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

As Required by

Special Terms and Conditions 74

and 42 CFR § 431.428

Texas Health and Human Services

Commission

Q4 & Annual Report

December 2022

TEXAS
Health and Human Services

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1. Preface

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

State	Texas Health and Human Services Commission
Demonstration Name	Texas Healthcare Transformation and Quality Improvement Program - "1115 Transformation Waiver"
Approval Dates	Initial approval date: December 12, 2011 15-Month Extension approval date: May 2, 2016 Renewal approval date: December 13, 2017 Extension approval date: January 15, 2021
Approval Period	December 13, 2017-September 30, 2022 (prior approval period) January 15, 2021-September 30, 2030
Demonstration Goals and Objectives	The Texas Healthcare Transformation and Quality Improvement Program Section 1115 Waiver enables the State to expand use of Medicaid managed care to achieve program savings, while also preserving locally funded supplemental payments to hospitals. The goals of the demonstration are to: • Expand risk-based managed care statewide; • Support the development and maintenance of a coordinated care delivery system; • Improve outcomes while containing cost growth; and • Transition to quality-based payment systems across managed care and providers.

2. Executive Summary

According to the Special Terms and Conditions (STCs) of the Demonstration, the Texas Health and Human Services Commission (HHSC) provides the monitoring report for Demonstration Year (DY) 11, which began October 1, 2021[1]. Pursuant to 42 CFR § 431.428, Texas provides this quarterly and annual report to demonstrate how the goals and objectives were met as Texas Medicaid served over five million Medicaid beneficiaries through risk-based Medicaid managed care authorized under this waiver while finalizing the transition from the Delivery System Reform Incentive Payment (DSRIP) pool to integrated directed payment programs, continuing the Uncompensated Care (UC) pool, and launching the Public Health Provider Charity Care Program.

Growth in Caseload

As of September 2022, Texas had over 5.5 million full benefit clients in Medicaid. Prior to the federal public health emergency (PHE), full benefit caseloads were under 4 million and experiencing overall declines due to sustained positive economic conditions and record low unemployment levels. This growth in Medicaid underscores the significant impact the federal COVID-19 public health emergency (PHE) and states that maintain continuous Medicaid coverage quality for an increase in federal Medicaid funding which has had an impact on Texas' Medicaid enrollment.

Medicaid Managed Care Enrollment

In the beginning of state fiscal year (SFY) 2022, HHSC contracted with 17 managed care organizations (MCOs). Effective January 1, 2022, Molina Healthcare acquired Cigna-HealthSpring. Cigna-HealthSpring submitted deliverables during quarter one of SFY22. The State continues to contract with 16 MCOs and 3 dental maintenance organizations (DMOs). Each MCO covers one or more of the service delivery areas (SDAs), while each dental plan provides statewide services (See ***Attachment A***). Approximately 95 percent of Texas Medicaid beneficiaries are enrolled in Medicaid Managed Care (MMC). The PHE continuous Medicaid coverage requirement has had the largest impact on the STAR program, which serves parent/caretakers, pregnant women, and children. The STAR+PLUS and STAR Kids programs have not experienced the same degree of impact. These programs include members with special health care needs (MSHCN) who are managed care clients either requiring regular, ongoing therapeutic intervention and evaluation, or with serious, ongoing illness, or a disability that may last for a significant period of time, all of which led to longer lengths of stay in Medicaid.

Initiatives

During quarter four of federal fiscal year (FFY) 2022, HHSC continued to implement several new initiatives and programs. The state received final approval of the directed payment programs set forward in the DSRIP transition plan and STCs. The state launched the Public Health Provider-Charity Care Pool and worked with the Centers for Medicare and Medicaid Services (CMS) to resize the UC Pool. The state continues to make DSRIP payments related to the last program year; the final payment will be made in January 2023. Finally, in response to legislative direction, the state submitted 1115 waiver amendments to extend Medicaid eligibility for women postpartum and transition Case Management for Children and Pregnant Women into managed care.

[1] Demonstration Year 11 includes work that is tied to the state fiscal year as well.

DSRIP and UC

The State continued to operate supplemental payment programs. The State submitted the DSRIP program deliverables, as required by the CMS-approved DSRIP Transition Plan, to support a successful transition. A total of $2.18 billion was paid to DSRIP providers in FFY22 for Demonstration Years (DY) 9-10 reported achievement. The UC pool continued under the new structure implemented October 1, 2019. A total of up to $3.87 billion will be paid for FFY21. Texas' budget neutrality workbook was updated and reveals Texas continues to have a positive gain through the design and implementation of MMC.

Evaluation Activities

Evaluation activities during DY11 focused primarily on the refinement of future evaluation designs and deliverables. Specifically, HHSC received CMS approval on a revision for the 1115 Evaluation Design covering DYs 7-11, received CMS approval on the 1115 Evaluation Design covering DYs 10-19, and identified evaluation updates needed for the upcoming Interim Evaluation Report #1 (due on March 31, 2024, in accordance with the January 2021 STCs). Collectively, these revisions expand the scope and improve the rigor of the state's evaluation of the 1115 Waiver. HHSC also received CMS approval of Texas A&M University's Revised Interim Evaluation Report (December 2017 STCs) during DY11. Key takeaways from the Interim Evaluation Report (December 2017 STCs) were summarized in the Annual Monitoring Report for DY10.

COVID-19 Public Health Emergency

In response to the PHE and financial strains impacting the Texas healthcare system, Texas submitted an extension application in November 2020. Texas and CMS worked together to negotiate and 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 MCOs, and the network of contracted providers actively responding to the PHE. The COVID-19 PHE continues to be a key challenge impacting the 1115 Transformation Waiver. It has significantly impacted both costs and caseload.

On October 13, 2022, the PHE was extended by the Secretary of the Department of Health and Human Services for another 90 days. The approved accommodations from April 2021 "Emergency Preparedness and Response Attachment K," are set to extend to the end of the PHE.[2] The PHE is not expected to end until after January 11, 2023, as the Secretary of HHS did not provide 60-day advance notice to states in November 2022 which would have signaled the PHE is actually ending on January 11, 2023. In response to the PHE, HHSC implemented temporary provider rate increases to support recruitment and retention of direct care workforce providing home and community-based services. Workforce and staffing needs continue to be reviewed.

HHSC has an ongoing process to review flexibilities implemented during the PHE and determine if flexibilities are appropriate to end or make permanent in compliance with federal requirements.

This report discusses in more detail the highlights included in this summary section. Due to data lags associated with primary sources of record, corresponding data submission timelines, and data cleaning

[2] HHSC may end approved flexibilities that are no longer required or determined necessary prior to the end of the PHE.

