

**CENTERS FOR MEDICARE AND MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS (STCs)**

NUMBER: 11-W-00278/6

**TITLE: Texas Healthcare Transformation and Quality Improvement
Program**

AWARDEE: Texas Health and Human Services Commission

DEMONSTRATION PERIOD: December 12, 2011 through September 30, 2016

**CENTERS FOR MEDICARE & MEDICAID SERVICES
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I. PREFACE

The following are the Special Terms and Conditions (STCs) for the Texas Healthcare Transformation and Quality Improvement Program section 1115(a) Medicaid demonstration (hereinafter "Demonstration"). The parties to this agreement are the Texas Health and Human Services Commission (HHSC/State) and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth, in detail, the nature, character, and extent of Federal involvement in the Demonstrations, and the State's obligations to CMS during the life of the Demonstration. This Demonstration is effective the date of the approval letter through September 30, 2016, unless otherwise specified.

The STCs have been arranged into the following subject areas:

- I. Preface
- II. Program Description and Objectives
- III. General Program Requirements
- IV. Eligibility Derived from the Demonstration
- V. Demonstration Delivery Systems
 - A. Phased Expansion of Managed Care Delivery Systems
 - B. Assurances Related to the Ongoing Operation of Managed Care and Readiness Review Requirements for March 2012 Expansion
 - C. Eligibility
 - D. STAR AND STAR+PLUS (non-HCBS) Enrollment, Benefits and Reporting Requirements
 - E. Children's Dental Program
 - F. STAR+PLUS HCBS Enrollment, Benefits and Reporting Requirements
- VI. Funding Pools Under the Demonstration
- VII. General Financial Requirements
- VIII. Monitoring Budget Neutrality for the Demonstration
- IX. General Reporting Requirements
- X. Evaluation of the Demonstration

The following attachments have been included to provide supplemental information and guidance for specific STCs. The following attachments are incorporated as part of this agreement.

- Attachment A: Schedule of Deliverables
- Attachment B: Quarterly Report Template
- Attachment C: HCBS Service Definitions
- Attachment D: Quality Improvement Strategy for HCBS
- Attachment E: HCBS Quality Review Worksheet
- Attachment F: HCBS Fair Hearing Procedures
- Attachment G: HCBS Participant Safeguards
- Attachment H: UC Claiming Protocol and Application
- Attachment I: Regional Healthcare Partnership (RHP) Planning Protocol
- Attachment J: Program and Funding Mechanics Protocol
- Attachment K: Administrative Cost Claiming Protocol
- Attachment L: Consumer Support System Plan

II. PROGRAM DESCRIPTION AND OBJECTIVES

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 pre-paid 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.

The STAR and STAR+PLUS managed care programs will 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, and the second expansion occurred in March 2012, under section 1115 authority. A third expansion of STAR+PLUS will occur September 1, 2014 under section 1115 authority as a result of an amendment to the demonstration.

STAR is the primary managed care program serving low-income families and children, and STAR+PLUS provides acute and long-term service and supports to the aged, disabled, and chronically ill. Medicaid eligible adults who are not enrolled in Medicare, meet the level of care for Home and Community Based Services (HCBS), and reside in the MRSA, must enroll in a STAR managed care organization (MCO); children meeting these criteria can voluntarily enroll in STAR. STAR MCOs in the MRSA will provide 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.

STAR+PLUS, which serves beneficiaries meeting an institutional level of care (LOC) in the home or community, did not operate in the MRSA during the March 2012 expansion, but effective September 1, 2014, Medicaid eligible adults over age 21 who meet STAR+PLUS eligibility criteria and reside in the MRSA must enroll in STAR+PLUS. Clients under 21 who meet the criteria will be able to voluntarily enroll in STAR+PLUS effective September 1, 2014, thus will not be required to enroll.

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 will 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 will receive 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 will be 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 will be provided through STAR+PLUS; employment assistance and supported employment will be 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 will be provided via managed care.
- Effective March 1, 2015, nursing facility services will be 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 is not changing 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.

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 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.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The State must comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.
2. **Compliance with Medicaid and Children’s Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid program and CHIP expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), must apply to the Demonstration.
3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The State must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in Federal law, regulation, or policy affecting the Medicaid or CHIP program that occur during this Demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable.
4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy Statements.**
 - a) To the extent that a change in Federal law, regulation, or policy requires either a reduction or an increase in Federal financial participation (FFP) for expenditures made under this Demonstration, the State must adopt, subject to CMS approval, modified budget neutrality and allotment neutrality agreements for the Demonstration as necessary to comply with such change. The modified agreements will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under the subparagraph.
 - b) If mandated changes in the Federal law require State legislation, the changes must take effect on the day such State legislation becomes effective, or on the last day such legislation was required to be in effect under the law.
5. **State Plan Amendments.** The State will not be required to submit title XIX or XXI State plan amendments for changes affecting any populations made eligible solely through the Demonstration. If a population eligible through the Medicaid or CHIP State Plan is affected by a change to the Demonstration, a conforming amendment to the appropriate State Plan may be required, except as otherwise noted in these STCs.
6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, cost sharing, sources of non-Federal share of funding, budget neutrality, spending limits for funding pools, methodologies for determining amounts paid from pools (to the extent specified in the STCs), deadlines for deliverables, and other comparable program

elements must be submitted to CMS as amendments to the Demonstration. All amendment requests are subject to approval at the discretion of the Secretary, in accordance with section 1115 of the Act. The State must not implement changes to these elements without prior approval by CMS. Amendments to the Demonstration are not retroactive, and FFP will not be available for changes to the Demonstration that have not been approved through the amendment process set forth in paragraph 7 below (*Amendment Process*).

- 7. Amendment Process.** Requests to amend the Demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change, and may not be implemented until approved. CMS reserves the right to deny or delay approval of a Demonstration amendment based on non-compliance with these STCs, including, but not limited to, failure by the State to submit required reports and other deliverables in a timely fashion, according to the deadlines specified therein. Amendment requests must include, but are not limited to, the following:
- a) An explanation of the public process used by the State, consistent with the requirements of paragraph 14, to reach a decision regarding the requested amendment;
 - b) A data analysis which identifies the specific “with waiver” impact of the proposed amendment on the current budget neutrality agreement. Such analysis must include current total computable “with waiver” and “without waiver” status, on both a summary and detailed level, through the current extension approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the “with waiver” expenditure total as a result of the proposed amendment which isolates (by Eligibility Group (EG)) the impact of the amendment;
 - c) A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation, including a conforming title XIX State plan amendment, if necessary; and
 - d) A description of how the evaluation design will be modified to incorporate the amendment provisions.
- 8. Extension of the Demonstration.** States that intend to request demonstration extensions under sections 1115(e) or 1115(f) are advised to observe the timelines contained in those statutes. Otherwise, no later than 12 months prior to the expiration date of the Demonstration, the chief executive officer of the State must submit to CMS either a Demonstration extension request or a phase-out plan, consistent with the requirements of paragraph 9.

As part of the Demonstration extension request, the State must provide documentation of compliance with the transparency requirements in 42 CFR § 431.412 and the public notice and tribal consultation requirements outlined in paragraph 13, as well as include the following supporting documentation:

- a) Demonstration Summary and Objectives: The State must provide a summary of the Demonstration project, reiterate the objectives set forth at the time the Demonstration was proposed, and provide evidence of how these objectives have been met. If changes are requested, a narrative of the changes being requested, along with the objective of the change, and desired outcomes must be included.
- b) Special Terms and Conditions (STCs): The State must provide documentation of its compliance with each of the STCs. Where appropriate, a brief explanation may be accompanied by an attachment containing more detailed information. Where the STCs address any of the following areas, they need not be documented a second time.
- c) Waiver and Expenditure Authorities: The State must provide a list along with a programmatic description of the waivers and expenditures authorities that are being requested in the extension.
- d) Quality: The State must provide summaries of External Quality Review Organization (EQRO) reports, MCO and State quality assurance monitoring, and any other documentation of the quality of care provided under the Demonstration.
- e) Compliance with the Budget Neutrality Cap: The State must provide financial data (as set forth in the current STCs) demonstrating that the State has maintained, and will maintain, budget neutrality for the requested period of extension. CMS will work with the State to ensure that Federal expenditures under the extension of this project do not exceed the Federal expenditures that would otherwise have been made. In doing so, CMS will take into account the best estimate of current trend rates at the time of the extension.
- f) Interim Evaluation Report: The State must provide an evaluation report reflecting the hypotheses being tested and any results available.
- g) Demonstration of Public Notice 42 CFR §431.408: The State must provide documentation of the State's compliance with public notice process as specified in 42 CFR §431.408 including the post-award public input process described in 42 CFR §431.420(c), with a report of the issues raised by the public during the comment period and how the State considered the comments when developing the Demonstration extension application.

9. Demonstration Phase-Out. The State may only suspend or terminate this Demonstration in whole, or in part, consistent with the following requirements.

- a) Notification of Suspension or Termination: The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a phase-out plan. The State must submit its notification letter and a draft phase-out plan to CMS no less than 5 months before the effective date of the Demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, the State

must publish on its Web site, the draft phase-out plan for a 30-day public comment period. In addition, the State must conduct tribal consultation, in accordance with its approved tribal consultation State Plan Amendment. Once the 30-day public comment period has ended, the State must provide a summary of each public comment received, the State's response to the comment, and how the State incorporated the received comment into the revised phase-out plan.

The State must obtain CMS approval of the phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out activities must be no sooner than 14 days after CMS approval of the phase-out plan.

- b) Phase-out Plan Requirements: The State must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the State will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.
- c) Phase-out Procedures: The State must comply with all notice requirements found in 42 CFR §431.206, 431.210 and 431.213. In addition, the State must assure all appeal and hearing rights afforded to Demonstration participants as outlined in 42 CFR §431.220 and 431.221. If a Demonstration participant requests a hearing before the date of action, the State must maintain benefits, as required in 42 CFR §431.230. In addition, the State must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category, as discussed in the October 1, 2010, State Health Official Letter #10-008.
- d) Federal Financial Participation (FFP): If the project is terminated or any relevant waivers suspended by the State, FFP shall be limited to normal closeout costs associated with terminating the Demonstration including services and administrative costs of disenrolling participants.

10. CMS Right to Terminate or Suspend.

- a) CMS may suspend or terminate the Demonstration (in whole or in part) at any time before the date of expiration, whenever it determines, following a hearing, that the State has materially failed to comply with the terms of the project. CMS will promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date.
- b) **Finding of Non-Compliance.** The State does not relinquish its rights to challenge the CMS finding that the State materially failed to comply.

11. Withdrawal of Waiver Authority. CMS reserves the right to withdraw waivers of expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX and/or XXI. CMS will promptly notify the State in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the State an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs or disenrolling participants.

12. Adequacy of Infrastructure. The State will ensure the availability of adequate resources for the implementation and monitoring of the Demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other Demonstration components.

13. Public Notice, Tribal Consultation, and Consultation with Interested Parties. The State must comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The State must also comply with the tribal consultation requirements pursuant to section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act of 2009 and the tribal consultation requirements contained in the State's approved Medicaid State plan, when any program changes to the Demonstration, including (but not limited to) those referenced in paragraph 6, are proposed by the State.

In States with Federally recognized Indian tribes, consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 letter or the consultation process in the State's approved Medicaid State plan if that process is specifically applicable to consulting with tribal governments on waivers (42 C.F.R. §431.408(b)(2)).

In States with Federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the State is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any Demonstration proposal and/or renewal of this Demonstration (42 C.F.R. §431.408(b)(3)).

The State must also comply with the Public Notice Procedures set forth in 42 C.F.R. §447.205 for changes in statewide methods and standards for setting payment rates.

14. Post Award Forum: At least once each year, the State will afford the public with an opportunity to provide meaningful comment on the progress of the Demonstration. At least 30 days prior to the date of the planned public forum, the State must publish the date, time and location of the forum in a prominent location on its website. The State can use either its Medicaid Advisory Committee, or another meeting that is open to the public and where an interested party can learn about the progress of the Demonstration to meet the requirements of the STC. The State must include a summary in the quarterly report, as specified in STC

65, associated with the quarter in which the forum was held. The State must also include the summary in its annual report as required by STC 66.

15. Federal Financial Participation (FFP). No Federal matching funds for expenditures authorized for this Demonstration will be available prior to the effective date identified in the Demonstration approval letter.

IV. ELIGIBILITY DERIVED FROM THE DEMONSTRATION

This section governs the State's exercise of Expenditure Authority 3. Those groups made eligible by virtue of the expenditure authorities expressly granted in this demonstration are subject to Medicaid laws, regulations and policies, except as expressly identified as not applicable under expenditure authority granted in this demonstration.

16. STAR+PLUS 217-Like HCBS Eligibility Group. This section describes the eligibility requirements for the 217-Like group under the Demonstration.

- a) STAR+PLUS 217-Like HCBS Eligibility Group consists of persons age 21 and older , who satisfy the following:
 - i. Meet the STAR+PLUS Nursing Facility (NF) level of care requirement;
 - ii. Will receive home and community based-services; and
 - iii. Would be eligible in the same manner as specified under 42 CFR 435.217, 435.236 and 435.726 of the Federal Regulations and eligibility rules specified in section 1924 of the Social Security Act, if the home and community based services of the kind listed in Table 5 were provided under a 1915(c) waiver. The State does not use spousal impoverishment post-eligibility rules.
- b) This Demonstration eligibility group is active at the times and in the parts of the State as indicated below:
 - i. As of the implementation date of this Demonstration, in Column B counties (as defined in Table 1).
 - ii. Starting March 1, 2012 (or the implementation date for the STAR+PLUS expansion, if a later date), in Column E counties (as defined in Table 1).
 - iii. Starting September 1, 2014, (or the implementation date for the STAR+PLUS expansion, if a later date), in Column F counties (as defined in Table 1).
- c) The State retains the discretion to apply an interest list for the STAR+PLUS 217-Like Group as described in paragraph 41(c)(i)(A).

V. DEMONSTRATION DELIVERY SYSTEMS

This section governs the State's exercise of the following: waivers of the requirements for Statewideness (section 1902(a)(1)), Amount, Duration, and Scope of Services (section 1902(a)(10)(B)), Freedom of Choice (section 1902(a)(23)(A)), and Self-Direction of Care for HCBS Participants (section 1902(a)(32)), and Expenditure Authorities 1 through 4.

A. PHASED EXPANSION OF MANAGED CARE DELIVERY SYSTEMS

17. Transition of Existing section 1915(b) and 1915(c) Waiver Programs into the Demonstration. Prior to this Demonstration, the State operated managed care programs under the authority of section 1915(b) and 1915(c) waivers and provided HCBS through additional section 1915(c) waivers where managed care organizations did not operate. The following is a description of the 1915 (b) and (c) waivers that are affected by this Demonstration:

- a) STAR section 1915(b) waiver, TX 16 (ends with initial implementation of the Demonstration);
- b) STAR+PLUS section 1915(b) waiver, TX 12 (ends with initial implementation of the Demonstration);
- c) STAR+PLUS 1915 section (c) waiver, TX 0862 (Medical Assistance Only (MAO) eligibles) (ends with initial implementation of the Demonstration);
- d) STAR+PLUS 1915 section (c) waiver, TX 0325 (SSI eligibles) (ends with initial implementation of the Demonstration);
- e) Community Based Alternatives (CBA) section 1915(c) waiver, TX 0266 (ends in Column E counties that are not Column B counties, as defined in Table 1, when the March 2012 managed care expansion is implemented).
- f) Pending CMS approval, CBA section 1915(c) waiver, TX 0266, terminates effective August 31, 2014. Individuals in that waiver will transition to the STAR+PLUS 1115 HCBS program, effective September 1, 2014.

18. Description of Managed Care Expansion Plan. The State shall conduct geographic expansion of the STAR and STAR+PLUS programs according to the Service Areas defined below. The Primary Care Case Management (PCCM) delivery system in place prior to the Demonstration will terminate and transition to a capitated managed care delivery system. The State shall implement the STAR and STAR+PLUS Expansions on March 1, 2012, or a later date approved by CMS, and determined as part of the Readiness Review, whichever is later. The State shall notify CMS of a need for a delay in implementation, or CMS may identify such a need. Table 1 below defines the Service Areas and delivery systems according to the managed care expansion plan. (Note: the MRSA is defined in paragraph 19 in Table 1, Column D).

Table 1. Service Areas and Delivery Systems as Defined by the Expansion Plan

Note: Counties added to existing Service Areas are noted in italics.

Service Area	STAR Start of Demo Column (A)	STAR+PLUS Start of Demo Column (B)	STAR March 2012 Column (C)	STAR March 2012 Column (D) (MRSA)	STAR+PLUS March 2012 Column (E)	STAR+PLUS September 2014 Column (F) (MRSA)
Bexar	Atascosa, Bandera, Bexar, Comal, Guadalupe, Kendall, Medina, Wilson	Atascosa, Bandera, Bexar, Comal, Guadalupe, Kendall, Medina, Wilson	Atascosa, Bandera, Bexar, Comal, Guadalupe, Kendall, Medina, Wilson	N/A	Atascosa, Bandera, Bexar, Comal, Guadalupe, Kendall, Medina, Wilson	N/A
Dallas	Collin, Dallas, Ellis, Hunt, Kaufman, Navarro, Rockwall	Collin, Dallas, Ellis, Hunt, Kaufman, Navarro, Rockwall	Collin, Dallas, Ellis, Hunt, Kaufman, Navarro, Rockwall	N/A	Collin, Dallas, Ellis, Hunt, Kaufman, Navarro, Rockwall	N/A
El Paso	El Paso Hudspeth	N/A	El Paso, Hudspeth	N/A	<i>El Paso, Hudspeth</i>	N/A
Harris	Austin, Brazoria, Fort Bend, Galveston, Harris, Matagorda, Montgomery, Waller, Wharton	Austin, Brazoria, Fort Bend, Galveston, Harris, Matagorda, Montgomery, Waller, Wharton	Austin, Brazoria, Fort Bend, Galveston, Harris, Matagorda, Montgomery, Waller, Wharton	N/A	Austin, Brazoria, Fort Bend, Galveston, Harris, Matagorda, Montgomery, Waller, Wharton	N/A
Hidalgo	N/A	N/A	<i>Cameron, Duval, Hidalgo, Jim Hogg, Maverick, McMullen, Starr, Webb, Willacy, Zapata</i>	N/A	<i>Cameron, Duval, Hidalgo, Jim Hogg, Maverick, McMullen, Starr, Webb, Willacy, Zapata</i>	N/A

Service Area	STAR Start of Demo Column (A)	STAR+PLUS Start of Demo Column (B)	STAR March 2012 Column (C)	STAR March 2012 Column (D) (MRSA)	STAR+PLUS March 2012 Column (E)	STAR+PLUS September 2014 Column (F) (MRSA)
Jefferson	Chambers, Hardin, Jasper, Jefferson, Liberty, Newton, Orange, Polk, San Jacinto, Tyler, Walker	Chambers, Hardin, Jasper, Jefferson, Liberty, Newton, Orange, Polk, San Jacinto, Tyler, Walker	Chambers, Hardin, Jasper, Jefferson, Liberty, Newton, Orange, Polk, San Jacinto, Tyler, Walker	N/A	Chambers, Hardin, Jasper, Jefferson, Liberty, Newton, Orange, Polk, San Jacinto, Tyler, Walker	N/A
Lubbock	Carson, Crosby, Deaf Smith, Floyd, Garza, Hale, Hockley, Hutchinson, Lamb, Lubbock, Lynn, Potter, Randall, Swisher, Terry	N/A	Carson, Crosby, Deaf Smith, Floyd, Garza, Hale, Hockley, Hutchinson, Lamb, Lubbock, Lynn, Potter, Randall, Swisher, Terry	N/A	<i>Carson, Crosby, Deaf Smith, Floyd, Garza, Hale, Hockley, Hutchinson, Lamb, Lubbock, Lynn, Potter, Randall, Swisher, Terry</i>	N/A
Nueces	Aransas, Bee, Brooks, Calhoun, Goliad, Jim Wells, Karnes, Kenedy, Kleberg, Live Oak, Nueces, Refugio, San Patricio, Victoria	Aransas, Bee, Brooks, Calhoun, Goliad, Jim Wells, Karnes, Kenedy, Kleberg, Live Oak, Nueces, Refugio, San Patricio, Victoria	Aransas, Bee, Brooks, Calhoun, Goliad, Jim Wells, Karnes, Kenedy, Kleberg, Live Oak, Nueces, Refugio, San Patricio, Victoria	N/A	Aransas, Bee, Brooks, Calhoun, Goliad, Jim Wells, Karnes, Kenedy, Kleberg, Live Oak, Nueces, Refugio, San Patricio, Victoria	N/A
Tarrant	Denton, Hood, Johnson, Parker, Tarrant, Wise	Denton, Hood, Johnson, Parker, Tarrant, Wise	Denton, Hood, Johnson, Parker, Tarrant, Wise	N/A	Denton, Hood, Johnson, Parker, Tarrant, Wise	N/A

Service Area	STAR Start of Demo Column (A)	STAR+PLUS Start of Demo Column (B)	STAR March 2012 Column (C)	STAR March 2012 Column (D) (MRSA)	STAR+PLUS March 2012 Column (E)	STAR+PLUS September 2014 Column (F) (MRSA)
Travis	Bastrop, Burnet, Caldwell, Fayette, Hays, Lee, Travis, Williamson	Bastrop, Burnet, Caldwell, Fayette, Hays, Lee, Travis, Williamson	Bastrop, Burnet, Caldwell, Fayette, Hays, Lee, Travis, Williamson	N/A	Bastrop, Burnet, Caldwell, Fayette, Hays, Lee, Travis, Williamson	N/A
Rural (West Texas, Central Texas, and Northeast Texas service areas)	N/A	N/A	N/A	See STC 19	N/A	See STC 19

19. Medicaid Rural Service Area (MRSA). The MRSA consists of 164 counties and, prior to this Demonstration, Medicaid beneficiaries residing in this service area received services through the non-capitated PCCM program under the State plan. The following counties comprise the Medicaid Rural Service Area:

- a) West Texas: Andrews, Archer, Armstrong, Bailey, Baylor, Borden, Brewster, Briscoe, Brown, Callahan, Castro, Childress, Clay, Cochran, Coke, Coleman, Collingsworth, Concho, Cottle, Crane, Crockett, Culberson, Dallam, Dawson, Dickens, Dimmit, Donley, Eastland, Ector, Edwards, Fisher, Foard, Frio, Gaines, Glasscock, Gray, Hall, Hansford, Hardeman, Hartley, Haskell, Hemphill, Howard, Irion, Jack, Jeff Davis, Jones, Kent, Kerr, Kimble, King, Kinney, Knox, La Salle, Lipscomb, Loving, Martin, Mason, McCulloch, Menard, Midland, Mitchell, Moore, Motley, Nolan, Ochiltree, Oldham, Palo Pinto, Parmer, Pecos, Presidio, Reagan, Real, Reeves, Roberts, Runnels, Schleicher, Scurry, Shackelford, Sherman, Stephens, Sterling, Stonewall, Sutton, Taylor, Terrell, Throckmorton, Tom Green, Upton, Uvalde, Val Verde, Ward, Wheeler, Wichita, Wilbarger, Winkler, Yoakum, Young, and Zavala.
- b) Central Texas: Bell, Blanco, Bosque, Brazos, Burleson, Colorado, Comanche, Coryell, DeWitt, Erath, Falls, Freestone, Gillespie, Gonzales, Grimes, Hamilton,

Hill, Jackson, Lampasas, Lavaca, Leon, Limestone, Llano, Madison, McLennan, Milam, Mills, Robertson, San Saba, Somervell, Washington

- c) Northeast Texas: Anderson, Angelina, Bowie, Camp, Cass, Cherokee, Cooke, Delta, Fannin, Franklin, Grayson, Gregg, Harrison, Henderson, Hopkins, Houston, Lamar, Marion, Montague, Morris, Nacogdoches, Panola, Rains, Red River, Rusk, Sabine, San Augustine, Shelby, Smith, Titus, Trinity, Upshur, Van Zandt, Wood

B. ASSURANCES RELATED TO THE ONGOING OPERATION OF MANAGED CARE AND READINESS REVIEW REQUIREMENTS FOR SEPTEMBER 2014 EXPANSION

20. Managed Care Requirements.

- a. General. The State must comply with the managed care regulations published at 42 CFR 438, except as waived herein. Capitation rates shall be developed and certified as actuarially sound, in accordance with 42 CFR 438.6. The certification shall identify historical utilization of State Plan services used in the rate development process.
- b. Data requirements. All managed care organizations shall maintain an information system that collects, analyzes, integrates and reports data as set forth at 42 CFR 438.242. This system shall include encounter data that can be reported in a standardized format. Encounter data requirements shall include the following:
- i. *Encounter Data (Health Plan Responsibilities)*. The health plan must collect, maintain, validate and submit data for services furnished to enrollees as stipulated by the state in its contracts with the health plans.
 - ii. *Encounter Data (State Responsibilities)*. The state shall, in addition, develop mechanisms for the collection, reporting, and analysis of these, as well as a process to validate that each plan's encounter data are timely, complete and accurate. The state will take appropriate actions to identify and correct deficiencies identified in the collection of encounter data. The state shall have contractual provisions in place to impose financial penalties if accurate data are not submitted in a timely fashion. Additionally, the state shall contract with its EQRO to validate encounter data through medical record review.
 - iii. *Encounter Data Validation for New Capitated Managed Care Plans*. If the state contracts with new managed care organizations, the state shall conduct a validation 18 months after the effective date of the contract to determine completeness and accuracy of encounter data. The initial review shall include validation through a sample of medical records of demonstration enrollees.

- iv. *Submission of Encounter Data to CMS.* The state shall submit encounter data to the Medicaid Statistical Information System (MSIS) and when required T-MSIS (Transformed MSIS) as is consistent with Federal law. The state must assure that encounter data maintained at managed care organizations can be linked with eligibility files maintained at the state.

- c. State Advisory Committee. The State will maintain a State Medicaid Advisory Committee, which is comprised of Medicaid recipients, Managed Care Organizations, providers, community-based organizations and advocates serving or representing Medicaid recipients and other interested parties as set forth in Tex. Gov't Code sec. 533.041. The advisory committee will provide input and recommendations to the Health and Human Services Commission regarding the statewide implementation of Medicaid Managed Care, including input and recommendations regarding: 1) program design and benefits, 2) systematic concerns from consumers and providers, 3) the efficiency and quality of services delivered by Medicaid managed care organizations, 4) contract requirements for the Medicaid managed care organizations, 5) Medicaid managed care network adequacy, and 6) trends in claims processing. The advisory committee will also assist HHSC with issues relevant to Medicaid managed care to improve the policies established for and programs operating under Medicaid managed care, including early and periodic screening, diagnosis and treatment, provider and patient education issues, and patient eligibility issues. The State will maintain minutes from these meetings and use them in evaluating program operations and identifying necessary program changes. Copies of committee meeting minutes will be made available to CMS upon request and the outcomes of the meetings may be discussed on the demonstration monitoring calls.

- d. MCO Participant Advisory Committees. The State shall require each MCO, through its contracts, to create and maintain participant advisory committees through which the MCO can share information and capture enrollee feedback. The MCOs will be required to support and facilitate participant involvement and submit meeting minutes to the State. Copies of meeting minutes will be made available to CMS upon request.

- e. Independent Consumer Supports. To support the beneficiary's experience receiving medical assistance and long term services and supports in a managed care environment, the State shall create and maintain a system of consumer supports independent from the managed care plans to assist enrollees in understanding the coverage model and in the resolution of problems regarding services, coverage, access and rights.
 - i. Core Elements of the Independent Consumer Support System.
 - A. *Organizational Structure.* The Independent Consumer Supports System shall operate independently from any STAR+PLUS MCO. The organizational structure of the support system shall facilitate transparent and collaborative operation with beneficiaries, MCOs, and state government.

B. *Accessibility.* The services of the Independent Consumer Supports System will be available to all Medicaid beneficiaries enrolled in STAR+PLUS receiving Medicaid long-term services and supports (institutional, residential and community based). The Independent Consumer Supports system will be accessible through multiple entryways (e.g., phone, internet, office) and will have the capacity to reach out to beneficiaries and/or authorized representatives through various means (mail, phone, in person), as appropriate.

C. *Functions.* The Independent Consumer Supports system will be available to assist beneficiaries in navigating and accessing covered health care services and supports. Where an individual is enrolling in a new delivery system, the services of this system help individuals understand their choices and resolve problems and concerns that may arise between the individual and a provider/payer. The following list encompasses the system's scope of activity.

1. The system will offer beneficiaries support in the pre-enrollment stage, such as unbiased health plan choice counseling and general program-related information.
2. The system will serve as an access point for complaints and concerns about health plan enrollment, access to services, and other related matters.
3. The system will be available to help enrollees understand the hearing, grievance, and appeal rights and processes within the health plan as well as the fair hearing, grievance, and appeal rights and processes available at the state level and assist them through the process if needed/requested.

D. *Staffing and training.* The Independent Consumer Supports system will include individuals who are knowledgeable about the state's Medicaid programs; beneficiary protections and rights under Medicaid managed care arrangements; and the health and service needs of persons with complex needs, including those with a chronic condition, disability, and cognitive or behavioral needs. In addition, the Independent Consumer Supports System will ensure that its services are delivered in a culturally competent manner and are accessible to individuals with limited English proficiency. The system ultimately developed by the State may draw upon existing staff within the chosen organizational structure and provide substantive training to ensure core competencies and a consistent consumer experience.

E. *Data Collection and Reporting.* The Independent Consumer Supports System shall track the volume and nature of beneficiary

complaints and the resolution of such complaints on a schedule and manner determined by the State, but no less frequently than quarterly. This information will inform the state of any provider or contractor issues and support the reporting requirements to CMS.

- ii. Independent Consumer Supports System Plan. The State shall submit a plan to CMS describing the structure and operation of the Independent Consumer Supports system that aligns with the core elements provided in STC 20.e.i no later than May 1, 2014.
- iii. Reporting and Evaluation under the Demonstration. The state will report on the activities of the Independent Consumer Support System in the quarterly and annual reports. An approved Independent Consumer Support System Plan required will become Attachment L. Changes to Attachment L must be submitted to CMS for review and approval subject to STC 7. The State will evaluate the impact of the Independent Consumer Support Program in the Demonstration Evaluation per Section XVI of these STCs.

21. Managed Care Delivery Systems. The State has been granted the authority (subject to Readiness Review, as discussed below) to operate managed care programs in the areas described in paragraphs 18 and 19; therefore, a Demonstration amendment is not required to implement expansions in these service areas. However, any proposed changes in Demonstration authorities; implementation of managed care after June 1, 2012, in the service areas provided in Columns C, D, and E in Table 1; or changes in the populations included or excluded in the authorized service areas will require an amendment to the Demonstration as outlined in STC 7.

22. Readiness Review Requirements for September 1, 2014 expansion. The State will submit to CMS, documentation regarding network adequacy and capacity for the September 1, 2014, expansion and the March 1, 2015 nursing facility expansion, as described below:

- a) The Readiness Review for the September 1, 2014, and March 1, 2015, expansions will consist of the following elements:
 - i. Review and approval of managed care contract amendments; and
 - ii. Review of the State's plans for monitoring, overseeing, and ensuring compliance with MCO contract requirements, including network adequacy.
- b) Unless otherwise noted below, sixty (60) days prior to the State's planned implementation date for the September 1, 2014, and March 1, 2015, expansions, the State must submit the following to CMS review:

- i. A list of deliverables and submissions the State will request from health plans to establish their readiness, with a description of the State's approach to analysis and verification, due May 1, 2014, submitted by the state May 1, 2014, and under review by CMS);
 - ii. Plans for ongoing monitoring and oversight of MCO contract compliance;
 - iii. A contingency plan for addressing insufficient network issues;
 - iv. A plan for the transition from the section 1915(c) waiver programs to the STAR+PLUS HCBS program, submitted by the state on January 10, 2014 and under review by CMS;
 - v. Demonstrations of network adequacy according to the list of deliverables provided in paragraph 24(e); and
 - vi. Proposed managed care contracts or contract amendments, as needed, to implement the STAR and STAR+PLUS Expansions, submitted by the state December 17, 2013 and under review by CMS;
 - vii. Amendment to the Community Based Alternatives (CBA) section 1915(c) waiver (TX 0266) to allow beneficiaries to transition to STAR+PLUS, due 90 days prior to when it takes effect.
- c) CMS reserves the right to request additional documentation and impose additional milestones on the September 1, 2014 and March 1, 2015, expansions in light of findings from the 2014 and 2015 readiness review activities.
 - d) The State must postpone the September 1, 2014 or March 1, 2015, implementation of STAR+PLUS changes (in whole or in part) if requested to do so by CMS. CMS will provide the State its reasons, in writing, for requesting the postponement, which may be based on findings from the readiness review, and will modify the approved Demonstration as necessary to reflect the delay. CMS will endeavor to make any postponement request before June 1, 2014 for the September 1, 2014, expansion and before December 1, 2014, for the March 1, 2015, expansion, but reserves the right to make a request later should new material information become available that would give grounds for postponement.
 - e) Attempts To Gain an Accurate Beneficiary Address. The State will complete return mail tracking after first enrollment notification mailing and throughout the first 90 days of implementation. The State will use information gained from return mail to make additional outreach attempts through other methods (phone, email, etc.) or complete other

beneficiary address analysis from previous claims to strengthen efforts to obtain a valid address.

- f) Verification of Beneficiary's MCO Enrollment. The State shall implement a CMS approved process for an MCO, network and non-network providers, or the State to confirm enrollment of enrollees who do not have a card or go to the wrong provider.
- g) Sample Notification Letters. The State must send sample beneficiary notification letters to the existing Medicaid providers, either through direct mailing, posted on the STAR+PLUS website, or other widely distributed method, so providers are informed of what is being told to the beneficiaries regarding their transition to STAR+PLUS.
- h) Educational Activities for Beneficiaries and Providers. The State will conduct a series of educational events for beneficiaries and providers throughout the state during the five months prior to the implementation of the September 1, 2014, STAR+PLUS expansion.
 - i. Beneficiary educational events will consist of state and MCO staff traveling to locations throughout the state to provide enrollees and potential enrollees with information about STAR+PLUS and the MCOs. Events will be focused on the various demonstration populations including the elderly and HCBS participants. The educational events will educate beneficiaries on their MCO enrollment options, rights and responsibilities, and other important program elements. This effort will include, at a minimum, participation of ombudsman and any other relevant group providing enrollment support for beneficiaries. All informational materials will include contact numbers for the State Call Center and other contracted entities (e.g., fiscal intermediary, ADRCs) that can provide beneficiaries with enrollment support.
 - ii. Provider education events will be conducted primarily by the MCOs with the state in attendance. Events will occur throughout the state at times and places that will allow providers and their administrative staff, as appropriate, to attend. MCOs and the state will educate providers about the goals of STAR+PLUS and the MCOs will train providers and their administrative staff on basic processes and procedures.
- i) State Operated Call Center. The State must operate a call center independent of the MCOs for the duration of the demonstration. This can be achieved either by providing the call center directly or through other state contracted entities (e.g. ADRCs, Fiscal Intermediary). This entity should be able to help enrollees in making independent decisions about MCO choice, provide access to other state resources and enable enrollees to voice complaints about each of the MCOs independent of the MCOs.
- j) Call Center Response Statistics. During the first 30 days of implementation the State must review all call center response statistics daily to ensure all contracted entities are meeting requirements in their contracts. If deficiencies are found, the state and the entity

must determine how they will remedy the deficiency as soon as possible. After the first 30 days, if all entities are consistently meeting requirements, the state can lessen the review of call center statistics, but must still review all statistics at least weekly for the first 180 days of implementation. Data and information regarding call center statistics, including beneficiary questions and concerns, must be made available to CMS upon request.

- k) Implementation Calls with the MCOs. During the initial implementation of the STAR+PLUS expansion, the State must hold regular calls with the MCOs to discuss any issues that arise. The calls should cover all MCO operations and determine plans for correcting any issues as quickly as possible. The state must maintain weekly calls for the first 90 days and bi-weekly calls for the next 90 days. After the first 180 days of the program, the state may move to the regular timeframe intended for meeting with each of the MCOs.
- l) State Review of Beneficiary Complaints, Grievances, and Appeals. During the first six months of the STAR+PLUS expansion, the state must review complaint, grievance, and appeal logs for each MCO and data from the state or MCO operated incident management system on a monthly basis, to understand what issues beneficiaries and providers are having with each of the MCOs. This review should be particularly focused on issues raised by populations that were transitioned from a 1915(c) waiver. The state will use this information to implement any immediate corrective actions necessary. The State will continue to monitor these statistics throughout the demonstration period and report on them in the quarterly reports. Data and information regarding the beneficiary complaints, grievances, and appeals process must be made available to CMS upon request.

23. Contracts. No FFP is available for activities covered under contracts and/or modifications to existing contracts that are subject to 42 CFR 438 requirements prior to CMS approval of such contracts and/or contract amendments. The State shall submit any supporting documentation deemed necessary by CMS. The State will provide CMS with a minimum of 45 days to review and approve changes. CMS reserves the right, as a corrective action, to withhold FFP (either partial or full) for the Demonstration, until the contract compliance requirement is met.

24. Network Requirements. The State must, through contract with MCOs, ensure the delivery of all covered benefits, including high quality care. Services must be delivered in a culturally competent manner, and the MCO network must be sufficient to provide access to covered services to the low-income population. In addition, the MCO must coordinate health care services for Demonstration populations. The following requirements must be met by the State through its MCOs for the duration of the Demonstration.

- a) **Special Health Care Needs.** Enrollees with special health care needs must have direct access to a specialist, as appropriate for the individual's health care condition, as specified in 42 C.F.R. 438.208(c)(4).
- b) **Out of Network Requirements.** The State, through MCOs, must provide Demonstration populations with all Demonstration program benefits described within these STCs, and as specified in 42 CFR 438.206(b)(4), and must allow access to non-network providers, without extra charge, when services cannot be timely furnished through a geographically accessible preferred provider network.
- c) **Timeliness.** The State, through its MCOs, must comply with timely access requirements, and ensure their providers comply with these requirements. Providers must meet State standards for timely access to care and services, considering the urgency of the service needed. Network providers must offer office hours at least equal to those offered to the MCO's commercial line of business enrollees or Medicaid fee-for-service participants, if the provider accepts only Medicaid patients. Contracted services must be made available 24 hours per day, seven days per week, when medically necessary. The State, through the MCO contracts, must establish mechanisms to ensure and monitor provider compliance, and must take corrective action when noncompliance occurs.
- d) **Credentialing.** The State, through its MCOs, must demonstrate that the MCO providers are credentialed. The State must also require these MCOs to participate in efforts to promote culturally-competent service delivery.
- e) **Demonstrating Network Adequacy.** Annually, the State must provide adequate assurances that it has sufficient capacity to serve the expected enrollment in its service area.
 - i. The State must provide supporting documentation that must show that the MCO offers an adequate range of preventive, primary, pharmacy, and specialty service care for the anticipated number of enrollees in the service area. The network must contain providers who are sufficient in number, mix, and geographic distribution to meet the anticipated needs of enrollees. The supporting documentation for network adequacy by MCO includes the following:
 - (A) The MCO's Demonstration population enrollment;
 - (B) Service utilization based on the Demonstration population's characteristics and health care needs;
 - (C) The number and types of primary care, pharmacy, and specialty providers available to provide covered services to the Demonstration population;
 - (D) The number of network providers accepting the new Demonstration population;

- (E) The geographic location of providers and Demonstration populations, as shown through GeoAccess or similar software and identified according to the requirements contained in the State's MCO contract.
- ii. The State must submit the documentation required in subparagraphs (A), (C), (D), and (E) above to CMS in conjunction with the initial contract submission.
- iii. The State must submit this documentation to CMS any time that a significant change occurs in the health plan's operations that would affect adequate capacity and services. Significant changes include changes in services, benefits, geographic service area, or payments or the entity's enrollment of a new population.

25. Enrollment Broker Monitoring. The State shall submit the enrollment broker's monthly reports to CMS upon receipt. The reports should include information on activities including, but not limited to, community outreach events, call center intake statistics, and other enrollment broker activities as needed.

26. Notice of Change in Implementation Timeline. The State must notify CMS of any potential changes in the implementation and deliverables timelines as specified in the STCs.

27. Revision of the State Quality Strategy and Required Monitoring Activities by State.

i. Quality strategy. In accordance with Federal regulations at Subpart D 438.200 regarding Quality Assessment and Performance Improvement to ensure the delivery of quality health care and establishment of standards, the State must update its Quality Strategy to reflect all managed care plans operating under the STAR and STAR+PLUS programs and all quality improvement activities (such as the Delivery System Reform Incentive Payments Pool) proposed through this Demonstration and submit to CMS for approval. The State must obtain the input of recipients and other stakeholders in the development of its revised comprehensive Quality Strategy and make the Strategy available for public comment. The comprehensive Quality Strategy must be submitted to CMS for final approval within nine (9) months from the approval date of demonstration amendment #7 (which expands STAR+PLUS to the MRSA effective September 1, 2014). The State must revise the strategy whenever other significant changes are made, including changes through this Demonstration. The State will also provide CMS with annual reports on the implementation and effectiveness of the updated comprehensive Quality Strategy as it impacts the Demonstration. Until the revised comprehensive Quality Strategy is approved by CMS and implemented by the State, the State must continue with its pre-Demonstration Quality Strategy, which for HCBS is shown as Attachments D and E of these STCs.

ii. Required Monitoring Activities by State and/or External Quality Review Organization (EQRO). The State's EQRO process shall meet all the requirements of 42 CFR §438 Subpart E. In addition to routine encounter data validation processes that take place at the MCO and state level, the state must maintain its contract with its external quality review organization (EQRO) to

require the independent validation of encounter data for all MCOs at a minimum of once every three years. In addition, the State, or its EQRO having sufficient experience and expertise and oversight by the SMA, shall monitor and evaluate the MCOs' performance on specific HCBS requirements. These include but are not limited to the following:

a. Level of care determinations – to ensure that approved instruments are being used and applied appropriately and as necessary, and to ensure that individuals receiving HCBS services have been assessed to meet the required level of care for those services.

b. Service plans – to ensure that MCOs are appropriately creating and implementing service plans based on enrollee's identified needs.

c. MCO credentialing and/or verification policies – to ensure that HCBS services are provided by qualified providers.

d. Health and welfare of enrollees – to ensure that the MCO, on an ongoing basis, identifies, addresses, and seeks to prevent instances of abuse, neglect, and exploitation.

BENEFICIARIES SERVED THROUGH THE DEMONSTRATION

28. Eligibility Groups Affected by the Demonstration. Mandatory and optional Medicaid State plan groups described below are subject to all applicable Medicaid laws and regulations except as expressly waived under authority granted by this Demonstration and as described in these STCs. Any Medicaid State Plan Amendments to the eligibility standards and methodologies for these eligibility groups, including the conversion to a modified adjusted gross income standard effective January 1, 2014, will apply to this demonstration. These State plan eligible beneficiaries are required under the demonstration to enroll in managed care to receive benefits and may have access to additional benefits not described in the State plan.

