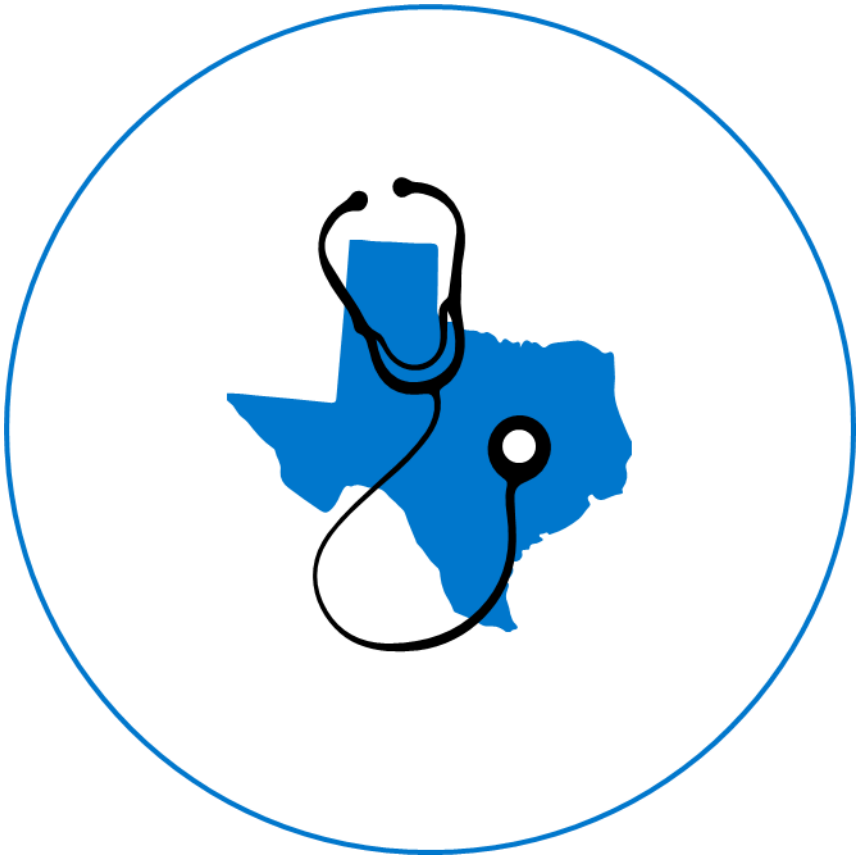

IDD LTSS Carve-In Cost-Effectiveness Evaluation – Final Report

Prepared for:
Texas – Health and Human Services Commission (HHSC)
HHSC Contract No. 529-15-0009-00001 | Request Number: 00021-R3

Version Dated: January 11, 2019

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1 Executive Summary

The majority of Medicaid Long Term Services and Supports (LTSS) for people with intellectual and developmental disabilities (IDD) in Texas are currently provided through Fee-for-Service (FFS) programs.[1] These include the Home and Community-based Services (HCS), Texas Home Living (TxHmL), Community Living Assistance Supports and Services (CLASS), and Deaf Blind with Multiple Disabilities (DBMD) waivers as well as Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID). As per Chapter 534, Government Code, HHSC shall transition the provision of Medicaid services currently provided to Medicaid recipients through the IDD FFS waivers and the ICF/IID program to a managed care (MC) delivery model. The statute requires the transition of the TxHmL waiver on September 1, 2020, and the HCS, CLASS, and DBMD waivers and ICFs/IID on September 1, 2021.

Acute care services for individuals with IDD in Texas transitioned from FFS to managed care beginning September 1, 2014. Acute care services include preventive care, primary care, other medical care provided for a condition having a relatively short duration, and behavioral health services. Additionally, LTSS for other individuals, including elderly populations and individuals with physical disabilities, are currently provided under various managed care programs in Texas.

HHSC engaged Deloitte Consulting LLP to evaluate the cost-effectiveness of transitioning the current FFS programs for IDD LTSS to managed care.[2] This report focuses on several activities to evaluate the cost-effectiveness of Managed LTSS (MLTSS) for individuals with IDD, including:

- Research and collection of publicly available data from other states that have experience with IDD MLTSS or MLTSS to inform assumptions for potential fiscal impacts in Texas
- A brief review and summary of Medicaid FFS and managed care rate setting methodologies in Texas

[1] Some IDD LTSS are provided via Community First Choice (CFC) separate from FFS programs.

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- A review of Texas' historical IDD acute care FFS and managed care data for individuals receiving services through each waiver and ICFs/IID, to the extent possible based on the limited data available
- An analysis of Texas' historical IDD LTSS FFS data for individuals receiving services through each waiver and ICFs/IID[3]

Based on the above activities, a cost-effectiveness model was developed to estimate the fiscal impact of a transition to IDD MTLSS in Texas. To determine cost-effectiveness, this model compares expenditure estimates for two future-states: (1) a future state in which HHSC continues to operate all IDD LTSS under the existing FFS waivers and programs (Status Quo, or SQ estimate) and (2) a future state in which various combinations of services offered under the current IDD LTSS FFS model are transitioned to managed care (MLTSS estimate). Some factors that drive fiscal impacts in the expenditure model include:

- The state's historical spending on IDD LTSS and the distribution of expenditures across various service categories for each waiver and ICFs/IID
- Fiscal impacts other states have seen in transitioning IDD LTSS services to managed care
- The extent to which Managed Care Organizations (MCOs) can influence expenditures for IDD LTSS, including levels of utilization and/or rates paid to providers
- Changes in administrative expenditures to operate IDD LTSS programs between FFS delivery models and managed care delivery models, where:
    - FFS administrative expenditures may be eliminated or reduced from IDD LTSS carve-in, and
    - New administrative expenditures may result from the IDD LTSS carve-in, such as provisions for non-claims expenses included in capitation payments to MCOs
- The impact of IDD LTSS on premium taxes, which represent a revenue source for the State of Texas under managed care
- The percentage of individuals with IDD who choose to enroll in managed care to receive LTSS instead of continuing to receive services in existing FFS waivers

[3] The analysis relied on data provided by HHSC, as well as publicly available data. From the data provided by HHSC, some of these data sources were developed by HHSC, while others were prepared or created by third parties and delivered to HHSC. As part of the analysis, all data was reviewed for reasonableness, but an audit was not performed on the data. To the extent the data contains errors or anomalies that were unknown at the time the data was provided, the analysis may be affected by those issues.

- HHSC's decisions with respect to the IDD LTSS carve-in, including which services should be carved in and for which waivers
- Considerations relating to quality of care and access to care for individuals with IDD.[4]

It is not anticipated that managed care will significantly affect the unit cost of IDD LTSS in Texas. The State has established fee-for-service reimbursement rates for the services considered in the managed care carve-in. This analysis assumes MCOs will reimburse providers at a similar fee schedule. While HHSC may adjust future rates for some IDD services, there is no cause to assume these will be a result of the managed care carve-in. Please see Section 5.2.4 for more detail on the managed care impact on unit costs.

Through research of other states that have transitioned IDD LTSS to a managed care model, a wide range of fiscal impacts were observed ranging from a 47% reduction in expenditures (for Arizona's estimated State Fiscal Year, or SFY, 2016-2021 1115 waiver budget neutrality) to a 10% increase in expenditures (from Kansas' observed real, trend-adjusted, percent change in spending for the state's Developmental Disability waiver from Calendar Year, or CY, 2013 - 2016). Please see Table 16 for more details on the range of fiscal impacts observed in other states.

For this study, managed care utilization adjustments were applied at the service category level and were different for each service category. The utilization adjustment range applied in the fiscal impact model ranged from 6.0% as the largest reduction impact to 0.0% or no impact on utilization. This range for each service category varied based on the research of where MCOs in other state programs were able to influence utilization. Certain services, such as Respite, Case Management, and Transportation, are either critical to the receipt of other required services for people with IDD or could result in negative life or health outcomes if not utilized properly. These service categories received either 0.0% or low adjustments to their estimated managed care utilization compared to FFS levels. Other services, such as Therapies and Residential, have relatively high historical expenditures along with a potential for evaluating service utilization for either less costly alternatives or appropriateness of service authorizations. These services received utilization adjustments closer to the high end of the range. Please see Section 5.2.3 for more detail on the managed care impact on utilization.

Per Chapter 534, certain IDD LTSS FFS waivers will continue to operate in parallel with the managed care programs following the IDD LTSS carve-in for services that are not carved-in or for individuals who opt-out of managed care. Because HHSC's claims adjudication contracts with external vendors are on a fixed fee basis (rather than per claim), the reduction in state administrative expenditures for these programs from the

[4] Please note, this report includes only general information on impacts in these areas as the scope of this research focuses on fiscal impacts. Detailed quality and access implications are being considered by a separate vendor in a separate report.

carve-in are expected to be minimal or zero. Since HHSC will need to include provisions within the capitation rates for MCOs' administrative expenditures, risk margin, and maintenance tax as a result of the IDD MTLSS carve-in, Texas' administrative expenditures overall are expected to increase. This increase in administrative expenditures is estimated to offset potential savings on claims expenditures described above, resulting in an overall cost increase for implementing IDD MLTSS under a managed care model. Please see Section 5.3 for more detail on the managed care impact on administrative expenditures.

To understand the potential range of fiscal impacts resulting from the transition to managed care, four different scenarios were modeled to represent the variability in assumptions and the different HHSC service carve-in choices. Table 1 shows a summary of these four scenarios.

Table 1. Summary of Scenarios Modeled

Assumption	Scenario 1	Scenario 2	Scenario 3	Scenario 4
All Services Carved-In or Some?[5]	All	Some	All	Some
Do HCS members have a MC/FFS choice?	Yes	No	Yes	No
Do CLASS or DBMD members have a MC/FFS choice? [6]	Yes	Yes	Yes	Yes
Do TxHmL or ICF/IID members have a MC/FFS choice?	No	No	No	No
Member Managed Care Election Percentage	25%	25%	10%	10%
Managed Care Unit Cost Adjustment	0%	0%	0%	0%
Managed Care Utilization Adjustment [7]	Higher	Higher	Lower	Lower
Managed Care Administrative Expenditure Increase [8]	Lower	Lower	Higher	Higher

These scenarios, along with more detailed assumptions, are described in more detail in Section 5.1 below.

[5] Please see Section 4.3 for the list of services that remain in FFS under Scenarios 2 and 4. These include only services in TxHmL and HCS (the other three programs carve in all services).
[6] CLASS and DBMD members would not have a choice if any of their services remain in FFS. HHSC chose to transition all services for these waivers for the purposes of the scenarios modeled in this report.
[7] Please see Section 5.2.3 for details on utilization impacts for each scenario.
[8] Please see Section 5.3 for details on administrative expenditure impacts.

According to Chapter 534, members currently receiving services under HCS, CLASS, or DBMD waivers will have a choice between continuing to receive services through their current FFS waiver or transitioning to managed care if HHSC chooses to carve *all* LTSS for these members into managed care. To account for this member choice component of Chapter 534, the cost-effectiveness model includes an assumption for the percentage of current members enrolled in these three waivers who will elect to switch to managed care. Table 2 below shows the assumed total number of member months for each program in total and in managed care.[9] This table shows the relative magnitude of members receiving services through managed care in each scenario.

Table 2. Estimated Number of Member Months Receiving Services in Managed Care SFYs 2021 - 2022 for TxHmL, SFY 2022 for other programs
Member Months in Managed Care | Percent of Total

Program	Total Member Months (FFS + MC)	Scenario 1 (All Services)	Scenario 2 (Some Services)	Scenario 3 (All Services)	Scenario 4 (Some Services)
TxHmL	160,976	160,976 | 100.00%	160,976 | 100.00%	160,976 | 100.00%	160,976 | 100.00%
HCS [10]	322,973	80,743 | 25.00%	322,973 | 100.00%	32,297 | 10.00%	322,973 | 100.00%
CLASS	66,737	16,684 | 25.00%	16,684 | 25.00%	6,674 | 10.00%	6,674 | 10.00%
DBMD	4,134	1,034 | 25.00%	1,034 | 25.00%	413 | 10.00%	413 | 10.00%
ICF/IID	61,116	61,116 | 100.00%	61,116 | 100.00%	61,116 | 100.00%	61,116 | 100.00%
Total	**615,936**	**320,553 | 52.04%**	**562,783 | 91.37%**	**261,476 | 42.45%**	**552,152 | 89.64%**

After accounting for the impacts to claims and administrative expenditures, Table 3 displays the All Funds (both state and federal) fiscal impact for each scenario. This shows that using the four scenarios and assumptions described in this report, implementing IDD MLTSS in Texas is estimated to result in approximately $22.5 million

[9] "Member months" or "caseload" refers to the total number of individuals enrolled for each month. For example, if an individual is enrolled in a waiver for twelve months within a State Fiscal Year, they generate twelve member months. Likewise, if an individual is enrolled in a plan for six months within a State Fiscal Year, they will generate six member months.

[10] For the HCS waiver, Scenarios 2 and 4 represent a situation in which some services remain in FFS. In those scenarios, members do not have a choice of managed care versus FFS, and 100% of members must receive services through HHSC's service-specific managed care or FFS decision. Because of this, 100% of members are shown as managed care in this table. The same number of members also receive services not carved into managed care through FFS in these scenarios.

to $72.1 million in additional expenditures when compared to the Status Quo total expenditures (claims and administrative expenditures) from SFY 2021 to 2022 of approximately $2,695.4 million, or $5,033.94 per member per month (PMPM).[11] This is equivalent to an increase of 0.84% to 2.67% compared to Status Quo claims and administrative expenditures. This is also equivalent to an increase of $36.59 to $117.04 PMPM for all members with IDD (both those staying in FFS and those moving to managed care). While there are savings achieved on LTSS claims, the amount of increased administrative expenditures outweighs savings from claims in the model. Please see Section 5.6 for more details on All Funds fiscal impacts as well as similar tables for each waiver and ICF/IID.

[11] Status Quo expenditures impacted include the total two-year expenditures from SFYs 2021-2022 for TxHmL and total one-year expenditures in SFY 2022 for the other IDD LTSS waivers and ICF/IID since those are the years managed care is expected to impact each program, per Chapter 534.

Table 3. Estimated Fiscal Impact of Transition to Managed Care for IDD LTSS[12]
Two-Year Total, SFYs 2021 - 2022
(Estimated MLTSS Spending vs. Status Quo Spending)
($ in thousands | % change from Status Quo)

Service Category / Expenditure Type[13]	Status Quo Expenditures Impacted, 2021 - 2022	Scenario 1 (All Services)	Scenario 2 (Some Services)	Scenario 3 (All Services)	Scenario 4 (Some Services)
PAS/HAB[14]	$1,110,977	-$17,441 | -1.57%	-$2,247 | -0.20%	-$6,021 | -0.54%	-$449 | -0.04%
Respite	$99,561	-$1,692 | -1.70%	-$68 | -0.07%	$0 | 0.00%	$0 | 0.00%
Case Management	$89,896	-$900 | -1.00%	-$65 | -0.07%	$0 | 0.00%	$0 | 0.00%
Nursing	$23,973	-$278 | -1.16%	-$34 | -0.14%	-$71 | -0.30%	-$7 | -0.03%
Therapies	$56,009	-$1,012 | -1.81%	-$1,135 | -2.03%	-$362 | -0.65%	-$527 | -0.94%
Residential	$890,091	-$13,351 | -1.50%	-$36 | 0.00%	-$3,560 | -0.40%	-$10 | 0.00%
Fees	$18,707	-$352 | -1.88%	-$438 | -2.34%	-$136 | -0.73%	-$188 | -1.01%
Transportation	$17,975	-$270 | -1.50%	-$1 | 0.00%	$0 | 0.00%	$0 | 0.00%
Intervener	$1,793	-$9 | -0.50%	-$9 | -0.50%	$0 | 0.00%	$0 | 0.00%
ICF Daily Care	$247,628	-$9,905 | -4.00%	-$9,905 | -4.00%	-$4,953 | -2.00%	-$4,953 | -2.00%
Other	$32,569	-$487 | -1.49%	-$1,153 | -3.54%	-$162 | -0.50%	-$562 | -1.72%
LTSS Claims Subtotal (A)	$2,589,179	-$45,697 | -1.76%	-$15,091 | -0.58%	-$15,264 | -0.59%	-$6,695 | -0.26%
Administrative Expenditures (B)	$106,236	$95,260 | 89.67%	$37,629 | 35.42%	$87,353 | 82.23%	$40,971 | 38.57%
Total without Premium Tax (C) = (A) + (B)	**$2,695,415**	**$49,563 | 1.84%**	**$22,538 | 0.84%**	**$72,088 | 2.67%**	**$34,276 | 1.27%**

To determine the federal and state share of total fiscal impacts, the total fiscal impacts without premium tax for each waiver were split into federal and state components using HHSC's estimated Federal Medical Assistance Percentages (FMAPs) for each program in SFYs 2021 to 2022. In addition to these expenditure allocations, premium tax impacts

[12] Some differences in tables throughout this report may exist due to rounding.
[13] Please see Appendix A for service category definitions.
[14] PAS/HAB is Personal Assistance Services/Habilitation

were applied to each portion to determine final net fiscal impacts for the State overall, HHSC, and the Federal government. Please see Section 5.4 for an explanation of how premium taxes are paid and Section 5.7 for more details on federal versus state net fiscal impacts.

As shown in Table 4 below, the estimated net fiscal impact to the State of Texas overall ranges from an expenditure increase of $3.7 million to $16.6 million in total during the two-year period from SFY 2021 to SFY 2022. The estimated impact to HHSC over the same period is an expenditure increase of $12.1 million to $34.6 million. The difference between the State's and HHSC's fiscal impact is derived from differences in premium taxes. For the State overall, premium taxes represent a net revenue equal to the FMAP multiplied by total premium taxes paid. For HHSC, premium taxes represent a net expense equal to (one minus the FMAP) multiplied by total premium taxes. Please see Appendices F through I for more details on these calculations.

Table 4. Estimated Federal vs. State Fiscal Impact Summary
Two-Year Total, SFYs 2021 – 2022
Estimated MLTSS Spending vs. Status Quo spending
($ in thousands)

	Scenario 1 (All Services)	Scenario 2 (Some Services)	Scenario 3 (All Services)	Scenario 4 (Some Services)
(A) Total Fiscal Impact (Claims + Admin) without Premium Tax	$49,564	$22,538	$72,089	$34,278
(B) Federal Portion of Claims + Admin Impact *(B) = FMAP * (A)*	$30,503	$13,703	$44,434	$20,715
(C) State Portion of Claims + Admin Impact *(C) = (1 - FMAP) * (A)*	$19,061	$8,835	$27,655	$13,563
(D) Federal Portion of Premium Tax	$14,799	$5,097	$11,047	$4,525
(E) HHSC Portion of Premium Tax	$9,323	$3,282	$6,901	$2,969
(F) Federal Net Fiscal Impact (after premium tax) *(F) = (B) + (D)*	$45,302	$18,800	$55,481	$25,240
(G) State Net Fiscal Impact (after premium tax) *(G) = (C) - (D)*	**$4,262**	**$3,738**	**$16,608**	**$9,038**
(H) HHSC Net Fiscal Impact (after premium tax) *(H) = (C) + (E)*	**$28,385**	**$12,117**	**$34,555**	**$16,531**

The analysis aims to provide a plausible range of fiscal impacts Texas may experience from implementing IDD MLTSS using the assumptions and methodologies described above. This report is not intended to provide a single "point estimate" of cost-effectiveness, as there are many unknowns in future trends and with HHSC's decisions regarding the IDD LTSS carve-in. Rather, it provides a range of reasonable estimates.

Finally, it is important to consider the implications of quality and access to LTSS for this population. While this analysis does not model the impact of these factors on expenditures, these considerations are vital for ensuring positive outcomes for individuals with IDD. A synthesis of national studies on managed care conducted by the Mallman School of Public Health at Columbia University and the Robert Wood Johnson

Foundation[15] reported some evidence of improved access to the usual sources of care for members in Medicaid managed care programs. Other results, however, show that access to care is unchanged or negatively impacted by a transition to managed care.

While general increased access to care could decrease expenditures through improved health outcomes for members, it is not apparent that the increase in access is consistent across all populations and managed care programs.[16] Similar to the findings on access to care, cost data on quality outcomes are not readily available and have varied results.[17] Over the past several years, some small case studies have indicated improved quality and outcomes in managed care with care management techniques by plans. Research conducted in five states that have implemented managed care programs indicated that "anecdotal evidence suggests" savings could be realized through implementation of effective care management techniques. Limited research has been conducted with people with more complex needs, however, such as individuals with IDD and older persons.[18]

[15] Michael Sparer, Mallman School of Public Health at Columbia University and the Robert Wood Johnson Foundation, "Medicaid managed care: Costs, access, and quality of care", (September 2012).
[16] Medicaid and CHIP Payment and Access Commission, "*Managed care's effect on outcomes*" (2018).
[17] Medicaid and CHIP Payment and Access Commission, "*Managed care's effect on outcomes*" (2018).
[18] The Robert Wood Johnson Foundation, *"Medicaid managed care: Costs, access, and quality of care"*, (2012).

2 Introduction

Chapter 534, Sections 201 and 202, provide direction for the timeline and basis of the transition of individuals receiving IDD LTSS via the FFS waivers to managed care. This IDD LTSS Cost-Effectiveness Evaluation analyzes the potential fiscal impacts of the transition of IDD LTSS in Texas from the current FFS model to a managed care delivery model.

2.1 Purpose of IDD LTSS Carve-in Cost-Effectiveness Evaluation

The State of Texas HHSC sought support to evaluate the cost-effectiveness of transitioning current FFS programs for IDD LTSS to managed care.

Section 534.201 outlines requirements for the transition of the TxHmL waiver to managed care. As per this section, the Medicaid benefits being provided to individuals in the TxHmL waiver are to transition to the STAR+PLUS Medicaid managed care program delivery model or the most appropriate integrated capitated managed care program delivery model, as determined by the commission, by September 1, 2020. The commission is to determine the most appropriate program based on:

- Cost-effectiveness;
- The experience of the STAR+PLUS Medicaid managed care program in providing basic attendant and habilitation services (the Community First Choice benefit); and
- The effectiveness of pilot programs created under the statute.

Section 534.202 outlines requirements related to the transition of the HCS, CLASS, and DBMD waivers; and ICFs/IID. As per this section, these programs are scheduled to transition to managed care on September 1, 2021. Similar to the TxHmL waiver, these programs are to transition to the STAR+PLUS Medicaid managed care program delivery model or the most appropriate integrated capitated managed care program delivery model, as determined by the commission. The determination for these programs, however, is to be based on cost-effectiveness and the experience of the transition of TxHmL waiver under section 534.201.

2.2 Approach

An evaluation of the fiscal impact under the proposed changes to IDD LTSS was conducted based on data provided by HHSC and informed by publicly available data and reports. While a detailed audit of the data was not conducted, high-level reasonableness checks of the data were performed where appropriate. Potential errors or omissions within the data will similarly affect the analysis results.

The analysis was performed in coordination with HHSC staff. Meetings with HHSC were conducted on a regular basis to review the underlying data, research, questions, assumptions and findings.

This IDD LTSS Cost-Effectiveness Evaluation includes a brief description of the background to this analysis and the programs being evaluated, the methodology, and specific assumptions used. It also includes a detailed description of the analysis and findings of the cost-effectiveness of transitioning IDD LTSS from FFS to a managed care delivery model in accordance with Chapter 534.

2.3 Proposed Transitions Evaluated Under IDD LTSS Carve-in Cost-Effectiveness Evaluation

Chapter 534 includes requirements related to each of the transitions mentioned in Section 2.1 above, specifically related to implementation options for the involved programs. Additional transition options evaluated in this report, such as whether specific services are carved-in or remain in FFS, were determined and directed by HHSC.

2.3.1 Texas Home Living Transition to Managed Care

As per Section 534.201, benefits for TxHmL waiver participants shall be transitioned to managed care by September 1, 2020. HHSC must determine the transition strategy for existing TxHmL waiver services. HHSC identifies the following transition options for these programs:

- Maintain operations of the TxHmL waiver in FFS in conjunction with the managed care program to only provide supplemental LTSS not available under managed care. This option means only some services previously available under the TxHmL waiver are carved into managed care; or
- Cease to operate the TxHmL waiver and provide all services and supports previously available via the waiver through the managed care program; or
- Cease to operate the TxHmL waiver and provide a portion of the services and supports previously available via the waiver through the managed care program.

Upon implementation of the managed care program, enrollment in the program is mandatory for services HHSC chooses to carve in. If HHSC chooses to retain some services under the TxHmL FFS waiver, individuals must receive those services under the waiver. In other words, individuals in the TxHmL waiver do not have a choice of FFS versus managed care delivery systems and must receive services based on HHSC's FFS or managed care service decisions.

2.3.2 Transition of Other Programs to Managed Care

Section 534.202 requires that benefits available through the HCS, CLASS, and DBMD waivers and ICFs/IID transition to managed care by September 1, 2021. HHSC must also determine the transition strategy for services provided to these beneficiaries. HHSC identifies the following transition options for these programs:

- Maintain operations of the HCS, CLASS, and DBMD waivers and ICFs/IID in FFS in conjunction with the managed care program to only provide supplemental LTSS not available under managed care. This option means only some services are carved into managed care, and waiver participants would continue to receive any other services through the FFS waiver; or
- Carve-in all services previously available under these waivers to managed care. Under this option, the HCS, CLASS, and DBMD waivers would continue to exist to serve members who choose to continue receiving services under their respective current waiver rather than choosing to receive these services under managed care.

Under both options above, HHSC could choose to remove certain services currently available under these programs altogether and not provide them under the waivers, ICFs/IID, or a managed care model.

If HHSC chooses to transition all currently available waiver services to managed care, participants have the option of:

- Continuing to receive services and supports via the FFS waiver; or
- Receiving services and supports through the managed care program. A participant who opts to transition to the managed care program may not transfer back to the waiver at a later date.

Only individuals receiving services through the waivers at the time of transition may choose to remain in their existing FFS waiver, and this decision may only be made if HHSC carves all services into managed care for the HCS, CLASS, or DBMD waivers. Individuals who enroll after the transition are required to receive their services under the managed care model.

For the ICFs/IID program, current or future participants do not have the choice to continue receiving services under FFS. Enrollment in the new managed care program is mandatory for this population once services are carved in.

2.4 IDD Programs Impacted by the Transition

Each of the programs that are scheduled to transition to managed care under Chapter 534 provide a different set of services and supports to individuals who meet specific functional eligibility criteria. The programs are administered using the Medicaid FFS model but are each designed to meet the circumstances of the eligibility group. For

example, the waivers differ in service packages and cost limitations. Table 5 below displays the enrollments and total costs for each Medicaid FFS waiver and the ICF/IID program, between SFY 2015 and SFY 2017.

Table 5. Annual Enrollment and Costs by Texas HHSC Waiver Program
SFYs 2015 – 2017

Program	SFY2015 Member Months	SFY 2015 Expenditures	SFY2016 Member Months	SFY2016 Expenditures	SFY 2017 Member Months	SFY 2017 Expenditures
TxHmL	82,004	$74,164,111	77,287	$130,762,843	80,488	$134,759,756
HCS	276,516	$1,385,084,467	285,225	$1,547,169,128	322,973	$1,606,549,269
CLASS	59,047	$208,742,134	55,383	$232,463,941	66,737	$260,990,811
DBMD	2,605	$8,876,398	2,972	$10,328,450	4,134	$12,937,028
ICF/IID	64,342	$245,416,871	56,658	$249,316,602	61,116	$245,773,521
Total	484,514	$1,922,283,981	477,535	$2,170,040,964	535,448	$2,261,010,385

For each Medicaid waiver, a breakdown of average annual spend by service is included. For purposes of this evaluation, HHSC's 158 different service codes were logically grouped into the following eleven service categories and are detailed by waiver below. Please see Appendix A for a full mapping of service codes to the following service categories:

- Personal Attendant Services/Habilitation (PAS/HAB)
- Respite
- Case Management
- Nursing
- Therapies
- Residential
- Fees
- Transportation
- Intervener

- ICF Daily Care
- Other

2.4.1 Texas Home Living (TxHmL) Waiver

The TxHmL waiver provides services to individuals with ID and DD who live in their own homes or family homes. Services are intended to enhance quality of life, functional independence, and health and well-being by supplementing, rather than replacing, existing informal or formal supports and resources. An individual enrolled in the TxHmL waiver receives required services up to $17,000 per service plan year.[19]

The TxHmL waiver includes the following services:

- PAS/HAB
- Respite
- Transportation
- Employment Services
- Consumer Directed Services
- Minor Home Modifications
- Adaptive Aids
- Nursing
- Therapies
- Dental Treatment
- Dietary Services
- Prescribed Drugs[20]

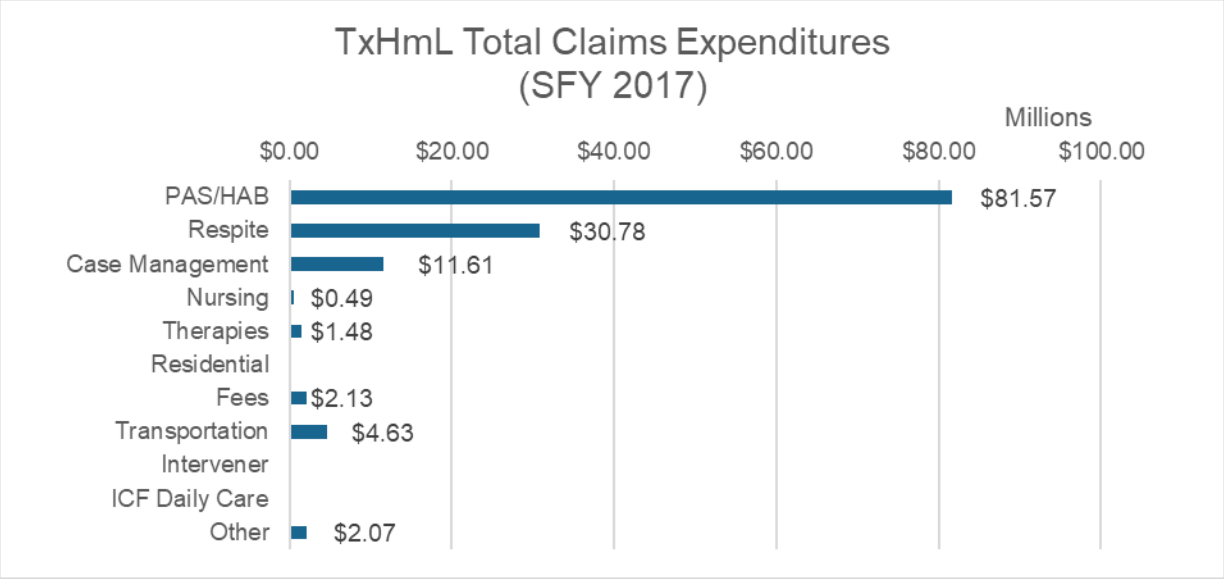
These TxHmL services are comprised of 40 different service codes that were charged in SFY 2017. Of these 40 service codes, three codes make up 70% of the Total Spend: PAS/HAB (38%), Respite-Hourly (17%) and Consumer Directed Services (CDS) PAS/HAB (15%). Please see Appendix B for details of the service codes charged in SFY 2017.