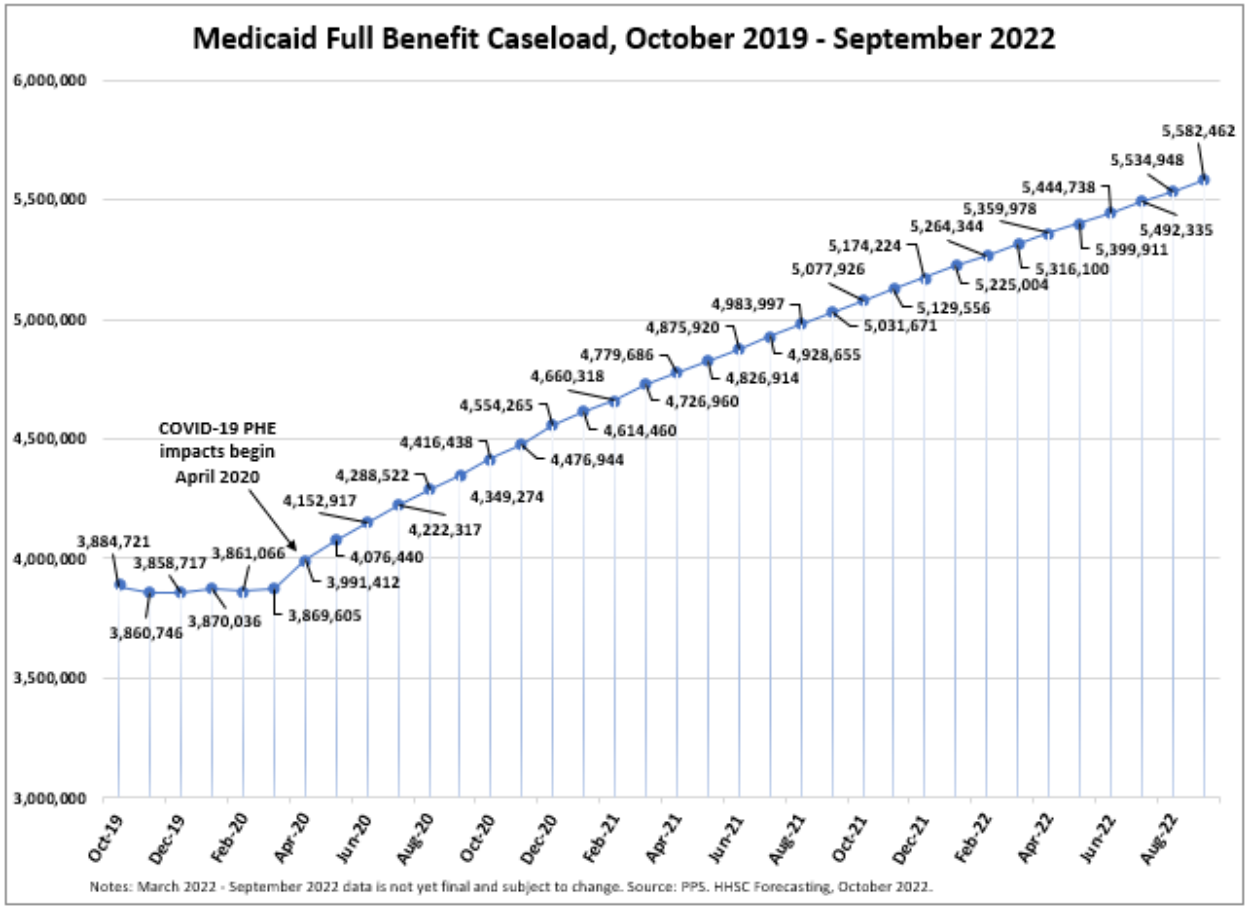
procedures, each data attachment referred to and submitted to CMS reflect varying reporting periods. Certain numbers in this report have been rounded up or down and may not add up precisely to the totals provided and percentages may also not precisely reflect the absolute figures.

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.

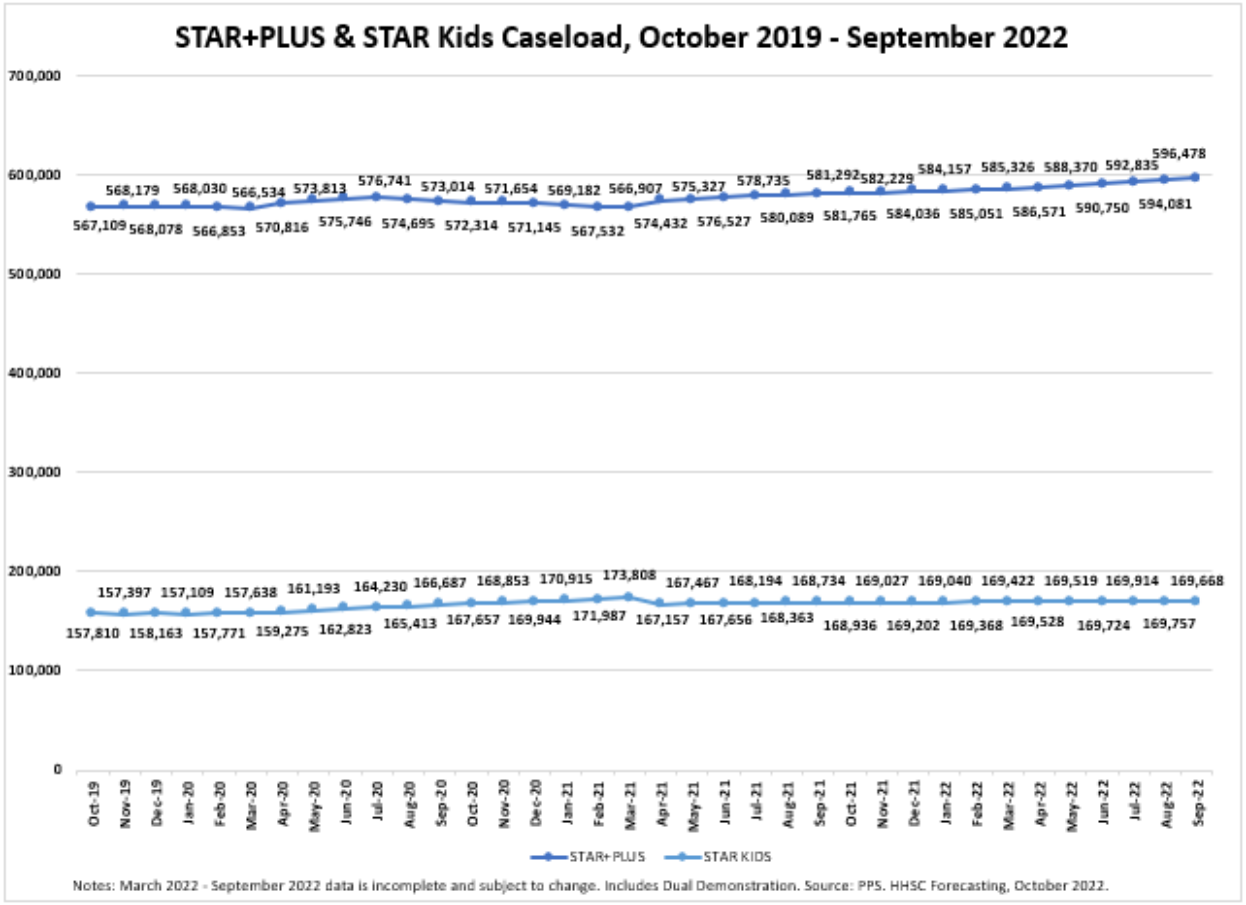
The graph below provides a visual look at the overall Medicaid caseload growth experienced during the PHE. Growth began in April 2020 and has increased by over 1.7 million clients.

Figure 1. Medicaid Full Benefit Caseload, October 2019 - September 2022



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.

Figure 2. STAR+PLUS & STAR Kids Caseload, October 2019 – September 2022



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

In ***Attachment B1***, an enrollment summary is broken out by product line, service delivery area, and MCO for SFY22 Q3 to show where caseloads are headed. Due to the amount of time required for accurate data collection and reporting, total enrollment counts are reported on a one-quarter lag. ***Attachment B2*** includes Medicaid and CHIP Enrollment Reports from December 2021 through February 2022. These reports include the estimated enrollment by delivery model, program, risk group, Medicaid MCOs, DMOs, and CHIP MCOs. The data are projections provided by Forecasting and are considered final after eight months. Since February 2021, the Full Benefits Medicaid in Texas caseload increased from 4,660,318 to 5,264,344 in February 2022. During that same period, the CHIP caseload in Texas decreased from 238,195 to 89,791.

Enrollment Counts for the Quarter by Populations Served

This subsection includes the latest quarterly enrollment counts for which final data is available. This enrollment summary includes all Medicaid clients to demonstrate both the total number served and the number of clients in Medicaid managed care authorized under the waiver. Unique client counts per quarter will be reported on a two-quarter lag and provided every other quarter.

Enrollment of Members with Special Health Care Needs

This subsection of the report addresses managed care enrollment of MSHCN. ***Attachment Q*** outlines STAR MSHCN details by SDA and MCO. HHSC has established contractual requirements and a template for the MCOs to submit quarterly MSHCN data. Because of the time required for data collection, MSHCN data are reported on a one-quarter lag.

All STAR Kids and STAR+PLUS members are deemed to be MSHCN. All STAR Kids and STAR+PLUS plans reported 100 percent MSHCN, as required in the contract. STAR Kids and STAR+PLUS 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 can be considered an administrative service performed by the STAR MCO. Service management also includes the development of a service plan to meet the members' short and long-term goals.

