1115 Waiver: Texas Healthcare Transformation and Quality Improvement Program Monitoring Report

As Required by
Special Terms and Conditions
74 and 42 CFR § 431.428

Texas Health and Human Services Commission
Q3 Report
August 2024

TEXAS
Health and Human Services

Table of Contents

List of Figures

List of Tables

1. Preface

Table 1. Texas 1115 Transformation Waiver Key Dates, Goals, and Objectives

State	Texas Health and Human Services Commission
Demonstration Name	Texas Healthcare Transformation and Quality Improvement Program - "1115 Transformation Waiver"
Approval Dates	Initial approval date: December 12, 2011 15-Month Extension approval date: May 2, 2016 Renewal approval date: December 13, 2017 Extension approval date: January 15, 2021
Approval Period	December 13, 2017-September 30, 2022 (prior approval period) January 15, 2021-September 30, 2030
Demonstration Goals and Objectives	The Texas Healthcare Transformation and Quality Improvement Program Section 1115 Waiver enables the State to expand the 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.

2. Executive Summary

According to the Special Terms and Conditions (STCs) of the 1115 Transformation Waiver Demonstration, the Texas Health and Human Services Commission (HHSC) provides the quarter three monitoring report for Demonstration Year (DY) 13, which began October 1, 2023.[1] Pursuant to 42 CFR § 431.428, HHSC provides this quarterly report to demonstrate how the goals and objectives were met as Texas Medicaid served over 4.1 million Medicaid beneficiaries through risk-based Medicaid managed care authorized under this waiver while finalizing the transition from the Delivery System Reform Incentive Payment (DSRIP) pool to integrated directed payment programs (DPPs), continuing the Uncompensated Care pool, and launching the Public Health Provider Charity Care Program.

Growth in Caseload

As of June 2024, Texas had over 4.1 million full benefit clients in Medicaid.[2] Prior to the federal public health emergency (PHE) due to the novel coronavirus (COVID-19), full benefit caseloads were under 4 million and experiencing overall declines due to sustained positive economic conditions and record low unemployment levels.

Medicaid Managed Care Enrollment

In the beginning of state fiscal year 2024, HHSC contracted with 16 managed care organizations (MCOs) and 3 dental maintenance organizations (DMOs). Effective January 1, 2024, Amerigroup was renamed Wellpoint and HHSC continues to incorporate the name change in deliverables received for state fiscal year 2024 quarter three. Each MCO covers one or more of the service delivery areas (SDAs), while each dental plan provides statewide services (See ***Attachment A***).

Approximately 97 percent of Texas Medicaid beneficiaries are enrolled in Medicaid managed care (MMC). The federal COVID-19 PHE continuous Medicaid coverage requirement has had the largest impact on the STAR program, which serves parent/caretakers, pregnant women, and children. The STAR+PLUS and STAR Kids programs have not experienced the same degree of impact. These programs include members with special health care needs (MSHCN) who are managed care clients either requiring regular, ongoing therapeutic intervention and evaluation, or with serious, ongoing illness, or a disability that may last for a significant period of time, resulting in longer lengths of stay in Medicaid.

[1] Demonstration Year 13 includes work that is tied to the state fiscal year as well.

[2] Enrollment data includes full-benefit Medicaid clients only. Data are final through December 2023. Data between January 2024 and June 2024 are preliminary with completion factors applied and are subject to change. The monthly data reported to CMS for the required Medicaid and CHIP Consolidated Appropriations Act Reporting Metrics do not encompass the same time period and will therefore differ.

Initiatives

During quarter three of federal fiscal year 2024, HHSC continued to operate the DPPs developed as part of the DSRIP Transition Plan.

COVID-19 Public Health Emergency

In response to the federal COVID-19 PHE and financial strains impacting the Texas health care system, HHSC submitted an extension application in November 2020. HHSC and the Centers for Medicare & Medicaid Services (CMS) worked together to negotiate and agree to updated terms. HHSC received approval on January 15, 2021. This was a key achievement and created financial certainty and security for Texas Medicaid, Medicaid MCOs, and the network of contracted providers actively responding to the PHE. The federal COVID-19 PHE continues to be a key challenge impacting the 1115 Transformation Waiver. It significantly impacted both costs and caseload.

The Consolidated Appropriations Act (CAA) of 2023 separated the continuous Medicaid coverage requirement of the Families First Coronavirus Response Act from the federal COVID-19 PHE declaration. HHSC started Medicaid redeterminations in April 2023 and completed all redeterminations by May 2024 in alignment with HHSC's federally approved End of Continuous Medicaid Coverage Mitigation Plan. HHSC reviewed all flexibilities implemented to address needs identified during the federal COVID-19 PHE to determine which flexibilities to end and which flexibilities to make permanent in compliance with federal requirements, including completing the process to implement administrative rule changes allowing remote delivery of services when clinically appropriate. HHSC published final notices regarding the federal COVID-19 flexibilities in advance of the federal COVID-19 PHE ending on May 11, 2023.

This report discusses in more detail the highlights included in this summary section. Due to data lags associated with primary sources of record, corresponding data submission timelines, and data cleaning procedures, each data attachment referred to and submitted to CMS reflects varying reporting periods. Certain numbers in this report have been rounded up or down and may not add up precisely to the totals provided; percentages may also not precisely reflect the absolute figures.

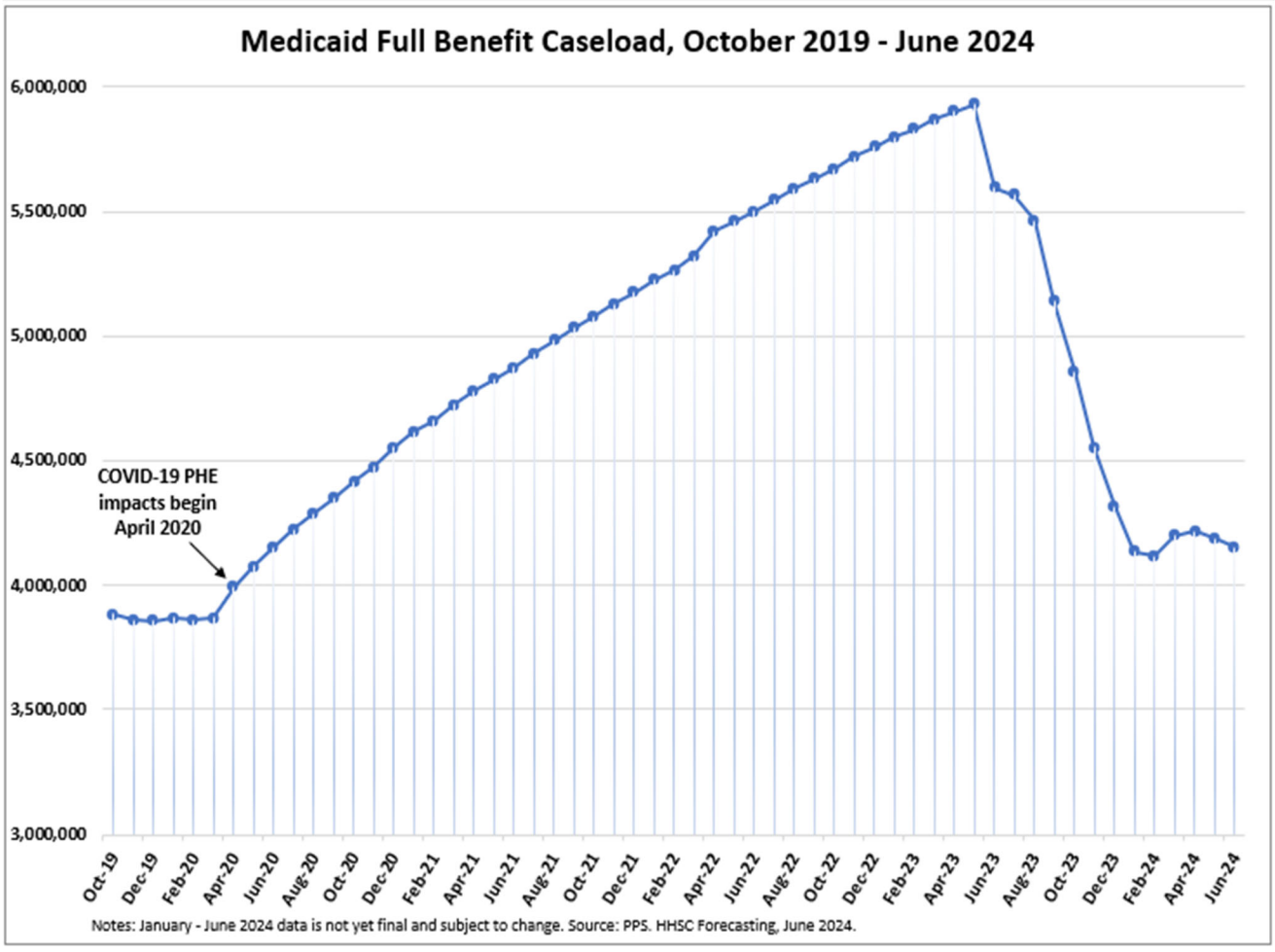
3. Enrollment

This section addresses trends and issues related to the 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.

The graph below provides a visual look at the overall Medicaid caseload growth experienced during the federal COVID-19 PHE. Growth began in April 2020 and increased by over 2 million clients while disenrollment from Medicaid was suspended.

Caseload growth began to decline in June 2023 once HHSC was federally required to resume Medicaid eligibility determinations which resulted in disenrollment for members determined ineligible. However, enrollment remains higher than the pre-PHE level by over 200 thousand clients.

