly run programs provide the option for community-based services to individuals with disabilities, when such services are appropriate and can be reasonably accommodated. In response to the *Olmstead* decision and other federal policy priorities, Texas Medicaid has expanded coverage for a broad range of LTSS.

The General Appropriations Act, S.B. 1, 77th Legislature, Regular Session, 2001 (Article II, HHSC, Rider 37) established the Promoting Independence Initiative—also called Money Follows the Person—whereby the funding for individuals moving from nursing facilities to community-based services could be transferred from the nursing facility budget to the community-based services budget. Rider 37 was later codified by H.B. 1867, 79th Legislature, Regular Session, 2005.

The Promoting Independence Initiative received a demonstration award through the DRA of 2005. Federal authorization of the demonstration ended in September 2016, but states were given supplemental grants through September 30, 2020. The Medicaid Extenders Act of 2019 extended authorization of the demonstration through July 31, 2024. Even though the authorization extends to 2024, there may not be funds for each year. The available funds will depend on re-obligation and congressional appropriations.

In March 2014, CMS issued a rule for the delivery of Medicaid home and community-based services, ensuring individuals have the option to receive services in fully integrated settings. These settings must provide full access to the greater community, opportunities to work in integrated settings, and opportunities for individuals to control their schedules and activities. They must also ensure individual rights to privacy, dignity and respect, and freedom from coercion and restraint—and allow for choice regarding services and who provides them.

CMS initially gave states until March 2019 to comply with the regulation, but in June 2017, issued an extension until March 2022. In July 2020, CMS provided an additional one-year extension due to COVID-19, giving states until March 2023 to comply.

Mental Health and Behavioral Health

Federal Legislation

The Paul Wellstone and Pete Domenici Mental Health Parity and Addition Equity Act (MHPAEA) of 2008:

- Required group health plans, that offer behavioral health benefits, to provide those services at parity with medical and surgical benefits. This does not impact FFS, but does apply to Medicaid and CHIP managed care programs.

The Substance Use Disorder Prevention That Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act of 2018:

- Directed funding to federal agencies and states to increase access to addiction treatment and to take mitigating steps, such as preventing over-prescribing opioids.
- Required Medicaid to report on adult behavioral health outcome measures, expand drug utilization reviews, share data between Medicaid and the state's prescription drug monitoring databases, expand the "qualified practitioners" who can prescribe buprenorphine for opioid treatment, and ensure health insurance coverage continuity for former foster youth to age 26 in any state they reside.

State Legislation

S.B. 1, 81st Legislature, Regular Session, 2009 (Article IX, Health-Related Provisions, Section 17.15):

- Authorized HHSC to add comprehensive substance use disorder (SUD) benefits for adults in Medicaid in order to reduce medical expenditures related to substance abuse.

S.B. 58, 83rd Legislature, Regular Session, 2013:

- Required HHSC to integrate behavioral health and physical health services into Medicaid managed care programs, by adding both mental health targeted case management and mental health rehabilitative services to the array of services provided by MCOs by September 1, 2014.

H.B. 10, 85th Legislature, Regular Session, 2017:

- Created a behavioral health ombudsman in the HHSC Office of the Ombudsman and established a mental health condition and SUD parity work group.
- Required HHSC and the Texas Department of Insurance to study and report on benefits provided by health benefit plans, both for medical or surgical expenses and for mental health conditions and SUDs.

S.B. 1, 85th Legislature, Regular Session, 2017 (Article II, HHSC, Rider 45):

- Required HHSC to develop performance metrics to increase accountability of MCOs for members with severe mental illness (SMI). These metrics must include integrated care, jail and emergency department diversion, post-release linkage to care, homelessness reduction, supportive housing, and medication adherence.
- Required HHSC to improve outcomes, care integration and enhanced cost control —against an established baseline for members with SMI—and report to the Legislative Budget Board (LBB) and the governor by November 1, 2018, detailing HHSC's performance metrics on providing services to members with SMI. If cost effective, Rider 45 mandates the development and procurement of a managed care program, in at least one service delivery area, to serve members with SMI. After conducting extensive research and data analysis on the rider's specific outcomes related to SMI, HHSC did not procure a managed care program for SMI population. Per the rider, a report was submitted outlining the results of the research and data analysis to the Legislature.

Technology, Patient Privacy and Fraud Prevention

Federal Legislation

The Health Insurance Portability and Accountability Act (HIPAA) of 1996:

- Mandated that all health plans, health care clearinghouses and health care providers must protect all individually identifiable health information that is held or transmitted by a covered entity or business associate. Protected health information includes digital, paper and oral information.
- Required standardized electronic exchange of administrative and financial health services information for all health plans, including Medicaid. All health care organizations must implement secure electronic access to health data and remain in compliance with privacy regulations set by the U.S. Department of Health and Human Services.
- Implemented the National Provider Identifier (NPI) system—in which each health care entity, including individuals, employers, health plans and health care providers—must have a unique 10-digit NPI number.

The Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009:

- Incentivized providers to adopt and meaningfully use electronic health records (EHRs) and advance health information exchange (HIE) systems. The EHR incentive program is set to end in 2021.
- Established health information exchange and data breach notification rules that build upon HIPAA privacy and security regulations.

State Legislation

S.B. 1107, 85th Legislature, Regular Session, 2017:

- Standardized requirements for telemedicine and telehealth services by specifying acceptable telemedicine and telehealth service delivery modalities; clarifying necessary physician-patient relationship requirements; and directing Texas Medical Board, Texas Board of Nursing, Texas Physician Assistant Board, and Texas State Board of Pharmacy to jointly develop administrative rules for valid prescriptions generated during a telemedicine visit.

Electronic Visit Verification

Electronic visit verification (EVV) is a set of computer-based tracking systems to verify the occurrence of personal attendant service visits—either by using an individual's home landline telephone or a small alternate device—in order to document the precise time a service delivery begins and ends.

The EVV program was first piloted following the direction of S.B. 7, 82nd Legislature, First Called Session, 2011. As of June 1, 2015, EVV has been required by state rule (15 TAC §354.1177) for attendant services in certain FFS and managed care home and community-based programs— including CFC and some waivers. HHSC requires EVV for 90 percent of attendant services.

The 21st Century Cures Act of 2016 mandated EVV for all Medicaid-funded programs delivering attendant services and made EVV mandatory for individuals using the Consumer Directed Services (CDS) option to receive those services. It reduced the federal payment under Medicaid for states that do not require the use of an EVV system. The effective date for attendant services is now January 1, 2021.

Children's Health Insurance Program

Founding Legislation

Federal Legislation

The Balanced Budget Act (BBA) of 1997 created the State Children's Health Insurance Program (SCHIP) under Title XXI of the Social Security Act (SSA) and appropriated nearly $40 billion for the program for federal fiscal years 1998–2007. SCHIP offered states three options when designing a program:

- Use SCHIP funds to expand Medicaid eligibility to children who were previously ineligible for the program.
- Design a separate state children's health insurance program.
- Combine both the Medicaid and separate state program options.

States that choose to expand their Medicaid programs are required to provide all mandatory benefits and all optional services covered under their Medicaid state plan, and they must follow the Medicaid cost-sharing rules. States that choose to implement a separate program have more flexibility. Within federal guidelines, they may determine their own SCHIP benefit packages.

Texas originally opted to expand Medicaid eligibility using SCHIP funds. In July 1998, Texas implemented Phase I of SCHIP, providing Medicaid to children age 15 through age 17 whose family income was under 100 percent of the federal poverty level (FPL). Phase I of SCHIP operated from July 1998 through September 2002. The program was phased out as Medicaid expanded to cover those children.

State Legislation

Senate Bill (S.B.) 445, 76th Legislature, Regular Session, 1999, enacted Phase II of SCHIP, which created the Texas Children's Health Insurance Program (CHIP). S.B. 445 specified that coverage under CHIP be available to children in families with incomes up to 200 percent of the FPL. Coverage under Phase II of the program began on May 1, 2000.

Texas CHIP was designed and operates as a separate child health program. Texas elected secretary-approved coverage for CHIP.

Program Reforms and Expansions

Federal Legislation

The Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000:

- Allowed states to retain unexpended federal fiscal year (FFY) 1998–99 federal allocations through FFY 2004.
- Granted states additional time to spend 50 percent of unused FFY 2000 and FFY 2001 federal allocations through FFY 2004 and FFY 2005, respectively.

The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009:

- Appropriated nearly $69 billion for FFY 2009–2013 and redesigned the allocation formula, so that it more closely reflected state spending.
- Required states to verify a CHIP applicant's citizenship.
- Mandated states apply mental health parity standards established under the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008.
- Allowed states to cover pregnant women above 185 percent of the FPL and up to the income eligibility level for children in CHIP.
- Allowed states to provide Medicaid and CHIP coverage to qualified immigrant children and pregnant women—without the previously required five-year delay.

Texas has implemented additional changes in accordance with CHIPRA guidance—including applying certain Medicaid managed care safeguards to CHIP, expanding dental services, and implementing mental health parity in CHIP.

Following CHIPRA, the Affordable Care Act (ACA) of 2010 extended federal funding for CHIP through FFY 2015 and increased the federal match rate for FFYs 2016–2019. Maintenance of effort (MOE) requirements prohibited states from restricting CHIP eligibility standards, methodologies or procedures through September 30, 2019. Medicaid payments are contingent upon meeting this CHIP MOE requirement. The ACA eliminated asset tests and most income disregards in CHIP financial eligibility determinations.

The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015:

- Extended federal funding for CHIP through FFY 2017, and fully funded state CHIP allotments through September 30, 2017, including funding the 23 percentage-point increase in federal matching funds authorized by the ACA.
- Extended CHIPRA outreach and enrollment grants and CHIPRA quality provisions, plus maintained MOE for children's coverage in Medicaid and CHIP through 2019.
- Made permanent the authorization for Transitional Medical Assistance, which provides time-limited Medicaid to low-income parents transitioning to employment at higher wages that otherwise would make them ineligible for Medicaid.

Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2018:

- Reauthorized CHIP funding through FFY 2027. The reauthorization legislation also extended the MOE provision, but phased out the associated super-enhanced federal match rate. In FFY 2020, the 23 percent bump reduced to 11.5 percentage points, and in FFY 2021, the match will return to the standard CHIP enhanced rate.

Federal funding for CHIP lapsed from October 2017 through February 2018. While some states received additional grant funding from the Centers for Medicare and Medicaid (CMS), Texas continued to fund CHIP using fiscal year 2017 carry-over funds.

The Substance Use Disorder Prevention That Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act of 2018:

- Required mental health and substance use disorder (SUD) services to be included as a category for basic services in CHIP (Section 5022). These services include inpatient and outpatient services, psychosocial rehabilitation, and crisis stabilization.

State Legislation

The 2006–07 General Appropriations Act, S.B. 1, 79th Legislature, Regular Session, 2005 (Article II, Health and Human Services Commission [HHSC], Rider 70):

- Authorized HHSC to expend funds to provide unborn children with health benefit coverage under CHIP. The result was CHIP Perinatal, which began in January 2007.
- Determined that CHIP Perinatal services are for the unborn children of pregnant women, who are uninsured and do not qualify for Medicaid due income or immigration status.

Recent Medicaid and CHIP State Legislation

86th Legislature, Regular Session, 2019	
Appeals and Fair Hearings	
S.B. 1207	Required Health and Human Services Commission (HHSC) and managed care organizations (MCOs) to issue notices to providers and members with clear and detailed information regarding either a denial, reduction or termination of coverage or a denial of a prior authorization (PA) request. Required that HHSC contract with an independent external medical reviewer (see Chapter 3, page 64).
Applied Behavior Analysis	
H.B. 1 (Article II, HHSC, Rider 32)	Authorized HHSC to use existing Children's Medicaid funds, if HHSC creates and implements a new Children's Medicaid benefit for Intensive Behavioral Intervention (IBI) for children with Autism Spectrum Disorder. IBI is one frequency level of Applied Behavior Analysis (ABA) treatment.
Managed Care Operations and Oversight	
H.B. 4533	Required HHSC to standardize and implement consistent definitions surrounding MCO grievance processes, as well as reporting and data collection for Medicaid.
H.B. 1 (Article II, HHSC, Rider 43)	Required HHSC to create an incentive program that allows MCOs to increase the percentage of default enrollment clients they receive based on quality, efficiency and effectiveness, and performance metrics.
Managed Care Service and Population Carve-ins	
H.B. 4533	Required HHSC to implement a pilot program for individuals with intellectual and developmental disabilities (IDD), traumatic brain injury, and similar functional needs in STAR+PLUS. Established new timelines and processes for transitioning IDD long-term services and supports (LTSS) into managed care.
H.B. 1576	Required HHSC to add non-emergency transportation services to managed care for coordination by the MCO. Nonmedical transportation services, which are a subset of demand response transportation services, will be provided for certain trips requested with less than 48-hour notice.
S.B. 750	HHSC must assess the feasibility of providing services in the Healthy Texas Women (HTW) program though managed care (see Maternal Health, page 121, for additional legislation related to managed care).

Maternal Health	
H.B. 253	Required HHSC to develop a postpartum depression strategic plan.
S.B. 750	Required HHSC to apply for federal funds to implement a model of care to improve the quality and accessibility of care for pregnant women with opioid use disorder. In December 2019, CMS awarded HHSC funding under the Maternal Opioid Misuse (MOM) Model. Required HHSC to develop a postpartum depression treatment network. Required HHSC to collaborate with MCOs to develop and implement cost-effective, evidence-based and enhanced prenatal services for high-risk pregnant women covered under Medicaid. HHSC must also assess the feasibility of providing services in the HTW program though managed care, and implement policies to improve the quality of maternal health in managed care. Required HHSC to develop an enhanced, cost-effective and limited postpartum care services package in HTW, and to implement strategies to ensure continuity of care for women transitioning from Medicaid to the HTW program.
S.B. 748	Established two separate pilot programs for pregnant women. One will provide services to pregnant women through a pregnancy medical home, while the other will provide prenatal and postpartum services through telemedicine and telehealth. Required a variety of program evaluations related to maternal health.
Pharmacy	
S.B. 1096	Required HHSC to make changes to pharmacy benefit requirements for the Medicaid STAR Kids population. Specifically, S.B. 1096 removes all Preferred Drug List (PDL) prior authorizations (PAs) and requires coverage of any drug without PA—including those produced by a manufacturer that has not entered into a federal rebate agreement with CMS. HHSC requires CMS approval prior to implementing changes (see STAR Kids, MDCP and STAR Health, page 122, for other drug-related PA legislation).
S.B. 1780	Allowed HHSC to enter into a value-based arrangement with a prescription drug manufacturer.

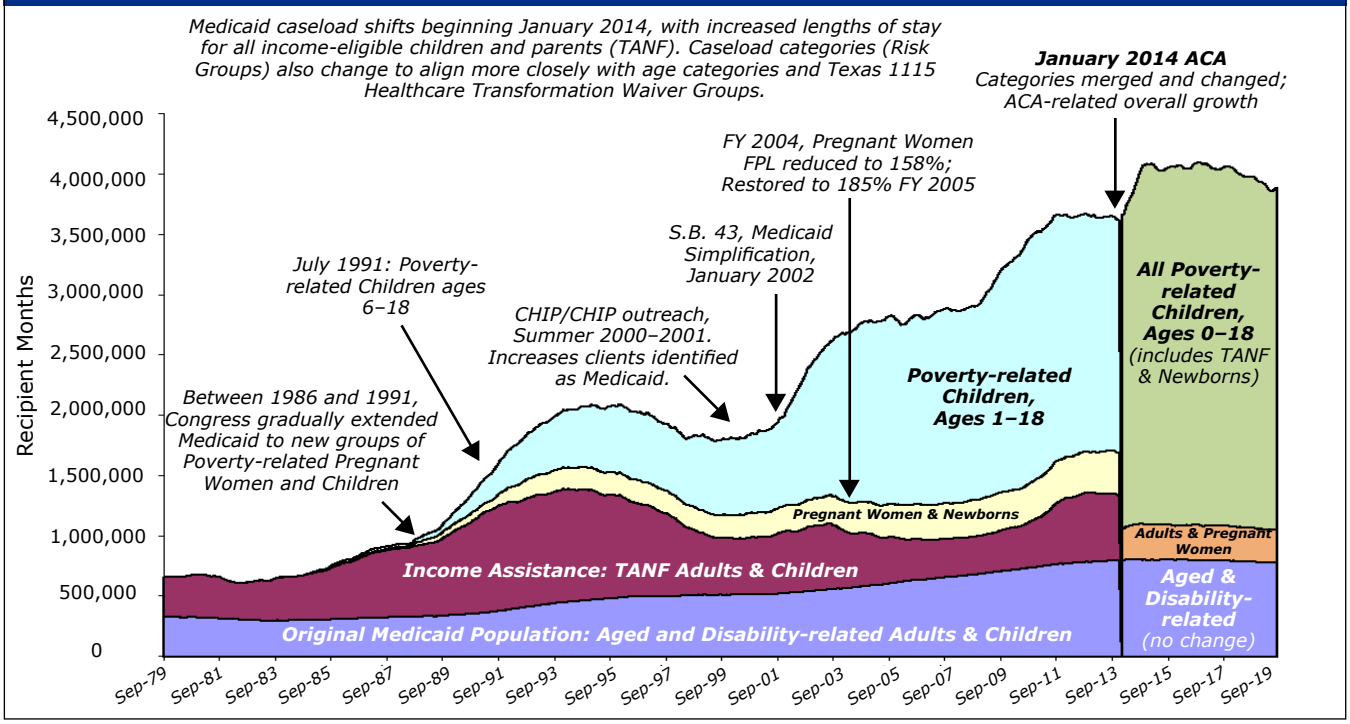
Prior Authorizations	
S.B. 1207	Required HHSC to establish time-frame guidelines for MCOs to issue decisions on PA requests, which must be published on MCO websites. Required HHSC to establish a uniform process and timeline for MCOs that receive an insufficient or inadequate PA request. Allowed a physician to discuss a PA request with another physician, who has a similar professional specialty, before a decision about the PA is determined. Required providers and members to receive a detailed notice when there is insufficient documentation for a PA request.
H.B. 3041	Required MCOs to publish information about submitting a PA and the process for communicating with the MCO about a PA request on their website. Required HHSC to allow, if practicable, renewal of a PA within 60 days of expiration for managed care and FFS.
Providers	
H.B. 4533	Required HHSC to phase out use of the Texas Provider Identifier (TPI) and switch to only using the National Provider Identifier (NPI) in order to identify providers.
S.B. 1991	Allowed service providers to utilize their own proprietary electronic visit verification (EVV) system and to be reimbursed by MCOs. Required HHSC to adopt rules that amend the MCO payment recovery and recoupment efforts process.
STAR Kids, MDCP and STAR Health	
S.B. 1207	Directed, for MDCP only, that the MCOs implement measures to ensure STAR Kids service coordinators provide results of the STAR Kids Screening Assessment Instrument (SK-SAI) to the child's parent or legally authorized representative (LAR). The legislation also required MCOs to offer an opportunity for a peer-to-peer with a physician whom the member chooses. In addition, HHSC must: 1. Streamline the SK-SAI and reassessment process. 2. Create guidelines for providing wraparound services when a child has private insurance coverage. 3. Create a Medicaid escalation helpline for individuals in MDCP and with Deaf Blind with Multiple Disabilities (DBMD) waivers. 4. Allow a child denied MDCP the option to: (a) be placed at the top (first position) of the MDCP interest list in order to receive a new assessment from a different MCO, or (b) join another waiver interest list in a position based on the date the child was first placed on the MDCP interest list.

S.B. 1096	Limited the ability of MCOs in the STAR Kids program to impose drug-related prior authorizations.
H.B. 4533	Required HHSC to expand the availability of the Consumer Directed Services (CDS) option in the MDCP waiver program.
H.B. 72	Directed HHSC to change managed care enrollment rules for children and young adults in the Adoption Assistance (AA) and Permanency Care Assistance (PCA) programs. Beginning September 1, 2020, as children transition from foster care to AA or PCA, they will remain in STAR Health for an additional two months to improve continuity of care. Certain AA and PCA children with disabilities have a choice between enrolling in STAR Kids or staying in STAR Health.
Telehealth	
H.B. 1063	Expanded home telemonitoring to pediatric patients who have been diagnosed with end-stage solid organ disease; have received an organ transplant; or require mechanical ventilation. Directed HHSC to assess whether telemedicine, telehealth and home telemonitoring services are cost-effective for the Medicaid program in its biennial report on telemedicine, telehealth and home telemonitoring services.
S.B. 748	Established a pilot program that provides prenatal and postpartum services through telemedicine and telehealth (see Maternal Health, page 121, for additional telehealth-related legislation).
S.B. 670	Removed the requirement for a health professional to be present with a client during a school-based telemedicine service. Required HHSC to ensure MCOs meet specified requirements for reimbursing telemedicine and telehealth services and promoting patient-centered medical homes. Granted Medicaid MCOs greater flexibility in determining which covered services to reimburse as telemedicine or telehealth services, but prohibited MCOs from denying coverage solely because the service was delivered remotely. Authorized HHSC to allow Federally Qualified Health Centers (FQHCs) to be telemedicine distant and patient site providers, contingent on appropriations.

