IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TEXAS
TYLER DIVISION

THE STATE OF TEXAS; TEXAS HEALTH AND HUMAN SERVICES COMMISSION	§	
Plaintiffs,	§	
v.	§	**CIVIL ACTION NO. 1:21-CV-191**
CHIQUITA BROOKS-LASURE, in her official capacity as Administrator of the Centers for Medicare & Medicaid Services, et al.	§	
Defendants.	§	

DEFENDANTS' COMBINED OPPOSITION TO PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION AND MOTION TO DISMISS FOR LACK OF SUBJECT MATTER JURISDICTION

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I. Introduction

Plaintiffs come before the Court to demand extraordinary relief that they do not need and that would require Defendants to take actions in excess of their authority. Notwithstanding the relief requested in Plaintiffs' motion, and indeed in this entire lawsuit, the Texas Healthcare Transformation Quality Improvement Program ("THTQIP" or the "demonstration project") will continue to allow Texas's Medicaid program to operate unchanged through September 30, 2022. Nevertheless, Plaintiffs seek to immediately enforce a nearly ten-year extension of THTQIP that was improperly approved by Defendants in a January 15, 2021 letter (hereinafter "January 15 Letter" or "January approval") without the notice and comment process required by statute and regulation. Through a letter dated April 16, 2021 (hereinafter "April 16 Letter"), Defendants notified Plaintiffs that the January approval was made in excess of Defendants' statutory and regulatory authority and was therefore void and without legal effect.

Preliminary injunctive relief is clearly unwarranted. Plaintiffs lack any likelihood of eventual success on the merits, because the alleged underlying agency action they seek to enforce, the January 15 Letter, is in excess of the agency's authority and thus void. Plaintiffs also cannot show a likelihood that they will suffer harm if extraordinary relief is not granted during the pendency of the case. Plaintiffs' concurrent administrative appeal of the April 16 Letter before the Department of Health and Human Services ("HHS") Departmental Appeals Board ("DAB") obliges Defendants to treat the January 15 Letter as in effect until the conclusion of that appeal. This regulatory requirement currently provides Plaintiffs with the identical relief they seek from this Court as a preliminary injunction. Moreover, because the prior approval of the THTQIP project does not expire for more than a year (until September 30, 2022), Plaintiffs have ample opportunity to reapply for an extension after complying with the necessary notice

and comment process. And indeed, at the time of filing this opposition, Plaintiffs have submitted a new application for extension of THTQIP that is under separate consideration by Defendants.

This case should also be dismissed for lack of subject matter jurisdiction under Federal Rule of Civil Procedure 12(b)(1).The Court lacks jurisdiction to consider Plaintiffs' claims under the Administrative Procedure Act ("APA") because there has been no final agency action and because Plaintiffs' claims are not ripe and Plaintiffs lack standing.

For the reasons explained below, Plaintiffs' Motion for Preliminary Injunction should be denied, and their case as a whole should also be dismissed for lack of subject-matter jurisdiction.

II. Factual and Procedural Background

Forty-two U.S.C. § 1315(a) permits the Secretary of HHS to "waive compliance with any of the requirements" of various sections of the Social Security Act ("SSA") to allow states to engage in "any experimental, pilot, or demonstration project, which, in the judgment of the Secretary, is likely to assist in promoting the objectives," of Medicaid. Defendant, the Centers for Medicare & Medicaid Services ("CMS"), first approved Texas's current demonstration project, THTQIP, in December of 2011. Defs.' Ex. 1, January 15 Letter, at 3.[1] The demonstration project authorizes certain Medicaid expenditures throughout the state of Texas through a variety of programs, and also includes two funding pools, the Uncompensated Care Pool and the Delivery System Reform Incentive Payment ("DSRIP"). *See id*. THTQIP was renewed first in 2016 and then again in 2017. *See* Compl. ECF No. 1, ¶ 5. The 2017 extension of THTQIP slated the project as a whole to expire on September 30, 2022. *See* Defs.' Ex. 2, April 16 Letter, at 1-2. The 2017 extension also imposed a separate September 30, 2021 expiration date for the DSRIP.

[1] Unless otherwise noted, for the Court's convenience Defendants' exhibits are presented without voluminous, secondary attachments duplicative of Plaintiffs' submissions or not relevant to the motions under consideration.

See Defs.' Ex. 3, Declaration of Judith Cash (July 26, 2021), ¶ 13. Under the terms of the 2017 extension, the DSRIP would not be renewed and Texas was obliged to wind down the program and transition out of federal funding for DSRIP by the scheduled September 30, 2021 end date. *Id*.

On November 27, 2020, approximately 22 months before the scheduled expiration of THTQIP as a whole, Plaintiffs sent CMS the application for extension of the demonstration project that is the subject of this litigation. Compl. ¶ 63. This extension application, identified as a "Section 1115 Demonstration Extension Section 1115(a) Fast Track Application," *see* Cash Decl. at 30 (Ex. E), requested an extension of 5 years, *id*. at 25, and an exemption from participation in the federal public notice and comment period mandated by the statute and regulations, *id*. at 70-71. Texas asserted that it was seeking to waive the federal notice and comment requirements of 42 C.F.R. § 431.416 because "[t]he state's health care system [was] experiencing significant pressure and uncertainty as Texas continues to respond to the Public Health Emergency," created by COVID-19. *Id*. at 70. The application also informed CMS that Texas was on track to wind down its DSRIP program and did not request an extension. Cash Decl. ¶ 13. On December 15, 2020, CMS informed Texas that its application for extension was complete and that it was "exempt from the requirements for public notice and comment." Cash Decl. at 23 (Ex. E).

On January 15, 2021, CMS approved a nearly ten-year extension of THTQIP, through September 30, 2030, with several significant changes from the original demonstration. *See generally*, Ex. 1, January 15 Letter. The January approval does not extend DSRIP and neither the Texas nor CMS expected that it would. *See id*. at 3. One change purportedly approved by the

January 15 Letter was the creation of a new uncompensated care pool, the Public Health Providers Charity Care Pool ("PHP-CCP"), to commence on October 1, 2021. *Id*. at 3-4.

On April 16, 2020, CMS issued a subsequent letter informing Texas that "CMS 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 state's request "did not articulate a sufficient basis for [CMS] to conclude that approving the state's emergency request…was needed to address a public health emergency or other sudden emergency threat to human lives." Ex. 2, April 16 Letter at 1-2. The letter explained in detail why "rescission" of the January 15 Letter was necessary based on the facts presented by Texas in its application and the requirements of the applicable statute and regulations. *See generally id*. The April 16 Letter also noted that the existing demonstration project was nevertheless authorized through September 30, 2022 and indicated that "should the state still wish to extend the demonstration past that date, [CMS] stand[s] ready to work with the state to accomplish state submission and CMS review of a complete extension application during the next eighteen months that the demonstration continues to be authorized." *Id*. at 2.

On May 14, 2021, the same day as the filing of this suit, Plaintiffs filed a Notice of Appeal with the DAB challenging CMS's April 16 Letter on the basis of its purported rescission of CMS's January 15 approval. Ex. 4, May 14, 2021 DAB Notice of Appeal. Plaintiffs' administrative appeal is premised on the same legal and factual grounds as this suit. *See id*. at 3-5. Plaintiffs asserted in their Notice that the appeal was "protective" only because, in their view "the dispute over CMS's actions does not fall within [the DAB's] jurisdiction." *Id*. at 1. Plaintiffs' argument is premised exclusively on their interpretation of the types of disputes listed as within the DAB's competence under 45 C.F.R. Part 16, App'x A. *Id*. Pursuant to its

procedures under that same Appendix, the DAB requested that CMS render its opinion on the DAB's jurisdiction to consider the appeal. Ex. 5 Acknowledgement of Appeal and Request to CMS; 45 C.F.R. Part 16, App'x A ¶ G. CMS advised the DAB that it did in fact have jurisdiction to consider the administrative appeal of the April 16 Letter pursuant to 45 C.F.R. Part 16 ¶ C(a)(4). Ex. 6 CMS Response to DAB Request at 2-3. Although the DAB has not yet decided its jurisdiction, per regulation, when, as here, the DAB requests CMS's written opinion regarding jurisdiction, "the [DAB] will be bound by the opinion," "[u]nless the Chair [of the DAB] determines that the opinion is clearly erroneous." 45 C.F.R. Part 16, App'x A ¶ G. Thus, there is little doubt that the DAB will continue to exercise its jurisdiction over the appeal.

Furthermore, during the pendency of a DAB appeal, the agency is barred from taking any action to implement the challenged decision. 45 C.F.R. 16.22(a). CMS has interpreted this requirement to oblige it to implement the January 15 extension approval as though it is not void until the administrative appeal is complete.[2]

Additionally, after the filing of both the instant lawsuit and their administrative appeal, Plaintiffs resubmitted a new application for extension of THTQIP. Ex. 7 July 14, 2021 Extension Application Letter. Plaintiffs' July 2021 extension application does not request an exemption from the required notice and comment procedures.

III. Standard of Review

In order to obtain a preliminary injunction, the party seeking the injunction must establish

> (1) a substantial likelihood that he will prevail on the merits, (2) a substantial threat that he will suffer irreparable injury if the injunction is not granted, (3) his threatened injury outweighs the threatened harm to the party whom he seeks

[2] This requirement does not prevent CMS from recovering any funds expended on the basis of an unauthorized approval if CMS eventually prevails on the merits of the DAB appeal and/or this litigation.

> to enjoin, and (4) granting the preliminary injunction will not disserve the public interest.

Bluefield Water Ass'n Inc. v. City of Starkville, 577 F.3d 250, 252-53 (5th Cir. 2009) (quoting *Lake Charles Diesel, Inc. v. Gen. Motors Corp.*, 328 F.3d 192, 195-96 (5th Cir. 2003)). The Fifth Circuit has "cautioned repeatedly that a preliminary injunction is an extraordinary remedy which should not be granted unless the party seeking it has clearly carried the burden of persuasion on all four requirements." *Id*. at 253. "A mandatory preliminary injunction—that is, a preliminary injunction that orders a party to 'take action' or perform certain acts—is particularly disfavored and should not be issued unless the facts and laws clearly favor the moving party." *Davis v. Angelina Coll. Bd. Of Trustees*, Case No. 17-cv-179, 2018 U.S. Dist. LEXIS 61798, at *2 (E.D. Tex. Apr. 11, 2018) (citing *Martinez v. Mathews*, 544 F.2d 1233, 1243 (5th Cir. 1976)).

Defendants also move to dismiss this case for lack of subject matter jurisdiction under Federal Rule of Civil Procedure 12(b)(1). "A case is properly dismissed for lack of subject matter jurisdiction when the court lacks the statutory or constitutional power to adjudicate the case." *Smith v. Regional Transit Auth.*, 756 F.3d 340, 347 (5th Cir. 2014) (internal citation omitted). "The burden of proving subject matter jurisdiction lies with the party asserting jurisdiction, and it must be proved by a preponderance of the evidence." *Southern Recycling, L.L.C. v. Aguilar*, 982 F.3d 374, 379 (5th Cir. 2020). A 12(b)(1) dismissal may be "based on '(1) the complaint alone; (2) the complaint supplemented by undisputed facts evidenced in the record; or (3) the complaint supplemented by undisputed facts plus the court's resolution of disputed facts.'" *Id*. (quoting *Barrera-Montenegro v. United States*, 74 F.3d 657, 659 (5th Cir. 1996)).

IV. Argument

a. Texas Has Not Established Entitlement to Preliminary Injunctive Relief

The Court must deny a motion for preliminary injunction if the plaintiff fails to satisfy even one of the prongs of the standard. Texas fails to carry its burden on any of the four prongs, and thus, its motion must be denied.

i. Texas Seeks A Mandatory Injunction and Cannot Satisfy The Heightened Standard That Applies.

Texas's brief implies that it is seeking a prohibitory injunction and thus needs to satisfy only the typical preliminary injunction standard. Pl.'s Mot. at 16. But Texas is not seeking merely to enjoin CMS from taking certain actions. It asks the Court to compel CMS to take action under the January 15 Letter, extending the demonstration project with significant modifications, including by providing federal funding for the modified project, during the pendency of the case. Such relief is mandatory in nature. *See, e.g.*, *Davis*, 2018 U.S. Dist. LEXIS 61798, at *2 ("Plaintiff is seeking a mandatory preliminary injunction that orders the Defendant to overturn his expulsion and allow Plaintiff to attend" Defendant's college.). Thus, Plaintiffs must satisfy a heightened standard, demonstrating that "the facts and law are clearly in [their] favor." *Id*. at *4; *Texas v. Ysleta Del Sur Pueblo*, Case No. 17-cv-179-PRM, 2018 U.S. Dist. LEXIS 54042, at *24-25 (W.D. Tex. March 29, 2018) ("[T]he Fifth Circuit has repeatedly held that mandatory injunctions warrant an even higher standard than prohibitory injunctions.") (collecting cases). For the reasons explained below, Texas has failed to meet the typical preliminary injunction standard for each of the four elements of the analysis and has come nowhere close to making the elevated showing necessary to obtain a highly disfavored mandatory injunction.

ii. Texas Will Not Suffer Irreparable Harm If The Preliminary Injunction Is Denied.

Texas's clearest failure to satisfy the preliminary injunction standard lies in its inability to demonstrate that extraordinary relief is needed to prevent irreparable harm. Plaintiffs have not

shown, and cannot show, that they will face irreparable harm, or any harm at all, if the requested preliminary injunction is not granted.

1. Texas Has No Likelihood of Suffering Any of the Harm Alleged During the Pendency Of The DAB Administrative Appeal Process

Plaintiffs appealed CMS's April 16 letter to the HHS DAB on the same bases as the underlying merits of this suit. The DAB is currently considering, and is expected to continue to assert jurisdiction over, the appeal, activating the Board's procedural regulations. Specifically, pursuant to 45 C.F.R. § 16.22(a), "[u]ntil the Board disposes of an appeal the respondent shall take no action to implement the final decision appealed."[3] In other words, because Texas timely filed an administrative appeal as to the April 16 Letter, CMS remains bound by its January 15 Approval Letter until the conclusion of the administrative appeal. CMS will treat the January extension of THTQIP as in effect throughout the DAB process. The operation of this regulation provides identical relief to that which Plaintiffs seek through their application for a preliminary injunction—that is, CMS treating the January approval as effective. Therefore, not only have Plaintiffs failed to establish irreparable harm, they cannot establish any harm while their DAB appeal is pending.

Because Plaintiffs are not imminently at risk of suffering any of the harm on which they premise their request for extraordinary relief, their motion for preliminary injunction must be denied. *See, e.g.*, *Optimus Steel, LLC v. U.S. Army Corps of Engineers*, 492 F. Supp. 3d 701, 724 (to meet the irreparable harm requirement "there must be 'a significant threat of injury from the impending action,' the injury must be 'imminent,' and 'money damages [can]not fully repair the harm.'" (quoting *Humana Inc. v. Jacobson*, 804 F.2d 1390, 1394 (5th Cir. 1986)).

[3] The exceptions enumerated in § 16.22(b) are not applicable to the circumstances of this appeal.

2. Even if Texas's DAB appeal were not pending, Texas's Alleged Harms Are Not Irreparable and Would Not Be Prevented by a Preliminary Injunction

Irreparable harm is "harm for which there is no adequate remedy at law," and "speculative injury is not sufficient; there must be more than an unfounded fear on the part of the applicant." *Daniels Health Scis., LLC v. Vascular Health Scis., LLC*, 710 F.3d 579, 585 (5th Cir. 2013). It is thus well-established that an injury is irreparable only "if it cannot be undone through monetary remedies . . . . Mere injuries, however substantial, in terms of money, time and energy necessarily expended in the absence of [an injunction], are not enough. The possibility that adequate compensatory or other corrective relief will be available at a later date, in the ordinary course of litigation, [weighs] heavily against a claim of irreparable harm." *Dennis Melancon, Inc. v. City of New Orleans*, 703 F.3d 262, 279 (5th Cir. 2012) (internal citations omitted).

Even after the disposition of the DAB appeal, if CMS prevails, Plaintiffs will be unable to demonstrate irreparable harm because their alleged harms are speculative and not irreparable. First, to the extent Plaintiffs' claim of harm is premised on the possibility that THTQIP as a whole will not be extended before it expires on September 30, 2022, this alleged harm is speculative and not sufficiently impending to warrant entry of a preliminary injunction. There is ample time prior to the September 30, 2022 expiration of the demonstration project to avert Texas's alleged harm, and there are several pathways for doing so. Plaintiffs' administrative appeal, or the merits of this lawsuit, or both, could reasonably be expected to be resolved before September 30, 2022. *See* 45 C.F.R. § 16.23 (establishing goals for duration of DAB appeals). Alternatively, CMS could consider and approve a new extension application before the September 30, 2022 expiration date. In its April 16 letter, CMS invited Texas to resubmit a proper application for extension, including compliance with the required notice and comment period, and indicated a willingness to collaborate with the state as it reviews and considers that application. *See* April 16 Letter at 1-2.

And, as noted *supra*, Plaintiffs have in fact reapplied to CMS for an extension of the overall THTQIP project, acknowledging the availability of this alternative and likely more expedient resolution. Ex. 7, July 14, 2021 Extension Application Letter.

Second, to the extent that Plaintiffs' alleged harms are premised on the expiration of DSRIP on September 30, 2021, the requested preliminary injunction would provide no relief and is therefore unwarranted. The alleged loss of funding and services Plaintiffs expect to occur, including their "fiscal cliff," is based on the overall termination of DSRIP. *See* Pls.' Mot. for Prelim. Inj. (hereinafter "PI Mot."), ECF No. 11, at 32-33. But the January 15 approval did not extend DSRIP and, consequently, granting the requested injunction would not compel Defendants to extend DSRIP. *See* January 15 Letter; Cash Decl. ¶ 13. Nor have Plaintiffs submitted an application to extend DSRIP. Cash Decl. ¶ 13. Plaintiffs' unsupported claim that they "abandoned" their opportunity to seek an extension of DSRIP when they negotiated the January approval with CMS is unavailing. Plaintiffs have been aware since 2017 that DSRIP would expire on September 30, 2021 and, far from submitting an application to extend DSRIP, Plaintiffs in fact submitted a plan for winding down DSRIP, which CMS approved in 2020. *Id*. Plaintiffs thus had no reasonable expectation that DSRIP would be extended and no legally cognizable harm related to that component of the demonstration. *See Id*. Finally, although PHP-CCP would be funded under the January 15 Letter beginning on October 1, 2021 that new demonstration feature is not intended to replace DSRIP, and even if it were it would account for only a small portion, 20% or less, of the prior DSRIP funding. *See id*. ¶ 14. Plaintiffs do not identify what, if any, portion of the "funding cliff" they allege would purportedly result from PHP-CCP not going into effect under the January 15 Letter as opposed to the end of DSRIP or of THTQIP as a whole, which are not implicated by the requested preliminary relief. *See Bluefield Water Ass'n*, 577 F.3d at 253 (the

moving party "must clearly carry the burden of persuasion" as to irreparable harm.) Moreover, whether this relatively small amount of lost funding, to the extent it is in fact threatened, would alone lead to any of the purportedly irreparable harms alleged by Plaintiffs, such as the closing of certain medical facilities, is entirely speculative.

Third, Texas's allegation that it has wasted time and money negotiating and implementing the extension approved in the January 15 letter, PI Mot. at 32, does not entitle it to a preliminary injunction. Any such resources have already been expended, and thus, the prospective injunctive relief Texas seeks will not remedy Plaintiffs' alleged loss. Moreover, if Plaintiffs eventually prevail on the merits and the January approval is confirmed, those expenditures will no longer be "lost and unrecoverable" because they will be in furtherance of the extended demonstration project.

Fourth, "uncertainty," *see* PI Mot. at 10-13, 33, is neither a cognizable harm nor would a preliminary injunction provide meaningful relief if it were. No State has an entitlement to the initiation or continuation of a demonstration project in the first instance, and CMS may permit any such project to expire in its sole discretion. *See generally*, 42 U.S.C. § 1315; 42 C.F.R. Subpart G. Additionally, it is apparent from the structure of the applicable statutes that in the absence of demonstration project waivers, states are subject to the default requirements of their Medicaid State Plan. *Cf*. 42 U.S.C. § 1315(a). Therefore, all relevant actors know or should know that they have no guarantee of operating under the auspices of a demonstration project beyond its expiration date, and of the specifics of the program that they will operate under once a demonstration project expires without extension.

Additionally, a preliminary injunction would not meaningfully alleviate the alleged harms of uncertainty in this case, because even if the Court granted a preliminary injunction,

Defendants could still prevail at final judgment. Thus, the uncertainty of whether the State could ultimately operate under the January approval would merely continue through the end of the case. Moreover, because the substance of Defendants' position is that the January approval was void ab initio, a favorable decision for Defendants would invalidate the extension and require the return of any federal money expended on programs authorized solely by CMS's January 15 extension approval. Thus, a preliminary injunction could actually increase uncertainty and result in greater future harm and disruption.

Finally, Texas has no standing parens patriae to represent its citizens against the Federal Government. *Alfred L. Snapp & Son v. Puerto Rico*, 458 U.S. 592, 609 n.16 (1982). And even if it did, for the reasons explained above, there is no threat of irreparable harm to the individual participants in Texas's Medicaid program that would be averted by the injunction Plaintiffs seek. There is no impending threat that THTQIP as a whole will terminate, DSRIP will expire regardless of the effect of the January 15 Letter; and any other uncertain threat alleged is inherently speculative.

iii. Texas Has No Likelihood Of Success On The Merits

Texas's briefing ignores entirely one necessary element of its obligation to demonstrate a likelihood of success on the merits, subject matter jurisdiction, and gives short shrift to another, the invalidity of CMS's purported January approval. Under normal circumstances, "the party seeking a preliminary injunction must establish at least some likelihood of success on the merits before the court may proceed to assess the remaining requirements." *Jefferson Cmty. Health Care Ctrs., Inc. v. Jefferson Parish Gov't*, 849 F.3d 615, 625 (5th Cir. 2017). However, in the case of a mandatory injunction, Plaintiff must show that the facts and law clearly favor its position. *Davis*, 2018 U.S. Dist. LEXIS 61798, at *2. Here, Plaintiffs have demonstrated no likelihood of success on the merits whatsoever, and therefore their motion should be denied.

1. This Court Lacks Subject Matter Jurisdiction to Consider Plaintiffs' Claims

"The United States has sovereign immunity from any lawsuit, unless that sovereign immunity has been waived." *M.D.C.G. v. United States*, 956 F.3d 762, 767-68 (5th Cir. 2020). Plaintiffs rely exclusively in this case upon the waiver of sovereign immunity contained in the Administrative Procedure Act ("APA"), 5 U.S.C. § 702. Compl., ¶ 25. However, this waiver, and review under the APA, are subject to limitations. The APA "only provides review over '[a]gency action made reviewable by statute and final agency action for which there is no other adequate remedy in a court.'" *Valerio v. Limon*, Case No. 20-cv-040, 2021 U.S. Dist. LEXIS 67590, at *8 (S.D. Tex. Feb. 4, 2021) (quoting 5 U.S.C. § 704). "Thus, plaintiffs may not sue under the APA unless....the action they seek to challenge is a final action." *Id*.

The purported action that Plaintiffs seek to challenge, CMS's April 16, 2021 letter, is not final agency action. Despite filing this case, Plaintiffs are concurrently engaged in the administrative appeal process specifically provided for such claims by HHS's regulations. *See supra* at 4-5. Those regulations permit a state wishing to dispute an agency decision related to a discretionary grant, such as a demonstration project, to seek review by the DAB. *See* 42 C.F.R. § 430.3(c), "Appeals under Medicaid" ("Disputes pertaining to discretionary grants, such as grants for special demonstration projects under sections 1110 and 1115 of the Act, which may be awarded to a Medicaid agency, are also heard by the Board."); *see also* 45 C.F.R. Part 16, "Procedures of the Departmental Grant Appeals Board." Texas elected to engage in the DAB process by filing a timely and otherwise complete notice of administrative appeal. See Ex. 5, Acknowledgment of Appeal and Request to CMS. "When an aggrieved party has exhausted all administrative remedies expressly prescribed by statute or agency rule, the agency action is 'final for the purposes of [5 U.S.C. § 704]' and therefore 'subject to judicial review.'" *Darby v.*

Cisernos, 509 U.S. 137, 146 (1993). In this case, however, Plaintiffs are currently engaged in an ongoing, unexhausted, administrative process that is expressly permitted by regulation, and therefore the challenged action is not final for APA purposes and the Court lacks jurisdiction to consider the case.

For the same reasons, Plaintiffs also do not have standing to bring this suit and their claims are not ripe. The plaintiff bears the burden of establishing both standing and ripeness. *Mississippi State Democratic Party v. Barbour*, 529 F.3d 538, 544 (5th Cir. 2008). To demonstrate standing:

> a plaintiff must show: (1) it has suffered, or imminently will suffer, a concrete and particularized injury-in-fact; (2) the injury is fairly traceable to the defendant's conduct; and (3) a favorable judgment is likely to redress the injury.

Id. (quoting *Houston Chronicle Publ'g Co. v. City of League City, Tex.*, 488 F.3d 613, 617 (5th Cir. 2007)). "An injury in fact is an invasion of a legally protected interest which is 'actual or imminent, not conjectural or hypothetical.'" *Id*. (quoting *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560 (1992)). For the reasons explained *supra*, Plaintiffs have no present or imminent injury because, during the pendency of the DAB appeal, Plaintiffs are receiving in substance the exact relief that they request in both their preliminary injunction motion and their Complaint. Plaintiffs' alleged injury is not imminent because the appeal process is ongoing, and their possible future harm is purely hypothetical because the administrative appeal may be decided in Plaintiffs' favor, preventing any of the alleged harms from ever coming to pass. The case is similarly not ripe because the alleged harm has not "matured sufficiently to warrant judicial intervention." *Id*. at 544-45 (quoting *Warth v. Seldin*, 422 U.S. 490, 499 n.10 (1975)). "Ripeness often overlaps with standing, 'most notably in the shared requirement that the injury be imminent rather than conjectural or hypothetical.'" *Id*. at 545 (quoting *Brooklyn Legal Servs.*

Corp. v. Legal Servs. Corp., 462 F.3d 219, 225 (2nd Cir. 2006)). Because Plaintiffs presently have no actual or imminent injury that is neither conjectural nor hypothetical, they cannot carry their burden to demonstrate either standing or ripeness. [4]

Therefore, the Court lacks subject matter jurisdiction to hear Plaintiffs' APA claims related to CMS's January and April letters at this time. At the conclusion of the administrative appeal process in which Plaintiffs are currently engaged, the Court will have authority to consider the final decision of the DAB. Alternatively, in light of the pending DAB appeal, the Court should stay its consideration of this case; it would be contrary to the interests of judicial economy to simultaneously duplicate the DAB procedures in this Court.

iv. CMS's January 2021 Approval Of Texas's Extension Request Was In Excess Of The Agency's Authority And Is Therefore Void

Plaintiffs also cannot show a likelihood of success on the merits because the January 2021 approval they seek to vindicate through this lawsuit was made in excess of the agency's authority and is therefore void. As Plaintiffs note in their motion, federal agencies, including CMS, have only the authority with which they are endowed by statute, PI Mot. at 16, and that authority is further cabined by the requirements of applicable regulations. CMS did not have authority to exempt Texas from the requirements of public notice and comment on the basis of

[4] If the Court determines that it does have subject matter jurisdiction, it may stay its consideration pending the resolution of the DAB appeal under the doctrine of primary jurisdiction. "[P]rimary jurisdiction attempts to maintain proper relationships between the courts and administrative agencies by suspending judicial process pending the 'referral' of certain issues to an administrative agency for its views…" *Elam v. Kansas City Ry.*, 635 F.3d 796, 809 (5th Cir. 2011) (citations omitted). Such referral is warranted when the case concerns "questions of fact or law within the peculiar competence of the agency." *Occidental Chem. Corp. v. Louisiana PSC*, 810 F.3d 299, 309 (5th Cir. 2016). Here the DAB is assessing CMS's interpretation of its own regulations and, inter alia, its assessment of what circumstances might undermine or compromise the purpose the projects it administers or the interests of the beneficiaries it serves. *See* 42 C.F.R. § 431.416(g). Thus, referral to the ongoing DAB process would serve the interests of good judicial administration.

the justification Texas presented. Thus, CMS's January 15 approval exceeded the agency's authority and is without effect.

CMS's statutory authority to approve demonstration projects is dependent on the promulgation of regulations, providing, *inter alia*, "a process for providing public notice and comment after the application is received by the Secretary, that is sufficient to ensure a meaningful level of public input." 42 U.S.C. § 1315(d)(2)(C). The agency's implementing regulations, promulgated at 42 C.F.R. Subpart G, in turn require CMS to "solicit public comment regarding such demonstration application[s] for 30 days." 42 C.F.R. § 431.416(b). Furthermore, "CMS *will not* render a final decision on a demonstration application until at least 45 days after notice of receipt of a completed application, to receive and consider public comments." 42 C.F.R. § 431.416(e)(1) (emphasis added). The agency may only forego this requirement if the conditions for "exemption from the normal public notice process" are met under § 431.416(g). *See* 42 C.F.R. § 431.416(e)(2). Consequently, if CMS exempted Texas from the notice and comment process, and subsequently approved its extension application, based on a showing that did not satisfy the conditions of § 431.416(g), such actions were ultra vires and without effect.

The record clearly demonstrates that Texas's asserted basis for exemption from the public notice and comment obligation fails to satisfy the requirements of § 431.416(g), and therefore that CMS "materially erred in granting Texas's [exemption] request." April 16 letter at 1. CMS is empowered to waive the public notice and comment requirement on a "demonstration extension request that addresses a natural disaster, public health emergency, or other sudden emergency threats to human lives." 42 C.F.R. § 431.416(g)(1). The requesting state

> must establish (or meet) all of the following criteria to obtain such an exemption from the normal public notice process requirements:
>
> (i) The State acted in good faith, and in a diligent, timely, and prudent manner;

> (ii) The circumstances constitute an emergency and could not have been reasonably foreseen;
>
> (iii) Delay would undermine or compromise the purpose of the demonstration and be contrary to the interests of beneficiaries.

42 C.F.R. § 431.416(g)(3). Contrary to these strict requirements, Texas's request for an exemption from public notice and comment was "premised on the state's conclusory assertion that healthcare providers in the state must have the financial stability they need to prepare for and respond to the COVID-19 public health emergency, and without an emergency approval of the extension request, the goals, purpose, and achievements from the THTQIP demonstration would be undermined." April 16 Letter at 3.

First, it is plain on the face of the request that the demonstration extension does not "address" the COVID-19 public health emergency as required by § 431.416(g)(1). The requested extension "contained no features that specifically address the COVID-19 public health emergency," and "did not request any new or modified authorities designed to address the COVID-19 public health emergency, or any other sudden emergency threats to human lives." April 16 Letter at 3. Additionally, CMS made available, prior to Texas's request at issue here, "a streamlined section 1115 demonstration application template" specifically to "request and receive expedited CMS approval for new demonstrations and demonstration changes needed to address the exigencies of [COVID-19]." *Id*. at 4. Texas, among other states, was aware of and had already used this separate procedure prior to the extension request at issue in this litigation to make adjustments specifically related to the public health emergency. *Id*. But Texas's demonstration project extension request that is the subject of this case was not submitted pursuant to this special process. Texas's public notice exemption request also did not make a meaningful attempt to explain how its demonstration project extension supposedly addressed COVID-19. *See generally* Cash Decl. at 34-36, 70-71 (Ex. E).

Second, the public notice exemption request does not establish that "the circumstances constitute an emergency." § 431.416(g)(3)(ii). At the time Texas requested to extend its demonstration project, the project as a whole was slated to continue for nearly two additional years. Although the COVID-19 public health emergency was ongoing, Texas's application gave no explanation as to why a delay of as little as 45 days to permit notice and comment would "undermine or compromise the purpose of the demonstration [or] be contrary to the interests of beneficiaries." 45 C.F.R. § 431.416(g)(3)(iii); *see* April 16 Letter at 3-4; 45 C.F.R. § 431.416(e)(1). Assuming for purposes of this analysis only that the expiration of the overall demonstration project on September 30, 2022, would compromise its purpose and be contrary to the interests of the beneficiaries, there was at the time of the extension request, and still remains, ample time for the parties to engage in a compliant extension process. Indeed, Texas acknowledged as much by reapplying for extension of its demonstration project on July 14, 2021. *See* July 14, 2021 Extension Reapplication. Moreover, at the time of Texas's public notice exemption request, the country was nearly nine months into the pandemic and there was no basis to assert that the conditions of the COVID-19 public health emergency "could not have reasonably been foreseen." § 431.416(g)(3)(ii).

To the extent Plaintiffs argue that the conditions of the public notice exemption regulations were met with regard to the DSRIP because it was slated to expire on September 30, 2021, Plaintiffs' explanation still falls far short for the same reasons. Texas had been aware of the expiration of DSRIP since at least December 21, 2017, and knew that federal financial support for that program would wind down by September 30, 2021. At the time Texas sought a public notice exemption, more than ten months remained before DSRIP was set to expire, which provided sufficient time to comply with the necessary notice and comment processes. *See* April

16 Letter at 4. Moreover, Texas did not even request an extension of DSRIP, and thus, there was no justification for expediting the approval in order to forestall the harms that would allegedly flow from the DSRIP expiration. *Id.*, *see also* Cash Decl. ¶13.

Plaintiffs argue that CMS's analysis is arbitrary and capricious because Plaintiffs' requested extension "addresses" the COVID-19 public health emergency. PI Mot. at 29-30. Plaintiffs' assertion that this requirement is met because general features of the existing demonstration project provide services that may be used in connection with a COVID-19 response is a facially implausible reading of 42 C.F.R. § 431.416, and CMS's contrary conclusion is well within its authority to interpret its own regulations. *See* 42 C.F.R. § 431.416(g)(1); *see also* April 16 Letter at 4 (THTQIP "is not, and has not since its 2011 inception, been designed to address the COVID-19 public health emergency or any other sudden emergency threat to human lives."). Plaintiffs' claim that the April 16 Letter asserts that COVID-19 is "irrelevant" to Texas's extension application is also unfounded. The April 16 Letter notes only that the existence in general of the public health emergency does not bear on Plaintiffs' improperly supported request to forgo public notice and comment. *See* April 16 Letter at 3-4. Plaintiffs also contend that the April 16 Letter is arbitrary and capricious because it ignores evidence that a public notice exception was necessitated by unforeseen circumstances related to the public health emergency. However, what Plaintiffs actually argue is that they provided evidence to CMS that an extension of THTQIP or DSRIP was necessitated by unforeseen circumstances. *See* PI Mot. at 30-31. The April 16 Letter does not conclude that extension of the demonstration project is improper or unwarranted; it merely concludes that the public notice exemption was not justified and invites Plaintiffs to apply for the extension again while also

complying with the notice and comment requirements (or adequately justifying an exemption). *See* April 16 Letter at 2.

Weighed against Plaintiffs' half-hearted attempt to justify an exemption to notice and comment, is the statutory and regulatory mandate to provide transparency and permit public input. *See* 42 U.S.C. § 1315(d); 45 C.F.R. § 431.416. Forgoing notice and comment unnecessarily is "contrary to the interest of the beneficiaries, as well as of Texas and CMS, because it deprive[s] beneficiaries and other interested stakeholders of the opportunity to comment on and potentially influence the state's request to extend a complex demonstration." April 16 Letter at 2. Improper exemption also "deprive[s] Texas and CMS of the benefit of public comments that might have helpfully informed Texas's design of the extension request and the decision to approve it." *Id*. The "interests of the beneficiaries and the public generally [are] harmed by the inability to comment on how the requested extension could affect their access to high quality healthcare or to suggest new or alternative approaches for how the state could better achieve the goals of the demonstration." *Id*. at 5.

Plaintiffs have therefore not carried their heavy burden to demonstrate that the law and facts clearly favor their argument on the merits, and their request for a mandatory preliminary injunction should be denied.

v. CMS's April 16 Letter Did Not Constitute Agency Action

Plaintiffs claim that CMS improperly exercised an authority that it did not possess in its April 16, 2021 letter. However, in reality, although the parties described the April letter as a "rescission" or "withdrawal," the agency was not in fact exercising any authority via the April letter. The April letter was merely an acknowledgement and notice to Plaintiffs that the action the agency purported to take in the January 15, 2021 letter, approval of the extension request

without a federal notice and comment period, was void ab initio. *See generally* April 16 Letter. Because the purported action in the January 15 Letter was null and void by operation of law, it was not necessary, or possible, for CMS to take any action to further undo the approval. Instead the April 16 Letter is in effect merely a notice to Plaintiffs that the January 15 approval lacked legal effect.

vi. If the April 16 Letter Constitutes Agency Action, CMS Acted Within Its Authority

If the Court does not agree that CMS's April 16 Letter is merely an acknowledgment and notice to Plaintiffs that the January 15 Letter is void, Plaintiffs still cannot show a likelihood of success on the merits. "[I]t is generally accepted that in the absence of a specific statutory limitation, an administrative agency has the inherent authority to reconsider its decisions." *Macktal v. Chao*, 286 F.3d 822, 825-26 (5th Cir. 2002). Section 1315(a), under which Plaintiffs requested and CMS purportedly approved the demonstration extension, *see infra*, does not contain any such "statutory mandate limiting further review of an agency order." *Id*. at 826; *see also* 42 U.S.C. § 1315(a). An agency may, using its inherent authority, reconsider any decision not so limited so long as that reconsideration is not "arbitrary, capricious, or an abuse of discretion," the reconsideration "occurs within a reasonable time after the first decision, and notice of the agency's intent to reconsider [is] given to the parties." *Macktal*, 286 F.3d at 826. CMS satisfied these requirements.

A court may not set aside agency action as arbitrary and capricious or an abuse of discretion unless:

> the agency has relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise.

Sierra Club v. United States EPA, 939 F.3d 649, 663-64 (5th Cir. 2019). This review "is narrow and [the court] must be mindful not to substitute [its] judgment for that of the agency." *Id.* (citation omitted). "Arbitrary and capricious review asks 'whether [the] agency articulated a rational connection between the facts found and the decision made.'" Worldcall Interconnect, Inc. v. FCC, 907 F.3d 810, 817 (5th Cir. 2018) (quoting *ExxonMobil Pipeline Co. v. U.S. Dep't of Transp.*, 867 F.3d 564, 571 (5th Cir. 2017)).

In this case, as explained in detail *supra* at 16-19, CMS made a legal decision based on the facts presented by Texas in its application for public notice exemption that the requirements of CMS's own regulation were not satisfied. *See* April 16 Letter. There is no allegation that CMS considered any impermissible factors. Moreover, Plaintiffs' allegation that CMS failed to consider reliance interests is both untrue, *see* April 16 Letter at 7, and irrelevant. CMS did consider any reliance interests and determined that none had accrued because THTQIP was operating on materially the same terms as it had been before the January approval and no material programmatic changes had yet been implemented. *Id.* In any event, Plaintiffs' alleged reliance interests, to the extent they exist, have no bearing on whether CMS's January 15 approval was in excess of CMS's legal authority to act. Finally, an "agency decision need only have a rational basis, and it does not have to be a decision which the court would have made." *Id.* The April 16 Letter articulates a rational connection between those facts contained in Texas's exemption request and CMS's determination that they did not satisfy the requirements of the public notice exemption regulations. *See* April 16 Letter. Thus, to the extent CMS took any action in its April 16 Letter, that action was not arbitrary, capricious, or an abuse of discretion.

CMS's April 16 Letter was also issued within a reasonable time. There is no specific time period that is definitively reasonable under this standard, but the April 16 Letter clearly qualifies.

Only three months elapsed between the January 15 and April 16 letters. And at the time CMS sent its April 16 Letter, there was still over a year and a half remaining before Texas's demonstration project was set to expire. Finally, Plaintiffs received notice of the agency's intent to reconsider its decision because the April 16 Letter, to the extent it represents any agency action, is not final. At the time CMS issued the letter, Plaintiffs had at least two avenues within the administrative process to prevent the April 16 Letter from taking permanent effect, and indeed they have pursued both in addition to this lawsuit. As described *supra* at 13, Plaintiffs filed an administrative appeal with the DAB rendering the April 16 Letter a non-final decision and preventing it from taking effect until the conclusion of the appeal. Plaintiffs also reapplied for an extension of the demonstration project as suggested by the April 16 Letter.

vii. Texas's Additional Merits Arguments Are Unavailing

Plaintiffs' remaining arguments fail to demonstrate a likelihood of success on the merits because they misunderstand the nature of the April 16 Letter and misread the requirements of the applicable statute and regulations.

First, Plaintiffs conflate the three independent approval authorities granted to CMS with regard to demonstration projects. Based on the circumstances of the extension request and the nature of the intended extension, CMS may consider approval through 42 U.S.C. §§ 1315(a), (e), or (f). *See* Cash Decl. ¶ 6; 42 C.F.R. § 431.412(c) (explaining different conditions applicable to extension requests under the different authorities of sections 1315(a), (e), and (f)); 42 C.F.R. § 431.424(d)(1) (stating that sections 1315(a), (e), and (f) create separate extension authorities). Plaintiffs premise several of their arguments on the requirements of § 1315(f), but their extension request sought approval under § 1315(a). Cash Decl. ¶ 12. Moreover, neither the initial extension requested nor the modified extension purportedly approved by the January 15 Letter

were permissible under § 1315(e) or (f) authority and thus must necessarily have been considered under § 1315(a). *See* Cash Decl. ¶¶ 7-9, 11-12. The most obvious indicator that the extension at issue cannot be subject to the requirements of § 1315(f) is the length of the extension. Section 1315(f) mandates that extensions approved under its authority be no longer than three years. Cash Decl. ¶ 8; 42 U.S.C. § 1315(f)(6) ("An approval of an application for an extension of a waiver project under this subsection *shall* be for a period not to exceed 3 years.") (emphasis added).[5] If the requirements of § 1315(f) were implicated by the extension at issue, which according to the January 15 Letter is for a period of nearly ten years, the approval would have been in excess of statutory authority (and void) for this additional reason as well. Accordingly, none of Plaintiffs' arguments premised on the alleged requirements of § 1315(f), including the 120-day limit to respond to applications and the automatic approval of extension applications, are legally correct and they have no likelihood of success on the merits.

Plaintiffs also misinterpret § 1315(a) to impose a restriction on CMS's authority to disapprove demonstration projects or extensions that does not exist. Plaintiffs allege that CMS "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 Medicaid." PI Mot. at 18. However, § 1315(a) does not impose any restrictions whatsoever on CMS's authority to deny or simply not respond to an application. If CMS chooses to waive any of the requirements of Medicaid, it may only do so to the extent that "in the judgment of the Secretary, [the project] is likely to assist in promoting the objectives" of Medicaid. 42 U.S.C. § 1315(a). But, if CMS instead decides not to waive any requirements, that decision is entirely discretionary; it does not require any finding by

[5] Section 1315(f)(6) contains an exception that permits extensions of 5 years in the sole case of "a waiver described in section 1396n(h)(2) of this title," a specific waiver not at issue here. Cash Decl. ¶ 7 n.1.

the Secretary that the requested waiver is not likely to assist in promoting the objectives of Medicaid. *Cf*. *id*. ("the Secretary *may* waive compliance" (emphasis added)).

For the same reason, the April 16 Letter does not violate any of CMS's regulations. As Plaintiffs note, CMS does not assert any regulatory authority to rescind the January approval in its letter. PI Mot. at 20. That is because the April 16 Letter does not reflect any agency action taken by CMS. Even if the letter were agency action, it would be action taken under the inherent authority of CMS to reconsider its own decisions, *see supra* at 21-23. Plaintiffs are simply wrong that the existence of other specific regulatory authorities compels a finding that this inherent authority does not exist. *Cf*. *Macktal v*. *Chao*, 286 F.3d at 825-26 (5th Cir. 2002) ("[I]t is generally accepted that in the absence of a specific statutory limitation, an administrative agency has the inherent authority to reconsider its decisions.").

Plaintiffs contend that the April 16 Letter does not satisfy the conditions for either termination of a demonstration project or withdrawal of a waiver under 42 C.F.R. § 431.420. PI Mot. at 21. First, as described *supra*, the April 16 Letter merely provides notice to Plaintiffs of the operation of law and does not reflect any action by CMS. Second, even if that were not the case, the voiding of the January 15 approval neither terminated the demonstration project nor withdrew any waivers that were part of the existing demonstration project. Although CMS is currently treating the January approval as effective as required by the DAB regulations, the original demonstration project has not been terminated and will remain ongoing with all waivers through September 30, 2022 if the administrative appeal ends or is disposed in CMS's favor. Therefore, these regulations are clearly inapplicable. Third, because CMS did not take any action through the April 16 Letter, its inaction cannot be arbitrary and capricious for failing to comply with the requirements of various regulations that were not implicated, Plaintiffs state that the

April 16 Letter is fatally defective for failing to comply with various regulations, PI Mot. at 23, but this allegation is entirely irrelevant. The January 15 approval would be in excess of agency authority and void as a matter of law whether or not the April 16 Letter ever existed, and Plaintiffs would be in the same position. Similarly, if the April 16 Letter is a reconsideration under CMS's inherent authority, it need only comply with the conditions explained supra at 21-22.

Each of Plaintiffs' arguments that the April 16 Letter violates the APA are also meritless for the same reasons.[6] The April 16 Letter does not represent any agency action and is merely a notice to Plaintiffs that the January 15 approval was void by operation of law. Issuing the April 16 Letter did not create any obligation to provide a notice and comment period, to consider Texas's alleged reliance interests, or to consider alternative remedies. Because CMS acted in excess of its authority in granting the approval contained in the January 15 Letter, it neither had nor exercised any authority to alter the January approval in its April 16 Letter. The April 16 Letter was merely a description of the legal state of affairs surrounding Plaintiffs' extension request, and as such it was not an agency action that created any rights or duties under the APA.

If, in the alternative, the April 16 Letter constituted agency action under CMS's inherent authority to reconsider, that action also was not arbitrary and capricious for the reasons explained *supra* at 22-23. While the agency's exercise of inherent authority to reconsider creates an

[6] Plaintiffs' reliance on COVID-related statues that do not actually govern the dispute in this case is also misplaced. PI Mot. at 19-20. They do not contend that any of the statutes cited actually speak "specifically to the topic at hand." *FDA v. Brown & Williamson*, 529 U.S. 120, 133 (2000). Nor do they contend that the statutes in any way amended CMS's statutory obligation to provide a public notice and comment process before approving the extension of a demonstration project. Moreover, even if these statutes were relevant (and they are not) Texas's requested demonstration extension does not address the COVID-19 pandemic and the April 16 Letter does not create an imminent risk to the provision of health services. *See supra* at 16-19.

obligation to notify the regulated entity of the reconsideration, unlike the specific regulatory authorities, there is no requirement to provide a period of public notice and comment or to consider alternative remedies. *See supra* at 21-22. To the extent Plaintiffs argue that reliance interests are an "important aspect of the problem" that must be considered under the arbitrary and capricious standard, that argument also fails as discussed *supra* at 22.

Finally, for the reasons enumerated supra at 16-19, Plaintiffs' claim that the April 16 Letter is arbitrary and capricious because its underlying legal premise is not in accordance with law fails. CMS "materially erred" in granting Plaintiffs' unsupported request for exemption from notice and comment and Plaintiffs have no likelihood of success on the merits of that claim.

b. Plaintiffs Have Not Demonstrated That The Balance Of The Equities Or The Public Interest Favors An Injunction

"Federal courts have considered the balance of equities and public interest factors together as they overlap considerably." *Texas v. United States*, Case No. 21-cv-00003, __ F. Supp. 3d __, 2021 U.S. Dist. LEXIS 33890, at *136 (S.D. Tex. Feb 23, 2021); *see also Nken v. Holder*, 556 U.S. 418, 435 (2009) ("These factors merge when the Government is the opposing party."). "In weighing equities, a court 'must balance the competing claims of injury and must consider the effect on each party of the granting or withholding of the requested relief.'" *Texas*, 2021 U.S. Dist. LEXIS 33890, at *136 (quoting *Winter v. NRDC, Inc.*, 555 U.S. 7, 24 (2008)). Meanwhile, "the public interest factor requires the court to consider what public interests might be injured and what public interests might be served by granting or denying a preliminary injunction." *Id*.

Because of the pendency of the DAB appeal and the requirement that CMS take no action on the April 16 Letter, both of these prongs of the analysis favor denial of the preliminary injunction. As explained *supra* at 8, in light of the pending administrative appeal, Plaintiffs have

failed to allege any harm at all, much less irreparable harm. If the requested preliminary injunction were granted, it would have no effect at all on the interests of Plaintiffs because it would be entirely duplicative of relief Plaintiffs are already receiving as a result of their administrative appeal.[7] Because the requested preliminary injunction would provide no additional relief, neither the balance of the equities nor the public interest favor its imposition.

The burden is on Plaintiffs to establish that all four factors "clearly favor" granting the requested injunction. Because Plaintiffs have failed to demonstrate that either the balance of equities or the public interest favor their position, the injunction must be denied.

V. Plaintiffs' Suit Should Be Dismissed For Lack Of Subject Matter Jurisdiction

As explained *supra* at 13-15, the Court lacks jurisdiction to consider Plaintiffs' claims because Plaintiffs are engaged in an ongoing administrative appeal. The APA waiver of sovereign immunity has not been activated in this case because there is no final agency action. Moreover, Plaintiffs do not have standing to bring this suit and their claims are not ripe while the DAB appeal is pending.

Although Defendants maintain that this Court is without jurisdiction to consider Plaintiffs' claims, if the Court does not agree, it should nevertheless stay district court proceedings pending resolution of the administrative appeal to further the interests of judicial economy. Because the DAB is considering the same "action" Plaintiffs challenge here, and because Plaintiffs will continue to receive the same relief requested in their motion for

[7] Similarly, because the operation of the DAB regulations imposes the same conditions as those requested for the preliminary injunction, a preliminary injunction would have no additional effect on the interests of the Defendants during the pendency of the DAB appeal. However, entry of a preliminary injunction would otherwise injure Defendants and the public interest because it would both require CMS to act in excess of its statutory authority, and would require CMS to expend resources in execution of the January 15 approval that it may later need to recoup.

preliminary injunction during the pendency of that appeal, a stay of the Court's procedures will best serve the interests of all parties.

VI. Conclusion

For the reasons explained herein, the Court should decline to exercise jurisdiction over this matter. Whether or not the Court exercises jurisdiction over this matter it should deny Plaintiffs' Motion for Preliminary Injunction.

Dated: July 26, 2021

Respectfully Submitted,

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CERTIFICATE OF SERVICE

I hereby certify that the foregoing document was served on all counsel of record by operation of the court's electronic filing system and can be accessed through that system.

DATED: July 26, 2021

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Defendants' Exhibit 1

January 15 Letter

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

January 15, 2021

Stephanie Stephens
State Medicaid Director
Texas Health and Human Services Commission
4900 Lamar Boulevard
MC: H100
P.O. Box 13247
Austin, Texas 78751

Dear Ms. Stephens:

Under section 1115 of the Social Security Act (the Act), the Secretary of Health and Human Services (HHS) may approve any experimental, pilot, or demonstration project that, in the judgement of the Secretary, is likely to assist in promoting the objectives of certain programs under the Act, including Medicaid. Congress enacted section 1115 of the Act to ensure that federal requirements did not "stand in the way of experimental projects designed to test out new ideas and ways of dealing with the problems of public welfare recipients." S. Rep. No. 87-1589, at 19 (1962), as reprinted in 1962 U.S.C.C.A.N 1943, 1961. As relevant here, section 1115(a)(1) of the Act allows the Secretary to waive compliance with the Medicaid program requirements of section 1902 of the Act, to the extent and for the period he finds necessary to carry out the demonstration project. In addition, section 1115(a)(2) of the Act allows the Secretary to provide federal financial participation (FFP) for demonstration costs that would not otherwise be considered as federally matchable expenditures under section 1903 of the Act, to the extent and for the period prescribed by the Secretary.

For the reasons discussed below, The Centers for Medicare & Medicaid Services (CMS) is approving your request, received on November 30, 2020, to extend Texas's section 1115(a) demonstration, entitled "Texas Healthcare Transformation and Quality Improvement Program" (THTQIP) (Waiver Number: 11-W-00278/6). This extension provides Texas a ten-year demonstration extension, effective with the date of this approval letter, with the demonstration now ending September 30, 2030. This extension reflects changes to the demonstration; updating Texas' Uncompensated Care (UC) funding and rebasing budget neutrality. CMS has otherwise updated the demonstration to include special terms and conditions (STCs) reflecting CMS policy changes since the demonstration's last renewal in 2017, to strengthen monitoring and evaluation, as well as state financing oversight.

CMS's approval of this section 1115(a) demonstration is subject to the limitations specified in the attached waivers, expenditure authorities, STCs, and any supplemental attachments defining the nature, character, and extent of federal involvement in this project. The state may deviate from the Medicaid state plan requirements only to the extent those requirements have been specifically listed as waived or not applicable to expenditures or individuals covered by expenditure authority.

Objectives of the Medicaid Program

As noted above, the Secretary may approve a demonstration project under section 1115 of the Act if, in his judgment, the demonstration is likely to assist in promoting the objectives of title XIX. Under section 1901 of the Act, the Medicaid program provides federal funding to participating states, "[f]or the purpose of enabling each State, as far as practicable under the conditions in such 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 to help such families and individuals attain or retain capability for independence or self-care." Act § 1901. As this statutory text makes clear, two Medicaid objectives are to enable states to "furnish … medical assistance" – i.e., healthcare services – to certain vulnerable populations and to furnish those populations with rehabilitation and other services to help them "attain or retain capability for independence or self-care." Act § 1901. Section 1115 demonstration projects also provide an opportunity for states to test policies that ensure the fiscal sustainability of the Medicaid program, better "enabling each [s]tate, as far as practicable under the conditions in such [s]tate", to furnish medical assistance, Act § 1901, while making it more practicable for states to furnish medical assistance to a broader range of persons in need.

We are committed to supporting states that seek to test measures that are likely to increase coverage, improve the health of beneficiaries, and support the fiscal sustainability of states' Medicaid programs. We expect that such demonstration policies will improve beneficiaries' physical and mental health, resulting in these beneficiaries consuming fewer health care services and resources while they are enrolled in Medicaid, which will preserve Medicaid program resources, make the Medicaid program more efficient, and potentially reduce the program's national average total annual cost per beneficiary of $7871.[1] Such measures can promote the objectives of the Medicaid statute by enabling states to make improvements and investments "as far as practicable under the conditions in such state[s]," SSA Section 1901, in the broader Medicaid program. These measures may enable states to stretch their resources further and enhance their ability to provide medical assistance to a broader range of persons in need, including by expanding the services and populations they cover.[2] By the same token, such measures may also preserve states' ability to continue to provide the optional services and coverage they already have in place. To the extent that either or both of these trends results in lower costs for the state over the long-term, it may allow the state to maintain the long-term fiscal sustainability of its Medicaid program and provide medical services to more Medicaid beneficiaries.

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[1] U.S. Department of Health and Human Services 2018 Actuarial Report on the Financial Outlook for Medicaid.

[2] States have considerable flexibility in the design of their Medicaid programs, within federal guidelines. Certain benefits are mandatory under federal law, but many benefits may be provided at state option, such as prescription drug benefits, vision benefits, and dental benefits. Similarly, states have considerable latitude to determine whom their Medicaid programs will cover. Certain eligibility groups must be covered under a state's program, but many states opt to cover additional eligibility groups that are optional under the Medicaid statute. In addition to expanding Medicaid coverage by covering optional eligibility groups and benefits beyond what the Medicaid statute requires, many states also choose to cover benefits beyond what is authorized by statute by using expenditure authority under section 1115(a)(2) of the Act. For example, recently, many states have been relying on this authority to expand the scope of services they offer to address substance use disorders (SUDs) beyond what the statute explicitly authorizes.

Background on Texas' Section 1115 Demonstration Program

The THTQIP section 1115 demonstration was implemented by the state of Texas ("state") on December 12, 2011 and extended for an additional five-year period on December 12, 2017. The THTQIP demonstration provides benefits through the state's Medicaid managed care and MLTSS programs – STAR, STAR+PLUS, STAR Kids, and Children's Medicaid Dental Services. The demonstration authorizes the state to require enrollment in managed care as a condition for Medicaid eligibility for most Medicaid populations. The state has three distinct managed care programs designed to serve different subpopulations. The STAR program is the primary managed care program serving low-income family and children. STAR+PLUS provides acute care and long-term service and supports (including home and community-based care) to the aged, disabled, and chronically ill. STAR Kids provides acute care and state plan long-term service and supports to children receiving SSI and disability-related (including Supplemental Security Income (SSI) related) Medicaid or who participate in a 1915(c) waiver.

All three programs (STAR, STAR+PLUS, and STAR Kids) operate in all areas of the state. Enrollees receive unlimited monthly prescriptions, which provide a more comprehensive benefit than the monthly prescription limit imposed under the state plan. Additionally, STAR-PLUS includes non-behavioral health inpatient services, which have historically been carved out of the managed care program.

The demonstration has included two funding pools since it was first approved in 2011: the Uncompensated Care (UC) pool and the Delivery System Reform Incentive Payment (DSRIP) pool. The UC pool is available to help defray the actual uncompensated care costs incurred by hospitals and other eligible providers for serving uninsured individuals in the state. The DSRIP pool provides incentive payments to providers to support their efforts to enhance access to care, improve quality, and reform the health care delivery system. The programs supported by the DSRIP align with the following four broad categories: infrastructure development, program innovation and redesign, quality improvements, and population-focused improvement. Reform activities are conducted by Regional Healthcare Partnerships that are financially led by a public hospital or local governmental entity that collaborates with a variety of healthcare providers to address challenges identified in the delivery system. Authority for the DSRIP pool expires September 30, 2021, which expiration is not affected by this extension. Furthermore, funding of the pools is not medical assistance and does not create Medicaid beneficiaries or provide benefits to individuals.