Table 2 below describes the state plan eligibility groups that are mandatory and voluntary enrollees into managed care. Delivery system participation in the various Service Areas is subject to the implementation schedule and Readiness Review requirements described earlier in this Section. Currently, STAR+PLUS member who enters a nursing facility remains in STAR+PLUS for four months, but the nursing facility services are paid through FFS. By September 1, 2014, the State will “turn off” the four month counter. To maintain continuity of care, members will remain in STAR+PLUS and the nursing facility services will continue to be paid through FFS. Effective March 1, 2015, nursing facility services will be paid through managed care.

Table 2. State Plan Populations Affected by the Demonstration

A=STAR Start of Demo; B = STAR+PLUS Start of Demo; C = STAR March 2012; D = STAR March 2012 (MRSA); E = STAR+PLUS March 2012; F= STAR January 2014; G = STAR+PLUS September 2014; * = Effective through August 31, 2014 (part of STAR+PLUS effective September 1, 2014 – see “G”)						
Medicaid Eligibility Group	Description and Medicaid Eligibility Group (MEG)	Income Limit and Resource Standards	STAR		STAR+	
			Mandatory	Voluntary	Mandatory	Voluntary
<u>Low Income Families</u> §1931 low income families	§1902(a)(10)(A)(i)(I) <u>MEG:</u> THTQIP-Adults (parents and caretaker relatives) OR Children (dependent children)	14% FPL (uses AFDC limits); \$2,000/\$3,000 if an aged or disabled member meets relationship requirement	A C D			
<u>Earnings Transitional</u> Twelve months	Individuals who lose eligibility under §1931 due to increase in income or new employment or loss	185% FPL; No resource test	A C D			

A=STAR Start of Demo; **B** = STAR+PLUS Start of Demo; **C** = STAR March 2012; **D** = STAR March 2012 (MRSA); **E** = STAR+PLUS March 2012; **F**= STAR January 2014; **G** = STAR+PLUS September 2014; * = Effective through August 31, 2014 (part of STAR+PLUS effective September 1, 2014 – see “G”)

Medicaid Eligibility Group	Description and Medicaid Eligibility Group (MEG)	Income Limit and Resource Standards	STAR		STAR+	
			Mandatory	Voluntary	Mandatory	Voluntary
TMA from increase in earnings, combined increase in earnings and child support, or loss of 90% earned income disregard	of earned income disregards; §1902(a)(52) <u>MEG:</u> THTQIP-Adults (parents and caretaker relatives) OR THTQIP-Children (dependent children)					
<u>Child Support Transitional</u> Four months post Medicaid resulting from child support	Individuals who lose eligibility under §1931 due to child or spousal support; §1902(a)(10)(A)(i)(I) <u>MEG:</u> THTQIP-Adults (parents and caretaker relatives) OR THTQIP-Children (dependent children)	N/A; No resource test	A C D			
<u>Poverty Level Pregnant Women</u>	§1902(a)(10)(A)(i)(IV), §1902(l)(1)(A) <u>MEG:</u> THTQIP-Adults	185% FPL; No resource test	A C D			
<u>Children Under 1</u> Poverty level infants	§1902(a)(10)(A)(i)(IV), §1902(l)(1)(B) <u>MEG:</u> THTQIP-Children	185% FPL; \$2,000/\$3,000 if aged or disabled member meets relationship requirement	A C D			
<u>Newborn Children</u> Children to age one born to Medicaid eligible mother	Deemed Newborn – mother was eligible for and received Medicaid for the birth; §1902(e)(4), 42 CFR §435.117 <u>MEG:</u> THTQIP-Children	N/A; No resource test	A C D			
<u>Children Age 1-5</u>	Poverty level children under 6; §1902(a)(10)(A)(i)(VI), §1902(l)(1)(C) <u>MEG:</u> THTQIP-Children	133% FPL; \$2,000/\$3,000 if aged or disabled member meets relationship requirement	A C D			

A=STAR Start of Demo; B = STAR+PLUS Start of Demo; C = STAR March 2012; D = STAR March 2012 (MRSA); E = STAR+PLUS March 2012; F= STAR January 2014; G = STAR+PLUS September 2014; * = Effective through August 31, 2014 (part of STAR+PLUS effective September 1, 2014 – see “G”)

Medicaid Eligibility Group	Description and Medicaid Eligibility Group (MEG)	Income Limit and Resource Standards	STAR		STAR+	
			Mandatory	Voluntary	Mandatory	Voluntary
<u>Children Age 6-18</u>	<p>Poverty level children under 19; §1902(a)(10)(A)(i)(VII), §1902(l)(1)(D)</p> <p>Note: All children at or below 100 percent FPL in this eligibility group are funded through title XIX. Title XXI funding for children between 100-133% FPL shall be claimed as outlined in 42 CFR § 433.11</p> <p><u>MEG:</u> If title XIX: THTQIP-Children If title XXI: THTQIP-MCHIP Children</p>	133% FPL; ¹ \$2,000/\$3,000 if aged or disabled member meets relationship requirement	A C D F			
<u>Former Foster Care Children¹</u>	<p>Former foster care children §1902(a)(10)(A)(i)(IX)</p> <p>Mandatory managed care for 18-26. Ages 18 through 20: choice between STAR Health and STAR program. Ages 21 up to 26: Mandatory STAR.</p> <p><u>MEG:</u> THTQIP-Adults (parents and caretaker relatives)</p>	N/A; No resource test	F			
<u>SSI Recipient 21 and older with Medicare (Dual)</u>	<p>Individuals receiving SSI cash benefits; §1902(a)(10)(A)(i)(II) §1902(a)(10)(A)(i)(II)(cc) Covers gap month children within the waiver; however, retroactive payments, including payment for the gap month, are paid via FFS</p> <p><u>MEG:</u> THTQIP-AMR</p>	74% FPL (SSI Limit); \$2,000 individual, \$3,000 couple			B E G	

¹ Note: The inclusion of children age 6-18 between 100-133 percent FPL and former foster care children is effective January 1, 2014, consistent with the state plan.

A=STAR Start of Demo; **B** = STAR+PLUS Start of Demo; **C** = STAR March 2012; **D** = STAR March 2012 (MRSA); **E** = STAR+PLUS March 2012; **F**= STAR January 2014; **G** = STAR+PLUS September 2014; * = Effective through August 31, 2014 (part of STAR+PLUS effective September 1, 2014 – see “G”)

Medicaid Eligibility Group	Description and Medicaid Eligibility Group (MEG)	Income Limit and Resource Standards	STAR		STAR+	
			Mandatory	Voluntary	Mandatory	Voluntary
<u>SSI Recipient under 21 with Medicare (Dual)</u>	Individuals receiving SSI cash benefits; §1902(a)(10)(A)(i)(II) §1902(a)(10)(A)(i)(II)(cc). Covers gap month children within the waiver; however, retroactive payments, including payment for the gap month, are paid via FFS <u>MEG: THTQIP-AMR</u>	74% FPL (SSI Limit); \$2,000 individual, \$3,000 couple				B E G
<u>SSI Recipient without Medicare 21 and older</u>	Individuals receiving SSI cash benefits; §1902(a)(10)(A)(i)(II). §1902(a)(10)(A)(i)(II)(cc). Covers gap month children within the waiver; however, retroactive payments, including payment for the gap month, are paid via FFS <u>MEG: THTQIP-Disabled</u>	74% FPL (SSI Limit); \$2,000 individual, \$3,000 couple	D*	A*	B E G	
<u>SSI Recipient without Medicare under 21</u>	Individuals receiving SSI cash benefits; §1902(a)(10)(A)(i)(II) §1902(a)(10)(A)(i)(II)(cc) Covers gap month children within the waiver; however, retroactive payments, including payment for the gap month, are paid via FFS <u>MEG: THTQIP-Disabled</u>	74% FPL (SSI Limit); \$2,000 individual, \$3,000 couple		A* D*		B E G
<u>Pickle Group 21 and older, with Medicare</u> Includes pre-Pickle eligibility group	Would be eligible for SSI if title II COLAs deducted from income; 42 CFR §435.134, 435.135 <u>MEG: THTQIP-AMR</u>	74% FPL (SSI Limit); \$2,000 individual, \$3,000 couple			B E G	
<u>Pickle Group 21 and older without Medicare</u> Includes pre-Pickle eligibility group	Would be eligible for SSI if title II COLAs were deducted from income; 42 CFR §435.134, 42 CFR §435.135 <u>MEG: THTQIP-Disabled</u>	74% FPL (SSI Limit); \$2,000 individual, \$3,000 couple	D*	A*	B E G	
<u>Pickle Group under 21 with Medicare</u>	Would be eligible for SSI if title II COLAs deducted from income; 42 CFR §435.135 <u>MEG: THTQIP-AMR</u>	74% FPL (SSI Limit); \$2,000 individual, \$3,000 couple				B E G
<u>Pickle Group under</u>	Would be eligible for SSI if title II	74% FPL (SSI Limit);		A*		B

A=STAR Start of Demo; B = STAR+PLUS Start of Demo; C = STAR March 2012; D = STAR March 2012 (MRSA); E = STAR+PLUS March 2012; F= STAR January 2014; G = STAR+PLUS September 2014; * = Effective through August 31, 2014 (part of STAR+PLUS effective September 1, 2014 – see “G”)

Medicaid Eligibility Group	Description and Medicaid Eligibility Group (MEG)	Income Limit and Resource Standards	STAR		STAR+	
			Mandatory	Voluntary	Mandatory	Voluntary
<u>21 without Medicare</u>	COLAs deducted from income; 42 CFR §435.135 MEG: THTQIP-Disabled	\$2,000 individual, \$3,000 couple		D*		E G
<u>Disabled Adult Children (DAC) 21 or over with Medicare</u>	§1635(c); §1935 MEG: THTQIP-AMR	74% FPL (SSI Limit); \$2,000 individual, \$3,000 couple			B E G	
<u>Disabled Adult Children (DAC) 21 or over without Medicare</u>	§1635(c); §1935 MEG: THTQIP-Disabled	74% FPL (SSI Limit); \$2,000 individual, \$3,000 couple	D*	A*	B E G	
<u>DAC under 21 with Medicare</u>	§1635(c); §1935 MEG: THTQIP-AMR	74% FPL (SSI Limit); \$2,000 individual, \$3,000 couple				B E G
<u>DAC under 21 without Medicare</u>	1635(c); §1935 MEG: THTQIP-Disabled	74% FPL (SSI Limit); \$2,000 individual, \$3,000 couple		A* D*		B E G
<u>Disabled Widow(er)</u>	Widows/Widowers, 1634(b); §1935 MEG: THTQIP-Disabled	74% FPL (SSI Limit); \$2,000 individual, \$3,000 couple	D*	A*	B E G	
<u>Early Aged Widow(er)</u>	Early Widows/Widowers, 1634(d); §1935 MEG: THTQIP-Disabled	74% FPL (SSI Limit); \$2,000 individual, \$3,000 couple	D*	A*	B E G	
<u>SSI Denied Children with Medicare, under age 19</u>	Children no longer eligible for SSI because of change in definition of disability; §1902(a)(10)(A)(i)(II) MEG: THTQIP-AMR	74% FPL (SSI Limit); \$2,000 individual, \$3,000 couple				B E G
<u>SSI Denied Children without Medicare, under age 19</u>	Children no longer eligible for SSI because of change in definition of disability; §1902(a)(10)(A)(i)(II) MEG: THTQIP-Disabled	74% FPL (SSI Limit); \$2,000 individual, \$3,000 couple		A* D*		B E
<u>Medicaid Buy-In (MBI) with Medicare</u>	BBA Work Incentives Group; §1902(a)(10)(ii)(XIII) MEG: THTQIP-AMR	250% FPL; \$2,000			B E G	
<u>Medicaid Buy-In (MBI) without Medicare</u>	BBA Work Incentives Group; §1902(a)(10)(ii)(XIII) MEG: THTQIP-Disabled	250% FPL; \$2,000	D*	A*		B E G
<u>Medicaid Buy-In for</u>	Family Opportunity Act (MBIC),	300% FPL;				B

A=STAR Start of Demo; B = STAR+PLUS Start of Demo; C = STAR March 2012; D = STAR March 2012 (MRSA); E = STAR+PLUS March 2012; F= STAR January 2014; G = STAR+PLUS September 2014; * = Effective through August 31, 2014 (part of STAR+PLUS effective September 1, 2014 – see “G”)

Medicaid Eligibility Group	Description and Medicaid Eligibility Group (MEG)	Income Limit and Resource Standards	STAR		STAR+	
			Mandatory	Voluntary	Mandatory	Voluntary
<u>Children (under age 19) with Medicare</u>	§1902(a)(10)(A)(ii)(XIX) MEG: THTQIP-AMR	No resource standard				E G
<u>Medicaid Buy-In for Children (under age 19) without Medicare</u>	Family Opportunity Act (MBIC), §1902(a)(10)(A)(ii)(XIX) MEG: THTQIP-Disabled	300% FPL; No resource standard		A* D*		B E G
<u>Nursing Facility age 21 and older</u>	Special income level group, in a medical institution for at least 30 consecutive days with gross income that does not exceed 300% of the SSI income standard; §1902(a)(10)(A)(ii)(V) MEG: THTQIP-AMR (with Medicare) OR THTQIP-Disabled (without Medicare)	300% SSI or Approx. 220% FPL; \$2,000 individual/ \$3,000 couple			B† E† G	
<u>217 Group without Medicare under 21</u>	Institutional eligibility and post-eligibility rules for individuals who are eligible as specified under 42 CFR 435.217, 435.236, and 435.726 and §1924 of the Act. MEG: THTQIP-Disabled (without Medicare)	300% SSI or Approx. 220% FPL; \$2,000 individual/\$3,000 couple. Use spousal impoverishment policy for eligibility, but not for post-eligibility.		D*		G
<u>217 Group without Medicare 21 and older</u>	Institutional eligibility and post-eligibility rules for individuals who are eligible as specified under 42 CFR 435.217, 435.236, and 435.726 and §1924 of the Act. MEG: THTQIP-Disabled (without Medicare)	300% SSI or Approx. 220% FPL; \$2,000 individual/\$3,000 couple. Use spousal impoverishment policy for eligibility, but not for post-eligibility.	D*		G	

† Only beneficiaries who enrolled in STAR+PLUS prior to a nursing facility admission remain enrolled in STAR+PLUS while in a nursing facility. These beneficiaries left STAR+PLUS after four months in a nursing facility.

29. Demonstration Expansion Population – STAR+PLUS 217-Like Eligibility Group

Table 3 below describes the demonstration expansion populations that are mandatory and voluntary enrollees into managed care. Delivery system participation in the various Service Areas is subject to the implementation schedule and Readiness Review requirements described earlier in paragraph 22. A STAR+PLUS member who enters a nursing facility remains in STAR+PLUS for four months, but payment for the nursing facility services is made outside of the managed care capitation rate directly to the nursing facility, at the otherwise applicable state plan rate. Effective March 1, 2015, nursing facility benefits will be a capitated service for STAR+PLUS members age 21 and older. STAR+PLUS members who enter a nursing facility on September 1, 2014, or later will remain enrolled in STAR+PLUS through February 28, 2015, provided they continue to be eligible for STAR+PLUS.

As described in STC 16, those groups made eligible by virtue of the expenditure authorities expressly granted in this demonstration are subject to Medicaid laws, regulations and policies, except as expressly identified as not applicable under expenditure authority granted in this demonstration.

Table 3. Demonstration Expansion Populations Made Eligible by the Demonstration

A=STAR Start of Demo; B = STAR+PLUS Start of Demo; C = STAR March 2012; D = STAR March 2012 (MRSA); E = STAR+PLUS March 2012; F = STAR January 2014; G = STAR+PLUS September 2014; * = Effective through August 31, 2014 (part of STAR+PLUS effective September 1, 2014 – see “G”)						
Expansion Eligibility Group	Description and MEG	Income Limit and Resource Standards	STAR		STAR+	
			Mandatory	Voluntary	Mandatory	Voluntary
217-Like Group Categorically needy individuals under the State plan receiving HCBS services (of the kind listed in Table 5) in the STAR+PLUS service areas.	Institutional eligibility and post-eligibility rules for individuals who would only be eligible in the same manner as specified under 42 CFR 435.217, 435.236, and 435.726 and §1924 of the Act, if the State had not eliminated its 1915(c) STAR+PLUS waivers. <u>MEG:</u> THTQIP-AMR (with Medicare) OR THTQIP-Disabled (without	300% SSI or Approx. 220% FPL; \$2,000 individual/\$3,000 couple.			B E G	

A=STAR Start of Demo; B = STAR+PLUS Start of Demo; C = STAR March 2012; D = STAR March 2012 (MRSA); E = STAR+PLUS March 2012; F = STAR January 2014; G = STAR+PLUS September 2014; * = Effective through August 31, 2014 (part of STAR+PLUS effective September 1, 2014 – see “G”)						
Expansion Eligibility Group	Description and MEG	Income Limit and Resource Standards	STAR		STAR+	
			Mandatory	Voluntary	Mandatory	Voluntary
	Medicare)					

30. Populations Not Affected by the Demonstration. The following populations receive Medicaid services without regard to the Demonstration.

- a) Medically Needy;
- b) IV-E eligible adoption assistance individuals, STAR Health enrollees, transitioning foster care youth, non-IV-E Foster Care and State subsidized adoption children, independent foster care adolescents, and optional categorically needy children eligible under 42 CFR 435.222;
- c) Women in the Medicaid Breast and Cervical Cancer Program;
- d) Residents of State Supported Living Centers;
- e) Undocumented or Ineligible (5-year bar) Aliens only eligible for emergency medical services;
- f) Prior to September 1, 2014, individuals residing in a nursing facility, who entered the nursing facility while enrolled in STAR+PLUS, and who have been in the nursing facility for at least four months;
- g) Individuals residing in a nursing facility who entered the nursing facility while enrolled in STAR, beginning with the month after the State receives notification that they entered the nursing facility; and
- h) Individuals enrolled in the Program for All Inclusive Care for the Elderly (PACE) program.
- i) Individuals enrolled in the Medically Dependent Children Program (1915(c))

j)

C. STAR AND STAR+PLUS (non-HCBS) ENROLLMENT, BENEFITS AND REPORTING REQUIREMENTS

31. Enrollment.

Time to Choose a Plan.

For implementation of the September 1, 2014 and March 1, 2015, changes, as described in Section II, potential beneficiaries, excluding pregnant women, will have 30 days to choose a managed care organization. Pregnant women will have 16 days to choose a managed care organization. Effective September 1, 2014, and March 1, 2015, all beneficiaries will have 15 days to choose a managed care organization.

- a) **Auto-Assignment.** If a potential beneficiary does not choose a managed care organization within the time frames defined in (a), he or she may be auto-assigned to a managed care organization. When possible, the auto-assignment algorithm shall take into consideration the beneficiary's history with a primary care provider, and when applicable, the beneficiary's history with a nursing facility. If this is not possible the State will equitably distribute beneficiaries among qualified MCOs.
- b) The State may automatically re-enroll a beneficiary in the same managed care organization if there is a loss of Medicaid eligibility for six months or less.

32. Disenrollment or Transfer. Individuals should be informed of opportunities no less than annually for disenrollment and ongoing plan choice opportunities, regularly and in a manner consistent with 42 CFR 438 and other requirements set forth in the Demonstration Special Terms and Conditions.

- a) **MCO Transfer at Request of Beneficiary.** Beneficiaries may request transfer to another managed care organization in the service area through the enrollment broker at any time.
- b) **Transfer to FFS at Request of Beneficiary** Recipients that are voluntarily enrolled in a managed care programs may request disenrollment and return to traditional Medicaid. Mandatory recipients must request disenrollment from managed care in writing to HHSC; however, HHSC considers disenrollment from managed care only in rare situations, when sufficient medical documentation establishes that the MCO cannot provided the needed services. An authorized HHSC representative reviews all disenrollment requests, and processes approved requests for disenrollment from an MCO. The Enrollment Broker provides disenrollment education and offers other options as appropriate.

- c) **Transfer to FFS at Request of MCO.** A managed care organization has a limited right to request a beneficiary be disenrolled from the managed care organization without the beneficiary's consent. HHSC must approve any managed care organization request for disenrollment of a beneficiary for cause. HHSC may permit disenrollment of a beneficiary under the following circumstances:
- i. The beneficiary misuses or loans his or her managed care organization membership card to another person to obtain services; or
 - ii. The beneficiary is disruptive, unruly, threatening or uncooperative to the extent that his or her membership seriously impairs the MCO's or provider's ability to provide services to the beneficiary, or to obtain new beneficiaries, and the beneficiary's behavior is not caused by a physical or behavioral health condition; or
 - iii. The beneficiary consistently refuses to comply with managed care restrictions (e.g., repeatedly using the emergency room in combination with refusing to allow the managed care organization to treat the underlying medical condition).

The managed care organization must take reasonable measures to correct the beneficiary's behavior prior to requesting disenrollment. Reasonable measures may include providing education and counseling regarding the offensive acts or behaviors. HHSC must notify the beneficiary of HHSC's decision to disenroll the beneficiary, if all reasonable measures have failed to remedy the problem. If the beneficiary disagrees with the decision to disenroll the beneficiary from the managed care organization, HHSC must notify the beneficiary of the availability of the complaint procedure and HHSC's fair hearing process. The managed care organization cannot request a disenrollment based on adverse change in the member's health status or utilization of services that are medically necessary for treatment of a member's condition.

d) **Impact of Nursing Facility Entry on Enrollment in STAR and STAR+PLUS.**

- i. For STAR+PLUS: Effective through February 28, 2015, individuals in a nursing facility are excluded from STAR+PLUS. STAR+PLUS members who enter a nursing facility can continue to be enrolled for four months. After four months, if still in a nursing facility, the member is disenrolled. Persons in a nursing facility may enter STAR+PLUS when discharged from the nursing facility through the Money Follows the Person program. STAR+PLUS members who enter a nursing facility on September 1, 2014, or later will remain enrolled in STAR+PLUS through February 28, 2015, provided they continue to be eligible for STAR+PLUS. Effective March 1, 2015, nursing facility services are included in STAR+PLUS.
- ii. For STAR: Individuals residing in a nursing facility who entered the nursing facility while enrolled in STAR are disenrolled from STAR, beginning with the month after the State receives notification they entered the nursing facility.

33. Benefits. The following Table 3 specifies the scope of services that may be made available to STAR and STAR+PLUS enrollees through the STAR and STAR+PLUS managed care plans. The schedule of services mirrors those provided in the Medicaid State plan, with the exception of 1915(b)(3)-like services as described in this waiver.

Should the State amend its State plan to provide additional optional services not listed below, coverage for those services may also be provided through the STAR and STAR+PLUS MCOs. The State will include non-behavioral inpatient hospital services in STAR+PLUS capitation as of the March 2012 expansion.

Table 3. State Plan Services for STAR and STAR+PLUS Participants

Adult/ Child	Service	Mandatory or Optional State Plan Services ²
Adult/Child	Inpatient Hospital Services ^{1,2,3}	Mandatory §1905(a)(1)
Adult/Child	Outpatient Hospital Services	Mandatory §1905(a)(2)
Adult/Child	Rural Health Clinic Services	Mandatory §1905(a)(2)
Adult/Child	(Federally Qualified Health Center (FQHC) Services	Mandatory §1905(a)(2)
Adult/Child	Laboratory and x-ray services	Mandatory §1905(a)(3)
Adult/Child	Diagnostic Services	Optional §1905(a)(13)
Child	EPSDT	Mandatory §1905(a)(4)
Adult/Child	Family Planning	Mandatory §1905(a)(4)
Adult/Child	Physician's Services	Mandatory §1905(a)(5)
Adult/Child	Medical and Surgical Services Furnished by a Dentist	Mandatory §1905(a)(5)
Adult/Child	Podiatrists' Services	Optional §1905(a)(6)
Adult/Child	Optometrists' Services	Optional §1905(a)(6)
Adult/Child	Intermittent or part-time nursing services provided by a home health agency	Mandatory for individuals who, under the State plan, are entitled to nursing facility services, §1902(a)(10)(D)
Adult/Child	Home health aide services provided by a home health agency	Mandatory for individuals who, under the State plan, are entitled to nursing facility services, §1902(a)(10)(D)
Adult/Child	Medical supplies, equipment, and appliances	Mandatory for individuals who, under the State plan, are entitled to nursing facility services, §1902(a)(10)(D)
Adult/Child	Physical therapy, occupational therapy, speech pathology, and audiology provided by a home health agency	Optional §1902(a)(10)(D), 42 CFR 440.70
Adult/Child	Clinic Services	Optional §1905(a)(9)
Adult/Child	Prescribed Drugs (beginning March 1, 2012) ⁴	Optional §1927(d)
Adult/Child	Non-prescription drugs (beginning	Optional §1927(d)

² This column describes whether a services is a required state plan service or if a state can elect to cover the service under the Social Security Act. All services listed here are covered in the Texas State plan.

Adult/ Child	Service	Mandatory or Optional State Plan Services ²
	March 1, 2012	
Adult/Child	Prosthetic Devices	Optional §1905(a)(12)
Adult/Child	Eyeglasses	Optional §1905(a)(12)
Adult/Child	Preventive Services	Optional §1905(a)(13)
Adult	Services for individuals over age 65 in IMDs – Inpatient, Not Nursing Facility	Optional §1905(a)(14)
Adult	Effective through February 28, 2015: Nursing facility services for enrollees age 21 and older – 4 month service limitation. Effective March 1, 2015: Nursing facility services (STAR+PLUS only)	Mandatory §1905(a)(4)
Child	Inpatient psychiatric facility services for individuals under age 21	Optional §1905(a)(16)
Adult (STAR+PLUS)	Rehabilitative Services – Day Activity & Health Services	Optional, Rehabilitation Service, 42 CFR 440.130(d)
Adult/Child	Effective September 1, 2014: Mental Health Rehabilitative Services	Optional, Rehabilitation Service, 1905(a)(13) and 42 CFR 440.130(d)
Adult/Child	Effective September 1, 2014: Targeted Case Management for Individuals with Chronic Mental	Optional 1915(a)(19), 1915(g)
Adult/Child	Nurse-Midwife Services	Mandatory §1905(a)(17)
Adult/Child	Certified pediatric or family nurse practitioners' services	Mandatory §1905(a)(21)
Adult/Child	Personal care services in the home	Optional §1905(a)(24), 42 CFR 440.170

¹ Substance use disorder treatment services are capitated services for STAR and STAR+PLUS, and MCOs may provide these services in a chemical dependency treatment facility in lieu of the acute care inpatient hospital setting. Similarly, the MCOs will be responsible for providing acute inpatient days for psychiatric conditions, and may provide these services in a free-standing psychiatric hospital in lieu of acute care inpatient hospital settings. The State does not include non-State plan services, such as room and board, in the STAR or STAR+PLUS capitation; however, the MCO is not restricted to only the delivery of State plan services when alternative services are a cost-effective and medically appropriate response to the needs of the member.

² The 30-day spell of illness limitation for hospital inpatient services that is described in the state plan does not apply to STAR enrollees. Effective September 6, 2013, the spell of illness limitation does apply to STAR+PLUS. As described in the state plan, the spell of illness limitation does not apply to certain approved transplants, nor to children age 20 and younger.

³ The annual benefit limitation on inpatient hospital services that is described in the state plan does not apply to STAR or STAR+PLUS enrollees.

+ The state plan prescription drug limitations for adults aged 21 and older do not apply to STAR or STAR+PLUS enrollees.

34. Self-Referral. Demonstration beneficiaries may self-refer for the following services:

- a) In-network behavioral health services;
- b) Obstetric and gynecological services, regardless of whether the provider is in the client's MCO network;
- c) In-network eye health care services, other than surgery, including optometry and ophthalmology;
- d) Family planning services, regardless of whether the provider is in the client's MCO network; and
- e) Services from a provider with the Early Childhood Intervention program for children ages 0-3 years with a developmental delay.

35. Federally Qualified Health Centers and Rural Health Centers. An enrollee is guaranteed the choice of at least one MCO which has at least one FQHC as a participating provider. If the enrollee elects not to select an MCO that includes a FQHC in the provider network, no FQHC services will be required to be furnished to the enrollee while the enrollee is enrolled with that MCO. The same requirements apply to Rural Health Centers.

36. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). The MCOs will fulfill the State's responsibilities for coverage, outreach, and assistance with respect to EPSDT services that are described in the requirements of sections 1905(a)(4)(b) (services), 1902(a)(43) (administrative requirements), and 1905(r) (definitions).

37. Marketing and Information. The State may permit indirect marketing by MCOs, including: radio, TV, billboard, bus signs, bench displays, newspaper, decals, and banners. Direct mail marketing is prohibited, with the exception of direct marketing conducted during HHSC-approved enrollment events. HHSC's managed care contracts and Uniform Managed Care Manual must include restrictions on offering gifts and other incentives to potential enrollees, and reporting and investigating alleged marketing violations.

- a) The State must require MCOs to translate marketing materials into languages of major population groups that comprise 10 percent or more of the population.
- b) All information provided to enrollees, inclusive of, and in addition to, educational materials, enrollment and disenrollment materials, benefit changes, and explanations and other communication, must fully comport with 42 CFR 438.10, and be accessible and understandable to individuals enrolled or potentially enrolled in the Demonstration.

38. Fair Hearing Procedures. For standard appeals, members have a right to access the fair hearing process at any time. For expedited appeals, members must exhaust the MCO's expedited appeals process before making a request for an expedited HHSC fair hearing.

39. STAR and STAR+PLUS (non-HCBS) Reporting Requirements. The State will be required to report to CMS the following topics within each report. Each report topic should include a brief description of the findings (if reported by MCOs as required under contract), any problems found, and any corrective action plans put in place either at the plan level or the State level to address the issues.

- a) Quarterly Progress Report – Provider termination rates (including primary care physicians and types of specialists) and reasons for termination; customer service reporting, including average speed of answer at the plans and call abandonment rates; Medicaid managed care helpline findings, MCO network adequacy reporting through Enrollment Broker reporting; and MCO compliance with access time/distance standards, including Geo Access mapping through HHSC Strategic Division Support.
- b) Bi-annual (Every Other Quarterly Progress Report) – Disenrollment requests by enrollees or the plans; summary of MCO appeals for the quarter; and outcomes of claims summary reporting including timeliness in processing claims, accuracy and any possible fraud and abuse detected, enrollment into managed care for people with special health care needs.
- c) Annual Report – CAHPS survey (for STAR or STAR+PLUS depending on the availability of the survey data), including report on provider wait times or appointment scheduling times; annual summary of network adequacy by plan, as specified in paragraph 27(e)(1), MCO compliance with provider 24/7 availability; summary of outcomes of any reviews or studies, including focused studies, External Quality Reviews, financial reviews, or other types of reviews or studies conducted by the State or a contractor of the State, as feasible and appropriate.

E. CHILDREN’S DENTAL PROGRAM

40. Implementation of the Children’s Dental Program. As of March 2012 (subject to the CMS readiness review, as discussed in STC 18), children’s primary and preventive Medicaid dental services shall be delivered through a capitated statewide dental services program (the Children’s Dental Program). Contracting dental maintenance organizations (DMOs) will develop networks of Main Dental Home providers, consisting of general dentists and pediatric dentists. The dental home framework under this statewide program shall be informed by the improved dental outcomes evidenced under the “First Dental Home Initiative” in the State. Services provided through the Children’s Dental Program are separate from the medical services provided by the STAR and STAR+PLUS managed care organizations, and are available to persons listed in Table 2 who are under age 21, with the exception of the groups listed in (b) below. 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.

- a) 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.

- b) Implementation of the Children's Dental Program is subject to the State demonstrating sufficient network adequacy, in accordance with the requirements and deliverables provided in paragraph 22(b) of these STCs, except that subparagraph 22(b)(iv) does not apply, and (to the extent that it cross-references requirements relating to primary care providers and pharmacy services in STC 24(e)) subparagraph 22(b)(v) does not apply. In addition, for purposes of this paragraph 40(b), references to the STAR and STAR+PLUS programs in paragraphs 22(b) and 24(e) are replaced with the Children's Dental Program. CMS acknowledges that the State already has submitted the readiness review deliverables due November 3, 2011.
- c) The State will continue to hold quarterly meetings with dental stakeholders, including dental care providers, as required under the *Frew* consent decree. The State will collect relevant data from each DMO to comply with CMS-416 reporting requirements.

F. STAR+PLUS HOME AND COMMUNITY BASED SERVICES (HCBS) ENROLLMENT, BENEFITS AND REPORTING REQUIREMENTS

41. Operations of the STAR+PLUS HCBS Program

- a) **Compliance with Specified HCBS Requirements.** All Federal regulations that govern the provision of HCBS under section 1915(c) waivers shall apply to the HCBS program authorized under section 1115, and provided through STAR+PLUS. The State shall include a description of the steps taken to ensure compliance with these regulations as part of the Annual Report discussed in paragraph 67. HCBS, under the Demonstration, shall operate in accordance with these STCs and associated attachments.
As of the initial approval of this Demonstration, these STCs define an HCBS program that operates in the same manner as under the approved section 1915(c) waiver authorities that were transferred to this Demonstration.
- b) **Regional Rollout and Transition of the Demonstration and Concurrent Ending of the section 1915(c) Waivers.**
 - i. The State must provide notice to STAR+PLUS HCBS participants residing in Column B counties (see Table 1) that the authority for such services is transferring from a section 1915(c) waiver authority to the Demonstration, that no action is required on behalf of the beneficiary, and that there is no disruption or changes to services. Such notice must be provided to said beneficiaries prior to the transfer of waiver authorities from section 1915(c) to the section 1115 Demonstration.

- ii. The State may implement STAR+PLUS in Column E counties that are not Column B counties (see Table 1) no earlier than March 1, 2012.
 - iii. The State must provide notice and any outreach and educational materials to all individuals currently enrolled in the section 1915(c) waiver known as Community Based Alternatives (control number 0266) that reside in Column E counties that are not Column B counties (see Table 1) where the Community Based Alternatives will terminate, and be replaced with the STAR+PLUS HCBS program. Such notice must be provided no later than 30 days prior to the transfer of waiver authorities from 1915(c) to the 1115 Demonstration. The transition plan for this population must be submitted to CMS as part of the Readiness Review specified in paragraph 22.
 - iv. The State may implement STAR+PLUS in the counties described in Column F of Table 1 no earlier than September 1, 2014.
 - v. Per an amendment and phase-out schedule for the section 1915(c) waiver, the State must simultaneously cease operation of the section 1915(c) waiver for persons who are elderly and/or disabled in the region in which the STAR+PLUS program is being implemented, in accordance with requirements for 1915(c) waiver termination, including submission of waiver amendments, public notice/tribal consultation requirements.
 - vi. The State must provide notice and any outreach and educational materials to all individuals currently enrolled in the section 1915(c) waiver known as Community Based Alternatives (control number 0266) that reside in STC 19 counties where the Community Based Alternatives will terminate and be replaced with the STAR+PLUS HCBS program. Such notice must be provided no later than 30 days prior to the transfer of waiver authorities from 1915(c) to the 1115 Demonstration. The transition plan for this population must be submitted to CMS as part of the Readiness Review specified in paragraph 22.
- c) **Determination of Benefits by Designation into a STAR+PLUS HCBS Group.** The STAR+PLUS HCBS Program provides long-term care services and supports as identified in Table 5 to two groups of people, as defined below:
- i. **STAR+PLUS 217-Like HCBS Group.** This group consists of persons age 21 and older, who meet the NF 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 NF care. The Demonstration population 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, as described below.

(A) **Interest List for STAR+PLUS 217-LIKE HCBS Group.** The State will operate an interest list for the STAR+PLUS 217-Like HCBS population in the Demonstration. An interest list is a waiting list that an individual is placed on when they express interest in enrollment, to the State or local agency that determines eligibility for STAR +PLUS. Individuals meeting all eligibility criteria are enrolled into this population on a “first-come, first-served” basis from the interest list, except that persons entering the Demonstration through Money Follows the Person (MFP) are placed at the head of the interest list. These lists must be managed on a statewide basis using a standardized assessment tool, and in accord with criteria established by the State. Interest list policies must be based on objective criteria and applied consistently in all geographic areas served. Persons living in the service areas provided in Column B, E, and F of Table 1 that are on an interest list for the CBA 1915(c) waiver program at the time of transition to STAR+PLUS must be included in the STAR+PLUS interest list, and be offered enrollment in the same priority order as would have occurred if STAR+PLUS had been in place at the time of their initial application.

(B) **Unduplicated Participant Slots for the 217-Like HCBS Group.** Table 4a below specifies the unduplicated number of participants for the 217-Like Group.

1. Column A reflects the following slots which were available beginning October 2011: (1) the number of unduplicated participant slots transferred from the STAR+PLUS 1915(c) waiver, TX 0862; (2) the 515 unduplicated participant slots transferred from the Community Based Alternatives (CBA) 1915(c) waiver, TX 0266; (3) individuals released from the interest list; and (4) individuals discharged from institutional care who are in the Money Follows the Person (MFP) Demonstration, in the areas of the State where the managed care expansion occurred on September 1, 2011.
2. Column B reflects the additional slots that were added in March 2012: (1) the 3,549 unduplicated participant slots transferred from the CBA 1915(c) waiver upon expansion of STAR+PLUS; (2) individuals released from the interest list; and (3) individuals discharged from institutional care who are in the MFP Demonstration.
3. Column C reflects the additional slots made available for the Nursing Facility Diversion Group, created June 1, 2013. The Nursing Facility Diversion Group was created as a subset of the STAR+PLUS 217-Like HCBS Group. This group consists of persons age 65 and older, and adults with physical disabilities age 21 and older, who meet the NF LOC as defined by the State, who qualify as members of the 217-Like HCBS Group, and who are at imminent risk of entering a nursing facility as a result of a

catastrophic episode. Examples of a catastrophic episode include: (1) an individual is significantly dependent on a caregiver to remain in the community and the caregiver passes away or is suddenly no longer able to provide care; (2) an individual has a community support system but must suddenly move where there is no support system; (3) an individual has a sudden occurrence that would cause imminent placement in a nursing facility because he can no longer care for himself; or (4) an individual is identified by the Texas Department of Family and Protective Services as being at imminent risk of nursing facility placement. The number of nursing facility diversion group slots for each DY is listed in the chart below. Nursing Facility Diversion Group slots may be encumbered only by individuals identified as belonging to the Nursing Facility Diversion Group.

4. Column D reflects the additional slots that will be added September 1, 2014: (1) an additional 7,159 participant slots that will be transferred from the CBA 1915(c) waiver upon expansion of STAR+PLUS; (2) individuals that will be continued to be discharged from institutional care who are in the MFP Demonstration; and (3) the addition of 33 nursing facility diversion slots in demonstration year four.

Table 4a. Unduplicated Number of Participants for the STAR+PLUS 217-Like HCBS Group					
Demonstration Year	Column A	Column B	Column C	Column D	Total
DY 1	8,794	3,798	n/a	n/a	12,592
DY 2	9,064	4,082	67	n/a	13,146 (67 of which are Nursing Facility Diversion Group slots)
DY 3	9,347	4,255	100	n/a	13,702 (100 of which are Nursing Facility Diversion Group slots)
DY 4	9,644	4,502	100	7,192	21,438 (133 of which are Nursing Facility Diversion Group slots)
DY 5	9,957	4,655	100	7,375	22,087 (133 of which are Nursing Facility Diversion Group slots)

- ii. **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 NF LOC as defined by

the State. Table 4b below specifies the unduplicated number of participants for the SSI-Related Eligible HCBS Group.

1. Column A column reflects the following participants eligible as of October 2011: (1) the number of unduplicated participants transferred from the STAR+PLUS 1915(c) waiver, TX 0325; (2) the 1,093 unduplicated participants transferred from the CBA 1915(c) waiver; and (3) individuals discharged from institutional care who are in the Money Follows the Person (MFP) Demonstration, in the areas of the State where the managed care expansion occurred on September 1, 2011.
2. Column B reflects the 7,348 unduplicated participants transferred from the CBA 1915(c) waiver upon expansion of STAR+PLUS in March 2012, as well individuals discharged from institutional care in the MFP Demonstration.
3. Column C reflects changes that take effect September 1, 2014: (1) an estimated 4,344 number of CBA 1915(c) participants who are SSI-related who will transfer to HCBS in demonstration year four due to the expansion of STAR+PLUS, (2) an estimated 582 individuals who are SSI related and will move from the CBA interest list into HCBS, and (3) approximately 72 SSI-related individuals who will enroll in HCBS through the MFP Demonstration. The number of SSI-related participants is assumed to follow normal STAR+PLUS enrollment growth in demonstration year five.

Table 4b. Unduplicated Number of Participants for the SSI-Related Eligible Group				
Demonstration Year	Column A	Column B	Column C	Total
DY 1	16,587	6,336	n/a	22,923
DY 2	18,909	6,563	n/a	25,472
DY 3	21,558	7,225	n/a	28,783
DY 4	24,575	7,950	4,998	37,523
DY 5	28,015	8,739	5,174	41,928

- d) **Eligibility for STAR+PLUS HCBS Benefits.** 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.

(A) Medical and / or functional needs are assessed according to 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.

(B) 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% of the cost of the level of care in a nursing facility.

- e) **Freedom of Choice.** The service coordinators employed by the managed care organizations must be required to inform each applicant or member of any alternatives available, including the choice of institutional care versus home and community based services, during the assessment process. The Freedom of Choice Form must be incorporated into the Service Plan. The applicant or member must sign this form to indicate that he or she freely chooses waiver services over institutional care. The managed care organization’s service coordinator also addresses living arrangements, choice of providers, and available third party resources during the assessment.
- f) **Service Plan.** In accordance with 42 CFR § 441.301(b)(1)(i), a participant-centered service plan of care must be developed for each participant. All waiver services must be furnished pursuant to the service plan, according to the projected frequency and type of provider. The service plan must also describe the other services, regardless of the funding source, and the informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the HHSC. Federal financial participation (FFP) may not be claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.
- g) **Benefit Package under the STAR+PLUS HCBS Program.** The following Table 5 describe the benefits available to 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. The services are further defined in Attachment C.

