

Medicaid Section 1115 Monitoring Report
 Texas Healthcare Transformation and Quality Improvement Program
 Demonstration Year DY7: October 1, 2017 – September 30, 2018
 State Fiscal Year FY18: September 1, 2017 – August 31, 2018
 Submitted on March 14, 2019

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

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

1. Preface

1.1 Transmittal Title Page

State	Texas Health and Human Services Commission
Demonstration Name	Texas Healthcare Transformation and Quality Improvement Program - Section 1115 Demonstration Annual Report
Approval Date	Initial approval date: December 12, 2011
Approval Period	Extension approval date: December 21, 2017 Expiration date: September 30, 2022
Demonstration Goals and Objectives	<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

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

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

According to the Special Terms and Conditions (STCs) of the Demonstration, the Texas Health and Human Services Commission (HHSC) provides its operational report for Demonstration Year (DY) 7 and State Fiscal Year 2018 (SFY18), from September 1, 2017, through August 31, 2018. This report provides the annual reporting requirements for the STAR, STAR Kids, STAR+PLUS, and the Children's Medicaid Dental Services (Dental Program). The STCs require the State to report on various topics, including: enrollment and disenrollment, network adequacy, benefits, consumer issues, quality, operation and policy, budget neutrality, demonstration evaluation, the Delivery System Reform Incentive Payment Program (DSRIP), and public forums.

During SFY18, the State contracted with 16 STAR (2 plans terminated mid-year), 10 STAR Kids, 5 STAR+PLUS, and 2 Dental Program plans. Each health plan covers one or more of the 13 STAR service delivery areas (SDAs), 10 STAR Kids and 13 STAR+PLUS SDAs while each dental plan provides statewide services. (See **Attachment A**).

There were two changes in Managed Care Organizations (MCO) in the STAR program during SFY18:

1. Christus terminated their contract with the State in February 2018; and
2. Sendero terminated their contract with the State in May 2018.

The Health and Human Services Commission (HHSC) staff evaluates and routinely monitors MCOs and dental maintenance organizations (DMOs) performance through self-reported data provided by the MCOs and DMOs and compiled by HHSC. If an MCO or DMO fails to meet a performance expectation, standard, schedule, or other contract requirement such as the timely submission of deliverables or at the level of quality required, the managed care contracts give HHSC the authority to use a variety of remedies, including:

1. Monetary damages (actual, consequential, direct, indirect, special, and/or liquidated damages (LDs)),
2. Corrective action plans (CAPs).

The information reflected in this document represents the most current information available at the time it was compiled. At the time the report is submitted to the Centers for Medicare and Medicaid Services (CMS), the sanction process between HHSC and the health and dental plans may not be complete. HHSC posts the final details of any potential enforcement actions taken against a health or dental plan each quarter on the following website:

<https://hhs.texas.gov/services/health/medicaid-chip/provider-information/managed-care-organization-sanctions>

3. Enrollment

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

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

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

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

In SFY18 from SFY Q3 to SFY Q4 total enrollment in STAR+PLUS increased by 1.21% and decreased in STAR (-1.09%), STAR Kids (-.46%), and the Dental Program (-.78%) (See **Attachment B1**).

The market share distribution ($Mktshare = \text{Total of each MCO QTR data} / \text{Program Total}$) in STAR, STAR Kids, and STAR+PLUS fluctuated less than 1% throughout SFY18. Market share distribution in the Dental Program remained steady as DentaQuest finished the year with 57.32% and MCNA had 42.68%.

The State’s enrollment broker, Maximus, reported an average of 3,671,832 unduplicated enrollments for the quarter encompassing October, November, and December 2017 for November 1st, December 1st, and January 1st effective dates for STAR, STAR+PLUS, and STAR Kids. The Dental Program reported an average of 2,935,259 total enrollments for the same time period. (See **Attachment L, Q4 pg 2**).

Enrollment Counts for the Quarter by Population

This subsection includes quarterly enrollment counts. Due to the time required for the data collection process, unique member counts per quarter are reported on a two-quarter lag. Enrollment counts are based on persons and not member months.

Enrollment Counts (DY7 Q1 October - December 2017)

Enrollment Counts (Demonstration Populations)	Total Number Served
Adults	332,003

Children	2,845,621
Aged and Medicare Related (AMR) (non MRSA - pre Sep14)	383,631
Disabled	430,783

Enrollment Counts (DY7 Q2 January - March 2018)

Enrollment Counts (Demonstration Populations)	Total Number Served
Adults	328,367
Children	2,841,243
AMR (non MRSA - pre Sep14)	382,562
Disabled	430,059

Enrollment of Members with Special Health Care Needs (MSHCN)

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

All STAR Kids and STAR+PLUS members are deemed to be MSHCN. All STAR Kids and STAR+PLUS plans reported 100% MSHCN, as required in the contract. STAR Kids and STAR+PLUS plans are required to provide service coordination to all members. In SFY18, STAR MCOs reported a total of 144,805 children and adults identified as MSHCN. See Attachment Q for detail by service area (SA) and MCO. (See *Attachment Q*)

STAR MCOs reported 21% of MSHCN had a service plan in SFY18. Additionally, four other plans reported more than 85% of MSHCN had a service plan (Aetna, Parkland, Christus and Driscoll).

Disenrollment

The State received a total of 25 disenrollment requests in SFY18 Quarter 3 and 4. (See *Attachment B2*). The State received the following in SFY18 Q3 and Q4: 9 disenrollment requests for STAR, 14 for STAR+PLUS, 2 for STAR Kids and none for the Dental Program. For 2018 Q4, the majority of requests for disenrollment were initiated by the Members or their representatives.

Provider Network

This subsection includes quarterly healthcare and pharmacy provider counts for STAR, STAR Kids, and STAR+PLUS and dental provider counts for the Dental Program. Attachment C1 provides the provider network count methodology. Across the STAR program statewide, the MCOs reported an increase (1.04%) in unique PCP providers, between SFY18 Q3 and Q4. The MCOs reported an increase (2.89%) for the STAR+PLUS program in unique PCP providers, between SFY18 Q3 and Q4. The MCOs reported an increase (1.42%) for the STAR Kids program in unique PCP providers, between SFY18 Q3 and Q4. (See *Attachment C2*)

Across the STAR program statewide, the MCOs reported an increase (4.87%) in unique specialists, between SFY Q3 and SFY Q4. The MCOs reported an increase (6.04%) for the STAR+PLUS program in unique specialists, between SFY Q3 and SFY Q4. The MCOs reported an increase (2.74%) for the STAR Kids program in unique specialists, between SFY Q3 and SFY Q4. (See *Attachment C2*)

Across the STAR program statewide, the MCOs reported an increase (3.71%) in unique pharmacies, between SFY Q3 and SFY Q4. The MCOs reported an increase (9.77%) for the STAR+PLUS program in unique pharmacies, between SFY Q3 and SFY Q4. The MCOs reported an increase (1.35%) for the STAR Kids program in unique pharmacies, between SFY Q3 and SFY Q4. (See *Attachment C2*)

Across the STAR program statewide, the DMOs reported an increase (2.62%) in unique dental providers, between SFY Q3 and SFY Q4. (See *Attachment C2*)

Attachment C3 details data reported by the MCOs regarding the number of PCPs and specialists terminated in SFY 2018. The MCOs reported a variety of reasons for provider termination, including: providers failed to re-credential, MCO terminated for cause, provider left group practice, provider moved and provider closed practice.

