

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

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

Texas Health and Human Services

Commission

Q4 & Annual Report

December 2021



TEXAS
Health and Human
Services

1. Preface

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	<p>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:</p> <ul style="list-style-type: none">• 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 Demonstration, the Texas Health and Human Services Commission (HHSC) provides its monitoring report for Demonstration Year (DY) 10, which began October 1, 2020¹. Pursuant to 42 CFR § 431.428, Texas provides this annual report to demonstrate how the goals and objectives were met as Texas Medicaid served almost five million Medicaid beneficiaries through risk-based Medicaid managed care authorized under this waiver while transitioning from the Delivery System Reform Incentive Payment pool to integrated state directed payment programs, maintaining the Uncompensated Care pool, and preparing to launch the Public Health Provider Charity Care Program.

The State contracted with 17 managed care organizations (MCOs) and 3 dental maintenance organizations (DMOs): 16 for STAR, 5 for STAR+PLUS, and 9 for STAR Kids. Each MCO covers one or more of the 13 STAR service delivery areas (SDAs), while each dental plan provides statewide services (See *Attachment A*).

Growth in Caseload

As of September 2021, Texas had 5 million full benefit beneficiaries enrolled in Medicaid which is an increase of almost 30% (over 1.1 million clients) compared to caseloads before the Public Health Emergency (PHE). Prior to the PHE, caseloads overall were experiencing declines due to sustained positive economic conditions and record low unemployment levels. Year over year growth for full benefit Medicaid beneficiaries in federal fiscal year 2021 was 17.7%. This underscores the significant impact the COVID-19 PHE and related Maintenance of Eligibility (MOE) policy has had on Texas Medicaid enrollment.

Medicaid Managed Care Enrollment

Approximately 95% of Texas Medicaid beneficiaries are enrolled in Medicaid Managed Care (MMC). The PHE has had the largest impact on the STAR program, which serves parents, pregnant women and children. The STAR Program is the largest Medicaid managed care program and has experienced 98% of the overall managed care growth in enrollment. The STAR+PLUS and STAR Kids programs did not experience the same degree of impact as these programs which serve disability related populations which are largely covered today due to their level of need and long lengths of stay in Medicaid.

Initiatives

The State is in the process of major initiatives related to complying with the federal Home and Community-Based Services regulations, adding new benefits, and implementing State legislation. In FY21, the State worked to develop an Independent Review Organization process that will be added to the existing appeal process in FY22; and incorporated non-emergency medical transportation (NEMT) services into the managed care model.

DSRIP and UC

The State continued to operate supplemental payment programs. The State submitted the Delivery System Reform Incentive Payment (DSRIP) program deliverables, as required by the CMS-approved DSRIP Transition Plan, to support a successful transition. A total of \$2.98 billion was paid to DSRIP

¹ Demonstration Year 10 includes work that is tied to the State fiscal year as well.

providers in FFY21 for DY8-10 reported achievement. The Uncompensated Care (UC) pool continued under the new structure implemented October 1, 2019. A total of up to \$3.87 billion will be paid for FFY 21. Texas' budget neutrality workbook was updated and reveals Texas continues to have a positive gain through the design and implementation of MMC.

Evaluation Findings

HHSC submitted the Interim Report from Texas A&M University to CMS on September 29, 2021. Detailed preliminary findings from the report are summarized in the Demonstration Evaluation Update section of this Annual Report. Key evaluation findings from the Interim Report include:

- Improvements in collaboration and quality-related outcomes among DSRIP providers;
- Reductions in the percentage of UC costs reimbursed;
- Improvements in access to care following the transition of some populations to MMC;
- Increases in Alternative Payment Models (APMs) among MCOs and DSRIP providers; and
- Overall cost savings for the Demonstration.

Network Adequacy in Medicaid Managed Care

HHSC uses geo-mapping analysis to determine MCO and DMO compliance with network distance requirements. If an MCO or DMO does not meet the required compliance standards, HHSC determines whether a contract remedy is appropriate. An MCO or DMO may request a special exception when it does not meet the standards. HHSC may grant exceptions for specific areas that do not have providers available for contracting, or if the MCO is unable to contract with providers in the area and has demonstrated reasonable efforts to do so.

HHSC uses a variety of tools to monitor and assess member access to care, including review of appointment wait times, analysis of out-of-network utilization and member complaints, service planning for members with special healthcare needs, and appointment availability studies. While none of these tools alone give a full picture of provider network adequacy, combined they help HHSC monitor member access to care and identify areas for improvement.

HHSC is continually evaluating network adequacy standards and monitoring processes for Medicaid managed care programs, as part of an ongoing effort to ensure that members have access to a choice of quality health care providers and medically necessary services.

COVID-19 Public Health Emergency

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

Extension Implementation

Difficulties related to operation of the 1115 Transformation waiver emerged with the letter from CMS rescinding its January 15, 2021 approval letter. The Texas 1115 Transformation waiver provides the authority under which most of Medicaid managed care is authorized. Without the terms previously negotiated and agreed to, Medicaid managed care, state directed payment programs within Medicaid

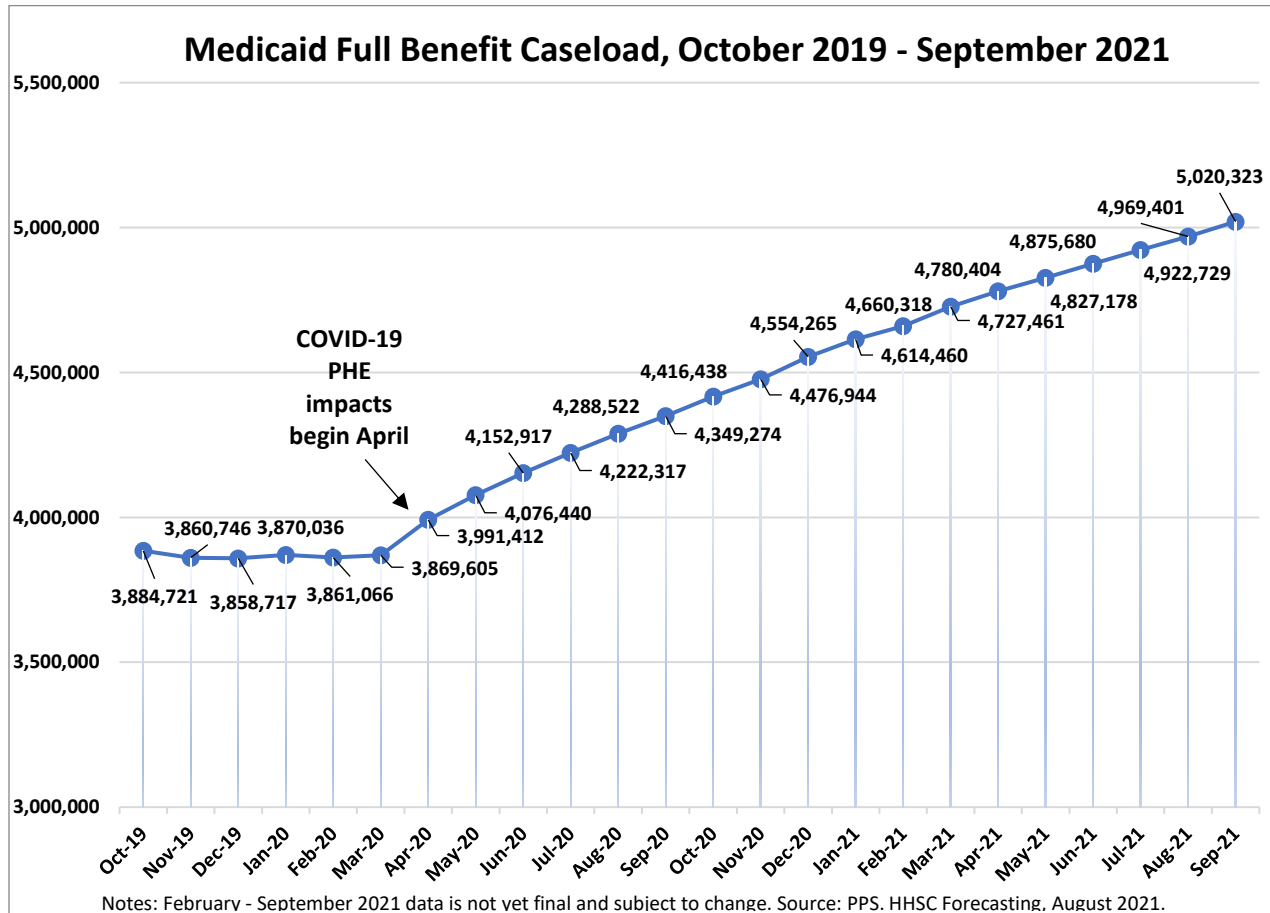
managed care, supplemental payments made possible through managed care savings, and various initiatives aimed at continuous improvement of the program are at risk.

This report discusses in more detail the highlights included in this summary section.

