Medicaid Section 1115 Monitoring Report
Texas Healthcare Transformation and Quality Improvement Program
Demonstration Year DY8: October 1, 2019 – September 30, 2020
State Fiscal Year FY20: September 1, 2019 – August 31, 2020
Submitted on August 14, 2020

**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 13, 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) 9 and State Fiscal Year 2020 (SFY20), from September 1, 2019, through August 31, 2020. This report provides the semiannual reporting requirements for 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, member issues, quality, operations and policy, budget neutrality, evaluation of the demonstration, the Delivery System Reform Incentive Payment Program (DSRIP), and public forums.

During SFY20, the State contracted with 18 managed care organizations (MCOs) and 2 dental maintenance organizations (DMOs): 16 for STAR, 10 for STAR Kids, 5 for STAR+PLUS. Each MCO covers one or more of the 13 STAR service delivery areas (SDAs), while each dental plan provides statewide services (*See **Attachment A***).

HHSC staff routinely evaluate MCO and DMO 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 contract gives HHSC the authority to use a variety of remedies, including:

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

The information reflected in this report represents the most current information available at the time 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 SFY20, from SFY Q1 to SFY Q2 total enrollment decreased in STAR (-0.33%), increased in STAR+PLUS (0.09%), and increased in STAR Kids (0.71%). The Dental Program had the highest decrease (-1.15%) in enrollment between Q1 to Q2 (See ***Attachment B1***). The market share distribution (*Mktshare=Total of each Program QTR data/Program Total*) in STAR, STAR Kids, and STAR+PLUS fluctuated 1% or less throughout SFY20. During Q2 the market share for STAR was at 80%, for STAR Kids 5%, and STAR+PLUS 15%. Market share distribution in the Dental Program remained steady as DentaQuest finished Q2 with 58% and MCNA with 42%.

The State's enrollment broker, MAXIMUS, submits monthly and quarterly reports summarizing unduplicated enrollments (See ***Attachment L)***. The averages for each quarter were calculated separately using the data in these reports. Averages in these reports are calculated by the enrollment broker using different months than the reporting quarters required by CMS for this demonstration.

The State's enrollment broker, MAXIMUS, reported unduplicated enrollments for SFY20 Q1, encompassing September 2019, October 2019, November 2019, with effective dates of October 1st, November 1st, December 1st for STAR, STAR+PLUS, and STAR Kids with an average of 3,468,360. The Dental Program reported total enrollments for the same time period with an average of 2,736,498. (See ***Attachment L, February 2020, pg. 4).***

Unduplicated enrollments for SFY20 Q2, encompassing December 2019, January 2020, February 2020, with effective dates of January 1st, February 1st, and March 1st for STAR, STAR+PLUS, and STAR Kids with an average of 3,445,055. The Dental Program reported total enrollments for the same time period with an average of 2,708,991. (See ***Attachment L, February 2020, pg. 4***).

For SFY20, the average of the first two quarters for STAR, STAR+PLUS, and STAR Kids is 3,456,707 and the average among all four quarters for The Dental Program is 2,722,744.

Enrollment Counts for the Quarter by Population

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

Enrollment Counts (DY9 Q3 April – June 2019)

Enrollment Counts (Demonstration Populations)	Total Number Served
Adults	311,043
Children	2,715,792
Aged and Medicare Related (AMR) (non-MRSA - pre Sep14)	380,640
Disabled	420,275

Enrollment Counts (DY9 Q4 July – September 2020)

Enrollment Counts (Demonstration Populations)	Total Number Served
Adults	315,619
Children	2,719,442
AMR (non-MRSA - pre Sep14)	381,574
Disabled	419,754

Enrollment of Members with Special Health Care Needs

This subsection of the report addresses managed care enrollment of members with special health care needs (MSHCN). ***Attachment Q*** outlines details by SDA and MCO. All STAR Kids and STAR+PLUS members are deemed to be MSHCN, and as such, all STAR Kids and STAR+PLUS plans reported 100% MSHCN, as required in the contract. STAR Kids and STAR+PLUS MCOs must provide service coordination to all members, unless the member declines service coordination or they are unable to reach the member.

STAR and CHIP MCOs must identify MSHCN based on criteria outlined in the managed care contract. STAR and CHIP MCOs must provide service management to MSHCN, unless the member declines service management or is unable to be reached. Service management is an administrative service

performed by the MCO to facilitate the development of a service plan and to coordinate services among a member's PCP, specialty providers, and non-medical providers.

In SFY 2020 Q2, STAR MCOs reported a total of 80,251 children and adults identified as MSHCN. See **Attachment Q** for detail by service area (SA) and MCO.

STAR MCOs reported 13.35% of MSHCN had a service plan in SFY 2020 Q2 (See **Attachment Q)**. Additionally, three plans reported more than 70% of MSHCN had a service plan (Aetna, Parkland, and United Healthcare). Seven MCOs reported less than 10 percent of MSHCN had a service plan (Amerigroup, Dell Children's, FirstCare, Scott and White, Texas Children's, Molina, Superior).

STAR MCOs who reported that their MSHCN did not have a service plan, reported statewide 10.15% were due to the member declining service management while 34.10% were due to the MCO being unable to reach the member.

Disenrollment

The State received no disenrollment requests during SFY20 Q1 or Q2.

Provider Network

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

Across the STAR program statewide, the MCOs reported a decrease (-11.9%) in unique PCP providers, between SFY20 Q1 and SFY20 Q2. The MCOs reported an increase (3.3%) for the STAR+PLUS program in unique PCP providers, between SFY20 Q1 and SFY20 Q2. The MCOs reported a decrease (--11.9%) for the STAR Kids program in unique PCP providers, between SFY20 Q1 and SFY20 Q2.