Legislative Impacts on Caseload

Enrollment in Texas Medicaid and the Children's Health Insurance Program (CHIP) can change in response to legislative requirements at the federal and state level. The figure below illustrates Texas Medicaid enrollment trends in response to legislative actions described throughout this appendix.

A.1: Texas Medicaid Caseload by Group, SFYs 1980–2019



Medicaid eligibility was historically linked to receiving financial assistance. In the 1980s, several federal laws were passed that extended coverage to populations ineligible for financial assistance programs. This expansion—to include a greater number of people with disabilities, children, pregnant women and older individuals—fueled the growth of the Medicaid program.

Caseloads declined in the late 1990s after Medicaid eligibility was de-linked from cash assistance and stricter eligibility requirements for Temporary Assistance for Needy Families (TANF) were introduced by The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996. In 2002, the number of children enrolled in Medicaid grew sharply due to the simplification of the Medicaid application process and six-month continuous eligibility. However, in 2003, Texas Medicaid's TANF population declined because adults did not comply with the Personal Responsibility Agreement (PRA). The Affordable Care Act (ACA) of 2010 contributed to caseload growth throughout the subsequent decade because of required programmatic and financial eligibility changes.

Managed Care in Texas

State Legislation

Senate Bill (S.B.) 10, 74th Legislature, Regular Session, 1995:

- Directed the Health and Human Services Commission (HHSC) to enact a comprehensive statewide restructuring of Medicaid, incorporating a managed care delivery system. HHSC began expanding, and continues to expand, its Medicaid managed care program through 1915(b) waivers under the authority of S.B. 10.

S.B. 6, 79th Legislature, Regular Session, 2005:

- Directed HHSC and the Department of Family and Protective Services (DFPS) to develop a statewide health care delivery model for all Medicaid children in foster care. STAR Health was implemented on April 1, 2008.

House Bill (H.B.) 1, 82nd Legislature, Regular Session, 2011, and S.B. 7, 82nd Legislature, First Called Session, 2011:

- Instructed HHSC to expand its use of Medicaid managed care. The Legislature directed HHSC to preserve federal hospital funding historically received as supplemental payments under the upper payment level (UPL) program.

S.B. 7, 83rd Legislature, Regular Session, 2013:

- Directed HHSC to implement cost-effective options for delivering basic attendant care and a voluntary long-term services and supports (LTSS) managed care pilot program, expand STAR+PLUS to the Medicaid Rural Service Area, and integrate acute care and LTSS for individuals age 65 and older and those with disabilities. Most adults being served through one of the 1915(c) waivers for individuals with intellectual and developmental disabilities (IDD)—and living in community-based settings or in an intermediate care facility for individuals with an intellectual disability or related condition (ICF/IID)—are now receiving acute care services through STAR+PLUS.
- Directed HHSC to develop the STAR Kids managed care program, tailored for children with disabilities—including children receiving Medically Dependent Children Program (MDCP) waiver benefits. STAR Kids was implemented statewide on November 1, 2016.
- Directed HHSC to develop quality-based outcome and process measures in quality-based payment systems by measuring potentially preventable events; rewarding use of evidence-based practices; and promoting health care coordination, collaboration and efficacy. HHSC initially implemented the medical and dental pay-for-quality (P4Q) programs in 2014. The programs were subsequently rede-

signed in 2016 and 2017. New medical P4Q programs were implemented in 2018 for STAR, STAR+PLUS and CHIP, as well as a new dental P4Q program. STAR Kids was added for 2020. However, due to COVID-19, HHSC is not currently implementing P4Q for calendar year 2020. Results for 2018 are on the Texas Healthcare Learning Collaborative Portal (THLCPortal.com).

S.B. 1, 83rd Legislature, Regular Session, 2013 (Article II, HHSC, Rider 51b[15]):

- Directed HHSC to transition remaining Medicaid fee-for-service (FFS) populations into managed care, as a cost containment measure. The rider stated that this reduction should be achieved through the implementation of a plan to improve care coordination through a capitated managed care program.

A.2: Development of Managed Care in Texas, 1994–2019

State Fiscal Year	Service Areas (SA) and Implementation Dates	Total Medicaid Managed Care Enrollment	% of Medicaid Population in Managed Care
1994	STAR implemented in Travis county and in the tri-county area	58,243	2.86%
1995	No change	65,388	3.16%
1996	The tri-county area was expanded to include three additional counties (renamed to STAR)	71,435	3.46%
1997	STAR expanded to the Bexar, Lubbock and Tarrant SAs The Travis county area was expanded to include surrounding counties	274,694	13.82%
1998	STAR expanded to the Harris SA STAR+PLUS implemented in the Harris SA	364,336	19.56%
1999	STAR expanded to the Dallas SA	425,069	23.45%
2000	STAR expanded to the El Paso SA	523,832	28.98%
2001	No change	623,883	33.35%
2002	No change	755,698	35.92%
2003	No change	988,389	39.71%
2004	No change	1,112,002	41.43%
2005	No change	1,191,139	42.85%
2006	Primary Care Case Management (PCCM) implemented in 197 counties	1,835,390	65.72%
2007	STAR expanded to the Nueces SA STAR+PLUS expanded to the Bexar, Travis, Nueces and Harris contiguous SAs STAR replaced PCCM in all urban areas	1,921,651	67.83%

A.2: Development of Managed Care in Texas, 1994–2019			
State Fiscal Year	**Service Areas (SA) and Implementation Dates**	**Total Medicaid Managed Care Enrollment**	**% of Medicaid Population in Managed Care**
2008	Integrated Care Management (ICM) implemented in the Dallas and Tarrant SAs STAR Health implemented statewide	2,039,340	70.86%
2009	The ICM program was discontinued	2,127,382	70.78%
2010	No change	2,362,091	71.62%
2011	STAR+PLUS expanded to the Dallas and Tarrant SAs	2,676,149	75.53%
2012	STAR expanded to Medicaid Rural Service Areas (MRSAs), replacing and discontinuing PCCM in all rural areas Pharmacy benefits were carved into all managed care programs, and inpatient hospital benefits were carved into STAR+PLUS The Children's Medicaid Dental Services program implemented statewide	2,893,965	79.16%
2013	No change	2,982,923	81.53%
2014	No change	3,012,262	80.41%
2015	STAR+PLUS expanded to all areas of the state Non-dual eligible clients, IDD waivers and nursing facility benefits were carved into STAR+PLUS Mental health targeted case management and mental health rehabilitative services were carved into all managed care programs Dual Demonstration program implemented in Bexar, Dallas, El Paso, Harris, Hidalgo and Tarrant counties	3,524,581	86.88%
2016	No change	3,570,411	87.93%
2017	STAR Kids implemented statewide NorthSTAR was discontinued	3,721,646	91.50%
2018	Adoption Assistance and Permanency Care Assistance were carved into STAR, and the Medicaid for Breast and Cervical Cancer program was carved into STAR+PLUS	3,776,096	93.89%
2019	No change	3,676,441	93.91%

Figures are Average Monthly Recipient Months and include STAR, STAR+PLUS, STAR Health, STAR Kids, PCCM, and ICM.
In the Dallas Service Area, most Medicaid eligible individuals receive Medicaid acute care services through the STAR program. Until FY 2017, they received their behavioral health services through NorthSTAR.

Appendix B

Texas Medicaid and CHIP services

Medicaid State Plan

Mandatory and Optional Services

The Social Security Act specifies a set of benefits that state Medicaid programs must provide and a set of optional benefits that states may choose to provide. A state may choose to provide some, all or no optional services specified under federal law. Some optional services that Texas chooses to provide are available only to clients (a) age 20 and younger, or (b) age 20 and younger or age 65 and older and who are in an institution for mental disease. If the client is age 20 and younger, all federally allowable and medically necessary services must be provided.

Mandatory and optional state plan services provided by Texas Medicaid include:

B.1: Acute Care Services	
Mandatory	**Optional***
• Inpatient hospital services • Outpatient hospital services • Laboratory and x-ray services • Physician services • Medical and surgical services provided by a dentist • Early and Periodic Screening, Diagnosis and Treatment services for individuals age 20 and younger • Family planning services and supplies • Federally Qualified Health Center services • Rural health clinic services • Nurse-midwife services • Certified pediatric and family nurse practitioner services • Home health services • Freestanding birth center services (when licensed or otherwise recognized by the state) • Transportation to medically necessary services • Tobacco cessation counseling for pregnant women • Extended services for pregnant women	• Prescription drugs • Medical or remedial care by other licensed practitioners: ▫ Nurse practitioners/certified nurse specialists ▫ Physician assistants ▫ Licensed midwife ▫ Certified registered nurse anesthetists ▫ Anesthesiologist assistants ▫ Psychologists ▫ Licensed clinical social workers** ▫ Licensed professional counselors ▫ Licensed marriage and family therapists • Podiatry*** • Limited chiropractic services • Optometry (including eyeglasses and contacts) • Telemedicine • Home telemonitoring • Hearing instruments and related audiology • Home health supplies provided by a pharmacy • Clinic services: ▫ Maternity clinic services ▫ Renal dialysis facility services ▫ Ambulatory surgical center services • Tuberculosis clinic services • Peer specialist services • Rehabilitation and other therapies: ▫ Mental health rehabilitative services ▫ Rehabilitation and other therapy services

B.1: Acute Care Services, Con't	
Mandatory	**Optional***
	▫ Substance use disorder treatment ▫ Physical, occupational and speech therapy • Case management services for pregnant women with high-risk conditions • Pregnancy-related and postpartum services for 60 days after the pregnancy ends • Services for any other medical conditions that may complicate pregnancy • Respiratory care services • Ambulance services • Emergency hospital services • Private duty nursing

B.2: Long-term Services and Supports	
Mandatory	**Optional***
• Nursing facility services for clients age 21 and older	• Intermediate care facility services for individuals with an intellectual disability or related condition • Inpatient services for clients who are in an institution for mental diseases and who are either age 21 and younger or age 65 and older • Services furnished under a Program of All-Inclusive Care for the Elderly • Day Activity and Health Services • 1915(i) Home and Community-based Services-Adult Mental Health Services • 1915(k) Community First Choice services: ▫ Attendant care (including habilitation) ▫ Emergency response services • Attendant services: ▫ Personal care/assistance services ▫ Community attendant services • Targeted case management for: ▫ Infants and toddlers with intellectual or developmental disabilities ▫ Adults with intellectual or developmental disabilities ▫ Individuals with chronic mental illness • Nursing facility services for individuals age 20 and younger • Prescribed Pediatric Extended Care Centers • Services provided in religious non-medical health care institutions

*Includes optional Medicaid services provided in Texas. Does not include all optional services allowed under federal policy.
**Except when delivered in a Federally Qualified Health Center setting.

CHIP State Plan

States can design their Children's Health Insurance Program (CHIP) using one of three frameworks established by federal law. States can either include their CHIP program within their Medicaid program, create a separate CHIP program, or create a combination of these two options. Texas CHIP operates as a separate CHIP program, but many CHIP services are the same as Texas Medicaid services.

Services provided by Texas CHIP include:

B.3: Services Covered by Texas CHIP
• Inpatient general acute and inpatient rehabilitation hospital services • Surgical services • Transplants • Skilled nursing facilities (including rehabilitation hospitals) • Outpatient hospital, comprehensive outpatient rehabilitation hospital, clinic (including health center), and ambulatory health care center services • Physician/physician extender professional services (including well-child exams and preventive health services, such as immunizations) • Laboratory and radiological services • Durable medical equipment, prosthetic devices and disposable medical supplies • Home and community-based health services • Nursing care services • Inpatient mental health services • Outpatient mental health services • Inpatient and residential substance abuse treatment services • Outpatient substance abuse treatment services • Rehabilitation and habilitation services (including developmental assessments and physical, occupational and speech therapy) • Hospice care services • Emergency services (including emergency hospitals, physicians and ambulance services) • Emergency medical transportation (ground, air or water) • Care coordination • Case management • Prescription drugs • Dental services • Vision • Chiropractic services • Tobacco cessation

Home and Community-based Waiver Programs

Federal law allows states to apply to the Centers of Medicare and Medicaid Services (CMS) for permission to depart from certain Medicaid requirements. These waivers allow states to develop creative alternatives to the traditional Medicaid program. The table below provides a list of Texas Medicaid waiver programs.

B.4: Texas Medicaid Waivers

Waiver	Description	Services Covered
Community Living Assistance and Support Services (CLASS)	CLASS provides home and community-based services to individuals who have related conditions, as an alternative for placement in an intellectual disability or related condition (ICF/IID). A related condition is a disability other than an intellectual or development disability, which originates before age 22 and which substantially limits life activity.	• Adaptive aids and minor home modifications • Medical supplies • Dental services • Nursing • Respite • Professional therapies* • Employment assistance and supported employment • Case management • Prevocational services • Residential habilitation transportation • Prescriptions • Support family services • Transition assistance services

B.4: Texas Medicaid Waivers		
Deaf Blind with Multiple Disabilities (DBMD)	DBMD provides home and community-based services as an alternative to residing in an intermediate care facility for individuals with an intellectual disability or related condition (ICF/IID) to people of all ages who are deaf, blind or have a condition that will result in deaf-blindness—and who also have an additional disability. The program focuses on increasing opportunities for individuals to communicate and interact with their environment.	• Adaptive aids and minor home modifications • Medical supplies • Dental services • Nursing • Respite • Professional therapies* • Employment assistance and supported employment • Case management • Day habilitation • Residential habilitation transportation • Assisted living • Prescriptions • Transition assistance services • Intervener • Orientation and mobility • Financial management services and support consultation**
Home and Community-based Services (HCS)	HCS provides individualized services to individuals of all ages who qualify for ICF/IID level of care, yet live in their family's home, their own home or other settings in the community.	• Adaptive aids and minor home modifications • Medical supplies • Dental services • Nursing • Respite • Professional therapies* • Employment assistance and supported employment • Day habilitation and residential services • Transportation • Transition assistance services • Financial management services and support consultation**

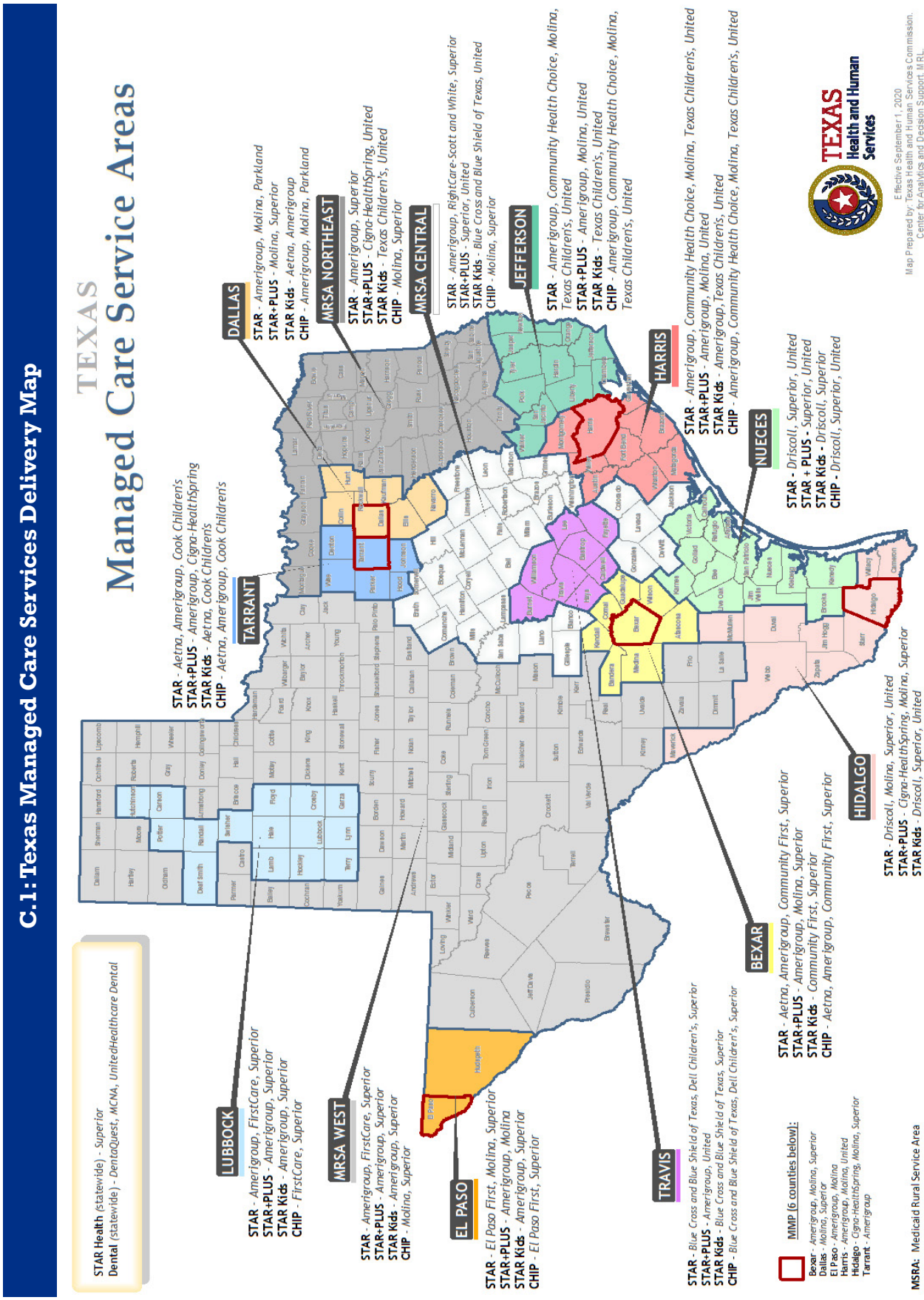
B.4: Texas Medicaid Waivers		
Medically Dependent Children Program (MDCP)	MDCP provides community-based services to children and youth age 20 and younger as an alternative to residing in a nursing facility.	• Adaptive aids and minor home modifications • Medical supplies • Respite • Employment assistance and supported • employment • Flexible family support services • Transition and transition assistance services
STAR+PLUS Home and Community-based Services (STAR+PLUS HCBS)	STAR+PLUS HCBS provides community-based services to adults with disabilities and people age 65 and older, as an alternative to residing in a long-term care facility. These services are delivered through the STAR+PLUS managed care program.	• Adaptive aids and minor home modifications • Medical supplies • Respite • Employment assistance and supported employment • Dental services • Adult foster care • Assisted living services • Emergency response services • Home-delivered meals • Transition assistance services • Personal assistance services • Nursing services • Physical, occupational and speech therapies • Cognitive rehabilitation therapy • Financial management services and support consultation**

B.4: Texas Medicaid Waivers		
Texas Home Living (TxHmL)	TxHmL provides selected services and supports for people with intellectual disabilities who live in their own homes or their family's home.	• Adaptive aids and minor home modifications • Medical supplies • Dental services • Nursing • Respite • Professional therapies* • Employment assistance and supported employment • Community support • Transportation • Day habilitation • Financial management services and support consultation**
Youth Empowerment Services (YES)	YES is a home and community-based waiver that allows for more flexibility in the funding of intensive community-based services for children and adolescents with severe emotional disturbances and their families.	• Adaptive aids and minor home modifications • Medical supplies • Dental services • Nursing • Respite • Professional therapies* • Employment assistance and supported employment • Community living support • Family supports and supportive family-based alternatives • Non-medical transportation • Paraprofessional services • Pre-engagement service (for non-Medicaid applicants) • Transition services

