Medicaid Section 1115 Monitoring Report
Texas Healthcare Transformation and Quality Improvement Program
Demonstration Year DY8: October 1, 2018 – September 30, 2019
State Fiscal Year FY18: September 1, 2018 – August 31, 2019
Submitted on September 16, 2019

*****Note:** This template is being finalized for review and approval by OMB. Until such time, its use is optional, although it conveys the nature and extent of monitoring information that CMS is seeking on 1115 demonstrations, and the state's comments on its structure and ease of use are helpful in finalizing it. In reporting budget neutrality and evaluation information, the state should report on the entire demonstration.*

Attachment X provides the draft set of CMS provided 1115 demonstration metrics. The state's project officer will provide the state with the demonstration's budget neutrality workbook.

1. Preface

1.1 Transmittal Title Page

State	Texas Health and Human Services Commission
Demonstration Name	Texas Healthcare Transformation and Quality Improvement Program - Section 1115 Demonstration Semi-annual Report
Approval Date	Initial approval date: December 12, 2011
Approval Period	Extension approval date: December 21, 2017 Expiration date: September 30, 2022
Demonstration Goals and Objectives	The Texas Healthcare Transformation and Quality Improvement Program Section 1115 Waiver enables the State to expand its use of Medicaid managed care to achieve program savings, while also preserving locally funded supplemental payments to hospitals. The goals of the demonstration are to: • Expand risk-based managed care statewide; • Support the development and maintenance of a coordinated care delivery system; • Improve outcomes while containing cost growth; and • Transition to quality-based payment systems across managed care and providers. The Texas Healthcare Transformation and Quality Improvement Program Section 1115 Waiver enables the State to expand its use of Medicaid managed care to achieve program savings, while also preserving locally funded supplemental payments to hospitals.

2. Executive Summary

This section should be brief and targeted to communicate key achievements, highlights, issues, and/or risks identified during the current reporting period. This section should also identify key changes since the last monitoring report, including the implementation of new program components; programmatic improvements (e.g., increased outreach or any beneficiary or provider education efforts); and highlight unexpected changes (e.g., unexpected increases or decreases in enrollment or complaints, etc.). Historical background or general descriptions of the waiver components should not be included in this section.

The state should embed substantive analytics in the sections that follow; this section is intended for summary level information only. The recommended word count for this section is 500 words or less.

According to the Special Terms and Conditions (STCs) of the Demonstration, the Texas Health and Human Services Commission (HHSC) provides its operational report for Demonstration Year (DY) 8 and State Fiscal Year 2019 (SFY19), from September 1, 2018, through August 31, 2019. This report provides the semiannual reporting requirements for the STAR, STAR Kids, STAR+PLUS, and the Children's Medicaid Dental Services (Dental Program). The STCs require the State to report on various topics, including enrollment and disenrollment, network adequacy, benefits, consumer issues, quality, operation and policy, budget neutrality, demonstration evaluation, Delivery System Reform Incentive Payment Program (DSRIP), and public forums.

During the SFY19, the State contracted with 16 STAR, 10 STAR Kids, 5 STAR+PLUS, and 2 Dental Program plans. Each health plan covers one or more of the 13 STAR service delivery areas (SDAs), while each dental plan provides statewide services (*See **Attachment A***).

HHSC staff evaluate and routinely monitor managed care organizations' (MCOs) and dental maintenance organizations' (DMOs) performance reported by the MCOs and DMOs and compiled by HHSC. If an MCO or DMO fails to meet a performance expectation, standard, schedule, or other contract requirement such as the timely submission of deliverables or providing the level of quality required, the managed care contracts give HHSC the authority to use a variety of remedies, including:

1. assessing monetary damages (actual, consequential, direct, indirect, special, and/or liquidated damages (LDs), and
2. developing corrective action plans (CAPs).

The information reflected in this report represents the most current information available at the time that it was compiled. The sanction process between HHSC and the health and dental plans may not be complete at the time the report is submitted to the Centers for Medicare and Medicaid Services (CMS). HHSC posts the final details of any potential enforcement actions taken against a health or dental plan each quarter on the following website:
https://hhs.texas.gov/services/health/medicaid-chip/provider-information/managed-care-organization-sanctions.

3. Enrollment

This section incorporates metrics for the relevant demonstration type. At the time of demonstration approval, CMS will work with states to confirm the appropriate set of metrics and measures for reporting. States should report the required enrollment metrics and measures in Appendix X.

The state should confirm it has submitted enrollment metrics for the demonstration by marking the checkbox.

☐ (Required) The state has attached the required enrollment metrics in Appendix X.

☒ (If applicable) The state does not have any issues to report related to enrollment metrics in Appendix X and has not included any narrative on this topic in the section that follows.

This section addresses trends and issues related to STAR, STAR Kids, STAR+PLUS, and Dental Program eligibility and enrollment; enrollment counts for the quarter; Medicaid eligibility changes; anticipated changes in populations and benefits; and disenrollment from managed care.

In SFY19 from SFY Q1 to SFY Q2 total enrollment decreased in STAR+PLUS (-0.83%), in STAR (-1.79%), and the Dental Program (-1.43%) and increased STAR Kids (0.19%) (See ***Attachment B1***).

The market share distribution (*Mktshare=Total of each MCO QTR data/Program Total*) in STAR, STAR Kids, and STAR+PLUS fluctuated less than 1% throughout SFY19. Market share distribution in the Dental Program remained steady as DentaQuest finished the year with 58% and MCNA had 42%.

The State's enrollment broker, Maximus, reported unduplicated enrollments for the quarter encompassing October, November, December 2018, and January 2019 (see table, page 4) with effective dates of November 1st, December 1st, January 1st and, February 1st for STAR, STAR+PLUS, and STAR Kids with an average of 3,556,306. The Dental Program reported total enrollments for the same time period with an average of 2,825,259 (See ***Attachment L, Q2, pg. 4***).

Enrollment Counts for the Quarter by Population

This subsection includes quarterly enrollment counts as required by STC 71. Because of the time required for the data collection process, unique member counts per quarter are reported on a two-quarter lag. Enrollment counts are based on people served, not member months.

Enrollment Counts (DY7 Q3 April - June 2018

Enrollment Counts (Demonstration Populations)	Total Number Served
Adults	326,212
Children	2,799,836
Aged and Medicare Related (AMR) (non MRSA - pre Sep14)	381,367
Disabled	428,568

Enrollment Counts (DY7 Q4 July - September 2018)

Enrollment Counts (Demonstration Populations)	Total Number Served
Adults	325,840
Children	2,796,173
AMR (non MRSA - pre Sep14)	381,852
Disabled	426,755

Enrollment of Members with Special Health Care Needs (MSHCN)

This subsection of the report addresses managed care enrollment of members with special health care needs (MSHCN).

All STAR Kids and STAR+PLUS members are deemed to be MSHCN. All STAR Kids and STAR+PLUS plans reported 100% MSHCN, as required in the contract. STAR Kids and STAR+PLUS plans are already required to provide service coordination to all members. In SFY19, STAR MCOs reported a total of 123,075 children and adults identified as MSHCN. See **Attachment Q** for detail by service area (SA) and MCO.

STAR MCOs reported 33% of MSHCN had a service plan in SFY19 (See **Attachment Q**). Additionally, five plans reported more than 60% of MSHCN had a service plan (Aetna, Parkland, Community Health Choice, United Healthcare, and Driscoll).

Disenrollment

The State received a total of 20 disenrollment requests in SFY19 (See ***Attachment B2***). The State received the following in SFY Q1 and SFY Q2: 12 disenrollment requests for STAR, 8 for STAR+PLUS, zero for STAR Kids and zero for the Dental Program. Most of the requests for SFY19 disenrollment were initiated by members or their representatives.

Provider Network

This subsection includes quarterly healthcare provider counts for STAR, STAR Kids, STAR+PLUS, and dental provider counts for the Dental Program (See ***Attachment C2***). For Provider Network Count Methodology see ***Attachment C1***.

Across the STAR program statewide, the MCOs reported an increase (0.5%) in unique PCP providers, between SFY Q1 and SFY Q2. The MCOs reported an increase (3.7%) for the STAR+PLUS program in unique PCP providers, between SFY Q1 and SFY Q2. The MCOs reported an increase (60.7%) for the STAR Kids program in unique PCP providers, between SFY Q1 and SFY Q2. For the dental program, unique Primary dental providers increased by 64.7%.

Across the STAR program statewide, the MCOs reported an increase (1.6%) in unique specialists, between SFY Q1 and SFY Q2. The MCOs reported an increase (2.3%) for the STAR+PLUS program in unique specialists, between SFY Q1 and SFY Q2. The MCOs reported an increase (6.6%) for the STAR Kids program in unique specialists, between SFY Q1 and SFY Q2. There was no change in the dental program in unique specialists.

Across the STAR population statewide, the MCOs reported an increase (1.2%) in unique dental providers, between SFY Q1 and SFY Q2. The MCOs reported an increase (0.9%) for the STAR+PLUS population in unique dental providers, between SFY Q1 and SFY Q2. The MCOs reported an increase (7.5%) for the STAR Kids program in unique dental providers, between SFY Q1 and SFY Q2.