Across the STAR program statewide, the MCOs reported a decrease (-4.8%) in unique specialists, between SFY20 Q1 and SFY20 Q2. The MCOs reported an increase (15.1%) for the STAR+PLUS program in unique specialists, between SFY20 Q1 and SFY20 Q2. The MCOs reported a decrease (-1.2%) for the STAR Kids program in unique specialists, between SFY20 Q1 and SFY20 Q2. There was no change in the dental program in unique specialists.

Across the STAR population statewide, the MCOs reported a decrease (-0.6%) in unique dental providers, between SFY20 Q1 and SFY20 Q2. The MCOs reported an increase (4.2%) for the STAR+PLUS population in unique dental providers, between SFY20 Q1 and SFY20 Q2. There were no changes in the STAR Kids program to unique dental providers, between SFY20 Q1 and SFY20 Q2. Across the dental program statewide, the DMOs reported a decrease (-2.6%) in unique primary dental providers between SFY20 Q1 and SFY20 Q2.

Across the STAR program statewide, the MCOs reported a decrease (-5.7%) in unique pharmacists, between SFY20 Q1 and SFY20 Q2. The MCOs reported an increase (13.2%) for the STAR+PLUS program in unique pharmacists, between SFY20 Q1 and SFY20 Q2. The MCOs reported an increase (0.6%) for the STAR Kids program in unique pharmacists, between SFY20 Q1 and SFY20 Q2.

Attachment C3 details the data reported by the MCOs regarding the number of PCPs and specialists terminated in SFY20. The MCOs reported a variety of reasons for provider termination for primary care providers and specialists. The top three reasons for PCP terminations included provider moved, provider left group practice, and provider closed practice. The top three reasons for specialist terminations included provider leaving group practice, provider failing to re-credential 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)***.

Attachment H1 provides PCP network access analysis by program and county type. All MCOs met PCP network access standards for the STAR, STAR+PLUS and STAR Kids programs for SFY20 Q2.

Specialist network access ensures specialty provider access within the distance standard of 90% of two providers for each specialty provider. The specialty providers include audiologist, behavioral health outpatient; cardiovascular disease; ear, nose and throat (ENT), Mental Health Targeted Case Management (TCM) and Mental Health Rehabilitative Services (MHR), nursing facility, OB/GYN, ophthalmologist, orthopedist, pediatric sub-specialty, prenatal care, therapy (occupational, physical, and speech), psychiatrist, 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 SFY20 Q2:

Audiologist

- STAR
  - Metro – FirstCare.
  - Micro – Driscoll Health Plan and Molina Healthcare of Texas.
  - Rural – FirstCare.
- STAR+PLUS
  - Metro – Amerigroup, Cigna-HealthSpring, Molina Healthcare of Texas.
  - Micro – Amerigroup, Cigna-HealthSpring, Molina Healthcare of Texas.
  - Rural – Amerigroup, Cigna-HealthSpring, Molina Healthcare of Texas.
- STAR Kids
  - Micro – Superior HealthPlan.
  - Rural – Amerigroup and Superior HealthPlan.

Behavioral Health – Outpatient

- STAR
  - Micro – Cook Children's Health Plan.
- STAR+PLUS
  - Metro – Amerigroup, Cigna-HealthSpring, Molina Healthcare of Texas.
  - Micro – Amerigroup, Cigna-HealthSpring, Molina Healthcare of Texas.
  - Rural – Amerigroup, Cigna-HealthSpring and Molina Healthcare of Texas.
- STAR Kids
  - Micro – Cook Children's Health Plan.

Cardiovascular Disease

- STAR
  - Metro – Parkland
  - Micro – Driscoll Health Plan, Molina Healthcare of Texas, Superior HealthPlan, UnitedHealthcare Community Plan.
  - Rural – FirstCare.
- STAR+PLUS
  - Metro – Amerigroup, Cigna-HealthSpring, and Molina Healthcare of Texas.
  - Micro – Cigna-HealthSpring, Molina Healthcare of Texas and Superior HealthPlan.
  - Rural – Amerigroup, Cigna-HealthSpring, and Molina Healthcare of Texas.
- STAR Kids
  - Metro – Blue Cross and Blue Shield of Texas.
  - Micro – Blue Cross and Blue Shield of Texas and Superior HealthPlan.
  - Rural – Amerigroup.

ENT (Otolaryngology)

- STAR
  - Metro – FirstCare.
  - Micro – Driscoll Health Plan, Molina Healthcare of Texas.
  - Rural – FirstCare.
- STAR+PLUS
  - Metro – Amerigroup, Cigna-HealthSpring, and Molina Healthcare of Texas.
  - Micro – Amerigroup, Cigna-HealthSpring, and Molina Healthcare of Texas.
  - Rural – Amerigroup, Cigna-HealthSpring, and Molina Healthcare of Texas.
- STAR Kids
  - Micro – Superior HealthPlan.
  - Rural – Amerigroup and Superior HealthPlan.