[19] As per TxHmL waiver renewal effective March 1, 2017, CMS control TX.0403.R03.00, available at: https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/providers/long-term-care/txhml/txhml-waiver-renewal-march-2017.pdf.

[20] Baseline Texas LTSS data used in this report did not include prescription drug expenditures and fiscal impacts for this service are not modeled.

When grouped into the eleven service categories analyzed in this evaluation, the SFY 2017 claims expenditures are as follows (Figure 1):

Figure 1 TxHmL Total Claims Expenditures by Service Category, SFY 2017



All TxHmL waiver services may be consumer directed or provided through the traditional provider-managed model. Approximately 20% of individuals enrolled in the waiver receive consumer-directed services.

Enrollment functions and case management services for the TxHmL waiver are provided by local intellectual and developmental disability authorities (LIDDAs) under contract with HHSC. Case management provided by the LIDDAs is funded through the Texas Medicaid State Plan as targeted case management.

There were approximately 6,400 people enrolled in the waiver as of January 31, 2018.[21]

[21] Data retrieved from the Texas Home Living Waiver Quarterly Dashboard for Fiscal Year 2018, Quarter 1.

2.4.2 Home and Community-Based Services (HCS) Waiver

The HCS waiver provides services to individuals with ID or a related condition[22] living in a variety of settings, including:

- the individual's own home,
- a family home, or
- residential services options, such as host home/companion care settings and three- or four-person group homes

The cost limit is 200 percent of the institutional average as of August 31, 2010. An individual enrolled in the HCS waiver receives services per a service plan based on an assessed level of need and the associated cost limit. Cost limits are designated for levels of need 1, 5, 6, 8 and 9; levels for 2, 3, 4 and 7 do not exist. Cost limits are defined as follows[23]:

- Intermittent (Level of Need 1), Limited (Level of Need 5), and Extensive (Level of Need 8): $167,468
- Pervasive (Level of Need 6): $168,615
- Pervasive Plus (Level of Need 9): $305,877

The HCS waiver provides the following services:

- Residential
- PAS/HAB
- Respite
- Employment Services
- Consumer Directed Services
- Transition Assistance
- Minor Home Modifications
- Adaptive Aids
- Nursing

[22] Meaning a condition that is a severe and chronic disability that is attributed to: (i) cerebral palsy or epilepsy; or (ii) any other condition, other than mental illness, found to be closely related to [intellectual disability] because the condition results in impairment of general intellectual functioning or adaptive behavior similar to that of individuals with [intellectual disability], and requires treatment or services similar to those required for individuals with [intellectual disability]; is manifested before the individual reaches age 22; is likely to continue indefinitely; and results in substantial functional limitation in at least three of the following areas of major life activity: (i) self-care; (ii) understanding and use of language; (iii) learning; (iv) mobility; (v) self-direction; and (vi) capacity for independent living (Texas HHS Approved Diagnostic Codes for Persons with Related Conditions Effective October 1, 2018 to September 30, 2019).

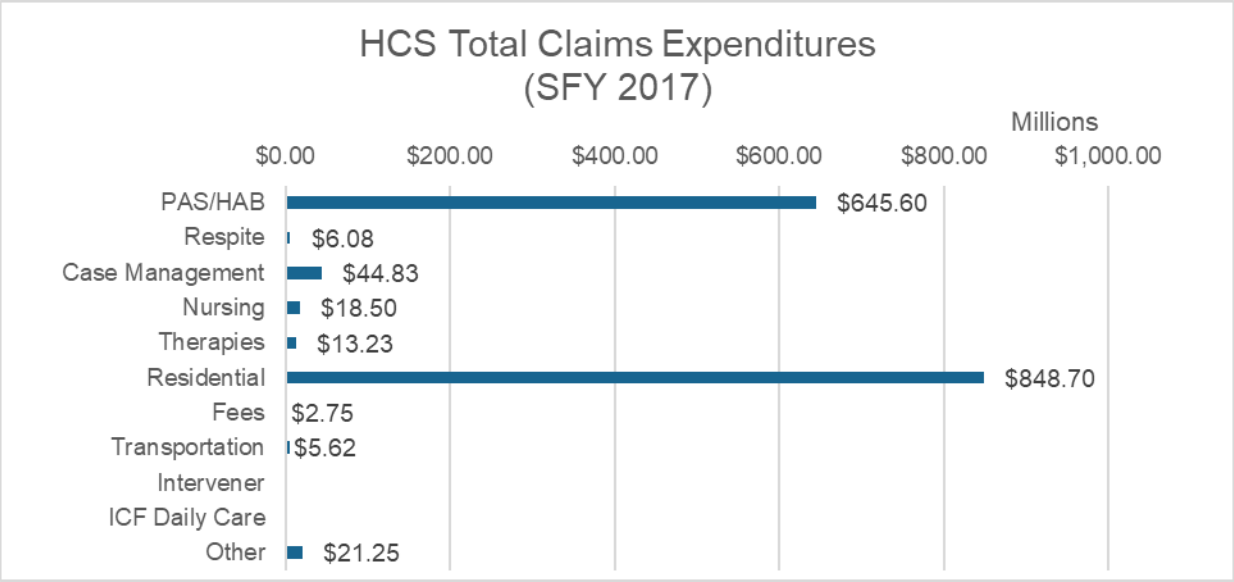
[23] As per HCS waiver amendment effective January 1, 2018, CMS control TX.0110.R06.12, available at https://hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/hcs-waivers/hcs-waiver-amendment12.pdf.

- Therapies
- Dental Treatment
- Dietary Services
- Prescribed Drugs[24]

These HCS services are comprised of 45 different service codes that were charged in SFY 2017. Of these 45 service codes, four codes account for approximately 87.6% of the Total Spend: Habilitation-Day (34.8%), Foster/Companion Care (24.8%), Residential Support Services (18.7%), and Supervised Living (9.3%). Please see Appendix C for details of the service codes charged in SFY 2017.

When grouped into the eleven service categories analyzed in this evaluation, the SFY 2017 claims expenditures are as follows (Figure 2):

Figure 2 HCS Total Claims Expenditures by Service Category, SFY 2017



All HCS waiver services may be provider-managed. The following HCS waiver services may be consumer-directed: supported home living, respite, nursing, employment assistance, supported employment, cognitive rehabilitation therapy. Only three percent of individuals enrolled in HCS receive consumer-directed services.

Enrollment functions and case management services for the HCS waiver are provided by LIDDAs under contract with HHSC. Case management provided by the LIDDAs is

[24] Baseline Texas LTSS data used in this report did not include prescription drug expenditures and fiscal impacts for this service are not modeled.

funded through the Texas Medicaid State Plan as targeted case management. There were approximately 27,300 people enrolled in the waiver as of January 31, 2018.[25]

2.4.3 Community Living Assistance Supports and Services (CLASS) Waiver

The CLASS waiver provides services to individuals with a related condition who live in their own homes or family homes. Services are designed to enhance individuals' quality of life, functional independence, and health and well-being. The cost limit for CLASS services is $114,736.07.[26] The CLASS waiver provides the following services:

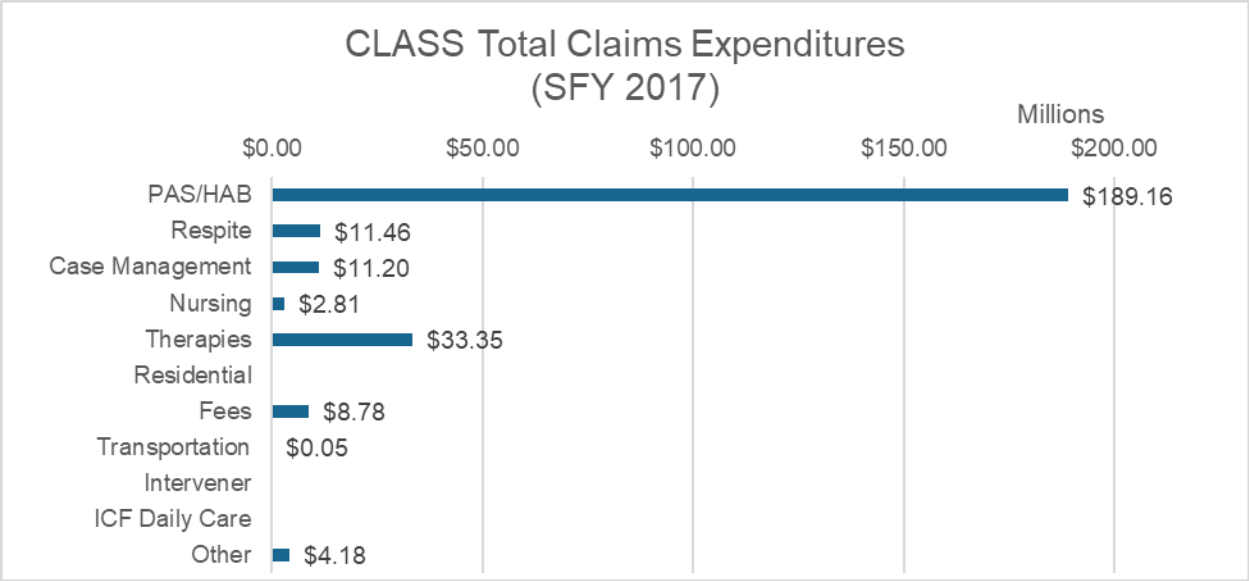
- PAS/HAB
- Case Management
- Employment Services
- Consumer Directed Services
- Respite
- Transition Assistance
- Minor Home Modifications
- Adaptive Aids
- Nursing
- Therapies
- Specialized Therapies
- Dental Treatment
- Dietary Services
- Prescribed Drugs[27]

These CLASS services are comprised of 49 different service codes that were charged in SFY 2017. Of these 49 service codes, two codes account for 71% of the Total Spend: PAS/HAB (38.1%) and CDS PAS/HAB (32.9%). Please see Appendix D for details of the service codes charged in SFY 2017.

[25] Data retrieved from the Home and Community Services Waiver Quarterly Dashboard for Fiscal Year 2018, Quarter 1, received from Health and Human Services Commission via email on May 3, 2018.
[26] Texas Administrative Code Title 40, Chapter 45.201(a)(5).
[27] Baseline Texas LTSS data used in this report did not include prescription drug expenditures and fiscal impacts for this service are not modeled.

When grouped into the eleven service categories analyzed in this evaluation, the SFY 2017 claims expenditures are as follows (Figure 3):

Figure 3 CLASS Total Claims Expenditures by Service Category, SFY 2017



All CLASS waiver services may be provider-managed. The following services may be consumer directed: residential habilitation, support consultation, nursing, therapies (physical, occupational, speech/language, cognitive rehabilitation), supported employment, employment assistance, and respite. Approximately 44 percent of individuals in the waiver receive consumer-directed services.

There were approximately 5,700 people enrolled in the waiver as of January 31, 2018.[28]

2.4.4 Deaf Blind with Multiple Disabilities (DBMD) Waiver

The DBMD waiver provides services to individuals who are deaf and/or blind and who also have at least one additional disability that limits functional ability. The waiver assists individuals to live independently in their own home, their parent's/guardian's home, or in a small group home setting. An individual enrolled in the DBMD waiver receives required services up to $114,736.07 per service plan year[29].

Services available through the DBMD waiver include:

- Residential (Assisted Living Services)
- PAS/HAB

[28] Data retrieved from the Community Living Assistance Supports and Services Waiver Quarterly Dashboard for Fiscal Year 2018, Quarter 1, received from Health and Human Services Commission via email on May 3, 2018.
[29] As per DBMD waiver renewal effective March 1, 2018, CMS control TX.0281.R05.00, available at https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/providers/health/DBMD_Renewal.pdf

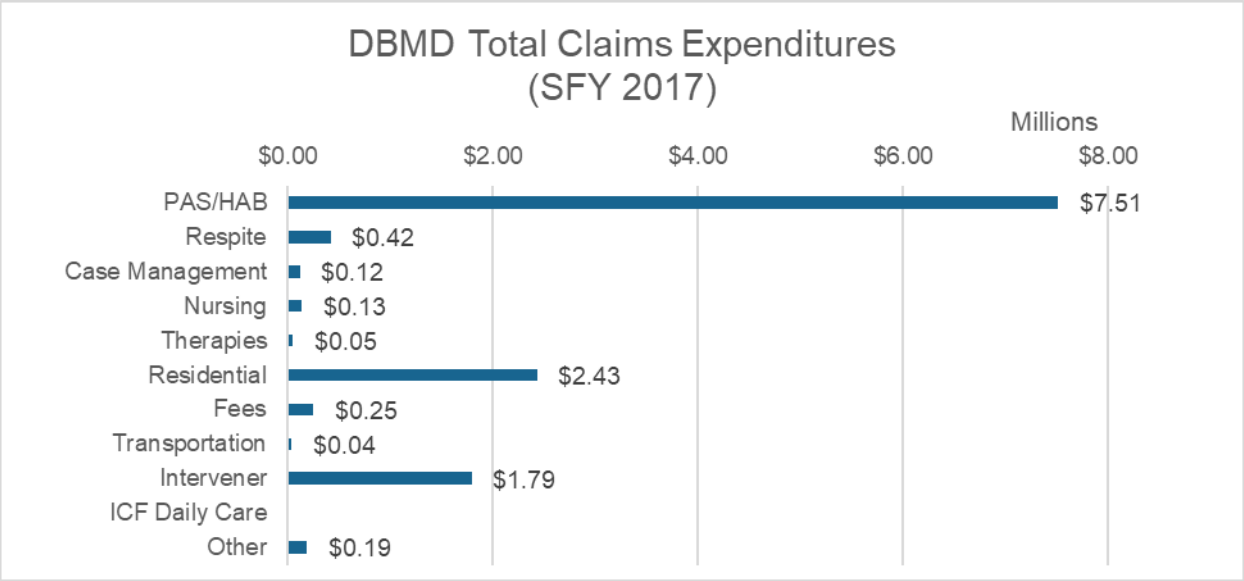
- Intervener
- Case Management
- Employment Services
- Consumer Directed Services
- Respite
- Transition Assistance
- Minor Home Modifications
- Adaptive Aids & Medical Supplies
- Nursing
- Therapies
- Dental Treatment
- Dietary Services
- Prescribed Drugs[30]

These DBMD services are comprised of 40 different service codes that were charged in SFY 2017. Of these 40 service codes, five codes account for 78.1% of the of the Total Spend: PAS/HAB (35.9%), CDS PAS/HAB (18.6%), Assisted Living – Apartment (10.5%), Intervener (7.0%), and Assisted Living – Habilitation 24 Hr. (6.1%). Please see Appendix E for details of the service codes charged in SFY 2017.

[30] Baseline Texas LTSS data used in this report did not include prescription drug expenditures and fiscal impacts for this service are not modeled.

When grouped into the eleven service categories analyzed in this evaluation, the SFY 2017 claims expenditures are as follows (Figure 4):

Figure 4 DBMD Total Claims Expenditures by Service Category, SFY 2017



All DBMD waiver services may be provider-managed. The following services may be consumer directed: residential habilitation, respite, intervener, supported employment, and employment assistance. Approximately 32 percent of individuals enrolled in the waiver receive consumer-directed services.

There were approximately 350 people enrolled in the waiver as of January 31, 2018.[31]

2.4.5 Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Condition (ICFs/IID)

ICFs/IID are 24-hour residential settings where individuals with ID or related conditions may receive services as per an individualized plan of care. The ICF/IID program utilizes professional staff to assist individuals in gaining skills to increase independence through the continuous, consistent provision of habilitation, specialized and generic training, treatment, health services, and related supports. Services include 24-hour residential, comprehensive and individualized health care, skills training, professional therapies, adaptive aids, participation in community activities, and vocational programs and employment services.

[31] Data retrieved from the Deaf Blind with Multiple Disabilities Waiver Quarterly Dashboard for Fiscal Year 2018, Quarter 1, received from Health and Human Services Commission via email on May 3, 2018.

There are two categories of ICFs/IID:

- State supported living centers, which support people with significant medical or behavioral health needs in a residential campus-based community
- Community-based ICFs/IID that provide 24-hour comprehensive residential care in small group or larger homes operated by private owners/operators

All ICFs/IID services were charged to a single service code in SFY 2017. This service code, Daily Care, accounts for 100 percent of the Total Spend, which was $245,773,521 in SFY 2017.

Enrollment functions for community-based ICFs/IID are provided by LIDDAs under contract with HHSC. Per Chapter 534, only community-based ICFs/IID will be included in the transition of Texas's long-term services and supports to managed care.

2.5 Reliance on Data

The analysis relied on data provided by HHSC as well as publicly available data. From the data provided by HHSC, some of these data sources were developed by HHSC, while others were prepared or created by third parties and delivered to HHSC. As part of the analysis, all data was reviewed for reasonableness, but an audit was not performed on the data. To the extent the data contains errors or anomalies that were unknown at the time the data was provided, the analysis may be affected by those issues.

3 Background

Texas Medicaid provides coverage for medical care and LTSS for eligible IDD members. HHSC's past transitions to managed care and the current IDD LTSS environment in Texas, which are described below, provide grounding that is critical to understanding how the programs and populations considered in this evaluation may be impacted by the transition of IDD LTSS from FFS to managed care.

3.1 Medicaid Managed Care in Texas

Texas first began to implement managed care programs in 1993, and now serves various populations through programs such as STAR, STAR+PLUS, STAR Health, Dual Demonstration, STAR Kids, CHIP, and CHIP Perinatal. The scope of this report and analysis includes the review of STAR+PLUS, STAR Health, and STAR Kids managed care programs. These managed care programs currently provide acute care services for children and adults in IDD programs.

3.1.1 STAR+PLUS

STAR+PLUS is an integrated model that provides acute, primary, behavioral health and LTSS to seniors and persons with disabilities; medical services to persons with IDD; and covers the Breast and Cervical Cancer Program (MBCC) for women receiving Medicaid. Individuals in this program receive all Medicaid benefits as well as help in the home with basic daily activities, help in making changes to the home, and short-term care to provide a break for caregivers.

Individuals enrolled in IDD programs first began receiving acute care services through STAR+PLUS in September 2014, when the program was expanded to include non-dual enrollees with IDD. In June 2015, Community First Choice (CFC) services were included as a state plan benefit in the STAR+PLUS program. CFC services are available to Medicaid enrollees who meet an institutional level of care, including individuals with IDD who are not enrolled in an IDD program. Available CFC services include:

- PAS
- Habilitation
- Support management
- Emergency response services

For individuals enrolled in the IDD waivers, the CFC state plan PAS/habilitation benefits are provided through the waiver infrastructure using the waiver provider. Transportation is provided as a waiver benefit and is offered in conjunction with CFC PAS/habilitation.

3.1.2 STAR Health

STAR Health is a managed care program that was introduced in April 2008 to improve the coordination of care for children in foster care and kinship care through the implementation of a statewide MCO. Services include comprehensive and integrated physical health, LTSS, behavioral health, vision, and dental benefits. Beginning November 1, 2016, STAR Health provided waiver benefits to recipients of the Medically Dependent Children Program (MDCP). Children in IDD programs were always enrolled in STAR Health for their non-waiver benefits. STAR Health also offers CFC services to children meeting an institutional level of care as of CFC implementation in June 1, 2015. Similar to STAR+PLUS, children in the IDD waivers receive CFC through their waiver provider.

3.1.3 STAR Kids

STAR Kids, implemented statewide in November 2016, is a managed care program that provides services to children with disabilities, including children receiving MDCP benefits. Through STAR Kids, children receive comprehensive benefits, including primary and specialty care, hospital services, prescription medications, and preventive care, as well as LTSS through the state plan, such as personal care and private duty nursing[32]. In November 2016, children in the IDD programs transitioned to STAR Kids managed care for their acute care services. Similar to the other programs, children in IDD waivers receive CFC services through their waiver program. Prior to STAR Kids, some children with disabilities were already enrolled in the STAR+PLUS managed care program for their acute care by choice. In November 2016 any children in STAR+PLUS for their acute care services were moved to STAR Kids.

3.1.4 Managed Care Strategy Pilot for LTSS IDD

Under Chapter 534, HHSC was authorized to develop a pilot to test the provision of MLTSS to individuals with IDD. HHSC developed a multi-phased approach to piloting a managed care strategy.

Phase I began in 2014 with the successful design of the pilot, which was accomplished through completion of the following:

- Gathering of information from stakeholders via statewide listening sessions and a Request for Information;
- Drafting of a concept paper, which was submitted to the Centers for Medicare & Medicaid Services (CMS) for discussion, feedback, and approval;
- Drafting of a Request for Proposals, which was issued;

[32] Adults enrolled in the IDD waivers only receive Medicaid-funded LTSS via the waivers and the CFC State Plan option.

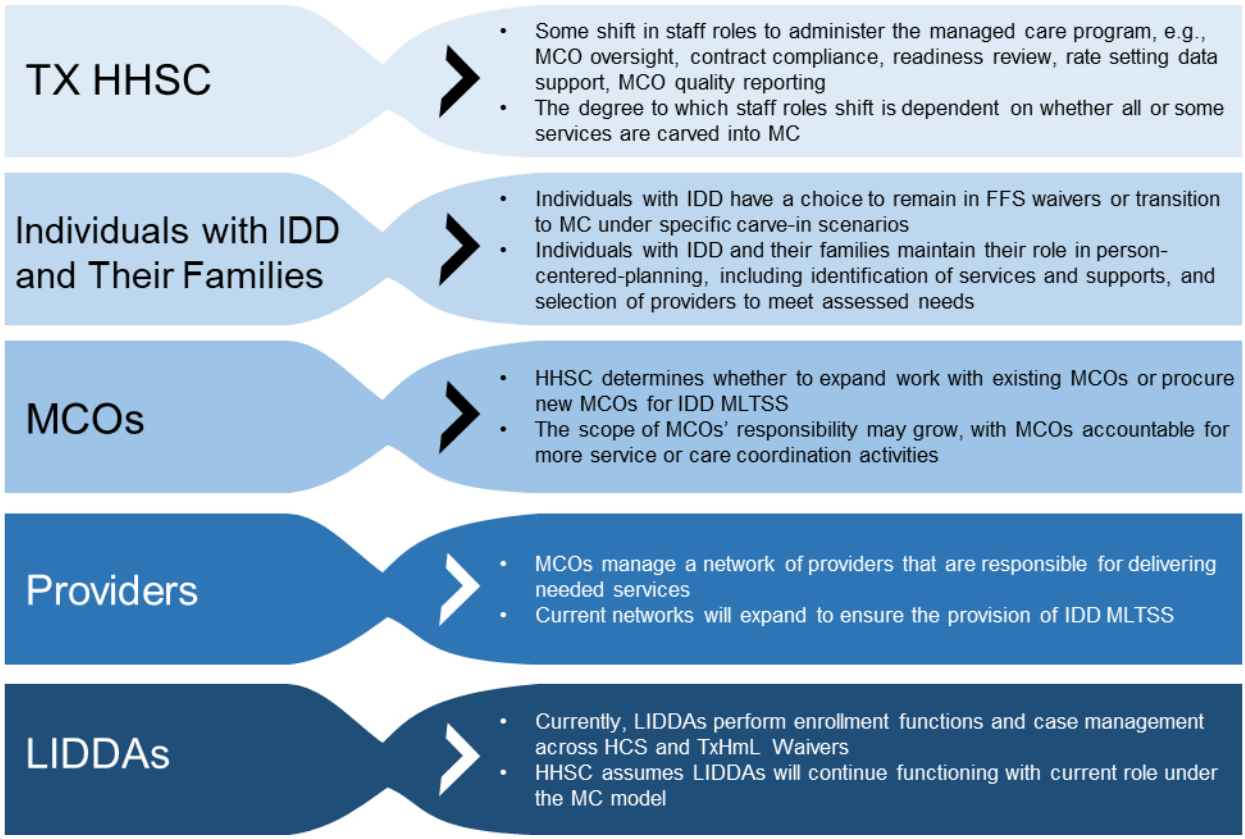
- Drafting of amendments for 1915(c) and 1115 waivers;
- Drafting of a proposed Readiness Review Timeline and Template.

During Phase II in September 2017, the Pilot Operationalization Phase, HHSC decided to end the pilot due to significant concerns related to cost-effectiveness, timeliness, and use of resources. For example, additional funds were not allocated to support the pilot despite the costs required to support extensive technology changes that would be needed, contractual amendments, communications, and stakeholder readiness. In addition, the tight deadlines established for the pilot provided insufficient time to adequately process the required waiver amendments, conduct planned and necessary communication strategies, ensure operational and systems readiness, and complete required procurement and contracting activities.

3.2 Texas IDD LTSS and Acute Care – Stakeholders across the Continuum

Individuals with IDD and their families, MCOs, direct service providers, and LIDDAS are stakeholders to consider in the transition of IDD LTSS services to managed care. Considerations of their future roles, which are largely dependent on the carve-in details selected by HHSC, are discussed in the graphic below (Figure 5). Currently, HHSC manages IDD LTSS programs while MCOs manage acute care services for individuals with IDD, a model that will change with the transition of IDD LTSS to managed care.

Figure 5. IDD LTSS Stakeholders in Texas



3.3 Medicaid FFS and Managed Care Payment Methods

Medicaid rate setting in Texas includes the establishment of rates for the IDD FFS waivers and the managed care programs. FFS waiver rates are established specific to each waiver service and can vary across services and waivers, while managed care rates are typically established on a per member basis. Rate setting processes in Texas are described in more detail below.

3.3.1 Medicaid FFS Payments

Medicaid rates for FFS waiver services may be established in a variety of ways and can vary by type of service. For example, the state may establish a standard FFS schedule with geographic variance to account for the cost of delivering services in different parts of the state, and/or include adjustments for the level of need required to accommodate provider costs associated with serving individuals with extraordinary needs. Rates may also be prospective or allow for retrospective cost settlement of interim rates. Regardless of the rate determination method employed for Medicaid waiver services, payments must be "consistent with efficiency, economy, and quality of care and [be] sufficient to enlist enough providers," as per §1902(a)30(A) of the Social Security Act.

Texas employs a variety of rate determination methods, utilizing multiple methods based on the type of service, for example, rebased modeled rates, pro-forma rates, median rates, and cost-based rates.

3.3.2 Managed Care Payments in Texas

Rates for Medicaid managed care are established as capitated payments, generally per member per month (PMPM), made to MCOs in exchange for the delivery of services to enrolled participants. Capitation rates must be actuarially sound, sufficient to cover all reasonable and appropriate costs for covered services and may be based on the state's FFS payment rates. States are able to establish capitation rates within the rate range that it has deemed actuarially sound. States may also define performance incentives for MCOs, identifying bonuses for meeting quality standards. A state may establish minimum fee schedules for providers in managed care. Finally, a state can mandate that MCOs participate in quality incentive programs.[33]

Capitation rates for the managed care programs in Texas are developed as a PMPM, which considers one year of encounter claims and applies trend assumptions for the rating period. Additional adjustments are made to reflect quality incentive programs, administrative expenses, and risk adjustment based on MCO member health. Certain specialty prescriptions are carved out and provided via FFS. Specific capitation rates are developed for the 13 managed care service delivery areas, then broken down by risk groups or rate cells.[34]

[33] Medicaid and CHIP Payment and Access Commission, "*Federal Requirements and State Options: Provider Payment"*, https://www.macpac.gov/wp-content/uploads/2017/03/Federal-Requirements-and-State-Options-Provider-Payment.pdf.