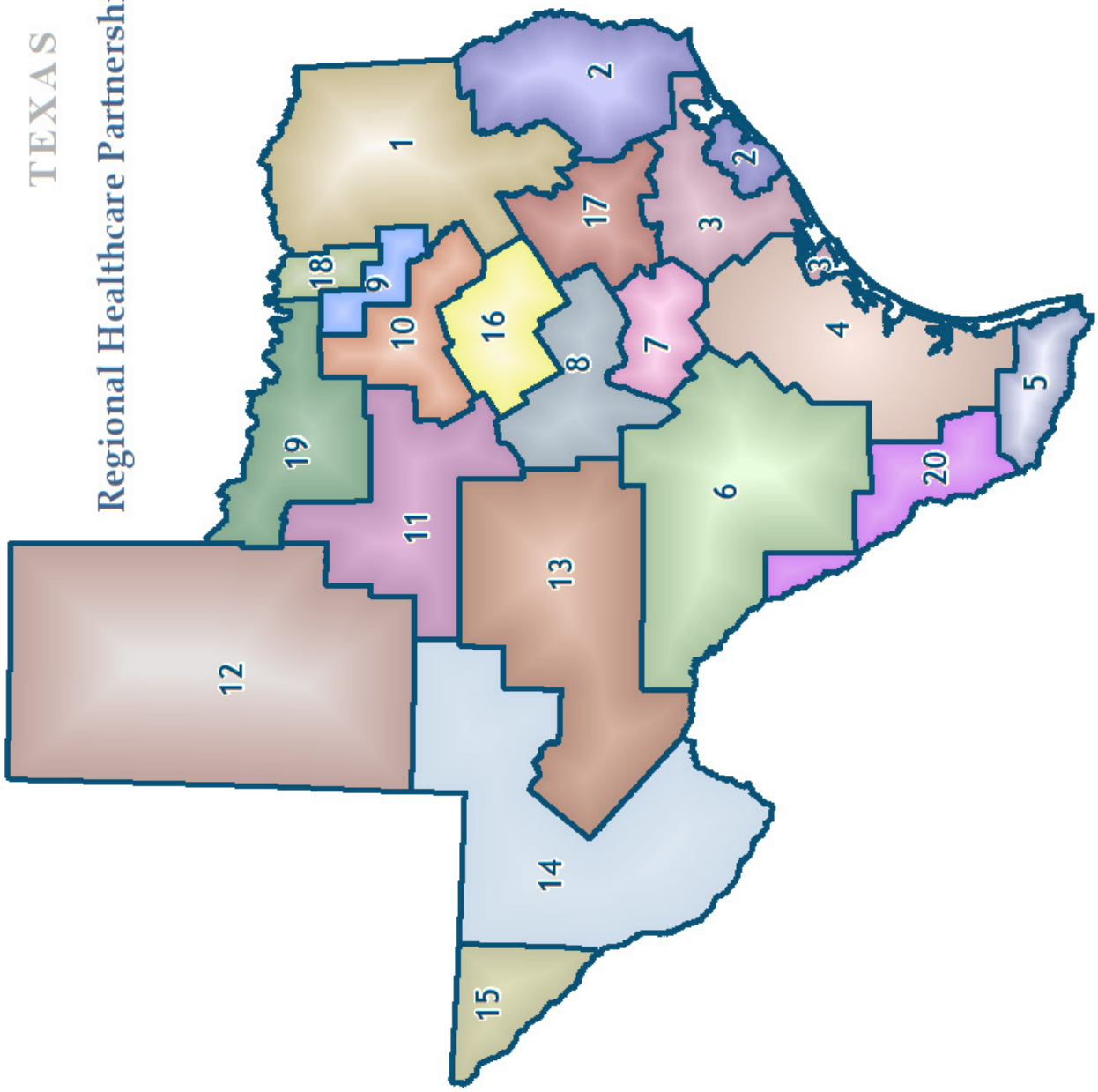
*Professional therapies may include: physical therapy, occupational therapy, speech and language pathology, audiology, social work, behavioral support, dietary services, and cognitive rehabilitation therapy.
**These services are only available to individuals using the Consumer Directed Service (CDS) delivery option.

Appendix C

Texas Medicaid and CHIP maps and figures


C.1: Texas Managed Care Services Delivery Map
TEXAS
Managed Care Service Areas
STAR Health (statewide) - Superior
Dental (statewide) - DentaQuest, MCNA, UnitedHealthcare Dental
DALLAS
STAR - Amerigroup, Molina, Parkland
STAR+PLUS - Molina, Superior
STAR Kids - Aetna, Amerigroup
CHIP - Amerigroup, Molina, Parkland
MRSA NORTHEAST
STAR - Amerigroup, Superior
STAR+PLUS - Cigna-HealthSpring, United
STAR Kids - Texas Children's, United
CHIP - Molina, Superior
MRSA CENTRAL
STAR - Amerigroup, RightCare-Scott and White, Superior
STAR+PLUS - Superior, United
STAR Kids - Blue Cross and Blue Shield of Texas, United
CHIP - Molina, Superior
JEFFERSON
STAR - Amerigroup, Community Health Choice, Molina, Texas Children's, United
STAR+PLUS - Amerigroup, Molina, United
STAR Kids - Texas Children's, United
CHIP - Amerigroup, Community Health Choice, Molina, Texas Children's, United
HARRIS
STAR - Amerigroup, Community Health Choice, Molina, Texas Children's, United
STAR+PLUS - Amerigroup, Molina, United
STAR Kids - Amerigroup, Texas Children's, United
CHIP - Amerigroup, Community Health Choice, Molina, Texas Children's, United
NUECES
STAR - Driscoll, Superior, United
STAR + PLUS - Superior, United
STAR Kids - Driscoll, Superior
CHIP - Driscoll, Superior, United
HIDALGO
STAR - Driscoll, Molina, Superior, United
STAR+PLUS - Cigna-HealthSpring, Molina, Superior
STAR Kids - Driscoll, Superior, United
CHIP - Molina, Superior
BEXAR
STAR - Aetna, Amerigroup, Community First, Superior
STAR+PLUS - Amerigroup, Molina, Superior
STAR Kids - Community First, Superior
CHIP - Aetna, Amerigroup, Community First, Superior
TRAVIS
STAR - Blue Cross and Blue Shield of Texas, Dell Children's, Superior
STAR+PLUS - Amerigroup, United
STAR Kids - Blue Cross and Blue Shield of Texas, Superior
CHIP - Blue Cross and Blue Shield of Texas, Dell Children's, Superior
EL PASO
STAR - El Paso First, Molina, Superior
STAR+PLUS - Amerigroup, Molina
STAR Kids - Amerigroup, Superior
CHIP - El Paso First, Superior
MRSA WEST
STAR - Amerigroup, FirstCare, Superior
STAR+PLUS - Amerigroup, Superior
STAR Kids - Amerigroup, Superior
CHIP - Molina, Superior
LUBBOCK
STAR - Amerigroup, FirstCare, Superior
STAR+PLUS - Amerigroup, Superior
STAR Kids - Amerigroup, Superior
CHIP - FirstCare, Superior
TARRANT
STAR - Aetna, Amerigroup, Cook Children's
STAR+PLUS - Amerigroup, Cigna-HealthSpring
STAR Kids - Aetna, Cook Children's
CHIP - Aetna, Amerigroup, Cook Children's
MMP (6 counties below):
Bexar - Amerigroup, Molina, Superior
Dallas - Molina, Superior
El Paso - Amerigroup, Molina
Harris - Amerigroup, Molina, United
Hidalgo - Cigna-HealthSpring, Molina, Superior
Tarrant - Amerigroup
MSRA: Medicaid Rural Service Area
MMP: Medicare - Medicaid Plan
TEXAS
Health and Human Services
Effective September 1, 2020
Map Prepared by: Texas Health and Human Services Commission.
Center for Analytics and Decision Support. M.RL.
August 13, 2020

C.2: 1115 Transformation Waiver Regional Healthcare Partnership Regions Map



Regional Healthcare Partnership Regions by County

RHP 1: Anderson, Bowie, Camp, Cass, Cherokee, Delta, Fannin, Franklin, Freestone, Gregg, Harrison, Henderson, Hopkins, Houston, Hunt, Lamar, Marion, Morris, Panola, Rains, Red River, Rusk, Smith, Titus, Trinity, Upshur, Van Zandt, and Wood.

RHP 2: Angelina, Brazoria, Galveston, Hardin, Jasper, Jefferson, Liberty, Nacogdoches, Newton, Orange, Polk, Sabine, San Augustine, San Jacinto, Shelby, and Tyler.

RHP 3: Austin, Calhoun, Chambers, Colorado, Fort Bend, Harris, Matagorda, Waller, and Wharton.

RHP 4: Aransas, Bee, Brooks, DeWitt, Duval, Goliad, Gonzales, Jackson, Jim Wells, Karnes, Kenedy, Kleberg, Lavaca, Live Oak, Nueces, Refugio, San Patricio, and Victoria.

RHP 5: Cameron, Hidalgo, Starr, and Willacy.

RHP 6: Atascosa, Bandera, Bexar, Comal, Dimmit, Edwards, Frio, Gillespie, Guadalupe, Kendall, Kerr, Kinney, La Salle, McMullen, Medina, Real, Uvalde, Val Verde, Wilson, and Zavala.

RHP 7: Bastrop, Caldwell, Fayette, Hays, Lee, and Travis.

RHP 8: Bell, Blanco, Burnet, Lampasas, Llano, Milam, Mills, San Saba, and Williamson.

RHP 9: Dallas, Denton, and Kaufman.

RHP 10: Ellis, Erath, Hood, Johnson, Navarro, Parker, Somervell, Tarrant, and Wise.

RHP 11: Brown, Callahan, Comanche, Eastland, Fisher, Haskell, Jones, Knox, Mitchell, Nolan, Palo Pinto, Shackelford, Stephens, Stonewall, and Taylor.

RHP 12: Armstrong, Bailey, Borden, Briscoe, Carson, Castro, Childress, Cochran, Collingsworth, Cottle, Crosby, Dallam, Dawson, Deaf Smith, Dickens, Donley, Floyd, Gaines, Garza, Gray, Hale, Hall, Hansford, Hartley, Hemphill, Hockley, Hutchinson, Kent, King, Lamb, Lipscomb, Lubbock, Lynn, Moore, Motley, Ochiltree, Oldham, Parmer, Potter, Randall, Roberts, Scurry, Sherman, Swisher, Terry, Wheeler, and Yoakum.

RHP 13: Coke, Coleman, Concho, Crockett, Irion, Kimble, Mason, McCulloch, Menard, Pecos, Reagan, Runnels, Schleicher, Sterling, Sutton, Terrell, and Tom Green.

RHP 14: Andrews, Brewster, Crane, Culberson, Ector, Glasscock, Howard, Jeff Davis, Loving, Martin, Midland, Presidio, Reeves, Upton, Ward, and Winkler.

RHP 15: El Paso and Hudspeth.

RHP 16: Bosque, Coryell, Falls, Hamilton, Hill, Limestone, and McLennan.

RHP 17: Brazos, Burleson, Grimes, Leon, Madison, Montgomery, Robertson, Walker, and Washington.

RHP 18: Collin, Grayson, and Rockwall.

RHP 19: Archer, Baylor, Clay, Cooke, Foard, Hardeman, Jack, Montague, Throckmorton, Wichita, Wilbarger, and Young.

RHP 20: Jim Hogg, Maverick, Webb, and Zapata.

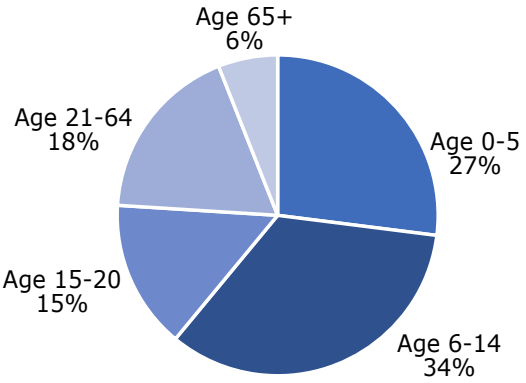
Demographics

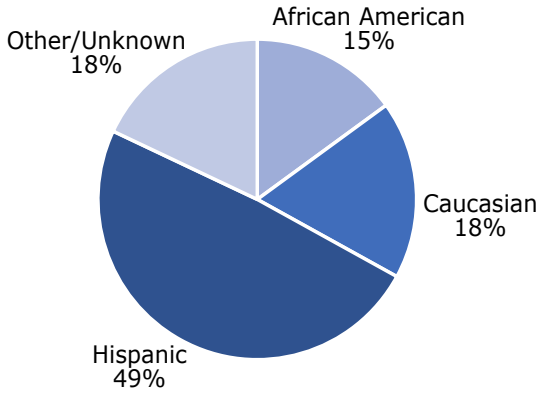
The number of Texas Medicaid and Children's Health Insurance Program (CHIP) clients can be expressed as a monthly average count or an annual unduplicated count. The monthly average count is the average number of clients on Medicaid or CHIP per month. The unduplicated count is the total number of individual Texans who received Medicaid or CHIP services over a period of time. In 2019, the monthly average count for Medicaid was 3,915,000 clients, and the monthly average count for CHIP was 408,000 clients.

In 2019, about 25 percent of Texas Medicaid clients were recipients due to age and disability-related reasons, 7 percent of clients were non-disabled adults, and 68 percent were non-disabled children. CHIP covers children, birth through age 18, who are not eligible for Medicaid due to income, but cannot afford private health insurance.

The following figures breakdown the total statistics for unduplicated clients, who received Medicaid or CHIP in 2019, by age group and ethnicity. As previously indicated, most Medicaid clients in any given year are children. In addition, Hispanics accounted for the largest portion of Medicaid clients, comprising 49 percent of the population. Meanwhile, 24 percent of CHIP clients were age 5 and younger, 56 percent were age 6 through age 14, and 20 percent were age 15 through age 18.

C.3: Medicaid Recipients by Age and Ethnicity, 2019

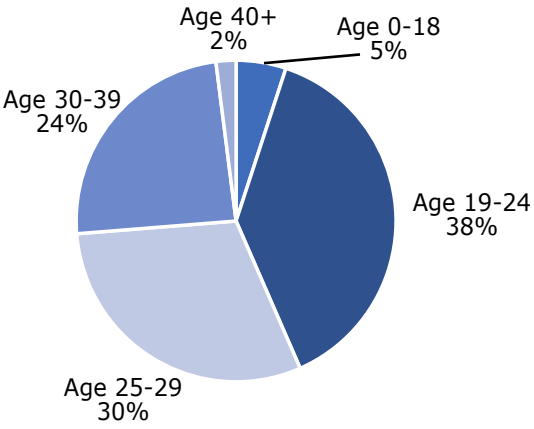


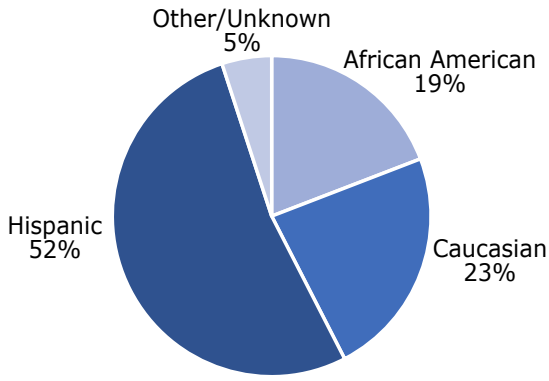


Medicaid covers low-income women for pregnancy-related services and newborns in low-income families. Pregnant women make up 4.3 percent of the Texas Medicaid and CHIP caseload. The following figures illustrate the distribution of pregnant women on Medicaid by age group and ethnicity. Almost 70 percent of the pregnant women in the Texas Medicaid program are between age 19 and age 29, while only 5 percent are age 18 and younger. Reflective of the Medicaid population as a whole, just over half, or 52 percent, of pregnant women receiving Medicaid are Hispanic.

Eighty-one percent of pregnant women receive services from Medicaid. The remaining 18 percent receive services from CHIP Perinatal.

C.4: Pregnant Women on Medicaid by Age and Ethnicity, 2019





CHIP Perinatal covers the unborn children of pregnant women who do not qualify for Medicaid due to income, but cannot afford private health insurance. In 2019, the monthly average caseload for CHIP Perinatal was 34,458.

Beginning in 2010, newborns under 185 percent of the federal poverty level (FPL) began moving out of CHIP Perinatal into Medicaid due to changes in eligibility. The Affordable Care Act (ACA) changed this income limit to 198 percent of the FPL effective January 2014 (see Appendix A, page 108).

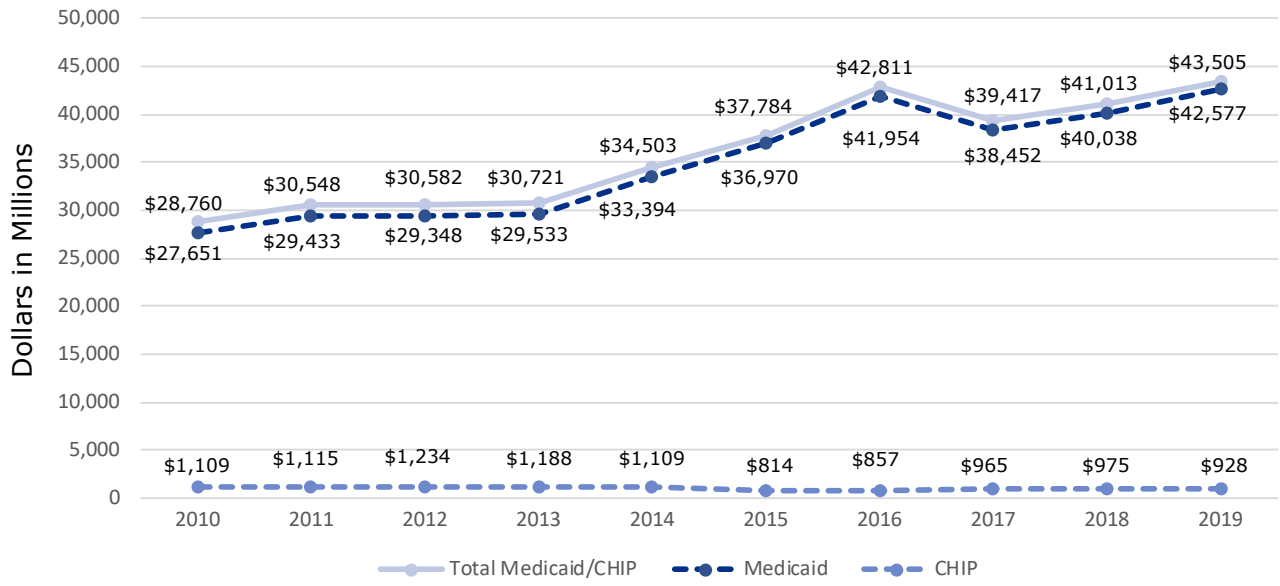
The following table shows the total average monthly caseload for the CHIP Perinatal population from 2010 to 2019—including the number of perinates and newborns below 185 percent of the FPL prior to the 2014 change, and the number of perinates and newborns below 198 percent of the FPL after the 2014 change.

C.5: CHIP Perinatal Caseload Summary, 2010–2019					
State Fiscal Year	**Total Caseload**	**Perinates 0%–184% FPL**	**Perinates 185%–200% FPL**	**Newborns 0%–184% FPL**	**Newborns 185%–200% FPL**
2010	67,148	36,158	433	30,215	342
2011	44,214	36,775	546	6,582	310
2012	37,190	36,238	652	0	300
2013	37,027	36,068	640	0	319
State Fiscal Year	**Total Caseload**	**Perinates 0%–197% FPL**	**Perinates 198%–202% FPL**	**Newborns 0%–197% FPL**	**Newborns 198%–202% FPL**
2014*	36,800	36,203	509	0	88
2015	36,535	35,703	742	0	90
2016	35,071	34,638	329	0	104
2017	34,458	33,969	389	0	100
2018	32,696	32,158	417	0	121
2019	30,856	30,272	445	0	139

*ACA income limit changes effective January 1, 2014.
Income limits do not include a five percentage point income disregard.

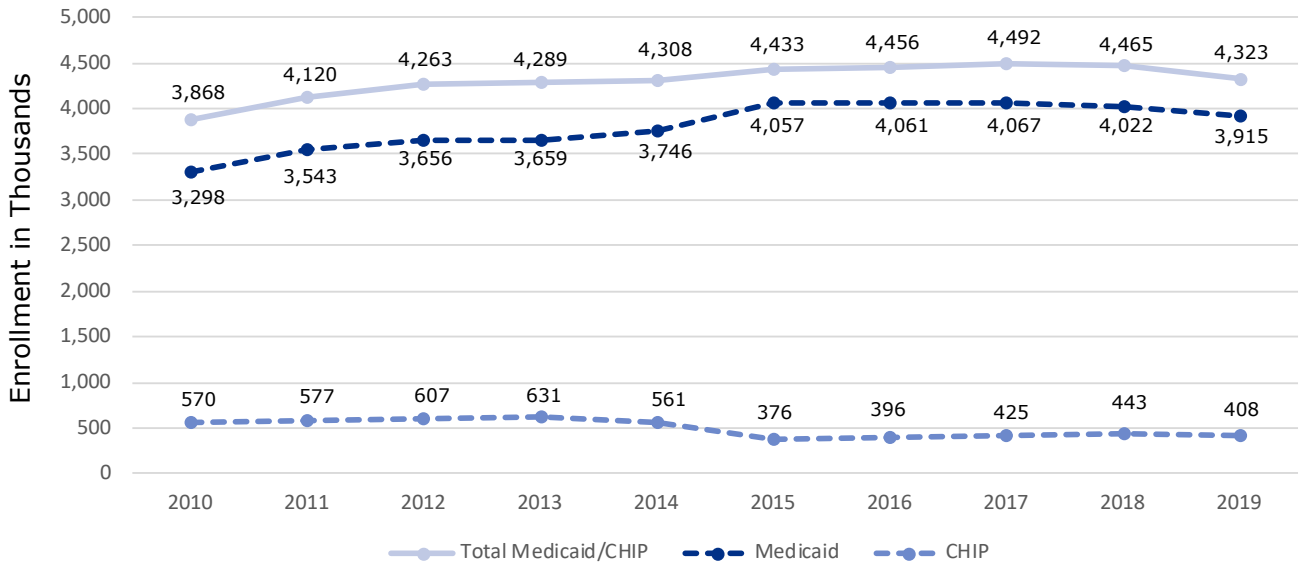
Budget and Enrollment

C.6: Annual Expenditures for Medicaid and CHIP, 2010-2019*



*Medicaid data is for FFYs 2010–2019 and CHIP data is for SFYs 2010–2019.