Mental Health Targeted Case Management (TCM) and Mental Health Rehabilitative Services (MHR)

- STAR
  - Metro – Aetna Better Health, Amerigroup, Community First Health Plans, Cook Children's Health Plan, Driscoll Heath Plan, FirstCare, Molina Healthcare of Texas, Right Care from Scott and White Health Plans, Superior HealthPlan, and UnitedHealthcare Community Plan.
  - Micro – Aetna Better Health, Amerigroup, Blue Cross Blue Shield, Community First Health Plans, Community Health Choice, Cook Children's Health Plan, Dell Children's Health Plan, Driscoll Health Plan, Molina Healthcare of Texas, Right Care from Scott and White Health Plans, Superior HealthPlan, Texas Children's Health Plan, and UnitedHealthcare Community Plan.
  - Rural – Amerigroup, Driscoll Health Plan, FirstCare, Molina Healthcare of Texas, Right Care from Scott and White Health Plans, Superior HealthPlan, and UnitedHealthcare Community Plan.
- STAR+PLUS
  - Metro – Amerigroup, Cigna-HealthSpring, and Molina Healthcare of Texas, Superior HealthPlan, and UnitedHealthcare Community Plan.
  - Micro – Amerigroup, Cigna-HealthSpring, and Molina Healthcare of Texas, Superior HealthPlan, and UnitedHealthcare Community Plan.
  - Rural – Amerigroup, Cigna-HealthSpring, and Molina Healthcare of Texas, Superior HealthPlan, and UnitedHealthcare Community Plan.

- STAR Kids
  - Metro – Aetna Better Health, Amerigroup, Blue Cross Blue Shield, Community First Health Plans, Cook Children's Health Plan, Driscoll Health Plan, Superior HealthPlan, Texas Children's Health Plan, and UnitedHealthcare Community Plan.
  - Micro – Aetna Better Health, Amerigroup, Blue Cross Blue Shield, Community First Health Plans, Cook Children's Health Plan, Driscoll Health Plan, Superior HealthPlan, Texas Children's Health Plan, and UnitedHealthcare Community Plan.
  - Rural –Amerigroup, Blue Cross Blue Shield, Driscoll Health Plan, Superior HealthPlan, Texas Children's Health Plan, and UnitedHealthcare Community Plan.

Nursing Facility

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

OB/GYN

- STAR
  - Micro - Driscoll Health Plan.Metro
  - Amerigroup, Cigna-HealthSpring, and Molina Healthcare of Texas.
  - Micro – Amerigroup, Cigna-HealthSpring, and Molina Healthcare of Texas.
  - Rural – Amerigroup, Cigna-HealthSpring, and Molina Healthcare of Texas.
- STAR Kids
  - Micro - Driscoll Health Plan.

Ophthalmologist

- STAR
  - Metro - Right Care from Scott and White Health Plans.
  - Micro – Amerigroup, Cook Children's Health Plan, Driscoll Health Plan, Superior HealthPlan, and UnitedHealthcare Community Plan.
  - Rural - FirstCare.
- STAR+PLUS
  - Metro – Amerigroup, Cigna-HealthSpring, Molina Healthcare of Texas.
  - Micro – Amerigroup, Cigna-HealthSpring, Molina Healthcare of Texas, and Superior HealthPlan.
  - Rural – Amerigroup, Cigna-HealthSpring, Molina Healthcare of Texas.
- STAR Kids
  - Metro - Blue Cross and Blue Shield of Texas, and Texas Children's Health Plan.
  - Micro - Cook Children's Health Plan, Driscoll Health Plan, Superior HealthPlan, and Texas Children's Health Plan.
  - Rural – Amerigroup, Superior HealthPlan, and Texas Children's Health Plan.

Orthopedist

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

- STAR+PLUS
  - Metro – Amerigroup, Cigna-HealthSpring, Molina Healthcare.
  - Micro – Amerigroup, Cigna-HealthSpring, Molina Healthcare of Texas and Superior HealthPlan.
  - Rural – Amerigroup, Cigna-HealthSpring, and Molina Healthcare of Texas.
- STAR Kids
  - Micro – Aetna Better Health, Superior HealthPlan
  - Rural – Superior HealthPlan.

Pediatric Sub-Specialty

- STAR
  - Micro – Amerigroup and Superior Health Plan.
  - Rural – FirstCare.
- STAR Kids
  - Metro – Blue Cross Blue Shield of Texas.
  - Micro – Aetna Better Health, Amerigroup, Superior HealthPlan, and Texas Children's Health Plan.
  - Rural – Amerigroup and Superior HealthPlan.

Prenatal

- STAR
  - Micro – Texas Children's Health Plan.
  - Rural - El Paso First and Texas Children's Health Plan.
- STAR+PLUS
  - Metro – Amerigroup, Cigna-HealthSpring, and Molina HealthSpring.
  - Micro – Amerigroup, Cigna-HealthSpring, and Molina HealthSpring.
  - Rural – Amerigroup, Cigna-HealthSpring, and Molina HealthSpring, and Superior HealthPlan.
- STAR Kids
  - Rural – Superior HealthPlan and Texas Children's Health Plan.

Psychiatrist

- STAR
  - Metro – Driscoll Health Plan and FirstCare.
  - Micro – Driscoll Health Plan, FirstCare, Superior HealthPlan, and UnitedHealthcare Community Plan.
  - Rural – Driscoll Health Plan, FirstCare and Superior HealthPlan.
- STAR+PLUS
  - Metro – Amerigroup, Cigna-HealthSpring, and Molina Healthcare of Texas.
  - Micro – Amerigroup, Cigna-HealthSpring, Molina Healthcare of Texas, and Superior HealthPlan.
  - Rural – Amerigroup, Cigna-HealthSpring, Molina Healthcare of Texas, and Superior HealthPlan.
- STAR Kids
  - Metro - Driscoll Health Plan.
    Micro - Driscoll Health Plan, Superior HealthPlan, Texas Children's Health Plan.
  - Rural - Driscoll Health Plan and Superior HealthPlan.