Table 5 HCBS Services

Service	Provider Directed	Participant Directed
Personal Assistance Service	X	X
Respite	X	X
Financial Management Services	X	
Support Consultation	X	X
Adaptive Aids and Medical Supplies	X	
Adult Foster Care	X	
Assisted Living	X	
Dental Services	X	
Emergency Response Services	X	
Home Delivered Meals	X	
Minor Home Modifications	X	
Nursing	X	X

Service	Provider Directed	Participant Directed
Occupational Therapy	X	X
Physical Therapy	X	X
Speech, Hearing, and Language Therapy	X	X
Transition Assistance Services	X	
Cognitive Rehabilitation Therapy (Effective March 6, 2014)	X	X
Supported Employment Services (Effective September 1, 2014)	X	X
Employment Assistance Services (Effective September 1, 2014)	X	X

- h) **Self-Direction of Home and Community Based Services.** STAR+PLUS participants who elect the self-direction opportunity will have the option to self-direct all or some of the long term services, as identified in Table 5, under the Demonstration. The services, goods, and supports that a participant self-directs will still be included in the calculations of the participant’s budget. Participant’s budget plans will reflect the plan for purchasing these needed services, goods, and supports.
- i. **Information and Assistance in Support of Participant Direction.** The State shall have a support system that provides participants with information, training, counseling, and assistance, as needed or desired by each participant, to assist the participant to effectively direct and manage their self-directed services and budgets. Participants shall be informed about self-directed care, including feasible alternatives, before electing the self-direction option. Participants shall also have access to the support system throughout the time that they are self-directing their care. Support activities must include, but are not limited to, financial management services and support consultation, defined as follows.
- (A) **Financial Management Services.** Financial management services provide assistance to members with managing funds associated with the services elected for self-direction. Financial management services include initial orientation and ongoing training related to responsibilities of being an employer, and adhering to legal requirements for employers. The financial management services providers, referred to as the Financial Management Services Agency (CDSA), serves as the member’s employer-agent, which is the Internal Revenue Service’s (IRS) designation of the entity responsible for making payables and withholding, and filing and depositing taxes on behalf of the members. As the employer-agent, the CDSA files required forms and reports to the Texas Workforce Commission.

- (B) **Support Consultation.** Support Consultation offers practical skills training and assistance to enable an individual to successfully direct those services the individual elects for participant-direction. This service is provided by a certified support advisor, and includes skills training related to recruiting, screening, and hiring workers, preparing job descriptions, verifying employment eligibility and qualifications, completion of documents required to employ an individual, management of workers, and development of effective back-up plans for services considered critical to the individual's health and welfare in the absence of the regular provider or an emergency situation. Support consultation is provided only by a certified support advisor certified by the Department of Aging and Disability Services.
- ii. **Participant Direction by Representative.** The participant who self-directs one or more services may appoint a volunteer designated representative to assist with or perform employer responsibilities to the extent approved by the participant. The participant documents the employer responsibilities, and that only a non-legal representative freely chosen by the participant or legally authorized representative may serve as the designated representative to assist in performance of employer responsibilities, to the extent desired by the individual or legally authorized representative. The participant documents the employer responsibilities that the designated representative may and may not perform on the participant's behalf.
- iii. **Participant Budget Authority.** The participant's budget authority is operated and developed as follows:
- (A) The participant has budget authority and decision-making authority over the budget to reallocate funds among services included in the budget; to determine the amount paid for services within the State's established limits; to substitute service providers and to schedule the provision of services; to specify additional service provider qualifications consistent with established criteria; to specify the provision of services consistent with service specifications in Attachment C for services that may be self-directed as specified in Table 5; to identify service providers and refer for provider enrollment; to authorize payment for waiver goods and services; and to review and approve provider invoices for services rendered.
- (B) All participants, in conjunction with the CDSA, must develop a budget based on the service plan. The amount of funds included in the service plan is calculated by the service planning team based on the planned waiver services and the adopted reimbursement rate. The service plan is developed in the same manner for the participant who elects to have services delivered through the consumer directed services option as it is for the participant who elects to have services delivered through the traditional provider-managed option.

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

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

iv. **Disenrollment from Self-Direction.** A participant may voluntarily disenroll from the self-directed option at any time and return to a traditional service delivery system. A participant may also be involuntarily disenrolled from the self-directed option for cause, if continued participation in the consumer directed services option would not permit the participant's health, safety, or welfare needs to be met, or the participant or the participant's representative, when provided with additional support from the CDSA, or through Support Consultation, has not carried out employer responsibilities in accordance with the requirements of this option. If a participant is terminated voluntarily or involuntarily from the self-directed service delivery option, the State will transition the participant to the traditional agency direction option and will have safeguards in place to ensure continuity of services.

i) **Fair Hearing.** For standard appeals, members have a right to access the fair hearing process at any time. For expedited appeals, members must exhaust the MCO's expedited appeals process before making a request for an expedited HHSC fair hearing. Procedures related to fair hearings are described in Attachment F.

j) **Participant Safeguards.** The State must follow all member safeguard procedures as described in Attachment G of these STCs.

42. Quality Improvement Strategy for the STAR+PLUS HCBS Program. The State will abide by the Quality Improvement Strategy that existed under the section 1915(c) waivers under the STAR+PLUS program prior to this Demonstration. The Quality Improvement Strategy is described in detail in Attachments D and E. This Quality Improvement Strategy will remain in full force until CMS approves the comprehensive quality strategy described in paragraph 27.

VI. FUNDING POOLS UNDER THE DEMONSTRATION

The terms and conditions in Section VI apply to the State's exercise of the following Expenditure Authorities: (5) Expenditures Related to the Uncompensated Care Pool, (6) Expenditures Related to Transition Payments, and (7) Expenditures Related to the Delivery System Incentive Reform Payment (DSRIP) Pool.

43. Terms and Conditions Applying to Pools Generally.

- a) The non-Federal share of pool payments to providers may be funded by state general revenue funds, transfers from units of local government, and certified public expenditures that are compliant with section 1903(w) of the Act. Any payments funded by intergovernmental transfers must remain with the provider, and may not be transferred back to any unit of government.
- b) The State must inform CMS of the funding of all payments from the pools to hospitals or other providers through a quarterly payment report to be submitted to CMS within 60 days after the end of each quarter, as required under paragraph 65 of the STCs. This report must identify the funding sources associated with each type of payment received by each provider.
- c) By December 31, 2011, the State must submit Medicaid State plan amendments to CMS to remove all supplemental payments for inpatient hospital, outpatient hospital, and physician services from its State plan, with an effective date of October 1, 2011.
- d) The State will ensure that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope or quality of services available under the State plan or this Demonstration. The preceding sentence is not intended to preclude the State from modifying the Medicaid benefit through the State Plan amendment process.

44. Uncompensated Care (UC) Pool. Payments from this pool will help defray uncompensated costs of care provided to Medicaid or Demonstration eligibles or to individuals who have no source of third party coverage, for the services provided by hospitals or other providers, as discussed below. Two types of payments can be made from the UC Pool: (1) UC Payments (described in subparagraph (a) below), and (2) in DY 1 only, Transition Payments (described in (b) below). Annual UC payments are limited to the annual amounts identified in paragraph 46.

- a) **UC Payments.** Funds may be 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 Medicaid eligible or uninsured individuals incurred by hospitals, clinics, or by other provider types, as agreed upon by CMS and the State and defined at subparagraph (iv) below. Expenditures must be claimed in accordance with CMS-approved claiming protocols for each provider type and application form in Attachment H. FFP is not available for any UC Payments other than Transition Payments in DY 1 prior to CMS approval of the claiming protocol and application for that particular provider type for which payments are sought. For any provider seeking to receive UC Payments in DY1, the total payment under the Medicaid State plan, Disproportionate Share Hospital (DSH) allotment, UC Payments, and Transition Payments cannot exceed the actual cost of providing services to Medicaid beneficiaries and the uninsured as defined in the cost claiming protocol.

- i. **UC Application.** To qualify for a UC Payment, a provider must submit to the State an annual UC Application that will collect cost and payment data on services eligible for reimbursement under the UC Pool. Data collected from the application will form the basis for UC Payments made to individual hospitals and non-hospital providers. The State must require hospitals to report data in a manner that is consistent with the Medicare 2552-96 cost report, or for non-hospital providers, a CMS-approved cost report consistent with Medicare cost reporting principles.
 - (A) After CMS has approved the applicable protocol, the State may begin accepting applications from providers for UC Payments in DY 1. Thereafter, providers are required to submit their UC Applications to the State by September 30 of each year, in order to qualify for a UC Pool payment for the DY that begins on October 1st.
 - (B) Cost and payment data included on the application must be based on the Medicare 2552-96 cost report, or for non-hospital providers, a CMS-approved cost report consistent with Medicare cost reporting principles for a Federal fiscal year (FFY) that is two years prior to the DY in which UC Payments are to be made, in order to allow time for providers to finalize their cost reports from that data year and submit their application data to HHSC. (For example, FFY 2010 would be the data year for UC Payments under the UC pool in DY 1.) The State may trend the data to model costs incurred in the year in which payments are to be made. Subsequent DY applications will be used to reconcile estimates for prior years. For example, uncompensated care cost data from a DY 3 application will be used to determine the actual uncompensated care for DY 1 UC Payments for a qualifying provider. Any overpayments identified in the reconciliation process that occurred in a prior year must be recouped from the provider, with the FFP returned to CMS. During the reconciliation process, if a provider demonstrates that it has allowable uncompensated costs consistent with the protocol that were not reimbursed through the initial UC Payment (based on application figures), and the State has available UC Pool funding for the year in which the costs were accrued, the State may provide reimbursement for those actual documented unreimbursed UC costs through a prior period of adjustment.
 - (C) Any provider that meets the criteria below may submit a UC Application to be eligible to receive a UC Payment.
 - (I) Private providers must have an executed indigent care affiliation agreement on file with HHSC.
 - (II) Only providers participating in a RHP are eligible to receive a UC Payment, although exceptions may be approved by CMS on a case by case basis.

(D) When submitting the UC Application, providers may request that cost and payment data from the data year be adjusted to reflect increases or decreases in costs, resulting from changes in operations or circumstances. A provider may request that:

(I) Costs not reflected on the filed cost report, but which would be incurred for the spending year, be included when calculating payment amounts; or

(II) Costs reflected on the filed cost report, but which would not be incurred for the spending year, be excluded when calculating payment amounts.

Adjustments described in subparagraphs (I) and (II) above cannot be considered as part of the application for reconciliation of a prior year payment. Such costs must be properly documented by the provider, and are subject to review by the State. Such costs are subject to reconciliation to future year applications to ensure that providers actually incurred such eligible uncompensated costs.

(E) All applicable inpatient and outpatient hospital UC payments, including Transition Payments, received by a hospital provider count as title XIX revenue, and must be included as offsetting revenue in the State's annual DSH audit reports. Providers receiving both DSH and UC Payments cannot receive total payments under the State plan and the UC Pool (related to inpatient and outpatient hospital services) that exceed the hospital's total eligible uncompensated costs. UC Payments for physicians, non-physician professionals, pharmacy, and clinic costs are not considered inpatient or outpatient Medicaid payments for the purpose of annual hospital specific DSH limits and the DSH audit rule. All reimbursements must be made in accordance with CMS approved cost-claiming protocols that are consistent with the Medicare 2552-96 cost report or, for non-hospital providers, a CMS approved cost report consistent with Medicare cost reporting principles.

- ii. **UC Payment Protocol.** The State must submit for CMS approval a funding and reimbursement protocol that will establish rules and guidelines for the State to claim FFP for UC Payments. The State may not claim FFP for any UC Payments until a draft UC Protocol is submitted to CMS by March 1, 2012, and such protocol is approved by CMS. The approved UC Payment Protocol will become Attachment H to these STCs. The UC Payment Protocol must include precise definitions of eligible uncompensated provider costs and revenues that must be included in the calculation of uncompensated cost. The Protocol will also identify the allowable source documents to support costs; it will include detailed instructions regarding the calculation and documentation of eligible costs, the tool used by the State and providers to apply for UC Payments, and a timetable and reconciliation of payments against actual cost documentation. This process will align the application process (based on prior cost periods) to the reconciliation process (using the application costs

from subsequent years to reconcile earlier payments). Protocols will contain not only allowable costs and revenues, it will also indicate the twelve (12) month period for which the costs will apply.

The State must submit a UC Payment Protocol for each non-hospital provider type that may seek UC payments. FFP will not be available for UC Payments made to a non-hospital provider type until a cost-claiming protocol consistent with the Medicare cost reporting principles is approved by CMS. .

- iii. **UC Payments to Hospitals and Physician Groups in DY 1.** The State will allow eligible hospitals and physician groups (see paragraph 44(b) *Transition Payments*) to submit a CMS-approved UC Application in DY 1 to be eligible for UC Payments in DY 1. Eligible hospitals and physician groups that do not submit a UC Application will only be eligible for Transition Payments in DY 1, as described in section (b) below. For eligible hospitals and physician groups that submit a UC Application, the State will reconcile the Transition Payments and UC Payments made to ensure the total UC Pool payments paid in DY 1 do not exceed the total amount of actual UC costs in that year. Hospitals and physician groups that are paid based on the UC Application will be subject to the reconciliation provisions described in subsection (a)(i)(B) above. All UC and Transition Payments made for DY 1 are subject to UC Pool annual limits for DY 1.
- iv. **UC Payments to Non-Hospital Providers.** UC Payments may be provided only to the following qualifying non-hospital providers: physician practice groups, government ambulance providers, government dental providers, and other providers in rural RHPs with no public hospitals. The State cannot claim FFP for UC Payments made to providers of the types listed here until CMS has approved an uncompensated care protocol specific to that provider type, which will be incorporated into Attachment H. UC Payments are considered to be Medicaid payments to providers and must be treated as Medicaid revenue when determining total title XIX funding received, in particular for any provider utilizing certified public expenditures as the non-Federal share of a Medicaid payment.
- v. **Annual Reporting Requirements for UC Payments.** The State will submit to CMS two reports related to the amount of UC Payments made from the UC Pool per Demonstration year. The reporting requirements are as follows:
 - (A) By December 31st of each Demonstration year, starting with DY 2, the State shall provide the following information to CMS:
 - (I) The UC payment applications submitted by eligible providers; and
 - (II) A chart of estimated UC Payments to each provider for a DY.

- (B) Within ninety (90) days after the end of each Demonstration year, beginning with the end of DY 2, the State shall provide the following information to CMS:
- (I) The UC Payment applications submitted by eligible providers;
 - (II) A chart of actual UC payments to each provider for the previous DY;
 - (III) For reconciliation payments to providers, the UC payments made to the provider in the prior Demonstration year and the reconciliation costs against the actual payments made to said provider.
- b) **Transition Payments.** During DY 1 only, the State will make Transition Payments to hospitals and physician groups that received supplemental payments under the Medicaid State plan for claims adjudicated during FFY 2011. This transition period ensures that these providers are eligible to secure historical Medicaid funding as the State develops the pool payment methodologies. These Transition Payments are available only during DY 1 subject to UC pool annual limits for DY 1. No protocol must be approved by CMS for the State to make Transition Payments; instead, Transition Payments are subject to the following requirements:
- i. A hospital or physician group is eligible to receive Transition Payments if it:
 - (A) Is enrolled as a Texas Medicaid provider;
 - (B) Received a supplemental payment under the Medicaid State plan for claims adjudicated in one or more months between October 1, 2010, and September 30, 2011;
 - (C) Has a source of intergovernmental transfer (IGT) or State general revenue appropriated as the non-federal share of the Transition Payment consistent with section 1903(w) of the Act; and
 - (D) Submitted any documentation that would have been required to receive a supplemental payment under the State Plan to HHSC before September 30, 2011, and submits any other documentation requested by HHSC.
 - ii. Transition Payments will be based on the following methodology:
 - (A) Participating hospitals and physician groups will be eligible to receive total Transition Payments equal to the amount the provider received in supplemental payments for claims adjudicated during FFY 2011, annualized to cover the entire twelve (12) month period of DY 1.

- (B) Participating providers are eligible to receive one-fourth of their total Transition Payment amount each quarter in DY 1, beginning October 1, 2011, through the quarter ending September 30, 2012.
- (C) The State must provide CMS with a list of all hospitals and physician groups that will receive Transition Payments under this section, as well as the amounts of 2011 State plan supplemental payments and 2012 (DY 1) Transition Payments. The State must identify the source of funding for each DY 1 Transition Payment as a part of this list.
 - (I) The State will provide a list of estimated maximum Transition Payments within forty-five (45) days of approval of the Demonstration; and
 - (II) The State will provide a list of actual Transition Payments made within ninety (90) days of the end of DY 1.
- iii. For hospitals qualifying for and receiving DSH payments for FFY 2012, Transition Payments are considered title XIX payments and must be treated as revenues when determining DSH eligible uncompensated costs as part of the annual DSH audits, except for transition payments related to hospital-based physician practice groups.
- iv. The supplemental provider payments to hospitals and physicians made in November and December 2011 under the Medicaid State plan in the amount of \$466,091,028 will be considered as if they were payments under this Demonstration, and will be included in the budget neutrality test, and the amount available as payment from the UC Pool. The State may count these payments under the UC Pool limit for any of the five years of the Demonstration.
- v. The State may not receive FFP for UC Payments, other than those described here in paragraph 44(b), until the UC Protocol is approved by CMS.

45. Delivery System Reform Incentive Payment (DSRIP) Pool. The DSRIP Pool is available for the development of a program of activity that supports hospitals' efforts to enhance access to health care, the quality of care, and the health of the patients and families they serve. The program of activity funded by the DSRIP shall be based in Regional Healthcare Partnerships (RHPs) that are directly responsive to the needs and characteristics of the populations and communities comprising the RHP. Each RHP will have geographic boundaries, and will be directed and financially supported by a public hospital or a local governmental entity with the authority to make intergovernmental transfers (IGTs). In collaboration with participating providers, the public hospital or local governmental entity will develop a delivery reform and incentive plan that is rooted in the intensive learning and sharing that will accelerate meaningful improvement within the providers participating in the RHP. Individual hospitals' DSRIP proposals must flow from the RHP plans, and be consistent with the hospitals' shared mission and quality goals within the RHP, as well as

CMS's overarching approach for improving health care through the simultaneous pursuit of three aims: better care for individuals (including access to care, quality of care, and health outcomes; better health for the population; and lower cost through improvement (without any harm whatsoever to individuals, families or communities).

- a) **Focus Areas.** There are 4 areas for which funding is available under the DSRIP, each of which has explicit connection to the achievement of the Three Part Aim. Projects will be identified within the following categories, and included in the full list of projects provided in the RHP Planning Protocol, and may include projects such as those identified below within each category.
- i. **Category 1: Infrastructure Development** – This category lays the foundation for delivery system transformation through investments in technology, tools, and human resources that will strengthen the ability of providers to serve populations and continuously improve services:
 - (A) Expand primary care capacity,
 - (B) Expand behavioral healthcare capacity,
 - (C) Expand specialty care capacity,
 - (D) Expand clinical and administrative reporting systems that support quality improvement,
 - (E) Increase training of primary care workforce, and
 - (F) Expand reporting and HIT systems and capabilities.
 - ii. **Category 2: Program Innovation and Redesign** – This category includes the piloting, testing, and replicating of innovative care models:
 - (A) Primary care redesign,
 - (B) Behavioral healthcare redesign,
 - (C) Increase specialty care access/redesign referral process,
 - (D) Adoption of medical homes,
 - (E) Expansion of chronic care management models,
 - (F) Implement /expand care transition programs, and
 - (G) Implement real-time Hospital acquired Infections (HAI) system.
 - iii. **Category 3: Quality Improvements** – This category includes outcome reporting and improvements in care that can be achieved within four years.
 - iv. **Category 4: Population Focused Improvements** – This category includes reporting measures across several domains selected by a RHP based on community assessments that demonstrate the impact of delivery system reform investments made in previous years under the Demonstration. The domains may include:
 - (A) Patient experience,
 - (B) Preventive health,
 - (C) Care coordination, and
 - (D) At-risk groups.

- b) **Regional Healthcare Partnerships.** Regional Healthcare Partnerships will be developed throughout the State to more effectively and efficiently deliver care and provide increased access to care for low-income Texans. Each RHP will include a variety of healthcare providers to adequately respond to the needs of the community, and the process of forming each RHP will evidence meaningful participation by all interested providers. Each RHP will be anchored financially (i.e. single point of contact for the RHP) by a public hospital (or in areas with no public hospital, anchored financially by the governmental entity providing IGTs to support funding pool payments) that will be responsible for developing the RHP's DSRIP plan in coordination with other identified RHP providers. To the extent that the public hospital is a government entity eligible to participate in the funding of the Medicaid program, they may be the source of the non-Federal share. The RHP DSRIP plan will identify the community needs, the projects, and investments under the DSRIP to address those needs, community healthcare partners, the healthcare challenges, and quality objectives within the RHP and the metrics described in State protocol associated with each project and quality objective. These plans must be submitted to the State and CMS for approval, and must delineate total DSRIP funding associated with the plan.
- c) **Hospital DSRIP Plans within the RHP.** RHP anchoring entities providing IGT for Uncompensated Care (UC) and DSRIP Payments within an RHP will develop RHP plans in good faith, to leverage public and non-public hospital and other community resources to best achieve delivery system transformation goals within RHP areas consistent with the Demonstration's requirements. RHP plans shall include estimated funding available by year to support UC and DSRIP payments, and specific allocation of funding to UC and to DSRIP projects proposed within the RHP plan. RHP anchoring entities shall provide opportunities for public input to the development of RHP plans, and shall provide opportunities for discussion and review of proposed RHP plans prior to plan submission to the State. In accordance with the guidelines specified in the RHP Planning Protocol (see paragraph 45(d)(ii)(A) *RHP Planning Protocol*), a final RHP DSRIP Plan must include maximum payment amounts for UC and DSRIP Payments. These amounts may be proportionally adjusted based on available non-Federal share.
- d) **DSRIP Plans and Protocols.** The State may not claim DSRIP funding until the following milestones have been met:
- i. By March 31, 2012, the State must submit to CMS for approval a document that describes the State's plan for and status on forming the RHPs, identifying the public hospitals directing each RHP, and the general projects and quality measures to be addressed in each RHP DSRIP, and potential provider partners that will comprise the RHP.

- ii. No later than August 31, 2012, CMS, the State and Texas hospitals will, through a collaborative process, finalize the following two protocols to implement the DSRIP program.

(A) **RHP Planning Protocol:** This protocol will include a master list of potential project/interventions for each Category 1-4 and related milestones, and metrics which RHPs may select from, in developing their 5-year plans. When developing the RHP Planning Protocol, the State should consider ways to structure the different projects that will facilitate the collection, dissemination, and comparison of valid quantitative data to support the Evaluation Design required in Section X. From these, the State must select a preferred research plan for the applicable research question, and provide a rationale for its selection. To the extent possible, RHPs should use similar metrics for similar projects across RHPs to enhance the evaluation and learning experience between RHPs. To facilitate evaluation, the RHP Planning Protocol must identify a core set of Category 3 and Category 4 metrics that all participating hospitals must be required to report. This RHP Planning Protocol will become Attachment I.

(B) **Program Funding and Mechanics Protocol:** This protocol will include information on State and CMS review and approval processes for RHP plans, RHP and State reporting requirements, incentive payment mechanisms and payment methodologies, and penalties for missed milestones. This protocol will become Attachment J.

- iii. No later than October 31, 2012, urban and rural RHPs must submit their final RHP DSRIP Plans to the State and CMS for approval. Except for Category 3 for non-hospital RHPs, the final RHP DSRIP Plans must address all four focus areas described in paragraph 45(a). The final RHP DSRIP Plan must also identify the metrics that will be used by each provider selecting that project within the RHP, so that all providers selecting a particular project or quality measure will be held to the same standard reporting requirement. The final RHP DSRIP Plan will also include payment methodologies for each metric providing an annual maximum budget for each final RHP DSRIP Plan, and penalties for missed milestones.

- iv. Payments from the DSRIP Pool may begin during DY 1, based on approved final RHP DSRIP Plans and successful completion of the metrics associated with DSRIP incentive payments. The State will not claim FFP for DSRIP Payments until the RHP Planning Protocol and Program Funding and Mechanics Protocol are approved by CMS.

- e) **DSRIP Payments are Not Direct Reimbursement for Expenditures or Payments for Services.** Payments from the DSRIP pool are intended to support and reward hospital systems and other providers for improvements in their delivery systems that support the simultaneous pursuit of improving the experience of care, improving the health of

populations, and reducing per capita costs of health care. Payments from the DSRIP Pool are not considered patient care revenue, and shall not be offset against disproportionate share hospital expenditures or other Medicaid expenditures that are related to the cost of patient care (including stepped down costs of administration of such care) as defined under these Special Terms and Conditions, and/or under the State Plan.

46. Limits on Pool Payments. Expenditures eligible for FFP for UC Pool and DSRIP Pool in each DY may not exceed the amounts shown in Table 6.

Table 6. Pool Allocations According to Demonstration Year (total computable)

Type of Pool	DY 1 (2011-2012)	DY 2 (2012- 2013)	DY 3 (2013- 2014)	DY 4 (2014-2015)	DY 5 (2015-2016)	Totals
UC	3,700,000,000	3,900,000,000	3,534,000,000	3,348,000,000	3,100,000,000	\$17,582,000,000
DSRIP	500,000,000	2,300,000,000	2,666,000,000	2,852,000,000	3,100,000,000	\$11,418,000,000
Total/DY	4,200,000,000	6,200,000,000	6,200,000,000	6,200,000,000	6,200,000,000	\$29,000,000,000
% UC	88%	63%	57%	54%	50%	60%
% DSRIP	12%	37%	43%	46%	50%	40%

47. Assurance of Budget Neutrality.

- a) By October 1 of each year, the State must submit an assessment of budget neutrality to CMS, including a summation of all expenditures and member months already reported to CMS, estimates of expenditures already incurred but not reported, and projections of future expenditures and member months to the end of the Demonstration, broken out by DY and Medicaid Eligibility Group (MEG) or other spending category.
- b) Should the report in (a) indicate that the budget neutrality Annual Target for any DY has been exceeded, or is projected to be exceeded, the State must propose adjustments to the limits on UC Pool and DSRIP Pool limits, such that the Demonstration will again be budget neutral on an annual basis, and over the lifetime of the Demonstration. The new limits will be incorporated through an amendment to the Demonstration.

48. Transition Plan for Funding Pools. No later than March 31, 2015, the State shall submit a transition plan to CMS based on the experience with the DSRIP pool, actual uncompensated care trends in the State, and investment in value based purchasing or other payment reform options.

VII. GENERAL FINANCIAL REQUIREMENTS

This project is approved for title XIX expenditures applicable to services rendered during the demonstration period. Effective January 1, 2014, this project is approved for title XXI expenditures applicable to services rendered during the demonstration period for certain children ages 6-18 between 100-133% FPL. This section describes the general financial requirements for these expenditures.

49. Quarterly Expenditure Reports. The State must provide quarterly title XIX expenditure reports using Form CMS-64, to separately report total expenditures for services provided through this Demonstration under section 1115 authority that are subject to budget neutrality. This project is approved for expenditures applicable to services rendered during the Demonstration period. CMS shall provide FFP for allowable Demonstration expenditures, only as long as they do not exceed the pre-defined limits on the costs incurred, as specified in Section VIII.

The state shall provide quarterly title XXI expenditure reports using the Form CMS64.21U/CMS64.21UP to report total title XXI expenditures for services provided to M-CHIP children under the section 1115 authority until its XXI allotment is spent and then using the 64.9/64.9P Waiver form with waiver name of "THTQIP-M-CHIP." CMS will provide Federal financial participation (FFP) for allowable Texas title XXI demonstration expenditures that do not exceed the state's available title XXI funding and then Federal participation at the enhanced rate under Title XIX once the state's Title XXI funding is fully exhausted.

50. Expenditures Subject to the title XIX Budget Neutrality Expenditure Limit.

- a. All expenditures for Medicaid services for Demonstration participants (as defined in paragraphs 28 [Table 2], 29, 33 [Table 3], and 41 [Table 5]) are Demonstration expenditures subject to the budget neutrality expenditure limit, except expenditures for the services listed as follows:
 - i. Nursing facility services (for dates of service before March 1, 2015);
 - ii. Medical transportation;
 - iii. Medicare premiums;
 - iv. In Column D counties only, Community Based Alternatives 1915(c) waiver services, primary home care and day activity and health services (for dates of service before September 1, 2014), and
 - v. Other 1915(c) waiver programs as follows: Medically Dependent Children Program (TX 0181), Consolidated Waiver Program (TX 0373 and TX 0374), Deaf Blind with Multiple Disabilities (TX 0281), Home and Community-Based Services (TX 0110), Community Living Assistance and Support Services (TX 0221), Texas Home Living

(TX 0403), and Youth Empowerment Services (TX 0657).

- b. All Funding Pool expenditures (as defined in Section VI) are Demonstration expenditures subject to the budget neutrality expenditure limit.

51. Reporting Expenditures in the Demonstration. The following describes the reporting of expenditures subject to the budget neutrality expenditure limit:

- a. **Use of Waiver Forms.** In order to track expenditures under this Demonstration, the State must report Demonstration expenditures through the Medicaid and Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual (SMM). All Demonstration expenditures claimed under the authority of title XIX of the Act, and subject to the budget neutrality expenditure limit, must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the Demonstration Project Number (11-W-00278/6) assigned by CMS.
- b. **Reporting By Date of Service.** In each quarter, Demonstration expenditures (including prior period adjustments) must be totaled and reported on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver by Demonstration Year (DY). The DY for which expenditures are reported is identified using the project number extension (a 2-digit number appended to the Demonstration Project Number). Expenditures must be assigned to DYs on the basis of date of service (except for pool payments, as discussed below). The date of service for premium payments is identified as the DY that includes the larger share of the month for which the payment is principally made. Pool payments must be reported by DY as follows: Transition payments must be reported for DY 1, UC payments must be reported in a manner consistent with the payment timeframes specified in the UC Pool Protocol, and DSRIP payments must be reported based on the payment methodologies and annual maximum budgets specified in the final master DSRIP plans. DY 1 will be the year beginning October 1, 2011, and ending September 30, 2012, and subsequent DYs will be defined accordingly.
- c. **Use of Waiver Forms.** Each quarter, the State must identify separate forms CMS-64.9 Waiver and/or 64.9P Waiver by Waiver Name to report expenditures that belong in the following categories:
 - i. "THTQIP-Adults" – Medicaid service expenditures for all participating individuals whose MEG is defined as Adults;
 - ii. "THTQIP-Children" – Medicaid service expenditures for all participating individuals whose MEG is defined as Children;
 - iii. "THTQIP-AMR" – Medicaid service expenditures for all participating individuals

who are aged, or who are disabled and have Medicare, except for 1915(c) waiver services described in (v) below;

- iv. “THTQIP-Disabled” – Medicare service expenditures for all participating individuals who are disabled and do not have Medicare, except for 1915(c) waiver services described in (v) below;
- v. “THTQIP-CBA 1915(c)” – Expenditures for CBA 1915(c) waiver services for all individuals who reside in Column E counties that are not Column B counties (only used for expenditures with dates of service between October 1, 2011 and the implementation date of the March 2012 STAR+PLUS expansion);
- vi. “THTQIP-UC” – All expenditures that count against UC Pool limits, except those described in (vii);
- vii. “THTQIP-UC UPL” – Medicaid State plan supplemental provider payments to hospitals or physician groups made between October 1, 2011 and the approval date of the Demonstration; and
- viii. “THTQIP-DSRIP” – All DSRIP Pool expenditures.
- ix. “THTQIP-QUALIFIED” – Medicaid service expenditures for all participating individuals whose MEG is defined as Qualified aliens. Title XXI expenditures for this group are excluded from budget neutrality but are counted against the Title XXI allotment as described in paragraph (d) below.
- x. “THTQIP-M-CHIP” – All expenditures for children who are ages 6-18 and between 100-133% FPL, or children served in CHIP on December 31, 2013 due to assets in excess of Medicaid eligibility limits. These are children who meet the definition of “targeted low-income child” specified in section 2110 (b)(1) of the Social Security Act. Title XXI expenditures for this group are excluded from budget neutrality but are counted against the Title XXI allotment as described in paragraph (d) below.

d. Title XXI Funded Groups in the Waiver.

Expenditures for THTQIP-Qualified and THTQIP-M-CHIP under title XXI must be reported on separate Forms CMS-64.21U and/or 64.21UP in accordance with the instructions in section 2115 of the State Medicaid Manual, identified using Waiver Name “THTQIP-M-CHIP” or “THTQIP-QUALIFIED.”

- i. Title XIX funds for children who are ages 6-18 and between 100-133% FPL meeting the definition of “targeted low-income child” specified in section 2110(b)(1) of the Social Security Act (M-CHIP children) are available under this demonstration if the

state exhausts its title XXI allotment once timely notification as described in subparagraph (iii) has been provided.

ii. If the state exhausts its title XXI allotment prior to the end of a Federal fiscal year, title XIX Federal matching funds are available for these M-CHIP children. During the period when title XIX funds are used, expenditures related to this demonstration population must be reported as waiver expenditures on the Forms CMS 64.9 Waiver and/or CMS 64.9P Waiver, identified using Waiver Name “THTQIP-M-CHIP.” To initiate this:

1. The state shall provide CMS with 120 days prior notice before it begins to draw down title XIX matching funds for the M-CHIP children demonstration population;

2. The State shall submit:

a) An updated budget neutrality assessment that includes a data analysis which identifies the specific “with waiver” impact of the proposed change on the current budget neutrality expenditure cap. Such analysis shall include current total computable “with waiver” and “without waiver” status on both a summary and detailed level through the current extension approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the “with waiver” expenditure total as result of the proposed change which isolates (by Eligibility Group) the impact of the change;

b) An updated CHIP allotment neutrality worksheet.

iii. If the state exhausts its title XXI allotment prior to the end of a Federal fiscal year, the expenditures attributable to the M-CHIP children demonstration population will count toward the budget neutrality expenditure cap calculated under STC58, using the per member per month (PMPM) amounts for TANF Children described in STC 58(b)(ii), and will be considered expenditures subject to the budget neutrality cap as defined in STC 56(a).

e. **Pharmacy Rebates.** Because pharmacy rebates are not reflected in the data used to determine the budget neutrality expenditure limit, all pharmacy rebates must be reported on Forms CMS-64.9 Base or Forms CMS-64.9P Base, and not on any waiver form associated with this Demonstration.

f. **Cost Settlements.** For monitoring purposes, cost settlements related to the Demonstration must be recorded on Line 7 or 10.B, in lieu of Line 9. For any other cost settlements (i.e., those not attributable to this Demonstration), the adjustments should be reported, as instructed in the State Medicaid Manual. The amount of non-claim specific

cost settlements will be allocated to each DY based on the larger share of the coverage period for which the cost settlement is made.

- g. **Premium and Cost Sharing Adjustments.** Premiums and other applicable cost-sharing contributions that are collected by the State from enrollees under the Demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet Line 9D, columns A and B. In order to assure that these collections are properly credited to the Demonstration, premium and cost-sharing collections (both total computable and Federal share) should also be reported separately by Demonstration Year on the Form CMS-64 Narrative. In the calculation of expenditures subject to the budget neutrality expenditure limit, premium collections applicable to Demonstration populations will be offset against expenditures. These section 1115 premium collections will be included as a manual adjustment (decrease) to the Demonstration’s actual expenditures on a quarterly basis.
- h. **Mandated Increase in Physician Payment Rates in 2013 and 2014.** Section 1202 of the Health Care and Education Reconciliation Act of 2010 (Pub. Law 110-152) requires state Medicaid programs to pay physicians for primary care services at rates that are no less than what Medicare pays, for services furnished in 2013 and 2014. The federal government provides a Federal medical assistance percentage of 100 percent for the claimed amount by which the minimum payment exceeds the rates paid for those services as of July 1, 2009. The state may exclude from the budget neutrality test for this demonstration the portion of the increase for which the federal government pays 100 percent. These amounts should be reported on the base forms CMS-64.9, 64.21, or 64.21U (or their “P” counterparts), and not on any waiver form.
- i. **Administrative Costs.** Administrative costs are not included in the budget neutrality expenditure limit, but the State must separately track and report additional administrative costs that are directly attributable to the Demonstration. All attributable administrative costs must be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver, using Waiver Name “TX Reform Admin.”
- j. **Administrative Cost Claiming Protocol.** The State must maintain a CMS-approved Administrative Cost Claiming Protocol, to be incorporated as Attachment K to these STCs, which explains the process the State will use to determine administrative costs incurred under the Demonstration. CMS will provide Federal financial participation (FFP) to the State at the regular 50 percent match rate for administrative costs incurred according to limitations set forth in the approved Administrative Cost Claiming protocol. No FFP is allowed until a claiming protocol is approved by CMS.
- k. **Claiming Period.** All claims for expenditures subject to the budget neutrality expenditure limit (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the Demonstration period (including any cost settlements) must be made within 2

years after the conclusion or termination of the Demonstration. During the latter 2-year period, the State must continue to identify separately on the CMS-64 waiver forms, the net expenditures related to dates of service during the operation of the section 1115 Demonstration, in order to account for these expenditures properly to determine budget neutrality.

52. Reporting Member Months. The following describes the reporting of member months for Demonstration participants.

- a. For the purpose of calculating the budget neutrality expenditure limit, the State must provide to CMS, as part of the quarterly report required under paragraph 65 of these STCs, the actual number of eligible member months for all Demonstration participants, according to the MEGs defined in paragraphs 28 (Table 2) and 29.
- b. To permit full recognition of “in-process” eligibility, reported member month totals may be revised subsequently, as needed. To document revisions to totals submitted in prior quarters, the State must report a new table with revised member month totals indicating the quarter for which the member month report is superseded.
- c. The term “eligible member months” refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes 3 eligible member months to the total. Two individuals, who are eligible for 2 months each, contribute 2 eligible member months to the total, for a total of 4 eligible member months.

53. Standard Medicaid and CHIP Funding Process.

- a. The standard Medicaid funding process must be used during the Demonstration. The State must estimate matchable Demonstration expenditures (total computable and Federal share) subject to the budget neutrality expenditure limit, and separately report these expenditures by quarter for each Federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS shall make Federal funds available based upon the State’s estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.
- b. The standard title XXI funding process will be used during the demonstration for M-CHIP children. The state must estimate matchable M-CHIP expenditures on the quarterly Form CMS-37. As a footnote to the CMS-37, the state shall provide updated estimates of expenditures for the M-CHIP children demonstration populations. CMS will make Federal funds available based upon the state’s estimate, as approved by CMS.

Within 30 days after the end of each quarter, the state must submit the Form CMS-61.21 U-Waiver quarterly CHIP expenditure report. CMS will reconcile expenditures reported on the Form CMS-64.21U-waiver with Federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

54. Extent of Federal Financial Participation for the Demonstration. Subject to CMS approval of the source(s) of the non-Federal share of funding (see paragraph 55, *Sources of Non-Federal Share*), CMS shall provide FFP at the applicable Federal matching rates for the Demonstration as a whole as outlined below, subject to the budget neutrality limits described in section X of these STCs:

- a. Administrative costs, including those associated with the administration of the Demonstration;
- b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid State plan and waiver authorities;
- c. Net expenditures and prior period adjustments, made under approved Expenditure Authorities granted through section 1115(a)(2) of the Act, with dates of service during the operation of the Demonstration;
- d. Net expenditures for Funding Pool payments.

55. Sources of Non-Federal Share. The State certifies that the matching non-Federal share of funds for the Demonstration is State/local monies. The State further certifies that such funds shall not be used as the match for any other Federal grant or contract, except as permitted by law. All sources of non-Federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-Federal share of funding are subject to CMS approval.

- a. CMS may review, at any time, the sources of the non-Federal share of funding for the Demonstration. The State agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.
- b. Any amendments that impact the financial status of the program shall require the State to provide information to CMS regarding all sources of the non-Federal share of funding.
- c. Under all circumstances, health care providers must retain 100 percent of the STAR and STAR+PLUS reimbursement amounts claimed by the State as a Demonstration expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the State and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating

expenses of conducting business (such as payments related to taxes (including health care provider-related taxes), fees, and business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.

VIII. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

56. Limit on Title XIX and XXI Funding.

- a) The State shall be subject to a limit on the amount of Federal title XIX funding that the State may receive on selected Medicaid expenditures during the period of approval of the Demonstration. The limit is determined by using a per capita cost method, with an aggregate adjustment for projected supplemental provider payments. The budget neutrality expenditure targets are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire Demonstration. Actual expenditures subject to the budget neutrality expenditure limit shall be reported by the State using the procedures described in Section VII.
- b) The state will be subject to a limit on the amount of Federal title XXI funding that the state may receive on demonstration expenditures for M-CHIP children during the demonstration period. Federal title XXI funding available for demonstration expenditures for M-CHIP children is limited to the state's available allotment, including currently available reallocated funds and contingency funds. Should the state expend its available title XXI Federal funds for the claiming period, no further enhanced title XXI Federal matching funds will be available for costs of the approved title XXI child health program or demonstration until the next allotment becomes available.
 - i. Exhaustion of title XXI Funds. After the State has exhausted title XXI funds, expenditures for M-CHIP children, may be claimed as title XIX expenditures. The State shall report expenditures for these children as waiver expenditures on the Forms CMS 64.9 Waiver and/or CMS 64.9P Waiver in accordance with paragraph 51.d.
 - ii. Exhaustion of title XXI Funds Notification. The State must notify CMS in writing of any anticipated title XXI shortfall at least 120 days prior to an expected change in claiming of expenditures for the M-CHIP children. The State must follow Medicaid State plan criteria for these beneficiaries unless specific waiver and expenditure authorities are granted through this Demonstration.

57. Risk. Under this budget neutrality agreement, Texas shall be at risk for the per capita cost of participating Medicaid and Demonstration eligibles, but not for the number of Demonstration eligibles. In this way, Texas will not be at risk for changing economic conditions that impact enrollment levels; however, by placing Texas at risk for the per capita costs for Medicaid and

Demonstration eligibles, CMS assures that the Federal Demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no Demonstration.

58. Budget Neutrality Expenditure Limit. The following describes the method for calculating the budget neutrality expenditure limit:

- a. For each DY of the budget neutrality agreement, an Annual Target is calculated as the sum two components.
 - i. The Per Capita Component is the sum of six sub-components, calculated as the projected per member per month (PMPM) cost, times the actual number of member months (reported by the State in accordance with paragraph 52) for the MEGs identified in (b) below.
 - ii. The Aggregate Component is a projection of what certain supplemental payments to providers would have cost each year in the absence of the Demonstration, as shown in (c) below.
- b. The following tables give the projected PMPM costs to be used in the Per Capita Component calculation in each DY. PMPM costs for four of the six sub-components are shown in Table 8a, and for the remaining two sub-components are shown in Table 8b.
 - i. Table 8a gives the projected without-waiver costs of medical services for included populations. The Base Year PMPMs include fee-for-service claims and capitation payments for Medicaid State plan services and 1915(c) home and community based services, and an attributed share of inpatient hospital supplemental payments, divided by base year member-months. FY 2012 President’s Budget Medicaid Baseline trends are used to project without-waiver PMPM costs.
 - ii. The PMPM amounts shown in Table 8b represent additional without-waiver costs that would have occurred for Adults and Children had the State carried out its plan to carve inpatient hospital services out from the capitated benefit for current STAR participants. These amounts follow the same President’s Budget trends as the corresponding rows in Table 8a; however, per mutual agreement, these amounts will phase down to \$0, starting in DY 3. The Base Medical PMPMs for AMR include NF costs, starting March 1, 2015 (DY 4).