[34] These include eight risk groups or rate cells for both the STAR and the STAR+PLUS programs, seven risk groups or rate cells for the STAR Kids and CHIP programs, three risk groups for the Dual Demonstration, and aggregate statewide rates for the STAR Health program.

4 Approach and Methodology

4.1 Overview of Approach

A cost-effectiveness model was developed to evaluate the fiscal impacts of providing IDD LTSS under managed care in Texas. Using a range of assumptions and carve-in scenarios, the model provides the ability to analyze the fiscal impacts of the IDD LTSS transition. The following future-state scenarios were compared to assess the potential fiscal impact of the transition to managed care:

1. **Status Quo:** under the Status Quo scenario, HHSC continues to operate all IDD LTSS under the existing FFS waivers and programs, including TxHmL, HCS, CLASS, DBMD, and ICFs/IID. Using assumed trends from HHSC's budget and assumed administrative data attributable to each IDD LTSS program, estimated utilization and service costs by service category and administrative expenditures were developed for each IDD LTSS FFS program for SFYs 2018-2022.

2. **Managed Long-Term Services and Supports (MLTSS):** under the MLTSS scenario, various combinations of services offered under the current IDD LTSS FFS model are transitioned to managed care. The cost-effectiveness model applies several assumptions to adjust Status Quo expenditures under a managed care delivery model. Assumptions used in the model are detailed in Section 4.3 below, and include the impact of managed care on utilization, unit costs, and administrative expenditures. This estimate accounts for the flexibility Chapter 534 permits HHSC to determine which IDD LTSS services to carve in to managed care and which may remain under the FFS model. The MLTSS estimate also accounts for the Chapter 534 provision that provides members currently receiving FFS waiver services a choice to continue receiving FFS waiver services rather than move into the managed care arrangement, should HHSC choose to carve in all services of the HCS, CLASS or DBMD waivers.

Comparing the MLTSS and Status Quo scenarios provides an assessment of the fiscal impact of managed care on IDD LTSS. Based on the assumptions and data described in Sections 4.2 and 4.3, the differences between the MLTSS scenarios and Status Quo scenarios were compared to assess managed care fiscal impacts for Texas under various carve-in possibilities, which were determined by HHSC.

Four different scenarios were modeled to understand the potential range of fiscal impacts, as shown in Table 6 below.

Table 6. Summary of Scenarios Modeled

Assumption	Scenario 1	Scenario 2	Scenario 3	Scenario 4
All Services Carved-In or Some?[35]	All	Some	All	Some
Do HCS members have a MC/FFS choice?	Yes	No	Yes	No
Do CLASS or DBMD members have a MC/FFS choice?[36]	Yes	Yes	Yes	Yes
Do TxHmL or ICF/IID members have a MC/FFS choice?	No	No	No	No
Member Managed Care Election Percentage	25%	25%	10%	10%
Managed Care Unit Cost Adjustment	0%	0%	0%	0%
Managed Care Utilization Adjustment [37]	Higher	Higher	Lower	Lower
Managed Care Administrative Expenditure Increase [38]	Lower	Lower	Higher	Higher

These scenarios, along with more detailed assumptions, are described in more detail in Section 5.14.3 below.

[35] Please see Section 4.3 for the list of services that remain in FFS under Scenarios 2 and 4. These include only services in TxHmL and HCS (other three programs carve in all services).
[36] CLASS and DBMD members would not have a choice if any of their services remain in FFS. HHSC chose to transition all services for these waivers for the purposes of the scenarios modeled in this report.
[37] Please see Section 5.2.3 for details on utilization impacts for each scenario.
[38] Please see Section 5.3 for details on administrative expenditure impacts.

4.2 Data Used in Analysis

Various data sources were utilized to develop the fiscal impact estimates of providing IDD LTSS under managed care. Some of the data used in the model were provided by HHSC while other sources were publicly available, such as state data reported to CMS, capitation rate-setting documents, waiver applications, and published evaluations and reports.

All data provided by HHSC were reviewed for reasonableness prior to analysis; however, a full audit of the data was not conducted. Where possible, data provided by HHSC were compared against publicly available reports and CMS data to determine data reasonability. In certain cases, there were discrepancies between HHSC's data and the external sources. These anomalies and potential errors in the data may impact analysis and results and are discussed in greater detail below.

4.2.1 Historical Texas IDD LTSS Waiver and ICF/IID Data

HHSC provided aggregate monthly historical FFS data for IDD LTSS under each IDD waiver as well as ICFs/IID from SFY 2012 to SFY 2017. HHSC organized the data by program (TxHmL, HCS, CLASS, DBMD, or ICFs/IID), service code, county, age (under 21, or 21+), and dual-eligible status. The data included total paid dollars, units of service, and number of enrolled members by month of service for each data breakdown. These data served as the base period claims and enrollment data from which the Status Quo and MLTSS expenditure estimates were developed.

Table 7 below shows a summary of total expenditures for each program by state fiscal year.

Table 7. Historical IDD LTSS FFS Expenditures by State Fiscal Year (in thousands)

Program	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017
TxHmL[39]	$46,211	$58,498	$63,604	$74,164	$130,763	$134,760
HCS	$1,199,571	$1,237,151	$1,288,294	$1,385,084	$1,547,169	$1,606,549
CLASS	$131,064	$132,763	$144,442	$208,742	$232,464	$260,991
DBMD	$6,873	$7,120	$7,354	$8,876	$10,328	$12,937
ICF/IID	$268,703	$268,345	$263,082	$254,417	$249,317	$245,774
Total	$1,652,422	$1,703,877	$1,766,776	$1,931,283	$2,170,041	$2,261,011

Documentation from HHSC to directly check the reasonability of the summarized historical IDD LTSS FFS expenditures data provided by HHSC was unavailable for this evaluation. Instead, the total claims for each waiver were compared to control totals from CMS summary reports available publicly to weigh the reasonability of the data. The CMS data is from two sources:

- A summary of CMS-372 reports,[40] which states submit to CMS to document that the waiver meets cost neutrality requirements. These data were used to compare TxHmL, HCS, CLASS, and DBMD claims expenditures for the most recent report available, which used data from 2013-2014.[41]

- A summary of CMS-64 reports,[42] which states submit to CMS to claim federal matching funds. These data were used to compare ICF/IID claims expenditures for the most recent report available, which used data from Federal Fiscal Year (FFY) 2016.

[39] The increase in TxHmL costs between SFY 2015 and 2016 is due to the implementation of Community First Choice (CFC), which as a state plan benefit is not limited by waiver cost ceilings. TxHmL, with the lowest annual cost limit, saw the largest increase in expenditures. The state draws down an enhanced match rate for CFC services.
[40] The Truven Health Analytics summary of 2013-2014 CMS-372 data is available at https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/cms-372-report-2014.pdf
[41] CMS-372 defines a year based on the waiver's effective date.
[42] The IBM Watson Health summary of 2016 CMS-64 Medicaid LTSS expenditures is available at https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpenditures2016.pdf

Table 8 and Table 9 show the discrepancies identified between the data submitted by HHSC and the CMS reports discussed above:

Table 8. IDD Waiver FFS Data Comparison to CMS-372
(Expenditures in thousands, HHSC Data minus CMS-372)

Waiver	SFY2013 Expenditure Difference	SFY 2013 Percent Difference	SFY2014 Expenditure Difference	SFY2014 Percent Difference
TxHmL	($45)	(0.09%)	($572)	(1.09%)
HCS	$320,802	27.15%	$329,916	26.90%
CLASS	($11,245)	(5.66%)	($11,183)	(5.49%)
DBMD	($585)	(8.21%)	($408)	(5.54%)

Table 9. ICF/IID FFS Data Comparison to CMS-64 (expenditures in thousands)

Federal Fiscal Year (FFY)	Expenditure Difference (HHSC Data Minus CMS-64)	Percent Difference (HHSC Data Minus CMS-64)
2013	($6,293)	(2.35%)
2014	($10,810)	(4.11%)
2015	($14,878)	(5.85%)
2016	($18,812)	(7.55%)

Table 8 shows that the data provided by HHSC for the HCS waiver has over $320 million (26.9%) more claims expenditures than the CMS-372 reports for 2013 and 2014, while the other waivers have less expenditures than the CMS-372 reports. Additionally, Table 9 shows variation between HHSC's ICF/IID data and the "ICF–private" line in the Texas LTSS Expenditures summary of the CMS-64 report for FFY 2013-2016.

There are several potential explanations for the discrepancies observed, including that the reports have different purposes and may include different payments for services for different time periods. For example, there may be some expenditures included in the raw claims pull from HHSC that were not included in the CMS data, such as payments from Texas' CFC or Money Follows the Person Demonstration (MFPD) programs. Additionally, the CMS-64 reports expenditures on a date-paid basis while HHSC's raw claims pull was on a date of service basis.

The comparison to the CMS-372 and CMS-64 reports was meant to be a high-level, proxy comparison with the understanding that there were known differences between

these reports and the data used for the analysis. While efforts were made to reconcile or explain the differences observed, the exact causes of the discrepancies were not able to be identified within the analysis timeframe; therefore, the data provided by HHSC was used as the basis for the analysis with identified discrepancies noted. Because of these discrepancies, the fiscal impact in terms of total dollars presented in this report may vary by a similar amount as the differences noted in Table 8 and Table 9. However, the PMPM and percent fiscal impact conclusions should still be reasonable and allow for meaningful analysis.

The data received for eligible member months were also reviewed and were found to be consistent with quarterly dashboards produced by HHSC. Table 10 provides a summary of total member months by waiver for each year of data.

Table 10. Historical IDD LTSS FFS Eligible Member Months by State Fiscal Year

Program	SFY2012	SFY2013	SFY2014	SFY2015	SFY2016	SFY2017
TxHmL	54,393	63,854	73,891	82,004	77,287	80,488
HCS	242,875	245,860	252,174	276,516	285,225	322,973
CLASS	57,817	56,812	56,455	59,047	55,383	66,737
DBMD	1,811	1,843	1,944	2,605	2,972	4,134
ICF/IID	69,034	68,457	66,643	64,342	56,658	61,116
Total	425,930	436,826	451,107	484,514	477,525	535,448

4.2.2 Historical Texas LIDDA Targeted Case Management Data

In addition to the historical waiver and ICF/IID data, this evaluation utilized HHSC's claims data for targeted case management (TCM). As an approved Medicaid State Plan service, TCM is provided outside of the FFS waivers for participants of the TxHmL and HCS waivers. Third party LIDDAs provide TCM for the TxHmL and HCS waivers. Because these services are not administered through the waivers for members in TxHmL and HCS, the claims information was not included in the HHSC claims pull and was collected separately from the LIDDAs. These data were combined with the FFS LTSS data to complete the baseline experience data for SFYs 2012-2017.

Table 11. Historical Targeted Case Management Expenditures from LIDDAs (in thousands)

Program	SFY2012	SFY2013	SFY2014	SFY2015	SFY2016	SFY2017
TxHmL	$8,558	$10,130	$11,197	$11,936	$12,469	$11,610
HCS	$37,401	$37,754	$37,496	$39,968	$43,684	$44,827

4.2.3 Historical Texas IDD Acute Care, PCS, PDN, and CFC Data

In addition to the baseline FFS LTSS data, HHSC provided historical acute care, Personal Care Services (PCS), Private Duty Nursing (PDN), and CFC claims and enrollment data. Where applicable, trends in these data were used to inform assumptions for the IDD LTSS cost-effectiveness model.

The acute care data was provided as quarterly claims and enrollment (distinct member counts) from SFYs 2012-2017. These contained claims for Inpatient, Outpatient, Professional, and Dental service categories for individuals with IDD. The data included claims paid on a FFS basis as well as claims paid by MCOs under the Texas managed care programs (STAR, STAR+PLUS, STAR Kids, and STAR Health).

The PCS, PDN, and CFC data was provided using the same breakdowns as the acute care data. While data for services under both FFS and managed care was requested, only data on claims paid under FFS was available which did not allow for a comparison of service expenditures under managed care versus FFS.

Baseline Texas LTSS data used in this report did not include prescription drug expenditures and fiscal impacts for this service are not modeled.

4.2.4 State Administrative Expenditures

HHSC provided total Medicaid administrative expenditures on a quarterly Federal Fiscal Year (FFY) basis between FFY 2014 and FFY 2017. Efforts were made to obtain an accurate measurement of administrative expenditures directly attributable to IDD LTSS services. However, this breakdown of administrative expenditures was not readily available or measurable. Therefore, several assumptions were required to derive estimates of historical administrative expenditures for each IDD LTSS waiver. These assumptions are explained in detail in Section 4.3.

Since total historical Medicaid administrative expenditures were provided on a FFY basis (which begins in October), adjustments were made to restate the data consistent with the modeling approach using a SFY basis (which begins in September). These adjustments were made by interpolating the average monthly administrative expenditures for each quarter and adding or subtracting the average expenditures for

the month of September to reach a total estimated amount for each SFY. The summary of the data is shown in Table 12 below:

Table 12. Historical Total Texas All Funds Administrative Expenditures (in thousands)

Basis	2014	2015	2016	2017
FFY Actual	$1,445,978	$1,456,424	$1,505,040	$1,507,684
SFY Estimated	$1,434,664	$1,473,320	$1,503,135	$1,498,988

To estimate the amount of administrative expenses attributable to each IDD LTSS waiver and ICFs/IID, the ratio of total Medicaid administrative expenditures to total Medicaid expenditures (excluding administrative expenditures) was calculated for each year. This ratio was then applied to each FFS program's IDD LTSS expenditures for each year to arrive at the estimated administrative expenditures for each program.

Table 13 and Table 14 provide a summary of administrative expenditure ratios and corresponding estimated IDD LTSS waiver administrative expenditures for each year.

Table 13. Historical Administrative Expenditure Ratios

Metric	SFY 2012[43]	SFY 2013[44]	SFY 2014	SFY 2015	SFY 2016	SFY 2017
Admin Ratio	4.10%	4.10%	4.49%	4.15%	3.72%	4.06%

[43] Because administrative data was not provided for 2012 or 2013, these ratios were assumed equal to the average of SFY 2014-2017 ratios. 2012 and 2013 data do not affect the analysis, but are shown to be consistent with IDD LTSS claims data and for historical context.
[44] Because administrative data was not provided for 2012 or 2013, these ratios were assumed equal to the average of SFY 2014-2017 ratios. 2012 and 2013 data do not affect the analysis, but are shown to be consistent with IDD LTSS claims data and for historical context.

Table 14. Estimated Historical Administrative Expenditures (in thousands)[45]

Program	SFY2012	SFY2013	SFY2014	SFY2015	SFY2016	SFY2017
TxHmL	$1,896	$2,400	$2,855	$3,078	$4,859	$5,467
HCS	$49,219	$50,761	$57,831	$57,490	$57,492	$65,174
CLASS	$5,378	$5,447	$6,484	$8,664	$8,638	$10,588
DBMD	$282	$292	$330	$368	$384	$525
ICF/IID	$11,025	$11,010	$11,810	$10,560	$9,264	$9,971

4.2.5 Estimated Waiver Trends from HHSC Budget

HHSC provided forecasted FFS data for TxHmL, HCS, CLASS, DBMD, and ICFs/IID. These included forecasted caseloads, expenditures per client, and total expenditures for SFYs 2019-2022, and were used to develop baseline PMPM trend assumptions.

4.2.6 Estimated Federal Medical Assistance Percentages (FMAP) for Texas

HHSC provided estimated FMAP percentages for SFYs 2020-2022 for each of the IDD LTSS waivers and ICFs/IID. Because CFC services receive an enhanced FMAP from the federal government, each IDD waiver has a "blended" FMAP reflecting the enhanced Federal match on CFC expenditures and the regular Federal match on non-CFC expenditures. The evaluation used these FMAPs to determine the breakdown of federal versus state fiscal impacts, as discussed in Section 5.7. Table 15 below shows the estimated FMAPs by waiver.

[45] Estimated administrative expenditures are equal to total claims times the administrative ratios from Table 13 for each program and year.

Table 15. HHSC Estimated FMAP (Federal Share)

Program	SFY2020	SFY2021	SFY2022
TxHmL	63.08%	63.21%	63.21%
HCS	60.08%	60.21%	60.21%
CLASS	63.92%	64.05%	64.05%
DBMD	62.80%	62.93%	62.93%
ICF/IID	59.66%	59.79%	59.79%

4.2.7 Texas Managed Care Rate Setting Documents

Various capitation rate setting documents were examined from Texas managed care programs, including STAR+PLUS, STAR Kids, STAR Health, and Dual Demonstration.[46] To the extent necessary, assumptions or data included in these documents were used to supplement other fiscal impact data points found in other states.[47] Select data points gathered from these documents include:

- Assumed fixed administrative expenditures used for STAR+PLUS in SFY 2019 capitation rates: **$20.00 PMPM**
- Assumed variable administrative expenditures used for STAR+PLUS in SFY 2019 capitation rates: **5.75% of premium**
- Risk margin used for STAR+PLUS in SFY 2019 capitation rates: **1.75% of premium**
- Premium tax used for STAR+PLUS in SFY 2019 capitation rates: **1.75% of premium**
- Maintenance tax used for STAR+PLUS in SFY 2019 capitation rates: **$0.06 PMPM**

[46] Texas rate setting documents can be found at https://rad.hhs.texas.gov/managed-care-services
[47] STAR+PLUS assumptions were the primary focus of this report, as STAR+PLUS is the managed care model referenced specifically in Chapter 534.

- Approximate percent of the qualified dual-eligible members in select counties who left FFS to move into Dual Demonstration (SFY 2019 Dual Demonstration rate certification) since its introduction in March 2015: **35%**

- Assumed managed care savings for IDD acute care transition to STAR+PLUS, SFY 2015: **5%** (this assumption was reduced to **0%** in the SFY 2016 capitation rates)

- Assumed managed care savings used for STAR Kids in SFY 2019 capitation rates: **7.5%**

4.2.8 Program and Policy Changes

HHSC also provided documents detailing historic changes made to the waiver programs, including TxHmL, HCS, CLASS, DBMD, and the MDCP. These documents were used to inform potential causes of outliers, changes, or trends identified in the historical Texas IDD LTSS data.

4.2.9 Other State Fiscal impacts

In addition to the Texas-specific historical data noted above, the analysis utilized publicly available fiscal impact data on other states that have transitioned to managed care. Sources include waiver application budget neutrality exhibits, capitation rate setting documents, published evaluations and studies, and state-specific and comparative expenditure reports posted online. While much of the data included the actual fiscal impact that states experienced, some data points, including those derived from waiver applications and rate setting documents, were assumed fiscal impacts.

This data was used along with Texas-specific data to inform fiscal impact assumptions in the cost-effectiveness model. Efforts were made to find other-state data points specific to IDD LTSS. However, in many cases the data included non-IDD members, acute care services, or both. While there are no states that have identical programs to Texas, states with IDD MLTSS or MLTSS programs for similar populations were identified and analyzed.

Table 16 below provides a summary of the select data points found in other states. This table shows a wide range of fiscal impacts, ranging from a 47% reduction in expenditures (for Arizona's estimated SFY 2016-2021 1115 waiver budget neutrality) to a 10% increase in expenditures (from Kansas' observed real, trend-adjusted, percent change in spending for the state's Developmental Disability waiver from CY 2013-2016).

The context of how other states and their programs were similar to or different from Texas was considered when using this data to inform the model assumptions. Significant outliers due to state or programmatic differences were discarded to narrow the range and enhance the reasonableness of the assumptions. For example, Arizona's

and Wisconsin's fiscal impact data were viewed as outliers in comparison to Texas. Arizona's IDD MLTSS program is focused on adults at "immediate risk of institutionalization," which is not the focus of Texas' IDD LTSS carve-in at this time.[48] Wisconsin experienced large IDD MLTSS savings due in large part to the transition away from what were previously inefficient county-based FFS rates.[49] The level of savings experienced in Arizona and Wisconsin, for example, is not expected in Texas due to programmatic differences.

Finally, the type of data found for each state varied. Fiscal impact types included total expenditures, PMPM, per person, and risk-adjusted values. Table 16 below demonstrates that most states included in the analysis either experienced or estimated some cost savings related to claim expenditures. However, administrative expenses were not included in most of these evaluations and could offset reported savings.

[48] Health Management Associates (HMA), "Final Report Pilot to Serve Persons with Intellectual and Developmental Disabilities," October 2010.
[49] Information based on discussions with representatives from the Wisconsin Department of Health Services

Table 16. Summary of Other State Fiscal Impact Data[50]

State	Year(s)	Data Point	Actual Results or Estimated?	IDD, non-IDD, or All?	LTSS, Acute, or Both?	Type of Data	Notes
AZ	1990 - 1993	-34.13%	Actual	IDD	LTSS	PMPM	Average PMPM savings percentage (actual managed care expenditures minus estimated FFS expenditures)
AZ	2012-2015	-38.29%	Actual	IDD	LTSS	Total expenditures	Average percent difference, actual With Waiver expenditures minus Without Waiver expenditures
AZ	2016 - 2021	-46.78%	Estimated	IDD	LTSS	Total expenditures	Average percent difference, estimated With Waiver expenditures minus Without Waiver expenditures
IA	Q4 2016-2018	-5.21%	Actual	All	Both	Total expenditures	Combined percent difference, With Waiver estimation minus Without Waiver estimation
IA	2018	-1.53%	Estimated	IDD	LTSS	PMPM	Annualized managed care adjustment for Intellectual Disability HCBS waiver in SFY 2018 IA Health Link Capitation Rate Certification
KS	2013-2016	+10.00%	Actual	IDD	Both	Trend-Adjusted PMPM	Approximate real, trend-adjusted, percent change in spending PMPM for Developmental Disability waiver

[50] Please see Appendix J for a listing of resources used in Table 16.

State	Year(s)	Data Point	Actual Results or Estimated?	IDD, non-IDD, or All?	LTSS, Acute, or Both?	Type of Data	Notes
KS	2014-2017	-4.57%	Estimated	IDD	LTSS	Total expenditures	Combined percent difference, With Waiver estimation minus Without Waiver estimation, in KanCare waiver amendment application
NM	2014-2018	-1.99%	Estimated	non-IDD	Both	PMPM	Combined percent difference, With Waiver estimation minus Without Waiver estimation, in original 1115 Centennial Care waiver application for members who meet Nursing Facility Level of Care - includes “NF LOC” and “Mi Via”
TN	2015 - 2016	-6.86%	Actual	IDD	LTSS	Per Person expenditures	Percent change in average per person LTSS expenditures for individuals with I/DD from the period prior to MC implementation (07/01/15-06/30/16) to the period after MC implementation (07/01/16-06/30/17)
NY	2015-2019	-3.19%	Estimated	non-IDD	Both	Total expenditures	Combined percent difference, With Waiver estimation minus Without Waiver estimation for Total MLTC Duals population in New York’s Partnership Plan

State	Year(s)	Data Point	Actual Results or Estimated?	IDD, non-IDD, or All?	LTSS, Acute, or Both?	Type of Data	Notes
WI	2012	-24.00%	Actual	IDD	LTSS	Risk-Adjusted Average Monthly PMPM	Difference between Family Care IDD MLTSS and Legacy FFS waivers currently existing in other counties
WI	2016	-24.24%	Actual	IDD	LTSS	Risk-Adjusted Average Monthly PMPM	Difference between Family Care IDD MLTSS and Legacy FFS waivers currently existing in other counties

4.3 Assumptions and Limitations

Because the cost-effectiveness analysis conducted in this report is a prospective or forward-looking analysis, several assumptions and limitations exist. Select factors and future HHSC decisions regarding the carve-in options play a role in determining the cost-effectiveness of IDD MLTSS and are discussed in detail below. This report is intended to provide a range of fiscal impacts for HHSC based on plausible scenarios, given the assumptions and limitations discussed below. Actual experience may differ from the results discussed in this report.

4.3.1 Carve-In Scenarios

This analysis assumes that HHSC will carve in IDD LTSS services following the timeline put forth in Government Code Chapter 534. This means that members enrolled in TxHmL are assumed to begin receiving LTSS through managed care on September 1, 2020, while members in HCS, CLASS, DBMD, and ICFs/IID are assumed to begin receiving these services through managed care on September 1, 2021.

While HHSC has the flexibility to carve all services into managed care or only certain services for each waiver, two carve-in scenarios were modeled after discussion with and direction from HHSC:

1. **All Services Carved In:** Under this scenario, HHSC would provide all IDD LTSS under managed care. This includes targeted case management services for TxHmL and HCS which are currently provided by third-party LIDDAs. Existing members in

HCS, CLASS, and DBMD would have an option to receive services in managed care or remain in their current FFS waiver.

2. **Portion of, or "Some," Services Carved In:** Under this scenario, HHSC would choose to continue providing some TxHmL and HCS services under the existing FFS waivers. The select services that remain under FFS waivers in this scenario are not definite, but were assumed and directed by HHSC. All services in CLASS, DBMD, and ICFs/IID are carved into managed care in this scenario. Per Chapter 534, members in CLASS and DBMD would have an option to receive services in managed care or remain in their current FFS waiver, while members in the other three programs (TxHmL, HCS, and ICFs/IID) would not have this option. Members in TxHmL, HCS, and ICFs/IID would continue to receive the "carved out" services through FFS. Per HHSC, the following service categories, as defined in Appendix A, were modeled to remain in FFS under this scenario:

    - TxHmL: Case Management, Respite, PAS/HAB (including day habilitation and CFC PAS/HAB), Nursing, Transportation, and Behavioral Supports (included within "Therapies" service category)

    - HCS: Case Management, Respite, PAS/HAB (including day habilitation and CFC PAS/HAB), Nursing, Transportation, Behavioral Supports (included within "Therapies" service category), and Residential

HHSC provided guidance on carve-in scenarios to use for this modeling, but no decisions have been made regarding which specific waiver services would be transitioned to managed care and which would remain in fee-for-service (FFS) in a partial carve-in. These models do not indicate any preference or recommendation of HHSC regarding whether specific services should be carved in or remain in FFS. The models were developed to represent a range of options, but do not represent all the possible scenarios. Assumptions about which specific services are carved in to managed care or kept in FFS impact the cost estimates.

CLASS and DBMD were modeled as a full carve-in in all scenarios. The providers for CLASS and DBMD are licensed home and community support services agencies (HCCSAs) and are already a common provider type in managed care. HCCSAs provide for the full range of waiver services, which aligns with a full carve-in model. The assumptions used for modeling impacts to CLASS and DBMD do not indicate a preference or recommendation of HHSC regarding whether specific services should be carved in or remain in FFS in those programs.

As shown above, the partial carve-ins for TxHmL and HCS were modeled with certain service categories remaining in FFS. Specific services modeled to remain in FFS include: service coordination/case management, respite, personal assistance services, habilitation, day habilitation, community support services (transportation), nursing, and behavioral supports. For HCS, residential services are also kept in FFS. Aside from

case management and residential, these services could all be provided by a single provider agency and are all interrelated in terms of delegated tasks. The providers for TxHmL and HCS services today are certified through the state and are not licensed HCSSAs.

Targeted case management was kept in FFS in these partial carve-in scenarios. Targeted case management is a state plan service provided through local intellectual and developmental disability authorities (LIDDAs). The models assume LIDDAs would continue to provide case management.

Several residential service options are available in HCS. The certified comprehensive provider for HCS residential services has more direct involvement in people's daily lives than other provider types. Thus, HHSC chose to model a partial carve-in keeping residential services in FFS.

The assumptions used for modeling impacts to TxHmL and HCS do not indicate a preference or recommendation of HHSC regarding whether specific services should be carved in or remain in FFS in these programs.

The actual carve-in scenarios (i.e., the inclusion or exclusion of certain services in IDD LTSS managed care) may differ from those discussed above.

4.3.2 Caseload Changes

This report models the fiscal impact managed care may have on the current FFS population. For this reason, future caseload (calculated as "member months") is assumed equal to the SFY 2017 caseload amount for each year of this analysis (SFYs 2018 – 2022), with no increase or decrease in caseload assumed.[51] Table 17 and Table 18 show the actual historical and estimated future caseloads for each program under the Status Quo future state. These tables display the 0% increase in caseload assumed from SFY 2017 levels.

This assumption also aligns with HHSC's caseload estimation data for SFYs 2019 – 2022, which show minimal or no change from year to year. To the extent that caseload does vary in future years, the results of this analysis would be expected to vary from actuals accordingly.

[51] "Member months" or "caseload" refers to the total number of individuals enrolled for each month. For example, if an individual is enrolled in a waiver for twelve months within a State Fiscal Year, they generate twelve member months. Likewise, if an individual is enrolled in a plan for six months within a State Fiscal Year, they will generate six member months.