Therapy (Occupational, Physical, and Speech)

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

Urologist

- STAR
  - Micro - Community Health Choice, Cook Children's Health Plan, Driscoll Health Plan, Molina Healthcare of Texas, and Texas Children's Health Plan.
  - Rural – Amerigroup, Community Health Choice, FirstCare, Right Care from Scott and White Health Plans, Superior HealthPlan, Texas Children's Health Plan, and UnitedHealthcare Community Plan.
- STAR+PLUS
  - Metro – Amerigroup, Cigna-HealthSpring, and Molina Healthcare of Texas.
  - Micro – Amerigroup, Cigna-HealthSpring, Molina Healthcare of Texas, and Superior HealthPlan.
  - Rural – Amerigroup, Cigna-HealthSpring, Molina Healthcare of Texas, Superior HealthPlan, and UnitedHealthcare Community Plan.
- STAR Kids
  - Metro – Superior HealthPlan, Texas Children's Health Plan, and UnitedHealthcare Community Plan.
  - Micro – 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.

The DMOs (DentaQuest and MCNA) met the network access standard throughout SFY20. ***Attachment H under the page titled H3*** provides dentist analysis by DMO and county designation.

Access to dental specialty providers (orthodontist, pediatric dentist, and prosthodontist) was limited in most county types across the state. DMOs did not meet all performance standards. Pediatric dental was the only dental specialty provider that DMOs had data to provide for Q2. ***Attachment H under the page titled H4*** provides dental specialty analysis by provider type and county designation.

Network Adequacy Standard Exceptions

HHSC is reviewing its methodology and monitoring processes in an effort to ensure the most precise representation of actual performance with thorough and comprehensive reporting and analysis conducted prior to issuance of liquidated damages. While all MCOs and DMOs are under corrective action for network adequacy, HHSC is focusing its monitoring efforts ensuring implementation strategies of access to care plans and member education initiatives.

MCOs and DMOs 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 impacted 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 is subject to remedies such as liquidated damages or a corrective action plan.

Access to Pharmacy

MCOs are required to provide pharmacy access to members in each service delivery area (SDA) within the contractual performance standards. Effective SFY19, the performance standards changed as follows:

For counties included in the Medicaid Rural Service Area (MRSA), the following standards apply to STAR:

- In a Metro County, at least 75% 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% 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% of Members must have access to a Network Pharmacy within 15 miles or 25 minutes of the Member's residence; and
- At least 90% 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 standards apply:

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

The Annual SFY19 report did not include Pharmacy data due to contract changes in MCO reporting from quarterly to annually, which created a delay in validating the data. **Attachment J** details the Geo-distance results for SFY20 Q2.

The following MCOs did not meet all pharmacy access performance standards in SFY19 Q4:

- STAR MRSA
  - Metro – Amerigroup and Superior HealthPlan.
  - Micro – Amerigroup.
  - Rural – Amerigroup.
- STAR All Other Counties:
  - Metro – Amerigroup, Driscoll Health Plan, Molina Healthcare of Texas, Superior HealthPlan, and UnitedHealthcare Community Plan.
  - Micro – Aetna, Amerigroup, Blue Cross and Blue Shield, Community Health Choice, Cook Children's Health Plan, Community First Health Plans, Dell Children's Health Plan,

Superior HealthPlan, Texas Children's Health Plan, and UnitedHealthcare Community Plan.
    - Rural – Amerigroup, Driscoll Health Plan, El Paso First, Molina Healthcare of Texas, Superior HealthPlan, and UnitedHealthcare Community Plan.
- STAR Kids
    - Metro – Amerigroup, Blue Cross and Blue Shield, Children's Medical Center Health Plan, Community First Health Plans, Driscoll Health Plan, Superior HealthPlan, Texas Children's Health Plan, and UnitedHealthcare Community Plan.
    - Micro – Aetna, Amerigroup, Blue Cross and Blue Shield, Community First Health Plans, Cook Children's Health Plans, Superior HealthPlan, Texas Children's Health Plan, and UnitedHealthcare Community Plan.
    - Rural – Amerigroup, Blue Cross and Blue Shield of Texas, Children's Medical Center Health Plan, Driscoll Health Plan, Superior HealthPlan, Texas Children's Health Plan, and UnitedHealthcare Community Plan.

No data was provided from STAR+ PLUS MCOs because the capitation rates do not include the costs of Medicaid wrap-around services for outpatient drugs and biological products for STAR+PLUS Members. HHSC makes supplemental payments to the MCO for these Medicaid wrap-around services based on encounter data received by HHSC's Administrative Services Contractor during an encounter reporting period.

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. HHSC monitors PCPs with Open Panel at an 80% benchmark. In SFY20 Q2, all MCOs and DMOs, except Cook Children's in STAR (75%) and STAR Kids (73%) and Community First STAR Kids (78%) met the 80% benchmark. However, HHSC has not identified access to care concerns, issues, or complaints. Cook Children's contracts with 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 who have a closed panel to agree to take on new members normally achieved on a case-by-case basis. This arrangement has allowed Cook Children's to maintain these providers in the network**.** Based on these justifications, HHSC is not pursuing remedial action against Cook Children's.

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 MCOs listed below exceeded OON utilization standards in SFY20 Q2. The State will continue to monitor these MCOs and will require corrective action or other remedies if appropriate.