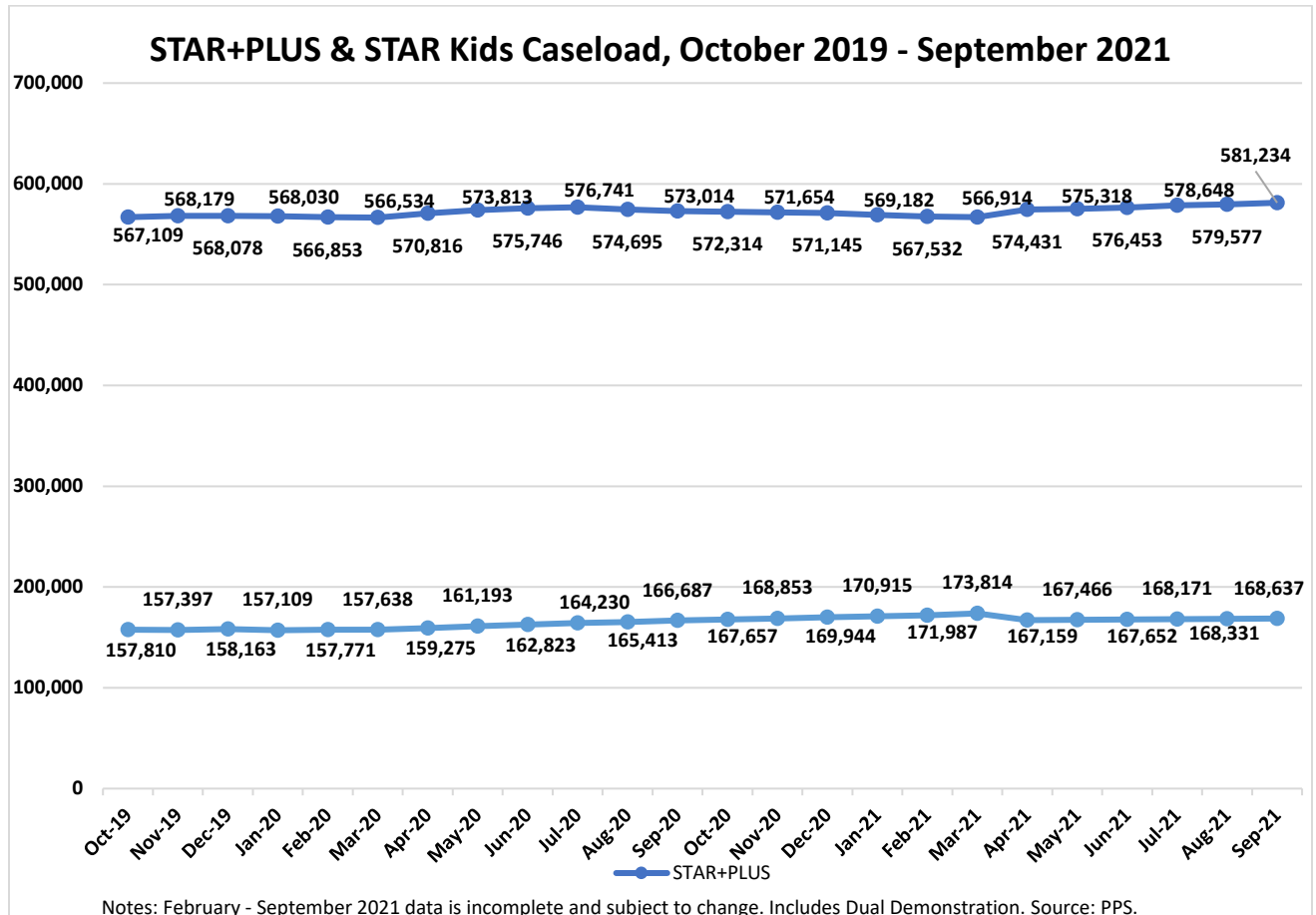
3. Enrollment

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.

The graph below provides a visual look of the overall Medicaid caseload growth experienced during the PHE. Growth began in April 2020 and has increased by over 1.1 million clients.



Ninety eight percent of the growth in managed care during the PHE has been attributed to the STAR program while disability related managed care programs have experienced minimal impact. The graph below illustrates the impact to the STAR Kids and STAR+PLUS programs, which serve aged, blind, and disabled clients.



***STAR+PLUS is the one notated in darker blue at the top of the above graph.**

In **Attachment B1**, an enrollment summary is broken out by product line, service delivery area, and MCO for SFYQ3 to show where caseloads are headed. **Attachment B2** includes Medicaid and CHIP Enrollment Reports from December 2020 through February 2021, which include estimated enrollment by delivery model, program, risk group, Medicaid MCOs, DMOs, and CHIP MCOs. These data are projections provided by Forecasting and considered final after eight months. Because of the time required for data collection, total enrollment counts are reported on a one-quarter lag.

Enrollment Counts for the Quarter by Populations Served

This subsection includes the latest quarterly enrollment counts for which we have final data. This enrollment summary includes all of Medicaid to demonstrate the total served and those in Medicaid managed care authorized under the waiver. Unique client counts per quarter will be reported on a two-quarter lag.

Enrollment Counts (DY10 Q1 October – December 2020)

<u>Enrollment Counts (Unduplicated Demonstration Populations)</u>	<u>Total Number Served</u>
<u>Adults</u>	<u>419,413</u>
<u>Children</u>	<u>3,061,432</u>
<u>Aged and Medicare Related (AMR) (non-MRSA – pre Sep14)</u>	<u>375,904</u>
<u>Disabled</u>	<u>421,401</u>

Enrollment Counts (DY10 Q2 January – March 2021)

<u>Enrollment Counts (Unduplicated Demonstration Populations)</u>	<u>Total Number Served</u>
<u>Adults</u>	<u>465,754</u>
<u>Children</u>	<u>3,153,150</u>
<u>Aged and Medicare Related (AMR) (non-MRSA – pre Sep14)</u>	<u>373,932</u>
<u>Disabled</u>	<u>423,715</u>

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).

All STAR Kids and STAR+PLUS members are deemed to be MSHCN. All STAR Kids and STAR+PLUS plans reported 100% MSHCN, as required in the contract. STAR Kids and STAR+PLUS managed care organizations (MCOs) are required to provide service coordination to all members, unless the member declines. STAR MCOs must identify MSHCN based on criteria outlined in the managed care contract. STAR MCOs are required to provide service management to MSHCN unless the member declines service management or is unable to be reached. Service management includes the development of a service plan to meet the member’s short- and long-term goals.

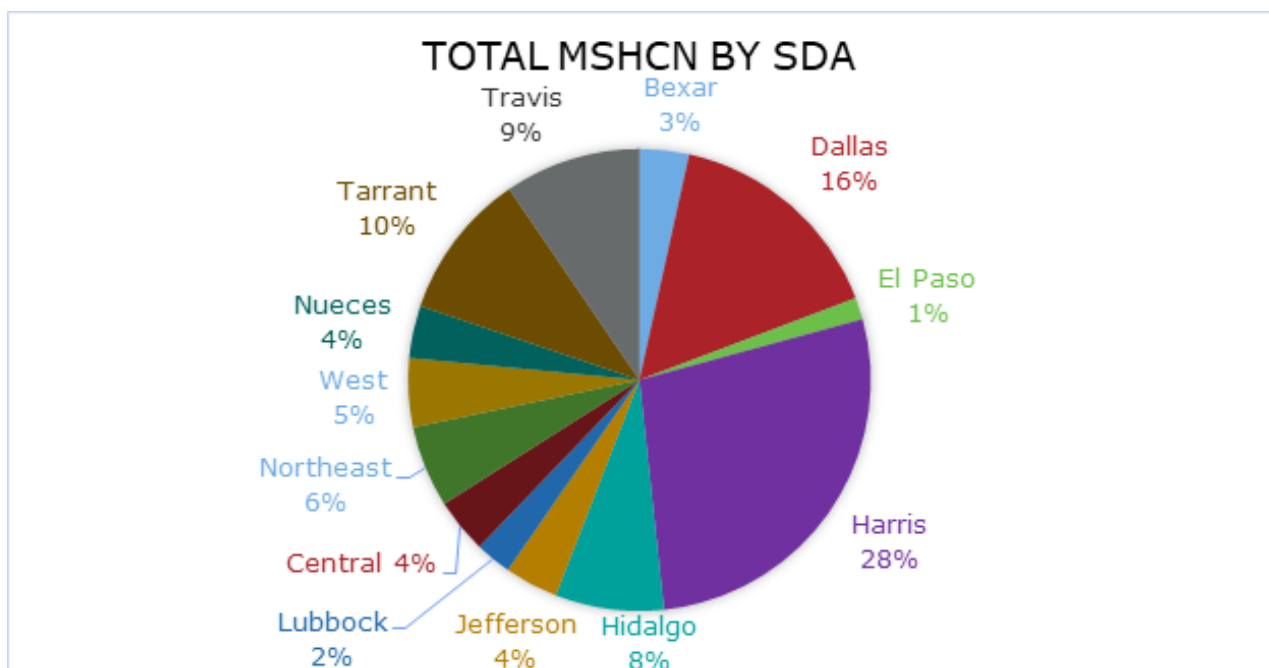
Attachment Q outlines STAR MSHCN details by service delivery area (SDA) and MCO. SFY 2021 Q4 data excludes 14 MSHCN from Parkland due to reporting errors. HHSC has established contractual requirements and a template for the MCOs to submit quarterly MSHCN data.

The number without service plans includes those who declined and those who could not be reached. Percentages represent the proportion of MSHCN without service plans who declined Service Management or whom the MCO was unable to reach. An MSHCN is defined as a member who: (1) has a serious ongoing illness, a chronic or complex condition, or a disability that has lasted or is anticipated to

last for a significant period of time, and (2) requires regular, ongoing therapeutic intervention and evaluation by appropriately trained health care personnel.

In SFY21 Q4, the overall percentage of STAR MSHCN with service plans has slightly increased since the last reporting period. Four MCOs reported more than 60% of their MSHCN in certain SDAs had a service plan (Aetna, Community Health Choice, Driscoll, and United). Five MCOs (Amerigroup, Blue Cross Blue Shield, Community First, Parkland, and Texas Children’s) reported less than 10% of their MSHCN in certain SDAs had a service plan.

Harris SDA holds the most MSHCN with 27.54% (30,213) of all reported STAR MSHCN. Dallas SDA holds the second-most reported MSHCN with 15.77% (17,306 STAR MSHCN). See chart below for additional detail.



A quarter-by-quarter analysis for SFY21 indicates that the total number of identified MSHCN has increased from 95,525 to roughly 110,000, and the percentage of MSHCN with a service plan has consistently been between 18 and 21 percent. A comparison of SFY20 MSHCN data also shows an upward trend in the total number of identified MSHCN. The increase in the total number of identified MSHCN may be due to the increase in total STAR enrollment seen in SFY21.

Over time, the number of identified MSHCN may have varied for some MCOs that have changed identification processes. STAR MCOs rely on various mechanisms to identify and verify MSHCN in addition to member self-identification. Most STAR MCOs employ a combination of methods including provider referrals, risk assessments, member self-assessments, and utilization reviews.

HHSC conducts quality checks in each quarterly submission of the MSHCN Report to assess reporting errors and follow-up with the MCOs. In SFY22, staff will conduct a targeted review of low performing MCOs. In addition to targeted reviews, HHSC will conduct 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 STAR MSHCN service management and service planning, to ensure policies and practices align with performance standards, including managed care contract requirements. If any issues are discovered during the operational reviews, HHSC takes appropriate steps to address performance and compliance.

Beginning in March 2022, HHSC will collect more detailed data from MCOs on service management and service coordination across all managed care programs, including contact attempts, reasons members declined service management, and the date the service plan was last updated. HHSC plans to develop a data visualization dashboard to monitor trends.