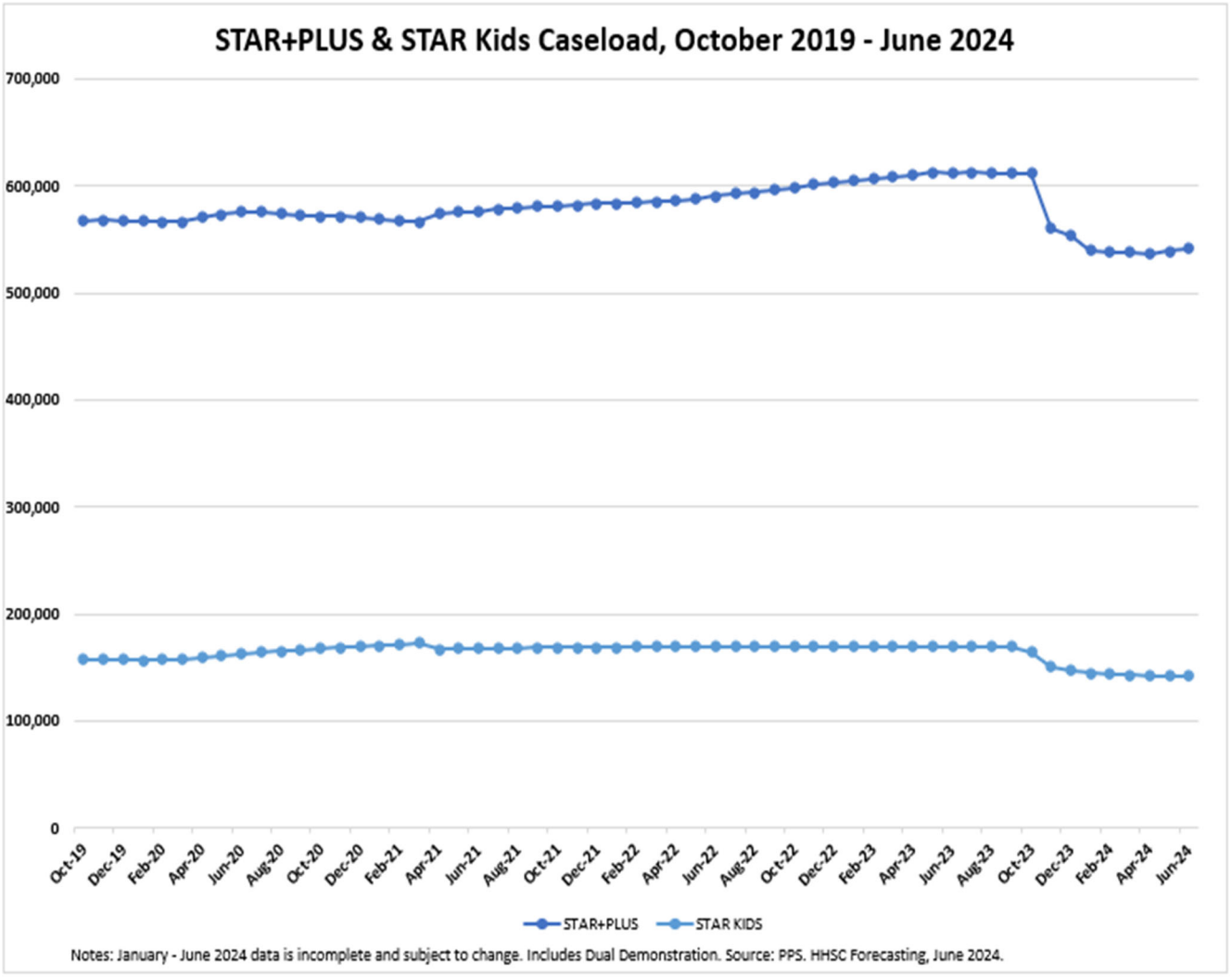
Figure 1. Medicaid Full Benefit Caseload, October 2019 - June 2024



Note: Data in the figure above includes full-benefit Medicaid clients only. Data are final through December 2023. Data between January 2024 and June 2024 are preliminary with completion factors applied and are subject to change. The monthly data reported to CMS for the required Medicaid and CHIP CAA Reporting Metrics do not encompass the same time period and will therefore differ.

The graph below illustrates the impact to the STAR Kids and STAR+PLUS programs. The STAR Kids program provides acute and long-term services and supports to children with disabilities, and the STAR+PLUS program provides these services and supports to older adults and adults with disabilities. More than 96 percent of the growth in managed care during the federal COVID-19 PHE was attributed to the STAR program, while disability-related managed care programs experienced minimal impact.

Figure 2. STAR+PLUS & STAR Kids Caseload, October 2019 - June 2024



Note: STAR+PLUS is notated in darker blue at the top of the above graph.

In ***Attachment B1***, an enrollment summary is broken out by product line, SDA, and MCO for state fiscal year 2024 quarter two to show where caseloads are headed. Due to the amount of time required for accurate data collection and reporting, total enrollment counts are reported on a one-quarter lag. ***Attachment B2*** includes Medicaid Enrollment Reports from September 2023 through November 2023. These reports include enrollment by delivery model, program, risk group, Medicaid MCOs and DMOs. The data are considered final after eight months.

HHSC's enrollment broker, MAXIMUS, submits a biannual summary of unduplicated enrollments by program (*See* ***Attachment L***). ***Attachment L*** encompasses the MAXIMUS enrollment report for December 2023 through May 2024 for STAR,

STAR+PLUS, STAR Kids, and the Dental program. The STAR, STAR+PLUS, and STAR Kids Programs reported an average of 3,756,073 total enrollments per month. The Dental program reported an average of 2,933,502 total enrollments in the reporting period. The ***Attachment L*** enrollment data reflect a different point-in-time and methodology than is reported in ***Attachment B1*** and ***Attachment B2***. Similarly, ***Attachment L*** does not capture disenrollment data and will not align with the federally required monthly CMS Medicaid and CHIP CAA Reporting Metrics. Disenrollment data in alignment with the monthly CMS Medicaid and CHIP CAA Report Metrics is reported in the Member Disenrollment section of this report.

Enrollment of Members with Special Health Care Needs

This subsection of the report addresses managed care enrollment of MSHCN. All STAR Kids and STAR+PLUS members are deemed to be MSHCN, as required in the managed care contract. STAR MCOs must identify MSHCN based on criteria outlined in the managed care contract.

MCOs are required to provide service coordination to all STAR, STAR Kids and STAR+PLUS MSHCN, unless the member declines or is unable to be reached. Service coordination also includes the development of a service plan to meet the members' short and long-term goals. The definition of MSHCN is provided in ***Attachment Q***.

MCOs are contractually required to submit a monthly MSHCN Service Coordination Report using an HHSC prescribed template (See ***Attachment Q***). The Service Coordination Report includes data on service coordination across all managed care programs by SDA and MCO, including contact attempts, reasons members declined service coordination, and the date the service plan was last updated. Because of the time required for data collection, this data is reported for the last month in the previous quarter. HHSC identified an error in previous submissions of ***Attachment Q*** that resulted in inaccurate counts of the number of members declining service plans. The corrected data was analyzed, and it was determined approximately one percent fewer members declined service plans. No other data elements in ***Attachment Q*** were affected by this error.

In February 2024, state fiscal year 2024 quarter two, STAR MCOs reported 120,156 children and adults identified as MSHCN. STAR Kids MCOs reported 143,615 children and STAR+PLUS MCOs reported 486,190 adults as MSHCN. STAR MCOs reported 16 percent of MSHCN had a service plan, while STAR Kids and STAR+PLUS reported 49 percent and 55 percent of members had a service plan, respectively (See ***Attachment Q***). The number of members without service plans includes members who declined, could not be reached, or located, died during the report period, moved out of the service area or state, and who had a service plan in development.

When comparing February 2024 to previous months, the overall percentage of MSHCN with service plans has remained consistent across all programs.

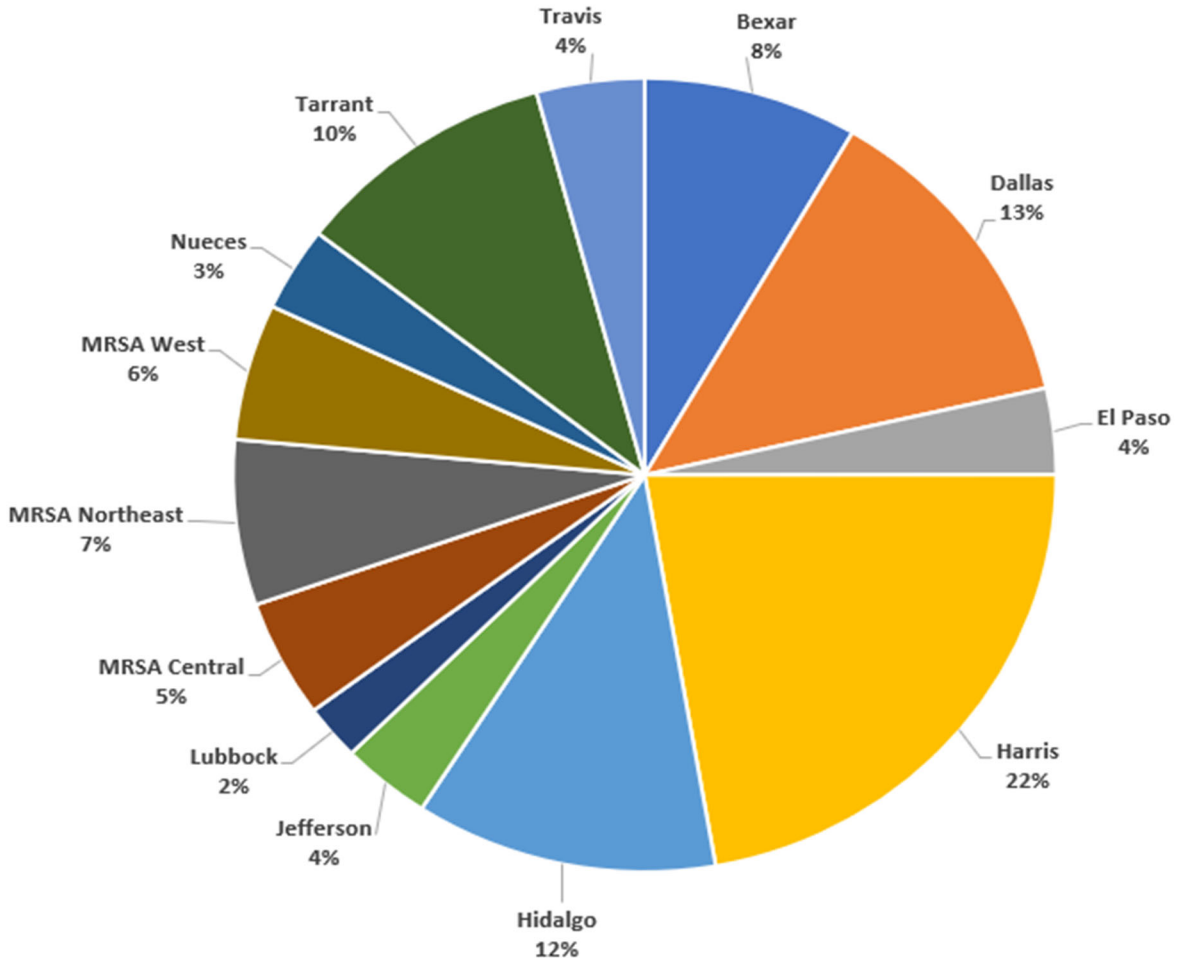
Service coordination is an integral service for members with complex care needs. HHSC is analyzing Service Coordination Report data to identify barriers to the provision of service coordination and evaluating policy to ensure members are informed of and have access to necessary service support. HHSC reviews each Service Coordination Report submission to assess reporting errors and conducts targeted technical assistance and intervention with MCOs.