OON Emergency Room (ER)

- STAR
  - Amerigroup: MRSA Central SDA
  - Dell Children's: Travis SDA
  - Molina: Harris SDA
  - Texas Children's: Harris SDA
- STAR+PLUS
  - Cigna-HealthSpring: Hidalgo SDA
  - Superior: Lubbock SDA
- STAR Kids
  - BCBS: MRSA Central SDA
  - Cook Children's: Tarrant SDA
  - Texas Children's: MRSA Northeast

OON Inpatient

- STAR
  - Dells Children's: Travis SDA
  - Molina: Dallas and Harris SDA
- STAR+PLUS
  - Amerigroup: Harris SDA
- STAR Kids
  - BCBS: MRSA Central SDA
  - Cook Children's: Tarrant SDA
  - Superior: Bexar SDA
  - Texas Children's: MRSA Northwest

OON Other and Outpatient

- STAR
  - Aetna: Tarrant SDA
  - Community First: Bexar SDA
  - United: Nueces SDA
- STAR Kids
  - BCBS: Travis SDA
  - Children's Medical Center: Dallas SDA

HHSC has approved special exception requests (SER) for the following MCOs/SDAs. HHSC is waiving remedies for COVID related issues. HHSC follows up with the MCOs on all non-compliance items.

OON Emergency Room (ER)

- STAR

- Dell Children's: Travis SDA
- Molina: Harris SDA

- STAR+PLUS
  - Cigna-HealthSpring: Hidalgo SDA

OON Inpatient

- STAR
  - Dell Children's: Travis SDA
  - Molina: Dallas and Harris SDA

OON Other and Outpatient

- STAR
  - United: Nueces SDA

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 (IDD) Transition

The Texas Legislature directed a change in the approach for the transition of long-term services and supports (LTSS) from a fee-for-service model to a managed care model through House Bill (HB) 4533, 86th Legislature, Regular Session, 2019. HB 4533 amends Government Code Chapter 534 and outlines two stages for implementation. Stage one directs a pilot program through the STAR+PLUS Medicaid managed care program to test person-centered managed care strategies and improvements based on

capitation. Stage two delays and staggers the carve-in of waivers and community intermediate care facilities programs to a Medicaid managed care model, or system redesign, beginning with Texas Home Living in 2027.

The Intellectual and Developmental Disabilities System Redesign Advisory Committee (IDD SRAC) will continue to coordinate and collaborate with HHSC throughout the pilot program and carve-ins. HB 4533 also establishes a Pilot Program Workgroup to aid in developing and advising HHSC on the operation of the pilot program.

The pilot program will be implemented September 1, 2023 and operate for at least 24 months. The pilot program is meant to test the delivery of LTSS for people with IDD or similar functional needs through managed care. The information gained through the pilot will be used to inform the final stage of the LTSS system redesign, ensuring the best possible outcomes for individuals with IDD and the most efficient use of Medicaid resources.

Compliance with Home- and Community-Based Services Settings Regulations

Texas continues to move toward compliance with the home-and community-based services settings rule put forth by CMS in March 2014. Although funding requested to assist in some aspects of HCBS, compliance did not move forward for the 86th Legislative Session, 2019. HHSC continues to analyze future funding needs. In the meantime, work continues on other aspects of compliance, such as rule revisions. Based on additional guidance issued by CMS in March 2019, HHSC continues to identify sites that may require submittal to CMS for heightened scrutiny. Over the next year HHSC will continue work on this initiative, which includes seeking CMS approval of the Texas Statewide Transition Plan.

Medicaid

Non-Emergency Medical Transportation Managed Care Carve-in - House Bill (HB) 1576

HB 1576 (86th Legislature, Regular Session, 2019) transfers coordination of non-emergency medical transportation (NEMT) services from managed transportation organizations (MTOs) to the Medicaid managed care organizations (MCOs) responsible for coordinating medical services. It also expands demand response services to include trips requested with less than 48 hours' notice and increases opportunities for transportation network companies to participate in the program. Beginning January 17, 2020, certain MCOs began piloting the delivery of the expanded demand response transportation services using value-added services. HHSC is planning for a June 2021 implementation date for the full carve in of NEMT into managed care. Impacted 1115 programs include STAR, STAR+PLUS, and STAR Kids.

Future Amendments

In response to the 2020-21 Texas General Appropriations Act (Rider 32, Article II, House Bill (HB) 1), which authorized the implementation of additional services for the treatment of eligible children with autism under the Texas Medicaid program, HHSC plans to submit an amendment to the 1115 Transformation waiver clarifying the coverage of certain early and periodic screening, diagnostic, and treatment (EPSDT) services for children and youth with a diagnosis of autism spectrum disorder (ASD).

House Bill (H.B.) 4533, SECTION 32, 86th Legislature, Regular Session, 2019 which requires HHSC to pursue a benefit for medically fragile individuals. If determined to be cost effective, the Health and Human Services Commission (HHSC) plans to submit an amendment to add this benefit to the 1115 Transformation waiver under the STAR+PLUS Home and Community Based Services (HCBS) program.

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 resolution occurs within 30 days of receipt. A 98% compliance standard is required. Currently data for SFY20 Q1 and Q2 are still pending MCO corrections due to the switch to TexConnect and changes in deliverables. The transition to the TexConnect Portal required MCOs to make system modifications to generate reporting in a text file submission format rather than complete an Excel spreadsheet. Aside from the format change, another key reporting change is the information provided in the new reporting requirements. Complaint and appeals reporting now includes member and/or provider specific data. Significant changes to the complaints reporting format, and several MCOs concerns regarding the complaints text file layout, prompted leadership approval of a soft launch for six months from the layout's implementation before HHSC would consider remedies for non-compliance.

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 the 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 SFY20 Q1 were 1,459 and in SFY20 Q2 1,748. ***Attachment O*** provides complaints performance summary.

OMCAT received a total of 670 complaints in SFY20 Q1 showing a 37% increase in complaints as compared to SFY20 Q2 at 916 total complaints. The percentage of change, by each program, between SFY20 Q1 and SFY20 Q2 is as follows: STAR (94% increase), STAR+PLUS (8% increase), STAR Kids

(37% increase), and Dental (85% increase). The top three complaint categories for OMCAT complaints in the second quarter were access to care, prescription services, and claims/payment.