Network Adequacy

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

MCOs met PCP network access standards for the STAR Kids program. However, STAR and STAR+PLUS programs each had one MCO in SFYQ4 fail to meet the access standard. *Attachment H1* provides PCP network access analysis by program and county type.

Specialist network access ensures specialty provider access within the distance standard of 90% of one provider for each specialty provider. The specialty providers include: behavioral health outpatient, cardiovascular disease, orthopedist, nursing facility, pediatrician, ENT, general surgeon, OB/GYN, ophthalmologist, psychiatrist, prenatal care, therapy (Occupational, Physical, and Speech), and urologist. (See *Attachment E*)

Specialist network access data is presented by provider type with respect to metro, micro, and rural county designations (See *Attachment H2*). MCO and SDA level data is monitored by HHSC, but due to the amount of raw data, information will be provided in the narrative below for those below the 90% benchmark at the MCO and county designation level.

The following MCOs did not maintain sufficient specialty providers in SFY18 Q4:

Cardiovascular Disease

- STAR
 - Metro: Driscoll and United Healthcare (UHC)
 - Micro: Driscoll, Molina, Texas Children’s Health Plan (TCHP), and UHC
 - Rural: Amerigroup, El Paso, First Care, Superior, UHC
- STAR Kids
 - Metro: Driscoll and UHC
 - Micro: Driscoll, Superior, TCHP, and UHC
 - Rural: Amerigroup, Superior, and UHC
- STAR PLUS
 - Micro: Cigna and Molina
 - Rural: Amerigroup

ENT

- STAR
 - Metro: Amerigroup, First Care, and Molina
 - Micro: Driscoll
 - Rural: Amerigroup and First Care
- STAR Kids
 - Metro: Amerigroup
 - Micro: Driscoll
 - Rural: Amerigroup
- STAR PLUS
 - Metro: Amerigroup
 - Micro: Amerigroup, Cigna, and Molina
 - Rural: Amerigroup

General Surgeon

- STAR
 - Metro: Amerigroup and UHC
 - Micro: Driscoll
 - Rural: El Paso, Superior, and TCHP
- STAR Kids
 - Metro: TCHP
 - Micro: Driscoll and UHC

- STAR PLUS
 - Metro: Amerigroup
 - Rural: Amerigroup

Nursing Facility

- STAR+PLUS
 - Metro, Micro, and Rural: Cigna

OBGYN

- STAR
 - Rural: Superior
- STAR Kids
 - Micro: Driscoll
- STAR PLUS
 - Metro, Micro, and Rural: Cigna

Ophthalmology

- STAR
 - Metro: Amerigroup and Superior
 - Micro: Cook, First Care, Molina, Superior, and UHC
 - Rural: Amerigroup, El Paso, First Care, and Superior
- STAR Kids
 - Metro: BCBS and TCHP
 - Micro: Aetna, Superior, Cook, TCHP, and UHC
- STAR PLUS
 - Metro: Superior
 - Micro: Cigna, Molina, and Superior
 - Rural: Amerigroup and Superior

Orthopedist

- STAR
 - Metro: Amerigroup
 - Micro: Amerigroup, Driscoll, Superior, and UHC
 - Rural: Amerigroup, El Paso, First Care, and Superior
- STAR Kids
 - Metro: TCHP
 - Micro: Driscoll, Superior, and UHC
- STAR+PLUS
 - Metro: Amerigroup, Cigna, and UHC
 - Micro: Amerigroup, Cigna, and Superior
 - Rural: Amerigroup

Pediatrician

- STAR
 - Metro: Amerigroup, First Care and Superior
 - Micro: UHC
 - Rural: First Care
- STAR Kids
 - Metro: Amerigroup and Blue Cross Blue Shield (BCBS)
 - Micro: BCBS, TCHP and UHC

Prenatal Care

- STAR
 - Micro: TCHP and UHC
- STAR Kids
 - Metro: TCHP
 - Micro: Driscoll, Superior, TCHP, and UHC
 - Rural: Driscoll and Superior
- STAR+PLUS
 - Metro: Cigna
 - Rural: Amerigroup, Cigna, Molina, and Superior

Psychiatrist

- STAR
 - Metro: First Care
 - Micro: Driscoll, First Care, and Superior
 - Rural: El Paso, First Care, and Superior
- STAR Kids
 - Metro: Superior
 - Micro: Driscoll, Superior, and TCHP
 - Rural: Superior
- STAR+PLUS
 - Micro: Cigna and Superior
 - Rural: Amerigroup and Superior

Therapy (Occupational, Physical, and Speech)

- STAR
 - Metro: First Care
 - Rural: Superior
- STAR+PLUS
 - Rural: Amerigroup

Urologist

- STAR
 - Metro: Amerigroup, Community Health Choice (CHC), Driscoll, Superior, TCHP, and UHC
 - Micro: Cook, Driscoll, Superior, TCHP, and UHC
 - Rural: Amerigroup, Driscoll, El Paso, First Care, Superior, and UHC
- STAR Kids
 - Metro: Amerigroup, Driscoll, Superior, TCHP, and UHC

- Micro: Cook, Driscoll, Superior, TCHP, and UHC
- Rural: Amerigroup, Driscoll, Superior, and UHC
- STAR+PLUS
 - Metro: Amerigroup, Cigna, Superior, and UHC
 - Micro: Molina, Superior, and UHC
 - Rural: Amerigroup, Cigna, Superior, and UHC

The DMOs (DentaQuest and MCNA) met the network access standard throughout SFY18 for main dentists. **Attachment H3** provides dentist analysis by DMO and county designation.

Access to dental specialty providers (endodontist, oral surgeons, orthodontist, pediatric dental, periodontists and prosthodontists) was limited in most parts of Texas. **Attachment H4** provides dental specialty analysis by provider type and county designation.