Member Disenrollment

The State received a total of zero requests to disenroll from any specific MCO in SFY21 Q4. *Attachment B3* includes quarterly and annual Dental, STAR, STAR Kids and STAR+PLUS, disenrollment summaries. The State received a total of seven Medicaid disenrollment requests for all of SFY21 compared to zero total disenrollment requests in SFY20.

Provider Network Enrollment

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*. Because of the time required for data collection, healthcare provider counts per quarter are reported on a one-quarter lag.

During SFY21 Q3, unique PCP provider enrollment continued to increase across all programs statewide. Similarly, unique pharmacist enrollment slightly increased across all programs during SFY21 Q3. Across the dental programs statewide, the DMOs reported a slight decrease in dental provider enrollment compared to SFY21 Q2,

Provider Termination

Attachment C3 details the data reported by the MCOs regarding the number of PCPs and specialists terminated in SFY21 Q3. The MCOs reported a variety of reasons for termination. For Q3, the top three reasons for PCP terminations included provider left group practice, provider moved, and termination requested by provider. The top three reasons for specialist terminations included provider left group practice, termination requested by provider, and provider failed to recredential.

3.1 Anticipated Changes to Enrollment

On Jan. 27, 2020, the Secretary of Health and Human Services declared a PHE due to the novel coronavirus. In March, 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 PHE period as a condition of receiving enhanced federal funding. As part of the emergency response, Texas Health and Human Services put automated processes in place to maintain Medicaid coverage.

On October 28, 2020, the Centers for Medicare and Medicaid Services (CMS) issued interim final rules which provided clarification on the continuous enrollment requirements in the Families First Coronavirus Response Act (FFCRA). CMS clarified States must transition individuals between eligibility categories

during the PHE, if the new Medicaid program provides the same tier of benefits or a higher tier of benefits. Texas has aligned with the interim final rule related to maintenance of eligibility as part of the FFCRA.

Beginning in February 2021, the Texas Health and Human Services Commission (HHSC) transitioned Medicaid clients to the appropriate program on an ongoing basis when there was a change in circumstance or when processing a renewal application. Generally, if a client no longer meets the criteria for their current program, and does not qualify for another Medicaid group, they will remain in their current group for the remainder of the PHE. There are some limited situations where an individual will not continue to receive Medicaid State Plan benefits such as when the individual leaves the State, voluntarily leaves the program, or is deceased.

With the anticipated end of the PHE in 2022, Texas is estimating that the PHE-impacted caseloads will experience a recovery over the course of 1 to 2 years before caseloads stabilize and resume normal growth trends. Texas continues to monitor new guidance from CMS related to the PHE.

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% of members, unless otherwise specified, have access to a choice of each provider type (PCPs, dentist, and specialty services) in each service delivery area (SDA) within a prescribed travel time and distance standards. 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 managed care plan'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 distance standard of 90%. During Q4, the MCOs met or exceeded the 90% standard for members' access to PCPs. Similarly, MCOs are required to maintain an adequate network of specialty providers such that 90% of members have access to at least two providers (except as noted below) within the time and distance standard for the specialty provider type. HHSC has established network adequacy standards for the following types of specialty providers: acute care hospital; audiologist; behavioral health outpatient; cardiovascular disease; ear, nose and throat (ENT); Mental Health Targeted Case Management (TCM) and Mental Health Rehabilitative Services (MHR); general surgeon; nursing facility; OB/GYN; ophthalmologist; orthopedist; pediatric sub-specialty; prenatal care; therapy (occupational, physical, and speech); psychiatrist; and urologist.

Attachment H2 presents the detailed specialty provider analysis by program and county designation (metro, micro, rural). During Q4 in every Medicaid managed care program, MCOs met or exceeded the 90% standard for members' access to specialty providers, except for audiologists and mental health TCM and MHR services. The evaluation of network adequacy compliance occurs at the county level. It is possible for an MCO's overall average compliance rate to be high yet still be below 90% in one or more counties. The table below summarizes the count of MCOs that did not meet the 90% compliance standard in one or more counties.

MCO Network Adequacy Summary – Specialty Providers – Number of MCOs that did not meet the standard, by Specialty Provider, Program and County designation SFY21 Q4*

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	7	14
	STAR+PLUS	0	5	5
	STAR Kids	0	7	7

Audiologist	STAR	7	8	8
	STAR+PLUS	5	4	5
	STAR Kids	5	4	5
Behavioral Health – Outpatient	STAR	0	1	0
	STAR+PLUS	0	0	0
	STAR Kids	0	1	0
Cardiovascular Disease	STAR	4	7	2
	STAR+PLUS	0	3	0
	STAR Kids	1	6	2
ENT (Otolaryngology)	STAR	2	4	2
	STAR+PLUS	0	1	0
	STAR Kids	0	2	2
Mental Health Targeted Case Management (TCM) and Mental Health Rehabilitative Services (MHR)	STAR	10	13	7
	STAR+PLUS	5	5	3
	STAR Kids	6	9	5
General Surgeon	STAR	0	1	0
	STAR+PLUS	0	0	0
	STAR Kids	0	0	0
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	2	7	1
	STAR+PLUS	0	0	0
	STAR Kids	1	2	2
Orthopedist	STAR	2	6	2
	STAR+PLUS	0	2	1
	STAR Kids	0	3	1
Pediatric Sub-Specialty <i>(The standard requires access to one provider)</i>	STAR	0	0	0
	STAR Kids	0	0	0
Prenatal	STAR	0	1	1
	STAR+PLUS	0	0	0
	STAR Kids	0	1	0
Psychiatrist	STAR	3	6	3
	STAR+PLUS	0	2	1

	STAR Kids	2	3	2
Therapy (Occupational, Physical, and Speech)	STAR	0	0	1
	STAR+PLUS	0	0	0
	STAR Kids	0	0	0
Urologist	STAR	2	7	7
	STAR+PLUS	0	3	3
	STAR Kids	1	3	3

*See Attachment H1-H2 for detailed data tables for each MCO.

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

The DMOs met the network access standard of 95% for Main Dentist throughout SFY21 Q4. **Attachment H3** provides dentist analysis by DMO and county designation.

DMOs did not consistently meet network access standards for dental specialty providers (Orthodontists, Endodontists and Pediatric dentists) in all county designation for SFY21 Q4. For Q4, DentaQuest met the standards for Pediatric Dental but did not meet the standards for Orthodontists or Endodontists in micro and rural counties. MCNA Dental met the standards for Pediatric Dental but did not meet the standard for Endodontists or Orthodontists in micro and rural counties. United Healthcare Dental did not meet standards for Endodontists in all counties, Orthodontist in micro and rural counties and Pediatric Dental in micro counties. The DMOs are on corrective action plans for these issues. **Attachment H4** provides dental specialty analysis by provider type and county designation.

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, 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, House Bill 1, 86th Legislature, Regular Session, 2019 (Article II, Health and Human Services Commission, Rider 157)², HHSC is enhancing provider network adequacy standards for Medicaid MCOs to ensure members have sufficient access to community care attendants. Managed care contracts have been updated to clarify that MCOs must ensure that a minimum of 90% 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. HHSC will begin reporting on this in future reports once data is available for the corresponding reporting period.

MCO Pharmacy Geo-mapping Summary

HHSC is reviewing its methodology and monitoring processes to determine if the distance and travel time standards for pharmacy are appropriate. Pharmacy network adequacy performance reports were shared with MCOs as informational only as of Q1 SFY21.

Attachment J details the Geo-distance results for SFY21 Q1 and Q2 to inform the process and information as HHSC continues to work on network adequacy as it relates to pharmacy. MCOs are

² <https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2020/rider-157-ca-workforce-dev-strat-plan-nov-2020.pdf>

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.
- 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.
- At least 90% of Members must have access to a 24-hour pharmacy within 75 miles or 90 minutes of the Member's residence.

MCO and DMO Network Adequacy Standard Exceptions

In FY 2020 and Q1 of FY 2021, HHSC focused its monitoring efforts on ensuring MCOs and DMOs implement access to care plans and member education initiatives. HHSC utilized this time to resolve data discrepancies and redesign the network adequacy corrective action process to include the exception request process. HHSC resumed the network adequacy corrective action process in Q2 SFY21. Based on the Q4 SFY21 network adequacy performance reports, HHSC requires MCO provider networks to comply with distance or travel time standards in accordance with managed care contract requirements. A Corrective Action Plan (CAP) is required if the MCO/DMO does not meet the performance standards outlined in UCMCM 5.28.1 Access to Network Providers - Performance Standards and Specifications in at least one county.

As a part of HHSC's process, MCOs and DMOs may submit an exception request for areas of non-compliance via 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, providing guidance and a list of network providers offering telehealth and telemedicine services, 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. If the exception request is denied, the MCO is subject to remedies such as liquidated damages or a corrective action plan.

Member and Provider Hotline Performance

The list below outlines performance standards of MCO and DMO Member and Provider Hotlines. 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;
- $\leq 1\%$ 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).
- $\leq 7\%$ call abandonment rate; and
- ≤ 2 minutes average hold time.

Beginning with data collected for November 2019, HHSC transitioned the MCO Hotline reporting to a new submission format. With the transition, HHSC modified how the average hold time was calculated to ensure accurate reporting across all MCOs by requiring the MCOs to submit the total hold time for all in-house and subcontracted entities. To allow for sufficient time to make system changes required by HHSC and the MCOs, submission of the total hold time did not implement until September 1, 2020. Once implemented, the average hold time was calculated on the backend by the portal. Because of the change, HHSC did not recommend or assess contractual remedies for State fiscal year 2020 to allow MCOs an adjustment period for the new submission format. Consistent with previous reporting, MCOs will continue to submit aggregated reports by program, but no longer submit by service delivery area. STAR and STAR+PLUS hotline reporting will continue to be aggregated together.

Data collection for MCO self-reported data for hotline performance measures transitioned to a new format in SFY20, requiring adjustments to submission, extraction, and reporting processes. As a result, reporting of the results has been delayed.

Included in **Attachment M1-M4** is retroactive data from SFY20 and SFY21 up to Q3. For all of SFY20, average hold time data was unable to be validated due to the system change to TexConnect. Average hold time data was not collected for SFY 2020 but is available beginning Q1 SFY 2021. Below is the information for the most recent quarter for which we have final data.

Member Hotline (STAR/STAR+PLUS - SFY21 Q3)

- All MCOs met the requirement to answer calls by the fourth ring except for Amerigroup, Cigna-HealthSpring, Community First, Community Health Choice, Cook Children's, El Paso Health, FirstCare, Molina, Parkland, and Scott & White.
- All MCOs met the 80% standard for answered by a live person within 30 seconds.
- All MCOs met the $\leq 7\%$ abandoned calls standard.