HHSC also conducts biennial operational reviews of MCOs. These operational reviews are comprised of an in-depth review of MCO operational compliance and performance across several areas, such as service coordination and service planning. This process is employed to ensure policies and practices align with performance standards, including managed care contract requirements. If any problems are discovered during the operational reviews, HHSC takes steps to address performance and compliance.

Table 2. MSHCN Members with a Service Plan by Program for February 2024

Program	Total MSHCN for Feb. 2024	Total MSHCN with a Service Plan	Percentage of Total MSCHN with a Service Plan
STAR	120,156	19,360	16%
STAR Kids	143,615	70,778	49%
STAR+PLUS	486,190	268,149	55%
Grand Total	**749,961**	**358,287**	**48%**

Figure 3. Total STAR, STAR Kids, and STAR+PLUS MSHCN by SDA for February 2024



Anticipated Changes to Enrollment

On January 27, 2020, the Secretary of Health and Human Services declared a federal PHE due to COVID-19. In March 2020, Governor Greg Abbott declared a disaster in Texas due to the COVID-19 pandemic. Additionally, the federal law passed in March 2020, H.R. 6201 (Families First Coronavirus Response Act), required states to maintain continuous Medicaid coverage during the federal COVID-19 PHE period as a condition of receiving enhanced federal funding.

On December 29, 2022, Congress passed the 2023 CAA which separated the continuous coverage requirement from the PHE declaration.

- The continuous Medicaid coverage requirement ended as of March 31, 2023.
- On April 1, 2023, HHSC began disenrolling members who were no longer eligible after receiving a Medicaid eligibility redetermination.

HHSC completed its 12-month unwinding effort. The unwinding period began in April 2023 with a phased eligibility review of Texans receiving Medicaid, focusing first on those least likely to still be eligible for Medicaid. HHSC was required to conduct renewals for all Medicaid recipients within 12 months of when the state began its unwinding period. HHSC redetermined the eligibility of Texans receiving Medicaid, in alignment with HHSC's federally approved End of Continuous Medicaid Coverage Mitigation Plan.

To address potential strain on the eligibility system during the unwinding period, HHSC identified multiple strategies aimed at increasing workforce capacity and/or reducing workload on eligibility workers. HHSC also engaged with providers, MCOs, and advocates to support members during this process by providing key messages that aimed to reduce member confusion and increase the likelihood of eligible members maintaining coverage.

Additionally, to address the needs of providers and members participating in Medicaid, HHSC implemented policy and process flexibilities during the federal COVID-19 PHE related to services, provider enrollment, and assessments. HHSC reviewed flexibilities implemented to address needs identified during the PHE and determined which flexibilities to end and which flexibilities to make permanent in compliance with federal requirements. HHSC published final notices regarding the COVID-19 flexibilities that ended on May 11, 2023, when the federal COVID-19 PHE ended, and the related provider and member notification requirements.

The Quarterly 1115 Transformation Waiver Monitoring Report and the monthly CMS Medicaid and CHIP CAA Reporting Metrics do not encompass the same time period, and thus will not reflect the same data. In alignment with CMS requirements, the monthly Unwinding Data Report reports on outcomes for the total beneficiaries due for a renewal in the reporting period (the previous month). This is defined as the total number of beneficiaries, including those receiving full or limited benefits, with an annual renewal due in the reporting period. The Quarterly 1115 Transformation Waiver Monitoring Report enrollment data includes a combination of final data, preliminary data for the past two quarters, and the most recent forecasting data for the month being reported, and only includes data for full beneficiaries.

Member Disenrollment

In alignment with CMS requirements, the monthly CMS Medicaid and CHIP CAA Reporting Metrics report details the total number of beneficiaries due for a renewal in the reporting period (the previous month). A member eligible for redetermination

is defined as a beneficiary, receiving full or limited benefits, with an annual renewal due in the reporting period. Between April 1, 2023, and April 10, 2024, 2,102,396 Medicaid and CHIP beneficiaries have been disenrolled.[3]

[3] This number reflects disenrollments for any Medicaid renewals initiated between April 1, 2023, and April 10, 2024. While the data source is the same as the monthly CMS Medicaid and CHIP CAA Reporting Metrics, the number of reported disenrollments also includes pending renewals completed after the monthly reporting period.

4. Provider Network & Network Adequacy

To ensure the availability and accessibility of services in a timely manner, MCOs are required to meet network adequacy standards for time and distance. These vary by provider type and county designation (metro, micro, rural). MCOs must ensure at least 90 percent of members, unless otherwise specified, have access to a choice of each provider type in each SDA within prescribed travel time and distance standards. The provider types include primary care providers (PCPs), as well as dentists and specialty services. The required distance and travel time standards vary by provider and county designation (see ***Attachment E*** and ***Attachments H1-H4)***.

Attachment H1 provides an analysis of the percentage of each MCO's members with at least two PCPs within the maximum distance from the member's residence (based on Medicaid enrollment files) by program and county designation (metro, micro, rural) within the time or distance standard of 90 percent. During state fiscal year 2024 quarter three, all MCOs met or exceeded the 90 percent standard for members' access to PCPs. Similarly, MCOs are required to maintain an adequate network of specialty providers such that 90 percent of members have access to at least two providers within the time and distance standard for the specialty provider type.

HHSC has established network adequacy standards for the following provider types and specialties: acute care hospital; audiologist; behavioral health outpatient; cardiovascular disease; ear, nose, and throat; Mental Health Targeted Case Management and Mental Health Rehabilitative Services; general surgeon; nursing facility; obstetrics and gynecology (OB/GYN); ophthalmologist; orthopedist; pediatric sub-specialty; prenatal care; substance use disorder (SUD) chemical dependency treatment; SUD opioid treatment; therapy (occupational, physical, and speech); psychiatrist; pharmacy; and urologist (see ***Attachment H2***).

Attachment H2 presents the detailed specialty provider analysis by program and county designation (metro, micro, rural). During state fiscal year 2024 quarter three and across all Medicaid managed care programs, MCOs met or exceeded the 90 percent standard for members' access to specialty providers for Behavioral Health-Outpatient, Nursing Facility, OB/GYN, Pediatric Sub-specialty and Therapy (occupational, physical, and speech). For the other specialty provider types, MCOs did not consistently meet network access standards during state fiscal year 2024 quarter three. The MCOs' performance is being reviewed for further actions. The evaluation of network adequacy compliance occurs at the county, provider specialty, and MCO program level. It is possible for an MCO's overall average compliance rate to be high yet still be below 90 percent in one or more counties. The table below includes the count of MCOs that did not meet the 90 percent overall average compliance rate in one or more counties.

Figure 4. Specialty Providers MCO Network Adequacy Summary for SFY2024 Q3

Type of Specialist	Program	Number of MCOs that did not meet the standard in a county		
		Metro County	Micro County	Rural County
Acute Care Hospital	STAR	2	6	14
	STAR+PLUS	0	3	4
	STAR Kids	0	4	6
Audiologist	STAR	5	7	7
	STAR+PLUS	1	4	3
	STAR Kids	3	5	5
Behavioral Health – Outpatient	STAR	0	0	0
	STAR+PLUS	0	0	0
	STAR Kids	0	0	0
Cardiovascular Disease	STAR	1	1	0
	STAR+PLUS	0	0	0
	STAR Kids	1	0	0
ENT (Otolaryngology)	STAR	0	2	1
	STAR+PLUS	0	1	0
	STAR Kids	0	2	2
General Surgeon	STAR	0	1	0
	STAR+PLUS	0	0	0
	STAR Kids	1	0	0
Mental Health Targeted Case Management (TCM) and Mental Health Rehabilitative Services (MHR)	STAR	9	14	8
	STAR+PLUS	4	4	4
	STAR Kids	5	9	5
Nursing Facility	STAR+PLUS	0	0	0
OB/GYN	STAR	0	0	0
	STAR+PLUS	0	0	0
	STAR Kids	0	0	0
Ophthalmologist	STAR	3	2	1
	STAR+PLUS	0	1	0
	STAR Kids	1	3	0
Orthopedist	STAR	0	3	0
	STAR+PLUS	0	1	1

	STAR Kids	0	3	0
Pediatric Sub-Specialty (*The standard requires access to one provider*)	STAR	0	0	0
	STAR Kids	0	0	0
Pharmacy	STAR	14	13	3
	STAR+PLUS	4	4	2
	STAR Kids	7	8	1
Prenatal	STAR	0	0	2
	STAR+PLUS	0	0	0
	STAR Kids	0	1	0
Psychiatrist	STAR	2	2	3
	STAR+PLUS	0	1	1
	STAR Kids	1	2	1
SUD Chemical Dependency Treatment	STAR	5	11	3
	STAR+PLUS	2	4	2
	STAR Kids	3	7	3
SUD Opioid Treatment	STAR	15	14	14
	STAR+PLUS	4	4	4
	STAR Kids	8	9	6
Therapy (Occupational, Physical, and Speech)	STAR	0	0	0
	STAR+PLUS	0	0	0
	STAR Kids	0	0	0
Urologist	STAR	1	3	1
	STAR+PLUS	0	0	1
	STAR Kids	0	3	2

Note: ***Attachment H2*** for detailed data tables for each MCO.

Attachment H3 provides dentist network analysis by DMO and county designation. During state fiscal year 2024 quarter three, all DMOs met the network access standard of 95 percent for Main Dentist in all county types.