MCOs may submit an exception request for areas of non-compliance. HHSC approves or denies the exception request based on the review of supporting information that demonstrates the MCO provider contracting efforts and assurance of access to care. If the exception request is denied, the MCO remains out of compliance and is subject to liquidated damages.

Access to Pharmacy

MCOs are required to follow the pharmacy geo-access standards and report performance outcome data quarterly for the following measures:

1. Access to a network pharmacy in rural counties within 15 miles (All Programs) – 90%
2. Access to a 24-hour pharmacy in all counties within 75 miles (All Programs)– 90%
3. Access to a network pharmacy in urban counties within 2 miles (Non-MRSA Only) – 80%
4. Access to a network pharmacy in urban counties within 2 miles (MRSA Only) – 75%
5. Access to a network pharmacy in suburban counties within 5 miles (Non-MRSA Only) – 75%
6. Access to a network pharmacy in suburban counties within 5 miles (MRSA Only) – 55%

MCOs met the pharmacy access standards in most service areas in SFY18. The following displays the SFY Q4 counts by service areas not meeting the access standards in STAR, STAR Kids, and STAR+PLUS.

1. Access to a network pharmacy in rural counties within 15 miles – 90%

STAR: Amerigroup, El Paso First, and Superior

STAR Kids: Amerigroup, Blue Cross Blue Shield of Texas (BCBS), Community First, Superior, and United Healthcare

STAR+PLUS: Amerigroup and Superior

2. Access to a 24-hour pharmacy in all counties within 75 miles – 90%

STAR: Amerigroup, Driscoll, First Care, Molina, Superior, and United Healthcare

STAR Kids: Amerigroup, Driscoll, Superior, and United Healthcare
STAR+PLUS: Amerigroup, Cigna-HealthSpring, Molina, and Superior

3. Access to a network pharmacy in urban counties within 2 miles - 80%

STAR: BCBS, Driscoll, Molina, Superior, and United Healthcare
STAR Kids: BCBS, Driscoll, Superior, and United Healthcare
STAR+PLUS: Cigna-HealthSpring, Molina, and Superior

4. Access to a network pharmacy in urban counties within 2 miles – 75%

STAR: Amerigroup, Superior
STAR Kids: None
STAR+PLUS: Superior

5. Access to a network pharmacy in suburban counties within 5 miles – 75%

STAR: Atena, Amerigroup, Community Health Choice, Molina, Superior, and Texas Children’s Health Plan
STAR Kids: Amerigroup, Superior, and United Healthcare
STAR+PLUS: Amerigroup, Molina, Superior and United Healthcare

6. Access to a network pharmacy in suburban counties within 5 miles – 55%

STAR: Amerigroup, FirstCare, and Superior
STAR Kids: Amerigroup, and Superior
STAR+PLUS: Amerigroup, Superior and United Healthcare

HHSC continues to work closely with MCOs to work toward complete compliance with the Pharmacy geo-access standards. The MCOs submit an exception request for service areas not meeting the pharmacy access standards. HHSC approves or denies the exception request based on the review of supporting information that demonstrates the MCO provider contracting effort and assurance of access to care. If the exception request is denied, the MCO remains out of compliance and the MCO is subject to liquidated damages. Attachment J provides pharmacy geo-access performance summary. (See *Attachment J*)

MCO’s Pharmacy Benefits Managers (PBM) may only contract with pharmacy providers that are enrolled with the HHSC’s Vendor Drug Program (VDP). MCO’s PBM assist all members with gaining access to care, this includes but is not limited mail-order delivery which may be accessed by both members who

require maintenance medications to manage chronic health conditions or for members who lack access to transportation where a pharmacy provider network deficiency exists. Mail order pharmacies are not included in travel time and distance performance; however, MCOs may utilize mail-order pharmacies, including specialty pharmacies that only mail prescriptions, to ensure member have access to care.

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. All MCOs and DMOs, except Cook Children’s and Texas Children’s met the 80% standard for providers accepting the new patients in SFY18. Cook Children’s performance in STAR program ranged from 69-70%. Texas Children’s performance in STAR ranged from 78-79% and in STAR Kids from 69-71%. Although Cook Children’s did not meet the benchmark for FY2018 for the STAR nor STAR Kids programs, the plan contracts with several PCPs that elect to maintain a closed panel. The PCPs provide services to a certain number of Medicaid clients as well as other clients not enrolled in these programs. In addition, Cook Children’s has the flexibility of working with certain PCPs with a closed panel to agree to take on new members; this is normally achieved on a case-by-case basis. This agreement has allowed Cook Children’s to maintain these providers. Texas Children’s also works with several providers that chose to have a closed panel and Texas’ Children’s continues to work with providers to maintain open panels in order to meet member needs.

Accessibility and Language Compliance

HHSC requires MCOs to make best efforts to ensure that PCPs are accessible 24 hours per day, 7 days a week and outlines very specific criteria for what constitutes compliance in 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 that routes 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 where the providers are non-compliant. 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 8.00% to 100%. Providers who are not in compliance with HHSC's contractual standards receive phone calls or letters detailing the contractual 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, trainings) 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.

MCOs submitted the provider’s language and accessibility survey results by program and SDA for SFY18. The survey results are as follow: STAR program provider compliance was 76% in accessibility and 77% in language, STAR Kids program provider compliance was 82% in accessibility and 83% in language, and STAR+PLUS program provider compliance was 60% in accessibility and 63% in language.

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 work toward compliance with the OON utilization standards. MCOs may submit a Special Exception Request (SERT) for areas of non-compliance. HHSC approves or denies the SERT based on the review of supporting information that demonstrates the MCOs unsuccessful 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 liquidated damages. **Attachment D2** provides OON utilization performance summary.

The following plans listed below exceeded OON utilization standards in 2018 SFQ4. The State will continue to monitor these plans and will require corrective action or other remedies if appropriate.