C.7: Average Monthly Medicaid and CHIP Enrollment, SFYs 2010-2019



C.8: Average Monthly Enrollment and Annual Expenditures for Long-term Services and Supports Programs and Services, 2019		
Program/Service Name	**Average Number of Clients Served per Month**	**Annual Expenditures, All Funds**
Facilities		
Nursing Facilities	60,190	$2,920,415,859
ICFs/IID	4,733	$253,304,014
SSLC	2,852	$644,808,589
Home and Community-based Services		
CAS	74,408	$821,007,059
CFC PAS/HAB Adult (STAR+PLUS; non-waiver)	1,406	$11,640,243
CFC PAS/HAB Adult (STAR+PLUS HCBS)	9,078	$98,236,861
CFC PAS/HAB Child (STAR Kids, STAR Health, FFS)	2,797	$16,408,726
CLASS	5,963	$290,751,949
DAHS	1,292	$8,328,462
DBMD	338	$15,629,970
HCS	28,669	$1,149,186,554
MDCP	5,381	$73,979,895
PAS (STAR+PLUS HCBS)	42,127	$364,454,338
PAS (STAR+PLUS; non-waiver)	101,001	$612,459,440
PCS (STAR Kids, STAR Health, FFS)	9,118	$21,633,237
STAR+PLUS HCBS with Dual Demonstration	61,446	$1,480,558,159
STAR+PLUS HCBS without Dual Demonstration	57,314	$1,382,161,936
TxHmL	4,548	$121,512,550
YES	1,646	$10,190,040
Other		
Hospice	8,857	$282,498,770
PACE	1,253	$42,104,582
Skilled Nursing Facility Medicare Co-insurance	1,647	$47,847,447

Because some programs may take up to three years to complete, the provided figures are not final.
Nursing facility expenditures include costs outside the daily rate.
SSLC expenditures may include some non-Medicaid costs.
MDCP and CLASS include Promoting Independence (rider).
MDCP expenditures are waiver services only, including STAR Kids and STAR Health MDCP.

C.9: Medicaid Expenditure History, FFYs 2015–2019

Federal Fiscal Year	Payer	Grant Benefits	Disproportionate Share Hospital	Uncompensated Care	Upper Payment Level	DSRIP	Clawback	CHIP Phase I	Administration	Survey and Certification	Total Medicaid
2019	FED	18,648,468,575	1,135,454,021	2,087,928,703	0	1,489,493,368	0	527,505,019	880,280,799	34,740,956	24,803,871,441
2019	FED-ARRA	0	0	0	0	0	0	0	12,697,190	0	12,697,190
2019	NONFED	13,261,596,951	815,280,033	1,517,288,370	0	1,070,166,468	481,830,280	35,391,653	567,268,631	11,585,207	17,760,407,593
2019	TOTAL	31,910,065,526	1,950,734,054	3,605,217,073	0	2,559,659,836	481,830,280	562,896,672	1,460,246,620	46,326,163	42,576,976,224
2018	FED	17,106,627,997	1,081,579,027	1,540,814,930	0	1,754,634,974	0	507,257,806	822,708,662	29,036,137	22,842,659,533
2018	FED-ARRA	0	0	0	0	0	0	0	22,003,400	0	22,003,400
2018	NONFED	12,777,021,171	819,932,090	1,174,000,086	0	1,330,166,318	489,795,321	40,162,197	532,639,351	9,976,953	17,173,693,487
2018	TOTAL	29,883,649,168	1,901,511,117	2,714,815,016	0	3,084,801,292	489,795,321	547,420,003	1,377,351,413	39,013,090	40,038,356,420
2017	FED	15,949,253,442	1,017,299,170	1,540,241,906	0	1,604,753,947	0	733,099,118	915,164,055	31,011,499	21,790,823,137
2017	FED-ARRA	0	0	0	0	0	0	0	51,840,168	0	51,840,168
2017	FED-ACA	(41,561)	0	0	0	0	0	0	0	0	(41,561)
2017	NONFED	12,290,313,332	793,261,567	1,198,100,572	0	1,251,691,974	462,902,271	60,944,177	540,679,435	11,292,410	16,609,185,738
2017	TOTAL	28,239,525,213	1,810,560,737	2,738,342,478	0	2,856,445,921	462,902,271	794,043,295	1,507,683,658	42,303,909	38,451,807,482
2016	FED	16,030,379,491	1,680,300,179	3,513,327,443	0	1,510,079,934	0	406,135,213	910,544,054	31,487,209	24,082,253,523
2016	FED-ARRA	0	0	0	0	0	0	0	57,651,639	0	57,651,639
2016	FED-ACA	(5,829,324)	0	0	0	0	0	0	0	0	(5,829,324)
2016	NONFED	11,879,923,210	1,239,498,723	2,582,312,821	0	1,133,154,677	406,131,303	31,185,078	536,844,295	11,224,325	17,820,274,432
2016	TOTAL	27,904,473,377	2,919,798,902	6,095,640,264	0	2,643,234,611	406,131,303	437,320,291	1,505,039,988	42,711,534	41,954,350,270
2015	FED	15,442,364,936	1,367,834,218	2,080,629,579	0	1,432,632,157	0	297,843,117	886,094,144	22,605,040	21,530,003,191
2015	FED-ARRA	0	0	0	0	0	0	0	86,157,065	0	86,157,065
2015	FED-ACA	106,855,855	0	0	0	0	0	0	0	0	106,855,855
2015	NONFED	10,789,116,883	970,120,562	1,466,393,531	0	1,035,305,295	370,092,170	123,939,980	484,172,478	7,535,012	15,246,675,911
2015	TOTAL	26,338,337,674	2,337,954,780	3,547,023,110	0	2,467,937,452	370,092,170	421,783,097	1,456,423,687	30,140,052	36,969,692,022

C.10: Medicaid Expenditure History, FFYs 2010–2014

Federal Fiscal Year	Payer	Grant Benefits	Disproportionate Share Hospital	Uncompensated Care	Upper Payment Level	DSRIP	Clawback	CHIP Phase I	Administration	Survey and Certification	Total Medicaid
2014	FED	14,982,927,389	905,058,004	1,451,339,911	0	1,348,925,140	0	117,437,708	737,229.930	19,236,614	19,562,154,776
2014	FED-ARRA	0	0	0	0	0	0	0	146,532,831	0	146,532,831
2014	FED-ACA	101,838,600	0	0	0	0	0	0	0	0	101,838,600
2014	NONFED	10,027,061,825	621,178,089	997,553,985	0	949,464,943	372,286,605	47,794,336	562,215,287	6,412,204	13,583,967,274
2014	TOTAL	25,111,827,814	1,526,236,093	2,448,893,976	0	2,298,390,083	372,286,605	165,232,044	1,445,978,048	25,648,818	33,394,493,481
2013	FED	14,209,243,885	133,812,750	1,885,406,398	0	287,667,948	0	28,657,109	646,050,231	22,731,210	17,213,569,531
2013	FED-ARRA	(2,722,794)	0	0	0	0	0	0	185,694,886	0	182,972,092
2013	FED-ACA	82,774,190	0	0	0	0	0	0	0	0	82,774,190
2013	NONFED	9,540,324,425	92,935,191	1,325,138,105	0	197,438,203	376,596,140	11,728,774	502,399,429	7,577,070	12,054,137,337
2013	TOTAL	23,829,619,706	226,747,941	3,210,544,503	0	485,106,151	376,596,140	40,385,883	1,334,144,546	30,308,280	29,533,453,150
2012	FED	13,773,119,669	882,595,210	0	1,400,669,919	0	0	28,108,056	651,723,257	22,796,293	16,759,012,404
2012	FED-ARRA	6,301,635	0	0	12,501,171	0	0	0	209,039,020	0	227,841,826
2012	NONFED	9,833,604,615	633,370,455	0	981,318,763	0	344,689,503	11,194,337	549,535,172	7,598,764	12,361,311,609
2012	TOTAL	23,613,025,919	1,515,965,665	0	2,394,489,853	0	344,689,503	39,302,393	1,410,297,449	30,395,057	29,348,165,839
2011	FED	14,093,145,087	956,328,092	0	1,829,711,562	0	0	20,859,639	589,699,290	23,918,822	17,513,662,492
2011	FED-ARRA	1,395,373,748	0	0	231,747,606	0	0	0	167,790,509	0	1,794,911,863
2011	NONFED	7,741,106,553	622,813,407	0	977,218,223	0	277,468,044	7,982,215	490,315,493	7,912,940	10,124,816,875
2011	TOTAL	23,229,625,388	1,579,141,499	0	3,038,677,391	0	277,468,044	28,841,854	1,247,805,292	31,831,762	29,433,391,230
2010	FED	12,670,015,218	991,515,974	0	1,849,499,135	0	0	0	585,452,634	23,347,881	16,119,830,842
2010	FED-ARRA	2,599,216,338	0	0	366,322,520	0	0	0	1,368,805	0	2,966,907,663
2010	NONFED	6,231,480,571	696,673,993	0	925,963,561	0	188,351,774	0	513,545,911	7,782,627	8,563,798,437
2010	TOTAL	21,500,712,127	1,688,189,967	0	3,141,785,216	0	188,351,774	0	1,100,367,350	31,130,508	27,650,536,942

Glossary

Abuse

Provider or client practices that result in unnecessary costs to Medicaid—including reimbursements for services that are not medically necessary or that fail to meet professionally recognized standards for health care and actions that are inconsistent with sound fiscal, business or medical practices.

Accelerated Monitoring

A contractual non-compliance remedy that utilizes more frequent or extensive monitoring than standard monitoring practices. Examples of accelerated monitoring practices include additional reporting requirements, escalated corrective action plans (CAPs) and onsite reviews.

Access-based Fee (ABF)

Under the fee-for-service (FFS) delivery model, access-based fees (ABFs) are a type of Medicaid rate used to pay physicians and other practitioners for services. Rates for physicians and other practitioners are uniform statewide and are categorized as either resource-based fees (RBFs) or ABFs. ABFs are calculated based on the following: historical charges, the current Medicare FFS rates, reviews of Medicaid fees paid by other states, surveys of providers' costs to deliver a service, and Medicaid fees for similar services. ABFs account for deficiencies in RBF methodology to adequately ensure access to health care services for Medicaid clients. Reimbursement rates for services outlined above are evaluated at least once every two years as a part of a biennial fee review process. See also Fee-for-Service (FFS) Rates and Resource-based Fee (RBF).

Activities of Daily Living (ADLs)

Activities of Daily Living (ADLs) are activities essential to daily personal care—including bathing or showering, dressing, getting in or out of a bed or a chair, using a toilet, and eating. Assistance with ADLs is a service offered through state plan long-term services and supports (LTSS) programs, including Primary Care Services (PCS), Community Attendant Services (CAS), Personal Assistance Services (PAS), Primary Home Care (PHC), and Day Activity and Health Services (DAHS). See also Long-term Services and Supports (LTSS).

Acuity Risk Adjustment

Before capitation rates for managed care organizations (MCOs) are finalized, an acuity risk adjustment is made to reflect the health status, or acuity, of the population enrolled in each MCO. This adjustment recognizes the anticipated cost differential among multiple MCOs in a service area due to the variable health status of their respective memberships. See also Capitation Rates.

Acute Care Services

Acute care services focus on preventive care, diagnostics and treatments. Acute care services covered by Medicaid include but are not limited to: inpatient and outpatient hospital services, laboratory and x-ray services, and physician services. Medicaid covers acute care services for all clients. See also Appendix B, page 130, for a full list of acute care services offered in Texas.

Acute Care Utilization Review (ACUR)

Acute Care Utilization Reviews (ACUR) are one type of review designed to monitor managed care organizations (MCOs) and ensure they are authorizing, justifying and providing appropriate, medically necessary services to Medicaid clients. For this review, a team of nurses conducts a desk review of a targeted sample set of medical records. This sample set is selected based on complaints, the severity and frequency of non-compliance instances, and the volume or cost of particular services. Nurses from the ACUR team conduct an in-depth review of the sample cases—including their authorization process, medical necessity determination, timeliness and accuracy of the resolution.

Administrative Expense Limits (Admin Cap)

The amount of allowable Medicaid administrative expenses by managed care organizations (MCOs) are limited by administrative expense limits (Admin Cap). The Admin Cap is compared to reported administrative expenses by the MCO. Any amounts over the Admin Cap become disallowed expenses and are added to the MCO's net income. MCOs are not prevented from incurring expenses that they consider necessary to the successful operation of their business. The Admin Cap only pertains to their ability to record those expenses on their financial statistical reports (FSRs). See also Financial Statistical Report (FSR).

Agency Option

The agency option refers to one option Medicaid clients have in determining how they receive certain long-term services and supports (LTSS), where services are delivered through a provider agency. The provider agency is the employer of attendants or other direct service workers and is responsible for all employment and business operations.

Either the service coordinator case management agency (for the Community Living Assistance and Support Services [CLASS] waiver program) or provider agency (for Deaf Blind with Multiple Disabilities [DBMD]) coordinates with the individual or authorized representative to monitor and ensure clients are satisfied with their services. See also Provider Agency.

Aging and Disability Resource Center (ADRC)

Aging and Disability Resource Centers (ADRCs) provide older adults, people with disabilities, and their family members with educational information about long-term services and supports (LTSS) and serve as a point of access for LTSS programs. Each ADRC partners with a network of local service agencies to coordinate information and referrals for individuals needing access to both private and public LTSS programs and benefits, including Medicaid. There are 22 ADRCs operating throughout Texas.

Alberto N. v. Young

A federal lawsuit settled in May 2005 that requires Health and Human Services Commission (HHSC) to comply with Title XIX of the Social Security Act (42 U.S.C. §1396 et seq.) by providing all medically necessary in-home Medicaid services to children age 20 and younger who are eligible for the Medicaid Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program.

All Patient Refined Diagnosis Related Group (APR-DRG)

All Patient Refined Diagnosis Related Group (APR-DRG) comes from the Diagnosis Related Group (DRG) classification system, which provides a means of relating the type of patients a hospital treats to the costs incurred by the hospital. APR-DRGs are an expansion of the basic DRGs to be more representative of non-Medicare patients and to incorporate severity of illness subclasses. See also Diagnosis Related Group (DRG).

Alternative Payment Model (APM)

An alternative payment model (APM) is a payment approach that rewards providers for delivering high-quality, cost-efficient care. APMs link a percentage of the provider's overall payment to a measure of either quality or quality and cost. As part of building a strong pay-for-quality (P4Q) program that incentivizes managed care organizations (MCOs) to achieve better performance, the Health and Human Services Commission (HHSC) developed contractual requirements for MCOs to have minimum thresholds of their overall payments to health care providers be in the form of an APM. For a certain percentage of these payments, the provider must have some degree of risk, called the risk threshold. See also Pay-for-Quality (P4Q).

Alternative Prospective Payment System (APPS)

Like prospective payment systems (PPSs), alternative prospective payment systems (APPSs) are methods of reimbursement in which payment is made based on a predetermined, fixed amount—which is, in turn, based on the classification system of that service. However, where PPS rates are inflated annually for primary care using the Medicare Economic Index (MEI), APPS rates are inflated annually using 100.5 percent of the MEI. APPSs may be used by Federally Qualified Health Centers (FQHCs). If an FQHC chooses the APPS method, rates may be prospectively reduced to better reflect the reasonable costs or the PPS rates.

Amount, Duration and Scope

Amount, duration and scope refer to how a Medicaid benefit is defined and limited in a state Medicaid plan. Each state defines these parameters, so state Medicaid plans vary in what they cover.

Appointment Availability

Appointment availability is a measurement used to assess client access to care within the managed care delivery system. It is measured by the time between when a member contacts a provider and the date of the first available appointment. Managed care organizations (MCOs) can reduce the use of emergent care by ensuring members have timely access to regular and preventive care. The Health and Human Services Commission (HHSC) contractually requires MCOs to follow appointment availability standards—for STAR, Children's Health Insurance Program (CHIP), STAR Kids, STAR Health, and STAR+PLUS—based on the type of medical appointment requested. Texas' external quality review organization (EQRO) conducts secret shopper studies to evaluate MCO compliance with these availability standards. See also Mystery Shopper Method.

Audits

An audit is an official inspection of performance or finances that is conducted by independent contractors or outside agencies, such as the Office of Inspector General (OIG). See also Office of Inspector General (OIG).

B

Behavioral Health Services

Behavioral health services generally refer to the treatment of mental health conditions and substance use disorders (SUDs). These services may be provided by the following: therapists in private practice, physicians, private and public psychiatric hospitals, community mental health centers, comprehensive provider agencies, and substance use treatment facilities. Screening services include Health and Behavioral Assessment and Intervention (HBAI) and Screening, Brief Intervention and Referral to Treatment (SBIRT). Treatment services include but are not limited to: psychiatric diagnostic evaluation and psychotherapy, psychological and neuropsychological testing, mental health targeted case management, psychotropic medications, and medication assisted therapy for SUDs. See also Health and Behavioral Assessment and Intervention (HBAI); Screening, Brief Intervention and Referral to Treatment (SBIRT); and Substance Use Disorder (SUD).

Better Birth Outcomes

Better Birth Outcomes (BBO) is a collaborative effort between the Health and Human Services Commission (HHSC) and the Department of State Health Services (DSHS). BBO aims to improve access to women's preventive, interconception, prenatal and perinatal health care. There are currently more than 30 BBO initiatives. See also Healthy Families Project, Long-acting Reversible Contraception (LARC), Perinatal Advisory Council, Texas Alliance for Innovation on Maternal Bundle Implementation (TexasAIM), and Texas Neonatal Intensive Care Unit (NICU) Project (TNP).

Breast and Cervical Cancer Services (BCCS)

Breast and Cervical Cancer Services (BCCS) clinic sites provide quality, low-cost, and accessible breast and cervical cancer screening and diagnostic services to women. These clinic sites are the point of access for women applying to the Medicaid Breast and Cervical Cancer (MBCC) program. See also the Medicaid Breast and Cervical Cancer (MBCC) program.

C

Capitation Rate

Through actuarially sound methodologies, Texas develops a per member per month (PMPM) rate, or capitation rate, for each risk group within all state service areas for its various Medicaid and Children's Health Insurance Program (CHIP) managed care programs. These capitation rates differ across risk groups and service areas, but they are the same for each managed care organization (MCO) within a service area. The managed care rate-setting process involves a series of mathematical adjustments to arrive at the final rates paid to the MCOs. Capitation rates are derived primarily from MCO historical claims experience, also called encounter data. In case of possible fluctuations in claims cost, a risk margin is typically added. While the calculation method remains largely the same, how capitation rates are determined varies by program. Capitation rates, paid monthly to MCOs, constitute the primary way the state pays for services. See also Encounter Data and Per Member Per Month (PMPM).

Care Coordination

The value of managed care relies on care coordination provided by managed care organizations (MCOs). Care coordination includes services performed by MCOs or by primary care providers—such as assistance with setting up appointments, locating specialty providers and member health assessments. In particular, MCOs are required to identify and provide care coordination for members with special health care needs (MSHCN). The MCO is responsible for working with MSHCN and their families, as well as their health care providers, to develop a seamless package of care in which all needs are met through a comprehensive service plan. This coordination is available to MSHCN, including women with high-risk pregnancies, members with high-cost catastrophic cases, and individuals with mental illness and co-occurring substance abuse. See also Members with Special Health Care Needs (MSHCN).