Table 17. Total Number of Actual Historical Caseload

Program	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	2012 - 2017 Total
TxHmL	54,393	63,854	73,891	82,004	77,287	80,488	431,917
HCS	242,875	245,860	252,174	276,516	285,225	322,973	1,625,623
CLASS	57,817	56,812	56,455	59,047	55,383	66,737	352,251
DBMD	1,811	1,843	1,944	2,605	2,972	4,134	15,309
ICF/IID	69,034	68,457	66,643	64,342	56,658	61,116	386,250
Total	425,930	436,826	451,107	484,514	477,525	535,448	2,811,350

Table 18. Total Estimated Number of Future Caseload Under Status Quo

Program	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	2018 - 2022 Total
TxHmL	80,488	80,488	80,488	80,488	80,488	402,440
HCS	322,973	322,973	322,973	322,973	322,973	1,614,865
CLASS	66,737	66,737	66,737	66,737	66,737	333,685
DBMD	4,134	4,134	4,134	4,134	4,134	20,670
ICF/IID	61,116	61,116	61,116	61,116	61,116	305,580
Total	535,448	535,448	535,448	535,448	535,448	2,677,240

4.3.3 FFS PMPM Trend

To develop a future state Status Quo scenario, trend assumptions are required to model future baseline PMPMs. Table 19 below shows the actual historical PMPMs for each program modeled, along with the SFY 2012 to 2017 annualized PMPM trend. These actual historical PMPM trends were considered for projecting future PMPMs under the Status Quo. However, the actual historical annual PMPM trends for Texas' IDD waivers had significant variability (ranging from -19% to +49% when displayed by service category) due in large part to changes in services over the years. Because of this variability, this evaluation does not use historical trends.

Table 19. Actual Historical IDD LTSS PMPMs and Trends

Program	SFY 2012 PMPM	SFY 2013 PMPM	SFY 2014 PMPM	SFY 2015 PMPM	SFY 2016 PMPM	SFY 2017 PMPM	2012 - 2017 Annual PMPM Trend
TxHmL	$849.57	$916.12	$860.78	$904.40	$1,691.91	$1,674.28	14.53%
HCS	$4,939.05	$5,031.93	$5,108.75	$5,009.06	$5,424.38	$4,974.25	0.14%
CLASS	$2,266.88	$2,336.89	$2,558.54	$3,535.19	$4,197.39	$3,910.74	11.52%
DBMD	$3,795.03	$3,863.49	$3,782.86	$3,407.45	$3,475.25	$3,129.42	-3.78%
ICF/IID	$3,892.33	$3,919.91	$3,947.63	$3,954.13	$4,400.38	$4,021.43	0.65%
Total	$3,879.56	$3,900.59	$3,916.54	$3,986.02	$4,544.35	$4,222.65	1.71%

Instead of historical trends, this analysis assumes PMPMs are equal to the annual PMPM trend estimated by HHSC for SFYs 2019 – 2022, as shown in Table 20 below. The trends shown are applied uniformly across all service categories within each waiver. Table 21 shows the estimated future PMPMs after applying the trends from Table 20.

Table 20. HHSC Estimated Annualized FFS PMPM Trends by Program, SFYs 2019-2022

	TxHmL	HCS	CLASS	DBMD	ICF/IID
Trend	5.88%	0.90%	2.80%	0.00%	0.15%

Table 21. Estimated Future IDD LTSS PMPMs Using HHSC Budget Trends Under Status Quo

Program	SFY 2018 PMPM	SFY 2019 PMPM	SFY 2020 PMPM	SFY 2021 PMPM	SFY 2022 PMPM	2018 - 2012 Annual PMPM Trend
TxHmL	$1,772.70	$1,876.91	$1,987.24	$2,104.06	$2,227.74	5.88%
HCS	$5,019.11	$5,064.38	$5,110.05	$5,156.13	$5,202.63	0.90%
CLASS	$4,020.27	$4,132.87	$4,248.63	$4,367.63	$4,489.96	2.80%
DBMD	$3,129.42	$3,129.41	$3,129.40	$3,129.40	$3,129.39	0.00%
ICF/IID	$4,027.48	$4,033.54	$4,039.61	$4,045.69	$4,051.78	0.15%
Total	$4,278.85	$4,336.54	$4,395.79	$4,456.68	$4,519.26	1.38%

Other data sources were considered for this assumption, including CMS estimated national trends for related services and CMS-64 historical LTSS trends. HHSC's

estimated trend was deemed the most appropriate source because it most closely aligns with the population modeled and the expected future expenditure increases.

Multiplying the estimated future member months shown in Table 18 by the PMPMs shown in Table 21 results in the total estimated claims under the Status Quo, as shown in Table 22 below.

Table 22. Total Estimated Future IDD LTSS Claims Under Status Quo (in thousands)

Program	SFY 2018 Claims	SFY 2019 Claims	SFY 2020 Claims	SFY 2021 Claims	SFY 2022 Claims	2018 - 2022 Total Claims
TxHmL	$142,681	$151,069	$159,949	$169,351	$179,306	$802,357
HCS	$1,621,038	$1,635,657	$1,650,408	$1,665,291	$1,680,310	$8,252,703
CLASS	$268,301	$275,816	$283,541	$291,483	$299,647	$1,418,787
DBMD	$12,937	$12,937	$12,937	$12,937	$12,937	$64,685
ICF/IID	$246,143	$246,514	$246,885	$247,256	$247,628	$1,234,426
Total	$2,291,100	$2,321,992	$2,353,719	$2,386,319	$2,419,828	$11,772,958

4.3.4 Managed Care Adjustments

When evaluating the fiscal impact MCOs may have on IDD LTSS, two factors typically drive the analysis: unit cost and utilization. It is not anticipated that managed care will significantly affect the unit cost of IDD LTSS in Texas. The State has established fee-for-service reimbursement rates for the services considered in the managed care carve-in. This analysis assumes MCOs will reimburse providers at a similar fee schedule. While HHSC may adjust future rates for some IDD services, there is no cause to assume these will be a result of the managed care carve-in. Thus, unit costs for each service were assumed to be equal in the Status Quo and MLTSS future states.

Considering the assumed limited impact that MCOs will have on IDD LTSS unit costs in Texas, it was assumed that fiscal impacts on IDD LTSS expenditures would result from a change in utilization of services. This could include the reduction of services as well as a shift to lower cost services. Based on data points from Table 16 above, discussions with HHSC, discussions with representatives from other states, and actuarial judgment, a range of managed care utilization impact was determined to be a cost reduction of 0.0% to 6.0%, varying by service category. Section 5.2.3 below contains more detail on the assumed utilization impact for various service categories.

4.3.5 Administrative Expenditure Adjustments

Under managed care, there will likely be a change in administrative expenditures incurred under FFS as well as administrative expenditures built into the managed care capitation payment. Because of this change, an assumption is required to quantify the

additional impact managed care may have on administrative expenditures. The changes to administrative expenditures can be grouped into two categories:

1. State expenditures that were previously incurred under the FFS model that would not be necessary under managed care or otherwise shifted to the MCOs

2. New expenditures that were not previously incurred under the FFS model that will be present under managed care

FFS administrative expenditures were considered to identify expenditures that could potentially shift (i.e., be incurred by MCOs) in a managed care model, such as FFS claims adjudication. For FFS claim adjudication expenditures, HHSC currently has a contract with a third-party vendor to adjudicate claims and process encounter records. HHSC noted that this contract is a fixed price for all services, rather than per claim, so there is no expected cost reduction for FFS claims adjudication due to potential changes in volume. HHSC also noted that the claims that may potentially impact pricing are those that require manual intervention. Since LTSS claims are fully system-processed, requiring no manual intervention, there are no expected cost reductions. The possibility that certain staff roles pertaining to the FFS aspects of the waiver programs may no longer be needed was also considered. However, since it is likely that aspects of the FFS waivers will be maintained, it is anticipated that the need for these roles will remain or evolve to accommodate changes in workloads.

The potential need for new staff under managed care was considered, particularly related to additional need for MCO oversight. The expenditures for these staff are addressed separately in Section 5.5.

Several new non-claim expenses (categorized in this analysis as administrative) are expected to be incurred under managed care. These non-claim expenses come from the provision for administrative expenditures, maintenance tax, and risk margin paid to MCOs in capitation rates. The additional expenditures can be grouped into two categories:

1. Expenditures that are paid as a percent of premium in the capitation rates. These include variable administrative expenses and risk margin.

2. Expenditures that are paid on a PMPM basis in the capitation rates. These include fixed administrative expenses and maintenance taxes.

To determine the potential magnitude of these additional expenditures, the non-claims expenses included in the SFY 2019 STAR+PLUS capitation rates for the IDD Medical risk group were examined. These items include the following:[52]

- Percent of premium administrative expenditures of 5.75% of premium (equivalent to 7.50% of IDD LTSS claims)
    - This will result in additional administrative expenditures which will be included in the capitation rates
- Risk margin of 1.75% of premium (equivalent to 2.28% of IDD LTSS claims)
    - This will result in additional expenditures which will be included in the capitation rates
- Fixed administrative expenditures of $20.00 PMPM and maintenance tax of $0.06 PMPM
    - A majority of beneficiaries with IDD already have their acute care services covered under managed care. Administrative expenses for these members are already included in the capitation rates. Thus, these amounts were not added as an additional expense for members already receiving other services through the managed care program.
    - However, there are other individuals with IDD who will be new to managed care. The members receiving services through the IDD waivers and ICFs/IID who are not currently in managed care for their acute services are adults (aged 21 and over) who are dually-eligible for Medicare and Medicaid (duals). When the LTSS services for these members transition to managed care, the administrative PMPM will be added to the capitation rates, and therefore was included in the analysis.

To calculate the impact of dual-eligible adults being added to managed care, the percentage of total member months that are dual-eligible adults for each waiver was calculated. This percentage was assumed constant across future periods. Additionally, the percentage of dual-eligible members electing managed care was assumed to be the same as the percentage of total members electing managed care (25% for Scenarios 1 and 2, 10% for Scenarios 3 and 4) for the populations and carve-in scenarios for which this is possible. The number of dual-eligible adult member months was then multiplied by the $20.06 PMPM (sum of the $20.00 fixed administrative expense PMPM and $0.06 PMPM maintenance tax) to estimate the amount of the non-claims expense component

[52] Rudd and Wisdom, Inc. *"State of Texas Medicaid Managed Care STAR+PLUS Program Rate Setting State Fiscal Year 2019,"* June 29, 2018. https://rad.hhs.texas.gov/sites/rad/files/documents/managed-care/2019/2019-09-star-plus.pdf

of the future capitation rates for these members. Table 23 below shows the dual-eligible member months as a percentage of total member months for each waiver in SFY 2017.

Table 23. Adult Dual-Eligible Member Months as a Percent of Total Member Months, SFY 2017

	Percentage Dual-Eligible Adults
TxHmL	29.57%
HCS	55.95%
CLASS	25.11%
DBMD	28.50%
ICF/IID	64.54%
Total	**48.91%**

The percent of premium assumptions noted above from the capitation rates were analyzed as a percent of managed care claims plus administrative expenditures in our model. After accounting for incremental expenditures due to the percent of premium administrative expenditures and risk margin provisions, the estimated increase in administrative expenditures due to managed care is roughly 7.50% of managed care claims plus administrative expenditures, which equates to 9.78% of claims in the SFY 2019 STAR+PLUS IDD Medical risk group. Because there is still some uncertainty regarding FFS administrative expenditures that could potentially be removed or additional state administrative expenditures not yet known, a range for additional variable administrative expenditures of 7.00% to 9.00% of managed care claims plus administrative expenditures (applied in the model as 9.00% to 11.00% of claims) was developed. This incremental increase of 9.00% to 11.00% of claims is added to the current 4.10% of claims applied to FFS claims to result in a total range of 13.10% to 15.10% of managed care claims. This results in the following administrative adjustments used for managed care claims, as shown in Table 24. The amounts shown below are in addition to administrative expenditures from FFS claims, which equal total FFS claims multiplied by 4.10%.

Table 24. Managed Care Administrative Expenditure Assumptions
SFYs 2021 - 2022
($ in thousands | % of MC Claims | % of MC Claims + Admin)

	Scenario 1 (All Services)	Scenario 2 (Some Services)	Scenario 3 (All Services)	Scenario 4 (Some Services)
(A) Total MC Claims, SFY 2021-2022	$1,048,812 | 100.00% | 88.21%	$364,300 | 100.00% | 87.26%	$780,311 | 100.00% | 86.67%	$325,808 | 100.00% | 85.64%
(B) Percentage applied to all MC claims	13.10%	13.10%	15.10%	15.10%
(C) Variable MC admin = (A) * (B)	$137,427 | 13.10% | 11.56%	$47,734 | 13.10% | 11.43%	$117,851 | 15.10% | 13.09%	$49,207 | 15.10% | 12.93%
(D) Additional MC PMPM adjustment applied to only dual-eligible adults	$20.06	$20.06	$20.06	$20.06
(E) Total dual-eligible adults member months	136,706	272,237	106,910	269,547
(F) Fixed MC admin from dual-eligible adults = (D) * (E)	$2,742 | 0.26% | 0.23%	$5,461 | 1.50% | 1.31%	$2,145 | 0.27% | 0.24%	$5,407 | 1.66% | 1.42%
(G) Total MC Admin = (C) + (F)	$140,169 | 13.36% | 11.79%	$53,196 | 14.60% | 12.74%	$119,996 | 15.38% | 13.33%	$54,614 | 16.76% | 14.36%
(H) Total MC Claims + Admin = (A) + (G)	$1,188,981 | 113.36% | 100.00%	$417,495 | 114.60% | 100.00%	$900,307 | 115.38% | 100.00%	$380,422 | 116.76% | 100.00%

Premium tax included in the capitation rates is also considered and is discussed below and in Section 5.4. – Impact on Premium Taxes.

4.3.6 Member Managed Care Election Percentage

According to Chapter 534, members currently receiving services under HCS, CLASS, or DBMD waivers will have a choice between continuing to receive services through their current FFS waiver or transitioning to managed care if HHSC chooses to carve all waiver LTSS for these members into managed care. To account for this member choice component of Chapter 534, the cost-effectiveness model includes an assumption for the

percentage of current members enrolled in these three waivers who will elect to switch to managed care.

There is limited data available regarding the percentage of members electing managed care over FFS for IDD members, LTSS services, or even Medicaid overall. In Texas' SFY 2019 rate certification document for HHSC's Dual Demonstration (managed care) program, it was noted that since the start of the program in March of 2015, approximately 35% of eligible members elected to receive Medicare services under the Dual Demonstration rather than FFS.[53] A 2009 study of the cost-effectiveness of California's Medi-Cal Managed Care program noted that among the program's populations with voluntary enrollment, only 15% chose managed care.[54] While specific data relating to IDD MLTSS member enrollment percentage was not available, representatives from another state (where IDD MLTSS is voluntary) noted that approximately 20% of the population chose managed care.[55]

Based on the information above and HHSC's understanding of members' preferences to continue receiving care in the same program, a managed care voluntary election assumption range was determined to be 10 to 25%. This assumption is applied differently depending on the scenario modeled, as discussed in the Section 5 - Analysis, below.

Table 25 below shows the assumed total number of member months for each program in total and in managed care. [56] This table shows the relative magnitude of members receiving services through managed care in each scenario.

[53] Rudd and Wisdom, Inc. "State of Texas Medicaid Managed Care Rate Setting Dual Eligibles Integrated Care Demonstration Project State Fiscal Year 2019," July 29, 2018.
[54] Riner, R. M. *"Challenging the Cost Effectiveness of Medi-Cal Managed Care,"* May 2009. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2691508/
[55] Information based on discussions with representatives from the Wisconsin Department of Health Services
[56] "Member months" or "caseload" refers to the total number of individuals enrolled for each month. For example, if an individual is enrolled in a waiver for twelve months within a State Fiscal Year, they generate twelve member months. Likewise, if an individual is enrolled in a plan for six months within a State Fiscal Year, they will generate six member months.

Table 25. Estimated Number of Member Months Receiving Services in Managed Care SFYs 2021 - 2022 for TxHmL, SFY 2022 for other programs
Member Months in Managed Care | Percent of Total

Program	Total Member Months (FFS + MC)	Scenario 1 (All Services)	Scenario 2 (Some Services)	Scenario 3 (All Services)	Scenario 4 (Some Services)
TxHmL	160,976	160,976 | 100.00%	160,976 | 100.00%	160,976 | 100.00%	160,976 | 100.00%
HCS [57]	322,973	80,743 | 25.00%	322,973 | 100.00%	32,297 | 10.00%	322,973 | 100.00%
CLASS [58]	66,737	16,684 | 25.00%	16,684 | 25.00%	6,674 | 10.00%	6,674 | 10.00%
DBMD [59]	4,134	1,034 | 25.00%	1,034 | 25.00%	413 | 10.00%	413 | 10.00%
ICF/IID	61,116	61,116 | 100.00%	61,116 | 100.00%	61,116 | 100.00%	61,116 | 100.00%
Total	**615,936**	**320,553 | 52.04%**	**562,783 | 91.37%**	**261,476 | 42.45%**	**552,152 | 89.64%**

4.3.7 Premium Tax

HHSC includes a provision for premium tax in the capitation rates paid to MCOs. For SFY 2019, this amount was equal to 1.75% of managed care claims plus administrative expenditures for STAR, STAR Health, STAR+PLUS, STAR Kids, and Dual Demonstration. Because there are several non-claim expenses included in capitation rates that are not present in the IDD LTSS cost-effectiveness model, the assumption used for this analysis was restated to be on a percent of claims basis rather than percent of managed care claims plus administrative expenditures. This analysis assumes that premium taxes equal 2.30% of LTSS claims. This is the amount paid by

[57] For the HCS waiver, Scenarios 2 and 4 represent a situation in which some services remain in FFS. In those scenarios, members do not have a choice of managed care versus FFS, and 100% of members must receive services through HHSC's service-specific managed care or FFS decision. Because of this, 100% of members are shown as managed care in this table. The same number of members also receive services through FFS in these scenarios.
[58] While Chapter 534 allows members to choose managed care or FFS if all services are carved in for CLASS and DBMD, HHSC did not choose to model keeping services for these two waivers in FFS, so all four scenarios represent all services under managed care for these waivers. Thus, members have a choice of managed care versus FFS in all scenarios for these waivers.
[59] While Chapter 534 allows members to choose managed care or FFS if all services are carved in for CLASS and DBMD, HHSC did not choose to model keeping services for these two waivers in FFS, so all four scenarios represent all services under managed care for these waivers. Thus, members have a choice of managed care versus FFS in all scenarios for these waivers.

HHSC in the SFY 2019 STAR+PLUS capitation rates for the IDD Medical risk group across all Service Delivery Areas (SDAs). Because premium taxes affect the State, HHSC, and the federal government differently, these impacts were modeled separately from claims and administrative expenses.

See Section 5.4 for a breakdown of the fiscal impact of premium taxes for each of these entities.

4.3.8 Limitations

The analysis aims to provide a plausible range of fiscal impacts Texas may experience from implementing IDD MLTSS using the assumptions and methodologies described above. This report is not intended to provide a single "point estimate" of cost-effectiveness, as there are many unknowns in future trends and with HHSC's decisions regarding the IDD LTSS carve-in. Rather, it provides a range of reasonable estimates. Additionally, this analysis includes several limitations as described below:

- The analysis does not consider the effect improved life or health outcomes may have on expenditures for the IDD population. While quality and access to effective LTSS is of great importance to this population and other stakeholders, analysis of the potential fiscal impacts of quality and access was not included in the scope of this evaluation. These topics are described qualitatively in Section 5.8 below. HHSC has contracted with a separate vendor to evaluate the implications of quality and access to LTSS for individuals with IDD.

- When modeling expenditures for members electing managed care over FFS for the programs and situations for which this is possible, the analysis assumed that the members transitioning to managed care would have the same average acuity, risk, and cost as those staying in FFS. Thus, no adjustments were made to account for potential differences in member risk.

- Because this analysis focuses on cost-effectiveness for people with IDD currently receiving LTSS, no fiscal impacts were modeled for people with IDD who will be receiving LTSS for the first time through managed care. People who are currently in the waivers will leave for various reasons, and new people will be enrolled to fill vacancies. It is possible that the new individuals will receive more cost-effective services through MCO authorizations, leading to overall reduced expenditures. Sufficient evidence was not found to provide guidance for fiscal impact assumptions for current versus new enrollees, so these impacts were not included in this analysis.

- This analysis did not incorporate the effect of proposed policy changes to the IDD LTSS waivers. While these changes may impact overall future expenditures, they are only hypothetical currently and are being determined independently from managed care decisions.

- When determining utilization adjustments for the transition to managed care for specific services, consideration was not explicitly given to possible interdependencies or shifts from one service category to another. For example, shifts from supported home living to residential assistance to address changes in need were not explicitly modeled, rather the impact was implicitly included in the assumptions. Individual service categories were assessed independently with respect to the possible impact of managed care.

- For simplicity and purposes of this analysis, it was assumed that the bulk of impacts on utilization would occur upon transition to managed care. However, some utilization impacts may be realized over time due to the time it may take to review plan and utilization by care managers.

- The utilization ranges were developed based on the assumption that MCOs could have more flexibility in managing service plans and utilization for newer enrollees than with existing beneficiaries who sometimes have long-standing service plans and utilization patterns. Thus, the range of utilization impacts implicitly includes potential differences in the higher impact that may be seen by new waiver enrollees compared to existing waiver enrollees.

- As the managed care program matures, HHSC could realize reduced state administrative expenditures from what was modeled through program efficiencies (e.g. shifting of staff responsibilities as additional individuals transition to managed care, renegotiation of vendor contracts, etc.). In addition, MCO administrative expenses can continue to be reevaluated over time to identify potential efficiencies. Thus, it is possible administrative expenses could be lower in the future and be less than what was modeled.

- This analysis assumes future caseload is equal to the SFY 2017 amounts for each year. To the extent that caseload does vary in future years, the results of this analysis would be expected to vary from actuals accordingly.

As noted in Section 4.2 above, some discrepancies exist between the underlying data used for this analysis and published CMS data. While there are several potentially valid reasons for these discrepancies, the specific cause was not identified for this analysis. Any errors or omissions in the underlying data may cause the total fiscal impact of this analysis to be off by the same amount. However, it is assumed the PMPM and percentage impacts are still representative.

5 Analysis – Cost-Effectiveness of IDD MLTSS Carve-In

As IDD LTSS moves into managed care in Texas, the study explores four areas that could impact resulting fiscal estimates from SFYs 2021-2022: (1) IDD LTSS service mix and claims, (2) administrative expenditures (including state expenditures as well as administrative load, risk margin, and maintenance taxes paid to MCOs), (3) number of member months in managed care, and (4) premium taxes. These factors are detailed below, along with a description of the various scenarios modeled, and final summary tables showing detailed fiscal impacts by waiver and in aggregate.

5.1 Carve-In Scenarios

As discussed in Section 4.3, the cost-effectiveness model compared the difference between MLTSS expenditures and Status Quo expenditures for four scenarios that represent a reasonable range for the fiscal impact of implementing IDD MLTSS in Texas for SFYs 2021 – 2022.

Table 26 details the assumptions used for each scenario.

Table 26. Assumptions Used for Modeled Scenarios

Assumption	Scenario 1	Scenario 2	Scenario 3	Scenario 4
All Services Carved-In or Some?[60]	All	Some	All	Some
Do HCS members have a MC/FFS choice?	Yes	No	Yes	No
Do CLASS or DBMD members have a MC/FFS choice?[61]	Yes	Yes	Yes	Yes
Do TxHmL or ICF/IID members have a MC/FFS choice?	No	No	No	No
MC Utilization Adjustment, High Impact	-6.0%	-6.0%	-4.0%	-4.0%
MC Utilization Adjustment, Medium Impact	-4.0%	-4.0%	-2.0%	-2.0%
MC Utilization Adjustment, Low Impact	-2.0%	-2.0%	0.0%	0.0%
Member Managed Care Election Percentage[62]	25%	25%	10%	10%
Baseline Annual PMPM Trend (SFY 2018-2022) - TxHmL[63]	5.88%	5.88%	5.88%	5.88%
Baseline Annual PMPM Trend (SFY 2018-2022) - HCS	0.90%	0.90%	0.90%	0.90%
Baseline Annual PMPM Trend (SFY 2018-2022) - CLASS	2.80%	2.80%	2.80%	2.80%
Baseline Annual PMPM Trend (SFY 2018-2022) - DBMD	0.00%	0.00%	0.00%	0.00%
Baseline Annual PMPM Trend (SFY 2018-2022) - ICF/IID	0.15%	0.15%	0.15%	0.15%
Admin Ratio applied to FFS Claims[64]	4.10%	4.10%	4.10%	4.10%
Admin Ratio applied to MC Claims	13.10%	13.10%	15.10%	15.10%
Admin PMPM Adjustment for Dual-Eligible Adults[65]	$20.06	$20.06	$20.06	$20.06

In Scenario 1, all services are carved into managed care. However, individuals in HCS, CLASS, and DBMD have a choice to receive services through managed care or FFS. Individuals in the other two programs do not have a choice to receive services through managed care or FFS. This scenario has higher reductions in utilization, a higher member managed care election percentage, and a lower admin ratio increase relative to Scenarios 3 and 4.

In Scenario 2, only some services are carved into managed care. However, individuals in CLASS and DBMD have a choice to receive services through managed care or FFS because all services are carved in for these waivers. Individuals in the other three programs do not have a choice to receive services through managed care or FFS. This scenario has higher reductions in utilization, a higher member managed care election percentage, and a lower admin ratio increase relative to Scenarios 3 and 4.

In Scenario 3, all services are carved into managed care. However, individuals in HCS, CLASS, and DBMD have a choice to receive services through managed care or FFS. Individuals in the other two programs do not have a choice to receive services through managed care or FFS. This scenario has lower reductions in utilization, a lower member managed care election percentage, and a higher admin ratio increase relative to Scenarios 1 and 2.

In Scenario 4, only some services are carved into managed care. However, individuals in CLASS and DBMD have a choice to receive services through managed care or FFS because all services are carved in for these waivers. Individuals in the other three programs do not have a choice to receive services through managed care or FFS. This scenario has lower reductions in utilization, a lower member managed care election percentage, and a higher admin ratio increase relative to Scenarios 1 and 2.

[60] Please see Section 4.3 for the list of services that remain in FFS under Scenarios 2 and 4.
[61] CLASS and DBMD members would not have a choice if any of their services remain in FFS. HHSC chose to transition all services for these waivers for the purposes of the scenarios modeled in this report.
[62] Member choice assumption only affects HCS, CLASS, and DBMD and only if all services are carved into managed care for a given waiver.
[63] All baseline trends come from HHSC's estimated PMPM trends by waiver over the period covered by this analysis. The cost-effectiveness model applied trends uniformly across each service category within a waiver.
[64] "Admin Ratio" is defined as total administrative expenditures attributable to IDD LTSS divided by total IDD LTSS claims. The admin ratio applied to managed care includes estimated state administrative expenditures plus admin and risk margin paid to MCOs in capitation rates.
[65] This assumption comes from the $20.00 PMPM for fixed administrative expenses plus $0.06 PMPM for maintenance tax applied in the SFY STAR+PLUS capitation rates. Since dual-eligible adults (21 years and older) in IDD waivers are not currently receiving acute care services through managed care, these individuals would be added to managed care under the carve-in and result in an additional cost. The $20.06 PMPM is multiplied by the number of dual-eligible adult member months for each year to come up with an estimate of additional fixed administrative expenditures paid to MCOs for these members.

For additional details on the “MC Utilization Adjustment” assumptions, please see Section 5.2.3. For additional details on the Member Managed Care Election Percentage and baseline trend, and administrative expenditure assumptions, please see Section 4.3. For additional details on the admin ratio and dual-eligible adult PMPM adjustment assumptions, please see Section 5.3.

As detailed in Section 4.3, the following are services that remain in FFS under Scenarios 2 and 4:

- TxHmL: Case Management, Respite, PAS/HAB (including day habilitation and CFC PAS/HAB), Nursing, Transportation, and Behavioral Supports (included within “Therapies” service category)

- HCS: Case Management, Respite, PAS/HAB (including day habilitation and CFC PAS/HAB), Nursing, Transportation, Behavioral Supports (included within “Therapies” service category), and Residential

5.2 Impact on IDD LTSS Claims

There are three primary reasons why IDD LTSS claims may be impacted by a transition to managed care: the number of member months, service utilization, and the cost per unit of service (or unit cost). These items are discussed below, along with a summary of the resulting total IDD LTSS claims impact for each waiver and ICFs/IID. For simplicity and purposes of this analysis, it was assumed that the bulk of impacts on utilization would occur upon transition to managed care. However, some utilization impacts may be realized over time due to the time it may take to review plan and utilization by care managers.

5.2.1 Impact on Member Months in Managed Care

Table 27 below shows the assumed total number of member months for each program in total and in managed care. This table shows the relative magnitude of members receiving services through managed care in each scenario.