STAR

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

STAR+PLUS

- Cigna: Hidalgo and Tarrant SDAs
- Molina: Dallas, Harris, and Hidalgo SDAs
- Superior: Dallas SDA
- United: Harris and Jefferson SDAs

STAR Kids

- Aetna: Tarrant SDA
- Amerigroup: Lubbock and Harris SDAs
- Children's Medical: Dallas and Nueces SDAs
- United: MRSA Central SDA

HHSC has approved special exception requests for the following MCOs/SDAs:

- Aetna (STAR-Bexar and Tarrant SDAs)

- Amerigroup (STAR-Harris and MRSA Central SDAs, STAR Kids- Harris and Lubbock SDAs and STAR+PLUS-Tarrant and Harris SDAs)
- First Care (STAR-MRSA West SDA)
- Texas Children’s (STAR-Harris SDA)
- Superior (STAR+PLUS-Dallas and MRSA West SDAs)
- Cigna (STAR+PLUS-Hidalgo and Tarrant SDAs)
- United (STAR+PLUS-Harris and MRSA Central SDAs)
- Dell Children’s (STAR- Travis)
- Children’s Medical Center (STAR Kids- Dallas)

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

Enrollment Issues/Trends: New and Continued

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

3.2 Anticipated Changes to Enrollment

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

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

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

4. Benefits

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

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

- *Use of incentivized services*

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

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

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

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

Service Utilization

Attachment S depicts expenditure charts by program and claim type for SFY17. The total spending in STAR, STAR Kids, and STAR+PLUS in SFY 17 as follows: professional claims was 36.47%, outpatient was 23.90%, drug was 17.56%, inpatient was 15.88%, and dental spending was 6.19%. "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 account for about one-third of expenditures.

4.1 Benefit Issues: New and Continued

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

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

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

4.2 Anticipated Changes to Benefits

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

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

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

Maternal Depression Screening

As of July 1, 2018 maternal depression screenings conducted at an infant's Texas Health Steps Checkup are a benefit of Texas Medicaid. Texas Health and Safety Code, Section 62.1511 requires Medicaid and CHIP to reimburse a maternal depression screening for the mother of an enrollee regardless of whether the mother is also an enrollee.

Peer Support Services

Peer support is an evidence-based practice in which peers use their life experiences recovering from mental health or substance use conditions, along with skills learned in formal training, to deliver strengths-based, person-centered services. Texas Government Code, Section 531.09, HHSC assembled a stakeholder workgroup to provide input on the development of Medicaid rules to define requirements for training, certification, scope of services, and supervision of certified peer specialists. Rule adoption occurred December 28, 2018.

Breastfeeding Support Services

Texas Medicaid developed additional medical necessity criteria to improve access to breast pump equipment for breastfeeding mothers and their infants. Updates included: addition of breast pump equipment specifications; new medical necessity criteria for mothers and infants; updated frequency limitations for breast pumps and parts; changes to prior authorization requirements; updated documentation requirements.

Wound Care Equipment and Supply

Major changes and updates to the medical benefit policy, for wound care equipment and supply, include the following: updating benefit language, revised quantity limitations, new prior authorization criteria, updated documentation requirements, a new prior authorization form, and updated place of service and provider type.

5. Demonstration-related Appeals

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

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

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

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

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

Complaints and Appeals Received by MCOs

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

The total number of STAR complaints and appeals received by plans decreased from 3502 in 2018 SFYQ3 to 3186 in 2018 SFYQ4. STAR plans collectively reported 1507 member complaints, 1254 member appeals and 425 provider complaints in 2018 SFYQ4.

The total number of STAR Kids complaints and appeals received by plans decreased from 1748 in 2018 SFYQ3 to 1585 in 2018 SFYQ4. STAR Kids plans collectively reported 212 member complaints, 1206 member appeals and 167 provider complaints in 2018 SFYQ4.

The total number of STAR+PLUS complaints and appeals received by plans increased from 3731 in 2018 SFYQ3 to 4265 in 2018 SFYQ4. STAR+PLUS plans collectively reported 1980 member complaints, 1600 member appeals and 685 provider complaints in 2018 SFYQ4.

The total number of DMO complaints and appeals received by plans increased from 448 in 2018 SFYQ3 to 599 in 2018 SFYQ4. DMO plans collectively reported 258 member complaints, 315 member appeals and 26 provider complaints in 2018 SFYQ4.

The following MCOs did not meet performance standards during SFY 18 Q4 Month 3:

STAR

Member Appeals

- Scott and White, and United Healthcare (UHC) did not meet the performance standards for timely resolution of member appeals.
 - Scott and White stated the appeals and grievances team has hired a new manager and there are new oversight processes in place to ensure timely response to member appeals.
 - UHC reports, of 28 appeals resolved, 1 behavioral health (BH) appeal was not resolved within 30 days. The appeal was not resolved timely due to processing delays related to BH appeals entry and staffing challenges.

Provider Complaints

- Molina, and Superior did not meet the performance standards for timely resolution of provider complaints.
 - Molina is currently on a CAP.

Member Complaints

- Amerigroup did not meet the performance standards for timely resolution of member complaints.
 - Amerigroup stated a singular case caused the 90% performance level; The Grievance Intake Representative failed to set up the 1 case in a timely manner. Disciplinary action has been taken with the Grievance Intake Representative in response to the untimely case. Additionally, the MCO reported a strengthened oversight process to perform daily monitoring of cases in each representative's queue to ensure all cases are being set up timely upon receipt.

STAR+PLUS

Member Appeals

- Cigna-HealthSpring, and United Healthcare did not meet the performance standards for timely resolution of member appeals.
 - Cigna-HealthSpring reported one-member appeal was closed untimely as the result of a user error involving a member appeal form. Coaching was provided and the member's services continued throughout the appeal process without disruption.
 - UHC reported of 133 appeals resolved, 3 BH appeals were not resolved within 30 days. The appeals were not resolved timely due to processing delays related to BH appeals entry and staffing challenges.

Provider Complaints

- Molina, and UHC did not meet the performance standards for timely resolution of provider complaints.
 - Molina did not meet standards of 98%. Molina is currently on a CAP.
 - UHC did not meet the performance standard for total provider complaints resolved within 30 days. The MCO is subject to LDs. MCOs response as to the cause of the noncompliance: 1 complaint was resolved more than 30 days after receipt. This represents a 4.6% decrease from 2018Q3 (100%). Of 21 complaints resolved, 1 was not resolved within 30 days. Although the complaint was addressed within 30 days, the complaint resolution letter was mailed to the provider 31 days after receipt, due to a data entry error by the analyst

Member Complaints

- Molina and Superior did not meet the performance standards for timely resolution of member complaints.
 - Molina is currently on a CAP.
 - Superior stated there was a change in roles of team member no longer doing intakes. The team member worked on the complaint once they realized the complaint needed to be processed and advised team members of the complaint intake changes.