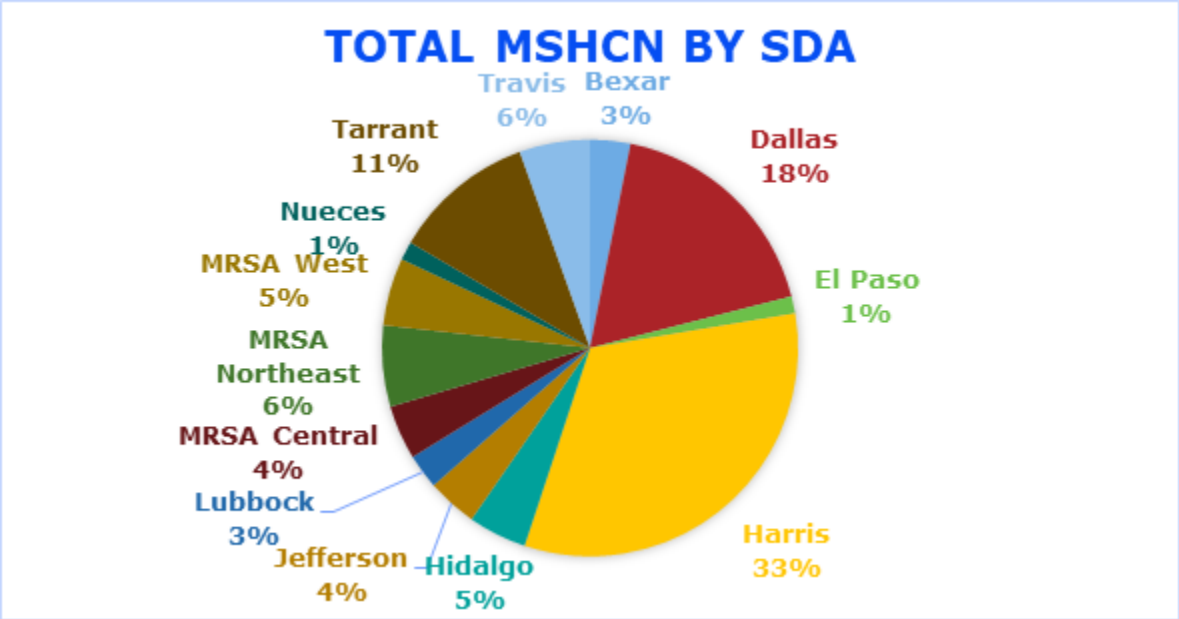
The number of members without service plans includes those who declined and those who could not be reached. An MSHCN is defined as a member who:

> (1) Is in one or more groups designated by HHSC. These groups include pregnant women identified as high risk, members with behavioral health conditions, members with serious ongoing illness or a chronic complex condition that is anticipated to last for a significant period and requires ongoing therapeutic intervention and evaluation; or
>
> (2) Has been identified as MSHCN based on the MCO's assessment of each individual member's needs.

In SFY22 Q3, STAR MCOs reported a total of 118,126 children and adults identified as MSHCN. STAR MCOs reported 18.94 percent of MSHCN had a service plan and 81.06 percent of MSHCN did not have a service plan. (See ***Attachment Q***). In SFY22 Q3, the overall percentage of STAR MSHCN with service plans has decreased since the last reporting period. Two MCOs reported more than 60 percent of their MSHCN in certain SDAs had a service plan (Aetna and United). Two MCOs (Community First and Texas Children's) reported less than 10 percent of their MSHCN in certain SDAs had a service plan.

Harris SDA holds the most MSHCN with 32.76 percent (38,701) of all reported STAR MSHCN. Dallas SDA holds the second most reported MSHCN with 17.87 percent (21,112) of all reported STAR MSHCN. See chart below for additional detail.

Figure 3. Total MSHCN by SDA



HHSC conducts quality checks in each quarterly submission of the MSHCN Report to assess reporting errors and follow-up with the MCOs. In SFY22 and SFY23, staff will conduct a targeted review of a sample of STAR and CHIP MSHCN service plans. In addition to targeted reviews, HHSC conducts biennial operational reviews of MCOs. These operational reviews are comprised of an in-depth review of MCO operational compliance and performance across several areas, such as STAR MSHCN service management and service planning, to ensure policies and practices align with performance standards, including managed care contract requirements. If any problems are discovered during the operational reviews, HHSC takes appropriate steps to address performance and compliance.

Beginning in August 2022, HHSC began collecting 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 will develop a data visualization dashboard to monitor trends.

Member Disenrollment

There were no Medicaid members disenrolled during SFY22 Q4. During SFY22, one Medicaid member was disenrolled due to the member moving out of state.

3.1 Anticipated Changes to Enrollment

On January 27, 2020, the Secretary of Health and Human Services declared a PHE due to the novel coronavirus. In March 2020, Governor Greg Abbott declared a disaster in Texas due to the COVID-19 pandemic. Additionally, the federal law passed in March 2020, H.R. 6201 (Families First Coronavirus

Response Act), required States to maintain continuous Medicaid coverage during the federal PHE period as a condition of receiving enhanced federal funding. As part of the emergency response, HHSC put automated processes in place to maintain Medicaid coverage.

On October 28, 2020, 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 continuous Medicaid coverage requirements as part of the FFCRA.

Beginning in February 2021, 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 in the same tier of benefits, the client will remain in their current group for the remainder of the continued eligibility period. There are limited situations where an individual will not continue to receive Medicaid State Plan benefits such as when the individual moves out of state, voluntarily withdrawals from the program, or dies.

Based on the new guidance provided by CMS on March 3, 2022, Texas' PHE unwinding plan for completing redeterminations will be a population-based, phased approach to end continuous coverage. HHSC's unwinding approach staggers Medicaid redeterminations for continuous coverage. Using the most recent case information, this approach will prioritize redeterminations into the following groups:

1. Individuals most likely to be ineligible (e.g., members who aged out of Medicaid, or adult recipients who no longer have an eligible dependent child in their household) or those who transitioned to another program (i.e., CHIP, or pregnant women who may transition to Healthy Texas Women).
2. Individuals transitioned to a different Medicaid eligibility group; Medicaid children, parent/caretaker and waiver groups pending information; and certain Modified Adjusted Gross Income (MAGI) population groups (e.g., children, people receiving Transitional Medical Assistance).
3. All remaining individuals from the previous groups, including those most likely to remain eligible when continuous coverage ends.

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

Additionally, to address the needs of providers and members participating in Medicaid during the PHE, HHSC has implemented policy and process flexibilities related to services, provider enrollment, and assessments. HHSC has an ongoing process to review these flexibilities and determine if it is appropriate to end flexibilities or make permanent, in compliance with federal requirements.

4. Provider Network & Network Adequacy

To ensure the availability and accessibility of services in a timely manner, MCOs are required to meet network adequacy standards for time and distance. These vary by provider type and county designation (metro, micro, rural). MCOs must ensure at least 90 percent of members, unless otherwise specified, have access to a choice of each provider type (PCPs, dentist, and specialty services) in each SDA within 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 percent. During SFY22 Q4, all MCOs met or exceeded the 90 percent standard for members' access to PCPs. Similarly, MCOs are required to maintain an adequate network of specialty providers such that 90 percent of members have access to at least two providers (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 SFY22 Q4, and across all Medicaid managed care programs, MCOs met or exceeded the 90 percent standard for members' access to specialty providers for OB/GYN, Pediatric Sub-specialty, Prenatal Care, and Therapy. 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 percent in one or more counties. The table below summarizes the count of MCOs that did not meet the 90 percent overall average compliance rate in one or more counties.

Figure 4. MCO Network Adequacy Summary – Specialty Providers – Number of MCOs that did not meet the standard, by Specialty Provider, Program and County designation SFY22 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	13
	STAR+PLUS	1	4	4

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

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

Attachment H3 provides dentist analysis by DMO and county designation. During SFY22 Q4, all DMOs met the network access standard of 95 percent for Main Dentist in Metro County, no DMOs met the network access standard in Micro County.

Attachment H4 provides dental specialty analysis by provider type and county designation. The DMOs did not consistently meet network access standards for dental specialty provider types during SFY22 Q4. The DMOs' performance is being reviewed for further actions. DentaQuest consistently met all standards for all dental specialty provider types.

Figure 5. DMO Network Adequacy Summary

Provider Type	DMO	Number of DMOs that did not meet the standard in a county		
		Metro County	Micro County	Rural County
Main Dentist	DentaQuest	0	0	0
	MCNA Dental	0	0	0
	Superior HealthPlan	0	0	0
	United HealthCare Dental	0	1	0
Endodontist	DentaQuest	0	0	0
	MCNA Dental	1	1	1
	Superior HealthPlan	1	1	1
	United HealthCare Dental	1	1	1
Orthodontist	DentaQuest	0	0	0
	MCNA Dental	1	1	1
	Superior HealthPlan	1	1	1
	United HealthCare Dental	1	1	0
Pediatric Dentist	DentaQuest	0	0	0
	MCNA Dental	0	0	0
	Superior HealthPlan	1	0	0
	United HealthCare Dental	0	0	0

*See Attachments H3 and H4 for detailed data tables for each DMO.
**HHSC may grant an exception during the corrective action process.