Extent and Scope of the Demonstration

What CMS is approving based on the state's request

Public Health Providers Charity Care Pool

Overview

This demonstration extension will provide new authority for the state to receive FFP for payments made through the Public Health Providers Charity Care Pool (PHP-CCP) starting October 1, 2021. CMS will provide Texas with expenditure authority for ten years of PHP-CCP

funding. Total funding will not exceed $500 million (total computable) in each of the first two years of the program's implementation. In subsequent years, this pool is subject to resizing based on actual charity care costs incurred by eligible providers.

Beginning on October 1, 2021 through September 30, 2022, payments are limited to publicly owned and operated community mental health clinics (CMHCs), local behavioral health authorities (LBHAs), or local mental health authorities (LMHAs), local health departments (LHDs), and Public Health Districts (PHD). These payments are to defray the cost of uncompensated costs of furnishing medical services to Medicaid eligible or uninsured individuals incurred by qualifying providers. Funding of the new PHP-CCP is not medical assistance and does not create Medicaid beneficiaries. As these providers lack formal charity care programs and accounting systems able to capture charity care costs consistent with CMS definition, CMS is providing a one-year transition period for these providers to bring their accounting systems and charity care programs into compliance with CMS' UC policy. As such, the providers may receive reimbursement for Medicaid shortfall for one single year, before they will instead be solely eligible for reimbursement based on actual charity care costs. This is consistent with CMS' previous handling of UC pools; states and their providers, including Texas, have historically been provided approximately a year in order to align with CMS' UC policy upon the creation or renewal of an existing UC pool that did not align with CMS' UC policy.

Starting October 1, 2022 through September 30, 2030, payments from this pool may be made to the same classes of providers, used to defray the actual uncompensated cost of medical services, provided to uninsured individuals as charity care including uninsured full or partial discounts, that provide all or a portion of services free of charge to patients who meet the provider's charity care policy and that adhere to the charity care principles of the Healthcare Financial Management Association. Aggregate annual amounts available for annual PHP-CCP Pool payments beyond the first two years will be reassessed in 2022 to align with actual uncompensated care cost. Expenditures for PHP-CCP payments must be claimed in accordance with new CMS-approved claiming protocols for each provider type. The methodology used by the state to determine PHP-CCP payments will ensure that payments to CMHCs, LBHAs, LMHAs, LHDs, and PHDs are distributed based on uncompensated cost, without any relationship to source of non-federal share, as specified in Attachment T of the demonstration special terms and conditions (STCs). Payments to providers must not exceed the provider's actual uncompensated care costs, except in the first year of the program's operations during which providers may also receive reimbursement not to exceed their actual Medicaid shortfall. As stated above, funding of the new PHP-CCP is not medical assistance and does not create Medicaid beneficiaries.

PHP-CCP Pool Resizing

CMS will resize the PHP-CCP Pool limits for Federal Fiscal Year (FFY) 24-28 based on a reassessment of the amount of uncompensated charity care costs provided by Texas CMHCs, LBHAs, LMHAs and LHAs, to take place by September 1, 2023. The state and CMS will collaborate on the reassessment, which will be based on the CMS-approved cost reports described in Attachment T for the most recent available year. The results of the reassessment will be used to revise the PHP-CCP Pool limits for FFY 24-28. If the reassessment of PHP-CCP Pool limits is not completed to produce an updated PHP-CCP Pool limit by September 1, 2023,

all payments from the pool will be unavailable until the reassessment is completed. The recalculated PHP-CCP pool limits will become the final PHP-CCP pool limits for FFY 24-28.

CMS and Texas will perform another reassessment of PHP-CCP pool limits for FFY 29-30 by September 1, 2028, following the same parameters. The recalculated PHP-CCP pool limits will become the final PHP-CCP pool limits for FFY 29-30. If the reassessment of PHP-CCP Pool limits is not completed to produce an updated PHP-CCP Pool limit by September 1, 2028, all payments from the pool will be unavailable until the reassessment is completed.

Resizing the Existing UC Pool

CMS is not making substantive changes to the methodology of the current UC Pool through this demonstration renewal. However, CMS will resize the UC pool in 2022, establishing an amount for 2022-2026, and then again in 2027, with the latter resizing using the most recent complete cost reports from eligible hospital providers (hospital fiscal year 2025 data). When CMS rebases the UC Pool in 2022, CMS will use hospital fiscal year 2019 data, as CMS and Texas believe this represents the best way to avoid capturing data impacted by COVID-19 expenditures or changes in utilization. If CMS were to utilize 2020 or 2021 cost reports, the data would not reflect a steady state depiction of charity care costs within the state, and the pool would need to be modified again given the unique landscape of 2020 and 2021. Using 2019 data also reflects a true depiction of charity care costs within Texas, as opposed to CMS or Texas attempting to calculate a hypothetical amount for 2020 as if COVID-19 had not existed.

Budget Neutrality Rebasing

Per the State Medicaid Director's Letter issued on August 22, 2018, CMS and Texas will rebase the budget neutrality per member per month (PMPM) amount that will be effective in FFY 2023 (October 1, 2022-September 30, 2023) using FFY 2022 (October 1, 2021-September 30, 2022) data to establish the rebased without-waiver (WOW) PMPMs for use beginning in FFY 2023. To calculate the new rebased amount, the budget neutrality will be adjusted to account for annualized amounts of approved state-directed payments (pending state legislative approval) made in FFY 2022. In response to the Public Health Emergency, CMS will allow for a one-time adjustment to budget neutrality to account for impacts of COVID-19 on enrollment and expenditures. In addition, the state will be authorized to rollover any savings accrued by the state during the five years immediately preceding the extension, consistent with the savings accrual policy outlined in State Medicaid Director's Letter (SMDL) #18-009.

Within the 10-year approval timeframe, a second round of rebasing with actuals will occur for FFY 2028 (October 1, 2027-September 30, 2028) using October 1, 2026-September 30, 2027 as the base. The state will also be authorized to rollover any savings accrued by the state in each demonstration year starting with DY12 through DY16, as those are the five fiscal years immediately preceding the rebasing that will occur for DY17.

State Directed Payments

Texas plans to implement new State Directed Payments (SDPs). The state intends to submit requests for CMS approval for directed payment programs in accordance with 42 CFR 438.6(c).

As part of the STCs, CMS will assess compliance with regulatory requirements through ongoing monitoring. These payments are not being approved or opined upon as part of this demonstration renewal. The approved STCs attached to the letter outline the process Texas should follow for submitting requests for approval, in addition to and reflecting CMS' process for reviewing and approving state directed payment programs. To the extent regulatory requirements concerning state-directed payments in 42 CFR part 438 are not expressly waived or identified as not applicable, they continue to apply in full force; in the event of any incompatibility between regulatory requirements and what is stated in the STCs, the regulations would prevail.

Additional Updates to the STCs

The following changes are considered updates to the existing demonstration, but do not constitute changes to the policy design of the Texas' 1115 demonstration.

Home and Community-Based Services Protections

In recent years, CMS has worked to emphasize to states that carving 1915(c) waivers or 1915(i) state plan authorities into section 1115(a) demonstrations does not result in less rigor in how those authorities are monitored or beneficiaries are protected. In this demonstration approval, CMS inserted new STCs into the demonstration, consistent with those in other demonstrations, which will help ensure that Texas applies the same beneficiary safeguards and provides the same information to CMS it would have, had the services not been authorized under the section 1115 demonstration but remained in 1915(c) or 1915(i) authorities.

Managed Care and Managed Long-Term Services and Supports (MLTSS)

The demonstration renewal will include an extension of the state's Medicaid managed care and MLTSS programs – STAR, STAR+PLUS, STAR Kids, and Children's Medicaid Dental Services – for an additional ten years. CMS is not making any substantive changes to the requirements for these programs. Findings from the state's evaluation reports[3] indicated a statistically significant increase in the trend of the percentage of children receiving at least one preventive dental visit and a statistically significant decrease in the trend of the percentage of children aged 0-20 years with tooth decay or cavities after full implementation of managed care between 2011 and 2018. Additionally, caregivers of STAR Kids children receiving specialized services were more likely to report positive experiences with child healthcare under the STAR Kids program compared to caregivers surveyed pre-implementation.

Monitoring and Evaluation

During this extension period, monitoring and evaluation for the demonstration will be strengthened and shall focus on assessing the performance of the demonstration and whether the demonstration is effective in achieving the objectives of the program. Throughout the life-cycle

[3]Preliminary Evaluation of Texas's Section 1115 Demonstration, dated December 7, 2020, and Evaluation of Texas's Medicaid Managed Care STAR Kids Program Focus Study, dated November 13, 2019. CMS is in the process of reviewing these reports and once approved, they will be made available on: Medicaid.gov (https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/83231).

of the demonstration approval period, monitoring will support tracking the state's progress towards its demonstration goals. The evaluation will focus on studying whether the demonstration policies, such as the resizing of the UC pool and PHP-CCP pool as well as the state directed payments and the managed care and MLTSS programs, are effective in producing the desired outcomes for beneficiaries, providers, and the Medicaid program overall.

The extension of this demonstration will require Texas to conduct robust monitoring of the demonstration policies, including reporting on enrollment and enrollment changes over time, access to care, quality of care, and health outcomes. The performance metrics will provide data to demonstrate how the state is progressing towards meeting the demonstration's goals, and will cover key policies under this demonstration, including but not limited to, Medicaid Managed Care (e.g., trends related to the provider network and network adequacy to ensure MCO's meet service delivery area time/distance standards, and trends related to enrollment in STAR, STAR KIDS, STAR+PLUS, Dental Program, and Members with Special Health Care Needs), and UC (e.g., providers reporting UC costs). The performance metrics will also reflect all other components of the state's demonstration.

Consistent with CMS requirements for all section 1115 demonstrations, the state will undertake rigorous evaluation of the demonstration policies during this 10-year extension period. The state is required to prepare a strong evaluation design for the entirety of the demonstration approval period that is subject to CMS approval, and conduct—in alignment with the evaluation design—three interim evaluations and one summative evaluation pertaining to the ten-year demonstration extension period. The key provisions under the demonstration will be tested via hypotheses and research questions approved in the state's evaluation design. In assessing the extent to which the demonstration achieves the key policy outcomes and objectives, the state must identify, through robust statistical methods, viable in-state or out-of-state comparison populations, or use other rigorous methodological approaches, such that the impact of the demonstration can be estimated. Overall, the state will be expected to make a significant and sustained effort to conduct a robust evaluation covering comprehensively the demonstration policy components.

The demonstration extension includes robust monitoring and evaluation requirements, and the demonstration may be suspended or withdrawn, if monitoring and evaluation data raise concerning evidence. Specifically, these STCs outline that CMS reserves the right to require the state to take corrective action, which could include suspending implementation of specific provisions of the demonstration, if monitoring or evaluation data indicate substantial and sustained directional change inconsistent with state targets (such as substantial and sustained trends indicating increased difficulty accessing services). CMS further has the ability to suspend implementation of part or the whole of the demonstration should corrective actions not effectively resolve these concerns in a timely manner. The STCs will aid the state and CMS in measuring and tracking the demonstration's impact, and give CMS additional tools to protect beneficiaries if necessary. Further, CMS reserves the right to withdraw expenditure authorities at any time, subject to the conditions described in the STCs, if it determines that continuing the expenditure authorities would no longer be in the beneficiaries' interest or promote the objectives of Medicaid.

Determination that the Demonstration Extension is Likely to Assist in Promoting Medicaid's Objectives

Under section 1901 of the Act, the Medicaid program provides federal funding to participating states "[f]or the purpose of enabling each state, as far as practicable under the conditions in such 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 to help such families and individuals attain or retain capability for independence or self-care."

The demonstration will provide demonstration funding, including through the UC pool and newly authorized PHP-CCP pool, in a manner that improves the sustainability of the safety net.

The continuation of the existing UC pool, plus the PHP-CCP for qualifying community providers, promotes stability in safety net providers that provide care to Medicaid beneficiaries. Without providing funding to offset the obligation of certain providers to provide charity care to the indigent, they might not have the capacity or funding to operate at a level consistent with adequate access for Medicaid beneficiaries. The demonstration also establishes a new pool that provides reimbursement to safety net providers serving the Medicaid population, such as community mental health centers, local health authorities, and local mental health authorities. Absent the new PHP-CCP pool, providers may not find it feasible to continue providing care at the same level as they currently provide to Medicaid beneficiaries, and either downsize operations or close entirely. Funding of the existing UC pool and new PHP-CCP pool, which is not medical assistance, does not provide benefits to individuals, and does not create Medicaid beneficiaries, promotes the objectives of Medicaid by helping stabilize safety net providers.

The 10-year extension permits greater financial certainty for the state and its safety net providers that serve Medicaid populations. This demonstration sets out predictable funding during the uncertain budgetary times.

In keeping with the state's long-term goals for the demonstration as a whole, which include lowering costs, the state will evaluate the financial impacts of the entire demonstration. The extension STCs require the state to investigate cost outcomes for the demonstration as a whole, with evaluation research questions that include but are not limited to: the administrative costs of demonstration implementation and operation, Medicaid health service expenditures, and provider uncompensated care costs. In addition, the state must use results of hypothesis tests aligned with other demonstration goals and cost analyses together to assess the demonstration's effects on Medicaid program sustainability.[4]

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[4] The state is also expected to include cost and sustainability assessment for the THTQIP demonstration approval period 2018-2020 in the summative evaluation report, draft of which is due to CMS on June 30, 2022, in alignment with the state's CMS-approved evaluation design from this period, 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-appvd-demo-eval-dsgn-080218.pdf.

Consideration of Public Comments

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act) (as amended (42 U.S.C. 1320b-5)). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences of the COVID-19 pandemic, to the extent necessary, as determined by CMS, to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers can continue to deliver the most effective care to their beneficiaries in light of the COVID-19 public health emergency.

Transparency regulations at 42 CFR 431.416(g) state that CMS may expedite approval of a section 1115 demonstration, and exempt both the federal and state public notice and input process set forth at 42 CFR 431.408, when there are unforeseen circumstances resulting from a natural disaster, public health emergency, or other sudden emergency that directly threatens human lives that warrants an exception to the normal public notice process. To exercise the discretionary authority permitted by 42 CFR 431.416(g), the following conditions must be met: i) the state acted in good faith, and in a diligent, timely, and prudent manner; ii) the circumstances constitute an emergency and could not have been reasonably foreseen; and iii) delay would undermine or compromise the purpose of the demonstration and be contrary to the interests of beneficiaries.

The Secretary's declaration of COVID-19 as a public health emergency meets the criteria described in 42 CFR 431.416(g) for CMS to exercise its regulatory discretion to exempt federal transparency requirements. CMS assessed that Texas' section 1115 demonstration extension request met the three conditions to warrant an exception to the normal public notice process as follows: i) the state did act in good faith in developing an application that aligned with federal requirements; ii) COVID-19 is an unprecedented worldwide outbreak of respiratory disease that could not have been reasonably foreseen; and iii) the timeframes associated with the normal public notice process would have imminently jeopardized the stability of the state's provider network to continue to provide services to the low-income and vulnerable populations they serve. With these exemption conditions established, CMS will publish this approval on the Medicaid.gov[5] website within 15 days of the date of this letter as required by 42 CFR 431.416(g)(4).

Other Information

CMS's approval of this demonstration extension is subject to the limitations specified in the enclosed authorities and special terms and conditions (STC), which define the nature, character, and extent of federal involvement in this project. The state may deviate from the Medicaid state

[5] The Medicaid.gov webpage for the Texas Healthcare Transformation and Quality Improvement Program is available here: https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/83231.

plan requirements only to the extent they have been specifically listed as waived or not applicable to expenditures or individuals covered by expenditure authority.

This approval is also subject to your written acknowledgement of the award and acceptance of STCs within 30 calendar days of the date of this letter. Please send written acceptance to your project officer, Diona Kristian. Ms. Kristian is available to answer any questions concerning your section 1115(a) demonstration and may be contacted as follows:

Diona Kristian
Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-25-26
7500 Security Boulevard
Baltimore, MD 21244-1850
Email: Diona.Kristian@cms.hhs.gov

If you have question regarding this approval, please contact Ms. Teresa DeCaro, Acting Director, State Demonstrations Group, Center for Medicaid & CHIP Services at (410) 786 9686.

We look forward to continuing to work with you and your staff on Texas' section 1115 demonstration.

Sincerely,

[redacted]

Seema Verma

Enclosure

cc: Ford Blunt, State Monitoring Lead, CMS Medicaid and CHIP Operations Group

Defendants' Exhibit 2

April 16 Letter

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

April 16, 2021

Stephanie Stephens
State Medicaid Director
Texas Health and Human Services Commission
4900 Lamar Boulevard
MC: H100
P.O. Box 13247
Austin, Texas 78751

Dear Ms. Stephens:

On January 15, 2021, the Centers for Medicare & Medicaid Services (CMS) approved a request from Texas to amend and extend its section 1115(a) demonstration titled "Texas Healthcare Transformation and Quality Improvement Program (THTQIP)" (project number 11-W-00278/6) for a ten-year extension through September 30, 2030. The THTQIP demonstration was previously approved through September 30, 2022, and the recent extension included significant programmatic changes to the existing demonstration's structure. CMS approved this extension based on the state's November 30, 2020 application submission that included a request to exempt the extension application from the public notice and comment process requirements for section 1115 demonstrations that generally apply under section 1115(d)(2) of the Social Security Act (the Act) and implementing regulations in 42 C.F.R. Part 431, Subpart G.

On December 15, 2020, CMS informed Texas that its application was complete and that CMS was approving the state's request for an exemption from the public notice and comment requirements. Texas asserted that this exemption was necessary to provide financial stability for providers in the state, as well as the state's Medicaid program, in the midst of the COVID-19 public health emergency. On January 15, 2021, CMS approved the state's request to extend the THTQIP demonstration with substantial modifications from the state's extension application, including but not limited to a new uncompensated care pool and a new approval period through September 30, 2030, instead of through September 30, 2027, as the state requested in its application.

Although Texas requested an exemption from the public notice and comment process, the state nevertheless undertook a state-level notice and comment process. On November 27, 2020, the state both published a notice of the extension request in the *Texas Register* and provided written notification to tribal representatives, after which the state held tribal and public hearings about the extension request on December 4, 7, and 8, 2020. These public notice materials were consistent with the state's extension application as submitted to CMS on November 30, 2020, and did not reflect the substantial modifications that were ultimately approved, including the new uncompensated care pool and the new approval period through September 30, 2030.
Upon further review, we have determined that CMS materially erred in granting Texas's request for an exemption from the normal public notice process under 42 C.F.R. § 431.416(g), as further

explained below. We have determined that the state's exemption request did not articulate a sufficient basis for us to conclude that approving the state's emergency request for an exemption from the normal public notice process was needed to address a public health emergency or other sudden emergency threat to human lives, as required under 42 C.F.R. § 431.416(g). The state's exemption request in its application did not establish that the request to extend the demonstration, which was already authorized through September 30, 2022, was substantially related to the public health emergency for COVID-19 or any other sudden emergency threat to human lives, that the circumstances surrounding the extension request constituted an emergency, or that delay sufficient to complete the public notice and comment process before approval of the extension request would have undermined or compromised the purpose of the demonstration or been contrary to the interest of beneficiaries. Rather, the erroneous initial determination to approve an exemption from the normal public notice and comment requirements was itself contrary to the interest of beneficiaries, as well as of Texas and CMS, because it deprived beneficiaries and other interested stakeholders of the opportunity to comment on, and potentially influence, the state's request to extend a complex demonstration – already authorized through September 30, 2022 – into the next decade. The demonstration would not yet expire for a significant period of time, and the extension also included new programmatic features not ever previously approved by CMS. Furthermore, the exemption from the normal public notice process deprived Texas and CMS of the benefit of public comments that might have helpfully informed Texas's design of the extension request and the decision to approve it. Therefore, in the interest of comporting with federal statutory and regulatory protections for public participation in the development of section 1115 demonstration applications and extensions, we are rescinding the approval issued on January 15, 2021. The waivers, expenditure authorities, and Special Terms and Conditions (STCs) that were in effect with our October 13, 2020 issuance of technical corrections to the THTQIP section 1115 demonstration will continue to be in effect, including reinstatement of the demonstration expiration date associated with those STCs. Withdrawing the January 15, 2021 extension approval is necessary to avoid uncertainty and adverse consequences that could result from reliance on the January 15, 2021 approval, the precise terms of which Texas might not request and CMS might not approve once informed by feedback from beneficiaries and other stakeholders who would be impacted by the extension of the THTQIP section 1115 demonstration. Accordingly, the THTQIP section 1115 demonstration is currently authorized through September 30, 2022. Should the state still wish to extend the demonstration past that date, we stand ready to work with the state to accomplish state submission and CMS review of a complete extension application during the next eighteen months that the demonstration continues to be authorized.

Section 1115(d)(2)(A) of the Act and 42 C.F.R. § 431.408(a) require a state-level process for public notice and comment, including public hearings, be completed prior to submitting a section 1115 demonstration extension application to CMS, to ensure a meaningful level of public input in the state's development of its application. Following receipt of a complete extension application from the state, including documentation of the state's compliance with the state-level public notice process (*see* 42 C.F.R. § 431.412(c)(2)(vii)), CMS is required to complete a federal-level public notice and comment process, as provided under section 1115(d)(2)(C) of the Act and 42 C.F.R. § 431.416(b), to further inform our review and determination of the state's application. Federal regulations at 42 C.F.R. § 431.416(g) set forth a narrow exemption from these state and federal public notice requirements, which we may approve to expedite a decision

on a proposed demonstration or demonstration extension request that addresses a natural disaster, public health emergency, or other sudden emergency threats to human lives. To obtain an exemption from the normal public notice process, the state must meet all three criteria specified in 42 C.F.R. § 431.416(g)(3): (i) the state acted in good faith, and in a diligent, timely, and prudent manner; (ii) the circumstances must constitute an emergency that could not have been reasonably foreseen; and (iii) it must be the case that delay would undermine or compromise the purpose of the demonstration and be contrary to the interests of beneficiaries. Upon further consideration of the state's exemption request, CMS's approval, and the effect of depriving beneficiaries and other interested stakeholders of an opportunity to comment on the extension and associated demonstration changes that we initially approved, we have determined that the state's exemption request did not articulate a sufficient basis for us to conclude that the state's emergency request for an exemption from the normal public notice process met the criteria specified in 42 C.F.R. § 431.416(g) for this narrow exception.

Texas's rationale for seeking exemption from the normal public notice process was premised on the state's conclusory assertion that healthcare providers in the state must have the financial stability they need to prepare for and respond to the COVID-19 public health emergency, and without an emergency approval of the extension request, the goals, purpose, and achievements from the THTQIP demonstration would be undermined. However, the state's exemption request did not meaningfully explain why the extension request addressed the COVID-19 public health emergency or any other sudden emergency threat to human lives, as required under 42 C.F.R. § 431.416(g)(1) and (2); why the circumstances constituted an emergency, as required under 42 C.F.R. § 431.416(g)(3)(ii); or why delay would undermine or compromise the purpose of the demonstration or be contrary to the interest of beneficiaries, as required under 42 C.F.R. § 431.416(g)(3)(iii).[1]

The THTQIP section 1115 demonstration extension request contained no features that specifically address the COVID-19 public health emergency. The demonstration was initially approved effective December 12, 2011 and, had already been extended through September 30, 2022, before the COVID-19 public health emergency began. Moreover, the state did not request any new or modified authorities designed to address the COVID-19 public health emergency, or any other sudden emergency threat to human lives. Instead, as Texas stated in its request for an exemption from the public notice and comment requirements, the state decided to "forgo[] requesting any modifications or complex or substantive changes to the waiver" to "achieve timely submission" of its request to extend the demonstration for an additional five years, through September 30, 2027. Although we ultimately approved substantial modifications to the demonstration as part of the January 15, 2021 extension approval, neither Texas's exemption request nor any later submission from the state attempted to explain why a five-year extension period – let alone the longer extension through September 30, 2030 or the new uncompensated care pool that the state did not initially request but that we ultimately approved – was necessary to address an emergency. And, in any event, none of the changes initially requested by the state

[1] Because we find that we erroneously concluded that Texas's application sufficiently demonstrated that the extension request addressed a public health emergency, that the circumstances constituted an emergency, and that delay would undermine or compromise the purpose of the demonstration or be contrary to the interest of beneficiaries, we need not consider whether Texas sufficiently demonstrated that it met the requirements under 42 C.F.R. § 431.416(g)(3)(i).

or that CMS approved was in fact geared to address the COVID-19 public health emergency or any other sudden emergency threat to human lives.

Moreover, to the extent Texas needed to make changes to the THTQIP demonstration to address the COVID-19 public health emergency, we have made available a streamlined section 1115 demonstration application template to do so. Many states, including Texas, have used this template to request and receive expedited CMS approval for new demonstrations and demonstration changes needed to address the exigencies of the COVID-19 public health emergency. Through that mechanism, states can, for example, request authority for certain supplemental payments to providers or to modify payment rates to ensure the financial stability of Medicaid providers affected by the public health emergency.

Additionally, considering the existence of the COVID-19 public health emergency and the financial pressures that many providers across the nation have experienced as a result, the state did not identify any circumstances that constituted a genuine emergency with respect to its request for an exemption from the public notice and comment requirements. It is unclear why Texas, or Medicaid providers in the state, reasonably could have been concerned about the stability of Medicaid payments authorized under the demonstration in the near term, as the demonstration already was authorized for almost an additional two years at the time of the state's extension request. While one component of the demonstration – the Delivery System Reform Incentive Payment (DSRIP) program – was slated to expire a year before the rest of the demonstration, on September 30, 2021, Texas was aware since CMS's December 21, 2017 demonstration extension approval that this authority would expire on September 30, 2021, and was specifically required under the terms of that approval to be working on a transition plan to operate the DSRIP program under traditional Medicaid authorities, or otherwise prepare for the cessation of federal financial participation in the DSRIP program after September 30, 2021. Rather than an emergency justifying an urgent demonstration extension without public notice and comment, the winding down of the DSRIP program was well known to the state and should have been a matter of state planning before the COVID-19 public health emergency. Furthermore, the January 15, 2021 extension approval did not alter the September 30, 2021 expiration of DSRIP program authority.

In view of the foregoing, Texas did not demonstrate in its request for an exemption from the public notice requirement that delaying approval of the extension application long enough to complete the state-and federal-level public notice and comment processes would undermine or compromise the purpose of the demonstration or be contrary to the interests of beneficiaries. Simply put, there was adequate time at the time of application to conduct the state-level public notice process and submit a complete extension application to CMS, and for us to conduct the federal-level public notice process and take action on the extension application, before the DSRIP program's expiration date of September 30, 2021, and certainly before the rest of the demonstration expires on September 30, 2022. In fact, there is still sufficient time today to accomplish an extension while respecting all applicable federal legal requirements. Therefore, Texas has not shown that approval of the exemption from the public notice process was needed to avoid undermining or compromising the purpose of the demonstration – which is not, and has not since its 2011 inception, been designed to address the COVID-19 public health emergency or any other sudden emergency threat to human lives.

Furthermore, delaying the extension application submission and approval long enough to conduct the state- and federal-level public notice and comment processes would not have been contrary to the public interest where there was no ordinary programmatic or extraordinary emergency-related need for expedited extension approval. Instead, our erroneous approval of the state's request for an exemption from the public notice process was contrary to the interests of beneficiaries, as well as other interested stakeholders, because it deprived them of the opportunity to comment on, and potentially influence the design of, the state's section 1115 demonstration project, which encompasses almost all of the state's Medicaid program, affecting approximately four million beneficiaries in the state and involving billions of dollars of state and federal spending annually.

Even if we initially approved the extension without modification through September 30, 2027, as the state originally requested, specifically, the interests of beneficiaries and the public generally would have been harmed by the inability to comment on how the requested extension could affect their access to high quality health care or to suggest new or alternative approaches for how the state could better achieve the goals of the demonstration. The public notice and opportunity for comment generally required by federal statute and regulation is of heightened importance in connection with this extension, which is the longest extension period ever approved for this demonstration. Where the state did not demonstrate an exigent need for the exceptionally expedited approval process, it was contrary to the interest of beneficiaries to deprive them and other stakeholders (including providers) of the opportunity to comment on this lengthy extension and the substantial associated programmatic changes that CMS approved, including a significant new uncompensated care pool that would funnel $1 billion to selected providers in the state in just the first two years of payments from the pool. Stakeholders, including beneficiaries and providers, were denied the opportunity to learn how this new uncompensated care pool for certain providers would affect their interests, for example, whether and how it would promote the overall stability of the state's Medicaid provider network or improve access to services, and whether payments to the specific providers eligible for the pool are likely to promote access to the particular services and in the particular areas where improved access is most needed.

By its terms, the regulatory exemption from the normal public notice process is only available in the event of a natural disaster, public health emergency, or other sudden emergency threat to human lives, 42 C.F.R. § 431.416(g)(1). 42 C.F.R. § 431.416(g)(2) further emphasizes that the circumstances supporting the exemption must "*directly threaten*[] human lives" (emphasis added). As discussed above, the only reason stated in Texas's request for an exemption from the public notice requirements was to help provide financial certainty for providers in the state, and for the Texas Medicaid program itself. While the state did not request any new authorities in its application, or the extension of any authorities that were set to expire before September 30, 2022, the state explained that expediting its extension request would be the state's "primary way to provide certainty to providers."

We understand the concerns of the state and providers in the state, as well as the relevance of the demonstration's continuation to the Texas Medicaid program. However, the state did not provide any information to substantiate that an expedited decision on the extension request would alleviate provider concerns, which were principally related to the financial impacts of reduced hours, location closures, and the provision of fewer non-COVID-19 related services due

to the effects of the public health emergency. Nor did the state demonstrate that there would be any consequence for providers or the Texas Medicaid program if the state and CMS adhered to the federal statutory and regulatory requirements for meaningful public notice and opportunity for comment prior to extension application submission and approval. Merely easing abstract concerns about the continuation of the THTQIP demonstration, already authorized for another twenty-two months after the date of Texas's extension request, would not address the stresses on the Medicaid system due to the public health emergency, nor do those abstract concerns themselves reach the level of a "sudden emergency threat to human lives," let alone a circumstance that "directly threatens human lives," within the meaning of 42 C.F.R. § 431.416(g)(1) and (2).

In sum, the state did not articulate a sufficient basis for us to conclude that approving the state's emergency request for an exemption from the normal public notice process was needed to address the COVID-19 public health emergency or other sudden emergency threat to human lives. Instead, Texas's request for an extension of the THTQIP demonstration and the amendments we initially approved alongside the extension were ordinary programmatic actions that could have proceeded, and still may proceed, through the ordinary programmatic processes, as provided in section 1115(d) of the Act; 42 C.F.R. Part 431, Subpart G; and the STCs governing the THTQIP demonstration. The state did not articulate any rationale in its request for an emergency exemption that, consistent with the implementing regulations in 42 C.F.R. § 431.416(g), could be sufficient to override Congress' general intent, expressed in section 1115(d)(2)(A) and (C) of the Act, that there should be a process to "ensure a meaningful level of public input" with respect to demonstration applications and extensions, *cf.* 77 Fed. Reg. 11,678, 11,679 (Feb. 27, 2012) (discussing statutory requirement to issue regulations to "ensure the public has adequate opportunities to provide meaningful input into the development of State demonstration projects, as well as in the Federal review and approval of State demonstration applications and renewals [that is, extensions]").

For these reasons, we have determined that our initial approval of Texas's request for an exemption from the normal public notice requirements was in error, because the state's request did not provide sufficient justification for why it met the criteria in 42 C.F.R. § 431.416(g). Specifically, the state's request did not sufficiently demonstrate that its extension request addressed a natural disaster, public health emergency, or other sudden emergency threat to human lives; the circumstances of the state's exemption and extension requests constituted an emergency; and that a delay sufficient to complete the state- and federal-level public notice and comment processes would have undermined or compromised the purpose of the demonstration or been contrary to the interest of beneficiaries.

Our error in this regard was not harmless; it has deprived beneficiaries and other interested stakeholders of the opportunity to comment on, and potentially influence the design or continuation of, the THTQIP demonstration, for which we approved a lengthy extension period of almost ten years. As Texas indicated in its request for an exemption from the normal public notice process, the THTQIP demonstration is critical for providing comprehensive health coverage to beneficiaries and for maintaining Medicaid provider network stability to promote access to care. Therefore, it is especially important that the interests of beneficiaries, providers, and other affected stakeholders are adequately addressed in the design of the state's proposal for

extending the THTQIP demonstration and in our decision to approve it. With the absence of the required public notice and comment process, Texas has been deprived of the benefit of public comments that could have informed the features of the extension request it submitted, and CMS has been deprived of the benefit of public comments that could have informed the determination whether to approve the state's request (or a revised version thereof). On the other hand, the THTQIP demonstration is operating today without material change from the demonstration's operations as it was approved before our January 15, 2021 approval; and because payments from the new uncompensated care pool are not authorized until October 1, 2021, no material programmatic changes have been implemented at this time and the state has not incurred a reliance interest based on the January 15, 2021 approval.

Accordingly, we are rescinding our approval of the state's 42 C.F.R. § 431.416(g) exemption request and our January 15, 2021 demonstration extension approval, and providing Texas the opportunity to resubmit its completed application after going through the necessary public notice and comment procedures required under section 1115 of the Act and its implementing regulations. We are withdrawing the January 15, 2021 extension approval, rather than leaving it in place while Texas and CMS conduct the required state- and federal-level public notice and comment processes, to avoid uncertainty for Texas and providers in Texas. On December 28, 2020, after we initially approved the emergency exemption from the public notice requirements but before we approved the extension, we received a letter from three public interest groups opposing our approval of the exemption from the normal public notice process and arguing that public notice and an opportunity for comment were needed so that Texans could weigh in on changes that could better serve Texans and the goals of the Medicaid program. Leaving the January 15, 2021 extension approval in place during public notice and comment would risk creating a misplaced expectation on the part of the state or providers in the state that the demonstration extension necessarily will proceed according to the January 15, 2021 approval.

Therefore, to avoid any adverse consequences that might result from the state or providers in the state making plans based on the January 15, 2021 approval, we have determined that leaving this approval in effect would not be an appropriate approach to remedy the underlying procedural errors and are instead withdrawing that extension approval while affording the state the opportunity to resubmit a complete extension application. The waivers, expenditure authorities, and STCs that were in effect with our October 13, 2020 issuance of technical corrections to the THTQIP demonstration will continue to be in effect, including reinstatement of the demonstration expiration date associated with those STCs. Accordingly, the THTQIP section 1115 demonstration is currently authorized through September 30, 2022. The established timeline for the interim and summative evaluation reports and all other reporting requirements as described in the STCs, dated October 13, 2020, remains in effect. CMS looks forward to continuing to work with the state on the interim and summative evaluation reports.

We recognize that, should the state wish to proceed with its extension request, the state must comply with the requirements in 42 C.F.R. § 431.408 for public notice and an opportunity for comment, including applicable tribal consultation requirements, before submitting to us a complete application to extend the demonstration that meets the requirements of 42 C.F.R. § 431.412(c). We stand ready to provide whatever technical assistance might be helpful to the

state in meeting these requirements to speed the submission of a complete extension application for our review.

To the extent that Texas wishes specifically to address challenges raised by the COVID-19 pandemic, as noted above, we released a separate COVID-19 section 1115 demonstration template that can include an expedited public notice process for state efforts to directly respond to the public health emergency. In fact, as you know, we approved an amendment on September 3, 2020 to the THTQIP demonstration using this emergency template to allow Texas to provide expanded services to certain beneficiaries. We are available to provide technical assistance on further flexibilities that could be available to Texas, including through the COVID-19 section 1115 demonstration template, which could directly address the COVID-19 public health emergency. For example, this template could be used to authorize certain supplemental payments to providers or to modify payment rates, if the state has concerns about the financial stability of providers in the state arising from the public health emergency.

CMS is committed to working with Texas on achieving our shared goals for the Medicaid program, including through the THTQIP section 1115 demonstration project. We are available to provide technical assistance, should the state decide to move forward with an extension application consistent with all applicable federal legal requirements. If you have questions, please contact Ms. Judith Cash, Acting Deputy Director, Center for Medicaid & CHIP Services, at (410) 786-9686.

Sincerely,

Elizabeth Richter
Acting Administrator

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF TEXAS
TYLER DIVISION

THE 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.: 1:21-cv-00191

DECLARATION OF JUDITH CASH

I, Judith Cash of the Center for Medicaid and CHIP Services (CMCS) at the Centers for Medicare & Medicaid Services (CMS), declare that the following statements are true and correct to the best of my knowledge and belief, and that they are based on my personal knowledge as well as information provided to me in the ordinary course of my duties.

1. I am employed by the Department of Health and Human Services (HHS) in CMCS at CMS, located at 7500 Security Boulevard, Baltimore, MD 21244. I am the Acting Deputy Director for CMCS within CMS at HHS. I have held this position since December 7, 2020. Before that, I served as the Director of the State Demonstrations Group (SDG) within CMCS and as Deputy Director for Policy in SDG. I have been employed at CMS since 2012.

2. CMCS is a component of CMS. It is charged with administering the Medicaid program and serves as CMS's focal point for assistance with formulation, coordination, integration, and implementation of all national program policies and operations relating to Medicaid, the Children's Health Insurance Program (CHIP), and the Basic Health Program (BHP). CMCS works in partnership with states, assists state agencies in successfully carrying out their responsibilities for effective program administration and protecting beneficiaries, and, as necessary, supports states in correcting problems and improving the quality of their operations. CMCS also identifies and proposes modifications to program measures; regulations; laws; and policies to reflect changes or trends in the health care industry, program objectives, and beneficiaries' needs.

3. In my role, I manage a team of professional and administrative staff with a variety of advanced degrees in fields including economics, law, medicine, public health, public policy, finance, and business operations. My team is responsible for policy development, management, oversight, budget, and performance issues related to Medicaid, CHIP and BHP on behalf of CMS. My team and I regularly interact with representatives from states and other stakeholders.

4. As relevant to this lawsuit, my team includes the SDG, which ensures that Medicaid and CHIP section 1115 demonstration projects support the objectives of the Medicaid statute, including as amended by the Affordable Care Act, which involves supporting states that are interested in expanding Medicaid and/or reforming their service delivery, eligibility, benefits, or provider payment systems through the use of demonstration authorities. With respect to Medicaid demonstration projects under section 1115 of the Social Security Act, the SDG assists states in developing proposed projects, reviews states' applications, negotiates the terms of a state's proposed demonstration project, recommends approval or disapproval of states' projects

to the CMS official who ultimately approves or disapproves those projects, assists states with approved projects with technical matters in implementing their projects, monitors and evaluates states' progress throughout the life of approved projects, and oversees states' compliance with their special terms and conditions (STCs).

5. Due to the nature of my official duties, I am familiar with decision-making processes at CMCS and the process for approving applications for Medicaid section 1115 demonstration projects, as well as applications to extend or amend approved projects.

6. States with approved demonstration projects that wish to extend the life of that project can submit an extension application under any one of three provisions of section 1115, subsections (a), (e), or (f). 42 U.S.C. § 1315(a), (e), and (f); 42 C.F.R. § 431.412(c). All extension applications must include certain information and must comply with the state public notice-and-comment process set forth at 42 C.F.R. § 431.408. *See* 42 C.F.R. § 431.412(c)(2)(i)–(vii). However, the statute provides for more streamlined processes for extension applications that satisfy the conditions of sections 1115(e) and (f) than the process that applies for extension applications under section 1115(a).

7. The subsection (e) extension application process is available for state-wide comprehensive projects where "a waiver of compliance with requirements of [the Medicaid statute] is granted under subsection (a)," provided the application uses the same terms and conditions as the previously approved project, the state submits its application at least one year before the project is set to expire, and the extension is no longer than three years (or 5 years in the case of some projects not at issue here).[1] 42 U.S.C. § 1315(e)(1), (2), and (6). For extension

[1] Five year extensions are available for demonstration projects that provide medical assistance to "dual eligible individuals," that is, individuals who are eligible for both Medicare and Medicaid. *See* 42 U.S.C. §§ 1315(e)(2); 1396n(h)(2). Texas's demonstration project extension application at issue in this litigation does not fall into this category.

applications under subsection (e), the Secretary must respond to the state's request within six months, or the request will be deemed granted. *Id.* § 1315(e)(3).

8. The subsection (f) application process is available for projects that have already been extended at least once under the terms of subsection (e), provided the further extension requested is no longer than three years. *Id.* § 1315(f). For extension applications under subsection (f), the state must submit its application at least 120 days before the expiration of the current demonstration period. After receiving such an application, CMS must notify the state within 45 days whether it intends to review the project's STCs. *Id.* § 1315(f)(2). If CMS does review the STCs, it must propose any changes to those STCs to the state within another 45 days and must conclude its negotiations with the state over those proposed changes within 30 days. *Id.* § 1315(f)(3), (4). For applications under subsection (f), if CMS misses any of those deadlines or fails to disapprove the state's application within 120 days after the state submitted it, that application is deemed approved. *Id.* § 1315(f)(5)(B).

9. If a state's extension application does not meet all of the conditions necessary for an extension application under subsection (e) or (f), CMS reviews that application under subsection (a). For example, if a state were to submit an application to extend its demonstration project for a period longer than three years, or the application proposes substantial amendments to the state's previously approved project, CMS may review that extension application in the same manner and using the same processes as a new demonstration project application under section 1115(a). Under subsection (a), the Secretary may approve any demonstration project that, in his judgment, "is likely to assist in promoting the objectives of" the Medicaid statute "to the extent and for the period he finds necessary to enable such State or States to carry out such

project." There is no deadline for CMS to act to approve or disapprove a state's extension application submitted under subsection (a).

10. CMS has established a "fast track" process for reviewing states' extension applications, and states seeking approval for an extension application under this fast-track process must use a streamlined application based on whether the state is seeking an extension under subsection (a), (e), or (f). Attached to this Declaration are Exhibits A through C, which contain the application certification statements available on CMS's website for extension applications under subsections (a), (e), and (f), respectively. Also attached to this Declaration is Exhibit D, which is the Fast-Track Template for extension applications that make changes to an existing program. Attached to this Declaration is Exhibit E, which contains Texas's November 30 extension application. And a CMS Informational Bulletin dated July 24, 2015, which describes the Fast Track application process and discusses the types of demonstration projects that can use the process, is attached to this Declaration as Exhibit F. *See* also 1115 Application Process, CMS, https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-application-process/index.html. Any state seeking an extension of an approved demonstration project using the Fast Track process must identify whether its extension application is one under subsection (a), (e), or (f). *See* Ex. A–C.

11. Within fifteen days of when CMS receives a state's Medicaid 1115 extension application, it reviews the application for completeness and, if the application is complete, sends the state a written notice informing the state that it has received its completed application. CMS then posts the state's application on CMS's website and begins a thirty-day public comment period. As part of the fifteen-day completeness review period, CMS reviews whether the state has identified its extension application as an application under section 1115(a), (e), or (f). If the

state has identified its application as one under subsections (e) or (f), CMS determines whether the application meets the statutory requirements for such applications. If CMS determines an application under subsection (e) or (f) does not meet those statutory requirements, it notifies the state in writing that it will treat the application as one submitted under section 1115(a). *See* 42 C.F.R. § 431.412(c)(1). CMS will treat an extension application submitted under section 1115(e) as an application under section 1115(a) if the state has requested changes to its demonstration project, 42 U.S.C. § 1315(e)(6), or if the state has requested an extension longer than three years, *id.* § 1315(e)(2) among other reasons. CMS will treat an application submitted under section 1115(f) as one under section 1115(a) if the state makes substantial changes to its demonstration project such that the application should be treated "as an application for a new demonstration," 42 C.F.R. § 431.412(c)(1), or if the state has requested an extension longer than three years, 42 U.S.C. § 1315(f)(6), among other reasons.

12. As stated above, the 120-day deadline for CMS to approve or disapprove a demonstration project applies only to applications to extend projects under section 1115(f). Texas's application is clearly identified as an extension application under section 1115(a) as demonstrated by the document titled "Section 1115 Demonstration Extension Section 1115(a) FastTrack Application Supporting Documentation." Ex. E, at 8. And even if Texas had requested approval under section 1115(e) or (f), CMS would nevertheless have treated it as an extension application under section 1115(a) (and sent Texas a letter to that effect) because Texas requested an extension longer than three years. *Id.* at 3 ("The extension request is for 5 years."); *see* 42 U.S.C. § 1315(f)(6). There is no deadline for CMS to act on Texas's extension application under section 1115(a).

13. Texas's application did not seek to extend its DSRIP funding beyond its planned end date of September 30, 2021. *Id.* at 32–33. The DSRIP component of Texas's demonstration project has existed since 2012 and authorized Texas to make payments to providers intended to incentivize those providers to innovate and make systemic changes to the health system that would improve the quality of care. Ex. E, at 11. Under the terms of CMS's prior approval of Texas's demonstration project, its DSRIP program is scheduled to expire on September 30, 2021, and Texas has been planning for the phase out of federal funding to implement its DSRIP by developing "new programs and policies to sustain quality improvement" since 2017 when Texas and CMS first established the DSRIP end date. *Id.* at 4–5, 56. CMS approved Texas's transition plan on September 2, 2020. *Id.* at 56. And Texas's 2020 extension application noted that "Texas is on target and will continue working with CMS to successfully achieve the DSRIP Transition goals as approved." *Id.* at 10. Texas's application requested no changes to the DSRIP program, including its expiration date. *Id.* at 14. Texas stated in its application that it had separately requested an extension of the DSRIP program, *id.*, but it has never submitted such an application to CMS. CMS intended to end DSRIP on schedule would not have approved such a request. Accordingly, Texas's DSRIP program will end, even if the requested preliminary injunction is in place, on September 30, 2021.

14. The only feature of Texas's proposed demonstration project extension that would take effect before October 1, 2022, is the new uncompensated care pool purportedly approved by CMS in its January 15 Letter, which would authorize Texas to make up to $500 million in payments to certain types of providers to reimburse them for some of their uncompensated care costs beginning October 1, 2021. That uncompensated care pool is a new demonstration feature, and as such Texas has never made payments to providers through that uncompensated care pool.

CMS did not intend that new uncompensated care pool to be a replacement for Texas's expiring DSRIP funding. To the extent these new uncompensated care funds are intended to replace DSRIP funding, they would replace only 20% of the $2.5 billion or more per year that providers received through the DSRIP. Texas has also submitted a separate application to use state-directed payments (SDP), through amendments to the state's contracts with managed care organizations, to replace the remaining 80% of DSRIP funding. The SDP application is independent from the Medicaid 1115 demonstration project and is not at issue in this case. *See* 42 C.F.R. § 438.6. The SDP application is still under review at CMS but is unlikely to be approved prior to October 1, 2021. Accordingly, any financial loss that Texas, providers, or beneficiaries allegedly face as a result of the expiration of Texas's DSRIP funding would occur even if CMS's January approval was legally effective. Only a small portion of this alleged loss could be replaced by the new uncompensated care pool purportedly approved in CMS's January 15 Letter. The termination of DSRIP funding is an expected consequence of the existing demonstration project and is independent of any action or inaction by CMS in the January 15 or April 16 letters.

Pursuant to 28 U.S.C. § 1746, and under penalty of perjury, I declare the foregoing is true and correct to the best of my knowledge.

Judith A. Cash -S Digitally signed by Judith A. Cash -S Date: 2021.07.26 17:19:12 -04'00'

Date

JUDITH CASH

EXHIBIT A

[State] Application Certification Statement - Section 1115(a) Extension

This document, together with the supporting documentation outlined below, constitutes [insert state] application to the Centers for Medicare & Medicaid Services (CMS) to extend the [insert demo name and project no] for a period of [insert no. up to 5] years pursuant to section 1115(a) of the Social Security Act.

Type of Request (*select one only*):

_____ **Section 1115(a) extension <u>with no</u> program changes**

This constitutes the state's application to the Centers for Medicare & Medicaid Services (CMS) to extend its demonstration without any programmatic changes. The state is requesting to extend approval of the demonstration subject to the same Special Terms and Conditions (STCs), waivers, and expenditure authorities currently in effect for the period [insert current demo period].

The state is submitting the following items that are necessary to ensure that the demonstration is operating in accordance with the objectives of title XIX and/or title XXI as originally approved. The state's application will only be considered complete for purposes of initiating federal review and federal-level public notice when the state provides the information as requested in the below appendices.

- **Appendix A:** A historical narrative summary of the demonstration project, which includes the objectives set forth at the time the demonstration was approved, evidence of how these objectives have or have not been met, and the future goals of the program.
- **Appendix B:** Budget/allotment neutrality assessment, and projections for the projected extension period. The state will present an analysis of budget/allotment neutrality for the current demonstration approval period, including status of budget/allotment neutrality to date based on the most recent expenditure and member month data, and projections through the end of the current approval that incorporate the latest data. CMS will also review the state's Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) expenditure reports to ensure that the demonstration has not exceeded the federal expenditure limits established for the demonstration. The state's actual expenditures incurred over the period from initial approval through the current expiration date, together with the projected costs for the requested extension period, must comply with CMS budget/allotment neutrality requirements outlined in the STCs.
- **Appendix C:** Interim evaluation of the overall impact of the demonstration that includes evaluation activities and findings to date, in addition to plans for evaluation activities over the requested extension period. The interim evaluation should provide CMS with a clear analysis of the state's achievement in obtaining the outcomes expected as a direct effect of the demonstration program. The state's interim evaluation must meet all of the requirements outlined in the STCs.

- **Appendix D:** Summaries of External Quality Review Organization (EQRO) reports, managed care organization and state quality assurance monitoring, and any other documentation of the quality of and access to care provided under the demonstration.
- **Appendix E:** Documentation of the state's compliance with the public notice process set forth in 42 CFR 431.408 and 431.420.

_____ **Section 1115(a) extension <u>with</u> minor program changes**

This constitutes the state's application to the Centers for Medicare & Medicaid Services (CMS) to extend its demonstration with minor demonstration program changes. In combination with completing the Section 1115 Extension Template, the state may also choose to submit a redline version of its approved Special Terms and Conditions (STCs) to identify how it proposes to revise its demonstration agreement with CMS.

With the exception of the proposed changes outlined in this application, the state is requesting CMS to extend approval of the demonstration subject to the same STCs, waivers, and expenditure authorities currently in effect for the period [insert current demo period].

The state's application will only be considered complete for purposes of initiating federal review and federal-level public notice when the state provides the information requested in Appendices A through E above, along with the Section 1115 Extension Template identifying the program changes being requested for the extension period. Please list all enclosures that accompany this document constituting the state's whole submission.

1. Section 1115 Extension Template
2. [List Enclosure]
3. [List Enclosure]
4. [List Enclosure]

The state attests that it has abided by all provisions of the approved STCs and will continuously operate the demonstration in accordance with the requirements outlined in the STCs.

Signature:_____ **Date:**_____
[Governor]

CMS will notify the state no later than 15 days of submitting its application of whether we determine the state's application meets the requirements for a streamlined federal review. The state will have an opportunity to modify its application submission if CMS determines it does not meet these requirements. If CMS reviews the state's submission and determines that any proposed changes significantly alter the original objectives and goals of the existing demonstration as approved, CMS has the discretion to process this application full scope pursuant to regular statutory timeframes for an extension or as an application for a new demonstration.

EXHIBIT B

[State] Application Certification Statement - Section 1115(e) Three Year Extension

This document, together with Appendices A through D, constitutes [insert state] application to the Centers for Medicare & Medicaid Services (CMS) to extend its demonstration entitled, [insert demo name and project no], without any programmatic changes pursuant to section 1115(e) of the Social Security Act. The state is requesting CMS' approval for a 3-year extension of the demonstration subject to the same approved Special Terms and Conditions (STCs), waivers, and expenditure authorities currently in effect for the period [insert current demo period].

CMS' expedited review and assessment of the state's request to continue the demonstration without any substantive program changes is conditioned upon the state's submission and CMS' assessment of the below items that are necessary to ensure that the demonstration is operating in accordance with the objectives of title XIX and/or title XXI as originally approved. The state's application will only be considered complete for purposes of initiating federal review and federal-level public notice when the state provides the information as requested in the below appendices.

- **Appendix A:** A historical narrative summary of the demonstration project, which includes the objectives set forth at the time the demonstration was approved, evidence of how these objectives have or have not been met, and the future goals of the program.
- **Appendix B:** Budget neutrality assessment, and projections for the projected 3-year extension period. The state will present an analysis of budget/allotment neutrality for the current demonstration approval period, including status of budget/allotment neutrality to date based on the most recent expenditure and member month data, and projected through the end of the current approval period. CMS will also review the state's Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) expenditure reports to ensure that the demonstration has not exceeded the Federal expenditure limits established for the demonstration. The state's actual expenditures incurred over the period from initial approval through the current expiration date, together with the projected costs for the requested 3-year extension period, must comply with CMS budget/allotment neutrality requirements outlined in the STCs.
- **Appendix C:** Interim evaluation of the overall impact of the demonstration that includes evaluation activities and findings to date, in addition to plans for evaluation activities over the 3-year extension period. The interim evaluation should provide CMS with a clear analysis of the state's achievement in obtaining the outcomes expected as a direct effect of the demonstration program. The state's interim evaluation must meet all of the requirements outlined in the STCs.
- **Appendix D:** Summaries of External Quality Review Organization (EQRO) reports, managed care organization and state quality assurance monitoring, and any other documentation of the quality of and access to care provided under the demonstration.
- **Appendix E:** Documentation of the state's compliance with the public notice process set forth in 42 CFR 431.408 and 431.420.

The state attests that it has abided by all provisions of the approved STCs and will continuously operate the demonstration in accordance with the requirements outlined in the STCs.

Signature:_____ **Date:**_____

[Governor]

CMS will notify the state no later than 15 days of submitting its application of whether we determine the state's application meets the requirements for a streamlined federal review under section 1115(e). The state will have an opportunity to modify its application submission if CMS determines it does not meet the requirements of section 1115(e).

EXHIBIT C

[State] Application Certification Statement - Section 1115(f) Three Year Extension

This document, together with the supporting documentation outlined below, constitutes [insert state] application to the Centers for Medicare & Medicaid Services (CMS) for a 3-year extension of its approved demonstration entitled, [insert demo name and project no], pursuant to section 1115(f) of the Social Security Act.

Type of Request (*select one only*):

_____ Section 1115(f) extension <u>with no</u> program changes

This constitutes the state's application to the Centers for Medicare & Medicaid Services (CMS) to extend its demonstration without any programmatic changes. The state is requesting to extend approval of the demonstration subject to the same Special Terms and Conditions (STCs), waivers, and expenditure authorities in effect for the period [insert current demo period].

The state is submitting the following items that are necessary to ensure that the demonstration is operating in accordance with the objectives of title XIX and/or title XXI as originally approved. The state's application will only be considered complete for purposes of initiating federal review and federal-level public notice when the state provides the information as requested in the below appendices.

- **Appendix A:** A historical narrative summary of the demonstration project, which includes the objectives set forth at the time the demonstration was approved, evidence of how these objectives have or have not been met, and the future goals of the program.
- **Appendix B:** Budget/allotment neutrality assessment, and projections for the projected 3-year extension period. The state will present an analysis of budget/allotment neutrality for the current demonstration approval period, including status of budget/allotment neutrality to date based on the most recent expenditure and member month data, and projections through then end of the current approval that incorporate the latest data. CMS will also review the state's Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) expenditure reports to ensure that the demonstration has not exceeded the federal expenditure limits established for the demonstration. The state's actual expenditures incurred over the period from initial approval through the current expiration date, together with the projected costs for the requested 3-year extension period, must comply with CMS budget/allotment neutrality requirements outlined in the STCs.
- **Appendix C:** Interim evaluation of the overall impact of the demonstration that includes evaluation activities and findings to date, in addition to plans for evaluation activities over the 3-year extension period. The interim evaluation should provide CMS with a clear analysis of the state's achievement in obtaining the outcomes

expected as a direct effect of the demonstration program. The state's interim evaluation must meet all of the requirements outlined in the STCs.

- **Appendix D:** Summaries of External Quality Review Organization (EQRO) reports, managed care organization and state quality assurance monitoring, and any other documentation of the quality of and access to care provided under the demonstration.
- **Appendix E:** Documentation of the state's compliance with the public notice process set forth in 42 CFR 431.408 and 431.420.

_____ **Section 1115(f) extension <u>with</u> program changes**

This constitutes the state's application to the Centers for Medicare & Medicaid Services (CMS) to extend its demonstration with minor demonstration program changes. In combination with completing the Section 1115 Extension Template, the state may also choose to submit a redline version of its approved Special Terms and Conditions (STCs) to identify how it proposes to revise its demonstration agreement with CMS.

With the exception of the proposed changes outlined in this application, the state is requesting CMS to extend approval of the demonstration subject to the same STCs, waivers, and expenditure authorities currently in effect for the period [insert current demo period].

The state's application will only be considered complete for purposes of initiating federal review and federal-level public notice when the state provides the information requested in Appendices A through E above, along with the Section 1115 Extension Template identifying the program changes being requested for the extension period. Please list all enclosures that accompany this document constituting the state's whole submission.

1. Section 1115 Extension Template
2. [List Enclosure]
3. [List Enclosure]
4. [List Enclosure]

The state attests that it has abided by all provisions of the approved STCs and will continuously operate the demonstration in accordance with the requirements outlined in the STCs.

Signature:_____ **Date:**_____
[Governor]

CMS will notify the state no later than 15 days of submitting its application of whether we determine the state's application meets the requirements for a streamlined federal review under section 1115(f). The state will have an opportunity to modify its application submission if CMS determines it does not meet the requirements of section 1115(f). If CMS reviews the state's submission and determines that the proposed changes significantly alter the original objectives and goals of the existing demonstration as approved, CMS has the discretion to process this application full scope pursuant to regular statutory timeframes for an extension or as an application for a new demonstration.

EXHIBIT D

Centers for Medicare & Medicaid Services

Section 1115 Demonstration
FAST TRACK Extension Template for Program Changes

Proposed Demonstration Changes for the Extension Period

A. General Description. Provide an overall description of the changes the state proposes for the extension of the demonstration. Specifically, include information on the expected impact these proposed program changes will have on populations covered by the demonstration and how it furthers the approved objectives and goals of the demonstration.

