Financial Models to Support State Efforts to Coordinate Care for Medicare-Medicaid Enrollees

Demonstration Proposal

Texas

Summary: In July 2011, CMS released a State Medicaid Directors' letter regarding two new models CMS will test for States to better align the financing of the Medicare and Medicaid programs, and integrate primary, acute, behavioral health and long term supports and services for Medicare-Medicaid enrollees. These two models include:

- Capitated Model: A State, CMS, and a health plan enter into a three-way contract, and the plan receives a prospective blended payment to provide comprehensive, coordinated care.
- Managed Fee-for-Service Model: A State and CMS enter into an agreement by which the State would be eligible to benefit from savings resulting from initiatives designed to improve quality and reduce costs for both Medicare and Medicaid.

To participate, States must demonstrate their ability to meet or exceed certain CMS established standards and conditions in either/both of these models. These standards and conditions include factors such as beneficiary protections, stakeholder engagement, and network adequacy among others. In order for CMS to determine whether the standards and conditions have been met, States are asked to submit a demonstration proposal that outlines their proposed approach for the selected financial model(s). The Texas Health and Human Services Commission has submitted this proposal for CMS review.

As part of the review process, CMS will seek public comment through a 30-day notice period. During this time, interested individuals or groups may submit comments to help inform CMS' review of the proposal.

CMS will make all decisions related to the implementation of proposed demonstrations following a thorough review of the proposal and supporting documentation. Further discussion and/or development of certain aspects of the demonstration (e.g., quality measures, rate methodology, etc.) may be required before any formal agreement is finalized.

Publication of this proposal does not imply CMS approval of the demonstration.

Invitation for public comment: We welcome public input on this proposal. To be assured consideration, please submit comments by 5 p.m. EDT, June 30, 2012. You may submit comments on this proposal to TX-MedicareMedicaidCoordination@cms.hhs.gov .

Texas
Dual Eligibles Integrated Care Demonstration Project

APPLICATION

May 2012

Texas Health and Human Services Commission
Medicaid and CHIP Division

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for Health Services Operations

Texas Application for the
Dual Eligibles Integrated Care Demonstration Project

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A. Executive Summary

Texas has long recognized the need to integrate care for older adults and persons with disabilities in the state's Medicaid program. Texas was one of the first states with an innovative Medicaid managed care program, STAR+PLUS, designed specifically to integrate acute care services with long-term services and supports (LTSS) for at-risk populations. This program, which recently expanded to additional service areas in the state, has had longstanding support from the state's federal partner, the Centers for Medicare and Medicaid Services (CMS).

Full dual eligible[1] individuals in the urban centers in Texas most often receive acute care services through Medicare fee-for-service (FFS) and LTSS from a STAR+PLUS managed care organization (MCO). For those dual eligibles that choose to enroll in a Medicare Advantage Plan or Special Needs Plan (MA/SNP) for their acute care services, a significant percentage are not enrolled in the same MCO for their LTSS. Based on a recent data sample, only about 20 percent of the total STAR+PLUS dual eligible population was also enrolled in a Medicare Advantage health plan for their Medicare services. Of those individuals, a little over a third were enrolled with the same MCO for both STAR+PLUS and the affiliated Medicare Advantage/Special Needs Plan (MA/SNP). Even when they are in the same MCO, contract requirements between Medicare and Medicaid are not in alignment around common service and health outcomes, and as a result, quality and efficiency are compromised.

To address these issues, the Texas Health and Human Services Commission (HHSC) is proposing through this demonstration opportunity to implement a fully integrated, capitated approach that involves a three-party agreement among HHSC, CMS, and the STAR+PLUS MCOs. A MCO with both an existing STAR+PLUS contract with HHSC and a MA/SNP contract with CMS will offer a full array of Medicaid and Medicare services for the targeted population. The integrated agreement will provide a single point of accountability for the delivery, coordination and management of primary, preventive, acute, specialty, and behavioral health services, LTSS, and prescription medications. Texas will target implementation of its integrated care initiative for January 2014.

To accomplish this objective, Texas will leverage its existing STAR+PLUS contracts, for which a new procurement was recently completed. Full dual eligible individuals enrolled in the STAR+PLUS program (excluding the voluntary child population) are the target population for this demonstration project.

Texas' proposal for integrated care includes the following program elements:

- All Medicare and Medicaid services will be provided through a single managed care organization;
- Medicaid MCOs must have a corresponding Medicare MCO (MA/SNP) in the STAR+PLUS counties where they operate;
- Dual eligibles who are mandatorily enrolled in STAR+PLUS will be passively enrolled into the MA/SNP plan that corresponds to their STAR+PLUS MCO. These individuals will be allowed to opt out of their MA/SNP on a monthly basis.
- A comprehensive provider network will provide the full array of Medicare and Medicaid services, with data sharing and coordination across providers and the continuum of care to enhance care coordination;
- Person-centered medical homes to address the needs of enrollees with multiple chronic conditions or a single serious and persistent mental health condition;

[1] Individuals who are eligible for Medicare and full Medicaid benefits are considered "full dual eligibles."

- A single care coordinator to assist in the development of person-centered plans of care based on enrollee choice and to facilitate access to community-based care whenever possible;
- Quality management strategies and measurements unavailable in the current Medicare FFS models; and
- Consumer protections, including grievance and appeal processes that meet the standards required by both Medicare and Medicaid.

Summary Table of Texas' Dual Eligible Integrated Care Model	
Target Population	Full dual eligible adults, who are required to participate in STAR+PLUS
Total Full Benefit Medicare-Medicaid Clients Statewide	**328,500**
Total Enrollees Eligible for Demonstration	**214,402**
Geographic Service Area	All STAR+PLUS services areas (see page 12-13). Texas may choose to phase-in the implementation, beginning with the most populous counties: ***Group 1***: 7 counties with >10,000 STAR+PLUS dual eligible enrollees—*approximately 145,000 (67%)* (Bexar, Cameron, Dallas, El Paso, Harris, Hidalgo and Tarrant) ***Group 2***: 8 counties with 2,500 - <10,000 STAR+PLUS dual eligible enrollees—*approximately 32,000*) (Cameron, Nueces, Tarrant, Travis, and Webb) ***Group 3***: 7 counties with 500 – 2,499 STAR+PLUS dual eligible enrollees—*approximately 25,000*) ***Group 4***: 53 counties with fewer than 500 STAR+PLUS dual eligible enrollees—*approximately 13,000*)
Summary of Covered Benefits	Services would include all Medicare benefits, including parts A, B and D; and Medicaid benefits, including wrap-around services and long-term supports and services.
Financing Model	Capitated Medicaid Managed Care Organizations, also participating as Medicare Advantage Plans or Special Needs Plans (MA/SNP), will provide accountability for fully integrated package of Medicare and Medicaid benefits.
Summary of Stakeholder Engagement/Input	Texas will engage a wide variety of stakeholders in the design of the integrated care program, including dual eligible clients, advocacy groups, and provider associations, through a series of initial and ongoing meetings throughout the State of Texas (see Section D, pages 21-23). Texas has developed a distribution list of stakeholders interested in this project which will be updated as appropriate to include all pertinent stakeholders. Additionally, Texas has established an email box at: medicaidprogramminnovation@hhsc.state.tx.us, to respond to questions and collect ongoing stakeholder input, and has also created a webpage for the project, to provide information and updates to stakeholders at: http://www.hhsc.state.tx.us/medicaid/dep/index.shtml.
Proposed Implementation Date(s)	**January 1, 2014**

B. Background

i. Current System

Texas has an estimated 328,500 individuals statewide who are fully dual eligible. About two thirds of those reside in the more urban areas of the state and are enrolled in the state's capitated managed care program for Aged/Medicare-related/Blind and Disabled, called STAR+PLUS. The remaining dual eligibles—those living in the rural parts of the state—receive their Medicaid benefits through the traditional FFS system.

Whether through the FFS system or managed care, the state primarily provides community-based LTSS to these individuals, including personal assistance services, assisted living, nursing, consumer directed services, dental services, and others. Some categories of services, including home health, durable medical equipment, and physical therapy, overlap with those provided under Medicare Part B.

It is well-documented that health care costs for the dual eligible population are higher than most other groups served by either Medicare or Medicaid. Higher spending for this population results because they are poor, older or have disabilities, and often have chronic physical and mental health problems.[2]

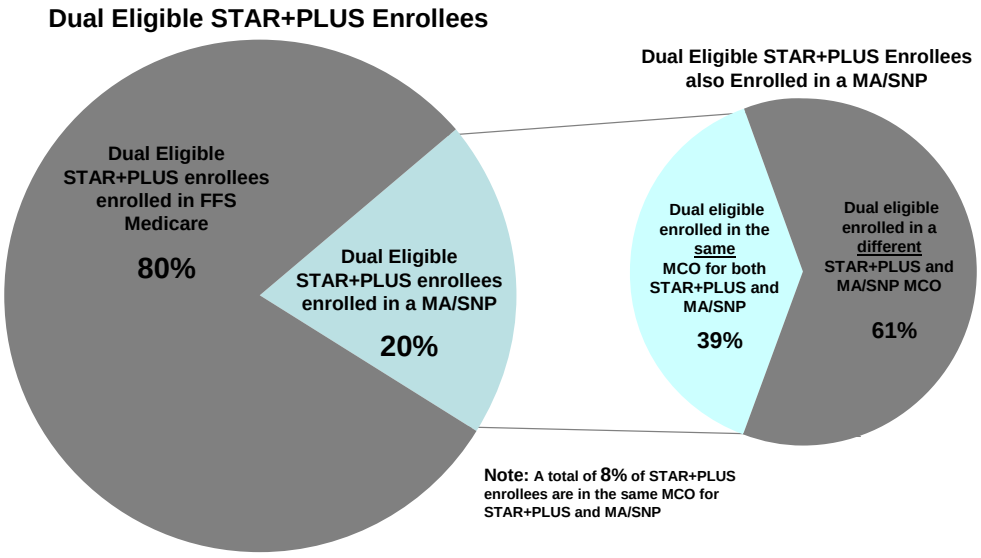
CMS estimates that the federal government spent $29.5 billion for Medicare services in Texas in calendar 2007, of which $11 billion (37%) was for care related to dual eligibles. During the same period, Texas reported spending $4.2 billion. The largest share of federal spending was for hospital services (33%) while the largest share of state spending (60%) was for institutional long-term care.