In addition to monitoring network adequacy performance of the MCOs related to primary and specialty care, HHSC continues to enhance efforts to monitor long-term services and supports, 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

Texas Legislature, Regular Session, 2019 (Article II, HHSC, Rider 157)[3], 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 percent of their members have timely access to community attendant care services upon authorization of services. Timeliness is defined as within seven days from the authorization. Initial data will provide a baseline for future performance monitoring, with the expectation that MCO performance will improve over time. In the coming quarters, HHSC expects to continue refining and improving the collection and analysis of this data. As the data and analysis processes continue to mature and more baseline data is compiled, HHSC expects the data quality to become more refined. HHSC will begin reporting on this in future reports once data is available for the corresponding reporting period.

MCO Pharmacy Geo-mapping Summary

Due to competing priorities, HHSC was unable to complete the process of reviewing the current and proposed methodology to determine if changes to the pharmacy distance and travel time standards are appropriate. The review is rescheduled for November 2023. Pharmacy network adequacy performance reports were shared with MCOs as informational only.

Attachment J details the Geo-distance results for SFY22 Q1 to inform the process and information as HHSC continues to work on network adequacy as it relates to pharmacy. MCOs are required to provide pharmacy access to members in each 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 percent of Members must have access to a Network Pharmacy within 2 miles or 5 minutes of the Member's residence.
- In a Micro County, at least 55 percent of Members must have access to a Network Pharmacy within 5 miles or 10 minutes of the Member's residence.
- In a Rural County, at least 90 percent of Members must have access to a Network Pharmacy within 15 miles or 25 minutes of the Member's residence.
- At least 90 percent of Members must have access to a 24-hour pharmacy within 75 miles of the Member's residence.

For all other counties and programs, the following standards apply.

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

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

Managed Care Provider Network

This subsection includes quarterly healthcare provider counts for STAR, STAR+PLUS, STAR Kids, and dental provider counts for the dental program (See ***Attachment C2***). Provider Network Count Methodology may be found in ***Attachment C1***. Because of the time required for data collection, healthcare provider counts per quarter are reported on a one-quarter lag.

During SFY22 Q3, unique PCP provider enrollment decreased across all programs statewide. Specialist provider enrollment decreased in the STAR and STAR Kids programs but increased in STAR+PLUS. Additionally, unique pharmacist enrollment slightly decreased across all programs during SFY22 Q3. Across the dental programs statewide, the DMOs reported an increase in dental provider enrollment compared to the previous quarter.

Provider Termination

Attachment C3 details the data reported by the MCOs regarding the number of PCPs and specialists terminated in SFY22 Q3. The MCOs reported a variety of reasons for termination. For SFY22 Q3, the top three reasons for PCP and specialist terminations included: the provider left a group practice, termination was requested by the provider, and the provider failed to recredential. Because of the time required for data collection, provider termination counts per quarter are reported on a one-quarter lag.

MCO and DMO Network Adequacy Standard Exceptions

House Bill 4, 87th Texas Legislature, Regular Session, 2021, requires HHSC, to the extent it is feasible, consider and include the availability of telehealth services and telemedicine medical services within the provider network of a Medicaid managed care organization. HHSC revised the existing process for the Network Performance Reports, that incorporates a way to consider MCO teleservices in Medicaid and CHIP provider access standards prior to a Corrective Action Plan (CAP) being issued to MCOs. MCOs and DMOs that are non-compliant with time or distance requirements can submit an action plan that informs HHSC of how they are ensuring access to care using teleservices. A formal CAP will be requested if the MCO's plan is insufficient. The revised process implemented using SFY22 Q4 provider network reports. 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.

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 CAP.

Hotline Performance

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

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

Included in ***Attachment M1-M4*** is data from SFY22 Q3. Because of the time required for data collection, Member Hotline data are reported on a one-quarter lag. A summary of findings using aggregated MCO self-reported data is reported below.

Member Hotline **(STAR/STAR+PLUS - SFY22 Q3)**

- All MCOs met the 80 percent standard for answered by a live person within 30 seconds.
- All MCOs met the ≤ 7 percent abandoned calls standard.
- All MCOs average hold times were under two minutes.

Member Hotline **(STAR Kids – SFY22 Q3)**

- All MCOs met the 80 percent standard for answered by a live person within 30 seconds.
- All MCOs met the ≤ 7 percent abandoned calls performance standard.
- All MCOs average hold times were under two minutes.

Behavioral Health Hotline **(STAR/STAR+PLUS – SFY22 Q3)**

- All MCOs met the 80 percent standard for answered by a live person within 30 seconds.
- All MCOs met the ≤ 7 percent abandoned calls standard.
- All MCOs average hold times were under two minutes.

Behavioral Health Hotline **(STAR Kids – SFY22 Q3)**

- All MCOs met the 80 percent standard for calls answered by a live person within 30 seconds.
- All MCOs met the ≤ 7 percent abandoned calls standard.
- All MCOs average hold times were under two minutes.

Provider Hotline **(STAR/STAR+PLUS – SFY22 Q3)**

- Fifteen MCOs met the ≤ 7 percent abandoned calls standard, except for one.
- Fifteen MCOs met the requirement for ≤ 2 minutes average hold time, except for one.

Provider Hotline **(STAR Kids – SFY22 Q3)**

- All MCOs met the ≤ 7 percent abandoned calls standard.
- All MCOs met the requirement for ≤ 2 minutes average hold time.

Dental Hotline **(SFY22 Q3)**

- All MCOs met the standard that 80 percent of all calls must be answered by a live person within 30 seconds, for member hotline.

- All MCOs met the ≤ 7 percent abandoned calls standard for member and provider hotline.
- All MCOs average hold times were under two minutes for member and provider hotlines.

The above instances of non-compliance are being addressed by HHSC. 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 percent benchmark.

Quarterly healthcare provider counts are reported on a one-quarter lag. In SFY22 Q3, all MCOs and DMOs met the 80 percent benchmark, except Community First Health Plan (77 percent) and Cook Children's (68 percent) in STAR and Cook Children's (66 percent) in STAR Kids. HHSC is monitoring and has not identified access to care concerns, issues, or complaints with these MCOs.

Appointment Availability

HHSC conducts four appointment availability (AA) studies each state fiscal year to assess how quickly members get in-person appointments. HHSC managed care contracts outline MCO provider network standards for timely appointments and the availability of specialist appointments without referrals. To promote and monitor program improvement, HHSC presents the results to the MCOs and issues corrective action plans and liquidated damages to MCOs that did not meet contractual standards.

Figure 6. 2022 Appointment Availability Behavioral Health Study Results

Program	Standard	2022
STAR (Child)	Behavioral Health (14 days)	83.7%
STAR (Adult)	Behavioral Health (14 days)	81.9%
STAR Kids	Behavioral Health (14 days)	79.5%
STAR+PLUS	Behavioral Health (14 days)	81.5%

HHSC will continue to conduct AA studies in 2023 for PCP, vision care, prenatal care, and behavioral health care.

Accessibility and Language Compliance

MCOs submit provider language and accessibility survey results by program and SDA on an annual basis. Deliverables for SFY21 are due from MCOs on December 30, 2022 and will be summarized in the SFY23 Q1 report.

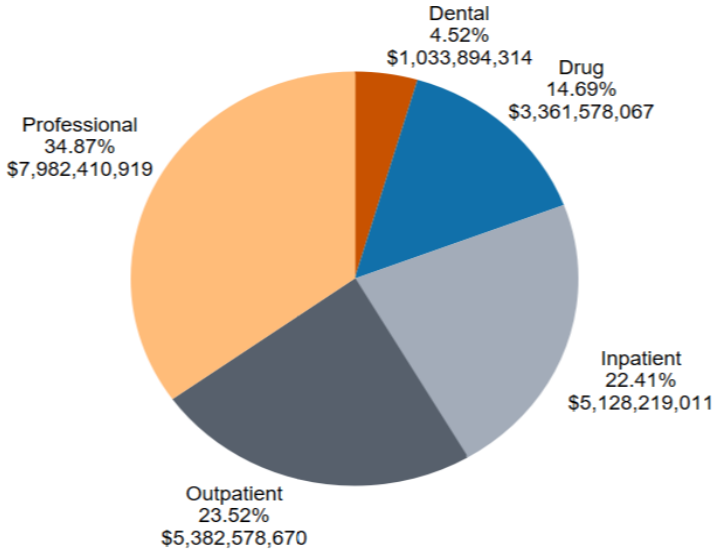
HHSC requires MCOs to make best efforts to ensure that PCPs are accessible 24 hours per day, 7 days a week, and outlines specific criteria for what constitute compliance with the managed care contracts. For example, providers must offer after-hours telephone availability through an answering service, 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 percent to 100 percent. Providers who are not in compliance with 24/7 accessibility standards receive phone calls or letters from the MCOs detailing the requirements and are subject to remediation methods including mailed provider re-education letters regarding the managed care contractual standards, follow-up surveys, face-to-face re-education (e.g., evaluating and coaching provider staff, 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 SFY21, covering September 1, 2021, through August 31, 2022. 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, MCO, 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 SFY21 are shown in the figure below.