Table 27. Estimated Number of Member Months Receiving Services in Managed Care SFYs 2021 - 2022 for TxHmL, SFY 2022 for other programs
Member Months in Managed Care | Percent of Total

Program	Total Member Months (FFS + MC)	Scenario 1 (All Services)	Scenario 2 (Some Services)	Scenario 3 (All Services)	Scenario 4 (Some Services)
TxHmL	160,976	160,976 | 100.00%	160,976 | 100.00%	160,976 | 100.00%	160,976 | 100.00%
HCS [66]	322,973	80,743 | 25.00%	322,973 | 100.00%	32,297 | 10.00%	322,973 | 100.00%
CLASS	66,737	16,684 | 25.00%	16,684 | 25.00%	6,674 | 10.00%	6,674 | 10.00%
DBMD	4,134	1,034 | 25.00%	1,034 | 25.00%	413 | 10.00%	413 | 10.00%
ICF/IID	61,116	61,116 | 100.00%	61,116 | 100.00%	61,116 | 100.00%	61,116 | 100.00%
Total	**615,936**	**320,553 | 52.04%**	**562,783 | 91.37%**	**261,476 | 42.45%**	**552,152 | 89.64%**

5.2.2 Total Status Quo Claims

After applying baseline PMPM trends, Table 28 shows the total claims under the Status Quo (assuming all services and all members remain in FFS). The table is used to illustrate cost impacts shown in Section 5.2.6. After applying utilization and unit cost assumptions as described in Sections 5.2.3 and 5.2.4 along with the service carve-in scenarios described in Section 5.1 and member months shown in Section 5.2.1, these costs are adjusted to reflect new costs under managed care, as shown in the MLTSS claims in Section 5.2.5. The difference between the MLTSS table and the Status Quo table below is the claims impact.

[66] For the HCS waiver, Scenarios 2 and 4 represent a situation in which some services remain in FFS. In those scenarios, members do not have a choice of managed care versus FFS, and 100% of members must receive services through HHSC's service-specific managed care or FFS decision. Because of this, 100% of members are shown as managed care in this table. The same number of members also receive services through FFS in these scenarios.

Table 28. Estimated Total Claims Expenditures Under Status Quo Scenario Impact Period (SFYs 2021-2022 for TxHmL, SFY 2022 for other programs) ($ in thousands)

Program	Scenario 1 (All Services)	Scenario 2 (Some Services)	Scenario 3 (All Services)	Scenario 4 (Some Services)
TxHmL (FFS)	$348,658	$348,658	$348,658	$348,658
TxHmL (MC)	$0	$0	$0	$0
TxHmL Total	$348,658	$348,658	$348,658	$348,658
HCS (FFS)	$1,680,310	$1,680,310	$1,680,310	$1,680,310
HCS (MC)	$0	$0	$0	$0
HCS Total	$1,680,310	$1,680,310	$1,680,310	$1,680,310
CLASS (FFS)	$299,647	$299,647	$299,647	$299,647
CLASS (MC)	$0	$0	$0	$0
CLASS Total	$299,647	$299,647	$299,647	$299,647
DBMD (FFS)	$12,937	$12,937	$12,937	$12,937
DBMD (MC)	$0	$0	$0	$0
DBMD Total	$12,937	$12,937	$12,937	$12,937
ICF/IID (FFS)	$247,628	$247,628	$247,628	$247,628
ICF/IID (MC)	$0	$0	$0	$0
ICF/IID Total	$247,628	$247,628	$247,628	$247,628
Total (FFS)	**$2,589,180**	**$2,589,180**	**$2,589,180**	**$2,589,180**
Total (MC)	**$0**	**$0**	**$0**	**$0**
Overall Total	**$2,589,180**	**$2,589,180**	**$2,589,180**	**$2,589,180**

5.2.3 Impact on Service Utilization

As discussed in Section 4.3, a range of utilization reductions between 0.0 and 6.0%, varying by service category, was modeled. This range was derived from fiscal impacts observed in other states and supplementary data gathered from HHSC such as assumed managed care savings in STAR+PLUS and STAR Kids capitation rates.

In applying the utilization impact range to various IDD service categories, several factors were analyzed, including:

- Operational implications of services
- The characteristics of individuals served by each waiver
- Waiver policies, including the overall scope of benefits and expenditure limitations, and
- Historical service expenditures

With input from HHSC, service categories were identified that are either critical to the receipt of other necessary services or are vital in meeting the specific needs of individuals receiving waiver services and/or caregivers. As an illustration, Case Management is a critical service, with case managers responsible for plan development, coordination of services, and monitoring of plan implementation and service delivery. Other examples are Respite services that help to ensure the well-being of unpaid caregivers, and, Intervener services, a service specific to the DBMD waiver that is critical to meeting the needs of individuals with vision and/or hearing deficits. These critical services are categorized as having a 'low' managed care impact, meaning that they received either 0.0% or low adjustments to their estimated managed care utilization compared to FFS levels.

The remainder of the impacts were identified on the premise, based on discussions with other states, that MCOs are able to influence delivery of the "right service, in the right amount, at the right time." Overall historical expenditures and waiver policies were reviewed to identify the specific impact for the remaining service categories. Service categories in the 'high' managed care impact category are those identified as having the highest historical expenditures along with a significant potential for evaluating service utilization for either less costly alternatives or appropriateness of service authorizations. Residential services, for example, as a more intensive and wide-ranging service, have one of the highest historical service expenditures. The residential service category accommodates varied models of service with differing levels of supervision and structure to meet the needs of individuals. This provides the opportunity to correlate the model of residential service to individual need. In addition, there are additional opportunities to explore effective strategies to identify individuals who are interested in and could be successful in more integrated and less costly service options. In addition, Therapies (in particular, Specialized Therapies) have high utilization and the potential to be assessed for appropriateness of service authorization.

Service categories with a 'mid' managed care impact categorization show moderate levels of historical spending, with the potential ability for MCOs to impact service authorizations. For example, the Fees service category (a broad category used to represent payments to providers or contractors for activities necessary for the provision of services but not the provision of the service itself) could be evaluated to identify whether the Fees service is now being met by the MCO under the new managed care model. Personal Assistance Services/Habilitation (PAS/HAB) is a service category that shows high utilization, but is generally a cost-effective alternative to some of the more structured service options (i.e. Residential).

Table 29 below summarizes the assumed impact of managed care on IDD LTSS service categories (High, Mid, Low) along with utilization adjustments used in various model scenarios. The utilization ranges were developed based on the assumption that MCOs could have more flexibility in managing service plans and utilization for newer enrollees than with existing beneficiaries who sometimes have long-standing service

plans and utilization patterns. Thus, the range of utilization impacts implicitly includes potential differences in the higher impact that may be seen by new waiver enrollees compared to existing waiver enrollees. Service categories are generally self-explanatory, with the exception of "Other," which includes several services which constitute a relatively low percentage of total IDD LTSS spend, such as adaptive aids, minor home modifications, dental, supported employment, financial management services, and assessments. The mapping of service codes to the eleven service categories is located in Appendix A.

Table 29. Assumed Managed Care Utilization Impact by Service Category

Service Category	Managed Care Impact	Utilization Adjustment (Scenarios 1 and 2)	Utilization Adjustment (Scenarios 3 and 4)
PAS/HAB	Mid	-4.0%	-2.0%
Respite	Low	-2.0%	0.0%
Case Management	Low	-2.0%	0.0%
Nursing	Mid	-4.0%	-2.0%
Therapies[67]	High	-6.0% / -3.45% / -3.09%	-4.0% / -2.30% / -2.06%
Residential	High	-6.0%	-4.0%
Fees	Mid	-4.0%	-2.0%
Transportation	Low	-2.0%	0.0%
Intervener	Low	-2.0%	0.0%
ICF Daily Care	Mid	-4.0%	-2.0%
Other	Mid	-4.0%	-2.0%

5.2.4 Impact on Unit Costs

It is not anticipated that managed care will affect the unit cost of IDD LTSS in Texas. While other states experienced some IDD LTSS savings from MCOs negotiating lower

[67] One of the services included in the "Therapies" service category is Behavioral Supports (service codes 14, 43A, and 43AV). Scenarios 2 and 4 are modeled assuming certain LTSS services remain in FFS. One of these services HHSC requested to remain in FFS is Behavioral Supports in TxHmL and HCS. Because all TxHmL and HCS services in the "Therapies" service category except Behavioral Supports are carved into managed care in these scenarios, the utilization adjustments shown in this table were changed to reflect Behavioral Supports remaining in FFS. This change was equal to the initial adjustment (0.94 and 0.96, respectively) plus the percentage of total "Therapies" expenditures in Behavioral Supports (42.58% in TxHmL, 48.42% in HCS) times (one minus the initial adjustment). The preceding formula results in a TxHmL "Therapies" utilization adjustment of -3.45% (TxHmL) and -3.09% (HCS) for Scenario 2; and -2.30% (TxHmL) and -2.06% (HCS) for Scenario 4.

rates with providers, these were due to state-specific conditions such as Wisconsin's county-based FFS prior to implementing managed care. In Wisconsin, when the state implemented managed care for IDD LTSS, MCOs were able to eliminate geographical rate differences that derived solely from differing county rate-setting methodologies (and not based on actual geographical differences in expenditures).[68] Because Texas currently administers its IDD LTSS waivers at the state level, it is assumed there are little to no inefficiencies in Texas IDD LTSS rates, and managed care will not likely materially influence unit costs for these services.

While HHSC may adjust future rates for some IDD services, there is no cause to assume these will be a result of the managed care carve-in. Thus, unit costs for each service were assumed to be equal in the Status Quo and MLTSS future states.

5.2.5 Total MLTSS Claims

After applying utilization and unit cost assumptions as described in Sections 5.2.3 and 5.2.4 along with the service carve-in scenarios described in Section 5.1 and member months shown in Section 5.2.1, the Status Quo costs are adjusted to reflect new costs under managed care, as shown in the MLTSS claims in Table 30 below. The difference between the MLTSS table and the Status Quo table is the claims impact shown in Section 5.2.6.

[68] Information based on discussions with representatives from the Wisconsin Department of Health Services

Table 30. Estimated Total Claims Expenditures Under MLTSS Scenario Impact Period (SFYs 2021-2022 for TxHmL, SFY 2022 for other programs) ($ in thousands)

Program	Scenario 1 (All Services)	Scenario 2 (Some Services)	Scenario 3 (All Services)	Scenario 4 (Some Services)
TxHmL (FFS)	$0	$333,969	$0	$333,969
TxHmL (MC)	$337,068	$14,123	$344,041	$14,384
TxHmL Total	$337,068	$348,092	$344,041	$348,353
HCS (FFS)	$1,260,232	$1,641,382	$1,512,279	$1,641,382
HCS (MC)	$399,062	$37,495	$162,986	$38,140
HCS Total	$1,659,294	$1,678,877	$1,675,265	$1,679,522
CLASS (FFS)	$224,735	$224,735	$269,682	$269,682
CLASS (MC)	$71,854	$71,854	$29,341	$29,341
CLASS Total	$296,589	$296,589	$299,023	$299,023
DBMD (FFS)	$9,703	$9,703	$11,643	$11,643
DBMD (MC)	$3,104	$3,104	$1,268	$1,268
DBMD Total	$12,807	$12,807	$12,911	$12,911
ICF/IID (FFS)	$0	$0	$0	$0
ICF/IID (MC)	$237,723	$237,723	$242,676	$242,676
ICF/IID Total	$237,723	$237,723	$242,676	$242,676
Total (FFS)	**$1,494,670**	**$2,209,789**	**$1,793,604**	**$2,256,676**
Total (MC)	**$1,048,811**	**$364,299**	**$780,312**	**$325,809**
Overall Total	**$2,543,481**	**$2,574,088**	**$2,573,916**	**$2,582,485**

5.2.6 Impact on IDD LTSS Claims in Total

Table 31 below shows the overall impact of the carve-in on IDD LTSS claims after applying the managed care utilization adjustments shown in Section 5.2.3. This table is the difference between the total claims in the MLTSS table (Table 30) and the total claims in the Status Quo table (Table 28). Small rounding discrepancies may occur between the numbers shown below and the differences between the tables above.

Table 31. Estimated IDD LTSS Claims Expenditure Impact
Two-Year Total from SFYs 2021-2022
Estimated MLTSS Spending vs. Status Quo Spending
($ in thousands | % change from Status Quo)

Program	Status Quo Claims Impacted[69]	Scenario 1 (All Services)	Scenario 2 (Some Services)	Scenario 3 (All Services)	Scenario 4 (Some Services)
TxHmL	$348,658	-$11,590 | -3.32%	-$566 | -0.16%	-$4,617 | -1.32%	-$305 | -0.09%
HCS	$1,680,310	-$21,015 | -1.25%	-$1,432 | -0.09%	-$5,045 | -0.30%	-$787 | -0.05%
CLASS	$299,647	-$3,058 | -1.02%	-$3,058 | -1.02%	-$624 | -0.21%	-$624 | -0.21%
DBMD	$12,937	-$130 | -1.00%	-$130 | -1.00%	-$26 | -0.20%	-$26 | -0.20%
ICF/IID	$247,628	-$9,905 | -4.00%	-$9,905 | -4.00%	-$4,953 | -2.00%	-$4,953 | -2.00%
Total	**$2,589,180**	**-$45,697 | -1.76%**	**-$15,091 | -0.58%**	**-$15,264 | -0.59%**	**-$6,695 | -0.26%**

Table 31 demonstrates that under the given scenarios and assumptions, managed care results in roughly $15.1 million to $45.7 million (0.58% to 1.76% of impacted Status Quo claims) in IDD LTSS claims savings for the two-year period from SFYs 2021-2022 when compared to the Status Quo. These savings are largely driven by HCS, TxHmL, and ICFs/IID. Please see Sections 5.6.3, 5.6.2 and 5.6.6 for details on the fiscal impacts for these three programs.

When comparing scenarios in which all services are carved in (1 and 3) to scenarios in which some services are carved in (2 and 4), the “all services” scenarios result in more claims savings. This is the result of more claims savings for TxHmL and HCS in Scenarios 1 and 3 since the majority of services are assumed to remain in FFS under Scenarios 2 and 4 for these two waivers.

5.3 Impact on Administrative Expenditures

As discussed in Section 4.2, administrative data directly attributable to IDD LTSS was not available. Instead, the amount of administrative expenditures attributable to IDD LTSS waivers and ICFs/IID was estimated. First, an “admin ratio” was calculated by dividing the total Medicaid administrative expenditures by the total Medicaid service expenditures. This admin ratio was then multiplied by the total IDD LTSS claims for each IDD waiver and ICFs/IID to estimate the administrative expenditures specific to the IDD waiver or ICFs/IID. The average historical administrative expenditure ratio

[69] Status Quo expenditures impacted include the total two-year expenditures from SFYs 2021-2022 for TxHmL and total one-year expenditures from 2022 for the other IDD LTSS waivers and ICF/IID. Those are the years modeled in this report that managed care is expected to impact for each program, per Chapter 534.

using this analysis is 4.10% of claims, which is the ratio applied to FFS claims under the Status Quo and MLTSS future states.

Per Chapter 534, existing IDD LTSS FFS waivers will continue to operate in parallel with the managed care programs following the IDD LTSS carve-in for services that are not carved-in or for individuals who opt-out of managed care. Because HHSC's claims adjudication contracts with external vendors are on a fixed fee basis (rather than per claim), the reduction in administrative expenditures for these programs from the carve-in is expected to be minimal or zero. As discussed in Section 4.3, IDD MTLSS claims are expected to result in additional administrative expenses and risk margin paid to MCOs. These additional expenditures are assumed to be in the range of 9.00% of managed care claims (in Scenarios 1 and 2) to 11.00% of managed care claims (in Scenarios 3 and 4). After adding these incremental expenditures to the baseline FFS admin ratio of 4.10 percent, this results in admin ratios of 13.10% and 15.10% of managed care claims under the respective scenarios. These rates are in addition to the 4.10% applied to claims that remain under FFS in the MLTSS future state.

In addition to the percent of claims increase, an adjustment was made to account for the addition of dual-eligible members age 21 and over, who are not currently receiving acute care services through managed care. The SFY 2019 STAR+PLUS capitation rates include a provision for fixed administrative expenditures of $20.00 PMPM plus $0.06 PMPM for maintenance tax. This total of $20.06 PMPM was multiplied by the number of dual-eligible adults assumed in each waiver, based on 2017 enrollment data, to come up with an added administrative fiscal impact for these members.

Table 32 and Table 33 below show the detailed build-up of total administrative expenditures under Status Quo and MLTSS. These include expenditures from SFYs 2021-2022 for TxHmL and SFY 2022 for the other four programs.

Table 32. Estimated Status Quo Administrative Expenditure Build-Up
Impact Period (SFYs 2021-2022 for TxHmL, SFY 2022 for other programs)
($ in thousands)

	Scenario 1 (All Services)	Scenario 2 (Some Services)	Scenario 3 (All Services)	Scenario 4 (Some Services)
(A) Total FFS Claims	$2,589,179	$2,589,179	$2,589,179	$2,589,179
(B) Admin Ratio applied to FFS claims	4.10%	4.10%	4.10%	4.10%
(C) Estimated Total SQ Admin = (A) * (B)	**$106,236**	**$106,236**	**$106,236**	**$106,236**

Table 33. Estimated MLTSS Administrative Expenditure Build-Up
Impact Period (SFYs 2021-2022 for TxHmL, SFY 2022 for other programs)
($ in thousands)

	Scenario 1 (All Services)	Scenario 2 (Some Services)	Scenario 3 (All Services)	Scenario 4 (Some Services)
(A) Total FFS Claims	$1,494,670	$2,209,789	$1,793,604	$2,256,676
(B) Admin Ratio applied to FFS claims	4.10%	4.10%	4.10%	4.10%
(C) MLTSS FFS Admin Subtotal = (A) * (B)	$61,327	$90,669	$73,593	$92,593
(D) Total MC Claims	$1,048,812	$364,300	$780,311	$325,808
(E) Admin Ratio applied to MC claims	13.10%	13.10%	15.10%	15.10%
(F) MLTSS MC Admin Subtotal = (D) * (E)	$137,427	$47,734	$117,851	$49,207
(G) Dual-Eligible Adult PMPM Assumption	$20.06	$20.06	$20.06	$20.06
(H) Total Dual-Eligible Adult Member Months in MC	136,706	272,237	106,910	269,547
(I) MLTSS MC Admin Subtotal = (G) * (H)	$2,742	$5,461	$2,145	$5,407
(J) Total MLTSS Administrative Spend = (C) + (F) + (I)	**$201,496**	**$143,865**	**$193,589**	**$147,207**

Table 34 below shows the estimated fiscal impact range for IDD LTSS administrative expenditures, considering HHSC's various carve-in options and assumptions as discussed in preceding sections. This table equals the difference between MLTSS administrative expenditures from Table 33 and Status Quo administrative expenditures from Table 32. Small discrepancies between the table below and the differences in tables above may exist due to rounding.

Table 34. Estimated Administrative Fiscal impact
Two-Year Total, SFYs 2021-2022
Estimated MLTSS Spending vs. Status Quo Spending
($ in thousands | % change from Status Quo)

Program	Status Quo Administrative Expenditures Impacted[70]	Scenario 1 (All Services)	Scenario 2 (Some Services)	Scenario 3 (All Services)	Scenario 4 (Some Services)
TxHmL	$14,306	$30,816 | 215.41%	$2,203 | 15.40%	$38,610 | 269.89%	$2,525 | 17.65%
HCS	$68,944	$35,960 | 52.16%	$6,941 | 10.07%	$18,084 | 26.23%	$7,788 | 11.30%
CLASS	$12,295	$6,425 | 52.26%	$6,425 | 52.26%	$3,236 | 26.32%	$3,236 | 26.32%
DBMD	$531	$280 | 52.74%	$280 | 52.74%	$141 | 26.51%	$141 | 26.51%
ICF/IID	$10,160	$21,780 | 214.36%	$21,780 | 214.36%	$27,282 | 268.52%	$27,282 | 268.52%
Total	**$106,236**	**$95,260 | 89.67%**	**$37,629 | 35.42%**	**$87,353 | 82.23%**	**$40,971 | 38.57%**

The figures presented in Table 34 illustrate that under the given scenarios and assumptions, administrative expenditures (including state administrative expenditures plus expenditures paid to MCOs for administrative expenditures, risk margin, and maintenance tax) increase by approximately $37.6 million to $95.3 million (35.42% to 89.67% when compared to Status Quo administrative expenditures) under managed care over the two-year period of SFY 2021 to SFY 2022. Additional costs associated with new FTE positions are not included in the table above but are discussed in section 5.5.

[70] Status Quo expenditures impacted include the total two-year expenditures from SFYs 2021-2022 for TxHmL and total one-year expenditures from 2022 for the other IDD LTSS waivers and ICF/IID. Those are the years modeled in this report that managed care is expected to impact for each program, per Chapter 534.

As discussed in previous sections, this increase in expenditures is due to a variety of factors, including:

1. Additional payments to MCOs for variable administrative expenditures (5.75% of managed care claims plus administrative expenditures) plus risk margin (1.75% of managed care claims plus administrative expenditures), resulting in approximately 7.50% of managed care claims plus administrative expenditures or 9.78% of claims.

2. Additional payments to MCOs for fixed administrative expenditures ($20.00 PMPM) plus maintenance tax ($0.06 PMPM) for dual-eligible adults who are new to managed care (i.e., the members do not currently receive acute care services through managed care).

3. The lack of reduced state administrative expenditures because FFS waivers will continue to operate after the carve-in. Claims adjudication contracts with external vendors are paid on a fixed fee basis.

4. The uncertainty in these expenditure changes is reasonably accounted for in the 9.00% to 11.00% range of administrative expenditure increase.

As the managed care program matures, HHSC could realize reduced state administrative expenditures from what was modeled through program efficiencies (e.g. shifting of staff responsibilities as additional individuals transition to managed care, renegotiation of vendor contracts, etc.). In addition, MCO administrative expenses can continue to be reevaluated over time to identify potential efficiencies. Thus, it is possible administrative expense could be lower in the future and be less than what was modeled.

5.4 Impact of Premium Taxes

HHSC includes a provision for state premium tax within the capitation rates paid to MCOs for each managed care program. For SFY 2019, this amount was equal to 1.75% of premium for STAR, STAR Health, STAR+PLUS, STAR Kids, and Dual Demonstration. MCOs ultimately pay this amount back to the State as a tax for operating as an insurance entity. Additionally, the portion of the capitation rate related to premium taxes is funded in part by the federal government through the FMAP. In effect, because HHSC only funds a portion of the premium tax provision in the capitation rates, but the state receives the full amount of the tax from the MCOs, the premium tax represents net revenue to the State overall under a managed care model, but a net expense to HHSC. The amount of this state revenue is equal to the FMAP times the state premium tax embedded in the capitation rates (assumed as 1.75% of managed care claims plus administrative expenditures in this analysis). The IDD LTSS carve-in's impact on state premium tax revenue is summarized in Table 35 below.

Table 35. Estimated State Premium Tax Revenue Impact
Two-Year Total, SFYs 2021-2022
($ in thousands | % of Status Quo claims + administrative expenditures)

Program	Status Quo Claims + Administrative Expenditures Impacted[71]	Scenario 1 (All Services)	Scenario 2 (Some Services)	Scenario 3 (All Services)	Scenario 4 (Some Services)
TxHmL	$362,963	$4,900 | 1.35%	$205 | 0.06%	$5,002 | 1.38%	$209 | 0.06%
HCS	$1,749,254	$5,526 | 0.32%	$519 | 0.03%	$2,257 | 0.13%	$528 | 0.03%
CLASS	$311,941	$1,059 | 0.34%	$1,059 | 0.34%	$432 | 0.14%	$432 | 0.14%
DBMD	$13,468	$45 | 0.33%	$45 | 0.33%	$18 | 0.14%	$18 | 0.14%
ICF/IID	$257,789	$3,269 | 1.27%	$3,269 | 1.27%	$3,337 | 1.29%	$3,337 | 1.29%
Total	**$2,695,415**	**$14,799 | 0.55%**	**$5,097 | 0.19%**	**$11,047 | 0.41%**	**$4,525 | 0.17%**

As Table 35 shows, state premium tax revenues range from roughly $4.5 million to $14.8 million (0.17% to 0.55% of Status Quo claims and administrative expenditures) over the two-year period of SFY 2021 to SFY 2022. The amount of premium tax varies across scenarios based on the relative amount of managed care claims under each scenario, which depends on the utilization adjustments and percent of members choosing managed care.

5.5 Impact of Additional Full-Time Equivalents (FTEs)

HHSC expects that there may be a need for ten additional MCO oversight FTEs. Based on the assumptions below, HHSC predicts they may need six contract specialist IVs and four program specialist IVs. The estimated annual expenditures for these ten FTEs is $619,560 per the following assumptions.

HHSC FTE Assumptions:

- The IDD LTSS carve-ins occur according to timeline established in Texas Chapter 534 (i.e. TxHmL in 2020 and HCS, CLASS, DBMD, and ICFs/IID in 2021).

[71] Status Quo expenditures impacted include the total two-year expenditures from SFYs 2021-2022 for TxHmL and total one-year expenditures from 2022 for the other IDD LTSS waivers and ICF/IID. Those are the years modeled in this report that managed care is expected to impact for each program, per Chapter 534.

- Services will be carved into STAR+PLUS, STAR Kids, and STAR Health
- Oversight will yield data that allows HHSC to track and trend IDD LTSS utilization and service authorizations as well as break out the IDD waiver population in any data currently collected in STAR+PLUS
- Additional expenditure estimates are not affected by the number of waivers or services carved into managed care

In addition to staff for MCO oversight, an estimation was made for one additional program specialist VI at a cost of $6,066 per month (or $72,792 per year). When added to the ten additional FTEs for MCO oversight, this results in a total added staff expense of approximately $692,352 per year, or $1,384,704 over the two-year period from SFY 2021 to SFY 2022.[72] These expenditures are added and addressed separately in the overall cost-effectiveness summary below in Section 5.6 and are not included in the administrative expenditure line item shown in tables throughout this report.

5.6 Overall Cost-Effectiveness Summary

The summary tables throughout this section include fiscal impacts by service and administrative expenditures for each waiver and ICFs/IID as well as in total. Fiscal impacts are displayed for the State of Texas as a whole compared to HHSC and the federal government. Finally, the assumed breakdown of fiscal impacts between children and adults in the IDD programs was analyzed based on the 2017 adult/children expenditure distribution.

5.6.1 Cost-Effectiveness of Managed Care in Total for IDD LTSS

Table 36 demonstrates the All Funds fiscal impact across all IDD waivers and ICFs/IID before premium taxes are paid and before the FMAP is applied to distribute federal and state fiscal impacts. In total, the expenditures increase by roughly $22.5 million to $72.1 million (0.84% to 2.67%) relative to the Status Quo over the two-year period of SFY 2021 to SFY 2022. This is equivalent to an increase of $36.59 to $117.04 PMPM for all members with IDD (both those staying in FFS and those moving to managed care). While there are estimated savings achieved on LTSS claims, the estimated amount of increased administrative expenditures outweighs any savings from claims. This conclusion of increased IDD LTSS overall expenditures is in line with the conclusions of the historical fiscal impact estimate for STAR+PLUS managed care overall. In the Rider 61(a) report, it was estimated that STAR+PLUS resulted in increased expenditures of $0.3 billion to $2.9 billion (0.7% to 8.0%) when compared to hypothetical FFS expenditures.[73]

[73] Texas Health and Human Services Commission (HHSC), *"Rider Report 61,"* August 17, 2018. Page 98. https://hhs.texas.gov/reports/2018/08/rider-61-evaluation-medicaid-chip-managed-care

Table 36. Estimated Fiscal Impact of Transition to Managed Care for IDD LTSS
Two-Year Total, SFY 2021 - 2022
(Estimated MLTSS Spending vs. Status Quo Spending)
($ in thousands | % change from Status Quo)

Service Category / Expenditure Type[74]	Status Quo Expenditures Impacted, 2021 - 2022	Scenario 1 (All Services)	Scenario 2 (Some Services)	Scenario 3 (All Services)	Scenario 4 (Some Services)
PAS/HAB[75]	$1,110,977	-$17,441 | -1.57%	-$2,247 | -0.20%	-$6,021 | -0.54%	-$449 | -0.04%
Respite	$99,561	-$1,692 | -1.70%	-$68 | -0.07%	$0 | 0.00%	$0 | 0.00%
Case Management	$89,896	-$900 | -1.00%	-$65 | -0.07%	$0 | 0.00%	$0 | 0.00%
Nursing	$23,973	-$278 | -1.16%	-$34 | -0.14%	-$71 | -0.30%	-$7 | -0.03%
Therapies	$56,009	-$1,012 | -1.81%	-$1,135 | -2.03%	-$362 | -0.65%	-$527 | -0.94%
Residential	$890,091	-$13,351 | -1.50%	-$36 | 0.00%	-$3,560 | -0.40%	-$10 | 0.00%
Fees	$18,707	-$352 | -1.88%	-$438 | -2.34%	-$136 | -0.73%	-$188 | -1.01%
Transportation	$17,975	-$270 | -1.50%	-$1 | 0.00%	$0 | 0.00%	$0 | 0.00%
Intervener	$1,793	-$9 | -0.50%	-$9 | -0.50%	$0 | 0.00%	$0 | 0.00%
ICF Daily Care	$247,628	-$9,905 | -4.00%	-$9,905 | -4.00%	-$4,953 | -2.00%	-$4,953 | -2.00%
Other	$32,569	-$487 | -1.49%	-$1,153 | -3.54%	-$162 | -0.50%	-$562 | -1.72%
LTSS Claims Subtotal (A)	$2,589,179	-$45,697 | -1.76%	-$15,091 | -0.58%	-$15,264 | -0.59%	-$6,695 | -0.26%
Administrative Expenditures (B)	$106,236	$95,260 | 89.67%	$37,629 | 35.42%	$87,353 | 82.23%	$40,971 | 38.57%
Total without Premium Tax or FTEs (C) = (A) + (B)	**$2,695,415**	**$49,563 | 1.84%**	**$22,538 | 0.84%**	**$72,088 | 2.67%**	**$34,276 | 1.27%**
Additional FTE Expenditures (D)	N/A	$1,385	$1,385	$1,385	$1,385
Total without Premium Tax (E) = (C) + (D)	**$2,695,415**	**$50,948 | 1.89%**	**$23,923 | 0.89%**	**$73,473 | 2.73%**	**$35,661 | 1.32%**

[74] Please see Appendix A for service category definitions.
[75] PAS/HAB is Personal Assistance Services/Habilitation

In the scenarios in which all services are carved in (Scenarios 1 and 3), the greatest claims savings come from three service categories: PAS/HAB, Residential, and ICF Daily Care. These services not only represent a large portion of total IDD LTSS spend, but also represent services with which MCOs have greater opportunity to evaluate service utilization for either less costly alternatives or appropriateness of service authorizations. In Scenarios 2 and 4, Residential claims savings decrease substantially since HCS Residential remains under FFS in these scenarios.