Based on recent data, about one in five dual eligible Medicaid STAR+PLUS enrollees received their Medicare services through a MA/SNP. A little over a third of those individuals were enrolled in a MA/SNP health plan that was affiliated with their STAR+PLUS health plan, which means that only about eight percent of the total STAR+PLUS dual eligible population was enrolled in STAR+PLUS and an affiliated MA/SNP for their Medicaid and Medicare services. Texas hopes to dramatically increase those numbers under this integrated model. This will result in improved care coordination and health outcomes for participating dual eligible enrollees and financial and administrative efficiencies.

The chart below shows the estimated percentage of STAR+PLUS enrollees who are also enrolled in a MA/SNP.

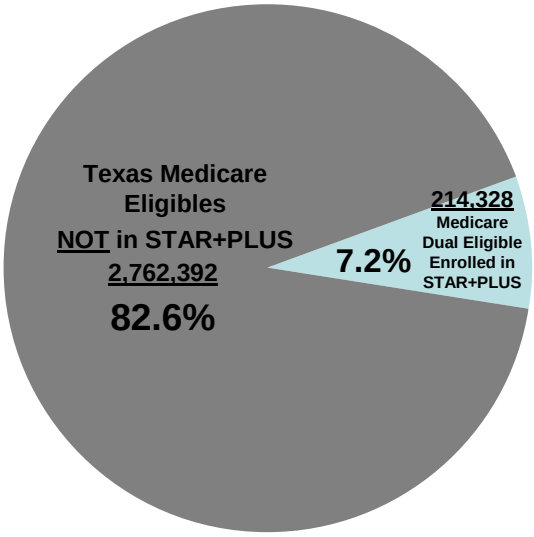
[2] Judy K., Watts, M. & Lyons, B. (July 2010), *Chronic Disease and Co-Morbidity among Dual Eligibles: Implications for Patterns of Medicaid and Medicare Service Use and Spending*. A report prepared for the Kaiser Commission on Medicaid and the Uninsured, Washington, D.C.

STAR+PLUS Enrollees and MA/SNP Enrollment



To put this in perspective, the chart below provides 2010 Medicare data provided by CMS. Texas' total STAR+PLUS dual eligible population (214,328) makes up about 7.2 percent of the total Texas Medicare population. As shown above, about 20 percent of the total STAR+PLUS (about 43,000) are currently enrolled with an MA/SNP, which makes up about 1.4 percent of the total Texas Medicare population.

2010 Total Texas Medicare Eligible Population and STAR+PLUS Enrollment



Note: Approximately 1.4% of Texas Medicare eligibles are Medicad STAR+PLUS enrollees, enrolled with a MA/SNP for their Medicare services.

ii. Issues/Barriers

In Texas, as in other parts of the United States, care for dual eligibles is bifurcated between the acute care services provided under Medicare, and the LTSS provided by the state Medicaid program. More formalized structures are needed for Medicare acute care providers

to collaborate and consult with their Medicaid counterparts. And there can be confusion for dual eligible clients and providers where services are ostensibly available in both programs.

Lack of coordination between the two programs has other consequences. Better coordination is needed to steer individuals away from expensive inpatient hospital and nursing facility care and into less expensive options, when appropriate, that can provide earlier and ultimately better care. Today, dually eligible individuals can be discharged from the hospital and into a nursing facility because their Medicare providers are unaware of community-based Medicaid services that may be a more suitable and cost-effective alternative for the individual. Conversely, the fragmented system existing today lacks incentives to encourage nursing facilities and community LTSS providers to arrange for medical care for dual eligibles in their current setting rather than through the hospital.

In addition, the lack of data sharing for health information between Medicare and Medicaid makes it difficult for Medicare and Medicaid providers to communicate, and for case managers and service coordinators to develop service plans and coordinate health care across the two programs.

In the STAR+PLUS program, Texas has largely overcome barriers hindering coordinated care between acute and LTSS for those individuals who receive all their services through Medicaid. Texas would like the opportunity, through this demonstration project, to build on this success in order to fully integrate care for dually eligible individuals, with the goal of improving care and health outcomes for this vulnerable population.

iii. Texas Vision for Integrating Care for Dual Eligibles

Texas' vision is a fully integrated approach in which all Medicare and Medicaid services[3], including comprehensive prescription drug coverage, are provided through a single, accountable managed care organization (MCO). The MCO will be responsible for delivering Medicaid benefits though its STAR+PLUS agreement and Medicare benefits through its Medicare Advantage agreement. The state's STAR+PLUS MCOs will retain responsibility for the service coordination function, including the coordination of Medicare services and collaboration with Medicare providers.

The establishment of a health home for each dually eligible individual is a crucial component to the success of the integrated model. Health homes will be centered around a Primary Care Provider (PCP), selected by the individual, or assigned if one is not selected. MCOs will assist PCPs in providing and arranging health home services. Depending on the needs of the individual, health home services can include preventive and health promotion services; primary care; referral to and coordination with specialists and LTSS providers; clinical case management to manage chronic and complex health conditions; and service coordination to facilitate access to and coordination of MCO services, social services, and patient and family supports.

Building on the STAR+PLUS model, as an adjunct to and complement of the health home, MCOs will have dedicated service coordinators who will be essential in working with the individual and their PCP and specialists, and with coordinating the individual's acute and LTSS. Service coordinators will be furnished when requested by an individual or provider, or when an MCO's assessment of the enrollee's health and support needs indicates the need for one. The health home, coordinated with and supported by the service coordination

[3] Individuals residing in nursing facilities (beyond an initial four month period) or state supported living centers and those enrolled in 1915(c) waivers are excluded from STAR+PLUS.

feature, will be the foundation for comprehensive integration across all Medicaid and Medicare services.

HHSC and the MCOs will incorporate into the integrated model the lessons learned from the Texas Medical Foundation (TMF) Health Quality Institute's pilot on reducing hospital readmissions, so that the transition out of the hospital is better managed and coordinated, and communication among hospitals, providers, nursing homes and home health agencies is improved.

Texas, like many other states, believes mandatory enrollment in the same MCO for both Medicare and Medicaid services would promote better health outcomes; however, CMS has indicated it will require states to allow enrollees to opt out of the MA/SNP. Texas understands CMS' position and appreciates public input that strongly advocates for preserving the ability for dual eligibles to choose to opt out of their enrollment with a MA/SNP, Texas agrees that the demonstration project should be initially implemented with a passive enrollment into a MA/SNP, with a monthly option to opt out of enrollment with that Medicare health plan and either choose another MA/SNP or FFS Medicare. Texas proposes to revisit this policy in year two of the project, to assess whether it makes sense to establish a lock-in period 90-days after the individual's enrollment into a MA/SNP, because we strongly believe that enrolling individuals into the same MA/SNP and STAR+PLUS MCO will better enable the state to improve quality of care and control costs by greatly decreasing the percentage of individuals receiving their Medicare and Medicaid services through a fragmented, uncoordinated system.

The integrated model will include features designed to simplify processes and reduce confusion for clients and providers. For the first time, Medicare and Medicaid will be working together to develop a single, consolidated process for enrollment, member and provider services such as hotlines, member materials, and complaint and appeal procedures. This will lead to more efficient and less expensive administration of the two programs, and greater satisfaction for enrollees and providers.

Through the benefits offered from a single managed care approach, CMS, HHSC and enrollees can expect a greater level of accountability from MCOs to provide appropriate services, coordinate health care, and facilitate improved communication among providers. Quality measurement of MCO performance will be a key strategy to provide feedback to MCOs and to encourage better administration of the program. Better quality management of services and improved health outcomes will be the ultimate goals of the demonstration.

iv. Eligible Populations

The target population for this demonstration project is full dual eligible adults (age 21 and above) residing in a STAR+PLUS Service Area, and are required to receive their Medicaid benefits through the STAR+PLUS managed care program.

Note: Texas will exclude dual eligible children (under age 21) who reside in a STAR+PLUS Service Area and have chosen to receive their Medicaid services through the STAR+PLUS managed care program. (These children participate in STAR+PLUS on a voluntary basis and may opt out of the program at any time and return to the traditional Medicaid fee-for-services program.)

Excluded

The following types of Medicaid-eligible individuals are excluded from participation in STAR+PLUS, and therefore are excluded from this demonstration project:

- Persons in institutional settings:
  - Persons residing in a nursing facility[4];
  - Residents of Intermediate Care Facilities for Persons with Mental Retardation (ICF-MR);
  - Residents of Institutions of Mental Diseases or State Hospitals.
- Persons enrolled in a 1915(c) waiver program:
  - Community Living Assistance and Support Services;
  - Medically Dependent Children Program;
  - Home and Community-based Services;
  - Deaf Blind with Multiple Disabilities;
- Individuals not eligible for full Medicaid benefits (e.g., community attendant services, Qualified Medicare Beneficiary, Specified Low-income Medicare Beneficiary, Qualified Disabled and Working Individual, and undocumented aliens);
- Individuals receiving long term services and supports through non-Medicaid funded programs; and
- Individuals enrolled in the STARHealth Program (children in state conservatorship).

The following two tables provide information on statewide dual eligibles and STAR+PLUS enrolled dual eligibles in Texas in state fiscal year 2011.

Texas Statewide Medicaid Dual Eligible Population
Monthly Average Enrollment
State Fiscal Year 2011

	TOTAL	Age 21-64	Age >65
All Texas Dual Eligibles	**586,608**	202,123	384,485
Texas Full Duals	**327,530**	100,681	226,849

The table below provides estimated STAR+PLUS enrollment numbers for State Fiscal Year 2013, and provides an estimate of the total target population for this project.

[4] This does not include the first four months that an individual is in a nursing facility. A STAR+PLUS enrollee who enters a nursing facility will remain in STAR+PLUS. If the individual is in a nursing facility for more than four months, the individual will be disenrolled from STAR+PLUS, and receive their Medicaid services through the traditional fee-for-service program.