Figure 7. 2022 Expenditures by Claim Type



"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 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 why the MCO was unsuccessful in provider contracting efforts. If approved, the MCO submits a recalculated OON Utilization Report, excluding the utilization of the aforementioned provider(s). If the recalculation does not bring the MCO into compliance, the MCO remains non-compliant and is subject to contract action such as assessing liquidated damages or implementing a CAP.

Attachment D provides OON utilization performance summary for SFY22 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 SFY22 Q3 and have a SERT in place or are finalizing a SERT bringing the MCOs into compliance. HHSC will continue to monitor these MCOs and will require corrective action or other remedies as appropriate.

OON Emergency Room (ER) (<20 percent Standard)
- STAR
    - Community Health Choice – Approved SERT on file
    - Dell Children's – Approved SERT on file

OON Inpatient (<15 percent Standard)
- STAR
    - Dell Children's – Approved SERT on file
    - Parkland – Approved SERT on file

OON Other Outpatient (<20 percent Standard)
- All MCOs met the <20 percent standard for Other Outpatient.

Oversight of MCOs and DMOs

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

1. Developing CAPs.

2. Assessing monetary damages (actual, consequential, direct, indirect, special, and/or liquidated damages (LDs)).

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

5. Waiver Amendments and Upcoming Managed Care Initiatives

Waiver Amendments

The following amendments have been submitted to CMS.

Medically Fragile

House Bill 4533, 86th Texas Legislature, Regular Session, 2019 (Section 32), requires HHSC to pursue a benefit for medically fragile individuals. If determined to be cost effective, the legislation directed 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 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 Texas Legislature, Regular Session, 2019, directs 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 the bill. This amendment was submitted to CMS on November 5, 2021. HHSC and CMS continue to discuss the amendment.

Maternal and Child Health

House Bill 133, 87th Texas Legislature, Regular Session, 2021, directs HHSC to:

- Transition targeted Case Management for Children and Pregnant Women (CPW) services to Medicaid managed care. HHSC submitted this amendment on May 4, 2022, with a requested effective date of September 1, 2022. HHSC and CMS continue to discuss the amendment.
- Extend postpartum Medicaid coverage from 60 days to six months following delivery or involuntary miscarriage. HHSC submitted this amendment on May 25, 2022, with a requested effective date of September 22, 2022. HHSC and CMS continue to discuss the amendment.
- Transition the Healthy Texas Women (HTW) program services[4] into managed care. HHSC plans to implement HTW managed care in Q2 of SFY2025.

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

HHSC continues work toward implementation of a pilot program through the STAR+PLUS Medicaid managed care program to test person-centered managed care strategies and improvements under a capitated model.[5] The pilot program will inform the future carve-in of waivers and community intermediate care facilities 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

[4] https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/83311
[5] As required by House Bill 4533, 86th Texas Legislature, Regular Session, 2019.

disabilities (IDD), traumatic brain injury, and people with similar functional needs. The pilot program will operate in one SDA selected by HHSC with up to two STAR+PLUS Medicaid managed care plans. The pilot program will be implemented in phases and will operate for at least 24 months. Phase 1 will begin September 1, 2023. Phase 2 will begin February 1, 2024, and is when clients begin receiving services. HHSC and CMS are meeting monthly to review the draft amendment.

The Intellectual and Developmental Disabilities System Redesign Advisory Committee (IDD 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 IDD SRAC are having joint meetings to focus on the pilot. HHSC has begun to operationalize programmatic elements including service coordination and consumer directed services.

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 conducting heightened scrutiny assessments on all STAR+PLUS HCBS assisted living facility settings. Proposed State rule amendments were posted for informal public comment in March 2022. HHSC is also revising managed care contracts to require MCOs to ensure their contracted providers comply with the HCBS settings regulations. These contract amendments became effective in September 2022. HHSC plans to replace the current fee-for-service day habilitation service with a new, fully compliant service called individualized skills and socialization in the Home and Community-based Services, Texas Home Living, and Deaf Blind with Multiple Disabilities 1915(c) waiver programs. Individualized skills and socialization service is designed to ensure compliance with the federal HCBS settings regulation and enhance individuals' opportunities for community integration. CMS provided initial approval to HHSC of the Texas Statewide Transition Plan on December 21, 2022.

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 dedicating resources at HHSC to coordinate and support a Workforce Development Taskforce.

- HHSC identified the Office of Disability Services Coordination as the dedicated resource to launch, support, and manage a taskforce. The Direct Service Workforce Development Taskforce (DSW Taskforce), launched in March 2021, is a collaborative workgroup whose purpose is to explore long-term recruitment and retention (non-wage based) strategies, which were proposed by stakeholders, within the community attendant, personal care attendant, and direct service

workforce. The DSW Taskforce provided input into the THTQIP 1115 Waiver application, HHSC's spending plan in response to the ARPA (American Rescue Plan Act) 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. The project plan has two main goals—enhance workforce development and improve data collection—and 16 objectives each with numerous research and data activities within a three state-fiscal-year project period. Seven of the objectives are already complete. During Q2, HHSC posted and awarded a contracted vendor to establish a direct service employer registry. The registry aims to connect direct care workers with potential employers. Direct care workers would have access to training through the registry at no cost. Implementation began in Q3 and will continue through the anticipated target completion date in May 2023. During Q3, HHSC released two surveys to gain insight into the needs of direct care workers and perceptions of the local workforce development boards on recruitment and retention efforts. During Q4, HHSC analyzed and reported the survey data and will continue to incorporate the findings into the project.

Critical Incident Management System

HHSC has implemented a new statewide critical incident management system (CIMS) for reporting critical incidents. The new system complies with guidance issued by CMS on March 12, 2014. The 2020-2021 General Appropriations Act, House Bill 1, 86th Legislature, Regular Session, 2019, appropriated funding to streamline the level of critical incident information received and to standardize the format for the new CIMS. HHSC has worked diligently with FEI Systems, the CIMS vendor, to configure a platform to collect all required critical incident information across all 1915(c) and STAR+PLUS Home and Community-Based Services programs. It includes information on abuse, neglect, and exploitation allegations (ANE) in addition to other non-ANE critical incidents required by program policy. All direct-care waiver providers in the impacted programs are required to report information into the new system. CIMS went live for fee-for-service waiver providers in July 2022. HHSC has given those providers a grace period to November 1, 2022, to fully utilize the system. MCO Long-Term Services and Supports provider rollout will occur at a later date. The implementation process required provider training by program, system testing, coordination between reporting systems, and assessments of program reporting requirements. HHSC continues to closely monitor all ongoing activities involved with CIMS implementation.

6. Demonstration-related Appeals and Complaints

Complaints Received by the State and MCOs

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

Attachment O[6] includes complaints data compiled from both MCOs/DMOs and HHSC for members and providers. The reports in ***Attachment O*** reflect SFY22 Q2. 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 the 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 is reported on a one-quarter lag and provides a performance summary of member appeals for SFY22 Q3. During the reporting period, STAR MCOs collectively reported 2,401 member appeals resolved. STAR+PLUS MCOs reported 2,250 and STAR Kids MCOs reported 1,089 member appeals resolved. DMOs collectively reported 454 member appeals resolved.

Member Appeal reports are submitted monthly. Most MCOs met the compliance standard for one or more months; Parkland was the only MCO that did not meet the 98 percent compliance standard for 30-day appeals resolved timely in the STAR program during the quarter. Identified instances of non-compliance are reviewed quarterly for remedies, as stated in the contract, that include but are not limited to CAPs 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 during SFY22. These attachments include the total number of referrals received and the allegation category.

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

Claims Summary Reports

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

Claims summary counts are reported on a one-quarter lag and reflect data through SFY22 Q3. ***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 HHSC receives appeal requests from applicants and clients contesting actions taken regarding benefits and services for various programs. Fair Hearings Officers conduct fair hearings and administrative disqualification hearings statewide for 169 eligibility programs within HHSC, including the waiver programs.