Across the STAR program statewide, the MCOs reported an increase (0.7%) in unique pharmacies, between SFY Q1 and SFY Q2. The MCOs reported an increase (0.3%) for the STAR+PLUS program in unique pharmacies, between SFY Q1 and SFY Q2. The MCOs reported a decrease (1.2%) for the STAR Kids program in unique pharmacies, between SFY Q1 and SFY Q2.

Across the dental program statewide, the DMOs reported an increase (64.7%) in unique main dental providers and (0.4%) in unique dental providers between SFY Q3 and SFY Q4 (See ***Attachment C2).***

Attachment C3 details the data reported by the MCOs regarding the number of PCPs and specialists terminated in SFY19. The MCOs reported a variety of reasons for provider termination, including providers failing to re-credential, providers leaving group practice, and termination requested by provider.

Network Adequacy

MCOs are required to provide access for at least 90% of members in each service delivery area (SDA) to each provider type (PCPs, dentist, and specialty services) within the prescribed distance standards (See ***Attachment E***).

MCOs met PCP network access standards for the STAR+PLUS and STAR Kids programs. However, El Paso First under STAR in SFY Q1 and SFY Q2 failed to meet the access standard. ***Attachment H1*** provides PCP network access analysis by program and county type.

Specialist network access ensures specialty provider access within the distance standard of 90% of two providers for each specialty provider. The specialty providers include behavioral health outpatient; cardiovascular disease; orthopedist; nursing facility; pediatrician; ear, nose and throat (ENT); general surgeon; OB/GYN; ophthalmologist; psychiatrist; prenatal care; therapy (occupational, physical, and speech); and urologist.

Attachment H2 (included in Attachment H) displays specialty provider analysis by program and county designation. The following MCOs did not maintain sufficient specialty providers in SFY19 Q2:

Cardiovascular Disease

- STAR
  - Metro - Driscoll Health Plan, Molina Healthcare of Texas, and Parkland.
  - Micro - Driscoll Health Plan, Molina Healthcare of Texas, Superior HealthPlan, and UnitedHealthcare Community Plan.
  - Rural - El Paso Health and FirstCare.

- STAR Kids
  - Metro - Blue Cross and Blue Shield of Texas, Children's Medical Center Health Plan, and Driscoll Health Plan.
  - Micro - Blue Cross and Blue Shield of Texas, Driscoll Health Plan, and Superior HealthPlan.
  - Rural - Superior HealthPlan.

- STAR+PLUS
  - Micro - Molina Healthcare of Texas and Superior HealthPlan.

ENT (otolaryngology)

- STAR
  - Metro – FirstCare.
  - Micro - Driscoll Health Plan, Molina Healthcare of Texas, and UnitedHealthcare Community Plan.
  - Rural – Amerigroup and FirstCare.

- STAR Kids
  - Metro - Blue Cross and Blue Shield of Texas.
  - Micro - Driscoll Health Plan and Superior HealthPlan.
  - Rural - Amerigroup and Superior HealthPlan.

- STAR+PLUS

  - Micro - Molina Healthcare of Texas.
  - Rural – Amerigroup.

General Surgeon

- STAR
  - Micro - Cook Children's Health Plan and FirstCare.
  - Rural - El Paso Health and FirstCare.
- STAR+PLUS
  - Micro - Cigna-HealthSpring.

Nursing Facility

- STAR+PLUS
  - Metro - Cigna-HealthSpring.
  - Micro - Cigna-HealthSpring.
  - Rural - Cigna-HealthSpring.

OB/GYN

- STAR
  - Micro - UnitedHealthcare Community Plan.
- STAR+PLUS
  - Metro - Cigna-HealthSpring.
  - Micro - Cigna-HealthSpring.
  - Rural - Cigna-HealthSpring.

Ophthalmologist

- STAR
  - Metro - Right Care from Scott and White Health Plans.
  - Micro - Cook Children's Health Plan, Driscoll Health Plan, Superior HealthPlan, and UnitedHealthcare Community Plan.
  - Rural - El Paso Health, FirstCare, Right Care from Scott and White Health Plans, and Superior HealthPlan.
- STAR Kids
  - Metro - Blue Cross and Blue Shield of Texas, and Children's Medical Center Health Plan.
  - Micro - Aetna Better Health, Cook Children's Health Plan, Driscoll Health Plan, Superior HealthPlan, Texas Children's Health Plan, and UnitedHealthcare Community Plan.
  - Rural – Amerigroup, Superior HealthPlan, and UnitedHealthcare Community Plan.
- STAR+PLUS
  - Micro - UnitedHealthcare Community Plan.
  - Rural - Superior HealthPlan.

Orthopedist

- STAR

  - Micro - Driscoll Health Plan, Molina Healthcare of Texas, and UnitedHealthcare Community Plan.
  - Rural - El Paso First, FirstCare, and Texas Children's Health Plan.

- STAR Kids
  - Micro - Aetna Better Health, Driscoll Health Plan, Superior HealthPlan, and Texas Children's Health Plan.
  - Rural - Texas Children's Health Plan and UnitedHealthcare Community Plan.

- STAR+PLUS
  - Metro - Cigna-HealthSpring.
  - Micro – Amerigroup, Cigna-HealthSpring, and Molina Healthcare of Texas.
  - Rural – Amerigroup.

Pediatrician
- STAR
  - Micro – Amerigroup, Superior Health Plan, and UnitedHealthcare Community Plan.
  - Rural – FirstCare.

- STAR Kids
  - Micro - Aetna Better Health, Texas Children's Health Plan, and UnitedHealthcare Community Plan.

Prenatal
- STAR
  - Rural - El Paso Health, FirstCare, and Texas Children’s Health Plan.

- STAR Kids
  - Metro - Children's Medical Center Health Plan.
  - Micro - Community First Health Plans and Texas Children's Health Plan.
  - Rural - Texas Children's Health Plan and UnitedHealthcare Community Plan.

- STAR+PLUS
  - Metro - Cigna-HealthSpring.
  - Rural – Amerigroup.

Therapy (Occupational, Physical, and Speech)
- STAR
  - Rural - El Paso Health and FirstCare.

Psychiatrist
- STAR
  - Metro - Driscoll Health Plan
  - Micro - Cook Children's Health Plan, Driscoll Health Plan, FirstCare, and Molina Healthcare of Texas.
  - Rural –El Paso Health, FirstCare.
- STAR Kids

  - Metro - Driscoll Health Plan.
  - Micro - Cook Children's Health Plan, Driscoll Health Plan, Superior HealthPlan, Texas Children's Health Plan.
  - Rural – Blue Cross and Blue Shield of Texas, Superior HealthPlan.
- STAR+PLUS
  - Superior HealthPlan

Urologist

- STAR
  - Metro - UnitedHealthcare Community Plan.
  - Micro - Community Health Choice, Cook Children's Health Plan, Driscoll Health Plan, Molina Healthcare of Texas, Texas Children's Health Plan, and UnitedHealthcare Community Plan.
  - Rural – Amerigroup, Community Health Choice, El Paso Health, FirstCare, Molina Healthcare of Texas, Superior HealthPlan, Texas Children's Health Plan, and UnitedHealthcare Community Plan.

- STAR Kids
  - Metro - Cook Children's Health Plan, Superior HealthPlan, Texas Children's Health Plan, and UnitedHealthcare Community Plan.
  - Micro - Cook Children's Health Plan, Driscoll Health Plan, Superior HealthPlan, Texas Children's Health Plan, and UnitedHealthcare Community Plan.
  - Rural – Amerigroup, Superior HealthPlan, Texas Children's Health Plan, and UnitedHealthcare Community Plan.

- STAR+PLUS
  - Metro - Cigna-HealthSpring.
  - Micro - Cigna-HealthSpring, Molina Healthcare of Texas, and Superior HealthPlan.
  - Rural – Amerigroup, Cigna-HealthSpring, Superior HealthPlan, and UnitedHealthcare Community Plan.

The DMOs (DentaQuest and MCNA) met the network access standard throughout SFY19. ***Attachment H under the page titled H3*** provides dentist analysis by DMO and county designation.

Access to dental specialty providers (endodontist, oral surgeon, orthodontist, pediatric dental, periodontist and prosthodontist) was limited in most county types across the state. ***Attachment H under the page titled H4*** provides dental specialty analysis by provider type and county designation.

MCOs may submit an exception request for areas of non-compliance. HHSC approves or denies the exception request based on the review of supporting information that demonstrates the MCO provider contracting efforts and assurance of access to care. As part of the exception, the MCO must implement strategies to proactively contact and provide education to the affected members on how to access care by approaches such as providing a list of network providers in the area, how to access care outside of the area, how to contact member services and the Member Hotline, what to do in case of an emergency, and how to access non-emergent medical transportation and the MCOs' transportation value-added service, if available. The MCO must ensure continuity of care and offer single case agreements with a provider to ensure the member's continued care, as necessary. If the exception request is denied, the MCO remains

out of compliance and is subject to contract action such as assessing monetary damages or implementing a corrective action plan.