Texas STAR+PLUS Dual Eligible Population by Service Area
Estimated Monthly Average Enrollment
State Fiscal Year 2013

STAR+PLUS	TOTAL	Age 21-64	Age >65
TOTAL STAR+PLUS Duals	**214,328**	**82,128**	**132,200**
Bexar SA	**25,339**	10,410	14,921
Dallas SA	**28,062**	10,573	17,484
El Paso SA	**15,144**	6,039	9,100
Harris SA	**50,419**	16,171	34,220
Hidalgo SA	**42,611**	16,991	25,606
Jefferson SA	**8,242**	4,057	4,182
Lubbock SA	**7,145**	2,849	4,294
Nueces SA	**11,722**	4,508	7,213
Tarrant SA	**15,687**	6,346	9,338
Travis SA	**10,030**	4,186	5,842

C. Care Model Overview

i. Proposed Delivery System

As previously discussed, the state's demonstration proposal is founded on a delivery system in which Medicaid services for dual eligibles are provided through the STAR+PLUS program and Medicare services through an affiliated MA/SNP. STAR+PLUS is a capitated, integrated delivery system for acute care services and community-based LTSS for approximately 394,225 Medicaid enrollees who have a disability and/or chronic illness. Full duals make up a more than half of the total STAR+PLUS enrollees.

Full duals receive most acute care services and outpatient drug benefits through Medicare; however, Medicaid is responsible for certain "wrap services," such as copayments for Medicare services and Medicaid-only benefits. Medicaid will also pay for some services when the dual eligible client exhausts the Medicare benefit. Please refer to Section C(ii) for additional information regarding wrap services.

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

Effective March 1, 2012, additional services were added to the STAR+PLUS capitation: 1) prescription drug benefits; and, 2) non-behavioral health inpatient hospital services. Prior to March 1, 2012, non-behavioral health inpatient hospital services were carved out of the STAR+PLUS managed care benefit. Including inpatient hospital services and prescription

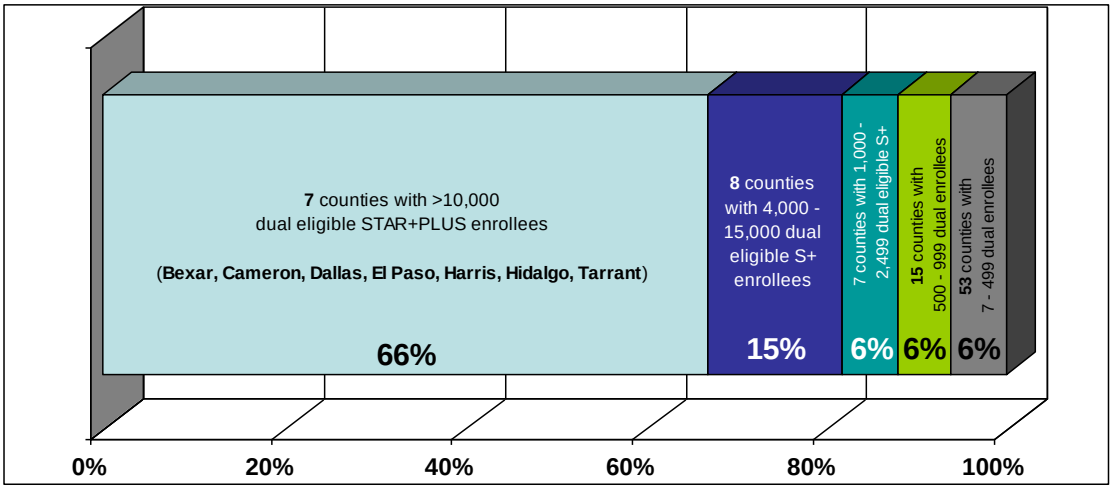
medication in the capitated benefit package is an important step in developing a fully "integrated program," which encompasses the medical, behavioral health, and LTSS needed by an individual who is eligible for both Medicare and Medicaid.

Geographic Service Areas/Counties

STAR+PLUS operates in several, mostly urban service areas (see map on page 13). Effective March 2012, the STAR+PLUS program expanded into the Lubbock, El Paso, Jefferson and Hidalgo service areas.

About 66 percent of dual eligibles individuals enrolled in STAR+PLUS reside in seven counties: Bexar (San Antonio), Cameron (Brownsville) Dallas, El Paso, Harris (Houston), Hidalgo (McAllen) and Tarrant (Fort Worth). Another 15 percent reside in 8 additional STAR+PLUS counties: Collin, Fort Bend, Jefferson, Maverick, Nueces (Corpus Christi), Starr, Travis (Austin), and Webb (Laredo). About 11 percent reside in 22 less populous counties, where STAR+PLUS enrollment of dual eligible individuals is between 500 and 4,000 in a STAR+PLUS county. The remaining STAR+PLUS dual eligibles (about 13,000) reside in more rural counties (53), as depicted below.

Breakout of STAR+PLUS Enrollees by Counties with Highest Concentration of Dual Eligible Individuals



In implementing this demonstration project, Texas may choose a phased-in implementation approach, beginning in January 2014, which focuses first on a subset of the more populous STAR+PLUS counties.

STAR+PLUS Service Areas/Counties

Bexar Service Area (San Antonio) - Bexar, Atascosa, Bandera, Comal, Guadalupe, Kendall, Medina, and Wilson Counties

Dallas Service Area - Dallas, Collin, Ellis, Hunt, Kaufman, Navarro, and Rockwall Counties

El Paso Service Area – El Paso and Hudspeth Counties

Harris Service Area (Houston) - Harris, Austin, Brazoria, Fort Bend, Galveston, Matagorda, Montgomery, Waller, and Wharton Counties

Hidalgo Service Area (South Texas) - Hidalgo, Cameron, Duval, Jim Hogg, Maverick, McMullen, Starr, Webb, Willacy and Zapata Counties

Lubbock Service Area - Lubbock, Carson, Crosby, Deaf Smith, Floyd, Garza, Hale, Hockley, Hutchinson, Lamb, Lynn, Potter, Randall, Swisher, and Terry Counties

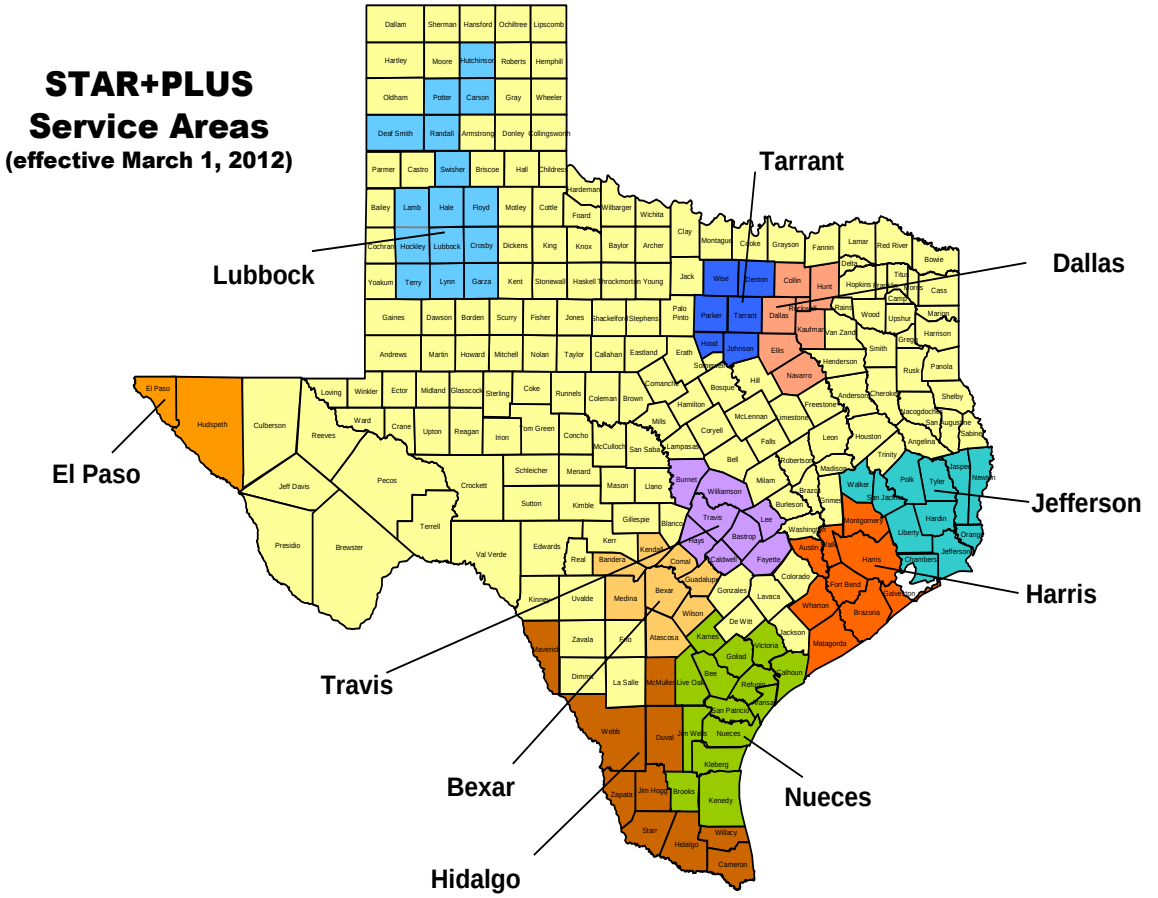
Nueces Service Area (Corpus Christi) - Nueces, Aransas, Bee, Brooks, Calhoun, Goliad, Jim Wells, Karnes, Kenedy, Kleberg, Live Oak, Nueces, Refugio, San Patricio, and Victoria Counties

Tarrant Service Area (Fort Worth) - Tarrant, Denton, Hood, Johnson, Parker, Tarrant, and Wise Counties

Travis Service Area (Austin) - Travis, Bastrop, Burnet, Caldwell, Fayette, Hays, Lee, and Williamson Counties

Jefferson Service Area - Jefferson, Chambers, Hardin, Jasper, Liberty, Newton, Orange, Polk, San Jacinto, Tyler and Walker Counties

Texas STAR+PLUS Program Service Areas (as of March 2012)



Enrollment Methods

As set forth above, Texas received public input strongly advocating for preserving the ability for dual eligibles to choose to opt out of their enrollment with a MA/SNP. Texas will implement the demonstration project with passive enrollment into a MA/SNP, including a monthly option to opt out of enrollment with that Medicare health plan, and either choose another MA/SNP or FFS Medicare.