Case Management for Children and Pregnant Women

Case Management for Children and Pregnant Women is a component of Texas Health Steps. This Medicaid benefit provides health-related case management services to children age 20 and younger or pregnant women who are eligible for Medicaid. Case managers assist eligible clients in gaining access to medically necessary medical, social and educational services—as well as other services related to their health condition, health risk or high-risk condition. Services include assessing the needs of eligible clients, developing a

service plan with clients and families, making referrals, problem-solving, advocacy, and follow-up regarding client and family needs. See also Texas Health Steps.

Centers for Medicare and Medicaid Services (CMS)

The Centers for Medicare and Medicaid Services (CMS) is the federal agency within the U.S. Health and Human Services responsible for administering Medicare and overseeing state administration of Medicaid. States submit a Medicaid state plan that serves as the contract between the state and CMS. CMS must approve the plan and any amendments to the plan. CMS also approves any waivers for which states can apply. See also State Plan.

Chemical Dependency Treatment Facility (CDTF)

Chemical dependency treatment facilities (CDTFs) are any facilities that offer treatment for persons with a substance use disorder (SUD). CDTFs must be licensed and regulated by the state, except for Medication Assisted Therapy (MAT) services.

Children's Health Insurance Program (CHIP)

The Children's Health Insurance Program (CHIP) provides acute care, behavioral health care, dental services and pharmacy services for children in families with too much income to qualify for Medicaid but cannot afford to buy private health insurance. Children covered through CHIP generally receive similar services as children covered through Medicaid. See also Children's Health Insurance Program (CHIP) Perinatal.

Children's Health Insurance Program (CHIP) Perinatal

Children's Health Insurance Program (CHIP) Perinatal services are for the unborn children of pregnant women who are uninsured and do not qualify for Medicaid. Services include prenatal visits, prescription prenatal vitamins, labor and delivery, and postpartum care.

Children's Hospital

According to the Centers of Medicare and Medicaid Services (CMS), a certified children's hospital is a freestanding or hospital-within-hospital that predominantly treats individuals age 20 and younger.

Children's Medicaid

Children's Medicaid serves children age 18 and younger who meet the program's household income limits. Children's Medicaid provides acute care, behavioral health services, dental services, prescription drug benefits, and long-term services and supports. Children in the program are typically enrolled in the STAR managed care program, although some children with disabilities may be enrolled in STAR Kids. Children's Medicaid recipients also

receive Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program services, known in Texas as Texas Health Steps. See also Early and Periodic Screening, Diagnosis and Treatment (EPSDT); STAR; STAR Kids; and Texas Health Steps.

Children's Medicaid Dental Services (CMDS) Program

The Children's Medicaid Dental Services (CMDS) program is a managed care program that provides dental benefits for children and youth on Medicaid, birth through age 20. There are two dental maintenance organizations (DMOs) operating statewide. See also Dental Maintenance Organization (DMO).

Chronic Care Management

Under managed care, managed care organizations (MCOs) must provide chronic care management programs and services. These programs and services must be part of a person-centered approach and address the needs of high-risk members with complex chronic or co-morbid conditions. See also Care Coordination.

Client

A client is an individual who has applied for and is enrolled in Medicaid, Children's Health Insurance Program (CHIP), or both. If enrolled into a health plan, they may also be referred to as a member.

Clinical Prior Authorization

Clinical prior authorizations are evidence-based reviews designed to ensure the clinical appropriateness of a drug or drug class based on factors such as age, availability of alternative medications, or possible drug interactions. They may apply to an individual drug or a drug class that is included on federal formulary and may have preferred or non-preferred status on the Preferred Drug List (PDL). With the assistance of the Texas Drug Utilization Review Board, the Vendor Drug Program develops, manages and reviews clinical prior authorizations across both fee-for-service (FFS) and the managed care programs. Participating managed care organization (MCOs) are required to perform certain clinical prior authorizations and may perform others at their discretion. See also Non-preferred Prior Authorization, Preferred Drug List (PDL), Prior Authorization, Texas Formulary, and Vendor Drug Program (VDP).

Community Attendant Services (CAS)

Community Attendant Services (CAS) are state plan, home and community-based, long-term services and supports (LTSS) that include assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). These services are available to eligible adults and children.

Community First Choice (CFC)

Community First Choice (CFC) is a federal option that allows states to provide home and community-based attendant services and supports to Medicaid recipients with disabilities. To be eligible, an individual must require an institutional level of care. Individuals can receive CFC services and keep their spot on an interest list or continue to receive services in a waiver program. CFC services must be provided in community-based settings.

Community Living Assistance and Support Services (CLASS)

Community Living Assistance and Support Services (CLASS) is a 1915(c) waiver program that provides home and community-based services to people who have a related condition diagnosis qualifying them for placement in an intermediate care facility for individuals with an intellectual disability or related condition (ICF/IID). A related condition is a disability other than an intellectual or developmental disability, which originates before age 22 and which substantially limits life activity. See also Appendix B, page 133, for a full list of services offered through CLASS. Eligibility determinations for CLASS are based on level of care (LOC) criteria outlined in the Texas Administrative Code. CLASS has an interest list. See also Intermediate Care Facility for Individuals with an Intellectual Disability or Related Condition (ICF/IID) and Interest List.

Complaints

The Health and Human Services Commission (HHSC) monitors managed care organization (MCO) complaints, grievances and appeals processes for both members and providers. Data is used as a mechanism to flag for early warning of potential systemic problems that warrant investigation, point to the need for policy clarifications, or signal larger operational issues.

Comprehensive Care Program (CCP)

Federal law expanded the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program, known in Texas as Texas Health Steps, to cover any medically necessary and appropriate health care services used for treating all physical and mental illnesses or conditions found in a screening. These benefits are included in Texas Health Steps but are referred to in Texas as the Comprehensive Care Program (CCP). See also Texas Health Steps.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey is a nationally recognized and validated tool for collecting standardized information on member

experiences with health plans and services. This survey focuses on consumer perceptions of quality, such as the communication skills of providers and ease of access to health care services. See also National Core Indicators-Aging and Disabilities (NCI-AD) Survey.

Consumer Directed Services (CDS) Option

Consumer Directed Services (CDS) is a service delivery option for some individuals receiving long-term services and supports (LTSS) that allows the individual or the individual's legally authorized representative to be the employer of record for the direct care workers providing services—giving greater choice and control over the delivery of services. The individual or legally authorized representative can hire, train, supervise and dismiss the employee when necessary. Individuals may appoint a designated representative to assist with some employer responsibilities, like approving time sheets.

Contractor

A person or organization with which the state has successfully negotiated an agreement for the provision of required tasks.

Corrective Action Plan (CAP)

In cases of contractual non-compliance, the Health and Human Services Commission (HHSC) may use corrective action plans (CAPs) to hold managed care organizations (MCOs) accountable. The CAP process requires MCOs to provide HHSC with the following: a detailed explanation of the reasons for the deficiency; an assessment or diagnosis of the cause; actions taken to cure or resolve the deficiencies, including short- and long-term solutions; and actions taken to prevent future occurrences. HHSC administers CAPs monthly, and reviews, approves and closes CAPs once appropriate actions have been taken to address the non-compliance.

Cost-sharing

Cost-sharing refers to a co-paying arrangement, in which the state shares the cost of care with another party. Most families participating in Children's Health Insurance Program (CHIP), for example, pay an annual enrollment fee and pay co-payments for doctor visits, prescription drugs, inpatient hospital care and non-emergent care provided in an emergency room setting. See also Children's Health Insurance Program (CHIP).

Crisis Diversion

Crisis Diversion is a reserved capacity group for the Home and Community-based Services (HCS) program. Individuals qualify as members of this reserved capacity group if they have an intellectual or developmental disability and are at imminent risk of being

admitted or re-admitted to an institution. See also Home and Community-based Services (HCS) and Reserved Capacity Group.

D

Day Activity and Health Services (DAHS)

Day Activity and Health Services (DAHS) are state plan, community-based, long-term services and supports (LTSS). DAHS is offered during the day, Monday through Friday, to clients residing in the community. Services provided at licensed day activity and health services centers include nursing and personal care, meals, transportation, and social and recreational activities.

Deaf Blind with Multiple Disabilities (DBMD)

Deaf Blind with Multiple Disabilities (DBMD) is a 1915(c) waiver program that provides community-based services to people who are deaf and blind and also have a third disability (e.g., an intellectual disability), as an alternative to institutional care in an intermediate care facility for individuals with an intellectual disability or related condition (ICF/IID). See also Appendix B, page 134, for a full list of services offered through DBMD. Eligibility determinations for DBMD are based on level of care (LOC) criteria outlined in the Texas Administrative Code. DBMD has an interest list. See also Intermediate Care Facility for Individuals with an Intellectual Disability or Related Condition (ICF/IID).

Default Enrollment

Default enrollment occurs when clients do not exercise their right to choose a managed care organization (MCO) and are automatically assigned to a health plan.

Deferral

A deferral refers to the withholding of federal funding, if the Texas Medicaid or Children's Health Insurance Program (CHIP) is determined to be out of compliance with federal regulations by the Centers of Medicare and Medicaid Services (CMS).

Delivery Supplemental Payment

Delivery supplemental payments are separate lump sums paid to managed care organizations (MCOs), as part of their capitation payments, to cover newborn delivery expenses. This payment is computed for each service area.

Delivery System Reform Incentive Payment (DSRIP) Pool

The Delivery System Reform Incentive Payment (DSRIP) pool is one of two hospital funding pools under the 1115 Transformation waiver along with Uncompensated Care (UC) pool. DSRIP funding provides financial incentives that encourage hospitals and other providers to focus on achieving quality health outcomes. Participating providers develop and implement programs, strategies and investments to enhance the following: access to health care services, quality of health care and health systems, cost-effectiveness of services and health systems, and the health of the patients and families served. To earn DSRIP funds, providers must undertake projects from a menu of projects agreed upon by Centers for Medicare and Medicaid Services (CMS) and Health and Human Services Commission (HHSC) within the Regional Healthcare Partnership (RHP) planning protocol. See also Regional Healthcare Partnership (RHP).

Dental Maintenance Organization (DMO)

Dental maintenance organizations (DMOs) deliver and manage comprehensive dental services to eligible Medicaid and Children's Health Insurance Program (CHIP) clients. For Medicaid and Children's Health Insurance Program (CHIP) there are two DMOs that operate throughout Texas.

Dental Quality Alliance (DQA)

The Dental Quality Alliance (DQA) is an organization convened by the American Dental Association at the request of Centers for Medicare and Medicaid Services (CMS). The DQA has developed national evidence-based oral health care performance measures that have been tested for feasibility, validity, reliability and usability.

Diagnosis Related Group (DRG)

The Diagnosis Related Groups (DRGs) are a patient classification system that provide a means of relating the type of patients a hospital treats to the costs incurred by the hospital. The system was originally used by the Centers for Medicare and Medicaid Services (CMS) for hospital payment for Medicare clients, and it has been expanded to be more inclusive of non-Medicare clients. Under this system, each patient is classified into a DRG on the basis of clinical information. Hospitals are paid a pre-determined rate for each DRG admission. For fee-for-service (FFS) clients receiving inpatient or outpatient care, the rate is calculated using a standardized average cost of treating a Medicaid inpatient admission and a relative weight for each DRG.

Disallowance

A disallowance refers to the recoupment of federal funds by the Centers for Medicare and Medicaid Services (CMS), should CMS allege that certain claims are not allowable.

Disproportionate Share Hospital (DSH)

Disproportionate Share Hospital (DSH) is a designation for hospitals that serve a higher than average number of Medicaid and other low-income patients. See also Disproportionate Share Hospital (DSH) Funding.

Disproportionate Share Hospital (DSH) Funding

Disproportionate Share Hospital (DSH) funding is special funding for hospitals that serve a disproportionately large number of Medicaid and low-income patients. DSH funds are not tied to specific services for Medicaid-eligible patients. There are no federal or state restrictions on how disproportionate share hospitals may use their funds. They may use the payments to cover the uncompensated costs of care for low-income patients, including Medicaid patients. DSH payments have been an important source of revenue by helping hospitals expand health care services to the uninsured, defray the cost of treating low-income patients, and recruit physicians and other health care professionals to treat patients.

Drug Utilization Review (DUR)

Drug utilization reviews (DURs), prospective and retrospective, are used by the Health and Human Services Commission (HHSC) and managed care organizations (MCOs) to evaluate client use of prescription drugs. See also Prospective Drug Utilization Review (DUR), Retrospective Drug Utilization Review (DUR), and Texas Drug Utilization Review (DUR) Board.

Dually Eligible

Individuals who are dually eligible qualify for both Medicare and Medicaid benefits. Medicare is a federally paid and administered health insurance program. Medicaid is a state-administered health care and long-term care program jointly funded by the state and the federal government. Dually eligible individuals or couples may get partial or full Medicaid benefits. If only getting partial Medicaid benefits, an individual or couple will be enrolled into the Medicare Savings Program. Dually eligible individuals typically qualify for Medicaid for the Elderly and People with Disabilities (MEPD) and receive benefits through the STAR+PLUS managed care program. Dually eligible MEPD recipients may also be enrolled into a Medicaid-Medicare Plan (MMP) or a Dual-Eligible Special Needs Plans (D-SNP). See also Dual-Eligible Special Needs Plan (D-SNP), Medicaid for the Elderly and People with Disabilities (MEPD), Medicaid-Medicare Plan (MMP), Medicare Savings Program, and STAR+PLUS.

E

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program is a required Medicaid state plan benefit for eligible children and youth, birth through age 20. In Texas, this program is referred to as Texas Health Steps. See also Texas Health Steps.

Early Childhood Intervention (ECI)

Early Childhood Intervention (ECI) is a statewide program that provides services to families with children age 3 and younger who have developmental delays or disabilities.

Electronic Visit Verification (EVV)

Electronic Visit Verification (EVV) is a computer-based tracking system that electronically verifies the occurrence of personal attendant service visits by documenting the precise time a service delivery begins and ends. EVV helps prevent fraud, waste and abuse with the goal of ensuring Medicaid recipients receive care that is authorized.

Emergency Medicaid

The Emergency Medicaid program provides medical coverage designed to meet a sudden, critical health condition. Most covered individuals apply for this benefit only after an emergency occurs. If determined eligible, the individual is covered by Medicaid only from the start of a qualifying emergency medical condition to when the event is stabilized, as verified by a medical provider.

Encounter Data

Used in the calculation of managed care organization (MCO) capitation rates, encounter data refers to the historical claims experience of MCOs for a base period of time. Encounter data includes the records of the health care services for which MCOs pay and the amounts MCOs pay to providers of those services. See also Capitation Rates.

Enhanced Federal Medical Assistance Percentage (EFMAP)

The enhanced federal medical assistance percentage (EFMAP) is used to determine federal matching funds for Children's Health Insurance Program (CHIP). Derived from each state's average per capita income, the Centers for Medicare and Medicaid Services (CMS) updates

this rate annually. Consequently, the percentage of total CHIP spending that is paid for with federal funds also changes annually. The EFMAP for Texas in federal fiscal year 2019 was 70.73 percent and in state fiscal year 2019 was 70.65 percent. See also Federal Medical Assistance Percentage (FMAP) and Matching Funds.

Experience Rebate

Experience rebate is the process of determining the amount of profit earned through the Medicaid managed care program that a managed care organization (MCO) must share with the state of Texas.

External Medical Review (EMR)

Medicaid clients who are denied services or program eligibility can appeal directly to the Health and Human Services Commission (HHSC) by requesting a fair hearing. As part of that request, they have the option to ask for an external medical review (EMR) before their fair hearing. During an EMR, an independent review organization (IRO) examines the client's case and can uphold or change the service denial or eligibility determination. Unlike a fair hearing, EMRs are privately conducted and additional evidence cannot be submitted by the member, the MCO or HHSC. EMRs must occur after a health plan appeal if a managed care organization (MCO) made the original decision to deny services or eligibility. See also Fair Hearing and Independent Review Organization (IRO).

External Quality Review Organization (EQRO)

An external quality review organization (EQRO) assesses managed care organization (MCO) performance on several metrics—access to care, utilization of care and quality of care—for all MCOs participating in Medicaid and Children's Health Insurance Program (CHIP) medical and dental managed care programs. The Institute for Child Health Policy at the University of Florida has been the EQRO for Texas since 2002.

Fair Hearing

Medicaid clients who are denied services or program eligibility can appeal directly to the Health and Human Services Commission (HHSC) by requesting a fair hearing. During a fair hearing, an HHSC fair hearings officer publicly reviews evidence submitted by the client, the MCO, or HHSC program staff—and can uphold or change the original eligibility decision. While additional evidence may be submitted by either party, evidence submitted

by the MCO or HHSC must be presented to the client before the hearing. Fair hearings must occur after a health plan appeal if a managed care organization (MCO) made the original decision to deny services or eligibility. See also External Medical Review (EMR) and Health Plan Appeal.

Federal Medical Assistance Percentage (FMAP)

The federal medical assistance percentage (FMAP) determines the amount of federal matching funds Texas receives for Medicaid. Derived from each state's average per capita income, the Centers for Medicare and Medicaid Services (CMS) updates the rate annually. Consequently, the percentage of total Medicaid spending that is paid with federal funds also changes annually. As the state's per capita income increases in relation to the national per capita income, the FMAP rate decreases. For federal fiscal year 2019, Texas' Medicaid FMAP was 58.19 percent. See also Enhanced Federal Medical Assistance Percentage (EFMAP) and Matching Funds.

Federal Poverty Level (FPL)

The Federal Poverty Level (FPL) is a measure of income set by the U.S. Department of Health and Human Services used to determine eligibility for government programs and services, like Medicaid and Children's Health Insurance Program (CHIP). The FPL is updated yearly.

Federally Qualified Health Center (FQHC)

Federally Qualified Health Centers (FQHCs) include all organizations receiving grants under Section 330 of the Public Health Service Act. FQHCs qualify for enhanced reimbursement from Medicare and Medicaid, as well as other benefits. FQHCs serve underserved areas or populations, offer a sliding-scale fee, provide comprehensive services, have an ongoing quality assurance program, and have a governing board of directors.

Fee-for-Service (FFS)

Fee-for-service (FFS) is a healthcare payment system under which providers receive a payment for each unit of service they provide. Under FFS, clients can go to any Medicaid provider, and the provider will submit claims directly for Medicaid covered services. Currently, only eight percent of Medicaid clients in Texas still receive services through FFS. The remaining 92 percent of clients are enrolled into one of the managed care programs. See also Managed Care.

Fee-for-Service (FFS) Rates

Fee-for-service (FFS) rates are paid directly to providers—physicians, other medical practitioners, pharmacists and hospitals. The Health and Human Services Commission (HHSC)

is responsible for establishing reimbursement methodologies. However, the commission consults with stakeholders and advisory committees when considering changes to FFS reimbursement rates. All proposed rates are subject to a public hearing, and all proposed reimbursement methodology rule changes are subject to a 30-day public comment period as part of the approval process. Changes in FFS rates will often impact managed care capitation rates.

Financial Criteria

Texans who apply for Medicaid or the Children's Health Insurance Program (CHIP) must meet certain financial criteria to be eligible for services. Generally, financial eligibility is measured by comparing an applicant's income to the U.S. Department of Health and Human Services definition of the federal poverty level (FPL) for annual household incomes. Federal law currently requires that Modified Adjusted Gross Income (MAGI) be the primary measurement tool used to calculate financial eligibility for most Medicaid applicants. See also Federal Poverty Level (FPL) and Modified Adjusted Gross Income (MAGI).

Financial Statistical Report (FSR)

Managed care organizations (MCOs) are required to submit quarterly financial statistical reports (FSRs). FSRs include information on medical and administrative expenses and are one source for establishing capitation rates in future years. Validation of these reports is an important component of contract oversight, and FSRs are audited yearly.

Fraud

Fraud refers to an intentional deception or misrepresentation made by a person or entity with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. This term does not include unintentional technical, clerical or administrative errors.

Freedom of Choice

In general, a state must ensure that Medicaid clients are free to obtain services from any qualified provider. Exceptions are possible through Medicaid waivers and special contract options.

Freedom of Choice 1915(b) Waivers

Section 1915(b) waivers allow states to use a central broker (e.g., enrollment broker) to assist people with choosing a managed care organization (MCO), to use cost savings to provide additional services, or to limit client choice of Medicaid providers by requiring Medicaid clients join MCOs. Texas has used these waivers to provide an enhanced benefit

package—beyond what is available through the state plan—with cost savings from managed care.

Frew v. Young

A class action lawsuit filed against Texas in 1993, which alleged that the state did not adequately provide Medicaid Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services. In 1995, the state negotiated a consent decree that imposed certain requirements on the state. In 2007, the state negotiated a set of corrective action orders with the plaintiffs to implement the consent decree and increase access to EPSDT services. Since 2007, the Health and Human Services Commission (HHSC) and the Department of State Health Services (DSHS) have actively worked to meet the requirements of the corrective action orders.