Access to Pharmacy

MCOs are required to follow the pharmacy geo-access standards and report performance outcome data to HHSC. This information will be reported in the Annual report during quarter 4 because of contract changes effective September 1, 2018 that changed MCO reporting from quarterly to annually. The reporting standards changed as well. The changes are as follows:

For counties included in the Medicaid Rural Service Area, the following standard applies to STAR:

• In a Metro County, at least 75 percent of Members must have access to a Network Pharmacy within 2 miles or 5 minutes of the Member's residence;
• In a Micro County, at least 55 percent of Members must have access to a Network Pharmacy within 5 miles or 10 minutes of the Member's residence;
• In a Rural County, at least 90 percent of Members must have access to a Network Pharmacy within 15 miles or 25 minutes of the Member's residence; and
• At least 90 percent of Members must have access to a 24-hour pharmacy within 75 miles of the Member's residence.

For all other counties and Programs, the following standard applies:

• In a Metro County, at least 80 percent of Members must have access to a Network Pharmacy within 2 miles or 5 minutes of the Member's residence;
• In a Micro County, at least 75 percent of Members must have access to a Network Pharmacy within 5 miles or 10 minutes of the Member's residence;
• In a Rural County, at least 90 percent of Members must have access to a Network Pharmacy within 15 miles or 25 minutes of the Member's residence; and
• At least 90 percent of Members must have access to a 24-hour pharmacy within 75 miles or 90 minutes of the Member's residence.

Provider Open Panel

MCOs submit provider files identifying the number of PCPs and main dentists who are accepting new Medicaid patients, which are described here as "open panel" PCPs and "open practice" dentists. In SFY19 Q2, all MCOs and DMOs, except Cook Children's and Blue Cross Blue Shield, met the 80% benchmark for providers accepting new patients in SFY19. Cook Children's performance in STAR and STAR Kids program was 74%. Blue Cross Blue Shield's performance in STAR Kids was 44%. BCBS stated they submitted their SFY19 Q2 PCP Open Panel report incorrectly which originally reported them at 15.14%. They included specialists when calculating the number of providers who are open to new patients when it should have only included PCPs. They resubmitted the report on May 15, 2019 which brought them to 44%. BCBS continues to work to correct their data and stated they anticipate meeting the benchmark once the data is corrected. Although Cook Children's did not meet the benchmark for the STAR nor STAR Kids programs, the MCO contracts with several PCPs that elect to maintain a closed panel. The PCPs provide services to a certain number of Medicaid clients as well as other clients not enrolled in these programs. In addition, Cook Children's has the flexibility of working with certain PCPs with a

closed panel to agree to take on new members; this is normally achieved on a case-by-case basis. This agreement has allowed Cook Children's to maintain these providers.

Out-of-Network (OON) Utilization

MCOs are required to submit the OON Utilization Report for each service delivery area (SDA) in which the MCO operates. In each SDA, the OON utilization should not exceed the following standards:

- 15% of inpatient hospital admissions
- 20% of emergency room (ER) visits
- 20% of total dollars billed for other outpatient services

HHSC continues to work closely with MCOs to ensure compliance with the OON utilization standards. MCOs may submit a Special Exception Request Template (SERT) for areas of non-compliance. HHSC approves or denies the SERT based on the review of supporting information that demonstrates the MCO was unsuccessful in provider contracting efforts. If approved, the MCO submits a recalculated Out-of-Network Utilization Report excluding the utilization of the aforementioned provider(s). If the recalculation does not bring the MCO into compliance, the MCO remains out of compliance and is subject to contract action such as assessing monetary damages or implementing a corrective action plan. ***Attachment D*** provides OON utilization performance summary.

The following MCOs listed below exceeded OON utilization standards in SFY19 Q2. The State will continue to monitor these MCOs and will require corrective action or other remedies if appropriate.

<u>OON Emergency Room (ER)</u>
STAR

- Aetna: Bexar SDA
- Amerigroup: Harris and MRSA Central SDAs
- Dell Children's: Travis SDA
- Molina: Dallas and Harris SDAs
- Texas Children's: Harris SDA
- United: Nueces SDA

STAR+PLUS

- Cigna: Tarrant SDA
- Molina: Dallas SDA
- United: Harris SDA

STAR Kids

- Amerigroup: Harris SDA
- Children's Medical: Dallas SDA
- Texas Children's: Harris SDA

<u>OON Inpatient</u>
STAR

- Aetna: Bexar SDA
- Amerigroup: MRSA Central SDA
- Dell Children's: Travis SDA

- Molina: Dallas and Jefferson SDAs

STAR+PLUS
- Cigna: Hidalgo, MRSA Northeast, and Tarrant SDAs
- Molina: Dallas SDA
- United: Harris SDA

STAR Kids
- Blue Cross Blue Shield: MRSA Central SDA

<u>OON Other and Outpatient</u>
STAR
- Aetna: Bexar and Tarrant SDAs
- Molina: Jefferson SDA
- United: Nueces SDA

STAR+PLUS
- Cigna: Tarrant SDA
- Molina: Jefferson SDA

HHSC has approved special exception requests for the following MCOs/SDAs:
- Aetna (STAR-Bexar and Tarrant SDAs)
- Amerigroup (STAR-Harris and MRSA Central SDAs, STAR Kids- Harris and Lubbock SDAs and STAR+PLUS-Tarrant and Harris SDAs)
- FirstCare (STAR-MRSA West SDA)
- Texas Children's (STAR-Harris SDA)
- Superior (STAR+PLUS-Dallas and MRSA West SDAs)
- Cigna (STAR+PLUS-Hidalgo and Tarrant SDAs)
- United (STAR+PLUS-Harris, STAR- Nueces- Q2, and MRSA Central SDAs)
- Dell Children's (STAR- Travis)
- Children's Medical Center (STAR Kids- Dallas)
- Molina (STAR- Harris, STAR/STAR PLUS- Dallas, CHIP- RSA, STAR/STAR PLUS- Hidalgo and STAR/STAR PLUS- Jefferson)

In this narrative section, the state should discuss any relevant trends that the data shows in enrollment, eligibility, disenrollment, access, and delivery network. Changes (+ or -) greater than two percent should be described here. As an example, the number of beneficiaries enrolled in the last quarter decreased by 5% due to a State Plan Amendment that decreased the FPL levels. The recommended word count for this section is no more than 250 words (1-2 paragraphs). Note that each distinct trend should be described more succinctly via the tables in Section 3.1.

3.1 Enrollment Issues/Trends: New and Continued

**Note: If an issue was noted as resolved in the previous report, it should not be reported in the current report.*

3.2 Anticipated Changes to Enrollment

The state should use this narrative section to explain any anticipated program changes that may impact enrollment-related metrics. For example, the state projects an x% increase in enrollment due to an increase in the FPL limits which will be effective on X date". The recommended word count for this section is 150 words or less.

If no changes are anticipated, this section should be blank and the state should mark the checkbox.

☒ The state does not anticipate changes to enrollment at this time.

4. Benefits

This section incorporates metrics for the relevant demonstration type. At the time of demonstration approval, CMS will work with states to confirm the appropriate set of metrics and measures for reporting. States should report these metrics and measures for benefits in Appendix X.

Benefit metrics in Appendix X may include the following subsections, depending on the demonstration design:

- *Use of incentivized services*
- *Use of other services*
- *Healthy behaviors*
- *Other utilization or benefit-related metrics*

The state should confirm it has submitted benefit metrics for the demonstration by marking the checkbox.

☐ (Required) The state has attached completed the benefit metrics in Appendix X.

☒ (If applicable) The state does not have any issues to report related to the benefits metrics in Appendix X and has not included any narrative.

In this narrative, the state should discuss any relevant trends that the data shows in benefit access, utilization, and delivery network. The recommended word count for this section is 150 words (1-2 paragraphs). Note that issues should be described more succinctly in the sections that follow.

4.1 Benefit Issues: New and Continued

The state should use this section to explain any new benefit-related issues and provide updates on previously reported issues. For each issue, the state should provide a brief summary that references the data reported in Appendix X, the estimated number of impacted beneficiaries, the known or suspected cause(s) of the issue, and the plan to remediate the issue, including a timeline for resolution (if applicable). The state should also use this section to provide updates on benefit-related issues identified in previous reports. When applicable, the state should also note when issues are resolved.

If the state is not aware of benefit issues, this section should be blank.

**Note: If an issue was noted as resolved in the previous report, it should not be reported in the current report.*

4.2 Anticipated Changes to Benefits

The state should use this narrative section to explain any anticipated program changes that may impact benefit-related metrics. For example, new legislation was recently signed by the Governor which will add an adult dental benefit effective X date. The recommended word count for this section is 150 words or less.

If none are anticipated, this section should be blank and the state should mark the checkbox.

☐ The state does not anticipate changes to benefits at this time.

Medicaid Managed Care

Long Term Services and Supports for Individuals with Intellectual and Developmental Disabilities Transition

In 2013, the Texas Legislature directed HHSC to add community intermediate care facilities (ICFs) and home and community-based long-term supports and services for individuals with intellectual and developmental disabilities (IDD) to the Texas managed care system, in consultation with the IDD System Redesign Advisory Committee (IDD SRAC).

The Texas Legislature passed House Bill 4533 to require a pilot prior to carving the programs in, and delay and re-order the carve-ins. The pilot will implement on September 1, 2023, and the subsequent carve-ins will occur on a timeline from 2027-2031.