5.6.2 Cost-Effectiveness of Managed Care for TxHmL

Table 37 displays detailed fiscal impacts for services currently offered under the TxHmL waiver. Given the scenarios and assumptions evaluated for this waiver, costs to the state are higher under each of the four managed care scenarios evaluated than they would be under FFS. Total expenditures increased for this waiver by approximately $1.6 million to $34.0 million (0.45% to 9.37%) over the two-year period of SFY 2021 to SFY 2022. This is equivalent to an increase of $10.16 to $211.17 PMPM for all members in the TxHmL waiver (both those staying in FFS and those moving to managed care).

When considering a managed care carve-in, costs are higher if all TxHmL services are carved into managed care compared to only some. The vast majority of the claims savings for this waiver come from the PAS/HAB service category. In Scenarios 2 and 4, this service category remains in FFS, resulting in lower claims savings overall. Although these two scenarios have lower claims savings, the lower amount of administrative expenditures increase (due to lower managed care claims) results in a lower expenditure increase overall relative to Scenarios 1 and 3.

Table 37. Estimated Fiscal Impact of Transition to Managed Care for TxHmL
Two-Year Total, SFY 2021 – 2022
(Estimated MLTSS Spending vs. Status Quo Spending)
($ in thousands | % change from Status Quo) [76]

Service Category / Expenditure Type	Status Quo Expenditures Impacted, 2021-2022	Scenario 1 (All Services)	Scenario 2 (Some Services)	Scenario 3 (All Services)	Scenario 4 (Some Services)
PAS/HAB[77]	$211,043	-$8,442 | -4.00%	$0 | 0.00%	-$4,221 | -2.00%	$0 | 0.00%
Respite	$79,629	-$1,593 | -2.00%	$0 | 0.00%	$0 | 0.00%	$0 | 0.00%
Case Management	$30,037	-$601 | -2.00%	$0 | 0.00%	$0 | 0.00%	$0 | 0.00%
Nursing	$1,270	-$51 | -4.00%	$0 | 0.00%	-$25 | -2.00%	$0 | 0.00%
Therapies	$3,826	-$230 | -6.00%	-$132 | -3.45%	-$153 | -4.00%	-$88 | -2.30%
Residential	$0	$0 | 0.00%	$0 | 0.00%	$0 | 0.00%	$0 | 0.00%
Fees	$5,501	-$220 | -4.00%	-$220 | -4.00%	-$110 | -2.00%	-$110 | -2.00%
Transportation	$11,989	-$240 | -2.00%	$0 | 0.00%	$0 | 0.00%	$0 | 0.00%
Intervener	$0	$0 | 0.00%	$0 | 0.00%	$0 | 0.00%	$0 | 0.00%
ICF Daily Care	$0	$0 | 0.00%	$0 | 0.00%	$0 | 0.00%	$0 | 0.00%
Other	$5,362	-$214 | -4.00%	-$214 | -4.00%	-$107 | -2.00%	-$107 | -2.00%
LTSS Claims Subtotal (A)	$348,658	-$11,590 | -3.32%	-$566 | -0.16%	-$4,617 | -1.32%	-$305 | -0.09%
Administrative Expenditures (B)	$14,306	$30,816 | 215.41%	$2,203 | 15.40%	$38,610 | 269.89%	$2,525 | 17.65%
Total without Premium Tax (C) = (A) + (B)	**$362,964**	**$19,226 | 5.30%**	**$1,636 | 0.45%**	**$33,993 | 9.37%**	**$2,220 | 0.61%**

[76] All percentages shown in this table use the Status Quo expenditures for each expenditure type in the denominator. For example, the PAS/HAB percentage equals the total claims change for PAS/HAB divided by the total PAS/HAB claims impacted under the Status Quo. Likewise, the administrative expenditure percentage uses total administrative expenditures impacted under the Status Quo for the denominator and the total fiscal impact percentage uses total claims plus total administrative expenditures impacted for the denominator.

[77] PAS/HAB is Personal Assistance Services/Habilitation

5.6.3 Cost-Effectiveness of Managed Care for HCS

Table 38 displays detailed fiscal impacts for services currently offered under the HCS waiver. Given the scenarios and assumptions evaluated for this waiver, costs to the state are higher under each of the four managed care scenarios evaluated than they would be under FFS. Total expenditures increased for this waiver by approximately $5.5 million to $14.9 million (0.31% to 0.85%) for the one-year period of SFY 2022. This is equivalent to an increase of $17.06 to $46.27 PMPM for all members in the HCS waiver (both those staying in FFS and those moving to managed care). The primary drivers for claims savings in this waiver are PAS/HAB and Residential services.

When considering a managed care carve-in, costs are higher if all HCS services are carved into managed care compared to only some. This is because under Scenarios 2 and 4 (when only some services are carved in), only a small amount of services are assumed to be provided under managed care. This leads to a small amount of managed care claims from which to apply increased administrative expense assumptions.

Table 38. Estimated Fiscal Impact of Transition to Managed Care for HCS
One-Year Total, SFY 2022
(Estimated MLTSS Spending vs. Status Quo Spending)
($ in thousands | % change from Status Quo)[78]

Service Category / Expenditure Type	Status Quo Expenditures Impacted, SFY 2022	Scenario 1 (All Services)	Scenario 2 (Some Services)	Scenario 3 (All Services)	Scenario 4 (Some Services)
PAS/HAB[79]	$675,244	-$6,752 | -1.00%	$0 | 0.00%	-$1,350 | -0.20%	$0 | 0.00%
Respite	$6,360	-$32 | -0.50%	$0 | 0.00%	$0 | 0.00%	$0 | 0.00%
Case Management	$46,885	-$234 | -0.50%	$0 | 0.00%	$0 | 0.00%	$0 | 0.00%
Nursing	$19,348	-$193 | -1.00%	$0 | 0.00%	-$39 | -0.20%	$0 | 0.00%
Therapies	$13,835	-$208 | -1.50%	-$428 | -3.09%	-$55 | -0.40%	-$285 | -2.06%
Residential	$887,662	-$13,315 | -1.50%	$0 | 0.00%	-$3,551 | -0.40%	$0 | 0.00%
Fees	$2,871	-$29 | -1.00%	-$115 | -4.00%	-$6 | -0.20%	-$57 | -2.00%
Transportation	$5,883	-$29 | -0.50%	$0 | 0.00%	$0 | 0.00%	$0 | 0.00%
Intervener	$0	$0 | 0.00%	$0 | 0.00%	$0 | 0.00%	$0 | 0.00%
ICF Daily Care	$0	$0 | 0.00%	$0 | 0.00%	$0 | 0.00%	$0 | 0.00%
Other	$22,221	-$222 | -1.00%	-$889 | -4.00%	-$44 | -0.20%	-$444 | -2.00%
LTSS Claims Subtotal (A)	$1,680,310	-$21,015 | -1.25%	-$1,432 | -0.09%	-$5,045 | -0.30%	-$787 | -0.05%
Administrative Expenditures (B)	$68,944	$35,960 | 52.16%	$6,941 | 10.07%	$18,084 | 26.23%	$7,788 | 11.30%
Total without Premium Tax (C) = (A) + (B)	**$1,749,254**	**$14,945 | 0.85%**	**$5,509 | 0.31%**	**$13,039 | 0.75%**	**$7,001 | 0.40%**

[78] All percentages shown in this table use the Status Quo expenditures for each expenditure type in the denominator. For example, the PAS/HAB percentage equals the total claims change for PAS/HAB divided by the total PAS/HAB claims impacted under the Status Quo. Likewise, the administrative expenditure percentage uses total administrative expenditures impacted under the Status Quo for the denominator and the total fiscal impact percentage uses total claims plus total administrative expenditures impacted for the denominator.

[79] PAS/HAB is Personal Assistance Services/Habilitation

5.6.4 Cost-Effectiveness of Managed Care for CLASS

Table 39 displays detailed fiscal impacts for services currently offered under the CLASS waiver. Given the scenarios and assumptions evaluated for this waiver, costs to the state are higher under each of the four managed care scenarios evaluated than they would be under FFS. Total expenditures increased for this waiver by approximately $2.6 million to $3.4 million (0.84% to 1.08%) for the one-year period of SFY 2022. This is equivalent to an increase of $39.14 to $50.47 PMPM for all members in the CLASS waiver (both those staying in FFS and those moving to managed care). The primary drivers for claims savings in this waiver are PAS/HAB and Therapies.

Because there are no services for this waiver that are anticipated to remain under FFS, there is not a difference between Scenarios 1 and 2 or between Scenarios 3 and 4. Similar to all other programs, the increased administrative expenditures outweigh any claims savings achieved for this program.

Table 39. Estimated Fiscal Impact of Transition to Managed Care for CLASS
One-Year Total, SFY 2022
(Estimated MLTSS Spending vs. Status Quo Spending)
($ in thousands | % change from Status Quo)[80]

Service Category / Expenditure Type	Status Quo Expenditures Impacted, SFY 2022	Scenario 1 (All Services)	Scenario 2 (Some Services)	Scenario 3 (All Services)	Scenario 4 (Some Services)
PAS/HAB[81]	$217,177	-$2,172 | -1.00%	-$2,172 | -1.00%	-$434 | -0.20%	-$434 | -0.20%
Respite	$13,154	-$66 | -0.50%	-$66 | -0.50%	$0 | 0.00%	$0 | 0.00%
Case Management	$12,857	-$64 | -0.50%	-$64 | -0.50%	$0 | 0.00%	$0 | 0.00%
Nursing	$3,222	-$32 | -1.00%	-$32 | -1.00%	-$6 | -0.20%	-$6 | -0.20%
Therapies	$38,295	-$574 | -1.50%	-$574 | -1.50%	-$153 | -0.40%	-$153 | -0.40%
Residential	$0	$0 | 0.00%	$0 | 0.00%	$0 | 0.00%	$0 | 0.00%
Fees	$10,084	-$101 | -1.00%	-$101 | -1.00%	-$20 | -0.20%	-$20 | -0.20%
Transportation	$63	$0 | -0.50%	$0 | -0.50%	$0 | 0.00%	$0 | 0.00%
Intervener	$0	$0 | 0.00%	$0 | 0.00%	$0 | 0.00%	$0 | 0.00%
ICF Daily Care	$0	$0 | 0.00%	$0 | 0.00%	$0 | 0.00%	$0 | 0.00%
Other	$4,796	-$48 | -1.00%	-$48 | -1.00%	-$10 | -0.20%	-$10 | -0.20%
LTSS Claims Subtotal (A)	$299,647	-$3,058 | -1.02%	-$3,058 | -1.02%	-$624 | -0.21%	-$624 | -0.21%
Administrative Expenditures (B)	$12,295	$6,425 | 52.26%	$6,425 | 52.26%	$3,236 | 26.32%	$3,236 | 26.32%
Total without Premium Tax (C) = (A) + (B)	**$311,942**	**$3,368 | 1.08%**	**$3,368 | 1.08%**	**$2,612 | 0.84%**	**$2,612 | 0.84%**

[80] All percentages shown in this table use the Status Quo expenditures for each expenditure type in the denominator. For example, the PAS/HAB percentage equals the total claims change for PAS/HAB divided by the total PAS/HAB claims impacted under the Status Quo. Likewise, the administrative expenditure percentage uses total administrative expenditures impacted under the Status Quo for the denominator and the total fiscal impact percentage uses total claims plus total administrative expenditures impacted for the denominator.

[81] PAS/HAB is Personal Assistance Services/Habilitation

5.6.5 Cost-Effectiveness of Managed Care for DBMD

Table 40 displays detailed fiscal impacts for services currently offered under the DBMD waiver. Given the scenarios and assumptions evaluated for this waiver, costs to the state are higher under each of the four managed care scenarios evaluated than they would be under FFS. Total expenditures increased for this waiver by approximately $0.1 million to $0.2 million (0.85% to 1.11%) for the one-year period of SFY 2022. This is equivalent to an increase of $27.82 to $36.28 PMPM for all members in the DBMD waiver (both those staying in FFS and those moving to managed care). The primary drivers for claims savings in this waiver are PAS/HAB and Residential.

Because there are no services for this waiver that are anticipated to remain under FFS, there is not a difference between Scenarios 1 and 2 or between Scenarios 3 and 4. DBMD is the smallest IDD LTSS program examined in this analysis, and thus represents the smallest fiscal impact source. Similar to all other programs, the increased administrative expenditures outweigh any claims savings achieved for this program.

Table 40. Estimated Fiscal Impact of Transition to Managed Care for DBMD
One-Year Total, SFY 2022
(Estimated MLTSS Spending vs. Status Quo Spending)
($ in thousands | % change from Status Quo)[82]

Service Category / Expenditure Type	Status Quo Expenditures Impacted, SFY 2022	Scenario 1 (All Services)	Scenario 2 (Some Services)	Scenario 3 (All Services)	Scenario 4 (Some Services)
PAS/HAB[83]	$7,512	-$75 | -1.00%	-$75 | -1.00%	-$15 | -0.20%	-$15 | -0.20%
Respite	$418	-$2 | -0.50%	-$2 | -0.50%	$0 | 0.00%	$0 | 0.00%
Case Management	$118	-$1 | -0.50%	-$1 | -0.50%	$0 | 0.00%	$0 | 0.00%
Nursing	$133	-$1 | -1.00%	-$1 | -1.00%	$0 | -0.20%	$0 | -0.20%
Therapies	$53	-$1 | -1.50%	-$1 | -1.50%	$0 | -0.40%	$0 | -0.40%
Residential	$2,429	-$36 | -1.50%	-$36 | -1.50%	-$10 | -0.40%	-$10 | -0.40%
Fees	$251	-$3 | -1.00%	-$3 | -1.00%	-$1 | -0.20%	-$1 | -0.20%
Transportation	$40	$0 | -0.50%	$0 | -0.50%	$0 | 0.00%	$0 | 0.00%
Intervener	$1,793	-$9 | -0.50%	-$9 | -0.50%	$0 | 0.00%	$0 | 0.00%
ICF Daily Care	$0	$0 | 0.00%	$0 | 0.00%	$0 | 0.00%	$0 | 0.00%
Other	$189	-$2 | -1.00%	-$2 | -1.00%	$0 | -0.20%	$0 | -0.20%
LTSS Claims Subtotal (A)	$12,937	-$130 | -1.00%	-$130 | -1.00%	-$26 | -0.20%	-$26 | -0.20%
Administrative Expenditures (B)	$531	$280 | 52.74%	$280 | 52.74%	$141 | 26.51%	$141 | 26.51%
Total without Premium Tax (C) = (A) + (B)	**$13,468**	**$150 | 1.11%**	**$150 | 1.11%**	**$115 | 0.85%**	**$115 | 0.85%**

[82] All percentages shown in this table use the Status Quo expenditures for each expenditure type in the denominator. For example, the PAS/HAB percentage equals the total claims change for PAS/HAB divided by the total PAS/HAB claims impacted under the Status Quo. Likewise, the administrative expenditure percentage uses total administrative expenditures impacted under the Status Quo for the denominator and the total fiscal impact percentage uses total claims plus total administrative expenditures impacted for the denominator.
[83] PAS/HAB is Personal Assistance Services/Habilitation

5.6.6 Cost-Effectiveness of Managed Care for ICFs/IID

Table 41 displays detailed fiscal impacts for services currently offered under ICFs/IID. Given the scenarios and assumptions evaluated for this waiver, costs to the state are higher under each of the four managed care scenarios evaluated than they would be under FFS. Total expenditures increased for this program by approximately $11.9 million to $22.3 million (4.61% to 8.66%) for the one-year period of SFY 2022. This is equivalent to an increase of $194.30 to $365.37 PMPM for all members in ICFs/IID (both those staying in FFS and those moving to managed care). ICF Daily Care is the only service category offered under this program, and claims savings amounted to the assumed four percent and two percent utilization adjustments for this service category. Similar to all other programs, the increased administrative expenditures outweigh any claims savings achieved for this program.

Table 41. Estimated Fiscal Impact of Transition to Managed Care for ICFs/IID
One-Year Total, SFY 2022
(Estimated MLTSS Spending vs. Status Quo Spending)
($ in thousands | % change from Status Quo)[84]

Service Category / Expenditure Type	Status Quo Expenditures Impacted, SFY 2022	Scenario 1 (All Services)	Scenario 2 (Some Services)	Scenario 3 (All Services)	Scenario 4 (Some Services)
PAS/HAB[85]	$0	$0 | 0.00%	$0 | 0.00%	$0 | 0.00%	$0 | 0.00%
Respite	$0	$0 | 0.00%	$0 | 0.00%	$0 | 0.00%	$0 | 0.00%
Case Management	$0	$0 | 0.00%	$0 | 0.00%	$0 | 0.00%	$0 | 0.00%
Nursing	$0	$0 | 0.00%	$0 | 0.00%	$0 | 0.00%	$0 | 0.00%
Therapies	$0	$0 | 0.00%	$0 | 0.00%	$0 | 0.00%	$0 | 0.00%
Residential	$0	$0 | 0.00%	$0 | 0.00%	$0 | 0.00%	$0 | 0.00%
Fees	$0	$0 | 0.00%	$0 | 0.00%	$0 | 0.00%	$0 | 0.00%
Transportation	$0	$0 | 0.00%	$0 | 0.00%	$0 | 0.00%	$0 | 0.00%
Intervener	$0	$0 | 0.00%	$0 | 0.00%	$0 | 0.00%	$0 | 0.00%
ICF Daily Care	$247,628	-$9,905 | -4.00%	-$9,905 | -4.00%	-$4,953 | -2.00%	-$4,953 | -2.00%
Other	$0	$0 | 0.00%	$0 | 0.00%	$0 | 0.00%	$0 | 0.00%
LTSS Claims Subtotal (A)	$247,628	-$9,905 | -4.00%	-$9,905 | -4.00%	-$4,953 | -2.00%	-$4,953 | -2.00%
Administrative Expenditures (B)	$10,160	$21,780 | 214.36%	$21,780 | 214.36%	$27,282 | 268.52%	$27,282 | 268.52%
Total without Premium Tax (C) = (A) + (B)	**$257,788**	**$11,875 | 4.61%**	**$11,875 | 4.61%**	**$22,330 | 8.66%**	**$22,330 | 8.66%**

[84] All percentages shown in this table use the Status Quo expenditures for each expenditure type in the denominator. For example, the PAS/HAB percentage equals the total claims change for PAS/HAB divided by the total PAS/HAB claims impacted under the Status Quo. Likewise, the administrative expenditure percentage uses total administrative expenditures impacted under the Status Quo for the denominator and the total fiscal impact percentage uses total claims plus total administrative expenditures impacted for the denominator.
[85] PAS/HAB is Personal Assistance Services/Habilitation

5.7 Comparison of Fiscal Impacts Between Federal and State Share

To determine the federal and state share of total fiscal impacts, two calculations are required:

1. The application of HHSC's estimated FMAPs for SFY 2021 – 2022, as shown in Section 4.2, to the claims and administrative fiscal impacts for each waiver. This allocates the fiscal impact before premium tax to the federal and HHSC portion. As discussed in Section 4.2, the estimated FMAPs reflect an enhanced federal match on CFC services, which differs by waiver.

2. The allocation of premium tax payments to various entities (Federal government, State of Texas, and HHSC). As detailed in Section 5.4, the net effect to these entities is as follows:

    - Federal government: premium taxes result in a net expense, equal to the total premium tax multiplied by the FMAP

    - State of Texas: premium taxes result in a net revenue, equal to the total premium tax multiplied by the FMAP

    - HHSC: premium taxes result in a net expense, equal to the total premium tax multiplied by (one minus the FMAP)

Table 42 shows a summary of the net fiscal impact, after accounting for premium taxes, for each entity. Based on the scenarios analyzed, the net fiscal impact to the State of Texas overall ranges from an aggregate increase of $3.7 million to $16.6 million over the two-year period of SFY 2021 to SFY 2022. The impact to HHSC over the same period is an increase of $12.1 million to $34.6 million. While expenditures for the State increase overall, the increase from claims and administrative expenses is offset in part by increased premium tax revenue. The federal government pays for a larger portion of the claims and administrative expenditure increase and pays a portion of the premium tax, resulting in a higher range of expenditure increase.

Please see Appendices F (Scenario 1), G (Scenario 2), H (Scenario 3), and I (Scenario 4) for tables detailing the calculations summarized in Table 42. These appendices show the build-up of the final net fiscal impact calculation for each entity by waiver and overall.

Table 42. Estimated Federal vs. State Fiscal Impact Summary
Two-Year Total, SFYs 2021 – 2022
Estimated MLTSS Spending vs. Status Quo Spending
($ in thousands)

	Scenario 1 (All Services)	Scenario 2 (Some Services)	Scenario 3 (All Services)	Scenario 4 (Some Services)
(A) Total Fiscal Impact (Claims + Admin) without Premium Tax	$49,564	$22,538	$72,089	$34,278
*(B) Federal Portion of Claims + Admin Impact (B) = FMAP * (A)*	$30,503	$13,703	$44,434	$20,715
*(C) State Portion of Claims + Admin Impact (C) = (1 - FMAP) * (A)*	$19,061	$8,835	$27,655	$13,563
(D) Federal Portion of Premium Tax	$14,799	$5,097	$11,047	$4,525
(E) HHSC Portion of Premium Tax	$9,323	$3,282	$6,901	$2,969
(F) Federal Net Fiscal Impact (after premium tax) (F) = (B) + (D)	$45,302	$18,800	$55,481	$25,240
(G) State Net Fiscal Impact (after premium tax) (G) = (C) - (D)	**$4,262**	**$3,738**	**$16,608**	**$9,038**
(H) HHSC Net Fiscal Impact (after premium tax) (H) = (C) + (E)	**$28,385**	**$12,117**	**$34,555**	**$16,531**

5.7.1 Comparison of Fiscal Impacts Between Children and Adults

To illustrate the relative magnitude of fiscal impacts between children (under 21) and adults (21 and over), this analysis assumed a constant distribution of claims expenditures for children and adults. Table 43 below shows the fiscal impact breakdown between these two age groups, using the SFY 2017 total expenditure distribution. For example, in 2017, 65.44 percent of TxHmL expenditures can be attributed to adults, therefore this same percentage was applied to the fiscal impacts for this waiver. Because the majority of expenditures in each waiver for 2017 were from adults, the same is expected for the fiscal impacts from managed care. In total, approximately 89.53 percent of estimated claims and administrative fiscal impacts relate to adults.

Table 43. Comparison of Estimated Fiscal Impacts Between Children and Adults
Two-Year Total, SFYs 2021 – 2022
(Estimated MLTSS Spending vs. Status Quo Spending)
($ in thousands | % of total fiscal impact)

Program	Impact Type	Scenario 1 (All Services)	Scenario 2 (Some Services)	Scenario 3 (All Services)	Scenario 4 (Some Services)
TxHmL	Total Fiscal impact (Claims + Admin)	$19,226 | 100.00%	$1,636 | 100.00%	$33,993 | 100.00%	$2,220 | 100.00%
TxHmL	*Adults (21+) Impact*	$12,582 | 65.44%	$1,071 | 65.44%	$22,245 | 65.44%	$1,453 | 65.44%
TxHmL	*Children (<21) Impact*	$6,644 | 34.56%	$565 | 34.56%	$11,748 | 34.56%	$767 | 34.56%
HCS	Total Fiscal impact (Claims + Admin)	$14,945 | 100.00%	$5,509 | 100.00%	$13,039 | 100.00%	$7,001 | 100.00%
HCS	*Adults (21+) Impact*	$13,976 | 93.52%	$5,152 | 93.52%	$12,194 | 93.52%	$6,547 | 93.52%
HCS	*Children (<21) Impact*	$969 | 6.48%	$357 | 6.48%	$845 | 6.48%	$454 | 6.48%
CLASS	Total Fiscal impact (Claims + Admin)	$3,368 | 100.00%	$3,368 | 100.00%	$2,612 | 100.00%	$2,612 | 100.00%
CLASS	*Adults (21+) Impact*	$2,390 | 70.98%	$2,390 | 70.98%	$1,854 | 70.98%	$1,854 | 70.98%
CLASS	*Children (<21) Impact*	$978 | 29.02%	$978 | 29.02%	$758 | 29.02%	$758 | 29.02%
DBMD	Total Fiscal impact (Claims + Admin)	$150 | 100.00%	$150 | 100.00%	$115 | 100.00%	$115 | 100.00%

Program	Impact Type	Scenario 1 (All Services)	Scenario 2 (Some Services)	Scenario 3 (All Services)	Scenario 4 (Some Services)
DBMD	*Adults (21+) Impact*	$107 | 71.23%	$107 | 71.23%	$82 | 71.23%	$82 | 71.23%
DBMD	*Children (<21) Impact*	$43 | 28.77%	$43 | 28.77%	$33 | 28.77%	$33 | 28.77%
ICF/IDD	Total Fiscal impact (Claims + Admin)	$11,875 | 100.00%	$11,875 | 100.00%	$22,330 | 100.00%	$22,330 | 100.00%
ICF/IDD	*Adults (21+) Impact*	$11,505 | 96.88%	$11,505 | 96.88%	$21,634 | 96.88%	$21,634 | 96.88%
ICF/IDD	*Children (<21) Impact*	$370 | 3.12%	$370 | 3.12%	$696 | 3.12%	$696 | 3.12%
Total	Total Fiscal impact (Claims + Admin)	$49,563 | 100.00%	$22,538 | 100.00%	$72,088 | 100.00%	$34,276 | 100.00%
Total	*Adults (21+) Impact*	$44,372 | 89.53%	$20,177 | 89.53%	$64,537 | 89.53%	$30,686 | 89.53%
Total	*Children (<21) Impact*	$5,191 | 10.47%	$2,361 | 10.47%	$7,551 | 10.47%	$3,590 | 10.47%

5.8 Managed Care Transition Considerations

The transition to a managed care health care delivery system is often aimed at managing expenditures, utilization and quality. Medicaid managed care provides opportunities for states to deliver health care and other Medicaid benefits (e.g. LTSS) through contractual arrangements between the state Medicaid agency and MCOs. The contracted MCOs accept an established PMPM payment for the delivery of services. Managed care objectives frequently include improved quality, increased access to care, and reduction in overall program expenditures.[86]

The transition to managed care may affect aspects of quality and access to care, which are discussed broadly below. Note that this report includes only general information on impacts in these areas as the cost-effectiveness evaluation is focused on fiscal impacts. Detailed quality and access implications are being considered by another vendor in a separate report.

[86] Centers for Medicare & Medicaid Services, "*Managed Care*", available at https://www.medicaid.gov/medicaid/managed-care/index.html

5.8.1 Access to Care and Resulting Fiscal impacts

The managed care capitation rate reimburses MCOs an established amount per member per month, rather than reimbursing for each treatment and/or service separately. Managed care plans are required to meet federal statutory requirements related to access to care. These requirements, which are specific to MCOs, include criteria related to network adequacy, accessibility, and provider capacity. States frequently establish additional standards, including the specifications for defining provider network adequacy. Texas currently requires MCOs to provide evidence of geographic provider network adequacy compared to target populations and distance standards,[87] but is establishing new network adequacy standards based on the availability of providers in a certain geographical area.[88] Texas also requires that MCOs contract with telehealth providers to ensure access to specialty care in rural areas of the state.[89]

Available research on managed care transitions generally focuses on the implementation of traditional Medicaid programs. Limited evidence on access to care is available specific to managed long-term services and supports. A synthesis of national studies on managed care conducted by the Mallman School of Public Health at Columbia University and the Robert Wood Johnson Foundation[90] reported some evidence of improved access to the usual sources of care for members in Medicaid managed care programs. Other results, however, show that access to care is unchanged or negatively impacted by a transition to managed care. Researchers synthesizing access studies surmise that varied results may be due to varying provider reimbursement methodologies utilized by managed care plans, the limited nature of some managed care provider networks, and the goal of managed care program to minimize certain services (i.e. emergency room services, institutional services, etc.).[91] In addition, the results of a 2017 survey of Medicaid managed care plans[92] reveals that most plans report potential access issues in specialty care, due to provider supply shortages.