In the fourth quarter of FY22, FFH received 506 fair hearing requests for the programs authorized under the waiver (38 for the STAR program, 109 for the STAR Kids program, and 353 for the STAR+PLUS program). Of the 506 fair hearing requests, 75 were withdrawn by the appellant, 114 were dismissed, 71 were upheld, and 6 were reversed by the presiding Fair Hearings Officer; 240 decisions are pending final resolution. The total number of fair hearing requests received during FY22 Q4 slightly decreased from FY22 Q3. However, the COVID-19 PHE continues to influence the number of fair hearings for the 1115 waiver programs.

6.1 Anticipated Changes to Appeals

HHSC implemented an External Medical Review (EMR) option, to be performed by an Independent Review Organization (IRO) in May 2022 and received 24 requests during the program's inaugural month. Monthly increases have been gradual since program implementation. The EMR is an option for a member to request further review of the MCO's adverse benefit determination. The EMR takes place between the MCO internal appeal process and the State Fair Hearings. The MCO has to provide the IRO the same set of records the MCO reviewed to determine service denial or reduction. EMRs are conducted by IROs contracted with HHSC. The role of the IRO is to act as an objective arbiter and decide whether the MCO's original adverse benefit determination must be reversed or affirmed. In the fourth quarter of FY22, HHSC received 90 EMR requests for the Medicaid Managed Care programs (15 for the STAR program, 27 for the STAR Kids program, 33 for the STAR+PLUS program, and 10 in the Medicaid Dental program). Of the 90 EMR requests, 59 MCO internal decisions were upheld by the IRO, 22 MCO internal decisions were overturned by the IRO, 2 MCO internal decisions were partially overturned by the IRO, 4 were withdrawn by the member after assignment to an IRO, 2 were withdrawn by the member before assignment to an IRO, and 1 was determined not eligible for an IRO review.

7. Quality

HHSC received initial MCO quality measure results in October 2022 for measurement year 2021. Complete and final 2021 results will be posted on the Texas Healthcare Learning Collaborative Portal (thlcportal.com). The results will help inform HHSC decisions about its quality improvement programs for measurement years 2023 and 2024. The COVID-19 PHE continued to affect survey completion rates in SFY 2021, which limited the number of respondents on the surveys. HHSC has increased outreach efforts to account for the low response rate.

The External Quality Review Organization (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 Organization Summary of Activities Report Contract Year 2021 (PDF)*. The SFY 2021 report was published in April 2022 and includes information on the possible impacts of the PHE on quality measure results.

8. HCBS Quality Assurance Reporting

As required by STC 75, HHSC submitted the first STAR+PLUS HCBS performance measure report on March 29, 2022. HHSC has continued to research current MCO deliverables and other Medicaid data sources in order to develop performance measures which will fully support the 1915(c) assurance requirements for the STAR+PLUS HCBS waiver program on a long-term basis. HHSC intends to implement the CMS Proposed Quality Measure Set, shared with State Medicaid Directors on July 21, 2022, into the annual performance measure reports for the SFY23 reporting period.

Additionally, HHSC amended the MCO contracts to support the potential inclusion of managed care reporting requirements with an effective date of September 1, 2022. HHSC is finalizing data collection and reporting processes for the second iteration of the report with a submission date of March 31, 2023.

9. Directed Payment Programs

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

State Fiscal Year 2022

On November 15, 2021, CMS approved two directed payment programs retroactive to September 1, 2021:

1. Directed Payment Program for Behavioral Health Services (DPP for BHS) and
2. Quality Incentive Payment Program (QIPP).

On March 25, 2022, CMS approved the remaining three directed payment programs retroactive to September 1, 2021:

1. Comprehensive Hospital Increase Reimbursement Program (CHIRP),
2. Texas Incentives for Physicians and Professional Services (TIPPS), and
3. Rural Access to Primary and Preventive Services Program (RAPPS).

HHSC, working with contracted Medicaid MCOs, has successfully implemented these programs.

The approval of these directed payment programs achieves the funding transition from DSRIP to Medicaid managed care. ***Attachments K1-K11*** include State Directed Payment data in the form of the required chart for CHIRP, DPP for BHS, QIPP, RAPPS, TIPPS, reporting results, and the minimum fee schedules in SFY22.The measures selected for each programs' evaluation design were informed in part by DSRIP best practices. Participating providers in CHIRP, DPP BHS, RAPPS, and TIPPS completed their Year 1 provider reporting in Q4.

State Fiscal Year 2023

HHSC submitted the state fiscal year 2023 preprints for the aforementioned five directed payment programs on March 1, 2022. CMS questions and HHSC responses are posted on HHSC's directed payment program website. CMS and HHSC had ongoing discussions during Q4, and approval for all five directed payment programs was received on August 1, 2022.

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 through FFY22 Q3. Figures 8 and 9 provide information on the eligibility groups in budget neutrality calculations.

HHSC developed FFY21 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 PHE and its potential impact on program utilization and cost. At the time the FFY21 rates were calculated (May/June 2020), there was little credible information on the impact of the PHE 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 percent compared to the FFY20 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.

DY11 Q4 July – September 2022

Figure 8. Eligibility Groups Used in Budget Neutrality Calculations

Eligibility Group	**Month 1 (July 2022)**	**Month 2 (Aug 2022)**	**Month 3 (Sep 2022)**	**Total for Quarter Ending 9/2022**
Adults	677,027	688,328	701,836	2,067,191
Children	3,525,431	3,552,855	3,582,323	10,660,609
AMR	367,947	369,448	370,583	1,107,979
Disabled	422,169	422,339	422,485	1,266,993

* These data are provided by HHSC Forecasting.

Figure 9.Eligibility Groups Not Used in Budget Neutrality Calculations

Eligibility Group	**Month 1 (July 2022)**	**Month 2 (Aug 2022)**	**Month 3 (Sep 2022)**	**Total for Quarter Ending 9/2022**
Foster Care	48,511	48,384	48,570	145,464
Medically Needy	100	95	95	291
CHIP-Funded	435,558	437,986	441,122	1,314,666
STAR+PLUS 217-Like HCBS	15,592	15,511	15,448	46,551

* These data are provided by HHSC Forecasting.

10.1 Anticipated Changes to Financial/Budget Neutrality

These STCs set forth a base year of federal 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 directed payment programs as a part of the DSRIP transition. The waiver reflects a DSRIP pool ending date of September 30, 2021, and the transition to directed payment programs starting September 1, 2021.

Texas Medicaid expenditures in FFY22, the base year, in conjunction with cost trends and adjustments will set the annual expenditure limit for the remainder of the 10-year waiver term.

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.
- Transition to quality-based payment systems across managed care and providers.

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

HHSC and the Medicaid MCOs achieved the following MMC milestones in SFY22 Q4, including:

- Implemented revisions to the STAR Kids Screening and Assessment Instrument to improve initial and reassessment processes, as directed by Senate Bill 1207, 86th Texas Legislature, Regular Session, 2019.
- Added Case Management for Children and Pregnant Women services into the array provided by Medicaid MCOs to current members.
- Implemented emergency triage, treatment, and transport (ET3) services in Medicaid, including managed care.

Challenges successfully navigated during SFY22 Q4 include:

- Continued implementation of a wide range of COVID-19 PHE member and provider flexibilities, including use of teleservices, to ensure member health and safety and continuity of care while planning for the end of the PHE.

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

- Allowing MCOs to provide more care coordination services using telecommunications or information technology.
- Expanding Medicaid coverage for women six months after delivery.
- Including HTW in managed care.
- Full compliance with the home and community-based settings regulations.
- Implementing the STAR+PLUS Pilot Program.
- Implementing a policy change to better serve medically fragile adults.
- Implementing additional services MCOs can provide in lieu of an inpatient hospitalization.