STAR Kids

Member Appeals

- Aetna, Cooks Children, and United Healthcare did not meet the performance standards for timely resolution of member appeals.
 - Aetna reported missing the target by one appeal. The reason for not resolving in a timely manner was strictly insufficient attention applied by the team in assuring resolution was completed within the required timeframe. A refresher training has been completed to assure this is not a continuous trend.
 - Cooks Children (CCHP) stated CCHP has reviewed the prior submission and would like to submit a corrected version. In reviewing the data, CCHP noted that there was both a PT and an OT appeal for a member. A request for an extension was requested and acknowledged and granted by CCHP. A resolution was provided within the 14-day extension period. CCHP corrected the spreadsheet to reflect 2 standard appeals resolved within 14 days as it was previously completed incorrectly. Although the spreadsheet reflects 94.87% for standard appeals, please notice the 5.41% for appeals over 30 days. These are inclusive of the two appeals for which an extension was requested, thus reflected by the 100% for standard 14-day extension. This is permissible per section 8.2.6.2 of the Medicaid MCO Member Appeals Process. It is the understanding of CCHP that this correction will reflect compliance on behalf of CCHP regarding appeal resolution timeframes. The MCO resubmitted the report putting them in compliance with % resolved over 30 days, but still out of compliance with % resolved within 30 days 98%(94.87).
 - UHC stated of 68 appeals resolved, 2 were not resolved within 30 days:1 behavioral health appeal was not resolved within 30 days due to staffing challenges and 1 appeal had a 14-day extension applied at the request of the member's representative. The appeal was not resolved within 44 days with an extension, and was resolved 59 days after receipt due to the health plan's decision to extend the appeal further in the best interests of the member, and the health plan's efforts to accommodate the requests of the member's representative. The appeal review was rescheduled twice and was completed after several attempts to correspond with the member's representative.

Provider Complaints

- Texas Children's Health Plan (TCHP) did not meet the performance standards for timely resolution of provider complaints.
 - This is the 3rd occurrence in 24 months for TCHP and HHSC has recommended LDs for not meeting performance standards.

Member Complaints

- Driscoll, and Superior did not meet the performance standards for timely resolution of member complaints.
 - Driscoll- The MCO stated the delay in response to one of the member complaints was due to delays by the DME company inadequately repairing the equipment (wheelchair)

for the member. The delay in response to one-member complaint was due to the STAR Kids complaints staff being out ill and causing a delay in the resolution letter being sent out on 10/2/2018. This complaint was received on 8/22/2018 and was resolved on 8/26/2018.

- Superior- MCO indicates the dates were entered incorrectly when complaint was logged. Superior Intake Supervisor has begun to monitor to ensure the correct dates are entered.

The dental program met standards throughout SFY18. *Attachment N1, N2, and N3* provides complaints and appeals performance summary.

Complaints received by the State

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

The OMCAT received a total of 939 complaints through its helpline in SFY18 Q4 showing a 2% decrease in complaints as compared to the third quarter. The percentage of change, by each program, between SFY Q3 and SFY Q4 is as follows: STAR (11% decrease), STAR+PLUS (7% increase), STAR Kids (9% decrease), and the Dental program (29% decrease). The top three reasons for OMCAT complaints in the fourth quarter include: access to long term services issues, access to in-network specialty care and provider issues, and access to prescriptions issues.

MCCO received a total of 110 legislative complaints in SFY18 Q4 showing a 5% increase as compared to the third quarter. The percentage of change, by each program, between SFY18 Q3 and Q4 is as follows: STAR (14% increase), STAR+PLUS (47% increase), and STAR Kids (22% decrease). The dental program received 2 complaints in Q3 and did not receive any complaints in Q4. The top three reasons for legislative complaints in SFY18 Q4 as follows: member claim/billing issues, reduction/cancellation of services issues, and benefit issues.

MCCO received a total of 264 member complaints in SFY18 Q4 with a 9% decrease as compared to the third quarter. The percentage of change between, by each program, between SFY Q3 and SFY Q4 is as follows: STAR (8% decrease), STAR+PLUS (16% decrease), and STAR Kids (12% increase). The dental program received 4 complaints in SFY Q3 and 6 complaints in SFY Q4. The top three reasons for member complaints in SFY Q4 were access to care, benefit, and member claim/billing issues.

MCCO received a total of 794 provider complaints in SFY18 Q4 with a 2% decrease as compared to the third quarter. The percentage of change, by each program, between SFY Q3 and SFY Q4 is as follows: STAR (7% decrease), STAR Kids (10% decrease), and STAR+PLUS (6% increase). The dental program received 10 complaints in SFY Q3 and 14 complaints in SFY Q4. The top three reasons for provider complaints in SFY Q4 were: denial of claim, denial/delay of payment, and member claim/billing issues.

Attachment O provides complaints performance summary.

Provider Fraud and Abuse

MCOs and DMOs are required to send referrals regarding Medicaid waste, abuse, or fraud to the HHSC Office of Inspector General (OIG). The OIG's office received a total of 147 fraud and abuse referrals from MCOs in SFY18. The OIG returned 36 of those cases to the MCO to determine appropriate action, launched an MPI full scale investigation of 38 cases, referred 37 cases to the Texas State Board of Pharmacy, transferred 11 cases to Litigation and 7 cases to Inspector General (IG) Medical Services, and closed 37 cases.

The OIG's office received a total of 34 fraud and abuse referrals from DMOs in SFY18. OIG returned 10 of those cases to the DMO to determine appropriate action, launched an MPI full scale investigation for 16 cases, transferred 4 cases into existing full scale cases, transferred 1 case Litigation and 3 cases to OIG Medical Services, and closed 4 cases.

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

Hotline Performance

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

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

Member Hotline (STAR/STAR+PLUS/CHIP-SFY 18 Q4 Month 3)

- All MCOs met the requirement to answer calls by the 4th ring and had less than 1% receive a busy signal.
- All MCOs (except Amerigroup) below the 80% standard for answered by a live person within 30 seconds.
- Amerigroup indicated they began an initiative to improve their First Call resolution. The initiative requires call center staff to take the time to help ensure they address each member's questions completely, which is necessitating a bit more time on each call increasing hold rates (initially) for which they indicated they have sought to address via the remediation actions noted. Sendero is the only MCO exceeding the <7% abandoned calls standard.
 - Amerigroups parent company Central Health, transitioned to Ring Central a web based phone application. Due to the transition, on August 1st 2018, Customer Service Representatives experienced a period of inability to login to the new phone system resulting in the high abandonment rate.
- All MCOS average hold times were under two minutes.

Member Hotline (STAR Kids-SFY18 Q4 Month 3)

- All MCOs met the requirement to answer calls by the 4th ring and had less than 1% receive a busy signal.
- All MCOs exceeded the <7% abandoned calls standard.
- Children’s Medical Center (CMC) was the only MCO below the 80% standard for answered by a live person within 30 seconds.
 - CMC reported a member call volume increase of 33.78% (349 calls) for August. Due to calls from LAR’s for information regarding THSteps and immunizations for preparation for back to school for members. Agents that were skilled to answer member and provider hotlines were assisting the provider hotline due to the provider call volume increase of 12.00% (477 calls) for August. This increase was due to an increase in authorizations for services and verification of authorizations and verifying status of claim appeals. Additionally, there was an employee on leave in the month of August and scheduled PTO.
- All MCOs average hold times were under two minutes.