Attachment H4 provides dental specialty network analysis by provider type and county designation. The DMOs did not consistently meet network access standards of 90 percent for dental specialty provider types during state fiscal year 2024 quarter three. The DMOs' performance is being reviewed for further actions.

Figure 5. DMO Network Adequacy Summary for SFY2024 Q3

Provider Type	DMO	Number of DMOs that did not meet the standard in a county*

		Metro County	Micro County	Rural County
Main Dentist	DentaQuest	0	0	0
	MCNA Dental	0	0	0
	United HealthCare Dental	0	0	0
Endodontist	DentaQuest	0	0	0
	MCNA Dental	1	1	1
	United HealthCare Dental	1	1	1
Oral Surgeon	DentaQuest	0	1	1
	MCNA Dental	0	0	0
	United HealthCare Dental	0	1	1
Orthodontist	DentaQuest	0	0	0
	MCNA Dental	0	1	1
	United HealthCare Dental	0	1	1
Pediatric Dentist	DentaQuest	0	0	0
	MCNA Dental	0	0	0
	United HealthCare Dental	0	1	0

Note: See ***Attachments H3 and H4*** for detailed data tables for each DMO.

*HHSC may grant an exception during the corrective action process.

In addition to monitoring network adequacy performance of the MCOs related to primary and specialty care, HHSC continues to enhance efforts to monitor long-term services and supports (LTSS), in particular, community attendant care. As part of the implementation of the Community Attendant Workforce Development Strategic Plan, required by the 2020-21 General Appropriations Act (GAA), House Bill (H.B.) 1, 86th Texas Legislature, Regular Session, 2019 (Article II, HHSC, Rider 157), HHSC is enhancing provider network adequacy standards for Medicaid MCOs to ensure members have sufficient access to community care attendants.

HHSC requires MCOs to ensure that a minimum of 90 percent of their members have timely access to community attendant care services upon authorization of services. Timeliness is defined as within seven days from the authorization. Following an analysis of MCO data received over several reporting periods, HHSC identified the need for a different solution to ensure the agency fully adheres with

both current and future requirements.[4] These solutions will require quality improvements to prior authorization data, improved connections to claims systems, and ongoing technical training and assistance for MCOs.

MCO Pharmacy Geo-mapping Summary

This update will be provided in the next annual report.

Managed Care Provider Network

This subsection includes quarterly health care 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***. Because of the time required for data collection, health care provider counts per quarter are reported on a one-quarter lag.

As compared to the previous quarter, the unique number of credentialed PCPs and specialists reported modest increases of 1.66 percent and .60 percent, respectively. Additionally, across the dental program statewide, the DMOs reported an increase of .28 percent. However, pharmacists reported a slight decline of .79 percent, with a reduction of 40 pharmacists.

Provider Termination

Attachment C3 details the data reported by the MCOs regarding the number of PCPs and specialists terminated in state fiscal year 2024 quarter two. The MCOs reported a variety of reasons for termination. For state fiscal year 2024 quarter two, the top three reasons for PCP and specialist terminations were: the provider left group practice (5,111), termination was requested by the provider (1,319), and other (3,308). Because of the time required for data collection, provider termination counts per quarter are reported on a one-quarter lag.

Compared to previous quarters, MCOs reported a significant increase in the number of provider terminations categorized as other. The total percentage increase from state fiscal year 2024 quarter one (689) to state fiscal year 2024 quarter two (3,308) is approximately 380 percent. However, the increase is limited to one MCO. Wellpoint reported 3,171 of the 3,308 total terminations categorized as other, representing 687 percent increase. Wellpoint's provider terminations did not create an insufficient provider network as the increase may represent duplicate providers across the programs. HHSC will continue to review provider terminations.

[4] In accordance with the Centers for Medicare & Medicaid Services, Department of Health and Human Services, Ensuring Access to Medicaid Services (CMS-2442-F) Final Rule, 89 Fed. Reg. 4052 (May 10, 2024).

MCO and DMO Network Adequacy Standard Exceptions

Chapter 531, Texas Government Code, Section 531.0216, requires HHSC, to the extent feasible, consider and include the availability of telehealth services and telemedicine medical services within the provider network of a Medicaid MCO. HHSC revised the existing process for the Network Performance Reports, that incorporates a way to consider MCO teleservices in Medicaid provider access standards prior to a Corrective Action Plan (CAP) being issued to MCOs. MCOs that are non-compliant with time or distance requirements can submit an action plan that informs HHSC of how they are ensuring access to care using teleservices. A formal CAP will be requested if the MCO's plan is insufficient. The MCO must ensure continuity of care.

As a part of HHSC's process, MCOs and DMOs may submit an exception request for areas of non-compliance using the network adequacy corrective action process. HHSC approves or denies the exception request based on the review of supporting information that demonstrates an MCO's provider contracting efforts and assurances 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; guidance and a list of network providers offering telehealth and telemedicine services; guidance on how to access care outside of the area; guidance on how to contact member services and the member hotline; guidance on what to do in case of an emergency; and guidance on how to access non-emergent medical transportation and the MCOs' transportation value-added service, if available. The MCO must ensure continuity of care.

If an exception request is denied, the MCO is subject to remedies such as a CAP or liquidated damages (LDs).

Hotline Performance

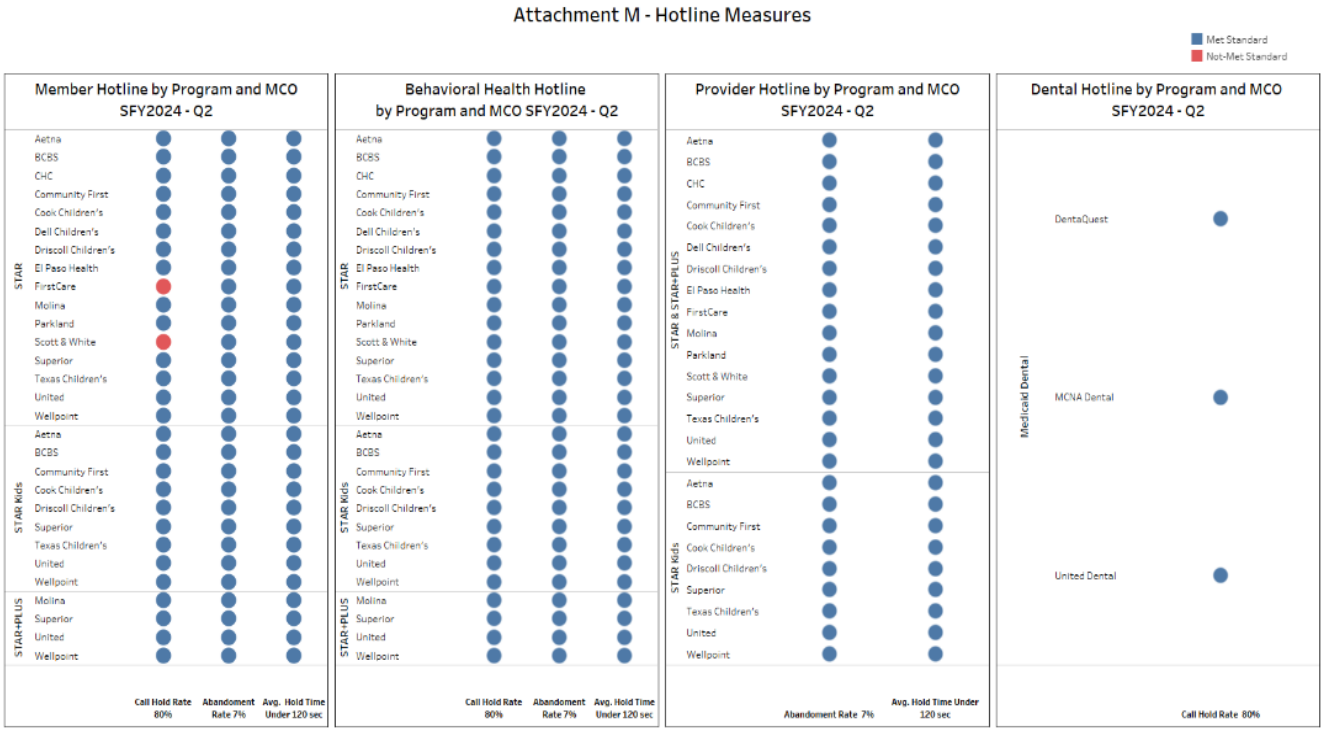
The MCOs and DMOs must have toll-free member and behavioral health hotlines (behavioral health hotline not applicable to DMOs), that members can call 24 hours a day, 7 days a week. The MCOs and DMOs must also have a toll-free provider hotline that is available for provider inquiries from 8:00 a.m.–5:00 p.m. local time for the Service Area, Monday through Friday, except for State-approved holidays. The performance standards for these member and provider hotlines are listed below:

- 80 percent of all calls answered by a live person within 30 seconds (not applicable for provider hotlines)
- ≤ 7 percent call abandonment rate
- ≤ 2 minutes average hold time

Included in ***Attachment M1-M4*** is data from state fiscal year 2024 quarter two. Because of the time required for data collection, hotline data are reported on a one-

quarter lag. A summary of findings using aggregated MCO self-reported data is reported below.

Figure 6. Hotline Performance SFY24 Quarter 2



All MCOs met all the Hotline contractual standards for state fiscal year 2024 quarter two except for two in STAR. FirstCare (78 percent) and Scott & White (77 percent) did not meet the Member Hotline 80 percent standard for calls answered by a live person within 30 seconds. These instances of non-compliance have been addressed by HHSC. MCOs not meeting compliance are reviewed quarterly for contractual remedies that include but are not limited to CAPs and LD assessments.

Provider Open Panel

MCOs submit provider files identifying the number of PCPs and main dentists who are accepting new Medicaid patients, which are described as "open panel" PCPs and "open practice" dentists. HHSC monitors PCPs with "open panel" at an 80 percent benchmark.

Quarterly health care provider counts are reported on a one-quarter lag. In state fiscal year 2024 quarter two, all MCOs and DMOs met the "open panel" 80 percent benchmark, except Community First (79 percent), Cook Children's (64 percent), and Molina (79 percent) in STAR; Cook Children's (65 percent) in STAR Kids; and

Molina (79 percent) in STAR+PLUS. HHSC is monitoring on an ongoing basis and has not identified access to care concerns, issues, or complaints with these MCOs.