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: March 2022 Available at http://www.txsmartbuy.com/esbddetails/view/HHS0011062
- Estimated Notice of Award: March 2023
- Start of Operations: February 2024

STAR

- RFP Posting: Q2 SFY23
- Estimated Notice of Award: Q2 SFY24
- Start of Operations: Q2 SFY25

STAR Kids

- RFP Posting: Q2 SFY24
- Estimated Notice of Award: Q2 SFY25
- Start of Operations: Q2 SFY26

12. Litigation Summary

Table 2. Consideration 1

Type of Consideration	*Ongoing litigation*
Summary of Consideration	*Frew, et al. v. Young*, *et al.* (commonly referred to as *Frew*), was filed in 1993, and was brought on behalf of children under age 21 enrolled in Medicaid and eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefits. The class action lawsuit alleged that the Texas EPSDT program did not meet the requirements of the Federal Medicaid Act. The lawsuit was settled by a consent decree in 1996. The decree requires numerous State obligations and is monitored by the Court. In 2000, the court found the State defendants in violation of several of the decree's paragraphs. In 2007, the parties agreed to eleven corrective action orders to bring the State into compliance with the consent decree and to increase access to EPSDT benefits. Currently, five of the eleven corrective action orders and their related consent decree paragraphs are fully dismissed: (1) Check-Up Reports and Plans for Lagging Counties, (2) Prescription and Non-Prescription Medications, Medical Equipment, and Supplies, (3) Transportation Program, (4) Health Care Provider Training, and most recently, (5) Outreach and Informing. Part III of the Managed Care CAO has also been dismissed. 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.
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 June 2022) at 4,177,803.

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. The project consists of three strategies and the Patient Unified Look-up System for Emergencies (PULSE). Successful implementation of the three strategies will result in increased HIE adoption 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 and PULSE.

HIE IAPD Strategies 1-3

Strategy 1/Medicaid Provider HIE Connectivity: As of September 30, 2022, 464 providers have been approved through Strategy 1 to join with the three local HIEs:C3HIE (formerly known as HASA), Greater Houston Healthconnect (GHH), and Rio Grande Valley HIE (RGVHIE). This includes 105 ambulatory practices, including Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs), and 43 hospitals.

Strategy 2/Texas HIE Infrastructure: Maintenance and enhancement of connectivity between participating local HIEs and Texas Medicaid, via the Texas Health Services Authority (THSA's) HIETexas, is ongoing. The framework for the exchange, transport, integration, and retrieval of electronic health information between and among healthcare entities continues to be supported. A master patient index (MPI) and HL7 integration engine are used to process data, including Admission, Discharge, Transfer (ADT) alerts and Consolidated-Clinical Document Architecture (C-CDA) messages, received from the three local HIEs currently participating in the project. HIETexas continues to support a user interface for individuals designated by HHSC, integration work and technical assistance for local HIEs, as well as activities and capabilities required for C-CDA Transition of Care summaries and Emergency Department Encounter Notification (EDEN) ADT alerts delivered to Texas Medicaid.
Additionally, patient census information is automatically obtained and ingested via the EDEN software platform for query services. This includes the capability to query and retrieve documents from multiple HIE networks at the local and national level. These queried documents can be pushed to Texas Medicaid and EDEN subscribers.

During Q4, C3HIE connected to THSA via the eHealth Exchange. This connectivity improves HIETexas' ability to deliver targeted and standardized data to Texas Medicaid.

Strategy 3/EDEN System: In addition to those providers and hospitals onboarded to the project via Strategy 1, C3HIE sends ADT alerts from all its existing hospital connections. Additionally, THSA is making direct connections with hospitals, urgent care facilities, and Skilled Nursing Facilities (SNFs)/rehabs. As of September 30, 2022, THSA has made direct connections to 102 hospitals and urgent care facilities. Forty direct connections are in progress and subscribers continue to be added. ADT alerts via the local HIEs and THSA's direct hospital connections continue to be received through HIETexas and sent to Texas Medicaid and EDEN subscribers. HHSC is currently analyzing the data for quality as part of the effort to build a repository that will make project data accessible and usable to various departments and program areas within HHS.

PULSE

PULSE infrastructure, which interconnects disparate health information from multiple sources in response to a disaster, continues to operate and is ready for use to help Texans during the upcoming hurricane season. PULSE allows authorized users to query for clinical data, support patient reunification efforts, and search public health emergency patient data. The HIETexas PULSE system is being maintained and prepared to be activated in the instance of a declared disaster in Texas.

During Q4, BCFS, American Red Cross, and the San Antonio Metro Health remained engaged and actively participated in HIETexas PULSE training and demonstrations. Dallas County, Austin Public Health, and North Central Texas Trauma Regional Advisory Council also attended demonstrations in Q4.

14. Evaluation

HHSC completed the following 1115 Waiver evaluation activities during FFY22 Q4:

- HHSC received CMS approval of Texas A&M University's (TAMU) Interim Report covering DYs 7-11 (2017 STCs) on August 2, 2022.
- HHSC continued coordinating with TAMU on Revision 6.1 of the 1115 Evaluation Design covering DYs 7-11 (2017 STCs) to reflect plans for the Interim Evaluation Report #1 (due on March 31, 2024, in accordance with the 2021 STCs). HHSC aims to submit Revision 6.1 of the 1115 Evaluation Design to CMS for review in early FFY23.
- HHSC held a virtual Quarterly Meeting with TAMU on August 22, 2022, and a follow-up a call on September 22, 2022, to discuss overall progress on the evaluation.
- HHSC analysts transferred evaluation-related data to TAMU in September 2022.

HHSC analysts prepared an evaluation narrative describing how the 1115 Evaluation Design may be impacted by an amendment to implement the STAR+PLUS Pilot Program under the 1115 waiver. HHSC aims to submit the amendment to CMS by Spring 2023.

HHSC completed the following key 1115 Waiver evaluation activities during DY11 (FFY22):

- HHSC submitted Revision 5.2 of the 1115 Evaluation Design covering DYs 7-11 to CMS on November 17, 2021. HHSC received CMS approval of Revision 5.2 of the 1115 Evaluation Design covering DYs 7-11 on March 16, 2022.
- HHSC received CMS approval of the Revised 1115 Evaluation Design covering DYs 10-19 on May 26, 2022 (2021 STCs).
- CMS provided feedback on the Interim Evaluation Report conducted by TAMU (submitted September 29, 2021, in accordance with the December 2017 STCs) on December 6, 2021. HHSC submitted TAMU's revised Interim Evaluation Report to CMS on February 4, 2022. HHSC received CMS approval of TAMU's revised Interim Evaluation Report on August 2, 2022.
- HHSC coordinated with TAMU and CMS on plans for the Interim Evaluation Report #1 (due on March 31, 2024, in accordance with the January 2021 STCs).
    - HHSC began developing Revision 6.1 of the 1115 Evaluation Design covering DYs 7-11 (2017 STCs) to reflect plans for the Interim Evaluation Report #1 (due on March 31, 2024, in accordance with the 2021 STCs).
    - HHSC aims to submit Revision 6.1 of the 1115 Evaluation Design to CMS for review in early federal fiscal year 2023.

Modifications to the Evaluation Design
HHSC received CMS approval of Revision 5.2 of the 1115 Evaluation Design covering DYs 7-11 on March 16, 2022. Revision 5.2 includes a reference CMS requested for Measure 1.1.5. No other changes to the 1115 Evaluation Design covering DYs 7-11 or the 1115 Evaluation Design covering DYs 10-19 were requested during DY11.

Description of Evaluation Findings or Reports

CMS approved TAMU's revised Interim Report on August 2, 2022. Key takeaways from the Interim Report were described in the Annual Monitoring Report for DY10. Additional evaluation findings will be summarized after the Interim Evaluation Report #1 is submitted (due on March 31, 2024, in accordance with the STCs).

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

Table 3. Evaluation-related Deliverables

Type of Evaluation Deliverable	Due Date	State Notes or Comments	Description of Any Anticipated Issues
Evaluation Design Plan (2017 STCs)	N/A	CMS approved the Evaluation Design on 8/2/2018.	N/A
Obtain Independent External Evaluator (2017 STCs)	N/A	HHSC executed the contract with TAMU on 8/31/2019.	N/A
Interim Evaluation Report (2017 STCs)	N/A	CMS approved TAMU's revised Interim Report to CMS on 8/2/2022.	N/A
Evaluation Design Plan (2021 STCs)	N/A	CMS approved the Evaluation Design on 5/26/2022.	N/A
Obtain Independent External Evaluator (2021 STCs)	5/26/2023	HHSC is in the preliminary stages of obtaining an independent external evaluator.	*No issues anticipated at this time*
Interim Evaluation Reports (2021 STCs)	3/31/2024[1]; 3/31/2027; 9/30/2029		*No issues anticipated at this time*
Summative Evaluation Report (2021 STCs)	3/30/2032		*No issues anticipated at this time*

Notes. [1] Interim Evaluation Report #1 under the 2021 STCs replaced the Summative Evaluation Report previously required under the 2017 STCs.

15. Delivery System Reform Incentive Payment Program

The 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.