MCCO received a total of 20 legislative complaints in SFY20 Q1 showing a 5% decrease compared to the SFYQ2 at 19 complaints. The percentage of change, by each program, between SFY20 Q1 and SFY20 Q2 is as follows: STAR (50% decrease) STAR+PLUS (29% increase), and STAR Kids (400% increase). The dental program had 2 complaints in SFY20 Q1 and zero in SFY20 Q2 (100% decrease). The top reasons for legislative complaints in SFY20 Q2 were denial or delay of payment and MCO/provider contract.

MCCO received a total of 33 member complaints in SFY20 Q1 with a 252% increase as compared to SFY20 Q2 at 116 total complaints. The percentage of change, by each program, between SFY20 Q1 and SFY20 Q2 is as follows: STAR (67% decrease), STAR+PLUS (50% increase), and STAR Kids (1,371% increase). The dental program received 7 complaints in SFY20 Q1 and 2 complaints in SFY20 Q2 (71% decrease). The top reasons for member complaints in SFY Q2 were utilization review referrals and denial or delay of payment.

MCCO received a total of 736 provider complaints in SFY20 Q1 with a 5% decrease as compared to SFY20 Q2 at 697 total complaints. The percentage of change, by program, between SFY20 Q1 and SFY20 Q2 is as follows: STAR (4% decrease), and STAR+PLUS (2% decrease), STAR Kids (36% decrease). The Dental program had a 48% increase receiving 31 complaints in SFY20 Q1 and 46 complaints in SFY20 Q2. The top reasons for provider complaints in SFY Q2 were denial of claim, claim recoupment, and delay of medically necessary treatment.

Though there was an increase in complaints received by OMCAT across program types, the largest increase was in the STAR Program (+94%, +173). The increase in STAR complaints was related to:

- Access to Out of Network Providers for clients in STAR. This was due to clients moving out of their service area. There was no trend in the MCO for these complaints.
- Prescription / Other Insurance – there was a trend in complaints against Texas Children's Health Plan.
- Access to In-Network Providers (not PCP) – many of these were related to members trying to find an OBGYN but the list of providers they received from the MCOs were either not taking the plans or not seeing new patients. There was no trend in MCOs. However, there was a trend with this issue.
- Access to PCP – no trends noted
- Balance Billing – no trends noted
- Access to DME – no trends noted

The increase in OMCAT complaints is also partially due to a change in statute that shifted many member complaints to OMCAT. As part of the no wrong door recommendation from Rider 61 from 85th Legislature and HB 4533 from the 86th Legislature regular sessions, the move to have all managed care client complaints from MCCO to OMCAT was to ensure complaints could be accepted from across the agency and funneled to OMCAT for intake and resolution. The approach taken includes communications to HHSC staff that anyone should be able to accept a member managed care complaint and funnel that complaint to OMCAT for consistent intake and resolution. Provider managed care complaints remain with MCCO.

Regarding MCCO member complaints, the numbers are small and therefore the percent is skewed and not reliable for trending. For example, when 1 complaint is received (Legislative one quarter and none the next it is a 100% decrease). Additionally, as more members become educated on the OMCAT process, they are less likely to reach out to MCCO.

Legislative decreases are anticipated to be due the fact that there were no major changes to the managed care programs and HHSC was not in a legislative session during the reporting period.

The Utilization Management Review (UMR) team submits referrals on behalf of STAR Kids members based on UMR audits of MCO cases for that program. These referrals are counted in MCCO member complaint data. This number will fluctuate with the UMR audits and are not member contacts rather UMR referrals resulting from a state audit.

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). Please see ***Attachments R1 and R2*** for MCO and DMO referral details. The OIG received a total of 77 fraud and abuse referrals from MCOs in SFY20 Q1 and 89 in Q2. These cases can have multiple dispositions; therefore, the disposition total will not add up to the total number of referrals received. In Q2, OIG launched an MPI full scale investigation of 17 cases, referred 1 case to the federal OIG, referred 10 cases to the Texas State Board of Pharmacy, referred 28 cases to Medicaid Fraud Control Unit (MFCU), transferred 4 cases to OIG Medical Services, and closed 75 cases.

The OIG's office received a total of 2 fraud and abuse referrals from DMOs in SFY20 Q1 and 9 in Q2. In Q2, OIG launched an MPI full-scale investigation for 4 cases, transferred 2 cases to OIG Medical Services, referred 5 cases to the MFCU, and closed 5 cases.

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.

MCOs have been instructed to aggregate totals by program and hotline type for all their STAR, CHIP and STAR+PLUS plans. Because MCOs expressed concerns that the average hold time was not being calculated correctly, MCOs will begin submitting the total hold time as of 9/1/2020. HHSC will use the total hold time values to calculate the average hold time on the back end to monitor MCO compliance. Due to this change HHSC will not produce any breakout by STAR, CHIP or STAR+PLUS alone for any MCO. CHIP and Medicaid Dental within the same DMO are also aggregated. HHSC will also no longer provide a breakout by SDA due to reporting changes and TexConnect data.

At this time the TexConnect deliverables report separates data based on in-house and individual subcontracted call centers. HHSC is working to get information on how MCO's calculate "Average Hold Time" in order to aggregate the in-house and subcontracted call center figures for that measure. The TexConnect deliverables for hotlines no longer collect "Call Pickup Rate" nor "Busy Signal Rate." HHSC will begin reporting these measures again on September 1, 2020 and plans to include the data in the next monitoring report.