Behavioral Health Hotline (STAR/STAR+PLUS/CHIP-SFY 18 Q4 Month 3)

- All MCOs met the requirement to answer calls by the 4th ring and had less than 1% receive a busy signal.
- All MCOs met the 80% standard for calls answered by a live person within 30 seconds.
- All MCOs average hold times were under two minutes.
- Sendero was the only MCO exceeding the <7% abandoned calls standard.
 - The MCO did not meet the % call abandonment rate, they indicated their subcontractor Beacon experienced challenges with their call routing as a result of a transition from Cisco to Avaya in July, and also resulting in higher hold rates.

Behavioral Health Hotline (STAR Kids-SFY 18 Q4 Month 3)

- All MCOs met the requirement to answer calls by the 4th ring and had less than 1% receive a busy signal.
- All MCOs met the 80% standard for calls answered by a live person within 30 seconds.
- Aetna was the only MCO exceeding the <7% abandoned calls standard.
 - MCO states there were a total of 10 calls and 1 abandoned call, which caused their overall abandon rate to exceed 7%. There were not enough calls to make up for the missed call.
- All MCOs average hold times were under two minutes.

Provider Hotline (STAR/STAR+PLUS/CHIP-SFY Q4 Month 3)

- All MCOs had less than 1% of calls receive a busy signal.

- All MCOs met the standard to answer calls by the 4th ring.
- Sendero was the only MCOs exceeding the <7% abandoned calls standard.
 - The MCO did not meet the % call abandonment rate, they indicated their subcontractor Beacon experienced challenges with their call routing as a result of a transition from Cisco to Avaya in July, and also resulting in higher hold rates.
- Sendero was the only MCO to exceed the average hold times under two minutes.
 - The MCO did not meet the % call abandonment rate, they indicated their subcontractor Beacon experienced challenges with their call routing as a result of a transition from Cisco to Avaya in July, and also resulting in higher hold rates.

Provider Hotline (STAR Kids-SFY 18 Q4 Month 3)

- All MCOs met performance standards for provider hotlines for month 3 of SFY18 Q4.

DMO member and provider hotline performance for DentaQuest and MCNA met all standards throughout SFY18.

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

5.1 Appeals Issues: New and Continued

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

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

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

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

5.2 Anticipated Changes to Appeals

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

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

6. Quality

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

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

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

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

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

1.1 CMS Adult and Child Core Measures

Texas reported Adult and Child core measures in fiscal year 2017. There were two measure changes for the year. The low birth weight measure in the core set has historically been reported using the Agency for Healthcare Research and Quality (AHRQ) specifications but CMS asked HHSC to report using the CMS/CDC specifications. The substance use disorder measure is an extra measure CMS asked HHSC to report on for participating in the innovation accelerator program.

For five of the Adult Core Set measures the state used a different methodology from the prior year for calculating the rate which impacts comparability across years.

1. Adult Body Mass Index Assessment
2. Antidepressant Medication Management
3. Breast Cancer Screening
4. Cervical Cancer Screening
5. Chlamydia Screening in Women Ages 21-24

For five of the Child Core Set measures the state used a different methodology from the prior year for calculating the rate which impacts comparability across years.

- Children and Adolescents' Access to Primary Care Practitioners
- Chlamydia Screening in Women Ages 16-20
- Developmental Screening in the First Three Years of Life
- Frequency of Ongoing Prenatal Care
- Timeliness of Ongoing Prenatal Care

6.1 Quality Issues: New and Continued

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

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

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

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

6.2 Anticipated Changes to Quality

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

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

7. Other Demo Specific Metrics

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

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

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

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

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

7.1 Other Metric Issues: New and Continued

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

For each issue, the state should provide a brief summary that references the data reported in Appendix X, the estimated number of impacted beneficiaries (if applicable), the known or suspected cause(s) of the issue, and the plan to remediate the issue, including a timeline for resolution (if applicable). The state

should also use this section to provide updates on other issues identified in previous reports. When applicable, the state should also note when issues are resolved.

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

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

7.2 Anticipated Changes to Other Metrics

The state should use this narrative section to explain any anticipated program changes that may impact other metrics. ”. The recommended word count for this section is 150 words or less.

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

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

8. Financial/Budget Neutrality

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

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

8.1 Financial/Budget Neutrality Issues: New and Continued

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

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

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

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

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

DY7 Q3 April -June 2018

Eligibility Groups Used in Budget Neutrality Calculations

Eligibility Group	Month 7 (Apr 2018)	Month 8 (May 2018)	Month 9 (Jun 2018)	Total for Quarter Ending June 2018
Adults	283,784	283,642	282,010	849,436
Children	2,624,040	2,613,125	2,604,279	7,841,445
AMR	354,534	354,342	354,209	1,063,084
Disabled	416,792	416,068	414,629	1,247,489

Eligibility Groups Not Used in Budget Neutrality Calculations

Eligibility Group	Month 7 (Apr 2018)	Month 8 (May 2018)	Month 9 (Jun 2018)	Total for Quarter Ending June 2018
Adults in MRSA	-	-	-	-
Foster Care	35,947	36,114	36,371	108,432
Medically Needy	180	168	162	509
CHIP-Funded	265,308	266,785	267,405	799,498
Adoption Subsidy	-	-	-	-
STAR+PLUS	18,092	18,194	18,294	54,580
217-Like HCBS				

DY7 Q4 July - September 2018

Eligibility Groups Used in Budget Neutrality Calculations

Eligibility Group	Month 10 (Jul 2018)	Month 11 (Aug 2018)	Month 12 (Sep 2018)	Total for Quarter Ending September 2018
Adults	284,244	283,805	286,763	854,812
Children	2,606,058	2,604,884	2,617,560	7,828,502
AMR	354,946	355,342	355,418	1,065,706
Disabled	414,991	413,259	413,315	1,241,564

Eligibility Groups Not Used in Budget Neutrality Calculations

Eligibility Group	Month 10 (Jul 2018)	Month 11 (Aug 2018)	Month 12 (Sep 2018)	Total for Quarter Ending September 2018
Adults in MRSA	-	-	-	-
Foster Care	36,244	36,226	36,284	108,754
Medically Needy	174	172	172	518
CHIP-Funded	265,716	264,087	263,017	792,821
Adoption Subsidy	-	-	-	-
STAR+PLUS 217- Like HCBS	18,375	17,956	17,897	54,228

8.2 Anticipated Changes to Financial/Budget Neutrality

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

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

9. Demonstration Operations and Policy

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

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

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

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

Claims Summary

The MCOs and DMOs submit monthly claims summary reports (CSR) to HHSC for the following services: acute care, behavioral health (BH), vision services, pharmacy claims, and long term services and supports (LTSS). MCOs and DMOs are required to pay clean claims and appealed claims on a timely basis, as well as resolve pending claims in a timely manner. 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: <1%
- clean electronic claims adjudicated within 18 Days: >98%
- clean non-electronic (paper) claims adjudicated within 21 Days: >98%

Both DMOs met the dental claim standards during SFY 18 Q3 and Q4. The MCOs not in compliance with the claims adjudication standards are listed below.