Texas proposes to revisit this policy in year two of the project, to assess whether it makes sense to establish a lock-in period 90-days after the individual's enrollment into a MA/SNP, because we strongly believe that enrolling individuals into the same MA/SNP and STAR+PLUS MCO will better enable the state to improve quality of care and control costs by greatly decreasing the percentage of individuals receiving their Medicare and Medicaid services through a fragmented, uncoordinated system. Texas firmly believes the demonstration will experience the best results if individuals are required to enroll in the same MCO for Medicaid and Medicare services.

Texas will work with CMS to ensure the passive enrollment process includes an educational component about the value of enrollment in a complementary MA/SNP product and that each beneficiary has been fully informed of the initiative and his or her rights and responsibilities.

STAR+PLUS Enrollment Process and Enrollment into the Dual Eligibles Integrated Care Project.

STAR+PLUS Enrollment

Texas has contracts with at least two qualified MCOs in each service area and offers enrollees a choice of managed care plans, as well as their choice of providers from within the MCO's contracted provider network. Currently, Medicaid STAR+PLUS eligible individuals are provided information on MCO choices and have 15 calendar days after an enrollment packet is mailed to them to select their STAR+PLUS MCO[5]. If no selection is made within the specified timeframe, the individual is defaulted into a STAR+PLUS MCO.

STAR+PLUS enrollees have the opportunity to change to a different STAR+PLUS MCO within the first 90 days after initial enrollment into an MCO, and annually thereafter. Under certain circumstances, enrollees may change STAR+PLUS MCO after that 90-day timeframe.

MA/SNP Enrollment

On the Medicare side, CMS will passively enroll STAR+PLUS enrollees into a MA/SNP, that corresponds to their STAR+PLUS health plan. Texas will work with CMS to develop a seamless process to effectively integrate Medicare's passive enrollment into the individual's MA/SNP with the state's STAR+PLUS enrollment processes. Texas also recognizes the need to fully inform and educate dual eligible individuals on the passive enrollment processes and potential impacts to their Medicare services and will work with CMS to develop comprehensive outreach and educational materials concerning passive enrollment and individuals' rights and responsibilities.

CMS will only allow MA/SNPs who are in good standing with Medicare to receive passive enrollments for this demonstration project. Texas will work with CMS to identify any MA/SNPs who are not in good standing with CMS in advance of the project implementation date, and will establish a process to verify MA/SNPs eligibility throughout the operation of the project.

[5] 1 Texas Administrative Code, Part 15, Chapter 353 Medicaid Managed Care, Subchapter E, §353.403. http://info.sos.state.tx.us/pls/pub/readtac$ext.ViewTAC?tac_view=5&ti=1&pt=15&ch=353&sch=E&rl=Y

Provider Networks and Services

STAR+PLUS MCOs are required to develop and maintain provider networks adequate to deliver all Medicaid covered benefits, with an emphasis on the special needs of persons with chronic conditions and disabilities. Each MCO network must provide convenient and timely access to care. As a result, Texas believes the STAR+PLUS networks will be complementary to the networks developed for affiliated Medicare MA/SNPs.

All providers must be licensed and/or certified in the State of Texas and be enrolled in the Texas Medicaid program in order to provide STAR+PLUS covered services. Providers must not be under sanction or exclusion from the Medicaid and Medicare programs and must have a valid National Provider Identifier (NPI). The STAR+PLUS MCO must ensure its providers and subcontractors meet all current and future state and federal eligibility criteria, reporting requirements, and any other applicable rules and/or regulations related to the contract.

Each STAR+PLUS MCO's provider network must be responsive to the linguistic, cultural, and other unique needs of any minority, older, disabled, or other special needs populations served by the STAR+PLUS MCO. This includes the capacity to communicate with STAR+PLUS enrollees in languages other than English, when necessary, as well as with those who require sign language interpreting.

Each STAR+PLUS MCO must enter into written contracts with properly credentialed providers. Additional information can be found within Texas' uniform managed care contract which is available online and incorporated by reference[6]. Many of these provider types are equivalent to those required by Medicare. Provider types include:

- Inpatient Hospital and medical services
- Children's Hospitals/Hospitals with specialized pediatric services
- Trauma centers
- Transplant centers
- Hemophilia centers
- Physician services
    - PCPs must be available and accessible 24 hours per day, seven (7) days per week, within the provider network.
    - The MCO must contract with a sufficient number of participating physicians and specialists within each service area to comply with established access requirements and meet enrollees' needs for all covered services.
- Urgent care clinics
- Laboratory services
- Pharmacy Providers
- Diagnostic imaging centers

In addition, STAR+PLUS requires that MCOs contract with the following additional provider types that may not be commonly included in Medicare Advantage networks:

- Home health services: STAR+PLUS MCOs must ensure that all enrollees living within the MCO's service area must have access to home health covered services provided as part of the acute care covered services, not the community LTSS.

[6] Texas Health and Human Services Commission Uniform Managed Care Terms & Conditions http://www.hhsc.state.tx.us/medicaid/UniformManagedCareContract.pdf, Section 8.1.4, Provider Network.

- Community Long Term Services and Supports: STAR+PLUS MCOs must ensure that all enrollees living within a MCO's service area must have access to medically necessary and functionally necessary covered services.

Under the integrated care program, STAR+PLUS MCOs will seek to include in its provider network a broad base of qualified providers currently serving the Medicare enrollees in the managed care entity's proposed service area(s).

For acute care services provided through the participating MA/SNPs, Texas will adopt Medicare's network adequacy standards, and will work with CMS to develop a supplemental process that would allow participating MA/SNPs to seek exceptions. Such exceptions will allow the MA/SNPs to focus their provider networks more specifically on the needs of the STAR+PLUS dual eligible population served in the demonstration project.

ii. Benefit Design

Texas' approach to integrating care for individuals who are dually eligible will eliminate the fragmentation in care delivery and financing through contracts with a single, managed care entity responsible for the delivery of all covered Medicare and Medicaid benefits. Medicaid and Medicare services will be provided through the enrollee's STAR+PLUS MCO and the MCO's affiliated MA/SNP.

Health Care Services for the Dual Eligibles Integrated Care Project

STAR+PLUS Services Medicaid (XIX)	Integrated Services (XIX & XVII)	MA/SNP Services Medicare (XVIII)
• Community-based LTSS • Medicaid Wrap Services • Medicare Cost Sharing[7]	• Service Coordination • Health Promotion and Wellness • Disease Management • Health Home Services • Coordination of BH Services • Integrated Quality Measures • Integrated Grievance and Appeals Processes • Marketing and Member Materials • Nursing facility (up to 4 months total)[8] • Value-added services offered by the MCO	• Inpatient and Outpatient Hospital (Part A) • Physician visits and other acute services (Part B) • Pharmacy (Part D)

Medicare Benefits. As described above, full dual eligibles in the program will receive Medicare acute care, outpatient drug benefits, and related services through the managed care entity's MA/SNP.

Medicaid Wrap-around Services. The STAR+PLUS program will supplement Medicare coverage by providing services and supplies that are available under the Texas Medicaid program. There are three categories of Medicaid wrap-around services:

[7] Currently paid by Medicaid, through a capitated arrangement with participating MA/SNP health plans.

[8] After a STAR+PLUS enrollee has been residing in a nursing facility for a four month period (does not have to be consecutive days), the individual is disenrolled from STAR+PLUS and receives their Medicaid services through the traditional FFS program.

1. Medicaid only services (i.e., services that do not have a corresponding Medicare service);
2. Medicare services that become a Medicaid expense due to meeting a benefit limitation on the Medicare side; and
3. Medicare services that become a Medicaid expense due to coinsurance (cross-over claims).

Outpatient drugs and biologicals, including pharmacy-dispensed and provider-administered outpatient drugs and biologicals not covered by Medicare will be included in Medicaid STAR+PLUS benefits as part of this initiative.

Behavioral Health. Coordination of the Medicare and Medicaid behavioral health benefits is critical to the long-term health of full dual eligible individuals and will be an integrated service provided through this model. Medicare provides inpatient and outpatient mental health services for this population. STAR+PLUS would provide wrap-around coverage for psychiatry and counseling, and substance use treatment services, including outpatient assessment, detoxification and counseling, and residential services. These services would be actively coordinated under the new integrated care model.

Community Based Long Term Care Services. Essential to the effective integration of care, STAR+PLUS benefits will include community based LTSS for dual eligibles. The following is a high-level listing of the long-term services and supports included under the STAR+PLUS Medicaid managed care program:

- ***Community Based Long-term Services and Supports*** for all enrollees
  - *Personal Attendant Services* (PAS) - All enrollees of a STAR+PLUS MCO may receive medically and functionally necessary PAS, if they have a demonstrated need.
  - *Day Activity and Health Services* (DAHS) – All enrollees of a STAR+PLUS MCO may receive medically and functionally necessary DAHS, if they have a demonstrated need.

- ***STAR+PLUS Home and Community Based Services*** for those enrollees who qualify for such services.

Texas provides an enriched array of home and community based Medicaid services to enrollees who would otherwise qualify for nursing facility care. The STAR+PLUS MCO must also provide medically necessary services that are available to those in the CBA waiver (within traditional Medicaid) to those enrollees who meet the functional and financial eligibility for STAR+PLUS Home and Community Services, as described in the Texas Healthcare Transformation and Quality Improvement Program (THTQIP) 1115 Waiver.