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

Member Hotline **(STAR/STAR+PLUS/CHIP - SFY20 Q2)**

- All MCOs met the requirement to answer calls by the fourth ring except for Children's Medical Center, Community First, Cook Children's, El Paso Health, Superior and Texas Children's.
- All MCOs met the 80% standard for answered by a live person within 30 seconds except for Texas Children's'
- All MCOs met the ≤ 7% abandoned calls standard.

Member Hotline **(STAR Kids – SFY20 Q2)**

- All MCOs met the requirement to answer calls by the fourth ring except for Community First, Cook Children's, Superior, Texas Children's and United.
- All MCOs met the 80% standard for answered by a live person within 30 seconds except for Texas Children's.
- All MCOs met the ≤ 7% abandoned calls standard.

Behavioral Health Hotline **(STAR/STAR+PLUS/CHIP –– SFY20 Q2)**

- All MCOs met the requirement to answer calls by the fourth ring except for Children's Medical Center, Community First, Superior, Texas Children's and United.
- All MCOs met the 80% standard for answered by a live person within 30 seconds.
- All MCOs met the ≤ 7% abandoned calls standard except for Texas Children's

Behavioral Health Hotline **(STAR Kids – SFY20 Q2)**

- All MCOs met the requirement to answer calls by the fourth ring except for Aetna, Community First, Superior and Texas Children's.
- 80% standard for answered by a live person within 30 seconds.
- All MCOs met the ≤ 7% abandoned calls standard.

Provider Hotline **(STAR/STAR+PLUS/CHIP – SFY20 Q2)**

- All MCOs met the requirement to answer calls by the fourth ring except for Children's Medical Center, Cigna-HealthSpring, Community First, Cook Children's, El Paso Health, Molina, Superior and Texas Children's.
- All MCOs met the ≤ 7% abandoned calls standard.

Provider Hotline **(STAR Kids – SFY20 Q2)**

- All MCOs met the requirement to answer calls by the fourth ring except for Children's Medical Center and Texas Children's.
- All MCOs met the ≤ 7% abandoned calls standard.

Dental Hotline **(STAR/STAR+PLUS/CHIP – SFY20 Q2)**

- DentaQuest met standards for provider hotline performance but not member hotline performance. MCNA did not meet any standards throughout SFY20 Q2.

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.

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.

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.

This section addresses the quarterly reporting requirements regarding financial and budget neutrality development and issues. **Attachment P** provides the budget neutrality summary. The tables below provide information on eligibility groups in budget neutrality calculations.

DY9 Q1 October – December 2019
Eligibility Groups Used in Budget Neutrality Calculations

Eligibility Group	**Month 1 (Oct 2019)**	**Month 2 (Nov 2019)**	**Month 3 (Dec 2019)**	**Total for Quarter Ending 12/2019**

Adults	271,561	246,093	262,302	797,956
Children	2,536,010	2,520,969	2,520,040	7,577,019
AMR	355,609	355,234	354,775	1,065,618
Disabled	405,279	404,241	404,920	1,214,440

Eligibility Groups Not Used in Budget Neutrality Calculations

Eligibility Group	**Month 1 (Oct 2019)**	**Month 2 (Nov 2019)**	**Month 3 (Dec 2019)**	**Total for Quarter Ending 12/2019**
Foster Care	35,133	34,766	34,104	104,003
Medically Needy	199	191	176	566
CHIP-Funded	261,196	260,227	259,173	780,596
STAR+PLUS 217-Like HCBS	18,378	18,453	18,421	55,253

DY9 Q2 January – March 2020
Eligibility Groups Used in Budget Neutrality Calculations

Eligibility Group	**Month 1 (Jan 2020)**	**Month 2 (Feb 2020)**	**Month 3 (Mar 2020)**	**Total for Quarter Ending 3/2020**
Adults	265,863	264,768	264,342	794,973
Children	2,516,866	2,514,534	2,508,803	7,540,204
AMR	355,358	354,386	355,228	1,064,972
Disabled	404,235	404,185	404,128	1,212,548

Eligibility Groups Not Used in Budget Neutrality Calculations

Eligibility Group	**Month 1 (Jan 2020)**	**Month 2 (Feb 2020)**	**Month 3 (Mar 2020)**	**Total for Quarter Ending 3/2020**
Adults in MRSA	-	-	-	-
Foster Care	33,798	33,635	33,368	100,801
Medically Needy	177	185	185	546
CHIP-Funded	259,048	260,048	263,590	782,685
Adoption Subsidy	-	-	-	-
STAR+PLUS 217-Like HCBS	18,394	18,579	18,381	55,354

8.1 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%

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.

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

STAR (SFY20 Q2 Month 3)
Acute Care Claims
% Clean Adjudicated within 30 days (98% STD)
- Community First

% Clean Adjudicated within 90 Days (99% STD)
- Community First

Behavioral Health Services Claims
% Clean Adjudicated within 90 Days (99% STD)
- Community Health Choice

% Clean Adjudicated within 90 Days (99% STD)
- Community First

STAR+PLUS (SFY20 Q2 Month 3)
Behavioral Health Services Claims
% Appealed Adjudicated within 30 Days (98% STD)
- Amerigroup
- Molina
- Superior

Long Term Care Claims
% Appealed Adjudicated within 30 Days (98% STD)

- Amerigroup

STAR Kids (SFY20 Q2 Month 3)

Acute Care Claims

% Clean Adjudicated within 30 days (98% STD)

- Community First

% Clean Adjudicated within 90 Days (99% STD)

- Community First

Behavioral Health Services Claims

% Clean Adjudicated within 30 Days (98% STD)

- Community First

% Clean Adjudicated within 90 Days (99% STD)