Compliance with Home and Community Based Services Settings Regulations

Texas continues to move toward full compliance with the home and community-based services settings rule put forth by CMS in March 2014. Work continues on areas identified as needing changes, such as rule revisions. HHSC is identifying sites that will potentially require submission to CMS for heightened scrutiny, considering the recent CMS guidance on heightened scrutiny. HHSC will continue working in partnership with its legislative leadership on this initiative, including obtaining CMS approval of the Texas statewide transition plan.

General Medicaid

Peer Support Services as a Medicaid Benefit

Texas Government Code, Section 531.0999, as amended by House Bill 1486, 85th Legislature, Regular Session, 2017, directed HHSC to adopt rules establishing training requirements for peer specialists to enable the provision of services to persons with mental illness or persons with substance use conditions. The bill also directed HHSC to create a Medicaid benefit for peer support services.

HHSC assembled a stakeholder workgroup to provide input on the development of Medicaid rules to define requirements for training, certification, scope of services, and supervision of certified peer specialists. HHSC implemented peer support services as a Medicaid benefit effective January 1, 2019.

5. Demonstration-related Appeals

This Appeals section incorporates metrics for the relevant demonstration type related to both appeals and grievances, as applicable (hereafter referenced as "Appeals"). At the time of demonstration approval, CMS will work with states to confirm the appropriate set of metrics for reporting. States should report these metrics for demonstration-related appeals in Appendix X.

Appeals metrics in Appendix X may include the following subsections, depending on the demonstration design. All appeals metrics in this report should be specific to the demonstration, and not the entire Medicaid program:

- *Medicaid eligibility appeals*
- *Medicaid benefit appeals*
- *System-specific appeal for demonstration (e.g., work requirement appeal)*
- *Other appeal-related metric, depending on the scope of appeals implied in the demonstration (e.g., work system appeals)*

The state should confirm it has submitted appeals metrics for the demonstration by marking the checkbox.

☐ (Required) The state has attached completed the appeals metrics in Appendix X.

☒ (If applicable) The state does not have any issues to report related to the appeals metrics in Appendix X and has not included any narrative.

Complaints and Appeals Received by MCOs

The MCOs and DMOs are required to track and monitor the number of member appeals and complaints and provider complaints received, to ensure that resolution occurs within 30 days of receipt. A 98% compliance standard is required.

Attachment N1, N2, and N3 provides complaints and appeals performance summary. Data discussed in the narrative are based on the most recent data available, which is the final month of Q2.

The total number of STAR complaints and appeals received by plans decreased from 2,909 in 2019 SFYQ1 to 2,556 in 2019 SFY Q2. STAR plans collectively reported 1,288 member complaints, 1,219 member appeals, and 402 provider complaints in 2019 SFY Q1. STAR plans collectively reported 991 member complaints, 1,176 member appeals, and 389 provider complaints in SFY19 Q2.

The total number of STAR+PLUS complaints and appeals received by plans decreased from 3,379 in 2019 SFYQ1 to 2,985 in SFY19 Q2. STAR+PLUS plans collectively reported 1,673 member complaints, 1,471 member appeals, and 289 provider complaints in SFY19 Q1. STAR+PLUS plans collectively reported 1,391 member complaints, 1,349 member appeals, and 245 provider complaints for SFY19 Q2.

The total number of STAR Kids complaints and appeals received by plans increased from 1,311 in SFY19 Q1 to 1,504 in 2019 SFY Q2. STAR Kids plans collectively reported 181 member complaints, 1,022 member appeals, and 108 provider complaints in SFY19 Q1. STAR Kids plans collectively reported 165 member complaints, 1,229 member appeals, and 110 provider complaints in SFY19 Q2.

The total number of DMO complaints and appeals received by plans decreased from 655 in SFY19 Q1 to 523 in SFY19 Q2. DMO plans collectively reported 213 member complaints, 420 member appeals, and 22 provider complaints in SFY19 Q1. DMO plans collectively reported 201 member complaints, 313 member appeals, and 9 provider complaints in SFY19 Q2.

STAR

Member Appeals

- Amerigroup did not meet the performance standards for timely resolution of member appeals.
- In Q2 Amerigroup in MRSA NE SDA was out of compliance for standard 30-day appeals reporting at 93%. The overturned appeals are a result of additional information received to warrant the overturned decisions for medical necessity. One overturned appeal was a result of additional information received during an appeal person to person to warrant the overturned decision for medical necessity. Amerigroup provided education to the provider and staff.
- Provider Complaints
  - Driscoll Children’s and Texas Children's did not meet the performance standards for timely resolution of provider complaints.
    - In Q2 Driscoll Children's Nueces was out of compliance for standard 30-day timely resolution of provider complaints reporting at 82%. The complaints that took over 30 days to resolve were each due to provider contract payment issues for 3 PCP contracts. This was an Evolent Health issue with an incorrect fee schedule loaded into the system for these provider contracts. The issue was resolved, the claims system was corrected with the correct fee schedule, and claims paid appropriately.
    - In Q2 Texas Children's Harris was out of compliance for standard 30-day timely resolution of provider complaints reporting at 50%. Complaints were not resolved in 30 days due to resolving complex complaints which have required more than 30 days to resolve. The variance is due to updating a report template and capturing provider counts appropriately. The complaint resolution process has had multiple challenges and is currently being revised to improve the process to meet the resolution 30-day timeline.
- Member Complaints
  - Driscoll Children's did not meet the performance standards for timely resolution of member complaints.
    - In Q2 Driscoll Children's Nueces was out of compliance for standard 30-day timely resolution of member complaints reporting at 94%. The complaint that took over 30 days to resolve was due to the MCO waiting on a response from the parent of a member. Driscoll Children's attempted to contact the parent on numerous occasions but was unsuccessful. Director of Quality was eventually able to contact a parent and the complaint was resolved.

STAR+PLUS

Member Appeals

- Superior did not meet the performance standards for timely resolution of member appeals for Q2.
  - Superior MRSA Central was out of compliance for standard 30-day appeals reporting at 97%. All cases were out of compliance for the same reason. The cases were resolved timely but when the cases were audited the resolution was not attached to the case so a letter was generated which caused the cases to be reported late. Effective April 2019, Superior implemented an internal audit of all Texas member cases resolved the prior day to ensure the letter is attached to the case.

Member Complaints

- Amerigroup and Superior did not meet the performance standards for timely resolution of member complaints for Q2.
  - Amerigroup MRSA West was out of compliance for standard 30-day timely resolution of member complaints reporting at 96%. A member complaint related to transportation with a completion date of 31 days was for a STAR+PLUS member. The member complaint was appropriately addressed; however, the complaint associate did not close the complaint action out timely and send the resolution letter within the 30-day time frame. The complaint associate received additional training and auditing of complaint resolution and complaint resolution requirement timeframes.
  - Superior MRSA Central was out of compliance for standard 30-day timely resolution of member complaints reporting at 95%. Two cases were out of compliance. One case was waiting for information to be submitted from the provider. One case was resolved timely, but when audited, the case resolution was not attached to the case so a new letter was generated, which caused the case to be reported late. Effective April 2019, Superior implemented an internal audit of all Texas member cases resolved the prior day to ensure the letter was attached to the case.

STAR Kids

Member Appeals

- Texas Children's did not meet the performance standards for timely resolution of member appeals in Q2.
  - Texas Children's Jefferson is out of compliance for standard 30-day appeals reporting at 94%. Texas Children's had one appeal that was not resolved within 30 days for STAR Kids Jefferson. The legally authorized representative (LAR) called the call center on 1/28/19 and 2/18/19 to request an appeal. In both cases the LAR spoke to someone with Citra the call center overflow vendor. The appeal request was not forwarded to the Unit Manager (UM) with either call received in January or February. A Texas Children's Call Center Representative spoke with the LAR on 3/19/19, the appeal request was then forwarded to the UM to process. UM processed the appeal request and decided on 3/20/19. As a result, appeals resolved within 30 days for this service area was 94.1%. UM Leadership spoke with the Member Services leadership regarding the issue. Member Services leadership stated the issue was addressed in a bi-weekly meeting with Citra.

Provider Complaints

- Aetna and Texas Children's did not meet the performance standards for timely resolution of provider complaints for Q2.
    - Aetna Tarrant was out of compliance for standard 30-day timely resolution of provider complaints reporting at 50%. One case was over 30 days due to issues with a staff member prioritizing of work. An individual meeting was held to address the issues. An Internal Performance Improvement Plan will begin if this continues for this individual.
    - Texas Children's Harris was out of compliance for standard 30-day timely resolution of provider complaints reporting at 47%. Standards not met for provider complaints due to resolving complex complaints which required more than 30 days to resolve. Texas Children's received 16 provider complaints but all 16 were in pending status. The variance was due to updating a report template and capturing provider counts appropriately. The complaint resolution process has had multiple challenges and is currently being revised to improve the process to meet the resolution 30-day timeline.
    - Texas Children's Jefferson was out of compliance for standard 30-day timely resolution of provider complaints reporting at 50%. Standards not met for provider complaints due to resolving complex complaints which required more than 30 days to resolve. Complaints were not resolved in 30 days due to resolving complex complaints which have required more than 30 days to resolve. The variance was due to updating a report template and capturing provider counts appropriately. The complaint resolution process has had multiple challenges and is currently being revised to improve the process to meet the resolution 30-day timeline.
    - Texas Children's MSRA NE was out of compliance for standard 30-day timely resolution of provider complaints reporting at 17%. Standards not met for provider complaints due to resolving complex complaints which required more than 30 days to resolve. Complaints were not resolved in 30 days due to resolving complex complaints which have required more than 30 days to resolve. The variance is due to updating report templates and capturing provider counts appropriately. The complaint resolution process has had multiple challenges and is currently being revised to improve the process to meet the resolution 30-day timeline.
    -

Dental

Member Appeals

- DentaQuest did not meet the performance standards for timely resolution of member appeals on Q2.
    - DentaQuest was out of compliance for standard 30-day appeals reporting at 96%. Per DMO regarding non-compliance, there were five cases in which a letter was found not attached to the case. When a new letter was generated, it caused the case to be reported late. There were two cases reported late due to staffing shortages. Remediation included open positions being filled between 11/12/18-3/18/19. As of 3/18/19, all the open positions have been filled. Effective April 2019, DentaQuest implemented an internal audit of all member cases resolved the prior day to ensure the letter is attached to the case.