Appointment Availability

Texas Government Code, §533.007[5], as amended by Senate Bill 760, 84th Texas Legislature, Regular Session, 2015, directs HHSC to establish and implement a process for direct monitoring of MCO provider networks, including the length of time a recipient must wait between scheduling an appointment with a provider and receiving treatment from the provider.

In federal fiscal year quarter three of 2024, the PCP study was conducted for STAR Child, STAR Adult, STAR+PLUS, and STAR Kids. The PCP study standard requires that a primary care appointment is made within specified timelines. The wait time standards per type of primary care are in the table below.

Figure 7. Primary Care Provider Wait Time Standards per Type of Care

Type of Care	Standard
Preventive health services for new child members	Within ninety (90) calendar days of enrollment
Preventive health services for adults	Within ninety (90) calendar days
Routine primary care (child and adult)	Within fourteen (14) calendar days
Urgent care (child and adult)	Within twenty-four (24) hours

Table 3 Percentage of Providers that Met the Uniform Managed Care Contract Appointment Availability Standards

Program	Standard	2024 Program Compliance
STAR Adult	Preventive	98.8%
	Routine	99.0%
	Urgent	100.%
STAR Child	Preventive	99.6%
	Routine	98.0%
	Urgent	100%
STAR+PLUS	Preventive	97.3%
	Routine	91.2%

[5] MCOs that do not meet minimum performance thresholds are subject to contract remedies, including CAPs and LDs.

	Urgent	100%
STAR Kids	Preventive	98.7%
	Routine	99.3%
	Urgent	100%

Accessibility and Language Compliance

MCOs submit provider language and accessibility survey results by program and SDA on an annual basis. Deliverables for state fiscal year 2023 are due from MCOs in December 2024, and will be summarized in the state fiscal year 2025 quarter one report.

HHSC requires MCOs to make best efforts to ensure that PCPs are accessible 24/7 and outlines specific criteria for what constitute compliance with the managed care contracts. For example, providers must offer after-hours telephone availability through an answering service; recorded messages with contact information for an on-call PCP; or call forwarding routing the caller to the on-call PCP or an alternate provider.

Each MCO is also required to systematically and regularly verify that covered services furnished by PCPs meet the 24/7 access criteria and enforce access standards in non-compliance. MCOs survey providers on a quarterly, semiannual, or annual basis to assess compliance for 24/7 and after-hours provider accessibility. MCOs utilize methods including computer-assisted telephone interviews, telephone surveys (non-computerized), mailed surveys, monthly secret shopper calls and face-to-face provider visits to measure provider accessibility compliance with the HHSC contractual standards.

Provider compliance rates for 24/7 accessibility ranged from 30 percent to 100 percent. Providers who are not in compliance with 24/7 accessibility standards receive phone calls or letters from the MCOs detailing the requirements and are subject to remediation methods including mailed provider re-education letters regarding the managed care contractual standards; follow-up surveys; face-to-face re-education (e.g., evaluating, and coaching provider staff, and training); and unscheduled calls to providers to reassess compliance. MCOs employ contractual remedies for the provider until compliance is achieved or the provider contract is terminated.

Service Utilization

This update will be provided in the next annual report.

Out-of-Network Utilization

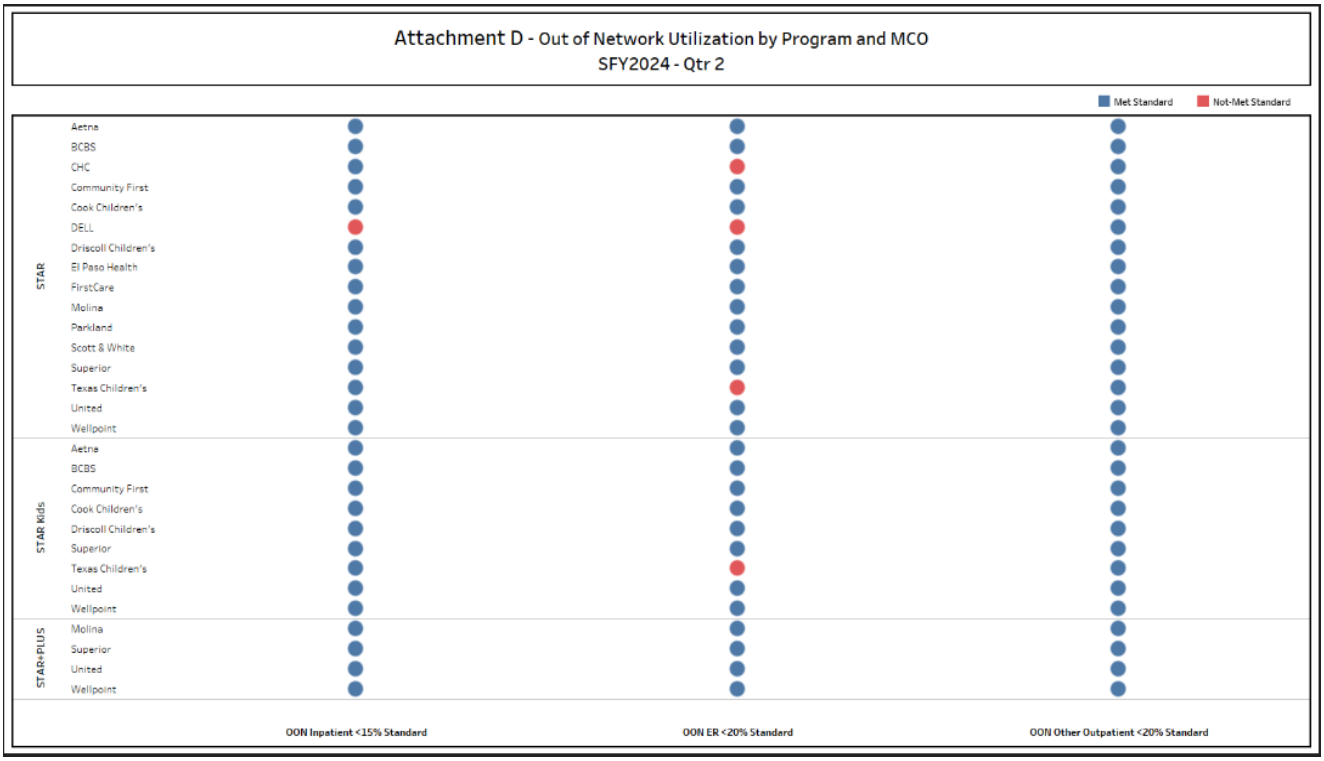
MCOs are required to submit the Out-of-Network (OON) Utilization Report for each SDA in which the MCO operates. In each SDA, the OON utilization should not exceed the following standards:

- 15 percent of inpatient hospital admissions.
- 20 percent of emergency room (ER) visits.
- 20 percent 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 why the MCO was unsuccessful in provider contracting efforts. If approved, the MCO submits a recalculated OON Utilization Report, excluding the utilization of the aforementioned provider(s). If the recalculation does not bring the MCO into compliance, the MCO remains non-compliant and is subject to contract action such as assessing LDs or implementing a CAP.

Attachment D provides the OON utilization performance summary for state fiscal year 2024 quarter two. Because of the time required for data collection, OON utilization counts are reported on a one-quarter lag. A summary of findings using aggregated data from MCOs in ***Attachment D*** is reported in the figure below. HHSC will continue to monitor OON utilization and will require corrective action or other remedies as appropriate.

Figure 8. Out of Network Utilization SFY24 Quarter 2



All MCOs except three met OON utilization standards in state fiscal year 2024 quarter two. Below is a list of MCOs who initially did not meet standards or who continue to be non-compliant.

- The standard for inpatient hospital admissions (STAR) is 15 percent.
  - Dell measured at 33.29 percent in quarter two.
  - Dell submitted an approved SERT with a recalculated inpatient hospital admission of 9 percent, thereby bringing Dell into compliance.

- The standard for ER visits (STAR) is 20 percent.
  - CHS measured at 29.27 percent. CHC did not submit an approved SERT.
  - Dell measured at 42.76 percent. Dell submitted an approved SERT, which resulted in a recalculated ER visit utilization of 14 percent that brought Dell into compliance.
  - Texas Children's measured at 34.06 percent. Texas Children's submitted a SERT. However, Texas Children's recalculated utilization of 24.3 percent exceeds the 20 percent standard.

- The standard for ER visits (STAR Kids) is 20 percent.

- Texas Children's measured at 27.42 percent. Texas Children's SERT resulted in a recalculation of 21.5 percent, which still exceeds the standard.

Oversight of MCOs and DMOs

HHSC staff routinely evaluate, and compile data reported by the MCOs and DMOs. All instances of non-compliance have been, or are being, addressed by HHSC. If an MCO or DMO fails to meet performance standards or other contract requirements such as accurate and timely submission of deliverables, HHSC uses a variety of remedies, including:

1. Developing CAPs.
2. Assessing monetary damages (actual, consequential, direct, indirect, special, or liquidated).

The information reflected in this report represents the most current information available at the time it was compiled. The remedies process between HHSC and the MCOs and DMOs may not be complete at the time the report is submitted to CMS.

5. Waiver Amendments and Upcoming Initiatives

Waiver Amendments

The following amendments have been submitted to CMS or are in development.

Dual Demonstration Phase-Out

CMS requires states to phase-out their Dual Demonstration Medicare-Medicaid Plans (MMPs) and encourages states to convert them to integrated Medicare Advantage Duel Eligible Special Needs Plans (D-SNPs) by December 2025. HHSC has decided to end the Dual Demonstration MMPs on December 31, 2025, and transition MMPs to integrated D-SNPs by January 1, 2026. As required by the CMS Contract Year 2023 Medicare Advantage and Part D Final Rule, HHSC is implementing new Medicare-Medicaid integration features to better serve dually eligible members. HHSC submitted its preliminary Dual Demonstration transition plan to CMS on September 30, 2022, as required by the CMS Contract Year 2023 Medicare Advantage and Part D Final Rule.