B. Expenditure Authorities. List any proposed modifications, additions to, or removal of currently approved expenditure authorities. Indicate how each new expenditure authority is necessary to implement the proposed changes and also how each proposed change furthers the state's intended goals and objectives for the requested extension period.

C. Waiver Authorities. List any proposed modifications, additions to, or removal of currently approved waiver authorities. Indicate how each new waiver authority is necessary to implement the proposed changes and also how each proposed change furthers the state's intended goals and objectives for the requested extension period.

D. Eligibility. List any proposed changes to the population(s) currently being served under the demonstration.

If the state is proposing to add populations, please refer to the list of Medicaid Eligibility Groups at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/List-of-Eligibility-Groups.pdf when describing Medicaid State plan populations, and for an expansion eligibility group, please provide a plain language description of the group(s) that is sufficiently descriptive to explain to the public.

If the state is proposing to remove any demonstration populations, please include in the justification how the state intends to transition affected beneficiaries into other eligible coverage as outlined in the Special Terms and Conditions (STCs).

E. Benefits and Cost Sharing. Describe any proposed changes to the benefits currently provided under the demonstration and any applicable cost sharing requirements. The justification should include any expected impact these changes will have on current and future demonstration enrollment.

F. Delivery System. Describe any proposed changes to the healthcare delivery system by which benefits will be provided to demonstration enrollees. The justification should include how the state intends a seamless transition for demonstration enrollees and any expected impact on current and future demonstration enrollment.

G. Budget/Allotment Neutrality. Describe any proposed changes to state demonstration financing (i.e., sources of state share) and/or any proposed changes to the overall approved budget/allotment neutrality methodology for determining federal expenditure limits (other than routine updates based on best estimate of federal rates of change in expenditures at the time of extension).

H. Evaluation. Describe any proposed changes to the overall demonstration evaluation design, research questions or hypotheses being tested, data sources, statistical methods, and/or outcome measures. Justification should include how these changes furthers and does not substantially alter the currently approved goals and objectives for the demonstration.

I. Other. Describe proposed changes to any other demonstration program feature that does not fit within the above program categories. Describe how these change(s) furthers the state's intended goals and objectives for the requested extension period.

State Contact Person(s)

Please provide the contact information for the state's point of contact for this demonstration extension application.

Name:
Title:
Agency:
Address:
City/State/Zip:
Telephone Number:
Email Address:

Name:
Title:
Agency:
Address:
City/State/Zip:
Telephone Number:
Email Address:

EXHIBIT E

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

State Demonstrations Group

December 15, 2020

Stephanie Stephens
State Medicaid Director
Texas Health and Human Services Commission
4900 Lamar Boulevard
MC: H100
P.O. Box 13247
Austin, Texas 78751

Dear Ms. Stephens:

Thank you for your application for a five-year extension of Texas' section 1115 demonstration, entitled "Texas Healthcare Transformation and Quality Improvement Program (THTQIP)" (project number 11-W002786) submitted on November 30, 2020. CMS completed our preliminary review of Texas' extension request, and we have determined that the state's extension request has met the requirements for a complete extension application and is exempt from the requirements for public notice and comment.

If you have additional questions, please contact your CMS project officer, Diona Kristian, at 410-786-1102 or diona.kristian@cms.hhs.gov.

Sincerely,

Angela D. Garner -S
Digitally signed by Angela D. Garner -S
Date: 2020.12.15 16:31:47 -05'00'

Angela D. Garner
Director
Division of System Reform Demonstrations

cc: Ford Blunt, State Lead, Medicaid and CHIP Operations Group

Centers for Medicare & Medicaid Services

Section 1115 Demonstration

FAST TRACK Extension Template

for Program Changes

TEXAS
Health and Human Services

Proposed Demonstration Changes for the Extension Period

A. **General Description.** Provide an overall description of the changes the state proposes for the extension of the demonstration. Specifically, include information on the expected impact these proposed program changes will have on populations covered by the demonstration and how it furthers the approved objectives and goals of the demonstration.

The Texas Health and Human Services Commission (HHSC) is submitting a "Fast Track" extension application to the Centers for Medicare & Medicaid Services (CMS) for an amendment to the Texas Healthcare Transformation Quality Improvement Program (THTQIP) waiver under section 1115 of the Social Security Act. The extension request is for 5 years, which will allow the 1115 waiver authority to run through 2027.

The requested extension will allow Texas continued flexibility to pursue the goals of the existing 1115 waiver. The extension will also create financial stability for Texas Medicaid providers, as HHSC works to transition the valuable work identified through Delivery System Reform Incentive Payment (DSRIP) innovations. The extension years as requested create a continuous demonstration period over 10 years, ending September 30, 2027. There are no substantial changes requested under this extension application, therefore, no substantive impact on populations covered by the demonstration.

Through this demonstration, the state aims to continue to:

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

B. **Expenditure Authorities.** List any proposed modifications, additions to, or removal of currently approved expenditure authorities. Indicate how each new expenditure authority is necessary to implement the proposed changes and also how each proposed change furthers the state's intended goals and objectives for the requested extension period.

There are no proposed modifications to currently approved expenditure authorities.

C. **Waiver Authorities.** List any proposed modifications, additions to, or removal of currently approved waiver authorities. Indicate how each new waiver authority is necessary to implement the proposed changes and also how each proposed change furthers the state's intended goals and objectives for the requested extension period.

There are no proposed changes to currently approved waiver authorities.

D. **Eligibility.** List any proposed changes to the population(s) currently being served under the demonstration.

If the state is proposing to add populations, please refer to the list of Medicaid Eligibility Groups at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/List-of-Eligibility-Groups.pdf when describing Medicaid State plan populations, and for an expansion eligibility group, please provide a plain language description of the group(s) that is sufficiently descriptive to explain to the public.

If the state is proposing to remove any demonstration populations, please include in the justification how the state intends to transition affected beneficiaries into other eligible coverage as outlined in the Special Terms and Conditions (STCs).

There are no proposed changes to currently approved eligibility.

E. **Benefits and Cost Sharing.** Describe any proposed changes to the benefits currently provided under the demonstration and any applicable cost sharing requirements. The justification should include any expected impact these changes will have on current and future demonstration enrollment.

There are no proposed changes to benefits and cost sharing.

F. **Delivery System.** Describe any proposed changes to the healthcare delivery system by which benefits will be provided to demonstration enrollees. The justification should include how the state intends a seamless transition for demonstration enrollees and any expected impact on current and future demonstration enrollment.

There are no proposed changes to the healthcare delivery system under the demonstration. Under the CMS approved DSRIP Transition Plan, HHSC is developing proposals for new programs and policies to sustain quality

improvement started under DSRIP and advance value in the Medicaid managed care program.

G. **Budget/Allotment Neutrality.** Describe any proposed changes to state demonstration financing (i.e., sources of state share) and/or any proposed changes to the overall approved budget/allotment neutrality methodology for determining federal expenditure limits (other than routine updates based on best estimate of federal rates of change in expenditures at the time of extension).

There are no proposed changes. The extended demonstration period continues current budget neutrality methodologies as illustrated in the STCs. A summary of our Budget Neutrality workbook is included as an attachment to this template.

H. **Evaluation.** Describe any proposed changes to the overall demonstration evaluation design, research questions or hypotheses being tested, data sources, statistical methods, and/or outcome measures. Justification should include how these changes furthers and does not substantially alter the currently approved goals and objectives for the demonstration.

The current CMS-approved 1115 evaluation design examines the three components of the THTQIP demonstration (DSRIP, UC Pool, MMC expansion), as well as the overall impact of the THTQIP demonstration (as measured by quality-based payment systems and transformation of the health care system for the Medicaid/low-income population in Texas). The current evaluation design includes 5 evaluation questions and 13 hypotheses. Preliminary findings suggest the THTQIP demonstration waiver is on track to meet its intended objectives. Specifically, early evidence suggests DSRIP has incentivized some forms of collaboration and improved health outcomes; MMC shows early signs of improved access and quality of care; more providers are participating in Alternate Payment Models; and, the demonstration generates overall cost savings.

Although preliminary findings from the THTQIP demonstration waiver are promising, the COVID-19 pandemic, which coincides with the final three years of the demonstration, presents a serious challenge to the final evaluation of the THTQIP demonstration waiver. The THTQIP extension would support the rigor of the evaluation in determining if the demonstration achieved its intended objectives by allowing for additional years of data to evaluate the impact of demonstration policies under stable conditions free of the COVID-19 pandemic. Moreover, additional years of the demonstration would allow HHSC to examine the DSRIP transition process and the impact of new benefits or populations recently carved into MMC.

The THTQIP demonstration waiver extension does not alter the overall goals and objectives of the evaluation; therefore, HHSC is not proposing changes to the approved evaluation questions. HHSC is also not proposing changes to hypotheses, data sources, statistical methods, and/or outcome measures for the evaluation of the UC Pool or components related to the overall impact of the THTQIP demonstration. HHSC proposes changes be considered to further the DSRIP and MMC expansion components. A discussion of potential changes and preliminary findings are included in APPENDIX C: Interim Evaluation. HHSC will submit a revision to the CMS-approved evaluation design incorporating these edits following approval of the THTQIP extension. HHSC does not anticipate that proposed adjustments will substantially alter the data sources or analytic methods used in the evaluation. The proposed changes to DSRIP and MMC expansion align with the current goals and objectives for the THTQIP demonstration.

I. **Other.** Describe proposed changes to any other demonstration program feature that does not fit within the above program categories. Describe how these change(s) furthers the state's intended goals and objectives for the requested extension period.

Major deletions and edits have been foregone to avoid involvement of any complex policy area as noted in the CMCS Informational Bulletin dated July 24, 2015. This application seeks an extension of the current demonstration waiver. Once sections expire, amendments can be prepared to clean up the STCs as needed.

State Contact Person(s)

Please provide the contact information for the state's point of contact for this demonstration extension application.

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Address:

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Telephone Number:
Email Address:

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

Texas Healthcare Transformation and Quality Improvement Program

Project #11-W-00278/6

Texas Health and Human Services Commission

November 27, 2020

TEXAS
Health and Human Services

Appendix A. Historical Summary

Waiver Approval: 2011 – 2022

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

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

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

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

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

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

The waiver also includes the Delivery System Incentive Reform Payment (DSRIP) and Uncompensated Care (UC) Programs. Currently, 288 Performing Providers participate in DSRIP, and 529 providers participate in the Uncompensated Care Program. Significant

participation in these programs has led to successful outcomes. As DSRIP transitions, it has also led to significant financial stress on providers. Texas is on target and will continue working with CMS to successfully achieve the DSRIP Transition goals as approved. Uncompensated Care revisions were implemented successfully.

HHSC significantly expanded risk based managed care to additional populations over the last 6 years under the current 1115 waiver. In 2014, HHSC expanded STAR+PLUS to the rural service areas making STAR+PLUS a statewide program and added individuals in an intellectual or developmental disability (IDD) waiver program or in an intermediate care facility to STAR+PLUS for their acute care services. In 2016, HHSC implemented a new managed care program for children with disabilities, STAR Kids. In 2017, HHSC moved individuals in adoption assistance, permanency care assistance, and Medicaid for breast and cervical cancer programs into the managed care model. This work supports a more coordinated care delivery system for these populations as they are able to benefit from service coordination offered by the managed care organization. MCOs are reimbursed through a risk-based capitation rate that helps ensure MCOs contain cost growth while still providing all medically necessary services that improve outcomes for individuals they serve.

HHSC expanded risk based managed care by adding new services to managed care programs under the current 1115 waiver. In 2014, Community First Choice (CFC) services were added under the state plan and became available in the managed care programs offered by the MCOs in all managed care programs. CFC improves outcomes for people receiving the services because often these individuals are on an interest list for a waiver program and these services help them to remain in the community while they wait for their name to come to the top of the interest list. In 2015, HHSC added nursing facility services to the STAR+PLUS program. The addition of nursing facility services supports a more coordinated care delivery system as individuals in nursing facilities are able to benefit from service coordination offered by the managed care organization. Also, having nursing facility services as part of the array offered by the STAR+PLUS MCOs helps to contain cost growth as the MCO has the incentive to help individuals transition to less costly services in the community.

Recently HHSC implemented changes to support a coordinated care delivery system by more quickly moving children to another managed care program when they go from foster care Medicaid to adoption assistance or permanency care assistance Medicaid. Thus eliminating any time in fee-for-service and ensuring a more seamless transition under the current 1115 waiver.

The Texas Medicaid program has been transitioning to a value-based model for some time now. For over 25 years, the state has gradually moved care delivered through Medicaid

away from traditional fee-for-service reimbursement to a managed care system where private health plans are financially responsible for controlling costs and improving quality. The transition to managed care has been supported by system initiatives to improve quality and efficiency in state health care services. Chief among these is the state's 1115 Healthcare Transformation and Quality Improvement Program Waiver, which includes incentive payments to hospitals and other providers for strategies to enhance access to health care, increase the quality and cost-effectiveness of care, and improve the health of patients and families through the Delivery System Reform Incentive Payment (DSRIP) program. DSRIP has been an effective incubator allowing the state to establish consensus priorities for health system improvement and test how flexible payment models can support patient centered care and clinical innovation. Since 2012, DSRIP providers have earned over $19 billion all funds (federal funds matched with intergovernmental transfer funds).

The DSRIP program structure, beginning in FFY 2018, evolved from a focus on projects and project-level reporting to targeted measure bundles (or measures, depending on performing provider type). Among the allowable menu of measure bundles and measures, State priority measure bundle areas for hospitals and physicians include:

- Chronic care: diabetes and heart disease care, pediatric asthma management
- Primary care and prevention
- Pediatric primary care
- Maternal care
- Integrated behavioral health/primary care
- Chronic non-malignant pain management
- Behavioral health and appropriate utilization

Other significant initiatives for increasing value in state health care include: the MCO Pay for Quality Program (P4Q); Program Improvement Projects (PIPs), which focus on improving quality across the managed care system; Hospital Quality Based Payment Program for Potentially Preventable Readmissions and Complications to incentivize quality and efficiency among hospitals; and Quality Incentive Payment Program (QIPP) to promote patient safety in nursing homes.

Finally, MCO Value-Based Contracting with Providers seeks to facilitate and encourage the development of alternative payment and flexible practice approaches between MCOs and their providers. Under this initiative, HHS created contractual targets for MCOs to connect provider payments to value using APMs, starting in calendar year 2018. The APM percentage targets increase over time. If an MCO fails to meet the APM targets or certain

allowed exceptions for high performing plans, the MCO must submit an action plan, and HHSC may impose graduated contractual remedies, including liquidated damages.

Waiver Extension

HHSC is working to expand Nonemergency Medical Transportation (NEMT) to the array of services provided by Medicaid managed care organizations (MCOs) for their members under the current 1115 waiver. In addition to providing the full array of NEMT services, HB 1576 (86th Regular Legislature) requires MCOs to provide NEMT demand response transportation services for certain trips requested with less than 48-hours' notice and increases opportunities for transportation network companies (TNCs) to provide demand response transportation services. This will expand risk-based managed care by no longer operating NEMT through managed transportation organizations under a state plan transportation broker model to MCOs under the 1115 waiver authority. This effort will improve outcomes and support a coordinated delivery system by making the same MCOs responsible for arranging health care services also responsible for arranging the NEMT some members require to access healthcare services.

HHSC will also be seeking to remove the cost cap for individuals meeting specific medically fragile criteria and removing the current state legislative requirement that the individual be deemed unable to safely be served in an institution under the current 1115 waiver. There will not be additional home and community-based services added to the program. Impacted individuals will continue to have access to services they are currently receiving. While the population impacted by this change is not new to managed care and will not receive new services, the new process for serving this very medically fragile population will improve the coordination of their care and improve health outcomes for them while containing cost growth. It is expected to result in a more cost-effective system, including better coordination of the person's care, a more streamlined system benefiting the person, their family, and their MCO, all of which will lead to improved health outcomes for these particularly vulnerable individuals.

HHSC is also actively working to implement the legislatively mandated STAR+PLUS Pilot Program under the current 1115 waiver. The pilot must be implemented by September 1, 2023 and will operate for at least 24 months. The eligibility criteria for the program will include Medicaid-eligible adults age 21 and over who meet one of the following:

- Individuals with an IDD or cognitive disability, including:
  - individuals with autism; and
  - individuals with significant complex behavioral, medical, and physical needs who are receiving home and community-based services through the STAR+PLUS Medicaid managed care program.

- Individuals enrolled in the STAR+PLUS Medicaid managed care program who:
  - are on a Medicaid waiver program interest list;
  - meet criteria for an IDD; or
  - have a traumatic brain injury that occurred after the age of 21.
- Other individuals with disabilities who have similar functional needs without regard to the age of onset or diagnosis.

The STAR+PLUS Pilot Program will operate in one service area selected by HHSC with up to two STAR+PLUS Medicaid managed care plans. The pilot will test the delivery of long-term services and supports (LTSS) for people with intellectual and development disabilities (IDD), traumatic brain injury that occurred after age 21, or people with similar functional needs as a person with IDD.

The STAR+PLUS Pilot Program is expected to further goals and objectives of the demonstration to expand risk based managed care to new populations as it will be offering home and community-based services to individuals with traumatic brain injury that currently could not qualify for a home and community-based waiver program. Additionally, this new program will also create and support a more coordinated care delivery system by having MCOs who currently provide acute care services for people with intellectual and developmental disabilities to also provide the long-term services and supports through a waiver program. This is expected to improve outcomes while containing cost growth.

HHSC would also like to call attention to the Public Health Emergency arising from the impact of COVID-19 which has significantly impacted Texas' health care delivery system. Texas recently released an open survey to all healthcare providers in Texas, which concluded on November 13, 2020. The results indicate a dire emergency of another kind is unfolding: The long-term stability of healthcare infrastructure and Medicaid provider networks is in jeopardy. CMS and Texas must act immediately to ensure that Medicaid clients retain access to care through a stable Medicaid managed care program, and that providers are financially stabilized by assured continuation of the Uncompensated Care pool available under the 1115 waiver and a successful DSRIP transition. According to survey results:

- 76% of providers said they were very concerned or extremely concerned about the financial impacts of COVID–19;
- 42% of providers reported reduced hours of service;
- 20% of providers actively reduced services unrelated to COVID–19;
- 23% of providers closed locations or facilities; and

- 27% of providers reported that COVID–19 demand has exceeded provider capacity.

Overtasked providers are considering dropping out of Texas Medicaid because of the overwhelming financial pressure and reduced service availability and locations. These problems are exacerbated by uncertainty over the future of the state's 1115 waiver. The extension application seeks to mitigate that uncertainty.

The scope of the COVID–19 public health emergency and its impacts on Texas Medicaid beneficiaries and providers continues to unfold, and its ultimate toll remains unknown. The state is acting expeditiously in response to the crisis to preserve and stabilize Medicaid program funding in order to protect the health, safety, and welfare of Medicaid beneficiaries and avoid further suffering for Texas families.

Under a 5-year extension of the current demonstration period through 2027, the State will continue the goals of the current 1115 Transformation Waiver. While the State has made significant progress toward the achievement of these goals, they remain ongoing priorities that will evolve and strengthen over time Texas Medicaid also continues to advance value by expanding performance measurement and implementing new ways to incentivize quality and cost efficiency. Under the extension, DSRIP will fully transition and Medicaid managed care expenditures will adjust to promote access to care and provide incentives that drive value.

Health Care Delivery System, Eligibility Requirements, Benefit Coverage and Cost Sharing

Texas currently operates four of its Medicaid managed care programs under the demonstration: STAR+PLUS (including STAR+PLUS Home and Community Based Services waiver), STAR, STAR Kids, and its children's dental services managed care program. Under these programs individuals receive the full array of state plan services (including EPSDT), in STAR+PLUS the HCBS waiver service array is offered, and MCOs provide services on a case-by-case and through value added services. MCOs also provide service management or service coordination to ensure individuals have their care coordinated to the level of their need.

The state is not requesting changes to the DSRIP program. DSRIP includes 288 performing providers who serve patients with a focus on Medicaid and Low Income Uninsured. Currently, the DSRIP program funding and authorization will expire October 1, 2021. HHSC has separately requested an extension of the DSRIP program authorization and funding for the final demonstration year of the current waiver in order to minimize the disruption to the healthcare system occurring as a result of COVID-19 and the timing of the planned DSRIP Transition. While the requested extension is pending a response from

CMS, the state continues to develop new proposals under the approved DSRIP Transition Plan and submit required deliverables.

Uncompensated Care (UC) payments are cost-based and help offset the costs of uncompensated care provided by hospitals and other providers. UC costs are federally defined as unreimbursed charity care costs. UC payments are based on each provider's uncompensated care costs as reported to the state on a UC application. The non-federal share is provided by local governmental entities. In order to receive UC payments, providers must participate in one of the twenty Regional Health Partnerships (RHPs).

Payments from this pool are used to defray the actual uncompensated cost of medical services that meet the definition of "medical assistance" contained in section 1905(a) of the Act, that are provided to uninsured individuals as charity care by hospitals, clinics, or by other provider types, including uninsured full or partial discounts, that provide all or a portion of services free of charge to patients who meet the provider's charity care policy and that adhere to the charity care principles of the Healthcare Financial Management Association. Annual UC Pool payments are limited to annual amounts. Expenditures for UC payments must be claimed in accordance with CMS-approved claiming protocols for each provider type and application form. The methodology used by the state to determine UC payments will ensure that payments to hospitals, clinics, and other providers are distributed based on uncompensated cost, without any relationship to source of non-federal share. HHSC will continue the UC pool through the demonstration extension period and is not requesting changes to the UC program. The UC program includes 529 providers which provide charity care to patients who meet their charity care policy.

The extension will not change the array of benefits provided under the current 1115 waiver authority. The extension does not make any changes to eligibility requirements. Extending the waiver will not have a significant impact on enrollment. Under the extension there will continue to be no beneficiary cost sharing.

The state is not requesting changes to the existing health care delivery system, eligibility requirements or benefit coverage through this extension request. Additionally, there will continue to be no cost sharing requirements related to premiums, co-payments, or deductibles as part of this extension request. There are not changes requested to DSRIP nor UC.

Managed Care Overview

Texas currently operates four of its Medicaid managed care programs under the demonstration: STAR+PLUS (including STAR+PLUS Home and Community Based Services waiver), STAR, STAR Kids, and its children's dental services managed care program.

Under these programs individuals receive the full array of state plan services (including EPSDT for those under 21), in STAR+PLUS the HCBS waiver service array is offered, and MCOs provide services on a case-by-case and through value added services. MCOs also provide service management or service coordination to ensure individuals have their care coordinated to the level of their need, this includes coordination with non-capitated services that exist outside of this section 1115 demonstration. Individuals who are members of federally-recognized tribes in Texas are voluntary to enroll in our managed care programs and can opt to remain in fee-for-service Medicaid. There is no cost sharing in any of these programs and that will remain the same through the demonstration extension period.

HHSC plans to continue these managed care programs and services through the demonstration extension period.

Managed Care Eligibility and Enrollment Requirements

STAR+PLUS.

STAR+PLUS provides acute and long-term service and supports to older adults and adults with disabilities, including individuals with breast and cervical cancer. Also, the STAR+PLUS program includes adults 21 and older who reside in an intermediate care facility for individuals with an intellectual or developmental disability (ICF/IID) or receiving 1915(c) waiver services (Home and Community-based Services (HCS), Texas Home Living (TxHmL), Community Living and Support Services (CLASS), or Deaf Blind with Multiple Disabilities (DBMD)) who do not have Medicare Part A and B. These individuals receive their state plan services through STAR+PLUS and receive their 1915(c) services through their respective waivers and waiver providers.

STAR+PLUS HCBS.

STAR+PLUS provides acute and long-term service and supports to older adults and adults with disabilities. The STAR+PLUS HCBS Program provides long-term services and supports to two groups of people, as defined below:

- STAR+PLUS 217-Like HCBS Group. This group consists of persons age 21 and older, who meet the nursing facility level of care (LOC), who qualify as members of the 217-Like HCBS Group, and who need and are receiving HCBS as an alternative to nursing facility care. This includes persons who could have been eligible under 42 CFR 435.217 had the state continued its section 1915(c) HCBS waiver for persons who are elderly and/or physically disabled. This group is subject to a numeric enrollment limitation.

- SSI-Related Eligibles. Persons age 65 and older, and adults age 21 and older, with physical disabilities that qualify as SSI eligibles and meet the nursing facility LOC as defined by the state.

Individuals can be eligible for HCBS under STAR+PLUS depending upon their medical and / or functional needs, financial eligibility designation as a member of the 217-Like STAR+PLUS HCBS Group or an SSI-related recipient, and the ability of the State to provide them with safe, appropriate, and cost-effective LTC services.

- Medical and / or functional needs are assessed according to level of care (LOC) criteria published by the State in State rules. These LOC criteria will be used in assessing eligibility for STAR+PLUS HCBS benefits through the 217-Like or SSI-related eligibility pathways.
- For an individual to be eligible for HCBS services, the State must have determined that the individual's cost to provide services is equal to or less than 202 percent of the cost of the level of care in a nursing facility.

STAR

STAR is the primary managed care program providing acute care services to low-income families, children, pregnant women, adoption assistance and permanency care assistance, and former foster care children.

STAR Kids

The STAR Kids program provides a continuum of services, including acute care, behavioral health, state plan long-term services and supports, and 1915(c) home and community based waiver services to children with disabilities. The following groups of Medicaid clients from birth through age 20 are mandatory in the STAR Kids program.

1. Children receiving SSI and disability-related (including SSI-related) Medicaid who do not participate in a 1915(c) waiver: these children will receive their state plan acute care services and their state plan long term services and supports (LTSS) through STAR Kids.
2. Children receiving HCBS services through the Medically Dependent Children's Program (MDCP) 1915(c) waiver: these children and young adults will receive the full range of state plan acute care services and state plan LTSS as well as MDCP 1915(c) HCBS waiver services through STAR Kids.
3. Children receiving HCBS through the following 1915(c) waivers -- CLASS, DBMD, HCS, TxHmL, and YES:

- Children enrolled in CLASS, DBMD, HCS and TxHmL receive their 1915(c) LTSS and 1915(k) (Community First Choice) services through their current 1915(c) waiver provider. These clients receive all other state plan LTSS and acute care services through STAR Kids.
- Children enrolled in the YES waiver receive their 1915(c) LTSS through their current 1915(c) provider. These clients receive all state plan LTSS, including 1915(k) services, as well as all acute care services through STAR Kids.

4. Children receiving SSI and disability-related (including SSI-related) Medicaid who reside in a community-based intermediate care facility for individuals with intellectual disabilities or a nursing facility: clients will continue to receive all long-term services and supports provided by the facility through the current delivery system. All non-facility related services will be provided through STAR Kids.

Children's Dental Program

Children's primary and preventive Medicaid dental services are delivered through a capitated statewide dental services program (the Children's Dental Program) to most children under 21. Contracting dental maintenance organizations (DMOs) maintain networks of Main Dental Home providers, consisting of general dentists and pediatric dentists. The dental home framework under this statewide program is informed by the improved dental outcomes evidenced under the "First Dental Home Initiative" in the State. The Children's Dental Program must conform to all applicable regulations governing prepaid ambulatory health plans (PAHPs), as specified in 42 C.F.R. 438.

The following Medicaid recipients are excluded from the Children's Dental Program, and will continue to receive their Medicaid dental services outside of the Demonstration: Medicaid recipients age 21 and over; all Medicaid recipients, regardless of age, residing in Medicaid-paid facilities such as nursing homes, state supported living centers, or Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions (ICF/ID); and STAR Health Program recipients.

Managed Care Benefits

STAR, STAR+PLUS, and STAR Kids enrollees are provided benefits in the same amount, duration, and scope as in the Medicaid State plan. Members under the age of 21 are also provided all EPDST benefits. In addition, the members of STAR+PLUS HCBS are provided 1915(b)(3)-like services as described below. Individuals in 1915(c) waivers receive all Texas state plan services based on medical necessity and delivered outside of managed care (e.g. dental, ICF/IID pursuant to their respective 1915(c) waivers), with the exception of MDCP which is provided by the STAR Kids MCOs. Services provided through the Children's Dental Program and DMOs are separate from the medical services provided

by the STAR, STAR+PLUS, and STAR Kids MCOs, and are available to persons who are under age 21, with the exception of the groups listed above. DMOs are expected to provide all medically necessary dental services in the same amount, duration and scope as in the Medicaid state plan.

STAR+PLUS HCBS Program

In addition to all state plan benefits, STAR+PLUS HCBS participants, whether in the 217-Like HCBS Group or the SSI-related group, that are provider-directed and, if the participant elects the option, self-directed, receive a number of other 217-Like HCBS Services including: Personal Assistance Services, Respite, Financial Management Services, Support Consultation, Adaptive Aids and Medical Supplies, Adult Foster Care, Assistive Living, Dental Services, Emergency Response Services, Home Delivered Meals, Minor Home Modifications, Nursing, Occupational Therapy, Physical Therapy, Speech, Hearing, and Language Therapy, Transition Assistance Services, Cognitive Rehabilitation Therapy, Supported Employment Services, and Employment Assistance Services.

Appendix B. Budget

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

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

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

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

Cost Growth Containment

Through initial managed care initiatives and continued expansions into the managed care delivery system, HHSC and the clients we serve have benefited from both increased coordination and quality of care. Over time, these same benefits and efficiencies have helped flatten the cost curve and maintain stable Medicaid client service cost trends year over year. For the current approved demonstration period over FFY12-22, with waiver Per Member Per Month (PMPM) annual cost growth trends are estimated to average 3.3%, a full 2% lower than without waiver PMPM cost growth for the same period (excluding UPL).

Enrollment

No impact to enrollment is expected as a result of the 1115 transformation waiver extension. There are no 1115 waiver policies that limit or impact Medicaid enrollment. While fiscal year trends during and following the Covid Public Health Emergency period are impacted due to policies and economic recovery, overall member months under the 1115 are expected to experience long term annual caseload growth trends of roughly 1% to 1.5% consistent with historical program growth.

Current enrollment growth during the PHE has been significant, with growth of over 12% since the PHE began. Annual growth of 10% over fiscal year 2021 is expected as the PHE continues and could increase depending on further PHE extensions and unemployment. While recovery is assumed over fiscal years 2022-2023, any number of factors can greatly influence the impact to Medicaid caseloads due to policy and economic conditions.

1115 MEG Total Member Months, DY06-DY21

	DY 06 (FFY 17)	DY 07 (FFY 18)	DY 08 (FFY 19)	DY 09 (FFY 20)	DY 10 (FFY 21)	DY 11 (FFY 22)
Aged and Medicare Related	4,260,091	4,260,293	4,254,228	4,295,619	4,316,342	4,348,666
Blind and Disabled	5,042,514	4,990,061	4,898,834	4,911,242	5,211,975	5,151,745
Adults	3,423,661	3,416,287	3,274,638	3,670,408	4,086,896	3,366,107
Children	31,460,800	31,614,307	30,691,208	32,018,364	35,249,138	32,945,528

	DY 12 (FFY 23)	DY 13 (FFY 24)	DY 14 (FFY 25)	DY 15 (FFY 26)	DY 16 (FFY 27)
Aged and Medicare Related	4,421,112	4,507,470	4,616,355	4,698,756	4,782,628
Blind and Disabled	5,114,843	5,130,933	5,220,264	5,304,033	5,389,146
Adults	3,323,019	3,364,809	3,411,887	3,455,563	3,499,799
Children	31,807,744	32,053,486	32,494,047	32,939,929	33,391,930

Based on actual data through July 2020, projected member months thereafter.

Appendix C. Interim Evaluation

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

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

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

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

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

The overarching objectives of the THTQIP demonstration waiver are to expand risk-based managed care to new populations and services, support the development and maintenance of a coordinated care delivery system, improve outcomes while containing cost growth, and transition to quality-based payment systems across managed care and providers. The THTQIP demonstration waiver achieves these objectives through three components: the DSRIP pool, the UC pool, and MMC expansion. The focus of the THTQIP evaluation is to determine if the THTQIP demonstration waiver achieved its intended objectives through the three components. The THTQIP evaluation is guided by five evaluation questions, with one question each pertaining to DSRIP, UC, MMC, and two questions pertaining to the demonstration overall. Each evaluation question is addressed through a minimum of one corresponding hypothesis and measure.[1] Altogether, the current THTQIP evaluation design includes 5 evaluation questions, 13 hypotheses, and 48 evaluation measures.

Evaluation Activities To Date

The THTQIP demonstration waiver is in the fourth year of the current renewal period. During the past four years, HHSC developed the CMS-approved evaluation design; procured an external evaluator; provided the external evaluator with data sources outlined in the evaluation plan; provided data-related technical assistance as requested by the external evaluator; participated in quarterly and ad hoc meetings with the external evaluator, and; submitted four revisions to the THTQIP evaluation design. The next scheduled evaluation deliverable is the interim evaluation report, which is on schedule to be submitted to CMS by September 30, 2021.

Preliminary Evaluation Findings

The external evaluator will deliver a draft of the interim report to HHSC for review on May 28, 2021. The external evaluator submitted preliminary findings to HHSC in support of this extension application on December 7, 2020. Key points from the preliminary findings are summarized below. Texas A&M University System's *Preliminary Draft Results*

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

(Supplement A) provides the full summary of preliminary findings provided by the external evaluator. Preliminary findings are still in draft form and are only provided for the purposes of this application.

Evaluation Question 1: Did the DSRIP program incentivize changes to transform the health care system for the MLIU population in Texas?

Preliminary findings suggest the DSRIP program incentivized collaboration in tangible resource sharing and data sharing agreements, but less so in other areas of collaboration, such as join service delivery. The DSRIP program has also supported improvements in Category C outcome measures such as heart disease management (A2-509) and primary care prevention (C1-502), but additional data is necessary to fully understand the impact of DSRIP on health outcomes.

Evaluation Question 2: Did the Demonstration impact unreimbursed costs associated with the provision of care to the MLIU population for UC providers?

Preliminary findings suggest the rate of UC cost reimbursement decreased over time. Analysis of the overall UC cost growth rate is currently underway.

Evaluation Question 3: Did the expansion of the MMC health care delivery model to additional populations and services improve healthcare (including access to care, care coordination, quality of care, and health outcomes) for MMC clients?

Preliminary findings provide some support for the premise that the expansion of MMC improved access to care and quality of care for renewal study populations, but additional data are necessary to fully understand the impact of the MMC expansion.

Evaluation Question 4: Did the Demonstration impact the development and implementation of quality-based payment systems in Texas Medicaid?

Preliminary findings suggest providers' use of Alternate Payment Models (APMs) increased, but organizations were somewhat ambivalent about the benefits of APMs. Organizations reported financial efficiency as the most common perceived benefit of APMs, and lack of MCO engagement as the most common perceived barrier to APM participation.

Evaluation Question 5: Did the Demonstration transform the health care system for the MLIU population in Texas?

Preliminary findings suggest the THTQIP demonstration waiver has resulted in overall cost savings and this trend is expected to continue.

Planned Evaluation Activities During THTQIP Extension

HHSC will continue to fulfill federal evaluation monitoring and reporting requirements during the THTQIP extension. The THTQIP demonstration waiver extension does not alter the overall goals and objectives of the evaluation; therefore, HHSC is not proposing modifications to the approved evaluation questions. HHSC is also not proposing changes to hypotheses, data sources, statistical methods, and/or outcome measures for the evaluation of the UC Pool (Evaluation Question 2) or components related to the overall impact of the THTQIP demonstration (Evaluation Questions 4 and 5). HHSC is proposing changes to further the DSRIP and MMC expansion components, as detailed below.

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

Changes to the DSRIP Evaluation Component

The CMS-approved evaluation design includes one evaluation question and four hypotheses related to DSRIP:

Evaluation Question 1: Did the DSRIP program incentivize changes to transform the health care system for the MLIU population in Texas?

- Hypothesis 1.1 DSRIP incentivized changes to the health care system that maintained or increased collaboration among providers.
- Hypothesis 1.2 DSRIP incentivized performing providers to improve continuity, quality, and cost of care for Medicaid clients with diabetes.
- Hypothesis 1.3 DSRIP incentivized performing providers to improve quality-related outcomes, specified as Category C population-based clinical outcome measures.
- Hypothesis 1.4 DSRIP transformed the health care system, resulting in improvements in population health, specified as DSRIP Category D outcomes.

DSRIP funds are scheduled to phase out during the final year of the current THTQIP demonstration waiver, which begins October 1, 2021. The current evaluation question and hypotheses pertaining to DSRIP will no longer be applicable after DSRIP's scheduled completion date. HHSC may continue to examine DSRIP or related transitional programs using a revised hypothesis and measure set focused on the DSRIP transition process and related programming under the THTQIP extension.

Changes to the MMC Evaluation Component

The CMS-approved evaluation design includes one evaluation question and four hypotheses pertaining to MMC:

Evaluation Question 3: Did the expansion of the MMC health care delivery model to additional populations and services improve healthcare (including access to care, care coordination, quality of care, and health outcomes) for MMC clients?

- Hypothesis 3.1 Access to care will improve among clients whose Medicaid benefits shift from FFS to a MMC health care delivery model.
- Hypothesis 3.2 Care coordination will improve among clients whose Medicaid benefits shift from FFS to a MMC health care delivery model.
- Hypothesis 3.3 Quality of care will improve among clients whose Medicaid benefits shift from FFS to a MMC health care delivery model.
- Hypothesis 3.4 Health and health care outcomes will improve among clients whose Medicaid benefits shift from FFS to a MMC health care delivery model.
- Hypothesis 3.5 Client satisfaction will improve among clients whose Medicaid benefits shift from FFS to a MMC health care delivery model.

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

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

Need for THTQIP Extension

Only preliminary evaluation findings are available for the THTQIP demonstration waiver at this time. However, based on preliminary findings HHSC believes the THTQIP demonstration waiver is on track to meet its intended objectives. Specifically, early evidence suggests DSRIP has incentivized some forms of collaboration and improved health outcomes; MMC shows early signs of improved access and quality of care; more providers are participating in APMs, and; the demonstration generates overall cost savings.

Although preliminary findings from the THTQIP demonstration waiver are promising, the COVID-19 pandemic, which coincides with the final three years of the demonstration, presents a serious challenge to the final evaluation of the THTQIP demonstration waiver. The pandemic and ensuing economic recession significantly reordered priorities for clients and providers in the state, impacting enrollment, utilization, and health care delivery across the Medicaid system. HHSC anticipates the COVID-19 pandemic will have a direct or indirect impact on many of the measures used in the THTQIP evaluation. Like most time-series designs, the THTQIP demonstration evaluation is vulnerable to external validity threats; COVID-19 introduces a number of confounding factors that undermine causal inference and impede evaluators' ability to isolate the impact of demonstration policies. At the time of writing, it is unknown how long the most severe effects of the COVID-19 pandemic will last, and it is unlikely that the current evaluation will be able to fully remove or account for the impacts of the pandemic. Additional years of data are necessary to evaluate the impact of demonstration policies under stable conditions free of the COVID-19 pandemic.

The THTQIP extension is also necessary to examine recent or forthcoming changes to the current THTQIP demonstration waiver. Specifically, the THTQIP extension would allow HHSC to examine the DSRIP transition process and the impact of new benefits or populations recently carved into MMC. Collectively, the THTQIP extension would support the rigor of the evaluation in determining if the THTQIP demonstration waiver achieved its intended objectives.

Resources

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

Appendix D. Quality Assurance Monitoring

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

External Quality Review

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

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

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

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

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

Multi-Year Focus

In summer 2016, the Texas Medicaid and CHIP external quality review organization (EQRO) began a multi-year focus study to evaluate the STAR Kids program and develop a set of quality measures for the STAR Kids population. The EQRO produced five reports for the study:

1. STAR Kids Program Focus Study Measures Background Report (February 10, 2017)
2. STAR Kids Program Focus Study Pre-Implementation Descriptive Report (May 26, 2017). https://hhs.texas.gov/sites/default/files//documents/about-hhs/process-improvement/quality-efficiency-improvement/STAR-Kids-Pre-Implementation-Report-052617.pdf
3. STAR Kids Post-Implementation Managed Care Organization (MCO) Interview Report (June 18, 2018). https://hhs.texas.gov/sites/default/files/documents/about-hhs/process-improvement/medicaid-chip-qei/star-kids-post-mco-interview-report-june-2018.pdf
4. Measures Feasibility Report (April 18, 2019)
5. Summary Report (November 13, 2019)

The final summary report contained a series of recommendations including

- Conducting regular NCI-CFS surveys with STAR Kids caregivers;
- Conducting additional studies with the STAR Kids-Screening and Assessment Instrument (SK-SAI) and Individual Service Plan (ISP);
- Conducting CAHPS surveys to assess member experiences;
- Creating quality of care measures specific to members enrolled in the Medically Dependent Children Program (MDCP); and,
- Conducting focus groups with MDCP caregivers.

These recommendations were incorporated into SB 1207, 86th Legislature, and HHSC has or is in the process of implementing them.

The annual Summary of Activities (SOA) reports to CMS all activities performed by the EQRO during the contract year. The SOA report presents findings by the Texas EQRO on activities for state fiscal year (SFY) 2018, which address quality of care in Texas Medicaid and CHIP. The report's recommendations include the following:

- validate and update provider addresses to improve the return rate on records requested from providers;

- identify members that most benefit from addressing social determinants of health (SDOH) and improve their access to care;
- continue to improve access to behavioral health care; and
- focus on improving key vaccination rates.

In response to these recommendations, MCOs are required to verify the provider address information prior to the EQRO requesting patient records for encounter data validation (EDV). In addition, MCOs and DMOs are subject to corrective action plans (CAPs) for data that does not meet minimum EDV quality standards.

HHSC, in conjunction with the EQRO, recently completed an analysis of state and national SDOH tools. HHSC plans to use this information to identify a recommended tool for Medicaid MCOs. In addition, the Medicaid/CHIP Services Department has formed an internal workgroup to further incorporate SDOH into quality initiatives.

In 2019, MCOs began a statewide, two-year performance improvement project (PIP) focused on members with complex behavioral health conditions. In 2020, PIPs focus on improving integration of behavioral health and physical health care, with the goal of reducing hospitalization.

To improve vaccination rates, HHSC has added immunizations for adolescents (IMA) as a quality measure in the Medical Pay-for-Quality (P4Q) program for STAR, CHIP and STAR Kids.

Quality Measures

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

- National Committee for Quality Assurance Healthcare Effectiveness Data and Information Set (HEDIS®) - A nationally recognized and validated set of measures used to gauge quality of care provided to members.
- Agency for Healthcare Research and Quality (AHRQ) Pediatric Quality Indicators (PDIs)/ Prevention Quality Indicators (PQIs) - PDIs use hospital discharge data to measure the quality of care provided to children and youth. PQIs use hospital discharge data to measure quality of care for specific conditions known as "ambulatory care sensitive conditions" (ACSCs). ACSCs are conditions for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications or more severe disease.

- 3M® Potentially Preventable Events (PPEs) - HHSC uses and collects data on Potentially Preventable Admissions (PPAs), Potentially Preventable Readmissions (PPRs), Potentially Preventable Emergency Department Visits (PPVs), Potentially Preventable Complications (PPCs), and Potentially Preventable Ancillary Services (PPSs).
- Consumer Assessment of Healthcare Providers & Systems (CAHPS®) Surveys - CAHPS Health Plan Surveys are nationally recognized and validated tools for collecting standardized information on members' experiences with health plans and services.

Initiatives

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

Administrative Interviews

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

Core Measure Reporting

CMS has a Children's and an Adult Health Care Quality Core Set of measures which states voluntarily report on for children in Medicaid and CHIP and adults in Medicaid. The EQRO assists HHSC in reporting core measures to CMS each year.[2]

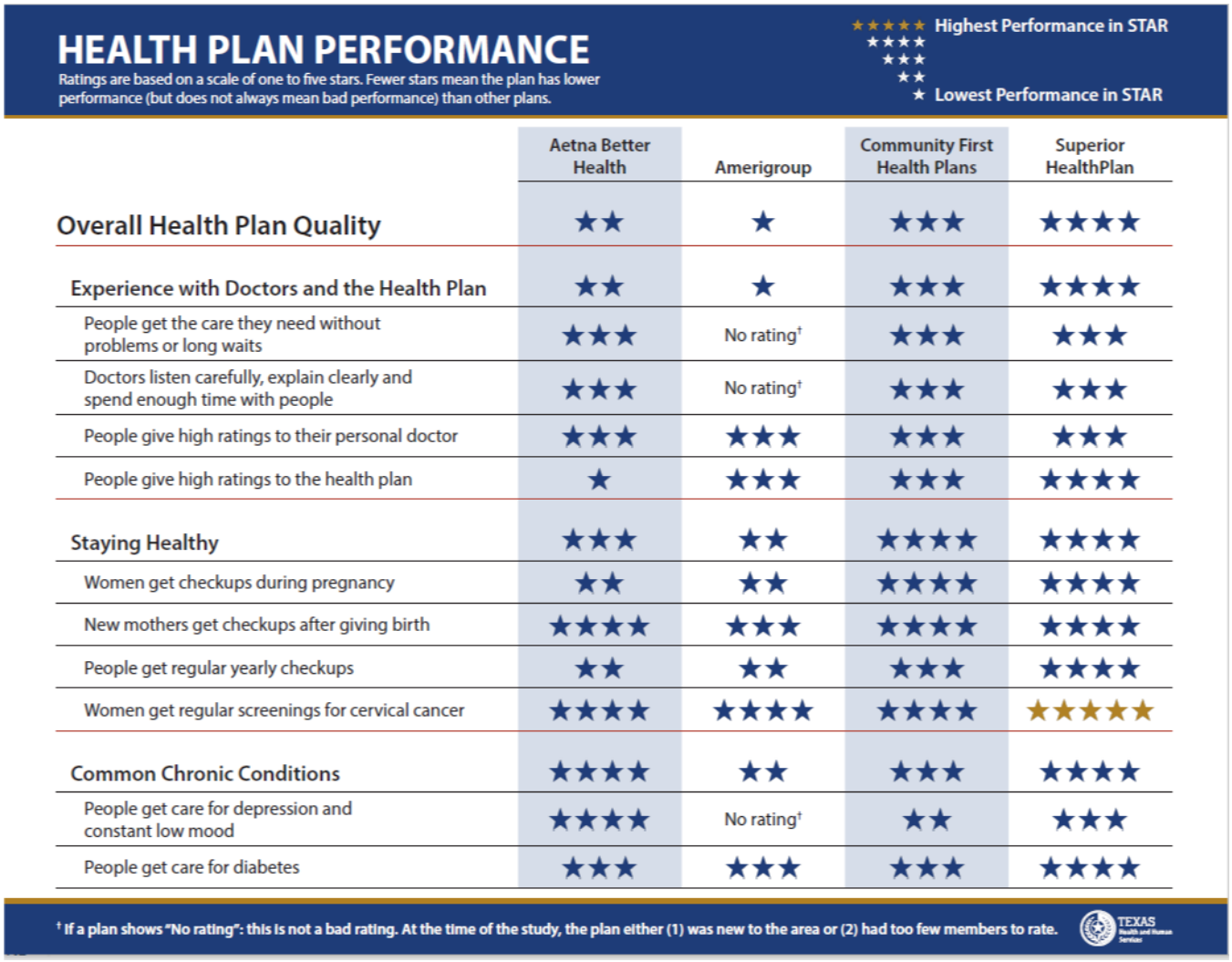
MCO Report Cards

HHSC provides information on outcome and process measures to Medicaid and CHIP members regarding MCO performance during the enrollment process. To comply with this requirement and the quality rating system required by 42 CFR 438.334, HHSC develops report cards for each program service area to allow members to compare the MCOs on specific quality measures. These report cards are intended to assist potential enrollees in selecting an MCO based on quality metrics. Report cards are posted on the HHSC website and included in the Medicaid enrollment packets. Report cards are updated annually.[3]

[2] https://www.medicaid.gov/medicaid/quality-of-care/quality-of-care-performance-measurement/adult-and-child-health-care-quality-measures/index.html
[3] https://hhs.texas.gov/services/health/medicaid-chip/programs/managed-care-report-cards

Figures 1 and Figure 2 show 2020 report cards for STAR adult members in the Bexar Service Area and STAR Kids members in the Harris Service Area.

Figure 1: STAR Adult Report Card, Bexar Service Area



HEALTH PLAN PERFORMANCE

Ratings are based on a scale of one to five stars. Fewer stars mean the plan has lower performance (but does not always mean bad performance) than other plans.

★★★★★ Highest Performance in STAR
★★★★
★★★
★★
★ Lowest Performance in STAR

	Aetna Better Health	Amerigroup	Community First Health Plans	Superior HealthPlan
Overall Health Plan Quality	★★	★	★★★	★★★★
Experience with Doctors and the Health Plan	★★	★	★★★	★★★★
People get the care they need without problems or long waits	★★★	No rating†	★★★	★★★
Doctors listen carefully, explain clearly and spend enough time with people	★★★	No rating†	★★★	★★★
People give high ratings to their personal doctor	★★★	★★★	★★★	★★★
People give high ratings to the health plan	★	★★★	★★★	★★★★
Staying Healthy	★★★	★★	★★★★	★★★★
Women get checkups during pregnancy	★★	★★	★★★★	★★★★
New mothers get checkups after giving birth	★★★★	★★★	★★★★	★★★★
People get regular yearly checkups	★★	★★	★★★	★★★★
Women get regular screenings for cervical cancer	★★★★	★★★★	★★★★	★★★★★
Common Chronic Conditions	★★★★	★★	★★★	★★★★
People get care for depression and constant low mood	★★★★	No rating†	★★	★★★
People get care for diabetes	★★★	★★★	★★★	★★★★

† If a plan shows "No rating": this is not a bad rating. At the time of the study, the plan either (1) was new to the area or (2) had too few members to rate.

TEXAS Health and Human Services

Network Adequacy

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

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

Pay-for-Quality

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

Another key initiative to improve Medicaid and CHIP quality of care is the medical P4Q program. Under medical P4Q, 3 percent of the MCOs' capitation is at-risk based on their performance on a series of key quality metrics that focus on prevention, chronic disease management, behavioral health, and maternal and infant health. MCOs are evaluated on their own year to year performance and compared to their peers at the state and national level.

Medical P4Q has led to marked improvement in quality. In comparing 2017 to 2018 program rates, all at-risk measures in all programs (i.e., STAR, CHIP and STAR+PLUS) showed improvement except for potentially preventable emergency room visits (PPVs) in STAR and CHIP. For example, rates for counseling for nutrition and physical activity increased by 8 percent in CHIP. In addition, rates for six or more well child visits in the first 15 months increased by 4 percent in STAR. Additional detail regarding each program's results are provided below.

2018 Medical P4Q Results

Overall, MCOs performed well. FirstCare (CHIP, STAR) was the only MCO to have a net recoupment across all programs ($3.7 million). While Molina had a recoupment for CHIP, gains in STAR more than offset the recoupment resulting in a net distribution overall. The sum of amounts recouped is apportioned to successful MCOs relative to the percentage they were eligible to earn. There are no amounts to be recouped in STAR+PLUS, so no dollars earned. No money is available for the bonus pool in any program.

In the tables that follow, the columns labeled "Potential" are based on each MCO's performance and reflect the maximum amount they could have earned or lost. The columns labeled "Actual" reflect the actual financial impact to each MCO, based on their performance and amounts available for payments. Attachment 2 presents each MCO's performance per measure and program, in summary and detail.

CHIP

In CHIP, only Molina and FirstCare are subject to recoupment out of 15 MCOs. Table 1 presents the total amounts earned or lost per MCO and Figure 3 summarizes CHIP MCOs' performance against benchmarks and performance against self on the at-risk P4Q measures.

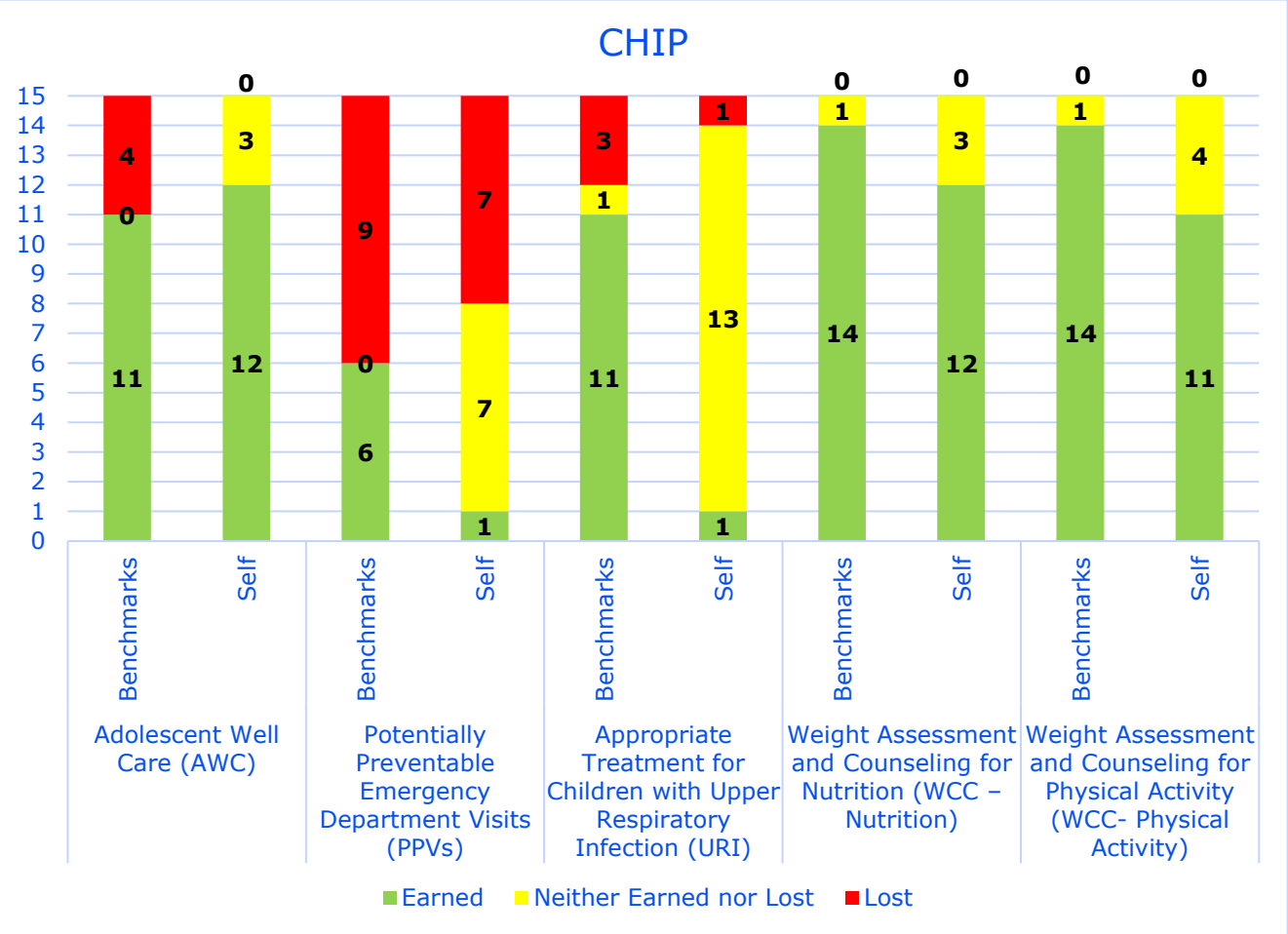
Table 1: CHIP Capitation Earned/Recouped by MCO[i]

MCO	2018 Capitation	Potential Percent Earned/ Recouped	Potential Dollars Earned/ Recouped	Actual Percent Earned/ Recouped	Actual Dollars Earned/ Recouped
Aetna Better Health	$12,638,456	0.47	$59,243	0.005	$629
Amerigroup	$98,358,993	1.41	$1,383,173	0.015	$14,686
Blue Cross Blue Shield of Texas	$8,600,747	0.47	$40,316	0.005	$428
Community First Health Plans	$25,499,485	0.28	$71,717	0.003	$761
Community Health Choice	$49,189,346	1.88	$922,300	0.020	$9,793
Cook Children's Health Plan	$35,367,648	1.69	$596,829	0.018	$6,337
Dell/Seton Health Plan	$12,322,433	1.69	$207,941	0.018	$2,208
Driscoll Health Plan	$16,056,881	1.31	$210,747	0.014	$2,238
El Paso First Health Plans, Inc	$12,280,560	0.94	$115,130	0.010	$1,222
FirstCare Health Plans	$7,093,344	-0.28	($19,950)	-0.281	($19,950)
Molina Healthcare of Texas, Inc.	$31,833,836	-0.19	($59,688)	-0.188	($59,688)
Parkland Community Health Plan	$37,646,219	1.31	$494,107	0.014	$5,246
Superior HealthPlan	$139,907,396	0.47	$655,816	0.005	$6,963
Texas Children's Health Plan	$122,286,440	2.06	$2,522,158	0.022	$26,779

MCO	2018 Capitation	Potential Percent Earned/ Recouped	Potential Dollars Earned/ Recouped	Actual Percent Earned/ Recouped	Actual Dollars Earned/ Recouped
UnitedHealthCare Community Plan	$15,730,603	1.41	$221,212	0.015	$2,349
Total			$7,421,050		$0

- *Adolescent Well Care (AWC) and Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)* - CHIP MCOs generally performed well on these preventive care measures, with 11 or more earning money on both performance against self and benchmarks. No MCOs lost capitation for performance on the WCC for Nutrition and Physical Activity. For AWC, four MCOs (Aetna, BCBS, Community First, and Molina) lost capitation for performance against benchmarks.
- *Appropriate Treatment for Children with Upper Respiratory Infection (URI)* - This measure evaluates judicious use of antibiotics. While only one MCO (Cook Children's) improved enough to earn money on performance against self, 11 CHIP MCOs earned money on performance against benchmarks.
- *Potentially Preventable Emergency Department Visits (PPVs)* - CHIP MCOs were most challenged by PPVs. Nine MCOs lost capitation on performance against benchmarks and seven MCOs' performance declined five or more percent for a capitation loss on performance against self.