April DY11 Reporting Payments

Providers reported achievement of DY10 Category B MLIU patients served and DY9 and DY10 Category C measures in April 2022. In total for April 2022 reporting, $1,780,416,126 was paid to DSRIP providers in July 2022, based on available Intergovernmental Transfer (IGT), for a total of $24.4 billion in DY1-10 DSRIP payments to date. ***Attachment X*** includes DSRIP providers' overall status for April DY11 reporting. ***Attachment Y*** provides estimated remaining payments.

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.

Twenty providers requested to carryforward their Category B reporting into DY11 and completed reporting on their Category B MLIU volume during the April DY11 reporting period. The DY10 accommodation allowed providers to earn close to $1.5 million more in Category B than if there had been no accommodation.

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 CY21 for DY9 achievement milestones, or DY10 achievement in CY21 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 CY20 and CY21 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 DY11 Category C Reporting

In April DY11, 2,593 Category C measures were eligible to report Performance Year 4 (PY4, which is 01/01/21 – 12/31/21) to potentially earn payment for remaining DY9 achievement milestones and DY10 reporting and achievement milestones.

Of the 2,511 achievement milestones (pay-for-performance) that were approved for PY4 (CY21) reporting in April 2022, 768 (or 31 percent) used the approved COVID-19 accommodations to earn payments. Providers earned $269,732,585.91 in payments that they would not have earned without the approved COVID-19 accommodations.

Overall, 83.12 percent of measures reported in April 2022 reported full achievement of the DY10 goal in PY4, and an additional 16.72 percent of measures reported partial achievement of the DY10 goal in PY4. For remaining DY9 achievement, 20.05 percent of measures were reported in April 2022 as fully achieving the DY9 goal in PY4, and an additional 79.04 percent of measures reported partially achieving the DY9 goal in PY4.

Providers may report remaining DY10 reporting and achievement milestones in October DY11. October 2022 will be the final DSRIP reporting opportunity.

The table below provides a summary of reported DY9 and DY10 achievement by measure type across April DY11 reporting and ***Attachment Z*** includes all Category C reporting and summaries by measure, Measure Bundle, provider type, measure type, and region.

Measure Type	P4P Measures Active in DY9-10	P4P Measures that have reported PY4 (CY21) in DY11	P4P 100% of AM-10.x Goal Achieved in PY4	P4P Partial Achievement of AM-10.x Goal in PY4	P4P 100% of AM-9.x Goal Achieved in PY4	P4P Partial Achievement of AM-9.x Goal in PY4
Cancer Screening	114	94%	86.92%	13.08%	31.58%	68.42%
Clinical Outcome	507	96%	77.11%	22.89%	20.87%	79.13%
Hospital Safety	231	100%	66.67%	33.33%	19.74%	80.26%
Immunization	252	96%	84.23%	15.77%	17.50%	82.50%
Population Based Clinical Outcome	111	98%	67.89%	29.36%	13.79%	75.86%
Process	1362	96%	88.76%	11.24%	20.13%	79.87%
Quality of Life	19	100%	94.74%	5.26%	NA*	NA*
All Measures	2612	96%	83.12%	16.72%	20.05%	79.04%

*Quality of Life AM-9.x were 100% achieved in PY3.

16. Charity Care Pools

Uncompensated Care Pool

As part of the extension of the 1115 Waiver, CMS required two resizing's of the UC pool based on hospital charity care reported by Texas hospitals. HHSC and CMS negotiated the policies that would inform the resizing process to follow a consistent methodology, but with modifications to ensure that the resizing did not include data that might be impacted by the COVID-19 PHE. The UC pool for Demonstration Years 12 through 16 of the current 1115 Waiver will be $4.51 billion per year. This is $638 million greater in UC funds per year than Texas providers currently receive for DY11. The UC pool will be resized again in 2027 for DYs 17 through 19.

Public Health Provider Charity Care Pool

On December 22, 2021, the HHSC received federal approval of the Public Health Providers – Charity Care Program (PHP-CCP) Protocol from the CMS under the 1115 Waiver. The PHP-CCP became operational October 1, 2021, and reimburses qualifying providers for certain medical services to defray the uncompensated costs of providing medical services to Medicaid recipients or uninsured individuals. In year 1 of the program, payments will reimburse uncompensated care and Medicaid shortfall. In year 2, the program will transition to reimbursements for charity care only. Total funding will not exceed $500 million (total computable) in each of the first two years of the program. In future years, this pool is subject to resizing based on actual charity care costs incurred by eligible providers.

17. Post Award Forum

HHSC provided the summary of the post-award forum, which was held during Q3, as required for the reporting period and in the annual report.

In compliance with STC 79, HHSC hosted a public post-award forum in-person and with a virtual attendance option webinar on June 9, 2022, to provide the public with updates on the progress of THTQIP waiver extension that was approved on January 15, 2021. The public forum was held at the Winters Building Public Hearing Room, 701 W. 51st Street Austin, TX 78751. The date, time, and location of the public forum were published on HHSC's website 30 days in advance of the meeting.

During the June 2022 post-award public forum, the public was provided with an update on the following Transformation waiver topics: 10-year waiver extension, supplemental payments, DPPs, DSRIP, budget neutrality, monitoring and reporting, amendment updates and evaluation design plan. Links to the 1115 DY10 annual report and COVID-19 resource pages were also provided to the public. Public comment was also received and documented at this meeting. Comments received related to support for the amendment extending postpartum coverage, support of PHP-CCP funding, DPPs, the DSRIP program and the 1115 Transformation Waiver in general. Requests for the PowerPoint presentation and agenda were received from some stakeholders. The presentation and agenda were posted to the HHSC website.

HHSC received written comments from the following stakeholders: Texas Health Resources, El Paso Department of Public Health, Every Body Texas, Texas Association of Community Health Centers, Texas Hospital Association, and Young Invincibles. Oral comments during the public forum were provided by the following Stakeholders: National Service Office for Nurse Family Partnership and Child First, Every Body Texas, Children's Defense Fund Texas, Texas Council of Community Centers, Young Invincibles, Smith County Champions for Children, Dillon Joyce, Ltd., Healthy Futures of Texas/Texas Women's Healthcare Coalition, March of Dimes, and Texans Care for Children. Following is a summary of the comments received at the post-award public forum.

- Several stakeholders provided feedback about postpartum coverage noting concerns about lack of comprehensive services for women once Medicaid coverage ends and losing Medicaid coverage at the end of the PHE when women no longer qualify for Medicaid. Comments included requesting postpartum coverage for one full year after birth; providing data and information about the improved health benefits and outcomes of extending postpartum coverage; and noting that Texas postpartum extension is an important means of addressing racial disparities, maternal health, and mortality. Stakeholders commented in support of the DPPs and advocated for state leadership to expand coverage to low-income working age adults and the Uncompensated Care pool. A stakeholder cited the eight-month transition of the DSRIP to the DPPs and delayed payments during that time that created stressors on the state's providers. The commenter continued to note that year 1 delay in the DPP prevented the state from paying rate enhancements ($7M per day existing rate enhancements expired) causing smaller hospitals and hospitals with large Medicaid volumes to deplete their cash reserves.

- A stakeholder noted it is important that HHSC unwinds the Medicaid continuous coverage provision carefully to minimize excessive coverage loss and supports HHSC's goal to maintain coverage for eligible populations and connect those transitioning off Medicaid.

- One stakeholder asked about reimbursement for local health departments and future amendments to PHP-CCP policy.

18. Report Attachments

Attachment A - Managed Care Organizations by Service Delivery Area. The attachment includes a table of the health and dental plans by Service Delivery Area.
Attachment B1 - Enrollment Summary. The attachment includes annual and quarterly Dental, STAR, STAR Kids and STAR+PLUS enrollment summaries.
Attachment B2 - Medicaid and CHIP Enrollment Reports. Includes Medicaid and CHIP Enrollment Reports from December through February 2022.
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.
Attachments 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, K5, K6, K7, K8, K9, K10, K11 – 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.
Attachment N - MCO Appeals. The attachment includes Dental, STAR, STAR Kids, and STAR+PLUS appeals received by MCOs.
Attachment O - HHSC and MCOs self-reported Complaints. The attachment includes information concerning Dental, STAR, STAR Kids, and STAR+PLUS complaints received by 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.
Attachments R1, R2 - Provider Fraud and Abuse. The attachments represent a summary of the referrals that STAR, STAR Kids, STAR+PLUS, and Dental Program plans sent to the OIG 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. The attachments are summaries of the MCOs' claims adjudication results.
Attachment X - DSRIP Provider Summary.
Attachment Y - DSRIP Remaining Payments.
Attachment Z - DSRIP Category C Summary Workbook.