G

Graduate Medical Education (GME) Payments

Graduate medical education (GME) payments to state-owned teaching hospitals cover the costs of program administrative staff, allocated facility overhead, and salaries and fringe benefits for residents and teaching physicians. See also State-owned Teaching Hospitals.

H

Health and Behavior Assessment and Intervention (HBAI)

Health and Behavior Assessment and Intervention (HBAI) services are designed to identify the psychological, behavioral, emotional, cognitive and social factors that are important to prevent, treat or manage physical health symptoms for children and youth, age 20 and younger. HBAI services help promote physical and behavioral health integration. See also Behavioral Health Integration.

Health and Human Services Commission (HHSC)

The Health and Human Services Commission (HHSC) is the single state agency implementing and overseeing Medicaid and the Children's Health Insurance Program (CHIP) for Texas. See also Single State Agency.

Health Insurance Premium Payment (HIPP) Program

The Health Insurance Premium Payment (HIPP) program reimburses people for their share of an employer-sponsored health insurance premium when it is determined that the cost of the premium is less than the cost of projected Medicaid expenditures. To be eligible for HIPP, an individual must be eligible for Medicaid or have a family member who is eligible or already receives Medicaid. The employer-sponsored health insurance must provide comparable coverage to Medicaid.

Health Plan

Managed care organizations (MCOs) are often referred to as health plans—a term which describes their function in providing medical coverage and coordinated care to Medicaid and Children's Health Insurance Program (CHIP) clients. See also Managed Care Organization (MCO).

Health Plan Appeal

Medicaid members who are denied services or eligibility by their managed care organization (MCO) can ask for a health plan appeal. During a health plan appeal, the MCO reconsiders their original decision and can change or uphold it. If the member disagrees with the outcome of their health plan appeal, they have the right to appeal directly to the Health and Human Services Commission (HHSC) through a fair hearing. See also Fair Hearing.

Healthcare Effectiveness Data and Information Set (HEDIS)

The Healthcare Effectiveness Data and Information Set (HEDIS) is a widely used set of performance measures for managed care organizations (MCOs). HEDIS data for Texas Medicaid and Children's Health Insurance Program (CHIP) managed care programs is posted and regularly updated on the Texas Healthcare Learning Collaborative (THLC) portal. See also Texas Healthcare Learning Collaborative (THLC) Portal.

Healthcare Payment Learning and Action Network (HCP-LAN)

The Health and Human Services Commission (HHSC) is using the Healthcare Payment Learning and Action Network (HCP-LAN) to accelerate the transition to alternative payment models (APMs) within managed care organizations (MCOs) in Texas Medicaid and the Children's Health Insurance Program (CHIP). See also Alternative Payment Model (APM) and Pay-for-Quality (P4Q).

Healthy Families Project

The Healthy Families Project is a Better Birth Outcome (BBO) initiative focused on women's health disparities and infant mortality risk reduction. The program seeks to increase access to family planning services and decrease the risk for infant mortality among African American/Black and Hispanic women. This project provides communities with flexible resources that they can use to implement customized healthcare interventions. See also Better Birth Outcomes (BBO).

Healthy Texas Women (HTW)

Healthy Texas Women (HTW) is a women's health and family planning program for low-income women age 15 through 44. To ensure continuity of care, HTW auto-enrolls women into the program when their Medicaid for Pregnant Women coverage ends. Women can still apply for HTW like they would for other Health and Human Services Commission (HHSC) programs. HTW was previously a state-administered, state-funded program. Through an 1115 Demonstration Waiver, HTW is now a Medicaid program that receives federal matching funds. HTW also offers an enhanced postpartum services for eligible HTW clients called HTW Plus. HTW Plus services include treatment for mental health conditions, including postpartum depression and substance use disorders (SUDs), and cardiovascular conditions.

Home and Community-based Services (HCS)

Home and Community-based Services (HCS) is a 1915(c) waiver program that provides community-based services to people with intellectual disabilities, as an alternative to institutional care in an intermediate care facility for individuals with an intellectual disability or related condition (ICF/IID). See also Appendix B, page 134, for a full list of services offered through HCS. Eligibility determinations for HCS are based on level of care (LOC) criteria outlined in the Texas Administrative Code. HCS has an interest list. See also Interest List and Intermediate Care Facility for Individuals with an Intellectual Disability or Related Condition (ICF/IID).

Home and Community-based Services–Adult Mental Health (HCBS-AMH)

The Home and Community-based Services–Adult Mental Health (HCBS-AMH) program helps individuals with serious mental illness remain in the community. The HCBS-AMH program provides an array of intensive HCBS tailored to an individual's assessed needs, preferences and goals.

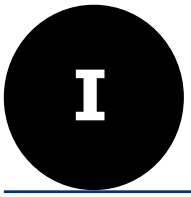
Home and Community-based Services (HCBS) 1915(c) Waivers

Home and Community-based Services (HCBS) 1915(c) waivers allow states to provide home and community-based services as an alternative for people who meet eligibility

criteria for care in an institution. See also Community Living Assistance and Support Services (CLASS), Deaf Blind with Multiple Disabilities (DBMD), Home and Community-based Services (HCS), Medically Dependent Children Program (MDCP), Texas Home Living (TxHmL), and Youth Empowerment Services (YES).

Hospital Quality-based Payment Program

The Hospital Quality-based Payment Program is an incentive/disincentive program that pays or recoups funds from hospitals according to their performance with fee-for-service (FFS) and managed care Medicaid patients—with the goal of improving quality and lowering costs. Through the program, hospitals and managed care organizations (MCOs) are financially accountable for certain potentially preventable events (PPEs) and can receive bonus payments for achieving low PPE rates. See also Potentially Preventable Event (PPE).



Income Disregards

An income disregard refers to an income source or amount that is deducted or disregarded in a financial eligibility determination. For applicants subject to the Modified Adjusted Gross Income (MAGI) methodology, a standard income disregard of five percent of the federal poverty level (FPL) is granted. For applicants not subject to MAGI, there are program-specific income disregards. See also Federal Poverty Level (FPL) and Modified Adjusted Gross Income (MAGI).

Income Limits

Income limits are used in financial eligibility determinations. They are calculated based on household size and a certain percentage of the federal poverty level (FPL), which varies by program. Medicaid and Children's Health Insurance Program (CHIP) applicants must meet income limits in order to be eligible for services. See also Federal Poverty Level (FPL).

Independent Review Organization (IRO)

An independent review organization (IRO) is a group of medical experts, who are unaffiliated with a managed care organization (MCO) or the Health and Human Services Commission (HHSC), contracted to conduct external medical reviews (EMRs). During an EMR, an IRO can uphold or change an MCO's or HHSC's decision to deny services or program eligibility. See also External Medical Review (EMR).

Inspection

Inspections, such as those conducted by the Office of Inspector General (OIG), are targeted examinations into specific areas of Health and Human Services Commission (HHSC) programs, systems or functions that may identify systemic trends of fraud, waste and abuse.

Instrumental Activities of Daily Living (IADLs)

Instrumental activities of daily living (IADLs) are activities essential to independent daily living—including preparing meals, shopping for groceries or personal items, performing light housework, and using a telephone. Assistance with IADLs is a service offered through state plan long-term services and supports (LTSS) programs—including Personal Care Services (PCS), Community Attendant Services (CAS), Personal Assistance Services (PAS), Primary Home Care (PHC), and Day Activity and Health Services (DAHS). See also Long-Term Services and Supports (LTSS).

Interest List

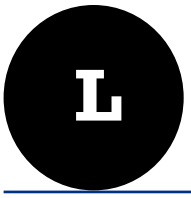
Demand for 1915(c) waiver programs, like Home and Community-based Services (HCS) and Community Living Assistance and Support Services (CLASS), often exceed capacity. Many Medicaid waiver programs maintain interest lists, which individuals can join at any time. When a program slot becomes available, the next person on the interest list may undergo an eligibility determination for the program. If they are found eligible, they may take the open slot. An individual can be on multiple interest lists at the same time and may stay on a program's interest list while enrolled in a different Medicaid program.

Intermediate Care Facility for Individuals with an Intellectual Disability or Related Condition (ICF/IID)

Intermediate care facilities for individuals with an intellectual disability or related condition (ICFs/IID) provide ongoing evaluation and individual program planning—as well as 24-hour supervision, coordination, and integration of health or rehabilitative services—to help individuals with an intellectual disability or related condition function to their greatest ability.

Interstate Compact on the Placement of Children (ICPC)

The Interstate Compact on the Placement of Children (ICPC) is an agreement between all 50 states, the District of Columbia, and the U.S. Virgin Islands, authorizing them to work together to ensure children placed across state lines for foster care or adoption receive adequate protection and support services. It establishes procedures for the placement of children across state lines and responsibilities for the agencies and individuals involved.



Lawful Permanent Resident (LPR)

Legal permanent residents (LPRs) are non-citizens who are lawfully authorized to live permanently within the U.S. They are often called "green card holders."

Level of Care (LOC)

Level of care (LOC) refers to the type and amount of care required by a resident of either a nursing facility or an intermediate care facility for individuals with an intellectual disability or related condition (ICF/IID). It is determined by evaluating the resident's medical, nursing care and personal-care needs. See also Intermediate Care Facility for Individuals with an Intellectual Disability or Related Condition (ICF/IID) and Nursing Facility.

Liquidated Damages (LDs)

Liquidated damages (LDs) are compensation for contractual non-compliance. The Health and Human Services Commission (HHSC) assesses LDs quarterly to address any harm incurred due to managed care organization (MCO) contractual non-compliance.

Local Intellectual and Developmental Disability Authority (LIDDA)

Local intellectual and developmental disability authorities (LIDDAs) serve as the point of entry for publicly funded intellectual and developmental disability (IDD) programs, whether the program is provided by a public or private entity. LIDDAs provide or contract to provide an array of services and supports for persons with IDD and enroll eligible individuals into Medicaid programs, such as intermediate care facilities for individuals with an intellectual disability or related condition (ICFs/IID), Home and Community-based Services (HCS), and Texas Home Living (TxHmL). They are also responsible for Permanency Planning for eligible clients seeking to move from an institutional setting to a community-based setting.

Local Mental Health Authority (LMHA)

Local mental health authorities (LMHAs), along with local behavioral health authorities (LBHAs), evaluate the mental health needs of the communities in their areas and plan, develop policy, and coordinate services and resources to address those needs. LMHAs

provide information, recommendations and referrals to individuals seeking mental health services.

Long-acting Reversible Contraception (LARC)

Through this Better Birth Outcome (BBO) initiative, Texas is working to increase access to this method of contraception to avert unintended pregnancies. Long-acting reversible contraception (LARC) devices are highly effective for preventing pregnancy, are easy to use, and last for several years. The Health and Human Services Commission (HHSC) has established an add-on reimbursement to incentivize utilization of immediate postpartum (IP) LARC for women enrolled in Medicaid for Pregnant Women. See also Better Birth Outcomes (BBO).

Long-term Services and Supports (LTSS)

Rather than treat or cure a disease or condition, long-term services and supports (LTSS) provide an individual support with ongoing, day-to-day activities. Clients typically eligible for LTSS include adults age 65 and older and those with physical or intellectual disabilities. LTSS may be delivered through managed care or fee-for-service (FFS) and in conjunction with a waiver program.

Managed Care

Managed care is a service delivery model where the Health and Human Services Commission (HHSC) contracts with managed care organizations (MCOs) to provide Medicaid and Children's Health Insurance Program (CHIP) services to clients. Overall care of patients under managed care is coordinated by the MCOs as a way to improve quality and control costs. Ninety-two percent of Medicaid clients in Texas are enrolled in managed care—where they select a health plan from the ones available in their service area and a primary care provider that coordinates their care. See also Health Plan, managed care organization (MCO), and Service Area and Primary Care Provider (PCP).

Managed Care Long-term Services and Supports Utilization Review (MLTSS UR)

The Managed Care Long-term Services and Supports Utilization Review (MLTSS UR) team conducts sampled reviews of STAR+PLUS Home and Community-based Services (HCBS) to determine how they, as managed care organizations (MCOs), conduct assessments and

use procedures and related information to determine appropriateness of member enrollment. The review includes ensuring MCOs are providing services according to their assessment of service needs.

Managed Care Organization (MCO)

A managed care organization (MCO) delivers and manages health services under a risk-based arrangement. The Health and Human Services Commission (HHSC) contracts with MCOs and pays them a per member per month (PMPM) rate, or capitation payment. MCOs are required to provide all covered, medically necessary services to their members, and are incentivized to control costs. Generally, Medicaid clients have a choice between at least two MCOs, or health plans, operating in their service area. See also Capitation Rate and Per Member Per Month (PMPM).

Managed Care Report Card

A managed care report card evaluates a managed care organization's (MCO's) performance using a one- through five-star rating system. Ratings are developed by surveying current members and analyzing claims data, and are updated yearly. Report cards are available on the Health and Human Services Commission (HHSC) website and are provided in all Medicaid and Children's Health Insurance Program (CHIP) enrollment packets.

Mandatory Benefits

The Social Security Act specifies a set of benefits state Medicaid programs must provide, or mandatory benefits. The state may also choose to provide some, all or no optional services specified under federal law. See also Appendix B, page 130, for a complete list of mandatory and optional benefits. See also Optional Benefits.

Matching Funds

Federal funds are a critical component of health care financing for the state of Texas. The amount of federal Medicaid funds that Texas receives is based primarily on the federal medical assistance percentage (FMAP), or Medicaid matching rate. The federal Children's Health Insurance Program (CHIP) funds that Texas receives are based on the enhanced federal medical assistance percentage (EFMAP).

Maternal Opioid Misuse (MOM) Model

The Maternal Opioid Misuse (MOM) model is a five-year project that seeks to facilitate better integration of prenatal care, addiction medicine and psychiatric care for pregnant women with an opioid use disorder (OUD) who are enrolled in Medicaid.

Medicaid

A joint federal-state entitlement program that pays for medical care on behalf of certain groups of low-income persons. The program was enacted federally in 1965 under Title XIX of the Social Security Act. Texas participation in Medicaid began September 1, 1967.

Medicaid Breast and Cervical Cancer (MBCC) Program

The Medicaid Breast and Cervical Cancer (MBCC) program provides Medicaid to eligible women diagnosed with breast or cervical cancer, including pre-cancerous conditions. To get MBCC, a woman must receive a screening at a Breast and Cervical Cancer Services (BCCS) clinic and apply for the program through the clinic. Women who have MBCC are enrolled into STAR+PLUS. Women remain eligible for MBCC if they are receiving active treatment, such as chemotherapy or radiation for breast or cervical cancer. See also Breast and Cervical Cancer Services (BCCS).

Medicaid Buy-In for Children (MBIC)

The Medicaid Buy-In for Children (MBIC) program offers low-cost Medicaid services to children with disabilities in families that make too much money to get Medicaid. Children with family countable income at or below 300 percent of the federal poverty level (FPL) may qualify for the program, and households at or below 10 percent of the FPL will not pay a premium. MBIC families make monthly payments according to a sliding scale that is based on family income.

Medicaid Buy-In (MBI) for Workers with Disabilities

The Medicaid Buy-In (MBI) for Workers with Disabilities program offers low-cost Medicaid services to adults with disabilities who work. Individuals with income below 250 percent of the federal poverty level (FPL) and resources at or below $5,000 may qualify and may pay a monthly premium to receive Medicaid benefits.

Medicaid Estate Recovery Program (MERP)

The Medicaid Estate Recovery Program (MERP) is required by federal and state law to recover—after time of death—certain long-term care and associated Medicaid costs of services provided to recipients age 55 and older.

Medicaid for Former Foster Care Children (FFCC)

Medicaid for Former Foster Care Children (FFCC) covers Medicaid clients who aged out of the foster care system in Texas at age 18 and who were receiving federally funded Medicaid when they aged out of foster care. FFCC clients are automatically enrolled in STAR Health through the month of their 21st birthday. Individuals may opt out of STAR

Health for STAR, which allows for a choice of health plans. After an individual attains age 21, coverage will transfer to STAR. FFCC clients may continue to be eligible up to the month of their 26th birthday. See also Medicaid for Transitioning Foster Care Youth (MTFCY).

Medicaid for Parents and Caretaker Relatives

Medicaid for Parents and Caretaker Relatives is a program for adults who are a related caretaker for a child who already has Medicaid and who meet the program's income limits.

Medicaid for Pregnant Women

Medicaid for Pregnant Women provides health coverage to low-income pregnant women—including acute care services, like prenatal care, labor and delivery, and postpartum care. Texas elects to extend Medicaid eligibility to pregnant women with a household income at or below 198 percent of the federal poverty level (FPL)—well above the federal requirement of 133 percent of the FPL. Pregnant women who qualify receive services through the STAR program. Newborns, whose mothers qualified for Medicaid for Pregnant Women or Emergency Medicaid for their labor and delivery, are enrolled into Children's Medicaid and receive 12 months of continuous coverage from their date of birth.

Medicaid for the Elderly and People with Disabilities (MEPD)

Medicaid for the Elderly and People with Disabilities (MEPD) serves people age 65 and older and individuals with disabilities who do not receive Supplemental Security Income (SSI). Individuals may qualify for this program through a facility, such as a nursing facility or an intermediate care facility for individuals with an intellectual disability or related condition (ICF/IID). MEPD covers long-term services and supports (LTSS), including long-term care facilities and state plan home and community-based services. See also Long-term Services and Supports (LTSS).

Medicaid for Transitioning Foster Care Youth (MTFCY)

Medicaid for Transitioning Foster Care Youth (MTFCY) covers former foster care youth who were not receiving Medicaid when they aged out of foster care at age 18. Such individuals are eligible through the month of their 21st birthday to receive services through the fee-for-service or managed care models. See also Medicaid for Former Foster Care Children (FFCC).

Medicaid Hospice Services

Medicaid hospice services are palliative care consisting of medical, social and support services to terminally ill individuals and their loved ones—when curative treatment is no

longer desired or possible and a physician has indicated the individual has six months or less to live.

Medicaid Lock-in Program

The Medicaid Lock-in Program is an Office of Inspector General (OIG) oversight, prescription drug program that operates by limiting clients to receiving or purchasing their prescriptions to one provider or pharmacy—in order to prevent the abuse or overuse of controlled substances. Individuals enrolled can only purchase their prescriptions from the pharmacy to which they are "locked in."

Medicaid-Medicare Plan (MMP)

Medicaid-Medicare Plans (MMPs) are designed to provide a fully integrated managed care model for individuals age 21 and older, who are dually eligible for Medicare and Medicaid. The model involves a three-party contract—between an MMP, the Health and Human Services Commission (HHSC), and the Centers for Medicare and Medicaid Services (CMS)—for the provision of the full array of Medicaid and Medicare services. All covered services, including acute care and long-term services and supports (LTSS), are provided by a single health plan. Participating individuals are required to be enrolled in STAR+PLUS. If eligible, individuals are passively enrolled into the program, but may choose to opt-out. MMPs operate in Bexar, Dallas, El Paso, Harris, Hidalgo and Tarrant counties.

Medical Home

A medical home consists of a patient's primary care provider (PCP) who delivers comprehensive preventive and primary care and provides referrals for specialty care and other covered services. See also Primary Care Provider (PCP).

Medical Necessity

Medical necessity is a measure used to determine an individual's eligibility for a program or service. Authorized providers assess whether a program or service is reasonable, appropriate and consistent with health care practice guidelines. The Health and Human Services Commission (HHSC) uses medical necessity to determine eligibility for programs and services delivered through fee-for-service. Managed care organizations (MCOs) also use medical necessity to make eligibility determinations for the programs and services they deliver. HHSC monitors the medical necessity determination for all MCOs through utilization reviews (URs). See also Utilization Reviews (URs).

Medical Transportation Program (MTP)

The Medical Transportation Program (MTP) is responsible for ensuring consistent, appropriate, reasonably prompt and cost-effective non-emergency medical transportation services to eligible Medicaid clients who need transportation to covered health care services.

Medically Dependent Children Program (MDCP)

The Medically Dependent Children Program (MDCP) is a 1915(c) waiver program delivered through the STAR Kids managed care program. MDCP provides a cost-effective alternative to living in a nursing facility to children with disabilities. Eligibility determinations for MDCP are based on medical necessity criteria outlined in the Texas Administrative Code. Managed care organizations (MCOs) provide medical necessity assessments, which are used by the Health and Human Services Commission (HHSC) to help determine whether an individual qualifies for MDCP. MDCP has an interest list. See also Appendix B, page 135, for a full list of MDCP services. See also STAR Kids.