Member Hotline (STAR Kids – SFY21 Q3)

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

Behavioral Health Hotline (STAR/STAR+PLUS SFY21 Q3)

- All MCOs met the requirement to answer calls by the fourth ring except for Cigna-HealthSpring, Community First, Community Health Choice, El Paso Health, FirstCare, Molina, Texas Children's, and United.
- All MCOs met the 80% standard for answered by a live person within 30 seconds.
- All MCOs met the $\leq 7\%$ abandoned calls standard.

Behavioral Health Hotline (STAR Kids – SFY21 Q3)

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

Provider Hotline (STAR/STAR+PLUS– SFY21 Q3)

- All MCOs met the requirement to answer calls by the fourth ring except for Aetna, Amerigroup, Cigna-HealthSpring, Community First, El Paso Health, Molina, Parkland, and Texas Children's.
- All MCOs met the $\leq 7\%$ abandoned calls standard except for Molina.
- All MCOs met the requirement for ≤ 2 minutes average hold time except Molina.

Provider Hotline (STAR Kids – SFY21 Q3)

- All MCOs met the requirement to answer calls by the fourth ring except for Aetna, Amerigroup, and Texas Children's.
- All MCOs met the $\leq 7\%$ abandoned calls standard.
- All MCOs met the requirement for ≤ 2 minutes average hold time.

Dental Hotline (STAR/STAR+PLUS– SFY21 Q3)

- DentaQuest met the $\leq 7\%$ abandoned calls standard for provider and member hotlines but did not meet average hold time standard or the requirement to answer calls by the fourth ring and 80% standard for answering by a live person within 30 seconds for both provider and member hotlines.
- MCNA met the $\leq 7\%$ abandoned calls and average hold time standard for provider hotlines but not for member hotlines and did not meet the requirement to answer calls by the fourth ring and 80% standard for answering by a live person within 30 seconds for member hotlines.
- United Dental met the $\leq 7\%$ abandoned calls and average hold time standard for provider and member hotlines but did not meet the requirement to answer calls by the fourth ring and 80% standard for answering by a live person within 30 seconds for both provider and member hotlines.

MCOs that have identified instances of non-compliance are reviewed quarterly for remedies as stated in the contract that include but are not limited to corrective action plans and liquidated damages 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 here as “open panel” PCPs and “open practice” dentists. HHSC monitors PCPs with “open panel” at an 80% benchmark.

Quarterly healthcare provider counts per quarter are reported on a one-quarter lag. In SFY21 Q3, all MCOs and DMOs, except Cook Children's in STAR (73.19%) and STAR Kids (71.21%) met the 80% benchmark. However, HHSC has not identified access to care concerns, issues, or complaints. 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.

Appointment Availability

HHSC conducts appointment availability studies to assess how quickly members get in-person appointments. In SFY2021 behavioral health and primary care provider studies were conducted. HHSC shared the 2021 results with MCOs but did not assess corrective action plans or liquidated damages because of the unknown impact of the PHE on providers' and members' ability to secure appointments.

Accessibility and Language Compliance

MCOs submit provider's language and accessibility survey results by program and SDA on an annual basis. Deliverables for SFY21 are due from MCOs on December 30, 2021 and will be summarized in the Q1 SFY22 report.

HHSC requires MCOs to make best efforts to ensure that PCPs are accessible 24 hours per day, 7 days a week 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 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% to 100%. 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/coaching provider staff, 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

Attachment S illustrates enrollment and expenditures by program and claim type for SFY20, covering September 1, 2020, through August 31, 2021. In each annual report, HHSC reports the prior fiscal years data in order to include more complete data. These visualizations represent Medicaid encounter utilization data and Medicaid client enrollment data reported by program, Manage Care Organization (MCO), Service Delivery Area (SDA) and claim type. These data are self-reported by the MCOs and are subject to change. The total spending in STAR, STAR+PLUS, and STAR Kids in SFY20 included:

- Professional claims: 36.70%
- Outpatient claims: 23.53%
- Drug claims: 16.05%

- Inpatient claims: 19.75%
- Dental Claims: 3.97%

“Inpatient” refers to inpatient hospital services and “outpatient” refers to services received at a hospital on an outpatient basis and at non-hospital facilities. Professional claims which include long term services and supports account for about one-third of expenditures. The dental claims referenced include all dental services provided by the DMOs for children in the above-referenced programs as well as the dental paid for in the STAR+PLUS HCBS program.

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 liquidated damages or implementing a corrective action plan.

Attachment D provides OON utilization performance summary for SFY21 Q3. Because of the time required for data collection, OON utilization counts are reported on a one-quarter lag. The MCOs listed below exceeded OON utilization standards in SFY21 Q3 and have a SERT in place bringing the MCOs into compliance. The State will continue to monitor these MCOs and will require corrective action or other remedies as appropriate.

OON Emergency Room (ER)

- STAR
 - CHC – SERT is in place to cover SFY21 Q3.
 - Dell Children’s – SERT is in place to cover reporting periods Q4 2020 through Q3 2021.
 - Parkland – No SERT or CAP are in place.

OON Inpatient

- STAR
 - CHC – SERT is in place for SFY21 Q3.
 - Dell Children’s – SERT is in place to cover reporting periods Q4 2020 through Q3 2021.
 - Parkland – No SERT or CAP are in place.
- STAR Kids
 - BCBS – No SERT is in place, however, a CAP is in place.
- STAR+PLUS
 - Molina – SERT is in place for SFY21 Q3.

OON Other Outpatient

- STAR

- Parkland – No SERT or CAP are in place.

Oversight of MCOs and DMOs

HHSC staff routinely evaluate MCO and DMO data 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, 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)).

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>.

Texas Medicaid launched a new process for tracking CAPs. As of September 2021, HHSC has transitioned to direct entry into the TexConnect Portal for tracking of CAPs. As actions are taken by HHSC to submit, approve, close or withdraw a CAP, letters are auto generated and sent directly to the MCO. Direct entry and visibility allow for transparency between HHSC and the managed care organizations.

5. Waiver Amendments and Upcoming Managed Care Initiatives

Waiver Amendments

The following amendments have been submitted to CMS.

Autism Services

Senate Bill 1, Article II, (Health and Human Services Commission) Rider 28, 87th Legislature, Regular Session, 2021 authorized the implementation of Applied Behavioral Analysis (ABA) services for the evaluation and treatment of eligible children/youth with autism under the Texas Medicaid program. HHSC has submitted a State plan amendment and an amendment to the 1115 Transformation waiver related to 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). The 1115 Transformation waiver amendment includes provisions for service delivery through Medicaid managed care organizations (MCOs) with non-risk payments outside of the capitation payments. Licensed Behavior Analysts (LBAs), Licensed assistant Behavior Analysts (LaBAs) and Behavior Technicians will be authorized to provide ABA services.

Medically Fragile

House Bill (H.B.) 4533, SECTION 32, 86th Legislature, Regular Session, 2019 required HHSC to pursue a benefit for medically fragile individuals. If determined to be cost effective, the legislation directed Health and Human Services Commission (HHSC) to submit an amendment to add this benefit to the 1115 Transformation waiver under the STAR+PLUS Home and Community Based Services (HCBS) program. HHSC submitted this amendment to CMS originally on September 1, 2020. After the original submission, CMS indicated the packet was not complete and HHSC was required to resubmit the packet to CMS. The second submission of the packet was on February 22, 2021. HHSC and CMS continue to discuss the amendment.

Preferred Drug List (PDL) Prior Authorizations (PA)

Senate Bill 1096, 86th Legislature, Regular Session, 2019 (S.B. 1096) directed HHSC to exempt STAR Kids members from all preferred drug list (PDL) prior authorizations (PAs) to meet the requirements of Section 533.005, Government Code (a)(23)(L), as added by S.B. 1096.

Specifically, S.B. 1096 removes all the PDL PAs for all members of the STAR Kids program except those PAs based on evidence-based clinical criteria and nationally recognized peer-reviewed information and those PAs designed to minimize waste, fraud, or abuse. To implement S.B. 1096, HHSC submitted a waiver amendment to propose waiving requirements in 42 C.F.R. §440.240, related to comparability of services for groups, to apply the PDL PA exemption to the STAR Kids program only. This amendment will not result in any changes to the formulary. This amendment, if approved, will give a member the opportunity to be prescribed any drug whether the drug has preferred or non-preferred status, although a member will not have access to drugs not covered by Medicaid.

HHSC anticipates submitting the following amendments in the future.

Maternal and Child Health

House Bill 133, 87th Legislature, Regular Session, 2021 (H.B. 133) directs HHSC to:

- Transition targeted case management services for children and pregnant women to Medicaid managed care;
- Transition Healthy Texas Women (HTW) program services, funded through the HTW 1115 waiver³, to managed care; and
- Seek federal approval to extend Medicaid coverage to six months postpartum for women who deliver or experience an involuntary miscarriage.

HHSC plans to request an amendment to the THTQIP 1115 waiver in SFY22 to:

- Transition the case management services for children and women.
- Extend Medicaid for Pregnant Women postpartum eligibility for certain women.

Long-Term Services and Supports for Individuals with Intellectual and Developmental Disabilities (IDD) Transition

HHSC continues work toward implementation of with House Bill (HB) 4533 (86th Legislature, Regular Session, 2019), which amends Texas Government Code, Chapter 534 and directs HHSC to develop and implement a pilot program through the STAR+PLUS Medicaid managed care program to test person-centered managed care strategies and improvements under a capitated model. The pilot program will inform the future 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 pilot program will serve individuals with intellectual and developmental disabilities (IDD), traumatic brain injury, and people with similar functional needs. The pilot program will operate in one service delivery area selected by HHSC with up to two STAR+PLUS Medicaid managed care plans. The pilot program will implement September 1, 2023 and operate for at least 24 months.

The Intellectual and Developmental Disabilities (IDD) System Redesign Advisory Committee (SRAC) and the Pilot Program Workgroup continue to meet and submit recommendations to aid in the development of the pilot program. The Pilot Program Workgroup and SRAC are having joint meetings to focus on the pilot.