Table 8a – Projected PMPM Costs, Base Medical and Included UPL

MEG	Base Year PMPM (SFY 2010)	Trend	DY 1	DY 2	DY 3	DY 4	DY 5
AMR	\$463.87	4.6%	\$509.43	\$532.87	\$557.46	\$888.78	\$1,144.15
Disabled	\$1,212.96	5.2%	\$1,348.07	\$1,418.17	\$1,493.00	\$1,610.13	\$1,712.45
Adults	\$784.30	5.8%	\$882.05	\$933.21	\$987.33	\$1,044.60	\$1,105.18

Children	\$252.48	5.2%	\$280.60	\$295.19	\$310.54	\$326.69	\$343.68
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Table 8b – Projected PMPM Costs, STAR FFSE and STAR UPL

MEG	Base Year PMPM (SFY 2010)	Trend	DY 1	DY 2	DY 3	DY 4	DY 5
Adults	\$152.76	5.8%	\$171.80	\$181.76	\$96.15	\$50.87	\$0
Children	\$20.02	5.2%	\$22.25	\$23.40	\$12.31	\$6.47	\$0

- c. The following table shows the calculation of the Aggregate Component for each DY. These projections were developed by the State and accepted by CMS, and are based on historical trends in supplemental payment amounts and UPLs. They represent what the State would have paid in supplemental provider payments in the absence of the Demonstration.

Table 9-- Aggregate Component

Payment Stream	DY 1	DY 2	DY 3	DY 4	DY 5
Inpatient Hospital UPL for Excluded Population	\$1,346,191,839	\$1,423,194,012	\$1,504,600,709	\$1,590,663,870	\$1,681,649,843
Outpatient Hospital UPL	\$58,024,149	\$61,343,130	\$64,851,957	\$68,561,489	\$72,483,206
Physician UPL	\$74,843,903	\$77,089,221	\$79,401,897	\$81,783,954	\$84,237,473
TOTAL	\$1,479,059,891	\$1,561,626,363	\$1,648,854,563	\$1,741,009,313	\$1,838,370,522

- d. The budget neutrality expenditure limit is the Federal share of the combined total of the Annual Targets for all DYs, and is calculated as the sum of the Annual Targets times the Composite Federal Share (defined in (e) below). This limit represents the maximum amount of FFP that the State may receive for title XIX expenditures during the Demonstration period.
- e. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the State on actual Demonstration expenditures during the approval period (as reported through the MBES/CBES and summarized on Schedule C) by total computable Demonstration expenditures for the same period as reported on the same forms.

- f. CMS policy requires that budget neutral savings cannot be derived from hypothetical populations. In this Demonstration, the STAR+PLUS 217-Like HCBS Eligibility Group is the only hypothetical population. On request from CMS, the State must provide separate expenditure and member month totals by MEG for individuals in the STAR+PLUS 217-Like HCBS Eligibility Group to allow any saving attributable to that group to be netted out of the budget neutrality calculation.

59. Future Adjustments to the Budget Neutrality Expenditure Limit. CMS reserves the right to adjust the budget neutrality expenditure limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new Federal statutes, or policy interpretations implemented through letters, memoranda, or regulations with respect to the provision of services covered under this Demonstration. CMS reserves the right to make adjustments to the budget neutrality expenditure limit if any health care-related tax that was in effect during the base year with respect to the provision of services covered under this Demonstration, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care-related tax provisions of section 1903(w) of the Social Security Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

60. Enforcement of Budget Neutrality. CMS shall enforce budget neutrality over the life of the Demonstration rather than on an annual basis. However, if the State exceeds the calculated cumulative target limit by the percentage identified below for any of the DYs, the State shall submit a corrective action plan to CMS for approval.

DY	Cumulative Target Definition	Percentage
DY 1	Cumulative budget neutrality cap plus:	3 percent
DY 2	Cumulative budget neutrality cap plus:	1 percent
DY 3	Cumulative budget neutrality cap plus:	0.5 percent
DY 4	Cumulative budget neutrality cap plus:	0 percent
DY 5	Cumulative budget neutrality cap plus:	0 percent

61. Exceeding Budget Neutrality. If the budget neutrality expenditure limit has been exceeded at the end of this Demonstration period, the excess Federal funds shall be returned to CMS. If the Demonstration is terminated prior to the end of the budget neutrality agreement, the budget neutrality test shall be based on the time elapsed through the termination date.

IX. GENERAL REPORTING REQUIREMENTS

62. General Financial Requirements. The State will comply with all general financial requirements under title XIX set forth in these STCs.

63. Reporting Requirements Relating to Budget Neutrality. The State will comply with all reporting requirements for monitoring budget neutrality set forth in these STCs. The State must submit any corrected budget neutrality data upon request.

64. Monthly Calls. CMS shall schedule monthly conference calls with the State. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the Demonstration. Areas to be addressed include, but are not limited to:

- a. The health care delivery system;
- b. Enrollment, quality of care, and access to care;
- c. The benefit package;
- d. Performance of hospitals according receiving incentive payments as described in the STCs;
- e. Audits, lawsuits;
- f. Financial reporting and budget neutrality issues;
- g. Progress on evaluations;
- h. State legislative developments; and
- i. Any Demonstration amendments, concept papers or State plan amendments under consideration by the State.

CMS shall update the State on any amendments or concept papers under review as well as Federal policies and issues that may affect any aspect of the Demonstration. The State and CMS (both the Project Officer and Regional Office) shall jointly develop the agenda for the calls.

65. Demonstration Quarterly Reports. The State will submit progress reports 60 days following the end of each quarter (Attachment B). Information required for the first quarter of DY 1 (December 2011 – February 2011) will be included in the second quarter report for DY 2 (March 2012 – May 2012). The intent of these reports is to present the State’s analysis and the status of the various operational areas. These quarterly reports will include, but are not limited to:

- a. A discussion of the events occurring during the quarter or the anticipated to occur in the near future that affect health care delivery, enrollment, quality of care, access, the benefit package, and other operational issues;
- b. Action plans for addressing any policy, operations, and administrative issues identified;
- c. Monthly enrollment data during the quarter and Demonstration Year to Date by eligibility group;
- d. Budget neutrality monitoring tables;
- e. Grievance and appeals filed during the quarter by beneficiaries in STAR and STAR+PLUS

66. Demonstration Annual Report. The State will submit a draft annual report documenting accomplishments, project status, quantitative, and case study findings, utilization data, and policy and administrative difficulties in the operation of the Demonstration. The State will submit the draft annual report no later than 120 days after the end of each operational year. Within 60 days of receipt of comments from CMS, a final annual report will be submitted for the Demonstration Year to CMS.

67. Transition Plan for the Expansion of Medicaid Eligibility in 2014. On or before November 1, 2012, the State is required to submit a draft a transition plan describing how the State plans to coordinate the transition of any individuals enrolled in the Demonstration who may become eligible for a coverage option available under the Affordable Care Act without interruption in coverage to the extent possible. The plan must also describe the steps the State will take to support adequate provider networks for Medicaid State plan populations in 2014. The Plan will include a proposed schedule of activities that the State may use to implement the Transition Plan. After submitting the initial Transition Plan for CMS approval, the State must include progress updates in each quarterly and annual report. The Transition Plan shall be revised as needed.

X. EVALUATION OF THE DEMONSTRATION

68. Submission of a Draft Evaluation Plan. The State shall submit to CMS for approval a draft evaluation design for an overall evaluation of the Demonstration no later than 120 days after CMS approval of the Demonstration. The draft evaluation design must discuss the outcome measures that shall be used in evaluating the impact of the Demonstration during the period of approval. It shall discuss the data sources, including the use of Medicaid encounter data, and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the Demonstration shall be isolated from other initiatives occurring in the State. The draft design shall identify whether the State will conduct the evaluation, or select an outside contractor for the evaluation.

- a. Domains of Focus. The Evaluation Design must, at a minimum, address the research questions listed below. For questions that cover broad subject areas, the State may propose a more narrow focus for the evaluation.
 - i. What is the impact of the managed care expansion on access to care, the quality, efficiency, and coordination of care, and the cost of care? This impact should be measured for health care services in general, as well as specifically evaluating the following:
 - (A) What is the impact of including pharmacy benefits in the capitated managed care benefit on access to prescription drugs? Does the effect vary by service area?
 - (B) What is the impact of managed dental care on the likelihood that children receive recommended dental services? For example, have the dental managed care organizations been successful in meeting the target utilization measures set in the State's dental performance dashboard?

- (C) How does the State's Experience Rebate provision compare to Medical Loss Ratio regulation as a strategy for ensuring that managed care plans spend an appropriate amount of their premium revenue on medical expenses? Would the same plans return approximately the same amounts to the State under a Medical Loss Ratio requirement as under the Experience Rebate, or would the results differ? Are there changes that could be made to either model to improve upon the intended purpose of such mechanisms?
 - (D) What is the impact of including the non-behavioral health inpatient services in the STAR+PLUS program in terms of access to and quality of care and program financing?
 - (E) What is the impact of carving in behavioral health services to STAR and STAR+PLUS as compared to the carving out of behavioral health services in the service area of the NorthSTAR 1915(b) waiver on coordination and quality of care?
 - (F) What is the impact of the STAR+PLUS nursing facility carve-in on quality of care?
- ii. What percentage of providers' uncompensated care cost was made up by payments from the UC Pool? What was the distribution of percentage of UC Pool funds and DSRIP funds among types of providers (hospitals v. community providers, public hospitals vs. other hospitals)?
 - iii. Were the Regional Health Partnerships able to show quantifiable improvements on measures related to the goals of:
 - (A) Better Care for Individuals (including access to care, quality of care, health outcomes),
 - (B) Better Health for the Population, and
 - (C) Lower Cost Through Improvement, especially with respect to per capita costs for Medicaid, uninsured, and underinsured populations, and the cost-effectiveness of care?
 - (D) To what degree can improvements be attributed to the activities undertaken under DSRIP?
 - iv. How effective were the Regional Health Partnerships as a governing structure to coordinate, oversee, and finance payments for uncompensated care costs and incentives for delivery system reform? If issues were encountered, how were they addressed? What was the cost-effectiveness of DSRIP as a program to incentivize change? How did the amount paid in incentives compare with the amount of improvement achieved?
 - v. What do key stakeholders (covered individuals and families, advocacy groups, providers, health plans) perceive to be the strengths and weaknesses, successes and challenges of the expanded managed care program, and of the UC and DSRIP pools?

What changes would these stakeholders recommend to improve program operations and outcomes?

- b. **Evaluation Design Process:** Addressing the research questions listed above will require a mix of quantitative and qualitative research methodologies. When developing the RHP Planning Protocol, the State should consider ways to structure the different projects that will facilitate the collection, dissemination, and comparison of valid quantitative data to support the Evaluation Design required in Section X. From these, the State must select a preferred research plan for the applicable research question, and provide a rationale for its selection. To the extent applicable, the following items must be specified for each design option considered:
 - i. Quantitative or qualitative outcome measures;
 - ii. Proposed baseline and/or control comparisons;
 - iii. Proposed process and improvement outcome measures and specifications;
 - iv. Data sources and collection frequency;
 - v. Robust sampling designs (e.g., controlled before-and-after studies, interrupted time series design, and comparison group analyses);
 - vi. Cost estimates;
 - vii. Timelines for deliverables.
- c. **Levels of Analysis:** The evaluation designs proposed for each question may include analysis at the beneficiary, provider, and aggregate program level, as appropriate, and include population stratifications to the extent feasible, for further depth.

69. Final Evaluation Design and Implementation. CMS shall provide comments on the draft evaluation plan described in paragraph 68 within 60 days of receipt, and the State shall submit a final design within 60 days after receipt of CMS comments. The State shall implement the evaluation plan and submit its progress in each of the quarterly and annual reports.

70. Evaluation Reports.

- a) **Interim Evaluation Report.** The state must submit an Interim Evaluation Report by October 1, 2015, or in conjunction with the State's application for renewal of the Demonstration, whichever is earlier. The purpose of the Interim Evaluation Report is to present preliminary evaluation finds, plans for completing the evaluation design, and submitting a Final Evaluation Report according to the schedule outlined in subparagraph (b). The State shall submit the final Interim Evaluation Report within 60 days after receipt of CMS comments.
- b) **Final Evaluation Report.** The State shall submit to CMS a draft of the Final Evaluation Report by January 31, 2017. The State shall submit the Final Evaluation Report within 60 days after receipt of CMS comments.

- c) CMS may defer up to \$10 million in FFP if evaluation reports are not submitted on time or do not meet the requirements specified in the CMS-approved evaluation plan if the deficiency is material. CMS will work with HHSC to rectify issues with these reports prior to deferring any FFP.

71. Cooperation with Federal Evaluators. Should CMS undertake an independent evaluation of any component of the Demonstration, the State shall cooperate fully with CMS or the independent evaluator selected by CMS. The State shall submit the required data to CMS or the contractor.

**Attachment A
Schedule of Deliverables**

Monthly Deliverables		
Monthly	Monitoring Call	64
Monthly, upon receipt	Enrollment Broker Reports	25
Quarterly Deliverables		
60 days after end of each quarter	Quarterly Progress Reports (The first quarterly report due in DY 1 will encompass Oct. 2011 – March 2012)	39(a) and (b), 65
	Quarterly expenditure, budget neutrality, member month reports	49, Section VIII, and 52
60 days after end of each quarter	Quarterly Payment Reports	43(b)
Dec. 31, 2011	Medicaid State Plan Amendments to remove all supplemental payments for inpatient hospital, outpatient hospital, and physician services from the State plan	43(c)
Annual Deliverables		
Beginning DY 2, December 31st of each DY	Estimated UC Payments	44(a)(v)(A)
Beginning DY 2, 90 days following end of DY	Actual UC Payments and any Reconciliation	44(a)(v)(B)
120 days after end of each Demonstration year	Draft Annual Report	66, 39(c)
Within 60 days of receipt of comments from CMS, annually	Final Annual Report	66
Oct. 1 st of each year	Assessment of Budget Neutrality	47(a)
Annually; anytime significant changes occur	Adequate assurances of sufficient capacity to serve the expected enrollment in service area	24
Annually	Annual Reports on Implementation and Effectiveness of Quality Strategy	27
Other Deliverables		

**Attachment A
Schedule of Deliverables**

12 months before expiration of Demonstration	Request For Extension	8
5 months prior to the effective date of Demonstration's suspension or termination	Notification letter and Draft Phase-Out Plan	9
Post 30-day public comment period	Revised Phase-Out Plan incorporating public comment	9
The earlier of the date of Application for Renewal or October 1, 2015	Interim Evaluation Report	8 and 70(a)
120 days after expiration of Demonstration (January 31, 2017)	Draft Evaluation Report	70(b)
Within 60 days of receipt of CMS comments on Draft Evaluation Report	Final Evaluation Report	70(b)
No later than 120 days prior to planned implementation and may not be implemented until approved	Demonstration amendments, including requests for changes subject to the amendment process	6 and 7
Within 9 months from approval date of Demonstration	Comprehensive Quality Strategy, revision upon any significant changes	27
Submitted Nov. 3, 2011	Plans for ongoing monitoring and oversight of MCO contract compliance	22(b)(ii)
Submitted Nov. 3, 2011	Contingency Plan for addressing insufficient network issues	22(b)(iii)
Submitted Nov.	Transition plan from the 1915(c) waiver	22(b)(iv),

Attachment A
Schedule of Deliverables

28, 2011		
Dec. 23, 2011	Demonstrations of Network Adequacy	22(b)(v), 24(e)
Dec. 23, 2011	Proposed managed care contracts or contract amendments	22(b)(vi)
March 31, 2012	State's plan for formation of RHPs	45(d)(i)
August 31, 2012	Program Funding and Mechanics Protocol	45(d)(ii)(A)
August 31, 2012	RHP Planning Protocol	45(d)(ii)(B)
March 1, 2012	Draft UC Protocol	44(a)(ii)
October 31, 2012	Initial DSRIP plans from RHPs	45(d)(iii)
November 12, 2012	Transition Plan for the Expansion of Medicaid Eligibility in 2014	67
March 31, 2015	Transition Plan for Funding Pools	48

Attachment B
Quarterly Report Template

Under Section IX, paragraph 65 (*Demonstration Quarterly Report*) of these STCs, the State is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant Demonstration activity from the time of approval through completion of the Demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the State. A complete quarterly progress report must include an updated budget neutrality monitoring workbook. An electronic copy of the report narrative, as well as the Microsoft Excel workbook must be provided.

NARRATIVE REPORT FORMAT:

Title Line One – Texas Healthcare Transformation and Quality Improvement Program

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:

Example: Demonstration Year: 1 (12/12/2011 – 9/30/2016)

Federal Fiscal Quarter: 1/2012 (10/011 - 12/11)

Footer: December 12, 2011 – September 30, 2016

I. Introduction

Present information describing the goal of the Demonstration, what it does, and the status of key dates of approval/operation.

II. Enrollment and Benefits Information

Discuss the following:

- Trends and any issues related to STAR and STAR+PLUS eligibility, enrollment, disenrollment, access, and delivery network.
- Any changes or anticipated changes in populations served and benefits. Progress on implementing any Demonstration amendments related to eligibility or benefits.

Please complete the following table that outlines all enrollment activity under the Demonstration. The State should indicate “N/A” where appropriate. If there was no activity under a particular enrollment category, the State should indicate that by “0”.

Attachment B
Quarterly Report Template

Enrollment Counts for Quarter

Note: Enrollment counts should be person counts, not member months

Demonstration Populations	Total No.
Adults	
Children	
AMR	
Disabled	

III. Outreach/Innovative Activities to Assure Access

Summarize marketing, outreach, or advocacy activities to potential eligibles and/or promising practices for the current quarter to assure access for STAR and STAR+PLUS enrollees or potential eligibles.

IV. Collection and Verification of Encounter Data and Enrollment Data

Summarize any issues, activities, or findings related to the collection and verification of encounter data and enrollment data.

V. Operational/Policy/Systems/Fiscal Developments/Issues

Identify all other significant program developments/issues/problems that have occurred in the current quarter or are anticipated to occur in the near future that affect health care delivery, including, but not limited to, program development, quality of care, approval and contracting with new plans, health plan contract compliance and financial performance relevant to the Demonstration, fiscal issues, systems issues, and pertinent legislative or litigation activity.

VI. Action Plans for Addressing Any Issues Identified

Summarize the development, implementation, and administration of any action plans for addressing issues related to the Demonstration.

VII. Financial/Budget Neutrality Development/Issues

Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS 64 and budget neutrality reporting for the current quarter. Identify the State's actions to address these issues.

VIII. Member Month Reporting

Enter the member months for each of the EGs for the quarter.

**Attachment B
Quarterly Report Template**

A. For Use in Budget Neutrality Calculations

Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
Adults				
Children				
AMR				
Disabled				

B. Not Used in Budget Neutrality Calculations

Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX

IX. Consumer Issues

A summary of the types of complaints or problems consumers identified about the program or grievances in the current quarter. Include any trends discovered, the resolution of complaints or grievances, and any actions taken or to be taken to prevent other occurrences.

X. Quality Assurance/Monitoring Activity

Identify any quality assurance/monitoring activity or any other quality of care findings and issues in current quarter.

XI. Demonstration Evaluation

Discuss progress of evaluation plan and planning, evaluation activities, and interim findings.

XII. Regional Healthcare Partnership Participating Hospitals

Enclosures/Attachments

Identify by title the budget neutrality monitoring tables and any other attachments along with a brief description of what information the document contains.

State Contact(s)

Identify the individual(s) by name, title, phone, fax, and address that CMS may contact should any questions arise.

Date Submitted to CMS

**Attachment C
HCBS Service Definitions**

The following are the provider guidelines and service definitions for HCBS provided to individuals requiring a nursing facility level of care under STAR+PLUS.

Service	Service Definition
Adaptive Aids and Medical Supplies	<p>Adaptive aids and medical supplies are specialized medical equipment and supplies which include devices, controls, or appliances that enable members to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.</p> <p>This service also includes items necessary for life support, ancillary supplies, and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Texas State Plan, such as: vehicle modifications, service animals and supplies, environmental adaptations, aids for daily living, reachers, adapted utensils, and certain types of lifts.</p> <p>The annual cost limit of this service is \$10,000 per waiver plan year. The \$10,000 cost limit may be waived by the HHSC upon request of the managed care organization.</p> <p>The State allows a member to select a relative or legal guardian, other than a legally responsible individual, to be his/her provider for this service if the relative or legal guardian meets the requirements for this type of service.</p>
Adult Foster Care	<p>Adult foster care services are personal care services, homemaker, chore, and companion services, and medication oversight provided in a licensed (where applicable) private home by an adult foster care provider who lives in the home. Adult foster care services are furnished to adults who receive these services in conjunction with residing in the home.</p> <p>The total number of individuals (including persons served in the waiver) living in the home cannot exceed three, without appropriate licensure. Separate payment will not be made for personal assistance services furnished to a member receiving adult foster care services, since these services are integral to and inherent in the provision of adult foster care services.</p> <p>Payments for adult foster care services are not made for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep, and improvement. The State allows a member to select a relative or legal guardian, other than a spouse, to be his/her provider for this service if the relative or legal guardian meets the requirements to provide this service.</p>
Assisted Living	<p>Assisted living services are personal care, homemaker, and chore services; medication oversight; and therapeutic, social and recreational programming provided in a homelike environment in a licensed community facility in conjunction with residing in the facility. This service includes 24-hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety, and security. Other individuals or agencies may also furnish care directly, or under arrangement with the community facility, but the services provided by these other entities supplement that provided by the community facility and do not supplant those of the community facility.</p>

**Attachment C
HCBS Service Definitions**

Service	Service Definition
	<p>The individual has a right to privacy. Living units may be locked at the discretion of the individuals, except when a physician or mental health professional has certified in writing that the individual is sufficiently cognitively impaired as to be a danger to self or others if given the opportunity to lock the door. The facility must have a central dining room, living room or parlor, and common activity center(s) (which may also serve as living rooms or dining rooms. The individual retains the right to assume risk, tempered only by the individual's ability to assume responsibility for that risk. The State allows an individual to select a relative or legal guardian, other than a spouse, to be his/her provider for this service if the relative or legal guardian meets the requirements to provide this service. Nursing and skilled therapy services (except periodic nursing evaluations if specified above) are incidental, rather than integral to the provision of assisted living services. Payment will not be made for 24-hour skilled care or supervision. Federal financial participation is not available in the cost of room and board furnished in conjunction with residing in an assisted living facility.</p>
<p>Cognitive Rehabilitation Therapy (effective March 6, 2014)</p>	<p>Cognitive rehabilitation therapy is a service that assists an individual in learning or relearning cognitive skills that have been lost or altered as a result of damage to brain cells/chemistry in order to enable the individual to compensate for the lost cognitive functions. Cognitive rehabilitation therapy is provided when determined to be medically necessary through an assessment conducted by an appropriate professional. Cognitive rehabilitation therapy is provided in accordance with the plan of care developed by the assessor, and includes reinforcing, strengthening, or reestablishing previously learned patterns of behavior, or establishing new patterns of cognitive activity or compensatory mechanisms for impaired neurological systems.</p> <p>Qualified providers</p> <ul style="list-style-type: none"> • Psychologists licensed under Texas Occupations Code Chapter 501. • Speech and language pathologists licensed under Title 3 of the Texas Occupations Code, Subtitle G, Chapter 401. • Occupational therapists licensed under Title 3 of the Texas Occupations Code, Subtitle H, Chapter 454.
<p>Dental Services</p>	<p>Dental services which exceed the dental benefit under the State plan are provided under this waiver when no other financial resource for such services is available or when other available resources have been used.</p> <p>Dental services are those services provided by a dentist to preserve teeth and meet the medical need of the member. Allowable services include:</p> <ul style="list-style-type: none"> • Emergency dental treatment procedures that are necessary to control bleeding, relieve pain, and eliminate acute infection; • Operative procedures that are required to prevent the imminent loss of teeth; • Routine dental procedures necessary to maintain good oral health; • Treatment of injuries to the teeth or supporting structures; and • Dentures and cost of fitting and preparation for dentures, including extractions, molds, etc. <p>The State allows a member to select a relative or legal guardian, other than a spouse, to be his/her provider for this service if the relative or legal guardian meets the requirements to</p>

**Attachment C
HCBS Service Definitions**

Service	Service Definition
	provide this service. Payments for dental services are not made for cosmetic dentistry. The annual cost cap of this service is \$5,000 per waiver plan year. The \$5,000 cap may be waived by the managed care organization upon request of the member only when the services of an oral surgeon are required. Exceptions to the \$5,000 cap may be made up to an additional \$5,000 per waiver plan year when the services of an oral surgeon are required.
Emergency Response Services	Emergency response services provide members with an electronic device that enables certain members at high risk of institutionalization to secure help in an emergency. The member may also wear a portable “help” button to allow for mobility. The system is connected to the person’s phone and programmed to signal a response center once a “help” button is activated. Trained professionals staff the response center. Emergency response services are limited to those members who live alone, who are alone for significant parts of the day, or who have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision. The State allows a member to select a relative or legal guardian, other than a spouse, to be his/her provider for this service if the relative or legal guardian meets the requirements to provide this service.
Employment Assistance	<p>Assistance provided to an individual to help the individual locate paid employment in the community. Employment assistance includes:</p> <ul style="list-style-type: none"> • identifying an individual's employment preferences, job skills, and requirements for a work setting and work conditions; • locating prospective employers offering employment compatible with an individual's identified preferences, skills, and requirements; and • contacting a prospective employer on behalf of an individual and negotiating the individual's employment. <p>In the state of Texas, this service is not available to individuals receiving waiver services under a program funded under section 110 of the Rehabilitation Act of 1973. Documentation is maintained in the individual’s record that the service is not available to the individual under a program funded under the Individuals with Disabilities Education Act (20 U.S.C. §1401 et seq.).</p> <p>An employment assistance service provider must satisfy one of these options:</p> <p>Option 1:</p> <ul style="list-style-type: none"> • a bachelor's degree in rehabilitation, business, marketing, or a related human services field; and • six months of documented experience providing services to people with disabilities in a professional or personal setting. <p>Option 2:</p> <ul style="list-style-type: none"> • an associate's degree in rehabilitation, business, marketing, or a related human services field; and • one years of documented experience providing services to people with disabilities in a professional or personal setting. <p>Option 3:</p> <ul style="list-style-type: none"> • a high school diploma or GED, and • two years of documented experience providing services to people with

**Attachment C
HCBS Service Definitions**

Service	Service Definition
	disabilities in a professional or personal setting.
Financial Management Services	<p>Financial management services provide assistance to members with managing funds associated with the services elected for self-direction. The service includes initial orientation and ongoing training related to responsibilities of being an employer and adhering to legal requirements for employers. The financial management services provider, referred to as the Consumer Directed Services Agency, also:</p> <ul style="list-style-type: none"> • Serves as the member’s employer-agent; • Provides assistance in the development, monitoring, and revision of the member’s budget; • Provides information about recruiting, hiring, and firing staff, including identifying the need for special skills and determining staff duties and schedule; • Provides guidance on supervision and evaluation of staff performance; • Provides assistance in determining staff wages and benefits; • Provides assistance in hiring by verifying employee’s citizenship status and qualifications, and conducting required criminal background checks in the Nurse Aide Registry and Employee Misconduct Registry; • Verifies and maintains documentation of employee qualifications, including citizenship status, and documentation of services delivered; • Collects timesheets, processes timesheets of employees, processes payroll and payables, and makes withholdings for, and payment of, applicable Federal, State, and local employment-related taxes; • Tracks disbursement of funds and provides quarterly written reports to the member of all expenditures and the status of the member’s Consumer Directed Services budget; and • Maintains a separate account for each member's budget. <p>The State allows a relative or legal guardian, other than a legally responsible member, to be the member's provider for this service if the relative or legal guardian meets the requirements for this type of provider.</p>
Home Delivered Meals	Home delivered meals services provide a nutritionally sound meal to members. The meal provides a minimum of one-third of the current recommended dietary allowance for the member as adopted by the United States Department of Agriculture.
Minor Home Modifications	Minor home modifications are those physical adaptations to a member’s home, required by the service plan, that are necessary to ensure the member's health, welfare, and safety, or that enable the member to function with greater independence in the home. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the member’s welfare. Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the member, such as carpeting, roof repair, central air conditioning, etc. Adaptations that add to the total square footage of the home are excluded from this benefit. All services are provided in accordance with applicable State or local building codes. Modifications are not made to settings that are leased, owned, or controlled by waiver providers. The State allows a member to select a relative or legal guardian, other than a spouse, to be the member’s provider for this service if the relative or legal guardian meets the requirements to provide this service.

**Attachment C
HCBS Service Definitions**

Service	Service Definition
	<p>There is a lifetime limit of \$7,500 per member for this service and \$300 yearly for repairs. To request approval to exceed the service cost cap for minor home modifications, the managed care organization must send a written request to HHSC along with appropriate documentation which must include the cost estimate and an assurance that the Plan of Care is within the member's overall cost ceiling and adequate to meet the needs of the member. Once the \$7,500 cap or a higher amount approved by HHSC is reached, only \$300 per year per member, excluding the fees, will be allowed for repairs, replacement, or additional modifications. The home and community support services provider is responsible for obtaining cost-effective modifications authorized on the member's ISP by the managed care organization.</p>
Nursing	<p>Nursing services are those services that are within the scope of the Texas Nurse Practice Act and are provided by a registered nurse (or licensed vocational nurse under the supervision of a registered nurse), licensed to practice in the State. In the Texas State Plan, nursing services are provided only for acute conditions or exacerbations of chronic conditions lasting less than 60 days. Nursing services provided in the waiver cover ongoing chronic conditions such as medication administration and supervising delegated tasks. This broadens the scope of these services beyond extended State plan services.</p>
Occupational Therapy	<p>Occupational therapy consists of interventions and procedures to promote or enhance safety and performance in activities of daily living, instrumental activities of daily living, education, work, play, leisure, and social participation.</p> <p>Occupational therapy services consist of the full range of activities provided by a licensed occupational therapist, or a licensed occupational therapy assistant under the direction of a licensed occupational therapist, acting within the scope of his/her State licensure. Texas assures that occupational therapy is cost-effective and necessary to avoid institutionalization. The State allows a member to select a relative or legal guardian, other than a spouse, to be the member's provider for this service if the relative or legal guardian meets the requirements to provide this service.</p>
Personal Assistance Services	<p>Personal assistance services provide assistance to members in performing the activities of daily living based on their service plan. Personal assistance services include assistance with the performance of the activities of daily living and household chores necessary to maintain the home in a clean, sanitary, and safe environment. Personal assistance services also include the following services: protective supervision provided solely to ensure the health and safety of a member with cognitive/memory impairment and/or physical weakness; tasks delegated by a registered nurse under the rules of the Texas Board of Nursing; escort services consist of accompanying, but not transporting, and assisting a member to access services or activities in the community; and extension of therapy services. The attendant may perform certain tasks if delegated and supervised by a registered nurse in accordance with Board of Nursing rules found in 22 Texas Administrative Code, Part 11, Chapter 224. The home and community support services agency registered nurse is responsible for delegating any task to the attendant, and the home and community support services agency must maintain a copy of the delegation requirements in the member's case record.</p> <p>Health Maintenance Activities are limited to tasks that enable a member to remain in an independent living environment and go beyond activities of daily living because of the higher skill level required. A registered nurse may determine that performance of a health</p>

**Attachment C
HCBS Service Definitions**

Service	Service Definition
	<p>maintenance activity for a particular member does not constitute the practice of professional nursing. An unlicensed person may perform health maintenance activities without delegation. (See Board of Nursing rules at 22 Texas Administrative Code, Part 11, Chapter 225.) Licensed therapists may choose to instruct the attendants in the proper way to assist the member in follow-up on therapy sessions. This assistance and support provides reinforcement of instruction and aids in the rehabilitative process. In addition, a registered nurse may instruct an attendant to perform basic interventions with members that would increase and optimize functional abilities for maximum independence in performing activities of daily living such as range of motion exercises.</p> <p>The following contingencies apply to providers: Texas does not allow service breaks of personal assistance services for health and safety reasons; therefore, providers are required to have back-up attendants if the regular attendant is not available. The provider nurse may provide personal assistance services if the regular and back-up attendants are not available and nurse delegation is authorized.</p> <p>The State allows, but does not require, a member to select a relative or legal guardian, other than a spouse, to be the member’s provider for this service if the relative or legal guardian meets the requirements to provide this service. Personal assistance services will not be provided to members residing in adult foster care homes, assisted living facilities, or during the same designated hours or time period a member receives respite care.</p>
Physical Therapy	<p>Physical therapy is defined as specialized techniques for evaluation and treatment related to functions of the neuro-musculo-skeletal systems provided by a licensed physical therapist or a licensed physical therapy assistant, directly supervised by a licensed physical therapist. Physical therapy is the evaluation, examination, and utilization of exercises, rehabilitative procedures, massage, manipulations, and physical agents (such as mechanical devices, heat, cold, air, light, water, electricity, and sound) in the aid of diagnosis or treatment.</p> <p>Physical therapy services consist of the full range of activities provided by a licensed physical therapist, or a licensed physical therapy assistant under the direction of a licensed physical therapist, acting within the scope of state licensure. Physical therapy services are available through this waiver program only after benefits available through Medicare, Medicaid, or other third party resources have been exhausted. The State allows a member to select a relative or legal guardian, other than a spouse, to be the member’s provider for this service if the relative or legal guardian meets the requirements to provide this service.</p>
Respite	<p>Respite care services are provided to individuals unable to care for themselves, and are furnished on a short-term basis because of the absence of or need for relief for those persons normally providing unpaid services. Respite care may be provided in the following locations: member’s home or place of residence; adult foster care home; Medicaid certified NF; and an assisted living facility. Respite care services are authorized by a member’s PCP as part of the member’s care plan. Respite services may be self-directed. Limited to 30 days per year.</p> <p>There is a process to grant exceptions to the annual limit. The managed care organization reviews all requests for exceptions, and consults with the service coordinator, providers, and other resources as appropriate, to make a professional judgment to approve or deny the request on a case-by-case basis. Members residing in adult foster care homes and</p>

**Attachment C
HCBS Service Definitions**

Service	Service Definition
	assisted living facilities are not eligible to receive respite services. Other waiver services, such as Personal Assistance Services, may be provided on the same day as respite services, but the two services cannot be provided at the exact same time.
Speech, Hearing, and Language Therapy	Speech therapy is defined as evaluation and treatment of impairments, disorders, or deficiencies related to an individual's speech and language. The scope of Speech, Hearing, and Language therapy services offered to HCBS participants exceeds the State plan as the service in this context is available to adults. Speech, hearing, and language therapy services are available through the waiver program only after benefits available through Medicare, Medicaid, or other third party resources have been exhausted. The State allows a member to select a relative or legal guardian, other than a spouse, to be the member's provider for this service if the relative or legal guardian meets the requirements to provide this service.
Support Consultation	<p>Support consultation is an optional service component that offers practical skills training and assistance to enable a member or his legally authorized representative to successfully direct those services the member or the legally authorized representative chooses for consumer-direction. This service is provided by a certified support advisor, and includes skills training related to recruiting, screening, and hiring workers, preparing job descriptions, verifying employment eligibility and qualifications, completion of documents required to employ an individual, managing workers, and development of effective back-up plans for services considered critical to the member's health and welfare in the absence of the regular provider or an emergency situation.</p> <p>Skills training involves such activities as training and coaching the employer regarding how to write an advertisement, how to interview potential job candidates, and role-play in preparation for interviewing potential employees. In addition, the support advisor assists the member or his or her legally authorized representative to determine staff duties, to orient and instruct staff in duties and to schedule staff. Support advisors also assist the member or his or her legally authorized representative with activities related to the supervision of staff, the evaluation of the job performance of staff, and the discharge of staff when necessary.</p> <p>This service provides sufficient information and assistance to ensure that members and their representatives understand the responsibilities involved with consumer direction. Support consultation does not address budget, tax, or workforce policy issues. The State defines support consultation activities as the types of support provided beyond that provided by the financial management services provider. The scope and duration of support consultation will vary depending on a member's need for support consultation. Support consultation may be provided by a certified support advisor associated with a consumer directed services agency selected by the member or by an independent certified support advisor hired by the member. Support consultation has a specific reimbursement rate and is a component of the member's service budget. In conjunction with the service planning team, members or legally authorized representatives determine the level of support consultation necessary for inclusion in each member's service plan.</p>
Supported Employment Services	Assistance provided, in order to sustain competitive employment, to an individual who, because of a disability, requires intensive, ongoing support to be self-employed, work from home, or perform in a work setting at which individuals without disabilities are

**Attachment C
HCBS Service Definitions**

Service	Service Definition
	<p>employed. Supported employment includes adaptations, supervision, training related to an individual's assessed needs, and earning at least minimum wage (if not self-employed).</p> <p>In the state of Texas, this service is not available to individuals receiving waiver services under a program funded under section 110 of the Rehabilitation Act of 1973. Documentation is maintained in the individual's record that the service is not available to the individual under a program funded under the Individuals with Disabilities Education Act (20 U.S.C. §1401 et seq.).</p> <p>A supported employment service provider must satisfy one of these options:</p> <p>Option 1:</p> <ul style="list-style-type: none"> • a bachelor's degree in rehabilitation, business, marketing, or a related human services field; and • six months of documented experience providing services to people with disabilities in a professional or personal setting. <p>Option 2:</p> <ul style="list-style-type: none"> • an associate's degree in rehabilitation, business, marketing, or a related human services field; and • one year of documented experience providing services to people with disabilities in a professional or personal setting. <p>Option 3:</p> <ul style="list-style-type: none"> • a high school diploma or GED, and • two years of documented experience providing services to people with disabilities in a professional or personal setting
Transition Assistance Services	<p>Transition Assistance Services pay for non-recurring, set-up expenses for members transitioning from nursing homes to the STAR+PLUS HCBS program.</p> <p>Allowable expenses are those necessary to enable members to establish basic households and may include: security deposits for leases on apartments or homes; essential household furnishings and moving expenses required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed and bath linens; set-up fees or deposits for utility or service access, including telephone, electricity, gas, and water; services necessary for the member's health and safety, such as pest eradication and one-time cleaning prior to occupancy; and activities to assess need, arrange for, and procure needed resources (limited to up to 180 consecutive days prior to discharge from the nursing facility). Services do not include room and board, monthly rental or mortgage expenses, food, regular utility charges, or household appliances or items that are intended for purely recreational purposes. There is a \$2,500 limit per member.</p>

Attachment D
Interim Quality Improvement Strategy For STAR+PLUS HCBS Program

The following is the current approved strategy as found in the section 1915(c) STAR+PLUS waivers, and which the State has been given permission to use until such time as a comprehensive quality improvement strategy for the section 1115 waiver has been developed.

a. System Improvements.

The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application.

Health Plan Operations, a unit of Managed Care Operations, manages the External Quality Review Organization contract, the Managed Care Organization contracts, the Uniform Managed Care Manual, and the STAR+PLUS handbook. Health Plan Management staff work directly with the health plans to look at various administrative measures and manage complaints that are submitted to HHSC. Additionally, Long Term Services and Supports Policy staff, within the Medicaid and Children's Health Insurance Program (CHIP) Division, manages waiver activities. The Department of Aging and Disability Services carries out delegated functions related to operations of STAR+PLUS.

Health Plan Operations holds quarterly meetings with all parties listed above to examine data, discuss trends, and look for opportunities to address program issues and development improvement strategies. Health Plan Operations documents decisions and tracks them through minutes. Developing and implementing improvement strategies are accomplished through various methods, such as focusing the plans on particular quality measures through the performance at-risk capitation and Quality Challenge Pool. Other opportunities include directing the health plans to particular goals when they are developing their Performance Improvement Projects; making changes to the Managed Care Contracts, Uniform Managed Care Manual, or the STAR+PLUS handbook to address specific operational issues; and taking strategic initiatives forward for executive management review. Additionally, Health Plan Operations, in conjunction with the External Quality Review Organization, holds a quality forum twice per year to further develop the expertise of the health plans on initiatives that are important to the program.

Health Plan Operations is responsible for coordinating and organizing all of the above activities. As new initiatives or projects are developed, Health Plan Operations, working with the above parties, will track whether or not changes to the program have the intended effect and will recommend interventions or revisions when needed. These will be reported to the Deputy Director for Managed Care Operations.

The State of Texas contracts the Institute for Child Health Policy from the University of Florida to serve as the independent External Quality Review Organization to support many of the State's managed care quality and performance goals and objectives. In collaboration with the Institute for Child Health Policy, the Texas Health and Human Services Commission (HHSC) evaluates, assesses, monitors, guides, and directs the Medicaid managed care programs, as well as the contracted managed care organizations. The Institute for Child Health Policy incorporates experience and proven methodologies to evaluate program effectiveness and managed care organizations performance by using the Health Plan Employer Data and Information Set (HEDIS®), non- Health Plan Employer Data and Information Set, and Consumer Assessment of Health Plans Survey (CAHPS®) performance measure benchmarking. The Institute for Child Health Policy develops annual Quality of Care reports, which give information on a number of performance measures for the program. Additionally, data is collected on various quality measures on a quarterly basis. Complaints are also monitored and tracked through the HHS Enterprise Administrative Report and Tracking System. Finally, HHSC is working with the Institute for Child Health Policy to

Attachment D
Interim Quality Improvement Strategy For STAR+PLUS HCBS Program

develop a Long Term Services and Supports report that will include vital measures for indicating how successfully the program is operating.

The State Medicaid Agency is developing data collection methodologies for each performance measure. These methodologies will be completed by February 28, 2012. Data collection will begin in two service delivery areas later this year. Data collection for each performance measure across all service delivery areas will begin in February 2013. Preliminary analyses of the data and remediation data aggregation and analysis will begin during the in calendar year 2012 and full analyses will occur in calendar year 2013.

Processes for developing trending, prioritizing and implementing system improvements will begin in 2011. Field testing of processes will begin in 2011. Actual implementation of the processes will begin in calendar year 2012. The State will use the data analysis in looking at trends in the performance measures. The State will prioritize those areas that are of most importance to the health and welfare of the waiver member. If design changes are needed to the processes that the State uses to administrate and deliver waiver services, these will be developed and implemented in calendar year 2013. The quality improvement system should be fully operational and functional by calendar year 2013.

The contract between the State of Texas and the managed care organizations includes HHSC quality improvement components, such as enhanced value-based purchasing approaches, annual negotiated quality improvement goals, and semi-annual meetings with each managed care organization to assess the status of quality improvement activity. HHSC will incorporate the data and analysis from the performance measures into the overall performance evaluation of the managed care organizations.

Health Plan Operations will continue to develop procedures that will assess the quality of care for Medicaid managed care enrollees consistent with federal regulations and the Protocols for External Quality Review of Medicaid managed care organizations and Prepaid Health Plans, as adopted by Centers for Medicare and Medicaid Services (CMS). These procedures will include the use of surveys, data analysis, evaluation of performance improvement projects, evaluation of performance measures data analysis, and HEDIS®, non-HEDIS®, and CAHPS® benchmarking. From the reported results, HHSC will identify areas of improvement for the managed care organizations. HHSC will also utilize national performance indicators identified or developed by CMS in consultation with States and other relevant stakeholders.

b. System Design Changes

Health Plan Operations is responsible for coordinating and organizing all of the above activities. As new initiatives or projects are developed, Health Plan Operations will use data and analysis from evaluations conducted during the quarterly interims to track whether or not changes to the program have the intended effect and will recommend interventions or revisions as needed. These will be reported to the Deputy Director for Managed Care Operations as well as the members of the various forums that Health Plan Operations will conduct on a quarterly basis. Reports and recommendations for system and program changes produced by Managed Care Operations will be reviewed by executive management for approval. If design changes are needed to the processes that the State is using to administrate and deliver waiver services, these will be developed and implemented by the third year of the waiver renewal. The quality improvement system should be fully operational and functional by calendar year 2013.

Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

Attachment D
Interim Quality Improvement Strategy For STAR+PLUS HCBS Program

Executive management will be provided quarterly reports that will include an evaluation of the overall Quality Improvement Strategy with recommended changes that will result in program improvement. The State will develop processes for evaluation the Quality Improvement Strategy by calendar year 2013.

Attachment E HCBS Quality Review Worksheet

The following worksheet provides the sub-assurances and performance measures for level of care determinations, service plan development and maintenance, qualified providers, health and welfare, administrative authority, and financial accountability. This information was transferred from the State's 1915(c) STAR+PLUS waivers, and these measures will remain in effect under the Demonstration until such time as a comprehensive quality strategy has been developed and approved by CMS.

Where applicable, the State shall consider using the follow types of evidence to verify adherence to the sub-assurances for Level of Care Determinations, Service Plans, Qualified Providers, Health and Welfare, Administrative Authority, and Financial Accountability: Summary reports based on a significant sample of any single or combined method or source of evidence, such as On-site record reviews; Off-site record reviews; Training: record verification; On-site observations, interviews, monitoring; Analyzed collected data (including surveys, focus group, interviews, etc.); Trends, remediation actions proposed/taken; Provider performance monitoring, Operating agency performance monitoring; Staff observation or opinion; Participant/family observation/opinion; Critical events and incident reports; Mortality reviews; Program logs; Medication administration data reports, logs; Financial records (including expenditures); Financial audits; Meeting minutes; Presentation of policies; and Reports to HHSC on delegated administrative functions.

I. Level of Care (LOC) Determination

<i>The State demonstrates that it implements the processes and instrument(s) specified in its 1915(c) waiver for the STAR+PLUS program, which was subsumed by this Demonstration, for evaluating/reevaluating an applicant's/Demonstration participant's level of care consistent with care provided in a nursing facility. The State, through the Health and Human Services Commission, will collect the data indicated below based on a representative sample on a continuous, ongoing basis.</i>		
Sub-Assurances	CMS Expectations	Performance Measures
An evaluation for level of care is provided to all applicants for whom there is a reasonable indication that services may be needed in the future.	State submits evidence that it has reviewed applicant files to verify that individual level of care evaluations are conducted.	Number and percent of applicants who had a LOC evaluation prior to the receipt of services.
The level of care of enrolled participants is reevaluated at least annually.	State submits evidence that it reviews participant files to verify that reevaluations of level of care are conducted at least annually.	Number and percent of members' who received an annual determination of eligibility within 12 months from premium LOC evaluation
The process and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.	State submits that it regularly reviews participant files to verify that the approved instrument is used appropriately in all LOC redeterminations and the person(s) who implement LOC determinations are those specified under this Demonstration.	Number and percent of members' initial LOC determinations that were made using the instrument required by the State. Number and percent of members' annual LOC determinations that were made by a qualified evaluator.
Methods for Remediation/Fixing Individual Problems Related to Level of Care Determinations		
The State's Medicaid Management Information System (MMIS) prevents entry of Medical Necessity/LOC determinations that are not completed by a qualified person or are not completed using an approved instrument. If the system rejects the Medical Necessity/LOC, the managed care organization (MCO) must submit a Medical Necessity/LOC completed by a qualified person using an approved instrument. The system does not allow payment for services delivered to a person without a Medical Necessity/LOC determination. If a person receives services prior to the completion of the Medical Necessity/LOC determination, the MCO receives a reduced capitation payment. The State would require the MCO to complete the Medical Necessity/LOC determination within forty-five (45) days. If not completed within forty-five (45) days, the MCO is contacted directly for resolution and, if necessary, a corrective action plan will be issued. The State collects data and completed corrective action plans, which are retained in the State's database. If the redetermination is not completed timely, the MCO is paid a reduced capitation payment and must complete the Medical Necessity/LOC within 10 business days of notification by the State. If not completed within 10 business days, the MCO is contacted directly for resolution and, if necessary, a corrective action plan will be issued.		

II. Service Plans

Attachment E HCBS Quality Review Worksheet

The State demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for Demonstration participants receiving HCBS services. The State, through an independent external vendor that contracts with the Health and Human Services Commission, will collect and analyze the data indicated below annually using a proportional sampling approach at less than 100% review.

Sub-Assurances	CMS Expectations	Performance Measures
Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of Demonstration HCBS services or through other means.	The State demonstrates that service plans are reviewed periodically to assure that all participant needs are addressed and preferences considered.	Number and percent of members who had service plans that addressed members' needs (including health care needs) as indicated in the assessment(s); Number and percent of members' service plans that address members' goals as indicated in the assessment(s). Number and percent of members reporting that service coordinators asked about their preferences.
The State monitors service plan development in accordance with its policies and procedures.	The State submits evidence of its monitoring process for service plan development and any corrective action taken when service plans were not developed according to policies and procedures.	Number and percent of members' service plans that were developed in accordance with the State's policies and procedures.
Service plans are updated/ revised at least annually or when warranted by changes in the Demonstration participant's needs.	The State submits evidence of its monitoring process for service plan update/revision including service plan updates when a participant's needs changed and corrective actions taken when service plans were not updated/ revised according to policies and procedures	Number and percent of members' service plans that are renewed annually prior to service plan expiration date. Number and percent of members' service plans that addressed member needs including revisions when appropriate. Number and percent of members' service plan changes that occur within State required time frames when members' needs change.
Services are delivered in accordance with the service plan, including in the type, scope, amount, and frequency specified in the service plan.	The State submits evidence of the results of its monitoring process for ensuring the services identified in the service plan are implemented.	Number and percent of members whose services were delivered according to the service plan.
Participants are afforded choice: 1) Between Demonstration services and institutional care; 2) Between/among Demonstration services and providers.	The State submits evidence of the results of its monitoring process for ensuring services identified in the service plan are implemented.	Number and percent of members who were afforded choice between waiver services and institutional care. Number and percent of members who signed that they understand their right to change MCOs and who to contact.
Methods for Remediation/Fixing Individual Problems Related to Service Plans		
If a member's service plan is discovered not to meet the member's needs, goals, preferences, or risks, the State		

Attachment E HCBS Quality Review Worksheet

requires the MCO to revise the service plan based on the assessment, correcting any deficiencies within the State established timeframes. If a member's service plan is discovered not to have been developed according to standards set by the State, the State requires the MCO to revise the service plan according to State policies and procedures within State established timeframes.

The system does not allow payment for services delivered to a person without a service plan. If a person receives services prior to the completion of the services plan, the MCO receives a reduced capitation payment. The State would require the MCO to complete the services plan within forty-five (45) days. If not completed within forty-five (45) days, the MCO is contacted directly for resolution, and if necessary, a corrective action plan will be issued. If the redetermination is not completed timely, the MCO is paid a reduced payment and must complete the service plan within ten (10) business days of notification by the State. If not completed within ten (10) business days, the MCO is contacted directly for resolution and, if necessary a corrective action plan will be issued. The State collects data and completed corrective action plans, which are retained in the State's database.

If a member's service plan is not updated to address changes in need within State required timeframes, the State requires the MCO to revise the service plan correcting any deficiencies within State established timeframes. If a member is discovered to not have received services according to his or her service plan, the MCO will either be required to deliver the services according to the service plan, or to revise the service plan if the member's circumstances have changed and deliver services in accordance with the revised plan. If a member's service plan does not indicate that the member was provided choice of waiver services—the choice between waiver services and institutional care—and was not informed of the right to change MCOs, the MCO is required to meet with the member, within State established timeframes, to revise the member's service plan to indicate that the member If the member's choices are different than what is already being provided, the member's choices will be honored within established timeframes.

Attachment E HCBS Quality Review Worksheet

III. Qualified Providers

The State demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers. The State, through the Health and Human Services Commission, will collect the data indicated below based on a representative sample on a continuous, ongoing basis.

Sub-Assurances	CMS Expectations	Performance Measures
The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing services.	The State provides documentation of periodic review by licensing or certification entity.	Number and percent of new program providers that are licensed/certified as required, prior to the provision of services; Number and percent of program providers recertified by the MCOs which retain licensure/certification Number and percent of program providers that assure that personnel who provide services to members are qualified by licensing, certification, and State regulations;
The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.	The State provides documentation that non-licensed/non-certified providers are monitored on a periodic basis sufficient to provide protections to Demonstration participants.	Number and percent of new non-licensed providers of waiver services that meet background and training qualifications prior to the provision of services; Number and percent of non-licensed providers of waiver services that meet background and training qualifications prior to the provision of services;
The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved Demonstration.	The State provides documentation of monitoring of training and actions it has taken when providers have not met requirements (e.g., technical assistance, training).	Number and percent of providers who receive sState required training;

Methods for Remediation/Fixing Individual Problems Related to Qualified Providers

Individual problems may be discovered during monitoring activities by the State or any of the entities that have been delegated certain functions within the performance measures of this appendix. Those responsible for conducting the monitoring and frequency are described in each performance measure of this appendix. The options for remediation are as follows: For all performance measures related to provider qualifications, the State initiates remediation if an unqualified provider is discovered delivering services by requiring the MCO or the employing agency to terminate the provider's contract, recoup payment, transition members to qualified providers, and ref to the HHSC Office of Inspector General and the Department of Aging and Disability Service Regulatory if appropriate. If the State discovers that provider training was not received according to State requirements, the State will require that the MCO take action within State established timeframes, including, but not limited to, completion of training within specified timeframes, corrective action plans, and contract suspension or termination.

IV. Health and Welfare

**Attachment E
HCBS Quality Review Worksheet**

<i>The State demonstrates, on an ongoing basis that it identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation.</i>		
Sub-Assurances	CMS Expectations	Performance Measures
The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.	The State demonstrates that, on an ongoing basis, abuse, neglect, and exploitation are identified, appropriate actions have been taken when the health or welfare of a participant has not been safeguarded, and an analysis is conducted of abuse, neglect, and exploitation trends and strategies it has implemented for prevention.	Number and percent of member complaints that received follow-up within the required timeframe. Number and percent of newly enrolled members who received educational materials upon enrollment on reporting abuse, neglect and exploitation.
Methods for Remediation/Fixing Individual Problems Related to Member Health and Welfare		
<p>Individual problems may be discovered during monitoring activities by the State or any of the entities that have been delegated certain functions within the performance measures of this appendix. Those responsible for conducting the monitoring and frequency are described in each performance measure of this appendix.</p> <p>If the State discovers that a complaint has not been followed up on within the timeframe required by the State, the managed care organization is subject to various remedies which may include communicating with the managed care organization directly, requiring corrective actions to be completed when appropriate, assessing liquidated damages, freezing enrollment into the managed care organization, and termination of the MCO's contract. All remedies are accompanied by the assumption that the MCO will resolve the complaint. If the State discovers that upon enrollment a member was not provided educational material on reporting abuse, neglect, and exploitation, the managed care organization is required to provide the member with that material within State established timeframes.</p>		

Attachment E HCBS Quality Review Worksheet

V. Administrative Authority

The State demonstrates that it retains ultimate administrative authority over the Demonstration HCBS program and that its administration of the program is consistent with the approved Demonstration Terms and Conditions. The State no longer delegates responsibility to the Department of Aging and Disability Services and will revise these assurances to reflect changes made in conjunction with the September 1, 2014 expansion.

Sub-Assurances	CMS Expectations	Performance Measures
<p>The Medicaid agency retains ultimate administration authority and responsibility for the operation of the Demonstration's HCBS program by exercising oversight of the performance of Demonstration functions by other State and local/regional non-State agencies (if appropriate) and contracted entities.</p>	<p>State submits evidence of its monitoring of all delegated functions, and implementation of policies/procedures related to its administration authority over the Demonstration's HCBS program, including: memoranda of agreements, description of roles and responsibilities relative to program operations, monitoring, and remediation or system improvements instituted when programs are identified in the operation of the program.</p>	<p>Number and percent of enrollments completed by the Department of Aging and Disability Services within five days of posting service plan to a secure File Transfer Protocol server by the managed care organization.</p> <p>Number and percent of level of care evaluation determinations completed by Texas Medicaid Healthcare Partnership within required time frames.</p> <p>Number and percent of initial level of care evaluation determinations verified by the Department of Aging and Disability Services prior to service delivery.</p> <p>Number and percent of level of care redeterminations verified by the Department of Aging and Disability Services that were completed within required time frames.</p> <p>Number and percent of member service plans verified as meeting waiver requirements by the Department of Aging and Disability Services prior to service delivery.</p> <p>Number and percent of members' service plans authorized by the managed care organization prior to service delivery.</p> <p>Number and percent of managed care organizations that follow an agreed upon utilization process as outlined in their contracts.</p> <p>Number and percent of managed care organizations that contracted with only qualified Medicaid providers as outlined in their contracts.</p> <p>Number and percent of managed care organizations that demonstrate their credentialing process meets the State's criteria as outlined in their contracts.</p>

Attachment E HCBS Quality Review Worksheet

Methods for Remediation/Fixing Individual Problems Related to Administrative Authority

In reference to the execution of Medicaid provider agreements, the process varies somewhat in STAR+PLUS program. The managed care organizations contracted with the State of Texas to manage and operate the STAR+PLUS program contract only with providers that are Medicaid certified. The managed care organizations have a credentialing process to ascertain and confirm that the provider has a Medicaid provider agreement with the State along with meeting all applicable licensure and/or certification requirements prior to contracting with the managed care organization. Individual problems may be discovered during monitoring activities by the State or by any of the entities that have been delegated certain functions within the performance measures of this appendix. Those responsible for conducting the monitoring and frequency are described in each performance measure of this appendix. The options for remediation are listed below:

If the State discovers the Texas Medicaid Healthcare Partnership has not completed a level of care within required timeframes, the Texas Medicaid Healthcare Partnership will be required to complete the level of care within State established timeframes. The State monitors the timeliness requirement monthly using an automated contract management/monitoring system. If the requirement is identified as not being met in one month, a performance memo is sent to TMHP documenting the deficiency and corrective measures are requested. If a second "Not Met" is identified, the issues are referred to the Performance Group for an evaluation of a formal remedy under the Contract which include: oral notice of deficiency; written notice of deficiency; request for a corrective action plan; assessment of a performance remedy (i.e. liquidated damages, actual damages, etc.).

If the State discovers that the Department of Aging and Disability Services has not, within State established timeframes, completed an enrollment, verified a level of care appropriately, or verified a service plan, the State will, within five business days of the discovery, notify the Department of Aging and Disability Services of its finding and request that the Department of Aging and Disability Services respond with the reasons for the deficiency and its proposed corrective action. HHSC will notify the Department of Aging and Disability Services in writing of specific areas of the Department of Aging and Disability Services' performance that fail to meet performance expectations, standards, or schedules set forth in the operating agreement between the Department of Aging and Disability Services and HHSC or the STAR+PLUS waiver documents. The Department of Aging and Disability Services will, within ten business days (or another date approved by HHSC) of receipt of written notice, provide HHSC with a written response that explains the reasons for the deficiency, outlines the Department of Aging and Disability Services' plan to address or cure the deficiency, and states the date by which the deficiency will be cured. If the Department of Aging and Disability Services disagrees with HHSC's findings, this written response will state the reasons for disagreement with HHSC's findings. The Department of Aging and Disability Services' proposed cure of a deficiency is subject to approval of HHSC.

At its option, HHSC may require the Department of Aging and Disability Services to submit to HHSC a written plan to correct or resolve any noncompliance with the operating agreement between the two agencies. The corrective action plan must provide a detailed explanation of the reasons for the cited deficiency; the Department of Aging and Disability Services' assessment or diagnosis of the cause; and a specific proposal to cure or resolve the deficiency (including the date by which the deficiency will be cured). The corrective action plan must be submitted by the deadline set forth in HHSC's request for a corrective action plan. The corrective action plan is subject to approval by HHSC.

If the State discovers that a managed care organization has not, within State established timeframes, authorized a service plan, followed an agreed upon utilization process, contracted with qualified Medicaid providers, or demonstrated a credentialing process, the State will require the managed care organization to take corrective action within State established timeframes.

V. Financial Accountability

Attachment E HCBS Quality Review Worksheet

<i>The State demonstrates that it has designed and implemented an adequate system for assuring financial accountability of the Demonstration's HCBS program.</i>		
Sub-Assurances	CMS Expectations	Performance Measures
<p>State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved Demonstration.</p>	<p>The State submits results of its financial monitoring process for verifying maintenance of appropriate financial records as specified in the approved Demonstration.</p> <p>The State submits results of its review of Demonstration participant claims to verify that they are coded and paid in accordance with the Demonstration's reimbursement methodology.</p> <p>The State Demonstrations that interviews with State staff and providers are periodically conducted to verify that any identified financial irregularities are addressed.</p> <p>The State demonstrates that site visits are conducted with provides to verify that they maintain financial records according to provider agreements/contracts.</p>	<p>Number and percent of per member per month capitated payments paid to the managed care organization only for eligible Medicaid members.</p>
Methods for Remediation/Fixing Individual Problems Related to Financial Accountability		
<p>Individual problems may be discovered during monitoring activities by the State or any of the entities that have been delegated certain functions within the performance measures of this appendix. Those responsible for conducting the monitoring and frequency are described in each performance measure of this appendix. The options for remediation are as follows: If the State discovers that a capitated payment was made to a managed care organization for a non-eligible member, the State recoups the funds from the managed care organization. At the end of the month in which the member became ineligible, the member is disenrolled from the program.</p>		

Attachment F HCBS Fair Hearing Procedures

The material presented in Attachment F corresponds to the contents of Appendix F of the Application for a §1915(c) Home and Community-Based Services Waiver, Version 3.5.

I. Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing

The managed care organization (MCO) must develop, implement and maintain an Appeal procedure that complies with state and federal laws and regulations. When a Member or his or her authorized representative expresses orally or in writing any dissatisfaction or disagreement with an Action, the MCO must regard the expression of dissatisfaction as a request to Appeal an Action.

A Member must file a request for an Appeal with the MCO within 30 days from receipt of the notice of reduction, denial or termination of services.

The MCO's Appeal procedures must be provided to Members in writing and through oral interpretive services.

The MCO must send a letter to the Member within five (5) business days acknowledging receipt of the Appeal request. Except for the resolution of an Expedited Appeal, the MCO must complete the entire standard Appeal process within 30 calendar days after receipt of the initial written or oral request for Appeal. The timeframe for a standard Appeal may be extended up to 14 calendar days if the Member or his or her representative requests an extension; or the MCO shows that there is a need for additional information and how the delay is in the Member's interest. If the timeframe is extended and the Member had not requested the delay, the MCO must give the Member written notice of the reason for delay. The MCO must designate an officer who has primary responsibility for ensuring that Appeals are resolved within these timeframes and in accordance with the MCO's written policies.

In accordance with 42 C.F.R. § 438.420, the MCO must continue the Member's benefits currently being received by the Member, including the benefit that is the subject of the Appeal, if all of the following criteria are met:

1. The Member or his or her representative files the Appeal timely as defined in this Contract;
2. The Appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
3. The services were ordered by an authorized provider;

Attachment F
HCBS Fair Hearing Procedures

4. The original period covered by the original authorization has not expired; and
5. The Member requests an extension of the benefits.

If, at the Member's request, the MCO continues or reinstates the Member's benefits while the Appeal is pending, the benefits must be continued until one of the following occurs:

1. The Member withdraws the Appeal;
2. Ten (10) days pass after the MCO mails the notice resolving the Appeal against the Member, unless the Member, within the 10-day timeframe, has requested a Fair Hearing with continuation of benefits until a Fair Hearing decision can be reached; or
3. A State Fair Hearing officer issues a hearing decision adverse to the Member or the time period or service limits of a previously authorized service has been met.

In accordance with 42 C.F.R. § 438.420(d), if the final resolution of the Appeal is adverse to the Member and upholds the MCO's Action, then to the extent that the services were furnished to comply with the Contract, the MCO may recover such costs from the Member.

If the MCO or State Fair Hearing Officer reverses a decision to deny, limit, or delay services that were not furnished while the Appeal was pending, the MCO must authorize or provide the disputed services promptly and as expeditiously as the Member's health condition requires.

If the MCO or State Fair Hearing Officer reverses a decision to deny authorization of services and the Member received the disputed services while the Appeal was pending, the MCO is responsible for the payment of services.

The MCO is prohibited from discriminating or taking punitive action against a Member or his or her representative for making an Appeal.

In accordance with 42 C.F.R. §438.410, the MCO must establish and maintain an expedited review process for Appeals, when the MCO determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the Member's life or health. The MCO must follow all Appeal requirements for standard Member Appeals except where differences are specifically noted. The MCO must accept oral or written requests for Expedited Appeals.

Members must exhaust the MCO's Expedited Appeal process before making a request for an expedited Fair Hearing. After the MCO receives the request for an Expedited Appeal, it must hear an approved request for a Member to have an Expedited Appeal and notify the Member of the outcome of the Expedited Appeal within 3 business days, except that the MCO must complete investigation and resolution of an Appeal relating to an ongoing emergency or denial of continued hospitalization:

1. In accordance with the medical or dental immediacy of the case; and
2. not later than one business day after receiving the Member's request for Expedited Appeal is received.

Attachment F HCBS Fair Hearing Procedures

The MCO is prohibited from discriminating or taking punitive action against a Member or his or her representative for requesting an Expedited Appeal. The MCO must ensure that punitive action is neither taken against a provider who requests an expedited resolution or supports a Member's request.

If the MCO denies a request for expedited resolution of an Appeal, it must:

1. Transfer the Appeal to the timeframe for standard resolution, and
2. Make a reasonable effort to give the Member prompt oral notice of the denial, and follow up within two (2) calendar days with a written notice.

The MCO must inform Members that they have the right to access the Fair Hearing process at any time during the Appeal system provided by the MCO. In the case of an expedited Fair Hearing process, the MCO must inform the Member that the Member must exhaust the MCO's internal Expedited Appeal process prior to filing an Expedited Fair Hearing. The MCO must notify Members that they may be represented by an authorized representative in the Fair Hearing process.

If a Member requests a Fair Hearing, the MCO will submit to the request to the appropriate Fair Hearings office, within five (5) calendar days.

Within five (5) calendar days of notification that the Fair Hearing is set, the MCO will prepare an evidence packet for submission to the HHSC Fair Hearings staff and send a copy of the packet to the Member. The evidence packet must comply with HHSC's Fair Hearings requirements.

The Fair Hearings Officer makes the final decision on appeals submitted to Fair Hearings. The Fair Hearings Officers are employees of HHSC that are separate from the State Medicaid Agency. This provides for an independent review and disposition for the member. The MCO sends a letter to the member informing the member that if an appeal is filed timely the member's benefits/services will continue. The member may also contact a member advocate or service coordinator for assistance or clarification. All documentation related to the adverse action and/or requests are maintained by the managed care operation in the member's case file.

II. State Grievance/Complaint System

The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services.

A. Operational Responsibility

HHSC, the State Medicaid agency, and the MCO operate the grievance/complaint system.

The State Medicaid Agency operates and maintains an electronic complaint/grievance system that provides information to HHSC staff on any complaints/grievances related to members of the MCOs. The MCO is required by contract to develop, implement and maintain a member complaint and appeal system specific to their members.

Attachment F

HCBS Fair Hearing Procedures

The member is informed at enrollment that filing a grievance or making a complaint is not a prerequisite or substitute for Fair Hearing. The member is also informed that they can contact a Member Advocate or their service coordinator if they need assistance for issues related to making complaints or filing a grievance.

B. Description of System

The MCO must develop, implement, and maintain a Member Complaint and Appeal system that complies with the requirements in applicable federal and state laws and regulations.

The Complaint and Appeal system must include a Complaint process, an Appeal process, and access to HHSC's Fair Hearing System. The procedures must be the same for all Members and must be reviewed and approved in writing by HHSC or its designee. Modifications and amendments to the Member Complaint and Appeal system must be submitted for HHSC's approval at least 30 days prior to the implementation.

The MCO must have written policies and procedures for receiving, tracking, responding to, reviewing, reporting and resolving Complaints by Members or their authorized representatives. The MCO must resolve Complaints within 30 days from the date the Complaint is received. The Complaint procedure must be the same for all Members under the Contract. The Member or Member's authorized representative may file a Complaint either orally or in writing. The MCO must also inform Members how to file a Complaint directly with HHSC, once the Member has exhausted the MCO's complaint process.

The MCO's Complaint procedures must be provided to Members in writing and through oral interpretive services. The MCO must include a written description of the Complaint process in the Member Handbook. The MCO must maintain and publish in the Member Handbook, at least one local and one toll-free telephone number with Teletypewriter/Telecommunications Device for the Deaf (TTY/TDD) and interpreter capabilities for making Complaints.

The MCO's process must require that every Complaint received in person, by telephone, or in writing must be acknowledged and recorded in a written record and logged with the following details:

1. Date;
2. Identification of the individual filing the Complaint;
3. Identification of the individual recording the Complaint;
4. Nature of the Complaint;
5. Disposition of the Complaint (i.e., how the managed care organization resolved the Complaint);
6. Corrective action required; and
7. Date resolved.

The MCO is prohibited from discriminating or taking punitive action against a Member or his or her representative for making a Complaint.

Attachment F

HCBS Fair Hearing Procedures

If the Member makes a request for disenrollment, the MCO must give the Member information on the disenrollment process and direct the Member to the HHSC Administrative Services Contractor. If the request for disenrollment includes a Complaint by the Member, the Complaint will be processed separately from the disenrollment request, through the Complaint process.

The MCO will cooperate with the HHSC's Administrative Services Contractor and HHSC or its designee to resolve all Member Complaints. Such cooperation may include, but is not limited to, providing information or assistance to internal Complaint committees. The MCO must provide a designated Member Advocate to assist the Member in understanding and using the MCO's Complaint system until the issue is resolved.

Attachment G HCBS Participant Safeguards

The material presented in Attachment G corresponds to the contents of Appendix G of the Application for a §1915(c) Home and Community-Based Services Waiver, Version 3.5.

I. RESPONSE TO CRITICAL EVENTS OR INCIDENTS

The State operates a Critical Event or Incident Reporting and Management Process.

A. State Critical Event or Incident Reporting Requirements: The State has in place the reporting and investigation of abuse, neglect, and exploitation to ensure health and safety of waiver members.

1. The State definition of abuse, neglect and exploitation of adults, incident reporting requirements and reporting mechanism is found in Chapter 48 of the Human Resource Code (Investigations And Protective Services For Elderly And Disabled Persons):

Sec. 48.002. DEFINITIONS.

a) Except as otherwise provided under Section 48.251, in this chapter:

1. "Elderly person" means a person 65 years of age or older.
2. "Abuse" means:
 - A. the negligent or willful infliction of injury, unreasonable confinement, intimidation, or cruel punishment with resulting physical or emotional harm or pain to an elderly or disabled person by the person's caretaker, family member, or other individual who has an ongoing relationship with the person; or
 - B. sexual abuse of an elderly or disabled person, including any involuntary or nonconsensual sexual conduct that would constitute an offense under Section 21.08, Penal Code (indecent exposure) or Chapter 22, Penal Code (assaultive offenses), committed by the person's caretaker, family member, or other individual who has an ongoing relationship with the person.
3. "Exploitation" means the illegal or improper act or process of a caretaker, family member, or other individual who has an ongoing relationship with the elderly or disabled person using the resources of an elderly or disabled person for monetary or personal benefit, profit, or gain without the informed consent of the elderly or disabled person.
4. "Neglect" means the failure to provide for one's self the goods or services, including medical services, which are necessary to avoid physical or emotional harm or pain or the failure of a caretaker to provide such goods or services.

Sec. 48.002(a)(8).

"Disabled person" means a person with a mental, physical, or developmental disability that substantially impairs the person's ability to provide adequately for the person's care or protection and who is:

- (A) 18 years of age or older; or
- (B) under 18 years of age and who has had the disabilities of minority removed.

Attachment G HCBS Participant Safeguards

2. DADS licensing and contracting rules contain requirements related to reporting incidents and complaints. DADS regularly monitors a provider's compliance with these requirements.

All facilities and agencies providing services to waiver members are required to comply with the following requirements:

- All facilities and agencies providing services to waiver members must comply with the provisions of Chapter 250 of the Health and Safety Code (relating to Nurse Aide Registry and Criminal History Checks of Employees And Applicants For Employment In Certain Facilities Serving The Elderly, Persons With Disabilities, or Persons With Terminal Illnesses).
- Before a facility or agency hires an employee, the facility or agency must search the employee misconduct registry (EMR) established under §253.007, Health and Safety Code, and DADS' nurse aide registry (NAR) to determine if the individual is designated in either registry as unemployable. Both registries can be accessed on the DADS Internet website.
- A facility or agency is prohibited from hiring or continuing to employ a person who is listed in the employee misconduct registry or nurse aide registry as unemployable.
- A facility or agency must provide information about the employee misconduct registry to all employees in accordance with 40 Texas Administrative Code §93.3 (relating to Employee Misconduct Registry).
- In addition to the initial verification of employability, a facility or agency must:
 - conduct a search of the nurse aide registry and the employee misconduct registry annually during the month of each employee's employment anniversary date to determine if the employee is listed in either registry as unemployable; and
 - keep a copy of the results of the initial and annual searches of the nurse aide registry and employee misconduct registry in the employee's personnel file.

3. 40 Texas Administrative Code §92.102 (relating to Abuse, Neglect, or Exploitation Reportable to the State by Facilities and Agencies) also provides a process for reporting abuse, neglect, or exploitation to the State:

(a) Any facility or agency staff who has reasonable cause to believe that a resident is in a state of abuse, neglect, or exploitation must report the abuse, neglect, or exploitation to DADS' state office at 1-800-458-9858 and must follow the facility's internal policies regarding abuse, neglect, or exploitation.

(b) The following information must be reported to the department:

- (1) name, age, and address of the member;
- (2) name and address of the person responsible for the care of the member, if available;
- (3) nature and extent of the elderly or disabled person's condition;
- (4) basis of the reporter's knowledge; and
- (5) any other relevant information.

(c) The facility agency must investigate the alleged abuse or neglect and send a written report of the investigation to DADS' state office no later than the fifth calendar day after the oral report.

Attachment G HCBS Participant Safeguards

(d) A facility or agency may not retaliate against a person for filing a complaint, presenting a grievance, or providing in good faith information relating to personal care services provided by the facility.

4. Pursuant to Human Resource Code Sec. 48.151 (relating to Action On Report), the State is required to take the following actions:

Not later than 24 hours after the department receives a report of an allegation of abuse, neglect, or exploitation under Section 48.051, the department shall initiate a prompt and thorough investigation as needed to evaluate the accuracy of the report and to assess the need for protective services, unless the department determines that the report:

- a. is frivolous or patently without a factual basis; or
- b. does not concern abuse, neglect, or exploitation, as those terms are defined by Section 48.002.

5. DFPS investigatory requirements are described in Human Resources Code Sec. 48.152 (relating to Investigation):

An investigation by the department or a State agency shall include an interview with the elderly or disabled person, if appropriate, and with persons thought to have knowledge of the circumstances. The investigation may include an interview with an alleged juvenile perpetrator of the alleged abuse, neglect, or exploitation. The department or State agency may conduct an interview under this section in private or may include any person the department or agency determines is necessary.

6. Licensure Requirements

DADS licenses the following providers: Home and Community Support Services Agencies (40 Texas Administrative Code, Chapter 97); assisted living facilities (40 Texas Administrative Code, Chapter 92); adult foster care, serving four individuals (40 Texas Administrative Code, Chapter 92); intermediate care facilities for persons with mental retardation (40 Texas Administrative Code, Chapter 90); and nursing facilities providing out-of-home respite (VTCA Human Resources Code Chapter 145 40 Texas Administrative Code 48.6034).

DADS does not license or certify home-delivered meals providers; however, the home-delivered meals providers are required to comply with DADS contracting rules at 40 Texas Administrative Code, Chapter 49, and DADS program rules at 40 Texas Administrative Code, Chapter 55.

Adult foster care providers who serve three or fewer individuals are not licensed, but are reviewed annually for compliance with adult foster care home requirements. The requirements for adult foster care are found in the STAR+PLUS Handbook, which is incorporated by reference in the managed care contracts.

Attachment G HCBS Participant Safeguards

Emergency response services providers are licensed by the Department of State Health Services (25 Texas Administrative Code, Chapter 140, Subchapter B).

All providers, whether licensed by DADS or not, are required to report any instances of abuse, neglect, or exploitation of an individual to the Department of Family and Protective Services (DFPS) immediately upon suspicion of such activities. DFPS investigates assigned reports and makes a determination as to whether abuse, neglect, or exploitation occurred. In some instances, DFPS may offer services, if appropriate. Providers subject to DADS licensure are further required to report allegations of abuse, neglect, and exploitation directly to DADS immediately upon suspicion of such activities.

Providers make the reports of suspected abuse, neglect, or exploitation by telephone to either the State abuse hotline or the licensing complaint hotline. Individuals may report suspected instances of abuse, neglect, or exploitation using either telephone number 24 hours a day.

DADS requires licensed providers to have a disaster preparedness plan in place.

B. Participant Training and Education

At the time an applicant is enrolled in the LTSS STAR+PLUS waiver program, the managed care organization and contracted providers must ensure that the member is informed orally and in writing of the processes for reporting allegations of abuse, neglect, or exploitation. The toll-free numbers for HHSC, DADS and DFPS must be provided. Facilities must post the information in a conspicuous place. Home and community support services agencies must provide the information to the member at the time of admission. Evidence supporting compliance with these requirements is reviewed during DADS' on-site licensure surveys and managed care organization contract monitoring reviews of the program provider.

The service coordinators play a role in ensuring that waiver member receives training and education regarding protections from abuse, neglect, and exploitation. Service coordinators provide information regarding protections from abuse, neglect, and exploitation at the time the members are enrolled in the LTSS STAR+PLUS waiver program. Service providers advise waiver member of their rights to freedom from abuse, neglect, and exploitation by ensuring that the member read and sign the Consumer Rights and Responsibilities form. Training occurs at the time of the member's enrollment. Additional Training is provided upon the member's request.

In addition to the information provided to all members in the waiver, a CDSA provides members who elect the consumer directed services option with training and written information related to reporting allegations of abuse, neglect, and exploitation.

C. Responsibility for Review of and Response to Critical Events or Incidents

Attachment G HCBS Participant Safeguards

The Texas Department of Family and Protective Services (DFPS) is responsible for receiving and investigating reports of abuse, neglect, and exploitation for all adults. DFPS assigns a priority level to a complaint at the time of intake based on the perceived threat level to the member. DFPS must initiate a case by contacting a person with current and reliable information within 24 hours of intake, and must conclude the investigation within 30 days. The investigator may change the priority level based on information from the contact. DFPS must make the initial face-to-face contact with the alleged victim based on the priority level. The results of the investigation are reported to the complainant and other pertinent parties within 30 days by generating a letter from their automated system.

Texas Human Resources Code Chapter 48 requires that DFPS investigate persons thought to have knowledge of the circumstances regarding abuse, neglect, and exploitation. Texas Human Resources Code also provides certain laws to assist with investigations including access to records and a prohibition against interference with investigation or services.

All abuse, neglect and exploitation reported to the DFPS as required by licensure regulations are investigated. Investigation of some self-reported incidents may be completed without an on-site investigation. If further investigation is warranted to ensure compliance with federal, state, or local laws, an on-site investigation is scheduled.

The State's code on health and safety for waiver members addresses abuse, neglect and exploitation.

The State's regulatory agency publishes an online Employee Misconduct Registry that includes non licensed individuals that were investigated and found in violation of the health and safety of waiver members. As part of their licensure requirements, facilities and agencies are required to check the Registry prior to offering employment to anyone that will be providing direct service to a waiver member. Through their credentialing process, the managed care organizations ensure the agencies they contract with have met all licensure requirements.

D. Responsibility for Oversight of Critical Incidents and Events

In accordance with 42 Code of Federal Regulations, §431.10(e), HHSC is the Single State Medicaid Agency and retains oversight and full administrative authority over the waiver program.

The Texas Department of Family and Protective Services (DFPS) is also involved in administrative and operation activities. HHSC and DFPS are part of the Texas Health and Human Services Enterprise. DFPS is responsible for handling all reports of abuse, neglect, and exploitation related to adults receiving services in the community, including adults served by a Home and Community Support Services Agency licensed under Health and Safety Code, Chapter 142, except for those occurring in a facility subject to licensure by DADS.

Attachment G HCBS Participant Safeguards

As required by Texas Human Resources Code, §48.103, upon completion of an investigation in which abuse, neglect, or exploitation is validated against an employee of a Home and Community Support Services Agency or against an adult foster care provider, after the DFPS due process procedure has been completed, the DFPS Adult Protective Services caseworker releases the investigation findings to HHSC. HHSC reviews all investigation reports provided by DFPS. Based on the content of the report, HHSC may conduct an on-site survey of the provider or require the provider to submit evidence of follow-up action on the incident. The investigative findings and HHSC's follow-up on those findings is entered into the abuse, neglect, or exploitation database by HHSC staff. HHSC also records deaths in a database. Reports of critical incidents are compiled on a monthly basis for each program provider.

In preparation for annual and some intermittent reviews of providers, HHSC staff compiles data related to all critical incidents reported by or involving the program provider. HHSC may use this information in selecting the sample of individuals whose records will be reviewed and who may be interviewed to ensure appropriate follow-up was conducted by the provider.

All abuse, neglect and exploitation reported to the DFPS as required by licensure regulations are investigated. Investigation of some self-reported incidents may be completed without an on-site investigation. If further investigation is warranted to ensure compliance with federal, state, or local laws, an on-site investigation is scheduled.

Oversight activities occur on an ongoing basis. Information regarding validated instances of abuse, neglect or exploitation is monitored, tracked and trended for purposes of training HHSC staff and to prevent recurrence.

Providers are responsible for training their staff about reporting critical incidents and events.

II. SAFEGUARDS CONCERNING RESTRAINTS AND RESTRICTIVE INTERVENTIONS

The use of restraints or seclusion is permitted during the course of the delivery of waiver services.

A. Use of Restraints or Seclusion

1. Safeguards Concerning the Use of Restraints or Seclusion.

HHSC does not allow restraints in community-based settings except in an assisted living facility. The assisted living facility must have a policy about restraints and seclusion. The facility must notify the resident and, if applicable, their legal representative about HHSC's rules and the facility's policies about restraint and seclusion.

Licensing requirements for assisted living facilities prohibit the use of restraints unless it is a behavioral emergency and ordered by a physician. A provider may use physical or chemical

Attachment G HCBS Participant Safeguards

restraints (seclusion is not permitted) only if the use is authorized in writing by a physician or if the use is necessary in an emergency to protect the resident or others from injury. A physician's written authorization for the use of restraints must specify the circumstances under which the restraints may be used and the duration for which the restraints may be used. The provider must make every attempt to use behavior management and de-escalation techniques prior to considering physical or chemical restraints. Assisted living facilities that choose to accept and retain residents with written physician's authorization must maintain this document in the resident files. Any use of restraints must be documented by the provider in the resident's record.

A restraint may not be administered under any circumstance if it obstructs the resident's airway, including a procedure that places anything in, on, or over the resident's mouth or nose, impairs the resident's breathing by putting pressure on the resident's torso, interferes with the residents ability to communicate, or places the resident in a prone or supine position.

If the facility uses a restraint hold, they must use an acceptable restraint hold. The assisted living facility rules explain what qualifies as an unacceptable and acceptable restraint hold. After the use of restraint the facility must, with the resident's consent, make an appointment with the resident's physician no later than the end of the first working day after the use of the restraint and document in the resident's record that the appointment was made. If the resident refuses to see the physician, they must document the refusal.

The State does not prescribe specific elements with respect to the documentation for instances in which an approved restraint is utilized on a waiver participant. The facility must develop these criteria based on the individual.

As soon as possible, but no later than 24 hours after the use of restraint, the facility must notify the participant's legally authorized representative or an individual actively involved in the resident's care, unless the release of this information would violate other law.

Attendants must complete 16 hours of on the job supervision and training within the first 16 hours of employment following orientation. The training must include seven specified topics. One of the topics is behavior management practices, such as prevention of aggressive behavior and de-escalation techniques, to decrease the frequency of the use of restraints.

Direct care staff must complete one hour of training annually in behavior management practices, such as prevention of aggressive behavior and de-escalation techniques, fall prevention, and alternatives to restraints. Facilities that employ licensed nurses, certified nurse aides, or certified medication aides must provide annual in-service training, appropriate to their job responsibilities from one of six topics. One of the topics is restraint use.

A facility may adopt policies that allow less use of restraint than allowed by the State's rules. See 40 Texas Administrative Code §92.41(p)(7). All actions and measures related to restraints or seclusion are State specific.

Attachment G HCBS Participant Safeguards

DADS monitors improper use of restraints through on-site surveys and complaint investigations. As per the State's licensure requirements, the facility must demonstrate during on-site surveys and/or during a complaint investigation that a restraint policy is in place and the protocol used by the facility staff meets licensure parameters.

The State Uniform Managed Care Contract: Attachment B-1, Section 8.2.6, requires the managed care organizations to maintain written policies and procedures for informing members of their rights, consistent with 42 C.F.R. §438.100. Attachment B-1, Sections 8.1.5.1 and 8.1.5.3 establishes the general requirements for the managed care organizations member materials, including the Member Handbook. HHSC's Uniform Managed Care Manual (UMCM), which is incorporated by reference into the contract, provides the managed care organizations further guidance on the critical elements that need to be included in the member materials. Uniform Managed Care Manual Chapter 3.4 includes the critical elements for the Member Handbook, and Attachment L to this chapter provides the managed care organizations with template language regarding "Member Rights and Responsibilities."

UMCC Attachment B-1, 8.2.7 Medicaid Member Complaint and Appeal System

The managed care organization must develop, implement, and maintain a Member Complaint and Appeal system that complies with the requirements in applicable federal and state laws and regulations, including 42 Code of Federal Regulations §431.200, 42 Code of Federal Regulations Part 438, Subpart F, "Grievance System," and the provisions of 1 Texas Administrative Code Chapter 357 relating to Medicaid managed care organizations.

The Complaint and Appeal system must include a Complaint process, an Appeal process, and access to HHSC's Fair Hearing System. The procedures must be the same for all members and must be reviewed and approved in writing by HHSC or its designee. Modifications and amendments to the Member Complaint and Appeal system must be submitted for HHSC's approval at least 30 days prior to the implementation.