- Personal Attendant Services (including the three service delivery options: 1. Self-Directed; 2. Agency Model/Self-Directed; and 3. Agency Model)
- In-Home or Out-of-Home Respite Services
- Skilled Nursing Services (in home)
- Dental
- Emergency Response Services (Emergency call button)
- Home Delivered Meals

- Minor Home Modifications
- Adaptive Aids and Medical Supplies not available under the Texas Medicaid State Plan
- Physical Therapy, Occupational Therapy, Speech Therapy
- Adult Foster Care Services (excluding room and board)
- Assisted Living Services (excluding room and board)
- Transition Assistance Services (to help individuals transition to the community from nursing facilities)
- Financial Management Services (Consumer Directed Option service)
- Support Consultation (Consumer Directed Option service)

Nursing Facility Services. Medicare provides coverage for short-term nursing facility services (up to 100 days). From day one through day 20, Medicare pays the full cost of the nursing facility stay. From day 21 through day 100, Medicaid pays a daily copayment and Medicare pays the rest of the nursing facility stay cost. Beyond 100 days, Medicaid is the payor for nursing facility costs for full dual eligible individuals.

After a STAR+PLUS enrollee has been residing in a nursing facility for a four month period (does not have to be consecutive days), the individual is disenrolled from STAR+PLUS and receives their Medicaid services through the traditional fee-for-service program. Currently, on the Medicaid side, this nursing facility stay is carved out of the capitation payment to the STAR+PLUS MCO and paid through the Medicaid fee-for service program. In Medicare, it is carved-in to the capitation payment to the MA/SNPs. With the implementation of this project, HHSC intends to carve the Medicaid portion of this nursing facility stay (for the four month period) into the capitation payment to the participating STAR+PLUS MCOs.

It should be noted that although individuals residing in nursing homes (beyond the initial four-month period) are not enrolled in STAR+PLUS, Texas plans to establish an incentive program to encourage nursing homes to adopt strategies for reducing hospital inpatient admissions for their residents. This reduction in hospital admissions will have a positive effect on Medicare expenditures while increasing Medicaid expenditures; therefore, Texas is requesting that CMS allow savings to be generated through these quality improvements programs related to nursing home and hospital expenditures be included in the calculation of shared savings.

Service Coordination. The integration goals of this proposed demonstration will be achieved in large part though service coordination of Medicaid and Medicare benefits. Currently, the STAR+PLUS service coordinator must work with the PCP as a team, regardless of whether the PCP is in the MCO's network, to coordinate all STAR+PLUS covered services and any applicable non-capitated services. This requirement already applies to dual eligibles, as STAR+PLUS enrollees dually eligible for Medicare may have a PCP that is not in the MCO's provider network.

In order to integrate the enrollee's acute care and primary care and stay abreast of the enrollee's needs and condition, the service coordinator must also actively involve and collaborate with the enrollee's primary and specialty care providers, including behavioral health service providers, providers of non-capitated services, and Medicare Advantage health plan staff for qualified dual eligible enrollees. Texas will enhance this service

coordination function under the proposed integrated care model, as STAR+PLUS and MA/SNP services and goals become better aligned.

iii. New supplemental benefits and/or other ancillary/supportive services

Value-Added Services

Texas will permit STAR+PLUS MCOs and their affiliated MA/SNPs to propose additional services for coverage, pending approval by CMS. Currently, STAR+PLUS MCOs are allowed to offer supplemental services or benefits at no charge to the state. These are referred to as "value-added services." Value-added services (VAS) may be actual health care services, benefits, or positive incentives that will promote healthy lifestyles and improved health outcomes among enrollees. VAS that promote healthy lifestyles will target specific weight loss, smoking cessation, or other programs approved by HHSC.

Some examples of value-added services currently being offered by the STAR+PLUS MCOs include:

Specific to Dual Eligible Enrollees

- **Respite Care** - An additional eight (8) hours of respite services to caregivers and families. These services are in addition to the benefit under the STAR+PLUS Waiver (SPW).
- **Transportation Program -** Dual eligible members may be authorized for up to 18 trips for medical visits after exhausting their Medicare transportation benefit.

Offered to all STAR+PLUS Enrollees

- **Nutritional Dietary Support -** Members will have access to ten (10) home-delivered prepared meals at the time of discharge planning resulting from an acute inpatient hospital stay or discharge from a Nursing Facility (NF) back into the community setting
- **Over-the-Counter Medications** – Over-the-counter (OTC) medications not covered by the STAR+PLUS covered benefit through a mail order program.
- **Podiatry Services -** Routine podiatry visits, up to four times per year (exceeds the state's limit of every six months) for adults over age 21.

Value-added services that are approved by HHSC during the contracting process are included in the MCO's scope of services. Each MCO contract must specify the conditions and parameters regarding the delivery of the value-added services in the MCO's marketing materials and member handbook, and must clearly describe any limitations or conditions specific to the value-added services.

Under Texas' proposed integrated care program, value-added services of specific benefit to dual eligibles will be added or removed only by written amendment of the contract with HHSC. Texas will work with the MCO to ensure that VAS services to be offered by the MCO and their participating MA/SNP are appropriate, non-duplicative and well coordinated.

iv. Evidence-based Practices

Texas' approach to integrating care for dual eligibles will employ the following evidence-based practices as part of the overall care model under the managed care organization contracts.

Health Promotion and Wellness

Under the Texas proposal each MCO must propose, implement, and assess innovative member education strategies for wellness care and immunization, as well as general health promotion and prevention. MCOs must conduct wellness promotion programs to improve the health status of its enrollees. MCOs may cooperatively conduct health education classes with one or more of the contracted MCOs in the service area. Each MCO must work with its providers to integrate health education, wellness, and prevention training into each enrollee's care.

MCOs must also provide condition and disease-specific information and educational materials to enrollees, including information on its service coordination and disease management programs**.** Condition and disease-specific information must be oriented to various groups of enrollees, such as older individuals, persons with disabilities and non-English speaking enrollees as appropriate.

Health Homes

The establishment of a health home for each dually eligible individual is a crucial component to the success of the integrated model. Health homes will be centered around a primary care provider (PCP), selected by the individual, or assigned if one is not selected. MCOs will assist PCPs in providing and arranging health home services. Depending on the needs of the individual, health home services can include preventive and health promotion services; primary care; referral to and coordination with specialists and LTSS providers; clinical case management to manage chronic and complex health conditions; and service coordination to facilitate access to and coordination of MCO services, social services, and patient and family supports.

Chronic Care Management

For individuals with chronic or complex health conditions, the PCP may involve a team of health professionals to help manage the individual's health care. MCOs will assist and support health professional teams through service coordination, and will implement more flexible prior authorization and reimbursement strategies, as needed, to recognize the importance of a team approach for some individuals with chronic or complex conditions.

To supplement chronic care services provided in the PCP's office, MCO administrative services will emphasize chronic care management by implementing or assisting providers with the implementation of patient self-management education, evidence-based models and minimum standards of care, clinical case management, interventions that address the continuum of care, and mechanisms to modify or change interventions that are not proven effective.

Under the Texas demonstration, MCOs will align the supports, assistance, and requirements for health homes for enrollees in Medicaid and Medicare to encourage quality comprehensive health homes and chronic care management across the two programs.

v. Integration with current programs, waivers, state plan services

Texas will work with affected programs and agencies, as well as with CMS to fully determine the impact to existing Medicaid waivers and/or state plan services available to this population.

On December 12, 2011, CMS approved the **Texas Healthcare Transformation and Quality Improvement Program (THTQIP) 1115 Waiver** (Project Number 11-W-00278/6). The THTQIP 1115 waiver includes a statewide expansion of Medicaid managed care

(implemented March 1, 2012), creation of Regional Healthcare Partnerships, and transition to quality-based payment systems for managed care and hospitals. The THTQIP 1115 waiver allows Texas to expand managed care throughout the state while maintaining historic supplemental Medicaid funding to hospital providers. The STAR+PLUS Program operates under this THTQIP 1115 waiver.

In areas where there is a **Program of All-Inclusive Care for the Elderly** (PACE) in operation (subject to availability), clients may choose to enroll in PACE in lieu of STAR+PLUS.

The STAR+PLUS MCOs in the Dallas service area coordinate, as appropriate, with the **NorthSTAR program**, which provides behavioral health services to Medicaid clients in the region through a managed care model. Because CMS has indicated that the states' demonstration projects should fully integrate care for participating dual eligibles, Texas will plan to carve STAR+PLUS dual eligibles in the Dallas SA out of the NorthSTAR model and cover their Medicaid behavioral health wrap services through the participating STAR+PLUS MCOs.

Texas plans to implement a quality incentive payment program for nursing facilities that would link closely to the dual managed care initiative. This project would seek to reduce hospitalizations by creating a culture change and quality improvement model for nursing facilities that agree to provide these improvements on an at-risk basis. The nursing facility would receive an enhanced rate in return for achieving specified acute care savings above a defined savings trend. Failure to achieve the savings goal would result in recoupment of the incentive payment.

Initially, Texas will support this new program by using a portion of savings gained through participation in the Dual Eligibles Integrated Care Demonstration Project. Over time, the initiative would be self-funded through savings achieved through the program. It is expected that reduced hospitalizations, and quality improvements achieved through the incentive payment program for Texas nursing facilities would result in greater Medicare savings.

D. Stakeholder Engagement and Beneficiary Protections

i. Stakeholder Engagement

Initial Public Input

Since the demonstration opportunity was announced, Texas has participated in legislative hearings where members of the public were allowed to present testimony regarding high-level concepts for integrated delivery models for dual eligibles. The state has also been consulting with stakeholders informally regarding the structure and design of the proposed demonstration. This has included discussions with advocates for people with disabilities and for older adults. The state has also solicited informal input from potential implementing partners, including the STAR+PLUS MCOs and their affiliated MA/SNPs.

Two public meetings were held in March 2012, to lay out more detail on the state's proposed integrated model and seek input regarding the development of the application.

During the state's draft application 30-day public input period Texas held two public meetings to discuss the proposed model and seek input. These meetings were held on April 19, 2012 and May 2, 2012.

In addition, information was provided to the Native American tribes informing them of this project and Texas' intention to submit an application. HHSC staff attended a Tribal Conference the week of May 14th and further information on the application was provided to the tribes during the conference.