Initiatives

Compliance with Home- and Community-Based Services (HCBS) Settings Regulations

Texas continues efforts to comply with the federal HCBS settings regulations issued by CMS in March 2014. Compliance efforts include revising State rules and policies and submitting STAR+PLUS HCBS assisted living facility settings for heightened scrutiny review. Before the final compliance deadline of March 2023, HHSC plans to replace its current day habilitation service in the 1915(c) waivers, with a

³ <https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/83311>

new, more integrated service. HHSC is also amending the Texas Statewide Transition Plan for re-submission to CMS.

Community Attendant Workforce Development Strategic Plan

The Community Attendant Workforce Development Strategic Plan was submitted to the 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:

- Dedicate resources at HHSC to coordinate and support a Workforce Development Taskforce.
 - HHSC identified the newly established 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 THTQIP 1115 Waiver application, HHSC's spending plan in response to the American Rescue Plan Act of 2021 Section 9817 which provides States with a temporary ten 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.
- Add network adequacy measures for community attendants to the Medicaid managed care contracts.
 - HHSC is enhancing provider network adequacy standards for Medicaid MCOs to ensure members have sufficient access to community care attendants. Managed care contracts have been updated to clarify that MCOs must ensure that a minimum of 90% of their members have timely access to community attendant care services upon authorization of services.

6. Demonstration-related Appeals and Complaints

Complaints Received by the State and MCOs

In summer 2018, HHSC began a cross-divisional effort to revise and improve the tracking and trending of managed care complaints data. This effort resulted in the following:

- New HHSC complaint routing and resolution processes to improve consistency,
- New reporting requirements for MCO and DMO self-reported data, including changes to definitions and categories, and
- A more complete picture of emerging trends by compiling the complaints received through multiple divisions within HHSC and through the MCOs and DMOs into one report.

Prior to March 2019, all managed care member complaints were received and researched by Managed Care Compliance and Operations (MCCO), however as part of the restructuring of complaint processes, HHSC's Office of the Ombudsman (OOO) began handling managed care member complaints. The OOO works with the member and the MCO to address the complaint and coordinate any needed services. However, if a resolution cannot be reached, OOO forwards the complaint to MCCO.

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

Attachment O includes complaints data compiled from both MCOs/DMOs and HHSC for members and providers. The reports in *Attachment O* reflect SFY2021 Q1 and Q2 and subsequent monitoring reports 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/DMO.
- Outcome status by program and by MCO/DMO.
- Distribution of complaints and enrollment by MCO/DMO.
- Overall quarterly rate of complaints by MCO/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 expressed in number of complaints per 10,000 clients (otherwise referred to as rate). Complaint volumes may vary based on MCO/DMO size, program (e.g., STAR versus STAR+PLUS) and complexity of population served.

Member Appeals

Attachment N provides a performance summary of member appeals for all of SFY20 and Q1-Q3 for SFY21. For SFY21 Q3 STAR MCOs collectively reported 1,742 member appeals. STAR+PLUS MCOs collectively reported 2,671 member appeals. STAR Kids MCOs collectively reported 1,167 member appeals. DMOs collectively reported 447 member appeals.

Parkland operating the STAR program was the only MCO that did not meet the 98% compliance standard for 30-day appeals resolved timely in SFY21 Q3.

Appeals Remediation

Parkland is currently on a corrective action plan for this non-compliance. Identified instances of non-compliance are reviewed quarterly for remedies as stated in the contract that include but are not limited to corrective action plans and liquidated damages 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. These attachments reflect the current status of each case, and these cases can have multiple dispositions; therefore, the disposition total will not add up to the total number of referrals received. The OIG received 125 fraud and abuse referrals from MCOs and a total of 21 fraud and abuse referrals from DMOs in SFY21 Q4. For the year there were a total of 447 fraud and abuse referrals from MCOs and a total of 62 fraud and abuse referrals from DMOs. All DMO referrals for the year were related to non-appropriate billing. The majority of MCO referrals for the year were related to non-appropriate billing although there were referrals made for program non-compliance and attendant care fraud, waste, and abuse (FWA). Attendant care FWA levelled out to zero for the last two quarters of the year while program non-compliance maintained an average of about 6 referrals per quarter.

Claims Summary Reports

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%

Claims summary counts are reported on a one-quarter lag. **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 the Texas Health and Human Services (HHSC) receives appeal requests from applicants and clients contesting actions taken regarding benefits and services for various programs. Hearings Officers conduct fair hearings and administrative disqualification hearings statewide for 169 eligibility programs within HHSC, including the waiver programs.

In FY20, FFH received 1,914 fair hearings for the waiver programs (159 for the STAR program, 368 for the STAR Kids program and 1,387 for the STAR+PLUS program). Of the 1,914 fair hearings, 387 were withdrawn by the Appellant, 713 were dismissed, 471 were upheld and 343 were reversed by the presiding Fair Hearings Officer. In FY21, FFH received 2,296 fair hearings for the 1115 waiver programs (180 for the STAR program, 549 for the STAR Kids program, and 1,567 for the STAR+PLUS program). Of the 2,296 fair hearings, 420 were withdrawn by the Appellant, 767 were dismissed, 630 were upheld and 417 were reversed by the presiding Fair Hearings Officer. FFH saw an overall increase in fair hearings for the 1115 waiver programs from FY20 to FY21 of 19.96%. The STAR Kids program had an increase of 181 fair hearings, making it the largest increase for 1115 waiver programs; this increase translates to an increase of 49.2%, with STAR increasing 13.2%, and STAR+PLUS increasing 12.98%, respectively. The COVID-19 pandemic in FY20 influenced the number of fair hearings for the 1115 waiver programs, as denials were temporarily placed on hold. In FY21, 2,296 appeals were received; however, 62 decisions had not been issued during the fiscal year.

6.1 Anticipated Changes to Appeals

HHSC plans to implement an External Medical Review (EMR) option, to be performed by an Independent Review Organization (IRO). The EMR is an option for a Member to request further review of the MCO's adverse benefit determination. The EMR will take place between the MCO internal appeal process and the State Fair Hearings. The IRO will not consider new evidence that was not presented to the MCO but can do so at a Fair Hearing. The MCO will have to provide the IRO the same set of records the MCO reviewed to determine service denial. EMRs will be 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.

7. Quality

In July 2021, HHSC updated its [Texas Managed Care Quality Strategy](#). The strategy provides updated healthcare quality goals, below, and objectives.

1. Promoting optimal health for Texans at every stage of life through prevention and by engaging individuals, families, communities, and the healthcare system to address root causes of poor health
2. Strengthening person and family engagement as partners in their care to enhance respect for individual's values, preferences, and expressed needs
3. Providing the right care in the right place at the right time to ensure people can easily navigate the health system to receive timely services in the least intensive or restrictive setting appropriate
4. Keeping patients free from harm by building a safer healthcare system that limits human error
5. Promoting effective practices for people with chronic, complex, and serious conditions to improve people's quality of life and independence, reduce mortality rates, and better manage the leading drivers of health care costs
6. Attracting and retaining high-performing Medicaid providers, including medical, behavioral health, dental, and long-term services and supports providers to participate in team based, collaborative, and coordinated care

The PHE continued into 2021. HHSC received initial MCO quality measure results in October 2021 for measurement year 2020 and HHSC is assessing the impact of the PHE on those results. Full 2020 results will be posted to the Texas Healthcare Learning Collaborative Portal (thlcportal.com) when finalized. The results will help inform HHSC decisions about its quality improvement programs for measurement years 2021 and 2022.

The EQRO completes many required and optional quality review activities for HHSC each year. HHSC publishes an annual summary of EQRO activities that includes their key findings and recommendations. The most recent report is the [External Quality Review of Texas Medicaid and CHIP Managed Care Summary of Activities for SFY 2020](#). The SFY 2021 report will be published by April 30, 2022.

8. HCBS Quality Assurance Reporting

STAR+PLUS Home and Community Based Services performance measures have been developed in collaboration with multiple departments across HHSC. The performance measures continue to be refined as HHSC works with CMS for clarification on the first and subsequent reporting due dates.

HHSC is finalizing data collection and reporting processes for the first and subsequent reports. The first reporting timeframe will be for January 15, 2021, through September 30, 2021. Additionally, HHSC submitted a data request for MCOs to self-report on select performance measures as an ad hoc report. HHSC initiated the process to amend the MCO contracts and reporting requirements for an effective date of September 1, 2022.

HHSC is developing the structure of the report template, required by STC 75 and to be submitted by March 31, 2022.

9. State 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 state directed payment on an annual basis. *Attachments K1-K4* include State Directed Payment data in the form of the required chart for the Quality Incentive Payment Program (QIPP), Uniform Hospital Rate Increase Program (UHRIP), and the minimum fee schedules in SFY 2021.

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 forecasting data for SFY21 Q3. The tables below provide information on eligibility groups in budget neutrality calculations.

HHSC developed fiscal year 2021 Medicaid managed care rates that meet the actuarial soundness and federal requirements. Actuarial certification reports were submitted to CMS and the Office of the Actuary 45 days prior to the start of the rating period. HHSC has received CMS's approval of many of the contracts and capitation rates, but some approvals are still outstanding.

No adjustments to the rate development assumptions were made as a result of the COVID-19 pandemic and its potential impact on program utilization and cost. At the time the fiscal year 2021 rates were calculated (May/June 2020), there was little credible information on the impact of the pandemic specific to the Texas Medicaid population. In the actuaries' opinion, COVID-19 presented unprecedented challenges to setting prospective actuarially sound capitation rates that would appropriately consider the impact of COVID-19 on Medicaid cost and utilization. HHSC did not include these costs in the capitation rates and paid COVID-19 costs through a non-risk arrangement.

The rate changes varied by managed care program, MCO, region, and risk group, with an aggregate average rate increase of approximately 4% compared to the fiscal year 2020 capitation rates. This figure excludes the impact of mid-year revisions to the capitation rates. HHSC submitted fiscal year 2021 rate amendments for additional changes needed to ensure that the State is paying actuarially sound capitation rates.

DY10 Q4 July – September 2021

Eligibility Groups Used in Budget Neutrality Calculations

Eligibility Group	Month 1 (July 2021)	Month 2 (Aug 2021)	Month 3 (Sep 2021)	Total for Quarter Ending 9/2021
Adults	521,146	535,474	549,570	1,606,189
Children	3,177,732	3,200,206	3,227,059	9,604,997
AMR	352,874	352,301	352,726	1,057,901
Disabled	421,332	422,322	423,253	1,266,907

Eligibility Groups Not Used in Budget Neutrality Calculations

Eligibility Group	Month 1 (July 2021)	Month 2 (Aug 2021)	Month 3 (Sep 2021)	Total for Quarter Ending 9/2021
Foster Care	46,811	47,420	48,096	142,327
Medically Needy	117	116	116	349
CHIP-Funded	384,214	393,026	400,759	1,177,999
STAR+PLUS	18,504	18,535	18,744	55,784
217-Like HCBS				

HHSC Forecasting has provided this data.