Figure 3: CHIP MCO Performance by Measure



STAR

In STAR, only FirstCare out of 16 MCOs is subject to recoupment. Table 2 shows the actual dollars earned or lost by each MCO. Figure 4 presents MCO performance against benchmarks and against self on STAR P4Q measures.

Table 2: STAR Capitation Earned/Recouped by MCO[ii]

MCO	2018 Capitation	Potential Percent Earned/ Recouped	Potential Dollars Earned/ Recouped	Actual Percent Earned/ Recouped	Actual Dollars Earned/ Recouped
Aetna Better Health	$208,462,504	1.03	$2,149,770	0.047	$97,683
Amerigroup	$1,440,716,417	1.22	$17,558,731	0.055	$797,850
Blue Cross Blue Shield of Texas	$77,513,430	0.75	$581,351	0.034	$26,416
Community First Health Plans	$284,949,776	0.19	$534,281	0.009	$24,277
Community Health Choice	$825,959,465	1.78	$14,712,403	0.081	$668,516
Cook Children's Health Plan	$275,435,635	0.47	$1,291,105	0.021	$58,666
Dell/Seton Health Plan	$45,050,796	1.41	$633,527	0.064	$28,787
Driscoll Health Plan	$463,063,325	1.88	$8,682,437	0.085	$394,520
El Paso First Health Plans, Inc	$172,171,647	0.84	$1,452,698	0.038	$66,009
FirstCare Health Plans	$245,963,022	-1.50	($3,689,445)	-1.500	($3,689,445)
Molina Healthcare of Texas, Inc.	$252,846,368	1.22	$3,081,565	0.055	$140,023
Parkland Community Health Plan	$495,034,885	0.94	$4,640,952	0.043	$210,880
RightCare from Scott & White Health Plan	$127,242,677	0.75	$954,320	0.034	$43,363
Superior HealthPlan	$2,061,684,117	0.66	$13,529,802	0.030	$614,779

MCO	2018 Capitation	Potential Percent Earned/ Recouped	Potential Dollars Earned/ Recouped	Actual Percent Earned/ Recouped	Actual Dollars Earned/ Recouped
Texas Children's Health Plan	$865,191,531	0.84	$7,300,054	0.038	$331,706
UnitedHealthCare Community Plan	$485,064,936	0.84	$4,092,735	0.038	$185,969
Total			$77,506,285		$0

- *Well Child Visits in the First 15 Months of Life (W15)* - STAR MCOs generally performed well on ensuring infants receive the recommended number of well child visits, with more than half the MCOs earning money and no MCOs subject to recoupment for both performance against self and performance against benchmarks.

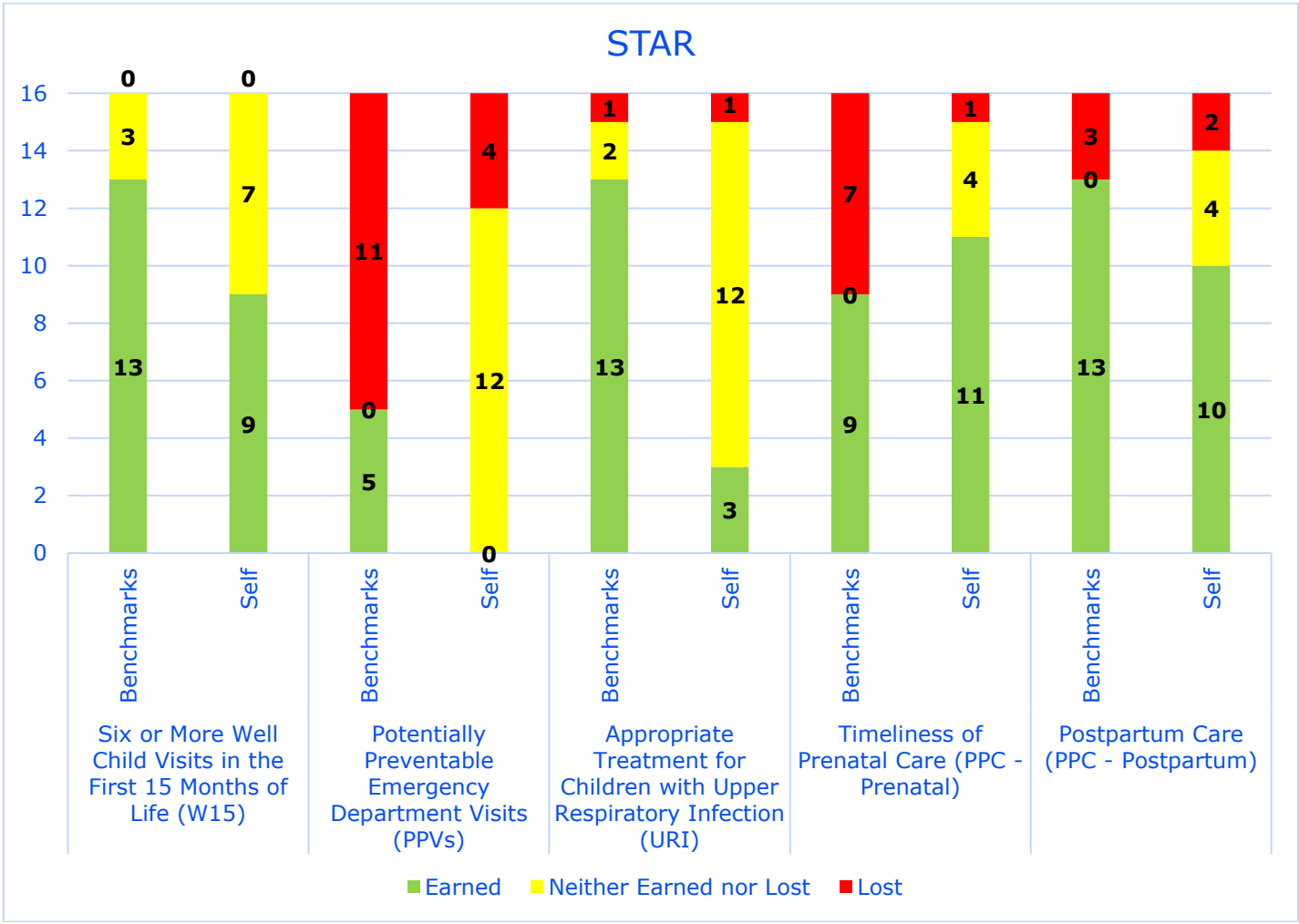
- *Prenatal and Postpartum Care (PPC)* - More than half the MCOs earned money for both performance against self and benchmarks on timeliness of prenatal care and postpartum care. Some MCOs lost capitation on these measures for performance against benchmarks, including seven MCOs on prenatal care and three on postpartum care. For performance against self, one MCO lost capitation on prenatal care (Texas Children's) and two MCOs (FirstCare and Scott & White) lost capitation on postpartum care.

- *URI* - MCOs generally performed well on the URI measure, with 13 MCOs earning capitation and only FirstCare losing capitation on performance against self and benchmarks.

- *PPVs* - Similar to CHIP, STAR MCOs were most challenged by PPVs, with 11 MCOs losing capitation on performance against benchmarks and four MCOs losing capitation on performance against self (El Paso, FirstCare[4], Molina, and United). No MCO achieved the five or more percent improvement required to earn capitation on performance against self.

[4] This may not reflect FirstCare's true performance due to their encounter data errors.

Figure 4: STAR MCO Performance by Measure



STAR+PLUS

In STAR+PLUS, none of the five MCOs are subject to recoupment and no money is available to redistribute. Table 3 shows the actual dollars earned by each MCO. Figure 5 presents MCO performance against benchmarks and against self on STAR+PLUS P4Q measures. While MCOs may have lost capitation on one or more measures, it was offset by capitation earned on other measures resulting in net overall capitation earned.

Table 3: STAR+PLUS Capitation Earned/Recouped by MCO[iii]

MCO		2018 Capitation	Potential Percent Earned/ Recouped	Potential Dollars Earned/ Recouped	Actual Percent Earned/ Recouped	Actual Dollars Earned/ Recouped
Amerigroup		$1,296,905,712	0.30	$3,890,717	0.0	$0
Cigna-HealthSpring		$426,826,409	0.30	$1,280,479	0.0	$0
Molina Healthcare of Texas, Inc.		$856,235,158	0.75	$6,421,764	0.0	$0
Superior HealthPlan		$1,493,042,737	0.90	$13,437,385	0.0	$0
UnitedHealthCare Community Plan		$1,287,229,942	0.45	$5,792,535	0.0	$0

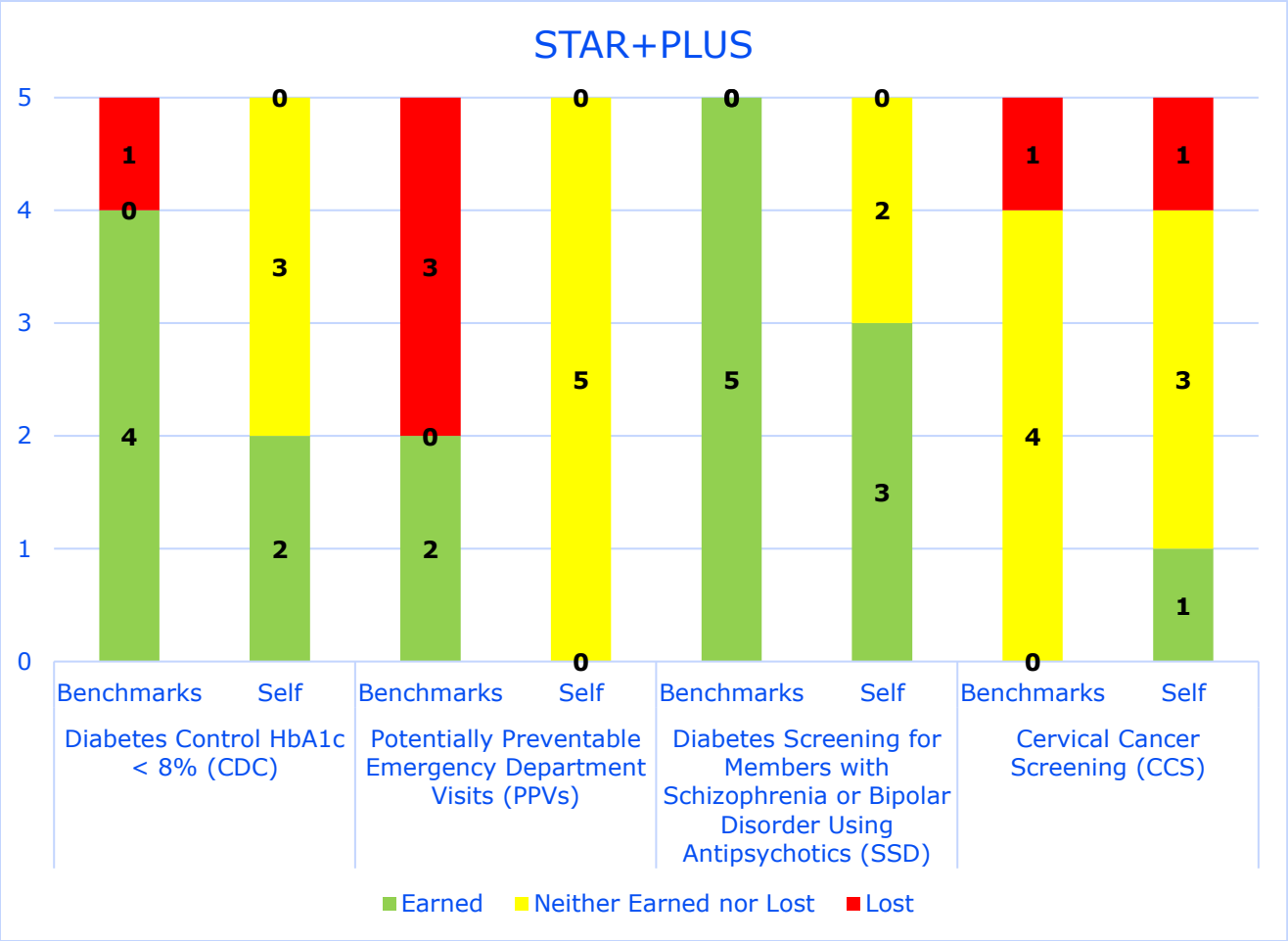
- *Cervical Cancer Screening (CCS)* - For performance against self, STAR+PLUS MCOs did not lose capitation on any of the measures except CCS, with one MCO's rate (United) declining more than the five percent threshold for recoupment. One MCO also lost capitation for performance against benchmark for this measure.

- *Diabetes Screening for Members Using Antipsychotics (SSD)* - All MCOs earned capitation on performance against benchmarks for the measure SSD. Three MCOs also earned capitation on performance against self for this measure.

- *PPVs* - Similar to STAR and CHIP, STAR+PLUS MCOs were most challenged by PPVs: three MCOs (Amerigroup, Cigna, and Molina) lost capitation on performance against benchmarks and no MCO achieved the five or more percent improvement required to earn capitation on performance against self.

- *Diabetes Control (CDC)* – Only one MCO lost capitation on performance against benchmarks for the CDC measure (Superior). Two MCOs earned capitation on performance against self for this measure (Molina and Superior).

Figure 5: STAR+PLUS Performance by Measure



HHSC's focus on maternal and infant health through P4Q, PIPs and other initiatives have resulted in significant improvement in infant and maternal health outcomes. From 2008 to 2018, there was a 24 percent rate of improvement in children receiving six or more well child visits in the first 15 months of life; a 26 percent rate of improvement for adolescents receiving an annual well child visit; and, a 14 percent rate of improvement in timeliness of prenatal care.

The medical P4Q program serves as a catalyst for MCOs to pursue value-based payment (VBP) arrangements with providers to achieve required P4Q outcomes. The state uses the Healthcare Payment Learning and Action Network (HCP LAN) Alternative Payment Model (APM) Framework[5] to guide this effort. APMs incentivize high-quality and cost-efficient care by linking healthcare payments to measures of

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

value. The LAN provides a menu of payment models from which MCOs can choose to develop APM contracts with their providers.

Medicaid Value-Based Enrollment

Pursuant to Texas Government Code §533.00511, HHS is implementing an incentive program that automatically enrolls a greater percentage of Medicaid recipients who have not selected a managed care plan into a plan based on quality of care, efficiency and effectiveness of service provision, and performance. The state's new autoenrollment method uses metrics aligned with the Triple Aim to promote value-based healthcare that achieves better care at lower costs.[6]

Alternative Payment Model (APM) Requirements

The P4Q and value-based enrollment programs serve as catalysts for managed care to pursue value-based payment arrangements with providers to achieve improved outcomes. APMs are payment arrangements in which some portion of an MCOs reimbursement to a provider is linked to measures of quality and outcomes. HHSC uses the Healthcare Payment Learning and Action Network (HCP LAN) Alternative Payment Model (APM) Framework[7] to help guide this effort. This framework provides a menu of payment models from which MCOs could choose to develop alternative payment contracts with their providers. Moving from one category to the next adds a level of risk to the payment model.

Under this initiative, HHS created contractual targets for MCOs to connect provider payments to value using APMs. The APM percentage targets increase over time. If an MCO fails to meet the APM targets or certain allowed exceptions for high performing plans, the MCO must submit an action plan, and HHSC may impose graduated contractual remedies, including liquidated damages.

The full range of contractual requirements for MCOs to promote VBP include:

- The establishment of MCO APM targets: Overall and risk-based APM contractual targets were established for MCO expenditures on VBP contracts with providers relative to all medical and pharmacy expenses. The targets start at 25 percent of provider payments in any type of APM and 10 percent of provider payments in risk-based APMs for calendar year 2018. These

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

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

targets increase over four years up to 50 percent overall and 25 percent risk-based by calendar year 2021.

- Requirements for MCOs to establish and maintain data sharing processes with providers.
- Requirements for MCOs to adequately resource this activity: MCOs and DMOs must dedicate sufficient resources for provider outreach and negotiation, provide assistance with data and/or report interpretation and initiate collaborative activities to support VBP and provider improvement.
- Requirements for MCOs to have a process in place to evaluate APM models: MCOs are required to evaluate the impact of APM models on utilization, quality, cost and return on investment.

HHSC collects reports on their APM initiatives on an annual basis. In general, most of the reported APM initiatives involve primary care providers, but MCOs also have reported APMs with specialists (including obstetricians/ gynecologists), behavioral health providers, hospitals, nursing facilities and long-term services and supports providers.

In 2018, the first target year for HHSC's Medicaid MCO APM targets, MCOs reported that 40 percent of their payments to providers were in an APM, with about 22 percent in a risk-based APM. As a whole, the Texas Medicaid and CHIP programs performed at or above contractually-required thresholds and national goals in 2018.

Performance Improvement Projects

The Balanced Budget Act of 1997 requires all states with Medicaid managed care to ensure MCOs conduct performance improvement projects (PIPs). 42 CFR 438.330 requires projects be designed to achieve, through ongoing measurements and interventions, significant improvement, sustained over time, in clinical care and nonclinical care areas that have a favorable effect on health outcomes and enrollee satisfaction. Health plans conduct PIPs to examine and improve areas of service or care identified by HHSC in consultation with Texas's EQRO as needing improvement. Topics are selected based on health plan performance on quality measures and member surveys. HHSC requires each health plan to conduct two PIPs per program. One PIP per health plan must be a collaborative with another health plan or a Delivery System Reform Incentive Payment project, or a community-based organization.

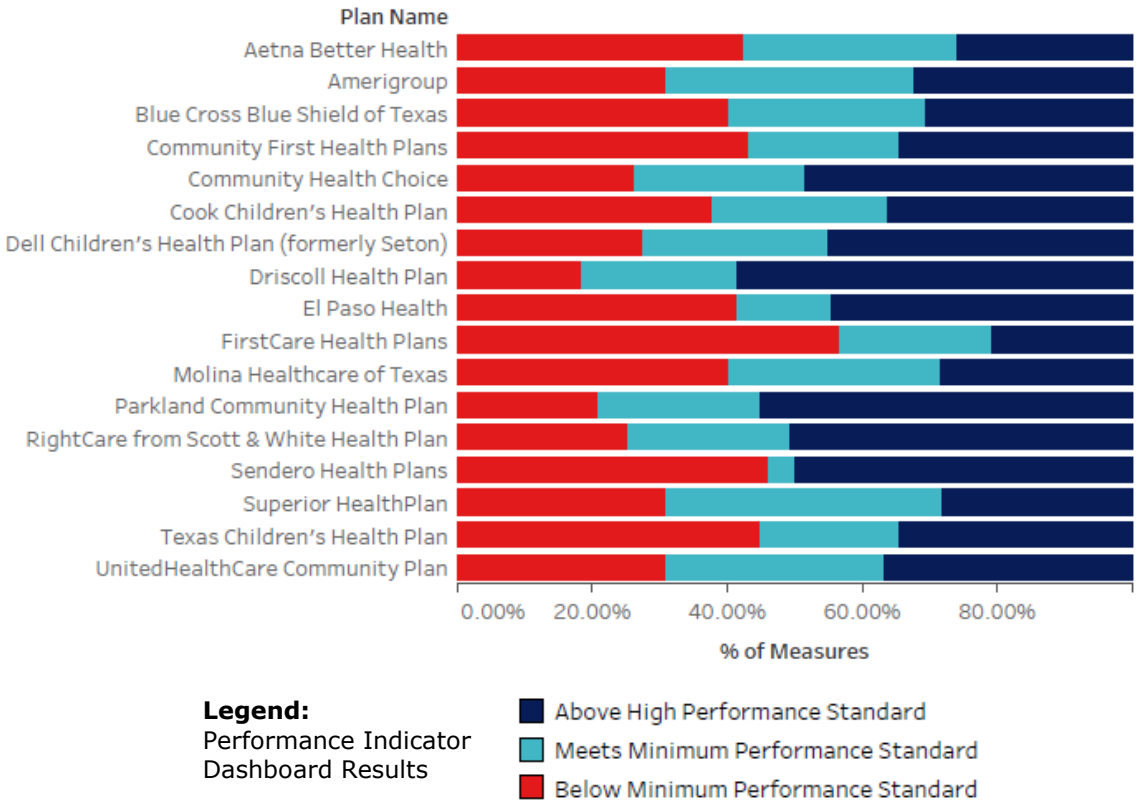
Performance Indicator Dashboards

The Performance Indicator Dashboards include sets of measures per program that identify key aspects of performance to support MCO accountability. HHSC expects Medicaid and CHIP MCOs to meet or surpass the HHSC-defined minimum standard

on more than two-thirds of the measures on the Performance Indicator Dashboard. The minimum standard is the program rate or the national average, whichever is lower, from two years prior to the measurement year.

Beginning with the measurement year 2018, an MCO whose per program performance is below the minimum standard on more than 33 percent of the measures on the dashboard is subject to remedies under the contract, such as placement on a corrective action plan (CAP). For more information, please see Chapter 10.1.14 of the Uniform Managed Care Manual.[8] Calendar year 2018 Performance Indicator Dashboard results for STAR, STAR+PLUS and CHIP are presented in Figures 6, 7 and 8, below, and added detail for these and other programs is available on the THLC portal.

Figure 6. STAR Performance Indicator Dashboard Results by MCO, CY 2018



[8] https://hhs.texas.gov/sites/default/files/documents/laws-regulations/handbooks/umcm/10-1-14.pdf

Figure 7. STAR+PLUS Performance Indicator Dashboard Results by MCO, CY 2018

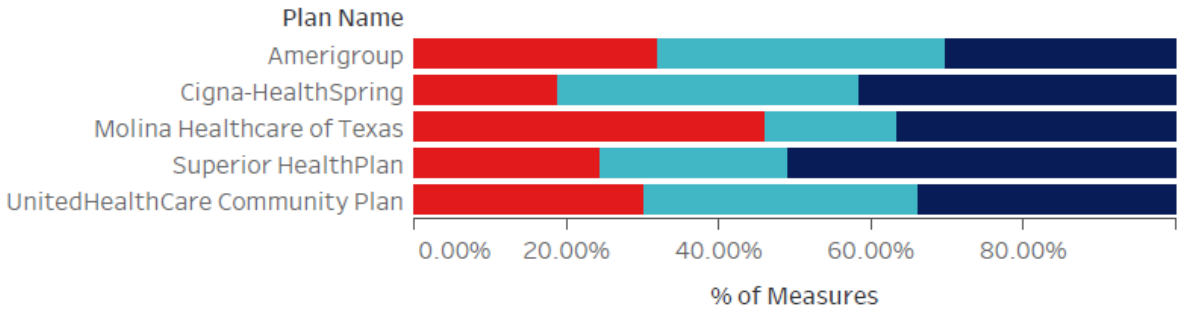
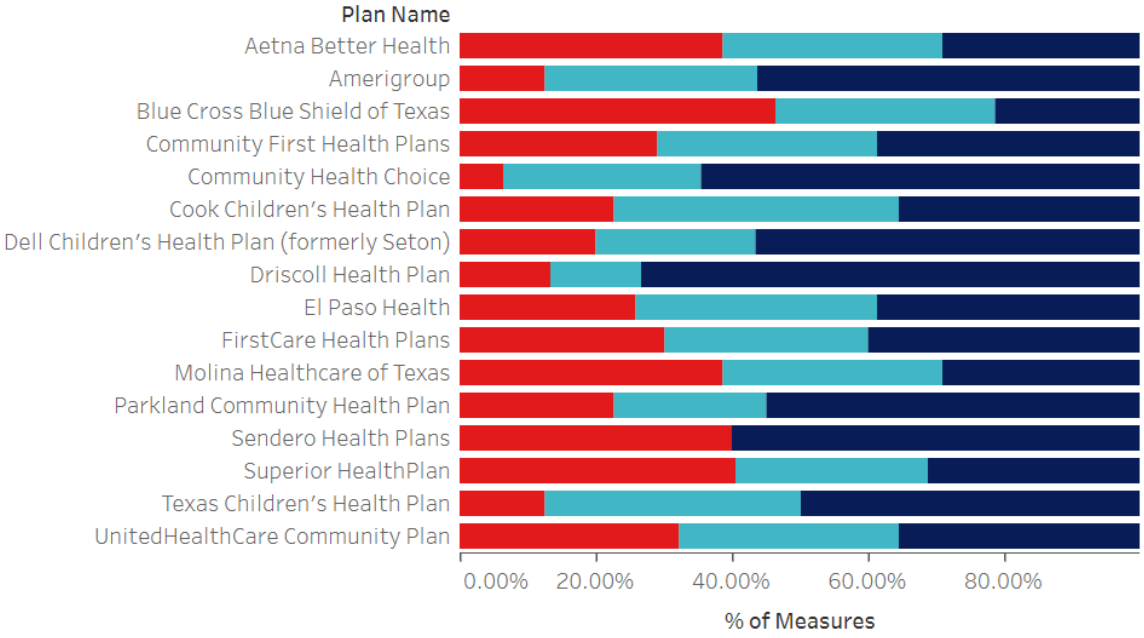


Figure 8. CHIP Performance Indicator Dashboard Results by MCO, CY 2018

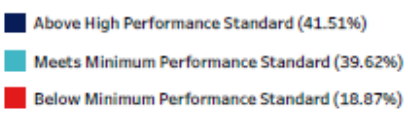


The Performance Indicator Dashboard measure sets are comprised of HEDIS and CAHPS survey measures and vary per program. The Dashboard for CHIP includes over 40 measures and sub-measures, STAR has over 60, and STAR+PLUS has over 50. For example, Figure 9, below, presents the performance for one STAR+PLUS MCO (Cigna HealthSpring) on each measure and sub-measure.

Figure 9. Example: STAR+PLUS MCO Performance, Cigna HealthSpring, CY 2018

2018 Performance Summary: HealthSpring

STAR+PLUS Program



Performance	Measure Description	Minimum Standard	High Standard	Plan Rate	Numerator	Denominator
Above High Performance Standard	CDC - HbA1c Control (<8%)	46.00	50.00	50.36	207	411
	PQI - Diabetes Short-term Complications Admission Rate (PQI 1)	37.00	34.00	28.24	67	237240
	PQI - Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI 5	166.00	157.00	134.58	206	153074
	PQI - Congestive Heart Failure (CHF) Admission Rate (PQI 8)	127.00	120.00	117.60	279	237240
	PQI - Bacterial Pneumonia Admission Rate (PQI 11)	50.00	47.00	46.79	111	237240
	PQI - Urinary Tract Infection Admission Rate (PQI 12)	40.00	37.00	29.51	70	237240
	PQI - Uncontrolled Diabetes Admission Rate (PQI 14)	20.00	18.00	14.75	35	237240
	PQI - Asthma in Younger Adults Admission Rate (PQI 15)	15.00	14.00	3.56	3	84166
	PQI - Rate of Lower-extremity Amputation among Patients with Diabetes (PQI 16)	15.00	14.00	13.49	32	237240
	PCE - Systemic Corticosteroids	68.00	72.00	73.50	513	698
	SPC - Total Adherence	56.00	61.00	63.48	372	586
	SPD - Received Statin Therapy	62.00	63.00	66.27	1377	2078
	PPE - Potentially Preventable Readmissions (PPR)	1.00	0.90	0.85	1024.84	1206.39
	SVY-Adult - % Good Access to Urgent Care	62.00	65.00	65.95		
	SVY-Adult - % Good Access to Specialist Appointment	54.00	55.00	60.96		
	SVY-Adult - % Good Access to Routine Care	56.00	61.00	61.91		
	SVY-Adult - % Good Access to Special Therapies	33.00	35.00	52.06		
	SVY-Adult - % Good Access to Behavioral Health Treatment or Counseling	52.00	54.00	56.85		
	SVY-Smoke - % Advised to Quit Smoking	39.00	48.00	49.41		
	PQI - Chronic PQI Composite Rate (PQI 92)	345.00	327.00	312.76	742	237240
	HVL - All Ages	67.00	70.00	71.10	155	218
	CDS - Non-HCBS Program Primary Home Care	2.50	2.60	4.31	28	650
Meets Minimum Performance Standard	AAB - Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	24.00	29.00	26.10	113	433
	ABA - Adult BMI Assessment	80.00	86.00	85.40	351	411
	AMM - Effective Acute Phase Treatment	47.00	52.00	50.54	375	742
	AMM - Effective Continuation Phase Treatment	33.00	36.00	33.42	248	742
	CCS - Cervical Cancer Screening	42.00	62.00	44.77	184	411
	CDC - Eye Exam	46.00	55.00	51.50	2059	3998
	MMA - Total Age 5 to 64 75% Covered	33.00	50.00	47.23	128	271
	PQI - Hypertension Admission Rate (PQI 7)	13.00	12.00	12.22	29	237240
	PCE - Bronchodilators	83.00	86.00	83.95	586	698
	SAA - 80% Coverage	57.00	61.00	60.02	764	1273
	SMD - Diabetes Monitoring for People with Diabetes and Schizophrenia	70.00	73.00	70.84	277	391
	SSD - Diabetes Screening	80.00	83.00	82.03	1520	1853
	SPC - Total Statin Therapy	73.00	76.00	75.42	586	777
	SPD - Statin Adherence	53.00	60.00	59.40	818	1377
	PPE - Potentially Preventable Admissions (PPA)	1.00	0.95	0.96	1820.55	1900.82
	PPE - Potentially Preventable Emergency Department Visits (PPV)	1.00	0.90	1.00	4743.48	4729.45
	SVY-Adult - % Good Access to Service Coordination	52.00	54.00	52.74		
	SVY-Adult - "% Rating Personal Doctor a "9" or "10""	66.00	69.00	67.79		
	SVY-Adult - "% Rating Their Health Plan a "9" or "10""	57.00	61.00	60.09		
	PQI - Diabetes PQI Composite Rate (PQI 93)	96.00	91.00	94.84	225	237240
	SVY-Adult - How Well Doctors Communicate Composite	75.00	79.00	78.58		
Below Minimum Performance Standard	CDC - Monitoring for Nephropathy	90.00	92.00	89.92	3595	3998
	CDC - HbA1c Testing	87.00	87.00	86.37	355	411
	CHL - Total	44.00	57.00	39.77	70	176
	PPC - Timeliness of Prenatal Care	63.00	84.00	55.05	60	109
	PPC - Postpartum Care	40.00	64.00	33.03	36	109
	AMR - Total 5 to 64 Ratios >= 50%	57.00	62.00	52.71	214	406
	PQI - Diabetes Long-term Complications Admission Rate (PQI 3)	44.00	42.00	45.95	109	237240
	SMC - Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	78.00	82.00	69.77	30	43
	PPE - Potentially Preventable Complications (PPC)	1.00	0.90	1.04	145.16	139.13
	CDS - HCBS Personal Attendant Services	6.40	6.70	3.25	1400	43057

Appendix E. Public Notice

Request to Waive: 42 CFR § 431.416(g)

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

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

Post-award Public Input Process Required by 42 CFR §431.420(c)

HHSC hosted a public forum via webinar on June 22, 2020 to provide the public with updates on the Texas Healthcare Transformation and Quality Improvement Program (THTQIP) 1115 waiver. The last public in person forum was held on June 24, 2019. The date, time, and location of the public forums were published on HHSC's website 30 days in advance of the meetings.

During the June 2020 public forum the public was provided with an update on the following Transformation waiver topics: Health Information Technology (IT) Strategic Plan, Delivery System Reform Incentive Payment program (DSRIP), Uncompensated Care, and Nursing Home Quality Incentive Payment Program. Links to the 1115 DY8 annual report and COVID-19 resource pages was also provided to the public. Public comment was also received and documented at this meeting. Comments received related to identifying external entities involved in the Health IT strategies, the process for creating new Medicaid benefits or programs, DSRIP operations and extension of DSRIP program, Value Based Purchasing, Uncompensated Care pool payments, and the potential to request an extension in light of COVID-19 as some other states are also doing. Requests for the PowerPoint presentation were received from some stakeholders and the slide deck was provided to those individuals electronically. During the forum, HHSC responded to comments and clarifying questions received.

Summary of Public Notice

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

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[i] Percentages have been rounded to fit this table.

[ii] Percentages have been rounded to fit this table.

[iii] Percentages have been rounded to fit this table.

Attachment M Historical Demonstration Information

The Texas Legislature, through the 2012-2013 General Appropriations Act and Senate Bill 7, instructed the Texas Health and Human Services Commission (HHSC) to expand its use of prepaid Medicaid managed care to achieve program savings, while also preserving locally funded supplemental payments to hospitals. The State of Texas submitted a section 1115 Demonstration proposal to CMS in July 2011 to expand risk-based managed care statewide consistent with the existing STAR section 1915(b) and STAR+PLUS section 1915(b)/(c) waiver programs, and thereby replace existing Primary Care Case Management (PCCM) or fee-for service (FFS) delivery systems. The state sought a section 1115 Demonstration as the vehicle to both expand the managed care delivery system, and to operate a funding pool, supported by managed care savings and diverted supplemental payments, to reimburse providers for uncompensated care costs and to provide incentive payments to participating hospitals that implement and operate delivery system reforms.

STAR and STAR+PLUS Programs

STAR is the primary managed care program providing acute care services to low-income families, children, and pregnant women. STAR+PLUS provides acute and long-term service and supports to older adults and adults with disabilities.

The STAR and STAR+PLUS managed care programs cover most beneficiaries statewide through three geographic expansions. The first expansion occurred on September 1, 2011, under existing section 1915(b) and section 1915(c) authorities; the second expansion occurred in March 2012, under section 1115 authority; and a third expansion of STAR+PLUS occurred on September 1, 2014 under section 1115 authority as a result of an amendment to the demonstration.

Effective March 1, 2012, the STAR program expanded statewide to include the three Medicaid rural service areas (MRSAs). Following this expansion, Medicaid eligible adults who were not enrolled in Medicare, met the level of care for Home and Community Based Services (HCBS), and resided in the MRSA, had to enroll in a STAR managed care organization (MCO); children meeting these criteria could voluntarily enroll in STAR. STAR MCOs in the MRSA provided acute care services, and will coordinate acute and long-term care services with section 1915(c) waivers, such as the Community Based Alternatives Program and the Community Living Assistance and Support Services Program, that exist outside of this section 1115 demonstration.

Effective September 1, 2014, STAR+PLUS expanded to the MRSA and Medicaid eligible adults over age 21 meeting STAR+PLUS eligibility criteria and residing in the MRSA were required to enroll in STAR+PLUS. Clients under 21 who meet the criteria may able to voluntarily enroll in STAR+PLUS effective September 1, 2014, and until the implementation of STAR Kids on November 1, 2016.

STAR and STAR+PLUS beneficiaries receive enhanced behavioral health services consistent with the requirements of the Mental Health Parity Act. As of March 2012, STAR+PLUS beneficiaries began receiving inpatient services through the contracted managed care organizations (MCOs). STAR+PLUS MCOs also provide Medicaid wrap services for outpatient drugs and biological products to dual eligible beneficiaries for whom the State has financial payment obligations. Additionally, Medicaid beneficiaries under the age of 21 received the full array of primary and preventive dental services required under the State plan, through contracting pre-paid dental plans.

Effective March 6, 2014, cognitive rehabilitation therapy services (CRT) will be provided through the STAR+PLUS HCBS program.

Effective September 1, 2014, the following additional benefits are provided:

- acute care services for beneficiaries receiving services through an intermediate care
- facility for individuals with intellectual disabilities or a related condition (ICF/IID), or an ICF/IID waiver are provided through STAR+PLUS; employment assistance and supported employment are provided through the STAR+PLUS home and community-based services (HCBS) program;
- mental health rehabilitation services will be provided via managed care; and
- mental health targeted case management for members who have chronic mental illness
- are provided via managed care.
- Effective March 1, 2015, nursing facility services are a covered benefit under
- STAR+PLUS managed care for adults over the age of 21,

Note: The NorthSTAR waiver in the Dallas service delivery area did not change as a result of the September 1, 2014 and the March 1, 2015 STAR+PLUS expansions.

Beginning January 1, 2014, children ages 6 - 18 with family incomes between 100 – 133 percent of the federal poverty level were transferred from the state's separate Children's Health Insurance Program (CHIP) to Medicaid in accordance with section 1902(a)(10)(A)(i)(VII) of the Act. Under the demonstration these targeted low-income children (M-CHIP) are required to enroll in managed care. For the purposes of eligibility and benefits, these children are considered a mandatory Medicaid

group for poverty-level related children and title XIX eligibility and benefit requirements apply. The state may claim enhanced match from the state's title XXI allotment for these M-CHIP children in accordance with title XXI funding requirements and regulations. All references to CHIP and title XXI in this document apply to these M-CHIP children only. Other requirements of title XXI (for separate CHIP programs) are not applicable to this demonstration.

STAR Kids Program

Effective November 1, 2016, the following four groups of Medicaid clients from birth through age 20 will become mandatory populations through a new program under the 1115 waiver - the STAR Kids Medicaid managed care program.

1. Clients receiving SSI and disability-related (including SSI-related) Medicaid who do not participate in a 1915(c) waiver: these children will receive their state plan acute care services and their state plan long term services and supports (LTSS) through STAR Kids.
2. Clients receiving HCBS services through the MDCP 1915(c) waiver: these children and young adults will receive the full range of state plan acute care services and state plan LTSS as well as MDCP 1915(c) HCBS waiver services through STAR Kids. The MDCP waiver will continue but will be operated by HHSC effective November 1, 2016. This is to ensure that options for MDCP services provided under the 1915(c) authority remain available to individuals in STAR Health, which services children and young adults in the conservatorship of the Department of Family and Protective Services.
3. Clients receiving HCBS through the following 1915(c) waivers -- CLASS, DBMD, HCS, TxHmL, and YES:
    a. Clients enrolled in CLASS, DBMD, HCS and TxHmL receive their 1915(c) LTSS and 1915(k) (Community First Choice) services through their current waiver provider, which are contracted with DADS. These clients receive all other state plan LTSS and acute care services through STAR Kids.
    b. Clients enrolled in the YES waiver receive their 1915(c) LTSS through their current HCBS delivery system, which is operated by DSHS. These clients receive all state plan LTSS, including 1915(k) services, as well as all acute care services through STAR Kids.
4. Clients receiving SSI and disability-related (including SSI-related) Medicaid who reside in a community-based intermediate care facility for individuals with intellectual disabilities or a nursing facility: clients will continue to receive all long-term services and supports provided by the facility through the current delivery system. All non-facility related services will be paid through STAR Kids.

Individuals in all four categories will receive a continuum of services, including acute care, behavioral health, and state plan long-term services and supports. STAR Kids managed care organizations will provide service coordination for all members, including coordination with non-capitated HCBS services that exist outside of this section 1115 demonstration. Indian children and young adults who are members of federally-recognized tribes and have SSI or disability-related (including SSI-related) Medicaid or who are served through one of the 1915(c) waivers, will be able to voluntarily enroll in STAR Kids or opt to remain in traditional fee-for service Medicaid.

Effective January 1, 2017, the NorthSTAR program (currently operated in Dallas, Ellis, Collin, Hunt, Navarro, Rockwall and Kaufman counties) will discontinue. All Medicaid behavioral health services previously provided to Medicaid-eligible individuals by NorthSTAR will be provided through the 1115 Medicaid STAR, STAR+PLUS and STAR Kids MCOs.[1,2]

Savings generated by the expansion of managed care and diverted supplemental payments will enable the state to maintain budget neutrality, while establishing two funding pools supported by Federal matching funds, to provide payments for uncompensated care costs and delivery system reforms undertaken by participating hospitals and providers. These payments are intended to help providers prepare for new coverage demands in 2014 scheduled to take place under current Federal law. The state proposes that the percentage of funding for uncompensated care will decrease as the coverage reforms of the Patient Protection and Affordable Care Act are implemented, and the percentage of funding for delivery system improvement will correspondingly increase.

Texas plans to work with private and public hospitals to create Regional Healthcare Partnerships (RHPs) that are anchored financially by public hospitals and/or local government entities, that will collaborate with participating providers to identify performance areas for improvement that may align with the following four broad categories: (1) infrastructure development, (2) program innovation and redesign, (3) quality improvements, and (4) population focused improvements. The non-Federal share of funding pool expenditures will be largely financed by state and local intergovernmental transfers (IGTs). Texas will continue to work with CMS in engaging provider stakeholders and developing a sustainable framework for the

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[1] For members enrolled in STAR Kids, these services will be available through MCOs beginning November 1, 2016.

[2] As with all other service areas, Mental Health Targeted Case Management and Mental Health Rehabilitative services will be paid through FFS for individuals who receive Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI) funded services or PASSAR services. All wrap-around services and crossover claims will be paid via FFS for dually eligible individuals not enrolled in the duals demonstration.

RHPs. It is anticipated, if all deliverables identified in this demonstration's STCs are satisfied, incentive payments for planning will begin in the second half of the first Demonstration Year (DY).

Through this demonstration, the state aims to:

- Expand risk-based managed care statewide;
- Support the development and maintenance of a coordinated care delivery system;
- Improve outcomes while containing cost growth;
- Protect and leverage financing to improve and prepare the health care
- infrastructure to serve a newly insured population; and
- Transition to quality-based payment systems across managed care and hospitals.

In May of 2016, CMS granted the demonstration a 15 month temporary extension to allow additional time for DSRIP projects to demonstrate their results. The extension also allows Texas to study its Medicaid payment and financing policies and providers' uncompensated care burdens, and prepare for the next stage in delivery system reform.

Effective September 1, 2017, the following populations are mandatory for managed care. Those who meet the STAR Kids eligibility criteria are mandatory to enroll in STAR Kids, and the remainder are mandatory to enroll in STAR.

- Clients enrolled in the Department for Family and Protective Services (DFPS)
- Adoption Assistance program.
- Clients enrolled in the DFPS Permanency Care Assistance program.

Effective September 1, 2017, women participating in the Medicaid for Breast and Cervical Cancer will transition to STAR+PLUS Medicaid managed care.

<The following paragraphs were added>

Delivery System Reform Incentive Payment Program (DSRIP) evolved from project-level reporting to provider-level outcome reporting to measure the continued transformation of the Texas healthcare system from DY1-6 to DY7-10. DSRIP providers report on required categories at the provider system level, rather than the project level. Regional Healthcare Partnerships (RHP) updated their RHP Plans during Q1, which HHSC reviewed and approved. This included providers updating their outcome measures and activities for reporting during DY9-10.

Providers continued to report performance achievement of DY7 Category C measures in Q1. DSRIP continues to provide technical assistance to correct reported baselines and performance.

Program Description, Goals, and Objectives to be Implemented or Extended Under the Demonstration Project

The state is not requesting changes to the existing goals and objectives of the demonstration through this extension request. The state has made strong strikes toward achieving the goals and objectives over the demonstration years; however, the state continue to work to expand risk-based managed care to new populations and services; support the development and maintenance of a coordinated care delivery system; improve outcomes while containing cost growth; and transition to quality-based payment systems across managed care providers. Progress towards the demonstration goals and objectives have been impacted by several factors, such as the public health emergency and managed care reprocurements, such that more time is needed to fully and successfully achieve them as anticipated.

The Texas Medicaid program has been transitioning to a value-based model for some time now. For over 25 years, the state has gradually moved care delivered through Medicaid away from traditional fee-for-service reimbursement to a managed care system where private health plans are financially responsible for controlling costs and improving quality. The transition to managed care has been supported by system initiatives to improve quality and efficiency in state health care services. Chief among these is the state's 1115 Healthcare Transformation and Quality Improvement Program Waiver, which includes incentive payments to hospitals and other providers for strategies to enhance access to health care, increase the quality and cost-effectiveness of care, and improve the health of patients and families through the Delivery System Reform Incentive Payment (DSRIP) program. DSRIP has been an effective incubator allowing the state to establish consensus priorities for health system improvement and test how flexible payment models can support patient centered care and clinical innovation. Since 2012, DSRIP providers have earned over $19 billion all funds (federal funds matched with intergovernmental transfer funds).

The DSRIP program structure, beginning in FFY 2018, evolved from a focus on projects and project-level reporting to targeted measure bundles (or measures, depending on performing provider type). Among the allowable menu of measure bundles and measures, State priority measure bundle areas for hospitals and physicians include:

Chronic care: diabetes and heart disease care, pediatric asthma management

Primary care and prevention

Pediatric primary care

Maternal care

Integrated behavioral health/primary care

Chronic non-malignant pain management

Behavioral health and appropriate utilization

Other significant initiatives for increasing value in state health care include: the MCO Pay for Quality Program (P4Q); Program Improvement Projects (PIPs), which focus on improving quality across the managed care system; Hospital Quality Based Payment Program for Potentially Preventable Readmissions and Complications to incentivize quality and efficiency among hospitals; and Quality Incentive Payment Program (QIPP) to promote patient safety in nursing homes.

Finally, MCO Value-Based Contracting with Providers seeks to facilitate and encourage the development of alternative payment and flexible practice approaches between MCOs and their providers. Under this initiative, HHS created contractual targets for MCOs to connect provider payments to value using APMs, starting in calendar year 2018. The APM percentage targets increase over time. If an MCO fails to meet the APM targets or certain allowed exceptions for high performing plans, the MCO must submit an action plan, and HHSC may impose graduated contractual remedies, including liquidated damages.

DSRIP Transition Plan Update

As required, HHSC submitted its Transition Plan to CMS by October 1, 2019, and submitted revisions to CMS on February 20, 2020. To help Texas sustain DSRIP successes HHSC is undertaking comprehensive analyses of populations served by DSRIP and interventions associated with improvements in health outcomes within focus areas of the Transition Plan. The Transition Plan was approved on September 2, 2020.

Waiver Extension

The state continues work to further the goals and objectives of the current demonstration in the following ways:

HHSC is working to expand Nonemergency Medical Transportation (NEMT) to the array of services provided by Medicaid managed care organizations (MCOs) for their members under the current 1115 waiver. In addition to providing the full array of NEMT services, HB 1576 (86th Regular Legislature) requires MCOs to provide NEMT demand response transportation services for certain trips requested with less than 48-hours' notice and increases opportunities for transportation network companies (TNCs) to provide demand response transportation services. This will expand risk-based managed care by no longer operating NEMT through managed transportation

organizations under a state plan transportation broker model to MCOs under the 1115 waiver authority. This effort will improve outcomes and support a coordinated delivery system by making the same MCOs responsible for arranging health care services also responsible for arranging the NEMT some members require to access healthcare services.

HHSC will also be seeking to remove the cost cap for individuals meeting specific medically fragile criteria and removing the current state legislative requirement that the individual be deemed unable to safely be served in an institution under the current 1115 waiver. There will not be additional home and community-based services added to the program. Impacted individuals will continue to have access to services they are currently receiving. While the population impacted by this change is not new to managed care and will not receive new services, the new process for serving this very medically fragile population will improve the coordination of their care and improve health outcomes for them while containing cost growth. It is expected to result in a more cost-effective system, including better coordination of the person's care, a more streamlined system benefiting the person, their family, and their MCO, all of which will lead to improved health outcomes for these particularly vulnerable individuals.

HHSC is also actively working to implement the legislatively mandated STAR+PLUS Pilot Program under the current 1115 waiver. The pilot must be implemented by September 1, 2023 and will operate for at least 24 months. The eligibility criteria for the program will include Medicaid-eligible adults age 21 and over who meet one of the following:

Individuals with an IDD or cognitive disability, including:

individuals with autism; and

individuals with significant complex behavioral, medical, and physical needs who are receiving home and community-based services through the STAR+PLUS Medicaid managed care program.

Individuals enrolled in the STAR+PLUS Medicaid managed care program who:

are on a Medicaid waiver program interest list;

meet criteria for an IDD; or

have a traumatic brain injury that occurred after the age of 21.

Other individuals with disabilities who have similar functional needs without regard to the age of onset or diagnosis.

The STAR+PLUS Pilot Program will operate in one service area selected by HHSC with up to two STAR+PLUS Medicaid managed care plans. The pilot will test the delivery of long-term services and supports (LTSS) for people with intellectual and development disabilities (IDD), traumatic brain injury that occurred after age 21, or people with similar functional needs as a person with IDD.

The STAR+PLUS Pilot Program is expected to further goals and objectives of the demonstration to expand risk based managed care to new populations as it will be offering home and community-based services to individuals with traumatic brain injury that currently could not qualify for a home and community-based waiver program. Additionally, this new program will also create and support a more coordinated care delivery system by having MCOs who currently provide acute care services for people with intellectual and developmental disabilities to also provide the long-term services and supports through a waiver program. This is expected to improve outcomes while containing cost growth.

HHSC would also like to call attention to the Public Health Emergency arising from the impact of COVID-19 which has significantly impacted Texas' health care delivery system. Texas recently released an open survey to all healthcare providers in Texas, which concluded on November 13, 2020. The results indicate a dire emergency of another kind is unfolding: The long-term stability of healthcare infrastructure and Medicaid provider networks is in jeopardy. CMS and Texas must act immediately to ensure that Medicaid clients retain access to care through a stable Medicaid managed care program, and that providers are financially stabilized by assured continuation of the Uncompensated Care pool available under the 1115 waiver and a successful DSRIP transition. According to survey results:

- 76% of providers said they were very concerned or extremely concerned about the financial impacts of COVID–19;
- 42% of providers reported reduced hours of service;
- 20% of providers actively reduced services unrelated to COVID–19;
- 23% of providers closed locations or facilities; and
- 27% of providers reported that COVID–19 demand has exceeded provider capacity.

Overtasked providers are considering dropping out of Texas Medicaid because of the overwhelming financial pressure and reduced service availability and locations. These problems are exacerbated by uncertainty over the future of the state's 1115 waiver. The extension application seeks to mitigate that uncertainty.

The scope of the COVID–19 public health emergency and its impacts on Texas Medicaid beneficiaries and providers continues to unfold, and its ultimate toll remains unknown. The state is acting expeditiously in response to the crisis to

preserve and stabilize Medicaid program funding in order to protect the health, safety, and welfare of Medicaid beneficiaries and avoid further suffering for Texas families.

Proposed Health Care Delivery System, Eligibility Requirements, Benefit Coverage and Cost Sharing

Texas currently operates 4 of its Medicaid managed care programs under the demonstration: STAR+PLUS (including STAR+PLUS Home and Community Based Services waiver), STAR, STAR Kids, and its children's dental services managed care program. Under these programs individuals receive the full array of state plan services (including EPSDT), in STAR+PLUS the HCBS waiver service array is offered, and MCOs provide services on a case-by-case and through value added services. MCOs also provide service management or service coordination to ensure individuals have their care coordinated to the level of their need.

The state is not requesting changes to the DSRIP program. DSRIP includes 288 performing providers who serve patients with a focus on Medicaid and Low Income Uninsured. Currently, the DSRIP program funding and authorization will expire October 1, 2021. HHSC has separately requested an extension of the DSRIP program authorization and funding for the final demonstration year of the current waiver in order to minimize the disruption to the healthcare system occurring as a result of COVID-19 and the timing of the planned DSRIP Transition. While the requested extension is pending a response from CMS, the state continues to develop new proposals under the approved DSRIP Transition Plan and submit required deliverables.

The UC program includes 529 providers which provide charity care to patients who meet their charity care policy.

The extension will not change the array of benefits provided under the current 1115 waiver authority. The extension does not make any changes to eligibility requirements. Extending the waiver will not have a significant impact on enrollment. Under the extension there will continue to be no beneficiary cost sharing.

The state is not requesting changes to the existing health care delivery system, eligibility requirements or benefit coverage through this extension request. Additionally, there will continue to be no cost sharing requirements related to premiums, co-payments, or deductibles as part of this extension request. There are not changes requested to DSRIP nor UC.

Enrollment

No impact to enrollment is expected as a result of the 1115 transformation waiver extension. There are no 1115 waiver policies that limit or impact Medicaid enrollment. While fiscal year trends during and following the Covid Public Health Emergency period are impacted due to policies and economic recovery, overall member months under the 1115 are expected to experience long term annual caseload growth trends of roughly 1% to 1.5% consistent with historical program growth.

Current enrollment growth during the PHE has been significant, with growth of over 12% since the PHE began. Annual growth of 10% over fiscal year 2021 is expected as the PHE continues and could increase depending on further PHE extensions and unemployment. While recovery is assumed over fiscal years 2022-2023, any number of factors can greatly influence the impact to Medicaid caseloads due to policy and economic conditions.

Evaluation

The overarching objectives of the THTQIP demonstration waiver are to expand risk-based managed care to new populations and services, support the development and maintenance of a coordinated care delivery system, improve outcomes while containing cost growth, and transition to quality-based payment systems across managed care and providers. The THTQIP demonstration waiver achieves these objectives through three components: the DSRIP pool, the UC pool, and MMC expansion. The focus of the THTQIP evaluation is to determine if the THTQIP demonstration waiver achieved its intended objectives through the three components. The THTQIP evaluation is guided by five evaluation questions, with one question each pertaining to DSRIP, UC, MMC, and two questions pertaining to the demonstration overall. Each evaluation question is addressed through a minimum of one corresponding hypothesis and measure.[2] Altogether, the current THTQIP evaluation design includes 5 evaluation questions, 13 hypotheses, and 48 evaluation measures.

Evaluation Activities

The THTQIP demonstration waiver is in the fourth year of the current renewal period. During the past four years, HHSC developed the CMS-approved evaluation design; procured an external evaluator; provided the external evaluator with data

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

sources outlined in the evaluation plan; provided data-related technical assistance as requested by the external evaluator; participated in quarterly and ad hoc meetings with the external evaluator, and; submitted four revisions to the THTQIP evaluation design. The next scheduled evaluation deliverable is the interim evaluation report, which is on schedule to be submitted to CMS by September 30, 2021.

Preliminary Evaluation Findings

The external evaluator will deliver a draft of the interim report to HHSC for review on May 28, 2021. The external evaluator submitted preliminary findings to HHSC in support of this extension application on December 7, 2020. Key points from the preliminary findings are summarized below. Texas A&M University System's *Preliminary Draft Results* (Supplement A) provides the full summary of preliminary findings provided by the external evaluator. Preliminary findings are still in draft form and are only provided for the purposes of this application.

Evaluation Question 1: Did the DSRIP program incentivize changes to transform the health care system for the MLIU population in Texas?

Preliminary findings suggest the DSRIP program incentivized collaboration in tangible resource sharing and data sharing agreements, but less so in other areas of collaboration, such as join service delivery. The DSRIP program has also supported improvements in Category C outcome measures such as heart disease management (A2-509) and primary care prevention (C1-502), but additional data is necessary to fully understand the impact of DSRIP on health outcomes.

Evaluation Question 2: Did the Demonstration impact unreimbursed costs associated with the provision of care to the MLIU population for UC providers?

Preliminary findings suggest the rate of UC cost reimbursement decreased over time. Analysis of the overall UC cost growth rate is currently underway.

Evaluation Question 3: Did the expansion of the MMC health care delivery model to additional populations and services improve healthcare (including access to care, care coordination, quality of care, and health outcomes) for MMC clients?

Preliminary findings provide some support for the premise that the expansion of MMC improved access to care and quality of care for renewal study populations, but additional data are necessary to fully understand the impact of the MMC expansion.

Evaluation Question 4: Did the Demonstration impact the development and implementation of quality-based payment systems in Texas Medicaid?

Preliminary findings suggest providers' use of Alternate Payment Models (APMs) increased, but organizations were somewhat ambivalent about the benefits of APMs. Organizations reported financial efficiency as the most common perceived benefit of APMs, and lack of MCO engagement as the most common perceived barrier to APM participation.

Evaluation Question 5: Did the Demonstration transform the health care system for the MLIU population in Texas?

Preliminary findings suggest the THTQIP demonstration waiver has resulted in overall cost savings and this trend is expected to continue.

Planned Evaluation Activities During THTQIP Extension

HHSC will continue to cooperate with federal evaluation monitoring and reporting requirements during the THTQIP extension. The THTQIP demonstration waiver extension does not alter the overall goals and objectives of the evaluation; therefore, HHSC is not proposing modifications to the approved evaluation questions. HHSC is also not proposing changes to hypotheses, data sources, statistical methods, and/or outcome measures for the evaluation of the UC Pool (Evaluation Question 2) or components related to the overall impact of the THTQIP demonstration (Evaluation Questions 4 and 5). HHSC is proposing changes to further the DSRIP and MMC expansion components, as detailed below.

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

Changes to the DSRIP Evaluation Component

The CMS-approved evaluation design includes one evaluation question and four hypotheses related to DSRIP:

Evaluation Question 1: Did the DSRIP program incentivize changes to transform the health care system for the MLIU population in Texas?

Hypothesis 1.1 DSRIP incentivized changes to the health care system that maintained or increased collaboration among providers.

Hypothesis 1.2 DSRIP incentivized performing providers to improve continuity, quality, and cost of care for Medicaid clients with diabetes.

Hypothesis 1.3 DSRIP incentivized performing providers to improve quality-related outcomes, specified as Category C population-based clinical outcome measures.

Hypothesis 1.4 DSRIP transformed the health care system, resulting in improvements in population health, specified as DSRIP Category D outcomes.

DSRIP funds are scheduled to phase out during the final year of the current THTQIP demonstration waiver, which begins October 1, 2021. The current evaluation question and hypotheses pertaining to DSRIP will no longer be applicable after DSRIP's scheduled completion date. HHSC may continue to examine DSRIP or related transitional programs using a revised hypothesis and measure set focused on the DSRIP transition process and related programming under the THTQIP extension.

Changes to the MMC Evaluation Component

The CMS-approved evaluation design includes one evaluation question and four hypotheses pertaining to MMC:

Evaluation Question 3: Did the expansion of the MMC health care delivery model to additional populations and services improve healthcare (including access to care, care coordination, quality of care, and health outcomes) for MMC clients?

Hypothesis 3.1 Access to care will improve among clients whose Medicaid benefits shift from FFS to a MMC health care delivery model.

Hypothesis 3.2 Care coordination will improve among clients whose Medicaid benefits shift from FFS to a MMC health care delivery model.

Hypothesis 3.3 Quality of care will improve among clients whose Medicaid benefits shift from FFS to a MMC health care delivery model.

Hypothesis 3.4 Health and health care outcomes will improve among clients whose Medicaid benefits shift from FFS to a MMC health care delivery model.