Upcoming Initiatives

Compliance with Home and Community-Based Services Settings Regulations

HHSC continues efforts to comply with the federal Home and Community-Based Services (HCBS) settings regulations issued by CMS in March 2014. Compliance efforts include revising HHSC rules and policies and conducting heightened scrutiny assessments on all STAR+PLUS HCBS assisted living facility settings. HHSC revised managed care contracts to require MCOs to ensure their contracted providers comply with the HCBS settings regulations. These contract amendments became effective in September 2022. HHSC received initial approval of the Statewide Transition Plan (STP) on December 21, 2022, and resubmitted a revised STP to CMS for final approval in March 2023, following a required public comment period. HHSC received final CMS approval of the STP in July 2023.

HHSC received CMS' "site visit report" in April 2023 summarizing CMS findings from CMS's recent site visit to Texas to assess several STAR+PLUS HCBS assisted living facility settings. HHSC worked with CMS to develop a CAP to address outstanding compliance actions identified in the report. The CAP was approved by CMS in October 2023 and outlines remediation activities to be completed by September 1, 2025.

Community Attendant Workforce Development Strategic Plan

The Community Attendant Workforce Development Strategic Plan was submitted to the Texas Legislature and Governor's office pursuant to legislative direction in 2019. The plan contains strategies related to recruiting and retaining community attendants and ensuring Medicaid recipients have adequate access to services. More specifically, the plan includes information and data about the community attendant workforce in Texas; feedback collected from stakeholders during a cross-agency forum and an online survey; and HHSC's long-term goals and recommendations for addressing challenges faced by individuals receiving community attendant care, as well as providers.

HHSC is currently working to implement the strategies identified in the strategic plan and explore stakeholder recommendations. Some of these strategies that relate directly to the waiver include dedicating resources at HHSC to coordinate and support a Workforce Development Taskforce.

- HHSC identified the Office of Disability Services Coordination as the dedicated resource to launch, support, and manage a taskforce. The Direct Service Workforce Development Taskforce (DSW Taskforce), launched in March 2021, is a collaborative workgroup whose purpose is to explore long-term recruitment and retention (non-wage based) strategies, which were proposed by stakeholders, within the community attendant, personal care attendant, and direct service workforce. The DSW Taskforce provided input into the Texas Healthcare Transformation and Quality Improvement Program (THTQIP) 1115 Transformation Waiver application, HHSC's spending plan in response to the American Rescue Plan Act (ARPA) Section 9817 which provides states with a temporary 10 percent point increase to the federal medical assistance percentage for Medicaid HCBS, and the project plan to explore recruitment and retention (non-wage based) strategies. The project plan has two main goals—enhance workforce development and improve data collection—and 28 individual projects within a three state-fiscal-year project period.

- During federal fiscal year 2024 quarter three, HHSC continued to make improvements to Direct Care Careers (DCC), an optional, online portal that connects potential employees with employers delivering HCBS through the State Plan and HCBS authorities (1915(c), 1915(i), 1915(j), and 1115).

- HHSC also began finalizing a promotional toolkit to advertise DCC. HHSC held multiple meetings with stakeholders in several regions including travel in June 2024 travel to El Paso to present on DCC. HHSC also held two DSW Taskforce meetings during this time period and began submitting monthly project governance reports to HHSC Community Services leadership on both the DSW Taskforce and DCC.

Critical Incident Management System

HHSC implemented a new statewide critical incident management system (CIMS) for reporting critical incidents in 2022. The new system complies with guidance issued by CMS on March 12, 2014. The 2020-2021 GAA, H.B. 1, 86th Texas Legislature, Regular Session, 2019, appropriated funding to streamline the level of critical incident information received and to standardize the format for the new CIMS. HHSC worked diligently with FEI Systems, the CIMS vendor, to configure a platform to collect all required critical incident information across all 1915(c) and the 1115 STAR+PLUS HCBS programs. It includes information on abuse, neglect, and exploitation (ANE) allegations in addition to other non-ANE critical incidents, including deaths, ER visits, hospital admissions, medication errors, serious injuries, elopement or lost/missing person, law enforcement interventions, seclusions, and restraints. The system ensures data collection at the individual level to inform ongoing quality improvement. The implementation process required provider training by program, system testing, coordination between reporting systems, and assessments of program reporting requirements. HHSC anticipates that future implementation will include the Medically Dependent Children Program and STAR+PLUS HCBS managed care waiver programs.

HHSC continues to closely monitor all ongoing activities involved with CIMS implementation.

6. Demonstration-related Appeals and Complaints

Complaints Received by the State and MCOs

HHSC monitors complaints received by the Office of the Ombudsman Managed Care Assistance Team and HHSC Managed Care Contracts and Oversight. MCOs and DMOs are required to track and monitor the number of member complaints, appeals, and provider complaints received, to ensure resolution occurs within 30 days of receipt. A 98 percent compliance standard is required.

Attachment O[6] includes member and provider complaints data compiled from MCOs, DMOs, and HHSC. The reports in ***Attachment O*** reflect state fiscal year 2024 quarter one. Subsequent complaints data will continue to be reported on a two-quarter lag. Complaint data are displayed by the following:

- Top five most frequent types of complaints overall, separately for members and providers, by program, and by MCO and DMO
- Outcome status by program and by MCO and DMO
- Distribution of complaints and enrollment by MCO and DMO
- Overall quarterly rate of complaints by MCO and DMO, including previous six quarters (as the data becomes available)

Generally, the total number of complaints submitted is small relative to the total number of individuals enrolled in Medicaid per month. Complaint data are represented as the number of complaints per 10,000 clients (otherwise referred to as rate). Complaint volumes may vary based on MCO and DMO size, program (e.g., STAR vs STAR+PLUS), and complexity of population served.

Member Appeals

Attachment N is reported on a one-quarter lag and provides a performance summary of member appeals for state fiscal year 2024 quarter two. During state fiscal year 2024 quarter two, STAR MCOs collectively reported 2,046 member appeals resolved. STAR+PLUS MCOs reported 2,343 and STAR Kids MCOs reported 1,066 member appeals resolved. DMOs collectively reported 382 member appeals resolved.

Member appeal reports are submitted monthly. All DMOs and most MCOs met the 98 percent compliance standard for 30-day appeals resolved timely for one or more months for state fiscal year 2024 quarter two. Scott & White (96 percent) did not meet the standard in the STAR program. Last quarter, FirstCare (97 percent) and

[6] Attachment O aggregates include STAR Health data, which is not a program included in the 1115 Demonstration Waiver.

Wellpoint (94 percent) did not meet compliance. Identified instances of non-compliance are reviewed quarterly for remedies, as stated in the contract, that include but are not limited to CAPs and LD assessments.

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 provider referral details during state fiscal year 2024 quarter three. These attachments include the total number of referrals received and the allegation category.

Attachment R1 shows MCO referrals to OIG increased 43 percent in state fiscal year 2024 quarter three (from a total of 111 MCO referrals to 159 MCO referrals). DMO referrals increased from seven in state fiscal year 2024 quarter two to 19 in state fiscal year quarter three (See ***Attachment R2***). OIG implemented internal process changes in state fiscal year 2024 quarter three, which resulted in an increase in MCO provider referrals. Referral trends can fluctuate from quarter to quarter due to the impact of fraud schemes.

Claims Summary Reports

MCOs and DMOs submit monthly claims summary reports to HHSC for the following services: acute care, behavioral health, vision services, pharmacy claims, and LTSS. The standards for the clean claims and appealed claims follow:

- Appealed claims adjudicated within 30 days: > 98 percent
- Clean claims adjudicated within 30 days: > 98 percent
- Clean claims adjudicated within 90 days: > 99 percent
- Clean electronic claims adjudicated within 18 days: > 98 percent
- Clean non-electronic (paper) claims adjudicated within 21 days: > 98 percent

Claims summary counts are reported on a one-quarter lag and reflect data for state fiscal year 2024 quarter two. ***Attachment V1*** provides a claims summary for the STAR program. ***Attachment V2*** provides claims summary for the STAR+PLUS program. ***Attachment V3*** provides a claims summary for the Dental program. ***Attachment V4*** provides a claims summary for the STAR Kids program.

Fair Hearings

The Fair and Fraud Hearings Department (FFH) of the Appeals Division of HHSC receives appeal requests from applicants and clients contesting actions taken regarding benefits and services for various programs. Fair Hearings Officers conduct fair hearings and administrative disqualification hearings statewide for 171 eligibility programs within HHSC, including the waiver programs.

In the third quarter of state fiscal year 2024, FFH received 628 fair hearing requests for the programs authorized under the waiver which resulted in a slight

increase (7 percent). Last quarter, 590 hearing requests were received. Of the 628 requests in the third quarter of state fiscal year 2024, 79 were reported for the STAR program as compared to 82 last quarter, 157 for STAR Kids which was 12 percent higher than last quarter (140), and 392 for STAR+PLUS as compared to 368 last quarter. Of the 628 fair hearing requests received in the quarter, 365 decisions were pending final resolution at the end of the quarter which was 19 more than last quarter. The data for the appeal requests were from appeals sent April 1, 2024, through June 30, 2024. The data for the decisions are from decisions issued from April 1, 2024, through June 30, 2024. Although an appeal request has been sent, the appeal may not be heard and decided prior to the end of the quarter, hence the difference in data.

External Medical Review

HHSC implemented an External Medical Review (EMR) option, to be performed by an Independent Review Organization (IRO) in May 2022. The EMR is an option for a member to request further review of the MCO's adverse benefit determination. The EMR takes place between the MCO internal appeal process and the State Fair Hearings. The MCO must provide the IRO the same set of records the MCO reviewed to determine service denial or reduction. EMRs are conducted by IROs contracted with HHSC. The role of the IRO is to act as an objective arbiter and decide whether the MCO's original adverse benefit determination must be reversed or affirmed.

In the third quarter of state fiscal year 2024, HHSC received 180 EMR requests for the following Medicaid managed care programs: 32 for the STAR program, 49 for the STAR Kids program, 99 for the STAR+PLUS program. Of the 180 EMR requests, 152 MCO internal appeal decisions were upheld by the IRO, 25 MCO internal appeal decisions were overturned by the IRO, one MCO internal appeal decision was partially overturned by the IRO, and two were withdrawn by the member prior to assignment to an IRO. There was an overall increase of 18 requests (11 percent) from the previous quarter. Due to the small numbers across all MCOs, no trends or issues were identified.