11.1 Anticipated Changes to Financial/Budget Neutrality

Texas and CMS negotiated and agreed to specific budget neutrality terms included in the January 2021 approval. These terms set forth a base year of fiscal year 2022 to be used in the first rebasing exercise. These terms identified adjustments for the base year and projected expenditures in Attachment U, inclusive of the proposed state directed payment programs as a part of the DSRIP transition. The waiver contemplated DSRIP ending September 30, 2021, and the transition to State directed payment programs starting September 1, 2021.

As such, Texas Medicaid expenditures in FY 2022, the base year, will set the annual expenditure limit for the remainder of the 10-year waiver term. Without the pending state directed payment programs contemplated in the waiver, the budget neutrality expenditures will be significantly reduced in FY22 and each year thereafter, inhibiting HHSC from sustaining provider payments going forward.

Budget neutrality could be impacted by waiver amendments, and in accordance with the adjustments set forth in STC 62.

11. Demonstration Operations and Policy

Medicaid Managed Care

The goals of the Texas Healthcare Transformation and Quality Improvement Program are to:

- Expand risk-based managed care to new populations and services;
- 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.

Texas Health and Human Services Commission provides coverage to approximately 5 million Texans under our managed care programs.

HHSC and the Medicaid MCOs achieved significant Medicaid Managed Care (MMC) milestones in FY21, including:

- Transitioned Non-Emergency Medical Transportation to managed care
- Established value-based default enrollment
- Entered into three new dental managed care contracts and a new enrollment broker contract
- Submitted and currently negotiating amendments related to ABA services for children under 21 with autism spectrum disorder and a policy change to better serve medically fragile adults

Key challenges successfully navigated during FY21 include:

- Quickly implemented a wide range of COVID-19 PHE member and provider flexibilities, including but not limited to teleservices, to ensure member health and safety and continuity of care
- Updated claims systems and prepared for the state directed payment program implementation

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

- Implementing revisions to the STAR Kids Screening and Assessment Instrument to improve initial and reassessment processes, as directed by Senate Bill (SB) 1207, 86th Texas Legislature, Regular Session. The initiative is intended to reduce the amount of time needed to complete the assessment, improve training and consistency in completion of the assessment, and streamline the annual reassessment process for a child who has not had a significant change in function that may affect medical necessity.
- Launch of the provider enrollment and management system
- Implementation of an external independent review organization process
- Allowing MCOs to provide more care coordination services using telecommunications or information technology Expanding Medicaid coverage for women six months after delivery
- Including Healthy Texas Women and Case Management for Children and Pregnant Women in managed care
- Full compliance with the home and community-based settings regulations
- Implementation of the STAR+PLUS Pilot Program

Public Health Emergency

Texas Health and Human Services (HHS) has continued its response to the COVID-19 PHE. For example, in 2021, the agency continued many flexibilities, started in 2020, permitting the remote delivery of case management, behavioral health, and some primary health care. Additionally, the State allowed for virtual or telephonic orientation for consumer directed services (CDS) and waived the 30-day spell of illness requirement in STAR+PLUS for 30 days statewide for stays related to COVID-19, allowing for 60 days total. As federal authorities granted emergency use authorizations and approvals for vaccines and COVID treatments, Texas added coverage for vaccines and treatments to the Medicaid program.

HHSC worked closely with MCOs to reduce barriers for member's accessing COVID vaccines. These efforts include ensuring the availability of non-emergency medical transportation to vaccine sites, including pharmacies, and providing vaccines to members who may be homebound. HHSC also began evaluating flexibilities put in place in response to the PHE which should be made permanent.

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

- Request for Proposals (RFP) Posting: Q2 FY2022
- Estimated Notice of Award: Q1 FY2023
- Start of Operations: Q1 FY2024

STAR

- RFP Posting: Q1 FY2023
- Estimated Notice of Award: Q3 FY2023
- Start of Operations: Q4 FY2024

STAR Kids

- RFP Posting: Q3 FY2023
- Estimated Notice of Award: Q1 FY2024
- Start of Operations: Q2 FY2025

Extension Application

Texas submitted an extension application of the 1115 THTQIP waiver on November 30, 2020. CMS approved this extension application on January 15, 2021. Difficulties operating the 1115 Transformation waiver emerged with the letter from CMS purporting to rescind their January 15, 2021, approval letter. The Texas 1115 Transformation waiver provides the authority under which most of Medicaid managed care is authorized. Without the terms previously negotiated and agreed to, Medicaid managed care, state directed payment programs within Medicaid managed care, supplemental payments made possible through managed care savings, and various initiatives aimed at continuous improvement of the program are at risk. The General Appropriations Act for the 2022-2023 biennium, 87th Legislature, Regular Session, 2021 (Article II, HHSC Rider 37) expressed the Legislature's intent that HHSC should seek a

renewal or extension of the current Section 1115 THTQIP waiver from CMS. Texas sought legal redress and submitted another extension application on July 14, 2021.

A federal court has issued a preliminary injunction against the rescission letter and set forth clarifying orders by which HHSC and CMS are to comply with the January 15, 2021 Special Terms and Conditions.

12. Litigation Summary

Consideration 1:

Type of Consideration	<i>Ongoing litigation</i>
Summary of Consideration	<p><i>Frew, et al. v. Young, et al.</i> (commonly referred to as <i>Frew</i>), 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.</p> <p>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.</p> <p>Another corrective action order was dismissed in December 2020 and is currently on appeal to the Fifth Circuit: Outreach and Informing, along with Part III of corrective action order: Managed Care.</p>
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 April of 2021) at 3,710,647.
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.

13. Health IT

Health Information Exchange (HIE) Connectivity Project Update

The HIE Connectivity Project is a Texas Medicaid initiative funded by CMS through the HIE Implementation Advance Planning Document (IAPD). The project's three strategies, one initiative, and associated goals/milestones were described in the Health Information Technology (HIT) Strategic Plan approved by CMS in May of 2020. Successful implementation of the three strategies will result in increased HIE adoption and use by Medicaid providers, creation of new HIE capacity in Texas, and bring clinical information into the Texas Medicaid program through HIE. The following is an update regarding progress made for each strategy, as well as the Patient Unified Lookup System for Emergencies (PULSE) initiative. In FY 21, the State saw an increase in Medicaid provider and hospital onboarding to the HIE Connectivity Project, maintenance of infrastructure supporting connectivity between Texas Health Services Authority (THSA) and contracted Local HIEs, and continued flow of clinical data to Texas Medicaid.

HIE IAPD Strategies 1-3

The FFY 2020/2021 milestone for Strategy 1 of the HIE Connectivity Project, as listed in the HIT Strategic Plan, is 200 Medicaid providers (including hospitals and ambulatory providers) connected to Local HIEs. Currently, three Local HIEs have contracted with HHSC to onboard and connect Medicaid providers and hospitals. These connections will facilitate electronic reporting and data exchange between providers and Texas Medicaid. As of September 15, 2021, 301 providers from 27 hospitals and 60 ambulatory practices have been approved, through this project, to join with the three Local HIEs. Twenty of these hospitals are connected for Emergency Department Event Notification (EDEN) only. THSA is also making direct connections with hospitals. As of September 15, 2021, THSA has made 41 direct connections.

Strategy 2 includes enhancing Texas' HIE infrastructure to support connectivity with the State's Medicaid system and assisting Local HIEs in implementing connections to HIE Texas, a set of State-level shared services managed by THSA. The FFY 2020/2021 milestones for this strategy, as listed in the HIT Strategic Plan, were implementation of a Master Patient Index (MPI) and eight HIEs connected to THSA as an outcome of this project. While the MPI has been implemented and infrastructure is in place to connect to Local HIEs, the original goal of eight HIEs connected to THSA has since been revised, as there are only 5 Local HIEs currently in existence in Texas. All three Local HIEs contracted through this project are connected to THSA

Strategy 3 assists Texas Medicaid in reducing emergency department (ED) utilization and hospital readmissions by enabling better follow-up care through the electronic receipt of Health Level Seven (HL7) Admission, Discharge, Transfer (ADT) data from hospitals. The FFY 2020/2021 milestone for this strategy, as listed in the HIT Strategic Plan, was for eight Local HIEs to contribute hospital ED ADT data as an outcome of this project. Currently, all three Local HIEs contracted through Strategy 1 have successfully transferred ADT, as well as Consolidated Clinical Document Architecture (C-CDA) data in near real-time, through THSA to Texas Medicaid. Two of these Local HIEs are sending ED ADT data. HHSC is in the process of building permanent storage and accessibility for receiving and distributing this data to the appropriate departments and organizations.

PULSE (Initiative 1)

HHSC is working with THSA on Texas' Patient Unified Look-up System for Emergencies (HIETexas PULSE) to improve the State's ability to provide patient medical information to qualified first responders during State and federal disasters, and has built PULSE software, infrastructure, and connectivity to HIEs. The FFY 2020/2021 milestone for this initiative, as described in the HIT Strategic Plan, is to develop a plan and the PULSE application, as well as to test and launch the application and implement the program. The upgraded PULSE Enterprise Edition (PULSE EE) went live this past hurricane season and was ready to be activated for a State or federally declared disaster. In September 2021, HIETexas PULSE was deployed and enrolled users in Louisiana as a response to Hurricane Ida. Lessons learned from this experience will be used to inform processes for future activations in Texas.

14. Evaluation

HHSC completed the following 1115 Waiver evaluation activities during SFY21 Q4:

- HHSC submitted the Interim Report from Texas A&M University (TAMU) to CMS on September 29, 2021. Key takeaways from the Interim Report are described below under Description of Evaluation Findings or Reports.
- HHSC analysts continued meeting with TAMU as needed to provide evaluation-related technical assistance and discuss the Interim Report prior to submission.
- HHSC met with CMS on July 23, 2021 to review and discuss options to expand upon Texas' External Quality Review Organization's STAR Kids study. On September 3, 2021, HHSC submitted documentation to CMS on the State's proposal to add a post-only component of key STAR Kids performance measures to the Interim Evaluation Report #1 corresponding to DY 7-11 (due on March 31, 2024). CMS approved the State's proposal on October 1, 2021. As requested by CMS, details of the evaluation approach are provided below under Modifications to the Evaluation Design.
- HHSC received feedback from CMS on Revision 5.1 of the CMS-approved evaluation design on April 5, 2021. HHSC analysts were still considering responses to CMS feedback at the end of SFY21 Q4.
- HHSC submitted a draft evaluation design in compliance with STC 82 focusing on DYs 10-19 to CMS on July 14, 2021. HHSC provided an overview of the draft evaluation design to CMS on July 22, 2021.