While general increased access to care could decrease expenditures through improved health outcomes for members, it is not apparent that the increase in access is

[87] Texas Health & Human Services Commission, "*Uniform Managed Care Terms & Conditions*" (Version 2.26).
[88] Discussion with HHSC staff, November 26-27, 2018.
[89] National Academy for State Health Policy, *"How States Structure Medicaid Managed Care to Meet the Unique Needs of Children and Youth with Special Health Care Needs"*. (April 2018).
[90] Michael Sparer, Mallman School of Public Health at Columbia University and the Robert Wood Johnson Foundation, "Medicaid managed care: Costs, access, and quality of care", (September 2012).
[91] Michael Sparer, Mallman School of Public Health at Columbia University and the Robert Wood Johnson Foundation, "Medicaid managed care: Costs, access, and quality of care", (September 2012).
[92] Rachel Garfield, Elizabeth Hinton, Elizabeth Cornachione, and Cornelia Hall, Kaiser Family Foundation, "Medicaid Managed Care Plans and Access to Care", (March 2018).

consistent across all populations and managed care programs.[93] In addition, the gaps in specialty care and dental services could result in potentially significant health issues and related expenditures, especially for people with complex medical and/or behavioral health needs.[94]

5.8.2 Quality of Care and Resulting Fiscal impacts

Federal regulations apply quality standards to managed care plans, and states frequently impose additional requirements via MCO contracts. Participation in quality improvement activities is often required by states, and compliance and achievement of performance goals often results in incentive payments or bonuses paid to MCOs. Texas, for example, has implemented a Pay for Quality (P4Q) Program. In the P4Q Program, a percentage of the capitation payment is placed 'at risk', and at the end of each rating period, the MCOs performance is evaluated. The 'at risk' dollars may be recouped for failure to meet performance expectations.

Similar to the findings on access to care, expenditure data on quality outcomes are not readily available and have varied results.[95] Research that is available relates to implementation of traditional Medicaid programs, and is not specific to managed long-term services and supports. Over the past several years some small case studies have indicated improved quality and outcomes in managed care through the use of care management techniques by plans. Research conducted in five states that have implemented managed care programs indicated that "anecdotal evidence suggests" savings can be realized through implementation of effective care management techniques. Limited research has been conducted with people with more complex needs, however, such as individuals with IDD and older individuals.[96]

[93] Medicaid and CHIP Payment and Access Commission, "*Managed care's effect on outcomes*" (2018).
[94] Medicaid and CHIP Payment and Access Commission, "*Managed care's effect on outcomes*" (2018).
[95] Medicaid and CHIP Payment and Access Commission, "*Managed care's effect on outcomes*" (2018).
[96] The Robert Wood Johnson Foundation, "Medicaid managed care: Costs, access, and quality of care", (2012).

6 Summary and Conclusion

Table 44 below shows a summary of the fiscal impacts described in previous sections for each waiver. This analysis shows an estimated All Funds expenditure increase of approximately $22.5 million to $72.1 million (0.84% to 2.67%) over the two-year period of SFY 2021 to SFY 2022. Using the methodology and assumptions discussed, expenditures increase under IDD MLTSS in Texas under all four scenarios. While the cost-effectiveness analysis shows opportunities for claims savings, this impact is offset by increased administrative expenditures. Because each FFS waiver will continue to operate in some fashion after the IDD LTSS carve-in, the administrative burden will likely increase as HHSC operates multiple IDD LTSS programs and pays additional MCO non-claims expenditures.

Another factor driving the results shown is the choice of services to keep in FFS under a partial carve-in. When comparing Scenarios 1 and 2 (or 3 and 4), the IDD LTSS carve-in results in lower overall expenditure increases when only some services are carved into managed care compared to all services. This is because the majority of services and claims for TxHmL and HCS remain under FFS in Scenarios 2 and 4. Although keeping these services in FFS results in lower claims savings, this also leads to lower administrative expenditure increases. This shows that the choice of which services to include in a partial carve-in affects the cost-effectiveness of the IDD LTSS carve-in.

Table 44. Estimated All Funds Claims and Administrative Fiscal Impacts, Two-Year Total, SFY 2021 – 2022, Estimated MLTSS Spending vs. Status Quo Spending ($ in thousands | % change from Status Quo)

Program	Impact Type	Status Quo Expenditures Impacted, 2021-2022	Scenario 1 (All Services)	Scenario 2 (Some Services)	Scenario 3 (All Services)	Scenario 4 (Some Services)
TxHmL	*Claims Impact*	$348,658	-$11,590 | -3.32%	-$566 | -0.16%	-$4,617 | -1.32%	-$305 | -0.09%
TxHmL	*Admin Impact*	$14,306	$30,816 | 215.41%	$2,203 | 15.40%	$38,610 | 269.89%	$2,525 | 17.65%
TxHmL	Program Subtotal	**$362,964**	**$19,226 | 5.30%**	**$1,636 | 0.45%**	**$33,993 | 9.37%**	**$2,220 | 0.61%**
HCS	*Claims Impact*	$1,680,310	-$21,015 | -1.25%	-$1,432 | -0.09%	-$5,045 | -0.30%	-$787 | -0.05%
HCS	*Admin Impact*	$68,944	$35,960 | 52.16%	$6,941 | 10.07%	$18,084 | 26.23%	$7,788 | 11.30%
HCS	Program Subtotal	**$1,749,254**	**$14,945 | 0.85%**	**$5,509 | 0.31%**	**$13,039 | 0.75%**	**$7,001 | 0.40%**
CLASS	*Claims Impact*	$299,647	-$3,058 | -1.02%	-$3,058 | -1.02%	-$624 | -0.21%	-$624 | -0.21%
CLASS	*Admin Impact*	$12,295	$6,425 | 52.26%	$6,425 | 52.26%	$3,236 | 26.32%	$3,236 | 26.32%
CLASS	Program Subtotal	**$311,942**	**$3,368 | 1.08%**	**$3,368 | 1.08%**	**$2,612 | 0.84%**	**$2,612 | 0.84%**
DBMD	*Claims Impact*	$12,937	-$130 | -1.00%	-$130 | -1.00%	-$26 | -0.20%	-$26 | -0.20%
DBMD	*Admin Impact*	$531	$280 | 52.74%	$280 | 52.74%	$141 | 26.51%	$141 | 26.51%
DBMD	Program Subtotal	**$13,468**	**$150 | 1.11%**	**$150 | 1.11%**	**$115 | 0.85%**	**$115 | 0.85%**
ICF/IID	*Claims Impact*	$247,628	-$9,905 | -4.00%	-$9,905 | -4.00%	-$4,953 | -2.00%	-$4,953 | -2.00%
ICF/IID	*Admin Impact*	$10,160	$21,780 | 214.36%	$21,780 | 214.36%	$27,282 | 268.52%	$27,282 | 268.52%
ICF/IID	Program Subtotal	**$257,788**	**$11,875 | 4.61%**	**$11,875 | 4.61%**	**$22,330 | 8.66%**	**$22,330 | 8.66%**
Total	*Claims Impact*	$2,589,180	-$45,697 | -1.76%	-$15,091 | -0.58%	-$15,264 | -0.59%	-$6,695 | -0.26%
Total	*Admin Impact*	$106,236	$95,260 | 89.67%	$37,629 | 35.42%	$87,353 | 82.23%	$40,971 | 38.57%
Total	Program Subtotal	**$2,695,416**	**$49,563 | 1.84%**	**$22,538 | 0.84%**	**$72,088 | 2.67%**	**$34,276 | 1.27%**

These results also show that three programs drive the majority of the fiscal impacts observed: TxHmL, HCS, and ICFS/IID. HCS is not only the largest IDD LTSS waiver in Texas, but members in this waiver also have the choice to receive services through managed care or FFS under an all-service carve-in scenario. This makes HCS an important waiver for HHSC to consider when assessing the cost implications of carve-in decisions. TxHmL and ICFS/IID do not have the same member choice component as the other three programs, but service carve-in decisions for these waivers can still change expenditures significantly. For example, when only some services are carved in under TxHmL, the fiscal impact decreases significantly. While institutional utilization has not been identified as a primary objective under the IDD LTSS carve-in and Chapter 534 does not consider carving in the largest, state-run institutions, this analysis shows some opportunity for ICF/IID claims savings, as the percent reduction in claims expenditures is the highest for this program.

This analysis serves as an indication of a reasonable range of potential fiscal impacts for the IDD LTSS carve-in; it is not intended to provide a single “point estimate” result, as there are still several unknown variables regarding HHSC’s carve-in decisions. Rather, it provides a range of reasonable estimates. The scenarios shown are representative in nature; if different services are carved in or kept in FFS, the corresponding results will change. Additionally, the analysis was conducted using baseline data that contained discrepancies when compared to CMS data, as described in Section 4.2. While the data were checked for reasonableness, a detailed audit was not conducted. If the data contain any errors or omissions that were not known at the time of this analysis, the results shown in this analysis will also change.

Finally, it is important to consider the implications of quality and access to LTSS for this population. While this analysis does not model the impact of these factors on expenditures, these considerations are vital for ensuring positive outcomes for individuals with IDD.

Appendix A – Service Code to Service Category Mapping

Service Code	Service Code Description	Service Category
12	Case Management	Case Management
12A	Targeted Case Management - Initial	Case Management
12B	Case Management - Self Directed - CDS	Case Management
12C	Targeted Case Management - Follow Up	Case Management
41	Requisition Fees - Adaptive Aids	Fees
41B	Requisition Fees - Minor Home Modifications	Fees
41C	Specifications - Adaptive Aids	Fees
41D	Specifications - Home Modifications	Fees
41E	Requisition Fees - Dental	Fees
41F	Requisition Fees - Specialized Therapies	Fees
41G	Inspections - Home Modifications	Fees
53A	Transition Assistance Services (TAS) Fees	Fees
62V	CDS Orientation Fee	Fees
63V	Monthly Administration Fee - CDS	Fees
38	Administrative Fee Monthly	Fees
41BA	TAS MHM Requisition Fee	Fees
1	Daily Care	ICF Daily Care
45	Intervener	Intervener
45A	Intervener I	Intervener
45AV	CDS Intervener I	Intervener
45B	Intervener II	Intervener
45BV	CDS Intervener II	Intervener
45C	Intervener III	Intervener
45CV	CDS Intervener III	Intervener
45V	Intervener - CDS	Intervener
13	Nursing Services	Nursing
13A	Nursing Services - LVN	Nursing
13AV	Nursing Services LVN - CDS	Nursing
13B	Nursing Services - RN	Nursing

Service Code	Service Code Description	Service Category
13BV	Nursing Services RN - CDS	Nursing
13C	Specialized Nursing RN	Nursing
13CV	Specialized Nursing RN - CDS	Nursing
13CVW	Specialized Nursing RN - CDS	Nursing
13CVY	Specialized Nursing RN - CDS	Nursing
13CW	Specialized Nursing RN	Nursing
13CY	Specialized Nursing RN	Nursing
13D	Specialized Nursing LVN	Nursing
13DV	Specialized Nursing LVN - CDS	Nursing
13DVW	Specialized Nursing LVN - CDS	Nursing
13DVY	Specialized Nursing LVN - CDS	Nursing
13DW	Specialized Nursing LVN	Nursing
13DY	Specialized Nursing LVN	Nursing
13VW	Nursing Services - CDS	Nursing
13VY	Nursing Services - CDS	Nursing
13V	Nursing Services - CDS	Nursing
15	Adaptive Aids / DME	Other
16	Minor Home Modifications	Other
20CFC	Emergency Response Services (ERS)	Other
29Y	Day Activity Health Services (DAHS)	Other
37	Supported Employment	Other
37V	Supported Employment - CDS	Other
3A	SNF Part A Full MEDICARE	Other
40	Assessment (Full- Partial- Annual)	Other
40A	Pre-Assessment	Other
40B	DSA Assessments	Other
53	Transition Assistance Services (TAS)	Other
54	Employment Assistance	Other
54V	Employment Assistance - CDS	Other
55	Support Family Service	Other
55A	Continued Family Support	Other
57CFV	CDS Support Consultation	Other
57V	Support Consultation - CDS	Other
5A	Dental - Waiver Programs	Other
5B	Dental Sedation	Other
60	Prescriptions	Other

Service Code	Service Code Description	Service Category
63CFV	CDS Financial Management Services	Other
65V	Overnight Support Services - CDS	Other
99	Expedited Payment / Services	Other
21	Prescriptions	Other
16B	TAS - Preenrollment MHM	Other
15V	Adaptive Aids / DME - CDS	Other
16V	Minor Home Modifications - CDS	Other
5AV	Dental - CDS	Other
10	Habilitation	PAS/HAB
10A	Habilitation - Delegated Nursing	PAS/HAB
10B	Prevocational Habilitation	PAS/HAB
10CFC	PAS/HAB	PAS/HAB
10CFV	CDS PAS/HAB	PAS/HAB
10V	Habilitation - Residential - CDS	PAS/HAB
17	Personal Assistance Services (PAS)	PAS/HAB
17A	PAS Delegated	PAS/HAB
17B	PAS Protective Supervision	PAS/HAB
17SW	PAS	PAS/HAB
17SY	PAS	PAS/HAB
17V	Personal Assistance Services (PAS) - CDS	PAS/HAB
27	Consumer Managed Personal Attendant Services	PAS/HAB
27A	CMPAS - Client Directed Services - CDS	PAS/HAB
17E	PAS Chore	PAS/HAB
10C	Habilitation - Day	PAS/HAB
58	Supported Home Living	PAS/HAB
58V	Supported Home Living - CDS	PAS/HAB
10CV	Habilitation - Day - CDS	PAS/HAB
52	Community Support Services	PAS/HAB
52V	Community Support Services - CDS	PAS/HAB
18	Adult Foster Care	Residential
19E	Assisted Living - Habilitation 24 Hr.	Residential
19F	Assisted Living - Habilitation Less Than 24 Hr.	Residential
19P	Residential Care Emergency Care Title XX Non-Apartment	Residential
19	Assisted Living - Apartment	Residential
46	Residential Support Services	Residential

Service Code	Service Code Description	Service Category
47	Supervised Living	Residential
11	Respite - In Home	Respite
11A	Respite - Out of Home	Respite
11AV	Respite - Out of Home - CDS	Respite
11FA	Respite - NF with 24 Hour Vent	Respite
11FB	Respite - NF with <24 Hour Vent	Respite
11FC	Respite - NF with Pediatric Trach	Respite
11MS	Specialized Respite - HCSS (RN / LVN)	Respite
11NS	Specialized Respite - LVN	Respite
11PS	Specialized Respite - RN	Respite
11PV	Respite - In Home - CDS	Respite
11RS	Specialized Adjunct - HCSS (RN / LVN)	Respite
11SS	Specialized Adjunct - LVN	Respite
11TS	Specialized Adjunct - RN	Respite
11O	Respite - Daily	Respite
11OV	Respite - Daily - CDS	Respite
11X	Respite - Hourly	Respite
11XV	Respite - Hourly - CDS	Respite
14	Behavioral Support Services	Therapies
15A	Customized Power Wheelchair	Therapies
15B	Customized Power Wheelchair Modifications	Therapies
15C	Customized Power Wheelchair Adjustments	Therapies
34	Dietary	Therapies
35	Audiology	Therapies
35B	Auditory Integration/Enhancement Training	Therapies
42	Specialized Therapies	Therapies
42A	Massage Therapy	Therapies
42B	Recreational Therapy	Therapies
42C	Music Therapy	Therapies
42D	Aquatic Therapy	Therapies
42E	Hippotherapy	Therapies
42F	Therapeutic Horseback Riding	Therapies
43A	Behavioral Support	Therapies
61	Cognitive Rehabilitation Therapy	Therapies
61V	CDS Cognitive Rehabilitation Therapy	Therapies
7	Occupational Therapy	Therapies

Service Code	Service Code Description	Service Category
7B	Customized Power Wheelchair Assessments by OT	Therapies
7V	Occupational Therapy - CDS	Therapies
7VW	Occupational Therapy - CDS	Therapies
7VY	Occupational Therapy - CDS	Therapies
8	Physical Therapy	Therapies
8B	Customized Power Wheelchair Assessments by PT	Therapies
8V	Physical Therapy - CDS	Therapies
8VW	Physical Therapy - CDS	Therapies
8VY	Physical Therapy - CDS	Therapies
9	Speech	Therapies
9V	Speech - CDS	Therapies
9VW	Speech Therapy - CDS	Therapies
9VY	Speech Therapy - CDS	Therapies
43	Behavior Communication Specialist	Therapies
44	Orientation and Mobility	Therapies
16A	TAS - Preenrollment MHM Assessment	Therapies
36	Social Work	Therapies
34V	Dietary - CDS	Therapies
35V	Audiology - CDS	Therapies
43AV	Behavioral Support - CDS	Therapies
48	HAB Transportation	Transportation
48V	CDS HAB Transportation	Transportation

Appendix B – Service Codes Charged in TxHmL in SFY 2017

Service Code	Service Code Description	Percent of Total Waiver Spend
10CFC	PAS/HAB	37.66%
11X	Respite - Hourly	17.15%
10CFV	CDS PAS/HAB	15.53%
10C	Habilitation - Day	6.98%
11XV	Respite - Hourly - CDS	5.69%
12A	Targeted Case Management - Initial	4.75%
12C	Targeted Case Management - Follow Up	3.87%
48	HAB Transportation	2.81%
63V	Monthly Administration Fee - CDS	1.48%
5A	Dental - Waiver Programs	0.96%
48V	CDS HAB Transportation	0.63%
9	Speech	0.51%
43A	Behavioral Support	0.42%
10CV	Habilitation - Day - CDS	0.36%
13B	Nursing Services - RN	0.31%
16	Minor Home Modifications	0.19%
5AV	Dental - CDS	0.09%
41E	Requisition Fees - Dental	0.09%
15	Adaptive Aids / DME	0.07%
37	Supported Employment	0.07%
37V	Supported Employment - CDS	0.06%
13A	Nursing Services - LVN	0.05%
43AV	Behavioral Support - CDS	0.04%
8	Physical Therapy	0.04%
9V	Speech - CDS	0.04%
63CFV	CDS Financial Management Services	0.03%
54	Employment Assistance	0.03%
7	Occupational Therapy	0.03%
16V	Minor Home Modifications - CDS	0.01%
54V	Employment Assistance - CDS	0.01%
41D	Specifications - Home Modifications	0.01%
34	Dietary	0.01%

Service Code	Service Code Description	Percent of Total Waiver Spend
41	Requisition Fees - Adaptive Aids	0.00%
15V	Adaptive Aids / DME - CDS	0.00%
7V	Occupational Therapy - CDS	0.00%
8V	Physical Therapy - CDS	0.00%
20CFC	Emergency Response Services (ERS)	0.00%
57CFV	CFC CDS Support Consultation	0.00%
13C	Specialized Nursing RN	0.00%
57V	Support Consultation - CDS	0.00%

Appendix C – Service Codes Charged in HCS in SFY 2017

Service Code	Service Code Description	Percent of Total Waiver Spend
10C	Habilitation - Day	34.78%
18	Foster/Companion Care	24.75%
46	Residential Support Services	18.75%
47	Supervised Living	9.33%
10CFC	PAS/HAB	3.27%
10CFV	CDS PAS/HAB	2.14%
12A	Targeted Case Management - Initial	1.59%
12C	Targeted Case Management - Follow Up	1.20%
5A	Dental - Waiver Programs	0.90%
13B	Nursing Services - RN	0.74%
14	Behavioral Support Services	0.40%
13A	Nursing Services - LVN	0.29%
9	Speech	0.28%
48	HAB Transportation	0.26%
15	Adaptive Aids / DME	0.25%
11X	Respite - Hourly	0.24%
11XV	Respite - Hourly - CDS	0.14%
48V	CDS HAB Transportation	0.09%
8	Physical Therapy	0.08%
63V	Monthly Administration Fee - CDS	0.08%
16	Minor Home Modifications	0.08%
41E	Requisition Fees - Dental	0.07%
13D	Specialized Nursing LVN	0.07%
37	Supported Employment	0.06%
7	Occupational Therapy	0.04%
13AV	Nursing Services LVN - CDS	0.02%
13C	Specialized Nursing RN	0.02%
34	Dietary	0.02%
41	Requisition Fees - Adaptive Aids	0.02%
54	Employment Assistance	0.01%
13BV	Nursing Services RN - CDS	0.01%
63CFV	CDS Financial Management Services	0.01%

Service Code	Service Code Description	Percent of Total Waiver Spend
53	Transition Assistance Services (TAS)	0.01%
37V	Supported Employment - CDS	0.00%
41D	Specifications - Home Modifications	0.00%
54V	Employment Assistance - CDS	0.00%
35	Audiology	0.00%
36	Social Work	0.00%
16B	TAS - Preenrollment MHM	0.00%
53A	Transition Assistance Services (TAS) Fees	0.00%
20CFC	Emergency Response Services (ERS)	0.00%
57CFV	CFC CDS Support Consultation	0.00%
41BA	TAS MHM Requisition Fee	0.00%
57V	Support Consultation - CDS	0.00%
16A	TAS - Preenrollment MHM Assessment	0.00%

Appendix D – Service Codes Charged in CLASS in SFY 2017

Service Code	Service Code Description	Percent of Total Waiver Spend
10CFC	PAS/HAB	38.08%
10CFV	CDS PAS/HAB	32.93%
42A	Massage Therapy	5.01%
42B	Recreational Therapy	4.30%
12	Case Management	4.29%
11PV	Respite - In Home - CDS	2.38%
63V	Monthly Administration Fee - CDS	2.18%
11	Respite - In Home	1.74%
42C	Music Therapy	1.43%
10B	Prevocational Habilitation	1.42%
41F	Requisition Fees - Specialized Therapies	1.16%
15	Adaptive Aids / DME	0.67%
42D	Aquatic Therapy	0.62%
42F	Therapeutic Horseback Riding	0.42%
13AV	Nursing Services LVN - CDS	0.39%
43A	Behavioral Support	0.36%
63CFV	CDS Financial Management Services	0.32%
8	Physical Therapy	0.29%
5A	Dental - Waiver Programs	0.27%
13A	Nursing Services - LVN	0.27%
13B	Nursing Services - RN	0.22%
11AV	Respite - Out of Home - CDS	0.18%
9	Speech	0.16%
16	Minor Home Modifications	0.12%
13D	Specialized Nursing LVN	0.12%
7	Occupational Therapy	0.11%
5B	Dental Sedation	0.10%
11A	Respite - Out of Home	0.09%
42E	Hippotherapy	0.07%
10V	Habilitation - Residential - CDS	0.05%
37V	Supported Employment - CDS	0.05%
13BV	Nursing Services RN - CDS	0.04%

Service Code	Service Code Description	Percent of Total Waiver Spend
13DV	Specialized Nursing LVN - CDS	0.03%
40	Assessment (Full- Partial- Annual)	0.02%
40B	DSA Assessments	0.02%
48V	CDS HAB Transportation	0.02%
41D	Specifications - Home Modifications	0.01%
20CFC	Emergency Response Services (ERS)	0.01%
7V	Occupational Therapy - CDS	0.01%
10	Habilitation	0.00%
13C	Specialized Nursing RN	0.00%
9V	Speech - CDS	0.00%
37	Supported Employment	0.00%
41G	Inspections - Home Modifications	0.00%
41C	Specifications - Adaptive Aids	0.00%
34	Dietary	0.00%
54V	Employment Assistance - CDS	0.00%
48	HAB Transportation	0.00%
8V	Physical Therapy - CDS	0.00%

Appendix E – Service Codes Charged in DBMD in SFY 2017

Service Code	Service Code Description	Percent of Total Waiver Spend
10CFC	PAS/HAB	35.88%
10CFV	CDS PAS/HAB	18.61%
19	Assisted Living - Apartment	10.50%
45	Intervener	6.97%
19E	Assisted Living - Habilitation 24 Hr.	6.11%
45V	Intervener - CDS	3.65%
10	Habilitation	3.35%
19F	Assisted Living - Habilitation Less Than 24 Hr.	2.17%
63V	Monthly Administration Fee - CDS	1.89%
11PV	Respite - In Home - CDS	1.75%
11	Respite - In Home	1.37%
45AV	CDS Intervener I	1.24%
45BV	CDS Intervener II	1.09%
12	Case Management	0.91%
45A	Intervener I	0.76%
15	Adaptive Aids / DME	0.67%
13A	Nursing Services - LVN	0.55%
13B	Nursing Services - RN	0.39%
5A	Dental - Waiver Programs	0.34%
48	HAB Transportation	0.31%
9	Speech	0.23%
17E	PAS Chore	0.17%
63CFV	CDS Financial Management Services	0.16%
45CV	CDS Intervener III	0.15%
5B	Dental Sedation	0.15%
16	Minor Home Modifications	0.13%
7	Occupational Therapy	0.12%
13D	Specialized Nursing LVN	0.10%
11A	Respite - Out of Home	0.06%
17	Personal Assistance Services (PAS)	0.05%
43A	Behavioral Support	0.05%
11AV	Respite - Out of Home - CDS	0.04%

Service Code	Service Code Description	Percent of Total Waiver Spend
41E	Requisition Fees - Dental	0.02%
41	Requisition Fees - Adaptive Aids	0.01%
41B	Requisition Fees - Minor Home Modifications	0.01%
8	Physical Therapy	0.00%
34	Dietary	0.00%
20CFC	Emergency Response Services (ERS)	0.00%
45C	Intervener III	0.00%
40A	Pre-Assessment	0.00%

Appendix F – Federal versus State Fiscal Impacts (Scenario 1)

Table 45. TxHmL Federal versus State Fiscal Impacts, Scenario 1 (All Services)
Estimated MLTSS Spending vs. Status Quo Spending, $ in thousands

	SFY2021	SFY2022	Total
Total Fiscal impact (Claims + Admin) (A)	$9,352	$9,874	$19,226
FMAP (B)	63.21%	63.21%	
*Federal Portion of Claims and Admin (C) = (A) * (B)*	$5,911	$6,241	$12,153
*HHSC Portion of Claims and Admin (D) = (A) * [1 - (B)]*	$3,441	$3,633	$7,073
Premium Taxes			
Total Managed Care Claims (E)	$163,722	$173,346	$337,068
*Total Premium Tax Paid to MCOs (F) = (E) * 2.30% of claims (~1.75% of premium)*	$3,766	$3,987	$7,753
FMAP (G)	63.21%	63.21%	
*Federal Portion of Premium Tax (H) = (F) * (G)*	$2,380	$2,520	$4,900
*HHSC Portion of Premium Tax (I) = (F) * [1 - (G)]*	$1,385	$1,467	$2,852
Net Fiscal impacts			
Federal Net Fiscal impact (J) = (C) + (H)	**$8,292**	**$8,762**	**$17,053**
State Net Fiscal impact (K) = (D) - (H)	**$1,060**	**$1,112**	**$2,173**
HHSC Net Fiscal impact (L) = (D) + (I)	**$4,826**	**$5,099**	**$9,925**

Table 46. HCS Federal versus State Fiscal Impacts, Scenario 1 (All Services)
Estimated MLTSS Spending vs. Status Quo Spending, $ in thousands

	SFY2021	SFY2022	Total
Total Fiscal impact (Claims + Admin) (A)	$0	$14,945	$14,945
FMAP (B)	60.21%	60.21%	
*Federal Portion of Claims and Admin (C) = (A) * (B)*	$0	$8,998	$8,998
*HHSC Portion of Claims and Admin (D) = (A) * [1 - (B)]*	$0	$5,947	$5,947
Premium Taxes			
Total Managed Care Claims (E)	$0	$399,062	$399,062
*Total Premium Tax Paid to MCOs (F) = (E) * 2.30% of claims (~1.75% of premium)*	$0	$9,178	$9,178
FMAP (G)	60.21%	60.21%	
*Federal Portion of Premium Tax (H) = (F) * (G)*	$0	$5,526	$5,526
*HHSC Portion of Premium Tax (I) = (F) * [1 - (G)]*	$0	$3,652	$3,652
Net Fiscal impacts			
Federal Net Fiscal impact (J) = (C) + (H)	**$0**	**$14,525**	**$14,525**
State Net Fiscal impact (K) = (D) - (H)	**$0**	**$420**	**$420**
HHSC Net Fiscal impact (L) = (D) + (I)	**$0**	**$9,599**	**$9,599**

Table 47. CLASS Federal versus State Fiscal Impacts, Scenario 1 (All Services)
Estimated MLTSS Spending vs. Status Quo Spending, $ in thousands

	SFY2021	SFY2022	Total
Total Fiscal impact (Claims + Admin) (A)	$0	$3,368	$3,368
FMAP (B)	64.05%	64.05%	
*Federal Portion of Claims and Admin (C) = (A) * (B)*	$0	$2,157	$2,157
*HHSC Portion of Claims and Admin (D) = (A) * [1 - (B)]*	$0	$1,211	$1,211
Premium Taxes			
Total Managed Care Claims (E)	$0	$71,854	$71,854
*Total Premium Tax Paid to MCOs (F) = (E) * 2.30% of claims (~1.75% of premium)*	$0	$1,653	$1,653
FMAP (G)	64.05%	64.05%	
*Federal Portion of Premium Tax (H) = (F) * (G)*	$0	$1,059	$1,059
*HHSC Portion of Premium Tax (I) = (F) * [1 - (G)]*	$0	$594	$594
Net Fiscal impacts			
Federal Net Fiscal impact (J) = (C) + (H)	**$0**	**$3,216**	**$3,216**
State Net Fiscal impact (K) = (D) - (H)	**$0**	**$152**	**$152**
HHSC Net Fiscal impact (L) = (D) + (I)	**$0**	**$1,805**	**$1,805**