7. Quality

Quality of Care

As part of all MCO's quality performance in Texas Medicaid, HHSC calculates annual and monthly quality measures and posts results on the Texas Healthcare Learning Collaborative (THLC) Portal. The Portal is at thlcportal.com. These Quality of Care (QOC) measures are the basis of many state quality improvement initiatives and used to further the state quality strategy. HHSC uses QOC measures to hold MCOs accountable for performance through the Performance Indicator Dashboard, Pay-for-Quality, Performance Improvement Projects, and Value Based Enrollment.

Final 2022 results are posted on the THLC portal. HHSC received preliminary measurement year 2023 results in May 2024 and final results are expected by fall 2024. The results provide valuable insights that HHSC uses to make informed decisions about how to enhance or adjust its quality improvement programs.

Performance Improvement Projects

On April 1, 2024, HHSC received the 2024 Performance Improvement Project (PIP) Revised Plan evaluations from the external quality review organization (EQRO). The PIP Revised plan evaluations show HHSC the extent MCOs incorporated the EQRO's feedback. The topics for MCOs include improving severe maternal morbidity outcomes among deliveries with preeclampsia, reducing the rate of uncomplicated c-sections, and improving follow-up after hospitalization for behavioral health reasons. The topic for DMOs is to increase fluoride varnish applications by collaborating with MCOs. The MCO's and DMO's interventions will be implemented from January 2024 to December 2025, with a final report due in the fall of 2026.

HHSC also received the 2020 and 2021 final PIP evaluations (except for follow-up care for children prescribed attention deficit hyperactivity disorder medication) from the EQRO on April 1, 2024. The 2020 PIP topics for MCOs include improving the rate of Follow-up After Hospital Admission for Mental Illness, improving the rate of Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM). The 2020 PIP topics for DMOs include improving the rate of the Dental Quality Alliance measure and improving the rate of Topical Fluoride for Children at Elevated Caries Risk. The results of these final PIPs will be in the EQRO's Annual Technical Report for state fiscal year 2024, posted to the HHSC website and submitted to CMS before April 30, 2025. The 2021 PIPs focused on reducing Potentially Preventable Admissions for members under the age of 21 years or improving immunizations in adolescents for MCOs and reducing dental-related Potentially Preventable Emergency Department Visits (PPVs) for DMOs.

Maternal Health

HHSC Quality Assurance is participating in a 5-Agency Maternal Health, Safety, Quality and Equity Task Force. This task force is looking to utilize a grand rounds format to improve knowledge of maternal resources. This effort will help build connections between hospitals and provider networks to ensure continuity and appropriate postpartum care post-discharge for high-risk mothers and babies.

HHSC Quality Assurance is collaborating with state partner, the Department of State Health Services (DSHS) to implement and standardize quality measurement pertaining to congenital syphilis identification and treatment. Data gathered from this effort will help provide more efficient and comprehensive care to combat a treatable sexually transmitted infection in both the maternal and child populations.

Additionally, HHSC is addressing non-medical drivers of health impacting maternal health through the implementation of House Bill 1575, 88th Texas Legislature, Regular Session, 2023. HHSC finalized the standardized questions that MCOs must use to screen all pregnant women for non-medical health-related needs, coordinate services and referrals, and share the results with HHSC. The MCO contract amendments, including the screening requirements, will be effective September 1, 2024.

Administrative Interviews

The EQRO finished their virtual site visit interviews with eight MCOs and DMOs to assess compliance with federal and state regulations. The EQRO is required to assess the MCOs and DMOs at least once in a three-year cycle and report their results in their Annual Technical Report. In addition to assessing regulatory compliance in the virtual site visits, the EQRO also asks non-regulatory questions to facilitate discussion between HHSC and the MCO or DMO. This year's non-regulatory topics included questions regarding the appropriateness of using telehealth for certain services; staffing challenges at the MCO or DMO and at their provider offices due to the pandemic; and race and ethnicity data quality.

Performance Indicator Dashboard

The Performance Indicator Dashboards include a set of measures for each managed care program. The measures assess various aspects of health care quality which HHSC has determined to be of greatest importance.

HHSC imposed CAPs on MCOs who did not meet minimum standards on 33.33 percent of quality metrics on the Performance Indicator Dashboard. The table below details the number of MCOs receiving a CAP by program area. These data are reported on a lag, representing measurement year 2022, and will continue to be reported on a lag. This year, plans were directed to address each measure that fell below the minimum standard, taking a wholistic approach to improving quality. As part of their CAP, MCOs are directed to provide root causes, interventions, and

improvement metrics for each measure below minimum standards. HHSC Quality Assurance closed all measurement year 2021 CAPs and has approved all measurement year 2022 CAPs for continued monitoring.

Figure 9. CAPs issued by Program, Measurement Year 2022

Program	Number of CAPs
STAR	14
STAR+PLUS	4
STAR Kids	8

8. HCBS Quality Assurance Reporting

This update will be provided in the next annual report.

9. Directed Payment Programs

Per STC 36, monitoring reports as required in STC 74, include completion of the State Directed Payment (SDP) Reporting Chart for each SDP on an annual basis.

State Fiscal Year 2024

HHSC submitted the fiscal year 2024 preprints for the five state DPPs on March 15, 2023. CMS approved all five programs on July 31, 2023.

10. Financial/Budget Neutrality

This section addresses the quarterly reporting requirements regarding financial and budget neutrality development and issues. The budget neutrality workbook is on a one-quarter lag (see ***Attachment P***) and provides actual data through federal fiscal year 2024, quarter two and forecasted data for federal fiscal year 2024, quarter three.

HHSC uses actuarially sound practices and principles to develop MCO capitation rates. Capitation rates are developed on a state fiscal year basis.

HHSC developed state fiscal year 2024 Medicaid managed care rates that meet the actuarial soundness requirements in 42 CFR §438.4. Actuarial certification reports were submitted to CMS and the Office of the Actuary 45 days prior to the start of the rating period. The rates for state fiscal year 2024 are still under review.

Rate changes vary by managed care program, MCO, region, and risk group, with an aggregate average rate increase of approximately 0.6 percent compared to the state fiscal year 2023 capitation rates. The aggregated average rate increase excludes the impact of mid-year revisions to the capitation rates, Network Access Improvement Program and the DPPs. HHSC submitted state fiscal year 2024 rate amendments to CMS on January 17, 2024, and April 19, 2024, for additional changes needed to ensure HHSC is paying actuarially sound capitation rates. HHSC also submitted a state fiscal year 2024 rate amendment to CMS on April 19, 2024, for changes required to address policy/benefit and DPP changes.

Anticipated Changes to Financial/Budget Neutrality

These STCs set forth a base year of federal fiscal year 2023 to be used in the first rebasing exercise. These terms identified adjustments for the base year and projected expenditures, as required by Attachment U[7], inclusive of the proposed DPPs as a part of the DSRIP transition. The waiver reflects a DSRIP pool ending date of September 30, 2021, and the transition to DPPs starting September 1, 2021.

HHSC Medicaid expenditures in federal fiscal year 2023, the base year, in conjunction with cost trends and adjustments will set the annual expenditure limit for the remainder of the 10-year waiver term.

[7] Attachment U is the Estimated Without Waiver Per Member Per Month Expenditures.

11. Demonstration Operations and Policy

Medicaid Managed Care

The goals of the THTQIP are detailed in Table 1. HHSC continues to include additional services within the risk-based managed care program to support a coordinated care delivery system. The savings attained under the 1115 Transformation Waiver reflect the changes in cost growth over time. The DSRIP transition to a sustainable, integrated payment system while evaluating quality performance of providers within MMC further aligns financial incentives and establishes a strong, steady foundation for the Texas Medicaid program.

HHSC and the Medicaid MCOs achieved the following MMC milestones in federal fiscal year 2024 quarter three, including:

- HHSC finalized the Medically Fragile Policy for STAR+PLUS MCOs to make it contractually required and included it in the STAR+PLUS MCO contract.

Challenges successfully navigated during federal fiscal year 2024 quarter three include:

- Activities related to the end of continuous coverage for individuals receiving continuous Medicaid coverage because of the COVID-19 PHE.

Upcoming major initiatives and activities that support the waiver goals include:

- Coming into full compliance with the HCBS settings regulations.
- Transitioning Medicaid-only services for dually eligible managed care members from a fee-for-service to a managed care service delivery system, as required by the 2024-2025 GAA, H.B. 1, 88th Legislative Session, Regular Session, 2023 (Article II, HHSC, Rider 32).

Procurement Activities

HHSC has created a plan to procure new contracts for STAR+PLUS, STAR, and STAR Kids according to the estimated timeline below.

STAR+PLUS

- In accordance with 1 Texas Administrative Code (TAC) §391.219, on July 14, 2023, HHSC issued a Notice of Award to the following Respondents:
    - United Healthcare Community Plan of Texas, LLC. – Bexar, Central Texas, Dallas, Harris, Hidalgo, Northeast Texas, Tarrant, and Travis Service Areas
    - Molina Healthcare of Texas, Inc. – Bexar, Dallas, El Paso, Harris, Hidalgo, Jefferson, Northeast Texas, and Tarrant Service Areas
    - Superior HealthPlan, Inc. – Central Texas, Dallas, Hidalgo, Lubbock, Nueces, Travis, and West Texas Service Areas

  - Amerigroup Insurance Company – Jefferson, Lubbock, Nueces, and West Texas Service Areas
  - Community First Health Plans, Inc. – Bexar Service Area
  - El Paso Health – El Paso Service Area
  - Community Health Choice Texas, Inc. – Harris Service Area
- Start of Operations: September 1, 2024

STAR

- Request for Proposals (RFP) Posted: December 7, 2022
- Estimated Notice of Award: Q1 SFY 2025
- Anticipated Start of Operations: Q1 SFY 2026

STAR Kids

- RFP Posting: Q3 SFY 24
- Estimated Notice of Award: Q1 SFY 2026
- Anticipated Start of Operations: Q1 SFY 2027

12. Litigation Summary

Type of Consideration	*Ongoing litigation-September 1, 1993*
Summary of Consideration	*Frew, et al. v. Young*, *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 (CAOs) to bring the State into compliance with the consent decree and to increase access to EPSDT benefits. Currently, six 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, (4) Health Care Provider Training, (5) Outreach and Informing, and most recently (6) Toll Free Numbers. Part III of the Managed Care CAO and portions of the Adequate Supply of Providers CAO have also been dismissed.