Modifications to the Evaluation Design

STAR Kids is a Texas MMC program that provides benefits to individuals 20 years or younger with a disability. STAR Kids began on November 1, 2016. At the time that the State was drafting the evaluation design for the 1115 Demonstration (2018-2022 approval period), Texas' EQRO was conducting a multi-year evaluation of STAR Kids. Because the study was still ongoing, a dedicated STAR Kids component was not included in the evaluation design CMS approved on August 8, 2018. CMS reviewed the EQRO's STAR Kids study and determined the study did not satisfy 1115 Demonstration evaluation requirements. As a result, HHSC will be adding the following new evaluation component to the Interim Evaluation Report #1 (due on March 31, 2024) on STAR Kids to fulfill the 1115 evaluation requirements, as confirmed by CMS via email on October 1, 2021. HHSC will add the following information on the STAR Kids add-on component as a new Appendix to the Evaluation Design.

STAR Kids Evaluation Design

The STAR Kids add-on component will include one evaluation question and five hypotheses:

- Evaluation Question 6. Did the STAR Kids MMC program improve access to and quality of care over time?
 - Hypothesis 6.1. Access to preventive care will maintain or improve over time.
 - Hypothesis 6.2. Effective treatment of chronic, complex, and serious conditions will maintain or improve over time.
 - Hypothesis 6.3. Appropriate use of health care will maintain or improve over time.
 - Hypothesis 6.4. Poor care or care coordination which may result in unnecessary patient harm will maintain or reduce over time.
 - Hypothesis 6.5. MMC member experience will maintain or improve over time.

The STAR Kids add-on component will be evaluated with a one-group posttest only design. This design will use consecutive population-based observations of STAR Kids measures to describe changes in MMC operation and performance over time. Measures will be analyzed through descriptive statistics and descriptive trend analysis (DTA), which plots and analyzes time-series data calculated at equally-spaced intervals to explain patterns in selected measures over time. The add-on component will rely on MMC performance measures calculated by the EQRO between January 1, 2017 (the first STAR Kids reporting date) through December 31, 2022, or the latest date available when TAMU is preparing the Interim Evaluation Report #1 (due on March 31, 2024). The table below provides an overview of the measures, data sources, and analytic methods for each hypotheses of the STAR Kids add-on component.

Evaluation Design Overview: STAR Kids Add-On Component

Evaluation Hypothesis	Measures ¹	Data Source	Analytic Methods
H6.1. Access to preventive care will maintain or improve over time.	6.1.1 Childhood immunization status (HEDIS [®]) 6.1.2 Immunizations for adolescents (HEDIS [®]) 6.1.3 Prenatal and postpartum care (HEDIS [®])	• EQRO-calculated MMC performance measures	• Descriptive statistics • DTA • Subgroup analysis ²
H6.2. Effective treatment of chronic, complex, and serious conditions will maintain or improve over time.	6.2.1 Follow-up care for children prescribed ADHD medication (HEDIS [®]) 6.2.2 Follow-up after hospitalization for mental illness (HEDIS [®]) ³	• EQRO-calculated MMC performance measures	• Descriptive statistics • DTA • Subgroup analysis ²
H6.3. Appropriate use of health care will maintain or improve over time.	6.3.1 Potentially preventable admissions (3M) 6.3.2 Potentially preventable emergency department visits (3M) ³	• EQRO-calculated MMC performance measures	• Descriptive statistics • DTA • Subgroup analysis ²
H6.4. Poor care or care coordination which may result in unnecessary patient harm will maintain or reduce over time.	6.4.1 Potentially preventable complications (3M) 6.4.2 Potentially preventable readmissions (3M)	• EQRO-calculated MMC performance measures	• Descriptive statistics • DTA • Subgroup analysis ²
H6.5. MMC member experience will maintain or improve over time.	6.5.1 Getting care quickly composite (CAHPS [®]) ³ 6.5.2 Getting needed care composite (CAHPS [®]) ³ 6.5.3 Rating of personal doctor (CAHPS [®]) ³ 6.5.4 Rating of health plan (CAHPS [®])	• EQRO-calculated MMC performance measures	• Descriptive statistics • DTA • Subgroup analysis ²

Notes. ¹ Measures reflect the evaluation design submitted to CMS on July 14, 2021. Future revisions or modifications to that evaluation design will be applied to the STAR Kids add-on component, as necessary. ² Subgroup analysis will only be performed where applicable. ³ Measure was included in the EQRO's STAR Kids study. The evaluator should summarize the EQRO's findings when interpreting this measure for contextual background.

Evaluation Findings or Results to Date

HHSC submitted the Interim Report from TAMU to CMS on September 29, 2021. The Interim Report primarily focuses on DYs 7-8⁴ and reflects the Evaluation Design initially approved by CMS on August 8, 2018.⁵ The table below summarizes key preliminary findings presented in the Interim Report.

Summary of Preliminary Evaluation Findings from Interim Report (September 2021)

Evaluation Component	Hypothesis	Key Preliminary Findings from Interim Report ¹
Delivery System Reform Incentive Payment (DSRIP)	Maintain or increase collaboration among providers (H1.1)	DSRIP providers reported increases in tangible resource sharing and data sharing agreements, but decreases in joint service delivery.
	Maintain or improve continuity, quality, and cost of care for Medicaid clients with diabetes (H1.2)	Preliminary claims-based analyses suggest DSRIP's impact on Medicaid clients with diabetes were mixed, but findings should be interpreted with caution due to methodological limitations.
	Improve quality-related outcomes (H1.3)	DSRIP providers reported some improvements in quality-related outcomes, however additional data is necessary.
	Improve population health outcomes (H1.4)	Potentially preventable events did not consistently vary across Regional Healthcare Partnerships, however additional data is necessary.
Uncompensated Care (UC)	Reduce the percentage of UC costs reimbursed (H2.1)	On average, UC providers experienced a reduction in the percentage of UC costs reimbursed over time, however this reduction was driven primarily by large and urban hospitals. Small and rural hospitals did not experience reductions in the percentage of UC costs reimbursed over time.
	Slow the UC cost growth rate (H2.2)	On average, the UC cost growth rate did not slow over time, but growth rates varied substantially across UC provider types. Small and State-run hospitals experienced significant reductions in the UC cost growth rate over time, but no other provider types experienced significant changes.

⁴ DYs covered in the Interim Report vary by evaluation component, measure, and study population. For more information, refer to the Evaluation Design initially approved by CMS on August 8, 2018 accessible at: <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/tx/Healthcare-Transformation-and-Quality-Improvement-Program/tx-healthcare-transformation-appvd-demo-eval-dsgn-080218.pdf>

⁵ HHSC has submitted multiple revisions to the Evaluation Design to CMS for approval. HHSC is currently in discussions with CMS on Revision 5.1, submitted to CMS for approval on January 8, 2021

Evaluation Component	Hypothesis	Key Preliminary Findings from Interim Report¹
Medicaid Managed Care (MMC)	Improve access to care (H3.1)	Most MMC populations experienced improvements in access to care following the transition to MMC, however additional data is necessary.
	Improve care coordination (H3.2)	Some MMC populations experienced improvements in care coordination following the transition to MMC; others experienced little to no change, however additional data is necessary.
	Improve quality of care (H3.3)	Limited data on quality of care were available for the Interim Report. The data available suggest most MMC populations experienced little to no change in quality of care following the transition to MMC. One MMC population experienced initial improvements in quality of care following the transition to MMC, however additional data is necessary.
	Improve health and health care outcomes (H3.4)	Most MMC populations experienced some improvements in health and health care outcomes following the transition to MMC, however additional data is necessary.
	Improve client satisfaction (H3.5)	Limited data on client satisfaction were available for the Interim Report. The data available suggest MMC populations experienced little to no change in client satisfaction following the transition to MMC, however additional data is necessary.
Overall Demonstration	Support the development of APMs (H4.1)	MCOs and DSRIP providers reported increases in APM engagement, but additional years of data are necessary to understand DSRIP provider perceptions of APMs.
	Reduce potentially preventable ED use (H5.1)	Potentially preventable ED use did not significantly change among the Medicaid and low-income uninsured population over time.
	Result in overall cost savings (H5.2)	The Demonstration resulted in an overall cost savings; total spending under the Demonstration was less than the projected spending without the Demonstration.

Notes. ¹ Evaluation findings presented in Table 2 are preliminary and therefore should be interpreted with caution. Full evaluation findings for the Evaluation Design approved by CMS on August 8, 2018 will not be available until the delivery of Interim Evaluation Report #1 (due on March 31, 2024).

15. Delivery System Reform Incentive Payment Program

The Delivery System Reform Incentive Payment (DSRIP) Program evolved from project-level reporting in DY1-6 to provider-level outcome reporting in DY7-10 to measure the continued transformation of the Texas healthcare system. DSRIP providers report on required categories at the provider system level, rather than the project level. DY7-10 is an opportunity to advance sustainability of providers' transformed systems, including development of alternative payment models (APMs) to continue services for Medicaid and low-income or uninsured (MLIU) individuals. Regional Healthcare Partnerships (RHP) updated their RHP Plans during DY9 Q1, which HHSC reviewed and approved. The plan updates provided an opportunity to reassess regional efforts toward a coordinated care delivery system. The plan updates also allowed providers to update their outcome measures selection and activities for reporting during DY9-10. Providers choose the focus areas of initiatives that drive system transformation and improve quality of services and health outcomes for individuals served.

October DY9 Reporting Payments

Providers reported achievement of DY9 Category B MLIU patients served, achievement of DY8 Category C measures, baselines for DY9 newly selected Category C measures, and DY9 Category D measures in October 2020. In total for October DY9 reporting and based on available Intergovernmental Transfer (IGT), \$516,591,505 was paid to DSRIP providers in January 2021.