Texas has developed a distribution list of stakeholders interested in this project. This list will be updated as appropriate to include all pertinent stakeholders. Additionally, Texas has established an email box at: medicaidprogramінnovation@hhsc.state.tx.us, to respond to questions and collect ongoing stakeholder input.

The opinions and input received from public stakeholders have been carefully considered in development the state's final application. Stakeholder input will be requested on an ongoing basis throughout the implementation and operation of the project. Some key comments received from stakeholders to date, include:

General

- General support for an integrated of Medicare and Medicaid services dual eligible individuals.
- Ongoing public input and involvement is needed.
- Recommendations to expand target population to include a broader group of dual eligibles, and recommendations to focus on a smaller subset of the STAR+PLUS population.
- Both support and opposition for passive enrollment. Additional detail on the states proposed process for passive enrollment was requested.
- General consensus that robust and ongoing consumer education and outreach is needed.
- Some recommend using Medicare's stricter marketing standards (marketed only by licensed brokers) in lieu of Medicaid's, while others recommend using Medicaid marketing standards.
- Support for adopting Medicare's grievance and appeals processes (60-day). Support for a uniform process, whether the state uses Medicaid (30-day) processes or Medicare's (60-day).

MA/SNPs

- Support for aligning MA/SNPs with the affiliated STAR+PLUS plan to align incentives and ensure better potential savings for the model.
- Support from MA/SNPs to allow non-STAR+PLUS affiliated MA/SNPs to participate in the program, through an expansion of existing MA/SNP contracts with the State to provide coverage of cost sharing and co-payments for cross-over claims.
- Support for applying Medicare's 5 STAR quality ratings when considering MA/SNP plans for participation in the project.
- If the state will allow MAP participation, it must ensure that there are no cost sharing or premium requirements for enrollees.

Benefits & Services

- Support for including Medicaid's portion of four months of nursing facility care under the STAR+PLUS MCO capitation payment (Medicare's portion is already included in MA/SNP capitation payment). No opposition expressed.

- Recommendation that nursing facility rates not be reduced, but potentially increased to help fund improvements and a primary project goal to reduce hospital inpatient stays and align incentives between nursing facilities and hospitals.
- Additional detail is needed on the state's plan for: health homes, chronic disease management, integration of services.
- Recommendation that the state establish (and pay for with savings) value-added services for this project.

Provider Networks

- Considerable concern about disruption of existing provider-patient relationships.
- Considerable concern expressed about the need to ensure network adequacy and access to services.
- Most recommendations were to utilize Medicare's network adequacy standards for this project.
- Some recommendations to modify Medicare's network adequacy standards to focus on population to be served, and not the total Medicare population in that county.
- Concern about continuity of care for enrollees

It is Texas' understanding that CMS will post Texas' final application on the CMS website for a 30-day public comment period. Texas will advise stakeholders of the website address, once it is available. Texas expects that discussions with stakeholders around areas of greater concern; e.g., passive enrollment, outreach and education, continuity of care, non-STAR+PLUS MA/SNPs, will continue as we work with CMS to develop the details of this demonstration model.

Ongoing Stakeholder Input

Texas intends to fully engage relevant stakeholders in discussions regarding this initiative over the next several months. HHSC will begin by leveraging existing on-going public stakeholder meetings where the agency makes regular presentations of public interest. These include:

- The Medical Care Advisory Committee and Texas Health and Human Services Commission Council, both of which have oversight regarding the state's administration of the Medicaid program (quarterly meetings).
- State health and human services regional advisory committees, established by statute, which typically meet quarterly and are located throughout the state.
- The Department of Aging and Disability Services (DADS) has a number of relevant advisory committees with whom HHSC closely works. These include the quarterly Promoting Independence Advisory Committee (PIAC) that was established as part of Texas' response to *Olmstead* and is composed of individuals with disabilities, family members, advocates and providers. HHSC also participates in other DADS advisory committee meetings, including the Aging and Disability Services Council, and the Money Follows the Person and Aging Texas Well advisory committees.
- HHSC also hosts quarterly meetings with the state's Native American tribes to review state and federal Medicaid and CHIP policy changes or guidance.
- STAR+PLUS MCOs participate in or conduct regular advisory committee meetings comprised of individuals that represent Medicaid beneficiaries and individuals who provide services and supports to Medicaid beneficiaries. Committee members' duties

include reviewing and providing input to key projects for the MCOs, providing recommendations on quality improvement and healthcare delivery, and providing feedback on member materials.

Additional public meetings, specific to this demonstration, will be scheduled as needed and appropriate.

Texas has created a webpage for the Dual Eligibles Integrated Care Project that will provide information and updates on the status of the project, which can be accessed at: http://www.hhsc.state.tx.us/medicaid/dep/index.shtml.

ii. Enrollee Protections

Consistent with state and federal Medicaid laws, STAR+PLUS contracts contain a number of provisions to protect enrollee rights. Texas' approach to integrating care for dual eligibles will employ the following practices related to enrollee protections and will align STAR+PLUS and MA/SNP MCO requirements when possible.

MCOs must include information on member rights and responsibilities within their member handbooks[9]. Texas will work with CMS to expand on this requirement, as appropriate.

Continuity of Care[10]

MCOs must ensure that the care of newly enrolled individuals is not disrupted or interrupted. All MCOs must take special care to provide continuity of care. Texas requires MCOs to ensure continuity in the care of newly enrolled members whose health or behavioral health condition has been treated by specialty care providers, or whose health could be placed in jeopardy if the medically necessary covered services are disrupted or interrupted.

All MCOs must take special care to provide continuity of care. MCOs must continue to reimburse an enrollee's existing out-of-network provider for medically necessary covered services until the enrollee can be moved to a network provider. MCOs must also cover emergency services provided by out-of-network network providers, and must allow access to out-of-network providers if services are not available through their networks, in accordance with 42 C.F.R. §438.206(b)(4).

If an enrollee moves out of a service area, the MCO must provide or pay out-of-network providers in the new service area who provide medically necessary covered services to enrollees through the end of the period for which the MCO received a capitation payment for the enrollee.

STAR+PLUS MCOs must ensure that each enrollee has access to a second opinion regarding the use of any medically necessary covered service. An enrollee must be allowed access to a second opinion from a network provider or out-of-network provider if a network provider is not available, at no cost to the enrollee, in accordance with 42 C.F.R. §438.206(b)(3).

Cultural Competence

MCOs must have a comprehensive, written cultural competency plan describing how it will ensure culturally competent services, and provide linguistic access and disability-related

[9] Texas Health and Human Services Commission Uniform Managed Care Manual, Chapter 3.4, Attachment Y, http://www.hhsc.state.tx.us/medicaid/umcm/Chp3/3-4.doc.
[10] Texas Health and Human Services Commission Uniform Managed Care Terms & Conditions http://www.hhsc.state.tx.us/medicaid/UniformManagedCareContract.pdf, Attachment B-1, Section 8.2.1, Continuity of Care and Out of Network Providers, pg. 8-78.

access. The cultural competency plan must describe how the individuals and systems within the MCO will effectively provide services to people of all cultures, races, ethnic backgrounds, and religions as well as those with disabilities in a manner that recognizes values, affirms, and respects the worth of the individuals and protects and preserves the dignity of each.

Access to Care

All covered services must be available to enrollees on a timely basis in accordance with the MCO contract requirements and medically appropriate guidelines, and consistent with generally accepted practice parameters. STAR+PLUS MCOs must comply with the access requirements as established by the Texas Department of Insurance (TDI) for all MCOs doing business in Texas, except as otherwise required by contract with HHSC.

STAR+PLUS MCOs must provide coverage for emergency services to enrollees 24 hours a day and seven days a week, without regard to prior authorization or the emergency service provider's contractual relationship with the MCO. STAR+PLUS MCOs' policy and procedures, covered services, claims adjudication methodology, and reimbursement performance for emergency services must comply with all applicable state and federal laws and regulations, whether the provider is network or out-of-network.

STAR+PLUS MCOs must provide that if medically necessary covered services are not available through network providers, the MCO must, upon the request of a network provider, allow a referral to a non-network physician or provider within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no event to exceed five business days after receipt of reasonably requested documentation. The MCO must fully reimburse the non-network provider in accordance with the out-of-network methodology as defined by HHSC in 1 Texas Administrative Code §353.4 or other applicable authority.

Member Services

MCOs must maintain a member services department to assist enrollees and their family members or guardians in obtaining Medicare and Medicare covered services for enrollees. Each MCO must maintain employment standards and requirements (e.g., education, training, and experience) for member services department staff and provide a sufficient number of staff.

MCOs must operate a toll-free hotline that enrollees can call 24 hours a day, seven days a week. The member services hotline must be staffed with personnel who are knowledgeable about its Medicaid and Medicare programs and covered services, between the hours of 8:00 a.m. to 5:00 p.m. local time for the service area, Monday through Friday, excluding state-approved holidays.

Member Complaint and Grievance Procedures

Texas will work with CMS to develop a unified set of complaints, grievances and appeals requirements and procedures for enrollees. The requirements and processes will incorporate all relevant Medicare Advantage, Medicare Part D and Medicaid managed care requirements, including notice requirements. These will be specified in the MCO's contract with HHSC.

Texas and CMS will develop a uniform internal MCO review process for member complaints, grievances and appeals in which the MCOs will maintain written policies and procedures for timely processing and resolution. The MCO will be responsible for tracking and monitoring each complaint, grievance or appeal by documenting the following information:

- Date
- Identification of the individual filing the matter
- Individual recording the matter
- Nature of the complaint, etc
- If an appeal, internal or external, standard or expedited
- Action required
- Date of resolution

MCOs will be required to provide enrollees with a written notice of any adverse actions. Members will be entitled to an internal review of those actions, and, if dissatisfied, will have access to a single independent review organization selected by CMS.

The member complaints, grievances and appeals process will be subject to the prior approval of CMS and Texas Medicaid.