- Community First

Litigation Summary

Consideration 1:

Type of Consideration	*Ongoing litigation*
Summary of Consideration	*Frew, et al. v. Phillips*, *et al.* (commonly referred to as *Frew*), was filed in 1993, and was brought on behalf of children under age 21 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 eleven corrective action orders to bring the state into compliance with the consent decree and to increase access to EPSDT benefits. Currently, four of the eleven 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 Adequate Supply of Health Care Providers corrective action order and several paragraphs of the consent decree relating to an adequate supply of healthcare providers. Plaintiffs appealed. On March 28, 2016, the Fifth Circuit 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." On April 7, 2020, the district court entered an order addressing provider "shortages" based on the Fifth Circuit's decision and denying the defendants' motion to reinstate the order vacating those portions of the CAO.
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 eleven corrective action orders were 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, 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 under age 21.
Estimated Number of Beneficiaries	Estimated (as of September 2019) at 3,015,982.
If Issue, Remediation Plan and Timeline for Resolution / Updates in Status if Previously Reported	HHSC and DSHS will continue to follow the obligations in the remaining portions of the

	consent decree and corrective action orders 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

The plan was developed to support the current HHS Vision and Mission statements by concentrated discussions about how HHSC is working together across the healthcare continuum to make improvements in provider technologies, most notably, electronic health record (EHR) systems, and develop methods for establishing interoperability over the next 5 to 10 years.

The Health IT Strategic Plan was submitted to the Centers for Medicare & Medicaid Services on March 31, 2020. It was approved by CMS on May 11, 2020. The Plan has been made public and may be found on the Medicaid.gov page. It has been posted on HHSC's website.

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 semiannual evaluation activities for SFY20:
Q1

- HHSC held an initial meeting with the Principal Investigator from Texas A&M University (TAMU) on November 14, 2019.
- HHSC created a Secure File Transfer Protocol (Globalscape) site for the 1115 Transformation Waiver. All HHSC and TAMU staff who require access completed account setup within Globalscape.
- HHSC analysts began uploading data to Globalscape. The initial round of data transfers continued into SFY20 Q2.
- HHSC analysts began providing data-related technical assistance as requested by TAMU.

Q2

- HHSC analysts finished transferring initial round of data to TAMU.
- HHSC scheduled a quarterly meeting with the Principal Investigator from Texas A&M University (TAMU) at the end of SFY Q2 and met early SFY Q3.
- HHSC analysts provided data-related technical assistance as requested by TAMU.

The table below lists evaluation-related deliverables. There are no anticipated barriers at this time.

Type of Evaluation Deliverable	Due Date	State Notes or Comments	Description of Any Anticipated Issues
Procurement of Independent External Evaluator	9/1/2019	*The contract with TAMU has been executed and initial funds dispersed.*	*No issues anticipated at this time*
Interim Evaluation Report	9/30/2021 *(or upon application for renewal)*	*TAMU is not able to generate a balanced comparison group for DSRIP claims analysis; alternate analytic strategies are being explored.*	*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*

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.

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 from DY1-6 to DY7-10. DSRIP providers report on required categories at the provider system level, rather than the project level. Regional Healthcare Partnerships (RHP) updated their RHP Plans during Q1, which HHSC reviewed and approved. This included providers updating their outcome measures and activities for reporting during DY9-10.

Providers continued to report performance achievement of DY7 Category C measures in Q1. In total for October DY8 reporting and based on available Intergovernmental Transfer (IGT), $568,078,913 was paid for DSRIP in January 2020, for a total of $16.9 billion in DY1-8 DSRIP payments to date. DSRIP continues to provide technical assistance to correct reported baselines and performance. ***Attachment W*** includes reported achievement and payments by Category and anchor reporting of DY8 progress. ***Attachment X*** includes DSRIP providers' overall status for October DY8 reporting. ***Attachment Y*** provides estimated remaining payments for DY7-8.

DSRIP Transition Plan Update

As required, HHSC submitted its Transition Plan to CMS by October 1, 2019, and submitted revisions to CMS on February 20, 2020. While the plan has not yet received final approval due to COVID-19 response priorities, HHSC continues to work toward milestone deliverables. To help Texas sustain DSRIP successes HHSC is undertaking comprehensive analyses of populations served by DSRIP and interventions associated with improvements in health outcomes within focus areas of the Transition Plan. HHSC has engaged stakeholders and invited input through a number of surveys around telehealth, advancing value-based payments, the regional healthcare partnership structure of the program, and quality improvement cost guidelines. HHSC created a Best Practices Workgroup of current DSRIP stakeholders to inform transition work through additional data support and expertise. HHSC has held two quarterly partner engagement meetings and monthly updates to keep all interested stakeholders informed on the transition progress. In response to the COVID-19 pandemic, HHSC has requested exceptions from CMS on specific waiver requirements.

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 provided an update on the post-award public forum in the previous semi-annual report.

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 (SFY20). The attachment includes annual and quarterly Dental, STAR, STAR Kids and STAR+PLUS enrollment 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.
J: MCO Pharmacy Geomapping Summary
Attachment L - Enrollment Broker Summary Report. The attachment provides a summary of outreach and other initiatives to ensure access to care.
Attachments M1-M4 - Hotline Summaries. The attachments provide data regarding phone calls and performance standards of MCO and DMO Member and Provider Hotlines.
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 2019). The attachments are summaries of the MCOs' claims adjudication results.
Attachment W – DSRIP Reporting Data. Includes reported achievement and payments by Category and anchor reporting of DY progress.
Attachment X - DSRIP Provider Summary.
Attachment Y - DSRIP Remaining Payments. Reported biannually after DSRIP payments are distributed.