Table 48. DBMD Federal versus State Fiscal Impacts, Scenario 1 (All Services)
Estimated MLTSS Spending vs. Status Quo Spending, $ in thousands

	SFY2021	SFY2022	Total
Total Fiscal impact (Claims + Admin) (A)	$0	$150	$150
FMAP (B)	62.93%	62.93%	
*Federal Portion of Claims and Admin (C) = (A) * (B)*	$0	$94	$94
*HHSC Portion of Claims and Admin (D) = (A) * [1 - (B)]*	$0	$56	$56
Premium Taxes			
Total Managed Care Claims (E)	$0	$3,104	$3,104
*Total Premium Tax Paid to MCOs (F) = (E) * 2.30% of claims (~1.75% of premium)*	$0	$71	$71
FMAP (G)	62.93%	62.93%	
*Federal Portion of Premium Tax (H) = (F) * (G)*	$0	$45	$45
*HHSC Portion of Premium Tax (I) = (F) * [1 - (G)]*	$0	$26	$26
Net Fiscal impacts			
Federal Net Fiscal impact (J) = (C) + (H)	**$0**	**$139**	**$139**
State Net Fiscal impact (K) = (D) - (H)	**$0**	**$11**	**$11**
HHSC Net Fiscal impact (L) = (D) + (I)	**$0**	**$82**	**$82**

Table 49. ICF/IID Federal versus State Fiscal Impacts, Scenario 1 (All Services)
Estimated MLTSS Spending vs. Status Quo Spending, $ in thousands

	SFY2021	SFY2022	Total
Total Fiscal impact (Claims + Admin) (A)	$0	$11,875	$11,875
FMAP (B)	59.79%	59.79%	
*Federal Portion of Claims and Admin (C) = (A) * (B)*	$0	$7,100	$7,100
*HHSC Portion of Claims and Admin (D) = (A) * [1 - (B)]*	$0	$4,775	$4,775
Premium Taxes			
Total Managed Care Claims (E)	$0	$237,723	$237,723
*Total Premium Tax Paid to MCOs (F) = (E) * 2.30% of claims (~1.75% of premium)*	$0	$5,468	$5,468
FMAP (G)	59.79%	59.79%	
*Federal Portion of Premium Tax (H) = (F) * (G)*	$0	$3,269	$3,269
*HHSC Portion of Premium Tax (I) = (F) * [1 - (G)]*	$0	$2,199	$2,199
Net Fiscal impacts			
Federal Net Fiscal impact (J) = (C) + (H)	**$0**	**$10,369**	**$10,369**
State Net Fiscal impact (K) = (D) - (H)	**$0**	**$1,506**	**$1,506**
HHSC Net Fiscal impact (L) = (D) + (I)	**$0**	**$6,973**	**$6,973**

Table 50. Total Federal versus State Fiscal Impacts, Scenario 1 (All Services)
Estimated MLTSS Spending vs. Status Quo Spending, $ in thousands

	SFY2021	SFY2022	Total
Total Fiscal impact (Claims + Admin) (A)	$9,352	$40,212	$49,564
FMAP (B)	63.21%	61.15%	
*Federal Portion of Claims and Admin (C) = (A) * (B)*	$5,911	$24,591	$30,503
*HHSC Portion of Claims and Admin (D) = (A) * [1 - (B)]*	$3,441	$15,621	$19,061
Premium Taxes			
Total Managed Care Claims (E)	$163,722	$885,089	$1,048,811
*Total Premium Tax Paid to MCOs (F) = (E) * 2.30% of claims (~1.75% of premium)*	$3,766	$20,357	$24,123
FMAP (G)	63.21%	61.01%	
*Federal Portion of Premium Tax (H) = (F) * (G)*	$2,380	$12,419	$14,799
*HHSC Portion of Premium Tax (I) = (F) * [1 - (G)]*	$1,385	$7,938	$9,323
Net Fiscal impacts			
Federal Net Fiscal impact (J) = (C) + (H)	**$8,292**	**$37,010**	**$45,302**
State Net Fiscal impact (K) = (D) - (H)	**$1,060**	**$3,202**	**$4,262**
HHSC Net Fiscal impact (L) = (D) + (I)	**$4,826**	**$23,559**	**$28,385**

Appendix G – Federal versus State Fiscal impacts (Scenario 2)

Table 51. TxHmL Federal versus State Fiscal Impacts, Scenario 2 (Some Services)
Estimated MLTSS Spending vs. Status Quo Spending, $ in thousands

	SFY2021	SFY2022	Total
Total Fiscal impact (Claims + Admin) (A)	$808	$828	$1,636
FMAP (B)	63.21%	63.21%	
*Federal Portion of Claims and Admin (C) = (A) * (B)*	$511	$523	$1,034
*HHSC Portion of Claims and Admin (D) = (A) * [1 - (B)]*	$297	$305	$602
Premium Taxes			
Total Managed Care Claims (E)	$6,860	$7,263	$14,123
*Total Premium Tax Paid to MCOs (F) = (E) * 2.30% of claims (~1.75% of premium)*	$158	$167	$325
FMAP (G)	63.21%	63.21%	
*Federal Portion of Premium Tax (H) = (F) * (G)*	$100	$106	$205
*HHSC Portion of Premium Tax (I) = (F) * [1 - (G)]*	$58	$61	$120
Net Fiscal impacts			
Federal Net Fiscal impact (J) = (C) + (H)	**$610**	**$629**	**$1,239**
State Net Fiscal impact (K) = (D) - (H)	**$198**	**$199**	**$397**
HHSC Net Fiscal impact (L) = (D) + (I)	**$355**	**$366**	**$721**

Table 52. HCS Federal versus State Fiscal Impacts, Scenario 2 (Some Services) Estimated MLTSS Spending vs. Status Quo Spending, $ in thousands

	SFY2021	SFY2022	Total
Total Fiscal impact (Claims + Admin) (A)	$0	$5,509	$5,509
FMAP (B)	60.21%	60.21%	
*Federal Portion of Claims and Admin (C) = (A) * (B)*	$0	$3,317	$3,317
*HHSC Portion of Claims and Admin (D) = (A) * [1 - (B)]*	$0	$2,192	$2,192
Premium Taxes			
Total Managed Care Claims (E)	$0	$37,495	$37,495
*Total Premium Tax Paid to MCOs (F) = (E) * 2.30% of claims (~1.75% of premium)*	$0	$862	$862
FMAP (G)	60.21%	60.21%	
*Federal Portion of Premium Tax (H) = (F) * (G)*	$0	$519	$519
*HHSC Portion of Premium Tax (I) = (F) * [1 - (G)]*	$0	$343	$343
Net Fiscal impacts			
Federal Net Fiscal impact (J) = (C) + (H)	**$0**	**$3,836**	**$3,836**
State Net Fiscal impact (K) = (D) - (H)	**$0**	**$1,673**	**$1,673**
HHSC Net Fiscal impact (L) = (D) + (I)	**$0**	**$2,535**	**$2,535**

Table 53. CLASS Federal versus State Fiscal Impacts, Scenario 2 (Some Services)
Estimated MLTSS Spending vs. Status Quo Spending, $ in thousands

	SFY2021	SFY2022	Total
Total Fiscal impact (Claims + Admin) (A)	$0	$3,368	$3,368
FMAP (B)	64.05%	64.05%	
*Federal Portion of Claims and Admin (C) = (A) * (B)*	$0	$2,157	$2,157
*HHSC Portion of Claims and Admin (D) = (A) * [1 - (B)]*	$0	$1,211	$1,211
Premium Taxes			
Total Managed Care Claims (E)	$0	$71,854	$71,854
*Total Premium Tax Paid to MCOs (F) = (E) * 2.30% of claims (~1.75% of premium)*	$0	$1,653	$1,653
FMAP (G)	64.05%	64.05%	
*Federal Portion of Premium Tax (H) = (F) * (G)*	$0	$1,059	$1,059
*HHSC Portion of Premium Tax (I) = (F) * [1 - (G)]*	$0	$594	$594
Net Fiscal impacts			
Federal Net Fiscal impact (J) = (C) + (H)	**$0**	**$3,216**	**$3,216**
State Net Fiscal impact (K) = (D) - (H)	**$0**	**$152**	**$152**
HHSC Net Fiscal impact (L) = (D) + (I)	**$0**	**$1,805**	**$1,805**

Table 54. DBMD Federal versus State Fiscal Impacts, Scenario 2 (Some Services)
Estimated MLTSS Spending vs. Status Quo Spending, $ in thousands

	SFY2021	SFY2022	Total
Total Fiscal impact (Claims + Admin) (A)	$0	$150	$150
FMAP (B)	62.93%	62.93%	
*Federal Portion of Claims and Admin (C) = (A) * (B)*	$0	$94	$94
*HHSC Portion of Claims and Admin (D) = (A) * [1 - (B)]*	$0	$56	$56
Premium Taxes			
Total Managed Care Claims (E)	$0	$3,104	$3,104
*Total Premium Tax Paid to MCOs (F) = (E) * 2.30% of claims (~1.75% of premium)*	$0	$71	$71
FMAP (G)	62.93%	62.93%	
*Federal Portion of Premium Tax (H) = (F) * (G)*	$0	$45	$45
*HHSC Portion of Premium Tax (I) = (F) * [1 - (G)]*	$0	$26	$26
Net Fiscal impacts			
Federal Net Fiscal impact (J) = (C) + (H)	**$0**	**$139**	**$139**
State Net Fiscal impact (K) = (D) - (H)	**$0**	**$11**	**$11**
HHSC Net Fiscal impact (L) = (D) + (I)	**$0**	**$82**	**$82**

Table 55. ICF/IID Federal versus State Fiscal Impacts, Scenario 2 (Some Services)
Estimated MLTSS Spending vs. Status Quo Spending, $ in thousands

	SFY2021	SFY2022	Total
Total Fiscal impact (Claims + Admin) (A)	$0	$11,875	$11,875
FMAP (B)	59.79%	59.79%	
*Federal Portion of Claims and Admin (C) = (A) * (B)*	$0	$7,100	$7,100
*HHSC Portion of Claims and Admin (D) = (A) * [1 - (B)]*	$0	$4,775	$4,775
Premium Taxes			
Total Managed Care Claims (E)	$0	$237,723	$237,723
*Total Premium Tax Paid to MCOs (F) = (E) * 2.30% of claims (~1.75% of premium)*	$0	$5,468	$5,468
FMAP (G)	59.79%	59.79%	
*Federal Portion of Premium Tax (H) = (F) * (G)*	$0	$3,269	$3,269
*HHSC Portion of Premium Tax (I) = (F) * [1 - (G)]*	$0	$2,199	$2,199
Net Fiscal impacts			
Federal Net Fiscal impact (J) = (C) + (H)	**$0**	**$10,369**	**$10,369**
State Net Fiscal impact (K) = (D) - (H)	**$0**	**$1,506**	**$1,506**
HHSC Net Fiscal impact (L) = (D) + (I)	**$0**	**$6,973**	**$6,973**

Table 56. Total Federal versus State Fiscal Impacts, Scenario 2 (Some Services)
Estimated MLTSS Spending vs. Status Quo Spending, $ in thousands

	SFY2021	SFY2022	Total
Total Fiscal impact (Claims + Admin) (A)	$808	$21,730	$22,538
FMAP (B)	63.21%	60.71%	
*Federal Portion of Claims and Admin (C) = (A) * (B)*	$511	$13,192	$13,703
*HHSC Portion of Claims and Admin (D) = (A) * [1 - (B)]*	$297	$8,538	$8,835
Premium Taxes			
Total Managed Care Claims (E)	$6,860	$357,439	$364,299
*Total Premium Tax Paid to MCOs (F) = (E) * 2.30% of claims (~1.75% of premium)*	$158	$8,221	$8,379
FMAP (G)	63.21%	60.79%	
*Federal Portion of Premium Tax (H) = (F) * (G)*	$100	$4,997	$5,097
*HHSC Portion of Premium Tax (I) = (F) * [1 - (G)]*	$58	$3,224	$3,282
Net Fiscal impacts			
Federal Net Fiscal impact (J) = (C) + (H)	**$610**	**$18,189**	**$18,800**
State Net Fiscal impact (K) = (D) - (H)	**$198**	**$3,541**	**$3,738**
HHSC Net Fiscal impact (L) = (D) + (I)	**$355**	**$11,762**	**$12,117**

Appendix H – Federal versus State Fiscal impacts (Scenario 3)

Table 57. TxHmL Federal versus State Fiscal Impacts, Scenario 3 (All Services)
Estimated MLTSS Spending vs. Status Quo Spending, $ in thousands

	SFY2021	SFY2022	Total
Total Fiscal impact (Claims + Admin) (A)	$16,525	$17,468	$33,993
FMAP (B)	63.21%	63.21%	
*Federal Portion of Claims and Admin (C) = (A) * (B)*	$10,445	$11,042	$21,487
*HHSC Portion of Claims and Admin (D) = (A) * [1 - (B)]*	$6,080	$6,426	$12,506
Premium Taxes			
Total Managed Care Claims (E)	$167,109	$176,932	$344,041
*Total Premium Tax Paid to MCOs (F) = (E) * 2.30% of claims (~1.75% of premium)*	$3,844	$4,069	$7,913
FMAP (G)	63.21%	63.21%	
*Federal Portion of Premium Tax (H) = (F) * (G)*	$2,429	$2,572	$5,002
*HHSC Portion of Premium Tax (I) = (F) * [1 - (G)]*	$1,414	$1,497	$2,911
Net Fiscal impacts			
Federal Net Fiscal impact (J) = (C) + (H)	**$12,875**	**$13,614**	**$26,489**
State Net Fiscal impact (K) = (D) - (H)	**$3,650**	**$3,854**	**$7,504**
HHSC Net Fiscal impact (L) = (D) + (I)	**$7,494**	**$7,924**	**$15,417**

Table 58. HCS Federal versus State Fiscal Impacts, Scenario 3 (All Services)
Estimated MLTSS Spending vs. Status Quo Spending, $ in thousands

	SFY2021	SFY2022	Total
Total Fiscal impact (Claims + Admin) (A)	$0	$13,039	$13,039
FMAP (B)	60.21%	60.21%	
*Federal Portion of Claims and Admin (C) = (A) * (B)*	$0	$7,851	$7,851
*HHSC Portion of Claims and Admin (D) = (A) * [1 - (B)]*	$0	$5,188	$5,188
Premium Taxes			
Total Managed Care Claims (E)	$0	$162,986	$162,986
*Total Premium Tax Paid to MCOs (F) = (E) * 2.30% of claims (~1.75% of premium)*	$0	$3,749	$3,749
FMAP (G)	60.21%	60.21%	
*Federal Portion of Premium Tax (H) = (F) * (G)*	$0	$2,257	$2,257
*HHSC Portion of Premium Tax (I) = (F) * [1 - (G)]*	$0	$1,492	$1,492
Net Fiscal impacts			
Federal Net Fiscal impact (J) = (C) + (H)	**$0**	**$10,108**	**$10,108**
State Net Fiscal impact (K) = (D) - (H)	**$0**	**$2,931**	**$2,931**
HHSC Net Fiscal impact (L) = (D) + (I)	**$0**	**$6,680**	**$6,680**

Table 59. CLASS Federal versus State Fiscal Impacts, Scenario 3 (All Services)
Estimated MLTSS Spending vs. Status Quo Spending, $ in thousands

	SFY2021	SFY2022	Total
Total Fiscal impact (Claims + Admin) (A)	$0	$2,612	$2,612
FMAP (B)	64.05%	64.05%	
*Federal Portion of Claims and Admin (C) = (A) * (B)*	$0	$1,673	$1,673
*HHSC Portion of Claims and Admin (D) = (A) * [1 - (B)]*	$0	$939	$939
Premium Taxes			
Total Managed Care Claims (E)	$0	$29,341	$29,341
*Total Premium Tax Paid to MCOs (F) = (E) * 2.30% of claims (~1.75% of premium)*	$0	$675	$675
FMAP (G)	64.05%	64.05%	
*Federal Portion of Premium Tax (H) = (F) * (G)*	$0	$432	$432
*HHSC Portion of Premium Tax (I) = (F) * [1 - (G)]*	$0	$243	$243
Net Fiscal impacts			
Federal Net Fiscal impact (J) = (C) + (H)	**$0**	**$2,105**	**$2,105**
State Net Fiscal impact (K) = (D) - (H)	**$0**	**$507**	**$507**
HHSC Net Fiscal impact (L) = (D) + (I)	**$0**	**$1,182**	**$1,182**

Table 60. DBMD Federal versus State Fiscal Impacts, Scenario 3 (All Services)
Estimated MLTSS Spending vs. Status Quo Spending, $ in thousands

	SFY2021	SFY2022	Total
Total Fiscal impact (Claims + Admin) (A)	$0	$115	$115
FMAP (B)	62.93%	62.93%	
*Federal Portion of Claims and Admin (C) = (A) * (B)*	$0	$72	$72
*HHSC Portion of Claims and Admin (D) = (A) * [1 - (B)]*	$0	$43	$43
Premium Taxes			
Total Managed Care Claims (E)	$0	$1,268	$1,268
*Total Premium Tax Paid to MCOs (F) = (E) * 2.30% of claims (~1.75% of premium)*	$0	$29	$29
FMAP (G)	62.93%	62.93%	
*Federal Portion of Premium Tax (H) = (F) * (G)*	$0	$18	$18
*HHSC Portion of Premium Tax (I) = (F) * [1 - (G)]*	$0	$11	$11
Net Fiscal impacts			
Federal Net Fiscal impact (J) = (C) + (H)	**$0**	**$91**	**$91**
State Net Fiscal impact (K) = (D) - (H)	**$0**	**$24**	**$24**
HHSC Net Fiscal impact (L) = (D) + (I)	**$0**	**$53**	**$53**

Table 61. ICF/IID Federal versus State Fiscal Impacts, Scenario 3 (All Services)
Estimated MLTSS Spending vs. Status Quo Spending, $ in thousands

	SFY2021	SFY2022	Total
Total Fiscal impact (Claims + Admin) (A)	$0	$22,330	$22,330
FMAP (B)	59.79%	59.79%	
*Federal Portion of Claims and Admin (C) = (A) * (B)*	$0	$13,351	$13,351
*HHSC Portion of Claims and Admin (D) = (A) * [1 - (B)]*	$0	$8,979	$8,979
Premium Taxes			
Total Managed Care Claims (E)	$0	$242,676	$242,676
*Total Premium Tax Paid to MCOs (F) = (E) * 2.30% of claims (~1.75% of premium)*	$0	$5,582	$5,582
FMAP (G)	59.79%	59.79%	
*Federal Portion of Premium Tax (H) = (F) * (G)*	$0	$3,337	$3,337
*HHSC Portion of Premium Tax (I) = (F) * [1 - (G)]*	$0	$2,244	$2,244
Net Fiscal impacts			
Federal Net Fiscal impact (J) = (C) + (H)	**$0**	**$16,688**	**$16,688**
State Net Fiscal impact (K) = (D) - (H)	**$0**	**$5,642**	**$5,642**
HHSC Net Fiscal impact (L) = (D) + (I)	**$0**	**$11,223**	**$11,223**

Table 62. Total Federal versus State Fiscal Impacts, Scenario 3 (All Services)
Estimated MLTSS Spending vs. Status Quo Spending, $ in thousands

	SFY2021	SFY2022	Total
Total Fiscal impact (Claims + Admin) (A)	$16,525	$55,564	$72,089
FMAP (B)	63.21%	61.17%	
*Federal Portion of Claims and Admin (C) = (A) * (B)*	$10,445	$33,989	$44,434
*HHSC Portion of Claims and Admin (D) = (A) * [1 - (B)]*	$6,080	$21,575	$27,655
Premium Taxes			
Total Managed Care Claims (E)	$167,109	$613,203	$780,312
*Total Premium Tax Paid to MCOs (F) = (E) * 2.30% of claims (~1.75% of premium)*	$3,844	$14,104	$17,947
FMAP (G)	63.21%	61.10%	
*Federal Portion of Premium Tax (H) = (F) * (G)*	$2,429	$8,617	$11,047
*HHSC Portion of Premium Tax (I) = (F) * [1 - (G)]*	$1,414	$5,487	$6,901
Net Fiscal impacts			
Federal Net Fiscal impact (J) = (C) + (H)	**$12,875**	**$42,606**	**$55,481**
State Net Fiscal impact (K) = (D) - (H)	**$3,650**	**$12,958**	**$16,608**
HHSC Net Fiscal impact (L) = (D) + (I)	**$7,494**	**$27,062**	**$34,555**

Appendix I – Federal versus State Fiscal impacts (Scenario 4)

Table 63. TxHmL Federal versus State Fiscal Impacts, Scenario 4 (Some Services)
Estimated MLTSS Spending vs. Status Quo Spending, $ in thousands

	SFY2021	SFY2022	Total
Total Fiscal impact (Claims + Admin) (A)	$1,092	$1,128	$2,220
FMAP (B)	63.21%	63.21%	
*Federal Portion of Claims and Admin (C) = (A) * (B)*	$690	$713	$1,403
*HHSC Portion of Claims and Admin (D) = (A) * [1 - (B)]*	$402	$415	$817
Premium Taxes			
Total Managed Care Claims (E)	$6,987	$7,397	$14,384
*Total Premium Tax Paid to MCOs (F) = (E) * 2.30% of claims (~1.75% of premium)*	$161	$170	$331
FMAP (G)	63.21%	63.21%	
*Federal Portion of Premium Tax (H) = (F) * (G)*	$102	$108	$209
*HHSC Portion of Premium Tax (I) = (F) * [1 - (G)]*	$59	$63	$122
Net Fiscal impacts			
Federal Net Fiscal impact (J) = (C) + (H)	**$792**	**$821**	**$1,612**
State Net Fiscal impact (K) = (D) - (H)	**$300**	**$307**	**$608**
HHSC Net Fiscal impact (L) = (D) + (I)	**$461**	**$478**	**$938**

Table 64. HCS Federal versus State Fiscal Impacts, Scenario 4 (Some Services) Estimated MLTSS Spending vs. Status Quo Spending, $ in thousands

	SFY2021	SFY2022	Total
Total Fiscal impact (Claims + Admin) (A)	$0	$7,001	$7,001
FMAP (B)	60.21%	60.21%	
*Federal Portion of Claims and Admin (C) = (A) * (B)*	$0	$4,215	$4,215
*HHSC Portion of Claims and Admin (D) = (A) * [1 - (B)]*	$0	$2,786	$2,786
Premium Taxes			
Total Managed Care Claims (E)	$0	$38,140	$38,140
*Total Premium Tax Paid to MCOs (F) = (E) * 2.30% of claims (~1.75% of premium)*	$0	$877	$877
FMAP (G)	60.21%	60.21%	
*Federal Portion of Premium Tax (H) = (F) * (G)*	$0	$528	$528
*HHSC Portion of Premium Tax (I) = (F) * [1 - (G)]*	$0	$349	$349
Net Fiscal impacts			
Federal Net Fiscal impact (J) = (C) + (H)	**$0**	**$4,743**	**$4,743**
State Net Fiscal impact (K) = (D) - (H)	**$0**	**$2,258**	**$2,258**
HHSC Net Fiscal impact (L) = (D) + (I)	**$0**	**$3,135**	**$3,135**

Table 65. CLASS Federal versus State Fiscal Impacts, Scenario 4 (Some Services) Estimated MLTSS Spending vs. Status Quo Spending, $ in thousands

	SFY2021	SFY2022	Total
Total Fiscal impact (Claims + Admin) (A)	$0	$2,612	$2,612
FMAP (B)	64.05%	64.05%	
*Federal Portion of Claims and Admin (C) = (A) * (B)*	$0	$1,673	$1,673
*HHSC Portion of Claims and Admin (D) = (A) * [1 - (B)]*	$0	$939	$939
Premium Taxes			
Total Managed Care Claims (E)	$0	$29,341	$29,341
*Total Premium Tax Paid to MCOs (F) = (E) * 2.30% of claims (~1.75% of premium)*	$0	$675	$675
FMAP (G)	64.05%	64.05%	
*Federal Portion of Premium Tax (H) = (F) * (G)*	$0	$432	$432
*HHSC Portion of Premium Tax (I) = (F) * [1 - (G)]*	$0	$243	$243
Net Fiscal impacts			
Federal Net Fiscal impact (J) = (C) + (H)	**$0**	**$2,105**	**$2,105**
State Net Fiscal impact (K) = (D) - (H)	**$0**	**$507**	**$507**
HHSC Net Fiscal impact (L) = (D) + (I)	**$0**	**$1,182**	**$1,182**

Table 66. DBMD Federal versus State Fiscal Impacts, Scenario 4 (Some Services)
Estimated MLTSS Spending vs. Status Quo Spending, $ in thousands

	SFY2021	SFY2022	Total
Total Fiscal impact (Claims + Admin) (A)	$0	$115	$115
FMAP (B)	62.93%	62.93%	
*Federal Portion of Claims and Admin (C) = (A) * (B)*	$0	$72	$72
*HHSC Portion of Claims and Admin (D) = (A) * [1 - (B)]*	$0	$43	$43
Premium Taxes			
Total Managed Care Claims (E)	$0	$1,268	$1,268
*Total Premium Tax Paid to MCOs (F) = (E) * 2.30% of claims (~1.75% of premium)*	$0	$29	$29
FMAP (G)	62.93%	62.93%	
*Federal Portion of Premium Tax (H) = (F) * (G)*	$0	$18	$18
*HHSC Portion of Premium Tax (I) = (F) * [1 - (G)]*	$0	$11	$11
Net Fiscal impacts			
Federal Net Fiscal impact (J) = (C) + (H)	**$0**	**$91**	**$91**
State Net Fiscal impact (K) = (D) - (H)	**$0**	**$24**	**$24**
HHSC Net Fiscal impact (L) = (D) + (I)	**$0**	**$53**	**$53**

Table 67. ICF/IID Federal versus State Fiscal Impacts, Scenario 4 (Some Services)
Estimated MLTSS Spending vs. Status Quo Spending, $ in thousands

	SFY2021	SFY2022	Total
Total Fiscal impact (Claims + Admin) (A)	$0	$22,330	$22,330
FMAP (B)	59.79%	59.79%	
*Federal Portion of Claims and Admin (C) = (A) * (B)*	$0	$13,351	$13,351
*HHSC Portion of Claims and Admin (D) = (A) * [1 - (B)]*	$0	$8,979	$8,979
Premium Taxes			
Total Managed Care Claims (E)	$0	$242,676	$242,676
*Total Premium Tax Paid to MCOs (F) = (E) * 2.30% of claims (~1.75% of premium)*	$0	$5,582	$5,582
FMAP (G)	59.79%	59.79%	
*Federal Portion of Premium Tax (H) = (F) * (G)*	$0	$3,337	$3,337
*HHSC Portion of Premium Tax (I) = (F) * [1 - (G)]*	$0	$2,244	$2,244
Net Fiscal impacts			
Federal Net Fiscal impact (J) = (C) + (H)	**$0**	**$16,688**	**$16,688**
State Net Fiscal impact (K) = (D) - (H)	**$0**	**$5,642**	**$5,642**
HHSC Net Fiscal impact (L) = (D) + (I)	**$0**	**$11,223**	**$11,223**

Table 68. Total Federal versus State Fiscal Impacts, Scenario 4 (Some Services) Estimated MLTSS Spending vs. Status Quo Spending, $ in thousands

	SFY2021	SFY2022	Total
Total Fiscal impact (Claims + Admin) (A)	$1,092	$33,186	$34,278
FMAP (B)	63.21%	60.34%	
*Federal Portion of Claims and Admin (C) = (A) * (B)*	$690	$20,025	$20,715
*HHSC Portion of Claims and Admin (D) = (A) * [1 - (B)]*	$402	$13,161	$13,563
Premium Taxes			
Total Managed Care Claims (E)	$6,987	$318,822	$325,809
*Total Premium Tax Paid to MCOs (F) = (E) * 2.30% of claims (~1.75% of premium)*	$161	$7,333	$7,494
FMAP (G)	63.21%	60.32%	
*Federal Portion of Premium Tax (H) = (F) * (G)*	$102	$4,424	$4,525
*HHSC Portion of Premium Tax (I) = (F) * [1 - (G)]*	$59	$2,909	$2,969
Net Fiscal impacts			
Federal Net Fiscal impact (J) = (C) + (H)	**$792**	**$24,448**	**$25,240**
State Net Fiscal impact (K) = (D) - (H)	**$300**	**$8,738**	**$9,038**
HHSC Net Fiscal impact (L) = (D) + (I)	**$461**	**$16,071**	**$16,531**

Appendix J – Resources Referenced in Other State Fiscal Impacts Table

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10. Wisconsin Department of Health Services, *"Report on the Cost-Effectiveness Analysis of Wisconsin's Long-Term Care (LTC) Programs,"* December 2013.

11. Milliman, *"Cross-Program Analysis for Calendar Year 2016,"* April 2018.