Member Complaints

- DentaQuest did not meet the performance standards for timely resolution of member complaints for Q2.
    - DentaQuest was out of compliance for standard 30-day timely resolution of member complaints reporting at 92%. Non-compliance was due to a staffing shortage. DentaQuest only resolved 92% of standard 30-day appeals. Five cases were resolved past the 30-day benchmark. Remediation included filling the open positions were between 11/12/18-3/18/19. As of 3/18/19, all the open positions have been filled.

Complaints received by the State

The State monitors complaints received by the Office of the Ombudsman Managed Care Assistance Team (OMCAT) and HHSC Managed Care Compliance and Operations (MCCO). The OMCAT unit continued to direct a managed care support network to better coordinate assistance provided to Medicaid managed care clients as mandated by state legislature. The network of entities includes the Ombudsman Office, the Long-Term Care Ombudsman, the HHSC Medicaid/CHIP Division, and Area Agencies on Aging.

Overall OMCAT and MCCO complaints in SFY19 Q1 were 1,720 and in SFY19 Q2 1,703 (1% decrease). Attachment O provides complaints performance summary.

OMCAT received a total of 724 complaints through its helpline in SFY Q2 showing a 11% decrease in complaints as compared to SFY Q1 at 818 total complaints. The percentage of change, by each program, between SFY Q1 and SFY Q2 is as follows: STAR (1% decrease), STAR+PLUS (16% decrease), STAR Kids (22% decrease), and the Dental program (0% decrease). The top three reasons for OMCAT complaints in the second quarter include: access to long-term services, access to prescriptions related to private insurance, and access to prescriptions related to unknown or other issues

MCCO received a total of 59 legislative complaints in SFYQ2 showing a 69% increase as compared to the SFY Q1 at 35 total complaints. The percentage of change, by each program, between SFY Q1 and SFY Q2 is as follows: STAR (33% decrease), STAR+PLUS (108% decrease), and STAR Kids (375% increase). The dental program received no complaints in Q1 and received one complaint in Q2. The top three reasons for legislative complaints in SFY Q2 include: access to care, coordination of benefits, and MCO/Provider contract issues.

MCCO received a total of 162 member complaints in SFY Q2 with a 17% increase as compared to SFY Q1 at 138 total complaints. The percentage of change, by each program, between SFY Q1 and SFY Q2 is as follows: STAR (55% increase), STAR+PLUS (4% decrease), and STAR Kids (46% increase). The dental program received 6 complaints in SFY Q1 and no complaints in SFY Q2. The top three reasons for member complaints in SFY Q2 include: access to care, member claim/billing issues, and quality of care.

MCCO received a total of 758 provider complaints in SFY Q2 with a 4% increase as compared to SFY19 Q1 at 729 total complaints. The percentage of change, by program, between SFY Q1 and SFY Q2 is as follows: STAR (4% increase), STAR Kids (2% decrease), and STAR+PLUS (3% increase), and the Dental program (53% increase). The dental program received 17 complaints in SFY Q1 and 26 complaints in SFY Q2. The top three reasons for provider complaints in SFY Q2 include: denial of claim, member claim/billing issues, and payment disputes.

Provider Fraud and Abuse
MCOs and DMOs are required to send referrals regarding Medicaid waste, abuse, or fraud to the HHSC Office of Inspector General (OIG). The OIG received a total of 128 fraud and abuse referrals from MCOs in SFY19 Q1 and Q2 combined. One complaint can be counted in multiple dispositions. The OIG returned 3 of those cases to the MCO to determine appropriate action, launched an MPI full scale investigation of 36 cases, referred 5 cases to the federal OIG, referred 10 cases to the Texas State Board of Pharmacy, transferred 4 cases to Litigation and 3 cases to Medical Services, and closed 89 cases.

The OIG's office received a total of 26 fraud and abuse referrals from DMOs in SFY 19 Q1 and Q2. OIG launched an MPI full scale investigation for 5 cases, transferred one case's information into existing full-scale cases, transferred 3 cases to Medical Services, referred 6 cases to the Medicaid Fraud Control Unit (MFCU), and closed 19 cases.

These cases can have multiple dispositions; therefore, disposition total will not add up to the total number of referrals received. Please see ***Attachments R1 and R2*** for MCO and DMO referral details.

Hotline Performance
The MCOs and DMOs must have a toll-free hotline that members can call 24 hours a day, 7 days a week. The MCOs are required to meet the following hotline performance standards:

- 99% of calls must be answered by the fourth ring;
- ≤1% busy signal rate for all calls (for behavioral health (BH), no incoming calls receive a busy signal;
- 80% of all calls must be answered by a live person within 30 seconds (not applicable for provider hotlines);
- ≤ 7% call abandonment rate; and
- ≤ 2 minutes average hold time.

Attachments M1, M2, M3, and M4 provide detailed hotline data.

Member Hotline **(STAR/STAR+PLUS/CHIP - SFY19 Q2)**

- All MCOs met the requirement to answer calls by the fourth ring.
- All MCOs had ≤1% busy signal rate.
- All MCOs, except Aetna (66%) met the 80% standard for answered by a live person within 30 seconds. Member Call Hold Rate measures were missed for Q2 due to staffing shortages caused by staffing model revisions, and unforeseen attrition were a major factor contributing to the metrics being missed for this quarter. Additionally, expansion of lines of business and extended training for the expansion also impacted this metric. All staffing, training, and expansion adjustments have been addressed by Aetna and have been successful at meeting and/or exceeding this metrics.
- All MCOs, except Parkland (8%), Texas Children's (9%) met the ≤ 7% abandoned calls standard. Parkland reported Member Services did not meet call hold rate measures for January and February 2019 due to staffing shortages caused by staffing model revisions, and unexpected attrition. The MCO has taken internal actions has to address the missed measures. Some of the actions implemented have been the hiring of additional staff, offering overtime to address any shortages, removal of all off the phone activities, as well as intensively and consistently

monitoring service levels. Texas Children's was out of compliance due to their transition from Carenet to Citra. During the initial startup period (Citra went live on 12/1/18), the system was unable to efficiently meet the call volume demands. Texas Children's has worked with Citra on re-evaluating processes to have a more successful outcome. Citra's current performance is now meeting compliant standards, and Texas Children's will continually monitor and immediately address any performance concerns.
- All MCOS average hold times were under two minutes except Parkland (144 seconds). Parkland Member Services did not meet call hold rate measures for January and February 2019 due to staffing shortages caused by staffing model revisions, and unexpected attrition. The MCO has taken internal actions to address the missed measures. Some of the actions implemented have been the hiring of additional staff, offering overtime to address any shortages, removal of all off the phone activities, as well as intensively and consistently monitoring service levels.

Member Hotline **(STAR Kids - SFY19 Q2)**
- All MCOs met the requirement to answer calls by the fourth ring.
- All MCOs had ≤1% busy signal rate.
- All MCOs met the 80% standard for answered by a live person within 30 seconds.
- All MCOs met the ≤ 7% abandoned calls standard.
- All MCOS average hold times were under two minutes.

Behavioral Health Hotline **(STAR/STAR+PLUS/CHIP- SFY19 Q2)**
- All MCOs met the requirement to answer calls by the fourth ring.
- All MCOs met the 80% standard for answered by a live person within 30 seconds.
- All MCOs, except Texas Children's (19%) met the ≤ 7% abandoned calls standard. Texas Children's was out of compliance due to their transition from Carenet to Citra. During the initial startup period (Citra went live on 12/1/18), the system was unable to efficiently meet the call volume demands. Texas Children's has worked with Citra on re-evaluating processes to have a more successful outcome. Citra's current performance is now meeting compliant standards, and Texas Children's will continually monitor and immediately address any performance concerns.
- All MCOs average hold times were under two minutes, except Texas Children's (121 seconds). Average Hold Time for month 1 not met for product lines. Texas Children's was out of compliance due to their transition from Carenet to Citra. Citra went live on 12/1/18. During the initial ramp up period, Citra was unable to efficiently meet the call volume demands. Texas Children's has worked with Citra on re-evaluating processes to have a more successful outcome. Citra's current performance is now meeting compliant standards, and Texas Children's will continually monitor and immediately address any performance concerns.