STAR (SFY 18 Q4 Month 3)

Acute Care Claims

- BCBS
- Community First
- Driscoll
- Molina
- TCHP
- Superior

Behavioral Health Services Organization Claims

- CHC
- Community First
- Cook Children's
- Driscoll, Parkland
- TCHP
- Parkland
- Superior
- Texas Children's Health Plan

STAR+PLUS (SFY 18 Q4 Month 3)

Acute Care Claims

- Superior

STAR Kids (SFY 18 Q4 Month 3)

Acute Care Claims

- Children's Medical Center
- Community First
- Driscoll
- Superior

Behavioral Health Services Organization Claims

- Community First
- Cook Children's
- Children's Medical Center
- Driscoll Children's
- TCHP

Long Term Care Organization’s Claims

- Children’s Medical Center
- Community First
- Texas Children’s

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

Litigation Summary

Consideration 1:

Type of Consideration	<i>Ongoing litigation</i>
Summary of Consideration	<p><i>Frew, et al. v. Phillips, et al.</i> (commonly referred to as <i>Frew</i>). The state is in ongoing federal-court level litigation regarding Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefits. <i>Frew</i> was filed in 1993 and was brought on behalf of individuals under age 21 enrolled in Medicaid and eligible for 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 district 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.</p> <p>In 2014, the parties jointly agreed to dismiss most of the Toll-Free Numbers corrective action order,</p>

Medicaid Section 1115 Monitoring Report
Texas Healthcare Transformation and Quality Improvement Program
Demonstration Year DY7: October 1, 2017 – September 30, 2018
State Fiscal Year FY18: September 1, 2017 – August 31, 2018
Submitted on March 14, 2019

	<p>and the related consent decree paragraph. One toll-free number remains under the Corrective Action Order and court monitoring.</p> <p>On January 20, 2015, the district court dismissed the Corrective Action Order: Adequate Supply of Health Care Providers and several paragraphs of the consent decree relating to an adequate supply of healthcare providers. Plaintiffs appealed. On March 28, 2016, the Fifth Circuit affirmed most of the district court's opinion but vacated and remanded to the district court for further proceedings portions of the district court's order regarding provider "shortages."</p>
Date and Report in Which Consideration Was First Reported	Q1 2015
Summary of Impact	The consent decree and corrective action orders touch upon many Medicaid program areas, and generally require the state to take actions intended to ensure access to or measure access to Medicaid services for children. The Texas Medicaid program must consider these obligations in many policy and program decisions for Medicaid services available for persons under age 21.
Estimated Number of Beneficiaries	3,190,511 (estimated as of August 2018).
If Issue, Remediation Plan and Timeline for Resolution / Updates in Status if Previously Reported	Defendants HHSC and DSHS will continue to follow the obligations in the remaining portions of the consent decree and corrective action orders until they are dismissed by the court.

10. Implementation Update

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

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

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

Health IT Strategic Plan Update

HHSC has conducted two interagency workgroup sessions on the potential uses of Health IT. The program areas in attendance included Medicaid, Public Health, Long Term Care, State Hospitals and State Supported Living Centers, Behavioral Health (BH), and Intellectually and Developmentally Disabled (IDD). Subsequent smaller sessions have been held with Medicaid and IDD/BH staff to identify business processes where information on the healthcare outcomes of the Medicaid population could add value, improve decision-making, and potentially decrease costs of program operations in areas in which the progress is measurable. The business areas developed use cases based on the data elements available through the consolidated clinical document architecture (C-CDA). These use cases will be the basis for formulating Medicaid's Health IT vision and goals for the next 5 to 10 years.

Next steps include an external stakeholder conference to ensure the planning process is in alignment with the direction of the state's health IT ecosystem; a gap analysis of where we are versus where we want to be and filling that gap by refining Medicaid's role in the governance of Health IT in Texas; strategies for moving and/or incentivizing a more connected and interoperable ecosystem; and the involvement of HHS advisory committees in the plan's review process.

HHSC remains on track to submit the Health IT Plan to CMS by the required deadline outlined in STC 39, October 1, 2019.

11. Demonstration Evaluation Update

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

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

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

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

Overview of Evaluation Activities

HHSC completed the following 1115 waiver evaluation activities during SFY18:

- HHSC submitted the initial Draft Evaluation Design Plan (dated April 19, 2018) to CMS on April 18, 2018. HHSC received CMS feedback on the Evaluation Design Plan on May 10, 2018.
- HHSC submitted the revised Evaluation Design Plan (Version 2.1, July 9, 2018) to CMS on July 9, 2018. CMS approved the revised Evaluation Design on August 2, 2018. HHSC posted the approved Evaluation Design Plan to the HHS website at: <https://hhs.texas.gov/laws-regulations/policies-rules/waivers/medicaid-1115-waiver/waiver-overview-background-resources>.
- HHSC began soliciting proposals for an external evaluator. HHSC sent a Project Proposal Quote Request (PPQR) to a list of Texas Universities on September 17, 2018.
- HHSC initiated internal discussions related to data dissemination for the external evaluator.
- HHSC is exploring options for surveying new populations carved into managed care (Adoption Assistance (AA), Permanency Care Assistance (PCA), and Medicaid for Breast and Cervical Cancer (MBCC)) through the state’s EQRO

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

Type of Evaluation Deliverable	Due Date	State Notes or Comments	Description of Any Anticipated Issues
DRAFT Evaluation Design Plan	4/20/2018	HHSC received feedback on DRAFT Evaluation Design Plan from CMS on May 10, 2018.	
Evaluation Design Plan, Version 2.1, July 9, 2018	7/09/2018	Revised Evaluation Design Plan submitted to CMS. It was approved by CMS on August 2, 2018.	
Interim Evaluation Report	9/30/2021 <i>(or upon application for renewal)</i>		<i>No issues anticipated at this time</i>
Summative Evaluation Report	3/30/2024		<i>No issues anticipated at this time</i>