2. State Oversight Responsibility

Agencies and providers are monitored by the DADS, the regulatory agency that licenses these types of facilities. The managed care organizations monitor contract performance on a biannual basis. DADS uses a State approved protocol when conducting on-site visits and surveys that includes appropriate use of restraints as per licensure requirements. Any evidence of licensure violations is investigated and sanctions are applied as per state law and rules.

DADS is the State agency responsible for overseeing the use of restraints. Inspection and survey staff perform inspections and surveys, follow-up visits, complaint investigations, investigations of abuse or neglect, and other contact visits from time to time as they deem appropriate or as required for carrying out the responsibilities of licensing or in response to complaints. An inspection may be conducted by an individual surveyor or a team, depending on the purpose of

Attachment G

HCBS Participant Safeguards

the inspection or survey, size of facility, and service provided by the facility, and other factors. To determine standard compliance which cannot be verified during regular working hours, night or weekend inspections may be conducted to cover specific segments of operation and will be completed with the least possible interference to staff and residents. Generally, all inspections, surveys, complaint investigations and other visits, whether routine or non-routine, made for the purpose of determining the appropriateness of resident care and day-to-day operations of a facility will be unannounced. Exceptions must be justified. Certain visits may be announced, including, but not limited to, visits to determine conditions when certain emergencies arise, such as fire, windstorm, or malfunctioning or nonfunctioning electrical or mechanical systems. The facility must make all books, records, and other documents maintained by or on behalf of a facility accessible to DADS upon request. These facility inspections provide information regarding the use of restraints in an assisted living facility. DADS also investigates incidents and complaints related to use of restraints to ensure the assisted living facility is complying with State requirements.

DADS is able to collect data on specific complaints or licensing survey deficiencies for assisted living facilities. DADS Data Management and Analysis monitors, tracks and trends data regarding validated instances of abuse, neglect or exploitation for purposes of training DADS staff and to prevent recurrence. Management and Analysis also reports the number of validated instances of abuse, neglect, or exploitation in assisted living facilities, including restraint use. The incidence of inappropriate restraint use has been so low that occurrences are addressed on a case-by-case basis; however, if the incidence were to increase, trends and patterns could be analyzed to prevent reoccurrences.

DADS will determine if a facility meets licensing rules, including both physical plant and facility operation requirements. Violations of regulations will be listed on an inspection checklist designed for the purpose of the inspection and will include specific reference to the Assisted Living Standards for the violations cited. At the conclusion of an inspection, the inspector will perform an exit conference, advising the assisted living facility of the findings resulting from the inspection. At the exit conference, the inspector will provide a copy of the inspection checklist to the assisted living facility and lists each violation discovered during the inspection, with specific reference to the standard violated. If, after the initial exit conference, additional violations are cited, the inspector will conduct an additional exit conference regarding the newly identified violations, with specific reference to the standard violated.

The facility must submit an acceptable Plan of Correction to the regional office not later than 10 calendar days after receiving the Statement of Deficiencies (Form CMS 2567) and not later than 10 working days after receiving the Statement of Violations (DADS Form 3724). An acceptable plan of correction must address the following areas:

- (1) how corrective action will be accomplished for those residents affected by the violation(s);

Attachment G HCBS Participant Safeguards

- (2) how the facility will identify other residents with the potential to be affected by the same violation(s);
- (3) the measures that will be put into place or systemic changes made to ensure the violation(s) will not recur;
- (4) how the facility will monitor its corrective actions to ensure that the violation(s) are being corrected and will not recur; and
- (5) dates when corrective action will be completed.

A clear and concise summary in nontechnical language of each licensure inspection, inspection of care, or complaint investigation will be provided by DADS. That summary will outline significant violations noted at the time of the visit, but will not include names of residents, staff, or any other statement that would identify individual residents or other prohibited information under general rules of public disclosure. The summary will be provided to the facility at the time the report of contact or similar document is provided. If the provider and the inspector cannot resolve a dispute regarding a violation of regulations, the provider is entitled to a regional level informal dispute resolution (IDR) for all violations. For a violation determined to be valid, the provider is entitled to an IDR at either the regional or state office level. A written request and all supporting documentation must be submitted to the Regional Director, Long Term Care-Regulatory, for a regional IDR, or to Long Term Care-Regulatory, Texas DADS, P.O. Box 149030 (E-343), Austin, TX 78714-9030, for a central office IDR, no later than the tenth calendar day after receipt of the official statement of violations. DADS will complete the IDR process no later than the 30th calendar day after receipt of a request from a facility. Violations deemed invalid in an IDR will be so noted in DADS records.

If the provider's license is either suspended or revoked, the managed care organization will terminate the provider's existing contract. Steps to transition all members who are using the provider as an assistive living facility will be taken by the managed care organization to ensure the health and safety of the members.

In an effort to provide consistent policy and process, the State incorporates the DADS Quality Assurance and Improvement (QAI) vision for restraint reduction in Texas Long Term Care (LTC) as methodology of assuring the health and welfare of waiver members residing in assistive living and adult foster care facilities where restraints are permitted on a limited basis. The DADS Quality Assurance and Improvement vision for restraint reduction in Texas LTC is a resident-centered evaluation and care planning for restraint-free environments. In this framework, the term restraints focuses exclusively on devices applied to a resident's wrists, trunk or waist that limit the resident's normal access to the environment or self and that the resident cannot remove at will without assistance. While the use of other devices that achieve these same ends is also discouraged, the findings described below apply only to these three general classes of devices. The DADS Quality Monitoring Program uses this structured resident assessment to evaluate the appropriateness of resident assessment, care planning and care for residents who are restrained.

Attachment G

HCBS Participant Safeguards

The Restraint Reductions Program includes the following elements and structure: unequivocal support from facility owners and administrators; restraint reduction education for all levels of direct care staff on every shift; restraint reduction education for medical staff and family members; use of a multidisciplinary restraint reduction team (a restraint Review Committee that includes a physician, nurse, Certified Nurses Aide staff, Administrator, housekeeping, others); use of a consultative, resident-centered, problem-solving approach; allocation of staff time specifically for restraint reduction; implementation of restraint reduction one unit or floor at a time; restraint reduction in the easiest residents first; use of restraint-free intervals to gradually reduce restraints in the most difficult residents; use of multiple interventions to solve individual clinical problems (average of three interventions per resident); long-term commitment to achieving a restraint-free environment (6-12 months to succeed); and on-going, scheduled re-evaluation of all residents who remain restrained.

The Program incorporates the following components: Identify any staff and family concerns or misconceptions about restraint use and restraint reduction; develop and distribute a restraint reduction education handout for family and staff to address concerns and false beliefs; use DADS Joint Trainings, handouts and Quality Matters Web presentations and resources to provide in-service and family education on restraint reduction; develop a plan for methodical restraint reduction and present it to staff, family and resident council; work with DADS Quality Monitors to test, evaluate and refine the restraint reduction program; create a Restraint Review Committee to evaluate all residents in restraints and all new orders for restraints; review and analyze data resulting from evaluations done by the Restraint Review Committee; begin with the Minimum Data Set Resident-Level QI Report to identify residents who are in restraints; visually identify additional residents not identified as being restrained by the Minimum Data Set report; evaluate each of these residents for appropriateness of restraints using the accompanying structured assessment instrument or a comparable instrument to evaluate each resident. Leave the completed assessment on the chart for future reference; use the results of structured assessment to identify residents who are not candidates for restraint reduction. Note the reasons in the resident's care plan. Ensure that in every instance there is a specific physician order for restraints and that the care plan addresses how the use of restraints will be monitored as well as when and how restraint reduction will be attempted; in each instance that restraint use is medically justifiable, schedule each such resident for periodic restraint use reevaluation. Evaluate the need for restraints justified as a temporary intervention for behavioral symptoms within a short time such as 24-48 hours that allows time for evaluation of causes and alternative interventions without permitting temporary restraint use to become on-going restraint use; for each remaining resident, identify the clinical problems for which restraints are currently being used; require the use of structured assessment for restraint use before restraints can be ordered; create a Restraint Review Committee that includes the facility Medical Director, an RN, physical therapist, other direct care staff and housekeeping; engage physical therapy/occupational therapy in the evaluation of the resident for restraint alternatives; require the Restraint Review Committee to approve all orders for restraints within 24 hours of the order; and use the Restraint Review Committee to develop care plan alternatives when structured assessment shows that there is no valid indication for the use of restraints. Reports of increased cases or unusual trends

Attachment G HCBS Participant Safeguards

and patterns would be forwarded to the Regulatory Agency. The Texas Administrative Code requires the Regulatory Agency to perform inspections and surveys, follow-up visits, complaint investigations, investigations of abuse or neglect, and other contact visits from time to time as they deem appropriate or as required for carrying out the responsibilities of licensing (40 T.A.C. §92.81).

Inspection and survey personnel as well as the managed care organizations have access to data and information collected by the Restraint Review Committee when conducting site visits, desk reviews or as a result of a complaint investigation.

Recommendations for improvement are included in an overall Quality Improvement Plan and are shared with the managed care organizations contracted with the providers.

B. Use of Restrictive Interventions

The State does not permit or prohibits the use of restrictive interventions. HHSC does not allow restrictive interventions in any setting. DADS Regulatory Services licenses home and community support services agencies and assisted living facilities. DADS monitors unauthorized use of restrictive interventions through on-site surveys and complaint investigations. All surveys and inspections are unannounced. Contracted home and community support services agencies are surveyed during their first year of operation, approximately 18 months after the initial survey, and at least every 36 months thereafter. Assisted living facilities are inspected annually. Licenses are valid for one year. The inspection includes observation of the care of residents.

III. MEDICATION MANAGEMENT AND ADMINISTRATION

A. Medication Management and Follow-Up

1. Responsibility

Home and community support services agencies, assisted living facilities, adult foster care providers, and nursing facilities must provide medication management as required by their license.

Home and community support services agencies are required to monitor all aspects of a participant's medication that the agencies administer. Medication management is monitored at annual and quarterly reevaluations.

Assisted living facilities and nursing facility providers are required to monitor all aspects of a participant's medication. Provider registered nurses review the participant's medications annually and upon significant change in the participant's condition.

Attachment G HCBS Participant Safeguards

DADS oversees medication management provided by its contractors through licensure surveys and complaint investigations. HCSSAs are surveyed within 18 months of their initial licensure and every three years thereafter. Assisted Living facilities are surveyed annually. The State imposes penalties such as requiring corrective action plans, administrative penalties and license revocation when harmful medication management practices are detected. DADS survey staff follow up to ensure corrective action plans are properly implemented.

The adult foster care providers are monitored by the regulatory agency that licenses these types of facilities. The managed care organizations monitor contract performance on a biannual basis. The appropriate regulatory agency uses a State-approved protocol when conducting on-site visits and surveys that includes appropriate medication management as per licensure requirements. Any evidence of licensure violations is investigated and sanctions are applied as per state law or rules. DADS Data Management and Analysis reports the number of validated instances of licensure violations, which includes medication administration errors. DADS Data Management and Analysis also publishes an annual list of the top 10 deficiencies and violations. DADS will produce a semi-annual report with all the data and associated analysis to the Single State Agency. This will enable the State to identify trends and patterns that will be analyzed to prevent reoccurrences of medication administration errors.

2. Methods of State Oversight and Follow-Up

Pursuant to 42 CFR Section 431.10(c), HHSC is the State Medicaid agency and retains full administrative authority over the LTSS STAR+PLUS waiver program.

DADS Regulatory Services licenses and monitors home and community support services agencies, assisted living providers, and nursing facilities. Medication management is part of the license requirements for these providers. DADS staff conduct follow-up surveys and inspections to ensure the provider has effectively implemented any corrective action plan required due to cited State violations.

DADS surveys home and community support services agencies during their first year of operation, approximately 18 months after the initial survey, and at least every 36 months thereafter. DADS surveys assisted living facilities annually and nursing facilities every nine to fifteen months. DADS may inspect licensed facilities or the home and community support services agencies more frequently if appropriate.

DADS enforces licensing requirements through on-site surveys and contract monitoring visits. The frequency of licensing surveys varies with each type of license. The State imposes penalties such as requiring corrective actions plans, administrative penalties and license revocation when harmful medication management practices are detected. DADS Contract and Regulatory staff follows-up to ensure corrective action plans are properly implemented.

Attachment G HCBS Participant Safeguards

The adult foster care providers are monitored by the regulatory agency that licenses these types of facilities. The managed care organizations monitor contract performance on a biannual basis. The appropriate regulatory agency uses a State-approved protocol when conducting on-site visits and surveys that includes appropriate medication management as per licensure requirements. Any evidence of licensure violations is investigated and sanctions are applied as per state law and rules.

B. Medication Administration by Waiver Providers: Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.

1. State Policy

Home and community support services agencies, assisted living facilities, and nursing facilities must administer medications as required by licensure. Licensure only allows licensed nurses, certified medication aides (under the direct supervision of a licensed nurse), or persons who administer medication as a registered nurse-delegated task to administer medications. The same requirements for assisted living facilities apply to adult foster care under the Texas Administrative Code, 40 TAC RULE §48.8907.

A registered nurse who supervises a medication aide or delegates medication administration must provide ongoing supervision and any necessary training to the unlicensed person. Registered nurses must follow procedures for delegation in accordance with the Nurse Practice Act.

Home and community support services agencies are responsible for monitoring medications but may not have any additional responsibilities. Assisted living facilities, and nursing facilities are required to monitor all aspects of a member's medication, regardless of whether the provider administers the medication or the member self-medicates. Home and community support services agency registered nurses review the member's medications annually and upon significant change in the member's condition.

Licensing requirements for assisted living facilities require the facility to provide monthly counseling to a member who self-medicates. The assisted living facility must report any unusual reactions to the member's physician. The assisted living facility must also document any time a member fails to take medication.

2. Medication Error Reporting

Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies). Errors are reported to the DADS. Providers are required to record any type of medication error, regardless of severity, in the member's clinical record. Any type of medication error, regardless of severity, must be reported to the State.

Attachment G HCBS Participant Safeguards

3. State Oversight Responsibility

DADS is responsible for monitoring compliance with licensing requirements, and the agency surveys licensed providers for compliance with licensing requirements on a regular basis. Licensing surveys include medication administration review.

DADS Data Management and Analysis reports the number of validated instances of licensure violations, which includes medication administration errors. DADS Data Management and Analysis also publishes an annual list of the top 10 deficiencies and violations. DADS will produce a semi-annual report with all the data and associated analysis to the Single State Agency. This will enable the State to identify trends and patterns that will be analyzed to prevent reoccurrences of medication administration errors.

IV. REMEDIATION

Individual problems may be discovered during monitoring activities by the State or any of the entities that have been delegated certain functions within the performance measures of this appendix. Those responsible for conducting the monitoring and frequency are described in each performance measure of this appendix.

The options for remediation are listed below:

If the State discovers that a complaint has not been followed up on within the timeframe required by the State, the managed care organization is subject to various remedies which may include communicating with the managed care organization directly, requiring corrective actions to be completed when appropriate, assessing liquidated damages, freezing enrollment into the managed care organization, and termination of the managed care organization's contract. All remedies are accompanied by the assumption that the managed care organization will resolve the complaint.

If the State discovers that upon enrollment a member was not provided educational material on reporting abuse, neglect, and exploitation, the managed care organization is required to provide the member with that material within State established timeframes.

Attachment H
UC Claiming Protocol and Application
Part 1: UC Claiming Protocol for Hospitals and Physician Groups

OVERVIEW

The intent of the Texas Medicaid Waiver Application (“UC Application”) is to provide a simplified way to subsidize the costs incurred by hospitals, physicians and mid-level professionals for patient care services (as further defined below) provided to Medicaid and Uninsured patients that are not reimbursed through the claims adjudication process or by other supplemental payments. All UC payments to providers and all expenditures described as UC permissible expenditures must not exceed the cost of services provided to Medicaid and Uninsured patients as defined and discussed in this protocol. These unreimbursed Medicaid and Uninsured costs are determined based on one of two UC tools depending on the type of entity providing the service. These tools have been approved by the Centers for Medicare and Medicaid Services (CMS). To the extent that there are UC expenditures a hospital provider wants to make against the UC cost limit, and the methodology for capturing such expenditures is not stated in this protocol, the expenditures must be approved by CMS prior to the submission of the reconciliation for the applicable period for the expenditures.

The Medicaid coverage limitations under Section 1905(a) of the Act, which exclude coverage for patients in an institution for mental diseases (IMD) who are under age 65, except for coverage of inpatient psychiatric hospital services for individuals under age 21, are applicable.

The Texas Hospital Uncompensated Care tool (“TXHUC”) will be utilized by hospitals to determine their unreimbursed costs for Medicaid and Uninsured patients for physicians’ and mid-level professionals’ direct patient care services where the hospital incurs these costs. In addition, if the hospital has unreimbursed hospital costs for services provided to Medicaid and Uninsured patients that were not paid via the claims adjudication process or thru the Medicaid Disproportionate Share (DSH) pool, these costs can be included in the TXHUC application. Also, for some hospitals meeting the criteria, unreimbursed pharmacy costs for take home drugs provided by the hospital to Medicaid and Uninsured patients will be included in the TXHUC application.

The Texas Physicians Uncompensated Care tool (“TXPUC”) will be utilized by physician and/or mid-level professional entities that provide direct patient care physician and/or mid-level professional services to Medicaid and Uninsured patients in a hospital setting and the professional entity is not reimbursed under a contractual or employment relationship by the hospital for these services. The professional entity may also include in its TXPUC application the costs related to direct patient care services provided to Medicaid and Uninsured patients in a non-hospital setting. Only physician entities that had previously received payments under the Texas Medicaid Physician UPL (Upper Payment Limit) program and their successor organizations are eligible to submit a TXPUC application under the 1115 Waiver program.

The costs and other data included in the initial UC application should be representative of the fiscal period from October 1, 2009 through September 30, 2010. The UC application should be submitted to the Texas Health and Human Services Commission (HHSC) by the deadline specified by HHSC on its website at <http://www.hhsc.state.tx.us/rad/hospital-svcs/1115-waiver.shtml>. Applications for future fiscal periods which will cover the period from October 1 through September 30 of the applicable years will be due to HHSC by the deadline specified by HHSC. For hospitals, due to the five (5) month time period for the completion of the Medicare cost report which serves as the basis for the costs to be reported on the UC application, some entities will not have completed their cost report prior to the deadline for the submission of their UC application. In these situations, the hospital should submit a full 12 months of data

Attachment H
UC Claiming Protocol and Application
Part 1: UC Claiming Protocol for Hospitals and Physician Groups

on the UC application based on the most recently completed Medicare cost reporting period that includes a minimum of twelve (12) months. It should be noted that when HHSC completes the reconciliation process, HHSC will utilize the hospital's actual data reported on their respective UC applications, weighted accordingly, to determine the hospital's final UC Pool distribution. This should not be an issue for physician and mid-level professional organizations since their financial data should be available immediately following the end of their respective fiscal years.

All costs and other data reported in the UC Application are subject to the Medicare regulations and Program instructions. The entity submitting the UC Application must maintain adequate supporting documentation for all information included in the UC Application in accordance with the Medicare program's data retention policies. The entity must submit the supporting documentation upon request from HHSC.

For purposes of the UC Application, a mid-level professional is defined as:

- Certified Registered Nurse Anesthetist (CRNA)
- Nurse Practitioner
- Physician Assistant
- Dentist
- Certified Nurse Midwife
- Clinical Social Worker
- Clinical Psychologist
- Optometrist

For purposes of the UC Application, a visit is defined as:

A face-to-face encounter between a patient and a physician and/or mid-level professional. Multiple encounters with the same physician and/or mid-level professional that take place on the same day and at a single location for the same diagnosis constitute a single visit. More than one visit may be counted on the same day (which may be at a different location) in either of the following situations:

- a) When the patient, after the first visit, suffers illness or injury requiring another diagnosis or treatment, two visits may be counted.
- b) When the patient is seen by a dentist and sees a physician and/or mid-level professional, two visits may be counted.

Texas Hospital Uncompensated Care Tool (TXHUC)

The TXHUC is comprised of a certification page, 4 primary schedules (a Summary Schedule and Schedules 1, 2 & 3) and various schedules. Schedules 1, 2 and 3 determine the hospital's unreimbursed costs for services provided to Medicaid and Uninsured patients related to physician and/or mid-level professional direct patient care costs, pharmacy costs, and DSH hospital costs, respectively. The supporting schedules are the schedules hospitals are required to submit to HHSC when applying for the Medicaid DSH program. Each of these schedules along with instructions for the completion of the schedule is detailed below.

Attachment H
UC Claiming Protocol and Application
Part 1: UC Claiming Protocol for Hospitals and Physician Groups

Attachment H
UC Claiming Protocol and Application
Part 1: UC Claiming Protocol for Hospitals and Physician Groups

Certification

The certification page must be signed and dated by an officer or administrator of the provider. An officer is defined as a member of the provider's senior management such as the chief executive officer, chief financial officer, chief operating officer, etc. The certification must contain an original signature and not a copy or electronic signature. If the TXHUC is an initial submission, it should be so indicated in the appropriate box on the certification page.

Upon receipt of a final and/or amended final Medicare cost report, the provider is required to submit a "final" TXHUC based on the costs and other data contained in the final cost report. This final TXHUC will be utilized by HHSC to perform a final reconciliation of the actual costs for the period and the cost utilized to determine the provider's distribution from the UC Pool for that period. If the TXHUC submission is a final submission, it should be so indicated in the appropriate box on the certification page.

Upon the termination of the 1115 Waiver, providers will be required to submit actual cost data in the prescribed format of the TXHUC for a minimum of two years for purposes of reconciling the UC Pool payments for the last two years of the Waiver with the provider's actual costs incurred for those fiscal periods

Summary Schedule

Column 1 - Summarizes the Medicaid and Uninsured costs determined on Schedules 1, 2 & 3. These amounts will flow automatically from the respective schedules and no input is required.

Column 2 – The initial distribution of the Uncompensated Care Pool ("UC Pool") for the fiscal period 10/1/2011 – 9/30/2012 will be based on the costs for the period from 10/1/2009 – 9/30/2010 as computed on Schedules 1, 2 & 3. If the provider knows these costs are not representative of their actual costs for the period from 10/1/2011 – 9/30/2012, due to changes in their contractual arrangements or other operational or economic issues, the provider can make an adjustment to these costs. The provider is required to maintain supporting documentation to support their adjustment amount and make this information available upon request from HHSC and/or CMS.

Column 3 – Represents the net Medicaid and Uninsured costs after any adjustments and is determined by summing the amounts in Columns 1 & 2. The net cost amount will be utilized to determine the provider's distribution from the UC Pool.

Schedule 1

The schedule computes the costs related to direct patient care services provided by physicians and mid-level professionals to Medicaid and Uninsured patients. To be included in the schedule, these costs must be recorded on the hospital's accounting records and reported on the hospital's Medicare cost report, Worksheet A, Columns 1 and/or 2.

The source for these costs and other data will be the hospital's Medicare cost report(s) that span the period from October 1 through September 30 two years prior to the demonstration year for which UC payments are being determined. If the hospital's cost reporting period is other than October 1 through

Attachment H
UC Claiming Protocol and Application
Part 1: UC Claiming Protocol for Hospitals and Physician Groups

September 30, it will be necessary to pro-rate the costs and other data from the applicable cost reports that span this period.

Column 1 - The direct patient care physician and/or mid-level professional costs are identified from the Medicare cost report. These professional costs are:

1. Limited to allowable and auditable physician and/or mid-level professional compensations that has been incurred by the hospital;
2. Physician's services to individual patients identified as professional component costs on Worksheet A-8-2, Column 4 of the cost report(s);
3. Or, for contracted physicians and/or mid-level professionals only, Worksheet A-8, if the physician and/or mid-level professional compensation cost is not reported by the hospital on Worksheet A-8-2 because the physicians are contracted solely for direct patient care activities (i.e., no administrative, teaching, research, or any other provider component or non-patient care activities); and
4. Removed from hospital costs on Worksheet A-8 / A-8-2

If the professional physicians' costs on Worksheet A-8-2, Column 4 include Medicare Part A costs (e.g. departmental administration, hospital committee activities, etc.) that were reported as professional component due to lack of a physicians' time study(s) to allocate the costs between professional and provider component and/or application of the Reasonable Compensation Equivalents (RCE) , these costs must be excluded from the physicians' costs related to direct patient care professional services and cannot be included for UC reimbursement purposes unless the following conditions are met:

- (1) The costs must be allocated between direct patient care (Medicare Part B) and reimbursable Medicare Part A activities. The costs associated with Medicare Part A activities must be subjected to the Medicare RCEs. If the hospital does not have adequate time studies for the application of the RCEs, then the hospital must obtain a proxy, signed and dated by the physician that estimates the amount of time spent on allowable Medicare Part A activities, teaching of interns & residents and medical students, research and direct patient care for the period the costs were incurred. The proxy should account for 100% of the physicians' time related to the costs incurred by the hospital. If the costs are for a group of physicians, each physician in the group must complete a proxy.
- (2) For a physician the hospital can elect to apply the RCE limit on an individual physician basis or in the aggregate.
- (3) The hospital must allocate the physicians' costs based on the physicians' proxy and apply the applicable RCE limits to the Medicare Part A non-teaching physicians'. The hospital must maintain auditable documentation of the determination of the allowable Part A non-teaching physician.
- (4) For cost reporting periods beginning on or after 10-1-2012, the hospital is expected to obtain adequate and auditable time studies from each physician and/or mid-level professional providing Medicare Part A services to the hospital for the proper application of the RCEs via the Medicare 2552 cost report. The physician and/or

Attachment H
UC Claiming Protocol and Application
Part 1: UC Claiming Protocol for Hospitals and Physician Groups

mid-level professional time study forms to be used are located on the Texas Health and Human Services Commission website. Time studies should be completed for a two (2) week period once per quarter during the fiscal year. Ideally, the time study period will not be the same two weeks in any 2 given quarters. Medicare Part A physician and/or mid-level professional costs will not be allowed to be included in the UC tool for cost reporting periods beginning on or after 10-1-2012.

Physician Part A costs in excess of the RCE limits cannot be included in Column 1. Physician costs related to direct patient care and physician Part A costs not in excess of the RCE limits should be reported on the respective line in Column 1 for cost reporting periods ending on or prior to 9-30-2012. For cost reporting periods beginning on or after 10-1-2012, Physician Part A costs cannot be included in Column 1. The physicians' costs should be reported in the cost center in which the expenses were reported on Worksheet A, Column 3 of the Medicare cost report.

Hospital costs for mid-level professional practitioner services that have been identified and removed from hospital costs on the Medicare cost report are to be included. Typically these costs are comprised of salaries and direct fringe benefits (payroll taxes, vacation and sick pay, health and life insurance, etc.), contract fees and professional liability insurance. The mid-level professional practitioner types to be included are:

- (1) Certified Registered Nurse Anesthetists
- (2) Nurse Practitioners
- (3) Physician Assistants
- (4) Dentists
- (5) Certified Nurse Midwives
- (6) Clinical Social Workers
- (7) Clinical Psychologists
- (8) Optometrists

To the extent these mid-level practitioners' professional compensation costs are not included in Worksheet A-8-2, Column 4, but are removed from hospital costs through an A-8 adjustment on the Medicare cost report, these costs may be recognized if the mid-level professional practitioners are Medicaid-qualified practitioners for whom the services are billable under Medicare separate from hospital services.

If the physician and/or mid-level practitioner costs are reported in a non-reimbursable cost center on the hospital's Medicare cost report, Worksheet A, these costs can be included in Column 1. The costs to be included would be the costs from Worksheet B Part I, the last column for the applicable line(s).

Hospitals may include physician and/or mid-level professional support staff compensation, data processing, and patient accounting costs as physician and/or mid-level professional-related costs to the extent that:

Attachment H
UC Claiming Protocol and Application
Part 1: UC Claiming Protocol for Hospitals and Physician Groups

1. These costs are removed from hospital inpatient and outpatient costs because they have been specifically identified as costs related to physician and/or mid-level professional services;
2. They are directly identified on W/S A-8 as adjustments to hospital costs;
3. They are otherwise allowable and auditable provider costs; and
4. They are further adjusted for any non-patient-care activities such as research based on the physician and/or mid-level professional time studies.

If these costs are removed as A-8 adjustments to the hospital's general service cost centers, these costs should be reported on the General Services line (line 1) in Column 1.

If the hospital has costs for physicians and one or more types of mid-level professional for a given cost center, the costs can be combined and the total reported in Column 1 provided the same allocation statistic will be utilized to apportion the costs to Medicaid and Uninsured. If the hospital elects to utilize different allocation statistics to apportion the physician and/or any type of mid-level professional costs for a given cost center the cost center can be subscripted.

Column 1a – The recommended apportionment statistic for physician and/or mid-level professional costs is total billed professional charges by cost center. If a hospital does not maintain professional charges by payer type separately in its patient accounting system, then the professional costs can be apportioned based on total billed hospital departmental charges. Total billed hospital departmental charges by cost center are identified from the hospital's applicable Medicare cost report(s).

If professional charges related to the physician and/or mid-level professional services whose costs are reported in Column 1 are utilized as the apportionment statistic, the professional charges must be from the same corresponding time period as the costs. The hospital must maintain adequate and auditable documentation to support the statistics reported in Column 1a.

If the hospital reports costs on the General Services line (Line 1) in Column 1, the recommended allocation statistic reported in Column 1a would be the aggregate total departmental charges (professional or hospital department, based on the apportionment statistic for the specific cost centers) for all cost centers.

Column 1b – The allocation basis the hospital elects to utilize to apportion the costs from Column 1 should be identified for each cost center. The approved allocation bases are total departmental professional charges if available. Otherwise departmental hospital charges may be utilized.

Column 2 - A cost to charge ratio (CCR) for each cost center is calculated by dividing the total costs for each cost center reported in Column 1 by the total allocation statistic for each cost center reported in Column 1a. If additional lines are added to Schedule 1, it will be necessary to copy the formula used to compute the CCR for the additional line(s).

Columns 3a & 3b – The applicable allocation statistics related to the physician and/or mid-level professional services provided to Medicaid Fee-For Service (FFS) patients are reported in Columns 3a and 3b based on the hospital's elected allocation basis reported in Column 1b. The allocation statistics applicable to Medicaid FFS inpatient services are reported in Column 3a and allocation statistics

Attachment H
UC Claiming Protocol and Application
Part 1: UC Claiming Protocol for Hospitals and Physician Groups

applicable to Medicaid FFS outpatient services are reported in Column 3b. The Medicaid FFS inpatient and outpatient statistics should be from the hospital's internal records and for the same fiscal period as the costs reported in Column 1 and total allocation statistics reported in Column 1a. If the hospital provided services to out-of-state Medicaid FFS patients, the charges related to those services should be included in Columns 3a and 3b as applicable.

Columns 3c & 3d – The Medicaid FFS inpatient and outpatient physician and/or mid-level professional costs are computed based on the CCR reported in Column 2 multiplied by the Medicaid FFS inpatient and outpatient allocation statistics reported in Columns 3a and 3b, respectively. If additional lines are added to Schedule 1, it will be necessary to copy the formula used to compute the Medicaid FFS inpatient and outpatient costs for the additional line(s).

Columns 4a & 4b - The applicable allocation statistics related to the physician and/or mid-level professional services provided to Medicaid Managed Care (HMO) patients are reported in Columns 4a and 4b based on the hospital's elected allocation basis reported in Column 1b. The allocation statistics applicable to Medicaid HMO inpatient services are reported in Column 4a and allocation statistics applicable to Medicaid HMO outpatient services are reported in Column 4b. The Medicaid HMO inpatient and outpatient statistics should be from the hospital's internal records and for the same fiscal period as the costs reported in Column 1 and total allocation statistics reported in Column 1a. If the hospital provided services to out-of-state Medicaid HMO patients, the charges related to those services should be included in Columns 3a and 3b as applicable.

Columns 4c & 4d – The Medicaid HMO inpatient and outpatient physician and/or mid-level professional costs are computed based on the CCR reported in Column 2 multiplied by the Medicaid HMO inpatient and outpatient allocation statistics reported in Columns 4a and 4b, respectively. If additional lines are added to Schedule 1, it will be necessary to copy the formula used to compute the Medicaid HMO inpatient and outpatient costs for the additional line(s).

Columns 5a & 5b - The applicable allocation statistics related to the physician and/or mid-level professional services provided to Uninsured patients are reported in Columns 5a and 5b based on the hospital's elected allocation basis reported in Column 1b. The allocation statistics applicable to Uninsured inpatient services are reported in Column 5a and allocation statistics applicable to Uninsured outpatient services are reported in Column 5b. The Uninsured inpatient and outpatient statistics should be from the hospital's internal records and for the same fiscal period as the costs reported in Column 1 and total allocation statistics reported in Column 1a.

Columns 5c & 5d – The Uninsured inpatient and outpatient physician and/or mid-level professional costs are computed based on the CCR reported in Column 2 multiplied by the Uninsured inpatient and outpatient allocation statistics reported in Columns 5a and 5b, respectively. If additional lines are added to Schedule 1, it will be necessary to copy the formula used to compute the Uninsured inpatient and outpatient costs for the additional line(s).

All revenue received by the hospital related to physician and/or mid-level professional services provided inpatients and outpatients covered by Medicaid FFS, Medicaid HMO and Uninsured patients should be reported on Line 102 of the respective Columns 3c & 3d, 4c & 4d and 5c & 5d. The revenue will be

Attachment H
UC Claiming Protocol and Application
Part 1: UC Claiming Protocol for Hospitals and Physician Groups

subtracted from the respective costs to determine the net costs to be included in the hospital's UC Application.

Schedule 2

The schedule computes the pharmacy costs related to prescription drugs provided by hospitals participating in the Texas Vendor Drug program. These pharmacy costs are not related to services provided by the hospital's retail pharmacy or billed to a third party payer under revenue code 253. If the pharmacy costs were included in the hospital's Texas Medicaid DSH Application, they should not be included in the TXHUC application.

Column 1 - The total costs for the cost center that contains the drug costs related to the prescription drugs provided under the Texas Vendor Drug program are reported in Column 1, Line 1. These costs are from the hospital Medicare cost report(s) Worksheet B, Part I, last column for the applicable cost center. If the hospital cost reporting period spans September 30, the costs from the two Medicare cost reports that span the period from October 1 through September 30 two years prior to the demonstration year for which UC payments are being determined should be pro-rated and added together to determine the pharmacy costs to be reported in Column 1, Line 1.

Column 1a – The total hospital departmental charges for the cost center that contains the drug charges related to the prescription drugs provided under the Texas Vendor Drug program are reported in Column 1a, Line 1. These charges are from the hospital Medicare cost report(s) Worksheet C, Part I, Column 8 for the applicable cost center. If the hospital cost reporting period spans September 30, the charges from the two Medicare cost reports that span the period from October 1 through September 30 two years prior to the demonstration year for which UC payments are being determined should be pro-rated and added together to determine the pharmacy charges to be reported in Column 1a, Line 1.

Column 1b – The allocation basis is hospital departmental charges. If the hospital wants to utilize an alternative allocation basis, they must submit a written request to Texas HHSC that identifies the alternative allocation basis and an explanation as to why the alternative allocation basis results in a more equitable apportionment of the pharmacy costs. HHSC will provide a written response to the hospital's request within 60 days of receiving the request and their decision is final.

Column 2 – The Cost-to-Charge ratio is computed by dividing the costs reported in Column 1 by the allocation statistic reported in Column 2. The CCR is carried out to six (6) decimal places.

Column 3b – The charges related to the prescription drugs provided to Medicaid FFS patients under the Texas Vendor Drug program are reported in Column 3b, Line 1. These charges are obtained from the hospital's internal records. These charges should be for services provided during the period from October 1 through September 30 two years prior to the demonstration year for which UC payments are being determined. The hospital must maintain the supporting documentation and submit it to HHSC upon request.

Column 3d – The costs related to the prescription drugs provided to Medicaid FFS patients under the Texas Vendor Drug program are computed by multiplying the charges reported in Column 3b by the CCR computed in Column 2.

Attachment H
UC Claiming Protocol and Application
Part 1: UC Claiming Protocol for Hospitals and Physician Groups

Column 4b - The charges related to the prescription drugs provided to Medicaid HMO patients under the Texas Vendor Drug program are reported in Column 4b, Line 1. These charges are obtained from the hospital's internal records. These charges should be for services provided during the period from October 1 through September 30 two years prior to the demonstration year for which UC payments are being determined. The hospital must maintain the supporting documentation and submit it to HHSC upon request.

Column 4d – The costs related to the prescription drugs provided to Medicaid HMO patients under the Texas Vendor Drug program are computed by multiplying the charges reported in Column 4b by the CCR computed in Column 2.

Column 5b - The charges related to the prescription drugs provided to Uninsured patients under the Texas Vendor Drug program are reported in Column 5b, Line 1. These charges are obtained from the hospital's internal records. These charges should be for services provided during the period from October 1 through September 30 two years prior to the demonstration year for which UC payments are being determined. The hospital must maintain the supporting documentation and submit it to HHSC upon request.

Column 5d – The costs related to the prescription drugs provided to Uninsured patients under the Texas Vendor Drug program are computed by multiplying the charges reported in Column 5b by the CCR computed in Column 2.

Line 2 - All revenue received by the hospital related to prescription drug services provided to Medicaid FFS, Medicaid HMO and Uninsured patients should be reported on Line 2 of the respective Columns 3d, 4d and 5d. This includes any rebates received from the Texas Vendor Drug program. The revenue will be subtracted from the respective costs to determine the net costs to be included in the hospital's UC Application.

Schedule 3

The schedule determines the hospital's Medicaid DSH costs (Medicaid shortfall and uninsured costs) in excess of the payments received by the hospital from the Texas Medicaid DSH Program. HHSC will complete the schedule based on the hospital's DSH hospital specific limit (HSL) and the DSH Program payments received by the hospital for the applicable fiscal year (10/1/20XX – 9/30/20YY) as described in the steps below.

Line 1 - For hospitals that submitted a DSH Application to HHSC for the applicable year consisting of the applicable federal fiscal year (FFY) DSH and Cost Report Collection Form worksheets, HHSC will determine the DSH HSL to be reported on Line 1 based on the data per their DSH Application. The hospital may not submit revised data.

If the hospital submitted a complete DSH Application and did not receive a payment from the DSH Pool, HHSC will determine the HSL to be reported on Line 1 based on the hospital's DSH Application submission utilizing the same methodology employed by HHSC in the determination of these costs for DSH Pool payment purposes. The hospital may not submit revised data.

Attachment H
UC Claiming Protocol and Application
Part 1: UC Claiming Protocol for Hospitals and Physician Groups

If the hospital did not submit the Cost Report Collection Form worksheet as part of its DSH Application, the hospital must submit this worksheet with its TXHUC Tool. HHSC will utilize the data from the hospital's DSH worksheet along with the data per the Cost Report Collection Form to calculate the hospital's DSH HSL to be reported on Line 1. HHSC will employ the same methodology used to compute the hospital-specific DSH costs (cap) for the determination of the DSH Pool payments to compute the DSH costs (cap) for inclusion in Line 1.

If the hospital did not submit a DSH Application to HHSC, they must complete the DSH and Cost Report Collection Form worksheets in the TXHUC Tool to allow HHSC to compute their DSH HSL for inclusion in Line 1. HHSC will employ the same methodology used to determine a hospital's DSH HSL utilized in the distribution of DSH Pool payments to determine a hospital's DSH HSL to be included in Line 1.

Line 2 – HHSC will determine the Texas Medicaid DSH Program payments received by the hospital for the applicable fiscal year and report the payments on Line 2.

Line 3 – The excess hospital DSH costs are computed by subtracting the DSH payments received on Line 2 from the DSH HSL on Line 1. The excess costs will be included in the hospital's costs to determine their distribution from the UC Pool. If the hospital's DSH payments on Line 2 exceeds its DSH HSL on Line 1, the negative amount is not offset against the hospital's other UC Pool costs as computed in the TXHUC.

DSH Application

This schedule is one of the two schedules included in the Texas Medicaid DSH Application. If the hospital submitted this schedule to HHSC as part of its Medicaid DSH Application for the period from October 1, 2009 through September 30, 2010, the hospital should not complete this schedule in conjunction with the submission of the TXHUC Tool. HHSC will utilize the data per the hospital's Medicaid DSH Application to compute the amounts to be reported on Schedule 3, Line 1.

If the hospital did not submit a DSH Application to HHSC for the period from October 1 through September 30 two years prior to the demonstration year for which UC payments are being determined, the hospital should complete this schedule in accordance with the instructions contained in the Instructions-DSH Data Collection schedule. If the hospital elects to not have its excess hospital DSH costs included in its UC Pool application, the hospital is not required to complete the schedule.

Cost Report Collection Form

This schedule is the second of the two schedules included in the Texas Medicaid DSH Application. If the hospital submitted this schedule to HHSC as part of its Medicaid DSH Application for the period from October 1 through September 30 two years prior to the demonstration year for which UC payments are being determined, the hospital should not complete this schedule in conjunction with the submission of the TXHUC Tool. HHSC will utilize the data per the hospital's Medicaid DSH Application to compute the amounts to be reported on Schedule 3, Line 1.

Attachment H
UC Claiming Protocol and Application
Part 1: UC Claiming Protocol for Hospitals and Physician Groups

If the hospital did not submit a DSH Application to HHSC or did not submit the Cost Report Collection Form schedule as part of its DSH Application to HHSC for the period from October 1 through September 30 two years prior to the demonstration year for which UC payments are being determined, the hospital should complete this schedule in accordance with the instructions contained in the Instructions-DSH Data Collection schedule. If the hospital elects to not have its excess hospital DSH costs included in its UC Pool application, the hospital is not required to complete the schedule.

Interim Reconciliation of Physician and Mid-Level Professional Services Payments to Hospitals

For the physician and/or mid-level professional, self-pay pharmacy and unreimbursed Medicaid DSH costs, UC payments for FFY 2012 are determined utilizing the TXHUC, which is based on data for services furnished during the 10/1/2009 – 9/30/2010. The FFY 2012 UC payments are reconciled to the costs per the as-filed Medicare cost reports for the fiscal period 10/1/2011 – 9/30/2012 once the cost report(s) have been filed with the State. If, at the end of the interim reconciliation process, it is determined that a provider received an overpayment, the overpayment will be properly credited to the federal government; if a provider was underpaid, the provider will receive an adjusted payment amount. Similar interim reconciliations will be conducted for each year of the waiver.

Attachment H
UC Claiming Protocol and Application
Part 1: UC Claiming Protocol for Hospitals and Physician Groups

Final Reconciliation of Physician and Mid-Level Professional Services Payments to Hospitals

Once the Medicare cost report(s) for the expenditure year has been finalized by the Medicare Fiscal Intermediary (FI) / Medicare Administrative Contractor (MAC), a reconciliation of the finalized costs to all UC payments made for FFY 2012 will be carried out, including adjustments for overpayments and underpayments if necessary. The same method as described for the interim reconciliation will be used except that the finalized Medicare UC physician and/or mid-level professional cost amounts and updated uninsured data will be substituted as appropriate. If, at the end of the final reconciliation process, it is determined that a hospital received an overpayment, the overpayment will be properly credited to the federal government. Similar final reconciliations will be conducted for each year of the Waiver.