Behavioral Health Hotline **(STAR Kids - SFY 19 Q2)**
- All MCOs met the requirement to answer calls by the fourth ring.
- 80% standard for answered by a live person within 30 seconds
- All MCOs, except Texas Children's (24%) and Superior (9%) met the ≤ 7% abandoned calls standard. HHSC is pending MCO response regarding the noncompliance. Superior will continue to work closely with Member Service Management and Work Force Management to ensure Superior is training/cross training accordingly early in the month to have the opportunity to meet the metrics. Texas Children's was out of compliance due to their transition from Carenet to Citra. During the initial startup period (Citra went live on 12/1/18), the system was unable to efficiently

meet the call volume demands. Texas Children's has worked with Citra on re-evaluating processes to have a more successful outcome. Citra's current performance is now meeting compliant standards, and Texas Children's will continually monitor and immediately address any performance concerns.

- All MCOs average hold times were under two minutes, except Texas Children's (140 seconds). Texas Children's was out of compliance due to their transition from Carenet to Citra. During the initial startup period (Citra went live on 12/1/18), the system was unable to efficiently meet the call volume demands. Texas Children's has worked with Citra on re-evaluating processes to have a more successful outcome. Citra's current performance is now meeting compliant standards, and Texas Children's will continually monitor and immediately address any performance concerns.

Provider Hotline **(STAR/STAR+PLUS/CHIP - SFY19 Q2)**

- All MCOs met the requirement to answer calls by the fourth ring.
- All MCOs had ≤1% busy signal rate.
- All MCOs met the ≤ 7% abandoned calls standard.
- All MCOS average hold times were under two minutes.

Provider Hotline **(STAR Kids - SFY19 Q2)**

- All MCOs met the requirement to answer calls by the fourth ring.
- All MCOs had ≤1% busy signal rate.
- All MCOs met the ≤ 7% abandoned calls standard.
- All MCOS average hold times were under two minutes.

DMO member and provider hotline performance for DentaQuest and MCNA met all standards throughout SFY19.

5.1 Appeals Issues: New and Continued

The state should use this section to explain any new appeals-related issues and provide updates on previously reported issues.

For each issue, the state should provide a brief summary that references the data reported in Appendix X, the estimated number of impacted beneficiaries, any known or suspected cause(s) of the issue, and the plan to remediate the issue, including a timeline for resolution (if applicable). The state should also use this section to provide updates on appeals-related issues identified in previous reports. When applicable, the state should also note when issues are resolved.

If the state is not aware of appeals issues, this section should be blank.

**Note: If an issue was noted as resolved in the previous report, it should not be reported in the current report.*

5.2 Anticipated Changes to Appeals

The state should use this narrative section to explain any anticipated program changes that may impact appeals-related metrics. If none are anticipated, this section should be blank, and the state should mark the checkbox. The recommended word count for this section is 150 words or less.

☐ The state does not anticipate changes to appeals at this time.

HHSC plans to add an External Review Organization to the existing appeal process and is in the beginning stages of planning for this initiative. The State will provide an update in the next annual report.

6. Quality

This Quality section incorporates quality measures for the relevant demonstration type. At the time of demonstration approval, CMS will work with the state to confirm the appropriate quality measures for reporting. States should report these quality measures in Appendix X.

Quality measures in Appendix X may include the following subsections, depending on the demonstration design:

- *Medicaid Adult and Child Core Set Measures*
- *To be determined*
- *To be determined*

The state should confirm it has submitted quality measures for the demonstration by marking the checkbox.

☐ (Required) The state has attached the quality measures in Appendix X.

☒ (If applicable) The state does not have any issues to report related to the quality measures in Appendix X and has not included any narrative.

CMS Adult and Child Core Measures

HHSC reported the 2018 Core Set measures to CMS in January 2019 (Q2 of SFY 2019). There were several changes in reporting from 2017-2018 Core measures.

2018 Core Set of Children's Health added the following measures, which HHSC reported on:

- Contraceptive Care- Postpartum Women Ages 15-20 (CCP)
- Contraceptive Care- All Women Ages 15-20 (CCW)
- Asthma Medication Ratio Ages 5-15 (AMR)

The following were removed from the 2018 reporting of Child Measures (reported in 2017):

- Frequency of Ongoing Prenatal Care (FPC)
- Medication Management for People with Asthma (MMA)

2018 Core Set of Adult's Health added the following measures, which HHSC reported on:

- Contraceptive Care- Postpartum Women Ages 21-44 (CCP)
- Contraceptive Care- All Women Ages 21-44 (CCW)
- Plan All-Cause Readmissions (PCR)
- Asthma Medication Ration: Ages 19-64 (AMR)
- Concurrent Use of Opioids and Benzodiazepines (COB)

No measures were removed from the 2018 reporting of Adult Measures (reported in 2017).

The state used different methodology for reporting Cervical Cancer Screening (CCS) on the Adult Core Measures from 2017-2018.

6.1 Quality Issues: New and Continued

The state should use this narrative section to explain any new quality-related issue and provide updates on previously reported issues.

For each issue, the state should provide a brief summary that references the data reported in Appendix X, the estimated number of impacted beneficiaries (if applicable), the known or suspected cause(s) of the issue, and the plan to remediate the issue, including a timeline for resolution (if applicable). The state should also use this section to provide updates on quality-related issues identified in previous reports. When applicable, the state should also note when issues are resolved.

If the state is not aware of quality issues, this section should be blank.

** Note: If an issue was noted as resolved in the previous report, it should not be reported in the current report.*

6.2 Anticipated Changes to Quality

The state should use this narrative section to explain any anticipated program changes that may impact quality-related metrics. If none are anticipated, this section should be blank and the state should mark the checkbox.

☐ The state does not anticipate changes related to quality at this time.

Pay-for-Quality

HHSC began to examine 2017 performance and recommend measures for the 2020 Pay-For-Quality (P4Q) program, including seeking input from internal and external stakeholders. HHSC and the EQRO also started analyzing changes to the 2019 HEDIS measures to determine any effect those changes may have on the 2019 P4Q program.

7. Other Demo Specific Metrics

This Other Metrics section incorporates other metrics selected for the demonstration type. States should report these metrics for quality in Appendix X.

Other Metrics in Appendix X include the following subsections, depending on the demonstration design:

- *To be determined*
- *To be determined*
- *To be determined*

If applicable, the state should confirm it has submitted other metrics for the demonstration by marking the checkbox.

☐ (If applicable) The state has attached completed the other metrics in Appendix X.

☒ (If applicable) The state does not have any issues to report related to the other metrics in Appendix X and has not included any narrative.

7.1 Other Metric Issues: New and Continued

The state should use this narrative section to explain any new issues.

For each issue, the state should provide a brief summary that references the data reported in Appendix X, the estimated number of impacted beneficiaries (if applicable), the known or suspected cause(s) of the issue, and the plan to remediate the issue, including a timeline for resolution (if applicable). The state should also use this section to provide updates on other issues identified in previous reports. When applicable, the state should also note when issues are resolved.

If the state is not aware of other issues, this section should be blank.

** Note: If an issue was noted as resolved in the previous report, it should not be reported in the current report.*

7.2 Anticipated Changes to Other Metrics

The state should use this narrative section to explain any anticipated program changes that may impact other metrics.". The recommended word count for this section is 150 words or less.
If none are anticipated, this section should be blank and the state should mark the checkbox.

☒ The state does not anticipate future changes to other metrics at this time.

8. Financial/Budget Neutrality

This Financial/Budget Neutrality section incorporates a budget neutrality workbook for the demonstration. At the time of demonstration approval, CMS will work with states to confirm the appropriate workbook for this demonstration. States should work with the project officer on developing the budget neutrality workbook. States should report its completed workbook as Appendix X.

☒ (Required) The state has attached completed the budget neutrality workbook in Appendix X.

8.1 Financial/Budget Neutrality Issues: New and Continued

The state should use this section to provide an analysis of the budget neutrality to date and to explain any new financial/budget neutrality-related issues. If a SUD component is part of the comprehensive demonstration, the state should provide an analysis of the SUD related budget neutrality and an analysis of budget neutrality as a whole.

For each issue, the state should provide a brief summary that references the data reported in Appendix X, including the fiscal impact and impacted Medicaid Eligibility Groups MEG(s), the known or suspected cause(s) of the issue, and the plan to remediate the issue, including a timeline for resolution (if applicable). The state should also use this section to provide updates on issues identified in previous reports.

When applicable, the state should also note when issues are resolved.

The state should use this section to provide an analysis of the budget neutrality to date and to explain any new financial/budget neutrality-related issues.

This section addresses the quarterly reporting requirements regarding financial and budget neutrality development and issues. **Attachment P** provides the budget neutrality summary.