Hypothesis 3.5 Client satisfaction will improve among clients whose Medicaid benefits shift from FFS to a MMC health care delivery model.

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

additional insight into whether the expansion of MMC improved health outcomes for clients in these programs.

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

Need for THTQIP Extension

Only preliminary evaluation findings are available for the THTQIP demonstration waiver at this time. However, based on preliminary findings HHSC believes the THTQIP demonstration waiver is on track to meet its intended objectives. Specifically, early evidence suggests DSRIP has incentivized some forms of collaboration and improved health outcomes; MMC shows early signs of improved access and quality of care; more providers are participating in APMs, and; the demonstration generates overall cost savings.

Although preliminary findings from the THTQIP demonstration waiver are promising, the COVID-19 pandemic, which coincides with the final three years of the demonstration, presents a serious challenge to the final evaluation of the THTQIP demonstration waiver. The pandemic and ensuing economic recession significantly reordered priorities for clients and providers in the state, impacting enrollment, utilization, and health care delivery across the Medicaid system. HHSC anticipates the COVID-19 pandemic will have a direct or indirect impact on many of the measures used in the THTQIP evaluation. Like most time-series designs, the THTQIP demonstration evaluation is vulnerable to external validity threats; COVID-19 introduces a number of confounding factors that undermine causal inference and impede evaluators' ability to isolate the impact of demonstration policies. At the time of writing, it is unknown how long the most severe effects of the COVID-19 pandemic will last, and it is unlikely that the current evaluation will be able to fully remove or account for the impacts of the pandemic. Additional years of data are necessary to evaluate the impact of demonstration policies under stable conditions free of the COVID-19 pandemic.

The THTQIP extension is also necessary to examine recent or forthcoming changes to the current THTQIP demonstration waiver. Specifically, the THTQIP extension would allow HHSC to examine the DSRIP transition process and the impact of new benefits or populations recently carved into MMC. Collectively, the THTQIP extension would support the rigor of the evaluation in determining if the THTQIP demonstration waiver achieved its intended objectives.

External Quality Review Organization (EQRO) reports, Managed Care Organization (MCO) and State Quality Assurance Monitoring

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

External Quality Review

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

Validation of MCOs' performance improvement projects,

Validation of performance measures,

Determination of MCOs' compliance with certain federal Medicaid managed care regulations, and

Validation of MCO and dental maintenance organization (DMO) network adequacy.

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

The EQRO produces reports to support HHSC's efforts to ensure managed care clients have access to timely and quality care in each of the managed care programs. The results allow comparison of findings across MCOs in each program and are used to develop overarching goals and quality improvement activities for Medicaid and CHIP managed care programs. MCO findings are compared to HHSC

standards and national percentiles, where applicable. A link to the annual EQRO Summary of Activities (SOA) Report can be found here.

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

Multi-Year Focus

In summer 2016, the Texas Medicaid and CHIP external quality review organization (EQRO) began a multi-year focus study to evaluate the STAR Kids program and develop a set of quality measures for the STAR Kids population. The EQRO produced five reports for the study:

- STAR Kids Program Focus Study Measures Background Report (February 10, 2017)
- STAR Kids Program Focus Study Pre-Implementation Descriptive Report (May 26, 2017). https://hhs.texas.gov/sites/default/files//documents/about-hhs/process-improvement/quality-efficiency-improvement/STAR-Kids-Pre-Implementation-Report-052617.pdf
- STAR Kids Post-Implementation Managed Care Organization (MCO) Interview Report (June 18, 2018). https://hhs.texas.gov/sites/default/files/documents/about-hhs/process-improvement/medicaid-chip-qei/star-kids-post-mco-interview-report-june-2018.pdf
- Measures Feasibility Report (April 18, 2019)
- Summary Report (November 13, 2019)

The final summary report contained a series of recommendations including

- Conducting regular NCI-CFS surveys with STAR Kids caregivers;
- Conducting additional studies with the STAR Kids-Screening and Assessment Instrument (SK-SAI) and Individual Service Plan (ISP);
- Conducting CAHPS surveys to assess member experiences;
- Creating quality of care measures specific to members enrolled in the Medically Dependent Children Program (MDCP); and,
- Conducting focus groups with MDCP caregivers.

These recommendations were incorporated into SB 1207, 86th Legislature, and HHSC has or is in the process of implementing them.

The annual Summary of Activities (SOA) reports to CMS all activities performed by the EQRO during the contract year. The SOA report presents findings by the Texas EQRO on activities for state fiscal year (SFY) 2018, which address quality of care in Texas Medicaid and CHIP. The report's recommendations include the following:

- validate and update provider addresses to improve the return rate on records requested from providers;
- identify members that most benefit from addressing social determinants of health (SDOH) and improve their access to care;
- continue to improve access to behavioral health care; and
- focus on improving key vaccination rates.

In response to these recommendations, MCOs are required to verify the provider address information prior to the EQRO requesting patient records for encounter data validation (EDV). In addition, MCOs and DMOs are subject to corrective action plans (CAPs) for data that does not meet minimum EDV quality standards.

HHSC, in conjunction with the EQRO, recently completed an analysis of state and national SDOH tools. HHSC plans to use this information to identify a recommended tool for Medicaid MCOs. In addition, the Medicaid/CHIP Services Department has formed an internal workgroup to further incorporate SDOH into quality initiatives.

In 2019, MCOs began a statewide, two-year performance improvement project (PIP) focused on members with complex behavioral health conditions. In 2020, PIPs focus on improving integration of behavioral health and physical health care, with the goal of reducing hospitalization.

To improve vaccination rates, HHSC has added immunizations for adolescents (IMA) as a quality measure in the Medical Pay-for-Quality (P4Q) program for STAR, CHIP and STAR Kids.

Quality Measures

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

- National Committee for Quality Assurance Healthcare Effectiveness Data and Information Set (HEDIS®) - A nationally recognized and validated set of measures used to gauge quality of care provided to members.
- Agency for Healthcare Research and Quality (AHRQ) Pediatric Quality Indicators (PDIs)/ Prevention Quality Indicators (PQIs) - PDIs use hospital discharge data to measure the quality of care provided to children and youth. PQIs use hospital discharge data to measure quality of care for specific conditions known as "ambulatory care sensitive conditions" (ACSCs). ACSCs

are conditions for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications or more severe disease.

- 3M® Potentially Preventable Events (PPEs) - HHSC uses and collects data on Potentially Preventable Admissions (PPAs), Potentially Preventable Readmissions (PPRs), Potentially Preventable Emergency Department Visits (PPVs), Potentially Preventable Complications (PPCs), and Potentially Preventable Ancillary Services (PPSs).
- Consumer Assessment of Healthcare Providers & Systems (CAHPS®) Surveys - CAHPS Health Plan Surveys are nationally recognized and validated tools for collecting standardized information on members' experiences with health plans and services.

Initiatives

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

Administrative Interviews

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

Core Measure Reporting

CMS has a Children's and an Adult Health Care Quality Core Set of measures which states voluntarily report on for children in Medicaid and CHIP and adults in Medicaid. The EQRO assists HHSC in reporting core measures to CMS each year.[3]

MCO Report Cards

HHSC provides information on outcome and process measures to Medicaid and CHIP members regarding MCO performance during the enrollment process. To comply with this requirement and the quality rating system required by 42 CFR 438.334, HHSC develops report cards for each program service area to allow members to compare the MCOs on specific quality measures. These report cards

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

are intended to assist potential enrollees in selecting an MCO based on quality metrics. Report cards are posted on the HHSC website and included in the Medicaid enrollment packets. Report cards are updated annually.[4]

Network Adequacy

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

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

Pay-for-Quality

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

Another key initiative to improve Medicaid and CHIP quality of care is the medical P4Q program. Under medical P4Q, 3 percent of the MCOs’ capitation is at-risk based on their performance on a series of key quality metrics that focus on prevention, chronic disease management, behavioral health, and maternal and infant health. MCOs are evaluated on their own year to year performance and compared to their peers at the state and national level.

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

Medical P4Q has led to marked improvement in quality. In comparing 2017 to 2018 program rates, all at-risk measures in all programs (i.e., STAR, CHIP and STAR+PLUS) showed improvement except for potentially preventable emergency room visits (PPVs) in STAR and CHIP. For example, rates for counseling for nutrition and physical activity increased by 8 percent in CHIP. In addition, rates for six or more well child visits in the first 15 months increased by 4 percent in STAR.

HHSC's focus on maternal and infant health through P4Q, PIPs and other initiatives have resulted in significant improvement in infant and maternal health outcomes. From 2008 to 2018, there was a 24 percent rate of improvement in children receiving six or more well child visits in the first 15 months of life; a 26 percent rate of improvement for adolescents receiving an annual well child visit; and, a 14 percent rate of improvement in timeliness of prenatal care.

The medical P4Q program serves as a catalyst for MCOs to pursue value-based payment (VBP) arrangements with providers to achieve required P4Q outcomes. The state uses the Healthcare Payment Learning and Action Network (HCP LAN) Alternative Payment Model (APM) Framework[5] to guide this effort. APMs incentivize high-quality and cost-efficient care by linking healthcare payments to measures of value. The LAN provides a menu of payment models from which MCOs can choose to develop APM contracts with their providers.

Medicaid Value-Based Enrollment

Pursuant to Texas Government Code §533.00511, HHS is implementing an incentive program that automatically enrolls a greater percentage of Medicaid recipients who have not selected a managed care plan into a plan based on quality of care, efficiency and effectiveness of service provision, and performance. The state's new autoenrollment method uses metrics aligned with the Triple Aim to promote value-based healthcare that achieves better care at lower costs.[6]

Alternative Payment Model (APM) Requirements

The P4Q and value-based enrollment programs serve as catalysts for managed care to pursue value-based payment arrangements with providers to achieve improved

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

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

outcomes. APMs are payment arrangements in which some portion of an MCOs reimbursement to a provider is linked to measures of quality and outcomes. HHSC uses the Healthcare Payment Learning and Action Network (HCP LAN) Alternative Payment Model (APM) Framework[7] to help guide this effort. This framework provides a menu of payment models from which MCOs could choose to develop alternative payment contracts with their providers. Moving from one category to the next adds a level of risk to the payment model.

Under this initiative, HHS created contractual targets for MCOs to connect provider payments to value using APMs. The APM percentage targets increase over time. If an MCO fails to meet the APM targets or certain allowed exceptions for high performing plans, the MCO must submit an action plan, and HHSC may impose graduated contractual remedies, including liquidated damages.

The full range of contractual requirements for MCOs to promote VBP include:

- The establishment of MCO APM targets: Overall and risk-based APM contractual targets were established for MCO expenditures on VBP contracts with providers relative to all medical and pharmacy expenses. The targets start at 25 percent of provider payments in any type of APM and 10 percent of provider payments in risk-based APMs for calendar year 2018. These targets increase over four years up to 50 percent overall and 25 percent risk-based by calendar year 2021.
- Requirements for MCOs to establish and maintain data sharing processes with providers.
- Requirements for MCOs to adequately resource this activity: MCOs and DMOs must dedicate sufficient resources for provider outreach and negotiation, provide assistance with data and/or report interpretation and initiate collaborative activities to support VBP and provider improvement.
- Requirements for MCOs to have a process in place to evaluate APM models: MCOs are required to evaluate the impact of APM models on utilization, quality, cost and return on investment.

HHSC collects reports on their APM initiatives on an annual basis. In general, most of the reported APM initiatives involve primary care providers, but MCOs also have reported APMs with specialists (including obstetricians/ gynecologists), behavioral health providers, hospitals, nursing facilities and long-term services and supports providers.

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

In 2018, the first target year for HHSC's Medicaid MCO APM targets, MCOs reported that 40 percent of their payments to providers were in an APM, with about 22 percent in a risk-based APM. As a whole, the Texas Medicaid and CHIP programs performed at or above contractually-required thresholds and national goals in 2018.

Performance Improvement Projects

The Balanced Budget Act of 1997 requires all states with Medicaid managed care to ensure MCOs conduct performance improvement projects (PIPs). 42 CFR 438.330 requires projects be designed to achieve, through ongoing measurements and interventions, significant improvement, sustained over time, in clinical care and nonclinical care areas that have a favorable effect on health outcomes and enrollee satisfaction. Health plans conduct PIPs to examine and improve areas of service or care identified by HHSC in consultation with Texas's EQRO as needing improvement. Topics are selected based on health plan performance on quality measures and member surveys. HHSC requires each health plan to conduct two PIPs per program. One PIP per health plan must be a collaborative with another health plan or a Delivery System Reform Incentive Payment project, or a community-based organization.

Performance Indicator Dashboards

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

Quality Assessment and Performance Improvement Programs

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

Hospital Quality-Based Payment Program

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

PPRs and 2.5 percent for PPCs. Measurement, reporting, and application of payment adjustments occur on an annual cycle.

Texas Healthcare Learning Collaborative Portal

The Texas Healthcare Learning Collaborative (THLC) portal is a secure web portal developed for use by HHSC and their Medicaid contractors to track performance data on key quality of care measures, including potentially preventable events (PPEs), Healthcare Effectiveness Data and Information Set (HEDIS) data, and other quality of care information. The data is interactive and can be queried to create more customized summaries of the quality results. Most of the data is available to the public with some additional information available to HHSC and MCO staff with a login.

Resources

HHSC quality webpage:

- https://hhs.texas.gov/about-hhs/process-improvement/medicaid-and-chip-quality-and-efficiency-improvement

Texas Healthcare Learning Collaborative Portal:

- https://thlcportal.com

Post-award Public Input Process Required by 42 CFR §431.420(c)

HHSC hosted a public forum via webinar on June 22, 2020 to provide the public with updates on the Texas Healthcare Transformation and Quality Improvement Program (THTQIP) 1115 waiver. The last public in person forum was held on June 24, 2019. The date, time, and location of the public forums were published on HHSC's website 30 days in advance of the meeting.

During the June 2020 public forum the public was provided with an update on the following Transformation waiver topics: Health Information Technology (IT) Strategic Plan, Delivery System Reform Incentive Payment program (DSRIP), Uncompensated Care, and Nursing Home Quality Incentive Payment Program. Links to the 1115 DY8 annual report and COVID-19 resource pages was also provided to the public. Public comment was also received and documented at this meeting. Comments received related to identifying external entities involved in the Health IT strategies, the process for creating new Medicaid benefits or programs, DSRIP operations and extension of DSRIP program, Value Based Purchasing, Uncompensated Care pool payments, and the potential to request an extension in light of COVID-19 as some other states are also doing. Requests for the powerpoint

presentation were received from some stakeholders and the slide deck was provided to those individuals electronically. During the forum, HHSC responded to comments and clarifying questions received.

SUPPLEMENT A

HEALTHCARE TRANSFORMATION AND QUALITY IMPROVEMENT RENEWAL EVALUATION

1115 Medicaid Waiver Demonstration Renewal in Texas DY6-DY11

Preliminary Draft Results

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DECEMBER 7, 2020

SCHOOL OF PUBLIC HEALTH
TEXAS A&M UNIVERSITY SYSTEM

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A. DSRIP

Evaluation Question 1: Did the DSRIP program incentivize changes to transform the health care system for the MLIU population in Texas?

COLLABORATION AMONG PROVIDERS

Hypothesis 1.1 DSRIP incentivized changes to the health care system that maintained or increased collaboration among providers.

Participating DSRIP providers were asked, via an electronic survey, about their collaborative ties to other DSRIP providers in their region. The principle types of ties between providers shared here are:

- Joint service delivery
- Tangible resource sharing
- Data sharing agreements

Across each of these dimensions, for these draft results, the networks in each region have been evaluated by the average number of ties each organization had, the density of ties within each region, and the centralization of ties within a region.

These questions were most recently asked of providers in 2020. They were also asked during the evaluation of the first waiver. Despite being in the midst of a pandemic, 2020 participation rates were high in most regions.

RHP	# of Providers	Participated	Rate	RHP	# of Providers	Participated	Rate
1	20	17	85.0%	11	15	11	73.3%
2	15	12	80.0%	12	36	26	72.2%
3	25	19	76.0%	13	13	10	76.9%
4	17	13	76.5%	14	10	8	80.0%
5	10	9	90.0%	15	8	8	100.0%
6	23	16	69.6%	16	7	7	100.0%
7	7	7	100.0%	17	12	9	75.0%
8	13	7	53.8%	18	6	6	100.0%
9	23	13	56.5%	19	12	10	83.3%
10	24	15	62.5%	20	4	3	75.0%
				Total	300	226	75.3%

Tentative Results:

Average number of ties

The first measure of interest is the average number of ties each provider had within its region. Each of the 20 regions within Texas has a different number of providers participating in the DSRIP program, a number that has generally decreased over time.

	# OF PROVIDERS FOR EACH TIME PERIOD				JOINT SERVICE DELIVERY AVERAGE TIES PER ORG.					
					Average_ties-T0	Average_ties-T1	Average_ties-T2	Average_ties-T3	Network Average - Overall Change	
					(Pre-Waiver)	-2013	-2015	-2020	T0 to T3	
	T0	T1	T2	T3						%
	(Pre-Waiver)	-2013	-2015	-2020					Point Change*	Change**
RHP 1	37	38	40	20	5.0	7.7	6.5	6.6	1.6	33%
RHP 2	17	17	17	15	5.4	5.6	2.9	4.7	-0.7	-13%
RHP 3	30	30	33	25	5.4	5.9	7.1	3.8	-1.6	-30%
RHP 4	25	25	25	17	4.7	6.2	4.9	3.5	-1.2	-26%
RHP 5	8	8	8	10	3.0	4.8	3.0	2.2	-0.8	-27%
RHP 6	27	27	27	23	3.7	4.2	11.0	4.6	0.9	24%
RHP 7	16	16	17	7	3.6	3.8	5.3	2.3	-1.3	-37%
RHP 8	16	16	18	13	4.4	4.3	5.1	2.3	-2.1	-47%
RHP 9	25	25	25	23	6.2	6.7	6.3	3.3	-2.9	-47%
RHP 10	30	30	33	24	6.7	6.8	5.6	2.8	-3.9	-58%
RHP 11	19	19	19	15	7.7	8.9	3.4	2.5	-5.2	-67%
RHP 12	37	37	39	36	10.1	10.0	7.3	5.9	-4.2	-42%
RHP 13	21	21	21	13	4.9	8.6	5.6	2.3	-2.6	-53%
RHP 14	12	12	13	10	5.3	6.0	6.0	2.6	-2.7	-51%
RHP 15	8	8	8	8	4.0	6.3	4.3	5.0	1.0	25%
RHP 16	9	9	10	7	4.9	6.7	5.2	3.1	-1.8	-37%
RHP 17	19	19	20	12	5.9	5.9	6.2	2.8	-3.1	-53%
RHP 18	10	10	10	6	3.4	4.8	3.2	1.7	-1.7	-50%
RHP 19	13	13	15	12	5.1	6.5	4.7	1.3	-3.8	-74%
RHP 20	8	8	8	4	4.0	4.0	4.0	2.0	-2.0	-50%
Mean across RHPs	-	-	-	-	5.2	6.2	5.4	3.3	-1.9	-37%

It is important to note that the number of participating providers decreased from the beginning of the waiver (T0) to 2020 (T3). Thus, there are often fewer providers to potentially share ties with in most of the regions. The average change in joint service delivery ties per organization within regions was -37%.

	# OF PROVIDERS FOR EACH TIME PERIOD				TANGIBLE RESOURSE SHARING AVERAGE TIES PER ORG.					
					Average_ties-T0	Average_ties-T1	Average_ties-T2	Average_ties-T3	Network Average-Overall Change	
					(Pre-Waiver)	-2013	-2015	-2020	T0 to T3	
	T0	T1	T2	T3						%
	(Pre-Waiver)	-2013	-2015	-2020					Point Change*	Change**
RHP 1	37	38	40	20	3.4	4.6	3.1	2.7	-0.7	-19%
RHP 2	17	17	17	15	2.1	2.9	1.4	1.6	-0.5	-24%
RHP 3	30	30	33	25	1.5	1.5	1.9	2.6	1.1	77%
RHP 4	25	25	25	17	1.4	2.1	2.6	0.7	-0.7	-51%
RHP 5	8	8	8	10	1.3	1.8	1.3	1.8	0.6	44%
RHP 6	27	27	27	23	3.4	5.0	3.7	1.6	-1.8	-53%
RHP 7	16	16	17	7	1.5	2.1	2.9	2.3	0.8	53%
RHP 8	16	16	18	13	1.3	1.5	2.7	2.2	1.0	76%
RHP 9	25	25	25	23	2.3	2.3	3.2	2.3	0.0	-1%
RHP 10	30	30	33	24	1.7	2.0	2.7	2.2	0.5	27%
RHP 11	19	19	19	15	1.2	1.4	1.6	2.4	1.2	107%
RHP 12	37	37	39	36	2.6	3.2	3.5	3.3	0.7	25%
RHP 13	21	21	21	13	1.4	3.2	1.9	1.1	-0.3	-23%
RHP 14	12	12	13	10	2.0	1.8	1.2	3.2	1.2	60%
RHP 15	8	8	8	8	2.8	4.3	1.3	3.3	0.6	20%
RHP 16	9	9	10	7	1.1	4.4	3.4	1.1	0.0	-1%
RHP 17	19	19	20	12	3.8	3.5	3.2	2.2	-1.6	-42%
RHP 18	10	10	10	6	1.6	1.6	2.6	1.0	-0.6	-38%
RHP 19	13	13	15	12	1.1	2.3	1.6	0.8	-0.3	-26%
RHP 20	8	8	8	4	1.3	1.8	0.3	2.0	0.8	60%
Mean across RHPs	-	-	-	-	1.9	2.7	2.3	2.0	0.1	5%

Again, it is important to note that the number of participating providers decreased from the beginning of the waiver (T0) to 2020 (T3). Thus, there are often fewer providers to potentially share ties with in most of the regions. Despite this, the average change in tangible resource sharing ties per organization within regions was +5%.

					FORMAL DATA SHARING AVERAGE TIES PER ORG.					
	# OF PROVIDERS FOR EACH TIME PERIOD				Average_ties-T0	Average_ties-T1	Average_ties-T2	Average_ties-T3	Network Average - Overall Change	
					(Pre-Waiver)	-2013	-2015	-2020	T0 to T3	
	T0	T1	T2	T3						%
	(Pre-Waiver	-2013	-2015	-2020					Point Change*	Change**
RHP 1	37	38	40	20	1.0	1.5	2.0	3.6	2.6	270%
RHP 2	17	17	17	15	0.9	1.2	1.8	2.8	1.9	198%
RHP 3	30	30	33	25	2.6	3.5	2.5	1.4	-1.2	-46%
RHP 4	25	25	25	17	0.9	2.1	1.5	1.2	0.3	36%
RHP 5	8	8	8	10	1.3	2.0	1.5	2.0	0.8	60%
RHP 6	27	27	27	23	1.6	2.4	3.9	2.1	0.5	29%
RHP 7	16	16	17	7	1.1	1.8	2.1	1.4	0.3	24%
RHP 8	16	16	18	13	1.4	1.5	2.2	0.8	-0.6	-42%
RHP 9	25	25	25	23	2.1	2.5	3.7	2.3	0.2	11%
RHP 10	30	30	33	24	2.8	2.5	2.0	2.4	-0.4	-14%
RHP 11	19	19	19	15	0.8	1.1	0.9	0.8	0.0	-5%
RHP 12	37	37	39	36	1.2	2.1	2.0	1.9	0.7	53%
RHP 13	21	21	21	13	2.2	3.0	2.1	0.8	-1.4	-63%
RHP 14	12	12	13	10	1.3	1.3	1.2	1.6	0.3	20%
RHP 15	8	8	8	8	1.8	4.5	3.0	2.8	1.1	60%
RHP 16	9	9	10	7	0.7	2.0	1.0	1.4	0.7	110%
RHP 17	19	19	20	12	2.3	2.5	2.7	1.7	-0.6	-27%
RHP 18	10	10	10	6	1.4	2.0	1.8	0.3	-1.1	-79%
RHP 19	13	13	15	12	0.2	2.0	0.7	0.5	0.3	225%
RHP 20	8	8	8	4	1.0	0.8	3.5	2.5	1.5	150%
Mean across RHPs	-	-	-	-	1.4	2.1	2.1	1.7	0.3	20%

Again, it is important to note that the number of participating providers decreased from the beginning of the waiver (T0) to 2020 (T3). Thus, there are often fewer providers to potentially share ties with in most of the regions. Despite this, the average change in data sharing agreement ties per organization within regions was +20%.

Network density

A better measure of trends in joint service delivery, tangible resource sharing, and data sharing agreements between DSRIP providers in a region is *network density*, which controls for any changes in the number of providers in each region over time. Network density is the number of existing ties between any of the organizations in a region divided by the total number of possible ties in that region. These results are shared below.

	JOINT SERVICE DELIVERY NETWORK DENSITY					
	Network Density -T0	Network Density-T1	Network Density-T2	Network Density-T3	Network Density - Overall Change	
	(Pre-Waiver)	-2013	-2015	-2020	T0 to T3	
					Point Change*	% Change**
RHP 1	14%	21%	17%	35%	21%	153%
RHP 2	34%	35%	18%	33%	-1%	-2%
RHP 3	19%	20%	22%	16%	-3%	-14%
RHP 4	20%	26%	20%	22%	2%	12%
RHP 5	43%	68%	43%	24%	-19%	-44%
RHP 6	14%	16%	42%	21%	7%	47%
RHP 7	24%	25%	33%	38%	14%	57%
RHP 8	29%	28%	30%	21%	-8%	-28%
RHP 9	26%	28%	26%	15%	-11%	-42%
RHP 10	23%	23%	17%	12%	-11%	-48%
RHP 11	43%	50%	19%	18%	-25%	-58%
RHP 12	28%	28%	19%	17%	-11%	-39%
RHP 13	24%	43%	28%	19%	-5%	-22%
RHP 14	48%	55%	50%	29%	-19%	-40%
RHP 15	57%	89%	61%	71%	14%	24%
RHP 16	61%	83%	58%	52%	-9%	-15%
RHP 17	33%	33%	33%	26%	-7%	-21%
RHP 18	38%	53%	36%	33%	-5%	-13%
RHP 19	42%	54%	33%	12%	-30%	-72%
RHP 20	57%	57%	57%	67%	10%	17%
Mean across RHPs	34%	42%	33%	29%	-5%	-14%

From the baseline, the average density of joint service delivery ties between DSRIP providers within a region changed by -5 percentage points, a 14% decrease.

	TANGIBLE RESOURCE SHARING NETWORK DENSITY					
	Network Density -T0	Network Density-T	Network Density-T2	Network Density-T3	Network Density - Overall Change	
	(Pre-Waiver)	-2013	-2015	-2020	T0 to T3	
					Point Change*	% Change**
RHP 1	9%	13%	8%	14%	5%	50%
RHP 2	13%	18%	9%	11%	-2%	-17%
RHP 3	5%	5%	6%	11%	6%	118%
RHP 4	6%	9%	11%	4%	-2%	-33%
RHP 5	18%	25%	18%	20%	2%	12%
RHP 6	13%	19%	14%	7%	-6%	-47%
RHP 7	10%	14%	18%	38%	28%	280%
RHP 8	8%	10%	16%	20%	12%	140%
RHP 9	10%	10%	13%	10%	0%	3%
RHP 10	6%	7%	8%	9%	3%	51%
RHP 11	6%	8%	9%	17%	11%	164%
RHP 12	7%	9%	9%	9%	2%	22%
RHP 13	7%	16%	10%	9%	2%	26%
RHP 14	18%	17%	10%	36%	18%	98%
RHP 15	39%	61%	18%	46%	7%	17%
RHP 16	14%	56%	38%	19%	5%	37%
RHP 17	21%	19%	17%	20%	-1%	-5%
RHP 18	18%	18%	29%	20%	2%	13%
RHP 19	9%	19%	11%	8%	-1%	-11%
RHP 20	18%	25%	4%	67%	49%	275%
Mean across RHPs	13%	19%	14%	20%	7%	54%

From the baseline, the average density of tangible resource sharing ties between DSRIP providers within a region changed by +7 percentage points, a 54% increase.

	DATA SHARING AGREEMENT NETWORK DENSITY					
	Network Density -T0	Network Density-T1	Network Density-T2	Network Density-T3	Network Density - Overall Change	
	(Pre-Waiver)	-2013	-2015	-2020	T0 to T3	
					Point Change*	% Change**
RHP 1	3%	4%	5%	19%	16%	603%
RHP 2	6%	7%	11%	20%	14%	240%
RHP 3	9%	12%	8%	6%	-3%	-33%
RHP 4	4%	9%	6%	7%	3%	91%
RHP 5	18%	29%	21%	22%	4%	23%
RHP 6	6%	9%	15%	9%	3%	44%
RHP 7	8%	12%	13%	24%	17%	220%
RHP 8	9%	10%	13%	8%	-1%	-13%
RHP 9	9%	10%	15%	10%	1%	15%
RHP 10	10%	9%	6%	11%	1%	14%
RHP 11	5%	6%	5%	6%	1%	28%
RHP 12	3%	6%	5%	6%	3%	74%
RHP 13	11%	15%	10%	6%	-5%	-45%
RHP 14	12%	12%	10%	18%	6%	49%
RHP 15	25%	64%	43%	39%	14%	56%
RHP 16	8%	25%	11%	24%	16%	188%
RHP 17	13%	14%	14%	15%	2%	17%
RHP 18	16%	22%	20%	7%	-9%	-55%
RHP 19	1%	17%	5%	5%	4%	290%
RHP 20	14%	11%	50%	83%	69%	481%
Mean across RHPs	9%	15%	14%	17%	8%	83%

From the baseline, the average density of data sharing agreement ties between DSRIP providers within a region changed by +8 percentage points, an 83% increase.

Centralization

Another network measure that was evaluated was the extent to which ties, in any of the dimensions (joint service delivery, tangible resource sharing, or data sharing agreements), were centralized around any particular provider. If a provider has a tie to everyone else in the region, but no other provider shares ties with a location other than the central provider, the degree of centralization would be 100%.

JOINT SERVICE DELIVERY NETWORK CENTRALIZATION	T_0 (Pre-Waiver)	T_1 -2013	T_2 -2015	T_3 -2020	Network Average - Overall Change T0 to T3	
					Point Change*	% Change**
RHP 1	53%	58%	45%	61%	8%	15%
RHP 2	25%	73%	36%	36%	11%	42%
RHP 3	35%	52%	36%	32%	-3%	-10%
RHP 4	24%	22%	32%	25%	1%	5%
RHP 5	38%	43%	19%	39%	1%	2%
RHP 6	26%	36%	50%	57%	31%	118%
RHP 7	26%	32%	33%	63%	37%	145%
RHP 8	50%	51%	39%	51%	1%	1%
RHP 9	35%	38%	35%	38%	3%	8%
RHP 10	53%	52%	75%	44%	-9%	-17%
RHP 11	52%	56%	35%	29%	-23%	-44%
RHP 12	70%	68%	30%	36%	-34%	-49%
RHP 13	45%	63%	57%	56%	11%	24%
RHP 14	40%	44%	49%	61%	21%	53%
RHP 15	38%	14%	52%	38%	0%	0%
RHP 16	34%	21%	39%	43%	9%	27%
RHP 17	44%	32%	34%	35%	-9%	-21%
RHP 18	22%	31%	39%	70%	48%	215%
RHP 19	68%	55%	60%	40%	-28%	-41%
RHP 20	19%	38%	38%	67%	48%	252%
Mean across RHPs	40%	44%	42%	46%	6%	15%

Joint service delivery ties became more centralized over time with a 6 percentage point increase from the beginning of the DSRIP program, a 15% increase.

TANGIBLE RESOURCE SHARING NETWORK CENTRALIZATION	T_0 (Pre-Waiver)	T_1 -2013	T_2 -2015	T_3 -2020	Network Average - Overall Change T0 to T3	
					Point Change*	% Change**
RHP 1	43%	35%	21%	25%	-18%	-42%
RHP 2	28%	36%	40%	28%	1%	2%
RHP 3	28%	17%	24%	34%	6%	22%
RHP 4	21%	22%	43%	16%	-5%	-23%
RHP 5	33%	43%	33%	17%	-16%	-49%
RHP 6	23%	83%	30%	32%	9%	38%
RHP 7	34%	45%	36%	63%	29%	84%
RHP 8	13%	27%	42%	53%	40%	298%
RHP 9	35%	30%	22%	24%	-11%	-31%
RHP 10	19%	26%	54%	37%	18%	90%
RHP 11	30%	16%	34%	21%	-9%	-30%
RHP 12	22%	17%	32%	23%	1%	7%
RHP 13	36%	65%	39%	19%	-17%	-48%
RHP 14	55%	56%	37%	81%	26%	49%
RHP 15	62%	52%	33%	52%	-10%	-16%
RHP 16	30%	57%	50%	20%	-10%	-34%
RHP 17	32%	28%	46%	31%	-1%	-4%
RHP 18	33%	19%	19%	30%	-3%	-10%
RHP 19	19%	95%	77%	24%	5%	27%
RHP 20	33%	24%	14%	67%	34%	101%
Mean across RHPs	32%	40%	36%	35%	3%	11%

Tangible resource sharing ties became more centralized over time with a 3 percentage point increase from the beginning of the DSRIP program, an 11% increase.

DATA SHARING AGREEMENTS NETWORK CENTRALIZATION	T_0 Pre-Waive	T_1 -2013	T_2 -2015	T_3 -2020	Network Average - Overall Change T0 to T3	
					Point Change*	% Change**
RHP 1	29%	39%	22%	73%	44%	148%
RHP 2	22%	34%	37%	92%	70%	325%
RHP 3	38%	46%	32%	48%	10%	25%
RHP 4	14%	18%	16%	20%	6%	42%
RHP 5	33%	38%	29%	42%	9%	26%
RHP 6	31%	32%	38%	59%	28%	93%
RHP 7	22%	25%	28%	37%	15%	69%
RHP 8	28%	19%	51%	24%	-4%	-13%
RHP 9	22%	20%	15%	19%	-3%	-15%
RHP 10	23%	20%	63%	45%	22%	96%
RHP 11	20%	18%	38%	26%	6%	33%
RHP 12	20%	15%	25%	36%	16%	81%
RHP 13	27%	72%	60%	42%	15%	58%
RHP 14	40%	40%	37%	33%	-7%	-18%
RHP 15	24%	29%	38%	43%	19%	81%
RHP 16	21%	96%	42%	37%	16%	73%
RHP 17	29%	22%	25%	25%	-4%	-14%
RHP 18	36%	28%	31%	20%	-16%	-45%
RHP 19	8%	98%	36%	27%	19%	224%
RHP 20	38%	24%	48%	33%	-5%	-13%
Mean across RHPs	26%	37%	35%	39%	13%	49%

Data sharing agreement ties became more centralized over time with a 13 percentage point increase from the beginning of the DSRIP program, a 49% increase.

Tentative Observations:

- The network density data (and, to some extent, the data on the average number of ties) points towards increased collaboration between DSRIP providers in a region in terms of tangible resource sharing and data sharing agreement over time, and decreased collaboration in terms of joint service delivery.
- The average level of centralization of ties within regions increased across each of the three dimensions of joint service delivery, tangible resource sharing, and data sharing agreements.
- Reviewers should be cautious regarding the interpretation of these results as causality cannot be assessed. Some of these trends may be related to general changes in the health care system over time, in addition to differential characteristics of providers that have either dropped out of the DSRIP program or joined over time.

DSRIP CLAIMS BASED ANALYSIS

Hypothesis 1.2 DSRIP incentivized performing providers to improve continuity, quality, and cost of care for Medicaid clients with diabetes.

HHSC will be submitting a revised Evaluation Design Plan to Centers for Medicare and Medicaid Services (CMS) with adjustments to the sampling strategy, analyses, and all measures associated with Hypothesis 1.2. This adjusted analysis is presently underway.

CATEGORY C POPULATION-BASED CLINICAL OUTCOME MEASURE

Hypothesis 1.3 DSRIP incentivized performing providers to improve quality-related outcomes, specified as Category C population-based clinical outcome measures.

This hypothesis question was evaluated using the following measures for performing providers focused on serving the Medicaid and low-income uninsured (MLIU) population:

- Improved Chronic Disease Management: Diabetes Care (A1-508)
- Improved Chronic Disease Management: Heart Disease (A2-509)
- Behavioral Health and Appropriate Utilization (H2-510)
- Primary Care Prevention - Healthy Texans (C1-502)
- Pediatric Primary Care (D1-503)

Example measure:

Improved Chronic Disease Management: Diabetes Care (A1-508)

- The objective of the A1: Improved Chronic Disease Management measure bundle is to develop and implement chronic disease management interventions that are geared toward improving management of diabetes and comorbidities, improving health outcomes and quality of life, preventing disease complications, and reducing unnecessary acute and emergency care utilization among the Medicaid and low-income (MLIU) population.
- Activities that performing providers participated in were targeted towards lowering HbA1c levels, providing timely education and medication for self-management,

improving care coordination and diabetes management at the health system level, delivering exercising and cooking classes, hiring and training community health worker (CHW) diabetic educators, promoting behavior change and self-management strategies, expanding chronic disease screening opportunities, and developing as well as delivering evidence-based diabetes prevention programs.

- Providers reported baseline and DY7 MLIU rates. Weighted mean rates were created for the A1-508: Reduce Rate of Emergency Department visits for Diabetes measure in order to adjust for the volume of the baseline MLIU as well as DY7 MLIU rates of each performing provider. The denominators of the MLIU baseline population for each performing provider were added up to find the overall denominator, multiplied by the unweighted rate, and summed to get the final weighted mean rates.

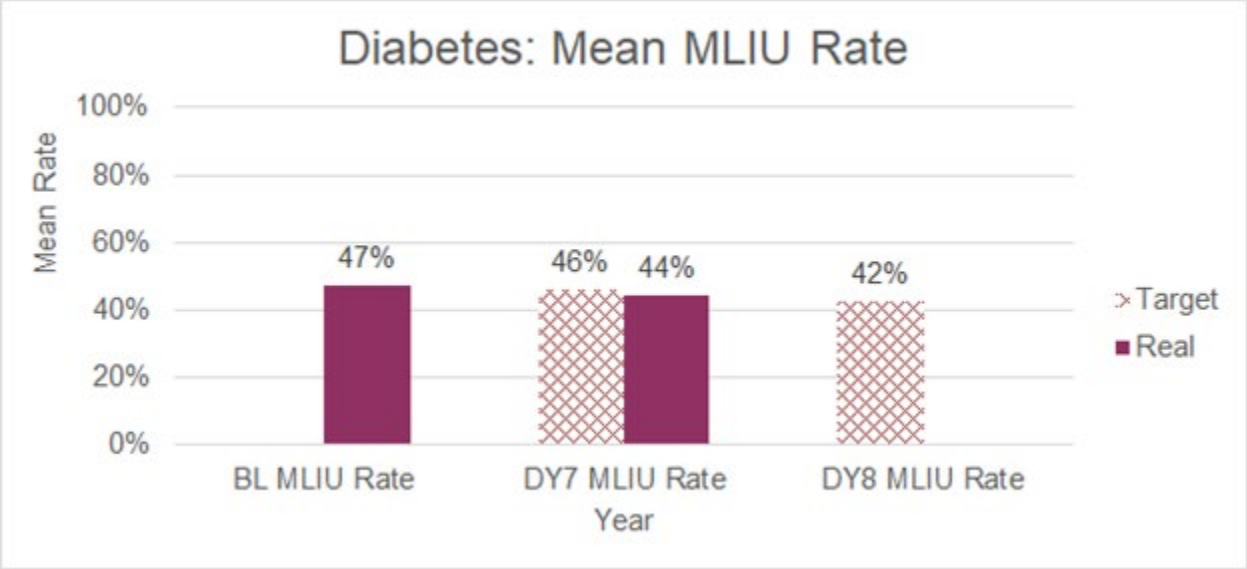


Figure A.3.1. MLIU Mean Rate for Diabetes, Measure ID=A1-508 (N=22)

- Numerator: Total number of ED visits with a primary or secondary diagnosis of diabetes (E101, E131, E110, E130, E10641, E11641, E106, E116, E108, E118, E109, E119)
- Denominator: DSRIP attributed target population for the provider system.
- Difference between baseline rate and DY7 rate not statistically significant after conducting Wilcoxon Signed Rank Sum test (p=0.1021).

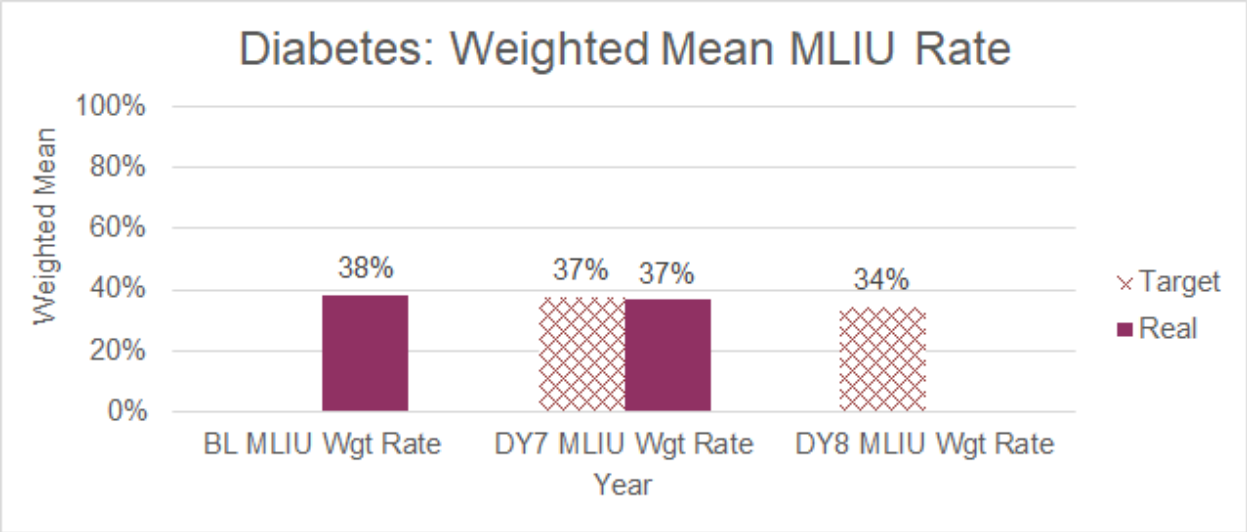


Figure A.3.2. MLIU Weighted Mean Rate for Diabetes, Measure ID=A1-508 (N=22)

- Numerator: Total number of ED visits with a primary or secondary diagnosis of diabetes (E101, E131, E110, E130, E10641, E11641, E106, E116, E108, E118, E109, E119)
- Denominator: DSRIP attributed target population for the provider system
- Difference between baseline rate and DY7 rate not statistically significant after conducting Wilcoxon Signed Rank Sum test (p=0.1021).

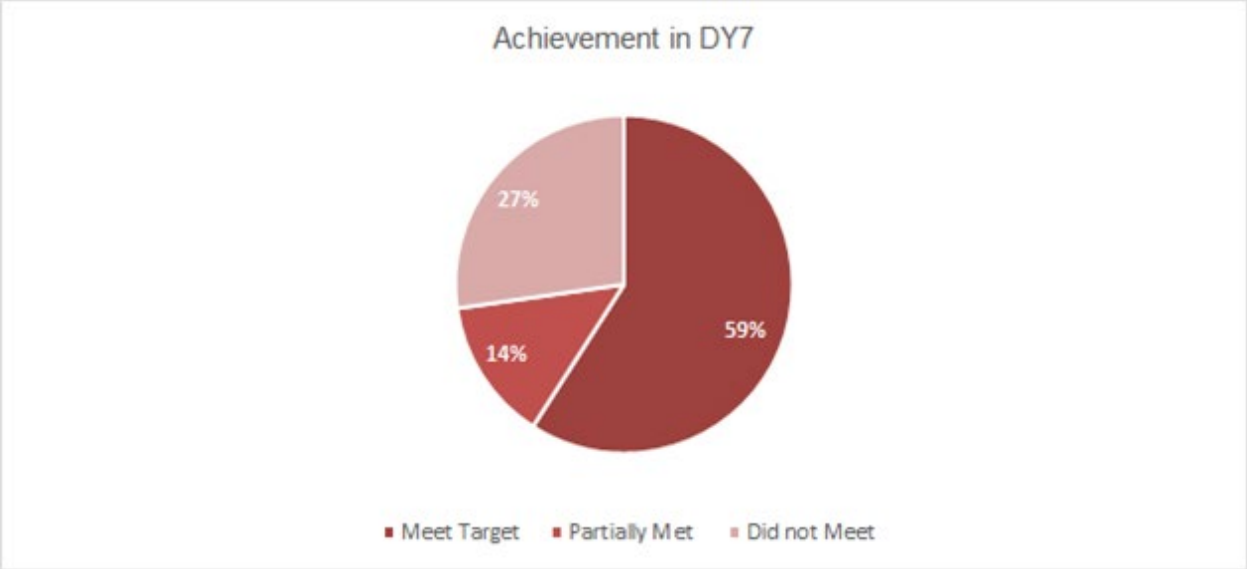


Figure A.3.3. Achievement in DY7 for Diabetes, Measure ID=A1-508 (N=22)

- DY7 goal = 2.5% improvement over baseline
- Partially met indicates than although an improvement was seen these providers did not meet the DY7 goal

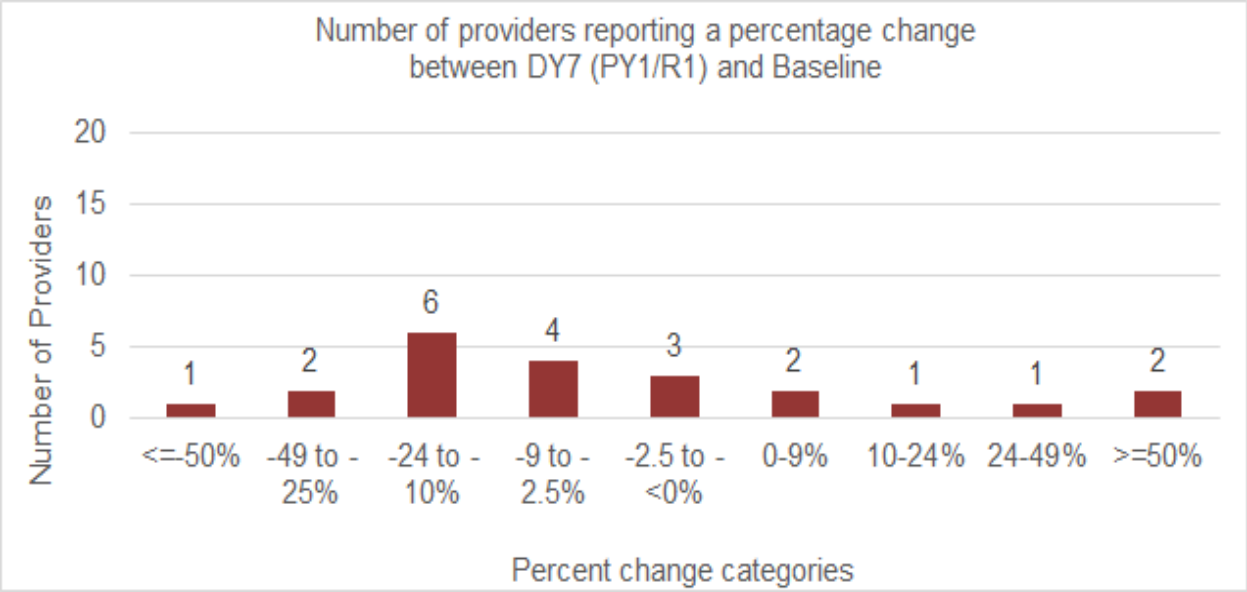


Figure A.3.4. Number of providers reporting a percentage change between DY7 (PY1/R1) and Baseline for Diabetes, Measure ID=A1-508 (N=22)

- DY7 goal = 2.5% improvement over baseline
- DY8 goal = 10% improvement over baseline (DY8 results are not available at this time, however, some providers saw a 10% or greater improvement in DY7)
- On the x-axis, the negative values represent favorable improvement

For each of the remaining measures:

- Improved Chronic Disease Management: Heart Disease (A2-509)
- Behavioral Health and Appropriate Utilization (H2-510)
- Primary Care Prevention - Healthy Texans (C1-502)
- Pediatric Primary Care (D1-503)

The weighted mean rates between baseline and DY8 are shown in the graphs below. The goals of 2.5% and 10% improvement for DY7 and DY8 remain the same for each measure.

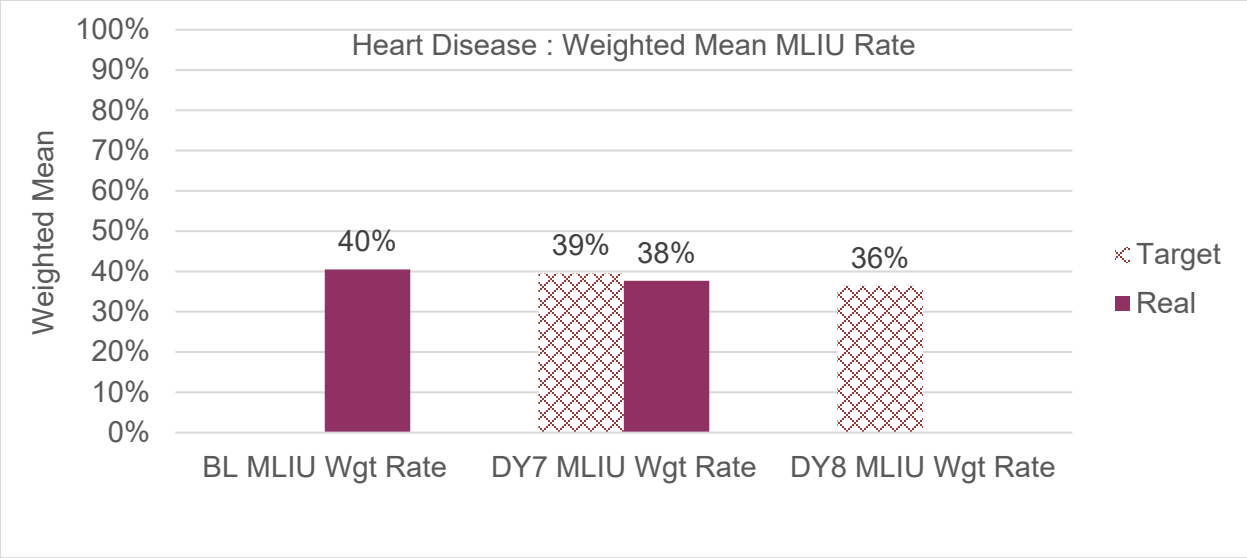


Figure A.3.6. MLIU Weighted Mean Rate for Heart Disease, Measure ID=A2-509 (N=12)

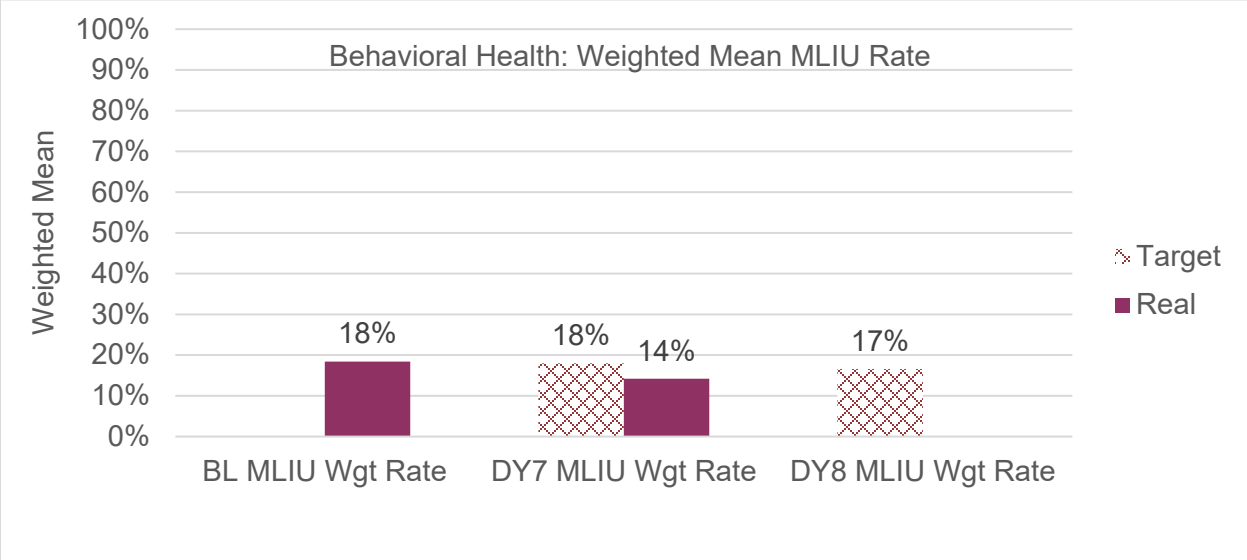


Figure A.3.7. MLIU Weighted Mean Rate for Behavioral Health, Measure ID=H2-510 (N=7)

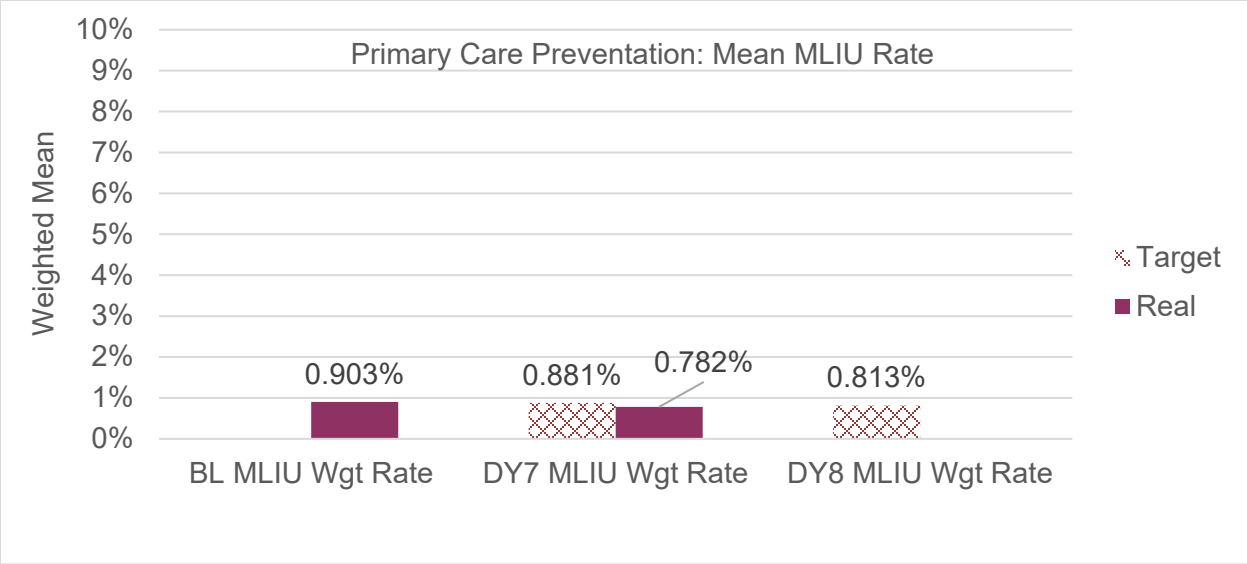


Figure A.3.8. MLIU Weighted Mean Rate for Primary Care Prevention, Measure ID=C1-502 (N=18)

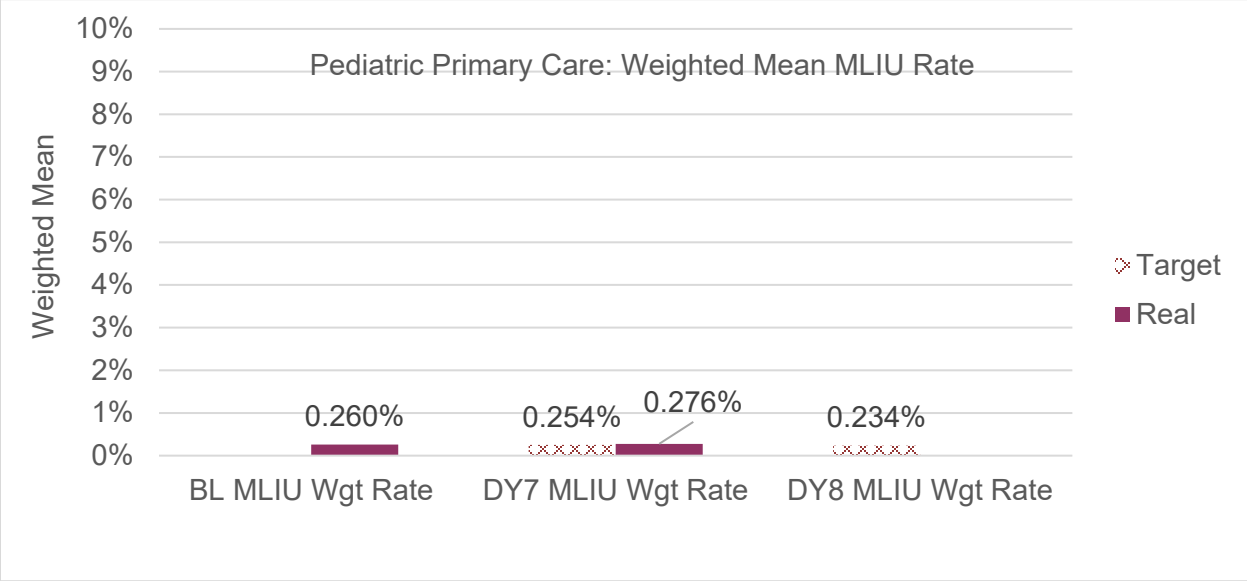


Figure A.3.9. MLIU Weighted Mean Rate for Pediatric Primary Care, Measure ID=D1-503 (N=10)

Tentative Observations

- Performing providers had a mixture of successes and challenges with meeting their DY7 and DY8 targets. While some were able to meet both of their goals in one year, others reported an increase from baseline or did not see enough of a decrease from baseline to meet specified targets for the MLIU population.