Marketing Practices and Member Materials

Texas will work collaboratively with CMS to provide a consistent set of enrollee information by integrating all outreach and enrollment materials and incorporating Medicare Part C and Part D requirements. The integrated documents will include, but not be limited to: outreach and education; enrollment and disenrollment; benefit coverage information; and operational letters for enrollment, disenrollment, claims or service denials, complaints, internal appeals, external appeals, and provider terminations. Such uniform, integrated materials will be required to be accessible and understandable to the enrollees that will be enrolled in STAR+PLUS. This includes individuals with disabilities and those with limited English proficiency, in accordance with current Federal guidelines for Medicare and Medicaid. All enrollee materials, in all forms, shall require approval by CMS and the State prior to use.

Texas will align with Medicare's marketing practices regarding marketing of MA/SNP plans. Texas and CMS will coordinate in monitoring marketing and outreach activities by MCOs or others in the demonstration to ensure compliance with federal and state laws regarding unfair or misleading marketing practices.

iii. Plan for Ongoing Stakeholder Input

A plan for ongoing stakeholder input is included in section D.i., of this application (on page 20).

E. Financing and Payment

i. Financial Alignment Model

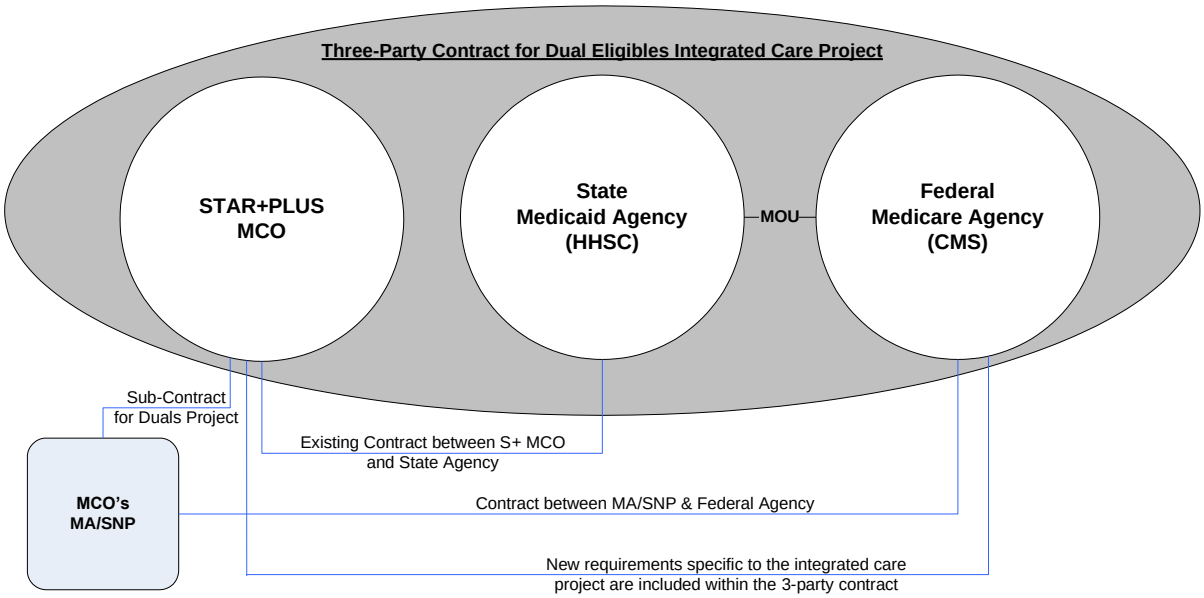
Three-Party Agreement

CMS describes contracting for this model as a three-party agreement (illustrated below), which would include the state Medicaid agency, the federal Medicare agency and the managed care organization (MCOs with STAR+PLUS and MA/SNP products). In addition to the three-party agreement, other agreements between the parties are also executed, as follows:

1. The Texas Medicaid agency (HHSC) and the federal Medicare agency (CMS) enter into a Memorandum of Understanding.

2. The STAR+PLUS MCO will apply through CMS to become a demonstration plan for this project in accordance with the CMS application process.
3. The MA/SNP signs their annual contract with the federal Medicare agency to provide services to the Medicare population.
4. The standard contract between the STAR+PLUS MCO and the Texas Medicaid agency remains in place with the MCO. The STAR+PLUS MCO is the prime MCO contractor for this project.
5. The STAR+PLUS MCO and their participating MA/SNP enter into a formal agreement to participate in this project. Any new requirements, specific to this demonstration project, are included within the three-party agreement between the STAR+PLUS MCO, HHSC and CMS.
6. To operate the Dual Eligibles Integrated Care Project, a three-party contract is executed between the: 1) STAR+PLUS MCO, 2) HHSC, and 3) CMS.

   For Texas, this agreement would be an addendum to the standing STAR+PLUS MCO contract, that would: 1) incorporate the STAR+PLUS contract by reference; 2) specify the new requirements for this project; and 3) make CMS a party to the contract.



MCO Contracting

Texas proposes to contract with individual managed care entities that have both a STAR+PLUS agreement with the state and an MA/SNP agreement with CMS. Under the proposal, the state will pay a capitation payment to the MCO for the Medicaid services, and CMS will pay the MCO for Medicare services.

In sum, the Texas demonstration will be a full-risk capitated model that will cover the full array of Medicaid and Medicare services for full dual eligible adults enrolled in the state's Medicaid STAR+PLUS program, in areas where the program operates.

CMS' and HHSC's actuaries will coordinate development of comprehensive capitation rates to cover the full array of Medicare and Medicaid covered services available to this population. The managed care organization will receive capitation payments from both the

State and CMS. CMS will pay the Medicare portion of capitation payment and the State will pay the Medicaid portion of the capitation payment to the MCOs.

For the Medicaid capitation rates, Texas intends to use the same dual eligible risk groups currently used for STAR+PLUS. The risk groups are: "Other Community Care" (OCC) and Community-Based Alternative" (CBA) services. OCC includes Primary Home Care and Day Activity Health Services available under the State Plan. CBA includes home and community-based waiver services.

HHSC holds five percent of the STAR+PLUS capitation at risk and MCOs must meet certain quality and access benchmarks in order to earn back this part of the premium. HHSC will work with CMS to adopt a similar practice for this demonstration project, and will coordinate benchmarks to encourage better integration of services.

ii. Payments to Providers

The STAR+PLUS MCOs and their affiliated MA/SNP will contract with providers and negotiate payment rates to be paid for services provided to this population. STAR+PLUS providers are generally paid on a negotiated fee for service basis by the STAR+PLUS MCOs.

For Medicaid services, Texas anticipates using the same STAR+PLUS MCO incentives as are currently in place. Based on federal guidance, the state will not direct provider payments absent a state or federal directive.[11] The state will actively monitor access to care to ensure that members have sufficient access to all covered services.

One goal of this project is to achieve savings and employ cost avoidance strategies through integrated and improved care management for the full continuum of services (Medicaid and Medicare) for these individuals. Comprehensively managing the health care of dually eligible individuals in one health plan could result in significant savings on the Medicare side through better coordinated health care, reduced hospital admissions, readmissions, and emergency room visits, and reduced skilled nursing home placements. Texas would be better able to implement strategies for nursing home diversion and reduced hospital admissions/readmissions with both acute care and community-based LTSS managed by a single managed care entity.

Texas plans to reinvest a portion of the savings attributed to the state through this demonstration in improvements and reforms to the overall LTSS system across the state.

F. Expected Outcomes

i. Quality and Cost Measurement

Consistent with CMS direction, Texas is looking forward to working with CMS to develop a single comprehensive quality management process and specific quality measures, standards and reporting requirements for this demonstration.[12]

[11] Federal Register, June 14, 2002, Volume 67, p. 40998, http://www.gpo.gov/fdsys/pkg/FR-2002-06-14/pdf/FR-2002-06-14.pdf.
[12] Center for Medicare and Medicaid Services, SMDL #11-008, at 7 (July 8, 2011).

STAR+PLUS MCOs are subject to current state and federal quality of care requirements. Texas has ongoing strategies that examine and address access standards, MCO structure and operations, and quality measurement and improvement, as well as other procedures to assess the quality of care provided to Medicaid managed care enrollees. Federal law also requires state Medicaid programs to arrange for an annual independent external review of Medicaid MCOs to assist the state in evaluating Medicaid managed care enrollees' access to timely and quality care and to develop quality improvement strategies when deficiencies are identified.

Texas will continue to require STAR+PLUS MCOs to collect and provide individual-level quality, cost, enrollment and utilization data for all enrollees, including dual eligibles, for the purposes of quality measurement and oversight. Texas will seek technical assistance from the Technical Assistance Resource Center within CMS to streamline and coordinate external quality reviews conducted by the Medicare Quality Improvement Organization and Medicaid External Quality Review Organization.

As is in the current MCO contracts, STAR+PLUS MCOs will continue to comply with applicable certificate of coverage and data specification and reporting requirements pursuant to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, P.L. 104-191 (August 21, 1996). The MCOs will also continue to comply with HIPAA Electronic Data Interchange (EDI) requirements, including the HIPAA-compliant format version and HIPAA notification requirements.[13]

Quality Improvement Goals

As with the other quality elements of the proposed demonstration, Texas intends to work jointly with CMS in the development of quality improvement goals related specifically to dual eligibles. Texas anticipates building these goals into the state's existing comprehensive quality measurement and improvement framework.

For STAR+PLUS, Texas has focused performance measurement efforts by developing a Performance Indicator Dashboard (Dashboard), which includes a series of performance measures that identify key aspects of performance to ensure the MCO's accountability. The Dashboard assembles performance indicators that assess many of the most important dimensions of the MCO's performance, and includes measures that, when publicly shared, will also serve to incentivize excellence. While the Dashboard measures are not currently focused on the dual eligible STAR+PLUS population, Texas will develop some key measures specific to the Medicaid and Medicare services provided to dual eligibles in the demonstration project to be included on the Dashboard.

Texas intends to distribute information on key performance indicators to MCOs on a regular basis, identifying an MCO's performance, and comparing that performance to other MCOs and to Texas standards and/or external benchmarks. Texas may recognize MCOs that attain superior performance and/or improvement by publicizing their achievements. For example, Texas may post information concerning exceptional performance on its website, where it will be available to both stakeholders and members of the public. Likewise, the state may post its final determination regarding poor performance or MCO peer group performance comparisons on its website, where it will be available to both stakeholders and members of the public.