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 CAOs were entered on April 27, 2007.
Summary of Impact	The consent decree and CAOs 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 December 2023) at 3,357,855.
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 CAOs until they are dismissed by the court.

Type of Consideration	*New litigation-November 7, 2023*
Summary of Consideration	On November 7, 2023, Wellpoint Insurance Company, formerly known as Amerigroup Insurance Company, filed a petition for injunctive relief in Travis County District Court against the Executive Commissioner (EC) in her official capacity, alleging that the EC acted in violation of state law when awarding contracts to MCOs for the STAR+PLUS Medicaid program. Wellpoint is asking the court to order HHSC to award them STAR+PLUS contracts in the Harris, Bexar, and El Paso Service areas.
Date and Report in Which Consideration Was First Reported	The lawsuit was filed on November 7, 2023. HHSC filed an answer and PTJ on December 8, 2023.

13. Health IT

Health Information Exchange Connectivity Project Update

The Health Information Exchange (HIE) Connectivity Project is a Texas Medicaid initiative supported by CMS and state funds. The project consists of three strategies. Successful implementation of the three strategies will result in increased HIE adoption by Medicaid providers, creation of new HIE capacity in Texas, bring clinical information into the Texas Medicaid program through HIE, and benefit Medicaid beneficiaries. The following is an update regarding progress made for each strategy, as well as another CMS-funded initiative, the Patient Unified Look-up System for Emergencies (PULSE).

HIE IAPD Strategies 1-3

Strategy 1/Medicaid Provider HIE Connectivity: Effective federal fiscal year, quarter one 2024, Strategy 1 is no longer supported by a match from CMS and is solely state-funded. As of June 30, 2024, 561 providers are currently approved through Strategy 1 to join with the three local HIEs: C3HIE (formerly known as HASA), Greater Houston Healthconnect, and Rio Grande Valley HIE (doing business as Connected Care Exchange). Providers onboarded through Strategy 1 belong to 137 ambulatory practices, including Federally Qualified Health Centers and Rural Health Clinics, and 51 hospitals.

Strategy 2/Texas HIE Infrastructure: Maintenance and enhancement of connectivity between participating local HIEs and Texas Medicaid, via the Texas Health Services Authority (THSA's) HIETexas, is ongoing. The framework for the exchange, transport, integration, and retrieval of electronic health information between and among health care entities continues to be supported. HIETexas continues to support a user interface for individuals designated by HHSC, integration work and technical assistance for local HIEs, as well as activities and capabilities required for Consolidated Clinical Document Architecture (C-CDA) Transition of Care summaries and Emergency Department Encounter Notification (EDEN) admission, discharge, and transfer (ADT) alerts delivered to Texas Medicaid.

HIETexas is still in the process of transitioning local HIEs to use the Redox platform to push C-CDAs to Texas Medicaid. Through this process, data mapping across the three contracted local HIEs will better standardize the data received by Texas Medicaid.

Strategy 3/EDEN System: In addition to those providers and hospitals onboarded to the project via Strategy 1, C3HIE sends ADT alerts from all existing hospital connections. Additionally, THSA is making direct connections with hospitals, urgent

care facilities, and Skilled Nursing Facilities (SNFs) or rehabs. As of June 30, 2024, 885 hospitals, including acute, behavioral health, and post-acute facilities, as well as urgent care centers, are sending ADT data through EDEN via C3HIE, THSA, and THSA's subcontractor, PointClickCare (PCC). A sharp increase in the total number of hospitals connected is due to PCC beginning to share its post-acute hospital data with EDEN this last quarter. EDEN data subscribers, including hospitals, ambulatory practices, and Medicaid MCOs, continue to be added. Currently, 139 health care entities have been approved as subscribers, of which 110 entities are live and receiving data. Only the subscribers connected to PCC's newer platform can receive data from the new post-acute connections. Subscribers still on the older platform, including Texas Medicaid, only have access to EDEN data from 301 hospitals. However, it is expected that all subscribers will transition to PCC's platform in the future.

PULSE

PULSE infrastructure, which interconnects disparate health information from multiple sources in response to a disaster, continues to operate. PULSE allows authorized users to query clinical data, support patient and family reunification efforts, and search PHE patient data. The HIETexas PULSE system can be deployed at the city, county, or state level to authenticate and assist disaster healthcare volunteer providers during this hurricane season.

The PULSE system has maintained 100 percent uptime to the eHealth Exchange from April 1 through June 30, 2024. THSA continues to provide PULSE demonstrations and trainings for end users, such as Austin Public Health, Red Cross, National EMR, and San Antonio MetroHealth.

14. Evaluation

HHSC completed the following 1115 Transformation Waiver evaluation activities during federal fiscal year 2024 (DY13), quarter three:

- HHSC submitted a draft evaluation proposal for the Medically Fragile and Case Management for Children and Pregnant Women amendments (approved by CMS on November 16, 2023) to CMS on April 29, 2024.
- HHSC held three calls with the external evaluator, Texas A&M University (TAMU) on April 11, 2024, May 9, 2024, and June 17, 2024. The purpose of these calls was to kick off TAMU's work on the next evaluation design and provide technical assistance (focused on DYs 10-19).
- HHSC submitted an Evaluation Report to CMS for the state's COVID-19 Spell of Illness 1115(a) Demonstration (originally approved by CMS on September 3, 2020) on May 3, 2024.

Modifications to the Evaluation Design

HHSC received CMS feedback on the state's proposed modifications to the 1115 Evaluation Design in response to the Medically Fragile and Case Management for Children and Pregnant Women amendments on June 14, 2024. HHSC will submit revisions to the 1115 Evaluation Design to CMS within 60 days of receipt (no later than August 13, 2024). HHSC will summarize modifications to the 1115 Evaluation Designs in the federal fiscal year 2024 quarter four and annual monitoring report.

Description of Evaluation Findings or Reports

HHSC submitted the Draft Interim Report #1, covering DYs 7-11, to CMS on March 28, 2024. A summary of the findings from the Interim Report were described in the federal fiscal year 2024, quarter two monitoring report. Additional evaluation findings will be summarized after the Interim Evaluation Report #2 is submitted (due on March 31, 2027), in accordance with the STCs.

Evaluation Deliverables

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

Table 4. Evaluation-Related Deliverables

Type of Evaluation Deliverable	Due Date	State Notes or Comments	Description of Any Anticipated Issues

Evaluation Design Plan	N/A	CMS approved the Evaluation Design on 5/26/2022.	N/A
Obtain Independent External Evaluator	N/A	HHSC executed the contract with TAMU on 3/15/2024.	N/A
Interim Evaluation Reports	3/31/2024;[1] 3/31/2027; 9/30/2029	HHSC submitted Interim Report #1 to CMS on 3/28/2024.	*No issues anticipated at this time*
Summative Evaluation Report	3/30/2032		*No issues anticipated at this time*

Notes. [1] Interim Evaluation Report #1 replaced the Summative Evaluation Report previously required under the 2017 STCs.

15. Charity Care Pools

Uncompensated Care Pool

This update will be provided in the next annual report.

Public Health Provider Charity Care Pool

This update will be provided in the next annual report.

16. Post Award Forum

The following is a summary of the post-award forum as required by 42 CFR § 431.420(c). In compliance with STC 79 of the 1115 Transformation Waiver, and as part of the Medical Care Advisory Committee meeting, HHSC hosted a public post-award forum in-person with a virtual attendance option on May 14, 2024, to provide the public with an annual update and an opportunity to provide comments on the progress of the 1115 Transformation Waiver. The public forum was held at the Winters Building Public Hearing Room, 701 W. 51st Street, Austin, Texas 78751. The date, time, and location of the public forum were published on HHSC's website 30 days in advance of the meeting.

During the post-award public forum, HHSC provided the public with an update on the following 1115 Transformation Waiver topics: amendments update, STAR+PLUS Procurement, supplemental payments, directed payment programs (DPPs), evaluation, and budget neutrality. A link to the 1115 Transformation Waiver DY12 annual report was also provided to the public. The presentation and agenda were posted to the HHSC website.

HHSC received comments from the following stakeholder: Texana Center, a Local Intellectual and Developmental Disability Authority contracted with HHSC.

The stakeholder expressed concerns about the new Day Activity and Health Services Individualized Skills and Socialization Services, staff wages, staff turnover, and community-based services provider network. The stakeholder acknowledged HHSC's effort to strengthen the direct care workforce through the strategic plan.

The stakeholder also expressed appreciation of HHSC's efforts to develop a CIMS reporting system that complies with CMS guidance but also expressed challenges with the new system such as increased manual documentation. These comments are outside the scope of the 1115 Transformation Waiver as they relate to a new service being added to several of Texas' 1915(c) waiver programs.

17. Report Attachments

Attachment A - Managed Care Plans by Service Area. The attachment includes a table of the health and dental plans by SDA.

Attachment B1 - **Enrollment Summary.** The attachment includes quarterly Dental, STAR, STAR Kids and STAR+PLUS enrollment summaries.

Attachment B2 - **Medicaid Enrollment Reports.** Includes Medicaid Enrollment Reports from June 2023 through August 2023.

Attachments C1, C2, C3 - Provider Network and Methodology. These 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.

Attachment D - **OON Utilization.** The attachment summarizes Dental, STAR, STAR Kids, and STAR+PLUS OON utilization.

Attachment E – Time and Distance Standards. The attachment shows HHSC's distance standards by provider type and county designation.

Attachments H1 - H4 - **Network Access Analysis.** The attachments include the results of HHSC's analysis for PCPs, main dentists, and specialists.

Attachment L – D-047 CMS Narrative 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 N - **MCO Appeals.** The attachment includes Dental, STAR, STAR Kids, and STAR+PLUS appeals received by MCOs.

Attachment O - **HHSC and MCOs self-reported Complaints.** The attachment includes information concerning Dental, STAR, STAR Kids, and STAR+PLUS complaints received by HHSC and MCOs.

Attachment P - **Budget Neutrality.** The attachment includes actual expenditure and member-month data as available to track budget neutrality.

Attachment Q – **Service Coordination Report.** The attachment outlines STAR MSHCN, STAR Kids, and STAR+PLUS details by SDA and MCO.

Attachments 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.

Attachments V1 - **V4** - **Claims Summary.** The attachments are summaries of the MCOs' claims adjudication results.