- The Primary Care and CHF/Angina/Heart failure measures (2 out of 5 measures for this evaluation question) revealed statistically significant decreases from baseline thus indicating that there is some improvement which may be linked to DSRIP activities of performing providers.

CATEGORY D POPULATION HEALTH OUTCOMES

Hypothesis 1.4 DSRIP transformed the health care system, resulting in improvements in population health, specified as DSRIP Category D outcomes.

This hypothesis question was evaluated using the following measures for performing providers:

- Potentially preventable admissions (PPA)
- Potentially preventable emergency department visits (PPV)
- Potentially preventable readmissions (PPR)
- Potentially preventable complications (PPC)

Example measure:

Potentially preventable Admissions (PPA)

- Potentially preventable admissions (PPA) are facility admissions that may have resulted from the lack of adequate access to care or ambulatory care coordination. This measure is 1 of 4 in the Category D Hospital Statewide Reporting Measure Bundle specified in the Measure Bundle Protocol.
- This RHP-level measure includes hospital admissions for any of the following ambulatory care sensitive conditions: congestive heart failure, diabetes, behavioral health/substance abuse, chronic obstructive pulmonary disease, adult asthma, pediatric asthma, angina and coronary artery disease, hypertension, cellulitis, respiratory infection, pulmonary edema and respiratory failure, and other.
- Providers reported PPA ratios for DY7 and DY8. Weighted mean ratios were created for the PPA measure in order to adjust for the volume of PPAs in each RHP using the actual number of PPAs reported for each performing provider. The actual number of PPAs reported for each provider was added up to find the overall denominator, multiplied by the unweighted ratio, and summed to get the final weighted ratio.

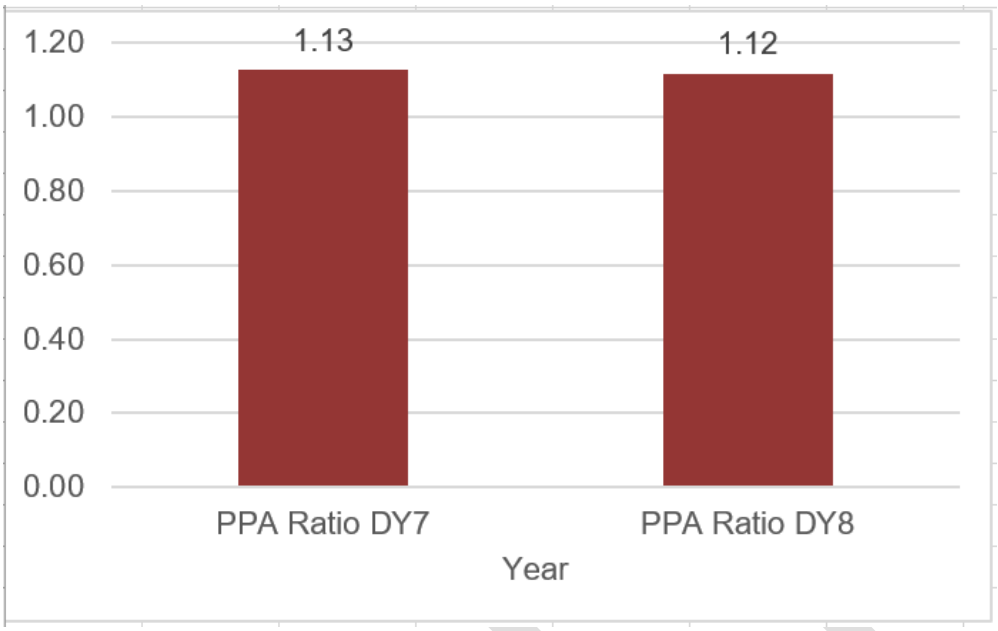


Figure A.4.1. Potentially preventable admissions (PPA) unweighted mean ratio, N=21

- Includes 20 RHPs and one NA group. The NA group consists of performing providers that could not be linked to an RHP.
- Difference between 2017 and 2018 ratio not statistically significant after conducting Wilcoxon Signed Rank Sum test (p=0.37).

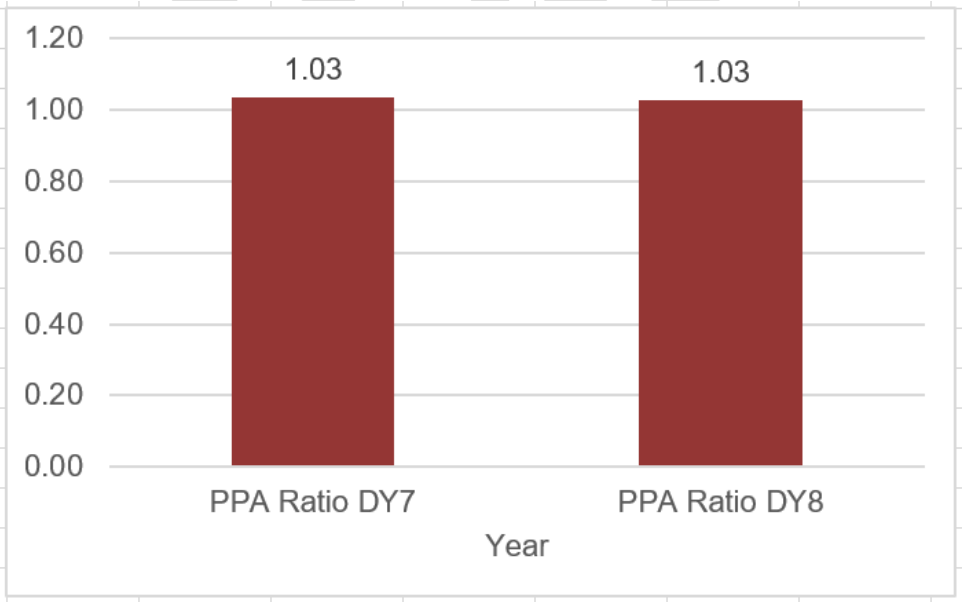


Figure A.4.2. Potentially preventable admissions (PPA) weighted mean ratio, N=21

- Includes 20 RHPs and one NA group. The NA group consists of performing providers that could not be linked to an RHP.
- Difference between 2017 and 2018 ratio not statistically significant after conducting Wilcoxon Signed Rank Sum test (p=0.37).

For each of the remaining measures:

- Potentially preventable emergency department visits (PPV)
- Potentially preventable readmissions (PPR)
- Potentially preventable complications (PPC)

The weighted mean rates between baseline and DY8 are shown in the graphs below.

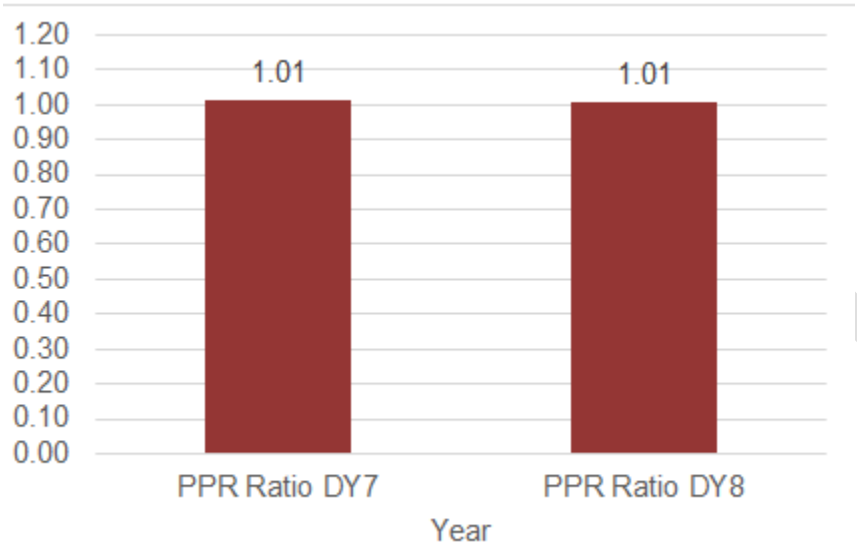


Figure A.4.2. Potentially preventable readmissions (PPR) weighted mean ratio, N=21

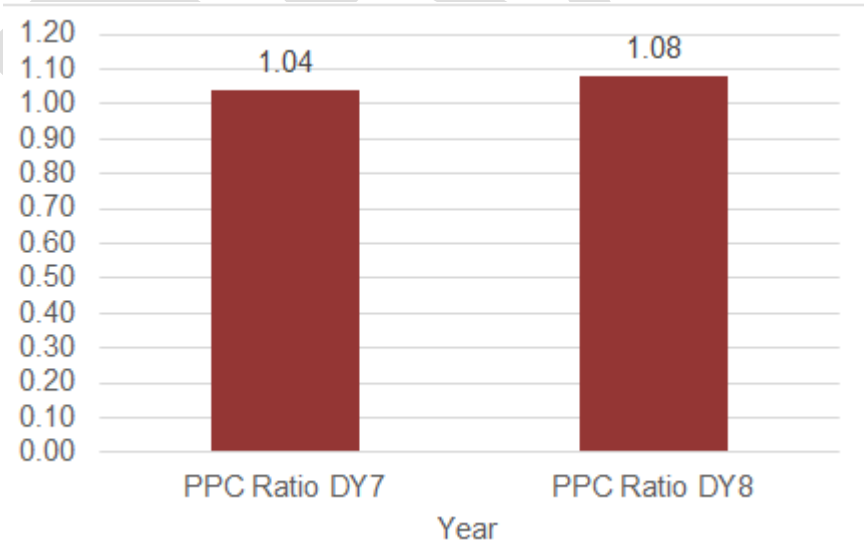


Figure A.4.2. Potentially preventable complications (PPC) weighted mean ratio, N=21

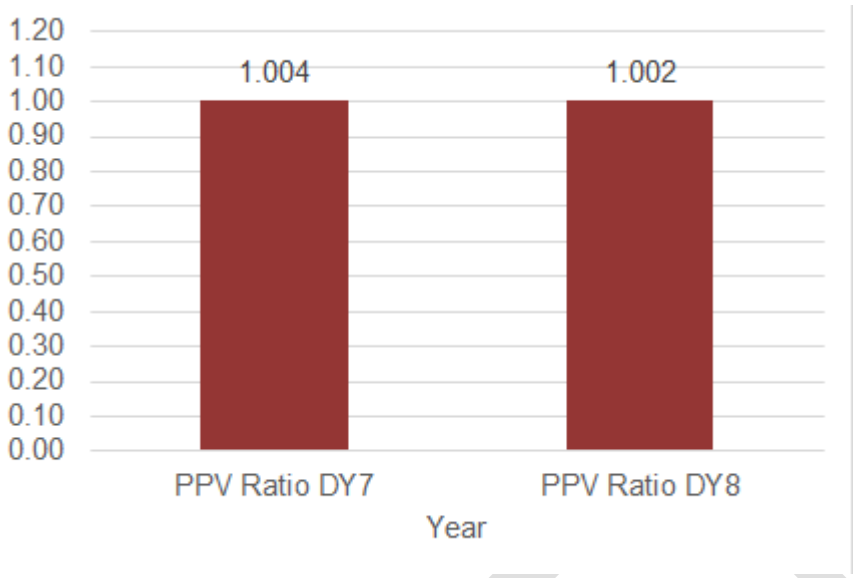


Figure A.4.2. Potentially preventable ED visits (PPV) weighted mean ratio, N=21

Tentative Observations

- At the RHP level, potentially preventable events- including potentially preventable admissions (PPA), potentially preventable emergency department visits (PPV), potentially preventable complications (PPC), and potentially preventable readmissions (PPR)- did not decrease significantly between DY7 and DY8 (i.e. after weighting, the ratios were not different from 1).
- These results only include data for DY7 to DY8. The overall measure will be calculated using data from DY7-DY11. As a result there is still time to assess if DSRIP transformed the health care system, resulting in improvements in population health.

SUMMARY OF EARLY RESULTS FROM THE DSRIP EVALUATION

Evaluation Question 1: Did the DSRIP program incentivize changes to transform the health care system for the MLIU population in Texas?

While many of the analyses remain underway, DSRIP providers have shown increased collaboration in a few areas (tangible resource sharing and data sharing agreements) but less in others (joint service delivery) since the beginning of the 1115 Waiver. Improvements have been seen for certain Category C clinical outcome measures [Improved Chronic Disease Management: Heart Disease (A2-509) and Primary Care Prevention - Healthy Texans (C1-502)] since the beginning of the Waiver renewal, when measures began to be evaluated at the provider level. Significant changes in Category D population health measures have not yet been found since the beginning of the Waiver renewal. As these are descriptive trends, causal inferences should not be made at this time. Once additional data are available and the claims analysis is complete, a better sense of the impact of the program on the measures outlined in the DSRIP Claims Based Analysis will be feasible.

B. UNCOMPENSATED CARE

Evaluation Question 2: Did the Demonstration impact unreimbursed costs associated with the provision of care to the MLIU population for UC providers?

Hypothesis 2.1 The percentage of UC costs reimbursed through UC payments for each type of UC (overall, Medicaid shortfall, uninsured shortfall) will decrease throughout DY1-DY8.

We measure the percentage of UC cost reimbursed for each hospital by dividing the total amount of UC reimbursed received by the hospital's total UC costs among hospitals receiving UC payments. To provide a comparable time trend across DY1 to DY8, we restricted the data to hospitals who received UC payments in seven or all (eight) demonstration years. We then plotted the average annual reimbursement rate in each year for all hospitals in Figure B.1. Unfortunately, we could not perform the same analysis at the Medicaid and uninsured shortfall reimbursed costs because only overall reimbursement data was collected.

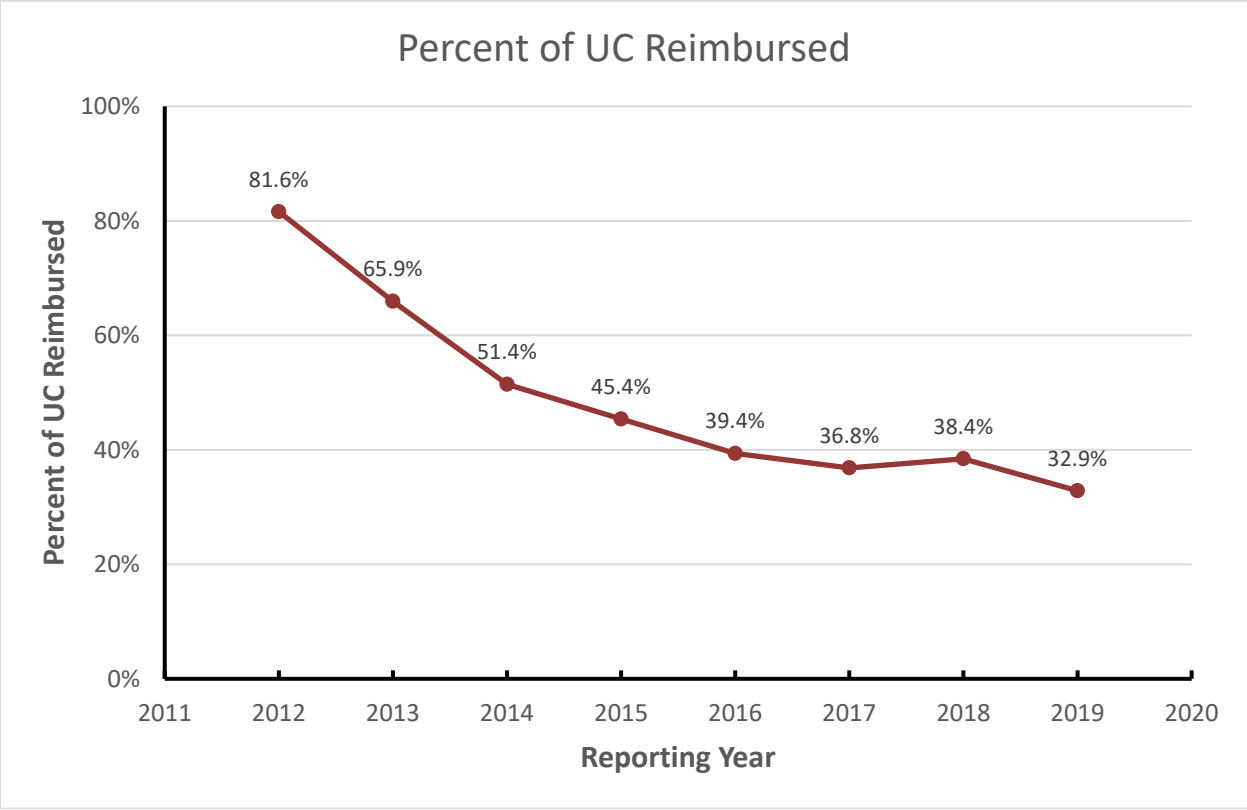


Figure B.1. Percentage of Overall UC cost reimbursed through UC payments

Notes: X-axis displays results for DY1 (2012 UC report using 2010 data) to DY8 (2019 UC report using 2017 data). The vertical red line separates the time period of the first waiver to the current waiver.

TENATIVE RESULTS & OBSERVATIONS:

- The percentage of UC cost reimbursed as measured decreased from about 81.6% in DY1 to about 32.9% in DY8.
- However, some of this decline over time may be attributable to changes over time in specific details in the UC payment system used to determine hospital UC costs eligible for reimbursement. Thus, annual estimates of percentage of UC cost reimbursed may not be directly comparable overtime without additional adjustments.

Hypothesis 2.2 The UC cost growth rate will slow over time for UC providers participating in the Demonstration.

We measure the change in UC cost growth from DY1 to DY8 by estimating a linear relationship between the UC growth rate and time in a regression model that adjusted for time varying hospital changes to account for hospital specific differences over time that may affect UC cost growth. We included hospital information from the American Hospital Association (AHA) on the hospital's bed size, ownership status, whether it had an HMO contract, whether it had a PPO contract, and total hospital admissions volume. We also included information from the UC hospital data, including the Disproportionate Share Hospital (DSH) payment to the hospital, the hospitals UC pool size, the number of hospitals in each UC pool, and hospitals rural hospital classification status. With all this information we estimated the following regression model to evaluate the impact on cost growth:

$$\text{UC Growth Rate}_{it}=\gamma_0+\gamma_1\text{Time}_t+\gamma_2\text{hospital}_{it}+\beta\,\mathbf{X_{it}}+\theta_i+\varepsilon_i$$

The term "UC growth rate" is defined as (UC costs – UC costs previous year) / (UC costs previous year). Time_i is a continuous time trend variable and is the variable of interest. Hospital_{it} describes the hospital based on the data in the American Hospital Association survey (total beds, type, HMO contract, etc.). Θ_i represents hospital fixed effects (this variable takes care of time-invariant differences between hospitals). Lastly, $\mathbf{X_{it}}$ includes other UC related hospital characteristics, such as the UC program, DSH payment, UC budget pool, number of hospitals in the budget pool, and Rider 38 status.

This analysis is presently underway.

C. MEDICAID MANAGED CARE (MMC)

Evaluation Question 3: Did the expansion of the MMC health care delivery model to additional populations and services improve healthcare (including access to care, care coordination, quality of care, and health outcomes) for MMC clients?

METHODS

Evaluation Question 3 was answered through two approaches and four primary data sources, as described below.

Descriptive Analysis

The Nursing Facility Quality Review (NFQR) Survey and the Consumer Assessment of Healthcare Providers and Systems Health Plan (CAHPS) Survey were utilized. The analysis for these surveys were descriptive statistics that were explored temporally as data was available. No pre-data was available for the CAHPS survey as the first year the child survey was conducted was 2019 and adults was 2020. Pre-data for the NFQR survey includes 2010, 2013, and 2015.The only NFQR post-data currently available is 2015.

In addition to the two surveys, a few of the other measures used descriptive analysis when Interrupted Time Series was not appropriate.

Interrupted Time Series Approach

To address many of the hypotheses under evaluation question 3, fee-for-service (FFS) claims and MMC encounter data were used to examine the impact of transitioning from FFS to MMC. We constructed interrupted time series (ITS) models, as indicated in Attachment A and where feasible given available data. The ITS models were used to identify two types of changes pre- versus post MMC implementation: a change in slope or trend and a change in intercept or level. One change point was included in most cases unless there was a clear rationale for modeling additional change points. Statistically significant changes were indicated at the $p<0.05$ level of significance. The pre-period was defined as the 24 months prior to MMC implementation. For measures where insufficient data were available, fewer months were included. The ITS models were specified as follows:

For One change point:

$$Y_t = \beta_0 + \beta_1 * time + \beta_2 * MMC + \beta_3 * postslope + \varepsilon_t$$

For two change points

$$Y_t = \beta_0 + \beta_1 * time + \beta_2 * MMC1 + \beta_3 * postslope1 + \beta_4 * MMC2 + \beta_5 * postslope2 + \varepsilon$$

Where β_0 =baseline level of outcome at beginning of pre-MMC period
β_1 = trend pre-MMC (slope)
β_2= immediate impact of MMC (level)
β_3= trend post-MMC (slope)

ACCESS TO CARE

Hypothesis 3.1 Access to care will improve among clients whose Medicaid benefits shift from FFS to a MMC health care delivery model.

Hypothesis 3.1 was addressed mainly through ITS modeling based on the FFS claims and MMC encounter data. Figure C.1.1 displays the percent of child clients who received at least one preventive dental visit during the reporting period. Initially post-MMC implementation, there was a decrease in the percentage level and a change to a steeper increasing slope, both statistically significant. The observed patterns support hypothesis 3.1.

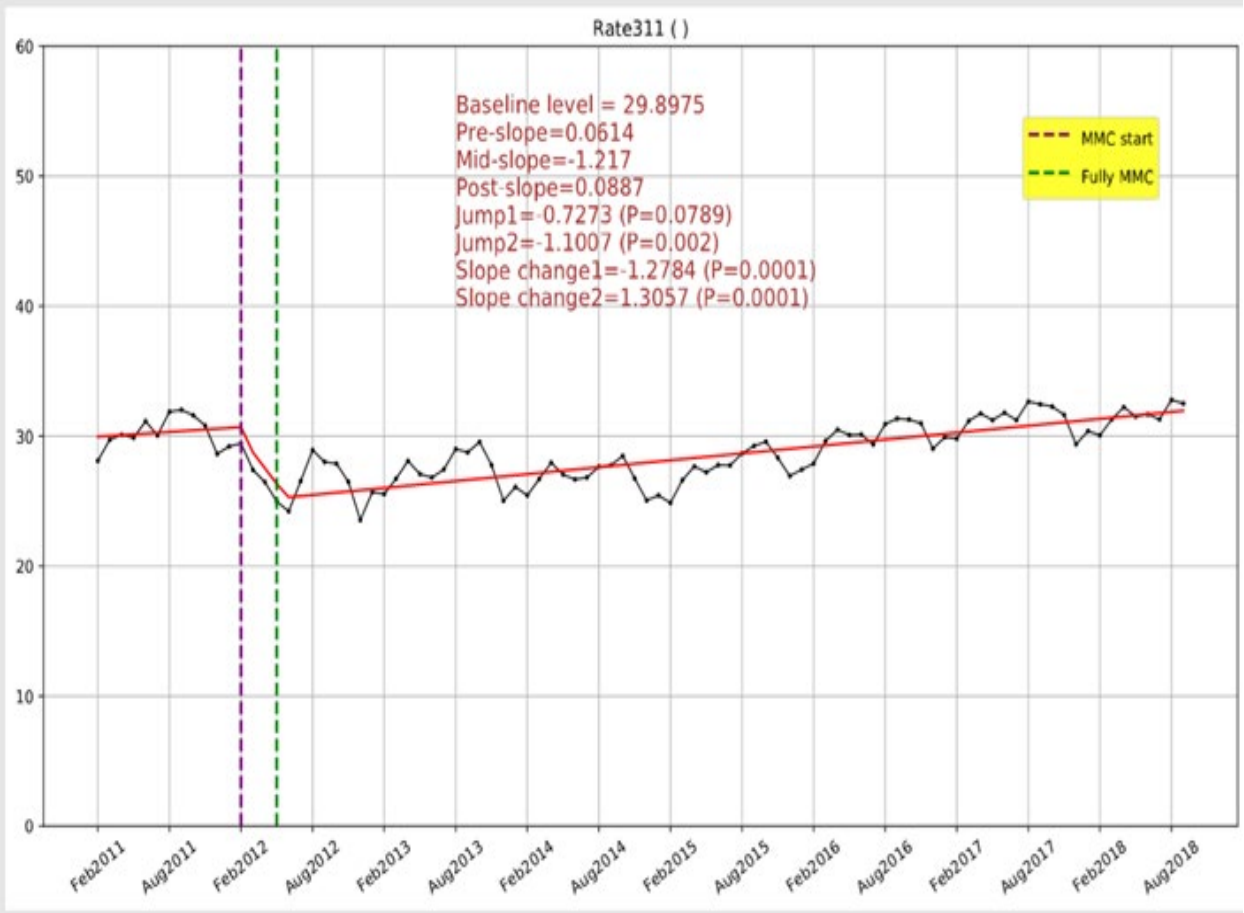


Figure C.1.1. Percent of child clients who received at least one preventive dental visit (Measure 3.1.1)

Figure C.1.2 displays the percent of FFCC members who had at least one ambulatory or preventive care visit in the last year. There was a change from an increasing trend to a decreasing trend from September 2017 to September 2018. However, MMC was not fully implemented until after September 2018. Therefore, additional months of data are needed to fully assess this measure.

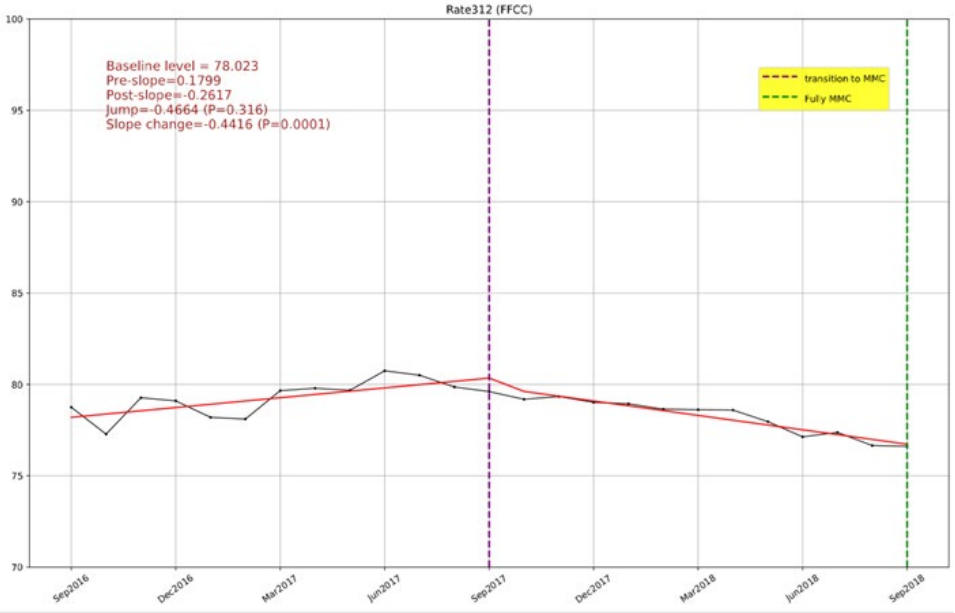


Figure C.1.2. Percent of FFCC members who had at least one ambulatory or preventive care visit in the last year (Measure 3.1.2)

Figure C.1.3 displays the percentage of MBCC members who had at least one ambulatory or preventive care visit in the last year. There was no observed difference after implementation of MMC. However, MMC was not fully implemented until after September 2018. Therefore, additional months of data are needed to fully assess this measure.

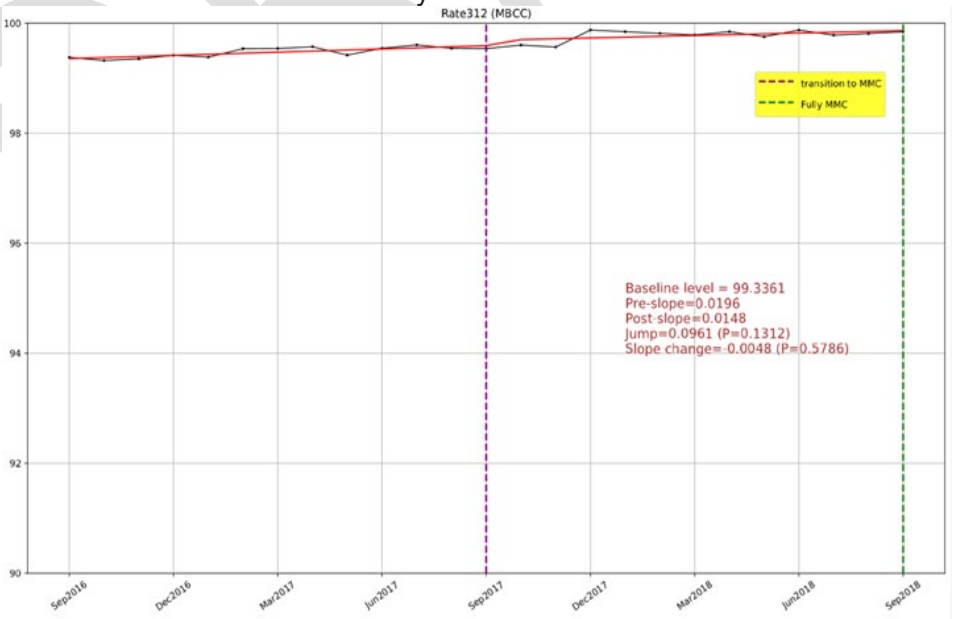


Figure C.1.3. Percent of MBCC members who had at least one ambulatory or preventive care visit in the last year (Measure 3.1.2)

Figure C.1.4 displays the percentage of NF members who had at least one ambulatory or preventive care visit in the last year. Immediately post-MMC implementation, there was a statistically significant change in slope to become steeper than the increasing trend pre-MMC. Once MMC was fully implemented in March 2016, the slope changed again (statistically significant) to become less steep, but still increasing.

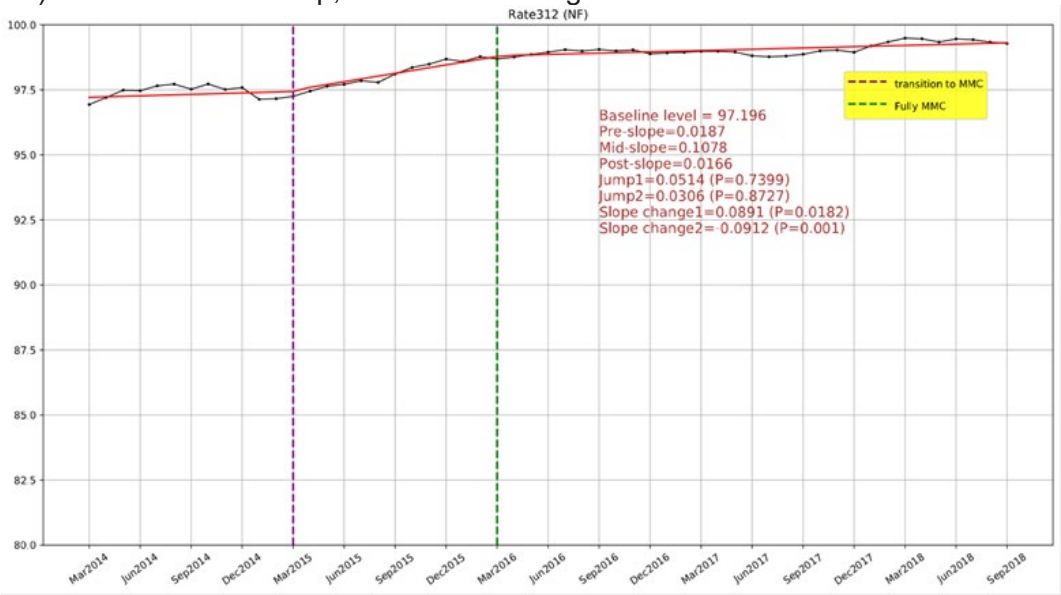


Figure C.1.4. Percent of NF members who had at least one ambulatory or preventive care visit in the last year (Measure 3.1.2)

Figure C.1.5 displays the percentage of AA members who had at least one visit with a PCP in the measurement year. There was a statistically significant change immediately following implementation of MMC in September of 2017 with respect to an increase in the percentage level and the slope remained increasing but steeper.

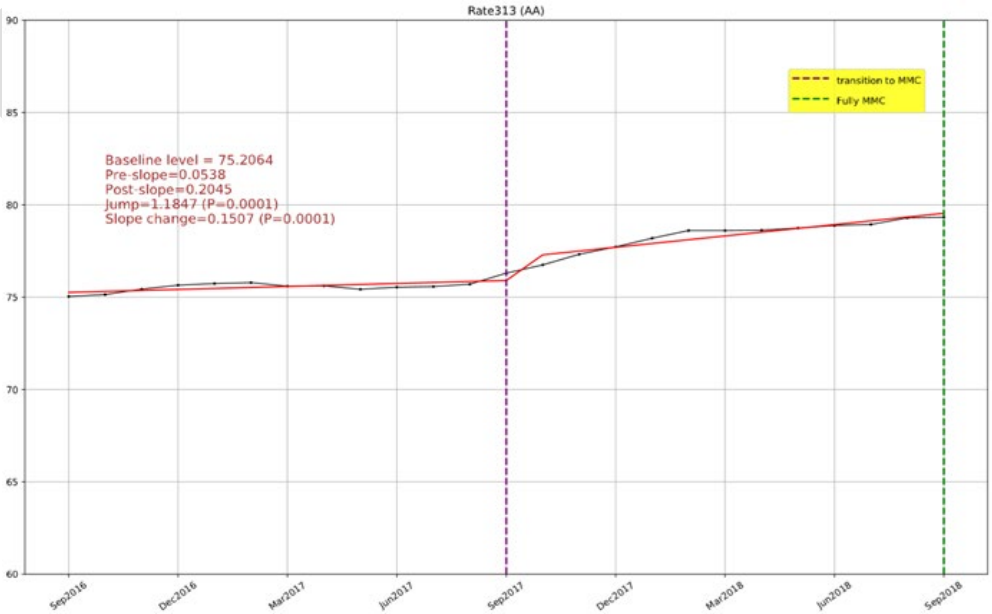


Figure C.1.5. Percent of AA members who had at least one visit with a PCP in the measurement year (Measure 3.1.3)

Table C.1.1 presents a summary of the ITS findings for hypothesis 3.1. Statistics are presented for the baseline level, the slope/trend values pre and post MMC, and level changes post-MMC implementation.

Table C.1.1. Summary of ITS results for Hypothesis 3.1

Measure	Baseline Value	Pre MMC Trend	Post MMC Level Change I	Post MMC Trend I	Post MMC Level Change II	Post MMC Trend II
3.1.1: Percent of child clients who received at least one preventive dental visit	29.90	0.06	0.72	**-1.22**	**-1.10**	**0.09**
3.1.2: Percent of FFCC members who had at least one ambulatory or preventive care visit in the last year.	78.02	0.18	-0.47	**-0.26**	n/a	n/a
3.1.2: Percent of MBCC members who had at least one ambulatory or preventive care visit in the last year.	99.34	0.02	0.10	0.015	n/a	n/a
3.1.2: Percent of NF members who had at least one ambulatory or preventive care visit in the last year.	97.20	0.02	0.05	**0.11**	0.03	**0.02**
3.1.3: Percent of AA members who had a visit with a PCP in the measurement year.	97.20	0.02	0.05	0.11	0.03	**0.02**

Note: Results in bold are significant at the $p<0.05$ level.

Key takeaways:

- There was an increasing trend in preventive dental care visits among child clients after full implementation of MMC. This trend was statistically significant. This finding is in line with the findings from 3.4.1 where a decreasing trend was observed for the percent of child clients who had tooth decay. This finding supports hypothesis 3.1.
- For MBCC members, significant changes were not observed for the percentage of members who had at least one ambulatory or preventive care visit in the last year. However, the baseline values for both populations were already close to 100 percent.
- For the FFCC members, additional months of data are needed to be able to adequately assess the impact of MMC implementation.
- For the NF members, the baseline increasing slope/trend became steeper (statistically significant) with no change in level. At full implementation of MCC one year after initial implementation, the slope changed again to become less steep, although still increasing and was statistically significant. This finding supports hypothesis 3.1.
- For the percentage of AA members who had at least one visit with a PCP in the measurement period, there was a statistically significant increasing trend post MMC implementation. This finding supports hypothesis 3.1.

CARE COORDINATION

Hypothesis 3.2 Care coordination will improve among clients whose Medicaid benefits shift from FFS to a MMC health care delivery model.

Hypothesis 3.2 was addressed mainly through ITS modeling based on the FFS claims and MMC encounter data.

Figure C.2.1 displays the rate of service coordination utilization in NF members. The rate is presented as the number of encounters per 1,000 member months. There was a small but statistically significant decrease in the level of the rate post-MMC implementation. There was no change in slope/trend, which remained increasing.

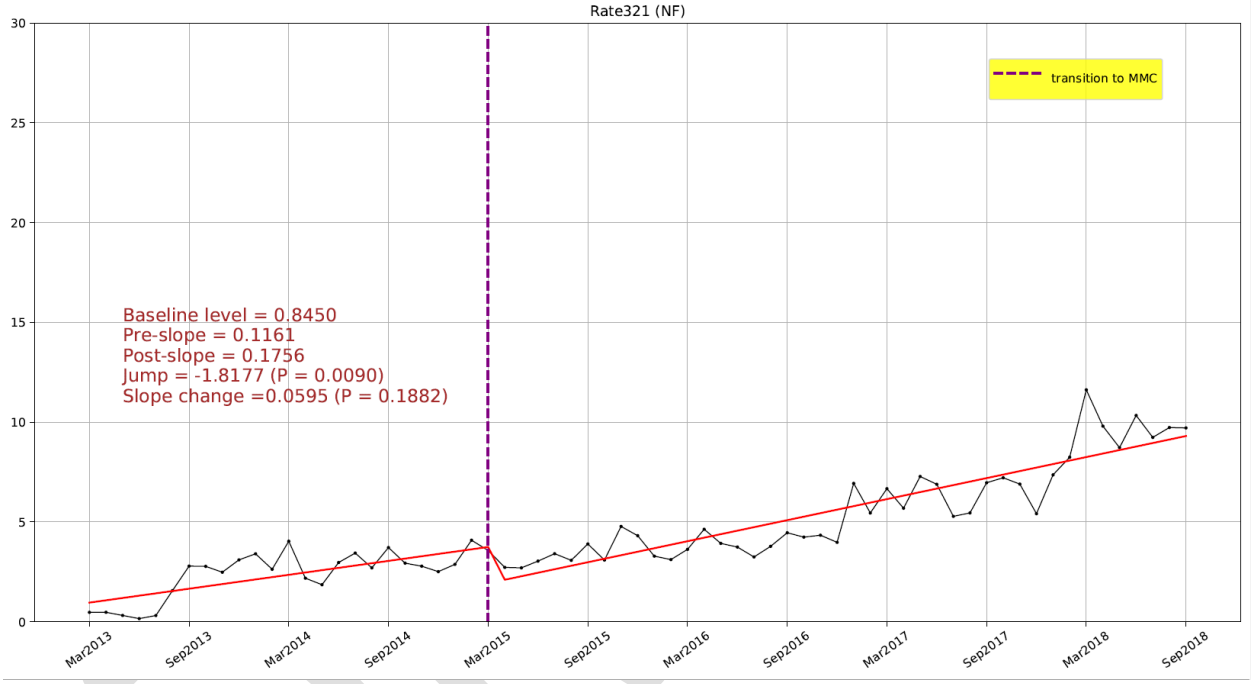


Figure C.2.1. Rate of service coordination utilization per 1,000 member months in NF (Measure 3.2.1)

Figure C.2.2 displays the rate of service coordination utilization in FFCC members. As with Figure C.2.1, the rate is presented as the number of encounters per 1,000 member months. There was a small decrease in level for the rate post-MMC implementation that was not statistically significant. There was no change observed in slope/trend and it remained increasing.

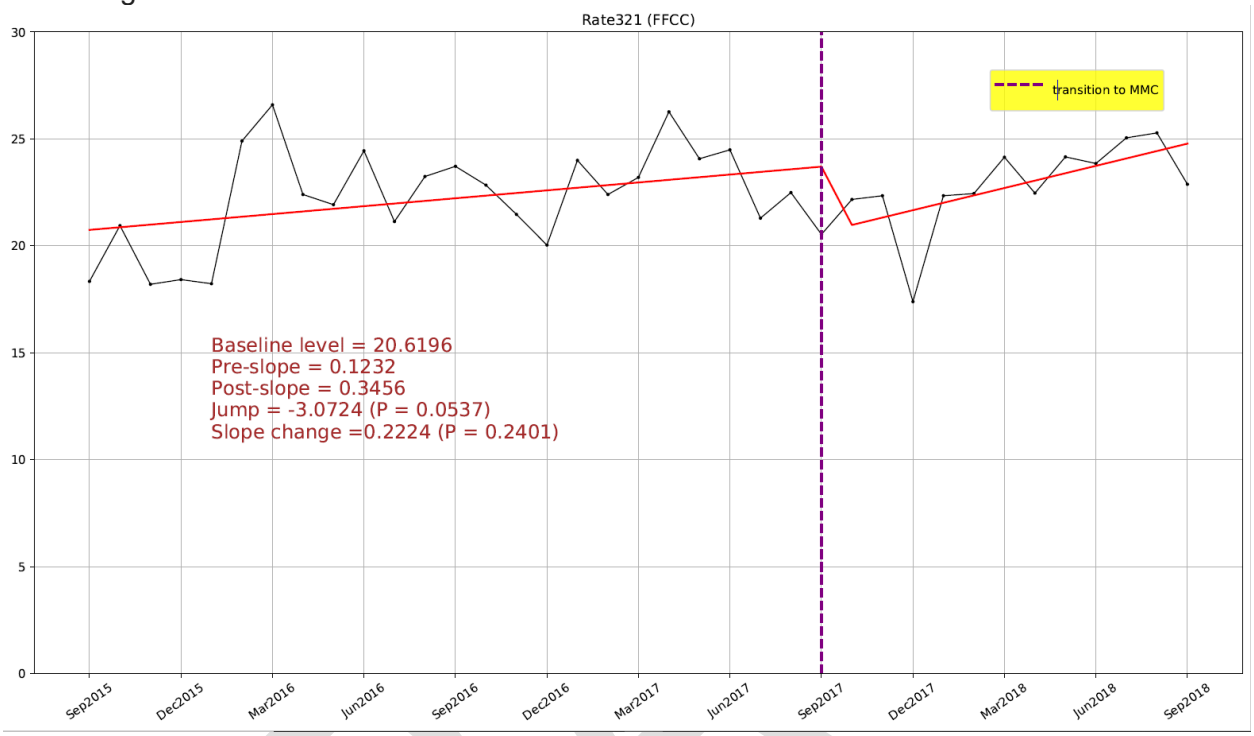


Figure C.2.2. Rate of service coordination utilization per 1,000 member months in FFCC (Measure 3.2.1)

Figure C.2.3 displays the rate of service coordination utilization in MBCC members. In line with Figures C.2.1 and C.2.2, the rate is presented as the number of encounters per 1,000 member months. There were no observed changes in level or slope/trend. The slope/trend remained relatively flat.

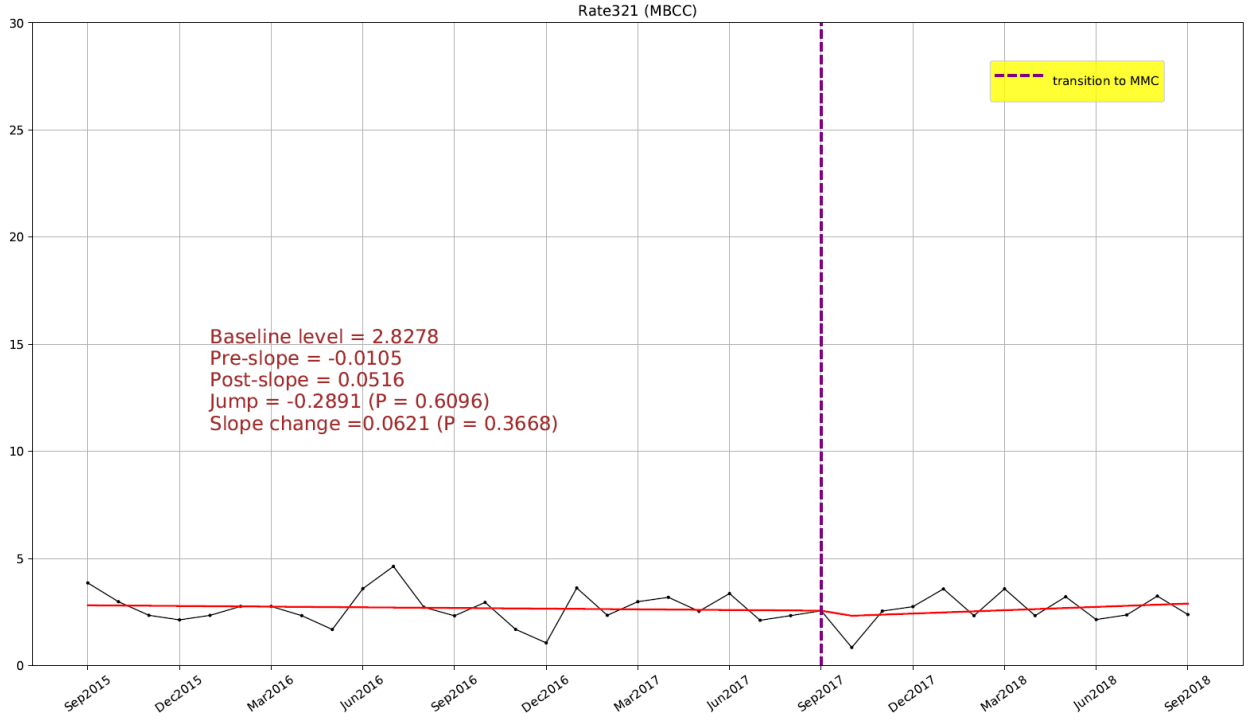


Figure C.2.3. Rate of service coordination utilization per 1,000 member months in MBCC (Measure 3.2.1)

Figure C.2.4 displays the rate (i.e., percentage) of the level of utilization of targeted case management among FFCC clients with SPMI. There was a statistically significant decrease in the level of the rate post-MMC, but the slope/trend remained unchanged and increasing.

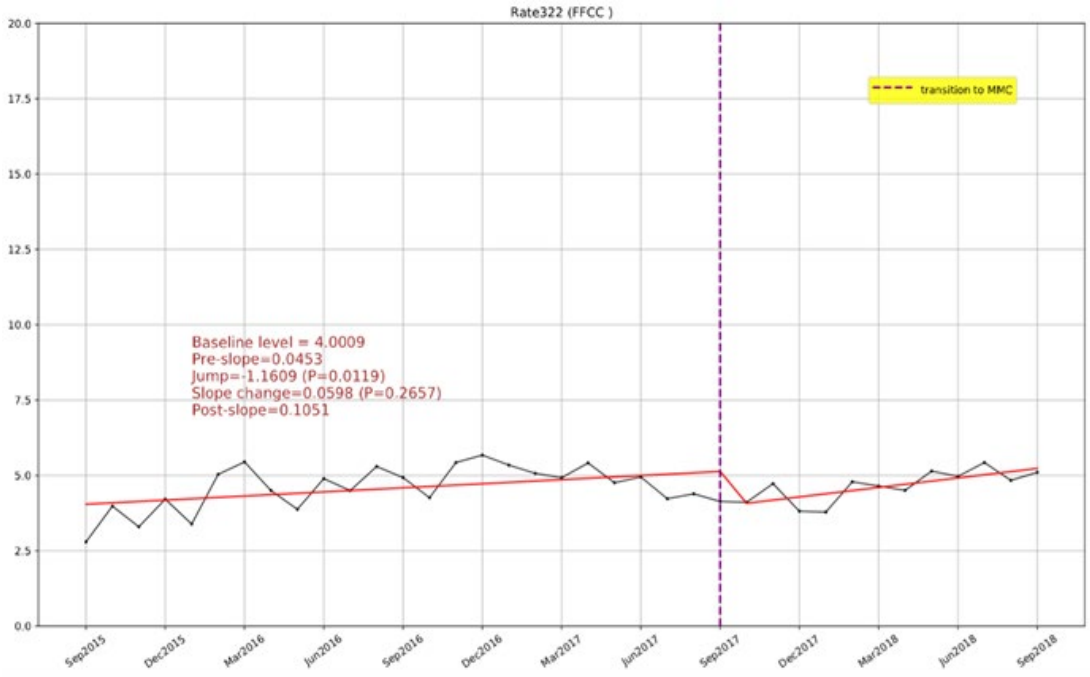


Figure C.2.4. Rate of the level of utilization of targeted case management among FFCC clients with SPMI (Measure 3.2.2)

Figure C.2.5 displays the rate (i.e., percentage) of the level of utilization of targeted case management among AA clients with SPMI. There was a statistically significant increase in the level of the rate post-MMC, but the slope/trend remained unchanged and increasing.

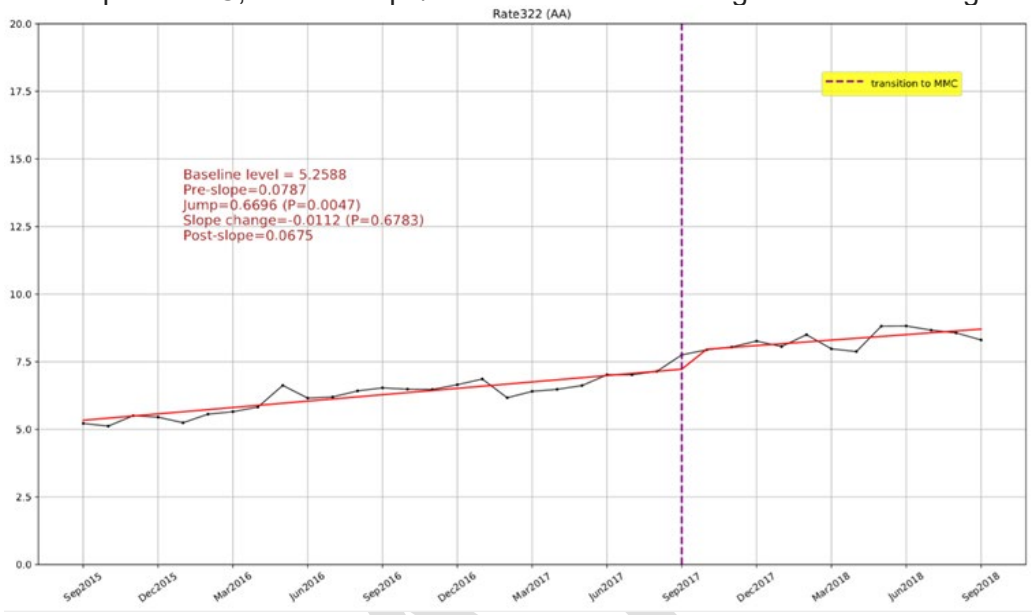


Figure C.2.5. Rate of the level of utilization of targeted case management among AA clients with SPMI (Measure 3.2.2)

Figure C.2.6 displays the rate (i.e., percentage) of the level of utilization of targeted case management among PCA clients with SPMI. There was no change in level of the rate post-MMC, and the slope/trend remained unchanged and increasing.

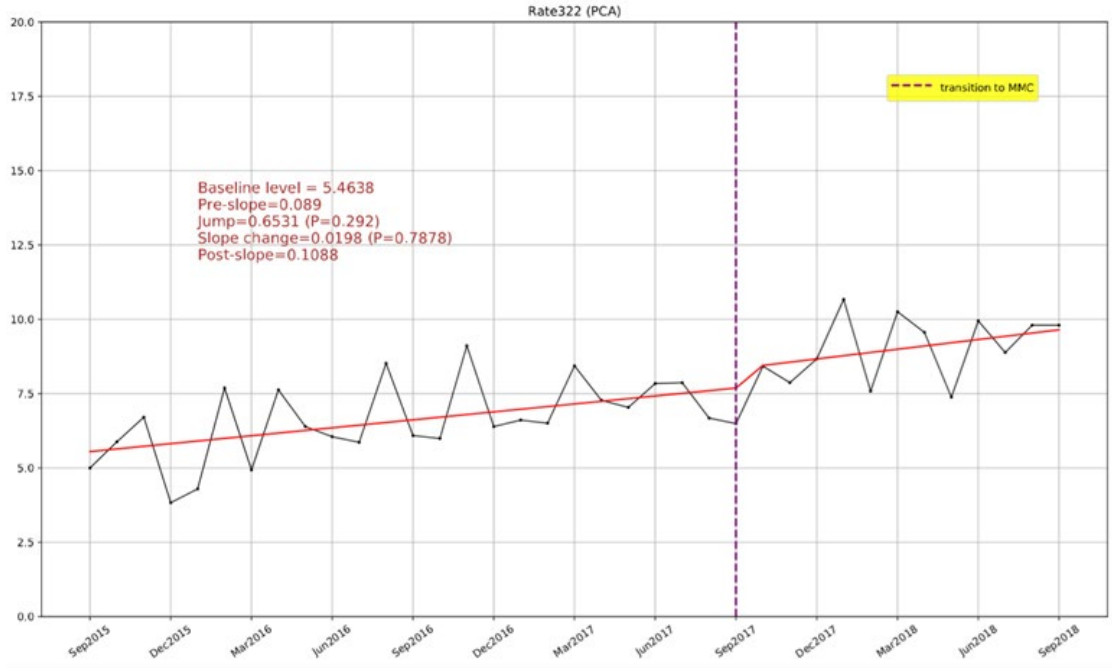


Figure C.2.6. Rate of the level of utilization of targeted case management among PCA clients with SPMI (Measure 3.2.2)

Table C.2.1 presents a summary of the ITS findings for hypothesis 3.2. Statistics are presented for the baseline level, the slope/trend values pre and post MMC, and level changes post-MMC implementation.

Table C.2.1. Summary of ITS results for Hypothesis 3.2

Measure	Baseline Value	Pre MMC Trend	Post MMC Level Change I	Post MMC Trend I
3.2.1: Rate of service coordination utilization in NF.	0.85	0.12.	**-1.82**	0.18
3.2.1: Rate of service coordination in FFCC.	20.62	0.12	-3.07	0.35
3.2.1: Rate of service coordination in MBCC.	2.83	-0.01	-0.30	0.05
3.2.2: Rate of the level of utilization of targeted case management among FFCC clients with SPMI.	4.00	0.05	**-1.16**	0.11
3.2.2: Rate of the level of utilization of targeted case management among AA clients with SPMI.	5.26	0.08	**0.67**	0.07
3.2.2: Rate of the level of utilization of targeted case management among PCA clients with SPMI.	5.46	0.09	0.65	0.11

Note: Results in bold are significant at the $p<0.05$ level.

Key takeaways:

- For the rate of encounters per 1,000 member months for service coordination among FFCC and MBCC, there was no evidence of changes due to the transition to MMC. This finding does not support hypothesis 3.2.
- For the rate of encounters per 1,000 member months for service coordination among NF, there was an initial and minimal decrease in level that was statistically significant, but no change in slope/trend. This finding does not support hypothesis 3.2.
- For clients who have SPMI, the rate (i.e., percentage) of targeted case management did not change among PCA clients. For AA clients, there was a statistically significant increase in level post MMC, but not the slope/trend. For FFCC clients, there was a statistically significant, minimal decrease in level, but no change in slope. These findings are mixed with respect to hypothesis 3.2.

QUALITY OF CARE

Hypothesis 3.3 Quality of care will improve among clients whose Medicaid benefits shift from FFS to a MMC health care delivery model.

The claims analysis is pending.

In addition to the claim analysis, the NFQR survey was used to examine behavior modification in clients whose Medicaid benefits shifted from FFS to an MMC health care delivery model (measure 3.3.4). Specifically, the NFQR survey was used to examine the percentage of NF clients on psychotropic medications with behavior modifications in their care plan. The two survey questions examined, included:

1) Is there an active prescription for any psychoactive medication (including antipsychotics/neuroleptics, anti-anxiety agents, antidepressants, sedative/hypnotics or psychomotor stimulants), on a routine and/or as needed basis?
2) Does the resident's care plan include behavior modification interventions, addressing the specific behaviors for which psychoactive medications were prescribed?

The questions to examine psychotropic medications use were not added until 2015; thus, only post MMC implementation data is reported. The 2015 NFQR survey found that 78.4% of NF clients had an active prescription for psychoactive medications with behavior modifications included in their care plan.

HEALTH AND HEALTH CARE OUTCOMES

Hypothesis 3.4 Health and health care outcomes will improve among clients whose Medicaid benefits shift from FFS to a MMC health care delivery model.

Initially, FFS claims and MMC encounter data were used to examine the impact of the implementation of MMC on health and health care outcomes (measures 3.4.1 and 3.4.2). ITS models were constructed to examine the impact on tooth decay and cavities in children and pressure ulcers in the NF population.

Figure C.4.1 displays the percentage of children ages 0-20 years who had tooth decay or cavities during the measurement period. Post-MMC implementation there were statistically significant changes in the level and slope/trend. The percentage level dropped and the slope changed direction from increasing pre-MMC to decreasing post-MMC.