Medically Needy with Spend Down Program

Through the Medically Needy with Spend Down Program, Medicaid pays for unpaid medical expenses for medical services provided to children age 18 and younger and pregnant women who meet the required Spend Down limits. Spend Down is the difference between an applicant's household income and the Medically Needy income limit. Applicants must have unpaid medical bills that exceed the Spend Down amount to receive benefits under the program. See also Medicaid for Pregnant Women.

Medicare Advantage Dual Eligible Special Needs Plan (D-SNP)

A Medicare Advantage Dual Eligible Special Needs Plan (D-SNP) is a managed care delivery model specifically designed to coordinate care between Medicare and Medicaid covered services for individuals who are dually eligible for both programs. D-SNPs can serve both full and partial benefit dual eligibles. D-SNPs can operate within or without the STAR+PLUS program. If in STAR+PLUS, a D-SNP must deliver Medicaid services through STAR+PLUS. D-SNPs that do not operate in STAR+PLUS are only responsible for covering member cost-sharing payments.

Medicare Savings Program

Through the Medicare Savings Program, Medicaid provides limited assistance to certain Medicare beneficiaries, known as partial dual eligibles, who do not qualify for full Medicaid benefits. Individuals in this program receive assistance with all or a portion of Medicare premiums, deductibles and coinsurance payments through Medicaid.

Medication Assisted Therapy (MAT)

Medication Assisted Therapy (MAT) is the use of medications in combination with counseling and behavioral therapies for the treatment of substance use disorders (SUDs), which can help some people sustain recovery. An example is the use of methadone for opioid use disorder (OUD).

Members with Special Health Care Needs (MSHCN)

Members with special health care needs (MSHCN) refers to managed care clients who either (a) require regular, ongoing therapeutic intervention and evaluation by appropriately trained personnel, or (b) have a serious, ongoing illness; a chronic or complex condition; or a disability that has lasted or is anticipated to last for a significant period of time. MSHCN may include women with high-risk pregnancies, members with high-cost catastrophic cases, and individuals with mental illness and co-occurring substance abuse. All members in STAR+PLUS and STAR Kids are considered MSHCN.

Modified Adjusted Gross Income (MAGI)

Modified Adjusted Gross Income (MAGI) is a tool used for financial eligibility determinations. MAGI uses federal income tax rules for determining income and household composition. Federal law requires financial eligibility for programs like Medicaid be determined using MAGI, except for people age 65 and older, individuals with disability, and those receiving Supplemental Security Income (SSI).

Mystery Shopper Method

The state's external quality review organization (EQRO) uses the mystery shopper method to evaluate whether providers meet appointment availability standards and to quantify the extent of provider directory issues. Using contact information provided by managed care organizations (MCOs), mystery shoppers contact network providers to see how quickly they can get appointments across all Medicaid programs.

National Core Indicators-Aging and Disabilities (NCI-AD) Survey

On a biennial basis, the Health and Human Services Commission (HHSC) participates in the National Core Indicators-Aging and Disabilities (NCI-AD) survey, which is similar to the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. This

allows the state to assess outcomes of services provided to members who participate in STAR+PLUS Home and Community-based Services (HCBS) and the Program of All-Inclusive Care for the Elderly (PACE).

Network Adequacy

Network adequacy refers to access to care standards that the provider networks of managed care organizations (MCOs) must meet in order to ensure clients are able to access all medically necessary covered services. Provider networks must establish minimum provider access standards—including minimum distance, travel time and appointment availability for member access to providers; expedited credentialing for certain provider types as specified by the Health and Human Services Commission (HHSC); and online publication of provider directories, with provider information updated at least weekly.

Non-financial Criteria

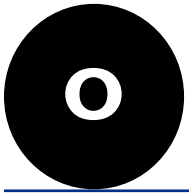
In addition to meeting financial eligibility criteria, applicants must meet non-financial criteria—including that they meet program-specific age limits, reside and intend to remain in Texas, provide a Social Security number (SSN) or apply for one, and meet citizenship or alien status program requirements. See also Qualified Aliens.

Non-preferred Prior Authorization

Non-preferred prior authorization may occur when prescribers choose medications listed on the Preferred Drug List (PDL) as "non-preferred" for their Medicaid patients. To prescribe the medication, the provider must obtain prior authorization from the Health and Human Services Commission (HHSC) or the patient's managed care organization (MCO) before the drug is dispensed. See also Clinical Prior Authorization, Preferred Drug List (PDL) and Prior Authorization.

Nursing Facility

Nursing facilities are long-term care facilities that provide services to meet the medical, nursing and psychological needs of people who have a level of medical necessity requiring nursing care on a regular basis.



Office of Inspector General (OIG)

The Office of Inspector General (OIG) is charged with safeguarding state health and human services by detecting and preventing fraud, waste and abuse and by ensuring the health and safety of Texans. The OIG engages in variety of activities related to Medicaid program integrity, including investigations, audits, inspections and reviews.

Operational Review

An operational review allows the Health and Human Services Commission (HHSC) to conduct an in-depth review of a managed care organization's (MCO's) operational compliance and performance across a number of areas to ensure policies and practices align with performance standards. HHSC conducts on-site biennial operational reviews of MCOs—including review modules on claims processing, member and provider training, complaints/appeals, encounter data, utilization management, and website critical elements.

Optional Benefits

The Social Security Act specifies a set of benefits state Medicaid programs must provide and a set of optional benefits states may choose to provide. The state may choose to provide some, all, or no optional services specified under federal law. See also Mandatory Benefits.

Pay-for-Quality (P4Q)

Pay-for-quality (P4Q) refers to programs that seek to reward the use of evidence-based practices and promote health care coordination and efficacy among managed care organizations (MCOs). The Health and Human Services Commission (HHSC) implements medical P4Q programs for STAR, STAR+PLUS, Children's Health Insurance Program (CHIP), and a dental P4Q program. Strong P4Q programs incentivize MCOs to pursue quality-based alternative payment models (APMs) with providers to help them achieve higher performance on P4Q measures. See also Alternative Payment Model (APM).

Pediatric Quality Indicator (PDI)

Pediatric quality indicators (PDIs), which are similar to prevention quality indicators (PQIs), use hospital discharge data to measure quality of care for ambulatory care sensitive conditions—which are conditions where effective outpatient care or early intervention can prevent hospitalization, complications or more severe disease. PDIs specifically screen for problems that children and youth may experience. See also Prevention Quality Indicators (PQIs).

Performance Improvement Project (PIP)

Performance improvement projects (PIPs) are an integral part of Texas' Managed Care Quality Improvement Strategy. Federal regulations require all states with Medicaid managed care programs to ensure health plans conduct PIPs. PIPs must use ongoing measurements and interventions to achieve significant improvement, over time, in health outcomes and enrollee satisfaction. Health plans conduct PIPs to improve areas of care identified by the Health and Human Services Commission (HHSC), in consultation with Texas' external quality review organization (EQRO), as needing improvement. See also External Quality Review Organization (EQRO).

Per Member Per Month (PMPM)

Per member per month (PMPM) rates are calculated for each risk group within each of the service areas in Texas—based on encounter data—and form the basis for the capitation rates paid to managed care organizations (MCOs) for the delivery of contractually required Medicaid and Children's Health Insurance Program (CHIP) services. See also Capitation Rate and Encounter Data.

Personal Assistance Services (PAS)

Personal Assistance Services (PAS) are state plan, community-based, long-term services and supports (LTSS) benefits for children and adults. PAS includes assistance with activities of daily living (ADLs) or instrumental activities of daily living (IADLs). In managed care, PAS can be delivered as an entitlement service, through the STAR+PLUS home and community-based services component, or through Community First Choice (CFC).

Personal Care Services (PCS)

Personal Care Services (PCS) are state plan, community-based, long-term services and supports (LTSS) benefits for children that include assistance with activities of daily living (ADLs) or instrumental activities of daily living (IADLs).

Pharmacy Benefits Manager

Each Medicaid and Children's Health Insurance Program (CHIP) managed care organization (MCO) contracts with a pharmacy benefits manager (PBM) to process prescription claims. The PBMs contract and work with pharmacies that dispense medications to Medicaid and CHIP managed care clients. MCOs must allow any pharmacy provider that is willing to accept the financial terms and conditions of the contract to enroll in the MCO's network.

Postpartum Depression

Postpartum depression is a mental health disorder that women may experience after giving birth. Symptoms must meet the diagnostic criteria set forth in the latest edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM).

Potentially Preventable Admission (PPA)

A potentially preventable admission (PPA) is a hospital admission or long-term care facility stay that might have been reasonably prevented with adequate access to ambulatory care or health care coordination. See also Potentially Preventable Event (PPE).

Potentially Preventable Complication (PPC)

A potentially preventable complication (PPC) is a harmful event or negative outcome, such as an infection or surgical complication, that occurs after a hospital admission or a long-term care facility stay and that might have resulted from care, lack of care or treatment during the admission or stay. See also Potentially Preventable Event (PPE).

Potentially Preventable Emergency Department Visit (PPV)

A potentially preventable emergency department visit (PPV) is emergency treatment for a condition that could have been treated or prevented by a physician or other health care provider in a non-emergency setting. See also Potentially Preventable Event (PPE).

Potentially Preventable Event (PPE)

Potentially preventable events (PPEs) are encounters, which could be prevented, that lead to unnecessary services or contribute to poor quality of care. PPEs are used to measure care quality. See also Potentially Preventable Hospital Admission (PPA), Potentially Preventable Complication (PPC), Potentially Preventable Readmission (PPR), and Potentially Preventable Emergency Department Visit (PPV).

Potentially Preventable Readmission (PPR)

A potentially preventable readmission (PPR) is a return hospitalization, within a set time, that might have resulted from problems in care during a previous hospital stay or from deficiencies in a post-hospital discharge follow up. See also Potentially Preventable Event (PPE).

Preadmission Screening and Resident Review (PASRR)

A Preadmission Screening and Resident Review (PASRR) supports individuals with a mental illness, intellectual disability or developmental disability—who are at higher risk for moving into a nursing facility—to live independently in the community or most integrated setting of their choice. The PASRR process identifies the goals, wishes, and needed services and supports for these individuals to live a person-centered life—safely, and integrated within their community. If an individual is at risk of moving into a nursing facility and needs higher level supports and services to remain with their family or in the community, then these individuals are PASRR positive and are eligible for these enhanced levels of care.

Preferred Drug List

The Preferred Drug List (PDL) is a tool used to control growing Medicaid drug costs, while also ensuring program recipients are able to obtain medically necessary medicines. The PDL in Texas classifies drugs as preferred or non-preferred based on safety, efficacy and cost-effectiveness. Prescribers who choose non-preferred medications for their patients must obtain prior authorization. The Vendor Drug Program (VDP) and its vendors perform supplemental rebate negotiation with manufacturers and manage the PDL centrally across all Medicaid programs. Participating MCOs must use the PDL in administering pharmacy benefits to their members. See also Texas Drug Utilization Review (DUR) Board and Vendor Drug Program (VDP).

Prescription Drugs

Prescription drugs are pharmaceuticals that require a medical prescription from a provider to be dispensed. Outpatient prescription drugs are a benefit of Children's Health Insurance Program (CHIP) and all managed care programs. For those enrolled in fee-for-service (FFS) Medicaid, Texas pays for all outpatient drug coverage through the Vendor Drug Program (VDP). See also Vendor Drug Program (VDP).

Prevention Quality Indicator (PQI)

Prevention quality indicators (PQIs) use hospital discharge data to measure quality of care for ambulatory care sensitive conditions—which are conditions where effective outpa-

tient care or early intervention can prevent hospitalization, complications or more severe disease.

Primary Care Provider (PCP)

In managed care, primary care providers (PCPs) coordinate the care of Medicaid and CHIP clients and are responsible for providing initial and primary care to patients, maintaining continuity of care, and making referrals to specialists. PCPs tend to be general practitioners, family practice doctors, pediatricians, OB/GYNs, specialty trained nurses, or health clinics. Once enrolled into one of the managed care programs, clients pick a health plan, which includes a directory of PCPs contracting with that plan.

Primary Home Care (PHC)

Primary Home Care (PHC) services are state plan, community-based, long-term services and supports (LTSS) benefits for children and adults that include assistance with activities of daily living (ADLs) or instrumental activities of daily living (IADLs).

Prior Authorization

A prior authorization is issued by a member's physician to document the medical necessity of a medication or medical service in certain situations before a managed care organization (MCO) can approve that medication or service. See also Clinical Prior Authorization and Non-clinical Prior Authorization.

Profit Limit

Managed care organizations (MCOs) are paid on a per member per month (PMPM) basis, also called a capitation rate. This rate includes a risk margin to account for fluctuations in predicted claims cost. This risk margin may result in profit for the plan. However, MCO profits are contractually limited and any profits earned over three percent are considered excessive profit and recovered by the Health and Human Services Commission (HHSC) through a tiered-experience rebate system. See also Per Member Per Month (PMPM) and Risk Margin.

Program of All-inclusive Care for the Elderly (PACE)

Program of All-inclusive Care for the Elderly (PACE) is a comprehensive care approach providing an array of services for a capitated monthly fee that is below the cost of comparable institutional care. PACE participants must be age 55 and older, live in a PACE service area, qualify for nursing facility level of care, and be able to live safely in the community at the time of enrollment. PACE participants receive all medical and social services needed through their PACE provider. PACE is available in Amarillo/Canyon, El Paso and Lubbock.

Promoting Independence (PI) Initiative

The Promoting Independence (PI) Initiative, also called Money Follows the Person (MFP) policy, provides the opportunity for individuals in need of long-term services and supports (LTSS) to move from facilities to community-based services. This better allows individuals to choose how and where they receive their LTSS. Other support services have since been developed to help identify individuals who want to leave an institutional setting and to assist them in relocating back to the community. PI is considered a reserve capacity group. See also Reserve Capacity Group.

Prospective Drug Utilization Review (DUR)

Prospective Drug Utilization Reviews (DURs) evaluate each client's drug history before medication is dispensed to ensure appropriate and medically necessary utilization. Therapeutic criteria for prospective DURs is determined by the Texas Drug Utilization Review (DUR) Board. See also Texas Drug Utilization Review (DUR) Board.

Prospective Payment System (PPS)

A prospective payment system (PPS) is a method of reimbursement in which payment is made based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system of that service. PPSs are used for inpatient and outpatient hospital reimbursement and rural health clinics (RHCs) reimbursement. Federally Qualified Health Centers (FQHCs) may be reimbursed using a PPS system or an alternative prospective payment system (APPS). PPS rates are inflated annually using the Medicare Economic Index (MEI) for primary care. See also Alternative Prospective Payment System (APPS).

Provider Agency

Provider agencies are the employers of attendants or other direct service workers, who provide long-term services and supports (LTSS), and are responsible for all of the employment and business operations-related activities. Provider agencies are licensed or certified by the Health and Human Services Commission (HHSC) and must comply with HHSC licensure and program rules.

Provider Credentialing

The process through which managed care organizations (MCOs) ensure that each health care provider meets all professional standards, including licensure.

Provider Enrollment Screening

The Office of Inspector General (OIG), in close collaboration with the Health and Human Services Commission (HHSC), completes the required state and federal disclosure and screening activities for high-risk providers seeking to enroll, re-enroll or revalidate their enrollment in Medicaid and other HHSC programs. See Office of Inspector General (OIG).

Psychiatric Hospital

A psychiatric hospital is an institution primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally ill people. The provisions for certification apply only where the entire institution is primarily for the treatment of mental illness. A psychiatric wing of a general hospital may not be certified.

Qualified Aliens

Qualified aliens are non-citizen, Texas residents who are potentially eligible for certain programs like Medicaid. Qualified aliens may be subject to different requirements, such as waiting periods and time-based eligibility limitations. There are several categories, including but not limited to: Legal Permanent Residents (LPRs), asylees and refugees, and victims of human trafficking. See also Legal Permanent Resident (LPR).

Qualified Disabled Working Individuals

Qualified Disabled Working Individuals are dually eligible individuals who can receive partial, but not full, Medicaid benefits. Their income must be less than or equal to 200 percent of the federal poverty level (FPL). The Texas Medicaid program pays Medicare Part A premiums for disabled working individuals.

Quality Assessment and Performance Improvement (QAPI) Projects

Federal regulations require Medicaid health plans to develop, maintain and operate quality assessment and performance improvement (QAPI) programs. QAPI programs are ongoing, comprehensive quality assessment and performance improvement programs for all the services that the managed care organization (MCO) provides.

Quality Incentive Payment Program (QIPP)

The Quality Incentive Payment Program (QIPP) seeks to improve quality and innovation in the provision of nursing facility services. Both public and private nursing facilities can participate in the program. Payments are made quarterly by the STAR+PLUS managed care organizations (MCOs) to the nursing facilities, based on their completion of required quality improvement activities and their performance on agreed-upon quality measures.

Readiness Reviews

The Health and Human Services Commission (HHSC) conducts readiness reviews to determine if a managed care organization (MCO) can provide the services that they are being contracted to provide. Readiness reviews are completed at least 90 days prior to the operational start of a contract to provide enough time to identify and remedy operational issues prior to contract start date.

Regional Healthcare Partnership (RHP)

Under the 1115 Transformation waiver, eligibility to receive Uncompensated Care (UC) or Delivery System Reform Incentive Payment (DSRIP) payments requires participation in one of the 20 Regional Healthcare Partnerships (RHPs) across Texas. RHPs collaborate to develop meaningful delivery system reforms and improve patient care for low-income populations. RHP plans include projects outlined in the RHP planning protocols. See also Regional Healthcare Partnership (RHP) Planning Protocols.

Regional Healthcare Partnership (RHP) Planning Protocols

Funds for the Delivery System Reform Incentive Payment (DSRIP) pool are divided into four categories, according to the Regional Healthcare Partnership (RHP) planning protocols: infrastructure development projects, program innovation and redesign projects, quality improvements, and population-focused improvements. Each of these four categories allow for the testing and piloting of new delivery system reforms, and assessments of their impact. See also Delivery System Reform Incentive Payment (DSRIP) Pool.

Research and Demonstration 1115 Waivers

Research and Demonstration 1115 waivers allow flexibility for states to test new ideas for operating their Medicaid programs—including implementing statewide health system

reforms; providing services not typically covered by Medicaid; or allowing innovative service delivery systems to improve care, increase efficiencies and reduce costs.

Reserved Capacity Group

A portion of 1915(c) waiver program slots are set aside for individuals in reserve capacity groups. When a waiver program slot opens, an individual from a reserve capacity group bypasses the general interest list and is given an eligibility determination for the program. Examples of reserved capacity groups are: Crisis Diversion and the Promoting Independence (PI) Initiative. See also Crisis Diversion.

Resource-based Fee (RBF)

Under the fee-for-service (FFS) delivery model, resource-based fees (RBFs) are a type of Medicaid rate used to pay physicians and other practitioners for services. Rates are uniform statewide and are categorized as either RBFs or access-based fees (ABFs). RBFs are calculated based on the actual resources required by an economically efficient provider to deliver a service. Reimbursement rates for services outlined above are evaluated at least once every two years as a part of a biennial fee review process. See also Access-based Fee (ABF) and Fee-for-Service (FFS) Rates.

Retrospective Drug Utilization Review (DUR)

Retrospective Drug Utilization Reviews (DURs) examine drug therapy after the person has received the medication. Retrospective DURs evaluates claims data to analyze prescribing practices, a person's medication use and pharmacy dispensing practices. The Health and Human Services Commission (HHSC) and managed care organizations (MCOs) conduct multiple reviews each calendar year on topics—such as identifying patterns of drug misuse, medically unnecessary prescribing or inappropriate prescribing. Intervention letters are sent to physicians to help better manage a person's drug therapy. The Texas Drug Utilization Review (DUR) Board also reviews and approves the retrospective DURs for fee-for-service (FFS). See also Texas Drug Utilization Review (DUR).

Risk Margin

In capitation rate setting, a risk margin is added in case of possible fluctuations in predicted claims cost. This margin is calculated as a percentage of the initial capitation rate. To the extent that a managed care organization (MCO) successfully manages member care and keeps medical costs and administrative costs on target, the risk margin may result in profit for the health plan. The Health and Human Services Commission (HHSC) has reduced the risk margin for most programs, and this new lower risk margin could potentially translate to additional profit limits. See also Capitation Rates and Profit Limits.

Rural Health Clinics (RHC)

A rural health clinic (RHC) is a clinic located in a rural area, designated by the U.S. Health Resources and Services Administration as a "shortage area." To qualify as an RHC, the clinic must be located in a non-urbanized and medically underserved area and have a nurse practitioner or physician assistant in the clinic 50 percent of the time. An RHC may not exist as a rehabilitation agency or serve primarily as a treatment facility for mental diseases.