DY8 Q1 October - December 2018

Eligibility Groups Used in Budget Neutrality Calculations

Eligibility Group	**Month 1 (Oct 2018)**	**Month 2 (Nov 2018)**	**Month 3 (Dec 2018)**	**Total for Quarter Ending 12/2018**
Adults	281,336	276,071	270,967	828,374
Children	2,605,045	2,539,086	2,583,058	7,781,189
AMR	357,367	355,628	355,058	1,068,052
Disabled	411,560	409,039	409,684	1,230,282

Eligibility Groups Not Used in Budget Neutrality Calculations

Eligibility Group	**Month 1 (Oct 2018)**	**Month 2 (Nov 2018)**	**Month 3 (Dec 2018)**	**Total for Quarter Ending 12/2018**
Adults in MRSA	-	-	-	-
Foster Care	36,648	36,429	35,827	108,904
Medically Needy	212	198	209	618
CHIP-Funded	266,783	266,359	266,236	799,378
Adoption Subsidy	-	-	-	-
STAR+PLUS 217-Like HCBS	16,532	17,807	17,727	52,644

DY8 Q2 January - March 2019

Eligibility Groups Used in Budget Neutrality Calculations

Eligibility Group	**Month 4 (Jan 2019)**	**Month 5 (Feb 2019)**	**Month 6 (Mar 2019)**	**Total for Quarter Ending 3/2019**
Adults	274,757	273,291	273,785	821,833
Children	2,579,638	2,567,832	2,565,389	7,712,859
AMR	355,065	355,055	355,178	1,065,298
Disabled	409,379	408,967	408,130	1,226,476

Eligibility Groups Not Used in Budget Neutrality Calculations

Eligibility Group	**Month 4 (Jan 2019)**	**Month 5 (Feb 2019)**	**Month 6 (Mar 2019)**	**Total for Quarter Ending 3/2019**
Adults in MRSA	-	-	-	-

Foster Care	53,336	35,392	35,292	106,019
Medically Needy	209	204	204	617
CHIP-Funded	267, 027	269, 516	268, 985	805, 573
Adoption Subsidy	-	-	-	-
STAR+PLUS 217-Like HCBS	17,644	17,637	17,603	52,884

8.2 Anticipated Changes to Financial/Budget Neutrality

The state should use this narrative section to explain any anticipated program changes that may impact financial/budget neutrality metrics. The recommended word count for this section is 150 words or less. If none are anticipated, this section should be blank and the state should mark the checkbox.

☒ The state does not anticipate future changes to budget neutrality at this time.

9. Demonstration Operations and Policy

The state should use this section to highlight significant demonstration operations or policy considerations that could positively or negatively impact beneficiary enrollment, access to services, timely provision of services, budget neutrality, or any other provision that has potential for beneficiary impacts. The state should also note any activity that may accelerate or create delays or impediments in achieving the demonstration's approved goals or objectives, if not already reported elsewhere in this document.

Such considerations could include the following, either real or anticipated:

- *Any changes to populations served, benefits, access, delivery systems, or eligibility*
- *Legislative activities and state policy changes*
- *Fiscal changes that would result in changes in access, benefits, populations, enrollment, etc.*
- *Related audit or investigation activity, including findings*
- *Litigation activity*
- *Status and/or timely milestones for health plan contracts*
- *Market changes that may impact Medicaid operations*
- *Any delays or variance with provisions outlined in STCs*
- *Systems issues or challenges that might impact the demonstration [i.e. eligibility and enrollment (E&E), Medicaid management information systems (MMIS)]*
- *Changes in key state personnel or organizational structure*
- *Procurement items that will impact demonstration (i.e. enrollment broker, etc.)*
- *Significant changes in payment rates to providers which will impact demonstration or significant losses for managed care organizations (MCOs) under the demonstration*
- *Emergency Situation/Disaster*

- *Other*

States should use the table provided below to present this information.

Claims Summary

The MCOs and DMOs submit monthly claims summary reports (CSR) to HHSC for the following services: acute care, behavioral health (BH), vision services, pharmacy claims, and long-term services and supports (LTSS). The standards for the clean claims and appealed claims follow:

- appealed claims adjudicated within 30 days: >98%
- clean claims adjudicated within 30 days: >98%
- clean claims adjudicated within 90 days: >99%
- clean electronic claims adjudicated within 18 Days: >98%
- clean non-electronic (paper) claims adjudicated within 21 Days: >98%

The MCOs not in compliance with the claims adjudication standards are listed below.

Attachment V1 provides claims summary for the STAR program. ***Attachment V2*** provides claims summary for the STAR+PLUS program. ***Attachment V3*** provides claims summary for the Dental program. ***Attachment V4*** provides claims summary for the STAR Kids program.

STAR (SFY 19 Q2 Month 3)
Acute Care Claims

- Aetna
- Community First
- Parkland
- Superior

Behavioral Health Services Organization Claims

- Aetna
- Community First
- Superior

STAR+PLUS (SFY 19 Q2 Month 3)
Acute Care Claims

- Superior

STAR Kids (SFY 19 Q2 Month 3)
Acute Care Claims

- Aetna
- Superior

Behavioral Health Services Organization Claims

- Aetna and
- Community First

Long Term Care Organization's Claims

- Texas Children's

Litigation Summary

Consideration 1:

Type of Consideration	*Ongoing litigation*
Summary of Consideration	*Frew, et al. v. Smith*, *et al.* (commonly referred to as *Frew*), was filed in 1993, and was brought on behalf of children birth through age 20 enrolled in Medicaid and eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefits. The class action lawsuit alleged that the Texas EPSDT program did not meet the requirements of the Federal Medicaid Act. The lawsuit was settled by a consent decree in 1996. The decree requires numerous state obligations and is monitored by the Court. In 2000, the court found the State defendants in violation of several of the decree's paragraphs. In 2007, the parties agreed to 11 corrective action orders to bring the state into compliance with the consent decree and to increase access to EPSDT benefits. Currently, 4 of the 11 corrective action orders, and their related consent decree paragraphs, are fully dismissed. (1) Check-Up Reports and Plans for Lagging Counties, (2) Prescription and Non-Prescription Medications, Medical Equipment, and Supplies, (3) Transportation Program, and (4) Health Care Provider Training. In 2014, the parties jointly agreed to vacate most of the Toll-Free Numbers corrective action order, and the related consent decree paragraphs. One toll-free number remains under the Corrective Action Order and court monitoring. On January 20, 2015, the district court vacated the corrective action order Adequate Supply of Health

	Care Providers and several paragraphs of the consent decree relating to an adequate supply of healthcare providers. Plaintiffs appealed. On March 28, 2016, the U.S. Fifth Circuit Court of Appeals affirmed most of the district court's opinion but vacated and remanded to the district court for further proceedings portions of the district court's order regarding provider "shortages."
Date and Report in Which Consideration Was First Reported	The lawsuit was filed on September 1, 1993. The consent decree was entered on February 20, 1996. The corrective action order was entered on April 27, 2007.
Summary of Impact	The consent decree and corrective action orders touch upon many program areas and generally require the state to take actions intended to ensure access to, or measure access to, Medicaid services for children. The Texas Medicaid program must consider these obligations in many policy and program decisions for Medicaid services available for persons from birth through 20 years of age.
Estimated Number of Beneficiaries	Estimated as of January 2019 as 3,069,698.
If Issue, Remediation Plan and Timeline for Resolution / Updates in Status if Previously Reported	HHSC and Department of State Health Services (DSHS) will continue to follow the obligations in remaining portions of the consent decree and corrective action order until they are dismissed by the court.

10. Implementation Update

The state should use this section to provide implementation updates on relevant aspects of the state's demonstration, as identified either during the approval process, in previous monitoring calls, or other implementation reviews or discussions pursuant to 42 CFR 431.420(b). The state should also use this section to report on any changes in implementation plans since the demonstration was approved, either via an amendment to the demonstration, or a change in how the state plans to execute the STCs.

In this section, the state should include any relevant trends that the data shows in benefit access, utilization, and delivery network if not already reported elsewhere in this document.

***NOTE**: If additional information is needed, the state should use the space below for a short narrative. The recommended word count for this section is 150 words.*

Health IT Strategic Plan Update

In December 2018, HHSC conducted an external stakeholder conference with representation that included managed care organizations, health care providers and trade associations, Healthcare Information and Management Systems Society, Healthcare Information and Management Systems Society, Texas-based Health Information Exchange organizations, Regional Healthcare Partnerships, and State staff from HHSC and the DSHS. Discussion topics included Health IT plans for the next 5 -10 years, opportunities for improving connectivity across the state and bending the healthcare cost curve.

HHSC used the information gathered from the multiple strategic planning sessions to develop a vision statement and goals for Health IT in Medicaid over the next 5 to 10 years. HHSC also developed a detailed outline of strategic plan report components and writing assignments for staff. HHSC is currently compiling the initial plan draft. The draft will be submitted for internal and external review. External review will be provided by the HHSC e Health Advisory Committee, which is comprised of industry experts in Health IT.

11. Demonstration Evaluation Update

The state should use this section to highlight relevant updates to the state's demonstration evaluation pursuant to 42 CFR § 431.424 and/or any federal evaluations in which the state is involved [per 42 CFR § 431.420(f) or 42 CFR § 431.400(a) (1) (ii) (C) (4)]. The state should include timely updates on evaluation work and timeline. Depending on when this report is due to CMS and the timing for the demonstration, this might include updates on progress with:

- *Evaluation design*
- *Evaluation procurement*
- *Evaluation implementation*
- *Evaluation deliverables (information presented in below table)*
- *Data collection, including any issues collecting, procuring, managing, or using data for the state's evaluation or federal evaluation*
- *For annual report per 42 CFR 431.428, the results/impact of any demonstration programmatic area defined by CMS that is unique to the demonstration design or evaluation hypothesis*
- *Results of beneficiary satisfaction surveys, if conducted during the reporting year, grievances and appeals*

The intent of this section is for the state to provide status updates on deliverables related to the demonstration evaluation and indicate whether the expected timelines are being met and/or if there are any real or anticipated barriers in achieving the goals and timeframes agreed to in the STCs.