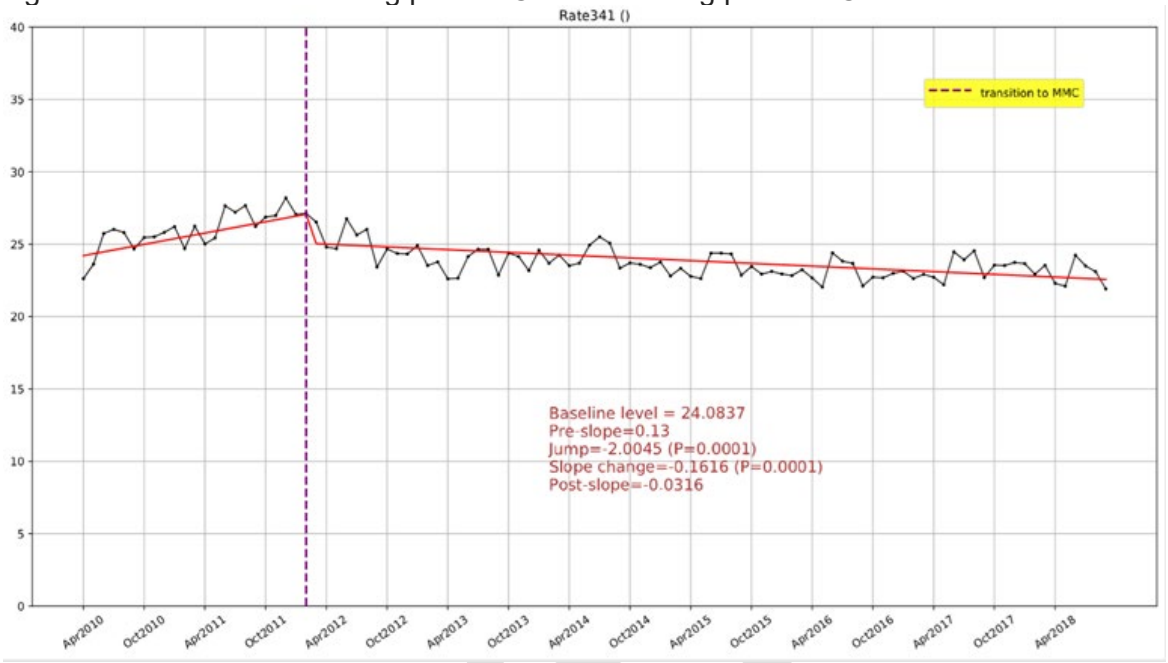


Figure C.4.1. Percentage of children, ages 0-20 years, who have had tooth decay or cavities during the measurement period (CMS Core Child Measure) (Measure 3.4.1)

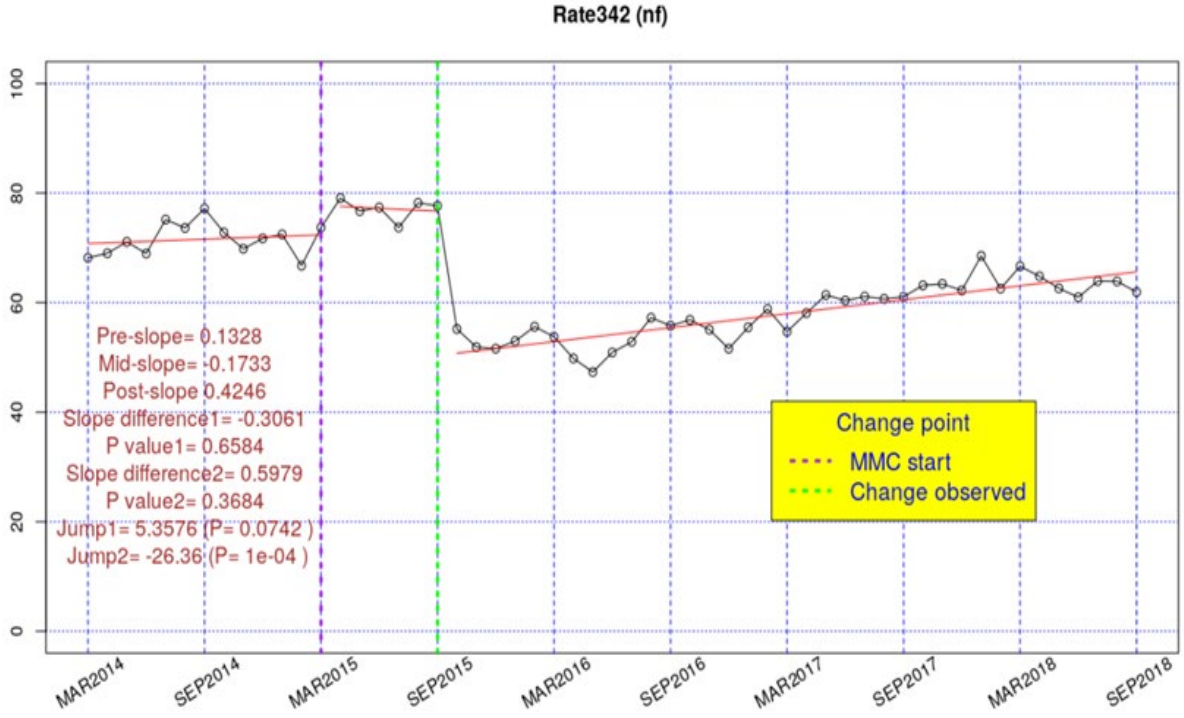


Figure C.4.2. Rate (number of pressure ulcers/1,000 member months) of pressure ulcers among NF clients (Measure 3.4.2)

Table C.4.1 presents a summary of the ITS findings for hypothesis 3.4. Statistics are presented for the baseline level, the slope/trend values pre and post MMC, and level changes post-MMC implementation.

Table C.4.1. Summary of ITS results for Hypothesis 3.4

Measure	Baseline Value	Pre MMC Trend	Post MMC Level Change I	Post MMC Trend I	Post MMC Level Change II	Post MMC Trend II
3.4.1: Percentage of children, ages 0-20 years, who have had tooth decay or cavities during the measurement period.	24.08	0.13	**-2.00**	**-0.03**	n/a	n/a
3.4.2: Rate of pressure (number of pressure ulcers/1,000 member months) ulcers among NF clients.	70.6451	0.13	**5.36**	-0.17	**-26.36**	0.42

Note: Results in bold are significant at the p<0.05 level.

Key takeaways:

- For the percentage of child clients who had tooth decay, the slope/trend was increasing pre-MMC, and post-MMC the slope/trend changed direction to decreasing (statistically significant). There was also a statistically significant decrease in level. This finding corroborates the pattern observed for 3.1.1 where a pattern of increased preventive dental care visits was observed. This finding supports hypothesis 3.4.1.
- For the rate of pressure ulcers per 1,000 member months, there was a level decrease post-MMC that was statistically significant, but this decrease was observed approximately 5 to 6 months after MMC implementation. There was no change in the increasing slope/trend pre-MMC to post-MMC. This finding provides some support for hypothesis 3.4.2.

In addition to the claim analysis, the NFQR survey was used to examine health and health care outcomes following the shift from FFS to a MMC health care delivery model (Measure 3.4.3). The NFQR survey examined NF residents with improvements in depressive symptoms with treatments by exploring the percentage of clients diagnosed with depression who reported improvement with treatment. The NFQR survey questions examined, included:

1) Has the resident been diagnosed with a depressive disorder (major depression, clinical depression, bipolar disorder, seasonal-affective disorder or dysthymia)?
2) What type of treatment is the resident receiving for depression?
3) Does the chart indicate that the resident has responded to treatment?

The questions to examine depression were not added until 2010. Overall on average the NFQR survey found that 60% of NF clients with depression reported an improvement with treatment. The percentage has been increasing since 2010, from 48% to 72.6% in 2015 (see Figure C.4.3).

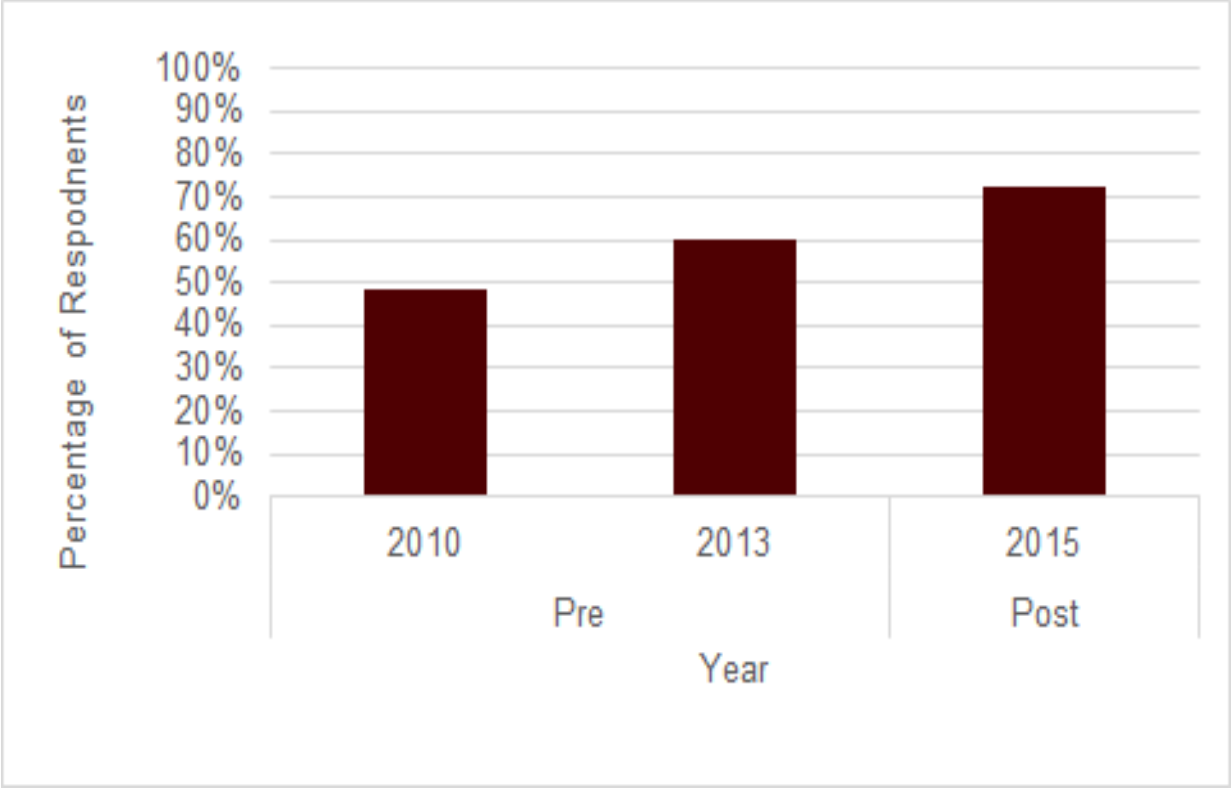


Figure C.4.3. Nursing Facility Quality Review (NFQR) Reported Percentage of NF Clients with Depression with an Improvement with Treatment, by Survey Year (Measure 3.4.3)

CLIENT SATISFACTION

Hypothesis 3.5 Client satisfaction will improve among clients whose Medicaid benefits shift from FFS to a MMC health care delivery model.

Hypothesis 3.5 was answered using NFQR and CAHPS surveys. The NFQR survey was used to examine client satisfaction with the nursing facility population through four survey questions (Measure 3.5.1). The questions included:

1. Overall, how satisfied are you with your (or your family member's) experience in this nursing facility?

Figure C.5.1. below displays the responses by survey year. Overall the average percentage of respondents who reported being satisfied with their experience in the nursing facility was 89.4% which was consistent over time. There was no difference between pre- and post-MMC implementation.

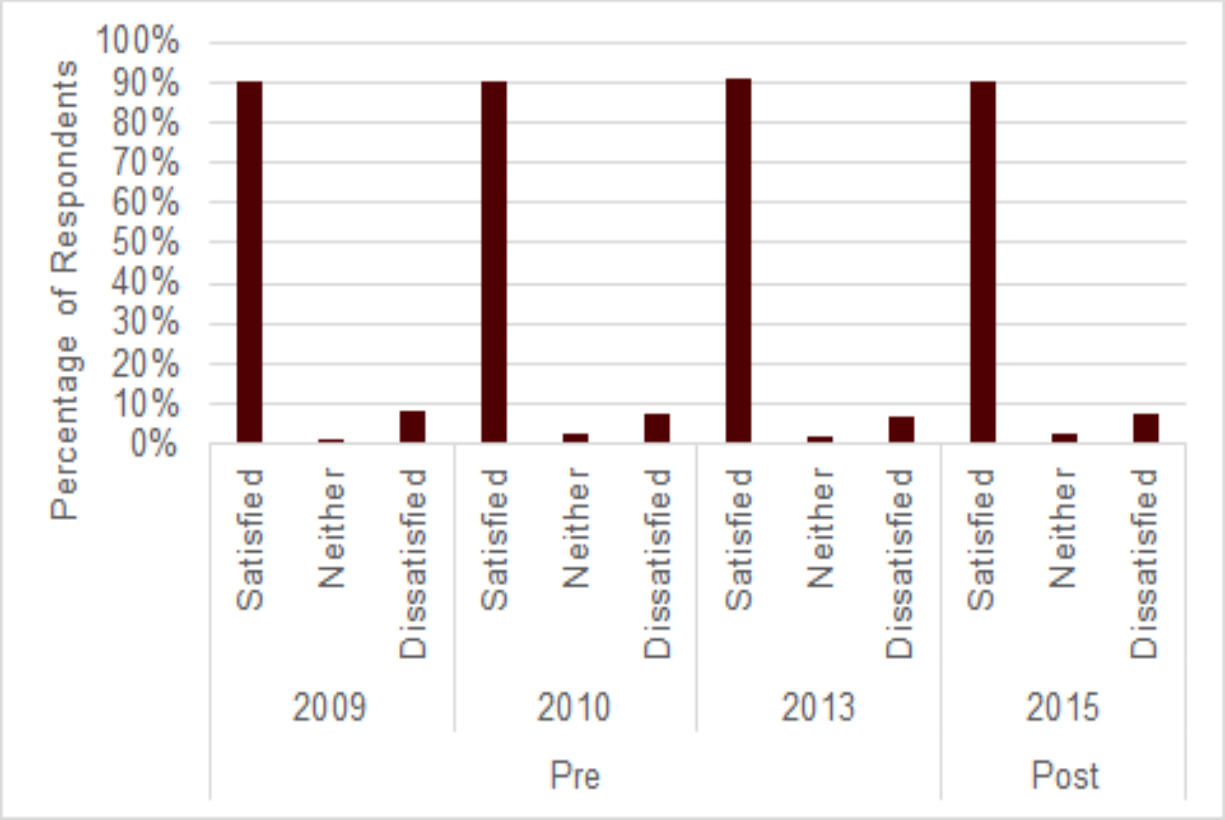


Figure C.5.1. Nursing Facility Quality Review (NFQR) Reported Satisfaction with Experience in Nursing Facility, by Survey Year (Measure 3.5.1)

2. Overall, how satisfied are you with your (or your family member's) health care services?

Figure C.5.2. below displays the responses by survey year. Overall the average percentage of respondents who reported being satisfied with their (or their family member's) health care services was 90.2% which was overall consistent. The highest percentage reported was in 2013 with 90.9% of respondents. There was a slight difference between pre- and post-MMC implementation, 90.3% vs. 89.4%, respectively.

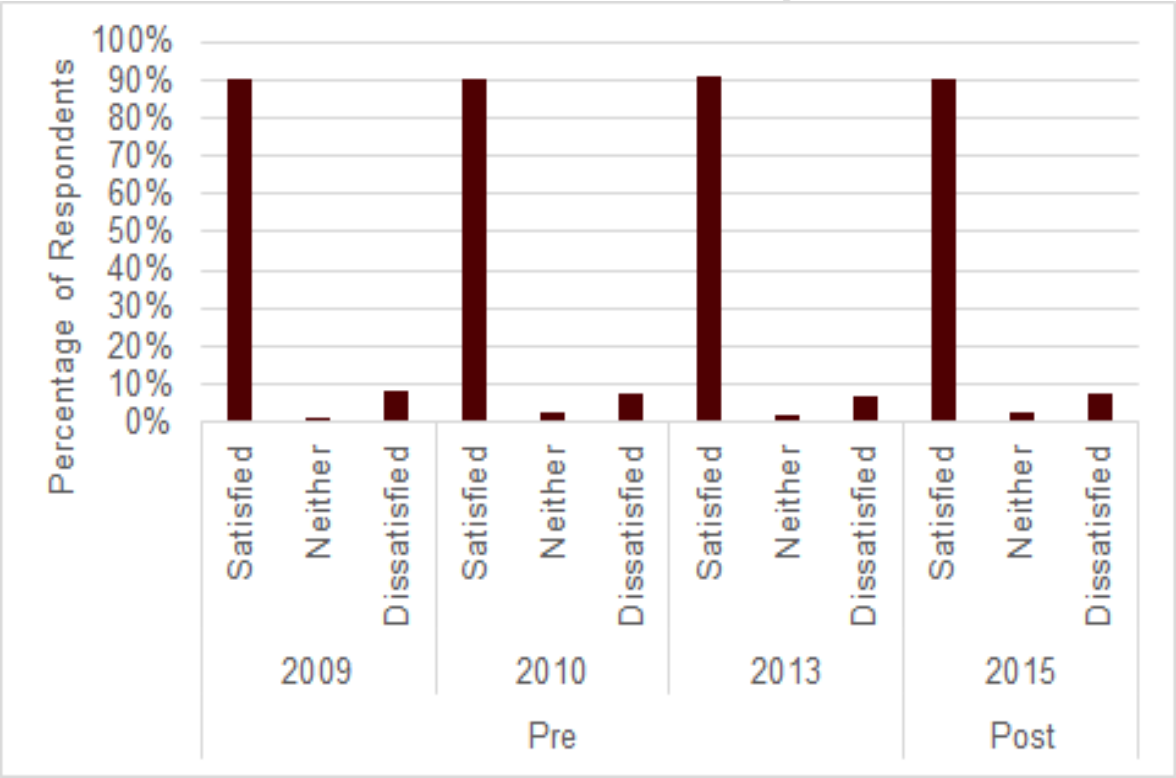


Figure C.5.2. Nursing Facility Quality Review (NFQR) Reported Satisfaction with Health Care Services Received, by Survey Year (Measure 3.5.1)

3. Do you ever have concerns that the facility does not address?

   Figure C.5.3. below displays the responses by survey year. Overall the average percentage of respondents who reported having concerns that the facility did not address was 15.4%. There was a slight difference between pre- and post-MMC implementation, 13.8% vs 20.2%, respectively.

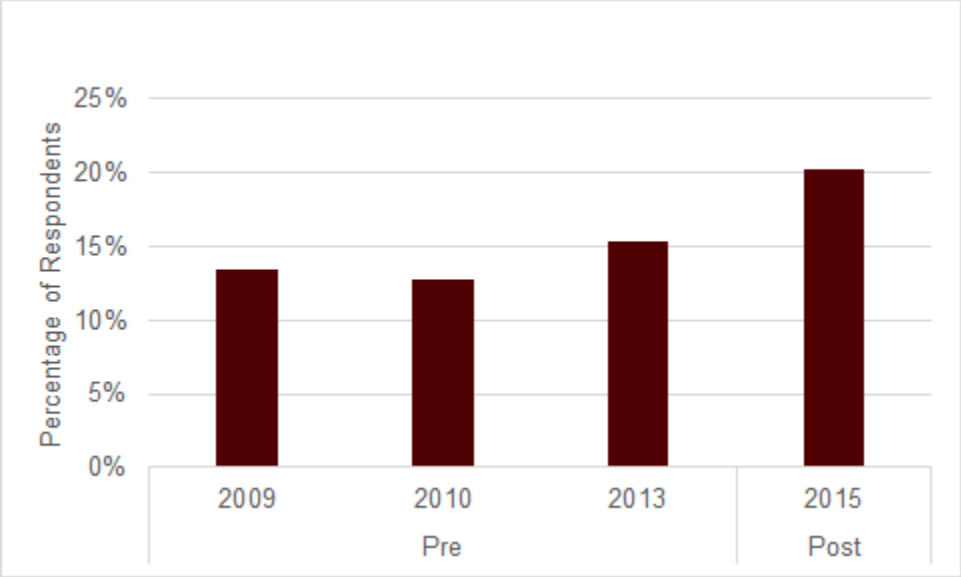


Figure C.5.3. Nursing Facility Quality Review (NFQR) Reported Percentage of Clients with Concerns the Facility Did not Address, by Survey Year (Measure 3.5.1)

4. Do you participate in meetings for planning your care?

   Figure C.5.4. below displays the responses for 2015 the only year the survey question was asked. Overall almost 19% of respondents reported always or most of the time participating in meetings for planning their care.

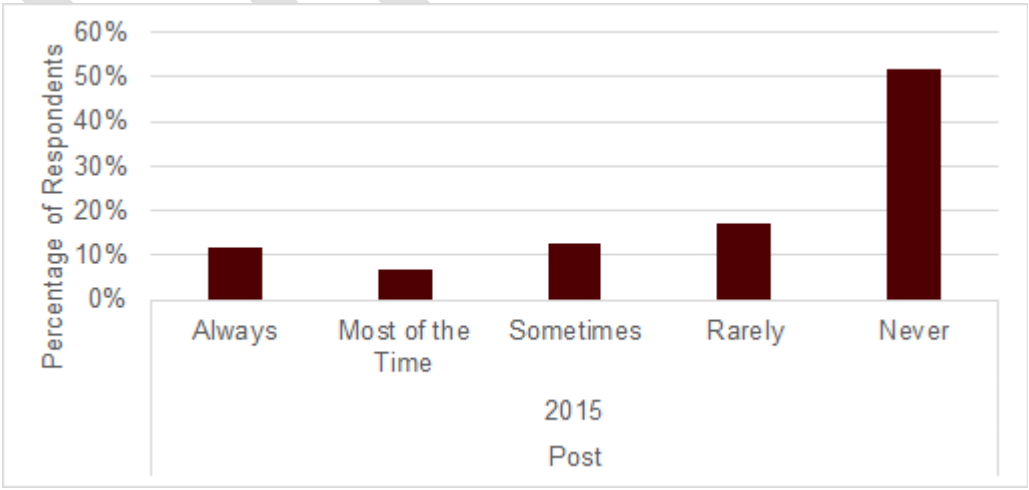


Figure C.5.4. Nursing Facility Quality Review (NFQR) Reported Participation in Care Plan Meetings, 2015 (Measure 3.5.1)

Next, the CAHPS Health Plan Survey was utilized to examine client satisfaction (Measure 3.5.2). At this time, only results from the 2019 CAHPS Health Plan Survey-Child were available. The 2020 CAHPS Health Plan Survey-Adult will be presented in the interim report. Client satisfaction was examined based on responses to "Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your child's health plan?". Overall 75% of the PCA population surveyed and 67% of the AA population surveyed rated their health plan as 9 to 10 (see Figure C.5.5.). The AA population had a higher percentage of respondents report ratings from 0 to 6, 14% vs 6%, respectively.

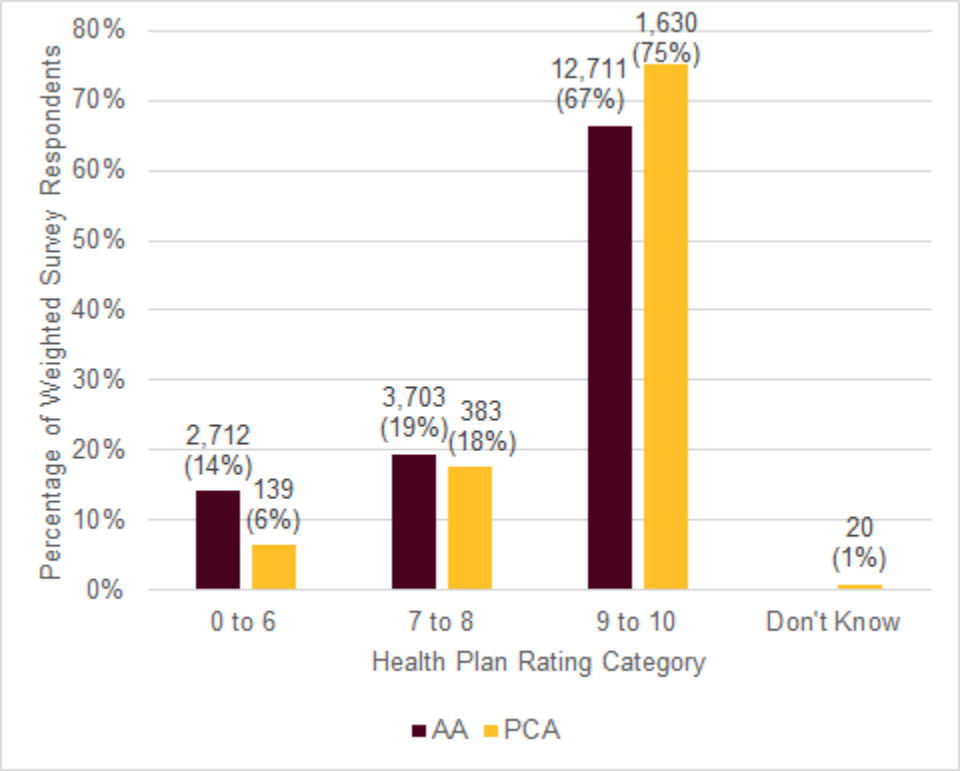


Figure C.5.5. Consumer Assessment of Healthcare Providers and System (CAHPS) Health Plan Rating by Population (Measure 3.5.2)

Key takeaways:

- The NFQR survey found:
  - Consistent percentages of survey respondents were satisfied with their experience in the nursing facility and health care services received pre- and post-MMC implementation.
  - A slightly higher percentage of survey respondents reported having concerns in the one post-demonstration available compared to pre-demonstration surveys.
  - Almost 19% of survey respondents reported participating in care plan meetings; unfortunately, there is no pre-data available to determine the impacts.
- The CAHPS survey demonstrated that a majority of those that completed the CAHPS Health Plan Survey-Child rated their health plan in the highest category. The survey was not conducted until 2019; thus, we are unable to make comparisons pre- and post- MMC implementation. There were slight differences between reported health plan ratings among AA and PCA populations.

SUMMARY OF EARLY RESULTS FROM THE MMC EVALUATION

Evaluation Question 3: Did the expansion of the MMC health care delivery model to additional populations and services improve healthcare (including access to care, care coordination, quality of care, and health outcomes) for MMC clients?

- The full impact of the expansion of MMC health care delivery model to additional populations and services cannot be fully examined until additional years of data are available
- Preliminary analysis provides some support for hypotheses:
    - 3.1: Access to care will improve among clients whose Medicaid benefits shift from FFS to MMC health care delivery model.
    - 3.4: Quality of care will improve among clients whose Medicaid benefits shift from FFS to an MMC health care delivery model.

D. OVERALL

ALTERNATIVE PAYMENT MODELS (APM)

Evaluation Question 4: Did the Demonstration impact the development and implementation of quality-based payment systems in Texas Medicaid?

The DSRIP program in the Texas Healthcare Transformation and Quality Improvement Program Medicaid 1115 Demonstration (Waiver) ran from 2012 sunsetting in September 2022. From there on out, managed care organizations (MCOs) and DSRIP providers will be required to move toward alternative payment models (APMs). Hence, it remains imperative to evaluate APMs throughout the Medicaid Program in Texas.

Development and Implementation of APMs

Hypothesis 4.1.1 The Demonstration will result in the development and/or implementation of a variety of APMs in Texas Medicaid.

We answered this question using Category A reporting data.

We described the pooled Category A reporting data for DY7 (2018) and DY8 (2019) through:

- Percentage of providers that have APMs
    - For Overall Texas
    - Per RHP
- Percentage of types of APM/value-based payment (VBP) arrangements for each DY
- Percentage of providers with types of APM framework for each DY

Results

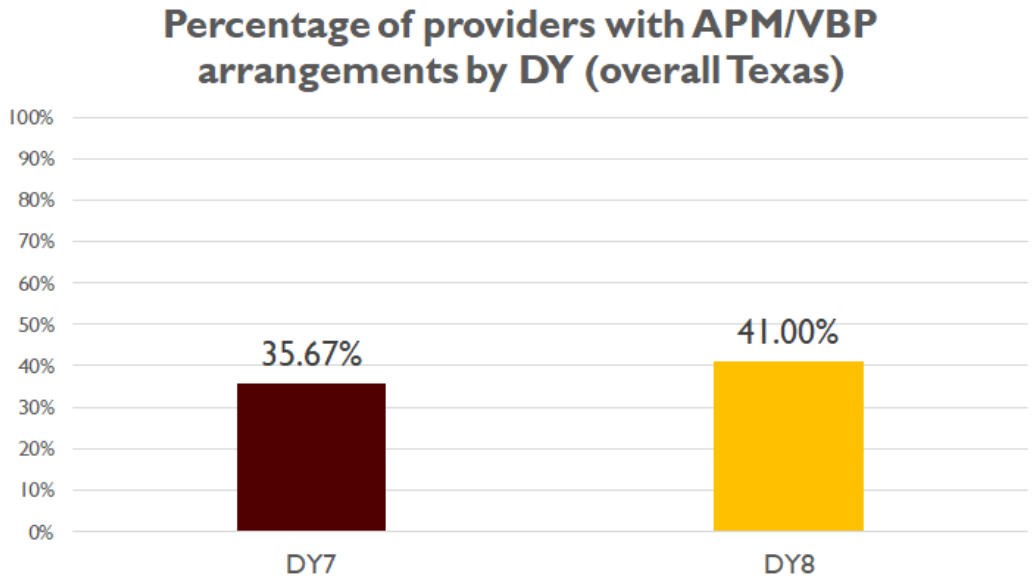


Figure D.1.1. Percentage of providers that have APMs (overall Texas)

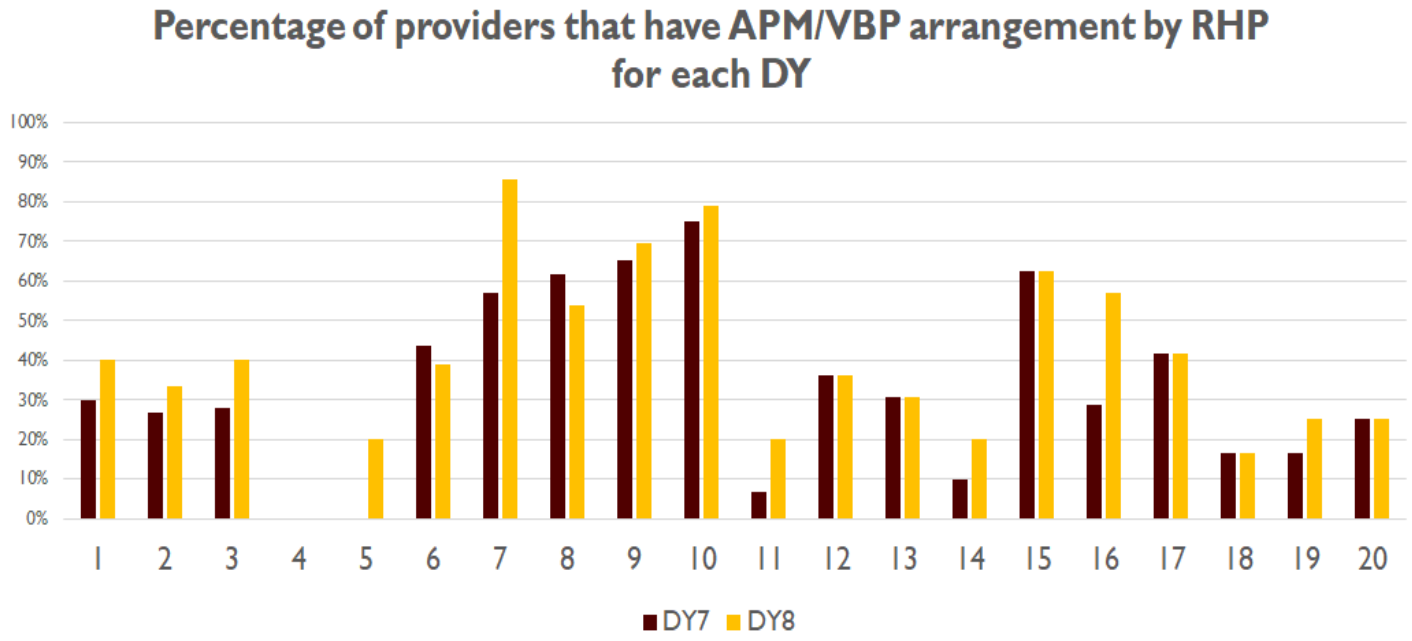


Figure D.1.2. Percentage of providers that have APMs (per RHP)

We divided the types of APM/VBP arrangements based on APM framework by the Health Care Payment Learning & Action Network (LAN) into the 4 categories shown in the figure D.1.3 below:

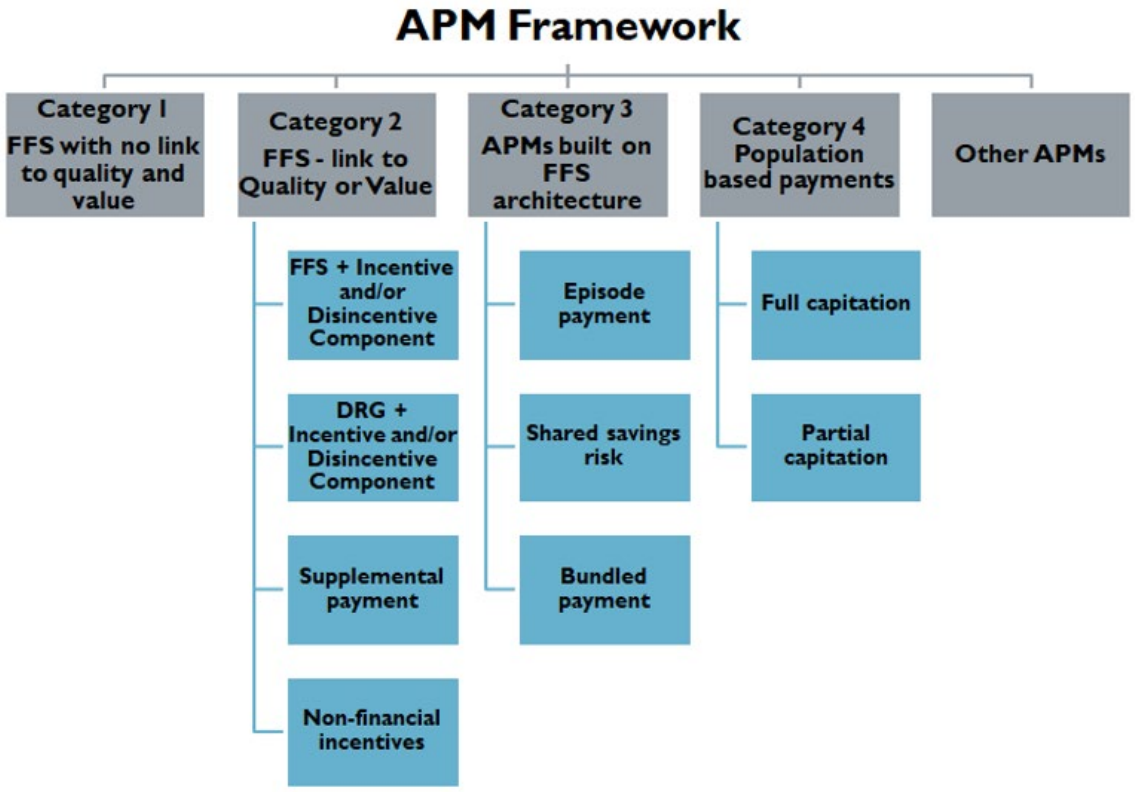


Figure D.1.3. APM framework.

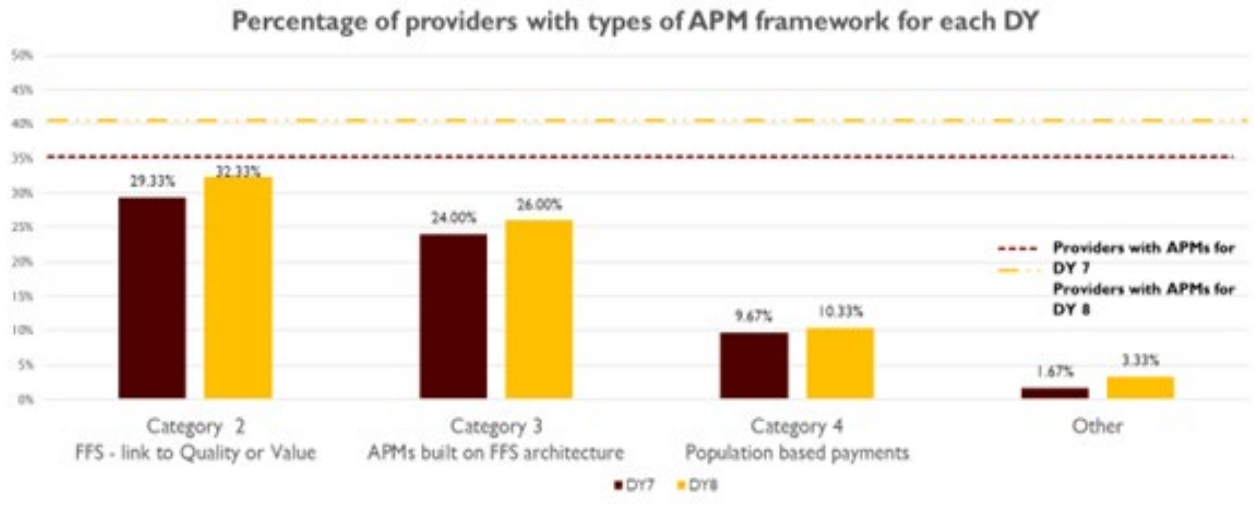


Figure D.1.4. Percentage of providers with types of APM framework for each DY

Barriers and benefits to developing and/or implementing APMs

Hypothesis 4.1.2 Perceived barriers to developing and/or implementing alternative payment models

Hypothesis 4.1.3 Perceived benefits to developing and/or implementing alternative payment models

Hypothesis 4.1.2 and 4.1.3 primarily used the APM section of the DSRIP wave 1 data (June 2020). The main analytical approach used was descriptive statistics for Likert scale questions and content analysis for the open-ended questions on benefits and challenges of APMs. Likert scale was 1 for strongly disagree and 5 for strongly agree.

Results

We received a total of 229 responses. Below are the graphs for mean scores by RHP with overall Texas average for the likert scale questions.

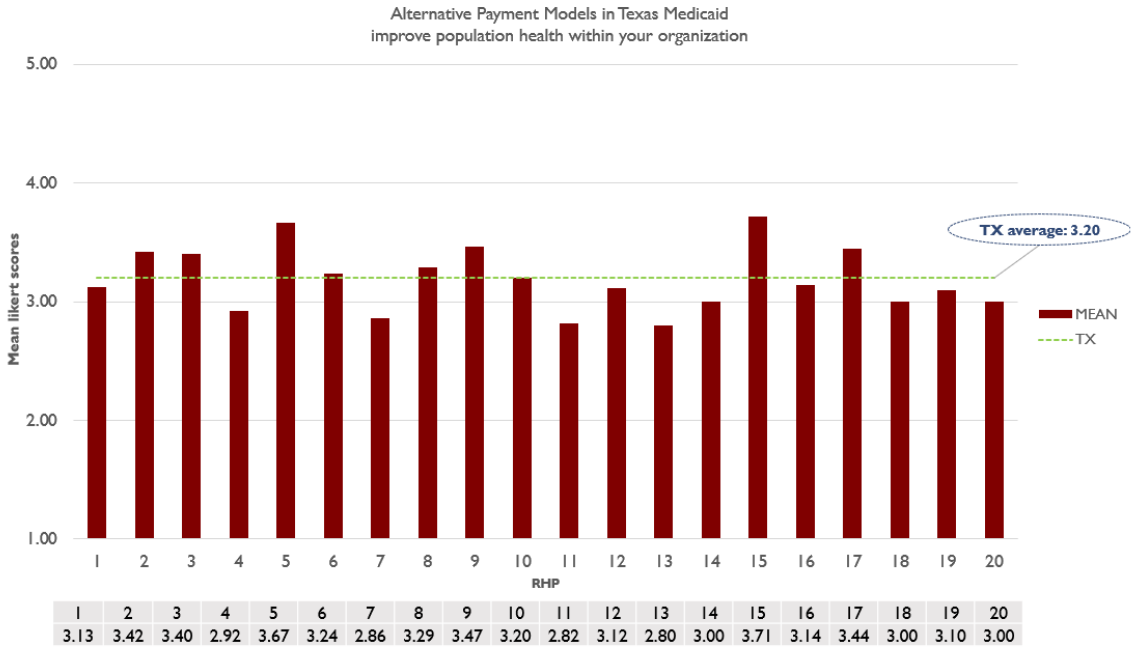


Figure D.1.5. Mean Likert Scores for APMs in Texas Medicaid improving population health within organizations

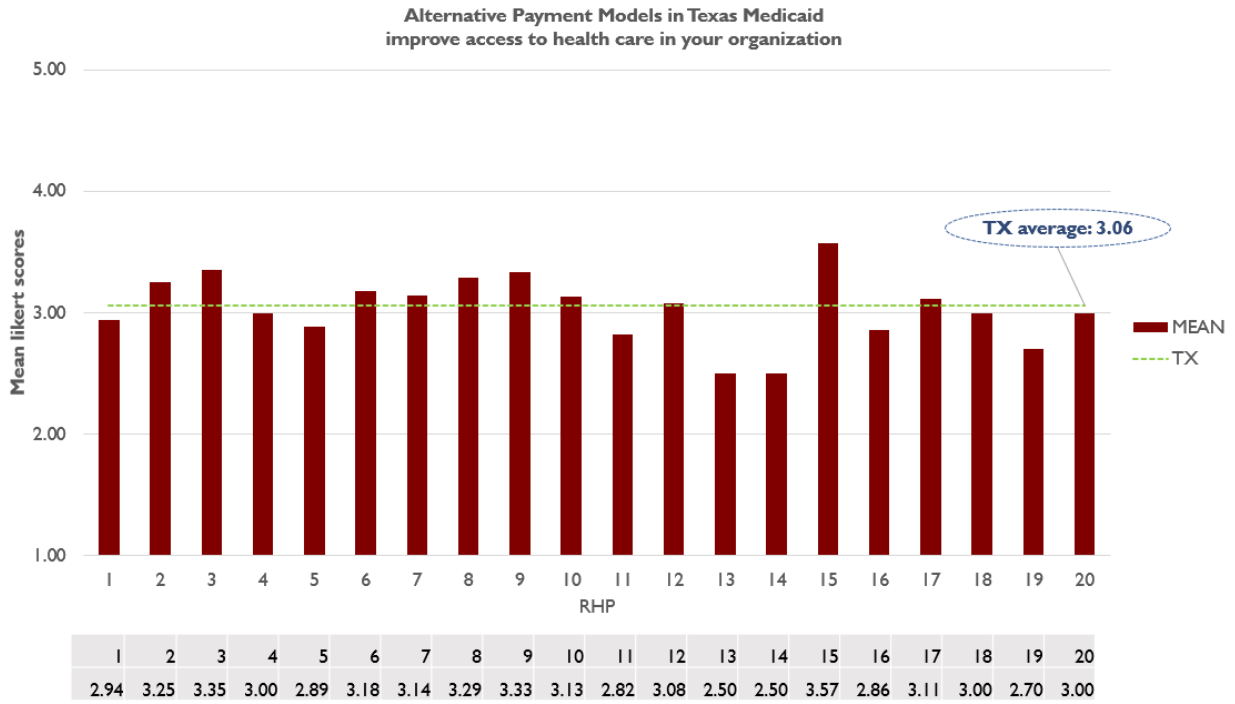


Figure D.1.6. Mean Likert Scores for APMs improving access within organizations

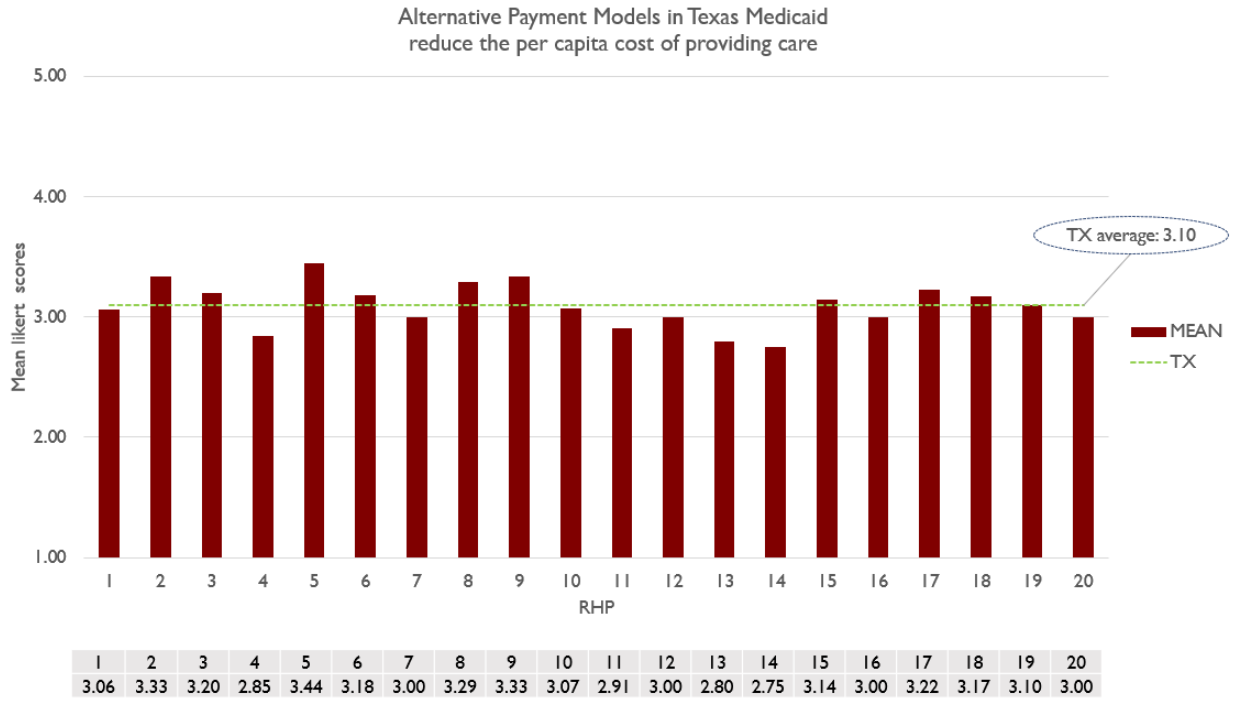


Figure D.1.7. Mean Likert Scores for APMs in Texas Medicaid reducing per capita cost of providing care within organizations

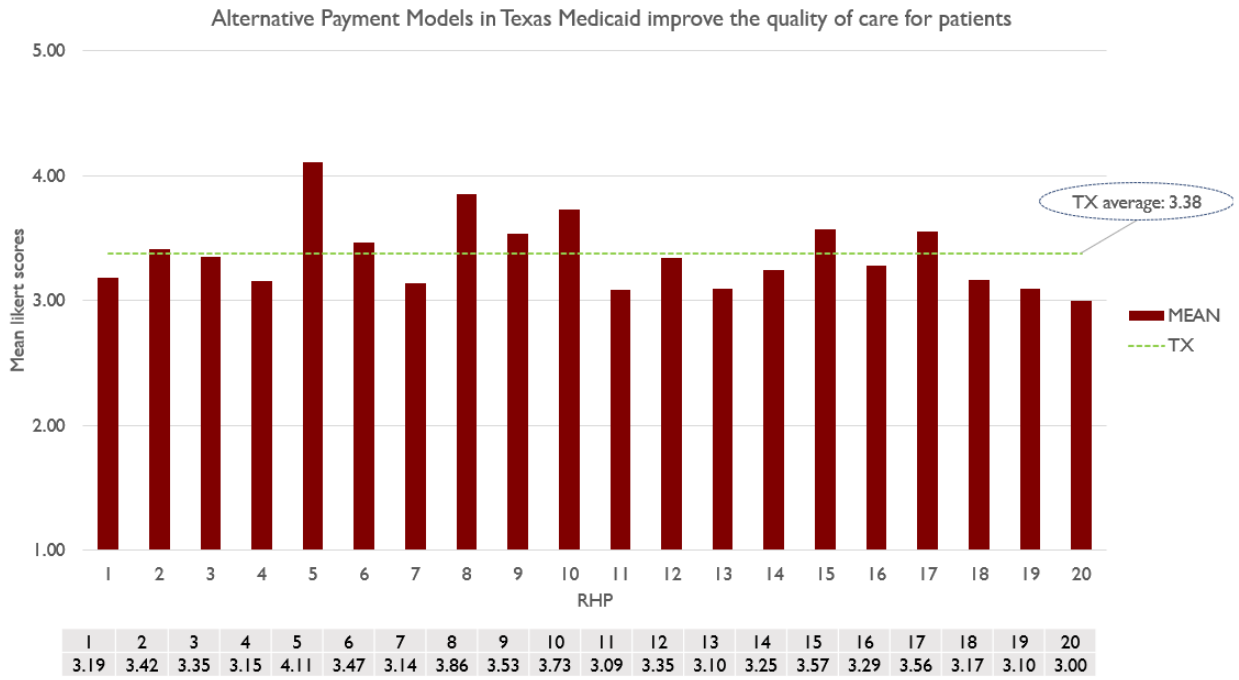


Figure D.1.8. Mean Likert Scores for APMs in Texas Medicaid improving quality of care for patients

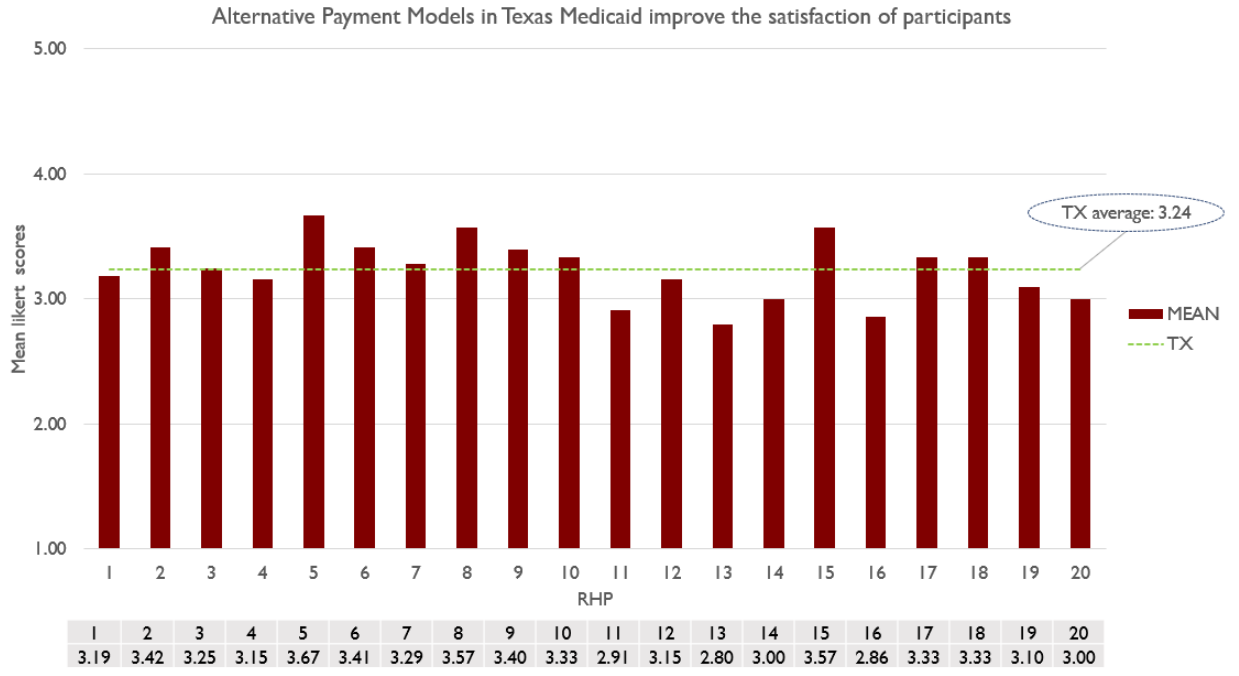


Figure D.1.9. Mean Likert Scores for APMs in Texas Medicaid improving satisfaction of participants

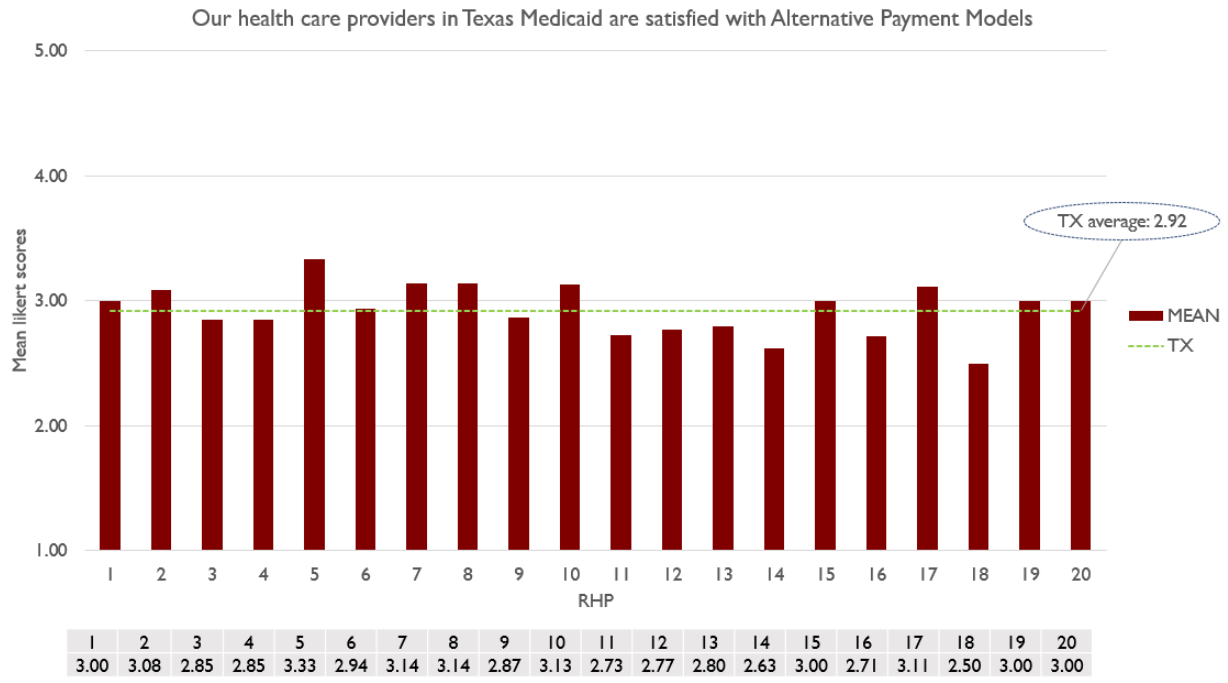


Figure D.1.10. Mean Likert Scores for provider satisfaction with APMs in Texas Medicaid

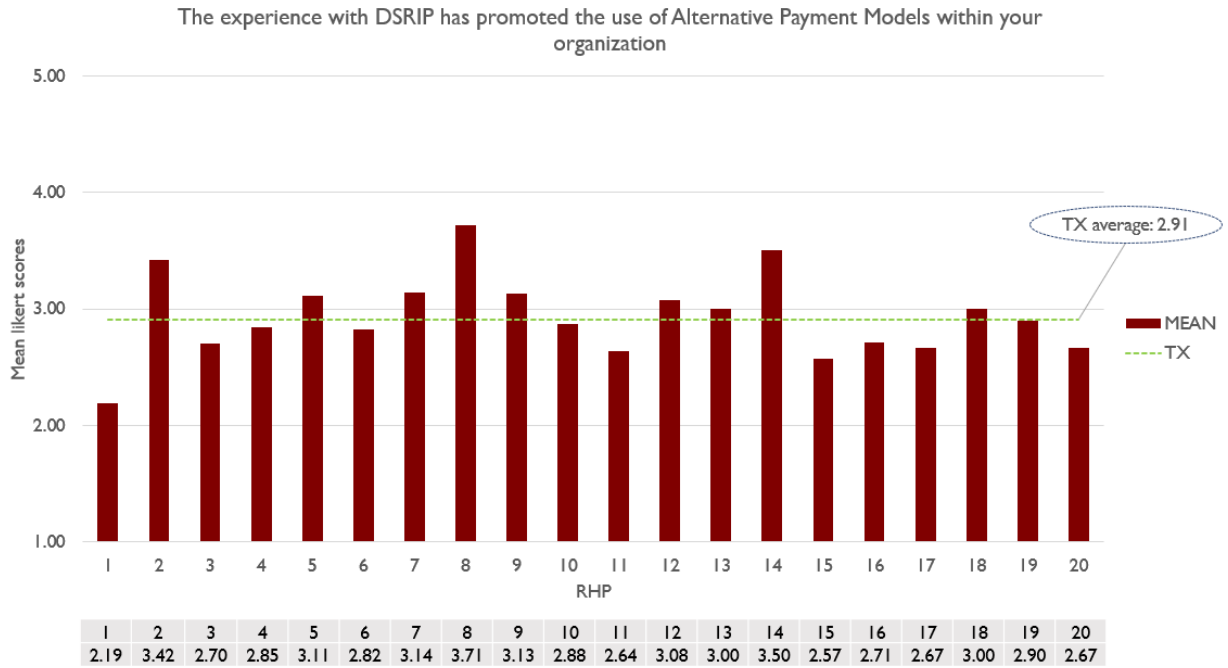


Figure D.1.11. Mean Likert Scores for DSRIP promoting use of APMs within organizations