[13] Texas Health and Human Services Commission Uniform Managed Care Terms & Conditions http://www.hhsc.state.tx.us/medicaid/UniformManagedCareContract.pdf, Attachment A, Sections 7.07, 11.03, and Attachment B Section 8.1.18.4.

Texas recognizes the importance of applying a variety of financial and non-financial incentives and disincentives for demonstrated MCO performance. It is Texas' objective to recognize and reward both excellence and improvement in performance. Therefore, incentives and disincentives will be linked to some of the measures in the Dashboard under the STAR+PLUS program**.** The MCO's performance relative to the annual performance improvement projects may be used by Texas to identify and reward excellence and improvement by the MCO in subsequent years. All areas of responsibility and all requirements in the STAR+PLUS MCO contracts will be subject to performance evaluation by Texas. Any and all responsibilities or requirements not fulfilled will be subject to contractual remedies, including without limitation, liquidated damages. Texas will work with CMS to ensure there are not inconsistencies in the performance management requirements between Medicaid and Medicare.

The Dashboard is not an all-inclusive set of performance measures; Texas will measure other aspects of the MCO's performance as well. HHSC is open to the inclusion of other quality measures designed to ensure enrollees are receiving high quality care. In collaboration with CMS, HHSC will evaluate all performance-based incentives and disincentive methodologies annually and in consultation with STAR+PLUS MCOs. HHSC may then modify the methodologies as needed, as funds become available, or as mandated by court decree, statute, or rule, in an effort to motivate, recognize, and reward MCOs for performance.

ii. Projected Savings for the Integrated Care Model

Texas anticipates that the proposed demonstration will result in significant reductions in Medicare program costs, with modest or no increase in state Medicaid costs. This expectation is a result of the state's experience with the STAR+PLUS program.

Beginning in 2007, STAR+PLUS MCOs were required by contract with Texas to manage inpatient services for their Medicaid-only enrollees and achieve substantial cost-savings, despite the fact that only behavioral health-related inpatient services were not capitated. The STAR+PLUS MCOs reduced inpatient costs on average in excess of 20 percent as compared with base year FFS costs. Outpatient service costs were also reduced.

A primary goal of STAR+PLUS is to prevent enrollees from entering institutional settings by providing appropriate levels of community-based care, and to move enrollees who are in institutional settings back into the community when possible. In addition, the contract contains a specific incentive designed to discourage inappropriate nursing facility admissions. This has resulted in reduced nursing facility costs for STAR+PLUS enrollees.

G. Infrastructure and Implementation

i. Program Management

The groundwork for management of an integrated care program for dual eligibles has already been established as Texas' proposal builds upon the existing STAR+PLUS program. Texas has strong state capacity to develop, implement and oversee an integrated managed care program. Texas has benefitted significantly from over ten years of experience administering the STAR+PLUS program. The state has the structure, staff, and contract resources to develop system changes and provide strong fiscal and programmatic oversight for its proposed integrated care program for dual eligibles enrolled in STAR+PLUS.

Texas is also well positioned to perform the various data analyses needed to develop and manage various elements of an integrated care model. Texas has extensive experience and capacity in using encounter data to establish rates for five different Medicaid managed care programs operating in the state of Texas, as well as for three PACE organizations. Of particular relevance is the fact that encounter data are used to establish risk adjustment for MCOs.

Texas' approach to implementing and overseeing the integration of individuals dually eligible for Medicare and Medicaid will draw from our project management experience in implementing and expanding Medicaid managed care programs across the state. The Managed Care Operations department of the Medicaid /CHIP Division at HHSC will take the lead in implementing and overseeing this project. Managed Care Operations is organized into three broad functional areas: Program Management, which includes Quality Assurance, Finance and Program/Policy Specialists; Operations Management which includes Program Development and Oversight and Operations; and Health Plan Management.

The implementation team will be drawn from each of these functional areas, supplemented with additional staff from across the HHSC Enterprise to assure a successful implementation.

Capacity to Receive and Analyze Medicare Data as Part of a Linked Database

Texas is eager for the opportunity to receive timely, accurate Medicare data as part of this demonstration. The state has sufficient storage capacity and staff expertise to receive and process Medicare data files. Being able to more efficiently align Medicaid with Medicare enrollment will be a vast improvement over the current process, where discrepancies in enrollment data can lead to confusion over coverage, or loss of benefits.

Texas looks forward to working in collaboration with the Federal Coordinated Health Care Office, and the Center for Medicare and Medicaid Innovation, as Texas pursues a model of integration uniquely suited to the state's need for improving access, quality and cost of care for its citizens who are dually eligible for Medicaid and Medicare.

ii. Implementation Strategy and Proposed Timeline

Attached is a Work Plan/Timeline that provides an initial description of the overall implementation strategy and anticipated timeline, including the activities associated with implementing Texas' proposed integrated care program. This high-level work plan identifies key tasks, milestones, and responsible parties.

H. Feasibility and Sustainability

i. Implementation Risks and Challenges

Under the proposed demonstration, Texas intends to mitigate risks prior to implementation. Because of Texas' vast experience with Medicaid managed care, the state is acutely aware of the risk and potential challenges associated with large scale implementation and expansion of such programs. To address the following identified risks, Texas will work collaboratively with CMS to develop and implement MA/SNP readiness review activities.

Texas completed comprehensive readiness reviews of all STAR+PLUS MCOs prior to the implementation of the March 1, 2012 managed care expansion. CMS requested, and Texas shared, details regarding these readiness review activities as part of federal approval of the THTQIP 1115 Waiver. The timing of these readiness reviews not only helps Texas and the

STAR+PLUS MCOs in determining their ability to participate in this demonstration project, it will also serve to streamline the readiness review process needed for this project, and establishes a strong framework to help mitigate potential risks and challenges specific to the implementation of this project.

Texas will work with CMS to develop readiness review requirements for new or revised program requirements specific to this demonstration project.

ii. Statutory and Regulatory Changes Needed

No statutory changes are needed. However, depending on the final negotiated program requirements, Texas may need to make changes to some administrative rules.

iii. Funding and Contracting Requirements

Because Texas' proposed integrated care program builds on the existing STAR+PLUS program, HHSC can leverage its existing infrastructure for the implementation of the Dual Eligibles Integrated Care Project. Subsequent to agreement with CMS on authority for the integrated care program and finalizing MOU details, including financing arrangement and other programmatic requirements, HHSC will execute contract amendments with STAR+PLUS MCOs and conduct associated readiness reviews for new or revised program requirements specific to this demonstration.

iv. Scalability of Model

The STAR+PLUS approach to integrated services, focused on hands-on and accountable care coordination is suited to small or large MCOs, urban or rural areas, and populations of varying characteristics. In Texas, enrollees in STAR+PLUS are generally those with the most complex health needs and most costly potential expenditures. However, through improved care coordination and management, STAR+PLUS has improved access to services, reduced duplication, and created a more effective delivery of health care services that benefits the dual eligible population, the State and the Federal government.

Over time, Texas may seek to develop a rural initiative to integrate care for full dual eligibles in the 164 rural Texas counties that comprise the Medicaid Rural Service Area (MRSA). Should Texas expand STAR+PLUS into all or part of the MRSA, then the demonstration will also include the expansion area(s).

v. Letters of Support

Attached are various letters of support from the Governor's Office and other relevant governmental stakeholders.

I. Additional Documentation

Texas recognizes that the State may be asked to provide additional documentation such as draft waiver applications, State Plan amendments, etc., as part of the proposal.

Workplan/Timeline Template

Timeframe	Key Activities/Milestones	Responsible Parties
7/8/11	CMS releases State Medicaid Director Letter for Integrated Care Models for States	CMS
9/29/11	Texas submits Mandatory Non-Binding Letter of Intent	Texas
10/17/11	Initial call with CMS to discuss process for the demonstration model	CMS & Texas
11/7/11 – ongoing	CMS and Texas begin calls to discuss project requirements	CMS
3/1/12 – 1/1/14 Ongoing	Initiate ongoing discussions and planning with STAR+PLUS MCOs	Texas
3/15/12	Texas requests Medicare data from CMS	Texas
3/19/12	Meeting with STAR+PLUS MCOs and their MA/SNP counterparts	Texas
3/22/12	Meeting with STAR+PLUS Stakeholders	Texas
4/12/12 – 5/11/12	Texas posts DRAFT application for 30-day public comment period	Texas
4/15/12	CMS provides aggregate data to Texas (3-4 weeks)	CMS
4/15/12 – 8/1/12	CMS/Texas Discussion and Refinement of Texas Plan	Texas & CMS
4/19/12	Public Meeting on Draft Application (#1)	Texas
4/16/12 – 5/15/12	Texas analyzes aggregate data and completes a preliminary assesses potential cost savings (4 weeks)	Texas
5/2/12	Public Meeting on Draft Application (#2)	Texas
5/12/12 – 5/30/12	Texas Finalizes Draft Application following public comment period	Texas
5/31/12	Texas Dual Eligibles Integrated Care Project Application due to CMS	Texas
8/1/12 - 9/30/12	MOU with CMS (2 months)	CMS & Texas
10/1/12 – 2/1/13	Three-party contract between CMS, Texas and participating MCOs negotiated (4 months)	CMS, Texas & MCOs
11/1/11 – 5/1/12	Planning and identification of operational, financial and systems changes needed at State level	Texas
12/1/12 – 3/31/13	Operating Manual must be developed, including complaint and appeals processes (5 months)	Texas
5/1/13 – 11/30/13	MCOs develop networks and systems and operational changes, complaint and appeals processes (7 months)	Texas (MCO)
7/1/12 – 3/31/13	State Systems and Operations development (9 months)	Texas
4/1/13 – 7/31/13	Readiness Review of participating Health Plans (by CMS and State) (8 months prior to implementation, for 3 months)	Texas & CMS
8/1/13	Outreach and Education, Client Communication (3-4 mo prior to implementation)	Texas
11/1/13	Begin Enrollment of Clients (for 1/1/14)	Texas
1/1/14	**Implementation/Operational Start Date**	Texas