Texas Physician Uncompensated Care Tool (TXPUC)

The purpose of the TXPUC is to determine the physician professional costs related to services provided to Medicaid (FFS & HMO) and Uninsured patients by physician organizations in a non-hospital setting. Only professional organizations who previously participated in the Texas Medicaid Physician UPL (“Physician UPL”) program are eligible to submit a TXPUC and receive a distribution from the UC Pool. Under the Physician UPL, supplemental payments were made only for physician services performed by doctors of medicine and osteopathy licensed in Texas. With effect from Demonstration Year (DY 2), all costs (direct and indirect) incurred by the physician organization related to services provided by mid-level professionals may be reported on the physician organization’s UC application.

For purposes of the TXPUC Application, a mid-level professional is defined as:

- Certified Registered Nurse Anesthetist (CRNA)
- Nurse Practitioner
- Physician Assistant
- Dentist
- Certified Nurse Midwife
- Clinical Social Worker
- Clinical Psychologist
- Optometrist

The TXPUC is based on established physician and/or mid-level cost finding methodologies developed by the Medicare program over the past 40 years. The schedules that follow use the same or similar methodology and worksheet identification process used by the Medicare hospital cost report.

For all the worksheets in the TXPUC, the cells requiring input are highlighted in green. All line numbers and descriptions are linked to Worksheet A. If lines are inserted, they must be inserted on all worksheets and in the same location.

The costs to be reported in the TXPUC are limited to identifiable and auditable compensation costs that have been incurred by the physician organization for services furnished by physicians and/or mid-level

Attachment H
UC Claiming Protocol and Application
Part 1: UC Claiming Protocol for Hospitals and Physician Groups

professionals in all applicable sites of service, including services provided in a hospital setting and non-hospital physician office sites for which the professional organization bills for and collects payment for the direct patient care services.

The basis for the total physicians' and/or mid-level professionals' compensation costs incurred by the professional organization will be the organization's general ledger. The costs should be representative of the services provided during the period from October 1 through September 30 two years prior to the demonstration year for which UC payments are being determined. If the organization's fiscal year straddles October 1 it will be necessary to pro-rate the costs for the two fiscal periods that comprise the period from October 1 through September 30 two years prior to the demonstration year for which UC payments are being determined.

Total costs, reported by cost centers/departments, are then allocated between clinical and non-clinical activities using a CMS-approved time-study. The physician and/or mid-level professional time study forms to be used are located on the Texas Health and Human Service Commission website. Time studies should be completed for a two (2) week period once per quarter during the fiscal year. Ideally, the time study period will not be the same two weeks in any 2 given quarters. Prior to October 1, 2012, the physician professional organization may use a CMS-approved benchmark RVU methodology in lieu of the CMS-approved time study to allocate physician compensation costs between clinical and non-clinical activities only. Effective October 1, 2012, the physician organization must utilize the CMS-approved time study to allocate physician and/or mid-level professional compensation costs between clinical and non-clinical activities. The allocation of physician and/or mid-level professional compensations costs based on the benchmark RVU methodology will not be accepted after September 30, 2012. The result of the CMS-approved time study (or the benchmark RVU methodology before October 1, 2012) is the physicians' and mid-level professionals' compensation costs pertaining only to clinical, patient care activities. The physicians' and mid-level professionals' compensation costs are reduced by National Institute of Health (NIH) grants to the extent the research activities component is not removed via physician time studies.

The physician clinical and/or mid-level professional costs are subject to further adjustments and offsets, including any necessary adjustment to bring the costs in line with Medicare cost principles. There will be an offset of revenues received for services furnished to non-patients and other applicable non-patient care revenues that were not previously offset or accounted for by the application of the CMS-approved time study.

The above physicians' and/or mid-level professionals' compensation costs must not be duplicative of any costs claimed on a hospital's TXHUC.

Additional costs that can be recognized as professional direct costs are, costs for non-capitalized medical supplies and equipment (as defined in the instructions for Worksheet A, Column 3 below) used in the furnishing of direct patient care.

Overhead costs will be recognized through the application of rate for indirect costs to be determined by the actual costs incurred by the physician organization for the applicable reporting period(s) included in the UC application. The determination of the facility-specific indirect rate is defined in the instructions for Worksheet A, Column 8 below. Other than the direct costs defined above and the application of an approved indirect rate, no other costs are allowed.

Attachment H
UC Claiming Protocol and Application
Part 1: UC Claiming Protocol for Hospitals and Physician Groups

Total billed professional charges by cost center related to physician and/or mid-level professional services are identified from provider records.

The total professional charges for each cost center related to Medicaid fee-for-service (FFS), Medicaid managed care (HMO), and uninsured physician and/or mid-level professional services, billed directly by the professional organization, are identified using auditable financial records. Professional charges related to services provided to out-of-State Medicaid FFS and HMO patients should be included in the Medicaid charges reported on the TXPUC. The professional organization must map the claims to the respective cost centers using information from their billing systems. Each charge must be mapped to only one cost center to prevent duplicate mapping and claiming. These charges must be associated with services furnished during the period covered by the TXPUC (the period from October 1 through September 30 two years prior to the demonstration year for which UC payments are being determined). The professional organization must prepare a worksheet that identifies professional charges related to physician and/or mid-level professional services provided to patients covered by Medicaid FFS, Medicaid HMO, uninsured and all other payers for each cost center to be used to report the total charges on Worksheet B and the Program charges on Worksheet D. The worksheet total charges must be reconciled to the total charges per the professional organization's general ledger and/or financial statements for the applicable fiscal period(s).

Certification

The certification page must be signed and dated by an officer or administrator of the provider. An officer is defined as a member of the entity's senior management such as the chief executive officer, chief financial officer, chief operating officer, etc. The certification must contain an original signature and not a copy or electronic signature.

Upon the termination of the 1115 Waiver, entities will be required to submit actual cost data in the prescribed format of the TXPUC for a minimum of two years for purposes of reconciling the UC Pool payments for the last two years of the Waiver with the provider's actual costs incurred for those fiscal periods

Summary Schedule

Column 1 - Summarizes the Medicaid and Uninsured costs determined on the applicable columns from Worksheet D. These amounts will flow automatically from the respective columns and no input is required.

Column 2 – The distribution of the Uncompensated Care Pool (“UC Pool”) for a specific demonstration year will be based on the costs for the period from October 1 through September 30 two years prior to the demonstration year as computed on Worksheet D. If the entity knows these costs are not representative of their actual costs for the demonstration year, due to changes in their contractual arrangements or other operational or economic issues, the entity can make an adjustment to these costs. The entity is required to maintain supporting documentation to support their adjustment amount and make this information available upon request from HHSC and/or CMS.

Attachment H
UC Claiming Protocol and Application
Part 1: UC Claiming Protocol for Hospitals and Physician Groups

Column 3 – Represents the net Medicaid and Uninsured costs after any adjustments and is determined by summing the amounts in Columns 1 & 2. The net cost amount will be utilized to determine the entity's distribution from the UC Pool.

Worksheet A

This worksheet is a summary of the allowable direct patient care costs for physicians and mid-level professionals. The worksheet is segregated into 3 sections. Lines 1 – 29 contain the costs for physicians and mid-level professionals for patient care services provided in a hospital-based setting. Lines 31 – 55 contain the costs for physicians and mid-level professionals for patient care services provided in a non-hospital-based setting. Lines 56 – 79 contain costs for physicians and mid-level professionals for patient care services provided in settings other than those identified in Sections 1 and 2.

Cost center descriptions are input on this worksheet and will flow to the other worksheets. If lines are added to this worksheet to accommodate the professional organization's unique cost centers, similar lines will need to be added to the other worksheets.

The professional organization's name, provider number, reporting period and indirect cost rate should be input on this worksheet and will flow to the other worksheets.

Column 1 – Physicians' and mid-level professionals' costs determined on Worksheet A-1 will flow to this column.

Column 2 – This column will not be utilized at this time.

Column 3 – Non-capital equipment and supplies costs related to direct patient care are input in this column. Non-capital equipment would be items such as the purchase of reusable surgical trays, scalpels or other medical equipment whose costs are expensed upon acquisition since they are below the organization's threshold for capitalization. Supplies would be items such as disposable supplies utilized during the treatment of patients (sutures, gauze pads, tape, bandages, needles and syringes, splints, etc.). The source for these costs is the professional organization's accounting records. The source for these costs must be maintained by the professional organization and submitted to HHSC or CMS upon request.

Column 4 – This column is the sum of Columns 1, and 3. If line(s) have been added to the worksheet, it will be necessary to copy the formula in this column from an existing line to the line(s) that were added.

Column 5 – Any reclassification of costs reported on Worksheet A-6 will flow to this column.

Column 6 – This column is the sum of Columns 4 and 5. If line(s) have been added to the worksheet, it will be necessary to copy the formula in this column from an existing line to the line(s) that were added.

Column 7 - Any adjustments of costs reported on Worksheet A-8 will flow to this column. For example, revenue received for National Institute of Health (NIH) grants, to the extent the research activities component is not removed via physician and/or mid-level professional time studies should be reported on this Worksheet.

Attachment H
UC Claiming Protocol and Application
Part 1: UC Claiming Protocol for Hospitals and Physician Groups

Column 8 – The indirect costs in this column are computed based on the costs reported in Column 6 multiplied by the indirect cost rate for the professional organization. The indirect cost rate will be determined based on the professional organization’s actual indirect costs to its total direct costs (allowable and nonallowable) for the applicable reporting period(s) covered by the UC application. If the professional organization’s fiscal period does not coincide with the reporting period covered by the UC application, the indirect cost ratio for the two periods should be weighted based on the number of months each period is within the UC application reporting period to determine the organization’s actual indirect cost ratio. The professional organization’s costs per its general ledger for the applicable fiscal period(s) should be used to identify the allowable direct and indirect costs to be used to compute the indirect cost rate. The indirect cost rate should be rounded to two (2) decimal places (e.g. 22.58%). The professional organization must submit its calculation of its indirect cost rate with its UC application.

Allowable indirect costs are defined as costs incurred by the professional organization in support of the physicians’ and mid-level professionals’ direct patient care services, regardless of the location where these services are performed. Medicare cost finding principles should be used to determine allowable indirect costs. Allowable indirect costs would include, but are not limited to, nurse staff and other support personnel salaries and fringe benefits involved in direct patient care, billing and administrative personnel salaries and fringe benefits related to direct patient care, space costs (building and equipment depreciation or lease, interest, utilities, maintenance, etc.) related to the space utilized to provide care to patients. Nonallowable indirect costs would include but are not limited to; advertising for the purpose of increasing patient utilization, bad debts related to accounts receivable, gain or loss on the sale of depreciable assets, fines or penalties imposed by local, state or federal government or their agencies. Any fringe benefits cost related to the physicians’ and mid-level professionals’ compensation costs should be included in Columns 1 and/or 2 of Worksheet A should not be included in the allowable indirect costs. The non-capital equipment and supply costs reported in Column 3 of Worksheet A above should also be excluded from allowable indirect costs.

Total costs would be determined based on the professional organization’s total expenses per its general ledger. The following is an illustrative example of the calculation of an indirect cost rate for a professional organization.

UC application reporting period	10/1/2009 - 9/30/2010	
Fiscal year end of professional organization	12/21/2009	12/31/2010
Total expenses per the general ledger	25,000,000	28,600,800
Bad Debts	(800,000)	(923,000)
Loss on sale of depreciable assets	(200,000)	(123,000)
N/A Advertising Expenses	(111,000)	(133,000)
Physician and mid-level professional compensation (from Col. 1)	(11,500,700)	(13,600,200)
Non capital equipment and supplies (from Col. 3)	(765,000)	(842,000)
Allowable Direct Expenses	(12,265,700)	(14,442,200)

Attachment H
UC Claiming Protocol and Application
Part 1: UC Claiming Protocol for Hospitals and Physician Groups

Allowable indirect costs	11,623,300	12,979,600
Total direct costs	13,376,700	15,621,200
Indirect cost ratio	86.89%	83.09%
Weighted indirect cost ratio	21.72%	62.32%
Allowable indirect cost ratio		84.04%

Column 9 – This column is the total physicians’ and mid-level professionals’ costs that flow to Worksheet B, Column 1. It is the sum of Columns 6, 7 and 8. If line(s) have been added to the worksheet, it will be necessary to copy the formula in this column from an existing line to the line(s) that were added.

Worksheet A-1

This worksheet determines the physicians’ and/or mid-level professionals’ compensation costs for direct patient care services. These costs are determined separately for services provided in a hospital-based and non-hospital based setting. If there are services provided in a unique setting, these costs are determined in Section 3. If a physician provides services in more than one setting, it will be necessary to report his/her data for each applicable setting separately. Data on this worksheet should be reported based on the physicians’ and/or mid-level professionals’ specialty/cost center identified on the worksheet.

Physicians’ and/or mid-level professionals’ compensation costs are comprised of the direct payments made by the professional organization to the physician and/or mid-level professional for all services provided by the physician and/or mid-level professional on behalf of the professional organization. These costs would be salaries and related fringe benefits, payments under a contractual arrangement between the physician and/or mid-level professional and the professional organizations, funding of a retirement and/or deferred compensation plan by the professional organization on behalf of the physician, and costs related to a health and/or long-term disability program for the physician and his/her dependents.

If the professional organization has a physician and/or mid-level professional time study to allocate the physicians’ and/or mid-level professionals’ compensation costs to direct patient care services and the physicians’ and/or mid-level professionals’ other activities, it is not necessary to complete this worksheet. The professional organization can complete a supporting schedule in which the time study can be applied to the physicians’ and/or mid-level professionals’ compensation costs and the result should be input directly in Column 1 of Worksheet A. In the absence of a physician and/or mid-level professional time study to allocate the physicians’ and/or mid-level professionals’ compensation costs between direct patient care services and the physicians’ and/or mid-level professionals’ other activities prior to 10-1-2012, the costs for direct patient care services will be determined based on each physician’s work Relative Value Units (RVUs) for direct patient care. Effective 10-1-2012, professional organizations are expected to obtain a time study from each physician and/or mid-level professional to be used in the allocation of the physicians’ and/or mid-level professionals’ compensation costs to direct patient care services and other activities. The physician and/or mid-level professional time study forms to be used are located on the Texas Health and Human Services website. Time studies should be completed for a two (2) week period once per quarter during the fiscal year. Ideally, the time study period will not be the same two weeks in any two given quarters.

Attachment H
UC Claiming Protocol and Application
Part 1: UC Claiming Protocol for Hospitals and Physician Groups

If a professional organization incurs costs for services provided by another entity under a contractual arrangement, those costs can be included. The professional organization would be required to offset the revenue received on its UC Application to eliminate any duplicate payment for the costs related to these services.

Column 1 – The physicians’ and/or mid-level professionals’ work RVUs are reported in this column for periods prior to 10-1-2012. The source for the work RVUs are the professional organization’s internal records. The source for the work RVUs should be maintained by the professional organization and made available upon request by HHSC and/or CMS. An individual physicians’ and/or mid-level professionals’ work RVUs cannot exceed the benchmark RVU for one FTE. For periods after 10-1-2012, the physician’s and/or mid-level professionals’ time related to direct patient care activities based on their time study is reported in this column.

Column 2 – The benchmark RVU for an FTE for each physician and/or mid-level professional specialty is reported in this column for periods prior to 10-1-2012. The benchmark RVUs for each physician specialty FTE are contained in the Benchmark RVU worksheet of the TXPUC. If the professional organization has a physician specialty that is not listed on the Benchmark RVU worksheet, the benchmark RVU for the physician specialty most closely related to the actual physician specialty should be utilized. The benchmark RVU must be multiplied by the number of physicians and mid-level professionals included in each cost center to determine the benchmark RVU to be reported in this column. For periods after 10-1-2012, the physician’s total time related to the physician’s compensation reported in Column 4 based on their time study is reported in this column.

Column 3 – The RVU percentage is computed based on the actual physicians’ and mid-level professionals’ RVUs reported in Column 1 divided by the benchmark RVUs reported in Column 2 for each line. The RVU percentage should not exceed 1.00000. If line(s) have been added to the worksheet, it will be necessary to copy the formula in this column from an existing line to the line(s) that were added.

Column 4 – The physicians’ and mid-level professionals’ compensation costs for each physician and/or mid-level professional/specialty/cost center are reported in this column. The source for the compensation costs are the professional organization’s internal records. The source for the physicians’ and mid-level professionals’ compensation costs should be maintained by the professional organization and made available upon request by HHSC and/or CMS.

Column 5 – The physicians’ and mid-level professionals’ compensation costs for direct patient care services are computed based on the RVU percentage in Column 3 multiplied by the total physicians’ and mid-level professionals’ compensation costs reported in Column 4. If line(s) have been added to the worksheet, it will be necessary to copy the formula in this column from an existing line to the line(s) that were added. The costs in this column flow to Worksheet A, Column 1.

Worksheet A-6

This reclassification worksheet is similar to the Worksheet A-6 in the Hospital 2552 Medicare cost report. It allows for the reclassification of costs between cost centers reported on Worksheet A. Any reclassifications reported on this worksheet will need to be input on Worksheet A, Column 5 in the applicable line.

Attachment H
UC Claiming Protocol and Application
Part 1: UC Claiming Protocol for Hospitals and Physician Groups

Worksheet A-8

This adjustments worksheet is similar to the Worksheet A-8 in the Hospital 2552 Medicare cost report. It allows for any required adjustment(s) to the costs reported on Worksheet A (e.g. NIH grant revenue if research costs are not identified via the time studies). All payments received for services provided to another entity's patients should be offset against the applicable costs. All payments received from another entity to subsidize the care provided to a patient who was referred by the entity should be offset against the applicable costs. Any adjustments reported on this worksheet will need to be input on Worksheet A, Column 7 in the applicable line.

Worksheet B

The worksheet calculates the cost-to-charge ratio (CCR) to be utilized in apportioning the physicians' and/or mid-level professionals' compensation costs for services provided to Medicaid and Uninsured patients that is the basis for the determination of the professional organization's distribution from the UC Physician Pool.

Column 1 – The net physicians' and mid-level professionals' costs from Worksheet A, Column 8 will flow to this column.

Column 2 – The physicians' and/or mid-level professionals' total billed charges are reported in this column. As an alternative, the professional organization can use the number of visits as the allocation basis to apportion the costs. If the professional organization does elect to utilize patient visits to apportion the costs, the allocation basis reported at the top of this column should be changed from Total Billed Charges to Patient Visits. For either allocation basis, the source for this data will be the professional organization's internal records. If the professional organization's fiscal period straddles October 1, it will be necessary to pro-rate the data from the two fiscal periods that encompass the period from October 1 through September 30 two years prior to the demonstration year for which UC payments are being determined.

Column 3 – The CCR is computed by dividing the costs reported in Column 1 of this worksheet by the total allocation basis reported in Column 2 of this worksheet.

Worksheet D

This worksheet computes the physicians' and/or mid-level professionals' costs for services provided to Medicaid FFS, Medicaid HMO and Uninsured patients. It utilizes the CCR determined on Worksheet B, Column 3 and the charges for physician and/or mid-level professional services. The source for the Medicaid FFS, Medicaid HMO and Uninsured data are the professional organization's internal records. If the professional organization's fiscal period straddles October 1, it will be necessary to pro-rate the data from the two fiscal periods that encompass the period from October 1 through September 30 two years prior to the demonstration year for which UC payments are being determined. The allocation basis reported on Worksheet B Column 2 must be the same as the apportionment basis reported on Worksheet D, Columns 2 – 7. If the professional organization elects to utilize patient visits to apportion the costs

Attachment H
UC Claiming Protocol and Application
Part 1: UC Claiming Protocol for Hospitals and Physician Groups

rather than billed charges, the apportionment basis at the top of Columns 2 – 7 should be changed from Billed Charges to Patient Visits.

Column 1 – The CCR from Worksheet B, Column 3 flows to this column.

Columns 2 through 7 – The apportionment statistics for inpatient and outpatient services provided to Medicaid FFS, Medicaid HMO and Uninsured patients are reported in the respective columns.

Columns 8 – 13 – The physicians' and mid-level professionals' costs for inpatient and outpatient services provided to Medicaid FFS, Medicaid HMO and Uninsured patients are computed by multiplying the CCR reported in Column 1 multiplied by the apportionment statistics reported in Columns 2 – 7 for the respective columns.

The total costs for each column are determined at the bottom of the worksheet. All revenues received from any source related to the physician and/or mid-level professional services provided to Medicaid FFS, Medicaid HMO and Uninsured should be reported on the Less Payments line at the bottom of the worksheet in the respective column. This would include any payments received from third-party payers, patient copays, etc.

The Net Unreimbursed Cost for Columns 8 through 13 flows to the Cost Summary worksheet of the TXPUC tool. This cost will be utilized to determine the professional organization's distribution from the UC Physician Pool.

Interim Reconciliation of Physician Payments to Professional Organizations

The physician UC payments for FY 2012 are determined utilizing the TXPUC that utilizes data for the fiscal period 10/1/2009 – 9/30/2010. These FY 2012 UC payments are reconciled to the data per the professional organization's TXPUC for the fiscal period 10/1/2011 – 9/30/2012 once the TXPUC has been filed with the State. If, at the end of the interim reconciliation process, it is determined that a provider received an overpayment, the overpayment will be properly credited to the federal government; if a provider was underpaid, the provider will receive an adjusted payment amount. Similar interim reconciliations will be conducted for each year of the waiver.

Final Reconciliation of Physician Payments to Professional Organizations

Once the TXPUC for the expenditure year has been finalized by the State, a reconciliation of the finalized costs per the TXPUC to all UC payments made for the same period will be carried out, including adjustments for overpayments and underpayments if necessary. The same method as described for the interim reconciliation will be used except that the finalized TXPUC physician and/or mid-level professional cost amounts and updated uninsured data will be substituted as appropriate. If, at the end of the final reconciliation process, it is determined that a hospital received an overpayment, the overpayment will be properly credited to the federal government. Similar final reconciliations will be conducted for each year of the Waiver.

Attachment H
UC Claiming Protocol and Application
Part 2: UC Claiming Protocol for Dental Providers

General:

Governmentally owned dental providers are eligible to participate in the supplemental payment program if they are directly funded by a local government, hospital authority, hospital district, city, county or state as specified in 42 CFR § 433.50 (i) which describes a unit of government. This would include providers such as public health clinics and departments, dental schools, mobile dental units or other dental facilities that are owned by the government. Providers wanting to participate in the program should contact the Texas Health and Human Services Commission (HHSC), Rate Analysis Department at 512-730-7401.

The cost report will include only allocable expenditures related to Medicaid, Medicaid Managed Care and Uncompensated Care as defined and approved in the Texas Healthcare Transformation and Quality Improvement 1115 Waiver Program.

The Dental Services Supplemental Payment Cost Report (cost report) must be prepared and completed on an annual basis for federal fiscal years ending on September 30. Cost reports are due to HHSC 180 days after the close of the applicable reporting period. An eligible provider who has been approved to submit a cost report for supplemental payment will prepare the cost report, attest to and certify the total actual Medicaid costs/expenditures. The completed cost report will be sent to:

HHSC Rate Analysis/Acute Care Services
Brown Heatly Building
Mail Code H-400
4900 North Lamar
Austin, TX 78751-2399

When using the Excel spreadsheet, many fields in the pages will automatically populate with information from another worksheet to avoid additional data entry and reduce errors. Therefore, only the **SHADED AREAS** of the cost report are to be completed. Please review and verify the accuracy of all information on the pages before completing the report.

For questions on completing the cost report, please contact the Health and Human Services Commission, Rate Analysis Department at 512-730-7401.

Definitions:

Cognizant agency—the agency responsible for reviewing, negotiating, and approving cost allocation plans or indirect cost proposals developed in accordance with the Office of Management and Budget Circular A-87.

Commercial Pay Insurance—health insurance that covers medical expenses and disability income for the insured. Commercial health insurance can be categorized according to its

Attachment H
UC Claiming Protocol and Application
Part 2: UC Claiming Protocol for Dental Providers

renewal provisions and type of medical benefits provided. Commercial policies can be sold individually or as part of a group plan.

Cost Allocation Plans—are the means by which costs are identified in a logical and systematic manner for reimbursement under federal grants and agreements.

Cost-to-charge-ratio (CCR)— a provider's reported costs are allocated to the Medicaid program based on a cost-to-billed-charge ratio. Cost-to-billed charge ratio is calculated as total allowable cost reported for the service period divided by total billed charges for the service period. This ratio is then applied to total billed charges associated with Medicaid paid claims to calculate total allowable billed charges for the cost report.

Direct Cost—means any cost which is identified specifically with a particular final cost objective. Direct costs are not limited to items which are incorporated in the end product as material or labor. Costs identified specifically with a contract are direct costs of that contract. All costs identified specifically with other final cost objectives of the contractor are direct costs of those cost objectives.

Federal Medical Assistance Percentage (FMAP)—the share of state Medicaid benefit costs paid for by the federal government.

Indirect Costs—cost incurred and identified with having two or more cost objectives but not specifically identified with any final cost objective.

Indirect Cost Rate—a device for determining in a reasonable manner the proportion of indirect costs each program should bear. It is the ratio, expressed as a percentage, of the indirect costs to the direct costs.

Intergovernmental Transfers (IGT)—State and local funds derived from taxes, assessments, levies, investments, and other public revenues within the sole and unrestricted control of a governmental entity and eligible for federal match under the 1115 Transformation Waiver. This does not include gifts, grants, trusts, or donations, the use of which is conditioned on supplying a benefit solely to the donor or grantor of the funds.

Medicaid Fee-For-Service (FFS)—the traditional health care payment system, in which providers receive a payment for each unit of service they provide

Medicaid Managed Care (MCO)—an entity that provides or contracts for managed health care. Medicaid payments are made by the MCOs to providers for services provided to Medicaid recipients.

Medicare—a federal system of health insurance for those who are 65 and older, disabled or have permanent kidney failure.

Attachment H
UC Claiming Protocol and Application
Part 2: UC Claiming Protocol for Dental Providers

Self-Pay—an individual who either does not have insurance or her/his insurance does not cover a particular procedure or provider and therefore, the individual is responsible for paying the provider.

Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver—the vehicle approved by HHSC and CMS for implementation of the waiver program under section 1115 of the Social Security Act.

Uncompensated Care (UC)—costs of uncompensated care provided to Medicaid eligibles or to individuals who have no funds or third party coverage for services provided by medical, dental or other providers.

Uninsured—an individual who has no health insurance or other source of third-party coverage for medical/health services.

Uninsured cost--the cost to provide dental services to uninsured patients as defined by the Centers for Medicare and Medicaid Services. An individual whose third-party coverage does not include the service provided is considered by HHSC to be uninsured for that service.

Unit of government—a state, city, county, special purpose district or other governmental unit in the State that: has taxing authority, has direct access to tax revenues, is a State university teaching hospital with direct appropriations from the State treasury, or is an Indian tribe as defined in Section 4 of the Indian Self-Determination and Education Assistance Act, as amended (25 U.S.C. 450b).

Page 1: Cover Page

Page 1 is the cost report cover page. This form includes a provider's national and state provider identification numbers. Each governmental provider enters its legal name and the appropriate contact information for all parties listed on the form. This information will be used by HHSC to contact the provider during the cost reconciliation and settlement process.

DIRECTIONS TO COMPLETE PAGE 1

Federal Fiscal Year: Enter the federal fiscal year for which the cost report will be completed (e.g., 2012). When this is entered on the cover page, this field will automatically transfer to subsequent pages.

Reporting Period: Enter the actual reporting period for which the cost report will be completed (e.g., 10/01/11 to 09/30/12). When this is entered on the cover page, this field will automatically transfer to subsequent pages.

Attachment H
UC Claiming Protocol and Application
Part 2: UC Claiming Protocol for Dental Providers

Texas Provider Identification Number (TPI): Enter the 9-digit TPI number for the provider that is completing the cost report. When this is entered on the cover page, this field will automatically transfer to subsequent pages.

National Provider Identification Number (NPI): Enter the 10-digit NPI number for the provider that is completing the cost report. When this is entered on the cover page, this field will automatically transfer to subsequent pages.

Provider Information

Provider Name: Enter the provider's legal name (e.g., Laredo Health Department Dental Clinic)

Provider Contact Name: Enter the provider's contact

Street Address: Enter the street address and also include the city, state, and zip code in this field.

Mailing Address: Enter the mailing address and also include the city, state, and zip code in this field.

Phone Number: Enter the phone number of the provider's contact.

Fax Number: Enter the fax number of the provider's contact.

Email: Enter the email of the provider's contact.

Chief Financial Officer / Business Manager

Name: Enter the name of the chief financial officer or business manager.

Title: Enter the title of the chief financial officer or business manager.

Business Name: Enter the business name (e.g. UT Health Science Center at San Antonio Dental School).

Mailing Address: Enter the mailing address and also include the city, state, and zip code in this field.

Phone Number: Enter the phone number of the chief financial officer or business manager.

Fax Number: Enter the fax number of the chief financial officer or business manager.

Email: Enter the email of the chief financial officer or business manager.

Report Preparer Identification

Name: Enter the name of the person responsible for preparing the cost report (this is the person HHSC should contact if there are questions).

Title: Enter the title of the report preparer.

Business Name: Enter the business name (e.g. UT Health Science Center at San Antonio Dental School).

Mailing Address: Enter the mailing address and also include the city, state, and zip code in this field.

Phone Number: Enter the phone number of the report preparer.

Fax Number: Enter the fax number of the report preparer.

Email: Enter the email of the report preparer.

Location of Accounting Records that Support this Report

Physical Address: Enter the Physical Address of the location where the provider maintains the accounting records that support the cost report and include the city, state, and zip code in this field. When this is entered on the cover page, this field will automatically transfer to the subsequent pages.

Page 2: General and Statistical Information

Attachment H
UC Claiming Protocol and Application
Part 2: UC Claiming Protocol for Dental Providers

DIRECTIONS TO COMPLETE PAGE 2

Page 2 is the General and Statistical Information page of the cost report. This page includes general provider and statistical information used in the cost report.

General Provider Information

1.00-1.03: These fields will automatically transfer from the Cover Page.

1.04: Enter either yes or no to indicate if the reporting period is less than a full federal fiscal year. If the cost report is being prepared for a partial fiscal quarter, enter a response that explains the reason why (e.g., no, Supplemental Payment Request Approval was effective beginning 3/1/20XX).

Cost Allocation Information

The purpose of this section is to obtain summary information regarding the cost allocation methodology the governmental entity utilized to allocate costs to various programs, grants, contracts and agreements. Additional information required to support an agency's methodology will be found on Page 7 Worksheet C.

1.05: Enter either yes or no to indicate whether your agency has an approved Cost Allocation Plan (CAP). Additional information must be provided on Page 7 Worksheet C.

1.06: If the answer to 1.05 is yes, enter the name of the Cognizant Agency.

1.07: Enter yes or no to indicate whether your agency has an approved Indirect Cost Rate (IDCR).

1.08: If the answer to 1.07 is yes, enter the name of the Cognizant Agency.

1.09: Enter either yes or no to indicate whether your agency will be using an IDCR on this report.

1.10: If the answer to 1.09 is yes, enter the IDCR Statistical Information.

1.11: Medicaid Fee-For-Service (FFS) Paid Claims Amount: Enter the total.

1.12: Total Medicaid FFS Billed Charges Associated with Medicaid Paid Claims: Enter the total.

1.13: Medicaid Managed Care Organization (MCO) Paid Claims Amount: Enter the total.

1.14: Total FFS Billed Charges Associated with Medicaid Paid Claims: Enter the total.

1.15: Uncompensated (Uninsured) Care Reimbursement: Enter the total.

1.16: Uncompensated (Uninsured) Care Billed Amount: Enter the total.

1.17: Total Allowable Costs for Reporting Period: This field will automatically transfer from Page 3 – Dental Cost Settlement, 2.40). This amount includes Medicaid FFS, Medicaid MCO and Uncompensated Care cost only.

1.18: Total Paid Claims and UC Reimbursement: This field will automatically add the total paid claims from Medicaid Fee-for-Service (line 1.11), MCOs (line 1.13) and UC reimbursement (line 1.15).

Attachment H
UC Claiming Protocol and Application
Part 2: UC Claiming Protocol for Dental Providers

1.19: Total Billed Charges: This field will automatically add the total billed charges from Medicaid Fee-for-Service (line 1.12), Medicaid Managed Care Organizations (line 1.14) and UC Billed Amount (line 1.16).

Additional Cost Data (For Informational Purposes Only)

In addition to the statistical information entered for Cost Reporting period, other cost data is being requested.

1.20: Medicare Costs: Enter the total.

1.21: Other (Self-Pay, Commercial Pay, etc.) Costs: Enter the total.

Page 3: Dental Cost Settlement

DIRECTIONS TO COMPLETE PAGE 3

Page 3 identifies and summarizes all dental services costs. Much of the information contained within this page is automatically pulled from other pages; however, there are unique items of cost that must be entered in this page.

Only allocable expenditures related to Medicaid Fee-for-Service, Medicaid Managed Care and Uncompensated Care as defined and approved in the Texas Healthcare Transformation and Quality Improvement 1115 Waiver Program will be included for supplemental payment.

Direct cost methods must be used whenever reasonably possible. Direct costing means that allowable costs, direct or indirect, incurred for the benefit of, or directly attributable to, a specific business component must be directly charged to that particular business component. Direct cost accounting may include:

1. Dedicated Cost Centers: Cost may be included for those cost centers that are solely dedicated to Medicaid and Uncompensated Care.
2. Multiple Cost Centers: Cost may be included for those cost centers that are not solely dedicated to Medicaid and Uncompensated Care. However, the provider must submit a detailed approved Cost Allocation Plan (CAP). If cost allocation is necessary for cost-reporting purposes, governmental providers must use reasonable methods of allocation and must be consistent in their use of allocation methods for cost-reporting purposes across all program areas and business entities. The allocation method should be a reasonable reflection of the actual business operations. Allocation methods that do not reasonably reflect the actual business operations and resources expended toward each unique business entity are not acceptable. Allocated costs are adjusted if HHSC considers the allocation method to be unreasonable. The provider must submit a detailed summary of their cost allocation methodology including a description of the components, the formula for calculating the percentage and any additional supporting documentation as required by HHSC. Supplemental schedules must also be attached to the cost report listing each employee, job title, total salary and benefits, the applicable allocation percentage and the allocation amount that will be included in the cost report. The amounts from the supplemental schedule allocated to the Medicaid and Uncompensated

Attachment H
UC Claiming Protocol and Application
Part 2: UC Claiming Protocol for Dental Providers

Care programs should match the amounts entered on Page 6 Worksheet B with additional detail entered on Page 7 Worksheet C.

If Indirect Cost (IDC) is included, that amount should be listed in line 2.30 (Other) with the detail described in either the Explanation Box or as a separate attachment. Indirect cost is calculated by multiplying the **Total Allowable** costs by the provider's approved indirect cost rate. IDCR detail should include the methodology for determining the IDCR, the percentage and amount of the IDCR and if the dental provider is already using the IDCR to claim cost on another report. If IDCR costs are claimed in line 2.30, indirect or administrative costs cannot also be claimed as non-clinical cost in lines 2.26 a., 2.27 a. or in administrative salaries and compensation in Page 6 (Worksheet B). IDCR costs may be disallowed if it is determined that the provider has already claimed those same IDCR costs on this or another report. Additional detail regarding an agency's IDCR must be provided on Page 7 Worksheet C.

This page sums the payroll expenses and adds other costs to calculate the total cost of dental services. Identified reductions, either from Page 6 or entered manually with descriptions in the Explanation Box, are subtracted to calculate the adjusted amount of dental costs allowable as part of the cost report. The cost report identifies the portion of allowable costs that are related to Medicaid FFS, Medicaid MCOs, and Uncompensated Care and applies the cost-to-charge-ratio applicable for the cost report period. This ratio is applied to billed charges associated with Medicaid FFS and MCO paid claims and Uncompensated Care billed charges resulting in the total computable amount for dental services. This amount is then reduced by Medicaid FFS, Medicaid MCO paid claims and any reimbursement received for Uncompensated Care. The resulting amount is then multiplied by the applicable federal medical assistance percentage (FMAP) to calculate the Federal and state amounts. The page is separated into the sections identifying:

Personnel/Payroll Expenses

2.00-2.21: If using hours as an allocation method enter the number of hours. Total paid hours include but are not limited to regular wage, sick and vacation hours. If personnel/payroll expenditure data is entered on Page 6 – Worksheet B – Payroll and Benefits, those costs will automatically transfer to this page.

2.22: State Unemployment Payroll Taxes: Enter the total (if applicable).

2.23: Federal Unemployment Payroll Taxes: Enter the total (if applicable).

2.24: Unemployment Compensation (Reimbursing Employer): Enter the total (if applicable).

2.25: Total Staff Costs: Will automatically calculate (sum of applicable items in 2.00-2.24).

Other Costs

2.26: Supplies and Materials: Supplies and materials include but are not limited to dental and medical supplies, office supplies, and maintenance supplies. Supplies and materials must be separated according to whether they are non-clinical or clinical. The total for non-clinical supplies and materials would be entered on 2.26 a. and the total for clinical supplies and materials would be entered on 2.26 b. Detail describing the supplies and materials along with the amount and allocation methodology should be entered in the Explanation Box or attached as a

Attachment H
UC Claiming Protocol and Application
Part 2: UC Claiming Protocol for Dental Providers

separate sheet. If a cognizant-agency- approved indirect cost rate is used, additional administrative (non-clinical) cost will not be permitted.

2.27: Equipment: Equipment costs include but are not limited to dental and medical equipment, computers and communication equipment. Equipment costs must be separated according to whether they are non-clinical or clinical. The total for non-clinical equipment would be entered on 2.27 a. and the total for clinical equipment would be entered on 2.27 b. Detail describing the equipment costs along with the amount and allocation methodology should be entered in the Explanation Box or attached as a separate sheet. If a cognizant-agency- approved indirect cost rate is used, additional administrative (non-clinical) cost will not be permitted.

2.28: Support Services: Enter the total and provide detail in the Explanation Box. Support services expenditures may include personnel and non-personnel expenditures such as information technology salaries and benefits and operating expenditures.

2.29: Depreciation: Depreciation information should first be entered on Page 5 – Schedule A – Depreciation and those costs will automatically transfer to this line.

2.30: Other: Enter the total and provide detail in the Explanation Box.

2.31: Total Direct and Indirect Dental Other Costs: Will automatically calculate (sum of 2.26 through 2.30).

2.32: Total Staff, Direct and Indirect Dental Other Costs: Will automatically calculate (sum of 2.25 and 2.31).

Reductions

2.33: Other Federal Funds and Grants: If expenditure data is entered on Page 6 – Worksheet B Payroll and Benefits, those costs will automatically transfer to this line.

2.34: Other: Enter the total and provide detail in the Explanation Box.

2.35: Total Reductions: Will automatically calculate (sum of 2.33 and 2.34).

Cost Settlement Calculation

2.40: Total Allowable Costs: Will automatically calculate (2.32 less 2.35).

2.41: Total Billed Charges: This field will automatically transfer from Page 2 – General & Statistical, 1.19.

2.42: Cost-to-Charge-Ratio (CCR) = Total Allowable Costs/Total Billed Charges: Will automatically calculate (2.40 divided by 2.41)

2.43: Total Billed Charges Associated with Medicaid Paid Claims and Uncompensated Care: This field will automatically transfer from Page 2 – General & Statistical, (sum of 1.06 and 1.08).

2.44: Medicaid Allowable Costs = CCR * Total Billed Charges Associated with Medicaid Paid Claims and Uncompensated Care: Will automatically calculate (2.42 multiplied by 2.43).

2.45: Total Medicaid Allowable Billed Charges: This field will automatically calculate the lesser of 2.43 or 2.44; this amount cannot exceed 2.43, Total Billed Charges Associated with Medicaid Paid Claims and Uncompensated Care).

2.46: Medicaid Paid Claims Amount and Uncompensated Care reimbursement: This field will automatically transfer from Page 1 – General & Statistical (sum of 1.05 and 1.07).

Attachment H
UC Claiming Protocol and Application
Part 2: UC Claiming Protocol for Dental Providers

2.47: Settlement Amount = Total Medicaid Allowable Billed Charges and Uncompensated Care Charges minus Medicaid Paid Claims Amount and Uncompensated Care Reimbursement: Will automatically calculate 2.45 minus 2.46

2.48: FMAP (Federal Medical Assistance Percentage): HHSC will enter the correct FMAP.

2.49: Federal Funds = Settlement Amount * FMAP: Will automatically calculate (2.47 multiplied by 2.48).

2.50: State Funds (IGT Amount): Will automatically calculate 2.47 less 2.49). Governmental entities are required to certify on Page 4 Cost Report Certification that they have completed the appropriate documentation required by HHSC and the Texas Comptroller's Office regarding the Intergovernmental Transfer (IGT) process. Once the cost report has been reviewed and accepted by HHSC, the provider will be notified of the amount required for the IGT.

Page 4 – Cost Report Certification

DIRECTIONS TO COMPLETE PAGE 4

Page 4 is the certification of costs included in the cost report. This form attests to and certifies the accuracy of the financial information contained within the cost report and that the report was prepared in accordance with State and Federal audit and cost principle standards. The signer is also certifying that the expenditures included in this cost report have not been claimed on any other cost report.

Most of the information in Page 4 will be updated automatically with information from previous pages. This page must be signed and included **UPON COMPLETION OF ALL OTHER PAGES**.

Upon completion of all other pages in the cost report, please have the appropriate person read and sign the form. **Scan and include the signed page** when sending the electronic version of the cost report to HHSC.

Signature Authority/Certifying Signature

Printed/Typed Name of Signer: Enter the name of the person that will be certifying the costs identified in the cost report.

Title of Signer: Enter the title of the signer.

Name of Provider: Enter the name of the Provider.

Address of Signer: Enter the address of the signer.

Phone Number: Enter the phone number of the signer.

Fax Number: Enter the fax number of the signer.

Email: Enter the email of the signer.

Signature of Signer and Date: The signer should sign and date the form.

Page 5 – Schedule A - Depreciation

DIRECTIONS TO COMPLETE PAGE 5

Page 5 identifies allowable depreciation expenses incurred by the provider for that portion which is related to Medicaid, Medicaid Managed Care and Uncompensated Care. This page will

Attachment H
UC Claiming Protocol and Application
Part 2: UC Claiming Protocol for Dental Providers

identify all depreciable assets for which there was a depreciation expense during the Cost Report period. Information on this page must come from a depreciation schedule maintained by the provider in accordance with straight line depreciation guidelines.

Vehicles, Equipment, Building, Etc.

For depreciation expenses, the straight line method should be used.

Asset Description: Enter the name and description of the asset. If there is the need to add additional lines, please do so.

Month/Year Placed in Service: Enter the month/year placed in service as identified on the provider's depreciation schedule.

Years Useful Life: Enter the number of years of useful life of the asset.

Cost: Enter the amount of initial cost.

Prior Period Accumulated Depreciation: Enter the amount of prior period accumulated depreciation.

Depreciation for Reporting Period: Enter the amount of current period depreciation expense.