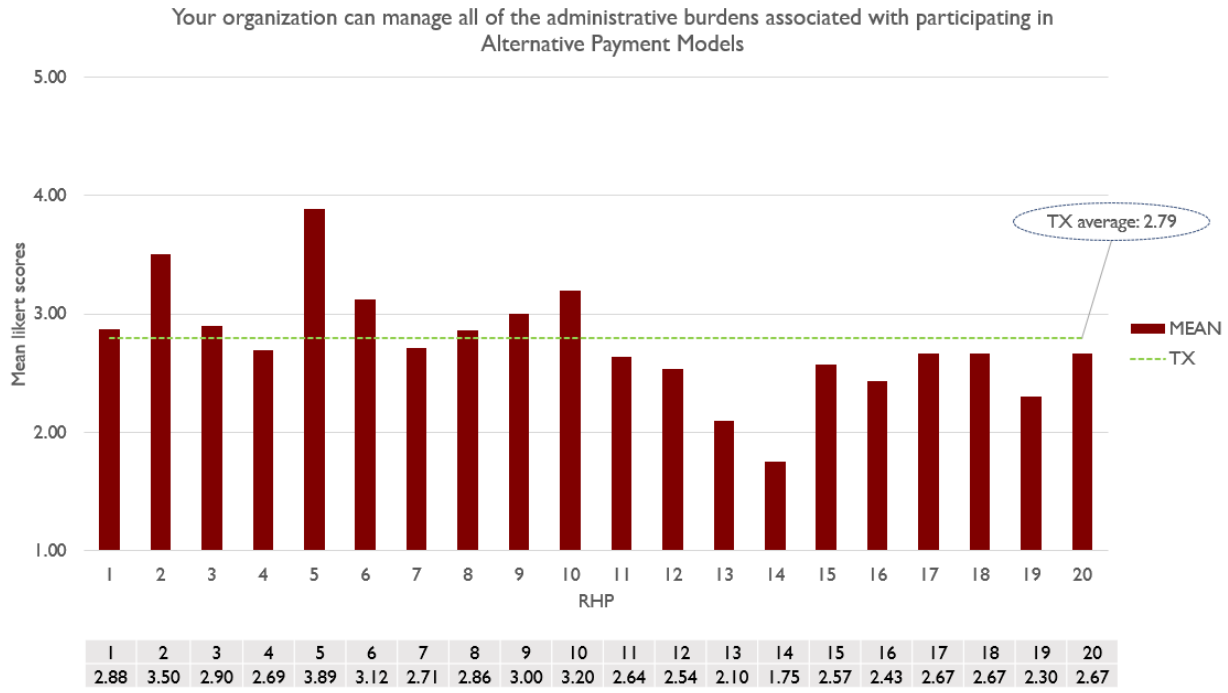


Figure D.1.12. Mean Likert Scores for organizations being able to manage all of the administrative burden associated with participating in APMs

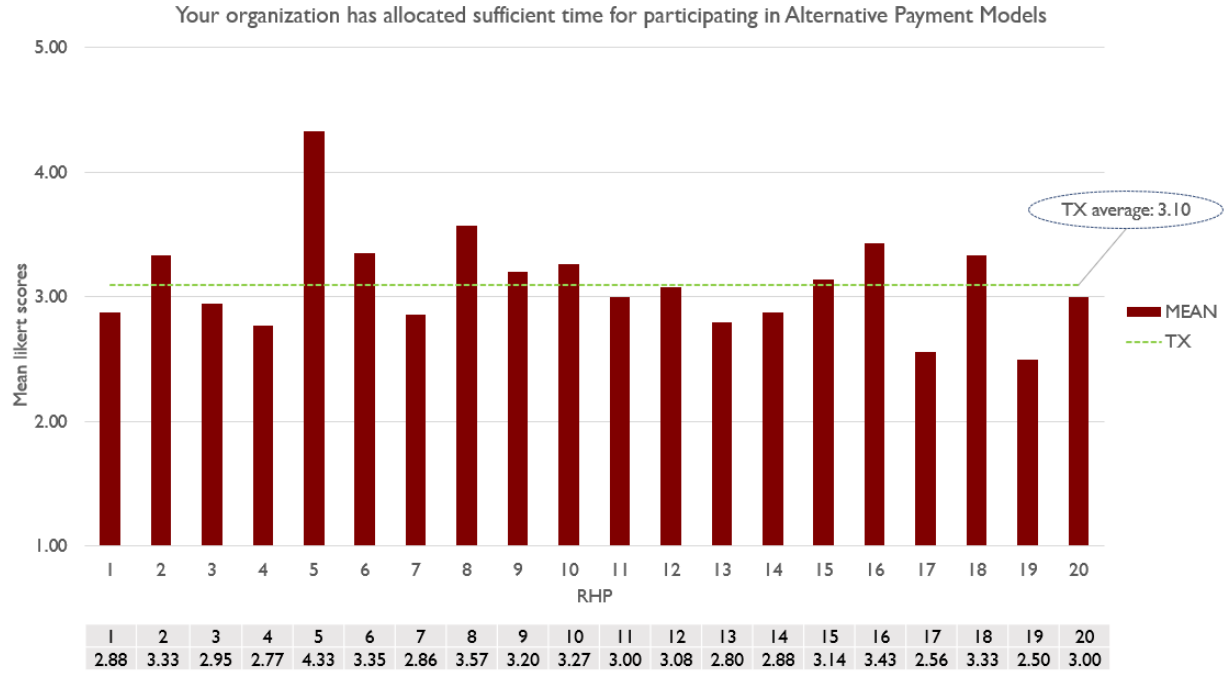


Figure D.1.13. Mean Likert Scores for organizations being able to allocate sufficient time for participating in APMs

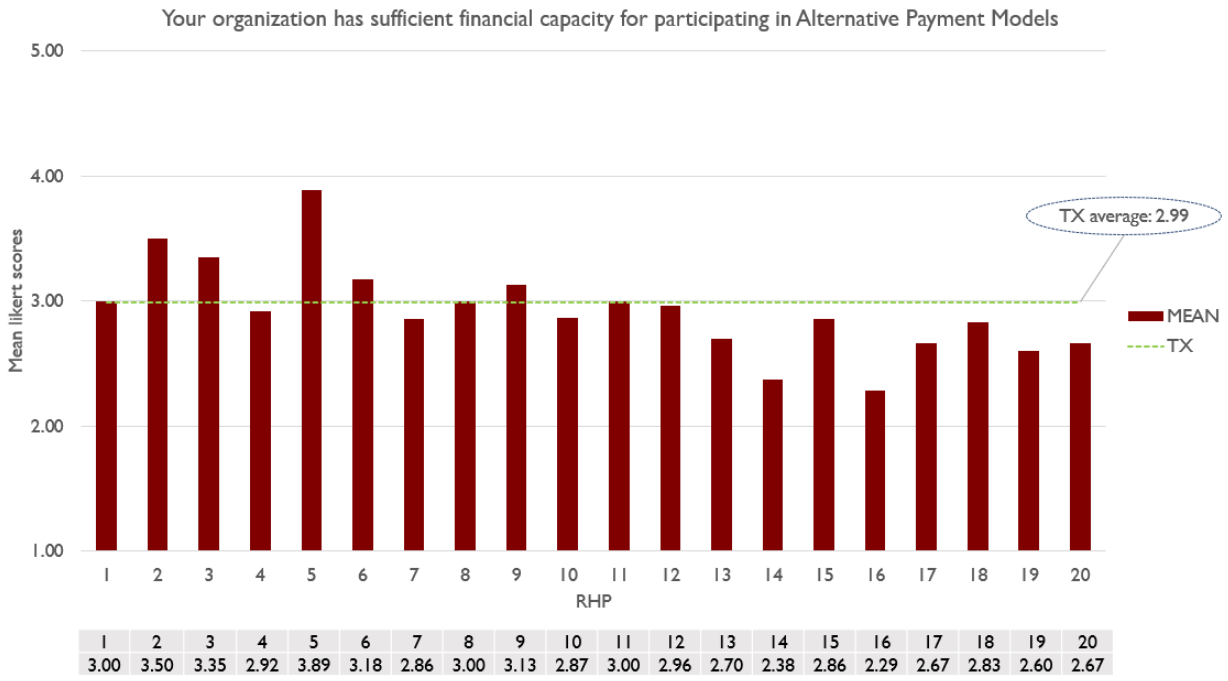


Figure D.1.14. Mean Likert Scores for organizations having sufficient financial capacity for participating in APMs

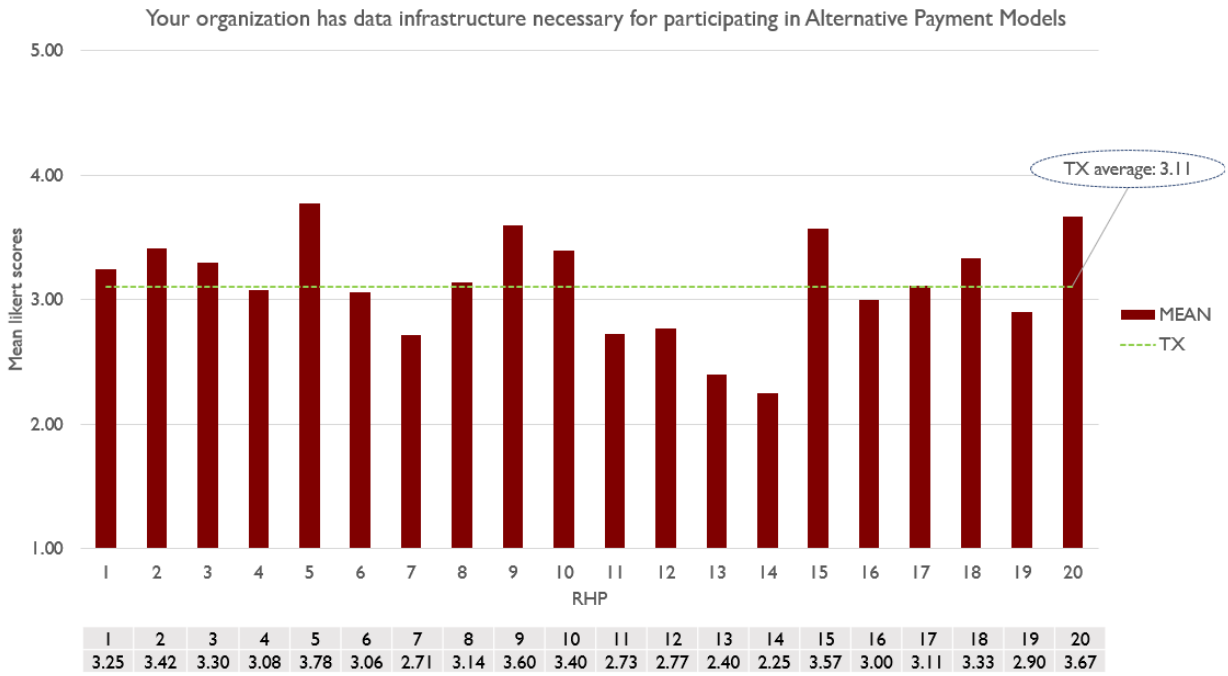


Figure D.1.15. Mean Likert Scores for organizations having data infrastructure necessary for participating in APMs

Content Analysis

Below are the results of content analysis of the open-ended questions to assess the perceived benefits and barriers to participating in Alternative Payment Model Initiatives.

Main themes for perceived benefits were financial efficiency, data sharing, quality of care, collaboration and care coordination are summarized in Table D.1.1

Table D.1.1. Main themes and quotes for perceived benefits to developing and/or implementing APMs

Themes	Quotes
Financial efficiency	"Participation in APMs have resulted in some increased revenue for the organization.."
Data sharing	"Finally, data sharing is a critical ingredient in the success for APMs. BTCS has recently seen an increased willingness from the MCOs to implement data sharing processes. Some MCOs are more advanced, having a more robust ability to share timely data reports. BTCS has also been able to grow the data sharing capacities through the implementation of Care Coordination, which has been incorporated into some of the APM agreements..."
Quality of care	"Benefits for alternative payment model participation include improved quality of patient care…"
Collaboration	"One of the benefits we have noted in participation in APMs is a better sharing of client data between Burke and the MCO. We have also been able to develop a more collaborative relationship with the MCOs, and have been able to demonstrate the value that Burke provides to the MCOs members.."
Care coordination	"Alternative arrangements have allowed Integral Care to invest in the areas demonstrably better for the client such as care coordination."

Main themes for perceived barriers were lack of MCO engagement, administrative burden, low volume setting, small organization, rurality, non-uniformity of quality/performance measures, and financial burden are described in Table D. 1.2.

Table D.1.2. Main themes and quotes for perceived barriers to developing and/or implementing APMs

Themes	Quotes
Lack of MCO engagement	"MCOs have not been very willing and open partners to this - they struggle to share data in a timely and meaningful way. It took over a year to come to an agreement, get data sources identified and vetted and then the payout was not all that significant.." "MCO's have not been willing to work due to the low volume of patients that we serve who receive Medicaid."
Administrative burden	"Challenges for alternative payment model participation include increased administrative burden regarding documentation and reporting…"
Low volume setting	"Organization is a small rural critical access hospital. Small volumes make it difficult to adopt APMs."

Small organization	"We are a small non-profit with very limited administrative bandwidth.."
	"As a smaller entity we don't have the resources.."
Rurality	"When a provider such as a small rural hospital does not have the depth of patients in any one insurance provider, participating in an APM would be tremendously risky financially."
Non-uniformity of quality/performance measures	"A major challenge faced by entering into VBP arrangements is the disparity in performance measurement criteria from different payers, which may not align with an organizations quality goals or governmental performance criteria. Tracking multiple quality metrics in a meaningful way places a heavy burden on a health system's resources."
Financial burden	"While we have definitely achieved success, it has been difficult to sustain positive performance and we continue to leave significant dollars on the table."

Tentative Results & Observations:

- Percentage of providers with APM/VBP arrangements in Texas increased from 35.67% in DY7 to 41.00% in DY8
- Most RHPs showed an increase in APM/VBP arrangements with the exception of RHP 4, 6, and 8.
- Through the APM section of the DSRIP wave 1 survey, we found that most organizations had neutral responses about how APMs improved access, population health, reduced costs, improved quality of care and satisfaction for participants.
- We also found that the organizations slightly disagreed that providers were satisfied with APMs. They also slightly disagreed that DSRIP promoted the use of APMs and that APMs were an administrative burden.
- Through content analysis we explored the perceived benefits and barriers to participation in APMs.
    - Most organizations perceived financial efficiency as a benefit to participation in APMs.
    - Lack of MCO engagement was perceived as the top barrier to participation in APMs.

Evaluation Question 5: Did the Demonstration transform the health care system for the MLIU population in Texas?

Emergency Department (ED) Analysis use for the MLIU population

Hypothesis 5.1: The Demonstration will result in a reduction of potentially preventable ED use for the MLIU population.

HHSC will be submitting a revised Evaluation Design Plan to CMS with adjustments to Measure 5.1.1 (potentially preventable emergency department use). We have obtained 2018 data for a feasibility analysis that has been completed. We have submitted Texas DSHS IRB to obtain 2016, 2017, and 2019 data to conduct ITS. We expect to receive all data needed to complete this section by January 2020.

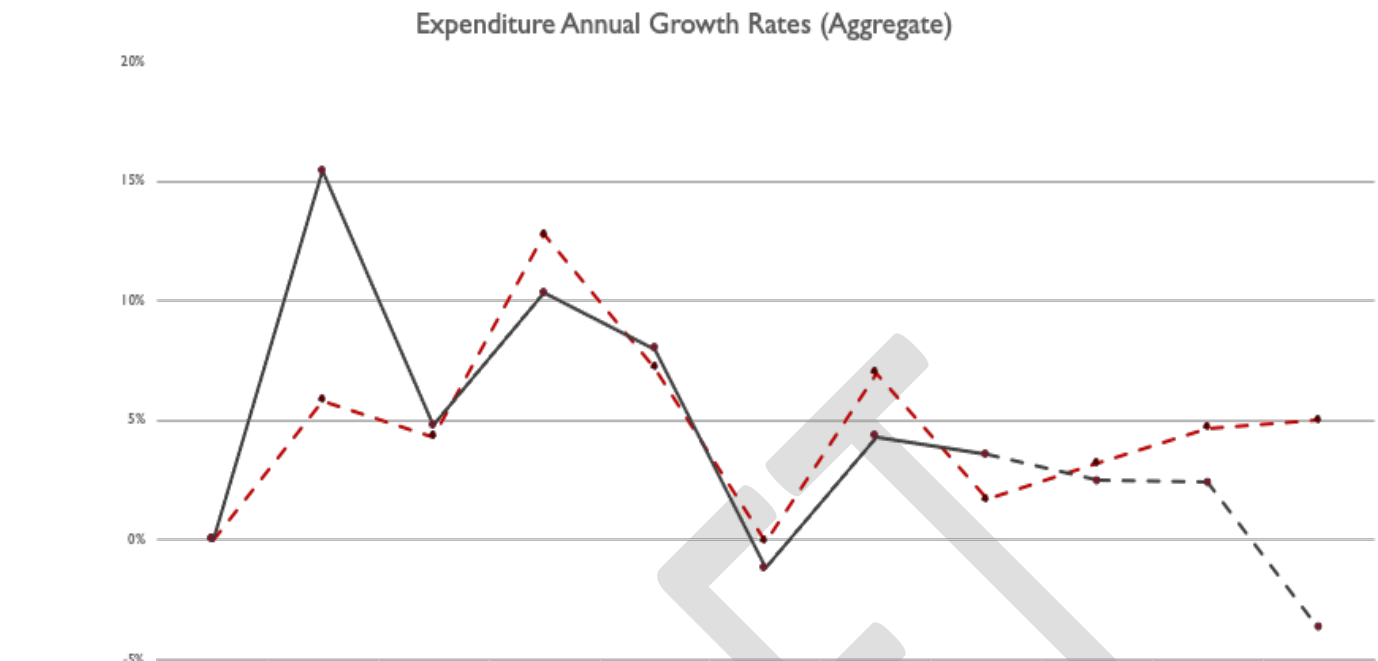
Budget Neutrality

Hypothesis 5.2: The Demonstration will result in overall cost savings compared to the Medicaid program without the Demonstration, as shown in the budget neutrality calculation.

HHSC provided the team with a Demonstration Budget Neutrality Worksheet which was used to examine annual growth rates pre- and post-demonstration (see figures D.2.2 and D.2.3).

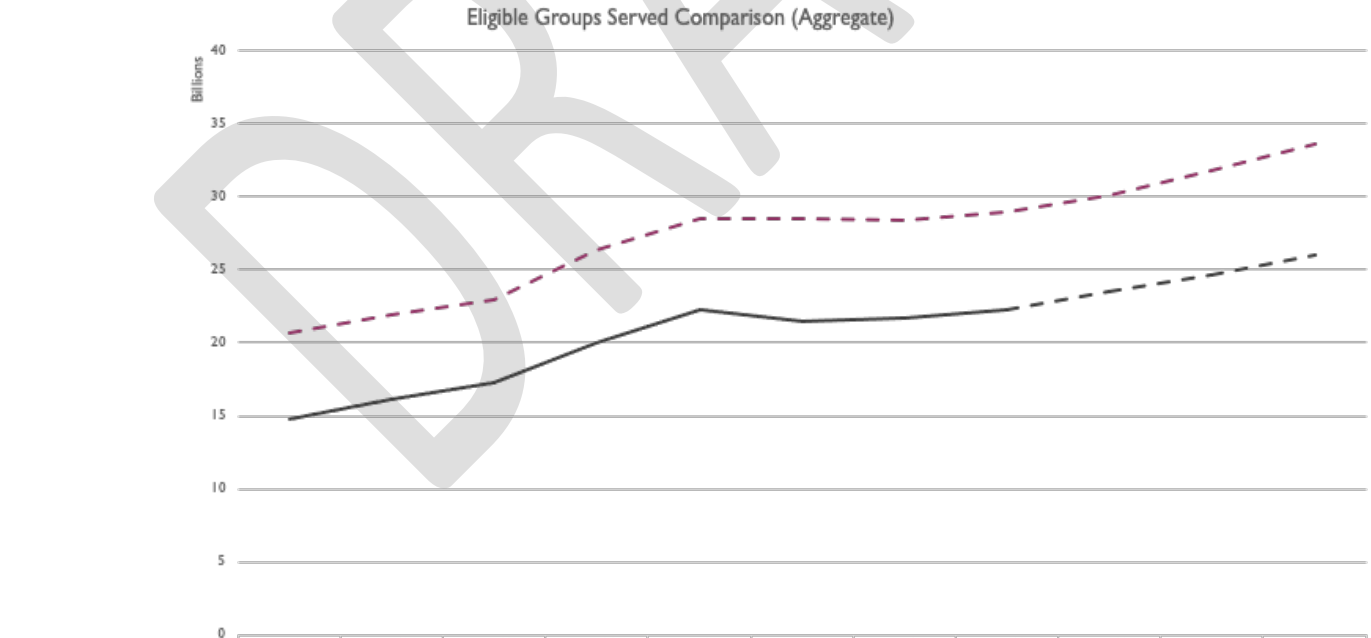
Tentative Results & Observations:

- The Demonstration has resulted in overall cost savings compared to the Medicaid program without the demonstration, as shown in the budget neutrality calculation.
- The projected spending also suggests that this trend in cost savings will continue.



	DY 01 (FFY 12)	DY 02 (FFY 13)	DY 03 (FFY 14)	DY 04 (FFY 15)	DY 05 (FFY 16)	DY 06 (FFY 17)	DY 07 (FFY 18)	DY 08 (FFY 19)	DY 09 (FFY 20)	DY 10 (FFY 21)	DY 11 (FFY 22)
WoW (Baseline)	0.00%	5.83%	4.32%	12.74%	7.18%	-0.06%	6.98%	1.71%	3.21%	4.66%	5.00%
WW	0.00%	15.40%	4.78%	10.33%	7.97%	-1.19%	4.33%	3.55%	2.49%	2.41%	-3.67%

Figure D.2.2. Expenditure Annual Growth Rate (Aggregate)



	DY 01 (FFY 12)	DY 02 (FFY 13)	DY 03 (FFY 14)	DY 04 (FFY 15)	DY 05 (FFY 16)	DY 06 (FFY 17)	DY 07 (FFY 18)	DY 08 (FFY 19)	DY 09 (FFY 20)	DY 10 (FFY 21)	DY 11 (FFY 22)
WW EGS Total Expenditures	14,724,701,146	16,170,034,376	17,293,268,170	19,998,390,261	22,265,778,623	21,506,266,643	21,714,643,963	22,217,416,852	23,457,664,119	24,648,314,240	26,003,087,936
WoW EGS Total Expenditures	20,648,115,262	21,935,711,693	22,910,305,585	26,405,397,563	28,486,367,595	28,467,715,108	28,407,572,618	28,972,794,020	30,072,341,960	31,746,459,946	33,637,696,593

Figure D.2.3. Eligible Groups Served (Aggregate)

EXHIBIT F

DEPARTMENT OF HEALTH AND
HUMAN SERVICES Centers for Medicare
& Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

CMCS Informational Bulletin

DATE: July 24, 2015

FROM: Vikki Wachino
Director

SUBJECT: **Implementation of a "Fast Track" Federal Review Process for Section 1115 Medicaid and CHIP Demonstration Extensions**

The Centers for Medicare & Medicaid Services (CMS) is establishing a new "fast track" process for reviewing proposals from states to extend established Medicaid and Children's Health Insurance Program (CHIP) section 1115 demonstrations that reauthorize longstanding policies with proven program outcomes. This process is designed to facilitate faster review of and federal decisions regarding state requests to extend established 1115 demonstrations, reducing administrative burden on states and the federal government.

This approach streamlines the extension process for those states with established demonstrations that are working successfully and who are not proposing to make major or complex policy changes to the demonstration. Timeframes for these reviews will be comparable to those CMS uses to make decisions on Medicaid section 1915 waivers or state plan amendments. This new approach provides for a more efficient federal review process, as well as a more effective assessment of demonstrations' progress in promoting high quality, accessible, and affordable health care coverage to beneficiaries.

The Social Security Act establishes three pathways through which states can propose to extend 1115 demonstrations: 1115(a), 1115(e) and 1115(f). This Informational Bulletin describes a streamlined approach for 1115(a) extensions and simplifications to the other two pathways.

Which State Demonstration Programs Qualify for the "Fast Track" Review Process?

The fast track extension process is available for states that meet the following four criteria:

1) have established demonstration programs, meaning that they have had at least one full extension cycle without substantial program changes;
2) have demonstrations in compliance with reporting deliverables and that have positive monitoring and evaluation results that indicate that the objectives of the demonstration and of the Medicaid/CHIP program have been achieved;
3) are not proposing major or complex changes (as discussed further below); and
4) use the streamlined extension application templates.

What is the "Fast Track" Review Process?

Section 1115(a) extensions

Section 1115(a) extensions are available to states with targeted or comprehensive demonstrations, and at the state's discretion, include requests to make program changes. With the new fast track process states would submit a state attestation, a streamlined extension template (that includes the information required for an extension application to be considered complete) and, if the state chooses, a redline version of the approved Special Terms and Conditions (STCs) to outline how the STCs would have to change to effectuate the requested program changes. CMS will review monitoring and evaluation information to assess progress with meeting Medicaid/CHIP program objectives and any specific program components the state has proposed to change as identified in the extension template.

CMS will offer states eligible for an 1115(a) fast track review a 5-year extension period. Currently, a minority of demonstrations, such as those that include dual eligible beneficiaries, are extended for more than three years at a time. There are no statutory timeframes for which CMS is required to render a decision on 1115(a) extensions; however, under this initiative, we are aligning the review timeframes with those CMS uses to make decisions on Medicaid Section 1915 waivers or State plan amendments.

> CMS successfully piloted this fast track process with the extension of a section 1115(a) demonstration in Colorado. The demonstration has been operating since 2002 and maintains federal funding for uninsured pregnant women with family incomes from 141 percent to 195 percent of the federal poverty level. Colorado submitted an extension application with no changes requested and showed positive outcomes in meeting the objectives of the demonstration. CMS' review focused on whether the demonstration had been operating successfully and that the demonstration would meet its future goals. CMS approved the demonstration extension for a 5-year period on July 24, 2015; completing federal review in 98 days.

Complex Policy Areas

There are certain policy areas that are inherently complex to review, and demonstration programs that involve these "complex policy areas" will not be eligible for the fast track process. Below, we identify an initial list of current demonstration policies considered to be complex policy areas not subject to fast track review.

Demonstration policies that CMS considers to be complex policy areas not eligible for the fast track review process to date are as follows:

- Medicaid Expansion Programs tied to enhanced Federal Medical Assistance Percentage (FMAP);

- Delivery system reform, financing, and payments arrangements that cannot be authorized under state plan authority, including delivery system reform incentive pools;
- Designated State Health Programs;
- Demonstrations with dual eligible Medicare and Medicaid populations;
- Establishing Home and Community-Based Services (HCBS), including those discussed in the 2014 HCBS final rule;
- Enrollment caps and eligibility limitations; and
- Uncompensated care pools.

CMS maintains the right to determine that a policy area, not previously identified as a complex policy area, will be considered as such and therefore not subject to fast track review. In these instances, CMS will issue an Informational Bulletin update to identify the new list of policy areas excluded from fast track review because of particular complexity or whose impact has not yet been evaluated to determine whether they meet the objectives of the Medicaid program, which is the statutory standard for 1115 approvals.

Section 1115(e) extensions

Section 1115(e) extensions are available to states with comprehensive demonstrations proposing no program changes. By statute, CMS can only consider an extension period of up to three years. With the new fast track process states would submit a state attestation and an abbreviated set of supporting documents required for an extension application to be considered complete. CMS is statutorily required to render a decision within six months of a state's submission; however, under this initiative, we are aligning the review timeframes with those CMS uses to make decisions on Medicaid Section 1915 waivers or State plan amendments.

Section 1115(f) extensions

States with extensions authorized under 1115(e) authority are eligible for three year extensions under 1115(f) authority. States can propose changes under this extension pathway. The 1115(f) pathway already outlines an expedited 120-day review process; however, very few states currently utilize this option. We believe that the new fast track process requiring submission of a state attestation and the streamlined extension template if changes are being requested will assist states with providing the information needed to meet the short target dates outlined in statute, thereby expanding the availability of this option for states.

Fast Track Application Process

As mentioned above, CMS has created a streamlined extension application for each 1115 extension option for states that want to be considered for the fast track process. The streamlined extension application comprises a state certification statement that identifies an abbreviated set of supporting documents to accompany the certification that are required for an extension application to be considered complete. There is also an extension template for the state to outline any proposed program changes. The streamlined application templates can be found on Medicaid.gov at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/application.html.

CMS will notify the state of whether its extension request meets the criteria for expedited review within 15 days of receiving it, as part of our assessment of application completeness. We also reserve discretion to determine that a state's extension application no longer qualifies for fast track review, if during the course of the federal review through work with the state or through public comment, we identify significant program concerns. Examples of such concerns are compliance or program integrity issues, or programmatic issues identified through public comment. We will promptly notify the state of our determination of whether we are reconsidering its extension request through the full 1115(a) process or fast track review. States will have an opportunity to modify their extension request in order to proceed with the fast track review process based on CMS feedback.

Improving 1115 Demonstration Monitoring

CMS' fast track review will coincide with a stronger and streamlined monitoring process for all state demonstrations. This will require renewed collaboration between CMS and states. To this end, CMS is revising some monitoring requirements for section 1115 demonstrations. The goal of this effort is to improve federal capacity to use consistent data to measure the impact that individual 1115 demonstrations have on Medicaid and CHIP beneficiaries and the health system. We intend to rely on state data reported through existing Medicaid and CHIP data systems, such as the Transformed Medicaid Statistical Information System (T-MSIS), and are reviewing the data states are beginning to provide through T-MSIS to revise 1115 monitoring requirements to ensure that states do not provide duplicative information. We are also reviewing monitoring terms and conditions for 1115 demonstrations to revise and strengthen monitoring requirements to focus on core performance-related data. This approach to monitoring will also facilitate a more efficient federal review of established demonstrations eligible for fast track extension. We will reach out to states to discuss potential changes to the monitoring requirements in their demonstration terms and conditions. We invite states to propose monitoring requirement changes to their CMS 1115 project officers. CMS is also developing an automated data collection and reporting tool that will make the submission of 1115 deliverables, such as quarterly reports, more structured and administratively simple.

State Demonstrations Group

CMCS has changed its organizational structure and is increasing staffing to support its work on section 1115 demonstrations and their growing role in delivering care to Medicaid and CHIP beneficiaries. This new group, which was created July 2015, has responsibility for reviewing and making recommendations on 1115 demonstration applications, amendments, and extensions, as well as for monitoring, oversight and evaluation of approved demonstrations. Eliot Fishman [Eliot.Fishman@cms.hhs.gov] is the State Demonstrations Group's (SDG) Director and Julia Hinckley [Julia.Hinckley@cms.hhs.gov] is its Deputy Director. SDG staff will assess state, federal, and stakeholder experience with the fast track review process and use that assessment to inform broader improvements to the 1115 demonstration approval and amendment process. CMCS invites suggestions on these reforms at 1115DemoRequests@cms.hhs.gov.

Next Steps

CMS will reach out to states 18 months prior to the expiration of their current demonstration with a fast track extension packet to assist the state in considering use of the new fast track process.

If you have questions about this bulletin, please contact Angela Garner, State Demonstrations Group, at Angela.Garner@cms.hhs.gov.

Defendants' Exhibit 4

May 14, 2021 DAB

Notice of Appeal

KEN PAXTON
ATTORNEY GENERAL OF TEXAS

JUDD E. STONE II
Solicitor General

(512) 936-2834
Judd.Stone@oag.texas.gov

May 14, 2021

U.S. Department of Health & Human Services
Departmental Appeals Board
Appellate Division, MS 6127
Cohen Building, Room G-644
330 Independence Ave., S.W.
Washington, D.C. 20201

Via E-File and certified mail

Re: Notice of Appeal—Rescission of Demonstration Project No. 11-W-00278/6

Dear Sir or Madam:

Earlier today, Texas and its Health and Human Services Commission ("Texas" or "the State") filed the enclosed complaint in the United States District Court for the Eastern District of Texas, Tyler Division. It challenges the purported rescission by the Centers for Medicare & Medicaid Services ("CMS") of (1) an extension to Texas's section 1115 demonstration project titled "Texas Healthcare Transformation and Quality Improvement Program" ("THTQIP") (project number 11-W-00278/6); and (2) a public-notice exemption under 42 C.F.R. section 431.416(g).

The Board lacks jurisdiction over this dispute. 42 C.F.R. section 430.3(c) explicitly states that 45 C.F.R. part 16, appendix A "lists all the types of disputes that [this] Board hears." That list does not include the termination of a demonstration project for reasons other than failure to comply with the project's terms. CMS does not purport to find that the State violated the terms of the THTQIP, and therefore a dispute over CMS's actions does not fall within this Board's jurisdiction.

Nevertheless, out of an abundance of caution, Texas files this protective notice of appeal should the district court hold otherwise. Texas respectfully requests that the

Board hold this appeal in abeyance pending resolution of its lawsuit. The amount in dispute is approximately $35 billion.

Background

The THTQIP was first approved in 2011 as part of the State's efforts to modernize its Medicaid system by expanding managed care to additional populations and services with the goal of incentivizing quality and improving care coordination, providing greater budget certainty, and creating opportunities for reimbursement of uncompensated costs incurred by certain providers to improve the overall health of Texans. In 2016, the State sought and was granted a fifteen-month extension so that it could further expand the managed-care model. A full five-year extension took effect on December 13, 2017, with the demonstration project originally scheduled to end on September 30, 2022.

Texas applied for a further extension of THTQIP in late 2020. Because the COVID-19 pandemic imposed a significant strain on Texas's Medicaid providers, the State faced a severe and immediately impending contraction in healthcare services and provider capacity. Texas therefore requested an exemption from the ordinary public-notice process under 42 C.F.R. section 431.416(g) and submitted evidence supporting that request. On December 15, 2020, CMS informed Texas that its extension application was complete, and confirmed that the application was exempt from notice-and-comment requirements.

After a period of negotiation, CMS granted Texas's application on January 15, 2021, authorizing an extension of Texas's demonstration project (as modified through the parties' negotiations) through 2030. The State's agencies and legislature immediately began implementing the new components of the demonstration project, which included crucial replacements for the Delivery System Reform Incentive Payment (DSRIP) program. DSRIP, a program that incentivizes hospitals and other providers to improve access to care and how care is delivered, is expiring in September 2021.

On April 16, 2021, the Acting Administrator of CMS sent a letter purporting to "rescind[] . . . approval of the state's 42 C.F.R. § 431.416(g) exemption request" and "withdraw[] the January 15, 2021 extension approval." CMS claimed that it had erred in granting the exemption, and that the State had "not incurred a reliance interest based on the January 15, 2021 approval." CMS specified no concrete harms

caused by its supposed error, failed to identify a statutory or regulatory basis for its purported revocations, and reached its decision without first affording the State an opportunity to comment.

Basis for Appeal

As explained in greater detail in the State's complaint, CMS's actions are unfounded and should be reversed for multiple reasons.

First, section 1115 of the Social Security Act, 42 U.S.C. § 1315, which empowers the Administrator to approve demonstration projects, does not also grant the Administrator the power to "rescind," "withdraw," or otherwise remove an extension of a demonstration project or reimpose conditions already validly waived by the Administrator. Thus, the Administrator acted in excess of her statutory authority by purporting to revoke the exemption and demonstration project.

Second, under 42 U.S.C. section 1315(f)(5)(A), the Administrator had, at most, 120 days to approve or disapprove the extension application. The Administrator's purported rescissions took place 122 days after CMS granted the exemption and confirmed the application was complete. They were therefore untimely.

Third, CMS violated its statutory directive to approve or disapprove a demonstration project only to the extent that choice "is likely to assist in promoting the objectives" of the Medicaid program. 42 U.S.C. § 1315(a). The rescission of the demonstration project threatens healthcare for over four-million Texans during a pandemic—an outcome that is impossible to square with Medicaid's goal of ensuring the provision of healthcare to citizens of limited means. The Administrator's only stated objection—purported procedural concerns—wholly fails to justify such a consequential decision.

Fourth, none of the Administrator's regulatory powers authorize the April 16 rescission. She may suspend or terminate a demonstration project only after determining "that the State has materially failed to comply with the terms of the demonstration project." 42 C.F.R. § 431.420(d)(1). The April 16 letter contained no such determination. The regulations also indicate that the Administrator may withdraw waivers, but only "based on a finding that the demonstration project is not likely to achieve the statutory purposes." *Id.* § 431.420(d)(2). No such finding is present in the letter. And in either event, the demonstration project's terms and

conditions require the Administrator to afford the State an opportunity to challenge these determinations at a hearing, *prior* to their effective date. The Administrator afforded the State no such opportunity.

Fifth, beyond the power to suspend or terminate a demonstration project or withdraw a waiver, the regulations do not empower the Administrator to rescind or reverse extensions or exemptions. Any attempt to assert such a power must follow the ordinary notice-and-comment procedure for new regulations. Because CMS did not engage in that process, the April 16 letter's purported rescissions were unlawful.

Sixth, because CMS may ordinarily approve a demonstration project only after notice and comment, so too must CMS provide a similar notice-and-comment procedure before *revoking* a demonstration project. By failing to provide such a procedure and neglecting to justify this failure in the April 16 letter, the Administrator's purported decision lacks legal force.

Seventh, CMS failed to consider that Texas and its Medicaid beneficiaries accrued substantial reliance interests—and expended significant resources—based on the January 15 extension. The Administrator's letter also reveals that CMS failed to consider less-intrusive alternatives that might have struck a reasonable compromise between the State's significant interests and whatever unparticularized, countervailing interests CMS considered relevant.

Eighth, the April 16 letter erred in asserting that Texas failed to show a sufficient basis for its request for a waiver of public notice-and-comment obligations. As required by 42 C.F.R. section 431.416(g), many aspects of the demonstration project address the public-health emergency caused by the COVID-19 pandemic, and extend or replace critical programs that would otherwise expire during the pandemic. The State also substantiated its need for an exemption with an extensive survey regarding the impact of COVID-19 on its provider network.

Ninth, CMS should be estopped from asserting that its grant of the public-notice exemption was in error. In December 2020, CMS encouraged Texas to seek an public-notice exemption, then assured the State that its exemption request was satisfactory and its extension application complete. The State reasonably relied on these assurance, incurring substantial costs in the process.

Finally, public reports suggest that the Administrator's proffered reasons for rescission were pretextual, and that the federal government is attempting to coerce the State into adopting the Medicaid expansion established by the Patient Protection and Affordable Care Act. The Supreme Court has already held that the federal government may not coerce States into accepting the Medicaid expansion by withholding funds. CMS's current actions are no different—and no more lawful.

Representation

The Office of the Attorney General of Texas represents the State in both the district court action and before this Board. The undersigned will serve as lead counsel in both actions and can be reached by telephone at (512) 936-2834, by email at Judd.Stone@oag.texas.gov, and by regular mail at P.O. Box 12548 (MC 059), Austin TX 78711-2548.

Respectfully submitted.

/s/ Judd E. Stone II

Judd E. Stone II
Solicitor General

(Enclosures)

Defendants' Exhibit 5

Acknowledgement of Appeal and Request to CMS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Departmental Appeals Board
Appellate Division, MS 6127
Room G-644, Cohen Building
330 Independence Avenue, SW
Washington, D.C. 20201

June 23, 2021

BY DAB E-FILE

Judd E. Stone II, Solicitor General
Office of the Attorney General
State of Texas
P.O. Box 12548
Austin, Texas 78711-2548

and

Deputy Associate General Counsel for Litigation
U.S. Dept. of Health & Human Services
Office of the General Counsel, CMS Division
Room 5300, Cohen Building
330 Independence Avenue, S.W.
Washington, D.C. 20201

Board Docket No. A-21-63

ACKNOWLEDGMENT OF NOTICE OF APPEAL AND REQUEST FOR CMS OPINION ON JURISDICTION

Appellant	:	Texas Health and Human Services Commission
Notice filed by	:	Judd E. Stone II
Dated	:	May 14, 2021
Appeal from decision of	:	Centers for Medicare & Medicaid Services
Date of appealed decision	:	April 16, 2021
Statute/program	:	42 C.F.R. § 1315/Medicaid
Presiding Board Member	:	Susan S. Yim
Board attorney contact	:	Ken Veilleux (202) 565-0130 (phone) (202) 565-0238 (FAX) ken.veilleux@hhs.gov

The notice of appeal described above has been received by the Departmental Appeals Board (Board).

The Appellant indicates in its notice of appeal that it disagrees with an April 16, 2021 decision by the Centers for Medicare & Medicaid Services (CMS) to: (1) rescind its January 15, 2021 decision approving Texas's request for an extension (through September 30, 2030) of its section 1115(a) Medicaid demonstration, titled "Texas Healthcare Transformation and Quality Improvement Program (THTQIP)"; and (2) withdraw approval of Texas's request to exempt its application to extend THTQIP from otherwise applicable public notice and comment requirements. Notice of Appeal at 1. The Appellant further asserts that: (1) it has filed a lawsuit in United States District Court for the Eastern District of Texas to challenge CMS's April 16, 2021 decision; (2) the "[t]he Board lacks jurisdiction" to review that decision; and (3) in an "abundance of caution," it filed the notice of appeal to protect its administrative appeal rights in the event the District Court decides that the parties' dispute must first be heard by the Board. *Id.* The Appellant requests that "the Board hold this appeal in abeyance pending resolution of its lawsuit." *Id.* at 1-2.

The Board is empowered to decide, on its own initiative, whether a dispute falls within its jurisdiction. *See* 45 C.F.R. Part 16, Appendix A, ¶¶ A and G (providing that the "Board Chair determines whether an appeal meets the requirements" concerning the "programs which use the Board for dispute resolution, the types of disputes covered, and any conditions for Board review of final written decisions resulting from those disputes"). When the availability of Board review is in question, the Board "will request the written opinion of the HHS component which issued the [disputed] decision." *Id.*, Appendix A, ¶ G. Accordingly, **the Board requests that, within 14 days of receipt of this letter,** CMS submit a letter or memorandum indicating whether or not it agrees with the Appellant that the Board lacks jurisdiction to review the parties' dispute concerning the April 21, 2021 decision and the reason(s) for its agreement or disagreement.

Once the Board receives CMS's response, the Board Chair will issue a ruling addressing the jurisdictional issue and the Appellant's request to maintain this case on its docket pending the disposition of Texas's lawsuit.

Since the Appellant has submitted its notice of appeal electronically using DAB E-File, both parties should make all future submissions by that method and will be deemed to have consented to accept electronic service of appeal-related documents via DAB E-File (including documents from the Board). A document will be deemed to be filed with the Board on a given day if it is uploaded to DAB E-File on or before 11:59 p.m. eastern time of that day.

Additional information about Board procedures and filing requirements may be found in 45 C.F.R. Part 16 http://www.ecfr.gov/) and in the Board's Appellate Division Practice Manual at http://www.hhs.gov/dab/divisions/appellate/practicemanual/manual.html.

By direction of the Presiding Board Member.

/s/ *Ken Veilleux*

Ken Veilleux
DAB Staff Attorney

cc: Deputy Assistant IG for Auditing
Office of the Inspector General

Chief Counsel
DHHS – Region VI

Administrator
Centers for Medicare & Medicaid Services
(by inter-office mail)

Office of Financial Management, CMS

Center for Medicaid and CHIP Services, CMS

Defendants' Exhibit 6

CMS Response to DAB Request

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD
APPELLATE DIVISION

TEXAS HEALTH AND HUMAN SERVICES COMMISSION, **Appellant,**	§	
v.	§	**DOCKET NO. A-21-63**
CENTERS FOR MEDICARE & MEDICAID SERVICES, **Respondent**	§	

CMS'S RESPONSE TO THE DAB'S ACKNOWLEDGEMENT OF NOTICE OF APPEAL AND REQUEST FOR CMS OPINION ON JURISDICTION

The Centers for Medicare & Medicaid Services (CMS), by and through the undersigned counsel, submits the attached letter from CMS in response to the Board's request that "CMS submit a letter or memorandum indicating whether or not it agrees with the appellant that the Board lacks jurisdiction to review the parties' dispute concerning the April 21, 2021 decision and the reasons(s) for its agreement or disagreement." Acknowledgement of Notice of Appeal and Req. for CMS Op. on Jurisdiction at 2.

Dated: 7/7/2021

Respectfully submitted,

Daniel J. Barry,
Acting General Counsel

Janice L. Hoffman
Associate General Counsel, CMS Division

/s/ Garrett F. Mannchen
Garrett F. Mannchen
Attorney, CMS Division
Department of Health and Human Services
Office of the General Counsel
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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop 00-00-00
Baltimore, Maryland 21244-1850

July 7, 2021

BY DAB E-FILE

Constance B. Tobias, Chair
Departmental Appeals Board
Appellate Division, MS 6127
Room G-644, Cohen Building
330 Independence Avenue, SW
Washington, D.C. 20201

Dear Chair Tobias:

This letter is in response to the Departmental Appeals Board's (DAB) June 23, 2021 request that the Centers for Medicare & Medicaid Services (CMS) submit a letter "indicating whether or not it agrees with the Appellant [(Texas)] that the Board lacks jurisdiction to review the parties' dispute concerning [CMS's] April 21, 2021 decision and the reason(s) for its agreement or disagreement." Acknowledgement of Notice of Appeal and Req. for CMS Op. on Jurisdiction, at 2. For the reasons set forth in this letter, we believe that the governing regulations and DAB rules make clear that the Board has jurisdiction over this appeal. Accordingly, we respectfully request that the Board proceed with this appeal. CMS intends to reach out separately to Texas's counsel to discuss the possibility of the parties jointly requesting that this appeal proceed using the Board's expedited procedures.

This appeal involves CMS's April 16, 2021 letter to Texas rescinding its January 15, 2021 approval of Texas's Section 1115 Demonstration Extension application. Under section 1115 of the Social Security Act, CMS[1] can waive certain requirements of the Medicaid statute to permit a state to implement an "experimental, pilot, or demonstration project" provided the Secretary determines that project "is likely to assist in promoting the objectives of" that statute. The statute requires applications seeking CMS's approval to go through state and federal public notice-and-comment processes "to ensure a meaningful level of public input." *Id.* § 1315(d)(1), (2)(A), (2)(C). CMS's regulations provide that CMS may waive the state and federal public notice-and-comment requirements if such a waiver is necessary to address "a natural disaster, public health emergency, or other sudden emergency threats to human lives." 42 C.F.R. § 431.416(g)(1).

[1] The Secretary has delegated authority to approve demonstration projects to CMS. *See* 66 Fed. Reg. 35437.

On November 30, 2020, Texas submitted a request to extend its longstanding demonstration project for five years, along with a request for an exemption from the public notice-and-comment requirements. Section 1115 Demonstration Extension Section 1115(a) Fast Track Application Supporting Documentation, Texas Health and Human Services Commission, App'x E (Nov. 30, 2021), available at https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/tx-healthcare-transformation-cmplt-ltr-state-phe-app-20201215.pdf. CMS granted Texas's exemption request on December 15, 2021 and approved a modified version of Texas's demonstration project on January 15, 2021. Letter from Angela D. Garner to Stephanie Stephens, CMS (Dec. 15, 2021), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/tx-healthcare-transformation-cmplt-ltr-state-phe-app-20201215.pdf; Letter from Seema Verma to Stephanie Stephens, CMS (Jan. 15, 2021), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/tx-healthcare-transformation-cms-approval-01152021.pdf. Those modifications included changing the length of the demonstration project extension from five years to ten and authorizing Texas to implement a new uncompensated care pool, neither of which Texas had requested. *See* Letter from Seema Verma to Stephanie Stephens at 1, 3–4.

CMS rescinded its January 15, 2021 approval in a letter dated April 16, 2021. Letter from Elizabeth Richter to Stephanie Stephens, CMS (April 16, 2021), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/tx-healthcare-transformation-cms-ltr-st.pdf. In that letter, CMS explained that its decision granting Texas an exemption from the public notice-and-comment process was erroneous and unlawful *ab initio*, because Texas's exemption request failed to "articulate a sufficient basis for us to conclude that approving the state's emergency request for an exemption from the normal public notice process was needed to address a public health emergency or other sudden emergency threat to human lives, as required under 42 C.F.R. § 431.416(g)." The agency explained that an exemption was also unnecessary because the demonstration features Texas sought to extend were not set to expire until September 30, 2022. *Id.* at 2. CMS further explained that its erroneous and unlawful decision to approve Texas's exemption request was not harmless error. *Id.* Texas's exemption from the state and federal public notice-and-comment processes had "deprived beneficiaries and other interested stakeholders of the opportunity to comment on, and potentially influence, the state's request to extend a complex demonstration—already authorized through September 30, 2022—into the next decade." *Id.* Thus, CMS rescinded the approval and invited Texas to resubmit its extension application following the notice-and-comment processes set forth in the regulations. *Id.* at 7–8.

CMS's regulations set forth the types of Medicaid decisions that are subject to DAB review. *See* 42 C.F.R. § 403.3. As relevant here, § 430.3(c) expressly states that "disputes pertaining to . . . demonstration projects under . . . section 1115 of the Act" will be heard by the DAB. The DAB's rules provide further guidance as to the types of agency decisions that are subject to DAB review. 45 C.F.R. part 16, App'x A(C). Appendix A lists four types of "written decisions" that the Board will review:

> (1) A disallowance or other determination denying payment of an amount claimed under an award, or requiring return or set-off of funds already received. This does not apply to determinations of award amount or disposition of unobligated

> balances, or selection in the award document of an option for disposition of program-related income.
> (2) A termination for failure to comply with the terms of an award.
> (3) A denial of a noncompeting continuation award under the project period system of funding where the denial is for failure to comply with the terms of a previous award.
> (4) *A voiding (a decision that an award is invalid because it was not authorized by statute or regulation* or because it was fraudulently obtained).

Id. (emphasis added).

CMS's opinion is that the DAB has jurisdiction to hear this appeal under CMS's regulations and the DAB's rules. CMS's April 16, 2021 letter—the subject of this appeal—rescinded CMS's January approval of Texas's demonstration project under Section 1115 of the Social Security Act. Under the plain language of § 430.3(c), this appeal is a dispute that "pertain[s] to . . . [a] demonstration project[] under . . . section 1115 of the Act." And CMS's rescission letter is the type of decision the DAB will hear because it is a "voiding" of the agency's earlier approval of that project, one of the four types of written decisions set forth in Appendix A.

Texas's argument that the DAB does not have jurisdiction over this appeal is based on its characterization of CMS's April 16, 2021 rescission letter as a "termination" and its conclusion that CMS's letter is not one of the types of disputes that the Board hears. Even accepting for the sake of argument Texas's premise—that the DAB would lack jurisdiction over CMS's decision terminating a state's Section 1115 demonstration project,[2]—Texas's characterization of CMS's rescission letter is wrong. CMS's April 16 letter is a "voiding" under the DAB's rules. In that letter, CMS states that it "materially erred" in its decision to grant Texas an exemption from the required notice-and-comment procedures, that the regulation did not permit such a waiver without Texas first demonstrating that such a waiver was necessary "to address a public health emergency or other sudden emergency threat to human lives," that Texas had not satisfied the regulation's requirements for an exemption request, and that the exemption was therefore not authorized by the regulation. *See* Letter from Elizabeth Richter to Stephanie Stephens, CMS at 1–2 (April 16, 2021), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/tx-healthcare-transformation-cms-ltr-st.pdf. CMS further explained that, because CMS's approval of Texas's exemption request was unlawful, Texas's demonstration application did not satisfy the state and federal public notice-and-comment requirements set forth in the statute. *Id.* at 2; *see also* 42 C.F.R. §§ 431.408 (state public notice-and-comment requirements), .416 (federal public notice-and-comment requirement). Accordingly, CMS rescinded its approval of Texas's demonstration project. Letter from Elizabeth Richter to Stephanie Stephens at 2. In short, CMS's April 16, 2021 letter was CMS's

[2] To be clear: because CMS's April 16, 2021 rescission letter is clearly a "voiding," it is not necessary for CMS to opine on whether the DAB has jurisdiction over termination decisions. Accordingly, CMS offers no opinion on the merits of Texas's argument that the DAB does not have jurisdiction over "the termination of a demonstration project for reasons other than failure to comply with the project's terms." Notice of Appeal at 1.

written decision that its prior approval of Texas's demonstration project was "not authorized by statute or regulation." 45 C.F.R. part 16, App'x A(C)(4).

Sincerely,

_____

JUDITH CASH
Acting Deputy Director, Center for Medicaid and CHIP Services
Department of Health and Human Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244
410-786-4473
Judith.Cash@cms.hhs.gov

Defendants' Exhibit 7

July 14, 2021 Extension Application Letter

GOVERNOR GREG ABBOTT

July 14, 2021

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue S.W.
Washington, D.C. 20201

Dear Secretary Becerra:

Please find Texas's re-application to extend the Texas Healthcare Transformation Quality Improvement Program (THTQIP- 11 -W-00278/6), a Medicaid waiver program operating under the authority of Section 1115(a) of the Social Security Act. Included with this letter are the documents comprising Texas's extension application, as required by 42 C.F.R. § 431.412(c), which have been prepared by the Texas Health and Human Services Commission (HHSC). Per your communications with HHSC, these materials reflect the same terms that Texas negotiated with CMS before CMS approved a waiver extension in January 2021. Texas maintains that this approval remains in effect. To the extent reapproval is necessary, your re-approval is requested by September 30, 2021.

Texas Medicaid has operated a Section 1115 Demonstration project authorizing Medicaid managed care since 2011. The State of Texas serves over 4.7 million Medicaid and CHIP beneficiaries, with 94 percent served within managed care. The THTQIP Waiver has deployed a cost-effective care model that encompasses 17 Managed Care Organizations and three Dental Maintenance organizations and their provider networks. With this effective model of care, Texas HHSC seeks to continue to advance innovation and drive quality for Texans.

The objective for Texas Medicaid to provide a cost-effective model of care while incentivizing high-quality care and outcomes remains clear. An extension of this current work is essential to maintaining vital financial support for our Medicaid providers across the great State of Texas. For questions about this request, please contact Cecile Erwin Young, the HHSC Executive Commissioner, at (512) 424-6502 or at Cecile.Young@hhs.texas.gov. Thank you for your consideration and prompt action to approve this extension.

Sincerely,

[Signature on file]
Greg Abbott
Governor

GA:hfd

Attachment

Texas Application Certification Statement - Section 1115(a) Extension

This document, together with the supporting documentation outlined below, constitutes Texas' application to the Centers for Medicare & Medicaid Services (CMS) to extend the Texas Healthcare Transformation and Quality Improvement Project #11-W-00278/6 for a period of approximately 10 years pursuant to section 1115(a) of the Social Security Act.

Type of Request (*select one only*):

_____ **Section 1115(a) extension <u>with no</u> program changes**

This constitutes the state's application to the Centers for Medicare & Medicaid Services (CMS) to extend its demonstration without any programmatic changes. The state is requesting to extend approval of the demonstration subject to the same Special Terms and Conditions (STCs), waivers, and expenditure authorities currently in effect for the period [insert current demo period].

The state is submitting the following items that are necessary to ensure that the demonstration is operating in accordance with the objectives of title XIX and/or title XXI as originally approved. The state's application will only be considered complete for purposes of initiating federal review and federal-level public notice when the state provides the information as requested in the below appendices.

- **Appendix A:** A historical narrative summary of the demonstration project, which includes the objectives set forth at the time the demonstration was approved, evidence of how these objectives have or have not been met, and the future goals of the program.
- **Appendix B:** Budget/allotment neutrality assessment, and projections for the projected extension period. The state will present an analysis of budget/allotment neutrality for the current demonstration approval period, including status of budget/allotment neutrality to date based on the most recent expenditure and member month data, and projections through the end of the current approval that incorporate the latest data. CMS will also review the state's Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) expenditure reports to ensure that the demonstration has not exceeded the federal expenditure limits established for the demonstration. The state's actual expenditures incurred over the period from initial approval through the current expiration date, together with the projected costs for the requested extension period, must comply with CMS budget/allotment neutrality requirements outlined in the STCs.
- **Appendix C:** Interim evaluation of the overall impact of the demonstration that includes evaluation activities and findings to date, in addition to plans for evaluation activities over the requested extension period. The interim evaluation should provide CMS with a clear analysis of the state's achievement in obtaining the outcomes expected as a direct effect of the demonstration program. The state's interim evaluation must meet all of the requirements outlined in the STCs.

- **Appendix D:** Summaries of External Quality Review Organization (EQRO) reports, managed care organization and state quality assurance monitoring, and any other documentation of the quality of and access to care provided under the demonstration.
- **Appendix E:** Documentation of the state's compliance with the public notice process set forth in 42 CFR 431.408 and 431.420.

___X_____ **Section 1115(a) extension <u>with</u> minor program changes**

This constitutes the state's application to the Centers for Medicare & Medicaid Services (CMS) to extend its demonstration with minor demonstration program changes. In combination with completing the Section 1115 Extension Template, the state may also choose to submit a redline version of its approved Special Terms and Conditions (STCs) to identify how it proposes to revise its demonstration agreement with CMS.

The state is requesting CMS extend the demonstration by approving the same STCs, waivers, and expenditure authorities that CMS approved on January 15, 2021, with the incorporation of amendments negotiated with and approved by CMS since January 15, 2021. The decision to resubmit the same STCs comes after careful review of all public comments related to this extension request.

The state's application will only be considered complete for purposes of initiating federal review and federal-level public notice when the state provides the information requested in Appendices A through E above, along with the Section 1115 Extension Template identifying the program changes being requested for the extension period. Please list all enclosures that accompany this document constituting the state's whole submission.

1. Governor Abbott Cover Letter
2. State Attestation
3. Extension Application
    a. Appendix A
    b. Appendix B
    c. Appendix C
    d. Appendix D
    e. Appendix E
4. Texas THTQIP 1115 Extension STCs (January 15, 2021)
5. Texas THTQIP 1115 Expenditure Authorities (January 15, 2021)
6. Updated Texas THTQIP 1115 Extension Waiver List (January 15, 2021)
7. Extension Attachments (A – V)
8. Standard Funding Questions
9. Budget Neutrality Workbook
10. External Evaluation

The state attests that it has abided by all provisions of the approved STCs and will continuously operate the demonstration in accordance with the requirements outlined in the STCs.

Signature: *[Signature on file]*
Hon. Greg Abbott

Date: 07/14/2021

CMS will notify the state no later than 15 days of submitting its application of whether we determine the state's application meets the requirements for a streamlined federal review. The state will have an opportunity to modify its application submission if CMS determines it does not meet these requirements. If CMS reviews the state's submission and determines that any proposed changes significantly alter the original objectives and goals of the existing demonstration as approved, CMS has the discretion to process this application full scope pursuant to regular statutory timeframes for an extension or as an application for a new demonstration.