April DY10 Reporting Payments

Providers continued to report achievement of DY9 Category B MLIU patients served, DY8 and DY9 Category C measures, and DY10 Category D measures in April 2021. In total for April DY10 reporting and based on available Intergovernmental Transfer (IGT), \$2,463,875,526 was paid to DSRIP providers in July 2021, for a total of \$2,980,467,031 paid in FFY21 and \$22.3 billion in DY1-10 DSRIP payments to date. October DY10 reporting results will be included in subsequent reports. **Attachment X** includes DSRIP providers' overall status for April DY10 reporting. **Attachment Y** provides estimated remaining payments for DY9-10.

COVID-19 Accommodations

In light of the significant impact of the COVID-19 PHE, HHSC and CMS agreed on flexibility for reporting and demonstrating achievement on certain reporting requirements for DY9 and DY10. The totals above reflect providers' use of the approved flexibilities. CMS approved a COVID-19 accommodation for Category B including:

- Broadening the definition of an encounter to include patient telephone calls for DY9-10.
- Allowing HHSC to adjust allowable variation across all providers.

Providers served an average of 96.5% of their DY8 Category B MLIU volume in DY9. The DY9 accommodation allowed providers to earn \$27.1 million more in Category B than if there had been no accommodations. CMS also approved the application of the DY9 Category B accommodation for October DY10 reporting.

CMS approved a COVID-19 accommodation for DY9-10 Category C including:

- Earning payment for DY9 or DY10 achievement milestones based on the higher of a provider's approved DY8 achievement, the statewide average approved DY8 achievement per measure or measure bundle, DY9 achievement in calendar year (CY) 2020 or CY2021 for DY9 achievement milestones, or DY10 achievement in CY2021 for DY10 achievement milestones.
- Using the average approved DY8 achievement per bundle measure as the minimum payment for a provider's DY9 or DY10 achievement milestone for measures that have been selected by 10 or fewer providers.
- Requiring providers to report CY2020 and CY2021 data to be eligible for payment on the Category C achievement milestones.

Providers may use the DY9 Category C accommodation during April or October DY10 reporting and the DY10 Category C accommodation during April or October DY11 reporting.

April DY10 Category C Reporting

In April DY10, 2,826 Category C measures were eligible to report Performance Year 3 (PY3, which is 01/01/20 – 12/31/20) to potentially earn payment for remaining DY8 achievement milestones and DY9 reporting and achievement milestones.

Of the 3,228 achievement milestones (pay-for-performance) that were approved for Performance Year (PY) 3 (CY2020) reporting in April 2021, 1,146 (or 36%) used the approved COVID-19 accommodations to earn payments. Providers earned \$445,848,417.85 in payments that they would not have earned without the approved COVID-19 accommodations.

Overall, 82.49% of measures were reported in April 2021 as fully achieving the DY9 goal in PY3, and an additional 17.35% of measures reported partially achieving the DY9 goal in PY3. For remaining DY8 achievement, 32.27% of measures were reported in April 2021 as fully achieving the DY8 goal in PY3, and an additional 67.09% of measures reported partially achieving the DY8 goal in PY3.

Providers may report remaining DY9 reporting and achievement milestones in October DY10 or carryforward DY9 achievement milestones to April DY11. DY10 reporting and achievement milestones will begin reporting in April DY11. DSRIP continues to provide technical assistance to correct Category C reported baselines and performance.

The table below provides a summary of reported achievement by measure type and **Attachment Z** includes all Category C reporting and summaries by measure, Measure Bundle, provider type, measure type, and region.

Measure Type	P4P Measures Eligible to Report PY3 in DY10	P4P Measures that have reported PY3 (CY20) in DY10	P4P 100% of AM-9.x Goal Achieved in PY3	P4P Partial Achievement of AM-9.x Goal in PY3	P4P 100% of AM-8.x Goal Achieved in PY3	P4P Partial Achievement of AM-8.x Goal in PY3
Cancer Screening	112	91.23%	81.73%	18.27%	24.00%	76.00%
Clinical Outcome	524	93.93%	76.04%	23.96%	30.63%	69.37%
Hospital Safety	238	95.76%	66.81%	33.19%	26.21%	73.79%
Immunization	251	94.44%	82.77%	17.23%	41.27%	58.73%
Population Based Clinical Outcome	278	91.89%	70.59%	25.49%	36.73%	55.10%
Process	1401	93.56%	88.34%	11.66%	31.22%	68.78%
Quality of Life	22	100.00%	100.00%	0.00%	100.00%	0.00%
All Measures	2826	93.75%	82.49%	17.35%	31.24%	68.13%

DSRIP Transition Plan Update

HHSC submitted all deliverables for eight milestones as required under the Transition Plan to CMS in FFY2021:

- Report on analysis of Demonstration Year (DY) 7-8 DSRIP quality data and related core activities was submitted in December 2020.
- Proposals for new programs, including state-directed payment programs, to sustain key DSRIP initiative areas in DY 11 were submitted in December 2020.
- Updated Texas Medicaid Managed Care Quality Strategy, updated Value-Based Payment (VBP) Roadmap, and report of Managed Care Organizations' Alternative Payment Model achievement were submitted in March 2021.
- Assessment of Social Factors Associated with Health Outcomes in Texas Medicaid was submitted in March 2021.
- Assessment of financial incentives for alternative payment models and quality improvement cost guidance was submitted in June 2021.
- Assessment of Texas Medicaid rural teleservices was submitted in June 2021.
- Report on options for RHP structure post-DSRIP was submitted in June 2021.
- Proposals for additional new programs, including potential new Medicaid benefits, to sustain key DSRIP initiative areas beginning in FFY23 were submitted in September 2021.

For DSRIP transition, HHSC has submitted preprints for four new directed payment programs proposed to begin in September 2021.⁶ As indicated in the DY11 new program proposals submitted to CMS, these programs are key to the DSRIP Transition for Medicaid providers and enrollees. The programs include new reporting requirements as a condition of participation, quality measures for program evaluation, and payments through Medicaid managed care. These programs are:

- Texas Incentives for Physician and Professional Services (TIPPS)
- Comprehensive Hospital Increased Reimbursement Program (CHIRP)
- Rural Access to Primary and Preventive Services (RAPPS)
- Directed Payment Program for Behavioral Health Services (DPP BHS)

HHSC held quarterly Partner Engagement and Executive Waiver Committee meetings and provided monthly updates to keep all interested stakeholders informed on the progress of the DSRIP Transition.

⁶ HHSC has submitted a fifth pre-print for the Quality Incentive Payment Program, which is unrelated to the DSRIP transition.

16. Charity Care Pools

Uncompensated Care Pool

The DY 10 Uncompensated Care Pool payments were distributed to hospital, public ambulance, physician groups, and public dental providers in accordance with the Attachment H protocol. DY 10 interim payments were critical to participating UC providers as they coped with COVID-19, which increased costs and resulted in decreased revenues. While payments issued during DY10 are primarily based upon historical cost data and trends, the payments will be reconciled to actual costs later; due to the unforeseeable impact that COVID-19 had on utilization patterns and cost trends, it is probable that the DY10 reconciliation when conducted will result in more variation between the interim data as compared to the final actual data than is usually observed during a UC reconciliation.

Public Health Provider Charity Care Pool

The Public Health Provider Charity Care Pool was not yet authorized to begin reimbursing providers for expenditures during DY10, but preparation activities in anticipation of the program launch on October 1, 2021 were intense. Texas HHSC formed a workgroup of interested stakeholders to provide input and guidance as the State developed and adopted rules for DY 11 and DY12 and after. The workgroup also provided input regarding the Attachment T protocol that was submitted for DY11, along with the proposed DY11 cost tool. The State also submitted a proposed Attachment T for DY12 and after. HHSC and providers continue to anxiously await CMS approval on the submitted deliverables so the program can successfully commence in DY11.

17. Post Award Forum

In compliance with STC 79, HHSC hosted a public forum via webinar on July 14, 2021 to provide the public with updates on the progress of Texas Healthcare Transformation and Quality Improvement Program (THTQIP) waiver extension that was approved on January 15, 2021. The date, time and location of the public forum was published on the HHSC website 30 days in advance of the meeting. During the public forum, HHSC provided an update on the extension, upcoming amendments, and provided a link to the 1115 DY9 annual report and COVID-19 resource pages. HHSC provided an opportunity for public comments. During the forum HHSC received general questions about the presentation and public comments regarding expanding Medicaid, PHP-CCP funding, the DSRIP program, and the state directed payment program for behavioral health services.

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 (SFY21). The attachment includes annual and quarterly Dental, STAR, STAR Kids and STAR+PLUS enrollment summaries.

Attachment B2 - Medicaid and CHIP Enrollment Reports - As of February 2021, which include finalized data from Q2.

Attachment B3 – Disenrollment Summary (SFY21). The attachment includes quarterly and annual Dental, STAR and STAR+PLUS disenrollment summaries.

Attachments C1, C2, C3 - Provider Network and Methodology. The attachments summarize STAR, STAR Kids, and STAR+PLUS network enrollment by MCOs, SDAs, and provider types. It also includes a description of the methodology used for provider counts and terminations.

Attachments D - Out-of-Network Utilization. The attachments summarize Dental, STAR, STAR Kids, and STAR+PLUS out-of-network utilization.

Attachment E - Distance Standards. The attachment shows the State’s distance standards by provider type and county designation.

Attachment H1-H4 - Network Access Analysis. The attachments include the results of the State’s analysis for PCPs, main dentists, and specialists.

Attachment J - MCO Pharmacy GeoMapping Summary. The attachment includes the STAR, STAR Kids, and STAR+PLUS plans’ self-reported GeoMapping results for pharmacy.

Attachments K1, K2, K3, K4 - State Direct Programs. The attachments display QIPP uniform rate increase and value-based payments, Nursing Facility Claims Minimum Fee Schedule including QIPP NF funds earned per Metric, UHRIP rate increase, and Rural Hospital MCO Encounter Minimum Fee Schedule.

Attachments M1-M4 - Hotline Summaries. The attachments provide data regarding phone calls and performance standards of MCO and DMO Member and Provider Hotlines.

Attachments 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 the State and MCOs.

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.

Attachment S - Service Utilization. The attachment displays Enrollment and Expenditure Graphs for the previous fiscal year.

Attachments V1-V4 - Claims Summary (SFY21). The attachments are summaries of the MCOs’ claims adjudication results.

Attachment X - DSRIP Provider Summary.

Attachment Y - DSRIP Remaining Payments. Reported biannually after DSRIP payments are distributed.

Attachment Z - DSRIP Category C Summary Workbook.