Years Useful Life: Enter the number of years of useful life of the asset as identified on the provider's depreciation schedule (e.g., 20 for twenty years of useful life).

Cost: Enter the amount of initial cost of the asset as identified on the provider's depreciation schedule.

Prior Period Accumulated Depreciation plus Depreciation for Reporting Period cannot exceed the total cost of an asset. In addition, assets that have been fully expensed should not be reported. For depreciation expense related to buildings where the provider's vehicles or staff is housed with other agencies or entities, **ONLY the portion related to the provider** may be reported. If this is the case, the provider must attach a supplemental page showing how the portion of the building related to the provider was calculated.

Page 6 – Worksheet B – Payroll and Benefits

DIRECTIONS TO COMPLETE PAGE 6

Page 6 includes the salary and benefits, and appropriate reductions for contract and employed staff related to the provision of dental services. Data entered on this page is only for that portion of an employee's salary and benefits that is applicable to Medicaid FFS, Medicaid MCOs and Uncompensated Care. Salary and compensation must be reported on a direct charge basis. This page includes several pre-populated staffing classifications for which information will need to be completed. These pre-populated classifications include:

Director: salary and benefit expenditures related to developing, administration, and overall operational effectiveness of the organization including strategic planning, leadership and oversight, including but not limited to:

- Director
- Director's Assistant

Attachment H
UC Claiming Protocol and Application
Part 2: UC Claiming Protocol for Dental Providers

Dental Director: salary and benefit expenditures related to planning, developing, scheduling, and the implementation of dental program services and activities, including but not limited to:

- Dental Director
- Dental Director's Assistant

Dentists and Dental Assistants: salary and benefit expenditures related to dental care including but not limited to:

- Dentists
- Dental Assistants

Safety Officer:

- Safety Officer
- Safety Officer Assistants

Billing Account Representatives: salary and benefit expenditures related to verification of patients' insurance coverage, including Medicaid, collection of third party insurance submissions and payments, and patient service related tasks, including but not limited to:

- Billing Representatives
- Account Representatives
- Patient Account Representative

Quality Assurance Technicians: salary and benefit expenditures related to analyzing performance and quality improvement program including but not limited to:

- Quality Assurance Technicians

For each employee, the following information must be included:

Employee Information

Employee #: Enter the employee #.

Last Name: Enter the last name.

First Name: Enter the first name.

Job Title/ Credentials: Enter the job title/credentials.

Attachment H
UC Claiming Protocol and Application
Part 2: UC Claiming Protocol for Dental Providers

Employee (E) /Contractor (C): Enter the appropriate designation, either an E or a C, for the employee.

Payroll and Benefits

Gross Salary: Enter the gross salary amount.

Contractor Payments: Enter the amount of contractor payments for the employee.

Employee Benefits: Enter the amount. This includes all benefits that are not discretely identified in Columns J-L of this page.

Employer Retirement: Enter the amount.

FICA: Enter the amount of FICA.

Medicare Payroll Taxes: Enter the amount.

Federal Funding Reductions

This section of the page is designed to identify the federal funding, or other payroll and benefit expenditure reduction necessary for the specific job classifications identified above. This section of the page is also designed to discretely identify the payroll and benefit expenditures for any individual employee/contractor that must have a portion of their salary and/or benefits reduced from allowable expenditures on the Cost Report. For each of the job classifications identified above, the following information must be included:

Allocated Funded Positions Entry: Enter the appropriate designation, either yes or no, for the employee for which a portion of their salary and/or benefits must be reduced from the total allowable costs. A yes in this field designates an employee for which a portion or all of their salary and benefit expenditures are funded by federal funds or grants. An no in this field designates an employee whose entire salary or a portion of whose salary and benefit expenditures are not funded by federal funds or grants, but whose costs still need to be removed from allowable expenditures as reported on the Cost Report.

Federal Funding: If the answer to the field previously is yes, then enter the amount of federal funding related to the employee's salary and benefits that must be reduced from the total allowable costs.

Other Funds: Enter the other amount to be removed related to the employee's salary and benefits that must be reduced from the total allowable costs.

Total Reduction: Will automatically calculate (sum of federal funding and other funds).

Attachment H
UC Claiming Protocol and Application
Part 2: UC Claiming Protocol for Dental Providers

Page 7 – Worksheet C – Cost Allocation Methodologies

DIRECTIONS TO COMPLETE PAGE 7

Page 7 details the cost allocation methodologies employed by the governmental entity.

- A. If you entered “yes” on Page 2, Line 1.05, please provide a copy of your agency’s approved Cost Allocation Plan (CAP).
- B. If you entered “yes” on Page 2, Line 1.06 and 1.09, please provide a copy of your agency’s approved Indirect Cost Rate (IDCR).
- C. If you do not have an approved CAP or IDCR but are using another cost allocation methodology, please provide a copy of your methodology and the supporting documentation.
- D. Please provide a list of personnel cost worksheets that support your CAP or IDCR.

Attachment H
UC Claiming Protocol and Application
Part 2: UC Claiming Protocol for Dental Providers

Appendix A - List of Participating Providers

University of Texas at San Antonio Health Science Center (UTHSC-SA) Dental School:
performs the patient billing activities for the dental school, the mobile dental unit, the Ricardo Salinas Dental Clinic and the Laredo Health Department Dental Clinic.

Attachment H
UC Claiming Protocol and Application
Part 3: UC Claiming Protocol for Ambulance Providers

General

Governmentally owned ambulance providers are eligible to participate in the supplemental payment program if they are directly funded by a local government, hospital authority, hospital district, city, county or state as specified in 42 CFR § 433.50 (i) which describes a unit of government. This would include providers such as public health clinics and departments. ,

The cost report will include only allocable expenditures related to Medicaid, Medicaid Managed Care and Uncompensated Care as defined and approved in the Texas Healthcare Transformation and Quality Improvement 1115 Waiver Program.

The Ambulance Services Supplemental Payment Cost Report (cost report) must be prepared and completed a governmental entity on an annual basis for fiscal years ending on September 30. Cost reports are due to HHSC 180 days after the close of the applicable reporting period. A provider who meets the definition of eligible governmental provider and who has been approved to submit a cost report for supplemental payment will prepare the cost report and will attest to, and certify through its cost report the total actual, incurred Medicaid and Uncompensated (uninsured) costs/expenditures, including the federal share and the non-federal share applicable to the cost report period. The completed cost report will be sent to the Texas HHSC at 11209 Metric Boulevard, Building H, Austin, TX 78758.

For the cost report to be accurate, only the **SHADED AREAS** of the cost report are to be completed.

Many worksheets (i.e. exhibits) will auto populate with information from another worksheet as to avoid additional extra data entry and to reduce errors. Please review and verify the accuracy of all information on all exhibits before completing the report.

For questions on completing the cost report, please contact the Health and Human Services Commission, Rate Analysis Department at 512-491-1802.

Definitions:

Cognizant agency - agency responsible for reviewing, negotiating, and approving cost allocation plans or indirect cost proposals developed in accordance with the Office of Management and Budget Circular A-87.

Cost Allocation Plans - are the means by which costs are identified in a logical and systematic manner for reimbursement under federal grants and agreements.

Cost-to-charge ratio -- A provider's reported costs are allocated to the Medicaid program based on a cost-to-billed-charge ratio. Cost-to-billed charge ratio is calculated as the Total Allowable Cost reported for the service period to represent the numerator of the ratio to the billed charges of the total Medicaid paid claims for the service period that represents the denominator of the ratio. This ratio is applied to

Attachment H
UC Claiming Protocol and Application
Part 3: UC Claiming Protocol for Ambulance Providers

calculate total billed charges associated with Medicaid paid claims or total computable amount for the cost report.

Direct Cost - means any cost which is identified specifically with a particular final cost objective. Direct costs are not limited to items which are incorporated in the end product as material or labor. Costs identified specifically with a contract are direct costs of that contract. All costs identified specifically with other final cost objectives of the contractor are direct costs of those cost objectives.

Federal Medical Assistance Participation (FMAP) Rate -- is the share of state Medicaid benefit costs paid for by the federal government.

Indirect Costs - **costs incurred and identified with having two or more cost objectives but not specifically identified with any final cost objective.**

Indirect Cost Rate - **is a device for determining in a reasonable manner the proportion of indirect costs each program should bear. It is the ratio, expressed as a percentage, of the indirect costs to the direct costs.**

Medicaid Fee-For-Service (FFS) Paid Claims -- Medicaid payments made by the Health and Human Services Commission through the Texas Medicaid Healthcare Partnership to enrolled providers for services provided to Medicaid recipients.

Medicaid Managed Care --provides for the delivery of Medicaid health benefits and additional services through an arrangement between a state Medicaid agency and managed care organizations (MCOs) that accept a set payment for these services. Medicaid payments are made by the MCO's to providers for services provided to Medicaid recipients.

Un-insured -- an individual who has no health insurance or other source of third-party coverage for medical/health services.

Uninsured cost -- the cost to provide ambulance services to uninsured patients as defined by the Centers for Medicare and Medicaid Services. An individual whose third-party coverage does not include the service provided is considered by HHSC to be uninsured for that service.

Medicare -- A federal system of health insurance for people over 65 years of age and for certain younger people with disabilities.

Other third-party coverage -

Commercial Pay Insurance -- health insurance that covers medical expenses and disability income for the insured. Commercial health insurance can be categorized according to its renewal provisions and type of medical benefits provided. Commercial policies can be sold individually or as part of a group plan.

Attachment H
UC Claiming Protocol and Application
Part 3: UC Claiming Protocol for Ambulance Providers

Self-Pay -- self pay patient pays in full at the time of visit for our services and we are not required to file claim or submit any documentation on his/her behalf to a third party.

Total Computable Amount – is the total Medicaid allowable amount payable for ambulance services prior to any reductions for interim payments.

Uncompensated Care (UC)—health care provided for which a charge was recorded but no payment was received; UC consists of two components, charity care in which the patient is unable to pay and bad debt in which a payment was expected but not received. Uncompensated care excludes other unfunded costs of care such as underpayment from Medicaid and Medicare.

Unit of government—a state, city, county, special purpose district or other governmental unit in the State that: has taxing authority, has direct access to tax revenues, is a State university teaching hospital with direct appropriations from the State treasury, or is an Indian tribe as defined in Section 4 of the Indian Self-Determination and Education Assistance Act, as amended (25 U.S.C. 450b).

Exhibit A: Cost Report Cover Page

Exhibit A is the cost report cover page. This form includes a provider’s National and State provider identification number that is used by HHSC as a means to obtain fee for service cost data included in the cost report. Each governmental provider must enter their entities legal name, name of person responsible for submitting the cost report, the cost preparers name and physical location, mailing address, phone number and Fax number of all contacts listed. The information will be used by HHSC to contact the provider as necessary through the cost reconciliation and cost settlement process.

DIRECTIONS TO COMPLETE EXHIBIT A

- Fiscal Year: Enter the Federal **Fiscal Year** for which the cost report will be completed (e.g., 2010).
- Reporting Period: Enter the actual **Reporting Period** for which the cost report will be completed (e.g., 10/01/10 to 09/30/11).
- Texas Provider Identification Number (TPI) Enter the **9-digit TPI** number for the provider that is completing the cost report (e.g., 1234567-89).
- National Provider Identification Number (NPI): Enter the **10-digit NPI** number for the provider that is completing the cost report (e.g., 1234567890).

Provider Information

- Provider Legal Name Enter the **Provider Legal Name** (e.g., (Health and Human Services Commission EMS). This is the name of the provider completing the cost report.
- Street Address: Enter provider **Street Address** (e.g., 11209 Metric Blvd., Bldg. H., Austin, TX 78758). Include the city, state, and zip code in this field.

Attachment H
UC Claiming Protocol and Application
Part 3: UC Claiming Protocol for Ambulance Providers

Mailing Address: Enter provider **Mailing Address** (e.g., 11209 Metric Blvd., Bldg H., Austin, TX 78758 or P.O. Box 85700, Mail Code H-360, Austin, TX 78708-5200). Include the city, state, and zip code in this field.

Phone Number: Enter the **Phone Number** of the provider's contact (e.g., (512) 123-4567).

Fax Number: Enter the **Fax Number** of the provider's contact (e.g., (512) 987-6543).

Email Address: Enter the **Email** address of the provider's contact (e.g., iampublic@xyzabc.com).

Business Manager / Financial Director

Business Manager/Financial Directors Name: Enter the **Name** of the business manager or financial director of the provider (e.g., Jane Doe).

Title: Enter the **Title** of the business manager or financial director of the provider identified in the field above (e.g., Director).

Email Address: Enter the **Email** address of the provider's contact (e.g., jqpublic@xyzabc.com).

Report Preparer Identification

Report Preparer Name: Enter the **Name** of the provider's contact or person responsible for preparing the cost report (e.g., Jane Doe). This is the name of the person that HHSC may contact if there are questions.

Title: Enter the **Title** of the provider's contact identified in the field above (e.g., Director).

Location of Accounting Records that Support this Report

Records Location: Enter the **Physical Address** of the location where the provider maintains the accounting records in support of the cost report (e.g., 11209 Metric Blvd., Bldg. H., Austin, TX 787581). Include the city, state, and zip code in this field.

Attachment H
UC Claiming Protocol and Application
Part 3: UC Claiming Protocol for Ambulance Providers

Exhibit 1: General and Statistical Information

Exhibit 1 is the General and Statistical Information page of the cost report. This exhibit includes general provider information and statistical information used in the cost report.

DIRECTIONS TO COMPLETE EXHIBIT 1

General Provider Information

Reporting Period – Begin Date: Enter the **Reporting Period – Beginning** date or the beginning date of the cost report period (e.g., 10/1/2010).

Reporting Period – End Date: Enter the **Reporting Period – Ending** date or the ending date of the cost report period (e.g., 9/30/2011).

Part Year Cost Report: Enter an answer to the question “**Is Reporting Period less than a full year?**” This question identifies if the cost report is being prepared for a period that is not an entire fiscal year. If the cost report is for an entire fiscal year (October 1 – September 30), then enter **No** in the field. If the cost report is being prepared for a partial fiscal year, enter a response that explains the reason why (e.g., Supplemental Payment Request Approval was effective beginning on 7/1/20XX).

Cost Allocation Information

The purpose of this section is to obtain summary information regarding the cost allocation methodology the governmental entity utilized to allocate costs to various programs, grants, contracts and agreements. Additional information supporting an agencies methodology will be found on Exhibit 7.

Cost Allocation Plan: Enter either Yes or No indicating whether your agency has an approved **Cost Allocation Plan (CAP)**. If the answer is yes, enter the **name of the Cognizant Agency** that approved the agency CAP.

Approved Indirect Cost Rate: Enter either Yes or No indicating whether your agency has an approved **Indirect Cost Rate**.

Indirect Cost Rate: Enter either Yes or No indicating whether your agency will be **utilizing an Indirect Cost Rate**. If yes, enter the Agencies Approved Indirect Cost Rate.

Statistical Information

This cost report uses a costs to billed charge ratio methodology that is applied to determine the portion of costs eligible for reimbursement under the Direct Medical settlement exhibit of the cost report (see Exhibit 2).

Summary of Payments and Billed Charge Data (Applicable to Cost Report)

Medicaid Fee for Service Paid Claims Amount: Enter the **Total Ambulance Medicaid fee-for-service (FFS) Paid Claims Amount** for the applicable cost report period identified on the form. The ambulance Medicaid fee-for-service entered must only be for **dates of service** during the cost report period.

Total Billed Charges Associated with Medicaid FFS Paid Claims: Enter the **Total Billed Charges associated with Medicaid FFS Paid Claims** for the applicable cost report period identified on the form. The total billed charges

Attachment H
UC Claiming Protocol and Application
Part 3: UC Claiming Protocol for Ambulance Providers

associated with Medicaid FFS paid claims entered must only be for **dates of service** during the cost report period.

Medicaid Managed Care Organization (MCO) Costs: Enter the total **MCO** Costs for services provided for the applicable Cost Report period identified on the form. The ambulance Medicaid MCO costs for services entered should be for dates of service during the cost report period.

Total Billed Charges Associated with **MCO** Costs: Enter the **Total Billed Charges associated with Medicaid MCO Claims** for the applicable cost report period identified on the form. The total billed charges associated with MCO paid claims entered must only be for **dates of service** during the cost report period.

Uncompensated Care (UC) (Uninsured) Billed Amounts (UC): Enter the total **UC** Charity and Bad Debt amounts billed for services provided for the applicable Cost Report period identified on the form. The ambulance UC costs for services entered should be for dates of service during the cost report period and must exclude all unfunded Medicaid and Medicare costs.

Total Uncompensated Care (UC) (Uninsured) Reimbursements Received Associated with **UC** Costs: Enter the **reimbursements received associated with UC Claims** for the applicable cost report period identified on the form. The total reimbursements received associated with UC claims entered must only be for **dates of service** during the cost report period.

Total Allowable Costs For Reporting Period: The **Total Allowable Costs** calculated are for the applicable cost report period identified on the direct service tab. The total allowable costs are only for dates of service during the cost report period.

Total Billed Charges for Reporting Period: The **Total Billed Charges** calculated are for the applicable cost report period identified on the form less the total allowable costs and less any reimbursements received. The total billed charges entered are only for dates of service during the cost report period.

Additional Cost Data (For Informational Purposes Only)

In addition to the statistical information entered for Cost Reporting period, other cost data is being requested

Attachment H
UC Claiming Protocol and Application
Part 3: UC Claiming Protocol for Ambulance Providers

Medicare Costs : Enter the total **Medicare Costs** for services provided for the applicable cost report period identified on the form. The ambulance Medicare costs for services entered should be for dates of service during the cost report period.

Other Third Party Coverage: Enter the total **Other third-party coverage (Self-Pay, Commercial Pay)** Costs for services provided for the applicable cost report period identified on the form. The ambulance “other” costs for services entered should be for dates of service during the cost report period.

Attachment H
UC Claiming Protocol and Application
Part 3: UC Claiming Protocol for Ambulance Providers

Exhibit 2: Direct Medical (Ambulance Services)

Exhibit 2 identifies and summarizes from other exhibits all ambulance services costs within the cost report. Much of the information contained within this exhibit is pulled from either Exhibit 5 or Exhibit 6; however, there are unique items of cost that are identified in this exhibit.

Only allocable expenditures related to Medicaid, Medicaid Managed Care and Uncompensated Care as defined and approved in the Texas Healthcare Transformation and Quality Improvement 1115 Waiver Program will be included for supplemental payment. This Exhibit sums the personnel expenses and adds additional costs to calculate the total cost of Medical and Uncompensated Care Services.

Direct cost methods must be used whenever reasonably possible. Direct costing means that allowable costs, direct or indirect, incurred for the benefit of, or directly attributable to, a specific business component must be directly charged to that particular business component.

For example, the payroll costs of a direct service employee who works across cost areas within one contracted program would be directly charged to each cost area of that program based upon that employee's continuous daily time sheets and the costs of a direct care employee who works across more than one service delivery area would also be directly charged to each service delivery area based upon that employee's continuous daily time sheets. Health insurance premiums, life insurance premiums, and other employee benefits are applied as direct costs.

Direct Cost Accounting may include:

- a. Dedicated Cost Centers which are comprised of a distinctly identifiable department or unit whose costs are associated with a specific activity; or
- b. Multiple Cost Centers which included cost for those cost centers that are not solely dedicated to one activity but may be allocated to multiple activities.

Governmental providers must use reasonable methods of allocation and must be consistent in their use of allocation methods for cost-reporting purposes across all program areas and business entities. The allocation method should be a reasonable reflection of the actual business operations. Allocation methods that do not reasonably reflect the actual business operations and resources expended toward each unique business entity are not acceptable. Allocated costs are adjusted if HHSC considers the allocation method to be unreasonable. The provider must submit a detailed summary of their cost allocation methodology including a description of the components, the formula for calculating the percentage and any additional supporting documentation as required by HHSC. Supplemental schedules must also be attached to the cost report listing each employee, job title, total salary and benefits, the applicable allocation percentage and the allocation amount that will be included in the cost report. The amounts from the supplemental schedule allocated to the Medicaid and Uncompensated Care programs should match the amounts entered on Exhibit 6 Schedule B with additional detail entered on Page 7 Worksheet C. Any change in cost-reporting allocation methods from one year to the next must be fully disclosed by the contracted provider on its cost report

Indirect Costs Rate

Attachment H
UC Claiming Protocol and Application
Part 3: UC Claiming Protocol for Ambulance Providers

If an Indirect Cost Rate (IDCR) is utilized, that rate must be applied to all appropriate cost objectives specifically identified in the cost report. Indirect cost is calculated by multiplying the **Total Allowable** costs by the provider's approved indirect cost rate. These indirect rates are developed by the state cognizant agency and are updated annually. The methodology used by the respective cognizant agency to develop the **Indirect Cost Rate** (IDCR) has been approved by the cognizant federal agency, as required by the CMS guide. Indirect costs are included in the claim as reallocated costs. The provider is responsible to ensure that costs included in the cost report not included in the indirect cost rate, and no costs will be accounted for more than once.

All indirect cost calculations developed to arrive at the total allowable costs must be included in Worksheet 7 of the cost report. All scenarios utilized to calculate the indirect cost must be fully explained as well. The provider must verify that no duplicative costs are included in line 2.33 "Other Cost". IDCR costs will be disallowed if it is determined that the provider has already claimed those same IDCR costs. All documents that support the indirect cost rate calculation must be maintained by the approved governmental entity and must be made immediately available upon request by HHSC.

Identified reductions, from Exhibit 6, are subtracted to calculate the adjusted amount of Direct Medical Costs allowable as part of the cost report. The cost report identifies the portion of allowable costs that are related to Medicaid FFS, Medicaid MCOs, and Uncompensated Care and applies the cost to charge ratio applicable for the cost report period. The ratio is applied to billed charges associated with Medicaid FFS, Medicaid MCOs, and Uncompensated Care paid claims resulting in the total computable amount for ambulance services. This amount is then reduced by the amount of Medicaid FFS, Medicaid MCOs paid claims and any reimbursement received for Uncompensated Care. The resulting amount is then multiplied by the applicable federal medical assistance percentage (FMAP) to calculate the amount of settlement due to, or owed by (if negative) the provider.

The exhibit is separated into the sections identifying:

- **Personnel / Payroll Expenses.** This section of the Exhibit includes, in part, expenditures from Exhibit 6.
- **Other Operating Costs.** This section of the Exhibit includes, in part, expenditures from Exhibit 5.
- **Reductions to Allowable Costs.** This section of the Exhibit includes reductions to expenditures identified in Exhibit 6.
- **Cost Settlement Calculation.** This section applies the cost to charge ratio calculation methodology to arrive at the final settlement due to or from the provider.

DIRECTIONS TO COMPLETE EXHIBIT 2

Personnel / Payroll Expenses

This section of the exhibit includes all personnel related expenditures and hours for the job classifications identified.

Attachment H
UC Claiming Protocol and Application
Part 3: UC Claiming Protocol for Ambulance Providers

Hours: Enter the number of **Hours** for each of the job classifications identified in this Exhibit and for which costs are identified in Exhibit 6. Hours for this exhibit represent total paid hours that are reported by the provider on their payroll report. Total paid hours include, but are not limited to:

- Regular wage hours
- Sick hours
- Vacation hours

Payroll Taxes/Unemployment Compensation: If applicable, enter the amount of the following payroll expenses:

- State Unemployment Payroll Taxes
- Federal Unemployment Payroll Taxes
- Unemployment Compensation (Reimbursing Employer)

Other Costs

This section of the Exhibit identifies other operating costs not related to the job classifications identified above. Within this section, Support Services or Other may include personnel-related expenditures not identified in the job classifications in the section above.

All costs identified in the section of the Exhibit are supported by supplemental schedules to the cost report, and will be supplied at the time of cost report submittal.

Supplies and Materials Costs: Enter the amount of **Supplies and Materials** expenditures incurred by the provider during the cost report period. Supplies and materials include, but are not limited to, the following:

- Medical supplies
- Office supplies
- Maintenance supplies
- Medical materials

Equipment Costs: Enter the amount of **Equipment** expenditures incurred by the provider during the cost report period. Equipment expenditures include, but are not limited to, the following non-depreciable items:

- Medical equipment
- Computers
- Radios
- Communications equipment

Support Services Costs: Enter the amount of **Support Services** expenditures incurred by the provider during the cost report period. Support Services expenditures may include personnel and non-personnel expenditures depending if the

Attachment H
UC Claiming Protocol and Application
Part 3: UC Claiming Protocol for Ambulance Providers

personnel expenditures are represented in the job classification categories identified in this Exhibit and detailed in Exhibit 6. Support Services expenditures include, but are not limited to, the following:

- Information technology salaries, benefits, and operating expenditures
- Telecommunications personnel and operating expenditures

Other Costs: Enter the amount of **Other** expenditures incurred by the provider during the Cost Report period. Other expenditures may include personnel and non-personnel expenditures depending if the personnel expenditures are represented in the job classification categories identified in this Exhibit and detailed in Exhibit 6. Other expenditures include, but are not limited to, the following:

- Depreciation expense (Exhibit 5)
- Parent organization allocated costs (discretely identified from prepared cost allocation plan (CAP))
- Other unit personnel and operating expenditures not otherwise identified (Indirect Cost)

Cost Settlement Calculation

Period of Service for Applicable Cost Report Period: Enter the **Period of Service** for the applicable cost report period. Example 10/01/20XX to 12/31/20XX. For part year cost reports, enter the period of service applicable only to the time frame a cost report is being submitted for.

Total Allowable Costs for Period of Services is the total allowable costs entered into the cost report less any “other federal funding” received (No entry is required).

Total Billed Charges for Period of Service: The **Total Billed Charges** for the applicable period of service (No entry is required).

Cost to Charge Ratio (CCR) is the result of dividing a provider’s Total Allowable Costs for the reporting period by the providers Total Billed Charges for the same period.

Total Charges Associated with , Medicaid, Paid Claims, Medicaid Managed Care Claims and Uncompensated Care Paid Fees: Enter the **Total Billed Charges Associated with Medicaid FFS and Medicaid MCO Paid Claims** for the period of service applicable to the cost report.

Attachment H
UC Claiming Protocol and Application
Part 3: UC Claiming Protocol for Ambulance Providers

Total Computable is the total Medicaid Allowable Costs for the period of service applicable to the cost report. The **Total Computable** amount is reduced by the amount of Medicaid Claims paid (Interim Payments) to a provider (TMHP) for the period of service applicable to the cost report. This calculation is equal to the **Settlement Amount** for the reporting period.

Federal Medical Assistance Participation Rate (FMAP): Enter the **FMAP rate** for the appropriate federal fiscal year of the cost report.

Amount due to the Provider is the net amount of the settlement due to or from a provider after the FMAP rate is applied.

Attachment H
UC Claiming Protocol and Application
Part 3: UC Claiming Protocol for Ambulance Providers

Exhibit 3 – Cost Report Certification

Exhibit 3 is the Certification of costs included in the cost report. This form attests to, and certifies the accuracy of the financial information contained within the cost report.

DIRECTIONS TO COMPLETE EXHIBIT 3

Most of the information in Exhibit 3 will be updated automatically with information from previous exhibits. This Exhibit must be signed and included **UPON COMPLETION OF ALL OTHER EXHIBITS**.

Upon completion of all other exhibits in the cost report, please **print this exhibit, sign the exhibit, have the form notarized, scan the exhibit, and include the signed exhibit** when sending the electronic version of the cost report to HHSC. Please have the appropriate person within the provider read and sign the form.

Signature Authority/Certifying Signature

Certifier Name: Enter the **Name of** the person that will be certifying the costs identified in the cost report (e.g., Jane Doe).

Title: Enter the **Title of Signer**, or the title of the person that will be certifying the costs identified in the cost report (e.g., Director).

Print: Please print this Exhibit and have the appropriate person identified above sign the certification form.

Date: Enter the **Date** that the appropriate person identified above signs the certification form (e.g., 1/1/2011).

Signature Authority Check Box: **Check the appropriate box** that corresponds to the title of the person signing this Exhibit.

Notary: Upon printing and signing this Exhibit, please have this form **Notarized** by a Notary Public.

Attachment H
UC Claiming Protocol and Application
Part 3: UC Claiming Protocol for Ambulance Providers

Exhibit 4 – Certification of Funds

Exhibit 4 is the Certification of Public Expenditure that allows the state to use the computable Medicaid expenditures as the non-federal match of expenditures to draw the federal portion of Medicaid funding as identified in the settlement. This form attests to, and certifies the accuracy of the provided financial information and that the report was prepared in accordance with State and Federal audit and cost principle standards and that the costs have not been claimed on any other cost report for federal reimbursement purposes. This Exhibit also identifies the amount of local provider expenditure that is allowable for use as the state match

DIRECTIONS TO COMPLETE EXHIBIT 4

Most of the information in Exhibit 4 will be updated automatically with information from previous exhibits. This Exhibit must be signed and included **UPON COMPLETION OF ALL OTHER EXHIBITS**.

Upon completion of all other exhibits in the cost report, please **print this exhibit, sign the exhibit, have the form notarized, scan the exhibit, and include the signed exhibit** when sending the electronic version of the cost report to HHSC. Please have the appropriate person within the provider read and sign the form.

Signature Authority/Certifying Signature

Print Please print this Exhibit and have the appropriate person sign the certification form.

Date: Enter the **Date** that the appropriate person identified above signs the certification form (e.g., 1/1/2011).

Certifier Name: Enter the **Name of Signer**, or the person that will be certifying the public expenditures identified in the cost report (e.g., Jane Doe).

Title: Enter the **Title of Signer**, or the title of the person that will be certifying the public expenditures identified in the cost report (e.g., Director).

Certifier Check Box **Check the appropriate box** that corresponds to the title of the person signing this Exhibit. If **Other Agent/Representative** is selected, please include the appropriate title in **Column N, Line 40**.

Notary Upon printing and signing this Exhibit, please have this form **Notarized** by a Notary Public.

Attachment H
UC Claiming Protocol and Application
Part 3: UC Claiming Protocol for Ambulance Providers

Exhibit 5 – Schedule A (Depreciation Schedule)

Exhibit 5 identifies allowable depreciation expenses incurred by the provider related to Medicaid, Medicaid Managed Care and Uncompensated Care. This Exhibit will identify depreciable assets for which there was a depreciation expense during the Cost Report period. Information on this Exhibit must come from a depreciation schedule maintained by the provider in accordance with appropriate accounting guidelines established by the provider and/or the parent organization of the provider. For depreciation expenses, the straight line method should be used. Prior Period Accumulated Depreciation plus Depreciation for Reporting Period cannot exceed the total cost of an asset. In addition, assets that have been fully expensed should not be reported.

DIRECTIONS TO COMPLETE EXHIBIT 5

Vehicles

For depreciation expense related to vehicles, the provider must follow depreciable asset thresholds already in place at the provider and/or parent organization. The vehicle depreciation expense as reported on the Cost Report must come from the provider's depreciation schedule.

Asset Description: Enter the **Description of the Asset** that will be included in this depreciation schedule. The name or account code, or both will suffice. If there is the need to add additional lines, please do so.

Month/Year Placed in Service: Enter the **Month/Year Placed in Service** as identified on the provider's depreciation schedule (e.g., January 2000, or 1/2000). This is the month and the year that the depreciable asset was first put into service.

Years Useful Life: Enter the number of **Years of Useful Life** of the asset as identified on the provider's depreciation schedule (e.g., 20 for twenty years of useful life).

Cost: Enter the amount of initial **Cost** of the asset as identified on the provider's depreciation schedule.

Prior Period Accumulated Depreciation: Enter the amount of **Prior Period Accumulated Depreciation** related to the asset as identified on the provider's depreciation schedule. This is the total amount of depreciable expenses to date related to the depreciable asset.

Depreciation for Reporting Period: Enter the amount of current period depreciation expense in the **Depreciation for Reporting Period** field related to the asset as identified on the provider's depreciation schedule. This is the total amount of depreciable expense incurred during the Cost Report period.

Equipment

For depreciation expense related to equipment, the provider must follow depreciable asset thresholds already in place at the provider and/or parent organization. The equipment

Attachment H
UC Claiming Protocol and Application
Part 3: UC Claiming Protocol for Ambulance Providers

depreciation expense as reported on the Cost Report must come from the provider's depreciation schedule.

Asset Description: Enter the **Description of the Asset** that will be included in this depreciation schedule. The name or account code, or both will suffice. If there is the need to add additional lines, please do so.

Month/Year Placed in Service: Enter the **Month/Year Placed in Service** as identified on the provider's depreciation schedule (e.g., January 2000, or 1/2000). This is the month and the year that the depreciable asset was first put into service.

Years Useful Life: Enter the number of **Years of Useful Life** of the asset as identified on the provider's depreciation schedule (e.g., 20 for twenty years of useful life).

Cost: Enter the amount of initial **Cost** of the asset as identified on the provider's depreciation schedule.

Prior Period Accumulated Depreciation: Enter the amount of **Prior Period Accumulated Depreciation** related to the asset as identified on the provider's depreciation schedule. This is the total amount of depreciable expenses to date related to the depreciable asset.

Depreciation for Reporting Period: Enter the amount of current period depreciation expense in the **Depreciation for Reporting Period** field related to the asset as identified on the provider's depreciation schedule. This is the total amount of depreciable expense incurred during the Cost Report period.

Building

For depreciation expense related to buildings where the provider's vehicles or staff are housed with other agencies or entities, **ONLY the portion related to the provider** may be reported. If this is the case, the provider must attach a supplemental exhibit showing how the portion of the building related to the provider was calculated.

Asset Description: Enter the **Description of the Asset** that will be included in this depreciation schedule. The name or account code, or both will suffice. If there is the need to add additional lines, please do so.

Month/Year Placed in Service: Enter the **Month/Year Placed in Service** as identified on the provider's depreciation schedule (e.g., January 2000, or 1/2000). This is the month and the year that the depreciable asset was first put into service.

Years of Useful Life: Enter the number of **Years of Useful Life** of the asset as identified on the provider's depreciation schedule (e.g., 20 for twenty years of useful life).

Cost: Enter the amount of initial **Cost** of the asset as identified on the provider's depreciation schedule.

Attachment H
UC Claiming Protocol and Application
Part 3: UC Claiming Protocol for Ambulance Providers

Prior Period Accumulated Depreciation : Enter the amount of **Prior Period Accumulated Depreciation** related to the asset as identified on the provider's depreciation schedule. This is the total amount of depreciable expenses to date related to the depreciable asset.

Depreciation for Reporting Period: Enter the amount of current period depreciation expense in the **Depreciation for Reporting Period** field related to the asset as identified on the provider's depreciation schedule. This is the total amount of depreciable expense incurred during the Cost Report period.

Attachment H
UC Claiming Protocol and Application
Part 3: UC Claiming Protocol for Ambulance Providers

Exhibit 6 – Worksheet B (Payroll and Benefits)

This exhibit includes the salary and benefits, and appropriate reductions related to contracted and employed staff of the provider applicable to Medicaid, Medicaid Managed Care and Uncompensated Care.. For this Exhibit, all employed and contracted staff related to the provision of Ambulance EMS services should be identified here.

This Exhibit includes several pre-populated staffing classifications for which information will need to be completed. The pre-populated staffing classifications include:

- **9-1-1 Call Technicians** This cost classification includes all personnel salary and benefit expenditures related to operation of emergency communications equipment used in receiving, sending, and relaying medical self-help in response to emergency calls, including, but not limited to:
 - 9-1-1 Call Technicians
 - 9-1-1 Call Technician Assistants
 - ...
- **Paramedics** This cost classification includes all personnel salary and benefit expenditures related to performing basic and advanced medical rescue procedures to access, stabilize, evacuate, and transport a patient to an appropriate medical facility's emergency department, including, but not limited to:
 - Paramedics
 - EMTs
 - ...
- **Training Coordinators** This cost classification includes all personnel salary and benefit expenditures related to providing training, quality, operational, and support of specific ambulance service training and organizational programs, including local pre-paramedic institutions, internal paramedic/communications medic instruction, training activities within Field Operations and Communications, and analysis of performance and quality improvement programs, including, but not limited to:
 - Training Coordinators
 - ...
- **Quality Assurance Technicians** Quality Assurance Technicians have the same job description as training coordinators above. This cost classification includes all personnel salary and benefit expenditures related to providing training, quality,

Attachment H
UC Claiming Protocol and Application
Part 3: UC Claiming Protocol for Ambulance Providers

- operational, and support of specific ambulance service training and organizational programs, including local pre-paramedic institutions, internal paramedic/communications medic instruction, training activities within Field Operations and Communications, and analysis of performance and quality improvement programs, including, but not limited to:
- Quality Assurance Techs
 - ...
- **Safety Officer** This cost classification includes all personnel salary and benefit expenditures related to developing, administering, implementing, and evaluating departmental occupational safety program and activities, including, but not limited to:
 - Safety Officer
 - Safety office assistant
 - ...
 - **Billing / Account Reps** This cost classification includes all personnel salary and benefit expenditures related to verification of patients' insurance coverage, including Medicaid, collection of third party insurance submissions and payments, and patient customer service related tasks, including, but not limited to:
 - Billing representative
 - Account representative
 - Patient account representative
 - ...
 - **CPR Technicians** This cost classification includes all personnel salary and benefit expenditures related to the coordination of all EMS activities related to community education of CPR and First Aid skills and techniques, including, but not limited to:
 - CPR Techs
 - ...
 - **Medical Director)** This cost classification includes all personnel salary and benefit expenditures related to the clinical oversight of pre-hospital treatment rendered by EMS personnel. The Medical Director costs shall only include those costs as identified to be related to including, but not limited to:
 - Medical Director
 - Medical Director Assistant
 - ...

Attachment H
UC Claiming Protocol and Application
Part 3: UC Claiming Protocol for Ambulance Providers

- **Director** This cost classification includes all personnel salary and benefit expenditures related to developing, administration, and overall operational effectiveness of the organization including strategic planning, leadership, and oversight of all operational aspects of the EMS Department, including, but not limited to:
 - Director
 - Director's Assistant
 - ...

- **Public Information Officer)** This cost classification includes all personnel salary and benefit expenditures related to planning and directing public information, public relations, media relations, or public involvement programs and developing, maintaining, and improving public awareness initiatives, including, but not limited to:
 - Public Information Officer
 - PIO Assistant
 - ...

- **Contracted EMT/Paramedics** This cost classification includes all contracted expenditures related to performing basic and advanced medical rescue procedures to access, stabilize, evacuate, and transport a patient to an appropriate medical facility's emergency department, including, but not limited to:
 - Contracted Paramedics
 - Contracted EMTs
 - ...

DIRECTIONS TO COMPLETE EXHIBIT 6

Employee Information

This section of the Exhibit is designed to identify employee information for the specific job classifications identified above. This section of the Exhibit is also designed to discretely identify the employee information for any individual employee/contractor that must have a portion of their salary and/or benefits reduced from allowable expenditures on the Cost Report.

For each of the job classifications identified above, the following information must be included:

Employee #: Enter the **Employee #** for the employee for which a portion of their salary and/or benefits must be reduced from the total allowable costs.

Attachment H
UC Claiming Protocol and Application
Part 3: UC Claiming Protocol for Ambulance Providers

Last Name: Enter the **Last Name** of the employee for which a portion of their salary and/or benefits must be reduced from the total allowable costs.

First Name: Enter the **First Name** of the employee for which a portion of their salary and/or benefits must be reduced from the total allowable costs.

Job Title/ Credentials: Enter the **Job Title / Credentials** of the employee for which a portion of their salary and/or benefits must be reduced from the total allowable costs.

Employee (E) /Contractor (C): Enter the appropriate designation, **either an E or a C**, of the employee for which a portion of their salary and/or benefits must be reduced from the total allowable costs. E designates an employee of EMS. C designates a contractor for EMS.

Payroll and Benefits

This section of the Exhibit is designed to identify payroll and benefit expenditures for the specific job classifications identified above. This section of the Exhibit is also designed to discretely identify the payroll and benefit expenditures for any individual employee/contractor that must have a portion of their salary and/or benefits reduced from allowable expenditures on the Cost Report.

For each of the job classifications identified above, the following information must be included:

Gross Salary: Enter the **Gross Salary** amount for the employee for which a portion of their salary and/or benefits must be reduced from the total allowable costs.

Contractor Payments: Enter the amount of **Contractor Payments** for the employee for which a portion of their salary and/or benefits must be reduced from the total allowable costs.

Employee Benefits: Enter the amount of **Employee Benefits** for the employee for which a portion of their salary and/or benefits must be reduced from the total allowable costs. This includes all benefits that are not discretely identified in Columns J-L of this Exhibit.

Employer Retirement: Enter the amount of **Employer Retirement** expenditure for the employee for which a portion of their salary and/or benefits must be reduced from the total allowable costs.

FICA: Enter the amount of **FICA** expenditure for the employee for which a portion of their salary and/or benefits must be reduced from the total allowable costs.

Attachment H
UC Claiming Protocol and Application
Part 3: UC Claiming Protocol for Ambulance Providers

Payroll Taxes: Enter the amount of **Payroll Taxes** expenditure for the employee for which a portion of their salary and/or benefits must be reduced from the total allowable costs.

Federal Funding Reductions

This section of the Exhibit is designed to identify the federal funding, or other payroll and benefit expenditure reduction necessary for the specific job classifications identified above. This section of the Exhibit is designed to discretely identify the payroll and benefit expenditures for any individual employee/contractor that must have a portion of their salary and/or benefits reduced from allowable expenditures on the Cost Report.

For each of the job classifications identified above, the following information must be included:

Allocated Funded Positions Entry: Enter the appropriate designation, **either a Y or a N**, for the employee for which a portion of their salary and/or benefits must be reduced from the total allowable costs. A “Y” in this field designates an employee for which a portion, or all of their salary and benefit expenditures are funded by federal funds or grants. A “N” in this field designates an employee for which a portion, or all of their salary and benefit expenditures are not funded by federal funds or grants, but still need to be removed from allowable expenditures as reported on the Cost Report.

Federal Funding: If the answer to the field previously is “Y”, then enter the amount of **Federal Funding** related to the employee’s salary and benefits that must be reduced from the total allowable costs as reported on the Cost Report.

Other Funds: Enter the amount of **Other Amount to be Removed** related to the employee’s salary and benefits that must be reduced from the total allowable costs as reported on the Cost Report.

Payroll and Benefits Entry: Enter the amount of Salary and appropriate Benefits for all other personnel and staff related to the job classifications identified above, for which no salary or benefit expenditures must be reduced from the total allowable costs.

Exhibit 7-Schedule C – Cost Allocation Methodologies

This exhibit details the cost allocation methodologies employed by the governmental entity.

- E. If you entered “yes” on Page 2, Line 1.05, please provide a copy of your agency’s approved Cost Allocation Plan (CAP).

Attachment H
UC Claiming Protocol and Application
Part 3: UC Claiming Protocol for Ambulance Providers

- F. If you entered “yes” on Page 2, Line 1.06 and 1.09, please provide a copy of your agency’s approved Indirect Cost Rate (IDCR).
- G. Please provide a list of personnel cost worksheets that support your CAP or IDCR