Rural Hospital

A rural hospital is typically categorized by its location outside of a city or metropolitan area and by its size and caseload, which are usually considerably smaller than urban hospitals.

School Health and Related Services (SHARS)

The School Health and Related Services (SHARS) program reimburses independent school districts, including public charter schools, for providing Medicaid services to children with disabilities. This program covers certain health-related services documented in a student's Individualized Education Program or, for audiology services only, a student's 504 plan. Services include audiology services; counseling; physician and nursing services; physical, speech, and occupational therapies; personal care services; and psychological services, such as assessments and transportation in a school setting.

Service Area (SA)

Service areas (SAs) are the geographic locations within the state where services are delivered by certain health plans and their providers. SAs may also be referred to as Service Delivery Areas (SDAs).

Service Comparability

In general, the state is required to provide the same level of services to all clients, except where federal law specifically requires a broader range of services or allows a reduced package of services.

Service Coordination

Managed care organizations (MCOs) are required to provide service coordination to STAR Health, STAR Kids and STAR+PLUS members who meet the eligibility criteria. Service coordination, as well as eligibility for the service, may be defined differently by program. For example, children in STAR Kids are automatically eligible for this service, while adults in STAR+PLUS must have complex health needs to receive service coordination. See also Service Management. See also A Closer Look, page 43.

Service Management

Managed care organizations (MCOs) are required to provide service management for STAR, STAR Health, and Children's Health Insurance Program (CHIP) members who meet the eligibility criteria. Like service coordination, the definition and eligibility criteria for service management may be defined differently by program. See also Service Coordination. See also A Closer Look, page 43.

Service Responsibility Option

Service Responsibility Option (SRO) is available in Medicaid managed care programs, Community Attendant Services (CAS), and Primary Home Care (PHC). SRO is a hybrid of the agency option and Consumer Directed Services (CDS) option–in which an individual, the provider agency, and when applicable the managed care organization (MCO) work together to provide the individual with increased control over the delivery of their services. In Medicaid managed care, services with the CDS option also have SRO. See also Consumer Directed Services (CDS) Option.

Single State Agency

As required by federal law, a single agency must be designated by each state to administer and supervise the administration of the Medicaid state plan. In Texas, the Health and Human Services Commission (HHSC) fulfills this function. See also Health and Human Services Commission (HHSC).

STAR

STAR is a statewide managed care program primarily for pregnant women, low-income children and their caretakers. Most people in Texas Medicaid get their coverage through STAR.

STAR Health

STAR Health is a statewide managed care program that provides coordinated health services to children and youth in foster care and kinship care. STAR Health benefits

include medical, dental and behavioral health services—as well as service coordination and a web-based electronic medical record, known as the Health Passport.

STAR Kids

STAR Kids is a statewide managed care program for children and youth age 20 and younger with disabilities, including children and youth receiving benefits under the Medically Dependent Children Program (MDCP) waiver.

STAR+PLUS

STAR+PLUS is a statewide managed care program for adults with disabilities and those age 65 and older.

STAR+PLUS Home and Community-based Services (HCBS) Program

STAR+PLUS Home and Community-based Services (HCBS) is a waiver program delivered through managed care that provides a cost-effective alternative to living in a nursing facility for individuals who are elderly or have disabilities. STAR+PLUS HCBS is delivered through the Texas 1115 Healthcare Transformation Waiver. Eligibility determinations for STAR+PLUS HCBS are based on medical necessity criteria outlined in the Texas Administrative Code. Managed care organizations (MCOs) provide medical necessity assessments, which are used by the Health and Human Services Commission (HHSC) to help determine whether an individual qualifies for STAR+PLUS HCBS. STAR+PLUS HCBS has an interest list. See also Appendix B, page 135, for a full list of STAR+PLUS HCBS services. See also STAR+PLUS.

State-owned Teaching Hospital

Teaching hospitals provide medical education, including post-graduate residency training programs, which incur higher expenses than hospitals without these programs. The portion of these costs attributable to serving Medicaid patients may be covered by Graduate Medical Education (GME) payments. See also Graduate Medical Education (GME) payments.

State Plan

State plans describe the nature and scope of the Medicaid program, including administration, client eligibility, benefits and provider reimbursement. All state plans must be approved by the Centers for Medicare and Medicaid Services (CMS). The state plan in Texas gives the Health and Human Services Commission (HHSC), as the single state agency, the authority to administer the Medicaid program. See also Single State Agency.

State Supported Living Center (SSLC)

State Supported Living Centers (SSLCs) are certified intermediate care facilities for individuals with an intellectual disability or related condition (ICFs/IID) that serve individuals with an intellectual disability who have medical or behavioral health needs. SSLCs provide 24-hour residential services, comprehensive behavioral treatment, health care, and other services in a campus setting.

Statewide Availability

In general, a state must offer the same benefits to everyone throughout the state. Exceptions to this requirement are possible through Medicaid waiver programs and special contracting options.

Substance Use Disorder (SUD)

A substance use disorder (SUD) occurs when an individual's use of a substance, such as alcohol or opioids, leads to health issues or problems in everyday life—work, school or home. The pattern must meet the diagnostic criteria set forth in the latest edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM). The benefits of Medicaid SUD treatment include assessment, outpatient treatment, medication assisted therapy (MAT), and residential and ambulatory detoxification. Services must be provided by a chemical dependency treatment facility (CDTF). See also Medication Assisted Therapy (MAT).

Sufficient Coverage

Federal law allows states to determine what constitutes "reasonably sufficient" coverage in terms of the amount, duration and scope of services. Each state defines these parameters; thus, state Medicaid plans vary in what and how much they cover.

Supplemental Hospital Funding

The Health and Human Services Commission (HHSC) administers supplemental hospital payment programs that help cover the cost of uncompensated care, incentivize improvements to care quality and fund graduate medical education. Examples include the Uncompensated Care (UC) and Delivery System Reform Incentive Payment (DSRIP) pools created under the 1115 Transformation waiver. See also Delivery System Reform Incentive Payment (DSRIP) Pool, Uncompensated Care (UC) Pool, and 1115 Transformation Waiver.

Supplemental Nutrition Assistance Program (SNAP)

The Supplemental Nutrition Assistance Program (SNAP), also known as food stamps, helps people buy the food they need for good health.

Supplemental Security Income (SSI)

Supplemental Security Income (SSI) is a federal cash assistance program for low-income individuals with disabilities and those age 65 and older. In Texas, all people eligible for SSI are automatically eligible for Medicaid.

Suspension of Default Enrollment

Suspension of default enrollment is a contractual non-compliance remedy that temporarily stops a managed care organization (MCO) from receiving clients through the default enrollment process. See also Default Enrollment.

Targeted Review

The Health and Human Services Commission (HHSC) conducts a targeted review of a managed care organization (MCO) when a significant or recurring problem occurs. The scope, entity and focus of targeted reviews vary based on the topics raised by complaints received and past instances of non-compliance.

Temporary Assistance for Needy Families (TANF)

The Temporary Assistance for Needy Families (TANF) program is a cash-assistance program that helps families pay for basic living needs.

Texas Department of Family and Protective Services (DFPS)

The Texas Department of Family and Protective Services (DFPS) is responsible for investigating charges of abuse, neglect or exploitation of children, elderly adults and adults with disabilities. DFPS also manages children in state conservatorship or foster care.

Texas Department of Insurance (TDI)

The Texas Department of Insurance (TDI) regulates both commercial and state-funded health insurance plans because managed care organizations (MCOs) are licensed as Health Maintenance Organizations (HMOs) in Texas. TDI requires MCOs to file a network adequacy report once a year. See also Network Adequacy.

Texas Drug Utilization Review (DUR) Board

The Texas Drug Utilization Review (DUR) Board is a Health and Human Services Commission (HHSC) advisory board whose members are appointed by the HHSC Executive Commissioner. The duties of the Texas DUR Board include developing and submitting recommendations to HHSC for the Preferred Drug List (PDL), suggesting restrictions or prior authorizations for certain prescription drugs, developing and reviewing educational interventions for Medicaid providers, and reviewing drug utilization across the Medicaid program. See also Clinical Prior Authorization and Preferred Drug List (PDL).

Texas Formulary

The Texas Formulary is a list of all the drugs covered by Texas Medicaid and the Children's Health Insurance Program (CHIP).

Texas Healthcare Learning Collaborative (THLC)

Texas Healthcare Learning Collaborative (THLC) is a website that serves as a public reporting platform, contract oversight tool, and a tool for managed care organization (MCO) quality improvement efforts. It was developed for use by the Health and Human Services Commission (HHSC), MCOs, providers, and the general public to obtain up-to-date MCO and hospital performance data on key quality-of-care measures—including potentially preventable events (PPEs), Healthcare Effectiveness Data and Information Set (HEDIS) data, and other quality-of-care information.

Texas Health Steps

Texas Health Steps is a required program, known in federal law as the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. Texas Health Steps provides medical and dental prevention and treatment services for children of low-income families, who are age 20 and younger and are enrolled in Medicaid. The program offers comprehensive and periodic evaluation of a child's health—including growth and development; nutritional status; and vision, dental and hearing care. See also Comprehensive Care Program (CCP).

Texas Home Living (TxHmL)

Texas Home Living (TxHmL) is a 1915(c) waiver program that provides community-based services to current Medicaid recipients with intellectual disabilities or related conditions, as an alternative to an intermediate care facility for individuals with an intellectual disability or related condition (ICF/IID). Eligibility determinations for TxHmL are based on level of care (LOC) criteria outlined in the Texas Administrative Code. TxHmL has an interest list. See also Appendix B, page 136, for a full list of TxHmL services.

Texas Neonatal Intensive Care Unit (NICU) Project (TNP)

The Texas Neonatal Intensive Care Unit (NICU) Project (TNP), a Better Birth Outcomes (BBO) initiative, is a research collaborative involving Texas Medicaid, the Texas Department of State Health Services (DSHS), the Dartmouth Institute for Health Policy and Clinical Practice, The University of Texas Health Science Center at Houston - School of Public Health, and the University of Florida - Institute for Child Health Policy. This study analyzes linked Medicaid, birth certificate and death certificate data for all Medicaid-paid births in Texas for calendar years 2010-2014 to better understand recent growth in Texas' NICU capacity and payments. See also Better Birth Outcomes (BBO).

Third-party Liability (TPL)

Third-party liability (TPL) is a requirement of federal law for Medicaid to be the payer of last resort. This means that other sources of coverage a client or Medicaid-eligible patient may have, such as private health insurance, may be required to pay claims before Medicaid. Medicaid is also required to take reasonable measures to identify liable third parties and process claims accordingly.

Time and Distance Standards

Time and distance standards are metrics used to ensure managed care organization (MCO) provider networks can and are sufficiently capable of providing their members access to medically necessary services.

U

Uncompensated Care (UC) Pool

The Uncompensated Care (UC) pool is one of two hospital funding pools under the 1115 Transformation waiver, along with the Delivery System Reform Incentive Payment (DSRIP) pool. UC payments are cost-based and help offset the costs of uncompensated care provided by hospitals and other health care providers. Though previously defined as either unreimbursed costs for Medicaid or uninsured patients incurred by hospitals, uncompensated care costs are currently defined as unreimbursed charity care costs. The pool has historically been smaller than the reported total uncompensated care costs. See also Delivery System Reform Incentive Payment (DSRIP) Pool and 1115 Transformation Waiver.

Uniform Hospital Rate Increase Program (UHRIP)

The Uniform Hospital Rate Increase Program (UHRIP) is designed to reduce hospitals' uncompensated care costs through enhanced payments to hospitals for medically necessary covered services provided to Medicaid managed care members.

Uniform Managed Care Contract

The uniform managed care contract is a legal document that establishes the requirements that all managed care organizations (MCOs) must follow.

Urban Hospital

An urban hospital is typically categorized by its location within a city or metropolitan area and its size and caseload, which are usually considerably larger than rural hospitals.

Vendor Drug Program

The Vendor Drug Program (VDP) provides outpatient drug coverage for individuals enrolled in fee-for-service (FFS). In addition, the VDP maintains control of certain aspects of the pharmacy administration for both FFS and managed care—including managing federal and supplemental drug rebates, the Preferred Drug List (PDL), and clinical prior authorizations. See also Clinical Prior Authorization, Fee-for-Service (FFS) and Preferred Drug List (PDL).

Waivers

Federal law allows states to apply to the Centers for Medicare and Medicaid Services (CMS) for permission to depart from certain Medicaid requirements. Federal law allows three types of waivers: Research and Demonstration 1115 waivers, Freedom of Choice 1915(b) waivers, and Home and Community-based Services (HCBS) 1915(c) waivers.

Waste

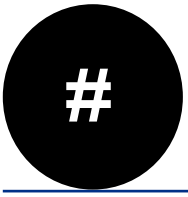
Waste refers to any practice that a reasonably prudent person would deem careless or that would allow inefficient use of resources, items or services.

Your Texas Benefits Website

A self-service website (YourTexasBenefits.com) where individuals can apply for Medicaid and other Texas Health and Human Services Commission (HHSC) programs. Clients can also accomplish the following online: view benefit information, edit and manage personal information, select their health plan, print temporary Medicaid cards or order replacement cards, set up and view their Texas Health Steps alerts, and view services provided by Medicaid.

Youth Empowerment Services (YES)

The Youth Empowerment Services (YES) is a 1915(c) waiver program that provides community-based services to children and adolescents age 3 through age 18 who have severe mental, emotional or behavioral disturbances–and their families.



1115 Healthcare Transformation Waiver

The expansion of managed care has resulted in the end of the Upper Payment Limit (UPL) program, as federal regulations prohibit supplemental payments to providers in a managed care context. To preserve federal hospital funding, the Health and Human Services Commission (HHSC) submitted—and the Centers for Medicare and Medicaid Services (CMS) approved—a proposal for a five-year Section 1115 Demonstration waiver, called the 1115 Healthcare Transformation waiver. The 1115 Healthcare Transformation waiver contains hospital funding pools, including the Uncompensated Care (UC) pool and the Delivery System Reform Incentive Payment (DSRIP) pool.

Acknowledgments

The Health and Human Services Commission's (HHSC's) Medicaid and CHIP Services (MCS) Department sincerely thanks the dozens of hard-working individuals throughout the organization who contributed to the 13th edition of the Texas Medicaid and CHIP Reference Guide, also endearingly referred to as the "Pink Book".

Creating each edition of this guide requires a full team effort. Publishing this year's edition, while also responding to an unprecedented public health emergency, is an example of the commitment of the individuals who work at HHSC.

Staff from MCS Change Management led the book's updates and continued evolution with support from the MCS Project Advisory and Coordination Team. The following areas provided critical program, financial and enrollment data:

- All MCS units
- HHSC Financial Services
- Access and Eligibility Services
- Center for Analytics and Decision Support
- Health, Developmental and Independence Services
- Health and Specialty Care System
- Intellectual and Developmental Disabilities (IDD) and Behavioral Health Services
- Office of the Inspector General
- Department of State Health Services (DSHS) Vital Statistics

Every attempt has been made to ensure the accuracy of the material reported in this book at the time of publication in December 2020.

Exhibit K

December 12, 2011

Mr. Billy Millwee
State Medicaid Director
Texas Health and Human Services Commission
4900 North Lamar
P.O. Box 13247
Austin, TX 78711

Dear Mr. Millwee:

We are pleased to inform you that Texas' request for a new Medicaid section 1115(a) Demonstration, entitled "Texas Healthcare Transformation and Quality Improvement Program" (Project Number 11-W-00278/6), has been approved for the period starting with the date of this approval letter through September 30, 2016.

Texas' new section 1115 Demonstration has a two-fold purpose: to expand the existing Medicaid managed care programs, STAR and STAR+PLUS, statewide, and to establish two funding pools that will assist providers with uncompensated care costs, and promote health system transformation.

The new Demonstration subsumes the State's existing section 1915(b) and 1915(b)/(c) waivers under which the STAR and STAR+PLUS managed care programs are currently operating. The populations served under the new Demonstration are unchanged from the section 1915 waivers. Pursuant to the planned statewide expansion of STAR and STAR+PLUS in March 2012, beneficiaries in both programs will have unlimited monthly access to medically necessary prescription medications, and STAR+PLUS beneficiaries will receive non-behavioral health inpatient services through their health plan. In addition, Medicaid-eligible children statewide will receive coverage for a full array of primary and preventive dental services through pre-paid dental health plans, through the Children's Dental Program. We commend the State on taking steps to move toward establishing comprehensive and coordinated care for the most vulnerable Texans, and we look forward to working with you in the coming months as you establish network adequacy prior to the planned March 2012 statewide expansion, and ensure the protections for beneficiaries built into the special terms and conditions.

The Demonstration also takes an important step forward by redirecting the supplemental payments that currently exist under the Medicaid State plan to the Demonstration in order to improve care delivery systems and capacity, while emphasizing accountability and transparency, and requiring demonstrated improvements at the provider level for the receipt of such payments.

The Delivery System Incentive Reform Payment (DSRIP) Pool is designed to incentivize activities that support hospitals' collaborative efforts to improve access to care and the health of

the patients and families they serve. The initiatives supported by the DSRIP will align with the following four broad categories, which are under development by the State: infrastructure development, program innovation and redesign, population-focused improvement, and clinical improvements in care. Reform activities will be conducted by Regional Healthcare Partnerships (RHPs) that are financially supported and directed by a public hospital or local governmental entity that will collaborate with other healthcare providers to evaluate current challenges in the delivery system, and agree to a course of investment and action to address those challenges over the course of the Demonstration. Payments will not be made from the DSRIP Pool until CMS has approved the plans submitted to the State by each Regional Healthcare Partnership (RHP), as specified in the Special Terms and Conditions (STCs).

Distributions from the Uncompensated Care (UC) Pool in the first year of the Demonstration are Transition Payments to hospitals and physician groups that received supplemental payments under the Medicaid State plan for claims adjudicated during FFY 2011. This transition period ensures that those providers are eligible to secure historical Medicaid funding as the State develops the pool payment methodologies. Distribution of funds from the Uncompensated Care Pool in the second year of the Demonstration is contingent upon approval by the Centers for Medicare & Medicaid Services (CMS) of the State's provider cost reporting tool and all required protocols as described in the STCs.

CMS acknowledges the State's withdrawal of the request to impose the monthly prescription drug limitation in place under the Medicaid State plan on STAR and STAR+PLUS enrollees. We appreciate the State's efforts to ensure that comprehensive benefits are provided to Medicaid beneficiaries, and CMS will work closely with Texas to monitor beneficiary access to covered services under the STAR and STAR+PLUS programs.

As previously discussed, CMS has not approved, and did not incorporate, the following requests from the State's proposal into the section 1115 Demonstration:

1. Federal funding for Designated State Health Programs;
2. Authority to shift funding between the UC and DSRIP Pools within a given Demonstration year; and to carry forward unspent UC or DSRIP funds to future Demonstration years.

As of the date of this letter, the Texas Demonstration is authorized through September 30, 2016, upon which date, unless reauthorized, all waivers and authorities granted to operate this Demonstration will expire. Our approval of this Demonstration project is subject to the limitations specified in the attached waiver and expenditure authorities. The State may deviate from Medicaid State plan requirements only to the extent that those requirements have been specifically waived or listed as inapplicable to expenditures for Demonstration expansion populations and other services not covered under the State plan.

The approval is also conditioned upon the State's compliance with the enclosed STCs, defining the nature, character, and extent of anticipated Federal involvement in the project. The award is subject to our receiving your written acknowledgement of the award, and acceptance of the STCs, waiver list, and expenditure authorities within 30 days from the date of this letter.

Your project officer for this Demonstration is Ms. Nicole Kaufman. She is available to answer any questions concerning your section 1115 Demonstration, and may be contacted as follows:

Ms. Nicole Kaufman
Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mailstop S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-6604
Facsimile: (410) 786-5882
Email: Nicole.Kaufman@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Kaufman and Mr. Bill Brooks, Associate Regional Administrator in our Dallas Regional Office. Mr. Brooks' address is:

Mr. Bill Brooks
Associate Regional Administrator
Division of Medicaid & Children's Health Operations
1301 Young Street, Suite 714
Dallas, TX 75202

We extend our congratulations to you on this award, and we appreciate your collaboration through the review process. If you have any questions regarding this correspondence, please contact Ms. Victoria Wachino, Director, Children and Adults Health Programs Group, Centers for Medicaid and CHIP Services, (410) 786-5647.

We look forward to continuing to work with you and your staff.

Sincerely,

/s/

Marilyn Tavenner
Acting Administrator

Enclosures

cc: Bill Brooks, Associate Regional Administrator, Dallas Regional Office
Cheryl Rupley, State Coordinator for Texas, Dallas Regional Office
Nicole Kaufman, Project Officer, Centers for Medicare & Medicaid Services