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

12. Other Demonstration Reporting

The state should use this section to cover pertinent information not captured in the above sections or in related appendixes. This includes any of the following, if applicable:

- *Real or anticipated issues submitting timely post-approval demonstration deliverables, including a plan for remediation*

Home and Community Based Services (HCBS) Regulations

- HHSC is committed to ensuring compliance with the federal HCBS regulations. In accordance with STC 43(a), HHSC has taken the following steps towards compliance:
 - In May 2017, CMS announced an extension deadline for all states to be in compliance with HCBS rules by March 2022. HHSC intends to resubmit the Texas Statewide Settings Transition Plan detailing compliance, remediation strategies, and timelines for the STAR+PLUS waiver program operating under the State’s 1115 Demonstration waiver to CMS in 2019.
 - Throughout 2017, HHSC has continued to provide stakeholders with updated information regarding the Texas transition plan and opportunities to answer stakeholder questions. HHSC is developing the compliance plan that will be included in the amended Texas Statewide Settings Transition Plan. Texas plans to resubmit the amended plan in 2019.
 - HHSC surveyed a representative sample of individuals served through HCBS STAR+PLUS who received assisted living or adult foster care services as part of its validation of the provider surveys. HHSC has analyzed the survey results and is using those results to inform the development of the compliance plan mentioned above.

Delivery System Reform Incentive Payment Program (DSRIP)

Delivery System Reform Incentive Payment Program (DSRIP) evolved from project-level reporting to provider-level outcome reporting to measure the continued transformation of the Texas healthcare system during DY7. DSRIP providers began reporting on required reporting categories at the provider system level, rather than the project level. In Q1 of DY7, CMS approved the five-year renewal of the 1115 waiver, and HHSC continued negotiations with CMS to approve the DSRIP protocols for DY7-8. In Q2, on January 19, 2018, CMS approved the DSRIP protocols. Also during Q1, providers had their second opportunity to report achievement of DY6 milestones and metrics and carry forward of DY5 milestones/metrics. In total for October DY6 reporting, providers reported achievement of 67% of the 10,094 DY5-6 Category 1-4 milestones/metrics and HHSC approved 96.6% of what was reported. Based on available Intergovernmental Transfer (IGT), \$2,372,402,849 was paid for DSRIP in January 2018, for a total of \$13.1 billion in DY1-6 DSRIP payments to date.

Regional Healthcare Partnerships (RHP) updated their plans during Q3, which HHSC reviewed and approved. This included providers selecting their outcome measures for reporting during DY7-8. Also during Q3, providers reported on DY6 carry forward, and their July payment reflected payment for submitting the DY7-8 RHP Plan update as well as any approved DY6 carry forward milestones and metrics. Providers had an early opportunity during Q4 to report baselines for their outcome measures for HHSC to review and provide any technical assistance before the regular reporting period in October 2018 and before performance is reported in DY8. **Attachment X** provides the providers’ project summaries. **Attachment Y** provides estimated remaining payments for DY6-7. **Attachment W** provides DSRIP report by RHP.

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

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

deliverables associated with the evaluation should be listed separately in the Demonstration Evaluation Update section.

12.1 Post Award Public Forum

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

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

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

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

- The state has provided the summary of the post-award forum (due for the period during reporting during which the forum was held and in the annual report).
- There was not a post-award public forum held during this reporting period and this is not an annual report.

The Medical Care Advisory Committee (MCAC) met on May 17, 2018. The date, time, and location of MCAC were published on HHSC's website prior to the meeting as well as the link to the last 1115 Annual Report. During the meeting information and updates were given pertaining to the DSRIP Program DY 7-8 rules, 1115 Waiver renewal approval which included changes to the UC pool and DSRIP pool. Additionally, HHSC provided information about the Quality Incentive Payment Program for Nursing Facilities.

The State Medicaid Managed Care Advisory Committee (SMMCAC) met on March 14, 2018 (DY7 Q2). The date, time, and location of MCAC were published on HHSC's website prior to the meeting. HHSC's Deputy State Medicaid Director provided an overview of the HHSC operational plan and agency direction. HHSC's Interim Director of Healthcare Transformation Waiver Medicaid and CHIP Services provided an update on the 1115 Waiver. Public comment was also received and documented at this meeting. The State Medicaid Managed Care Advisory Committee met on June 18, 2018 (DY7 Q3). The date, time, and location of SMMCAC were published on HHSC's website prior to the meeting. HHSC provided an update on general managed care and referenced PowerPoint entitled "SMMCAC Managed Care Update". HHSC presented on the intellectual and developmental disabilities carve-in. Public comment was also received and documented during this meeting.

13. Notable State Achievements and/or Innovations

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

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

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

14. Report Attachments

Attachment A – Managed Care Organizations By Service Delivery Area. The attachment includes a table of the health and dental plans by Service Delivery Area.

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

Attachment B2 -- Disenrollment Summary. The attachment includes annual and quarterly Dental, STAR, STAR Kids 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 D2 – Out-of-Network Utilization. The attachment summarizes 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.

Attachment L – Enrollment Broker Summary Report. The attachment provides a summary of outreach and other initiatives by the Enrollment Broker to ensure access to care.

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

Attachments N1-N3 – MCO Complaints. The attachments include Dental, STAR, STAR Kids, and STAR+PLUS complaints and appeals received by plans.

Attachment O – Complaints to HHSC. The attachment includes information concerning Dental, STAR, STAR Kids, and STAR+PLUS complaints received by the State.

Attachment P – Budget Neutrality. The attachment includes actual expenditure and member-month data as available to track budget neutrality. This document is updated with additional information in each quarterly report submission.

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.

Medicaid Section 1115 Monitoring Report
Texas Healthcare Transformation and Quality Improvement Program
Demonstration Year DY7: October 1, 2017 – September 30, 2018
State Fiscal Year FY18: September 1, 2017 – August 31, 2018
Submitted on March 14, 2019

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. Provides service utilization charts for SFY 17.

Attachments V1-V4 – Claims Summary. The attachments are summaries of the MCOs' claims adjudication results for STAR, STAR Kids, STAR+PLUS and the Dental.

Attachment W – DSRIP Reporting by RHP. The attachment includes a summary of the Demonstration Year 7 DSRIP reporting by RHP and annual reports from all anchors

Attachment X - DSRIP Project Summary DY7. The attachment includes a summary of the accomplishments, progress on core components, and Continuous Quality Improvement (CQI) for each DSRIP project.

Attachment Y- DSRIP Remaining Payments for DY 6-7. Reported biannually after DSRIP payments are distributed.