Narrative regarding the demonstration should be brief. The recommended word count for any narrative related to the above is about 250 words (1-2 paragraphs).

In addition to any status updates on the demonstration evaluation, the state should complete the below table to list anticipated evaluation-related deliverables related to this demonstration and their due dates.

HHSC completed the following 1115 Waiver evaluation activities during SFY 19:

- HHSC distributed a Project Proposal and Quote Request (PPQR) for an external evaluator on October 1, 2018 but did not receive any proposals by the due date. HHSC scheduled a second

release of the PPQR to occur during the first week of SFY 19 Q2. Responses were received by the requested due date.
- HHSC began initial development of the data dissemination timeline and a data dissemination workgroup that will be responsible for assembling and transferring data to the external evaluator after contract execution.
- HHSC amended its contract with the state's EQRO to collect data on new managed care populations through the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey (Adoption Assistance (AA), Permanency Care Assistance (PCA), and Medicaid for Breast and Cervical Cancer (MBCC)).

The table below lists evaluation-related deliverables. There are currently no anticipated barriers.

Type of Evaluation Deliverable	Due Date	State Notes or Comments	Description of Any Anticipated Issues
Procurement of Independent External Evaluator	9/1/2019	HHSC distributed the PPQR. HHSC anticipates selecting a University evaluator during SFY 19 Q2.	*No issues anticipated at this time*
Interim Evaluation Report	9/30/2021 *(or upon application for renewal)*		*No issues anticipated at this time*
Summative Evaluation Report	3/30/2024		*No issues anticipated at this time*

12. Other Demonstration Reporting

The state should use this section to cover pertinent information not captured in the above sections or in related appendixes. This includes any of the following, if applicable:
- *Real or anticipated issues submitting timely post-approval demonstration deliverables, including a plan for remediation*

Home and Community-Based Services (HCBS) Regulations
HHSC is committed to ensuring compliance with the federal HCBS regulations. In accordance with STC 43(a), HHSC has taken the following steps towards compliance:

1. HHSC continues to refine the Texas Statewide Settings Transition Plan detailing compliance, remediation strategies, and timelines for the STAR+PLUS waiver program operating under the State's 1115 Demonstration waiver and intends to resubmit to CMS in 2019.
2. HHSC has continued to provide stakeholders with updated information regarding the Texas transition plan and opportunities to answer stakeholder questions. HHSC is revisiting the compliance plan to ensure its consistent with legislative direction and the intent of the regulations. This plan will be included in the amended Texas Statewide Settings Transition Plan. Texas plans to resubmit the amended plan in 2019.

Delivery System Reform Incentive Payment Program

Delivery System Reform Incentive Payment Program (DSRIP) evolved from project-level reporting to provider-level outcome reporting to measure the continued transformation of the Texas healthcare system. DSRIP providers report on required categories at the provider system level, rather than the project level. In Q2 of DY8, HHSC submitted the changes to the Program Funding and Mechanics Protocol for DY9-10 to CMS. During Q1, providers had their first opportunity to report achievement of DY7 milestones and metrics. In total for October DY7 reporting and based on available Intergovernmental Transfer (IGT), $1,298,644,152 was paid for DSRIP in January 2019, for a total of $15.1 billion in DY1-7 DSRIP payments to date. Providers had an opportunity during Q2 to receive technical assistance from HHSC and correct reported baselines for their outcome measures before performance is reported in April 2019. ***Attachment Y*** provides estimated remaining payments for DY7-8.

Narrative should be brief. The recommended word count for any narrative should not exceed 250 words (2-3 paragraphs).

In addition to any status updates on the demonstration evaluation, the state should complete the below table to list any other deliverables related to this demonstration and their due dates. Note that deliverables associated with the evaluation should be listed separately in the Demonstration Evaluation Update section.

12.1 Post Award Public Forum

If applicable within the timing of the demonstration, the state should provide a summary of the annual post-award public forum held pursuant to 42 CFR § 431.420(c) indicate any resulting action items or issues. A summary of the post-award must be included in the monitoring report for the period during which the forum was held and in the annual report pursuant to 42 CFR § 431.428.

The state should confirm it has submitted required information for the post-award public forum by marking the checkbox.

Narrative should be brief. The recommended word count for any narrative should not exceed 250 words (2-3 paragraphs).

The state should confirm it has submitted required information for the post-award public forum by marking the checkbox.

☐ The state has provided the summary of the post-award forum (due for the period during reporting during which the forum was held and in the annual report).

☒ There was not a post-award public forum held during this reporting period and this is not an annual report.

The State Medicaid Managed Care Advisory Committee (SMMCAC) met on June 24, 2019. The last public forum was held in May of 2018. The SMMCAC meeting originally scheduled for May 2018 was rescheduled and the change was communicated to CMS as soon as the change was identified since

this meeting was more than a year after the last public forum. The State is working to align the public forum with the annual report timeframe. The date, time, and location of the SMMCAC meeting was published on HHSC's website prior to the meeting. An overview of the complaints process and data improvements was given, legislative updates were given, an update on the Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver, sizing of the uncompensated care pool for Demonstration years 9-11, and DSRIP were given by HHSC Directors. HHSC provided the SMMCAC a brief overview of the Texas Delivery System Reform Incentive Payment (DSRIP) program. 2021 will be the 10th and final year of the demonstration program. Texas must submit to the Centers for Medicare and Medicaid Services (CMS) a draft DSRIP Transition Plan by October 1, 2019. The Transition Plan will feature milestones for the transition of key DSRIP areas from the demonstration program to the broader state Medicaid delivery system. Staff presented committee members with an overview of the work that is underway to develop the transition plan, including the timeline and opportunities for stakeholder engagement. Public comment was also received and documented at this meeting.

13. Notable State Achievements and/or Innovations

This is a section for the state to provide any relevant summary of achievements and/or innovations in demonstration enrollment, benefits, operations, and policies pursuant to the hypotheses of the demonstration or that served to provide better care for individuals, better health for populations, and/or reduce per capita cost. Achievements should focus on significant impacts to beneficiary outcomes.

Whenever possible, narrative in this section should describe the achievement or innovation in quantifiable terms, e.g., number of impacted beneficiaries.

Narrative should be brief. The recommended word count for any narrative should not exceed 250 words (2-3 paragraphs).

14. Report Attachments

Attachment A – Managed Care Organizations by Service Delivery Area. The attachment includes a table of the health and dental plans by Service Delivery Area.
Attachment B1 -- Enrollment Summary (SFY19). The attachment includes annual and quarterly Dental, STAR, STAR Kids and STAR+PLUS enrollment summaries.
Attachment B2 -- Disenrollment Summary (SFY19). The attachment includes annual and quarterly Dental, STAR and STAR+PLUS disenrollment summaries.
Attachments C1, C2, C3 – Provider Network and Methodology. The attachments summarize STAR, STAR Kids, and STAR+PLUS network enrollment by MCOs, SDAs, and provider types. It also includes a description of the methodology used for provider counts and terminations.
Attachments D – Out-of-Network Utilization. The attachments summarize Dental, STAR, STAR Kids, and STAR+PLUS out-of-network utilization.

Attachment E – Distance Standards. The attachment shows the State's distance standards by provider type and county designation.
Attachment H1-H4 – Network Access Analysis. The attachments include the results of the State's analysis for PCPs, main dentists, and specialists.
Attachment L (Q1)– Enrollment Broker Summary Report. The attachment provides a summary of outreach and other initiatives to ensure access to care.
Attachment L(Q2) – Enrollment Broker Summary Report. The attachment provides a summary of enrollment number averages used in budget calculations.
Attachments M1-M4 – Hotline Summaries. The attachments provide data regarding phone calls and performance standards of MCO and DMO Member and Provider Hotlines.
Attachments N1-N3 – MCO Complaints. The attachment includes Dental, STAR, STAR Kids, and STAR+PLUS complaints and appeals received by plans.
Attachment O – Complaints to HHSC. The attachment includes information concerning Dental, STAR, STAR Kids, and STAR+PLUS complaints received by the State.
Attachment P – Budget Neutrality. The attachment includes actual expenditure and member-month data as available to track budget neutrality.
Attachment Q – Members with Special Healthcare Needs Report. The attachment represents total MSHCN enrollment in STAR, STAR Kids, and STAR+PLUS during the prior fiscal year.
Attachment R1-R2 – Provider Fraud and Abuse. The attachments represent a summary of the referrals that STAR, STAR Kids, STAR+PLUS, and Dental Program plans sent to the OIG during the biannual reporting period.
Attachments V1-V4 – Claims Summary (SFY 2018). The attachments are summaries of the MCOs' claims adjudication results.
Attachment Y- DSRIP Remaining Payments. Reported biannually after DSRIP payments are distributed.

For the attachments associated with this report, please email Eli.Greenfield@cms.hhs.gov